

When Mental Healthcare professionals cannot do  
the right thing: An exploration of how clinical  
psychologists make sense of their experiences of  
Moral Distress and conflicts of conscience

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## ABSTRACT

**Background:** Moral distress is an established concept in the healthcare ethics lexicon. However, scholarship has mainly been within nursing. Although many of the known sources of moral distress are common across the NHS - where demands have increased, alongside a reduction in resources, support and control - little is known about clinical psychologists' experiences of situations they consider ethically problematic and morally distressing.

**Methods:** Critical Narrative Analysis was carried out on data collected from semi-structured interviews with five clinical psychologists (CP's) working in the National Health Service to explore their experiences of MD.

**Results:** The difficulties raised, correspond to long-established issues in the NHS. The clinicians' narratives positioned CP's as 'at war' with an inaccessible, inappropriate, and unjust healthcare system. They told stories of being constantly confronted with ethically difficult scenarios, imposed by deteriorating, under-funded, under-resourced healthcare services and of being expected to work in ways that they felt unfitting and unsafe. It was witnessing this harm, and feeling powerless in the battle, that led to distress. Although clinicians wanted to create change, often they found themselves silenced, scapegoated and exhausted by the system, whose primary response to distress was to divorce it from context and personalise it. The NHS was depicted "as a depressingly impenetrable system, resistant to change". Characterised by an epistemically unjust organisational culture, where psychologists were routinely excluded from the decision-making discussions that mattered.

**Conclusions:** This research adds to the growing body of literature indicating the importance of providing care in environments that align with values and ethics for clinicians, clinical practice and clinical care. If MD is recognised as an issue of organisational culture, the solutions need to be systemic, requiring changes in policy and practice, to make safe spaces for difficult dialogues, and to foster a sense of moral community within clinical practice.



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## **LIST OF ABBREVIATIONS**

AMH Adult Mental Health

BPS British Psychological Society

BMA British Medical Association

CAMHS Community Adolescent Mental Health Teams

CMHT Community Mental Health Team

CNA Critical Narrative Analysis

CP/s Clinical Psychologist/s

CQC Care Quality Commission

HCP/s Healthcare Professional/s

HCPC Health and Care Professions Council

HEE Health Education England

IAPT Improving Access to Psychological Therapies

MD Moral Distress

NHS National Health Service

NICE National Institute of Clinical Excellence

UK United Kingdom

## **1. CHAPTER 1: BACKGROUND**

### **1.1. Moral Distress: Addressing technicalities in terminology**

This thesis starts by exploring clinical psychologists' experiences of situations they consider ethically problematic and morally distressing. Moral distress (MD) is a long-established concept in healthcare ethics lexicon. It was first coined by Jameton (1984) to describe the nurses experiences of being unable to do 'the right thing' in their work due to institutional constraints. Since Jameton's (1984) definition, a growing body of research (Batto & Pitton, 2018), found primarily within nursing (Crane, Bayl-Smith & Cartmill, 2013), has been studying and refining definitions of Moral Distress (See: McCarthy & Deady, 2008), attempting to address problems of causality and context (Morley, Ives, Bradbury-Jones & Irvine, 2017). Although different labels are used in the literature, including ethical dilemmas, conflicts and concerns, the concepts hold commonalities. At core, they describe experiences that result in a person feeling their values, standards or morals are threatened, that require decisions be made about how to act, that causes distress that can have consequences for both the person and beyond. In research, the concepts are often used interchangeably, with little justification. As a consequence of this lack of consensus, and of a desire to respect clinical psychologists' perspectives, in this thesis, preference has been given to personal definitions of challenges and conflicts. Conceptual and terminology differences are addressed comprehensively in Chapter 2, but for the purposes of the introduction, the terms "ethics" and "morals" are regarded as overlapping. Moral distress is understood to be a contextualised relational phenomenon that applies across all aspects of healthcare work (Willis, 2015).

### **1.2. Introduction**

Before understanding how clinical psychologists experience moral distress, we must first understand the context of their work in the National Health Service (NHS). A multiscale model is used in this introductory chapter to outline the complex ways that current issues in the NHS relate to the project: On a macro-level, an overview of the political climate is presented, noting key national (and international) politics, policy,

and economics that shape the landscape of healthcare in the UK. On a meso-level, the institutional characteristics of NHS England are addressed acknowledging the organisational factors that impact working experiences within mental health in the UK. At a micro-level, the specific challenges faced by clinical psychologists, as situated in the literature, are documented.

### 1.2.1. Political Climate, Politics and Economics of Care

Many reports document, on an international level, how the globalisation of neoliberalism, marked by industrialisation and marketisation, has resulted in the breakdown of Keynesian economic systems (Burns, 2015). The corresponding devaluation of collective responsibility and prioritisation of individual accountability has been used to justify redefining the welfare state (Macintyre, Ferris & Gonçalves, 2018), reducing benefits (Wilkinson & Pickett, 2017) increasing fragmentation & polarisation in a changed class structure (Savage, 2012).

On a national level, the 1980s saw UK political orthodoxy transition from post-war social demographic thinking to Thatcher's neoliberalist capitalist philosophies, which in turn, came to frame the landscape of care for the next four decades. Most recently, the UK political climate has been characterised by over a decade of austerity (Elliott, 2016). Initially presented to the public as a response to a national emergency (Wickham et al, 2020), austerity became a deeply political project (Krugman, 2015), deliberately designed by coalition and subsequent conservative governments to revise and reduce welfare provisions (Cummins, 2018). The morality of such a project is questionable (Blyth, 2013). At the time of writing this thesis, the alchemy of austerity (Clarke & Hoggett, 2019) has been overturned. Constraint did not result in the expansion of the economy but instead widened inequality and lowered economic growth (Kirkup, 2013). Far from being "all in it together" (Cameron, 2009), research shows that it has been the most vulnerable who have paid the greater price (Barr et al, 2016). Under austerity politics, fifty percent of cutbacks came from benefit and local government budgets (Centre for Welfare Reform, 2015), shrinking the UK public sector to the smallest among major economies (Taylor-Goody, 2012). Policies of localisation reversed

funding related to deprivation, meaning local authorities with the highest needs experienced the most significant cuts (Crossley, 2016; Innes & Tetlow, 2015). Austerity also saw benefits cut by twenty percent (Burns, 2021), saving the government an estimated £27 billion a year by 2020/2021 (Beatty & Fothergill, 2016) but pushing millions of people beneath the breadline. Adjusting for inflation, out-of-work benefit rates are currently at their lowest for 30 years (JFR, 2022). Since 2008, households living below the minimum income standard have increased by a third, with families with children among the worst effected (Cummins, 2018). Rising unemployment, the expansion of zero-hour contracts, the 1% cap on public sector pay, and reductions in state services have resulted in new generations of working poor, now represent the majority of those living in poverty (JRF, 2016). This matters as there is a long-established relationship between austerity, inequality and health outcomes.

### 1.2.2. Inequality and Mental Health

At an epidemiological level, the Marmot Review (2010) and The Spirit Level (Wilkinson & Pickett, 2009) studies have shown that wellbeing is sociologically determined, linking social inequality to declining population health. Although issues of causality are complex and intersectional (Crenshaw, 1989), the stresses of living with insecure housing, food poverty or debt can all contribute to poor mental health (Silva et al., 2016; Elliott, 2016). Especially when experienced alongside the pressures of navigating a patchy, punitive social system, increased stigma, discrimination and reduced social support (Hatzenbuehler and Phelan, 2013) which serve to further marginalise vulnerable people (Platt, Stace & Morrissey, 2017) and increase the likelihood of trauma (Rafferty et al., 2015). In mental health, this vicious circle of austerity is particularly stark. The cumulative impact on individuals and communities, has been described as “structural violence” (Kelly, 2005; Cummins, 2018). Alongside devaluing and defunding services, privatisation and the shift to consumerism have contributed to the commodification and instrumentalisation of mental suffering (Pilgrim and Bentall, 1999). Essentially meaning the demand for NHS and social services has been rising, at a time when funding has been reduced (Willis, 2015).

### 1.2.3. Covid-19 and changes in the healthcare landscape.

Covid-19 was a coronavirus, that sparked a global health pandemic in 2020, when governments worldwide responded to the threat of infectious disease by 'locking' down people, communities and services to minimise the perceived risk to population health. The data for this thesis were collected between September and December 2020, when the United Kingdom was in the second wave of lockdown. The vaccine was yet to be implemented, and there were high levels of frustration and fear. Two years later, the impact of covid on population and healthcare landscapes are emerging. It appears that the unprecedented state responses to support incomes and public spending (Garnham, 2020) were all temporary measures that mask the likely long-term loss of human capital (The British Academy Report, 2021).

Data shows that the pandemic has exasperated inequalities in the education sector, labour market, household living standards, health, wealth and wellbeing (Bundell et al., 2021). In addition, policies of social distancing, closures of community facilities, and imposed periods of isolation have caused sharp declines in the population's mental health (See, Banks & Xu 2020, Mind 2020), with people in some social groups (young adults, older adults, people with pre-existing physical and mental health conditions, BAME communities) showing a sharper deterioration than others (Blundell et al., 2021). Evidence from the UK forecasts that, as a direct impact of the pandemic, the equivalent of 10 million people will require mental health support during the next three to five years (Mental Health Foundation, 2021).

The pandemic has also substantially weakened the public finances. At the time of this report, the UK public sector deficit has reached 15% of gross domestic product, and net debt stands at 98% of national income (see OECD, 2021), meaning fiscal tightening is likely. The government has already responded by increasing national insurance and the tax-to-gross domestic product ratio, predicted to reach record level highs (Johnson et al., 2021). Early 2022 saw attention spotlight the cost-of-living crisis, predicted to place

sustained budgetary pressure on millions of households (JRF, 2022): Rising prices; tax increases; energy price hikes; social security cuts; stagnating wages all create a challenging environment, particularly for families already struggling to get by (JRF, 2022). This results in increased demand for mental health services.

### **1.3. Austerity and Mental Health Services**

#### 1.3.1. Healthcare policy in the UK: a rhetoric reality gap

In 2013, Beresford published a crushing critique of the position of mental health services within the UK, pointing out the growing disparity between government policy documents, which consistently promised the realisation of a revolution in mental health services, and the reality of service delivery. To review more recent progression, I have outlined an overview of policy, its promise and the reality of provision as outlined in the literature below:

In 2014, the NHS Five Year Forward View outlined an aim to achieve real parity of esteem between mental and physical health by 2020 and promised waiting standards for mental health (75% of people to start psychological treatment within six weeks of referral). Planning papers by NHS England for 2015-16 promised that Clinical Commissioning Group (CCG) spending on mental health services would increase in real terms to support this. In 2017, the government committed to investing £1 billion by 2020-21 to make access recommendations 'a reality' (Garratt & Laing, 2022). They then launched a mental health workforce plan (Stepping Forward, July 2017) which aimed to expand the mental health workforce across England, by creating 21,000 new posts by April 2021. In 2019, the NHS Long Term Plan (7 January 2019) backed this with additional funding, promising at least £2.3 billion annually by 2023/24. Later that year, HEE published a mental health workforce plan for England (Stepping forward to 2020/21), which further committed to expanding the mental health workforce.

However, on the NHS Mental Health Dashboard (a government published modelling system that measures progress against policy), a summary of the

latest information shows “significant progress” in some areas but notes others as “inadequate”. The latest data shows that, mental health problems represent the largest burden of disease in the UK (approximately 28%) yet receive only 13% of NHS health expenditure (JRF, 2022). It rarely features in local authority public health budget spending (less than 1.6% in 2018) and remains far below parity in local health spending, representing 14.8% in 2021/22 (DOH, 2020: 2021). It’s clear that mental health services remain far behind most physical health services in terms of resourcing, patients’ ability to access care and overall patient outcomes (BMA, 2018b). Last year, the government published the Levelling Up the United Kingdom White Paper (7 Feb 2022), acknowledging service shortcomings and addressing mental health inequalities in the UK, aiming to ‘Build Back Better’ post-Covid-19 (DOH, 2021). However, what will that mean? Previously success in one area has been found to be ‘often at the cost of provision in another’ (BMA, 2018a), such as prioritising rapid access to Improving Access to Psychological Therapies (IAPT) while delaying waiting times for psychological therapies in secondary care. Regarding workplace well-being: Recent Care Quality Commission (CQC) reports have concluded that ‘psychology services are often being provided in dated and inappropriate buildings’ (Care Quality Commission, 2022). The British Medical Association Surveys of mental health professionals (2019) found that ‘many of the workforce commitments are not on track to be met’ and others have little impact in this area. The demand for mental health services has grown at a considerable rate – up 21%, from 1.1 to 1.4 million people from 2016 to 2019 - yet the number of NHS staff delivering this support remains stagnant (BPS, 2022). Vacancy rates for the mental health workforce remain largely unchanged over the past few years at 12%, and staff report that there has been reduced access to ongoing training and the time available for reflective practice (Buchan et al., 2019). Significant investment is needed to reverse historical underfunding (Burns, 2015). Instead, gap between rhetoric and reality is widening.

### 1.3.2. Workplace realities

Despite the policy promises outlined above, a decade of austerity and neoliberal restructuring have damaged mental health services (Cummins,

2018). We know that Psychologists tend to enter the profession wanting to help others, which provides meaning in their lives (Knapp et al., 2007). However, the landscape of healthcare has changed. Privatisation, marketisation and austerity-led cuts (Thomas, 2014) spurred the drive towards 'payment by results' (Stuckler & Basu, 2002). Consequently, services have increasingly become model-specific, employing more, less extensively trained therapists, to offer manualised care to people with diagnoses' (Cooke & Watts, 2016). Control over 'who accesses what' tends to be held by commissioners and managers without specialist knowledge (Wren & Michie, 2003), who make decisions based on guidelines developed in line with medical models of mental illness, with high input from the pharmaceutical industry (Moncrieff, 2008). As a result: "Ethical corners are being cut" (Nuttgens & Chang, 2013, p.289). The values of professionals working in mental health settings, have become at odds with the everyday inhumanity of practice settings (See BPS, 2014). Narratives of individual responsibility and cure are said to obscure the structural causes of distress (Karban, 2017). Increasingly there is a danger that even though professional attitudes have shifted to incorporate wider perspectives on the social factors that cause mental distress, traditional service models cannot incorporate such thinking (Cummins, 2017).

The introduction of managed care has instead accelerated pressure to "do more with less" (Blyth, 2013). A growth in demand and a reduction in service provision means the vast majority of those in need do not receive any psychological help (Shafran et al., 2009). On the ground, staff report that there is a desperate shortage of inpatient beds, a reliance on out-of-area placements and a delayed (and dangerous) response to individuals in crisis (CQC, 2022), increased reliance on the MHA (Gilbert, 2021), and multiple service user reports documenting (personal) distress directly relating to policies such as the Work Capability Assessment and PIP (see Roberts et. al, 2022). The increasing pressures on services make them increasingly difficult to access, with particular difficulties faced by non-white service users, those with learning difficulties and people older in age, who "continue to be poorly served by mental and physical health care services" (LSE, 2012).



#### **1.4. Impact on the psychological workforce**

NHS staff often feel committed to and motivated by their clinical roles, yet psychologically harmed by their organisations (Wren, 2016). Increased demands coincide with reduced support and control, to create an imbalance that contributes to poor workplace wellbeing (Harris and Griffin, 2015). A Unite survey (2018) revealed that among NHS workers, morale was poor prior to covid, with 87% per cent of 3,112 respondents saying that workplace morale was worse or a lot worse than the year previously, with work-related stress named as the main factor. Smaller scale surveys indicate morale has declined year upon year (Oliver, 2018: Simionato, Simpson & Reid, 2019: Johnson et al., 2020).

Workforce shortages in mental health are affecting clinicians' workload, well-being and morale, and resulting in an unmanageable workload in an already challenging role (BMA, 2020). Strikingly, 52% of 1000+ multidisciplinary clinicians working in healthcare said that they were too busy to provide the care they would like on their last shift worked (BMA, 2021). The workforce is in crisis:

“The general picture across the country is one of highly scrutinised; micro-managed overstretched staff teams who are trying, against the odds, to create the safe psychological space that is needed for troubled anxious people to explore their worst fears” (Campling, 2015, p58)

According to Kinderman (2013), organisations are exerting increasing control over psychologists' time and resources, reducing workplace well-being, leading to a decrease in psychological satisfaction and a decline in self-esteem among psychologists (Sima et al., 2016). Nationwide well-being surveys (see Rao, 2016) report that psychological therapists have lower levels of job satisfaction than other NHS staff, painting a picture of burnout, low morale, high stress levels (92%, 2016) and depression (46%, 2015). A combination of clinical responsibilities (challenging, time-pressured caseloads), non-clinical job tasks (excessive administration and paperwork), and poor working conditions (reduced supervision) are said to be crucial factors that are contributing to a staffing crisis so pervasive that it is said to be

jeopardising the future of the NHS (Hazlegreaves, 2019). Clinical psychology is not immune to retention issues. Staffing shortages result in inconsistent care for patients and a chaotic workplace for clinicians, which increases the likelihood of people leaving (Buchan et al., 2019). Existing staff feel isolated because their organisations lack structures for discussing the emotional impact of their work (Fox, Prilleltensky & Austin, 2011).

The government attempted to address this by publishing a 'Psychological Professions Workforce Plan for England' in 2019 (NHS & HEE, 2019), however The British Psychological Society reviewed progress in January 2022 describing the plan as "ambitious", they note "we have not yet seen tangible benefits from the commitment to workforce expansion", noting that one in seven trained posts remain unfilled (BPS, 2022). They highlight that the down banding of psychology roles – referring to both the flattening of hierarchies across band 8 and the disappearance of band nine posts - described as one of the core reasons "a greater number of practitioners leaving the NHS for development and promotion opportunities" is a problem that UNITE (a healthcare union) have been raising "extensively over the past ten years". Clinical psychology appears to be employing strategies that prioritise recruitment (such as increasing training placements, and bank vacancies) rather than retention (Lavender, 2019). Leading many, including the Division of Clinical Psychology calling for urgent change at an organisational level (See: Varcoe et al., 2012).

## **2. CHAPTER 2: LITERATURE REVIEW**

### **2.1. Context of the literature review**

Moral distress was a term first coined by the nurse-philosopher Andrew Jameton, to describe the negative experience “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (1984, p. 6). Though this became a working definition for many investigators (Hanna, 2004), MD remains a continually shifting concept (Willis, 2015) undergoing evolution as subsequent research has studied and refined its characteristics and causes (McCarthy & Deady, 2008) to evidence the efficacy of the term and the effects it describes. This chapter discusses these elements of the theoretical debate whilst also exploring the evidence for organisational stressors and other causational factor models, summing what is currently known about clinicians’ responses to distressing experiences, and considering criticism of the literature.

### **2.2. Methods**

Initially, a scoping review of published literature was conducted in order to identify relevant theories and “map” key issues (Arksey & O’Malley, 2005). Keywords were meshed out into mind maps (see below), subsequently used as the basis of a more structural review of the literature.

1. Moral - principles, ethics, values, ‘should’, practice guidelines or codes.
2. Psychologists - clinical psychologists, clinicians, mental health, allied healthcare professionals, therapists, psychologist.
3. Moral Distress - Ethical distress, Moral stress (DeTinne, 2012), Ethical stress (Ulrich et al, 2007), Stress of conscience (Glasberg, 2006), Compassion fatigue (Potter, 2010), Empathy fatigue (Stebnicki, 2007), Burnout and Emotional Exhaustion (Maslach, 1996), Well-being, Coping.

Following PRISMA guidelines (Peters et al, 2015) search strategies were narrowed to dominant terms. The specific search strategies and results are charted in detail in Appendix A. A flow diagram is provided in Appendix B. It documents the limited evidence that met the inclusion criteria, once search terms were limited to psychologists. Overwhelmingly the literature generated related to nurses' experiences (81%). While this reflects the fact that mental health nurses represent the largest proportion of the NHS mental health service workforce (Bee et al, 2008), it was problematic for this thesis, as it meant there was insufficient data to complete a systematic literature review. There was a risk that this methodological approach would result in a replication of pre-existing peer reviewed publications (see Morley, 2021; Sanderson, 2019), rather than addressing the gaps in the literature.

Instead, a narrative approach was taken to capture the concept's complexity. A systemic, evolutionary route was followed, iteratively uncovering literature, research and policy from a wide range of sources to provide a backdrop to the study. I used the literature searched above, and its bibliographies to 'suggest' other search terms, including: Moral Injury (as used by the British Medical Association). I then grouped these articles to form a series of a priori topic headings for the literature review, which I refined following reading. Where there was a paucity of information in peer-reviewed journal articles, references from Internet web pages were included from reliable sources determined by the nature of the hosting organisation if they directly related to psychologists' distress, working conditions and/or mental health. Books were identified via a library search using the University of East London Online Catalogue (UELOC) and Google Books. The literature was continuously reviewed to ensure it was contemporaneous, until its final update in August 2022, toward the end of my ProfD study.

## **2.3. Moral Distress**

### 2.3.1. The evolution of a concept

Despite being studied for nearly four decades, it is the original definition by Jameton (1984) that is used as a starting point in most moral distress studies (Willis, 2015). Jameton coined the term to categorise how ethical problems arise in a hospital context. Moral distress was one of three pathways. The first

was moral uncertainty, described as "where one is unsure about the right thing to do, about what moral principles or values apply, or even what the moral problem is" (1984, p.6). Moral dilemmas were next, arising for practitioners "where moral principles seem to support two mutually inconsistent courses of action" (1984, p.6). Moral distress was said to be the final course, arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue" (1984, p.6). Later on, Jameton clarified moral distress as operating via a two-stage process (1993, p. 283): the first involving initial distress described as the 'feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values', the second capturing reactive distress that occurs 'when people do not act upon their initial distress' (1993, p. 544).

His work has had considerable influence on later empirical research. The first of which was performed by Wilkinson in 1987, who interviewed 24 hospital nurses. Based on their accounts, Wilkinson described moral distress as 'the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision' (Wilkinson, 1987, p. 16). However, she failed to clarify what it means to experience psychological disequilibrium (Čartolovni et al., 2021). Despite this, her findings established that MD has detrimental effects on personal and professional wellness. In doing so, it extended the causes of moral distress in the working definition to include internal and external factors.

This shift spurred Corley (1995) to introduce the idea of a component of distress being the need to balance moral sensitivity against moral autonomy. MD was redefined as "a consequence of the effort to preserve moral integrity when the persons act against their moral convictions" (p. 645). Corley et al. (2001b) were the first to formally identify common situations that cause moral distress. However, since then, a small army of qualitative and quantitative researchers have sought to identify some of the factors that impact the experience and the outcomes of moral distress. This has been part of the

difficulty with the evolution of the concept; rather than offer clarification, recent systematic reviews argue that the multiple definitions of MD have 'limited the utility' of studying the concept (Sanderson et al., 2019, p. 195).

### 2.3.2. Characteristics of MD:

Jameton's core theoretical concepts are not disputed. Instead, critical scholars have raised four main problems with these early definitions of moral distress: Fourie (2015) argues that the original aetiology requiring moral judgement and institutional constraint 'as necessary and sufficient conditions for MD' is too narrow. Hanna (2004) evidenced how affectivity fails to capture the sorrow or suffering experienced when facing a moral dilemma. While Batho and Pitton (2018) outlined that the epistemic threshold (the requirement for individuals to know of the right course of action) is too high, and the outcome criterion (who decides what is a 'nearly impossible' moral action) is too objective. Numerous definitions of MD have attempted to address such criticisms.

The problems with narrow conceptions, led to broader definitions of MD. In 2008, McCarthy and Deady expanded the definition to include "being unable to act upon a moral judgement or do what they believe is the right thing" (p.255). However, Musto and Rodney (2015) argue that this expansion falls foul of the same difficulties as listed above as it ignores the interaction between an individual's moral agency, institutional interests and resulting MD. Peter and Liaschenko (2004: 2013) responded by querying how distress could be centred on debates surrounding an individual's moral agency, highlighting that ethics and knowledge are socially connected and are born from shared experiences. They adopted a feminist ethical framework to argue that institutions often constrain the moral identity of caregivers, limit their ability to act as autonomous agents, and prevent them from acting in accordance with their core values. Herber et al. (2020) took the critique a step further, asking if there can ever be a definitive "right" course of action in highly emotive, highly context-dependent situations.

Campbell, Ulrich and Grady (2016) looked to broaden the debate beyond individual restraints. They presented six types of distress that they believe act as theoretical causes of MD. These include moral uncertainty, mild distress, delayed distress, moral dilemma, bad moral luck and distress by association. Subsequently, they defined MD as “one or more negative self-directed emotions or attitudes that arise in response to one’s perceived involvement in a situation that one perceives to be morally undesirable” (Campbell et al, 2016, p.6). However, this revision is so broad it risks becoming un-useful, or as Lucia Wocial puts it, ‘reduces the experience of moral distress to feeling bad because one is caught in a morally undesirable situation’ (Wocial, 2016, p.21).

### 2.3.3. Reflections on debate:

It’s clear that although MD is well established in the literature, there isn’t a single ‘working’ definition. Instead, critics argue that it tends to be captured by “messy” descriptions (Wocial, 2016, p.21) that bundle together a “relatively confused and complex list of necessary and sufficient conditions, causes and effects” (Morley et al., 2019). The lack of a unified approach in the MD article group has led scholars to question, “Is md a situation? A set of beliefs or attitudes? A range of emotions? A group of symptoms?” (Campbell et al., 2016, p.259). If MD now represents “whatever the scholars writing about it have taken it to mean” (Campbell, 2016, p.3). Why has this happened? Is the concept meaningless? Or is it that the body of work is searching to address something more ontological underlying moral suffering than the original definition defined? (See Herber, 2020). Recently, Rodney (2017) applied a relational ethical lens, to review 30 years of research on moral distress, acknowledging these criticisms, whilst suggesting the concept has continued utility in recognising reciprocity between organisations and individuals, particularly if researched in diverse practise areas such as MH, community, and long-term care.

### 2.3.4. Moving beyond debate:

Whilst the conceptual demands literature outline MD’s flaws, the conceptual core of MD remains worthy of investigation, as it retains a unique ability to

reveal structural issues and allow political and dimensions of professional practice be highlighted (Weinberg, 2009). To synthesise the information from the core body of research on moral distress, several reviews were consulted, including: Corley, 2002; Hanna, 2004; McCarthy and Deady, 2008; Hamric, 2014, Tigard, 2018). Information from these studies is used, alongside Morley et al. (2021) model, to outline what is currently known about causal models and clinician responses to experiences of MD and consider how MD could be prevented.

### 2.3.5. Causes of MD

Numerous sources of moral distress have been identified. Due to word count capacity, the following is not an exhaustive review but is my attempt, as the author, to capture what I believe to be the core components contained in the literature:

2.3.5.1. *Organisational environment*: Moral distress has been predominantly shown to arise in situations that involve negotiating organisational culture, conflicts and demands (Forde & Aasland, 2008; Morley et al. 2021). Research shows that while a particular patient case may trigger moral distress, MD “is almost always rooted in causes that extend beyond patients to team and organisation levels” (Epstein and Hameric, 2009: 2019). Contributing factors include: a lack of collaboration (Webber et al., 2015), poor peer support (Deady & McCarthy, 2010) and unsupportive management (Musto, Rodney and Vanderheide, 2015) as ‘team based’ sources of moral distress for nurses. On a systems level, known predictors of MD include inadequate or unsafe staffing (Corley et al., 2005b), personnel feeling forced to prioritise equally important tasks (Kälvemark et al., 2004), organisational pressure to control costs (Sporrong, Holland and Arnetz, 2006), high complex caseloads and/or high administrative load (Whitehead et al, 2015). Pressures that combine to result in professionals feeling as if they do not have enough time available for patients (Jameton, 2017).



2.3.5.2 *Patient care*: Yet it is perceived difficulties in the level of patient care that are most commonly discussed in the literature. Evidence outlines how experiences of either observing or participating in poor quality care has been found to be a major cause of nurse MD (Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004).

2.3.5.3 *Personal empowerment*: It's notable Hamric and Blackhall's investigation of Physicians MD experiences (2007) is to date the only study that failed to find a correlation between moral distress and ethical climate in healthcare work. This is not surprising when you consider that moral distress has been found to be associated with low levels of psychological and structural empowerment (Browning, 2013). Generally, physicians (the term used in the original research) have an increased ability to access sources of power than nurses. It is plausible that they have less experience of the epistemic inequalities in the workplace (Fricker, 2007), such as feeling excluded from decision-making processes (Corley et al., 2005) or being undermined in hierarchies (Reed & Rishel, 2015), that are linked to MD.

2.3.5.4. *Personal and professional identities*: Some definitions of MD hold individual moral agency as key to the development of distress (See Musto, Schrieber & Rodney, 2021). Personal constraints have received limited attention within the quantitative literature, however, Epstein and Delgado (2010) suggest that self-doubt, a lack of assertiveness, perceived powerlessness, limited understanding and socialisation to follow orders can impede one's ability to deliberate about moral issues. Barlem and Ramos, (2015) expand the model, linking identity constraint to likelihood of MD. Fear of losing one's job or anxiety about creating conflict also act as internal constraints (Hamric, 2012). These theories are further backed by empirical data showing how empathy and sympathy can act as important triggers for moral distress (See Schluter et al., 2008). The functions of other individual factors such as beliefs, coping strategies, and personality traits are infrequently investigated in the existing literature (Willis, 2015).

### 2.3.6 Consequences of MD.

The research on moral distress has primarily been concerned with the negative experiences of moral distress (Traudt et al., 2016). As described by Jameton (2013) and Corley et al. (2001), a key element in moral distress is an individual's sense of powerlessness. Feeling unable to 'do the right thing' changes our perception of ourselves (Austin et al, 2005). The experience of moral distress is associated with feelings of shame and guilt (Deady & McCarthy, 2010), self-blame and anger (Lemmo, 2022). Numerous narrative accounts document the physical, psychological and emotional pain and "suffering" (Rushton et al., 2013), caused by moral distress, described as 'an anguish' (Kavelmark, 2004), that impacts 'mind, body and relationships' (Nathaniel, 2006). Although not explicitly stated in Jameton's definition, most interpretations imply that moral distress entails a threat to one's moral integrity: the sense of wholeness and self-esteem that comes from having clearly defined values that match your behaviour and perceptions (Pauly, Varcoe and Storch, 2012). Consequently, morally distressed individual may feel belittled, unimportant or unintelligent and isolated in their personal and professional lives (Epstein & Delgado, 2010).

Recently Batho and Pitton (2018) built upon Barlem and Ramos (2015) work on in-expressivity, to publish a theoretical framework characterising individual responses to distress into internalising and externalising behaviours. Their 'alternative responses to MD' model, relied on a trauma-informed framework, to consider that both rebellion (rejecting the contexts that give rise to distress) - in-keeping with the pre-existing pattern of leaving that is in the literature – and acquiescence (accepting the contexts that give rise to distress and doing what is asked of you) should both be predicted responses to distress. Suggesting the experience of moral distress could present as a vicious cycle.

In terms of environmental impact: Moral Distress evokes significant physical and emotional experiences, that are associated with job dissatisfaction (Pauly et al., 2009; Hamerick, 2000), damaging both the worker, and the workplace environment (Weber, 2016). Above and beyond other workplace pressures, MD is connected to work weariness and turnover (DeTienne et al., 2012),

attrition from the healthcare profession (Morley et al, 2019), and distancing from patients (Ulrich et al., 2010). As secondary consequences, moral distress has been found to be closely correlated with compassion fatigue, practitioner burnout, and secondary traumatic stress, which, in turn, further contribute to staffing shortages and a greater likelihood of patients receiving inadequate attention (See: Wilkinson, 1987: Corley, 2005: Whitehead et. al, 2015).

Although many of the effects of MD are undoubtedly negative, Tiggard (2019) outlined the concepts positive capacities, detailing its instrumental value, which serves to reveal and affirm some of our most important concerns as moral agents and can, under certain circumstances, foster moral growth and reaffirm care and commitment towards patient wellbeing. Research has shown that when MD prompts improved organisational ethics support, it can serve as an opportunity for practitioners to learn from their experiences, enhancing self-reflection and moral sensitivity (Carse & Rushton, 2017). Thus, although the experience of MD can leave clinicians vulnerable, as a process, it appears to have utility, functioning as an 'ethical canary' (Somerville, 2004), that both warns us that something is significantly amiss and demands systematic reform.

#### 2.3.7. The Crescendo Effect

Repeated exposure to moral distress can have a cumulative effect. While Johnston (1993) labelled this reactive distress, Epstein and Hamric (2009) have described what they call the crescendo effect of moral residue. According to their model, repeated and unaddressed episodes of moral distress accumulate over time into a moral residue that becomes increasingly painful to bare. The Crescendo Effect is evidenced by Dodek et al. (2016) study, which found direct associations between the experiences of MD and participants' years of experience in nursing. According to Epstein and Dallos (2010), a significant factor in this complex process is the service structure itself, including but not limited to systemic problems of poor communication, insufficient collaboration, and powerlessness.

### 2.3.8. Mediators of distress

What is less known is how people manage these experiences. An important finding in the reviews is that nurses who experience MD cope differently. In Gutierrez's (2005) study, Nurses used withdrawal as a defence mechanism to cope with strong negative emotions. However, in Corley's (2001) investigation, social support from fellow nurses moderated the impact of distress. While the evidence shows that individual coping mechanisms are not enough to reduce the effects of MD (See Kälvemark 2004), different abilities to mediate distress, may be explained by differences in care environments, as per Corley et al. (2005) studies, showing the negative correlations between perceived ethical climate, and the frequency and intensity of nurses moral distress.

Other important mediators known to influence the frequency and intensity of moral distress are individual education level (Meltzer & Huckabay 2004) and team support (Schluter et al., 2008). Narrative reviews suggest that people who receive more support in stressful situations are likely to develop more effective coping skills (Meltzer & Huckabay, 2004). Further empirical evidence comes from Rathert et al.'s (2016) survey of 290 nurses working in an acute hospital in the USA. Their structural equation model demonstrated that moral voice completely moderated the relationship between MD and moral effectiveness, and partially moderated the relationship between MD and organisation ethical support. Control appears a critical moderator. This may explain why Dodek et al (2016) found that Consultant Doctors, considered to have the highest decision-making authority, reported lower levels of MD than the other multidisciplinary professions working in ICU.

### 2.3.9. Responses to address MD

The literature reviews a range of strategies that studies have trialled in attempts to support participants to decrease moral distress. Hamric and Epstein (2017) summarise these into three core categories of strategic approaches: direct, indirect, and general. Perhaps the most prominent model for directly addressing moral distress is presented in 'The 4A's to Rise Above Moral Distress' proposed by the American Association of Critical Care Nurses

who ask nurses to 'Ask, Affirm, Assess, and Act' in a way that requires high levels of self and other reflections, and places emphasis solely on individual responding (ACCN, 2004). Other direct interventions include moral distress mapping (Dudzinski, 2016), used by the Moral Distress Consultation Service (Hameric & Epstein, 2017). The model uses volunteer professionals overseeing a staff paging system, triaged to an ethics or moral distress consultant, both of whom offered a semi-structured reflective space, with further support provided by a team based weekly consult case review. Initially trialled as a QI mechanism, the goal of the MDCS was not to eradicate MD but to provide early intervention and opportunity for collaborative problem solving, whilst establishing a framework that acts as an institutional ethics resource.

General and indirect intervention strategies target the aspects of health care that might lead to moral discomfort. For instance, encouraging adjustments to the workplace, enhancing team communication, teaching leaders about moral distress. Wocial et al. (2010) outlined an evidence-based project involving Unit-Based Ethics Conversations. However, it's just one of many peer reviewed models. Accepted examples in the literature include ensuring that employees have the necessary skills to provide appropriate and safe services and encouraging advocacy and speaking up (Carse & Rushton, 2017; Ulrich et al., 2010, Wiegand & Funk 2012).

Overall what is important in the evidence on effective responding is that core interventions involve offering comfort or praise to those experiencing moral distress, rather than working to prevent our natural affective responses (Tigard, 2019). This goes against the growing trend in resilience training in the NHS workforce (see Oliver, 2018), requiring us to name the MD that touches all who work in the healthcare system rather than seeking to hide or diminish it.

#### 2.3.10. Efficacy and Measurement

There are no known standardised instruments or guidelines guiding the exploration of MD in qualitative research.

## 2.4. Bridging the research to psychologists

Though these issues have all been predominately studied in acute environments, amongst nursing professionals, it is clear that similar organisational demands and dilemmas exist in other clinical settings. MD has been identified among nearly all healthcare professionals, including physicians (Austin, Kagan, Rankel, & Bergum, 2007; Hamric & Blackhall, 2007), psychiatrists (Austin et al., 2008), pharmacists (Sporrong et al., 2005) and social workers (Mänttari-van der Kuip, 2019). Research indicates that MD may present differently across the disciplines (Whitehead et al., 2015). Yet, even given this, it remains almost a non-existent concept within mental healthcare literature. Through the scoping review, five papers were identified investigating MD within MH settings, looked at in detail below:

Austin and colleagues (2003,2005, 2007, 2008) produced a series of publications in Canada, based on hermeneutic phenomenological research. They used same discipline researchers, to interview 6-9 participants working in mental health professions, including psychiatrists, psychiatric nurses, social workers, and psychologists, exploring their experiences of MD. Their 2005 paper outlines how psychologists included institutional demands, team conflict, and interdisciplinary disputes, as contributing to their experiences of moral distress. Each participant described multiple occasions when they felt their principles had been jeopardised, resulting in them feeling 'horrible intolerable feelings' such as anger, shame, grief, embarrassment and sadness. Ways of coping/responding were influenced by a fear of repercussions, with some acting secretly, or remaining silent, rather than taking a stand. Others engrossed themselves in therapeutic work, turned to colleagues for support, or left their posts. The psychologists described persistent self-doubt about their ability to make changes. Their experiences reaching 'brick walls' made perseverance seem futile. However, for many, leaving was as difficult a choice, as staying.

Deady and McCarthy (2010) interviewed eight psychiatric nurses working in acute care settings in Ireland. Using thematic analysis, they confirmed the presence of moral distress among psychiatric nurses, grouping the main situations that were found to give rise to MD three groups 'professional and legal conflict'; limited

professional autonomy and scope of practice; and witnessing (sub)standard care and client autonomy” (p. 5). Participants felt disempowered, devalued and overwhelmed. These perceptions left participants feeling unsupported by their peers, let down by the system and stigmatised by the media and public, features of MD that impacted on their professional and personal lives, over extended periods of time. Although participants used wide-ranging strategies to cope with this, including denial of difficulties and attempts to adapt, the authors noted that ‘these appeared to be limited in their effect’. As a result, MD often meant practitioners acquiesced (to poor practice standards) or left.

Nuttgens and Chang (2013) explored existing research on moral distress, to theorise the possible practice implications on supervisory relationships for Counselling Psychologists. They summarised that MD occurs due to substandard supervision, supervisee vulnerability and non-disclosure, counterproductive events, and organisational pressures. To minimise the likelihood of MD, they recommended adding moral distress to the counselling vernacular so that it is named, discussed and reflected upon in individual supervision and in clinical training.

Musto et al. (2021) conducted research to identify ethical dilemmas faced by multidisciplinary healthcare providers in acute mental health settings in Canada. They used Grounded Theory to analyse interview data, documents and observations from 27 clinicians working in acute settings. They found that a core source of MD was the systemic barriers that practitioners constantly encountered that blocked humane practice. Concluding that practitioners believed the healthcare system has a “fundamental inability to respond consistently with respect, dignity, or compassion towards people struggling with MH issues” (Musto et al., 2021, p. 2461). Participants described striving to practice ethically but struggling to balance organisational processes and professional obligations without risking personal and professional vulnerability. Response strategies included ‘pushing back’ (acting strategically, holding onto professional identity) and ‘working through team relationships’ (identifying boundaries, strategic responding). The authors theorised that austerity had impacted on ethical practice, by shaping clinical environments and reducing opportunities for moral agency. Meaning more people were becoming ‘stuck’ in MD.

The research concluded by calling for shared responsibility and collaborative interventions across the micro, meso and macro-organisational levels.

Since the start of this research project, two further publications have examined Ethical Dilemmas and Moral Stress in the clinical workforce in the UK.

The British Medical Association ran the first-ever pan-profession survey of doctors in the UK, surveying 1933 doctors about their experiences of moral distress. Data was collected in March and April 2021, and the report was published in June 2021. They found that although the terms 'moral distress' and 'moral injury' were new to many respondents - 43.8% to 48.4%, respectively - 78.4% of respondents stated that moral distress resonated with their experiences at work. Of those who felt their experiences resonated, 60% reported experiencing distress prior to the pandemic, and nearly all respondents (96%) stated the pandemic had exacerbated the risk of moral distress, with insufficient staff and time, and increased individual mental fatigue the most common causes. The highest rates of distress were reported by doctors from ethnic minority backgrounds and those with disabilities, suggesting an equalities aspect to moral distress. Suggestion for alleviating moral distress included 'more attuned' management, alongside restructuring and better resourcing of services to meet patient (and practitioner) needs.

Spriggins, (2021) interviewed fourteen clinical psychologists practicing in adult mental health as part of her Doctoral Research Project submitted to the University of East London in 2021, asking them about their experiences of ethical dilemmas. Participants reported repeatedly facing ethical dilemmas with 'powerful' consequences: the relentless fight to stay aligned with one's values, led to an overwhelming tiredness. Participants described constantly battling a 'constraining system' which created services that were causing harm, both to those they intended to help, and to those working within them.

In conclusion, a body of literature on MD has grown over the past four decades as MD has come to be recognised as a systemic problem in healthcare settings, endangering the moral integrity and well-being of patients and clinicians, as well as the quality of care provided and received. Yet, MD remains a relatively unexplored



topic in mental healthcare. Where similar (but different) concepts are used to explain workplace distress. The implication in much of the mental health research is that distress in an individual problem and the solution is resilience. Models including burnout (Maslach, 1996) and compassion fatigue (Figley, 2000) describe what happens when repeated exposure to emotional and demand heavy workloads, means job stress outstrips resources, which reduce a clinician's ability to deliver compassionate care (Maben, 2008). Individuals are 'burnout' or 'compassion fatigued', as opposed to organisations. I wondered if moral distress's conceptualisation as a social, contextual, relational, phenomena, meant it was under-acknowledged and under-researched for psychologists, as its positioning is at odds with the professional tendency of the mental health industry to individualise distress? This is further explored in subsequent chapters.

## **2.5. Space for distress within psychology?**

Psychologists are also human, meaning their mental health difficulties change on a continuum, comparable to those found in the general public, with wellbeing known to be impacted by personal, social, contextual and professional demands (Tay, Alcock & Scior, 2018). The latter means psychologists face unique risk factors. The nature of the work predisposes them to burnout, vicarious traumatisation and compassion fatigue (Bearse et al., 2013). At the same time, their professional codes require them to provide a consistently high degree of patient care (Ray et al., 2013). Practice standards (See: BPS 2017) set high expectations for professional and personal resilience (Schwartz-Mette & Shen-Miller, 2018), which can act as barriers in recognising personal distress (Knapp et al, 2013) and delay seeking support (Wood et al., 1995). In the 1990's Pope and Tabachnick's seminal work, documented the shame and secrecy in the profession when considering personal mental illness. Although there have been emerging counter narratives, such as the wounded healer (Hadjiosif, 2021), the discourse largely remains unchanged (See HCPC, 2012, 2015). Assumptions of immunity encourage high expectations for personal efficacy (Wood et al., 1995). Experience is valued, but distress must be contained (Grace et al., 2020) and self-care remains an ethical imperative. In this 'delicate dance' of wellbeing (Rao, 2016), as a researcher I wondered, is there space for moral distress to be considered within clinical psychology?

### **3. CHAPTER 3: ADDRESSING GAPS IN THE LITERATURE**

#### **3.1. The Relevance of the Research**

The basis for this thesis grew out of my personal experiences of working in the NHS during clinical psychology training. In each of my placement rotations (Community Adult MH, CAMHS, Specialist Health, Tertiary Care Services), I observed that the settings were in transition. The teams were all coping with service restructuring and change (be it anticipated or already occurring), evoking stress and distress. I was left wondering why some appeared to be managing it better than others. My curiosity peaked when I noticed patterns in responding across settings and organisations. I was struck by the apparent lack of control staff had over the changes to their practice and their working environments. This contrasted with my previous experiences acting in a leadership role, where my job had been to offer short-term consultations and collaboratively problem-solve difficulties with care teams in crisis. In coming into the NHS, I had assumed that clinical psychology, as a profession of high status, was one of high power. Yet I was witnessing a different reality. Clinicians told me that they could not practice as they wanted and that these dilemmas were common in the NHS. I wondered if there was something about the profession in general, or if it was being in the NHS, that made practicing healthcare difficult, both for the people involved, and the organisation at large? This drew me to Group Analytic scholarship and to ideas of moral distress.

The timing of this thesis corresponded with my taking of two periods of maternity leave from the workforce meaning my project was extended and split into phases (see Appendix D). In this time, I noticed that the literature underpinning MD had evolved. Papers were beginning to move beyond debates of definition to centre on the core constructs of MD. Yet, the literature had continued to portray the development of MD predominantly as an individual experience. The role of the system was largely obscured. I was conscious that, while:

“Theories have the advantage of providing us with a grid of understanding within which we can interpret our observations; they also have the

disadvantage of holding us down with preconceptions, diminishing our opportunities for seeing phenomena afresh” (Obholzer, 1995, p.4)

I noted how current understandings (the meta-narrative) of moral distress situated individuals and organisations as separate entities. Yet, psychological understandings of organisations show they often function in response to individuals. I wondered why the literature rarely addressed issues of organisation culture, to unpick what we know about what is happening in healthcare that creates the conditions for distress. This is what this chapter aims to address:

### **3.2. Introducing psychoanalytical theories of organisational functioning:**

Psychoanalytical perspectives see organisations as sites where broader social and cultural dynamics are enacted (Fraher, 2004). This psych structure (Maccoby 1976) allows wider cultural trends and ethos, such as neoliberalist ideals, to weave themselves into the framework of organisations, affecting organisational leadership, communication and group relations (Carr 1993). In the UK, the Tavistock Clinic has drawn from the work of Melanie Klein, to study how individuals in large bureaucratic organisations, faced with uncertainty and anxiety, set up psychological boundaries through projections and introjections which seriously distort organisational rationality and task (Gabriel & Carr, 2002, p356). As an opening frame, organisations are seen as psychologically demanding, systemic generators of anxiety (Klein, 1952) that require containing, at organisational and individual levels (Bion, 1961). In containing anxieties, organisations often resort to dysfunctional routines, which block the expression of emotion or conflict (Menzies-Lyth, 1960) and undermine the original goals of functioning (Obholzer & Roberts, 1994: 2019). In doing this, theorists argue that they engage in a world of neurotic make-believe, producing collective delusions and chimerical projects (Jaques, 1955: 1995) whilst disregarding real problems (Petriglieri & Petriglieri. 2020). This becomes a vicious circle, which deepens the suffering (Ballant & Campling, 2011).

In this way, psychoanalytic theories help provide explanatory models as to why organisations like the National Health Service - that are designed at their core to care - can be the most susceptible workspaces to be impacted by corporate ethos,

and how the helping professions can unconsciously harm. By exploring the latent meaning of healthcare work and the complex interplay between work and worker, psychoanalytic approaches allow for deeper insight into contemporary issues of healthcare management and organisation (Garrett, 2015).

### **3.3. Psychoanalytic theories: as applied to the NHS**

The nature of healthcare work (Campling, 2015; Rosenthal 2017) is said to be a barrier to benevolent care. Healthcare work involves daily exposure to the reality of distress. This closeness to people who are suffering...” stirs up deep-seated fears about one’s capacity to damage and doubts about one’s ability to repair” (Hinshelwood & Skogstad, 2000, p.29). To guard against these anxieties, Menzies-Lyth (1960) wrote widely about the organisational defences that hospital structures and nursing staff employ to protect themselves, relying upon mechanisms such as fragmenting care and numbering patients to detach and depersonalise from their work. While these forms of avoidant coping were understandable, they carried detrimental effects, as practitioners disengaged from the emotions necessary to cultivate compassionate care (Maben, 2008).

We know that on an organisational level, concepts of splitting and projective identification suggest that unacceptable aspects of the institution, and one’s own practice, can be split off and perceived in others, in a bid to self-protect (Fotaki & Hyde, 2015). This splitting results in unconscious restructuring. Hinshelwood (1981) outlines how group differentiation unfolds under two principles: the process becomes increasingly located within individuals and the content of quarrels becomes increasingly specific. Pope and Burns (2003) drew on these models of early psychoanalytic thinking to explain how they contribute to the formation of cultures of censorship and silence in the NHS: Splitting divides team hierarchies (manager-worker, doctor-patient) into them and us, idealising the good, and through projection, demonising the bad (Carr, 2002). It explains how “adverse events can be both widely known about simultaneously concealed” (Hart & Hazelgrove, 2001, p. 261), as it leads to an inevitable breakdown in communication between groups (Stokes, 1981). Splitting functions to isolate and personalise problems, produce scapegoats, and

remove the pressure to review our own professional practices (Hinshelwood, 1981). Trapping both institutions and practitioners in 'no win' situations (Long 1999).

This narrowing of focus also contributes to institutions neglecting their primary tasks (Obholzer, 1995). Drawing on Bion's (1961) seminal work connecting the anxiety-driven need for containment and 'safe certainty', to organisations behaving in ways that unconsciously turn a 'blind eye' to conflicts and challenges, Brown and Starkey (2000) contend that this means organisations fail to learn. Their egos unconsciously employ self-defence mechanisms that uphold group self-esteem, producing cultural blind spots (Weick and Sutcliffe, 2003). Other scholars such as Heffernan (2011) suggest that 'blindness' in the NHS is more wilful. Drawing on the work of Susan Long (2008), Ballant and Campling (2011) describe how 'the pull to pervasion' involves both repression and distortion of the truth. In their observations of Healthcare Scandals in NHS Trusts, they describe observing patterns of organisational self-deception that "seduce accomplices and breed corruption" (2011, p140). Again, outlining how psychoanalytic perspectives can illuminate how the protection of image, can result in the normalisation of organisational corruption (Pope & Burns, 2003).

Pollock (2004) documents how organisations frequently fail to acknowledge that chronic under-resourcing means services cannot deliver interventions as recommended. Instead, responsibility is placed on individual clinicians and clinical approaches, who are put under increasing pressure to adhere to manualised or evidence-based practices, in a bid to quantify that the 'work works', without acknowledging its limitations (Rhodes et al., 2010). In effect, the NHS is changing to solve the wrong problem and experiencing the social cost (Hoggett, 1996: Clarke & Hoggett, 2019). In this way, theories of detachment could be said to explain how the patterns that have come to characterise moral distress have continued in the healthcare landscape (Ballant & Campling, 2011; Wren, 2014), relatively without recognition.

### 3.4. Ethical climate, culture and practices

If organisations are social systems that regulate employee behaviours through different mechanisms (Olson, 1998), their Ethical Climate is key in setting expectations of ethically correct behaviour and guiding how issues should be handled (Schein 1995). Ethical climates should be recognised as an important contributor to MD. Yet, little is known about how they influence distress (Back et al, 2016).

Although grounded in different schools of thought (Arnauld, 2006), the terms organisational culture and climate can be used interchangeably to make sense of the environment that affects the behaviours and attitudes of members of a particular social system (Reichers & Schneider, 1990). Within healthcare, Ethical Climate is described as the implicit and explicit values that drive healthcare delivery and shape its workplaces (Ellinas, Allan & Johannson, 2017). In a healthy ethical work environment, clinicians are respected, valued and have a voice regarding issues of concern (Sherman & Pross, 2010). Clinicians should feel it is safe for them to engage in moral decisions or serve as patient advocates, and their opinions should be integrated into the decision-making process” (Benoit et al, 2018). Empirical studies in health care settings, such as those by Pauley et al (2009: 2012), Corley et al (2001: 2002: 2005), Hamerick et al (2012), Hart (2005) and Ulrich et al. (2007) have identified that the more positive the ethical climate is perceived, the lower the reported moral distress was, and vice versa.

Ethical culture involves more than the existence of professional guidance. In the healthcare profession, an ethical aim is ‘first do no harm’ (Finlay, 2006). However, this can be subjective, and so individual caring professions often break down aspirations for quality care into codes of behaviour. For psychologists practising in the UK, it is the BPS (2018) and HCPC regulatory organisations that promote ethical behaviour by publishing guidelines for members. However, the guidelines cannot foresee every issue (Grace et al., 2018). Evidence documents that ethical dilemmas continue to exist: The most common types of ethical issues encountered by CPs include issues of confidentiality, multiple relationships, competence, organisational demands, and avoiding harm (Chiffey, 2018: Pettifor & Sawchuk, 2006:). Although

often assumed to be universal, models of ethical decision making (such as those by Betan, 1997 and Cottone, 2001) emphasise that principles are socially constructed, meaning context can influence decision making. This is evidenced in the literature that documents the existence of a gap between what CPs believe they should do, and what they report they would do (Bernard & Jara, 1987), which widen when confronted with situational challenges (Frencz-Kaddari et al, 2016) or when difficulties involve professional acquaintance (Wilkins et al, 1990).

The relationships between individuals, their ethical practices and their environments are reciprocal (Arnauld, 2006, p.34). Organisational theories document how clinicians make decisions based on an interconnected cultural ecosystem influenced by policy, financial structures, resource pressures, patient and family factors, and institutional leadership. We know from NHS scandals, such as the Mid-Staffordshire Trust, that ethical work climates can erode clinicians' moral foundation, silence concerns, and result in poor practice standards and risk to patients. The Francis Report (2013) highlighted the commonality of unethical work climates "found throughout the NHS system" (Francis, 2013, p. 1361). It is clear that the NHS is not immune from needing cultural change (Wren, 2014).

In sum, when we consider ideas of Ethical Climate in light of what we know about the current culture of care provision (as per Chapter 1), it is clear that there are increasing moral pressures on the workforce. Resulting in some scholars asking if we have reached a point of cultural crisis (O'Hara, 2012). It seems an appropriate time to investigate clinician moral distress.

### **3.5. Rationale for research:**

The literature reviewed provides a rationale for investigating clinical psychologists' experience of moral distress. Moral distress has been an important concept in the healthcare ethics lexicon for over 30 years. Yet, scholarship is limited in the mental health professions (Nuttgens & Chan, 2013). Helping to develop theoretical knowledge of how the phenomena operates in the psychology workforce, has the potential to enhance practitioner wellbeing, which is particularly important in these challenging times.

### **3.6. Research Aims and Questions:**

As my investigation of the phenomenon of moral distress evolved, it became clear that I could not accomplish my research goals by adhering to one theoretical perspective. My dive into the literature inspired me to want to cover both 'what was happening' for clinical psychologists, and 'why' it was happening, which involved capturing the moral terrain within which clinical psychologists work. The intention of my research was to conduct semi-structured interviews with clinical psychologists to explore:

(Q1) If clinical psychologists identified as having experienced moral distress, in order to explore how those experiences were understood, responded to and managed by those individuals and those around them, in their personal and professional identities, both at the time and after the event, and to present the findings in narrative form.

As a result, my aims were grounded in an epistemological complexity that required a framework that was capable of critically examining the phenomenon through multiple lenses.

(Q2) I wanted to investigate how agency, power, identity, institutions, and culture manifest themselves in broader narratives of moral distress and consider how this might affect patient health and the clinical psychology profession.

I concluded that this would be best accomplished by employing a Critical Narrative Analysis (CNA) bricolage research method discussed in further detail below.



## 4. CHAPTER 4: METHODOLOGY

### 4.1. Choice of Methodology:

#### 4.1.1. Ontological considerations

Investigating how people experience events and how they make sense of their world are the main objectives of qualitative research (Willig, 2001). This fits well with my interest in meaning, self-identities, and social and structural contexts. The research frames Moral Distress as an example of the concepts of equifinality and multifinality (Cicchetti & Rogosch, 1996) in which numerous causes can contribute to the condition and produce various consequences. The ontological premise is that the idea of a single positivist agenda is an impossibility, instead it assumes there are multiple intertwining layers of critical realities (Bhaskar, 1975) that exist independently of personal, relational, positional and socio-political knowledge, construction, and of human activity.

#### 4.1.2. Epistemological considerations

The research initially drew on constructionist epistemology, to understand how psychologists, as individuals and professionals, participate in meaning making in relation to their experiences of ethical practices and moral distress. While discourse is one way of producing meaning (Potter & Wetherall, 1987), language is not the only way of making sense of the social structures and processes behind reality (McAdams, 2019). The world is “more than textual” (Burr, 1998, p. 20). Bhaskar’s (1989: 2013) critical realist research position is therefore more fitting, as it holds both the nature and context of the work as significant. Bhaskar’s critical realism, takes a series of philosophical positions, to act as a middle ground between positivism and social constructionism (Willis, 2022). As a pluralist research frame, it combines deep ontological realism with epistemological relativism. Thus in practical terms, it acknowledges that there is something to know about, while understanding that different people will come to know this in different ways. An additional draw to Critical Realist philosophy is that Bashkar explicitly made social justice aims central to its philosophy.

Using a Critically Realist frame enabled me to balance some of the epistemological tensions I experience in professional practice: by acknowledging both a humanistic approach to understanding the world echoing the ethos of clinical psychology, and creating space for social constructionist notions of reality, positioning people in a social world (Usher, 1999). My interpretation of Bashkar's theory of realism is that everything matters in the production of knowledge (including items, individuals and organisations), at multiple and interdependent levels, including conceptual and cultural schema and stories. It acknowledges that knowledge is affected by research involvement (Mischler, 1968), contexts (Reissman, 2008) and time (Squire, 2008).

It's worth noting that this research took place amid a global pandemic, where work practices had been disrupted in unforeseen ways. The onslaught of Covid-19 and restrictions of personal and professional freedoms had implications for how knowledge was accessed, that are discussed in further detail below.

## **4.2. Positioning and Approach**

Crotty (1998) argues that research is primarily shaped by a researcher's worldview, as it impacts all parts of the work "from research questions to conclusion" (1998, p.7). In line with my research paradigm, qualitative methods are the most appropriate way to study my topic because they explore the complex social world (Lichtman, 2012). How social reality is conceived and studied, however, depends on the methodology (Howell, 2012). The main research positions considered suitable for this project will be discussed below:

### 4.2.1. Pluralism

I chose a pluralistic approach to situate the theoretical and practical research commitments of this project, predominantly as I was conscious of the importance of contexts when considering clinicians' experiences of moral distress. My interest in dominant discourses, relative ideologies and power

relations meant my questions did not sit neatly into a singular methodological approach. Instead, they interfaced between individual, social, and structural processes, which caused methodological challenges. I felt torn as:

“conventional good practice believes that for meaningful and accountable research, its epistemological underpinnings and its methods must be clearly identified, and consistent with the ontological positioning of the participants.” (Goodbody & Burns, 2011, p.171)

However, no single method provided the ability to examine multiple levels and versions of reality in a relational framework. I was concerned that the common methods assumptions and analytic procedures of separating individual cases into themes and patterns, risked decontextualising the sample (Starks & Trinidad 2007). I noted the growing recognition that single approaches can have difficulties actively incorporating theories that adequately contextualise the lives of people our work is designed to describe (Buchanan and Wiklund, 2020).

Instead, my approach was informed by Polkinghorne’s (2010) metaphors of utility. I felt a pluralistic approach would enable me ‘to do more’ (Goodbody and Burns, 2011). As Geelan (2006) highlighted, productive and interesting research often occurs when competing paradigms within studies collide. At the risk of epistemological tension (Coyle, 2010), a strength of pluralism is that it enables the construction of multiple ways of being (Frost et al., 2011). It incorporates social context and adds ‘ethical value’ in terms of rich outcomes, complex truths, ‘relevance’ and ‘fair dealing’ (Mays & Pope 2000). Though it requires work to avoid engendering methodological anarchism, it allows researchers to develop deep, holistic, multi-layered understandings (Smith, 2011), which are greater than the sum of their parts (Willig, 2019), therefore avoiding reductionism (Kincheloe, 2005).

#### 4.2.2. Phenomenology:

Phenomenological psychology is growing in popularity as a perspective fuelled in part by a wish to work with a methodology that “takes its participants seriously” (Langdrige, 2008, p.1126). Phenomenology appealed as a core tenant of its approach is that it rejects dualistic thinking, and instead seeks to establish rich descriptions of peoples’ experience, including acknowledging the significance of subjective experiences (Neubauer, 2019). For phenomenologists, participants experiences form the data (Langdrige, 2008).

“The aim of research is to capture as closely as possible the way in which the phenomenon is experienced within the context in which the experience takes place” (Giorgi & Giorgi 2003, p. 27).

Grounded in the ideas of Husserl (1975) the initial focus was on ‘the things’ participants experienced in their lived worlds (Lyons, 2007) requiring researchers to bracket their assumptions about the phenomena via epoché and reduction (Kakkori, 2009). More recent adaptations, have emphasised that interpretation is factual, situated in time and space (Heidegger 1962), meaning understanding is rooted in a world of doings and practice (Dreyfus 1991). Husserl’s ideas of ‘stepping back’, have been replaced with the need for researchers to take a reflective approach (Mortari, 2015). As researchers we must become aware of our own beliefs, biases and assumptions and try to reflect on what they bring to the analysis, in order to focus on the participant’s understanding (Langdrige, 2007). This is required of us, because it is assumed that it is impossible to assume ‘a view from nowhere’ (Riccoeur, 1981), as by its very existence, understanding is hermeneutic (Heidegger, 1927), vulnerable to bias and prejudice generated from history and culture (Gadamer, 1990). In phenomenology, ontology and epistemology are indistinct, as they exist only in the enaction of humans’ intentionality to be aware of and interpret them (Nigar, 2020).

During the initial stages of the research, I considered employing Interpretative Phenomenological Analysis (IPA), to look deeply into peoples’ descriptions of MD. However, I worried this wouldn’t allow me to attend to the wider

sociocultural positioning of the topic, or learn about people's emotional experiences. I recognised that I was also interested in the function of the narratives, in thinking about the impact of MD for participants as individuals and as clinicians, as well as systems. I didn't want to lose this aspect by prioritising themes within a purely phenomenological approach.

#### 4.2.3. Narrative Approaches

In narrative approaches, conversation becomes a key element, central to our understanding. Language acts as an interchange (White & Drew, 2011). Discourses are said to be more than reflections of lived experiences (Potter and Weatherall, 1987): the conversational content (Gadamer, 1960) and the narrative are important, with the latter acting as the main mechanisms used to make sense of our lived experience, organising disparate elements of human action and events, into meaningful wholes (Polkinghorne, 1988). Narrative identities are built by the stories we construct. Language is held as a tool of the interpretative process underlying the understanding of meaning. I was attracted to the idea that narrative research methods are able to offer a dual signature in their combination of social constructionist and phenomenological perspectives (Hiles & Cermák, 2008). However, I was concerned that focusing on individual's description of experiences, 'offered little potential for critique' (Habermas, 1971).

#### 4.2.4. An integrated Approach

As a researcher, I was unable to leave my social constructionist underpinning behind. I wondered about the effects of language (Willig, 2012): if participants may unknowingly reproduce oppressive discourses when reflecting on and recounting their own stories. I wanted to pay attention to the deeper meaning structures, to attend to power and politics and acknowledge the limitations imposed by the web of social, cultural, and historic linguistic processes that make talk an 'imaginative enterprise' (Reissmen, 1993) that is both subjective and socially situated. I decided to go back and read into the "family of approaches" of phenomenological analysis (See Smith, Flower and Larkin, 2009) where I could honour its tenets (the focus on experience, meaning and

content) but take a more interrogative stance to include the political sphere and a need for social change.

### **4.3. Critical Narrative Analysis**

The Critical Narrative Analysis (CNA) framework was pioneered by Langdrige (2007) to combine different aspects from different philosophical backgrounds, into one analytic framework. Despite its name, Langdrige outlines that CNA is informed by phenomenological hermeneutics. CNA draws from the philosophy of Ricoeur (1981) to attempt to work with language, power and politics (Langdrige, 2009). Meaning is made by analytically applying hermeneutics of ‘empathy and suspicion’ to critically investigate the stories we tell. The method combines narrative methods with critical theory to acknowledge the embedded nature of social ideals, in both participants’ and the researchers’, lived worlds. It aims not to uncover a hidden truth but to open-up new possibilities (Langdrige 2008). CNA was used in this research as a pluralistic method – a procedure and tool of data collection and analysis (Corbin & Strauss, 2008) - that enabled my research design to fit with the paradigm and research approach. Further information is detailed later in this chapter (See section 4.8)

### **4.4. Methodological Challenges**

When multiple methods are used to capture or access multiple aspects of reality, “the trick is to find the right tools for the job to investigate these qualities”, which can then be used to triangulate truths (Goodbody & Burns, 2011). Mathison (1988) argues that transparency about theory and reflexivity, are necessary to make sense of the different perspectives, while maintaining validity.

#### 4.4.1. Addressing Tensions

There are several methodological techniques that are said to enable pluralistic researchers to reconcile theoretical tensions. Bricolage is a concept used to describe pluralistic practices that maintain theoretical coherence (Kincheloe, 2005). In this approach, researchers combine different methods to compensate for their individual shortcomings (Denzin, 2012). Bricolage

involves attempts to find and develop multiple strategies to overcome the unidimensionality of single-method studies (Kincheloe, 2005). Wickens (2011) described utilising this technique to allow her data to become “prism like”, viewed from varied angles (patterns, linguistic features, narrative descriptions, interpretative layers) to offer differing descriptions of the data. Where each prism angle is said to produce different forms of knowledge, an epistemological rather than an ontological claim (Clarke et al., 2014). Simons et al. (2008) describe a similar process of ‘shifting the focus’ during their analysis of interview data, by “adjusting the lens” to bring into view particular aspects of the phenomenon” (p. 129). These techniques are essential in helping the pluralistic researcher to explicitly consider how the epistemological, methodological, and procedural components fit together in a coherent way (Walsh & Koelsch, 2012), while also allowing for the construction of different, and even conflicting versions of the social world (Savage, 2000).

Taking such a systemic approach to inquiry, goes against our disciplinary tendency to preference following pre-set procedures (Ponterotto et al., 2017). Yet, in-depth analysis of even the scientific method itself, shows it to be far from the clear consistent epistemological system it claims to be (Feyerabend, 1975). Thus, while critics of pluralistic qualitative researchers have labelled those using methodological variety “jacks of all trades” who perform different versions of reality (Denzin, 2012), CNA purports that although epistemological disjunctions and slipping modes matter (Goodbody & Burns, 2011), transparency and clarity are key. As Langdrige warned, the CNA method is “particularly demanding, ambitious and time-consuming” (2007, p.23). Notably, most previous studies using this method have been case studies. As a researcher, it was a challenge to look at a relatively large group without sacrificing the complexity of individual participants. Yet it is my belief that doing so opened stories and contexts that wouldn’t otherwise have been readily accessible, if alternative methodological approaches had been used.

#### **4.5. Design of the study**

#### 4.5.1. Ethics and Ethical Considerations

Ethical approval was granted by the University of East London School of Psychology Research Ethics Sub-committee. This ensures that I comply with ethical codes (BPS, 2014), maintain the confidentiality of participants, and protect them from any harm that their participation may cause. Good practice requires a commitment to additional considerations, especially as the research is interactional, relational and personal. I attempted to do this throughout all phases of the research process, from proposal to publication, by adopting an 'ethical attitude' (Josselson, 2007); consistently balancing scholarship standards with consideration of ethical matters, particularly holding in mind the need to protect participants and approach them with respect and a lack of judgement (Bryman & Bell, 2007).

#### 4.5.2. Participants and settings

Criterion sampling was used to recruit qualified clinical psychologists that had experience of working in the NHS in the previous two years. 12 people responded to my recruitment poster. Participants were informed of the study before consent was sought, privacy was assigned to them and their institutions/organisations, and they were made aware that they could withdraw from the research at any time. Six participants took part (see section 4.7.2 for details). Unfortunately, one interview was lost due to poor quality of the recording, the participant was informed, but an alternative time was not possible to rearrange, leaving five analysable participant interviews.

### **4.6. Data Collection**

#### 4.6.1. Interview style

Critical Narrative Analysis has much in common with other phenomenologically grounded narrative methods (See Bruner, 1990; McAdams, 1989), however, its focus on language as creating meaning in use and its positioning of narratives as social action (Potter & Weatherall, 1995) mean it understands that discourse – and as such interviews - become a situated tool for “preforming” identity (Langdridge, 2015). This has implications when designing an interview structure. As a researcher, I felt the pull towards



structuring my questions, to ensure tailoring the best use of the limited time available to capture the study content as closely as possible. Yet, to do so, risked subjugating the participant's voice. To strike a balance, narrative interviews were conducted using semi-structured style, where purposeful conversations (Kvale, 1996) were organised around various themes (Appendix J), used as a guiding framework (Patton, 2002). Sufficient flexibility remained to allow participants to develop the conversation in ways that were meaningful to them (Frost, 2011).

Narrative interviewing is an evidence-based qualitative methodology, demonstrated to allow respondents to report what happened during particular events or times in their lives (Flick, 2009). Questions were designed following established NI principals: opening by asking participants to tell me about the story of their work in clinical psychology, including peak experiences, turning points, times when their experiences may have been difficult for them and future plans (McAdams, 1993). During the interview, descriptions were welcomed, held as helping in "establishing the nature of the terrain" researchers wish to investigate (Langdrige, 2008). My concern was to provide a space that enabled me as the researcher to take care of the participant (Flowers and Langdrige, 2007), where natural storytelling could occur unhindered (Lewis, 2011) whilst acknowledging that my responses as the researcher were co-producing the narrative (Brinkman & Kvale, 2015). In this way, the interview became a co-constructed research method (Kvale 1996). The space was respectful, co-authored and hopefully honoured both mine, and the participants, agendas.

#### 4.6.2. Interviewee demographics

Four females and two males were interviewed as part of this project. This roughly corresponds to the male to female ratio of clinical psychology professionals in the UK (Baker & Nash, 2013). Other demographic aspects are not detailed. Whilst I acknowledge that this may fail to capture the complexities of distress, faced by those within the CP community that already experience marginalisation due to race, ethnicity, or other factors identified in

Burnham's (1992) GRAACES model, it was necessary in order to protect participant confidentiality.

However, it was noteworthy that participants responded from across the UK to express an interest in taking part. Those that volunteered their time included clinical psychologists that worked in varied settings (CAMHS, CMHT, OA, Inpatient, Private Practice, Hospital based and Primary Care), with different levels of responsibility (from newly qualified to Band 8d Consultant Psychologist positions) in Trusts across the United Kingdom. Taken together this suggests that experiences of MD were not restricted to particular roles or settings within the healthcare community.

#### 4.6.3. Interview details

Data was collected between November and December 2020. Due to COVID-19 restrictions interviews were conducted via videocall using Microsoft Teams. Interviews were recorded using internal Microsoft Teams technology, or where alternatives were requested (as with 3 participants), using an encrypted digital audio recording device. Consent forms were emailed to participants at least 24 hours prior to the interview date and time. Each participant had the opportunity to ask questions before the interview began and as the interview neared its end. Participants received a follow-up email shortly after the interview with a "debriefing sheet" (Appendix J) with information about available support and a reminder of their right to withdraw. Although a time of one hour was allocated for each interview; Interviews ranged in length from 39 to 98 minutes, with the shortest call being part-one of a two-part conversation that occurred in split fashion due to technological issues. Further details on settings are addressed below.

#### **4.7. Data Analysis: CNA**

CNA methodology is an ideographic teleological process that seeks to understand participants experiences in broader contexts. To do this, Langdrige's (2007: 2015) framework uses a synthesis of analytical tools, set across six non-discrete stages, that work the hermeneutic circle, allowing analysts to work critically with the data.

#### 4.7.1. Stage 1: A critique of the illusions of the subject

In the first stage, researchers undertake exercises of personal reflection, critically engaging with the subject matter in question, exploring how our own interests, beliefs, social identities, experiences, and personal goals, shape and inform the research (Willig, 2012). Langdridge provides set questions as a guide (see Appendix K). I found this helpful in drawing my attention to the depth of different potential influences from/of my personal and professional identities: As a researcher, I hold both an emic and etic perspective (Olive, 2014). My emic view lies in my role as a trainee clinical psychologist: I am (almost) part of the established culture of clinical psychology and am familiar with the historical and current contexts of the work (Merriam & Tisdell, 2015). I worked professionally in mental health for over ten years prior to training, and have felt overwhelmed, unsupported and burnout at different stages, and for different reasons in my career. This supported me to build rapport with participants (Gubba & Lincon, 1994). However, I also hold a different hat to many in my profession, in that I identify as a past and present service user and survivor of psychiatric services. I am an individual who has spent many years considering and reflecting on these issues, but even so, throughout the work, I needed to think (and feel) through my responses to moral distress as it related to these particular participants.

I welcomed that Langdridge explicitly asserts that as researchers 'we always have a view from somewhere' (2007) and thus recommends using social theory and discourse to articulate the underlying assumptions that shape perceptions. Akin to Wicken's (2011) prism, or Simmons' (2008) multiple lenses, the aim is facilitating the taking of multiple perspectives (McAdams, 1989). I thought about how research teaching tells us to be wary of confirmation bias, the Hawthorne effect, and other tendencies of humankind to hide answers, when they perceive social gain, stigma or threat. Yet, as clinical psychologists, we learn the power of asking 'hard questions' directly. We know from service user literature (Gayle, Cortez & Preiss, 2013) that raising 'hard questions' can create safe spaces for difficult topics to be spoken about. I wondered if asking about 'moral distress' for clinical psychologists would be

'difficult'. Is it ok to not be ok? I thought about ideas of structural stigma (Hatzenbuehler & Link, 2014) and those of recovery capital (Best & Laudet 2010), concepts of resilience (Sull, 2015) balanced against small acts of resistance (Wade, 1997). There were so many possibilities. I valued that taking a CNA approach would both give space to "under-heard stories" and foreground those that my participants would bring.

Using GRAACES as a structure (Burnham, 1992), I engaged in an active reflection on who I am as a doctoral researcher, a wife and mother, a practicing NHS clinician, a European migrant living comfortably, in my early thirties in London, navigating the same global pandemic and crisis of transition, as that of my participants. It meant I couldn't set aside my preconceptions but needed to carefully reflect and evaluate my relationship with my participants and their worlds, at every stage of the research. I needed to take care not to project my own subjectivity onto their narratives, to instead revel in our differences and the rich detail of their lifeworld.

#### 4.7.2. Stage 2: Identifying narratives, narrative tone and rhetorical function

Narratives are socially situated, interactive activities, that are commissioned and contained by social resources and conditions (Davies & Harré, 1990). Differing approaches to narrative analysis distinguish the what's from the how's of storytelling (Smith, 2007), navigating positioning dilemmas that echo epistemological debates discussed above. As suggested previously, this is a distinction I struggle to navigate – like Reissman (2005) - I don't see the positions as mutually exclusive, and so, I strove to capture both in this work.

CNA's second stage allows for this. It requires the researcher to prepare a narrative summary from interviews. I did this following Mischler's (1986) suggestion, chronologically organising main stories of distress, noting the beginning, middle and end points, as well as smaller stories. I counted the number and form of stories and then worked through these to identify the tone (emotional) and rhetorical function (argumentations, counter narratives). This helped me get to know the data. I thought about Jonathan's (2011) description of capturing 'the gem', a small remark or extract that might be key to

understanding a person's grasp of their world (Smith, 2011). For each interview a core tone was identified, along with its shifts throughout the transcript, doing this helped me to observe canonical narratives (Bruner, 1991) or "narratives that can be found in individual personal stories but represent broader societal stories of how lives should be lived" (Langdrige, 2007, p.147). I remained cautious to heed Langdrige's advice against using predetermined plot descriptors, and instead tried to use these moments as a guide to capture the kind of story that was being told.

The transcription phase marked the beginning of the analysis, as I could begin to "unpack" the structures that are essential to interpretation (Reissman, 1993). I took care to capture the interview in its full complexity, including the moments of silence, prominent gestures, and expressions of emotion (Gill, 2015), by marking notes in columns on transcripts. When doing so, I captured my own contributions, including cadence, and afterwards noted my emotional response and emerging thoughts (Crossley, 2000).

A transcription key, can be seen in Appendix L.

#### 4.7.3. Stage 3: Identities and identity work

The third stage is where the researcher tries to see what kind of person is being conjured up in the narrative being told (Langdrige, 2009). Following the philosophy of Ricoeur, Langdrige maintains that multiple identities may be constructed at various times, in various contexts, since our sense of selfhood is derived from the tales we tell ourselves and others (2007). Hence, he suggests researchers use this stage to consider 'both 'who' participants represent, and 'how' they want to be perceived' (Bamberg, 2010), as well as noting how this relates to what we know of the person and the topic being discussed (Langdrige, 2009, p.136). I did this by working through the transcript and examining my tone and rhetoric function notes, paying attention to "I" statements and positioning, as well as noting how events are organised, sequenced, and connected (Reissman, 2005). Acknowledging that we are all in a constant state of 'preforming' (Reissman, 2003), presenting and

representing our self-narratives and developing meaning making systems (Crossley, 2000).

#### 4.7.4. Stage 4: Thematic priorities and relationships

Stage four involves an analysis of the common themes underpinning a narrative. Langdrige advises against systematic coding as it can result in a loss of narrative form (2009) instead suggesting that the transcript is read closely to identify reoccurring ideas and themes, links and connections, akin to the therapist's role in practice (Langdrige, 2009). To do this, I highlighted key words and phrases, transferring emerging themes onto post-it notes which could be clustered and linked in an iterative process. I returned to the audio at times, to refine themes and identify relationships between them (Appendix M).

#### 4.7.5. Stage 5: Destabilising the narrative

This penultimate stage differentiates CNA from other forms of narrative analysis. Sometimes referred to as the 'political stage', it requires researchers to cast a critical analytical lens on the narratives to interrogate the social, political, and contingent positioning(s) of participants' stories (Langdrige, 2007). Unlike traditional narrative research, which delves into data to reveal hidden meanings (Andrews, 2021), this "imaginative suspicion" is said to "open up future possibilities" for interpretation (Langdrige, 2007a, p. 150). Conscious that 'all research is action that works for or against power' (Prilleltensky & Nelson, 2002), my hope was that taking this dialogic approach would facilitate a comprehensive treatment of themes structures and settings and open up the possibility for working 'prefiguratively', anticipating a better form of society in the process of struggling for it (Friere, 1972).

A key aim of my research was to understand participants experiences of moral distress in context, the hermeneutic I chose is from a critical, social constructionist stance advocated by Parker (1999) who draws our attention to the way that psychologists' life work and worlds are also embedded in social structures and connected with wider patterns of power and resistance. The narrative was further destabilised by my application of systemic

psychoanalytic theories of organisational culture, namely the seminal work of Menzies-Lyth whose essays seemed apt when thinking about the defences and dynamics that operate at organisational and societal levels. Using these hermeneutics of suspicion, helped me to think about how agency, power, identities, intersectionality's, institutions and culture were situated in similar, and different ways for participants.

Being aware that my own speaking role, influences the interaction between speakers that allows for the emergence of social and personal discourses in conversation (Reissman, 1993, p. 21), I expanded the analysis to consider how my involvement co-constructed narratives. I returned to transcripts, noting structural aspects such as self-interruptions, changes in tone and emotional expression and thought about the responses I made. I summarised this in a paragraph for each participant.

#### 4.7.6. Stage 6: Critical synthesis

In CNA the six analytic stages are said to complete the hermeneutic circle, allowing for the dynamic interpretation of data as the researcher moves between 'parts' and 'wholes' of the material, mining for multiple meanings, which are then themselves examined (Smith et al, 2009). To avoid creating incoherent understandings, Langdridge makes critical synthesis the final stage, privileging the voices of participants, identity work and feedback from the hermeneutic of suspicion. He suggests a summary of findings acts as the start of the Discussion.

### **4.8. Methodological issues**

#### 4.8.1. Recruitment:

Initially recruitment had been organised via the Research Departments of two local NHS trusts, access was granted, and initial steps were put in place to achieve HRA approval. However, the timing of the Covid-19 Pandemic meant restrictions were placed on such pathways, as Trusts looked to prioritise immediate staff wellbeing and issues of safe working practices. This presented me with a difficulty: Would clinicians considerations of Moral Distress have been altered by practicing in a changing environment? Would it

be possible to access the stories that I had hoped I would hear? Or would crisis working, dominate discussions? Should I be attempting to ask people about working under pressure, at a time where they were likely to be in 'survival' mode? Issues are addressed in Chapter 7.

Recruitment itself occurred at a time where racism, discrimination, ableism and uniformity were exposed in the structures of the profession (see ACP, 2019; Bajwa, 2020; Wood, 2020) and of the institutions in which we work (Hackett et al., 2020). I was mindful of terminology, would the term "moral" distress resonate for all cross culturally? Is it a loaded term? Given the multiple definitions would it be understood? I was concerned I may struggle to locate clinicians whose stories would allow the narratives elicited not be either impression-managed or obscured (Silverman, 2006). Therefore, when I designed the recruitment poster, I trialled alternative terms with peers and mentors, foregrounding the ethos of MD theory (being unable to practice as one would like to) rather than using the term itself.

#### 4.8.2. Interview settings

Due to covid restrictions, I conducted all the interviews online using encrypted video consultation software. This was different from what I had initially proposed, assuming participants would want to meet in 'safe and convenient' locations, such as office spaces or UEL rooms. I wondered how it would impact the work, would it be as easy to build rapport? To raise difficult questions? What would it mean for me, to hold issues of distress, remotely? Would I be able to assess risk? Would anybody want to take part? I was worried that using digital communication would make it difficult to retain the intricacies of face-to-face conversation, and may result in shallower, less authentic, dissatisfying interview experiences (Andrews, 2001). In practice, though there were times when technical issues caused the dialogue to sound stilted, typically caused by network difficulties disrupting narratives, requiring repetition. Overall, my experiences were consistent with that of Hanna (2012) who discovered that Skype interviews let participants feel in control of the situation and reduced access barriers, enabling increased participation.



## **4.9. Evaluation**

A detailed evaluation following Yardleys (2000) and Tracy's (2010) criteria for judging the quality of pluralistic research is outlined in the Discussion Chapter of this thesis.

## **5. CHAPTER 5: INDIVIDUAL NARRATIVES**

### **5.1. Introductions**

Five individuals shared their stories with me. Limited profile snapshots are shared to contextualise participants' contributions, however, due to the sensitive nature of the topic, personal details, including demographics and location, have been fictionalised and pseudonyms used.

1. Sara is a Principal Clinical Psychologist working in an Older Adult CMHT that is undergoing transition, redesign and relocation. She works part-time in Private Practice.
2. Beth is a Consultant Clinical Psychologist working in CAMHS. She has a senior management role in a medically-led team that is primarily commissioned to provide diagnostic services.
3. Maya is a Senior Clinical Psychologist working in an Older Adult CMHT, her background is in Neuro-Psychology, and her speciality is trauma-focused work. She works part-time in private practice with young people.
4. Tom is a Clinical Psychologist working in a Tier Three CAMHS Service in a therapeutic role. His background is in third-sector services. In his NHS role, Tom had been asked to take a supervisory position and felt it marked a turning point in his career.
5. Anne is a Senior Clinical Psychologist, working in Early Intervention Psychosis Services. She described coming to psychology as a late-career change.

### **5.2. Presentation of the Analysis**

The analysis is presented in three parts. In the first section, I present each of the five narratives, applying a hermeneutic of understanding to foreground participants' voices. To retain integrity, I preserved the structure of each narrative and merged the results of the opening three phases of analysis into this retelling. Later in this chapter, I introduce themes (phase 4 of analysis), synthesising the stories told. Examining the accounts collectively connected the experiences of MD showing their patterns: Individualised experiences of distress were located in common wider socio-

political contexts, with participants sharing frames of reference and modes of sense-making. These jointly told synopses painted a powerful picture of MD more akin to a community narrative (Johnstone, 2006). In the final part of the analysis, I applied a critical lens to the interpretation of the data. This hermeneutic of suspicion contextualised the stories and synthesised data. In this write-up, this section functions as a second-order analysis and forms the first part of the discussion.

### 5.2.1. Sara

Sara's story was one that was dominated by distress, persecution and despair, depicting a hero-to-victim tale. Her friendly demeanour and inviting intonation embodied warmth and openness that contrasted starkly with the experiences she shared. Sara described finding herself in an abusive relationship with her profession. Speaking with confidence and conviction, I found that she came across as a skilled and compassionate clinician. The conversation was easy, and yet at the same time, hard to hear. Langdrige (2007) suggests that tone provides significant insights into the expressed meanings of the storyteller. While Sara used humour to make light of her hard experiences, it was clear that she held on to high levels of anger and frustration and that her 'lightness' masked a despondency about a career she once loved.

Sara's grand narrative was weaved from a collection of sub-plots, stories she shared that outlined several occurrences whereby it was important to her to call out poor clinical practice. In these opening stages of the interview, Sara depicted herself as being loyal and dedicated to the NHS, determined to "work hard" to improve patient and team wellbeing, a warrior for their cause. Hope was foregrounded in the narrative. Yet, the backdrop of systemic difficulties persistently made for challenging working environments. Sara came to realise she was practising as if an 'outlaw', performing against the "protocol-driven", "tick-box focused" NHS. Hope faded.

"I don't know how many examples there are out there of NHS mental health services being structured and funded in a way that we know are

working...in the adult space, that's not happening... it's an issue everywhere and I think it's been getting worse".

Ultimately, the story Sara wanted to tell of herself differed from the story told. What emerged was a chronicle of victimhood. Sara reported feeling professionally "devalued" and disempowered, personally "blamed", and "burnout" by decades of battling to ensure her patients received an "adequate" level of care.

"It's like I've been in an abusive relationship for twenty years...and I think that's desperately sad, because it's a relationship that I want to work. It's an organisation I believe in. I haven't just stayed out of low self-esteem or anything. I stayed because I feel like things would get better. I feel like I can make this work. I feel like I can make a difference. But [pause, deep breath]... isn't that what everyone says in an abusive relationship."

The images she used invoke feelings of being under threat, out of control, and possibly fearing retaliation. They were evocative and effective, persuading me as a listener to have sympathy towards her situation. I was struck that for Sara her professional positivism was utterly juxtaposed with the weary personal acknowledgements that she feels "unsupported", isolated, misunderstood, reprimanded, censured, and stigmatised. Rather than be a champion, she had been relegated to being a vector for others in distress.

"I'm seen as that annoying person that's nagging them, that won't listen and know their place"

"I get scapegoated.....it feels like a way of undermining me"

This personalisation of distress results in a vicious cycle, where she described being excluded from positions of power:

"I feel very much the problem is routinely located in me. Even amongst senior psychology colleagues, the problem's located in me. Sara's burnt out, Sara's not well, Sara's not coping with things, Sara finds it hard to manage these kinds of responsibilities of the role and of the

system...There was definitely a point where I was quite happy to hold that if that's what was needed to happen in order to try to make things different, but actually, it's, it just disempowers you...it weakens your voice even further".

In Sara's grand narrative, the 'other' is portrayed as an authoritative, powerful figure, who could cause harm if they so choose. For Sara, it is the commissioning and hierarchical management systems – the medical and finance-led "command and control structures" - that are portrayed as the aggressors, leaving her "feeling powerless" with limited options but to submit or face continued reputational attack. Management are described as "determined, manipulative, unethical, unempathetic", said to show no "interest in" or "understanding of the individuals receiving or delivering services", as well as "no sense of the bigger picture". Sara believes that over twenty years in the NHS, she has increasingly witnessed services being structured "for the benefit of the trust, and not the patient... it's all about governance, how can we keep the system safe".

I wondered about Sara's position in this battle. If the monolithic "system" being a nameless 'other', allowed her to maintain a level of distance, from her (senior) role in the system, perhaps functioning to enable the status quo to continue whilst protecting her as a 'victim' from further damage to her sense of morality and identity. Sara reports that one of her main frustrations is her acknowledgement that she is positioned as outside of the decision-making system. For her, the experience of moral distress was cumulative - "I've reached a point where I can't take this anymore", "its death by a thousand cuts". It is this dual erosion of both her own professional identity, as well that of the identity of the profession as a whole – that underlies the intensity of her experiences:

"I felt like I had stuff to offer, but the doors were all shut. We don't want you. You are not the right banding for this...it's more than just feeling annoyed...it's structural diminishment of the role of psychology in services and...of evidence-based practice. It's having a significant role in services...(conversational gap)...I see my manager, my psychology

managers all burn out, all being bullied...it just feels like it isn't a safe place to be"

Sara ended the interview by speaking of a recent incident where a problem arose in her team that she has specific expertise in responding to, but although this was acknowledged, she was excluded from having a leadership role, and ultimately, following a brief exchange of ideas, was removed from the steering panel. The anger she experienced in its wake, changed the relationship she had with her work. It marked a repositioning of herself. This final turn in her story raised a sense of loss, Sara reflected that the additional time she had spent trying to "go so far above and beyond" in her professional role, had resulted in a sunken costs fallacy. Despite the personal and financial costs, her efforts went unnoticed, "unsupported" and unrewarded. In this final stage of our interview, Sara reflected that she was tired of "giv(ing) all" to being an NHS Psychologist. She remained fearful that without "substantial top-down cultural change" the NHS will become "a race to the bottom", but no longer wanted to be the warrior leading the charge. She shared that she felt she had reached a turning point, wherein she would like a better work life balance. As a result, she was looking to transition further into private work. Her hope had returned, but with a new lens, this time directed at her own wellbeing.

"I've always felt like... I've committed to this career route. I'm in the NHS, I'm a clinical psychologist, that's what I do... I've realised this year, it really doesn't have to be. I have to make it work for me, I have to make it work for my family, and I have to make it work for the clients that I serve, and there are other ways to do that outside of the NHS where I can do it without being confronted with moral injury every day, high distress every day, without feeling like I am compromising my own wellbeing, my families wellbeing, my financial wellbeing and without feeling like I'm compromising the quality of care that I am offering, and patient safety".

### 5.2.2. Beth

Beth spoke about how she is filled with feelings of conflict that revolved around issues of diagnosis, including the individualisation of difficulty and the removal of subjectivity in the diagnostic process. She would prefer to see a “less othering” system based on differences in functioning, descriptive of strengths and needs, rather than the “life-long labelling” of children as disordered.

“It’s immense holding that for me...I would go to bed wondering what it’s like for that child to now have that label because I made that decision out of that room on that particular day at that particular time”

The image she described, depicting the nightly occurrence of concern for her patients triggering self-doubt significant enough to disrupt her sleep, painted a powerful picture of a clinician struggling to align personal values and professional responsibilities. Yet, this contrasted with her initial positioning and tone. Beth presented as guarded. She redirected personal questions to focus of the experiences of her colleagues, teams, and the patients/families she cares for. Her tone was cautionary. Part of Beth’s narrative involved her justifying, contextualising and making sense of her continued work in an area that “did not fit with her values”. Beth explained that she hoped that if she kept silent about her doubts about the diagnostic system, she could protect families from holding distress, and allow them to access what they need from the system. There was tension in her tale: What was ethically right for families on an individual basis, was damaging for Beth and for the wider system. While she hated being part of the “conveyor belt” – she could intellectualise and rationalise the decision-making process, and thus distance herself from moral distress.

Beth acknowledged that she tends to manage distress on a daily basis by “avoiding thinking about it”. In a moment of reflection-in-action, she demonstrated her ability to ‘stand back’ and evaluate the situation, engaging in debate with herself, acknowledging her compliance with the system/a deficit model, and wondering why this had been a coping strategy for her. Her pause

prompted her to describe feeling “jaded”, “powerless” and professionally isolated in a ‘fixed’ structural ‘hierarchy’.

“where I work at the moment, you wouldn’t...there wouldn’t be a sense of allowing you to think of the conversation as ‘a difficult case’, yes it’s complex, but it just means you need to be more experienced, better at your job, complexity means you should do be better for the service really...work harder”

There was a fatalistic tone her acceptance that she has perhaps learnt not to challenge, as she’s not witnessed it leading to change. Beth linked her discomfort, to her numerous experiences of being “shut down”. She described feeling increasingly silenced as she held positions of increased seniority.

“The more experience you have, the more you are expected to have the answers”

“the further up I go, it gets more black and white, more categorical”...

She told of how raising questions had resulted in accusations of “sitting on the shelf”, associated unfairly, with being “inexperienced and lacking confidence”, even though she had been in post for ten years. This sub narrative of constant devaluation by peers and superiors, emerges involuntarily in Beth’s story as she began to relax and personalise her tale. I noticed that although I heard Beth’s language as academic and intellectual, responded to her seniority and thought of her as a knowledgeable teacher/wise advisor, she positioned herself differently. Beth questioned her expertise, quietly uttering on more than once occasion:

“If I was excellent...but...”.

Beth described additionally researching, learning, attending workshops, only to share new ideas for ways of case working that “went down like a led balloon”. It struck me that her experiences of being dismissed, invalidated personally as well as professionally had been painfully shaming for her. Her



experiences had resulted in her dismissing her strengths - her passion to think beyond the individual, her desire to partake in creating a society that values different abilities, the elements of her clinical practice that she believed made a clinical difference, were no longer part of her working practices. Beth had given up trying to better the system, due to its resistance to change.

Like Sara, Beth positioned the 'system' as the root of the problems. Quick decisions 'had to' be made "under pressure by commissioners". Scarce resources were far outstripped by high, and increasing, demand, with families often "on a three-year journey" or waitlist for support. Yet, rather than evoke anger, this was framed as normal. Beth saw her team as "comparatively lucky" as they at least had "time to give", and could "follow through", once families had accessed the system. Beth's spoke highly of her teams expertise, their years in practice, their compassionate approach to families. However, later in her narrative, she acknowledge that taking such a position, is 'part of maintaining the façade'.

"There's a kind of tyranny of niceness that you can't question...(telling ourselves) it's a **lovely** service and aren't we good and aren't we working hard, isn't it great, a sort of wonderfulness of all of it"

It's described that this facade renders the team impenetrable and perpetuates the status quo. It allowed Beth to focus on how she was "making the best of a bad situation". Framing the problem as "the white gates of power", operated by the medical system, as beyond the boundaries of her role, and for the most part, outside of her control.

Beth began our interview by wondering aloud if her daily decisions would stand up in "a moral court" over time. She ended by reflecting on her moral responsibility, asking aloud:

"Do I have to change? Or do I have to change it?"

Either way, change is needed.

### 5.2.3. Maya

Maya's main story, involved a critical appraisal of her work and working conditions, and her separation of the profession of clinical psychology, from its professional tools. She portrays herself as a nomad, amid a period of turmoil and tribalism.

The opening narrative was one depicting Maya's frustration with what she deemed "service factors" that disrupted her work. This first event functions to contextualise the difficulties she experienced. She spoke of being increasingly asked to do more with less, in a service that is under resourced, underfunded, with too high caseloads, limited patient treatment time and artificial access cut-offs. She described how services, including hers, can "too frequently" follow restrictive, coercive practices, that are often overly medical in their focus, that fail to meet patient needs. This section of the interview was practical in tone, almost analytic. Maya positioned herself as a narrator. She was candid, comic at times, openly critical of what she saw as happening in her work and her field. She portrayed services operating "at breaking point", unintentionally traumatising those they are designed to help.

"It's not the quality of care that you want...or tolerate for your loved ones"

"And that is quite morally distressing, to watch people effectively be harmed by a system. And not harmed in a way that you could pinpoint a member of staff and whistle blow but harmed...systemically, over many, many decades"

According to Riessman (2008), this narrative device of convincing her audience to consider how wrong and "inhumane" the system (or other) is, was probably strategic, functioning to assist Maya to maintain a sense of perspective, agency, and self-worth. This was the second-event in her story. Once she knew I understood the systems flaws, she build upon the practical. Our conversation changed from being an exercise in advocacy, to being a self-prompted reflection of her own accountability. This marked a flow change

in the orientation of her frustrations. Fifteen minutes in, there was now both a sense of 'this is how it is' and 'this is exhausting!' Supporting people "pushed to the point of crisis" had left Maya questioning herself, "am I giving false hope?":

"On your worst days, it makes you think, you know, are we ever going to get this right? Is there any point in keeping, beating your head against a brick wall like this with services?"

There is a sense for Maya that she is part of the problem. She feels "pointless" "powerless" "hopeless" and "stressed". Although she acknowledged that she carries some responsibility, her build-up of frustrations was directed at psychology, a profession that "gets it wrong so much of the time".

"The longer you spend in the field the worse it gets because you are just getting multiple examples of when it [effectiveness] hasn't come through"

Importantly, Maya doesn't believe the tools of psychology are not for the job, instead she argues that they are not being utilised effectively by the profession itself, nor taken seriously by services. Maya finds this disappointing. She describes how it has led her to be segregated and left her feeling 'lost'.

She distanced herself from blame by contemplating how she differs from others in her profession, focusing on how she values and recognises others expertise, whereas:

"there is an arrogance in psychology sometimes that we think our framework is the best and everyone else is just uneducated...so, at the risk of doing our profession a disservice, sometimes I think we need to be a lot more open to the fact that there are other ways of seeing problems as well."

Yet, her story is not a hero's journey. There is a humbleness to the stories of success that she shared – tales of changing team cultures, shifting medically trained colleague's language use, implementing trauma informed care. Maya owns that she could do these things, as she felt supported in sharing her stress within her personal friendship networks, her lines of management in her NHS role, and in the many avenues of private supervision that she has sought. She names the importance of a well-supportive team, having faith placed in her, a good safeguarding department, reflective supervision, all key aspects of structural supports that meant:

“on paper what would have been the hardest job, it certainly didn't feel it!”

The components of her story emerge to build a collective whole (Labov, 1972). Her distress is rooted in her feelings of abandonment by professional networks. She is at pains to point out that it is not: “(the) distressing work, the complex trauma of the client base“ nor “hearing difficult things....that wasn't unexpected. But the hierarchy is exhausting”. She feels unable to speak, “brow beaten”, “ground down”, silenced. She reflected: It “feels like you are fighting your own profession”.

Not only does the system enact “horrible, horrible patterns of care”, but so to do the professional networks, that outcast those that dare to raise questions or disagree. Psychology is illustrated as “Tribal”, to disagree, means to be “pretty much out in the cold”. There are no spaces for discussion, therefore, no space for change to occur. For Maya, this means they offer no hope, no containment, leaving her feeling unsafe. The distress is trifold:

“knowing the systems don't meet the needs of clients, knowing there is a huge amount of work to do to change an entire system so they do, and then the upward level of frustration when your professional body doesn't feel like it's working on the ground or actually understanding what the problems are”

She spoke about feeling unheard, unsupported at a service level and on a professional level. If psychology is tribal, Maya positions herself as nomadic, excluded from their tightly controlled membership. Her story was told as if she was on the outside, witnessing an unnecessary battle in disbelief. She spoke of psychology's feud with psychiatry and with mental health care 'system' with sadness. For her, it is the wrong fight:

“We're in systems that none of us really want to be working with...but we also can't pretend the systems don't exist”

She believes instead in negotiation, that there is space for ethics and values to be shared, patients should be key.

Later in the interview, she offers a glimpse into how it has impacted upon her. She is leaving the role! Although she talks of her team having “no psychological safety”, due to operating within a hierarchy that has meant they “never feel able to take risks, never feel respected, never feel valued”. She acknowledges that “it's a difficult place for everyone to be really”, as people feel “deskilled and devalued”. For Maya, this is seen as something to be celebrated rather than regretted. A loss for her team, but for her personally, a form of opportunity.

#### 5.2.4. Tom

In Tom's story, the main narrative was his self-characterisation as a 'temporary traitor'. His story is one of disillusionment. He outlines how his values have been gradually compromised, “ground away” by the structure in which he works, and growing sense of frustration with his professional identity. His story had tension at its core, between how he wants to support people, his perceived inability to do this in his practice, and his frustration that 'psychology' has become incompatible, with what it espouses to/'should' do.

Tom opened the interview by speaking of his values: social justice, social development, equality of opportunity. Tom wants to be able to support families by recognising their difficulties in context, but instead he describes his work in

CAMHS as “manualised” “pathologizing” “punitive” and “disempowering”. Like previous participants, he finds the deficit model difficult to hold. He believes this “model of shame” and individualised blame, is “deeply unhelpful”. There was an overarching tragic tone to his narrative, when he acknowledged:

“CAMHS is not set up structurally to be able to meet the needs of young people and families” ... “The expectations are clear, how many young people you are seeing each week, how many assessments you’ll do...we can’t meet holistic needs, you’ll have no time for...housing or citizens advice or children services or schools”

Intertwining narrative elements of turmoil, stigma, passivity, guilt, and struggle, he reflected it’s “a phenomenal waste of resources”, sharing with a deep sigh:

“often my goal is to move you people away from CAMHS as quickly as possible”.

Tom tells of how his professional and personal identity has been transformed by this tension. Like previous participants, Tom’s story brought battle images to the fore. However, Tom argued that he is not a loyal soldier, but rather, a reluctant agent, or in his words, a “temporary traitor”. There is a sense that Tom joined the forces (the psychological workforce) expecting a shared purpose, but is now disillusioned, feeling as if he was recruited to a false cause. In the battle of psychology versus politics, principles have been eroded. During the interview, Tom described his way of thinking as “cynical pragmatism”, capturing both his desire to be solution focused, and the hopelessness he feels about the (im)probability of change. As the interview progressed his expressions of passionate idealism, gave way to demonstrations of frustration. Tom struggled to identify the stakeholders. He questioned, who he should be supporting, and how that is best done. Tom told of how entrenched ideologies have resulted in key players being duped into fighting against themselves. He questions if he has bought into the propaganda:

“I feel like that (deficit) model’s so strong that families absorb those narratives on a lower level and then often- people getting used to it, and including my- well, I don’t know, it’s hard to say, but including myself at times...”

“and I think what... at various times, what are we doing? And what are we paying money for? and is it who’s best interest is it in? Um, you know, are we pro—protecting professionals to keep our jobs in this instance? Or actually are we doing best for the child and family?,”

His is a story of disenchantment. He believes psychology, as a profession, has become part of the problem. He described that:

“There’s something for me about psychology that’s sometimes not helpful in my view, un, we’ve kind of claimed to be...the height of interventions and the height of assessments and the height of formulations and the height of the work that we will make the difference in some ways...there is a prestige or otherwise, and it can be threatening to lose that, rather than empower others or communities”

Tom describes CAMHS as being a “sinking ship”, not fit for purpose and mentioned that he feels “washed away”. This evokes a strong visceral image: of psychology – the profession that had been the beacon of hope, instead representing an empty vessel. It is a façade. In his analogy, it is the children that are drowning. Fragmented services act as icebergs. Tidal waves of conservatism: “regulation, requirements for standardization and governance”, have meant that services have become “so safe, constrained, mainstream”, that their value has been “pummelled out” of them. Experience has shown him that psychology is no longer seen as the saviour:

“we’re going to need a rethink”

The situation is so dire that the old solutions are no longer viable. Creative experimentation is needed. Tom suggests that relational compassion and openness would help “drop the professional façade”. It was clear that Tom hated this dishonesty.

The end point of Tom's story centred around a sense of hopelessness. Tom acknowledged that he can't work as he has been any longer but was unsure of what comes next. At the time of taking part in this interview, he shared that family and personal life circumstances temporarily meant he to "had to take a break" and "*just work*". His aspirations thrust aside by the "day to day grind":

"it feels like a sad way to be having to think in terms of coping, survival, management."

This represented a gap between form and content in his narrative creating a sense of his story being unresolved. For Tom the reality of work, hasn't matched its promises and working outside of his value base has taken a toll. He positioned himself as at fault:

..." I used to have high standards... I still have hi-, re- reasonably high standards **sort of** like, you know, I'd want to do a really good job, and then I became... I have to do a good enough job, and that became where I'm at nowadays, sometimes it's... I have to do an okay enough job, within what resources and what's available to me. Um, and sometimes I do a bit of a crap job. Um, and I think that's hard as a practitioner"

#### 5.2.5. Anne

Anne's story of self is also one of conflict, an internal battle of "head versus heart". She opens by centring the idea that for her, psychology is a vocation, a late career change, wherein she feels she is still in the early stages of a new journey, committed to her profession and the patients she supports. Like previous participants, she proudly identified with the espoused values of clinical psychology, despite describing aspects of her work as "morally questionable". Herein lies the core of her main dilemma. Anne describes a service model that practices protocol driven, prescriptive, decontextualised, individualised therapies:



“the emphasis on, kind of, individual change and individual responsibility to change just feels really difficult to me”... “actually quite often the work that we do doesn’t fit that (model) at all”

But rather than report or challenge this, she noted that all clinicians tended to routinely alter session notes (“to make the note look more CBT”), offer sessions to those that should technically be excluded (“we fudge it a bit”) and work extra hours to do the parts of the work (housing letters, benefit letters) that are in line with their values (“I can’t see a chance for meaningful change without change in the environment”). This “wink” was described as being so commonplace, that it could be said to be a cultural ethos:

“we know it’s that, but well call it this, in order to tick this box for audit purposes”... “to keep the service funded”... “it’s not necessarily reflective of what’s happening on the ground”

For Anne, having to work in this way feels dissatisfying and distressing. Like others, she feels under pressure, “expected to do more with less”, as services are “oversubscribed”.

“what we’re finding really hard is the parts of the system don’t feel like they work together, because everybody’s under resourced, so everybody’s protecting their own... I’d really- I’d love to kind of understand because they can’t (pause) uh, I think- I’m not suggesting that the people who work in {commissioning} is bad people at all, I think they’re just working within an under resourced system and they have to make those kind of decisions, but I’d- I’d love to talk to them actually about how they feel about some of those decisions that they have made because you know, they can’t believe that it’s the best for the person”

The second part of the interview began when Anne’s animated tone, briefly gave way to resignation. I suspect reflecting upon her dilemmas, was too hard to hold, as she quickly changed topics, distancing herself from concerns,

by favourably comparing the scope and quality of work that she can achieve in her service to others:

“in some ways I’m fortunate in that *at least* I’m allowed to do what is right for me”

This set the scene for her positioning. She describes how she wants to be involved in changing ‘the system’:

“I can’t sit and listen to it anymore, because I’m finding it distressing you know, so I need to do something about it...”

However she feels petrified to do so, as her experiences witnessing scapegoating in previous posts, has taught her that ‘speaking up’ has consequences. She portrays advocacy as a futile and dangerous exercise (“nothing changes”). It is not the system that will be considered to be flawed, but the individuals reporting it:

“troublemakers” are “very badly tolerated and VERY badly sort of seen within the system...which is a shame really isn’t it, because you need advocates like that within the system”

For Anne, this despondency is a key part of her distress. Her tone is sad, her positioning self-critical.

“I’m relatively fortunate...my supervisor understands that this is the reality of the work”...“But – there’s also, there’s something I always feel uncomfortable with, this idea of, if we’re complicit with the system, it will never change.”

In Anne’s narrative, it is her role within the system that maintains her distress. Unlike the colleague who was bullied until he left the service, Anne remains, in a senior position, with responsibility for other colleagues wellbeing. On a surface level, she has a leadership role in this “tragedy”. Yet, she continues to feel powerlessness, excluded from decision making at a service level, feeling personally exhausted, underused and undervalued.

“I’m pretty senior within the team and I think there’s a little bit of an expectation on me to be a kind of representative for people...I do sometimes feel the pressure of that because you know, I’m relatively (pause) completely powerless to make any sort of change ....I think lots of clinical psychologists find this is very eroding over time and I think that’s why lots of them leave or you know...It can be quite corrosive....Once you start unpicking this stuff, it all gets a bit hard, doesn’t it, really (deep sigh)”

Anne ended our interview summing her experience with an analogy:

“It feels to me like you know, the bit at the end of star wars when their trying to blow up the death star and they’ve got to get whatever it is down into the little exhaust port, that’s what it feels like were trying to do, it feels like were trying desperately to you know, to work out how we get the rockets, the bombs into this tiny little exhaust port and we keep hitting the sides rather an getting it down the tiny port”

The Death Star was the empire’s ultimate weapon: a place of power, inhibited by top officials and stormtroopers the empires main manpower, a war machine that functioned as a small militarised city, a site where power was consolidated, considered impenetrable by many, including those in control. In the moment Anna describes, it was being attacked by a rebel alliance, who had refused to bow to its technological terror, the odds were stacked against them. It seemed an impossible task. In the movie, Luke (key character) switches off his computer and relies on his instinct and training to guide him, and succeeds in targeting the single point of weakness, destroying the star. In Anna’s analogy, she is part of the team that, like Luke, represent the rebel (vulnerable) side, however, in her version of the plot, they keep missing the target. Yet, she hasn’t given up. There is optimism that despite feeling as if the system is indestructible, perhaps one day, the right move, will bring about explosive change. This is what keeps her going in her work, and the message she tells herself, to “balance” her distress. She is working for a greater cause; her heart is what keeps her going in battle.

## 6. CHAPTER 6: SYNTHESIS, THEMES AND DISCUSSION

Synthesising the stories acted as an opportunity to explore the patterns and connections in CP's experiences, showing a master narrative present throughout the interviews. Images of war, battles and fighting functioned as a monomyth (Campbell, 1949) repeated across all participants, albeit with endless variations, plot twists and individually situated positions. In this section, I have captured these experiences in three major themes (See: Table 1). Foregrounding those that best respond to the research questions.

Table 1: Thematic Map:

<b>Theme:</b>	<b>Sub-theme:</b>
1. War of Attrition:	1.1: Death by 1000 cuts
	1.2: Witnessing harm, feeling powerless.
2. Responding to conflict	2.1 Compartmentalise and comply
	2.2: Becoming disruptors: Small acts of resistance
	2.3 Friendly fire: Scapegoating and other acts of character assignation
	2.4: Perpetuating problematic systems
	2.5 Surrendering or Deserting
3. Reflecting on the aftermath	3.1: Seeking an armistice
	3.2: Making personal reparations
	3.3: Hoping for a trainee-led uprising

### 6.1. War of attrition

The first theme captures participants experiences of moral distress. For all, the cause for conflict centred around system expectations, multiple voices retold stories of working in ways that they felt unfair, unfitting, and unsafe. It was witnessing this harm, and recognising their own roles in the battle, that led to distress.

#### 6.1.1. Death by 1000 cuts

Moral distress did not occur autonomously. Instead, it emerged through interactions with 'the system', including in response to feeling constantly

confronted with ethically difficult scenarios, imposed by deteriorating, under-resourced services, as a result of governmental restrictions and institutional constraints.

“what we’re finding really hard is the parts of the system don’t feel like they work together very well at the minute because everybody’s under resourced, so everybody’s protecting their own resource, and whether consciously or unconsciously, that meant- means that they make decisions about protecting resource rather than what’s best for the person, the individual, so quite often we’ll get people rejected because they’re um, not you know, they’ll be deemed to be not in crisis and it feels very frustrating because we know the people well enough that we know where they are heading, you know...” (Anne)

Anne’s implied shared understandings here, was common in participants narratives, indicating the commonality (and acceptance) of such restrictions on their practices. All participants spoke of working in fragmented, inaccessible services, where they had to manage “ridiculous caseloads” (Maya), “too long wait lists” (Beth), witnessing “people pushed to point of crisis”, “everyday” (Tom):

“you can never get care at the point you need it. Then when you do get there. You’re offered something short term, often put on a separate hidden waiting list” (Maya)

All felt that services had become “a numbers game” (Sara), focused on the number of clients, number of diagnoses, predominantly following ‘prescriptive, protocol driven’ models (Sara), that failed to fit with patient needs nor practitioner values. They were ashamed of the quality care they were being asked to deliver.

“the system enacts some horrible, horrible patterns in terms of care: People get well and then get discharged, which makes them feel abandoned, so then they have to act out to get back into the care system, which reinforces everything we were already struggling

with...that's really hard to watch people go round and round like that, a lot of times" (Maya)

"there's a great deal of blame and shame towards families who are disadvantaged...a constant message that they are doing something wrong...a punitive model where it funnels down, reinforcing of the message... it's communicated to the child, there's something wrong with you and you know, your behaviours out of order" (Tom)

When referring to cuts, or perceived service limits, participants spoke in exasperated tones, using clipped sentences and expressive language. Their descriptions painted images of erosion, that led to the framing of the first theme as a 'war of attrition'. The pressure was evident and their frustration powerful. There was no 'one main incident' as a trigger for MD – instead, all participants described that how the cumulative aspects of working as psychologists in the NHS, felt like "death by 1000 cuts" (Sara). The "corrosive daily grind" (Tom), "ground down" (Beth) their hope and energy.

#### 6.1.2. Witnessing harm

The system alone was an important but insufficient as a sole cause of MD, as although it captured the pressure participants felt under, it missed the affective and aesthetic dimensions of participants stories that were fundamental to the appearance of distress.

There was a sense that power's top-down distribution limited opportunity for change. At a macro level, participants described how the pathologisation of distress distributed responsibility onto individual patients, obscuring social and relational contexts, which sat at odds with their values as practitioners. What was clear from the narratives is that these difficulties were so commonplace they were 'accepted' as 'routine' part of practices.

"Because we get used to running on so little in the NHS. It feels like pointing out something fairly standard (pause) suddenly becomes a massive ask. It's **our** low expectations sometimes." (Maya)

For participants, there was a shared perception that they ought to serve as moral community leaders. They spoke of how they were expected to bring about change to improve well-being but outlined that this often felt like an “impossible task” (Tom), as organisational and systemic factors were constantly eroding their ability to do work that matters (all). Their professional obligations were not in line with professional values.

This was most obvious in examining the canonical narratives – a term was coined by Brunner (1999) to capture ideas of how stories should be lived. Participants told patients stories with understanding, empathy and compassion. Their validated their hurt and contextualised their difficulties. While each participant had their own positioning, there was nonetheless a shared belief in what constitutes wellbeing in line with broader tenements echoing ideas of Maslow’s hierarchy (1943), with all participants acknowledging that emotional wellbeing and happiness require that people are not struggling to meet their basic needs (food, housing etc). For example: Anne told a story of a mum who was advocating for her child’s care but was “just small enough to ignore”. The child had made attempts to end their life, the family were living in unsuitable, insecure housing. Anne, who was recalling completing a community assessment, reflected:

“**I hate**- sometimes that mum had done everything that she could, she’s made all the complaints to all the right people ... So she’s been **really** proactive, (pause) but you know, but it was me as a - you know - as somebody with ‘**doctor in their title**’ writing to the head of the housing association and copying in the MP and the councillor that she’s been involved with that got things moving in a more meaningful way, ...and I felt slightly (pause) you know, I always feel uncomfortable that it’s the kind of white middle class professional ‘riding in’ in that gets things moving when, the mum should’ve been able (exasperated sigh)”

However, these ‘core tasks’ supporting patient wellbeing, were often only catered for, by working outside of their job roles and working hours.

Anne: Em, Well I mean obviously it's over and above my job, isn't it, so you know, so it's not- it's not part of an hour long CBT session, but you know, I made time for it.... I guess that was- for me that was a way of managing. It's that thing of I can't sit and listen to it anymore because it- I'm finding it distressing you know, so I need to **do** something about it so I guess you know, **doing something** was definitely my way of coping with the distress.

Langdrige (2007) asks researchers to attend to stories untold. A re-reading of the data prompted me to return to certain sections of participants audio. I noticed that emotional cues (i.e. caught breaths, tense tones, clipped sentences, quick subject changes) were most prominent when participants were reflecting on their own roles and positions in their daily practices. The emotion was assigned to their roles, working conditions and workplace decisions. The voice with which they discussed patient harm, was not passive. Practitioners felt they were both witnessing and working for services that could harm. Throughout their stories, there was a tightly woven subtext of distress directly relating to issues of power. Patients expected them to have power, but they themselves felt powerless. This created tension, and subsequently, split responsibilities. Participants described feeling complicit, as their powerless rendered them unable to meet professional obligations:

"I'm definitely one of the- the smaller cogs even though I'm a bigger cog- big cog at a team level, I'm a smaller cog further up, so- and certainly not linked directly to the big cog, so there is that" (Anne)

## **6.2. Responding to conflict**

The second theme captures how clinical psychologists responded to conflict. The relationship was not a simple transaction of cause and effect, but instead, saw participants transition through stages: redefining their role, their ideas of what one can achieve and their relationships to patients, the service, their own work and



themselves. Their distress impacted on multiple dimensions. This is explored in further detail below:

#### 6.2.1. Compartmentalise and comply

Stage one describes how participants initially felt a responsibility to 'get on with it', to 'play the game' and prove their worth to their teams. Within their roles – participants spoke of responding by “doing more”, working longer, harder, making space outside of core hours to do the aspects of work that they felt important – examples of the 'hidden caseload' (Maya) included, writing housing support letters (Beth, Anne, Tom), welfare assessments (Tom), adding appendices to diagnostic assessments that offered tailored recommendations for support (Maya, Anne), researching and providing links to third sector agencies (Beth, Tom) and supporting team wellbeing (Beth, Maya, Sara). Until they found that they were emotionally exhausted, turned towards something new.

“I put so much, you know, I've given so much of my personal time and my personal energy, and I come back... like - I've been working late, I've been, you know, going so far and above and beyond at work, I come back tired (Sara)

#### 6.2.2. Becoming disruptors - small Acts of Resistance

Stage two saw people describe taking a 'curious', 'questioning' stance towards the elements of practices they were finding challenging. Common behaviours included raising queries in meetings (all), applying for leadership positions (Tom, Maya, Sara), turning to supervision (Beth), speaking 'up' to those in higher roles (all), raising safeguarding (Maya). All participants spoke of how these small acts required finding moral courage, as 'disrupting the status quo' (Tom, Maya, Sara) meant preparing themselves for attack.

“that's an extra level of stress when you feel like you're fighting your own profession sometimes” (Maya).

### 6.2.3. Friendly fire

It struck me that in every interview, I heard stories of isolation, of fear, of feeling “like a lone voice” (Tom). In parallel to the services they represent, practitioners felt siloed, fragmented from their teams, peers and colleagues. Like the patients they were expected to treat, their common experiences, were personified. Mirroring how the clinical systems located problems in individual patients, the management systems also individualised blame, condemning any individual who dared question the ‘status quo’. It seemed as if distress intensified, when participant’s felt silenced, stigmatised, or cast out.

“I put my head on the parapet, I say the things that need to be said...that is not easy, it’s a hard thing to do. What you end up as is scapegoated, as the people who do it, all leave” (Sara)

These experiences rendered those that acknowledged and challenged difficulties, feeling personally and professionally isolated. There was a resounding agreement that speaking up, in any way, was an unsafe act (Beth, Anne, Tom, Sara).

“I think that’s case across large parts of the NHS. It just takes one bad manager to completely destroy a team’s psychological safety. And then that’s hard because whatever stress you’re feeling you won’t be sharing” (Maya).

Services response to (system/care) difficulties was characterised as:

“shooting the messenger time and time again” (Sara).

All participants perceived that speaking out spurred their superiors to ascribe to them a personal characteristic that they did not wish to be seen to have, unwanted identities that had the potential to impair their professional identity. Those mentioned included – incompetence (Sara), inexperience (Beth), insecurity (Tom), anxiety (Maya), an inability to cope with the demands of the work (Anne). It eroded their values and identities as practitioners, and as people, and evoked strong emotional responses in those that shared their stories.

#### 6.2.4. Perpetuating problematic systems

A cost of this, was said to be the creation of an unsafe system. Parallels were drawn to previous NHS healthcare scandals, including the Francis inquiry:

“I can totally see how that would happen. I can see how that would happen almost everywhere I’ve ever worked” (Sara)

Although best captured by Sara, the sentiment of “top-down management” only being interested in stories of service success, was a common theme. Examples given included the routine dismissing/ignoring of high turnover (Anne & Maya), the purposeful designing of data such as excluding those who dropout of therapy (Beth), or who are unable to access services (Tom), the bullying of those who spoke out or dared to whistle blow (Maya). Sara described how selective consulting was so routinely practiced in services, to the extent that the NHS was said to be “creating a culture where there is not going to be any candour. Where problems are not going to get resolved...It’s just numbers” (Sara). The human aspects of mental health care were said to be eroded.

These were “the gems”, the small remarks that were key to showing participants’ grasp of the world. Participants were accepting that their working conditions were unsafe, both for themselves, and for patients, but exhausted by the battle.

#### 6.2.5. Surrendering or deserting

In turn, this spurred people to turn to the final stage, which I’ve themed ‘surrendering or deserting’. Participants described responding to distress by repeatedly moving jobs (Anne), trying new trusts (Tom, Sara, Maya, Beth), new areas of practicing (Tom, Sara, Maya, Beth), hoping new teams would be different. Occasionally there were stories of success. Beth and Maya described being significantly happier in their current roles. However, many also spoke of losing hope, of turning to private practise – at least part time - to find balance and respect a desire to practice in line with values.

“I used to be absolutely horrified that clinicians would use the same rooms as, to see someone privately after work, for money... and I was just shocked and flabbergasted, but now, I’m not at all...- it’s not about the money. Everyone I know who has worked privately is MUCH happier because it’s much better and they are much freer and it’s much more liberating” (Beth)

### **6.3. Reflecting on the Aftermath**

The final theme captures the perceived consequences of distress, including participants reflections on the aftermath of their experiences, and the solutions they offered for ‘resolving’? moral distress. It struck me that despite all of the difficulties named and spoken about, and the hurt carried in the narratives, overall, there was a sense that hope for restitution was not lost. Three key patterns of responding stood out for me:

#### 6.3.1. Seeking an Armistice

Primarily, participants described wanting to feel heard. They were seeking a peace agreement, willing to accept compromises in what the system can offer, acknowledging resource difficulties, but asking for respect, and to be allowed to practice in ways that support patients and their care. There wasn’t a ‘one-size-fits-all’ solution. Instead, there was an understanding of complexity, and multiple causality, and a wish to be heard.

Everyone hoped for change, all shared a belief that something different would be better. Most had realistic solutions, however, there was limited unity in the ideas shared. As a researcher, I was left with a sense that the focus has become a fight on what the system changes too, rather than that change is needed.

#### 6.3.2. Making personal reparations

A commonality was that participants turned to spaces outside of the NHS, to use their skills. Many described finding spaces for activism outside of their daily roles, via social media platforms (Sara, Beth, Maya, Tom), continual professional development (often self-funded) (Sara, Maya), establishing likeminded peer reflective practice groups across trust (often facilitated and attended outside of

core working time) (Anne). These initial actions were often motivated by events in their daily workspaces, yet hidden from their colleagues, teams and supervisors. Seen as individual attempts to redress injustices and reinstate balance in their practices.

### 6.3.3. Hoping for a trainee-led uprising

“The trainees are amazing, because trainees question straight away” (Beth) Finally, rereading the data led me to characterise that the conclusions of the interviews mostly had a similar theme. Perhaps, people were concerned about my role, as a trainee clinical psychologist – about to enter the field that they had spoken so disparagingly about. However, few were apologetic in this regard. Instead, it struck me that they often wanted to believe their final ‘change’ in tone, that there could be a ‘magical fairy tale’ world. There was a near certainty of people, that change to the better was possible. The dystopian world, the nightmare vision of an autocratic government extinguishing the rights of its citizens was pushed aside, and a highly ideological plan was made for an uprising. Led by trainees and those coming into a “changing profession”, who could trigger cultural change.

“we’re quite lucky ...we’ll take trainees [location removed], who are very, politically and systems minded which is lovely because you can see that sort of ripple out through our Trust” (Maya).

This was a fantasy with a marked ‘dissonance’ gap, change is needed but they can’t lead it. Their identities as helpers, were in contrast with their descriptions of how the work was eroding them. Yet, although there was burnout, there was no sense of compassion fatigue in narratives. Instead, the tendency was towards hoping “someone else” will find the solutions to “fix” what is happening.

## **6.4. Applying a critical analytical lens**

Stage 5 of Langridge’s methodology tasks the researcher to explicitly stand back from the data and apply a hermeneutic of suspicion, to read beneath the ideas. This final stage of the analysis was a critique of the narratives from a group

psychoanalytic perspective. As acknowledged earlier, the current political, social and organisational context of healthcare work is providing the conditions that generate heightened levels of anxiety. The NHS - and in particular mental health services - are operating as if in organisational crisis. Introducing the psychoanalytic lens at a systemic level (to examine power, form and function) highlights how current work has come to be out of line with practitioner values, and partly explains the patterns in responding to distress that are outlined above. Evoking reactive, rather than reflective, responses.

Given the breath of psychoanalytic ideals, a comprehensive analogy of all concepts couldn't be captured in the space available below: Table 2 attempts to capture the core theories that most relate to the narratives told.

Table 2: Linked Critical Psychoanalytic Theories

Themes	Core Components of MD	Adding a critical psychoanalytic lens.
War of attrition	The causes of distress	Systemic level: NHS defensive practices – distorted function. Fragmented services. Corporate ethos/fail to care. Political influence – cutbacks etc. competing for resources.
Responding to conflict	Responses to distress	Displaced anxiety. Splitting, mirroring, projection. Shifting blame (them us, isolating, scapegoating). Depersonalising Creating a 'psy-complex'. Group dynamics.
Reflecting on the aftermath	Implications: personal, professional, career level	Identity issues (failing to care). Death wish (i.e. leaving/abandonment of task). Burnout and emotional exhaustion. Unhealthy Ethical climate.  Solutions. Creating the space for cultural change.

#### 6.4.1. The nature of healthcare has changed

Object relations theories (Klien, 1921) partly explain how the political setting has transformed the NHS: The NHS was born in an era of post war thinking that sought collectivism and care, but now operates in a neoliberal culture that prizes individual capitalist success. No longer the universal, single and free at point of service system it was designed to be, it now functions as a neoliberal privatised organisation (Pollock, 2004), fragmented into 'foundation trusts' that are run like private businesses (Long, 1999) and have to compete against each other for, increasingly insufficient, resources (Hoggett, 2006, 2020). Spurred on by unconscious dynamics and fantasies that defend against anxieties of ageing, illness and death at population level (Fotaki, 2019), the focus has become profit maximisation. The constant fight for survival, undermines collaboration and compassion (Ballant & Campling, 2014). On an organisational level, the NHS itself is the fish out of water (Eilas, 1994)! It has become a battle of values versus power, that subsequently permeates the configuration of core of mental health services throughout the NHS (Pope & Burns, 2003).

This can be seen in our narratives: the stories told were snapshots, from individual practitioners, in different specialist areas of care. Yet, all participants spoke to a theme of increasing pressure to do 'more with less'. Stories of moments of compassionate care, were at odds with peoples' characterisation of services: repeatedly, staff teams were described as highly qualified, but resource poor. The daily 'jobs' of clinical staff were constrained. Staff were overworked and often unsupported. Frustration was felt in response to a lack of resources, a lack of consensus on what constitutes good practice, a lack of time, an excessive focus on outcomes and paperwork, ways of measuring that masked the true picture, remote from the realities of patient experience. The constant threat of cuts, resulted in desperate compliance, despite acknowledging the absurdity of the system requests. Participants recalled feeling compelled into performative action.

Menzies-Lyth's (1960/1988) writings explain how healthcare systems fail to care. She uses psychoanalytic theories to help us to understand how the

displacement of anxiety and blame, mean we can see these events, not individual experiences, but as patterns on a systems level, that accumulate to cause MD. Anxiety is displaced, fragmented into self (practitioners) against others (patients, the system), creating complex patterns of 'splitting', in line with Foucault's 'othering'. She explains that healthcare systems, avoid 'worrying' about the difficulties involved in healthcare work (namely the psychological stress of navigating suffering/death), by developing modes of functioning, that in-turn project anxieties into the work (categorisation), the workers (detachment and denial) and the patients (depersonalisation).

#### 6.4.2. Our understandings of distress have changed

Marketisation, is also said to have changed our understanding of health. Bell (2013) highlighted that a market-based approach to healthcare, results in the commodification and instrumentalisation of mental suffering, as consumerism defends against ideas of collective responsibility. Long (1999) labelled this the social cost of patient choice. From a psychodynamic perspective, fantasies of invincibility deny the inevitability of aging, disease, and death, and enable us to distance ourselves from the vulnerability of dependence. Or put more simply, the trend to medicalise misery (Thomas, 2019), means social contextual and political difficulties and differences, can be labelled and individualised. Such system shifts have 'responsibilised users', resulting in illness and disability being considered issues of lifestyle and choice (Fotaki, 2019). Exacerbating a toxic attachment between professionals and those in their care (Long, 1999).

#### 6.4.3. The work environment of the NHS has changed

Campling (2019) writes about the increasing misfit between industrial models and the task of delivering therapy. She expands Balint's observation that the humanistic values of healthcare are eroding rapidly under pressure from industrialisation (Balint, 2014). Noting how fast throughput, narrow focus, strict exclusion criteria, time rationed provision, and the introduction of manualised scripted therapies (all factors mentioned by participants as experienced as stressful in their roles) turn the emphasis of therapeutic work towards conformity, rather than quality (Gerada, 2020). An unintended consequence of



standardisation is depersonalisation (Risq, 2019). Patients feel objectified, while therapists feel distanced and deskilled (Rose, 2020). The lack of continuity of care, further disrupts both the therapeutic alliance and the therapist's own needs for containment, to access endings or whole stories. Leading some recent critics to summate that "Practising disappointment" has become the norm (Scanlon, 2011, p. 117). It's understandable that to avoid emotional burnout, health professionals detach (Risq, 2019).

Taken together these evolutions have induced a culture of fear, culminating in an existential anxiety among healthcare workers that they are witnessing and participating in the death of the NHS itself (Gerada, 2020). Not only is the work out of line with practitioner values, but the current structure subverts the type of care that the NHS is mandated to provide. This fetishization of governance upholds the myth of transparency and functionality, but it also requires clinicians to engage in a lying relationship with reality (Rizq, 2014). The institutional task becomes repressing the rhetoric-reality gap. The NHS' capacity for consideration, reflection, questioning, and tolerating uncertainty has been reduced (Malda-Castillo & Anderson, 2022). This results in clinical and organisational decisions that are defensive and leave little room for complex emotional responses to be processed. The system itself has become stuck and traumatised. To detach from its failures, it turned to cycles of idealisation, splitting and blame (Fotaki & Hyde, 2015). Pressure is spread in a cascade effect (Imison, 2018), and blame is projected onto others, creating extraordinary tension at the heart of the work environment in the NHS:

"The primary task of therapeutic health work (becomes) encountering this psychosocially constructed 'monstrousness' without becoming 'monsters'" (Scanlon, 2021, p.117).

The themes generated from participants' narratives capture this tension, they show how services were characterised by cultures of exclusion, fragmentation, and blame. The good pockets of thoughtful effective work represented segments of individual's devotion, whereby participants wanted to make a difference to peoples' health. Yet, often this was described as being

part of the 'vocation' of clinical psychology, rather than part of the business of the core profession. Serious concerns were raised about the transformation in NHS culture – towards care that could condemn and exclude the vulnerable, rather than seek empathetic understanding of them. Overall, the narratives left the impression was of the NHS as an 'unethical' culture whereby people were battling to re-install compassion, at the heart of healthcare, and were concerned that this was a hopeless task.

Overall, taking a psychoanalytical lens, highlights that the organisational culture is producing insecurity and competition without adequate containment, thereby reducing safety, increasing anxiety and fear and undermining meaningful learning. This research continues to build on Lyth's warnings, highlighting that there is a danger that unless the organisation understands the damage that it has caused to itself, reparation will be impaired. The hopes that the clinicians expressed above, will be diminished.

### **6.5. Synthesising the story of MD**

Creating a theoretical definition of Moral Distress was beyond the scope of this study. However, there were important aspects in participants narratives and themes, that contribute to the existing debate about the causes and contexts of Moral Distress. As a concept, MD was known and used by three of the five participants, but all five described experiences of distress that fit with current definitions of MD. Participants stories situate MD as an emotive experience, linked to multiple experiences of being unable to work as they would wish too, and in particular, to feeling that they were part of something that was doing/causing harm. Distress was located in the inevitability of the experiences of system constrains and the inability to create change.

### **6.6. Analytic reflections**

Given the exploratory nature of the topic, it felt important to explicitly name in the research questions that I was looking to understand participants experience (or lack thereof) of the construct of moral distress. While I understand that in doing so there

is a chance that my 'MD tinted glasses' risked the analysis being vulnerable to confirmation bias, I chose to do so as I worried that not naming MD, would mean missing the chance to understand it. This was an analytic tension present from the outset of this research: I set out to explore a previously unexplored topic (therefore likely unknown in the population), while also wanting to understand it and contextualise it. While I believed (based on the evidence) that it was likely to be relevant, as a researcher I remained open to the possibility that the concept wouldn't fit with participants narratives.

However, I was not expecting the level of distress that CP's expressed in their narratives. I was stuck by how difficult participants' experiences sounded, and how extensively they had tried and fought to work in line with their values, to make systemic changes. Every person described a similar system response to their distress (personalisation, projection, blaming), that was experienced as an individualised, isolated and isolating process, but was shown in the synthesising of narratives to be part of a wider pattern in teams, and in systems. This tells us something important about how distress operates, but as a trainee clinical psychologist, it was hard to hear.

I recognise that I due to my etic and emic roles, I occasionally found myself analysing the participants, rather than the problem. The reflexivity tasks embedded in CNA procedure supported me to recognise that I also had this desire to individualise distress (burnt-out, or distressed, individuals are easier to support, than broken systems). It reminded me that I, and my participants, as clinical psychologists, have a professional tendency to turn an inwards analytical (and often critical) lens. This contrasted with the task of analysis exploring MD as an experience that is theorised to have its roots in the social, political contextual factors. MD wasn't just about having to work in broken systems, but about CP and mental health systems role in perpetuating them. Taking a CNA lens was therefore an essential approach, to understanding how Moral Distress exists and operates in the psychology workforce, that I believe helped me to avoid falling into the pitfall of 'cultural blindness'.

## 6.7. Relating my research to the MD literature

The study aimed to explore whether, how and why clinical psychologists experienced moral distress and to consider how they construct, navigate, and manage these experiences in their personal and professional identities. As documented in Chapter 2, there are many different conceptual definitions of MD in the literature, with debate centring on variations of proposed causes, characteristics, and consequences of MD. The stories explored in this study were broadly consistent with the range of factors outlined previously. Participants spoke of relentless organisational (institutional) pressures (Jameton, 1984), to act in ways that were inconsistent with deeply held ethical values, principles or moral commitments (McCarthy & Deady, 2010) resulting in psychological (Wilkinson, 1988) and physiological stress effects (Nathaniel, 2006).

Overall, the experiences of MD was prominent in all of the narratives in this study. Participants spoke of the distress they experienced, because of thinking, feeling and worrying about having to make 'impossible' choices, when responding to ethically challenging experiences. Causes for conflict centred around system expectations, being asked to work in ways that participants felt were unfair, unfitting, and unsafe. The difficulties raised, correspond to long-established issues in the NHS (see Chapter 1). Participants described how competition for funding, meant often working within inadequate care structures, in understaffed, under resourced services. Where workplace demands, such as the pressure to follow 'prescriptive, protocol driven' models, often meant clinical work failed to fit with patient needs or practitioner values. Taken together, the individual narratives painted a depressing picture of the NHS: It was characterised as a deteriorating, dysfunctional system (Sara), that requires people wait for too long (Beth), to access disempowering (Tom), inappropriate (Maya) and unhelpful (Beth) models of care. Each participant outlined series of examples acknowledging itrogenetic harm. As practitioners, there was a sense that participants were ashamed of the quality care they were being told to deliver.

Synthesising the narratives, highlighted how emotive an experience MD was. Ultimately, being unable to work as they would wish to (Jameton, 1984), linked with

feelings of powerlessness and anger, both towards themselves, their work, the health service and the political agenda. The experience eroded participants personal and professional identities, repositioning relationships. Identity work showed that the response relationship was not a simple transaction of cause and effect, but instead, saw participants transition through stages: redefining their role, their ideas of what one can achieve and their relationships to patients, the service, their own work and themselves.

Echoing previous studies, coping with distress depended on a fear of repercussions (Hameric, 2014) and whether people had team support (Corley, 2005). Patterns mapped traditional trauma responses (flight, flight, freeze, appease). Most participants felt the current healthcare system was not supportive during challenging situations. The expectation was that people would comply, do more with less, work harder, until they burn out. The difficulties were so commonplace, they were considered routine parts of practice. Challenges were unwelcome. The systems response to being questioned, was to personalise doubt, and transfer it onto the individual. Participants told multiple stories of being isolated, scapegoated, fragmented either within their teams, or from broader services. Mirroring how clinical systems located problems in individual patients, management systems also individualised blame. A cost of this aggressive organisational strategy, was the creation of an epistemically unjust and unsafe system, akin to that found in the Francis report:

“I can see it happening everywhere I’ve ever worked” (Sara).

In this regard, the experience of Moral Distress, was not defined by ‘constraint’ (as per Jameton’s original definition) as it alone was not a sufficient condition. Instead, the individual narratives in this research highlighted that distress was located both in the inevitability of the experience, and the inability to create change. Practitioners felt they were both witnessing and working for services that could harm. MD was depicted as an overwhelming emotional experience, that occurred in a repetitive, cumulative fashion, evoking varied stress responses, whose impact intensified over time. Throughout participants’ stories, there were tightly woven subtexts of distress directly relating to issues of powerlessness (Barlem & Ramos, 2019), with

practitioners feeling complicit in perpetuating a (vicious) cycle! These issues didn't appear to relate to agency and autonomy (as Peter and Liaschenko 2013 proposed), but instead to feelings of responsibility and a recognition that the work itself was requiring serious compromises in integrity (Hameric & Wocial, 2013), at an individual and systemic level. The NHS was depicted "as a depressingly impenetrable system, resistant to change" (Anne). Characterised by an epistemically unjust organisational culture (Fricker, 2007), where psychologists were routinely excluded from the decision-making discussions that mattered (such as commissioning/service design).

This limited any instrumental value (Tiggard, 2019) that MD may have been assumed to have held, as although some participants were able to use their experiences as catalysts for change (Beth, Sara, Maya), often this involved finding safe spaces outside of professional roles for reflection and action and withdrawing from NHS work into private practice. In effect, seeking solace outside of the system. Leaving (or deserting as per theme 3) was seen as a protective action. The battle for change was best fought from outside.

However, it was the final subtheme, that marked the greatest differentiation from the literature. Despite the extent and impact of the distress experienced, participants retained a sense of hope. This is a novel contribution extending the current literature. MD was consistently identified an issue of organisational culture, as a problem that requires resistance, not resilience! There was hope that incoming trainees - those not yet 'ground down', by the 1000 cuts – could change the narrative. Perhaps they'd have the energy, the participants had lost.

## 7. CHAPTER 7: IMPLICATIONS, EVALUATIONS AND CONCLUSIONS

### 7.1. Implications

Included in my research aims was a consideration of the broader social, cultural and political narratives that may have been influenced or shaped by participants experiences of moral distress. This research supports the literature: Funding cuts have placed increasing pressures on the system, pushing clinical practice out of line with practitioner values, increasing workplace dissatisfaction and Moral Distress. Five main areas of implications will be discussed below:

#### 7.1.2. For the NHS

This research functions as a cautionary tale, an in-depth account of what not to do, when seeking to create healthy workplace and healthcare environments. The NHS needs not to be so “depressingly impenetrable” and resistant to change – there is reliable evidence that refusing cultural change is costly. The current practice of prioritising politics and profit over people, has meant the system is reaching crisis point. The NHS is not an ordinary industry. Efficiency needs to be analysed, and balanced, with the need for effective practice. If MD is recognised an issue of organisational culture, the solutions need to be systemic. The MD research has promise, in suggesting pathways that could help change ‘cultural blind spots’. Accountability should be focused on the broader functions of the service – i.e., Is the service caring for those it should, effectively – rather than on throughput, output, or specific models. This would enable less ‘defensive practice’.

#### 7.1.3. For policy

There is a need on a regulatory level to acknowledge that MD exists. To make people understand that this is not just happening to them. To understand the root causes and connections to patient care. The clinical psychologists that took part in this study, believed there is a need for urgent cultural reform of the NHS. They are not the first to call for such change, a series of reports by the Kings Fund (See Ham, 2018) outline the policy changes that would be needed to support a transformation.

#### 7.1.4. For clinical practice

When clinical practice sits out of line with values, there are implications for clinical psychology as a profession that our professional networks have an ethical obligation to respond to. This research adds to the growing body of literature indicating the importance of providing care in environments that align with values and ethics. If inequality influences healthcare outcomes (as previously established), then social justice cannot be divorced from the practice of psychology. Perhaps if more space could be made for the activist-identity (Rahim & Cooke, 2019), within clinical roles (rather than in outside spaces), it would help foster a sense of moral community within clinical practice. Ideally, this should begin in clinical training and be recommended as a core component of effective supervision. However, given the difficulties in advocacy, as outlined in the narratives above, any obligation to recognise and engage with socio-political issues must be accompanied by co-produced professional guidelines and support.

#### 7.1.5. For clinicians

The thematic synthesis highlighted important considerations for clinicians. This research echoes previous findings – that increase job demands, reduced support and control, contribute to poor workplace wellbeing (Harris & Griffin, 2015). Contrary to previous assumptions embedded in professional guidelines suggesting psychologists have immunity to distress (Good et al, 2009), practice-based evidence indicates that the culture of healthcare (Campling, 2015) is more likely to generate moral distress. Although the results here are not generalisable, taken with other research (such as Spriggins 2021, BMA 2021) the research suggests there is a need to have realistic expectations that psychologists will require support.

This study is one of the first to explore clinical psychologists experience of moral distress. The narratives highlighted both the commonality of the MD experience, and unique professional approaches to it. Including: the importance of informal networks, of mentoring, of protecting and prioritising process-based supervision and of being willing to turn an analytic lens to



one's own practice. We can all (unintentionally) be part of the picture that protects poor patterns of care. While it's not an individual's responsibility to create change, change cannot happen without acknowledgement of the problem. Talking about experiences has the power to remove shame and blame and opens opportunities to develop support networks. While organisations need to listen (and lead change), clinicians also need to find ways to have a voice, so they can be more than foot-soldiers in the battle for better care.

#### 7.1.6. For research

MD is not a new concept, there is a need to shift the focus of literature from the concept itself, to its utility. Specifically in terms of application to a psychological workforce, it could be beneficial to collect more data on prevalence. As well as seeking to further our understanding of MD's meaningful contribution, by researching how it compares to other theories of workplace stress: including, compassion fatigue and burnout. Are there differences in aetiology? Does MD function as a predictor? Power-mapping could be an interesting tool to use for future research, to find out if MD is the same outside of the NHS? The difference between "I don't want to be a clinical psychologist" (burnout) and "I am not able to be the clinical psychologist I want to be" (Moral Distress), shifts blame from individuals to system and culture. It has the potential to be a powerful tool in transforming healthcare practice and design.

A second area where it could be argued that this research has impact, is in its adoption of a pluralistic approach. Its strengths and limitations are further discussed below.

## **7.2. Evaluation**

Given the methodological conservatism of traditional evaluation tools (Denzin & Lincoln, 2000), and their limited acceptance of what is rigorous, valid research (Fine, 2016), it was decided alternative evaluation tools would be more appropriate (Smith & Deemer, 2000). However, qualitative research is not a unified field (Cohen &

Crabtree, 2008) meaning a generic set of criteria does (and should) not exist (Schwandt, 1996). Instead I have chosen to review my work against Yardleys (2000) and Tracy's (2010) values for judging quality pluralistic research.

#### 7.2.1. Validity/Credibility

My overall aim was to provide sufficient detail of methodological procedures to enable readers to understand how to conduct multiple analyses and know how knowledge was created (Frost & Nolas, 2011). My decision to include my analytical processes has contributed to making this possible. Thanks to this "thick description", the reader should be able to "audit" whether the interpretation(s) offered are sufficiently supported by the data (Mays and Pope, 2000).

#### 7.2.2. Representativeness

CNA is an ideographic method, in which there is evidence for smaller sample sizes in order to allow the exploration of rich detailed context (Morse, 2015). When examining a sample of published studies using this methodological approach, a range from one to eight participants was found (See: Ling 2013; Langdrige 2013). Whilst traditionally such "low" numbers were said to threaten the validity and generalisability of results (Luborsky & Rubinstein 1995), increasingly single case-studies are having a central place in qualitative psychological approaches (Smith et al, 2009), with nomothetic terms being dismissed in favour of evaluations being based on data adequacy (Vasileiou, Barnett & Thorpe, 2018). Information power is as much about quality of content, as quantity (Malterud et al, 2015). This work makes no claim of saturation. It is exploratory in nature. Given that clinical psychologists are a previously under-researched group, this research offers new, detailed formulations of how they experience moral distress, providing increased representation and sensitivity to context than previously existed in the literature (Yardley, 2000). The limited sample enabled its depth.

#### 7.2.3. Commitment, rigor and coherence

Yardley (2000) suggests that for pluralistic research to demonstrate rigour, researchers should provide adequate description of the procedures used. In

CNA the six-stage analytic procedure is deep and detailed. Its structure is designed as a critical interrogation, that asks multiple questions of the data, encouraging rigour and validity through the application of the varied hermeneutic interpretative lenses that require me as researcher to locate myself, the participants and the resulting findings in theoretical constructs and contexts (Tracy, 2010). Given the novel topic, effort was made to situate the research goals and narratives in literature, noting similarities as well as noting areas of difference, to ensure meaningful coherence with existing theories and paradigms (Tracy, 2010).

#### 7.2.4. Reflexivity

Reflexivity describes how the researcher and the research process influence the data that was gathered (Mays & Pope, 2000). It is said to establish sincerity and enable scrutiny (Tracy, 2010) by discouraging impositions of meaning by the researcher, thereby promoting validity (Willig, 2012) and increasing the integrity and trustworthiness of research (Finlay, 2009). CNA requires the researcher to apply a pluralism of reflective practices, both epistemologically (as per CNA Stage 1, section 4.8.1) and on an ongoing basis. To manage this, I made reflective notes in a research diary during all stages of data collection, transcription and analysis. I brought my reflections to a research group that I co-facilitated with fellow doctoral researchers, which was invaluable in supporting me balance my auto ethnographical sense of myself 'as an instrument' (Ellis & Bochner, 2000), without blocking out the object of the study or the participants voice (Finlay, 2009).

#### 7.2.5. Impact and importance

For Yardley (2017), 'importance' refers to the requirement for all research to generate knowledge that is useful. As outlined above, this research has implications that are useful in clinical practice and in the healthcare workforce, as well as representing a new approach in research that, in-itself, challenges traditional research paradigms.

#### 7.2.6. Addressing limitations

A final significant consideration is that data collection took place during the

Covid-19 pandemic in December 2020. Participants were working in the NHS, navigating the effects of unprecedented changes 'locking-down' their working environments, restricting their ability to offer therapeutic care. However, it was also at an early stage of the outbreak. This timeline may partly explain why C-19 rarely featured in participants responding. When it was raised (by me) Participants tended to highlight how the pandemic had only made already-existing systemic problems worse. There was a sense that the pandemic was a temporary crisis, whereas MD was longstanding.

#### 7.2.7. Final reflections

It was important for me as a researcher to produce a body of work, that was in line with my own values and ontological assumptions. There is nothing simplistic about this project: Choosing an under-researched topic, asking difficult questions, using an emerging research method, taking a political, critical stance – i.e., the nature and design of this research - means that its very dissemination represents a small act of resistance (Wade, 2000). Though I recognise that it is impossible to predict the true meaning of any research, as different readers will construe differing accounts of it (Goodbody & Burns, 2011), by putting the knowledge out into the world, I am hoping that it will have value, whatever the interpretation (Andrews, Squire & Tamboukou 2008), even if simply highlighting existing difficulties and prompting debate into this important but largely unspoken difficulty in the profession.

### **7.3. Concluding comments**

This thesis set out to explore clinical psychologists' experiences of situations they considered ethically problematic and morally distressing. The difficulties raised, correspond to long-established issues in the NHS. The clinicians' narratives positioned CP's as 'at war' with an inaccessible, inappropriate, and unjust systems. They told stories of being constantly confronted with ethically difficult scenarios, imposed by deteriorating, under-funded, under-resourced healthcare services. Of being expected to work in ways that that felt unfitting and unsafe. It was witnessing this harm, and feeling powerless in the battle, that led to distress. Although clinicians wanted to create change, often they found themselves silenced, scapegoated and

exhausted by the system, whose primary response to distress was to divorce it from context and personalise it. The NHS was depicted “as a depressingly impenetrable system, resistant to change” (Anne). Characterised by an epistemically unjust organisational culture (Fricker, 2007), where psychologists were routinely excluded from the decision-making discussions that mattered. Psychoanalytic theories were used as a tool to explain how these defensive practices occur and exacerbate unhealthy ethical climates. These theories and the thematic summaries together highlight important considerations for clinicians, clinical practice, and care systems. This research adds to the growing body of literature indicating the importance of providing care in environments that align with clinicians’ values and ethics. If MD is recognised as an issue of organisational culture, the solutions need to be systemic, requiring changes in policy and practice, to make safe spaces for difficult dialogues, and to foster a sense of moral community within clinical practice.

## References:

- Andrews, M., Squire, C., & Tamboukou, M. (2013). *Doing narrative research*. London: Sage.
- Andrews, M. (2021). Quality indicators in narrative research, *Qualitative Research in Psychology*, (18)3, 353-368. <https://doi.org/10.1080/14780887.2020.1769241>
- American Association of Critical-Care Nurses (2006). *AACN Public Policy Position Statement: Moral Distress*. Aliso Viejo, CA: Accessed 8th May 2020. Link: [https://www.emergingrnleader.com/wp-content/uploads/2012/06/4As\\_to\\_Rise\\_Above\\_Moral\\_Distress.pdf](https://www.emergingrnleader.com/wp-content/uploads/2012/06/4As_to_Rise_Above_Moral_Distress.pdf)
- Archer, M., Decoteau, C., Gorski, P., Little, D., Porpora, D., Rutzou, T., Smith, C., Steinmetz, G., & Vandenberghe, F. (2016). What is critical realism? *Perspectives: A Newsletter of the ASA Theory Section, Fall 2017*. Retrieved from: <http://www.asatheory.org/current-newsletter-online/what-is-critical-realism>
- Arksey, H., & O'Malley, L. (2005). *Scoping studies: Towards a methodological framework*. *International Journal of Social Research Methodology*, 8(1), 19–32. <https://doi.org/10.1080/1364557032000119616>
- Arnaud, A. (2006). *A New Theory and Measure of Ethical Work Climate: The Psychological Process Model (PPM) and the Ethical Climate Index (ECI)*. Retrieved from <https://commons.erau.edu/dbmanagement/11>
- Association of Clinical Psychologists (2019). *Racism in the Profession of Clinical Psychology*. Retrieved from: [https://acpuk.org.uk/acp-uk\\_statement\\_on\\_trainers\\_conference/](https://acpuk.org.uk/acp-uk_statement_on_trainers_conference/)

- Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses' experience of moral distress. *Nursing Inquiry*, 10, 177–183. <https://doi.org/10.1046/j.14401800.2003.00181.x>
- Austin, W., Kagan, L., Rankel, M., & Bergum, V. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics and Behavior*, 15(3), 197–212. [https://doi.org/10.1207/s15327019eb1503\\_1](https://doi.org/10.1207/s15327019eb1503_1)
- Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science*, 30(1), 81–88. <https://doi.org/10.1097/00012272-200701000-00009>
- Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2007). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy*, 11, 89–97. <https://doi.org/10.1007/s11019-007-9083-1>
- Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2008). The balancing act: Psychiatrists' experience of moral distress. *Medicine, Health Care and Philosophy*, 11(1), 89–97. <https://doi.org/10.1007/s11019-007-9083-1>
- Bajwa, S. (2020). Is the British Psychological Society institutionally racist? *BPS Blog (Chief Executive, 1st July)*. <https://www.bps.org.uk/blogs/chief-executive/british-psychological-society-institutionally-racist>
- Baker, M., & Nash, J. (2013). Women entering clinical psychology: Q-Sort narratives of career attraction of female clinical psychology trainees in the UK. *Clinical Psychology & Psychotherapy*, 20(3), 246–253. <https://doi.org/10.1002/cpp.788>
- Ballant, J., & Campling, P. (2011). *Intelligent kindness: Reforming the culture of healthcare*. London: Royal College of Psychiatrists.

- Bamberg, M. (2010). Who am I? Narration and its contribution to self and identity. *Theory & Psychology, 21*(1), 1–22.  
<https://doi.org/10.1177/0959354309355852>
- Banks, J. & Xu, X. (2020). The mental health effects of the first two months of lockdown and social distancing during the Covid-19 pandemic in the UK. *Institute of Fiscal Studies Working Paper w20(16)*. <https://doi.org/10.1920/wp>.
- Barlem, E. L., & Ramos, F. R. (2015). Constructing a theoretical model of moral distress. *Journal of Nursing Ethics, 22*(5), 608-615.  
<https://doi.org/10.1177/0969733014551595>.
- Barlow, D.H. & Nock, M. (2009). Why can't we be more idiographic in our research? *Perspectives on Psychological Science, 4*: 19-21.  
<https://doi.org/10.1111/j.1745-6924.2009.010>
- Barr, B., Taylor-Robinson, D., Stuckler, D., Loopstra, R., Reeves, A., Wickham, S., Whitehead, M. (2016). Fit-for-work or fit-for-unemployment? Does the reassessment of disability benefit claimants using a tougher work capability assessment help people into work? *J. Epidemiol. Community Health, 70*. 452–458. <https://doi.org/10.1136/jech-2015-206333>.
- Barnes, J., Caddick, N., Clarke, N.J., Cromby, J., McDermott, H., Willis, M.E.H. & Wiltshire, G. (2014). Methodological pluralism in qualitative research. *Qualitative Methods in Psychology Bulletin, 17*: 35-41. ISSN 2044-0820
- Batto, D., & Pitton, C. (Eds). *What Is Moral Distress? Experiences and Responses Green Paper*. February 2018. Retrieved from:  
<https://powerlessness.essex.ac.uk/wp-content/uploads/2018/02/MoralDistressGreenPaper1.pdf>
- Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157. <https://doi.org/10.1037/a0031182>



- Beatty, C., & Fothergill, S. (2016). *The Uneven Impact of Welfare Reform: The Financial Losses to Places and People*. Sheffield Hallam University; Sheffield, UK.
- Bee, P., Playle, J., Lovell, K., Barnes, P., Gray, R., Keeley, P. (2008). Service user views and expectations of UK registered mental health nurses: A systematic review of empirical research. *Int J Nurs Stud.* 45, 442-57.  
<https://doi.org/10.1016/j.ijnurstu.2007.02.008>
- Beecham, J & Knapp, M. (2001). Costing psychiatric interventions. In: G. Thornicroft (ed.) *Measuring Mental Health Needs*, Gaskell, 2nd edition, 200–224.
- Behr, H., & Hearst, L. (2008). *Group-Analytic Psychotherapy: A Meeting of Minds (3rd eds)*. London: Whurr Publishers.
- Bell, D. (2019). Neoliberalism is bad for your mental health. In: *The unconscious in social and political life. The Political Mind Series*: Bicester: Phoenix, pp. 79–102.
- Benoit, D., Jensen, H., Malmgren, J., Metaxa, V., Reyners, A., Darmon, M., Rusinova, K., Talmor, D., Meert, A., Cancelliere, L., Zubek, L., Maia, P., Michalsen, A., Vanheule, S., Kompanje, E., Decruyenaere, J., Vandenberghe, S., Vansteelandt, S., Gadeyne, B. (...) Piers, R. (2018). Outcome in patients perceived as receiving excessive care across different ethical climates: a prospective study. *Intensive Care Med.* 44(7).1039-1049.  
<https://doi.org/10.1007/s00134-018-5231-8>.
- Beresford, P. (2013). *Mental Health is in No Fit State, Whatever the Politicians Say*. Available online: <https://theconversation.com/mental-health-is-in-no-fit-state-whatever-the-politicians-say-15743> (accessed on 8 May 2020).

- Bernard, J., & Jara, C. (1986). The failure of clinical psychology graduate students to apply understood ethical principles. *Professional Psychology: Research and Practice*, 17(4), 313–315. <https://doi.org/10.1037/0735-7028.17.4.313>
- Betan, E. (1997). Toward a hermeneutic model of ethical decision making in clinical practice. *Ethics & Behavior*, 7(4), 347- 365. [https://doi.org/10.1207/s15327019eb0704\\_6](https://doi.org/10.1207/s15327019eb0704_6)
- Bhaskar, R. (1975: 2008). *A realist theory of science*. Routledge.
- Bhaskar, R. (1989). *Reclaiming reality: A critical introduction to contemporary philosophy*. London: Verso.
- Bhaskar, R., & Hartwig, M. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge. ISBN 086091951X
- Bion, W. (1961). *Experiences in groups and other papers*. London: Tavistock Publications, 1961.
- Blundell, R., Costa Dias, M., Cribb, J., Joyce, R., Waters, T., Wernham, T. & Xu, X. (2022). Inequality and the Covid crisis in the United Kingdom. *Annual Review of Economics*, 14(1), 607-636. <https://doi.org/10.1146/annurev-economics-051520-030252>
- Blumer, H. (1969). *Symbolic Interactionism*. Englewood Cliffs, NJ: Prentice Hall.
- Blyth, M. (2013). *Austerity: History of a Dangerous Idea*. Oxford University Press; Oxford, UK.
- Boden, Z. & Eatough, V. (2014). Understanding more fully: A multimodal hermeneutic-phenomenological approach. *Qualitative Research in Psychology*, 11, 160-177. <https://doi.org/10.1080/14780887.2013.853854>
- Bourdieu, P. (2010). *Distinction*. Routledge Classics; London, UK.

Boyle, D.A. (2015). Compassion fatigue: The cost of caring. *Nursing*, 45(7), 48–51.  
Doi:10.1097/01.NURSE.0000461857.48809.a1

British Academy (2021). *The COVID decade: Understanding the long-term societal impacts of COVID-19*, The British Academy, London. Available at:  
<https://www.thebritishacademy.ac.uk/documents/3238/COVID-decade-understanding-long-term-societal-impacts-COVID-19.pdf>

British Medical Association (2018a). *Lost in Transit: Funding mental health services in England*. London: British Medical Association.

British Medical Association (2018b). *Tackling the causes – promoting public mental health and investing in prevention*. London: British Medical Association.

British Medical Association. (2020). *Report on the Impact of Covid-19 on Mental Health in English*. Available at: <https://www.bma.org.uk/media/2750/bma-the-impact-of-covid-19-on-mental-health-in-england.pdf>. Accessed 19 August 2022.

British Medical Association (2021a). *The Moral Injury Project: What is Moral Injury*.  
<https://moralinjuryproject.syr.edu/about-moral-injury/>

British Medical Association (2021b) Rest, recover, restore: Getting UK health services back on track. <https://www.bma.org.uk/media/3910/nhs-staff-recover-report-final.pdf>

Brown, A. D., & Starkey, K. (2000). Organizational identity and learning: A psychodynamic perspective. *The Academy of Management Review*, 25(1), 102–120. <https://doi.org/10.2307/259265>

British Psychological Society. (2014). *The Core Purpose and Philosophy of the Profession*. Division of Clinical Psychology. Retrieved from:  
<https://www1.bps.org.uk/system/files/Public%20files/DCP/cat-713.pdf>

British Psychological Society. (2017). *Practice Guidelines: Third Edition*. Retrieved from:

[https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20%20Files/BPS%20Practice%20Guidelines%20\(Third%20Edition\).pdf](https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20%20Files/BPS%20Practice%20Guidelines%20(Third%20Edition).pdf)

British Psychological Society. (2018). *Code of ethics and conduct*. Ethics Committee of the British Psychological Society. Retrieved from:

<https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf>

British Psychological Society. (May 2022). Key recommendations to the *Health and Social Care Select Committee's Expert Panel Evaluation on workforce*.

Retrieved from: <https://committees.parliament.uk/writtenevidence/108696/pdf/>.

Brinkman, S. & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Thousand Oaks: Sage

Browning, A.M. (2013). Moral distress and psychological empowerment in critical care nurses caring for adults at the end of life. *American Journal of Critical Care*, 22(2): 143-151. <https://doi.org/10.4037/ajcc2013437>.

Bruner, J. (1987). Life as narrative. *Social Research*, 54, 11–32.

<https://www.jstor.org/stable/40970444>

Bruner, J. (1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press.

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry*, 18:1–21.

<https://www.jstor.org/stable/1343711>

Bruner, J. (2003). The narrative construction of reality. In M. Mateas & P. Sengers (Eds.), *Narrative intelligence*, pp. 41–62. Amsterdam. John Benjamin Publications.

- Bryman, A. & Bell, E. (2007). *“Business Research Methods”*, 2nd edition. Oxford University Press.
- Buchanan, J. & Wilklund, K. (2020). Why clinical science must change or die: Integrating intersectionality and social justice, *Women & Therapy*, 43, 3-4.  
<https://doi.org/10.1080/02703149.2020.1729470>
- Buchanan, J., Charlesworth, A., Gershlick, B., & Seccombe, I. (2019). A critical moment: NHS staffing trends, retention and attrition. The Health Foundation. Retrieved from:  
[https://www.health.org.uk/sites/default/files/upload/publications/2019/A%20Critical%20Moment\\_1.pdf](https://www.health.org.uk/sites/default/files/upload/publications/2019/A%20Critical%20Moment_1.pdf)
- Burnham, J. (1992). Approach – method – technique: making distinctions and creating connections. *Human Systems*, 3, 3–27.
- Burns, J.K. (2015). Poverty, inequality and a political economy of mental health. *Epidemiol Psychiatr Sci*, 24(2), 107-13.  
<https://doi.org/10.1017/S2045796015000086>.
- Butchard, S., & Greenhill, B. (2015). Giving clinical psychology a backbone. *Clinical Psychology Forum*, 276, 16–22.
- Burr, V. (1998). Overview: Realism, relativism, social constructionism and discourse. In Parker, I. (Ed.). *Social Constructionism, Discourse and Realism* (pp. 13–26). London: Sage
- Cameron, D. (2009) Conservative Conference Address, October 2009. Full copy of Speech Transcript retrieved from:  
<https://www.gov.uk/government/speeches/prime-ministers-speech-on-the-economy> (Accessed 08<sup>th</sup> June 2020).

- Campbell, J. (1949). *The Hero with a Thousand Faces* (1st ed.). Princeton, NJ: Princeton University Press. ISBN 9780691097435.
- Campbell, S., Ulrich, C. & Grady, C. (2016). A broader understanding of moral distress. *American Journal of Bioethics*, 16(1), 2–9.  
<https://doi.org/10.1080/15265161>.
- Campling, P. (2015). Reforming the culture of healthcare: the case for intelligent kindness. *BJPsych bulletin*, 39(1), 1-5.  
<https://doi.org/10.1192/pb.bp.114.047449>
- Care Quality Commission. (2018). *The state of health care and adult social care in England 2018/19*. London: Care Quality Commission. Retrieved from:  
[https://www.cqc.org.uk/sites/default/files/20191015b\\_stateofcare1819\\_fullreport.pdf](https://www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf)
- Care Quality Commission. (2022). *The state of health care and adult social care in England. 2021/22 Report*. Retrieved from:  
[https://www.cqc.org.uk/sites/default/files/2022-10/20221024\\_stateofcare2122\\_print.pdf](https://www.cqc.org.uk/sites/default/files/2022-10/20221024_stateofcare2122_print.pdf)
- Carr, A. & Gabriel, Y. (2002). Organizations, management and psychoanalysis : an overview. *Journal of Managerial Psychology*. Retrieved from  
<http://ezproxy.uws.edu.au/login?url=http://dx.doi.org/10.1108/02683940210432600>
- Carr, A. (1993) 'The Psychostructure of Work: Bend me, shape me, anyway you want me, as long as you love me it's alright', *Journal of Managerial Psychology* 8(6): 2-6. <https://doi.org/10.1177/135050849851005>
- Carr, A. (1998). Identity, Compliance and Dissent in Organizations: A Psychoanalytic Perspective. *Organization*, 5(1), 81- 99.  
<https://doi.org/10.1177/135050849851005>

- Carse, A., & Rushton, C. H. (2017). Harnessing the promise of moral distress: A call for re-orientation. *The Journal of Clinical Ethics*, 28(1), 15–29. PMID: 28436924.
- Čartolovni, A., Stolt, M., Scott, P.A. & Suhonen, R. (2021). Moral injury in healthcare professionals: A scoping review and discussion. *Nursing Ethics*, 28(5), 590-602. <https://doi.org/10.1177/0969733020966776>
- Chamberlain, K. (2000). Methodology and qualitative health research. *Journal of Health Psychology*, 5: 285-296. <https://doi.org/10.1177/135910530000500306>
- Chamberlain, K. (2012). Do you really need a methodology? *Qualitative Methods in Psychology Bulletin*, 13: 59-63.
- Schwartz-Mette, R. A., & Shen-Miller, D. S. (2018). Ships in the rising sea? Changes over time in psychologists' ethical beliefs and behaviors. *Ethics & Behavior*, 28(3), 176–198. <https://doi.org/10.1080/10508422.2017.1308253>
- Centre for Welfare Reform. (2015). *A Fair Society*; Centre for Welfare Reform: Sheffield, UK. Retrieved from: [www.centreforwelfarereform.org](http://www.centreforwelfarereform.org) (accessed on 8 May 2021).
- Cicchetti, D., & Rogosch, F. A. (1996). Equifinality and multifinality in developmental psychopathology. *Development and Psychopathology*, 8(4), 597-600. <https://doi.org/10.1017/S0954579400007318>
- Clarke, J., & Hoggett, P. (2019). Regressive modernisation? The changing patterns of social services delivery in the United Kingdom. In *Comparing Public Sector Reform in Britain and Germany* (pp. 224-243). Routledge.
- Clarke, N. J., Willis, M. E., Barnes, J. S., Caddick, N., Cromby, J., McDermott, H., & Wiltshire, G. (2015). Analytical pluralism in qualitative research: A meta-study. *Qualitative Research in Psychology*, 12(2), 182-201. <http://hdl.handle.net/10552/5934>

- Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *The Annals of Family Medicine*, 6, 331–339. <https://doi.org/10.1370/afm.818>
- Cooke, A. & Watts, J. (2016, February 17). We're not surprised half our psychologist colleagues are depressed. *The Guardian*. Retrieved from: <https://www.theguardian.com/healthcare-network/2016/feb/17/were-not-surprised-half-our-psychologist-colleagues-are-depressed>
- Corely, M.C., (2005). Nurse moral distress and ethical work environment. *Journal of Nursing Ethics*, 12(4), 381-390. <https://doi.org/10.1191/0969733005ne809oa>
- Corley, M.C., Elswick, R.K., Gorman, M., & Clor, T. (2001). Development and evaluation of a moral distress scale. *J adv Nurs* 2001; 33: 250–256. . <https://doi.org/10.1046/j.1365-2648.2001.01658.x>
- Corley, M.C. (1995). Moral distress of critical care nurses. *Am J Crit Care*, 4: 280–285. PMID: 7663591
- Cottone, R. & Claus, R. (2000). Ethical decision-making models: a review of the literature. *J Couns Dev*, 78: 275–283. <https://doi.org/10.1002/j.1556-6676.2000.tb01908.x>
- Coyle, A. (2010). Qualitative research and anomalous experience: A call for interpretative pluralism, *Qualitative Research in Psychology*, 7(1), 79-83. Doi: 10.1080/14780880903304600
- Crane, M., Bayl-Smith, P. & Cartmill, J. (2013) A recommendation for expanding the definition of moral distress experienced in the workplace. *The Australian and New Zealand Journal of Organisational Psychology*, 6(1), 1-9. DOI: 10.1017/orp.2013.1



- Crenshaw, K. (1989) Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Policies. *University of Chicago Legal Forum* 1989, no. 1, 139-167.
- Creswell, J. W. (1994). *Research design: Qualitative, quantitative, and mixed method approaches*. Thousand Oaks, CA: Sage Publications.
- Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches*. Thousand Oaks, CA: Sage Publications.
- Creswell, J. W., Hanson, W. E., Clark Plano, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counselling Psychologist*, 35(2), 236-264. <https://doi.org/10.1177/0011000006287390>
- Cromby, J. (2012). 'Feeling the way: Qualitative clinical research and the affective turn. *Qualitative Research in Psychology*, 9: 88-98.  
<https://doi.org/10.1080/14780887.2012.630831>
- Crossley, M. (2000). *Introducing Narrative psychology: Self, trauma and the construction of meaning*. London: Open University Press.
- Crossley, N. (2011). Not being mentally ill: Social movements, system survivors and the oppositional habitus. *Anthropol. Med*; 11, 161–180.  
<https://doi.org/10.1080/13648470410001678668>.
- Crossley, S. (2016). The Troubled Families Programme: In, for and against the state? *Soc. Policy Rev. Anal. Debate Soc. Policy*. 28, 127–146.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage.
- Cummins, I. (2017) *Critical Psychiatry: A Biography*. Critical Publishing; Northwich, UK.

- Cummins, I. (2018). The Impact of Austerity on Mental Health Service Provision: A UK Perspective. *Int. J. Environ. Res. Public Health*, 15(6), 1145. <https://doi.org/10.3390/ijerph15061145>
- Dalal, F. (2015). Statistical Spin: Linguistic Obfuscation – The Art of Overselling the CBT Evidence Base. *Journal of Psychological Therapies in Primary Care*, 4: 1-25. Retrieved from <http://dalal.org.uk/Farhad%20Dalal%20-%20Statistical%20Spin.pdf>
- Davies, B., & Harré, R. (1990). *Positioning: The social construction of selves*. *Journal for the Theory of Social Behaviour*, 20, 43–63. <https://doi.org/10.1111/j.1468-5914.1990.tb00174.x>
- Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care*, 46(3), 209–220. <https://doi.org/10.1111/j.1744-6163.2010.00260.x>
- Denzin, N.K. & Lincon, Y. (2000). *Handbook of Qualitative Research*. Sage. Thousand Oaks, C.A.
- Denzin, N.K. (2001). The reflexive interview and a performative social science. *Qualitative Research*, 1, 23–46. <https://doi.org/10.1177/14687941010010>
- Denzin, N. K. (2009). *The research act: A theoretical introduction to sociological methods*. New York, Aldine Transaction.
- Denzin, N. K. (2012). Triangulation 2.0. *Journal of Mixed Methods Research*, 6(2), 80-88. <https://doi:10.1177/1558689812437186>
- Department of Health and Social Care. (2000). *Reforming NHS Financial Flows; introducing payment by results*. London. Department of Health. Available at: [www.dh.gov.uk/prod\\_consum\\_dh/](http://www.dh.gov.uk/prod_consum_dh/)

groups/dh\_digitalassets/@dh/@en/documents/digitalasset/dh\_4018704.pdf  
(accessed on 20 September 2018).

Department of Health and Social Care. (2021). *Build Back Better: Our Plan for Health and Social Care*. Cabinet Office, Prime Minister's Office, Published 7 September 2021.

Department of Health and Social Care. (2021). *The NHS Constitution for England*. GOV.UK. <https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>

DeTienne, K. B., Agle, B. R., Phillips, J. C., & Ingerson, M.-C. (2012). The impact of moral stress compared to other stressors on employee fatigue, job satisfaction, and turnover: An empirical investigation. *Journal of Business Ethics*, 110(3), 377–391.

Dodek, P.M., Wong, H., Norena, M., Ayas, N., Reynolds, S.C., Keenan, S.P., Hamric, A., Rodney, P., Stewart, M. & Alden, L. (2016). Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. *Journal of Critical Care*, 31(1):178-82.  
<https://doi.org/10.1016/j.jcrc.2015.10.011>.

Dreyfus, H. L. (1991). Reflections on the Workshop on the self. *Anthropology and Humanism Quarterly*, 16(1), 27-31. <https://doi.org/10.1525/ahu.1991.16.1.27>

Dzeng E., Wachter R.M. Ethics in conflict: Moral distress as a root cause of burnout. *Journal of General International Medicine*. 2019;35:409–411.  
<https://doi.org/10.1007/s11606-019-05505-6>.

Elias, N. (1994). *The Civilizing Process*. Blackwell: Oxford. First published in German in 1939. First English Editions: *Volume 1, The History of Manners* (1978) Oxford: Blackwell; *State, Formation and Civilization* (1982) Oxford: Blackwell.

- Ellinas, C., Allan, N., & Johannson, A. (2017) Dynamics of organizational culture: Individual beliefs vs. social conformit PLOS Open Access.  
<https://doi.org/10.1371/journal.pone.0180193>
- Elliott, I. (2016). *Poverty and Mental Health: A Review to Inform the Joseph Rowntree Foundation's Anti-Poverty Strategy*. Mental Health Foundation; London, UK. Available at:  
<https://www.mentalhealth.org.uk/sites/default/files/2022-08/poverty-and-mental-health-report.pdf>
- Epstein, E. & Hamric, A. (2009). Moral distress, moral residue and the crescendo effect. *Journal of Clinical Ethics*, 20, 330-342. PMID: 20120853
- Epstein, E. & Delgado, S. (2010). Understanding and addressing moral distress. *The Online Journal of Issues in Nursing*, 15(3).  
<https://doi.org/10.3912/OJIN.Vol15No03Man01>
- Epstein, E., Whitehead, P., Prompahakul, C., Thacker, L. R., & Hamric, A. B. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics*, 10(2), 113–124.  
<https://doi.org/10.1080/23294515.2019.1586008>
- Festinger, L. (1962). *A theory of cognitive dissonance*. Cambridge, MA. Stanford university press.
- Feyerabend, P. (1975) *Against Method. Outline of an Anarchistic Theory of Knowledge*. London. New Left Books. ISBN 0-902308-91-2
- Fine, M. (2016). Just methods in revolting times, *Qualitative Research in Psychology*, 13:4, 347-365, DOI: 10.1080/14780887.2016.1219800
- Finlay, L. (2006). 'First do no harm'--a clear line in law and medical ethics. *Journal of the Royal Society of Medicine*, 99(5), 214–215.  
<https://doi.org/10.1177/014107680609900502>

- Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, 3: 6-25. <https://doi.org/10.29173/pandpr19818>
- Fischer, C.T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research*, 19: 583-590. <https://doi.org/10.1080/10503300902798375>
- Flick, U. (2009). *An introduction to qualitative research (4th ed.)*. London: Sage.
- Flowers, P. & Langdrige, D. (2007). Phenomenology and Critical Social Psychology. *Social and Personality Psychology Compass*, 2(3) pp. 1126–1142. <https://doi.org/10.1111/j.1751-9004.2008.00114.x>
- Fontana, A. and Frey, J.H. (2000). The interview: From structured questions to negotiated text. In N.K. Denzin and Y.S. Lincoln (eds), *Handbook of Qualitative Research*, pp. 645–672.. Thousand Oaks, CA: Sage.
- Forde, R. & Aasland, O.G. (2008). Moral distress among Norwegian doctors. *Journal of Medical Ethics*, 34(7), 521-525. <https://doi.org/10.1136/jme.2007.021246>.
- Foster, A., Bishop, B., Dickinson, A. & Klien, J. (2006) *Difference: An Avoided Topic in Practice*. London. Routledge. <https://doi.org/10.4324/9780429473715>
- Fotaki, M. & Hyde, P. (2014). Organizational blind spots: Splitting, blame and idealization in the National Health Service. *Human Relations*. 68. <https://doi.org/10.1177/0018726714530012>.
- Fotaki, M., & Hyde, P. (2015). Organizational blind spots: Splitting, blame and idealization in the National Health Service. *Human Relations*, 68(3), 441–462. <https://doi.org/10.1177/0018726714530012>

- Fotaki, M., Long, S., & Schwartz, H. S. (2012). What can psychoanalysis offer organization studies today? Taking stock of current developments and thinking about future directions. *Organization Studies*, 33(9), 1105-1120.
- Fotaki, M. (2019) 'Health services without care under marketized welfare: Throwing good money after bad'. In K Jackson and R. Rizq (eds) *The Industrialisation of Care: Counselling and Psychotherapy in a Neoliberal Age*. London. Karnac.
- Foucault, M., 1970. *The Order of Things: An Archaeology of the Human Sciences*. New York, NY: Routledge.
- Foucault, M. (1988). *Power Knowledge*. Random House.
- Foucault, M. (2002). *Archaeology of knowledge*. New York, NY: Routledge
- Fourie, C. (2015). Moral distress and moral conflict in clinical ethics. *Bioethics* 2015; 29: 91–97. <https://doi.org/10.1111/bioe.12064>
- Fox, D., Prilleltensky, I. & Austin, S. (2011) Critical Psychology for Social Justice: Concerns and Dilemmas. In Fox, D., Prilleltensky, I. & Austin, S. (Eds.), *Critical Psychology: An Introduction, (2nd ed., pp. 5-17)* London: Sage Publications Ltd.
- Fraher, Amy. (2004). Systems Psychodynamics: The Formative Years of an Interdisciplinary Field at the Tavistock Institute. *History of psychology*. 7. 65-84. 10.1037/1093-4510.7.1.65.
- Fricker, M. (2007). *Epistemic injustice: power and the ethics of knowing*. Oxford: Oxford University Press, 2-9. Retrieved from: <https://circulosemiotico.files.wordpress.com/2018/05/fricker-miranda-epistemic-injustice.pdf>

- Frost, N. (2009). 'Do you know what I mean?': The use of a pluralistic narrative analysis approach in the interpretation of an interview. *Qualitative Research*, 9: 9-29.
- Frost, N., Nolas, S.M. & Brooks-Gordon, B. (2010). Pluralism in qualitative research. *Qualitative Research*, 10: 441-460.
- Frost, N., Holt, A., Shinebourne, P., Esin, C., Nolas, S.M., Mehdizadeh, L., & Brooks-Gordon, B. (2011). Collective findings, individual interpretations: An illustration of a pluralistic approach to qualitative data analysis. *Qualitative Research in Psychology*, 8(1), 93-113. <https://doi.org/10.800/14780887.2010.500351>
- Frost, N. (2011). *Qualitative research methods in psychology: Combining core approaches*. McGraw-Hill Education (UK).
- Fusch, P. I., & Ness, L. R. (2015). Are We There Yet? Data Saturation in Qualitative Research. *The Qualitative Report*, 20(9), 1408-1416. <https://doi.org/10.46743/2160-3715/2015.2281>
- Gabriel, Y. & Carr, A. (2002). Organizations, management and psychoanalysis: An overview. *Journal of Managerial Psychology*. 17. 348-365. <https://doi.org/10.1108/02683940210432600>.
- Gadamer H. G. (2008). *Philosophical hermeneutics*. CA: University of California Press.
- Gadamer, H. (1960/1990). *Truth and Method*. (2<sup>nd</sup> ed). New York: Crossword.
- Gadamer, H.G. (1963) The Phenomenological Movement. In Linge, D.E. (Ed). *Philosophical Hermeneutics*. Berkeley: University of California Press.
- Garnham, A. (2020) After the pandemic. *IPPR Progressive Review*, 27:8-17. doi:10.1111/newe.12189.CrossRefGoogle Scholar

- Garratt, K. & Laing, J. (2022). House of Commons Research Briefing on Mental Health Policy in England. Published 6 June 2022. Retrieved from: <https://researchbriefings.files.parliament.uk/documents/CBP-7547/CBP-7547.pdf>
- Garrett, P.M. (2015). Words matter: Deconstructing “welfare dependency” in the UK. *Critical Radical Social Work*. **3**:389–406. <https://doi.org/10.1332/204986015X14382412317270>.
- Garrett, M. (2019). *Psychotherapy for psychosis: Integrating cognitive-behavioral and psychodynamic treatment*. New York. The Guilford Press.
- Gayle, B., Cortez, D. & Preiss, R. (2013). Safe Spaces, Difficult Dialogues, and Critical Thinking, *International Journal for the Scholarship of Teaching and Learning*: 7(2), 21-26. <https://doi.org/10.20429/ijstl.2013.070205>
- Geelan, D. (2006) *Undead Theories: Constructivism, Eclecticism and Research in Education*. Sense Publishers. Rotterdam.
- Gemil, G. & Oakley, J. (1992) Leadership: An Alienating Social Myth. *Human Relations*, 45(2), 113-129. <https://doi.org/10.1177/001872679204500201>
- Gerada, C. (2020). Surviving and Thriving in Medicine. In *Beneath the White Coat. Doctors, their minds and mental health*. (pp. 41-55). London. Routledge.
- Gill, J. (2015) How Meaningful Is Meaningful Use? *American Journal of Medical Quality*, 30(6), 509-511. [doi.org/10.1177/1062860614567433](https://doi.org/10.1177/1062860614567433)
- Gilburt, K. (2021) Report for the Kings Fund. *Understanding clinical decision-making at the interface of the Mental Health Act (1983) and the Mental Capacity Act (2005)*. Available at [https://www.york.ac.uk/media/healthsciences/images/research/prepare/report\\_sandtheircoverimages/Understanding%20the%20MHA%20&%20MCA%20interface.pdf](https://www.york.ac.uk/media/healthsciences/images/research/prepare/report_sandtheircoverimages/Understanding%20the%20MHA%20&%20MCA%20interface.pdf). Accessed date.



- Giorgi, A. P., & Giorgi, B. M. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (p. 243–273). American Psychological Association. <https://doi.org/10.1037/10595-013>
- Glasberg, A.-L., Eriksson, S., Dahlgvist, V., Lindahl, E., Strandberg, G., Soderberg, A., et al. (2006). Development and initial validation of the stress of conscience questionnaire. *Nursing Ethics*, *13*(6), 633–648. <https://doi.org/10.1177/0969733006069698>.
- Gomez, L. (1997). *An Introduction to Object Relations*. London: Free Association Books.
- Goodbury, L. & Burns, J. (2011). A Disquisition on Pluralism in Qualitative Methods: The Troublesome Case of a Critical Narrative Analysis, *Qualitative Research in Psychology*, *8*:2, 170-196, <https://doi.org/10.1080/14780887.2011.575288>
- Grace, B., Wainwright, T., Solomons, W., Camden, J. & Ellis-Caird, H. (2020). How do clinical psychologists make ethical decisions? A systematic review of empirical research. *Clinical Ethics*. *15*(4):213-224. <https://doi.org/10.1177/1477750920927165>
- Guba, E., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. D. Y. S. Lincoln (Ed.), *Handbook of qualitative research* (pp. 105 -117). London: Sage.
- Gutierrez, K. (2005). Critical care nurses' perceptions of and responses to moral distress. *Dimensions of Critical Care Nursing*, *24*(5), 229–241.
- Gutkind, D. (2020) The Industrialisation of care: counselling psychotherapy and the impact of IAPT, *Psychodynamic Practice*, *26*:3, 305-309. <https://doi.org/10.1080/14753634.2020.1757496>

- Habermas, J. (1971) *Knowledge and Human Interests*. J. J. Shapiro (trans.). Boston: Beacon. Retrieved from: <https://hugoribeiro.com.br/area-restrita/Habermas-knowledge-and-human-interests.pdf>
- Hackett, R.A., Ronaldson, A., Bhui, K. (2020). Racial discrimination and health: a prospective study of ethnic minorities in the United Kingdom. *BMC Public Health*, 20, 1652-1661. <https://doi.org/10.1186/s12889-020-09792-1>
- Hadjiosif, M. (2021). The ethos of the nourished wounded healer: A narrative inquiry, *European Journal of Psychotherapy & Counselling*, 23:1, 43-69, <https://doi.org/10.1080/13642537.2021.1881137>
- Ham, C., Charles, A. & Wellings, D. (2015). *Shared responsibility for health: the cultural change we need*. A report by The Kings Fund. Retrieved from: <https://www.kingsfund.org.uk/publications/shared-responsibility-health>
- Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook*, 48(5), 199–201. <https://doi.org/10.1067/mno.2000.110564>
- Hamric, A. B., & Blackhall, L. J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, 35(2), 422–429. <https://doi.org/10.1097/01.CCM.0000254722.50608.2D>
- Hamric, A. B. (2012). Empirical research on moral distress: Issues, challenges, and opportunities. *HEC Forum*, 24(1), 39–49. <http://dx.doi.org/10.1007/s10730-012-9177-x>
- Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare Professionals. *AJOB Primary Research*, 3(2), 1–9. <https://doi.org/10.1080/21507716.2011.652337>
- Hamric, A.B. (2014). A case study of moral distress. *J Hosp Palliat Nurs* 2014; 16: 457–463. <https://doi.org/10.1097/NJH.0000000000000104>

- Hamric, A. & Epstein, E. (2017). A Health System-wide Moral Distress Consultation Service: Development and Evaluation. *HEC Forum*, 29(2):127-143.  
<https://doi.org/10.1007/s10730-016-9315-y>.
- Hanna, D.R. (2004). Moral Distress: The state of the science. *Research and Theory for Nursing Practice: An International Journal*, 18(76). PMID:15083663
- Harris, C., & Griffin, M.T. (2015) Nursing on empty: Compassion fatigue signs, symptoms and system interventions. *Journal of Christian Nursing*, 32(2), 80-87. PMID:25898441
- Hart, E. & Hazelgrove, J. (2001). Understanding the organisational context for adverse events in the health services: the role of cultural censorship. *Qual Health Care*. 10(4). 257-62. <https://doi.org/10.1136/qhc.0100257>.
- Hart, E. (2005). Hospital ethical climates and registered nurses' turnover intentions. *Journal of Nursing Scholarship*, 37(2), 173–177.  
<http://dx.doi.org/10.1111/j.1547-5069.2005.00030.x>
- Hatzenbuehler, M., Phelan, J. & Link, B. (2013). Stigma as a fundamental cause of population health inequalities. *Am. J. Public Health*. 10(3), 813–821.  
<https://doi.org/10.2105/AJPH.2012.301069>
- Hazlegreaves, S. (2019, January 18). How can the NHS address the current staff retention crisis? Open Access Government.  
<https://www.openaccessgovernment.org/nhs-staffing-retention-crisis/57201/>
- Health and Care Professions Council. (2012). Standards of Conduct, Performance and Ethics. Retrieved from  
<http://www.hcpcuk.org/assets/documents/10003B6EStandardsofconduct,performanceandethics.pdf>

Health and Care Professions Council. (2015). Standards of proficiency: Practitioner psychologists. <https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency---practitioner-psychologists.pdf?v=637106257690000000>

Health and Care Professions Council. (2018a). Standards of conduct, performance and ethics, [www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/](http://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/) (accessed 23 January 2019).

Health and Care Professions Council. (2018b). Standards of proficiency for practitioner psychologists, [www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency-practitioner-psychologists.pdf](http://www.hcpc-uk.org/globalassets/resources/standards/standards-of-proficiency-practitioner-psychologists.pdf) (accessed 23 January 2019).

Hefferman, M. (2011) *Wilful Blindness. Why We Ignore the Obvious at Our Peril.* Walker & company. Bloomsbury Publishing.

Heidegger M. (1927/2011). *Being and Time*. New York, NY: Harper & Row.

Heidegger, M. (1962/2004). *Being and Time*. Trans. J. Macquarrie and E. Robinson. Oxford: Blackwell.

Herber, A., Liu, J. J., Nazarov, A., Plouffe, R. A., Forchuk, C. A., Deda, E., Gargala, D., ... & Richardson, J. D. (2021). Exploring Well-being of Healthcare Workers during the COVID-19 Pandemic: A Prospective Longitudinal Study Protocol. *JMIR Research Protocols*, 10(9), 32-66, <https://doi.org/10.2196/32663>

Hinshelwood, R.D. (1987). *What Happens in Groups*. London. Free Association Books.

Hinshelwood, R.D. (2001). *Thinking about institutions: Millieux and Madness*. London: Jessica Kingsley.

- Hinshelwood, R.D., & Skogstad, W. (2000). *Observing Organisations Anxiety, Defence and Culture in Health Care*. Hove: Brunner-Routledge
- Hoggett, P. (1996). New modes of control in the public service. *Public administration*, 74(1), 9-32. <https://doi.org/10.1111/j.1467-9299.1996.tb00855.x>
- Hoggett, P. (2006). Conflict, ambivalence, and the contested purpose of public organizations. *Human Relations*, 59(2): 175-194. <https://doi.org/10.1177/0018726706062731>
- Hoggett, P. (2020). The malady of the ideal and the assault on nature. *Psychoanalysis, Culture & Society*, 25(2), 213-229.
- Howell, K. E. (2012). *An introduction to the philosophy of methodology*. London: Sage.
- Hyatt, J. (2017). Recognizing moral disengagement and its impact on patient safety. *Journal of Nursing Regulation*, 7(4), 15–21. [https://doi.org/10.1016/S2155-8256\(17\)30015-7](https://doi.org/10.1016/S2155-8256(17)30015-7)
- Husserl, E. (1970). *The Crisis of European Sciences and Transcendental Phenomenology* Trans. D. Carr. Evanston: Northwestern University Press.
- Innes, D. & Tetlow, G. (2015). Delivering fiscal squeeze by cutting local government spending. *Fiscal Stud*, 26, :303–325. <https://doi.org/10.1111/j.1475-5890.2015.12056>.
- Imison ,C. (2018). *Addressing staff burnout: a moral and ethical imperative*, Nuffield Trust Comment. Available at: <https://www.nuffieldtrust.org.uk/news-item/addressing-staff-burnout-a-moral-and-ethical-imperative>
- Jameton, A. (1984). *Nursing Practice: The Ethical Issues*, Englewood Cliffs, NJ: Prentice Hall.

- Jameton A. (1993). Dilemmas of moral distress: moral responsibility and nursing practice. *AWHONNS Clinical Issues in Perinatal Women's Health Nursing*, 4: 542–551. PMID: 8220368.
- Jameton A. (2013). A reflection on moral distress in nursing together with a current application of the concept. *Journal of Bioethical Inquiry*; 10: 297–308.  
<https://doi.org/10.1007/s11673-013-9466-3>
- Jameton, A. (2017). What moral distress in nursing history could suggest about the future of Health Care. *AMA Journal of Ethics*, 19, 617–628.  
<https://doi.org/10.1001/journalofethics.2017.19.6.mhst1-1706>.
- Johnson, R. (1997). Examining the validity structure of qualitative research. *Education*, 118(2), 282–292.
- Johnson, J., Corker, C., & O'connor, D. B. (2020). Burnout in psychological therapists: A cross-sectional study investigating the role of supervisory relationship quality. *Clinical Psychologist*, 24(3), 223-235.  
<https://doi.org/10.1111/cp.12206>
- Johnston, D., Brauner, J. M., Mindermann, S., Sharma, M., Salvatier, J., Gavenčiak, T., ... & Kulveit, J. (2021). Inferring the effectiveness of government interventions against COVID-19. *Science*, 371(6531).  
<https://doi.org/10.1126/science.abd9338>
- Joseph Rountree Foundation (2016). *Monitoring poverty and social exclusion (MPSE Report)*. Available at: <https://www.jrf.org.uk/report/monitoring-poverty-and-social-exclusion-2016>
- Joseph Rowntree Foundation (2022). The essential guide to understanding poverty in the UK. Available at: <https://www.jrf.org.uk/report/uk-poverty-2022>

- Josselson, R. (2007). The ethical attitude in narrative research. In Clandinin, D. (Ed.). *Handbook of narrative inquiry: Mapping a methodology* (pp. 537–566). Thousand Oaks: Sage.
- Kakkori, L. (2009). Hermeneutics and Phenomenology Problems When Applying Hermeneutic Phenomenological Method in Educational Qualitative Research. *Paideusis: Journal of the Canadian Philosophy of Education Society* 18 (2):19-27. <https://doi.org/10.7202/1072329ar>
- Kälvemark S., Höglund A.T., Hansson, M.G., Westerholm, P., Arnetz, B. (2004). Living with conflicts-ethical dilemmas and moral distress in the health care system. *Social Science Medicine*, 58(6), 1075-84. PMID:14723903
- Karban, K. (2017), Developing a Health Inequalities Approach for Mental Health Social Work, *The British Journal of Social Work*, 47(3), 885–992. <https://doi.org/10.1093/bjsw/bcw098>
- Kelly, B. (2005). Structural violence and schizophrenia. *Social Science Medicine*, 61(3), 721–730. <https://doi.org/10.1016/j.socscimed.2004.12.020>. [
- Kincheloe, J. (2005). On to the next level: Continuing the conceptualisation of the bricolage. *Qualitative Inquiry*. 11(3), 323-350. <https://doi.org/10.1177/1077800405275056>
- Klien, M. (1952). The origins of transference. *The International Journal of Psychoanalysis*, 33, 433–438.
- Kinderman, P., Barr, B., & Whitehead, M. (2015). Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. *Social Science Medicine*, 147, 324-331. <https://doi.org/10.1016/j.socscimed.2015.11.009>.
- Knapp, S., Berman, J., Gottlieb, M. & Handelsman, M. (2007). When Laws and Ethics Collide: What Should Psychologists Do? *Professional Psychology*:

*Research and Practice*, 38(1), 54–59 <https://doi.org/10.1037/0735-7028.38.1.54>

Knapp, S., Handelsman, M., Gottlieb, M. & VandeCreek, L. (2013). The dark side of professional ethics. *Professional Psychology: Research and Practice*, 44(6), 371-377. <https://doi.org/10.1037/a0035110>

Krugman P. The Case for Cuts Was a Lie. Why Does Britain Still Believe It? [(accessed on 18 February 2018)]; *The Guardian*. 2015 Apr 29; Available online: [www.theguardian.com/business/ng-interactive/2015/apr/29/the-austerity-delusion](http://www.theguardian.com/business/ng-interactive/2015/apr/29/the-austerity-delusion).

Kvale, S. (1996). *Inter Views: An Introduction to Qualitative Research Interviewing*. Sage, Thousand Oaks, C.A.

Lacan, J. (1991). The Ego in Freud's Theory and in the Technique of Psychoanalysis, 1954-1955 Book II. The Seminar of Jacques Lacan. Norton & Co. ISBN 10: 0393307093 ISBN

Langdrige, D. (2004). The hermeneutic phenomenology of Paul Ricoeur: Problems and possibilities for existential– phenomenological psychotherapy. *Existential Analysis*, 15 (2), 243–255.

Langdrige, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Education.

Langdrige, D. (2008). Phenomenology and critical social psychology: directions and debates in theory and research. *Personality and Social Psychology Compass*, 2(3), 1126–1142, <https://doi.org/10.1111/j1751-9004.2008.00114.x>

Langdrige, D. (2009). Relating through difference: a critical narrative analysis. In: Finlay, Linda and Evans, Ken eds. *Relational Centred Research for Psychotherapists: Exploring Meanings and Experience*. Chichester, UK: Wiley-Blackwell, pp. 213–226.



- Langdridge, D. (2013). Gay fathers, gay citizenship: On the power of futurism and assimilation. *Citizenship Studies*, 17: 713-726.  
<https://doi.org/10.1080/13621025.2013.834127>
- Langdridge, D. (2015). Critical narrative analysis. *The Psychologist*, 28(8), 645- 646.  
ISSN 0952-8229.
- Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology*, 22(1), 51–67.  
<https://doi.org/10.1177/1359105315595120>
- Lavender, T. & Lavender, E. (2012). Training and staff retention: National issues and findings from the South Thames (Salmons) clinical psychology training programme. *Clinical Psychology Forum*. 1. 11-17.  
<https://doi.org/10.53841/bpscpf.2012.1.229.11>.
- Lemmo, D., Vitale, R., Girardi, C., Salsano, R., & Auriemma, E. (2022). Moral Distress Events and Emotional Trajectories in Nursing Narratives during the COVID-19 Pandemic. *International journal of environmental research and public health*, 19(14), 8349. <https://doi.org/10.3390/ijerph19148349>
- Lewin, K. (1947). Frontiers in group dynamics: *International Human Relations*, 1, 5–41. <https://doi.org/10.1177/001872674700100103>
- Lewin, K. (1948). *Resolving social conflicts: Selected papers on group dynamics*. New York: Harper & Row.
- Lewis, P. J. (2011). Storytelling as Research/Research as Storytelling. *Qualitative Inquiry*, 17(6), 505–510. <https://doi.org/10.1177/1077800411409883>
- Lincoln, Y. & Guba, E. (1985). *Naturalistic inquiry*. London: Sage

- London School of Economics (2012). *How Mental Illness Loses Out in the NHS*. [(accessed on 24 February 2018)]; Available online: <http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf>.
- Long, S. (1999). The tyranny of the customer and the cost of consumerism: An analysis using systems and psychoanalytic approaches to groups and society. *Human relations*, 52(6), 723-743. <https://doi.org/10.1023/A:1016990331598>
- Long, S., & Lepper, G. (2008). Metaphor in psychoanalytic psychotherapy: A comparative study of four cases by A practitioner–researcher. *British Journal of Psychotherapy*, 24(3), 343-364. <https://doi.org/10.1111/j.1752-0118.2008.00090.x>
- Luborsky MR, & Rubinstein RL. (1995). Sampling in qualitative research: rationale, issues. and methods, *Research in Aging*. 17(1):89–113. <https://doi.org/10.1177/0164027595171005>
- Lyons, E. (2007). *Analysing Qualitative Data in Psychology*. Sage Publishing. Thousand Oaks, C.A.
- Maben, J. & Griffiths, P. (2008). Nurses in Society: Starting the debate. National Nursing Research Unit, King's College London. Retrieved from: <http://www.netscc.ac.uk/hsdr/projdetails.php?ref=08-1819-213>
- Macintyre, A., Ferris, D., Gonçalves, B. & Quinn, N. (2018). What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action. *Palgrave Community*, 4(10). <https://doi.org/10.1057/s41599-018-0063-2>
- Madill, A., Flowers, P., Frost, N., & Locke, A. (2018). A meta-methodology to enhance pluralist qualitative research: One man's use of socio-sexual media and midlife adjustment to HIV. *Psychology & Health*. <https://doi.org/10.80/08870446.2018.1475670>

- Mänttari-van der Kuip, M. (2020). Conceptualising Work-Related Moral Suffering— Exploring and Refining the Concept of Moral Distress in the Context of Social Work, *The British Journal of Social Work*, 50(3), 741-757, <https://doi.org/10.1093/bjsw/bcz034>
- Mair, D. (2010). Fractured narratives, fractured identities: cross-cultural challenges to essentialist concepts of gender and sexuality. *Psychology & Sexuality*, 1(2), 156-169. <https://doi.org/10.1080/19419899.2010.484597>
- Malda-Castillo, J. & Anderson, D. (2022). Swimming in the waters of a sinking National Health Service (NHS): A group analytic perspective. *Group Analysis*, 55(1), 3–18. <https://doi.org/10.1177/0533316421997760>
- Malterud, K., Siersma, V. & Guassora, A. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*. 26(13),1753-1760. <https://doi.org/10.1177/1049732315617444>
- Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). The Maslach Burnout Inventory (3rd ed.). Consulting Psychologists Press.
- Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, 50(4), 370–396. <https://doi.org/10.1037/h0054346>
- Mason, V., Leslie, G., Clark, K. (2014). Compassion fatigue, moral distress, and work engagement in surgical intensive care unit trauma nurses: a pilot study. *Dimensions of Critical Care Nursing*, 33: 215–225. <https://doi.org/10.1097/DCC.0000000000000056>.
- Marmot, M., Allen, J., Goldblatt, P. et al. (2010). Fair society, healthy lives: strategic review of health inequalities in England post 2010. London: Marmot Review Team. Available online: [www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf](http://www.parliament.uk/documents/fair-society-healthy-lives-full-report.pdf).

- Mathison, S. (1988). Why Triangulate? *Educational Researcher*. 17(2):13-17.  
<https://doi.org/10.3102/0013189X017002013>
- Mays, N. & Pope, C. (2000). Qualitative research in health care. Assessing quality in qualitative research. *British Medical Journal*, 320(7226), 50-2.  
<https://doi.org/10.1136/bmj.320.7226.50>.
- McAdams, D. P. (1989). The Development of a Narrative Identity. In: Buss, D.M., Cantor, N. (eds) *Personality Psychology*. Springer, New York, NY.  
[https://doi.org/10.1007/978-1-4684-0634-4\\_12](https://doi.org/10.1007/978-1-4684-0634-4_12)
- McAdams, D. (1993). *The stories we live by: Personal myths and the making of the self*. New York: Guilford Press.
- McAdams, D. (2019). “First we invented stories, then they changed us”: The evolution of narrative identity. *Evolution Studies Imaginative Culture*, 3, 1–18.  
<https://doi.org/10.26613/esic.3.1.110>.
- McAdams, D., Josselson, R., & Lieblich, A. (2001). *Turns in the road: Narrative studies of lives in transition*. Washington: American Psychological Association. ISBN: 978-1-55798-773-0
- McCarthy, J. & Deady, R. (2008). Moral distress reconsidered. *Journal of Nursing Ethics*. 15, 254-262. <https://doi.org/10.1177/0969733007086023>
- McMahon, A. (2018). “Part of me feels like there must be something missing”: a phenomenological exploration of practicing psychotherapy as a clinical psychologist, *British Journal of Guidance & Counselling*, 46:2, 217-228,  
<https://doi.org/10.1080/03069885.2017.1413169>
- Meltzer, L., & Huckabay, L. (2004). Critical care nurses’ perceptions of futile care and its effect on burnout. *American Journal of Critical Care*, 13(3), 202–208.  
<https://doi.org/10.4037/ajcc2004.13.3.202>

Mental Health Foundation (2021). The UK wide Coronavirus: Mental Health in the Pandemic study. The Psychological Impact of Austerity. [(accessed on 15 March 2020)]; Retrieved from: <http://www.psychchange.org/psychologists-against-austerity.html>.

Menzies-Lyth, L.M. (1960). A Case-Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital. *Human Relations*, 13(2), 95-121.  
<https://doi.org/10.1177/001872676001300201>

Merriam, S. & Tisdell, E. (2015). *Qualitative Research. A Guide to Design and Implementation*. Wiley. ISBN 9781119003601

Mind Foundation. (2000). *The mental health emergency: how has the coronavirus pandemic impacted our mental health?* Retrieved from:  
[https://www.mind.org.uk/media-a/5929/the-mental-health-emergency\\_a4\\_final.pdf](https://www.mind.org.uk/media-a/5929/the-mental-health-emergency_a4_final.pdf)

Mishler, E. (1986a). The analysis of interview-narratives. In T. Sarbin (Ed.), *Narrative psychology* (pp. 233–255). New York, NY: Praeger.

Mishler, E. (1986b). *Research interviewing. Context and narrative*. Cambridge, MA: Harvard University Press.

Mishler, E. (2000). *Storylines: Craft artists' narratives of identity*. Cambridge, MA: Harvard University Press.

Moncrieff, J. (2008). *The Myth of the Chemical Cure: A critique of psychiatric drug treatment*. London: Palgrave MacMillan

Moran, D. (2000). *Introduction to Phenomenology*. London: Routledge.

- Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2017). What is 'moral distress'? A narrative synthesis of the literature. *Journal of Nursing Ethics*, 30(1), 1-17. <https://doi.org/10.1177/0969733017724354>.
- Morley G., Bradbury-Jones C., Ives J. (2019). What is 'moral distress' in nursing? A feminist empirical bioethics study. *Nursing Ethics*. 27, 1297–1314. <https://doi.org/10.1177/0969733019874492>
- Morley, G., Grady, C., McCarthy, J., & Ulrich, C. (2020). Covid-19: Ethical Challenges for Nurses. *Hastings Centre Rep.* 50(3), 35-39. <https://doi.org/10.1002/hast.1110>
- Morley G., Bradbury-Jones C., Ives J. (2021). The moral distress model: An empirically informed guide for moral distress interventions. *Journal of Clinical Nursing*. 31:1309–1326. <https://doi.org/10.1111/jocn.15988>.
- Morse, J.M. (2015) Data were saturated. *Qual Health Res.* 25(5):587–8. <https://doi.org/10.1177/1049732315576699>.
- Mortari, L. (2015). Reflectivity in Research Practice: An Overview of Different Perspectives. *International Journal of Qualitative Methods*, 14(5). <https://doi.org/10.1177/1609406915618045>
- Musto, L. & Rodney, P. (2015) Moving from conceptual ambiguity to knowledgeable action: Using a critical realist approach to studying moral distress, *Journal of Nursing Philosophy* 17(2). <https://doi.org/10.1111/nup.12104>
- Musto, L. C., Rodney, P. A., & Vanderheide, R. (2015). Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics*, 22(1), 91–102. <https://doi.org/10.1177/0969733014534879>
- Musto, L., Schreiber, R., & Rodney, P. (2021). Risking vulnerability: Enacting moral agency in the is/ought gap in mental health care. *Journal of Advanced Nursing*, 77(5), 2458–2471. <https://doi.org/10.1111/jan.14776>

- Mundasad, S. (2017, January 19). NHS staff shortages: Why so persistent? BBC News. Retrieved from: <https://www.bbc.com/news/health-38640068>
- Nathaniel, A. (2002). Moral distress among nurses. *Ethics and Human Rights*, 1(3), 3–8.
- Nathaniel, A. (2006). Moral reckoning in nursing. *Western Journal of Nursing*, 28, 419–438. <https://doi.org/10.1177/0193945905284727>.
- National Institute for Occupational Safety and Health. (2021). *Stress At work. Centers for Disease Control and Prevention*. Retrieved from: <https://www.cdc.gov/niosh/docs/99-101/pdfs/99-101.pdf>
- Navarro, V. (2020). *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life*. London. Routledge. ISBN 9780895033444
- Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on medical education*, 8(2), 90–97. <https://doi.org/10.1007/s40037-019-0509-2>
- NHS Digital. (2017). A report from Health Education England to support the delivery of the Five Year Forward View for Mental Health in England. Available at: <https://www.hee.nhs.uk/sites/default/files/documents/Stepping%20forward%20to%202021%20-%20The%20mental%20health%20workforce%20plan%20for%20england.pdf>
- NHS Digital. (2019). Out of Area Placements in Mental Health Services, August 2019. London: NHS Digital. Retrieved from: [www.digital.nhs.uk/data-and-information/publications/statistical/out-of-areaplacements-in-mental-health-services%20](http://www.digital.nhs.uk/data-and-information/publications/statistical/out-of-areaplacements-in-mental-health-services%20) (last accessed on 12.12.2019).
- NHS England. (2019). Mental Health Five Year Forward View Dashboard Q2 2020/21. London: NHS England.

NHS England. (2019b). The NHS Long Term Plan. London: NHS England. Retrieved from: [www.longtermplan.nhs.uk/areas-of-work/mental-health/](http://www.longtermplan.nhs.uk/areas-of-work/mental-health/) (last accessed on 6.12.2019).

NHS Improvement. (2019). New clinically-led review of NHS access standards. London: NHS Improvement.

Nigar, N. (2020) Hermeneutic Phenomenological Narrative Enquiry: A Qualitative Study Design. *Theory and Practice in Language Studies*, 10(1), 10-18, <http://dx.doi.org/10.17507/tpls.1001.02>

Nuttgens, S. & Chang, J. (2013) Moral distress within the supervisory relationship: Implications for practice and research. *Journal of Counsellor Education and Supervision*, 52, 284-296. <https://10.1002/j.1556-6978.2013.00043.x>

O'Hara, M. (2012). *Dancing at the edge*. Triarchy Press.

O'Donoghue, T. and Crossley, J. (2020) A critical narrative analysis of psychiatrists' engagement with psychosis as a contentious area. *International Journal of Social Psychiatry*, 66(7), 724–730. <https://doi.org/10.1177/0020764020934516>

Obholzer, A. & Roberts, V.Z. (1994). *The unconscious at work*. London: Routledge. ISBN-10 9780415102063

Obholzer, A. (1995). *The Unconscious at Work - an exploration of some factors influencing how people and organisations work*. The Sutherland Trust. Third Annual Lecture. Accessed 8 May 2020. Available at: <https://www.reallylearning.com/wp-content/uploads/2013/08/the-unconscious-at-work.pdf>

Obholzer, A. and Roberts, V. Z. (Eds) (2019 second edition), *The Unconscious at Work*. Routledge: London



- OECD Report (2021). OECD Economic Outlook. 1(2).  
<https://doi.org/10.1787/66c5ac2c-en>
- Olive, J. (2014) Reflecting on the tensions between Emic and Etic perspectives in life history research: lessons learned. *Forum Qualitative Sozialforschung*, v15.  
 URN: <http://nbn-resolving.de/urn:nbn:de:0114-fqs140268>
- Oliver, D. (2018). Moral distress in hospital doctors. *BMJ : British Medical Journal*, 360, 1–2. <https://doi.org/10.1136/bmj.k1333>
- Olson, L. (1988). Hospital nurses' perceptions of the ethical climate of their work setting. *Journal of Nursing Scholarship*. 30(4): 345-9.  
<https://doi.org/10.1111/j.1547-5069.1998.tb01331.x>.
- Oxfam Truth and Lies about Poverty (2013). Ending Comfortable Myths about Poverty. [(accessed on 3 March 2018)] Available at: <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/306526/rr-truth-and-lies-about-poverty-101213-en.pdf;jsessionid=9267417DB578C6EF916825552630486C?sequence=1>
- Parker, I. (1989). *The Crisis in Modern Social Psychology, and How to End It*. London: Routledge. ISBN 9780415706452.
- Parker, I. (1998). *Social constructionism, discourse and realism*. London: Sage.
- Parker, I. (1999). Critical psychology: Critical links. *Radical Psychology: A Journal of Psychology, Politics and Radicalism*. Retrieved from: [www.yorku.ca/faculty/academic/danaa/index.htm](http://www.yorku.ca/faculty/academic/danaa/index.htm) (last accessed November 3, 2018).
- Parker, I. (2007). Critical Psychology: What It Is and What It Is Not. *Social and Personality Psychology Compass*. 1(1). 1–15, <https://doi.org/10.1111/j.1751-9004.2007.00008.x>

- Patton, M. Q. (1990). *Qualitative evaluation and research methods (3rd Ed)*. SAGE Publications inc.
- Patton, M. Q. (2002). Two Decades of Developments in Qualitative Inquiry: A Personal, Experiential Perspective. *Journal of Qualitative Social Work*, 1(3). <https://doi.org/10.1177/1473325002001003636>
- Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. *Nursing Ethics*, 16(5), 561–573. <https://doi.org/10.1177/0969733009106649>.
- Pauly, B., Varcoe, C., Storch, J. (2012). Framing the issues: moral distress in health care. *HEC Forum* 24: 1–11. <https://doi.org/10.1007/s10730-012-9176-y>.
- Pettifor, J. L., & Sawchuk, T. R. (2006). Psychologists' perceptions of ethically troubling incidents across international borders. *International Journal of Psychology*, 41(3), 216–225. <https://doi.org/10.1080/00207590500343505>
- Petriglieri, G. & Petriglieri, J.L., (2020). The return of the oppressed: A systems psychodynamic approach to organization studies. *Academy of Management Annals*, 14, 411–449, <https://doi.org/10.5465/annals.2017.0007>
- Peter, E., & Liaschenko, J. (2004). Perils of proximity: a spatiotemporal analysis of moral distress and moral ambiguity. *Journal of Nursing Inquiry*, 11. 221-234. DOI: 10.1111/j.1440-1800.2004.00236.x
- Peter, E., Liaschenko, J. (2013). Moral distress re-examined: a feminist interpretation of nurses' identities, relationships, and responsibilities. *Journal of Bioethical Inquiry*, 10: 337–445. <https://doi.org/10.1007/s11673-013-9456-5>.
- Peters, M. D. J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *International*

Journal of Evidence-Based Healthcare, 13(3), 141–146.  
<https://doi.org/10.1097/XEB.0000000000000050>

Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health*, 8(3), 261–274. <https://doi.org/10.1080/09638239917427>

Platt S., Stace S., Morrissey J., (editors). *Dying From Inequality: Socioeconomic Disadvantage and Suicidal Behaviour*. Published in 2017. Samaritans; London, UK. Retrieved from:  
[https://media.samaritans.org/documents/Samaritans\\_Dying\\_from\\_inequality\\_report\\_-\\_summary.pdf](https://media.samaritans.org/documents/Samaritans_Dying_from_inequality_report_-_summary.pdf)

Polkinghorne, D. E. (1988). *Narrative knowing and the human sciences*. Albany, NY: SUNY Press.

Polkinghorne, D.E. (1989). Phenomenological Research Methods. In: Valle, R.S. and Halling, S. (Eds.), *Existential-Phenomenological Perspectives in Psychology: Exploring the Breadth of Human Experience*, Plenum Press, New York, 41-60.  
[https://doi.org/10.1007/978-1-4615-6989-3\\_3](https://doi.org/10.1007/978-1-4615-6989-3_3)

Polkinghorne, D. E. (2010). The practice of narrative. *Narrative Inquiry*, 20(2), 392-396. <https://doi.org/10.1075/ni.20.2.11pol>

Pollock, A.M. (2004). *NHS Plc: The Privatization of Our Health Care*. Verso. PMID: PMC1079392

Ponterotto, G., Levitt, H., Motulsky, S., Wertz, F. & Morrow, S. (2017). Recommendations for Designing and Reviewing Qualitative Research in Psychology: Promoting Methodological Integrity. *Qualitative Psychology. American Psychological Association*, 4(1), 2–22.  
<http://dx.doi.org/10.1037/qup0000082>

- Pope, K. S., Tabachnick, B. G. & Keith-Spiegel, P. (1988). Good and poor practices in psychotherapy: National Survey of Beliefs of Psychologists.. *Professional Psychology, Research, and Practice*, 19: 547–552.  
<https://doi.org/10.1037/0735-7028.19.5.547>
- Pope, K.S, Tabachnick, B.G. & Keith-Spiegel, P. (1987). Ethics of practice. The beliefs and behaviors of psychologists as therapists. *American Psychological Association*, 42(11), 993-1006. <https://doi.org/10.1037//0003-066x.42.11.993>.
- Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ : British Medical Journal*, 320(7227), 114–116.  
<https://doi.org/10.1136/bmj.320.7227.114>
- Pope, R. & Burnes, B. (2003). A model of organisational dysfunction in the NHS. *Journal of Health Organization and Management*, vol. 27 no. 6.  
<https://doi.org/10.1108/JHOM-10-2012-0207>
- Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London, UK: Sage. ISBN: 9780803980563
- Potter, J. & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2, 281–307.  
<https://doi.org/10.1191/1478088705qp045oa>
- Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipriano, D., Norris, L. & Olsen, S. (2010). Compassion fatigue and burnout: prevalence among oncology nurses. *Clinical Journal Oncology Nursing*. 14(5), 56-62.  
<https://doi.org/10.1188/10.CJON.E56-E62>.
- Prilleltensky, I., & Nelson, G. (2002). *Doing Psychology Critically: Making a Difference in Diverse settings*. Palgrave Macmillan/Springer Nature.

- Rahim, M., & Cooke, A. (2019). Should clinical psychologists be political? *Professional Issues in Clinical Psychology*.  
<https://doi.org/10.4324/9781351056267-10>
- Rathert, C., May, D., Chung, H. (2015). Nurse moral distress: A survey identifying predictors and potential interventions. *International Journal of Nursing Studies*. 53, 39-49. <https://doi.org/10.1016/j.ijnurstu.2015.10.007>.
- Rao, A. S., Bhutani,G., Clarke,J., Dosanjh,N., Parhar, S., Easton, S., & Van Laar, D. (2016). *A Case for the Charter for Staff Wellbeing & Resilience, New Savoy Conference*. Retrieved from: <https://beta.bps.org.uk/blogs/dr-amra-rao/delicate-dance-workforce-wellbeing-and-psychological-safety>
- Ray, S. L., Wong, C., White, D. & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology*, 19(4), 255–267. <https://doi.org/10.1177/1534765612471144>
- Reed, P.G., & Rishel ,C.J. (2015). Epistemic injustice and nurse moral distress: perspective for policy development. *Nursing Science Quarterly*, 28: 241–244. <https://doi.org/10.1177/0894318415585634>.
- Reichers, A. E., & Schneider, B. (1990). Climate and culture: An evolution of constructs. In B. Schneider (Ed.), *Organizational climate and culture* (pp. 5-39). San Francisco: Jossey-Bass.
- Rhodes, A., Cecconi, M., Hamilton, M., Poloniecki, J., Woods, J., Boyd, O., Bennett, D., Grounds, R. (2010). Goal-directed therapy in high-risk surgical patients: a 15-year follow-up study. *Intensive Care Med*. 36(8),1327-32.  
<https://doi.org/10.1007/s00134-010-1869-6>.
- Ricoeur, P. (1981). *Hermeneutics and the Human Sciences*. Trans. J. B. Thompson. Paris, France: Edition de la Maison des Sciences de l'Homme/Cambridge, UK: Cambridge University Press.

- Ricoeur, P. (1992). Narrative identity in P. Wood (Ed.), *On Paul Ricoeur: Narrative and interpretation* (pp.188-199). London. Routledge.
- Riessman, C. (2008). *Narrative methods for the human sciences*. Thousand Oaks: Sage Publications.
- Rizq, R. (2012) The perversion of care: Psychological therapies in a time of IAPT, *Psychodynamic Practice*, 18:1, 7-24, DOI: 10.1080/14753634.2012.640161
- Rizq, R., & Catherine, J. (2019). *The Industrialisation of Care: Counselling, psychotherapy and the impact of IAPT*. Monmouth. PCCS Books.
- Roberts, H., Stuart, S., Allan, S. & Gumley, A. (2022). 'It's Like the Sword of Damocles' – A Trauma-Informed Framework Analysis of Individuals' Experiences of Assessment for the Personal Independence Payment Benefit in the UK. *Journal of Social Policy*, 1-16. doi:10.1017/S0047279422000800
- Rodney, P. A. (2017). What we know about moral distress. *The American Journal of Nursing*, 117(2), 7–10. <https://doi.org/10.1097/01.NAJ.0000512204.85973.04>
- Roe, R. A. (2008). Time in applied psychology: The study of “what happens” rather than “what is”. *European Psychologist* 13: 37–52. <https://doi.org/10.1027/1016-9040.13.1.37>
- Rushton, C. H., Boss, R., Hallett, K., Hensel, J., Humphrey, G. B., Les, J., Mack, C., McCammon, S., Murray, J. S., Nathanson, E., Pniewski, J., Shuham, A. M., & Volpe, R. L. (2013). The many faces of moral distress among clinicians. *Narrative inquiry in bioethics*, 3(2), 89–93. <https://doi.org/10.1353/nib.2013.0039>
- Rutzou, T. (2016). “Reimagining Social Science”. *Journal of Critical Realism*, 15(4): 327-41.

- Sandelowski, M. (1996). One is the liveliest number: the case orientation of qualitative research. *Research in Nursing & Health*, 19(6), 525–529. <https://doi.org/10.1002/1098-240X>
- Sanderson, C., Sheahan, L., Kochovska, S., Lockett, T., Parker, D., Butow, P., & Agar, M. (2019). Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature. *Clinical Ethics*, 14(4), 195–210. <https://doi.org/10.1177/1477750919886088>
- Savage, M. (2000). *Class analysis and social transformation*. Open University Press.
- Savage, M. (2012). "Class, culture and politics." In: Amenta, E.; Nash, K. & Scott, A. (Eds). *The Wiley-Blackwell companion to political sociology*. West Sussex, Wiley-Blackwell, 294-304.
- Scanlon, C. (2021). On disappointment: promoting ordinary conversations in extraordinary times, *Journal of Psychosocial Studies*, 14(1), 19-32. Retrieved from <https://bristoluniversitypressdigital.com/view/journals/jps/14/1/article-p19.xml>
- Schein, E. (2010). *Organizational culture and leadership*: John Wiley & Sons. Hoboken.
- Schein, E. H. (1995). The Role of the Founder in Creating Organizational Culture. *Family Business Review*, 8(3), 221–238. <https://doi.org/10.1111/j.1741-6248.1995.00221.x>
- Schluter, J., Winch, S., Holzhauser, K. & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nursing Ethics*, 15(3), 304-21. <https://doi.org/10.1177/0969733007088357>.
- Shafran R., Clark D. M., Fairburn C. G., Arntz A., Barlow D. H., Ehlers A., Freeston M., Garety P. A., Hollon S. D., Ost L. G., Salkovskis P. M., Williams J. M., &

- Wilson G. T. (2009). Mind the gap: improving the dissemination of CBT. *Behaviour Research and Therapy*, 47: 902–909.  
<https://doi.org/10.1016/j.brat.2009.07.003>
- Sherman, R.O., & Pross, E. (2010). Growing Future Nurse Leaders to Build and Sustain Healthy Work Environments at the Unit Level. *The Online Journal of Issues in Nursing*. 15(1), 1-9. <https://doi.org/10.3912/OJIN.Vol15No01Man01>
- Silva, M., Loureiro, A. & Cardoso, G. (2016). Social determinants of mental health: A review of the evidence. *European Journal of Psychiatry*. 30, 259–292. ISSN 0213-6163
- Sima, W., Zanardellia, G., Loughrana, M., Mannarinoa, M., Clara, E. & Hillb, C. (2016). Thriving, burnout, and coping strategies of early and later career counseling center psychologists in the United States. *Counselling Psychology Quarterly*, 29(4), 382–404, <https://doi.org/10.1080/09515070.2015.1121135>
- Simionato, G., Simpson, S., & Reid, C. (2019). Burnout as an ethical issue in psychotherapy. *Psychotherapy*, 56(4), 470.  
<https://doi.org/10.1037/pst0000261>
- Simpson, P. & French, R. (2005). Thoughtful Leadership, *Organisational & Social Dynamics*, 5(2) 280-297. Available at: <https://uwe-repository.worktribe.com/OutputFile/1052112>
- Simons, L., Lathlean, J. & Squire, C. (2008). Shifting the focus: sequential methods of analysis with qualitative data. *Qualitative Health Research*, 18(1), 120-132.  
<https://doi.org/10.1177/1049732307310264>
- Smith, J.A. (2005). Advocating pluralism: Invited commentary on ‘Qualitative interviews in psychology: problems and perspectives’ by Jonathan Potter and Alexa Hepburn (eds). *Qualitative Research in Psychology*, 2, p. 309–311.



- Smith, J.A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well Being*, 2: 3–11. <https://doi.org/10.1080/17482620601016120>
- Smith, J.A. (2011) 'We could be diving for pearls': the value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin*, 12, 6-15. ISSN 2044-0820.
- Smith, J., Flower, P. and Larkin, M. (2009), *Interpretative Phenomenological Analysis: Theory, Method and Research*. London. Sage Publications. <https://doi.org/10.1080/14780880903340091>
- Smith, J.K. , and Deemer, D.K. (2000). The problem of criteria in the age of relativism . In N. K. Denzin &Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 877-896). Thousand Oaks, CA: Sage.
- Somerville, M. A. (2004). *The Ethical Canary: Science, society, and the human spirit*. McGill-Queen's Press. Canada. ISBN 9780773527843
- Sporrong, S.K., Holland, A. & Arnetz, B. (2006). Measuring moral distress in pharmacy and clinical practice. *Journal of Nursing Ethics*, 13, 416-427. <https://doi.org/10.1191/0969733006ne880oa>.
- Spriggins, K. (2021). *Moral Distress and Clinial Psychologists*. Doctoral thesis, University of East London. Retrieved from: <https://repository.uel.ac.uk/item/89y80>
- Squire, C. (2008). ESRC National Centre for Research Methods Review Paper. Centre for Narrative Research, University of East London. NCRM Review

Papers. NCRM/009. Retrieved from:

<https://eprints.ncrm.ac.uk/id/eprint/419/1/MethodsReviewPaperNCRM-009.pdf>

Starks, H. & Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research*, 17(10), 1372-1380.

<https://doi.org/10.1177/1049732307307031>

Stebnicki, M. A. (2007). Empathy fatigue: Healing the mind, body, and spirit of professional counselors. *American Journal of Psychiatric Rehabilitation*, 10(4), 317–338. <https://doi.org/10.1080/15487760701680570>

Stuckler, D. & Basu, S. (2013). *The Body Economic: Why Austerity Kills*. Basic Books. New York.

Sull, A., Harland, N., & Moore, A. (2015). Resilience of health-care workers in the UK; a cross-sectional survey. *Journal of Occupational Medicine and Toxicology*, 10(1), 1-8. <https://doi.org/10.1186/s12995-015-0061-x>

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology*, 74(9), 1545-1555. <https://doi.org/10.1002/jclp.22614>

Taylor-Gooby, P. (2012). Overview: Resisting welfare state restructuring in the UK. *Journal of Poverty Social Justice*, 20, 119–132. <https://doi.org/10.1332/175982712X652023>

Thomas, P. (2014). *Psychiatry in Context: Experience, meaning & communities*, Wyastone Leys: PCCS Books.

- Thomas, F. (2021). Medicalisation. In *Routledge International Handbook of Critical Issues in Health and Illness* (pp. 23-33). Routledge.
- Thorne, S. (2017). Metasynthetic madness: what kind of monster have we created? *Qual Health Res* 2017; 27: 3–12.
- The Francis Report: A Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary* (HC 947). The Stationery Office. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279124/0947.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf)
- The Nuffield Trust. (2020, February 29). *The NHS workforce in numbers*. Retrieved from: <https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers>
- Tiedje, L. B. (2000). Moral distress in perinatal nursing. *The Journal of Perinatal & Neonatal Nursing*, 14(2), 36–43. <https://doi.org/10.1097/00005237-200009000-00005>.
- Tigard, D. W. (2018). Rethinking moral distress: Conceptual demands for a troubling phenomenon affecting health care professionals. *Medicine, Health Care and Philosophy*, 21(4), 479–488. <https://doi.org/10.1007/s11019-017-9819-5>
- Tigard, D. W. (2019). The positive value of moral distress. *Bioethics*, 33, 601– 608. <https://doi.org/10.1111/bioe.12564>
- Tracy, S. J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. *Journal of Qualitative Inquiry*. 16: 837. <https://doi.org/10.1177/1077800410383121>
- Traudt, T., Liaschenko, J. & Peden-McAlpine, C. (2016). Moral Agency, Moral Imagination and Moral Community: Antidotes to Moral Distress. *The Journal of clinical ethics*. 27. 201-213. <https://doi.org/10.1086/JCE2016273201>.

- Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M. & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science Medicine*, 65(8), 1708-19. <https://doi.org/10.1016/j.socscimed.2007.05.050>.
- Unite. (2018). *Report on Applied Psychologists march to parliament to demand promised funding on mental health*: Retrieved from: <https://www.unitetheunion.org/news-events/news/2018/march/applied-psychologists-to-lobby-parliament-on-20-march-to-demand-promised-funding-on-mental-health/>
- Ussher, M. (1999). Commentary: Eclecticism and methodological pluralism: The way forward for psychological research. In M. Crawford, & E. Kimmel (Eds.), *Innovations in feminist psychological research*, 13(12), (pp 41–46). Cambridge: Cambridge University Press
- Varcoe, C., Pauly, B., Webster, G., & Storch, J. (2012). Moral distress: Tensions as springboards for action. *HEC Forum*, 24(1), 51–62. <http://dx.doi.org/10.1007/s10730-012-9180-2>
- Van Liew, J. R. (2012). Balancing confidentiality and collaboration within multidisciplinary health care teams. *Journal of Clinical Psychology in Medical Settings*, 19(4), 411-417. <https://doi.org/10.1007/s10880-012-9333-0>
- Vasileiou, K., Barnett, J., Thorpe, S. & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18, 148-161. <https://doi.org/10.1186/s12874-018-0594-7>
- Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary family therapy*, 19(1), 23-39. Available at: [http://solutions-centre.org/pdf/wade\\_1997.pdf](http://solutions-centre.org/pdf/wade_1997.pdf)

- Walsh, R., & Koelsch, L. E. (2012). Building across fault lines in qualitative research. *The Humanistic Psychologist*, 40(4), 380–390.  
<https://doi.org/10.1080/08873267.2012.724260>
- Webber, M., Reidy, H., Ansari, D., Stevens, M. & Morris, D. (2015). Enhancing social networks: A qualitative study of health and social care practice in UK mental health services. *Health and Social Care Community*. 23, 180–189.  
<https://doi.org/10.1111/hsc.12135>
- Weber, E. (2016). Moral Distress, Workplace Health, and Intrinsic Harm. *Journal of Bioethics*, 30(4), 244-250. <https://doi.org/10.1111/bioe.12181>
- Weick, K. E., & Sutcliffe, K. M. (2003). Hospitals as Cultures of Entrapment: A Re-Analysis of the Bristol Royal Infirmary. *California Management Review*, 45(2), 73–84. <https://doi.org/10.2307/41166166>
- White, J.& Drew, S. (2011). Collecting Data or Creating Meaning? *Qualitative Research Journal*. 11. 3-12. <https://doi.org/10.3316/QRJ1101003>.
- Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2015). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship*, 47(2), 117–125.  
<https://doi.org/10.1111/jnu.12115>
- Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing*; 52: 546–553.  
<https://doi.org/10.1111/j.1365-2648.2005.03621.x>
- Wickens, C. (2011). The investigation of power in written texts through the use of multiple textual frames. *International Journal of Qualitative Studies in Education*, 24(2), 151-164. <https://doi.org/10.1080/09518398.2010.495363>

Wickham, S., Bentley, L., Rose, T., Whitehead, M., Taylor-Robinson, D., Barr, B. (2020). Effects on mental health of a UK welfare reform, Universal Credit: a longitudinal controlled study. *Lancet Public Health*, 5, 157-64. [https://doi.org/10.1016/S2468-2667\(20\)30026-](https://doi.org/10.1016/S2468-2667(20)30026-)

Wiegand, D. L. & Funk, M. (2012). Consequences of clinical situations that cause critical care nurses to experience moral distress. *Nursing Ethics*, 19: 479–487. <https://doi.org/10.1177/0969733011429342>

Wilkinson R. & Pickett K. (2009) *The Spirit Level: Why Equality is Better for Everyone*. Penguin; London, UK: <https://doi.org/10.1017/S0047279413000366>

Wilkinson, J. M. (1987). Moral distress in nursing practice: Experience and effect. *Nursing Forum*, 23(1), 16–29. <https://doi.org/10.1111/j.1744-6198.1987.tb00794.x>

Williams, V., Boyle, G., Jepson, M., Swift, P., Williamson, T., & Heslop, P. (2014). Best interest decisions: Professional practices in health and social care. *Health and Social Care in the Community*, 22(1), 78-86. <http://dx.doi.org/10.1111/hsc.12066>

Willig, C. (2001). *Introducing qualitative research in psychology Adventures in theory and method*. Buckingham: Open University Press. Available at: [https://moodle.jku.at/jku/pluginfile.php/27585/mod\\_resource/content/1/Willig\\_2003\\_.pdf](https://moodle.jku.at/jku/pluginfile.php/27585/mod_resource/content/1/Willig_2003_.pdf)

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J.

Sher (Eds.), *APA handbook of research methods in psychology*, Vol 1: Foundations, planning, measures, and psychometrics. (pp. 5–21). American Psychological Association. <https://doi.org/10.1037/13619-002>

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research*, 19(3), 186–194. <https://doi.org/10.1002/capr.12204>

Willis, M. (2015) *Moral decisions, moral distress, and the psychological health of nurses*. Doctoral Thesis. Retrieved from: <https://dspace.lboro.ac.uk/2134/16817>

Wocial, L.D., Hancock, M., Bledsoe, P.D., Chamness, A.R., Helft, P.R. (2010). An evaluation of unit-based ethics conversations. *JONAS Healthcare Law Ethics Regulation*. 12(2): 48-54; <http://doi.org/10.1097/NHL.0b013e3181de18a2>.

Wocial, L. D. (2016). A Misunderstanding of Moral Distress, *The American Journal of Bioethics*, 16(12), 21-23, <http://doi.org/10.1080/15265161.2016.1239791>

Wood N. (2020). Racism in clinical psychology within the heart of the old empire. *South African Journal of Psychology*. 50(4):446-449. doi:10.1177/0081246320968233

Wood, B. J., Klien, S., Cross, H. J., Lammers, C. J. and Elliott, J. K. 1985. Impaired practitioners: Psychologists' opinions about prevalence, and proposals for intervention.. *Professional Psychology, Research, and Practice*, 16: 843–850.

Wren, B. & Michie, S. (2003). Staff experience of the health care system. In S. Llewellyn & P. Kennedy (Eds.), *Handbook of clinical health psychology*, pp. 41-60. Chichester: Wiley.

Wren, B. (2014). Managing staff experience to improve organisational culture. In L. Tate, E. Donaldson-Feilder & K. Teoh. (Eds) *Implementing culture change within the NHS: Contributions from Occupational Psychology*, pp. 18-25. The British Psychological Society. London. BPS Press.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215–228. <https://doi.org/10.1080/08870440008400302>

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative Psychology* (2nd ed., pp. 235–251). London: Sage.

Yardley, L. (2017). Demonstrating the validity of qualitative research, *The Journal of Positive Psychology*, 12(3), 295-296.  
<https://doi.org/10.1080/17439760.2016.1262624>

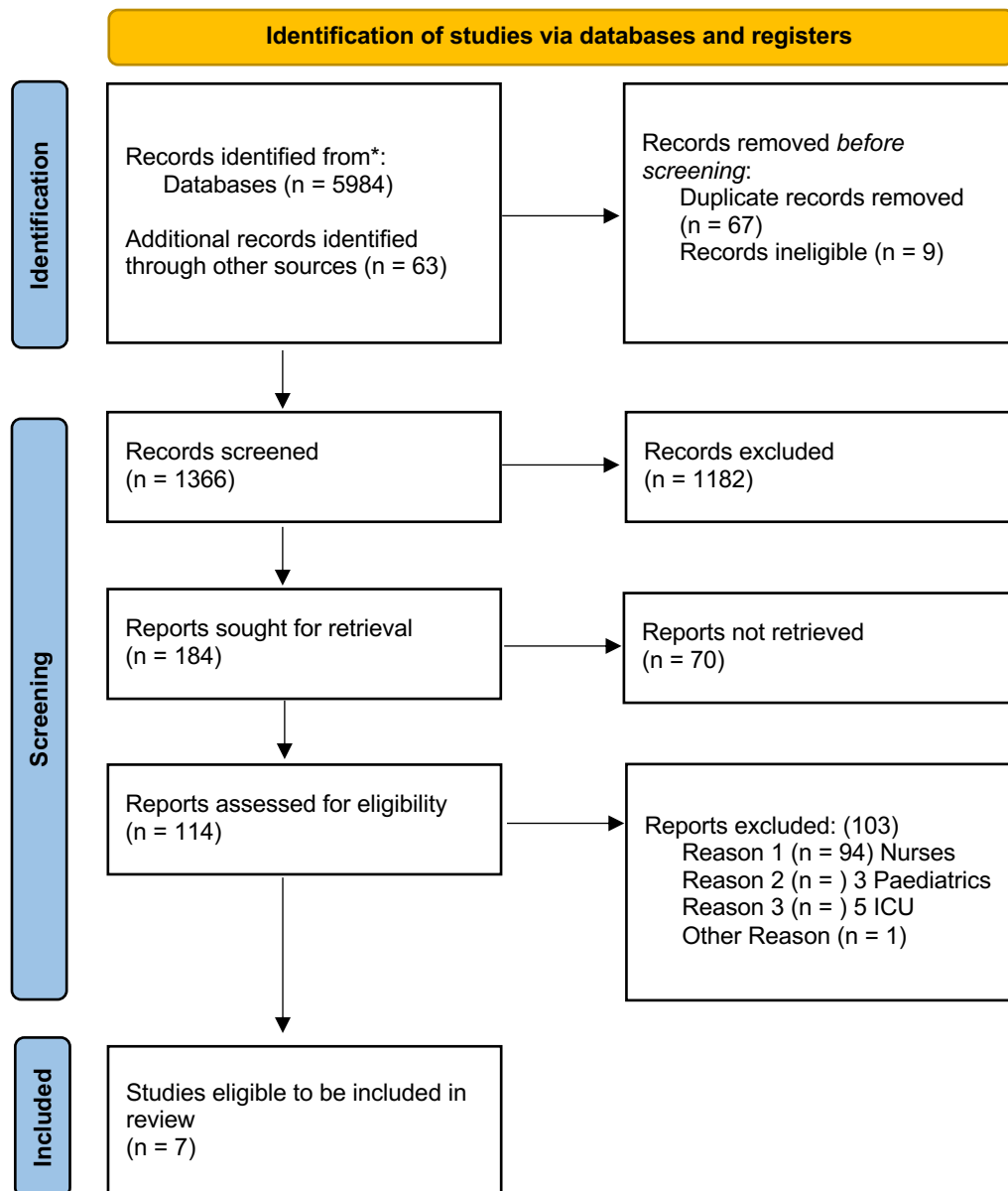


## Appendix A: Literature Search Strategy

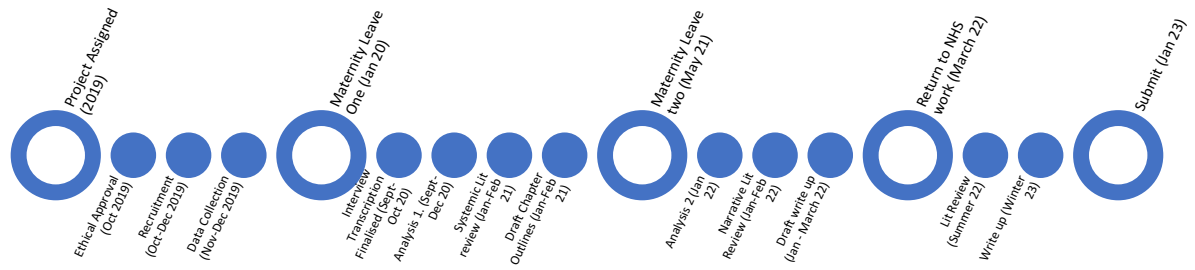
Following PRISMA guidelines (Peters et al, 2015) search strategies were narrowed to dominant terms, as described in the core text above. The criteria for this scoping review came from the aims and inclusion criteria for this study. An initial search was performed across several databases to refine search terms. The initial search strategy used 'psychologist' as a specific search phrase, including a combination of the following terms: "moral distress" AND (psychologist OR "mental health professional") OR (burnout OR compassion fatigue) OR (stress OR emotional exhaustion OR pressure OR cop\* OR well-being OR "mental health" OR Ethical\*). The electronic databases searched were EBSCO (PsycInfo, PsychARTICLES, CINAHC); Academic Search Complete; Pub Med, Cochrane and Google Scholar, for articles published prior to 1st February 2021. This attempt returned less than 15 (non-duplicate) articles, the majority of which spoke to experiences outside of the UK. Once the search lens was widened to 'health-care practitioners', removing 'Psychologist' as a search phrase, 5984 items were returned. Initially a decision was made to proceed with a broad lens – given the ethos of the research. A total of 6047 articles were identified through the search. Research titles and key-descriptors were used to 'sort' for relevance. Criterion for exclusion included articles researching MD outside of healthcare contexts (such as teaching or the military), those not relating to clinical practice, and full texts not being available to the researcher. A total of 1366 records were screened in further detail. Of those articles screened, 67 duplicate and 9 ineligible articles were removed (no English language version available). 184 full texts were sought for retrieval, of which 114 were assessable and were assessed for eligibility. 94 of these reports related solely to nurses experiences of moral distress and a further 9 were based in acute care settings (e.g. Nicu, specialist medicine). I realised that the articles remaining, did not capture the impact of delivering 'mental health' care. An alternative approach was needed.

## Appendix B: Scoping Review Process

Chart adapted from Peters et al. (2015), PRISMA Guidelines for reporting systematic reviews.



## Appendix C: Timeline of Research Phases





## University of East London

**Are you a Clinical Psychologist with experiences of ethical dilemmas or being 'unable to do the right thing' in your work? Does your role in the NHS enable you to practice as you would like?**

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**Have you ever wondered how these experiences might influence your clinical practice?**

This is what this project aims to explore.

We know that many of the known sources of moral distress are common in the NHS, where demands have increased, alongside a reduction in resources; support and control (see Sima et al, 2017).

It is likely that psychologists experience significant constraints on ethical practice in their everyday professional lives, yet, we know little about what it means in practice.

Would you like to play a role in changing this?

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**If you are interested in taking part or would like more information then please contact:**

Katie Doherty on [u1725757@uel.ac.uk](mailto:u1725757@uel.ac.uk)

**Who do we want to talk to?**

Qualified Clinical Psychologists:

- Currently Practicing in the NHS
- Or those practicing within the NHS in the previous two years
- Any settings, all experiences welcome!

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**What would I need to do?**

- Take part in a one-to-one interview that will take roughly 40-75 minutes, depending on your availability.
- We can conduct this interview in person or over skype, Teams or WebEx.
- All data will be anonymised to ensure confidentiality.

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This is a DCLinPsych Thesis Project and is sponsored by the University of East London.

Supervised by Dr. Martin Willis

Thank you for taking the time to read this poster

**UNIVERSITY OF EAST LONDON**  
**School of Psychology**

**APPLICATION FOR RESEARCH ETHICS APPROVAL  
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS  
(Updated October 2019)**

**FOR BSc RESEARCH  
FOR MSc/MA RESEARCH  
FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING  
& EDUCATIONAL PSYCHOLOGY**

**1. Completing the application**

1.1 Before completing this application please familiarise yourself with the British Psychological Society's [Code of Ethics and Conduct \(2018\)](#) and the [UEL Code of Practice for Research Ethics \(2015-16\)](#). Please tick to confirm that you have read and understood these codes

1.2 Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will then look over your application.

1.3 When your application demonstrates sound ethical protocol, your supervisor will submit it for review. It is the responsibility of students to check this has been done.

1.4 Your supervisor will let you know the outcome of your application. Recruitment and data collection must NOT commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (see section 8).

1.5 Please tick to confirm that the following appendices have been completed. Note: templates for these are included at the end of the form.

- The participant invitation letter
- The participant consent form
- The participant debrief letter

1.6 The following attachments should be included if appropriate:

- Risk assessment forms (see section 6)
- A Disclosure and Barring Service (DBS) certificate (see section 7)
- Ethical clearance or permission from an external organisation (see section 8)
- Original and/or pre-existing questionnaire(s) and test(s) you intend to use
- Interview protocol for qualitative studies
- Visual material(s) you intend showing participants.

## **2. Your details**

2.1 Your name: Kate Doherty

2.2 Your supervisor's name: Dr Martin Willis

2.3 Title of your programme: Doctorate of Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date):  
May 2021 - Due to Maternity Leave (Roughly Scheduled from December 2019 – October 2020)

## **3. Your research**

*Please give as much detail as necessary for a reviewer to be able to fully understand the nature and details of your proposed research.*

3.1 The title of your study:

When Mental Healthcare professionals cannot do the right thing: An exploration of how clinical psychologists make sense of their experiences of Moral Distress and conflicts of conscience.

Abstract:

Moral distress is said to occur when power and its unequal distribution (Barlem and Ramos, 2015) constrain moral identity and agency, restrict autonomy, and prevent professionals from acting in accordance with their own core values (Peter and Liaschenko, 2004). Feeling unable to 'do the right thing' has been found to have physical, psychological and behavioral consequences, re-shaping identities (Austin, 2015), impacting patient care (Musto & Rodney, 2015), and damaging workplace environments (Weber, 2016). Many of the known sources of moral distress are common across the NHS, where demands have increased, alongside a reduction in resources, support and control (see Sima et al, 2017). Despite the importance of moral distress scholarship in the healthcare ethics lexicon, and the likelihood that psychologists experience significant constraints on ethical practice in their everyday professional lives, scholarship in the area of MD is almost non-existent in the mental health

professions (Nuttgens and Chan, 2013). To this end, a critical examination of the application of the concept of moral distress in the context of the clinical psychology profession is proposed, using semi-structured interviews to explore how a number of NHS practicing Clinical Psychologists make sense of their experiences, and to critically consider how agency, power, identity, institutions and culture manifest themselves in participants narratives. Findings are hypothesized to be important in the effort to better mental health care.

### 3.2 Your research question:

The proposed study aims to increase understanding of the experience of moral distress for clinical psychologists, by allowing space for challenges and positive stories to be shared, in order to generate insight into:

1. Whether, how and why clinical psychologists experience moral distress
2. How they construct, navigate, and manage these experiences in their personal and professional identities. How did they at the time of a main event? Has this changed?

In relation to these stories of moral distress, this study will explore how agency, power, identity, institutions and culture manifest themselves in personal, professional and wider narratives, and think critically about what this might mean for the clinical psychology profession and their relations with patients.

### 3.3 Design of the research:

#### Epistemology

Phenomenological research is suitable for this project, as it is centrally concerned with content and meaning (Lyons, 2007). However, 'describing things as they are appearing' may offer little potential for critique (Habermas, 1971). Therefore, a critical realist stance is also considered, as it acknowledges reality is actively influenced by cultural, social and psychological factors (Riazi, 2016) which can be explored through language and context. Qualitative methodology helps access the 'voice' of individuals as opposed to 'expert' opinion and is suited to researching the richness of consultations (Lane & Tribe, 2010).

#### Approach

The concept of bricolage (Coyle, 2010) has been used to refer to pluralistic practices that maintain theoretical coherence (Kincheloe, 2005), in which the researcher combines different methods to compensate for their individual deficiencies (Denzin, 2010). Critical

Narrative Analysis (CNA) is one such framework. It attempts to work with language, power and politics (Langdrige, 2007) by drawing upon the hermeneutic philosophy of Ricoeur (1981) where meaning is appropriated through the critical interrogation of the stories we tell. By bringing together hermeneutics of empathy and suspicion (Riccour, 1996), Langdrige's method combines narrative methods with critical theory (2008) in order to understand the lived world of the participants, while illuminating the embedded nature of both participants, and the researcher, in social ideals. Given the nature of this study it seemed of interest to draw upon ideas from psychoanalytically informed critical social psychology: such as Parker's (1999) work on 'psychological culture', as well as Foucauldian ideas of the operationalisation of power (1975).

Interviews will be used as the method of data collection. Although the aim is to let the participant speak to understand the story as presented, to remain bound by the research focus of the study, a semi structured interview protocol is used (detailed below).

### 3.4 Participants:

#### Participants:

The proposed study will use purposeful sampling and include hour long interviews with 7-9 qualified clinical psychologists, in adherence with the guidelines for small projects from Braun & Clarke (2013). Participants will most likely be aged between 25 – 60. Recruitment is open to all Qualified Clinical Psychologists that have currently, or have in the previous two years, worked in the NHS in a professional capacity. There are no age, gender nor ethnicity constraints. Ideally participants will be sought that work in the Greater London Area. However the researcher is willing to travel should interest be expressed from other locations with the UK.

### 3.5 Recruitment:

#### Recruitment Protocol:

Participants will be recruited via a brief information 'advertising letter' describing the study, posted on the UK Based Clinical Psychology Facebook Group – a Facebook forum specifically for qualified clinical psychologists, or those in training- as well as specific interest groups Social Media Groups in clinical psychology. This is to enable access to clinicians working in a wide range of clinical services. There will also be a link posted to information about the study on Twitter, to enable clinicians to choose to take part.



Participants will be invited to express an interest in taking part in the study by opening a link, that accessed a detailed information letter describing the study. Participants will be invited to ask questions of the researcher, and to leave email contact details (anonymised to all apart from the researcher), if interested in taking part.

In addition to this, I have consulted with representatives from R&D departments in two London Based NHS Trusts. They are enthusiastic about the proposed research and willing to assist recruitment. Should HRA approval be sought, further participants will be recruited using email invitation via heads of service.

Interviews will be scheduled at a time and place convenient to the participant, at either UEL, or a community or NHS setting. Lone working procedures will be arranged with the field supervisor.

Due to the ongoing covid-19 pandemic, it is likely that governmental guidance may place restrictions on face-to-face working. In accordance to university protocol, should participants choose, interviews will take place using Microsoft Teams Video Conferencing platform, all recruitment and data protection protocol outline previously will be followed.

### 3.6 Measures, materials or equipment:

Measures:

As this research is exploratory and interested in individuals' perceptions, a qualitative approach will be used. Focus group methodology was considered due its naturalistic setting and value of shared conversations (Finch, Lewis & Turley, 2014). However, semi-structured interviews are deemed more suitable due to potential ethical considerations concerning anonymity. The use of narrative interviews, conducted in a semi-structured 'conversation with a purpose' style (Kvale, 1996), whereby questions are organised around a set of topics (Appendix 1) used as a guiding framework (Patton, 2002), should allow participants to develop conversation in ways that are salient to them (Frost et al, 2011). As well as enabling the researcher to critically engage with how the production of knowledge and interaction with participants is rooted in social context and power inequalities (Kolar, Ahmad, Chan & Erickson, 2015). A semi-structured interview guide has been developed after conducting a literature review, in consultation with my supervisor and with qualified clinicians practicing in the NHS. A copy of the potential questions and guiding topics are attached to this application.

### 3.7 Data collection and 3.8 Data Analysis

#### Data collection and analysis

After reading the information sheet together with participants, a consent form will be signed. Interviews will take place in a private room, lasting approximately 60-90 minutes and will be audio recorded using a digital recorder. Data will aim to be collected over 3 months between October – December 2020.

Data will be transcribed and analysed using in adherence with stage based analysis guidelines for Critical Narrative Analysis (Appendix 2).

#### Storage and use of personal data:

All quotations and identifiable information will be anonymised. Appropriate access controls will be put in place to ensure that access to confidential research information is restricted to those who need access on NHS computers. The researcher's laptop will also be used for the research and all information will be anonymised and stored in password protected documents, on a password protected user login.

Identifiable data and contact details will be kept for 1 year and then destroyed. Anonymised data will be kept for up to 5 years on a password protected computer accessed only by the researcher, in case the research is published. All electronic and audio records will then be destroyed. In the Participant Information letter it will be made clear that all names and identifiable information will be stored on a password protected spreadsheet on a computer login that the researcher has sole access to. The data will be treated confidentially and all names, places and identifiable information will be changed. The information sheet will specify that anonymized excerpts from the interview may be read by my supervisor, examiners and presented in the final report and academic journal article.

#### **4. Confidentiality and security**

*It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the [UEL guidance on data protection](#), and also the [UK government guide to data protection regulations](#).*

4.1 Will participants data be gathered anonymously? No

4.2 If not (e.g., in qualitative interviews), what steps will you take to ensure their anonymity in the subsequent steps (e.g., data analysis and dissemination)?

#### Storage and use of personal data:

All quotations and identifiable information will be anonymised. Appropriate access controls will be put in place to ensure that access to confidential research information is restricted to those who need access on NHS computers. The researcher's laptop will also be used for the research and all information will be anonymised and stored in password protected documents, on a password protected user login.

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4.3 How will you ensure participants details will be kept confidential? As above, only anonymised data will be kept (stored safely as per procedures above). All names and identifiable information (including location and specifics of services) will be treated as confidentially. Please see other sections for further details.

4.4 How will the data be securely stored? As above, on a password protected spreadsheet, on a password protected computer, that only the researcher has access to. In line with UEL data protection policy.

4.5 Who will have access to the data? Only, the researcher and her supervisor (if requested).

4.6 How long will data be retained for? Identifiable data and contact details will be kept for 1 year and then destroyed. Anonymised data will be kept for up to 5 years on a password protected computer accessed only by the researcher, in case the research is published. All electronic and audio records will then be destroyed.

## 5. Informing participants

All participants will be given information about the nature of the research before agreeing to take part, so will be aware that they will be asked about 'ethical dilemmas' or experiences when they felt "unable to do the right thing", and about any occasions when they may have experienced moral distress, when practicing in the NHS.

In the Participant Information letter it will be made clear that all names and identifiable information will be stored on a password protected spreadsheet on a computer login that the researcher has sole access to. The data will be treated confidentially and all names, places and identifiable information will be changed. The information sheet will specify that anonymized excerpts from the interview may be read by my supervisor, examiners and presented in the final report and academic journal article. They will also understand that they are free to pause or stop the interview, or withdraw from the research all together, at any stage of the research process.

A copy of the recruitment advertisement and information sheet are attached.

*Please confirm that your information letter includes the following details:*

5.1 Your research title:

- 5.2 Your research question:
- 5.3 The purpose of the research:
- 5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved:
- 5.5 That participation is strictly voluntary:
- 5.6 What are the potential risks to taking part:
- 5.7 What are the potential advantages to taking part:
- 5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked):
- 5.9 Their right to withdraw data (usually within a three-week window from the time of their participation):
- 5.10 How long their data will be retained for:
- 5.11 How their information will be kept confidential:
- 5.12 How their data will be securely stored:
- 5.13 What will happen to the results/analysis:
- 5.14 Your UEL contact details:
- 5.15 The UEL contact details of your supervisor:

*Please also confirm whether:*

- 5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature.

NO.

As above, participants will be told about the nature of the research and invited to share their thoughts and experiences.

- 5.17 Will the data be gathered anonymously? If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

No –As the data is collected as part of qualitative research it will not be gathered anonymously. However, careful consideration will be given to the management of data, to maintain confidentiality.

Given the small sample size, and the large number of practicing clinical psychologists in the

greater London area, the risk of inadvertent disclosure, once data is anonymised, should be limited. Information about participants, services and interview contents will be kept confidential to the researcher, with names and identifiable information changed to protect anonymity. To ensure that quotations are not identifiable, service identity will not be identified within quotations used. All forms and transcripts will be kept in a locked area, with access by only the researcher and supervisors.

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth?

No

## 6. Risk Assessment

*Please note: If you have serious concerns about the safety of a participant, or others, during the course of your research please see your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g. a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.*

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?

This study will be asking participants to think and talk about a sensitive issue, experiences, sources of and solutions to 'moral distress'. It is possible that some participants may find remembering experiences of experiences of significant constraint on ethical practice in their everyday professional lives difficult.

However, all participants will be given information about the nature of the research before agreeing to take part, so will be aware that they will be asked about 'ethical dilemmas' or experiences when they felt "unable to do the right thing", and about any occasions when they may have experienced moral distress, when practicing in the NHS. They will also understand that they are free to pause or stop the interview, or withdraw from the research all together. A Debrief sheet with contact details of relevant organisations will be given to all participants at the end of the interview and time will be provided to discuss any arising issues. To minimise risks, Interview questions have been developed with NHS consultants. The researcher (interviewer) has been taught to ask questions about difference and difficulties sensitively as part of the Doctorate in Clinical Psychology training.

Participants may benefit from a space to discuss their experiences and both advantages and challenges of working with NHS organisations. Research findings may contribute to better working relationships and funding opportunities in the future.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?

There are minimal health and safety risks for the researcher themselves. To minimise potential risk of physical harm from the participant towards the researcher during an interview, the researcher will ensure that her supervisor or member of the professional doctorate admin team know the whereabouts of the researcher and participants at all times. Local Health & Safety and lone working protocols and procedures will be followed. The researcher will carry a mobile with them and inform her DoS and Field Supervisor where and when she will be doing the interviews and inform them via phone once they have left.

There is always a small risk of emotional harm for the researcher, in listening, responding to and holding participants distress, however, literature shows that it is the avoidance of addressing these issues (rather than the raising of them) that can propagate and perpetuate emotional harm (Patel, 2019). The researcher (interviewer) commits to keeping a reflective diary, practicing self-care and making use of supervision, where appropriate, to discuss any issues should they arise.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?

Participants will receive a 'debriefing' letter, a copy of which is attached in the appendices. These are appropriate for the population of the study, who are practicing mental health practitioners, as such, the debrief letter first signposts towards peer support networks for professions experiencing distress (Integrate peer forums) and towards published guidelines from our professional body The British Psychological Society that normalises such experiences. There is also a section of seeking further help, via IAPT, Mind, the Samaritans or Sane, all mental health organisations, with contact details and hours of work. Finally there are links to online based support (An App, a podcast series and downloadable self help exercises) all via free to access websites that are peer reviewed and evidence based, proven to support individuals in coping with distress.

6.4 Does the research take place outside the UEL campus? If so, where?

All research will take place in UEL, or Online.

If so, a 'general risk assessment form' must be completed. This is included below as appendix 4. Note: if the research is on campus, or is online only, this appendix can be deleted. If a general risk assessment form is required for this research, please tick to confirm that this has been completed.

6.5 Does the research take place outside the UK? If so, where?

NO

If so, in addition to the 'general risk assessment form', a 'country-specific risk assessment form' must be also completed (available in the [Ethics folder in the Psychology Noticeboard](#)), and included as an appendix. If that applies here, please tick to confirm that this has been included:

However, please also note:

- For assistance in completing the risk assessment, please use the [AIG Travel Guard](#) website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the [Foreign Office travel advice website](#) for further guidance.
- For *on campus* students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Head of School (who may escalate it up to the Vice Chancellor).
- For *distance learning* students conducting research abroad in the country where they currently reside, a risk assessment must be also carried out. To minimise risk, it is recommended that such students only conduct data collection on-line. If the project is deemed low risk, then it is not necessary for the risk assessments to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).
- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

## 7. Disclosure and Barring Service (DBS) certificates

7.1 Does your research involve working with children (aged 16 or under) or vulnerable adults (\*see below for definition)?

NO

7.2 If so, you will need a current DBS certificate (i.e., not older than six months), and to include this as an appendix. Please tick to confirm that you have included this:

Alternatively, if necessary for reasons of confidentiality, you may email a copy directly to the Chair of the School Research Ethics Committee. Please tick if you have done this instead:

Also alternatively, if you have an Enhanced DBS clearance (one you pay a monthly fee to maintain) then the number of your Enhanced DBS clearance will suffice. Please tick if you have included this instead:

7.3 If participants are under 16, you need 2 separate information letters, consent form, and debrief form (one for the participant, and one for their parent/guardian). Please tick to confirm that you have included

these:

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language.

Please tick to confirm that you have done this

\* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, and people who have been involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children [click here](#).

## 8. Other permissions

9. Is HRA approval (through IRAS) for research involving the NHS required? Note: HRA/IRAS approval is required for research that involves patients or Service Users of the NHS, their relatives or carers as well as those in receipt of services provided under contract to the NHS.

9.1

NO      If yes, please note:

- You DO NOT need to apply to the School of Psychology for ethical clearance if ethical approval is sought via HRA/IRAS (please see [further details here](#)).
- However, the school *strongly discourages* BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
- If you work for an NHS Trust and plan to recruit colleagues from the Trust, permission from an appropriate manager at the Trust must be sought, and HRA approval will probably be needed (and hence is likewise strongly discouraged). If the manager happens to not require HRA approval, their written letter of approval must be included as an appendix.
- IRAS approval is not required for NHS staff even if they are recruited via the NHS (UEL ethical approval is acceptable). However, an application will still need to be submitted to the HRA in order to obtain R&D approval. This is in addition to a separate approval via the R&D department of the NHS Trust involved in the research.
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their



own social or professional networks or through a professional body like the BPS, for example.

9.2 Will the research involve NHS employees who will not be directly recruited through the NHS, and where data from NHS employees will not be collected on NHS premises?

YES

9.3 If you work for an NHS Trust and plan to recruit colleagues from the Trust, will permission from an appropriate member of staff at the Trust be sought, and will HRA be sought, and a copy of this permission (e.g., an email from the Trust) attached to this application?

NO

9.4 Does the research involve other organisations (e.g. a school, charity, workplace, local authority, care home etc.)? If so, please give their details here.

NO

Furthermore, written permission is needed from such organisations if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation. If that is the case, please tick here to confirm that you have included this written permission as an appendix:

Please note that even if the organisation has their own ethics committee and review process, a School of Psychology SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s as may be necessary.

## 9. Declarations

Declaration by student: I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name (typed name acts as a signature): Katie Doherty

Student's number: u1725757

Date: 17<sup>th</sup> September 2020

*Supervisor's declaration of support is given upon their electronic submission of the application.*

**School of Psychology Research Ethics Committee**

**NOTICE OF ETHICS REVIEW DECISION**

**For research involving human participants**

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**REVIEWER:** Hebba Haddad

**SUPERVISOR:** Martin Willis

**STUDENT:** Kate Doherty

**Course:** Doctorate in Clinical Psychology

**Title of proposed study:** When Mental Healthcare professionals cannot do the right thing: An exploration of how clinical psychologists make sense of their experiences of Moral Distress and conflicts of conscience

**DECISION OPTIONS:**

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

**DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY**

*(Please indicate the decision according to one of the 3 options above)*

2 – Minor amendment

**Minor amendments required (for reviewer):**

4.3 – Was blank. Please ensure a response to this.

**Major amendments required (for reviewer):**

**Confirmation of making the above minor amendments (for students):**

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

Student's name (*Typed name to act as signature*): *Katie Doherty*

Student number: u1725757

Date: 14<sup>th</sup> October 2020

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

**ASSESSMENT OF RISK TO RESEACHER (for reviewer)**

Has an adequate risk assessment been offered in the application form?

YES / NO

**Please request resubmission with an adequate risk assessment**

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

HIGH

**Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.**

MEDIUM (Please approve but with appropriate recommendations)

LOW

**Reviewer comments in relation to researcher risk (if any).**

**Reviewer** (*Typed name to act as signature*): Hebba Haddad

**Date:** 14.10.20

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

**RESEARCHER PLEASE NOTE:**

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

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard



**University of  
East London**



### **Participant Information Sheet**

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

#### **Who am I?**

I am a Final Year Trainee Clinical Psychologist, in the School of Psychology at the University of East London and am studying for a Doctorate in Clinical Psychology. As part of my studies I am conducting the research you are being invited to participate in.

#### **What is the research?**

I am conducting research looking to understand what happens when Mental Healthcare professionals encounter 'ethical dilemmas' or experiences when they felt "unable to do the right thing" or practice as they would like to. Specifically, I am looking to explore how clinical psychologists make sense of their experiences of Moral Distress and conflicts of conscience.

My research has been approved by the School of Psychology Research Ethics Committee. This means that my research follows the standard of research ethics set by the British Psychological Society.

#### **Why have you been asked to participate?**

Many of the known sources of moral distress are common across the NHS, where demands have increased, alongside a reduction in resources, support and control (see Sima et al, 2017). Despite the likelihood that psychologists experience significant constraints on ethical practice in their everyday professional lives, scholarship in this area is almost non-existent in the mental health professions (Nuttgens and Chan, 2013).

Recruitment is open to all Qualified Clinical Psychologists that have currently, or have in the previous two years, worked in the NHS in a professional capacity. Any settings and all experiences are welcome.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or analysed in any way and you will be treated with respect. You are quite free to ask me any further questions before you decide whether or not to participate.

#### **What will your participation involve?**

If you express your interest, you will be contacted by email with further details about the study.

If you agree to participate you will be asked to take part in a single, audio recorded interview, lasting between 40 to 75 minutes (depending on your availability). This can take part in person, or via Skype, Teams or Webex, depending on your needs.

The conversation will involve talking and reflecting with me about your experiences of clinical practice within in the NHS. I will ask you to share your experiences of navigating moral distress/ethical dilemmas in your work. I am interested in your story and in how you made sense of these experiences, individually, professionally and in light of social relational and systemic contexts.

I will not be able to pay you for participating in my research but your participation would be valuable in helping to develop knowledge and understanding of this area.

### **Your taking part will be safe and confidential**

Your privacy and safety will be respected at all times. Any identifiable information you provide about you, or your service(s), will be kept securely and separately from your audio-recording and analysis.

The interview transcripts will be carefully anonymised, removing any identifiable names, places and organisations. Transcripts will not be shared beyond the research team. Any verbatim excerpts to be quoted in the study, or in any write up of the research, will be cautiously selected to ensure that other people cannot identify you.

### **What will happen to the information that you provide?**

Data will be stored electronically and will be password protected. Your personal details, consent forms, and audio recordings, will be destroyed after the study is completed.

### **What if you want to withdraw?**

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. You do not have to answer all questions asked of them and can stop your participation at any time.

### **Contact Details**

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: **Katie Doherty (Email: [u1725757@uel.ac.uk](mailto:u1725757@uel.ac.uk))**

If you have any questions or concerns about how the research has been conducted please contact the research supervisor **Dr Martin Willis**. School of Psychology, University of East London, Water Lane, London E15 4LZ, (Email: [M.Willis@uel.ac.uk](mailto:M.Willis@uel.ac.uk))

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk))



**University of  
East London**



**Consent to participate in a research study**

When Mental Healthcare professionals cannot do the right thing: An exploration of how clinical psychologists make sense of their experiences of Moral Distress.

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

*Participant's Name (BLOCK CAPITALS)*

.....

*Participant's Signature*

.....

*Researcher's Name:* Kate Doherty (known as Katie)

*Researcher's Signature*

*Katie Doherty*

*Date:* .....

## Appendix I: Semi-Structured Interview Schedule



**Interviews will aim to enable the participant to tell their story. A guiding principal is empathic interpretation – where questions seek information that can generate shared understanding. Hence, the following are listed only as a guide to the interviewer**

Inviting participants to co-author the research agenda.

- **Thinking about the story of your life as it relates to being a clinical psychologist, can you tell me about your experiences?**
- Can you tell me a little about yourself, your work in the field? what interested you in this research?
- Can you tell me the story of your work in Clinical Psychology?

Opening/settling in period:

- What interested you in clinical psychology?
- What do you like about your role?
- What do you find difficult?
- Have things changed since you started working in clinical psychology? How/in what ways? What do you notice?

Enquiries into Conflicts of Conscience or Moral Distress

- Can you tell me about your own experiences of moral distress? Have your experience of MD changed since you started working in clinical services? How/in what ways? What do you notice?
- Do you experience ethical issues or dilemmas in your work? If yes, can you give me an example of a situation? What happened? How did you cope?
- Can you remember a particular situation that comes to mind from your work related to this definition? Will you share it with me?
- Why does that particular moment stand out to you?
- In the situation you have described, what would the ‘right thing to do’ have been?
- On reflection, what do you think the effects of this were? For you personally? Professionally? For patient(s)? For the service? Has your perception changed over time?
- Do you experience a discrepancy between the actual quality of care in your service, and the desirable quality? If yes, what do you think this is caused by? Does this impact upon your practice? Does it impact upon you? How do you cope, personally? professionally?

To enquire about Institutional aspects (resources, policy, systems)



- Are you able to describe any reasons why the right thing could not be done in this scenario?
- What factors prevented you from 'doing as you felt you should'?
- Are there additional examples of this that you've encountered?
- Are the examples you have provided common? Does this happen frequently?
- What in your working environment, is an obstacle to resolving such difficulties at your work?
- Do you encounter any personal obstacles?
- What factors supported you?

To enquire about relationships and roles (power imbalances, hierarchical structures, defined duties)

- Reflecting on relational factors influencing moral distress within your service, are you able to comment on what you feel is important? Is there anything different in relations where these situations do not arise?
- What is the communication like in your team?
- Who makes the decisions? Can you influence these? If yes, how do you do so? If no, how does this feel for you? What does this mean to you?
- Thinking explicitly about power, how did you feel at the time? What was the structure like in your service/team?
- What about patient's participation?
- Please tell about a significant situation involving an ethical issue that you think you handled in a good way? What was the outcome? (on you, for client, for service)

Final questions

- How has it felt talking to me today?
- Is there anything else I should have asked you?
- Is there anything else you would like to add?

Other prompts

- Can you tell me more about...?
- Can you give me an example?
- What is your experience of...?
- How do you feel about...?
- How has ..... changed over time?
- What sense do you make of...?
- What do you mean by...?
- What do you think people mean
- What do you think the effects of
- How did/do you manage



Dear Participant,

**Thank you for choosing to take part in this study.**

**Your time and interest are very much appreciated.**

This research set out to find out more about what happens when Mental Healthcare professionals cannot do the right thing. The research aims to explore how a number of NHS practicing Clinical Psychologists make sense of their experiences of Moral Distress and to critically consider how agency, power, identity, institutions and culture manifest themselves in participants narratives. It is hoped that findings will be important in the effort to better mental health care, for practitioners and patients.

The stories you have shared are important. However, so is your confidentiality. Please be assured that all data will be carefully anonymised in the write up of the study. Any identifiable names, places and organisations will be removed. Transcripts will not be shared beyond the research team. Any verbatim excerpts to be quoted in the study, or in any write up of the research, will be cautiously selected to ensure that other people cannot identify you.

If you would like further information about the study or would like to know about what my findings are when all the data has been collected and analysed then please contact me on [u1725757@uel.ac.uk](mailto:u1725757@uel.ac.uk). You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Please inform the researcher should you wish to do so.

If you feel that any of your associates, colleagues or friends would be interested in taking part in my study, please feel free to direct them to the recruitment poster, which contains more information about the research, a link to express an interest, and contact details for myself, and the research team

If taking part in this study has raised any specific concerns for you, or if you require support for any issue you may contact any of the following organisations:

**Access to Peer Support:**

- BPS: Statement The Division of Clinical Psychology recently (19<sup>th</sup> August 2020) recognised and publicly offered its support “for the unique and valued contribution that lived experience of mental health difficulties brings to individuals working within clinical psychology”...stating that when “lived experience is actively valued in aspiring, trainee and qualified clinical

psychologists, it can help to enrich practice and improve service provision". See the full document available here:

<https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Statement%20on%20clinical%20psychologists%20with%20lived%20experience%20of%20mental%20health%20difficulties.pdf>

- **In2gr8 Mental Health** - is a centre for valuing, destigmatising and supporting lived experience of mental health difficulties in mental health professionals. It is a peer network of mental health professionals with lived experience, offering peer support and a range of services (mentoring, consulting, workshops and webinars).  
<https://www.in2gr8mentalhealth.com>

### To speak with someone:

- **IAPT (Increasing Access to Psychological Therapies)** - you can self-refer to your local IAPT here (or be referred through consultation with your GP). Available at: <https://www.nhs.uk/service-search/find-a-psychological-therapies-service/>
- **Mind helpline.** Available Monday to Friday, 9am to 6pm. Phone: 0300 123 3393  
Website: [www.mind.org.uk](http://www.mind.org.uk)
- **Samaritans.** Offer confidential support for people experiencing feelings of distress or despair. Phone: 116 123 (free 24-hour helpline)  
Website: [www.samaritans.org.uk](http://www.samaritans.org.uk)

**SANE.** Offer Emotional support, information and guidance for people affected by mental illness, their families and carers.

Peer support forum: [www.sane.org.uk/supportforum](http://www.sane.org.uk/supportforum)

Website: [www.sane.org.uk/support](http://www.sane.org.uk/support)

### APP/Online based support:

- **The ACT Companion** is free to access during the coronavirus pandemic. Developed by Russ Harris and his team, it offers acceptance and commitment therapy exercises and tools, available at: <http://www.actcompanion.com>
- **Self Compassion Exercises** by Kristin Neff from The Self Compassion Org. Available at: <https://self-compassion.org/category/exercises/#guided-meditations>
- **Changing Minds** - A weekly podcast series from experts in psychology, neuroscience and behavioural sciences looking at the science underlying improving wellbeing during this time. Available at; <https://www.youtube.com/channel/UCpJgFovU8n1ehMIP3to4M4Q/>

### Contact Details:

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Martin Willis. School of Psychology, University of East London, Water Lane, London E15 4LZ. (Email: M.Willis@uel.ac.uk)

**or**

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ (Email: t.lomas@uel.ac.uk)

## Appendix K: Guided Personal Reflections

As part of the first stage of analysis Langdridge (2007) presents a series of questions for researcher to use as a guide to prompt self-reflection when conducting qualitative research. Answers are detailed in the body of work above (Section 4.8.1).

Please note this was hand completed. Copies of key words have been included below:

Why am I carrying out this study?	Personal interest. Relevance to CP practice. Lived experience. Desire to think about transforming care practices.
What do I hope to achieve with the research?	Voicing previously unheard stories – formal publication. Broadening my own awareness. Thinking about value based working – beyond the patient level. Systemic transformation.
What is my relationship to the topic being investigated?	Enmeshed. Is this a research risk or strength? CP in training. Previous service manager. Multiple hats
Am I an insider or outsider?	Both/and
Do I empathise with the participants and their experience?	Yes – but also, get frustrated. What does it mean to be a leader in the profession? Who holds power? Is there a danger is over-analysing MD? Why not applied frequently in psychological research?
Who am I, and how might I influence the research I am conducting in terms of age, sex, class, ethnicity, sexuality, disability and any other relevant cultural, political or social factors?	Removed. Identifying.
How do I feel about the work?	Excited. Scared. Material/Stories are hard to hold given my role in the field.
Are there external pressures influencing the work?	Yes. Political narratives. Covid. Is there a risk that publishing anything ‘negative’ about CP as a field, threatens patient engagement? Secondary harm?
How will my subject position influence the analysis?	Multiple and often conflicting layers of reality! Need to continuously check in. Transference? Countertransference? Hidden/assumed narratives? (given internal role?)
How might the outside world influence the presentation of findings?	Influences if it is safe for participants to speak. Influences my interpretation. Influences the ‘creation’ of the tales themselves. Everything from somewhere.
How might the findings impact on the participants?	Hopefully help them feel heard. Space to process/reflect. Take a helicopter view. Possibly be hard to share/difficult to do.
Might they lead to harm and, if so, how can I justify this happening?	Limited harm. Possibly hurt. Justified as (per ethics) limited risk – anonymised – people have chosen to take part/can withdraw. Core belief – talking can be helpful.
How might the findings impact on the discipline and my career in it?	Potential negative consequences for my own career – is an activist stance/ID me as different. Yet, is inline with my own values – so protective from burnout?
Might they lead to personal problems, and how prepared am I to deal with these should they arise?	Stories will involve distress/frustration. BUT need to use the spaces I have available. Personal reflection. Supervision (formal and peer spaces).
How might the findings impact on wider understandings of the topic?	Add to contributing literature.

How might your colleagues respond to the research?	Possible interest. Possible alienation? (self defence). Is there space to hear about the difficulties in CP on a systems level?
What would the newspapers make of the research?	Interested. Sensationalised. Must be careful of this.
Does the research have any implications for future funding (of similar research and/or related organisations)?	Hopefully. Could be looked at on a larger scale? BPS or NHS wellbeing surveys?
What political implications might arise as a result of the research	NHS reform – political and systemic issue. Small fish. Big ocean!

From: Langdrige, D. (2007). Phenomenological psychology: Theory, research and method (p. 59). London: Pearson Education.

Appendix L: Analytical processes- Transcription Key for Individual Narratives

Please note. Transcripts were printed and hand-coded. However, the work has been typed 1) to protect participants confidentiality and 2) as I am dyslexic and my spelling and handwriting are not clear. This is a section of a transcript that has been used to show the analytical process.

FOR THIS EXCERPT ONLY: A (rough) Coding Key (this matches the original handwritten work, in which I used coloured ink to code data)

Identity work	Coded in orange (who and how does Maya want to be perceived)
Positioning	Coded in blue
Core Idea's	Highlighted – emphasis all from authors original workings of text 1. Green tracks to patterns in distress itself. 2. Yellow tracks to 'difficult' experiences linked in narrative to distress 3. Purple tracks to
Tone	- BOLD (emphasis in Mayas speech) - Underlined words indicate where tone was judged by researcher to have meaningful impact/tell something about identity work - Other core tonal changes were hand noted and have been typed in side column.
Other:	- Main stories, messages and interpretations (including my own reflections) are noted – taken from original hand-written columns on transcripts

Time	Speaker.	Transcript	Analysis
00:09:37	MAYA	Yeah, definitely. I think it is something where you do qualify and you think, "Oh, if I'm not getting things done, it's just because I'm junior." (Laughter) And then I think you actually start to progress through the ranks you think "oh I'm still not getting things done and I'm not that junior anymore." I couldn't imagine what it's like for Band 9 but I agree that its possibly more stressful going forwards.... Yeah, it doesn't surprise me. I guess the other thing from the moral distress point of view is I don't know if you've got any particular age group in mind so just let me know if I'm veering. But I think the systems are setup in a really inaccessible way so that you have to hit crisis before you can access them.	<p>Positioning – possible influence of power. Implication that higher roles don't equal more power!</p> <p>Feeling 'pointless'. Rank as meaningless as no influence on ability to make changes. Distanced self from 'notions' of career progression. Unwanted? Or Impossible to achieve?</p> <p>Indicates a build-up of frustrations</p> <p>Use of descriptive words – as if a need to show/scale HOW BAD things are.</p> <p>(This echoes a previous sense of disappointment in professional structures)</p>
00:10:12	ME	Yes.	

00:10:12	MAYA	I think it's quite <b>an inhumane</b> way of doing things, so um, I've got teenagers that I support who self-harm very seriously. And we cannot get them into CAMHS until they have a referral from a hospital admission. So, it feels like really what we're doing is <b>pushing them to the point of a hospital admission before they then get the care that would have prevented the hospital admission.</b> And that's, you know, <b>you can't hide behind numbers on that (sigh).</b> These are families with children. <b>It's not quality of care you would want for your loved ones or tolerate for your loved ones.</b> And again, that's the stuff where overtime I've had parents email me pictures of the children's arms...	Strong tone  <b>Positioned as narrator – describing her experiences.</b>  A sense of Maya as analytical – her frame begins by naming the practical problem – contextualising difficulties – before orientating her frustrations to include herself and her own role.  Whose hiding?  Exasperated tone – A build-up of service factor frustrations  Parents having to fight to access kids care...
00:10:48	ME	Gosh.	
00:10:48	MAYA	...you know, that <i>type of thing</i> and it's, <b>that's the stuff that grinds you down rather than the bits of the job that should be difficult.</b>	Choice of wording – not a once off, or an event...a thing! Indicates frequency (and a distancing from this?)  Consequence - Identity – 'ground down'. MD at a personal cost
00:10:56	ME	Yeah. And what....?	
00:10:57	MAYA	So, that's <b>the service factors</b> I think.	
00:10:59	ME	Is, are they factors that have been consistent throughout all of your career or have they changed? Is it a pattern that's getting better or worse or...?	
00:11:08	MAYA	Yeah, that's a great question. I think it's certainly changed by area so <b>I've been lucky enough</b> to work in different parts of the country, some of which have been incredibly well-resourced and some of which have had terrible levels of resource. And that seems to be a lot about historical context, sort of <u>clinical champions</u> , <u>having really strong personalities that have led on development.</u> It certainly, it doesn't seem to be equitable, put it	<b>Pace/Flow change...</b>  Resources as moderator. Luck = exception to have resource  Strength is needed to lead. <b>A sense that others have done/been this, rather than herself!</b>



		that way. I do <b>think it's getting much worse</b> (.) particularly with kids. <b>I think CAMHS services are absolutely at breaking point. They can't recruit, they can't retain staff so it's never a criticism of the staff and the services but things are how they are, but certainly we're not having enough conversations about it,</b> I don't think.	Inequitable resource in services – getting worse  Tone – contrasts with language. Sounds casual – versus strength of words used! <b>ie. An acceptance? The silence contributes to the process</b>
00:11:50	ME	But when waiting lists get overloaded, the threshold for access increases and increases. But ultimately, the people that actually pay the cost of that are? (.)	
00:12:03	MAYA	Yeah, absolutely, the families. And children that are going through <b>these incredibly traumatic experiences</b> because the worry with my older adults head on is <b>it</b> can have all the things that led them self-harm in the first place and then the traumatic incidents that have come off the back of it to recover from. That's not setting them up for adult life in the way that we'd want to. And <b>the pressures on services mean that actually a lot of the time, you get a short-term one-to-one intervention whereas what you need is a long-term systemic one.</b>	IT = Services as re-traumatising, harmful.  Pressurised care = Care not meeting patient needs
00:12:32	ME	Yeah. So, even when...	
00:12:32	MAYA	So, again it's....	
00:12:32	ME	...you are accessing services that, the services that you are accessing perhaps aren't best fit.	
00:12:38	MAYA	Uh hm. Exactly. And <b>a lot of the time they want to give you a dose, it's very medical (laughter)</b>	System misfit. Nervous laughter, Pause. A Moment of self-reflection.
00:12:43	ME	Yea?	
00:12:43	MAYA	Dose of something and pretend you'll exit care as soon as possible which is not, it's not the language. <b>It's not the model of care that families in crisis need.</b>	Tone of exasperation!

00:12:51	ME	What would you like to see happening for families in crisis?	
00:12:56	MAYA	I think it comes down to, and it's so, so basic but <b>we get it wrong so much of the time.</b> It's what you would want to see for your family. <u>It's what I always think.</u> So, actually if I was a parent in crisis, I would want somewhere that I felt safe, that I felt understood, that offered hope and immediate containment but then showed me what the long-term plan was.	<p>Positioning – responsibility and ownership, being part of the system.</p> <p>Working hard to position self in a certain light – 'it's the system not me'</p> <p>A problematic lack of safety and containment in healthcare for families in need</p>
00:13:13	ME	Yeah.	
00:13:14	MAYA	And had one that actually fit my family's needs. And I think in terms of CAMHS like I say the waiting list is so long. You can never get care at the point you need it. Then when you do get there, you're offered something short-term, often to put you on a <b>separate hidden waiting list, there's lots of statistic fudging going on which I'm not proud of.</b> And then yeah, it's whether families actually get what they need, or they're then just kind of kicked out the system again feeling quite abandoned and quite unheard and....	<p>Whose hiding what from whom and why? Waitlists hidden from families. Data obscured (implied for services benefit). Critical of service offerings.</p> <p>Feelings of shame about what is happening.</p> <p>Kicked out – Abandoned – Unheard – powerful language. Care that rejects/neglects.</p>
00:13:42	ME	And how do you manage that in your private practice? Because that – am I right in thinking that's now the avenue that you meet these families in?	
00:13:50	MAYA	Yes...[.8 seconds of identifiable information removed]... And <u>we can do lovely slow-paced adjustment, very systemic working and that's brilliant.</u> That's like the best of the job. And sometimes, I support the ones that don't quite need CAMHS and that's great too because we know that they're not, kind of, in an unresponsive system but then there are kids that really do need CAMHS who really aren't supported in private practice. If you've got kids where they're kind of, they're starting with an eating	<p>The need for NHS and an MDT</p> <p>The tools of psychology – work/can help people in need</p> <p>BUT the system can be harmful/unresponsive/unsupportive</p>

		disorder, they need to be under an MDT, and similarly, if you've got kids that need medication changes, they need to be under an MDT with psychiatry. So, there's a lot we can't do in private practice, I'd say.	
00:14:35	ME	What does it mean for you to be holding that?	
00:14:38	MAYA	That's a very good question. Stress (Laughter) I would say it is the basics, particularly because within private practice, you're not typically in a team. You are one clinician, and the beauty of NHS working is we're usually part of a team.	Using humour to distance from impact?
00:14:51	ME	Yeah.	
00:14:51	MAYA	So, I'm very much a believer that resilience isn't an individual concept. It's a system's concept, so that's where we draw a lot of our resilience from in the NHS. (pause) It's personal responsibility as well. And I think that's what really links with the moral distress element is we're good clinicians when we take responsibility, when we don't say you know, I see you have these needs but that's someone else's problem. But the flipside of that is when those needs don't get met, you're still carrying responsibility for them.	Distress – linked with power/responsibility  Good – indicates that 'poor' clinicians exist. Gatekeeping. Transfer of risk. To be "good" clinicians we need to acknowledge that often we can't meet needs, but...What happens when we don't? Service responsibility or personal?.
00:15:20	ME	Yes, yeah.	
00:15:22	MAYA	So, it's finding that line between being as caring as you can, proactive as you can but not burning out on the back of needs that you couldn't really influence.	A sense that factors are an inevitability.- It's how you respond to them that matters.  A need to be boundaried
00:15:31	ME	And how do you do that?	
00:15:34	MAYA	(Laughter) That's a good question there. (Laughter) I think having a reflective space is a big thing because I'm in a great love of [type removed for confidentiality] therapy. And it's very easy to get into patterns without even realising that we're jumping back	Tone indicates a sense that balance is so impossible – it's funny to think about!

		into old patterns so you need to have, whether it's <u>peer supervision or formal supervision or personal therapy, you need to have something that lets you take the helicopter view.</u> Em, I think we are at risk of the same cognitive biases that all our clients are, saying that we can do a great job with nine people and just focus on the one that we don't feel we did a great job with.	Reflection/space to think as protective. Needed for good practice.
00:16:03	ME	Yeah. (Laughter)	
00:16:03	MAYA	There's something about having that reflective space to actually remind yourself of the work you're doing well. And that's a good thing. And I think....	
00:16:10	ME	Do you have that space?	
00:16:12	MAYA	Yes. I'm very lucky for my private practice work, I go even heavier on the supervision because I work with lots of different client groups so I have em, a sort of generic supervision. I have peer supervision. I have EMDR supervision. I get some specialist paediatric supervision as well.	Note - Question asked – intended to mean NHS, answered with respect to private practice!
00:16:34	ME	And do you mind me asking, is that supervision you've sourced yourself?	
00:16:38	MAYA	Yes.	
00:16:39	ME	Mm (pause) In your nhs work?	
00:16:39	MAYA	Yeah. And I think for me, I see it as like a business cost. It's part of good, good quality sustainable practice.	(Varied, useful) Supervision as an important part of quality practice
00:16:48	ME	Do you think that's the way that it should be? Um, or?	
00:17:06	MAYA	Yeah. No, it's not been a problem actually. Like I say, I think it's just something you have to see it as an essential, in the same way as printer paper.	
00:17:12	ME	Yeah? (Laughter)	
00:17:12	MAYA	(Laughter) It's part of staying well. It's part of offering good care. And think that private practice is a bit risky because <u>if your practice drifts in the NHS, chances are someone else will</u>	Accountability in NHS work – as a positive.

		notice. You get horror stories of people in private practice who've gone completely rogue without governance and all the rest of it so yeah, I think you just have to see it as an essential.	
00:17:32	ME	And does it feel different in terms of the spaces you can access privately/in private practice versus in your NHS work?	
00:17:37	MAYA	Hmm. I mean one of the things I'm really pleased with in private practice is actually, because you set your own supervision, you can source it from anywhere depending on what you prioritise. So, initially, I just had generic supervision, which was great and as my case load built, it wasn't quite enough.	
00:17:53	ME	Yeah.	
00:17:53	MAYA	And then when I started my EMDR training, I knew it could do better EMDR with specialist supervision.	
00:17:57	ME	Yeah.	
00:17:58	MAYA	So, I started that. And then I sat down one day and looked at my caseload and realised the cases that I was most stressed about were the self-harm, difficult family dynamics, so that's when I decided to have some extra paediatric supervision as well.	
00:18:11	ME	And that...that flexibility isn't available in your NHS position?	<i>Third time asking re NHS! The gap – was it how I asked the question? Or does it relate to Maya's defences? Is it a purposeful distancing?</i>
00:18:17	MAYA	My experience in supervision in the NHS and maybe I've just not pushed it enough is typically it's your line manager. It's kind of just a given that this is who you will be supervised by, unless you have a real problem with them, kind of thing. But I don't think it's, it's not seen in quite such a personal development sort of way, has been my impression.	Line management in NHS VERY different from private supervision discussed. TONE and confidence also contrasts. <i>Sense of ID shift.</i>  <i>Self-doubt re responsibility for this. A sense of uncertainty and insecurity in NHS ID. Despite acknowledging it as 'a given'.</i>

			NO space in NHS practice for reflection/being processed focused/for skills building!!
00:18:35	ME	Have you encountered any of those kind of moral distress moments within your NHS role?	
00:18:42	MAYA	<b>All the time, yeah.</b> And it's the same thing in terms of risk so we've got people who would be, they'd meet the criteria for what we'd call personality disorder diagnosis. <b>And the system enacts some horrible, horrible patterns in terms of care, of people get well and then they get discharged, which makes them feel abandoned, so then they have to kind of act out to get back into the care system, which just reinforces everything that we were already struggling with, along with the overdoses and the self-harm and everything that comes with that. And again, that's really hard to watch people go round and round that...a lot of times.</b>	Emphasis in tone. MD occurring ALL the time.  Witnessing the system harming patients – causes distress. Hard to watch. Horrible to be part of.  “we” is used when talking here about distress, as if it's a shared experience. This differs later from in the interview.  Psychology has the tools to understand the patterns that cause harm, but not to change them.
00:19:18	ME	Oh? And...	
00:19:26	MAYA	Yeah, yeah, yeah. And it's <b>really tough</b> because teams are under huge stress. So <u>my nurses</u> carry between 40 and 70 per caseload.	Positioning – ‘my’ indicates a higher role in hierarchy!
00:19:36	ME	Wow.	
00:19:36	MAYA	And yeah, it's a <i>ridiculous</i> number of people so again, it's not a criticism of the staff. But what happens when services get overloaded is <b>they just go back to the old routines</b> which means you can do the best formulations in the world but it's about how we respond as a team.	Caseloads as ridiculous – too much for staff “overloaded”  <b>Defensive practices emerge – in systems.</b>  The positioning of psychology within the team – the need to be part of, not ‘outside’ (nomadic role for M?)
00:19:51	ME	And how many clinicians are you to a nursing capacity, into the medical side of things?	
00:19:55	MAYA	I think in my older adults, everything is on a very small scale, so I think we've only got something like X (removed for	Under-resourced

		confidentiality) nurses and I'm only part-time in that role. And then a part-time psychiatrist. It's a very small amount of resource for a massive number of people.	
00:20:09	ME	I was going to say, yeah. There's, and an area that there is increasing referrals into...(pause) And I'm presuming there's been no increase in resourcing to a company that?	Leading questions. Note my own assumptions! Positioned as ally to Maya. A shared sense of 'knowing' how it is. Prompted reflection: What else is assumed/goes un-said.
00:20:22	MAYA	(Laughter) NO...If anything, it's more (.) when a nurse leaves you know someone else has to step in and pick up the role which is why the caseloads have got so ridiculous, in a way. So that is tricky. And that is quite, sort of morally distressing, to watch people effectively be harmed by a system. And not harmed in a way that you could pinpoint a member of staff and whistle blow but harmed, you know, systemically over many, many decades. And there's a massive push for ECT with older adults and that's very, very hard to watch.	Having to do more. Cyclical impact. People leaving increases pressure on those remaining  Repeated idea of there being harm is WATCHING systems cause harm OVER TIME. A sense of being 'outside' the problem. Harm caused by others  Second named MD event – a specific care practices – tone of disapproval/disgust
00:20:50	ME	Yes. How, how do you respond to that? How do you manage it?	
00:20:57	MAYA	Yeah, so I mean I'm lucky. I'm actually going to be leaving my older adult team soon but I'm in a very good team here, who are very trauma focused, so we've had a real push within the Trust to try and push for trauma informed care.	Observed Pattern – Maya named the problem. I asked about it. She slightly changes the topic. Focuses on positives. Again this appears to reduce once she settled into the interview.
00:21:08	ME	Okay.	
00:21:08	MAYA	Part of which would be helping people see why people present how they do and why ECT might not be the best option. Because for most of these people, they've never actually been offered trauma therapy.	
00:21:18	ME	Oh?	
00:21:18	MAYA	They've been diagnosed with something like bipolar. No one's even	Maya Disgust at what's happened. Elements of anger in words and

		looked at the kind of early childhood adversity, and then they've been put straight on to ECT.	tone. BUT ownership/responsibility is elsewhere - whose pushing/controlling? A sense of distance from the decision – contrasts with lead role in team.
00:21:26	ME	So, they've literally never been asked "what's happened to you"?	
00:21:28	MAYA	Yeah. They've just been looked at from a symptom perspective.	
00:21:28	ME	wow	
00:21:30	MAYA	Yeah.	
00:21:32	ME	And a management action?	
00:21:34	MAYA	Yeah. Uh hm.	
00:21:35	ME	You said there's been some space to push that within the Trust?	
00:21:39	MAYA	So, we're very lucky we've got very good psychology leadership, so we've got an 8d, I think he's quite senior anyway in psychology terms and <b>we just</b> managed to get trauma informed service setup. It's going to be particularly for people with complex PTSD but will influence the culture across the rest of the Trust as well.	Again, a sense that "good leadership" this is not the norm.  Even with good leadership, change has taken time! She feels she had a role in this change  The need for cultural change
00:21:55	ME	Yeah.	
00:21:57	MAYA	Yeah, it's very positive.	A sense that what has been happening is not ok, but SOME change is being achieved.
00:21:58	ME	So, that feels like it's been, kind of one avenue? looking to change the system?	
00:22:04	MAYA	Yes, yeah. Definitely.	
00:22:04	ME	Has there been other...?	
00:22:04	MAYA	At the moment, yeah...	
00:22:06	ME	No, no, sorry. I didn't mean to interrupt.	
00:22:10	MAYA	(Laughter) I was going to say we're quite lucky we're close to and we'll take trainees from the [LOCATION removed], who are very, like, politically and systems minded which is lovely because you can see that sort of ripple out through our Trust.	The trainees 'new' energy and ideas 'ripples' – contrasts with the 'energy' in the existing (overworked/burnt-out?) team?

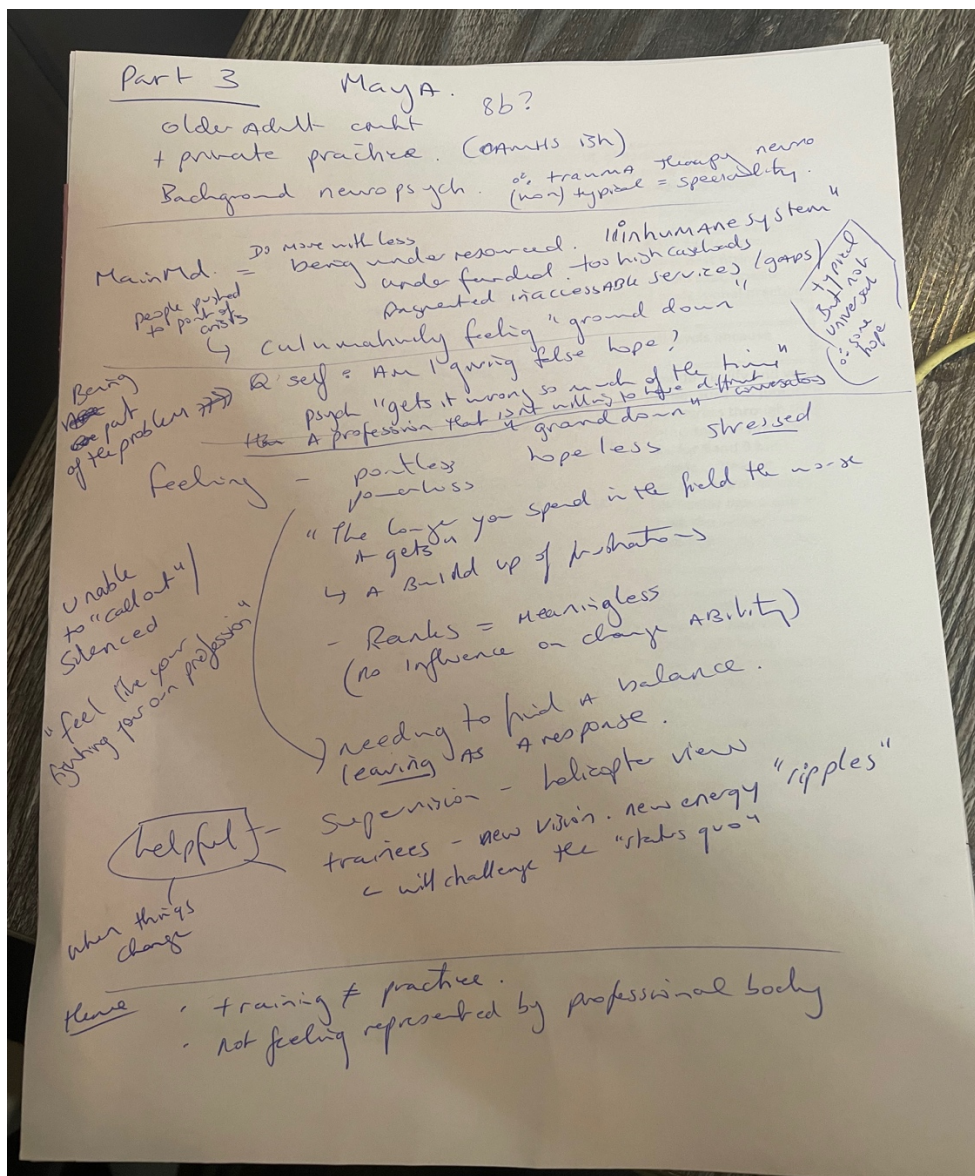


00:22:23	ME	So, something about having trainees in, that are maybe willing or more in a position to challenge?	
00:22:30	MAYA	Yeah, they're just um, yeah. They're just great. (Laughter) They've really kind of, they've not been raised with the status quo. So, if they come in and they don't like the way something looks, they call it and Em, it's really refreshing. (Laughter)	<p>Does the Trainee's position (against the status quo) contrast with her own role expectations/work ID?</p> <p>The acknowledgement that their contribution is 'refreshing' indicates its different from the norm/usual.</p>

Please note this is a section of text.

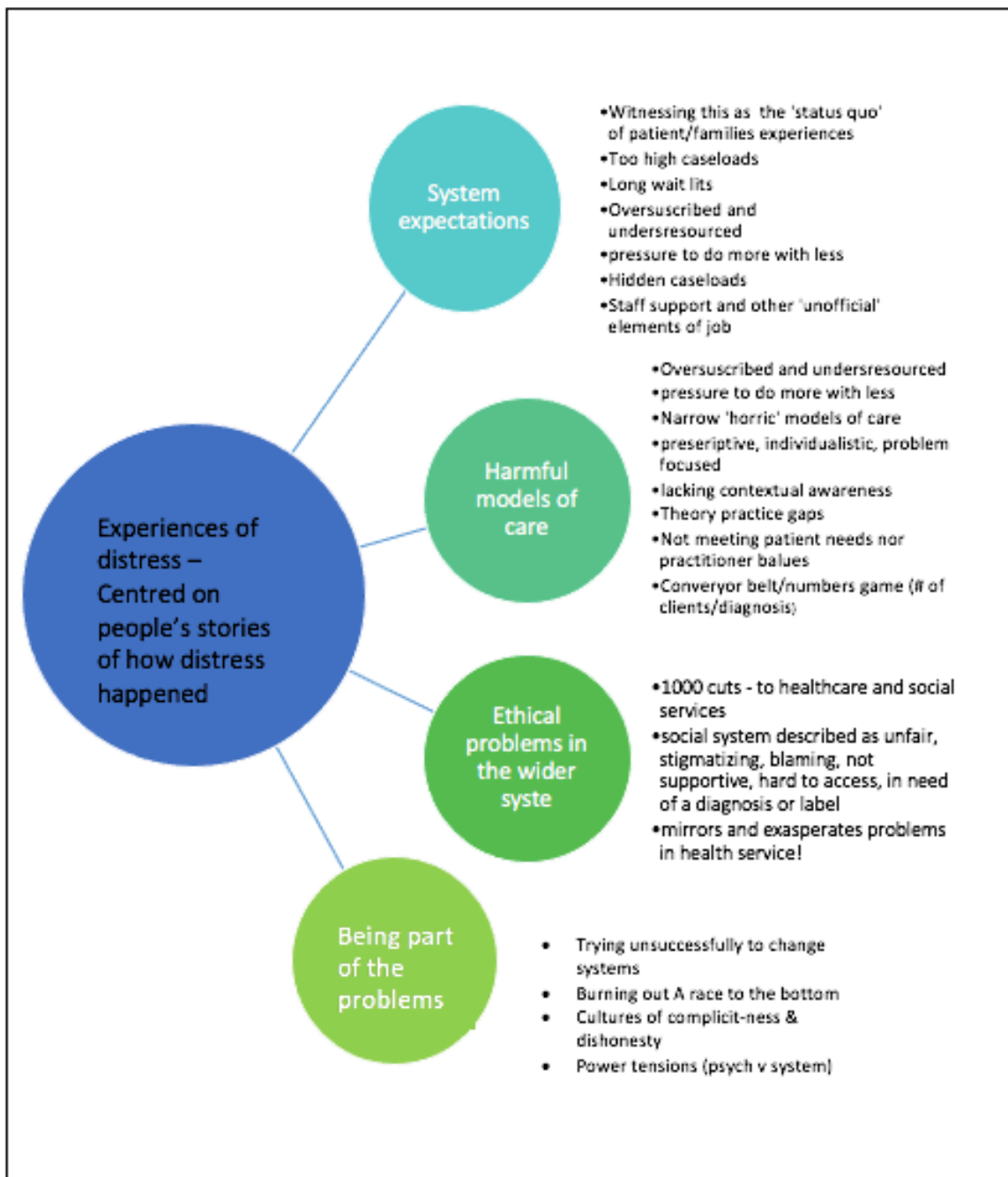
Total duration 72 minutes and 44 seconds

Example of handwritten workings: One page overview of Main Stories.



Appendix M: Analytical Processes: Synthesising and Themes

Synthesising core ideas 1



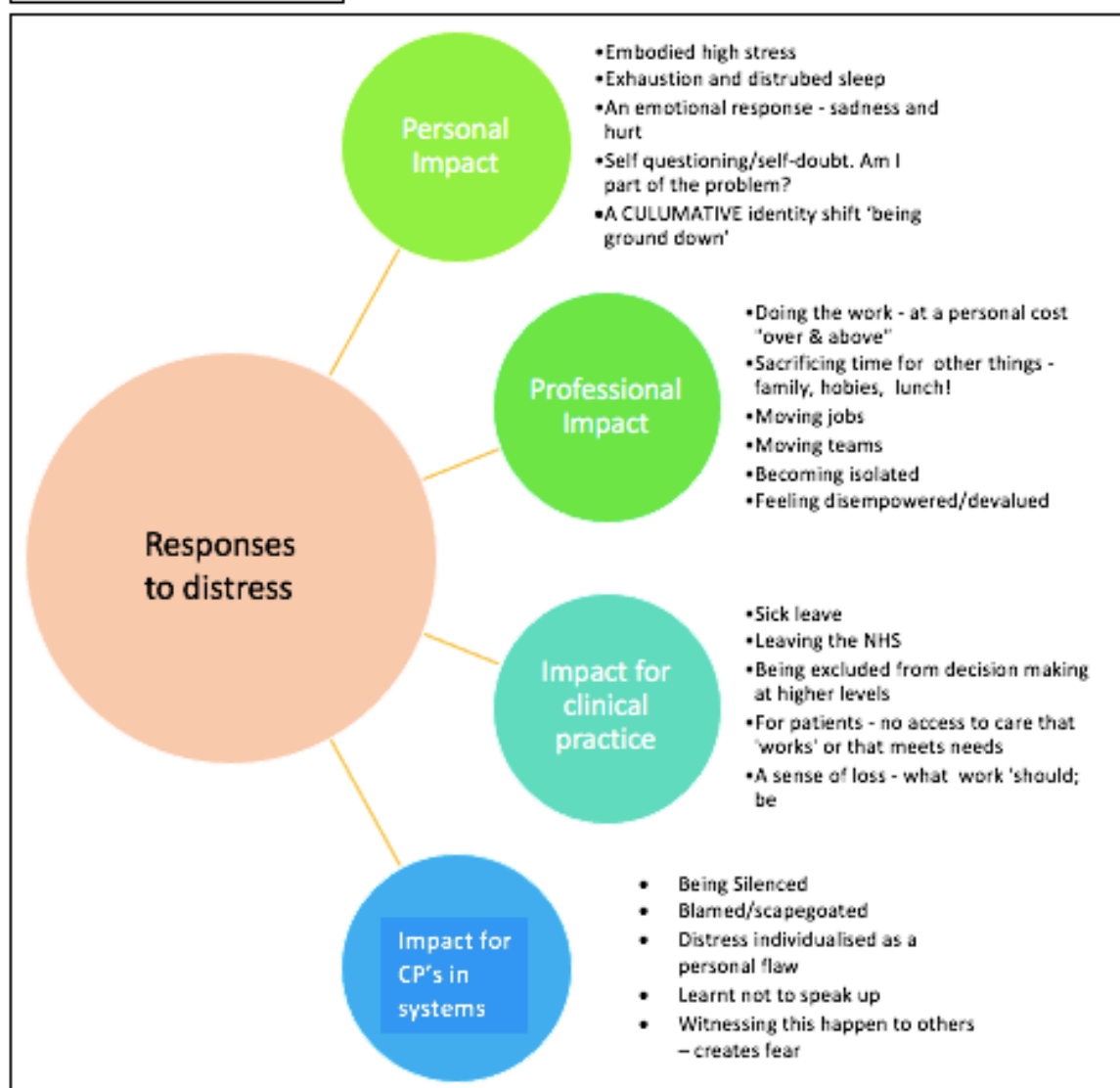
**Thoughts/reflections – identity changes and critical lens (noted in handwritten themes work):**

Distress wasn't a 'once off' experience. instead people spoke about its core features, how it came to be, how it developed over time based on "constantly" feeling in conflict

Tension between anger and loyalty to NHS – work seen as vocational. Distress from not being able to practice how they want to as psychologists

Ideas of the role of psychology – having inherent conflict – it's part of the role to notice/reflect, this means the role is always challenging, always distressing.

## Synthesising core ideas 2



### **Thoughts/reflections – identity changes and critical lens (noted in handwritten themes work):**

Whose causing this? Multi-layered- Hierarchy – being NON psychology or non clinical, commissioning structures, institutional/organisational difficulties, circular/self-fulfilling problem (unhealthy ethical climates).

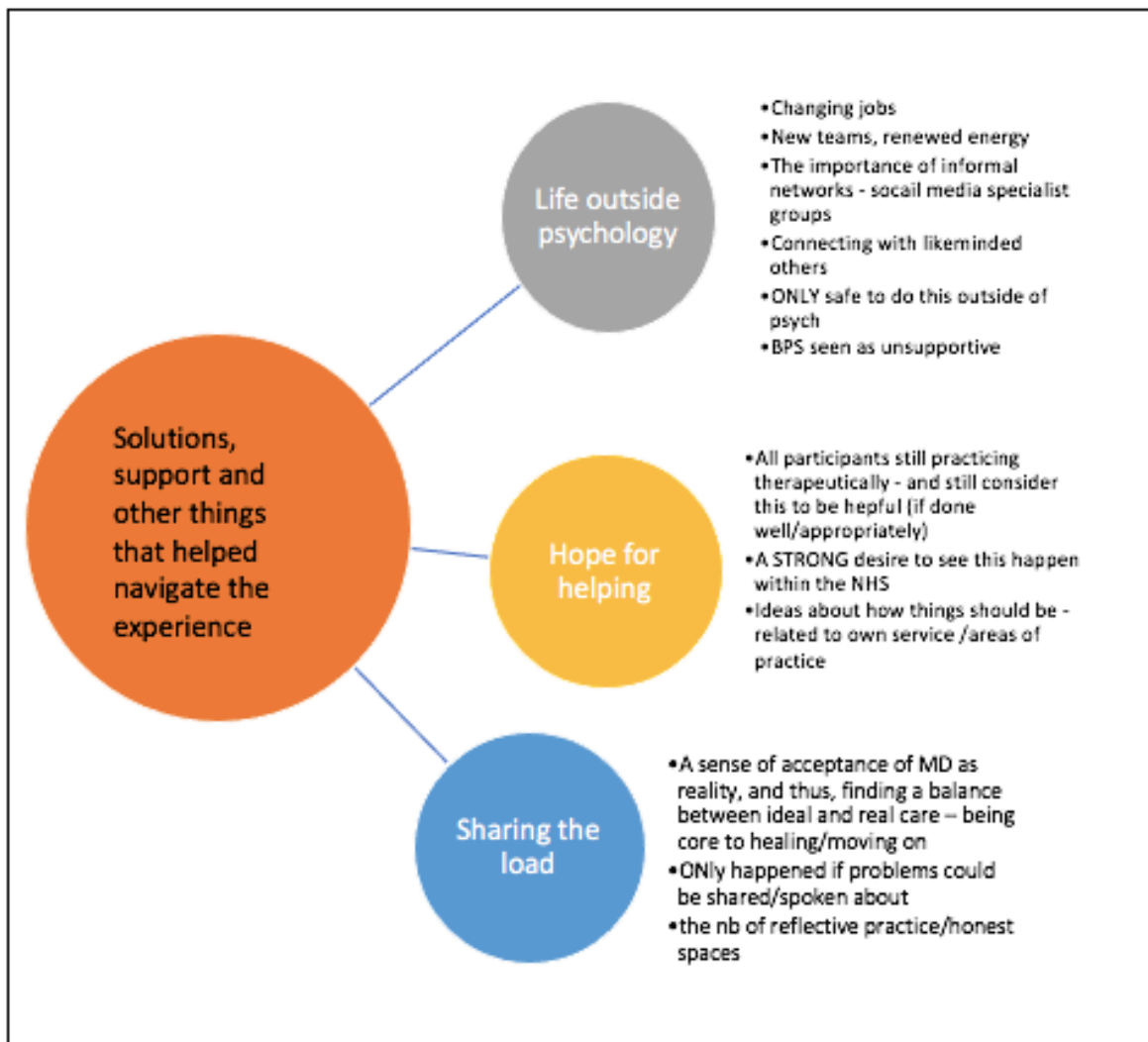
Who holds the power? Presumed to be CP's but rarely is, service area leads (support can make a difference), governmental funding and policy

Who is responsible for change? Reflective awakening in narratives that individuals could support each other! Accountability for change needs to be top down. Calls for change tend to come from grassroots or trainee positions up (ie. Direct feedback). Not heard!

Boundaries between personal and professional impact is blurred by identity shifts!

Immediate consequences (being scapegoated), connected to longer term impacts (sick leave, leaving the role, leaving the nhs) and the impact of these cultures of silence on those remaining (unsafe spaces)

### Synthesising core ideas 3



#### **Thoughts/reflections – identity changes and critical lens (noted in handwritten themes work):**

Timeline – all spoke about how this had gotten harder due to Covid – missing the informal spaces for ‘water cooler’ chat. Contributed to isolation.

In terms of identity having something outside the ‘job’ that feels meaningful was helpful. This included family/children, social support, value-based networks eg. Hearing voices, psychologists for social change, ACP, Unions.

Critical lens – Mismatch in tone/content between what people wanted to happen (ideal care – being able to do what works), and what they thought would happen (expecting further cuts, changes, restrictions on practices, life to be harder for patients due to environmental influences).

The idea of multiple layers of reality and understanding – ie. Trying to sort key narratives into sections highlights that there are no clear boundaries between what happens for people, how it impacts them, their work, and the system they work in, it’s all interconnecting and interdependent – relational.

Lots of talk about reflection on an individual level – but limited thought about system/organisational reflection – a sense of cultural blindness/wilfulness

Positioning - A limited belief the SYSTEM would be willing to change (despite IT KNOWING its difficulties). Therefore, hope should be top down, but has to be bottom up.

Examples of original groupings – via post it notes.

