A qualitative exploration of clinical psychologists' experiences as leaders of intersectional power and its impact on their responses to privilege and discrimination

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ABSTRACT

Background: Leadership and ‘inclusion’ are at the forefront of NHS policy and clinical psychologists (CPs) are considered to belong within this agenda. However, there lacks consensus on what leadership is. Nor is there clear guidance on how it can achieve ‘inclusion’. Current conceptualisations of leadership do not acknowledge the privilege and barriers faced by leaders, how they operate and their impact. Additionally, there is a lack of exploration of CPs perspectives, and minoritised and marginalised leaders’ experiences in particular.

Aim: To explore how CP leaders of any background working in the UK define their leadership style and approach to issues around privilege and discrimination.

Methodology: Semi-structured interviews were conducted with twelve participants who self-identified as leaders and were of mixed demographic backgrounds. Responses were analysed within a critical realist framework using reflexive thematic analysis (Braun & Clarke, 2006).

Results: The analysis generated one overarching theme reflecting the context within which leaders have long attempted to challenge discrimination, three subthemes and eight associated sub-themes. 1) *Personal risks and challenges* reflected ideas about the toll of their own personal experiences and effects on their relationships with others. 2) *Fitting the leadership mould* described how the profession of predominantly white CPs is no better at challenging discrimination than other professionals and despite being more readily accepted as leaders in contrast to racialised colleagues. 3) *Leadership roles and responsibilities* referenced divergent perspectives on the power, limits and responsibilities of leadership as well as a need to integrate personal and professional narratives.

Conclusion: The study highlights divergent ideas about leaders’ roles and responsibilities when it comes to issues of privilege and discrimination and explores the role of Whiteness in relation to this. Recommendations to enhance CPs ability and capacity to manage and address discrimination include a critical exploration of the concept of leadership in addition to the crucial process of self-

reflection for the benefit of service users, families, communities and the colleagues we serve and work alongside.

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1. **INTRODUCTION**

1.1. Overview

Leadership is considered key to delivering NHS strategy. This chapter will define key terms and concepts before outlining how the concept of leadership has evolved over time in the NHS and its importance in addressing issues of privilege and discrimination. Relevant literature will be reviewed to see how leadership approaches to privilege and discrimination are defined with a focus on healthcare staff perspectives, highlighting the lack of research centred on clinical psychologists (CP). The chapter will conclude with a rationale for the current study and the research questions.

My approach to the research is heavily influenced by critical race theory (CRT) and systemic approaches (Bronfenbrenner, 1979; Davies & Harré, 1990). Founded in law by Prof. Derrik Bell (Bell, 1980; Crenshaw, 1991), CRT is a practice of interrogating the role of race, a term without biological basis (Ifekwunigwe et al., 2017; Smedley & Smedley, 2005), and racism in society. Within it, the concept of "race" is considered to be socially constructed, and racial discrimination is understood as the common experience of most racialised and minoritised people. The construction of race, or racialisation, dates back to the 18th and 19th centuries (Ryde, 2019). A product of Whiteness, it sustains and operates alongside convergent interests such as patriarchy, and lays the foundation for state policies and practices such as Nazism, Apartheid and segregation in addition to psychiatric diagnoses such as drapetomania, the idea that enslaved people who tried to run away were mentally ill (Fernando, 2017). Racism is ingrained in every aspect of society from the foundations, it is in organisational culture, institutional and everyday practices (Delgado & Stefancic, 2013). As a result, Whiteness, a system which created hierarchies with a history of invisible advantage, privilege and power confers benefits to white people, laying the foundation for covert and overt oppression and discrimination due to class, gender and disability (Akala, 2019; Eddo-Lodge, 2018; Lorde, 1984a; Reeve, 2012).
The terms privilege and discrimination can be used to imply that these constructs are binary and static, that an individual is either privileged or subject to discrimination. However my thinking on these concepts is influenced by the writing

of Crenshaw (1991) on intersectionality in relation to race, gender and other identity categories on racialised women. According to Crenshaw, inequalities operate together and exacerbate each other to produce social power with the potential to be both a source of domination and empowerment. Thus there is an overall focus on power and intersectional power in this research. While I did not set out to specifically focus on any one dimension of power, my experiences and learning about the machinations of power to date have predominantly been around race, Whiteness and racism and this has influenced the focus of the research.

1.2. A Note on Language

This section focuses on language, its meanings and uses in different and changing contexts. Thus, context is provided for the use of specific terminology and to situate its use within the ontological and epistemological position of this report. Leadership, privilege, discrimination, will be outlined below including a critique of common terminology used in relation to these constructs. The constructs of race and racism are explored in 1.1. and the language of race is critically explored here in addition to providing context for my choice of language throughout this report. Writing as a white person (see 2.2.2.), I am mindful that the construct of race affects people differently according to how they are racialised. Within Whiteness, being white is constructed as the norm, while the construct of race is only applied to those who are othered as Black or Brown, for example. While I have aimed to be alert to the impact of my experiences and relationship to the language of race as a white person, I am aware that these constructs and my choice of terminology may affect people differently, depending on how they have been racialised in addition to their individual experiences and relationships to the language of race.

1.2.1. Leadership

At times considered integral to one another (Mintzberg, 1973), the terms leadership and management are used interchangeably and ambiguously within the literature. It is suggested they can be differentiated as the former being contextual, directional and visionary while the latter is considered a means of achieving those leadership

concerns (Kotter, 1990). Leadership can be understood as the negotiation of setting the task and creating the vision (Obholzer, 1994), as multi-faceted (Grint, 2000) and is conceptualised as a perceptual and behavioural phenomenon (Vance & Larson, 2002). The latter definition of leadership was favoured at the outset of this research.

However, these definitions are largely founded in a business context where value and success are based in a different currency. There is a lack of consensus about their applicability and relevance to healthcare (Dawes & Handscomb, 2005). This is evident in the simultaneous implementation of different and overlapping leadership frameworks within the NHS. A brief overview of the historical context and development of leadership will be given to situate current use of the term (see 1.3.).

1.2.2. Privilege and discrimination

My thinking on these concepts is influenced by the writing of Crenshaw (1991) on the impact of the intersection of race, gender and other identity categories on racialised women. The social power in delineating difference is highlighted as both a source of domination and empowerment. Crenshaw also argues that “ignoring difference within groups contributes to tension among groups” (pp. 1242) and where systems such as those of race, gender and class converge, interventions based solely on individuals who do not share the same backgrounds will be of limited help due to them facing different obstacles.

Burnham’s (2018) social GGRRAAACCEEESSS (gender, geography, race, religion, age, ability, appearance, culture, class/caste, education, employment, ethnicity, spiritualty, sexuality or sexual orientation) provides a useful framework for consideration of individual aspects of personal and social identity. While the framework is widely used it does not attend to power but rather individual binary points of differing personal and social identities. To attend to power in relation to peoples’ social identity, the concept of intersectionality is drawn on as it allows consideration of how marginalisation is influenced by interlocking aspects of power that can be influenced by peoples’ social identity. These personal and social identities are considered to intersect in any given context, affording different levels

of social, cultural and economic power (Crenshaw, 1991). As a result of these interlocking hierarchies, privilege can be considered “an invisible package of unearned assets…an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, code-books, passports, visas, clothes, compass, emergency gear and blank checks” (P. McIntosh, 2009, pp.91).

In the UK it is against the law to discriminate against, or treat anyone unfairly, because of their age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex, sexual orientation (Equality Act, 2010). Those with minoritised and marginalised (see 1.2.3. note on terminology) identities are more likely to experience prejudicial treatment, poorer physical and mental health (Marmot et al., 2010). Under the United Nations International Covenant on Economic, Social and Cultural Rights (1966), healthcare professionals are required to address social inequalities, discrimination and stigma which arise from privilege and discrimination. However, addressing discrimination on the basis of one aspect of identity is unlikely to adequately address the full dimensions of discrimination for an individual (Crenshaw, 1991).

1.2.3. Terminology

Descriptions of race and other marginalised identities often implicitly others and perpetuates Whiteness. The terminology used to describe identities also vary by location and researcher.

While not unproblematic, people who are not white will be referred to using the term ‘racialised’. The term racialised is not intended to define nor homogenise individuals’ community, identity or experiences, but to reflect the phenomenon that is inflicted upon them (Dalal, 2002). Where reported within the literature or direct quotes by participants, the specific term will be used. Differences and nuances across racialised experiences are erased by inappropriately grouping and referring to racialised individuals as ‘minorities’. For example, ‘Black, Asian and Minority Ethnic’ (BAME or BME) while widely used due to its perceived neutrality is considered redundant and unhelpful (Mohdin et al., 2021). Furthermore, though Black and Asian individuals in the UK may be in the minority category of race

(ONS, 2020), globally white people are the minority. The use of BME and other terms perpetuates the perception of white being the norm and serves to scaffold the dominance of power within white individuals. Consequently, the terms minoritised and marginalised will also be used to denote the othering which is done to people based on any other aspect of their circumstances or identity, such as class and sexuality.

The language of equality, diversity and inclusion (EDI) are used with reluctance in this report as they can be misleading. EDI initiatives and policies are often in name only and fail to elicit the meaningful conversations necessary to dismantle discrimination (Daiches, 2010). The terms are widespread in policy and literature, used to whitewash the structural nature of disadvantage, rendering those who benefit from and continue to maintain inequality invisible. By speaking the language of EDI, the perception of the ability to discriminate is nullified.

Reference is made to Whiteness and white fragility. Whiteness is the invisible systems of privilege and power which maintain hierarchies and oppression through ideological and cultural practices (S. Clarke & Garner, 2009); while white fragility is the expectation of white people that they will be insulated from race-based distress (DiAngelo, 2018). Where white people experience racial distress, white fragility functions to uphold white supremacy and manifests in defensive moves such as anger, fear, guilt, silence and leaving stress-inducing situations (DiAngelo, 2011). While many individuals do not consider themselves to be racist, their inaction, and therefore complicity, in the face of oppression is racist. Antiracism is the active opposition of racism, oppression and Whiteness (Kendi, 2019).

1.3. Leadership in the NHS

Since the inception of the NHS in 1948 there has been a lack of clarity about how leadership was being defined. Terminology has evolved from “administration”, to “management”, and now “leadership” (Martin & Learmonth, 2012). A brief overview of these changes will be given.

1.3.1. A brief history of leadership in the NHS 1948-2008

According to Mannion et al. (2010), four major phases of leadership development can be distinguished. These phases are loosely based around the presentation of policy packages which may not have been implemented until sometime later and it may have taken many years for the effects to become apparent. They are intended to summarise a complex mix of circumstances and situate the current issues concerning leadership in the English NHS.

- 1948-1983

  During this period the emphasis was on management and diplomacy (Harrison, 1988; Webster, 1988, 2002) and ensuring professionals were able to focus on clinical work. Organisational leadership was not a concern for clinicians. Two major policy reforms around this time, the Salmon Report (Ministry of Health, 1969) and the 1974 reorganisation (Department of Health and Social Security, 1973) led to the development of a hierarchical structure for nurses where seniority was designated numerically. It encouraged involvement of multi-disciplinary teams in management decisions, sometimes with the effect of minimal decision-making (Ham, 2014).

- General management: a performance regime 1984-1990

  Private sector management approaches were introduced following the Griffiths Report (1983) with the intention of appointing 'General Managers' whose roles would resemble chief executives in commercial companies. It led to the establishment of autonomously functioning tiers of management accountable to a board (Kumar, 2013). This was met with opposition by nurses due to their removal from senior management positions created following the Salmon Report (Owens & Glennerster, 1990).

- Quasi market 1991-1997

  The introduction of the purchaser and provider model was intended to raise quality of care in the belief it would lead to more disciplined healthcare

organisation (Department of Health, 1989, 1997) with management and control remaining centralised (Goodwin, 2000). Clinician leadership development was less of a focus and there was greater emphasis on developing those in managerial positions (Mohan, 1996).

- Investment and reform 1997-2008

  This period was characterised by modernisation and formalising a system of evaluating services based on evidence e.g., establishment of National Institute for Clinical Excellence in 1999 (NICE, 2022). More collaborative approaches were proposed by a Labour administration in attempts to move away from unhelpfully bureaucratic command-and-control mechanisms (Clarence & Painter, 1998; Exworthy et al., 1999). According to the NHS Plan (Department of Health, 2000), delivery of change would require leaders to be both clinical and managerial. Up until now, the NHS Plan saw leadership development as being ad hoc and incoherent with too few clinicans in leadership roles and too little opportunity for board members to develop leadership skills. The Darzi Review (Department of Health, 2008a, 2008b, 2009) emphasised the importance of leadership in various ways (Morrell & Hewison, 2013) including encouraging leadership at all levels. This led to the need to draw on a well-researched evidence base (Storey & Holti, 2013) and the establishment of the Leadership Centre as part of the Modernisation Agency (Department of Health, 2007) which delivered and co-ordinated leadership development programmes or initiatives.

1.3.2. Recent developments

Following marketisation of healthcare and cutbacks to management, the thinktank The King's Fund (2011) investigated the challenges facing management and leadership in the NHS to identify solutions and made recommendations for the future of leadership and management. Initial investigations concluded there was a need to engage staff and move towards distributed leadership and collaborative ways of working (Ham, 2014; The King's Fund, 2012). An emphasis on prevention, improved safety and quality recommended seeking improvement based on

commitment rather than compliance. The suggestion that this could be achieved through leadership which promoted standardisation of care with an emphasis on peer review and peer pressure (Ham, 2014) however, seemed rather reminiscent of a command-and-control approach. A shift in policy (NHS England, 2012, 2014) saw the concept of compassion integrated into the collaborative leadership approach supported by The King's Fund to ensure high quality compassionate care for patients (West et al., 2015). Compassionate leadership, characterised by attending, understanding, empathising, helping, and fostering psychological safety, is considered to imply collective leadership and key to positive inclusion and participation (West et al., 2017) has received considerable research attention (e.g., Brohi et al., 2021; de Zulueta, 2016; Evans, 2022; Foster, 2017; Hewison et al., 2019; West, 2021). It is argued to be a product of both bottom-up and top-down leadership (West et al., 2017), a solution to a crisis of leadership in the NHS and ideal to address inequalities (West, 2021).

The NHS Leadership Academy launched in 2012, aiming to become an umbrella for all national leadership development activity (NHS Leadership Academy, 2022c). This development activity became known as The Leadership Qualities Framework (LQF) and the Clinical Leadership Competency Framework was subsequently developed (CLCF) (NHS Leadership Academy, 2011).

CLCF set standards for outstanding distributed leadership, describing the qualities and competencies required in existing and aspiring leaders. Made up of twenty leadership domains, or competencies, in five clusters (demonstrating personal qualities; working with others; managing services; improving services; and setting direction) it offers staff a framework within which to analyse their leadership roles and responsibilities (NHS Leadership Centre, 2004). A one-year evaluation project of the LQF published as part of the guide included short descriptive case studies with a maximum length of one page and do not appear to be methodologically rigorous. While the framework was intended to allow flexibility and creativity in its application, it has been dubbed a panacea with regard to difficulties defining leadership and does nothing to shift the dominant identity it is assumed that NHS managers and professionals should adopt (Ford, 2005).

1.3.3. Leadership theory and discourse in a healthcare context

Leadership literature applied in healthcare largely draws on business contexts (Dawes & Handscomb, 2005). Heavy on theory and descriptive accounts, it offers little evidence that it has any effect on patient care or staff performance (Vance & Larson, 2002). A brief overview of frequently applied leadership approaches within healthcare is given below.

Though popular, trait theories have been debunked (Gibb, 1947; Mann, 1959) as little evidence of any innate, universal qualities have been identified (Alimo-Metcalfe, 2013). Transactional leadership, conceptualised as focused on the process of controlling, organising and short-term planning (Bass, 1985), was not difficult to implement in a healthcare setting. Patient-centred care and a values-based NHS were believed to be compatible with the moral aspects and mutual motivation between leaders and followers (Bolden, 2004) of transformational leadership. However the evidence supporting it was based on participants who largely operated according to the dominant trait theories of the time (Alimo-Metcalfe, 2013). The theories had not deviated from charisma and 'heroic' leadership, while failing to explore avoidant leader behaviours and the role of gender and culture (Hutchinson & Jackson, 2013)

Shared, collective or distributed leadership ideas have gained popularity as they value inclusivity (Oborn et al., 2013), prioritise collaboration both among individuals and across organisational silos, and develop cultures conducive to the delivery of high-quality healthcare (West et al., 2014). It is inherent in compassionate leadership as defined in 1.3.2. Encouraged by policy changes, leadership discourses shifted away from management and being the role of select individuals over the last twenty years towards distributed leadership across the system, from the most junior to senior individuals (Martin & Learmonth, 2012). It was claimed that with the requisite training and education, clinicians will be liberated from the constraint of top-down control and instead have greater autonomy allowing them to lead and shape services together with service users and the public (Department of Health, 2000, 2006, 2010, 2012).

In the face of established hierarchies maintained through institutional power, policy espousing distributed leadership has been insufficient (Martin et al., 2009b). The distribution of leadership and responsibility across all workers is sold as empowering individuals with expert local knowledge for the greatest chance of appropriate, lasting, and meaningful change. However medical clinicians' training continues to largely focus on becoming expert clinicians with advanced technical skills operating in a hierarchical system (Department of Health, 2008c). Distributed leadership presents a challenge for clinicians in the transition from clinician to leader, and between clinicians and managers (Marnoch et al., 2000) with different priorities and skill sets. Moreover, marginalised individuals and those in lower-status or subordinate roles in institutional hierarchies face the additional challenge of being asked to subvert established organisational and professional rules and norms (Finn, 2008). The premise that individuals exemplifying good practice will have a significant influence on peers and bring about welcome change in the context of organisational hierarchies and bureaucratic structures is paradoxical (Martin et al., 2009a; Martin & Learmonth, 2012; O'Reilly & Reed, 2010). In the face of decades of organisational hierarchy (Martin & Waring, 2013) and the machinations of Whiteness as it seeks to main the order of hierarchy, just how effective can distributed leadership be?

1.3. Leadership Challenges

1.3.1. Workforce discrimination

Following the Macpherson Inquiry highlighting the problem of institutional racism (Macpherson, 1999), the NHS launched the Race Equality Action Plan (Department of Health, 2004) to tackle discrimination. Diversity in leadership was considered beneficial to innovation, tackling discrimination, and improving patient care (Kline, 2015). However, the lack of accountability, transparency, sanctions, or incentives meant the action plan appeared to fail (Kline, 2015) and the striking absence of racialised staff in senior positions a decade later further suggested little had changed (Coghill, 2019; Kline, 2014).

NHS England launched The Equality and Diversity Council as part of the NHS Leadership Academy (2022b). While inclusion is core to the NHS Constitution, it remains one of the biggest challenges that health systems face globally, nationally and systemically (NHS Leadership Academy, 2022a). The Council aims to prioritise leadership, system, and culture change to create inclusive workplaces and ensure services and workplaces are free from discrimination while improving outcomes for protected groups across the health system. As Patel (2021) suggests, addressing institutional racism requires genuine commitment from senior leadership, alongside the participation of all senior and other managers. However these national initiatives, including the NHS Workforce Race Equality Standard (WRES, 2019, 2021) which monitors and reports indicators of racial inequality and discrimination, take only slow steps towards tackling discrimination and have little influence at local level, indicating a gap between current leadership discourses and practice.

1.3.2. Socio-political context

Discussions about the recruitment of publicly funded, NHS professionals from around the world, Islamophobia and migration were key topics during and following the 2016 BREXIT debate. Political and social discourse around the referendum legitimised cultures of extremism and intolerance where stigma, prejudice and discrimination through open hostility and acts of aggression (Bhui, 2016) contributed to the NHS staffing crisis (Milner et al., 2021; Spiliopoulos & Timmons, 2022).

1.3.2.1. Covid-19 pandemic

The outbreak of the Covid-19 pandemic in March 2020 placed all healthcare services under significant pressure (Department of Health, 2022; NHS England, 2022c) and highlighted continued health inequalities (Health Foundation, 2021; Lawrence, 2021) including inequality among NHS staff (NHS England, 2022a). A flurry of reflective publications and opinion pieces in the time of Covid-19 saw healthcare professionals look for best leadership practices at a time of great uncertainty. Publications appear grounded in clear chains of command with emphasis on good communication and compassion-based leadership approaches,

e.g. (Dalton, 2020; Nicola et al., 2020; Oliver, 2020; Saidi et al., 2020; Stoller, 2020).

1.3.2.2. George Floyd & Black Lives Matter

The murder of George Floyd in May 2020 in the United States triggered a resurgence of the Black Lives Matter movement (Smoot, 2020). It further emphasised the conversations about disparities among racialised healthcare workers amid the risk of Covid-19 (Brathwaite, 2020; McInnis, 2020) and healthcare inequality (Seewoodhary, 2021). It triggered messages of support and pledges from senior leaders stating their commitment to 'race equality' and 'just culture' for staff, partners, service users, carers, families and the communities they serve (e.g., BMA, 2020; Midlands Partnership Foundation Trust, 2020; Nottinghamshire NHS Leaders, 2020; Stevens, 2020). Staff responded in frustration, sharing their experiences of anti-blackness and questioning the lack of Black staff in senior positions (Abdulrahman, 2020). Recent plans to scrap a long-promised white paper due to set out plans to address health inequalities (Campbell, 2022) have potentially reinforced such perceptions.

1.3.2.3. Failings in care

The investigation into failings at Mid Staffordshire NHS Foundation Trust linked the poor care received by patients to poor care for staff (Francis, 2013). The poor work culture found was linked with management and leadership characterised as disengaged. To address these failings and ensure better quality care for patients, it was concluded that staff at every level in an organisation should receive high quality care. Failings in care highlighted in September 2022 by a BBC Panorama investigation at a mental health facility, the Edenfield Centre (BBC, 2022) show that the challenges facing leaders in healthcare remain pressing. In the face of 'wicked' social issues, leadership at every level is needed to deliver change across organisational and professional boundaries (Martin & Waring, 2013)

1.4. Critical Summary of Leadership in Healthcare

Leadership is at the forefront of NHS policy (Department of Health and Social Care, 2019; National Institute for Health Research, 2013; West et al., 2015) in the face of considerable social and political challenges. Where Whiteness operates,

‘inclusion’ is considered as part of the ‘fundamental DNA’ of leadership and change in the NHS, where taking a more power aware approach to leadership requires the creation of spaces where people can engage with issues of identity in relation to themselves and others (NHS Leadership Academy, 2019). However there is a lack of clarity and consensus over what leadership can achieve (Haycock-Stuart & Kean, 2012; Learmonth, 2014). Healthcare and business leadership literature is mainly theoretical or descriptive, with limited investigation of the application of proposed models (Storey & Holti, 2013; Vance & Larson, 2002).

Leadership, whether considered an individual or collective task, tends to be conceptualised as residing in the power behind the individual and at the expense of a greater understanding of the context. There is a failure to acknowledge how a change in leadership approach should be implemented within a complex healthcare system that has developed over many decades in the context of Whiteness. Instead, a change in leadership approach and policy may simply become another target to achieve (Tomkins & Simpson, 2015). Competency based leadership is argued to undermine the efforts of such a relationally complex activity and that instead, we need to include a wider range of perspectives and approaches and extend debate about leadership development (Hewison & Morrell, 2014). Collaborative and compassionate leadership has been proposed as a panacea for failings in care and poor treatment of staff (Bailey & Burhouse, 2019; Hewison et al., 2018). However within the theoretical descriptions of these approaches, there is an emphasis on what is done to others, without guidance on how to connect individuals to their own humanity and purpose, and little indication of introspection required on behalf of leaders. The drive to help implied by these approaches is symptomatic of Whiteness, as it contributes to an erasure of agency, an assumption of the absence of capability, a predisposition to see only deficits where there are strengths (Burgess, 2022). When leaders do not feel equipped or supported to live up to idealised notions about emotional warmth and connectivity, this risks disengagement. Furthermore, designing leadership approaches around concepts of kindness and compassion but not grappling with the reality of discrimination and the complexity of Whiteness compartmentalises the problem as something beyond the scope of our responsibility (Burgess, 2022).

The concept of leadership as it is currently applied within healthcare appears to serve to silently maintain hierarchy, order and control. It does not speak to an agenda that is truly committed to valuing difference and working towards equity. It is an oxymoron which not only places the burden on individuals to absolve one another of the failings embedded in the system, but neither acknowledges nor does anything to address political and power imbalances (Burgess, 2022; Kalra et al., 2009). As an arm of Whiteness, it is an effective means of imperceptible control achieved with employees developing “internalised compliance”, as opposed to the more obvious and therefore more easily challenged use of “external constraint”' (Delbridge & Ezzamel, 2005). In other words, it seeks to nurture the internal oppressor (Freire, 1993) and continue to maintain control and harbour power for those in the most privileged positions, albeit less obviously.

Within the range of leadership approaches described in the literature, many leadership approaches are conflated with one another (see 1.3.3.), lack clarity in terms of what is meant by leadership (see 1.3.2.) as well as true to life accounts of what it is to be a leader. For example, compassionate leadership and inclusive leadership are often used interchangeably, with both described as key tools for and as lending themselves naturally to addressing inequality. However, in reading the compassionate and inclusive leadership literature, it appears to have been written by and for people who are already in positions of leadership and power. This is evident in the language of inclusion which implies that formally designated leaders are the gatekeepers of privilege and power with the authority to open a metaphorical door to those who are discriminated against and marginalised. It perpetuates inequality as it positions those who are marginalised as, i) always having less power and thus misses the intersectional nature of power and ii) reinforces the idea of those who have power as the gatekeepers of authority to effect change, thus maintaining an ideological status quo that those who are already in power continue to have power. There is an absence of acknowledgement and discussion in the leadership literature of the complexity of leadership from the perspective of leaders who have experience of discrimination and a) how this affects their path to becoming, remaining and being seen as leaders, b) impacts on how they carry out their leadership role, as well as c) those

leaders' experiences of addressing inequality. There was also an absence of leaders' a) awareness of how their privilege affects their path to becoming, remaining and being seen as leaders, b) impacts how they carry out their leadership role, as well as c) those leaders' experiences of addressing inequality.

1.4.1. Clinical psychology & leadership

Clinical psychologists belong within the leadership agenda according to claims that core training equips CPs with valuable competencies that they can translate and bring to a style of leadership (BPS, 2010; Onyett, 2007; PPN, 2020) in keeping with current NHS priorities. Seen as leaders on ethics (Wainwright, 2014), CPs' communication skills, ability to develop relationships, work with teams, and manage complexity (BPS, 2017) mean they can be effective role models (Whomsley, 2014). However competence and confidence in these skills or the ability to assume a leadership role should not be assumed, despite CPs commonly consulting to organisations on organisational and systems improvement (Onyett, 2007).

The leadership agenda in CP has arguably been focused by concern about our own hierarchical position, the threat of Improving Access to Psychological Therapies (IAPT) to CP jobs (Carter & O'Reilly, 2016) and a parallel shift in medical colleagues being encouraged to exert influence and adopt a position of leadership (Department of Health, 2000, 2006, 2010, 2012). Are we really well placed to promote ethical working culture, be role models and leaders or are we also serving to maintain order and control in a system that wishes to sustain its power?

CPs have and continue to be complicit in Whiteness, causing harm through for example, medicalisation of distress, eugenics, or psychologising war and human rights violations (Newnes, 2011; Patel, 2011). The profession is dominated by white individuals at all levels (Odusanya, 2017; Prajapati et al., 2019; Wood & Patel, 2017), evident in the 'entertainment' at The Group of Trainers in Clinical Psychology 2019 (GTiCP) annual conference being a re-enactment of a 'slave' auction (Patel, 2019) and a subsequent apology issued by the British Psychological Society (BPS) which privileged Whiteness and perpetuated racism

(Mintah et al., 2020). Despite initiatives intended to ‘widen access’ to CP for minoritised and marginalised individuals (Cape et al., 2008; Health Education England, 2022; SLAM, 2022; Turpin & Coleman, 2010) training positions continue to be disproportionately offered to white individuals (CHPCCP, 2021). Those who are successful, report continued experiences of racism and being othered in the context of the discrimination founded and enshrined in psychological theories, models and practices, and not least among their peers (Adetimole et al., 2005; Iqbal, 2019; Odusanya, 2017; Prajapati et al., 2019; Tong et al., 2019). Yet many CPs would appear to be oblivious to the absence of ethics underpinning these few examples of harm.

Where is the exploration of individuals’ perceptions of their ability to discriminate? What are psychologists doing in the face of discrimination? How are psychologists leading in their teams? How can we begin to prevent further harm?

1.5. Researcher Motivation to Research the Topic

Alongside the literature, it is important to outline my own experiences and offer transparency around my choice of research topic.

Having spent several years in relatively junior positions prior to CP training and being encouraged to take on leadership tasks, I often questioned the power I was being led to believe I was given as I noticed this power could quickly be revoked or could be deemed to have been used incorrectly. I observed those who were my leaders grapple with trying to support their staff while also balance the demands of their own managers and leaders amid fluid clinical and service agendas. These experiences made me curious about the concept of leadership within organisations with such clearly delineated hierarchies as the NHS.

As a white Irish trainee CP, talking about privilege and discrimination has been something I have only gradually learned the language and continue to develop skills to explore while I work towards antiracism. In conversations with peers, qualified and senior CPs at university and on placement I have noticed how these conversations feel more or less comfortable with some than others, the range and sometimes lack of challenges and responses to discrimination. I also noticed the impact that these conversations had on my racialised or otherwise minoritised

colleagues. This led me to question how those in positions of influence approach issues of privilege and discrimination and any differences there may be amongst individuals.

These experiences drew me to explore the literature in relation to leadership, privilege and discrimination and I was strongly influenced by Eddo-Lodge (2018), Kendi (2019), and Lorde (1984a, 1984c, 1984d). Exploring these ideas with my research supervisor nurtured my interest and I undertook a more systematic examination of the literature.

1.6. Scoping Review

To better understand how leadership is represented in the healthcare literature in relation to privilege and discrimination a scoping review was undertaken.

1.6.1. Methodology

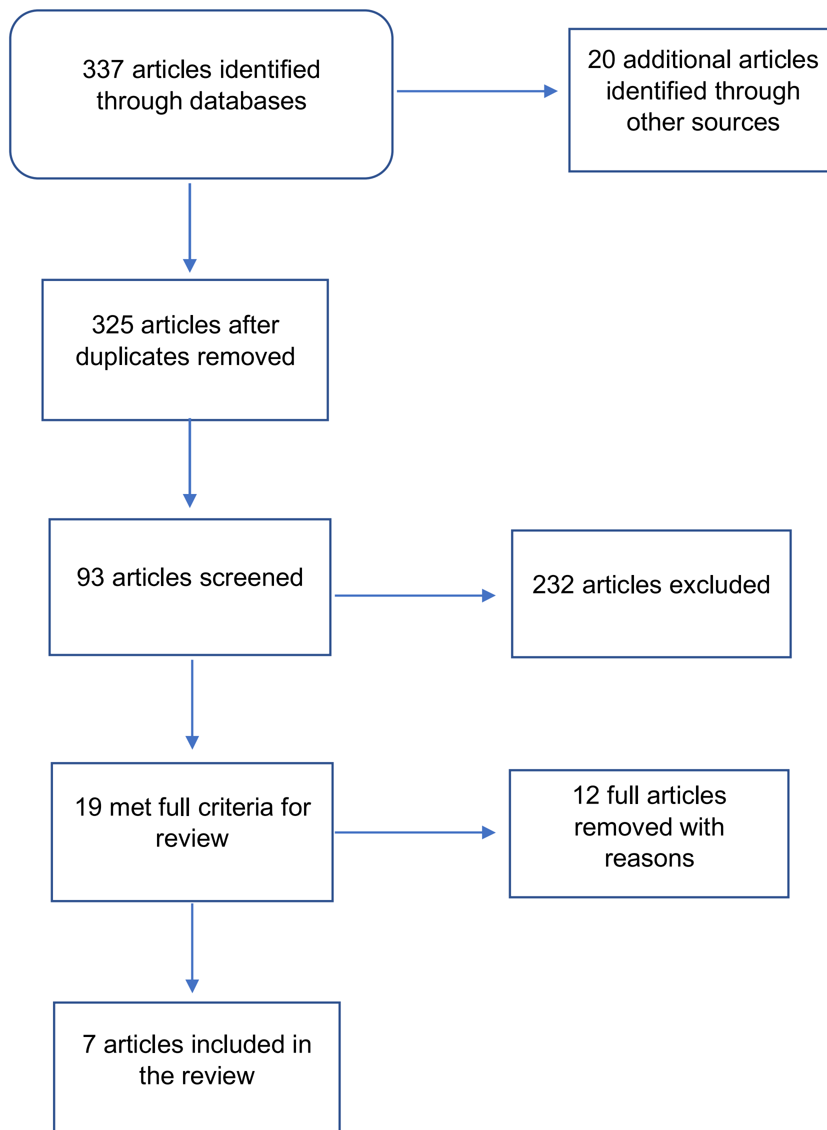
PsychInfo, Academic Search Complete and CINAHL Plus databases were searched to ensure breadth in the literature review. The searches were restricted to peer reviewed papers written since 2014 and in the English language. A combination of search terms was used including ‘leadership’, ‘leadership style’ ‘management’, ‘privilege’, ‘power’, ‘intersectionality’, ‘affirmative action’, ‘racism’, ‘bullying’, ‘discrimination’, ‘prejudice’, ‘inequality’, ‘diversity’, ‘inclusion’, ‘inequity’, ‘equality’, ‘healthcare’. The search terms were combined using boolean operators ‘AND’ as well as ‘OR’.

To ensure results were relevant to the topic of leadership, privilege, and discrimination in healthcare in the UK, titles and abstracts were read. Papers were excluded if they used only quantitative methodologies, did not directly involve the healthcare population, leadership was not the main focus of the research in addition to opinion pieces and book extracts. Additional relevant literature was sought using Google Scholar, the university’s research repository, and reference lists of relevant articles.

A total of 357 papers were found through the searches. 19 papers were read in full, with 7 meeting full inclusion criteria. The search process is visually outlined in

Figure 1. The NICE methodology checklist for qualitative studies (NICE, 2012) was used for the systematic review of papers due to its ontological and epistemological compatibility, and rigorous approach.

Figure 1. Scoping review search process



1.6.2. Scoping results

All literature found pertained to physical healthcare settings. A summary can be found in Table 1.

Table 1. Scoping review results

Study details	Research parameters	Definitions	Results	Limitations & conclusions
Gordon et al., 2015 **Quality score: ++** Sample: 65 medical trainees Intervention: None	Questions: What do medical trainees most commonly understand by the terms 'leadership' and 'followership'? What leadership discourses do trainees' definitions of leadership and followership map to? Thinking about the importance of context, how do conceptualisations of leadership and followership vary according to stage of training and specialty? Epistemology: Social constructionist	Leadership: a skill to be learned or a set of behaviours to be developed Approach: Individualist, contextual, relational and complexity discourses	11 group and 19 individual interviews identified 757 definitions of leadership, 15 dimensions of leadership and 13 dimensions of followership. Talk was mapped to four discourses of leadership identified within the literature: individualist (most commonly identified), contextual, relational and complexity (least commonly identified). Differences were found in definitions	Only specialty group, gender and racialised identity demographics reported. Researcher role is not clear. Focus on individual leaders; coordination or influencing a team. Context and organisational structures found to influence leadership more strongly than leadership training.

	Analysis: Thematic framework analysis Data: Qualitative study using semi-structured interviews		and discourses by training stage and specialty group.	
McCray et al., 2018 **Quality score: +** Sample: 9 senior medical doctors on bespoke postgraduate leadership programme using action learning sets (AL) and critical action	Question: Explore the experience of AL and CAL Epistemology: Social constructivism Analysis: Reflexive narrative inquiry Data: Qualitative study using structured and unstructured interviews	Leadership: Not defined Approach: AL and CAL	9 individual interviews identified the theme resilience when exploring differences in experience of AL and CAL	Context of the programme not well described; no demographics reported; conclusions are unclear. Critical action learning is found more helpful than action learning due to opportunities for relational safety.

learning sets (CAL)				
Monkhouse et al., 2018 **Quality score: -** Sample: 15 participants (healthcare professionals) in the Improving Global Health leadership development programme	Questions: Understand the impact of the IGH Fellowship on the leadership development of returned fellows and on their subsequent careers. Understand the process of personal development in order to further improve the aspects of the IGH Fellowship that facilitated leadership development. Epistemology: Not reported Analysis: Inductive thematic analysis Data: Mixed methods: questionnaire, free text	Leadership: Not defined; implied different to management Approach: Vertical leadership	15 interviews. Major themes were: Experience factors that instigate development; Personal developmental factors; Internal and external outcomes. 74 online survey responses elicited information about motivation for applying and the impact of the programme	Role of the researcher not described; no participant demographics; IGH programme ethically questionable therefore conclusions are not considered reliable. The programme was found to empower participants and view themselves as leaders.

	responses and semi-structured interviews			
Percival & Best, 2019 **Quality score: +** Sample: 5 successful completers of NHS leadership development programme still working in the organisation	Questions: Examine the perspectives of a group of NHS managers who have undergone leadership development. Understand how they are able to implement change from the leadership development programme into the day-to-day performance of their roles. Epistemology: Not reported Analysis: Inductive thematic analysis Data: Qualitative study using semi-structured interviews	Leadership: It is not management Approach: NHS leadership development programme using AL	5 individual interviews developed three main themes: personal development; organisational opportunities; perceptions of leadership and management	Limited participant demographics, it is not clear how the data was analysed to arrive at the results and data is not contextualised, thus the findings are not convincing. Distributed leadership is considered useful but difficult to implement due to organisational barriers
Phillips & Norman, 2019	Question: Understand the power nexus of ward	Leadership: Ensures quality	19 individual interviews, data	Limited detail about the range of data sources,

Quality score: ++ **Sample:** Three hospital ward leaders and 15 other nominated key stakeholders (i.e. patients and staff); documentary data	leadership in the context of an NHS hospital (the whole case), examining how ward leadership was particularised in specific situations on wards (embedded cases) Epistemology: Not reported Analysis: Constant comparative thematic analysis Data: Case study	care, optimal resource management and collaborative interprofessional working. Approach: Complex responsive processes	analysis and observations identified three main themes: managing patient flow; managing resources; providing assurance	difficult to determine quality of data collection without epistemology, no information about the researcher. Interdependency of power indicates need to focus on relational aspect of leadership and reflexivity.
Power et al, 2017 **Quality score: +** Sample: 1,231 primary care	Question: To determine experiences of leadership training of six primary care professions in Scotland and consider future development Epistemology: Not reported	Leadership: Not defined Approach: AL	Online free text questionnaire responses identified what participants found helpful about leadership training and barriers to training.	Different methods of distributing the survey not outlined; with such a large and varied sample there are likely to be distinct differences not possible to capture by

professionals in Scotland	Analysis: Thematic analysis Data: Mixed methods		Low participation in leadership training indicated.	survey; data analysis not clear. Clear evidence of training outcomes wanted, not much interest in training available in its current form?
Salway et al., 2016 **Quality score: ++** Sample: 19 Key Informants (KIs) from GP led commissioning groups; 75 Primary Care Trust staff and	Questions: To what extent and in what ways is ethnic diversity and inequity considered within healthcare commissioning? What factors influence this commissioning practice? Epistemology: Not reported Analysis: Deductive thematic analysis	Leadership: Not defined Approach: Not reported	Individual narrative interviews with KIs, individual interviews, workshops with 38 individuals identified three themes: marginalisation; ambivalence; and a lack of clarity and confidence	Role of researcher unclear; epistemology not outlined. Ethnic diversity and inequity is insufficiently considered within healthcare commissioning. The agenda is marginalised and regarded with ambivalence by predominantly white commissioners.

documents; 38 national commissioners participating in a workshop	Data: Case study and qualitative study using semi-structured interviews

1.6.2.1 Leadership development

Studies looking at leadership training and development in healthcare will be outlined.

Time and financial pressures were suggested to be barriers to leadership and leadership training, however a low response rate to a survey across professional groups perhaps also indicates a lack of interest and perceived utility in leadership or leadership training in its current form (Power et al., 2017). Nonetheless, participants reported desire for facilitation, mentoring and/or peer supported training while also wanting evidence that courses are beneficial and could show well-defined outcomes. A thin qualitative exploration of these themes offered limited insight into participants' views.

The Improving Global Health (IGH) programme aimed to encourage and make leadership development more accessible for all members of the multidisciplinary team (Monkhouse et al., 2018). Personal development opportunities such as exposure to different professions, cultures and attitudes; personal awareness of effective and ineffective leadership styles were found to empower participants. However, participants were primarily doctors (50/74), and most (65%) took a career gap in order to participate in the four-day training before beginning a three to nine month leadership placement in a 'resource-poor country' such as Cambodia, Tanzania, or South Africa, (Streeton et al., 2021) with the support of a UK-based mentor. To whom is a training programme requiring a months long international move accessible? While the programme reports having achieved its aim, it would appear to mainly benefit those who are already privileged to access leadership training. More importantly, where 'inclusion' is top of the agenda, how was a training programme exploitative of and likely harmful for host countries given ethical approval? The premise of sending individuals to 'resource-poor' countries to practice new skills with the support of a UK-based mentor is a re-enactment of colonialism and a highly questionable method of leadership training purporting to aim to increase access to leadership.

Leadership training designed to attend to issues of power using critical action learning (CAL) (Vince, 2008) enabled reflexivity, a change of pace in conversations that remained confidential and 'where issues that can shock are able to be discussed' (McCray et al., 2018). The nature of the issues that shock is not clear, nor to whom they are shocking. CAL was concluded to offer

participants additional emotional and social resources and the use of power collaboratively in resolving complex problems, reducing the impact of positional, professional and political power on preventing collective problem solving (McCray et al., 2018). Where power is located, how and with whom it is shared is not explored.

Training aimed to benefit staff in middle management positions tasked with leading change, highlighted change management which relied on developing key influential individuals and organisational barriers to bottom-up initiatives (Percival & Best, 2019). Paradoxically, the authors suggest senior managers could benefit from attending workshops and perhaps provide greater organisational impact. Training, supposedly designed to encourage distributed leadership undermines its purpose with a thin investigation of the barriers.

1.6.2.2. Leadership experiences

Studies looking at leadership experiences will be outlined.

Power in relation to job status or title within the organisation, and to other stakeholders together with the impact of policy was examined by Phillips & Norman (2020) in an acute hospital setting. Themes around providing assurance, how participants adopted a vision for the NHS comprised of numerous and sometimes conflicting values resulting in duplication of work were identified. Every level checking on the level below was suggested to create constraints and provide opportunities to penalise when noncompliance is identified. Therefore, power was not something that could be ‘given’ to ward leaders but was contingent on local interdependent human interaction which is constantly in flux. The authors outline how leadership programmes’ focus becomes the system or the individual and not the everyday interaction of ward leaders and others in the everyday activities of the hospital, proposing an emphasis instead on supporting development of reflexivity in supportive communities of practice which would allow more nuanced exploration of leadership. Indeed, in understanding this nuance it would be interesting to know more about the ward leaders in this study beyond their job role and how this may impact on their ongoing negotiations around power.

While not explicitly an exploration of leadership, a large-scale study of healthcare commissioners and commissioning inequities reported feelings of

disempowerment due to inconsistencies, resistance and a lack of support from managers and organisations felt by those described as having greater skill and commitment to ethnic equity (including some who self-identified as minoritised) (Salway et al., 2016). Concerns about being perceived as unprofessional and operating out of self-interest were reported by those who challenged inequities. Frustration or exhaustion was expressed at repeatedly being a lone voice raising issues, particularly in organisational spaces which were often predominantly white. Redressing the lack of representation on their primarily white British middle class service user forum was considered by a commissioning group as beyond their remit, and instead provider organisations were heavily relied on to be accessible to all. Performance monitoring against this agenda seemed to be avoided in anticipation of complexity and/or resistance by provider organisations. Commissioners were found to assume a lack of data and evidence on ethnic healthcare inequities when in reality this was not the case (Salway et al., 2016). According to the authors, EDI staff who were well embedded at a senior grade seemed important and more effective than frontline staff trying to enable skills and commitment to develop across organisations as they considered that commissioners were often considerably more privileged than minority ethnic service users. Here the authors appear to disregard their own findings of senior racialised individuals struggling to be heard amidst the clamour of white voices and divest those white individuals of any responsibility to examine their own roles in commissioning inequities.

1.6.2.3. Leadership conceptualisations

Context was considered to heavily influence conceptualisations of leadership in a study by L.J. Gordon et al. (2015). Medical trainees talked about certain individuals being ‘naturally’ drawn to leadership and being charismatic or dominant while some expressed anxiety that they may not possess these qualities and therefore may not be the ‘right person’ to undertake leadership. It is, however, unclear where these divergences lie. Taking a social constructionist approach, themes were mapped onto leadership discourses found in the literature (individualist, contextual, relational and complexity discourses) (L. J. Gordon et al., 2015) and centred on issues of hierarchy, collective vs individualistic leadership and gender in leadership. Trainees talked about the complex interplay among individuals, relationships, and context,

which meant that they took up leadership or follow positions according to what they felt were needs of the immediate situation. That the researchers found complexity was the discourse least mapped to talk across the dataset is perhaps reflective of their epistemological approach to the analysis. A social constructionist stance can invalidate an individual's experience, as while one individual (person A) may perceive a need for and themselves as enacting leadership in a given situation, another individual (person B) may not perceive a need for or enactment of leadership in that situation. If leadership is not part of person B's social construct, person A's experience is invalidated and thus the complexity of a situation is missed. A critical realist epistemology may have produced different results (see 2.1.1.). They observe the preference for more unsophisticated ways of understanding leadership (such as behaviours, hierarchy and personality), and an individualist focus yet fail to explore this in the study. Instead, it is suggested that educational approaches, which emphasise leader–follower relationships and distributed leadership processes, are required to narrow the theory–practice gap. While this may be the case, without engaging trainees in self-reflection around their assumptions of leadership, an educational approach is unlikely to be effective.

1.6.3. Limitations of the literature reviewed

Leadership remains ill-defined. With most of the leadership literature comprised of opinion pieces (e.g., Collins et al., 2020; Cozijnsen et al., 2020; Hofmeyer & Taylor, 2021; the essay collection of M. McIntosh et al., 2019) and despite policy changes, leadership remains focused on an idealised and heroic version of leadership. Where empirical literature does exist, it is of mixed quality, at times raising ethical concerns (e.g., Monkhouse et al., 2018). It is unclear whether leaders have awareness of privilege and the barriers facing some leaders' ability to carry out their role or progress in their career as no studies reported demographics in sufficient detail. While supposedly aiming to increase access to training opportunities, the premise of training programmes (McCray et al., 2018; Monkhouse et al., 2018; Percival & Best, 2019) remains firmly for the benefit of those who are already privileged. The language used to report on them, is constructed for the 'white gaze' (Morrison, 1998) where it is implied that readers are white, further constructing racialised and marginalised individuals as needing solutions or help and a continuity of the colonial project (Abimbola,

2019). When it comes to exploring leadership in relation to privilege and discrimination the literature is vague not only in its definition of leadership but also in its examination of privilege and discrimination, how it operates and its impact (L. J. Gordon et al., 2015; Phillips & Norman, 2020; Salway et al., 2016). Where the experiences of racialised leaders begins to be explored, their voices are given limited space to be heard while white leaders deny evidence of, fail to recognise their ability and responsibility to address racism (Salway et al., 2016). With so much emphasis on 'inclusion' and leadership in policy, literature that truly reflects the complexity of the role in response to discrimination and explores who leadership benefits is needed.

1.6.3. Conclusion

In summary, in scoping over 7 papers, none explored CPs' experiences of leadership and responding to issues of privilege and discrimination. The studies provided some insight into leadership, specifically in relation to inequalities.

While the leadership literature is vast, it consists primarily of opinion pieces and quantitative studies which appear to be written from the position of leaders who belong within the dominant culture or group and do not appear to have an awareness of privilege. There was little qualitative research on the experiences of those in leadership positions and those that did explore leadership perspectives were whitewashed, anonymised almost to the extent of being a blank canvas. When the concept of power and inequality was explored within leadership literature, it tended to be narrow in focus and primarily centred on issues of organisational hierarchy and gender while omitting significant areas of discrimination such as racism. The literature reflects an idealised view of leadership reified in a socio-historically informed view of leadership. It does not reflect the reality of leadership in response to inequalities, how CPs can address this nor the impact on leaders, in particular those who may not identify as part of a dominant group.

1.7. Rationale for Current Study

In reviewing the current literature, given the challenges currently facing healthcare workers in the UK and the potential role CPs have to play, it is vital that leaders are able to respond to issues of privilege and discrimination.

Leadership is considered key to addressing issues of inequality (NHS Leadership Academy, 2019; West et al., 2017), yet there is no research in this area within clinical psychology. Given the impact of discrimination on staff, service users and communities it is crucial that the CP workforce is equipped and supported in the face of discrimination. Whilst the profession aims to improve access to training for minoritised and marginalised individuals, it must also ensure that the qualified workforce is a space that is equipped to support them when faced with issues of privilege and discrimination.

There is a gap in understanding how CPs in a position of leadership approach issues around privilege and discrimination. Their approach will be shaped by their own experiences of privilege and discrimination. They may experience barriers and facilitators to responding to issues around privilege and discrimination.

1.7.1. Aims and research questions

Following the concerns and gaps identified in the literature, this study aims to explore how CPs define their leadership style and approach to issues around privilege and discrimination. This is likely to highlight implications for leadership training and development in addition to subsequent outcomes of this in relation to staff retention and service user care.

The questions for this research study were identified as:

1. How do leaders define their leadership style and approach to issues around privilege and discrimination?
2. In what ways do leaders' personal identity (experiences of privilege and discrimination) influence their approach to leadership?
3. What are the barriers and facilitators for leaders of responding to issues around privilege and discrimination?

2. METHODOLOGY

This chapter outlines the philosophical foundations, ethical considerations and analytic approach within this research.

2.1. Philosophical Assumptions

Several philosophical assumptions underpin this research (Chamberlain, 2014), outlining them will show how the research has been shaped and enable the evaluation of the study objectives (Willig, 2013).

2.1.1. Ontology and epistemology

The branch of philosophical theory about what exists or can be considered real is referred to as ontology (Chamberlain, 2014). A realist ontology assumes a knowable world with truths waiting to be discovered (Braun & Clarke, 2022). A critical realist ontology allows for the notion that a singular reality independent of human practices does not exist (Braun & Clarke, 2022) and that reality can include not just the natural or biological world but also human meanings and emotions (Maxwell, 2012). This research is interested in the experience of individual leaders' reality which is shaped differently according to aspects of their identity by social, political and cultural contexts (Bhaskar, 2013). For the purpose of this study a CP's job plan is viewed as a concept which exists in reality. Leadership, as an explicit part of a CP's job plan, is performed within a social context and can therefore be understood to exist but it is recognised that its existence is dependent on our understanding of the concept and as a transitive reality bound up with human practices (Pilgrim, 2014).

A critical realist epistemology, referring to how knowledge is acquired and what constitutes knowledge (Braun & Clarke, 2022), was considered appropriate for this study and informed the adoption of inductive reflexive thematic analysis (TA) (Braun & Clarke, 2019) as a method of data analysis. Critical realism, as an ontological and epistemological stance assumes the existence of an external world or reality, but that experiences and knowledge of this reality are mediated by language, culture and time (Bhaskar, 1978). Therefore, the data collected provides a subjective account of reality and is neither a reflection nor a direct representation of reality (Willig, 2013).

Within a critical realist approach different social identities are allocated to people relating to their physical and other characteristics. Privilege and discrimination can be experienced because of particular social identity categories. A CP's reality, which is shaped differently for each individual CP by cultural, language and political contexts of social identities (Bhaskar, 1978; Willig, 2016), and within which they conduct leadership activities is the focus of

this research. The participants' approach to leadership, privilege and discrimination is considered true to their reality, e.g., the anxiety described by a participant due to witnessing discrimination. The participant's unique context and resultant lens is shaped by their experiences of privilege and discrimination. A critical realist approach aims to explore how CPs who see themselves as leaders approach issues of privilege and discrimination within various contexts (Vincent & O'Mahoney, 2018).

An awareness that both the participant and I are shaped by multiple dimensions of reality, and each may influence the other, is required throughout the research process (Willig, 2016). Historical, political and social contexts influence the varied experiences of each individual in a conversation about privilege and discrimination. While this study aims to examine participants' objective reality, adopting a critical realist position allows the acknowledgement that this may not be possible and may instead highlight my interpretations of leadership, privilege and discrimination (Willig, 2016). Within this position, it is possible to recognise multiple contexts, develop greater understanding and in-depth exploration of these concepts.

The potential impact of social processes on participant responses, such as social desirability, is recognised within a critical realist stance (Bergen & Labonté, 2020).

2.2. Design

2.2.1 Qualitative approach

Given the lack of accounts and perspectives on how different aspects of privilege and discrimination might influence how leaders respond to issues of inequality and the resulting explorative nature of this research, a qualitative method was deemed most appropriate. Interviews were considered a more appropriate approach than others such as survey data and focus groups. Both personal experience and the literature indicated that discussion of privilege and discrimination in group settings (Lowe, 2014) could be a challenging forum in which to elicit responses with sufficient depth. Focus groups allow meaning making through discussion (Breen, 2006; Smithson, 2007), and would therefore not be appropriate in answering the research questions related to individuals'

approaches to leadership. Furthermore, given the emphasis on personal identity, privilege and discrimination, facilitating mixed groups of participants could result in the creation of discriminatory experiences more easily contained in individual interviews. Individual semi-structured interviews could explore the research question related to the influence of personal identity with greater curiosity and openness.

The study aimed to recruit approximately 12 participants in order to collect data which could offer sufficient breadth and depth for qualitative analysis (Malterud et al., 2015).

2.2.2. Reflexivity

The chosen epistemological position highlights the importance of reflexivity, the consideration that the impact of my own position and context on the research and any 'knowledge' produced is unavoidable (Nightingale & Cromby, 1999; Willig, 2013). Both the researcher and the research are considered to mutually shape one another and thus the continual consideration of the researcher's position is required (Attia & Edge, 2017).

My early experiences growing up in rural Ireland were heavily shaped by the seemingly indomitable and unquestionable authority of the Catholic church. Leaders within the church were highly influential across all aspects of society and cultivated power through a culture of compliance and silence. Subsequent revelations about abuses and collusion to conceal them for many years led me to begin to question authority, leadership and the roles and responsibilities of people in positions of power. Later, the invitation to take on a leadership role as a Psychological Wellbeing Practitioner in an Improving Access to Psychological Therapies (IAPT) service felt at odds with my level of training and seniority. At the same time, I observed divergent leadership discourses both within the service concerning the nature of the work, and about the service and the potential threat it posed to professions such as CP. This led me to wonder about the role of psychologists in shaping discourses and their position in the delivery of services as well as local and national agendas.

I am a white Irish woman who migrated alone to the UK as an adult. My understanding of the breadth and depth of inequalities, including a sense of the intangible nature of experiences of discrimination and its effects, has been

informed by my knowledge and experiences of the legacy of colonialism in Ireland and while living and raising a family outside my country of origin.

Navigating academia and a career in psychology without generational experience or access to social networks, I noticed the difference that others who either had access to or were in a position of greater influence could make to my life when they shared their privilege. I also noticed how it felt when those in positions of privilege and influence seemed unaware or unwilling to think about the differences in our positions.

I am grateful for conversations with my peers, university tutors and thesis supervisor which have been hugely helpful in developing my awareness, thinking, and understanding around issues of privilege and discrimination with regard in particular to that which I do not have personal experience of. Throughout the research, the use of supervision and a reflective journal were of particular benefit to my reflexivity where differences around race for example, had the potential to evoke strong reactions for both participants and I. Chapter 4 explores this further.

As a psychologist, I am interested in challenging the profession to examine itself and develop greater insight into issues surrounding CP leadership and responses to issues of privilege and discrimination in the wider contexts of CP roles.

2.3. Participants

2.3.1. Inclusion criteria

Individuals who were:

- Qualified as a CP
- Working in UK settings
- English speaking
- Self-identified as being in a leadership position

2.3.2. Recruitment

Social media platforms e.g., Twitter, Facebook and LinkedIn (Appendix 1: Recruitment poster) were used to advertise the research. Using convenience sampling of the researcher’s existing network and a snowball approach, where

participants were encouraged to share the study with other potential participants, participants were recruited. Interviews were conducted online, placing no restrictions on location of participants for conducting interviews.

Interested participants contacted me by email or private message and were provided with the participant information sheet (Appendix 2) with the full study details. Participants were invited to ask any questions they may have had.

Most individuals who expressed interest opted in to the study. Other than availability, no other reasons were given for choosing not to take part.

Twelve individuals participated in the study. Each participant completed a demographics (Appendix 3) and consent (Appendix 4) form prior to interview. The use of self-identification (e.g., ethnicity) aimed to reduce the possibility of participants feeling external restrictions were being placed on their identity. See Table 2 for further details (section 3.1.).

Participants were all considered to have capacity to consent to taking part.

2.4. Ethical Considerations

2.4.1. Ethical approval

Ethical approval (Appendix 5 and 6) was granted by the University of East London's (UEL) School of Psychology Research Ethics Committee.

The professional code of human research ethics (BPS, 2014) was used to guide ethical considerations. All elements of the study were given ethical approval by UEL prior to the collection of data.

2.4.2 Informed consent and confidentiality

Potential participants were provided with an information sheet outlining full details of the study, including research aims, what participation would involve, right to withdraw without consequence, an explanation of potential risks and how their data would be used and stored prior to consenting to taking part. Participants also had the opportunity to request information or ask me or the research supervisor questions before providing consent to participate, as well as during and following interviews. Before the interview started, consent was confirmed, and participants were reminded of their right to withdraw without reason at any point up until one week after the interview.

Confidentiality was ensured by storing participant names, contact details and consent forms securely and separately from video-recordings and transcriptions. Signed consent forms emailed to the researcher were saved securely and then deleted from my email account. Video-recordings were stored on UEL OneDrive on a password-protected account and deleted after transcriptions were finalised. Initial transcriptions were auto created but contained many errors requiring correction. All identifiable information (e.g., names of places/people) was removed. Only the research supervisor, examiners and I had access to the anonymised transcriptions. NVivo (12) software was used for analysis of anonymised transcriptions. Transcriptions and other anonymised data which may be required for publication/dissemination will be securely stored by the research supervisor for three years after which they will be deleted. A full data management plan was developed and approved by the Research Data Management Officer within UEL.

2.4.3 Minimising harm

Participants were asked to talk about leadership, in addition to their own experiences of privilege and discrimination. The potential for participants to find this distressing was considered and discussed with participants prior to consenting.

Participants were informed that they need only share what they feel comfortable with, could take breaks, pass on questions, or choose to end the interview at any point. Reflexive questioning within the interview was used to monitor how the participant was experiencing the process. No interviews were terminated due to reported or visible distress.

Participants were offered space at the end of the interview to debrief and talk about their experience of the process (see 4.1.4.) in addition to provision of written debrief information (Appendix 7) about support and networking organisations.

One participant requested a section of their interview be removed from the transcript out of concern it would not be possible to ensure their anonymity and potential repercussions. They did not wish to withdraw entirely. A copy of their transcript was sent to them as assurance that their wishes were maintained,

and they were satisfied with this. One participant chose to have their camera off for the majority of the interview and this was accommodated.

Neither the research supervisor nor I received any subsequent communication from any participants, thus it is indicated that the interviews did not trigger any complaints or other feedback. Participants may have experienced distress and used the signposting information from the debrief sheet. However the research supervisor and I were not aware of any participant distress.

2.4.4 Remuneration

In place of payment, participants were given a £10 voucher for BookLove as a token of appreciation of people's time, contribution, and respect for their willingness to share potentially difficult personal experiences.

2.5. Procedure

2.5.1. Interview schedule and pilot interview

Informed by Patel & Keval (2018) and the wider literature base, the interview schedule was designed to explore participants' approaches across any aspects of their leadership roles (clinically, within teams, and at policy level). A pilot interview using a draft interview schedule with one CP was used to establish whether the interview questions were clear and appropriate. Subsequently, several changes were made to the interview schedule. The feedback from this interview, alongside discussion in supervision, consultation with an Expert by Experience and university tutor, informed the final interview structure. It was advised that there were too many questions which were unlikely to provide the depth of data necessary to answer the research questions. For example, 'Do the circumstances in which the issue of privilege and discrimination arise, influence your response as a leader?' was changed to 'When you face a situation/issue relating to privilege/discrimination, what enables you to respond (or gets in the way of responding)?'.

A semi-structured format was used for the final interview schedule, including probing and follow up questions to allow for further clarification of points or exploration of participants' experiences (Appendix 8).

2.5.2. Recruitment

Recruitment was open for two months. Convenience and snowball sampling were used to recruit participants (see 2.3.2.).

2.5.3 Demographic information

As outlined in 2.2.1., the research was a qualitative exploration of the experiences of leaders and how this related to their own experiences of and responses to privilege and discrimination. In line with a critical realist epistemology and in order to locate participants' experiences and responses to privilege and discrimination, participants were asked to complete a demography form to allow consideration of participants' contexts while still maintaining their anonymity. Participants were requested to complete demographic information before the start of the interview (Appendix 3).

2.5.4. Interviews

Video conferencing using Microsoft Teams was used to conduct and record all interviews. Online approaches closely mimic the interactive features of more traditional face-to-face spoken interviews in that they provide real-time interaction between the researcher and participant, including visual interaction (Braun et al., 2017) essential to building rapport with participants (Silverman, 2013). They also offer greater flexibility in terms of recruiting participants from across a wider geographical area than the vicinity of a London based researcher and to those who may be restricted due to health, mobility, or time constraints (Horrell et al., 2015).

The information sheet and consent form (Appendix 2 and 4) were reviewed at the beginning of the interview and participants were offered a chance to ask questions (as per 2.4.2.). Participants were again offered the opportunity to ask questions at the end of the interview before the researcher offered a verbal debrief. The debrief form was emailed to the participants after the interview. All interviews lasted between 50 to 80 minutes.

One participant chose to have their camera off for most of the interview.

Memos were written following each interview and an extract is provided for transparency (Appendix 9).

2.5.5 Transcription

Auto transcription on Microsoft Teams transcribed the audio from each video recording. This was downloaded as a Word document. I compared auto-transcriptions back to the recordings, ensuring increased familiarity with the data set as part of the initial data analysis (Braun & Clark, 2006) as well as checking for accuracy. Transcription notations (Appendix 10) were adapted from (Banister et al., 1994), punctuated for readability and pauses of more than one second. Potentially identifying details such as geographical locations or names were replaced with words within [ ].

2.6. Analytic Approach

2.6.1 Rationale for thematic analysis

In line with the purpose of the project, the research questions, and a critical realist epistemological stance (Braun & Clarke, 2021c; Willig, 2013), inductive reflexive thematic analysis was chosen, as the questions focus on patterns of meaning across the personal experiences of participants (Braun & Clarke, 2021c). The subjectivity of the researcher is acknowledged in this approach as key when generating codes. The results are situated within a wider context as themes are developed from these codes using an analytical and reflexive approach (Braun & Clarke, 2021c).

According to Braun & Clarke's (2006, 2021) guide to TA, data analysis can be delineated into six distinctive and recursive processes. While this was an iterative and reflexive process linked to the six phases, it is presented in a linear format below for ease.

1. Familiarisation with the data: As I collected the data myself, I began an initial familiarisation with the data during the interview process, made initial notes regarding points of interest and initial reflections. This continued during the transcription, reading and re-reading of interviews and coded excerpts.
2. Initial code generation: Initial codes were generated within the dataset to highlight, sort and cluster areas of interest (Braun & Clarke, 2006). Codes were descriptive and interpretive (see Appendix 11 and 12 for samples).

3. Searching for themes: On further analysis early codes were re-coded, reorganised and grouped together where initial broader themes or sub-themes were identified. Themes represent “patterns of shared meaning, united by a central concept” between the codes and contribute in some way to answering the research questions (Braun & Clarke, 2021, p.341). The use of thematic or code maps and tables helped me to identify patterns (See Appendix 13 for example).
4. Reviewing themes: I repeatedly reviewed, reworked and refined themes, reading and re-reading data extracts to check for coherency. Themes were checked against the entire dataset to ensure they reflected the data collected.
5. Defining and naming themes: The definition of themes was supported by creating a narrative for each theme, and refinements included checking that the themes answered the research questions and presented a coherent story. To ensure themes were grounded in the data as well as my interpretations, attempts were made to use participants’ words and provide concise names for themes. The recursive process led to discarding some themes, the reworking of themes, including merging less-distinctive sub-themes and re-grouping of extracts to fit better with certain themes. The final thematic map can be found in Section 3.2.
6. Producing the report: The Discussion (see 4.) provides a thorough account of the analysis with the aim of describing the data gathered in response to the research questions and supported by extracts to illustrate.

2.8. Evaluating the Research Quality

To evaluate the research quality, Yardley’s (2000) criteria have been used. The Discussion (see 4.) provides an evaluation according to the research sensitivity to context, commitment and rigor, transparency, and coherence, as well as impact and importance.

3. RESULTS

This chapter presents one overarching theme, three discrete themes and eight relevant subthemes constructed through analysis of interview data. The themes are described using selected extracts from the participants' interviews.

3.1. Participant Demographics

Twelve participants took part in the study. Participant demographics are presented in Table 2.

Table 2. Participant demographics

Demographics	***N***	***%***
Age		
30-39	3	25
40-49	5	42
50-59	3	25
Prefer not to say	1	8
Gender		
Female	9	75
Male	3	25
Ethnicity		
White	9	75
Racialised	3	25
Language other than English		
Yes	4	33
No	8	66
Sexual orientation		
Heterosexual	9	75
Prefer not to say/ not answered	2	16
LGBTQ+	1	8
Disability		
Yes	2	16
No	9	75
Not answered	1	8
Dependents		
Yes	8	66

No	4	33
Socioeconomic background*		
Middle class	9	75
Working class	2	16
Prefer not to say/other	2	16
Spiritual/religious		
Yes	4	33
No	7	58
Prefer not to say	1	8
Belong to religious group		
Yes	3	25
No	9	75
Years since qualifying		
0-10	4	33
10-20	4	33
20-30	4	33
Leadership role		
Formal leadership	8	66
Informal leadership	2	16
Prefer not to say/other	2	16
Leadership training*		
Yes	8	66
No	4	33

*Numbers total greater than 12 due to overlap (e.g., some participants reported a working class background but now consider themselves middle class)

** Leadership training included NHS leadership academy and Trust specific courses (5), MSc organisational psychology (1), and other courses (3)

3.2. Themes

The overarching theme, three major themes and eight related sub-themes generated from the data to address the research questions are displayed in Table 3. A thematic table including participant contributions is shown in Appendix 14.

Table 3. Thematic Map of Study

Overarching Theme: We have been talking about this for 20 years	
Major Theme	**Sub-themes**
Theme 1: Personal risks and challenges	1. Challenging discrimination gets me "enemies"
	2. It's "about the relationships involved"
Theme 2: Fitting the leadership mould	1. "Clinical psychology is no different"
	2. A kind of a fringe position, a bit of a maverick
	3. Leadership culture stops you challenging
Theme 3: Leadership roles and responsibilities	1. "People doing the same job and the parity is different"
	2. Using the position of leadership
	3. You can't split the personal and the professional narrative

3.2.1. Overarching Theme: We have been talking about this for 20 years

Participants talked about the overall context of the hierarchical structure of services, a lack of service policies and their own personal journeys of becoming more aware of discrimination. Despite their efforts to challenge discrimination and its reinforcing structures, participants expressed their frustration that little has changed and for many, it never ends.

Participants talked about how the hierarchical nature of services can make it feel difficult to challenge discrimination. Where participants were faced with challenging individuals more senior to them, hierarchy was perceived as a barrier to responding due to concerns about potential repercussions:

> P4: "*if you had … a positive working relationship with somebody in seniority to you and you felt like you needed to challenge something that they had done or said… I think it is very difficult.*"

Participants suggested policies and processes do not incentivise individuals to examine their own position in relation to privilege and discrimination:

> P4: "*you can't be given any kind of bonus. You can't be penalised or … well it could be performance managed, but... the type of questions you're asking me would never be asked of an NHS leader or manager. Our appraisals are poor.*"

Others noted that protocols and policies to address discrimination alone are not necessarily helpful as, in the absence of serious repercussions to their actions, people will always find ways not to follow such directives and the people it was intended to be helpful to do not benefit:

> P6: "*Like being directive or authoritative and trying to make people do things that they don't want to do, there's just infinite ways for people to just not do things that they don't want to do"*

> P8: "*people start doing it as a tick box thing… it doesn't become useful to the people who it's meant to be useful to*"

The timing of a response, trying to initiate a discussion or intervention was discussed by several participants. Some talked about the events that sparked their own awareness, while others suggested needing to wait for people to be ready to have conversations about discrimination and to use that window of opportunity to bring about change such as the period following the murder of George Floyd:

> P6: *I have probably gone on a journey … in relation to the Black Lives Matter movement*

P5: "*identifying where is there a wave building that then you can sort of use to kind of push something forward a bit*."

Others spoke with a sense of frustration that a person had to be murdered for people to be willing to have more open conversations about racism:

P12: "*it's almost like someone has to die like George Floyd before people will talk about certain things. <Mhmm> But why does it have to get that bad?"*

Moreover, one participant shared their frustration with attempts to challenge discrimination and having these conversations for almost two decades:

P3: "*one of the things that really annoys me is that, um, I worked in training like, fifteen, twenty years ago, and we were having these same conversations then, and I just sort of think for goodness sake why, we're still here. It's ridiculous.*"

One participant suggested that, while the profession is meant to encourage self-reflection many psychologists remain unaware of themselves:

P2: "*clinical psychologists are people like anyone else, aren't they? …a profession that is supposed to be thinking about reflecting on yourself and what you bring to the role and the profession, is still being so blind to prejudice and privilege*."

3.2.2. Theme 1: Personal Risks & Challenges

When it came to challenging issues of privilege and discrimination, leaders spoke of repercussions of challenging discrimination on themselves, in terms of the toll of their own personal experiences of discrimination and effects on their relationships with others.

3.2.2.1 Challenging discrimination gets me "enemies"

Participants talked about how their attempts to challenge discrimination can lead to adversarial circumstances:

P10: "*that does get me [laughs] some enemies 'cause some people don't like that*"

Another participant talked about finding it easier to discuss discrimination with strangers online:

> P12: "*social media, Twitter and LinkedIn and so on. And to get involved in research and things makes it easier to confront certain things*"

One participant stated that their attempts to challenge discrimination had potential serious implications for their work:

> P1: "*[organisation] had a meeting about where they talked about blacklisting me*"

While others worried about consequences of challenging discrimination for themselves and their relationships with others:

> P4: "*the biggest barrier for most people is, uhm, worrying about the consequences for maybe themselves, their working relationships with that person maybe getting inadvertently getting something wrong"*

One participant described how their decision not to renew a contract for a member of staff due to their discriminatory behaviour "*led to an almighty backlash*" (P5) for them in their role.

Several participants spoke about leaving their jobs or knowing others who left jobs due to their experiences of trying to challenge discrimination:

> P12: "*people were off sick a lot and people left a lot, a lot of turnover*."

> P2: "*I'm not hanging about then. <Mhmm> I will go. And I did, and it was probably, it was the best thing that I did, but it was really sad that I had to do that*."

> P7: "*well it was so bad that I quit a job that you know, otherwise I liked*."

Participants talked about weighing up the potential risks of staying and potential impact on their health and wellbeing:

> P9: "*The are some things that you pick and choose. Is it worth fighting for? At what costs? Your health? Your wellbeing? <Mhmm> Life?"*

One participant began to describe the emotional impact of challenging discrimination by expressing disappointment, but feeling that this word did not do justice to how they felt:

P2: "*I can use the word is disappointing, but it's obviously more than disappointing, but I can't think of any other word to use*."

Several participants also talked about having to make uncomfortable choices about what to challenge and weighing up whether their action would make a difference or even potentially mean they could lose an opportunity to be part of a conversation at a later time:

P5: "*You know that the cost to you would be, you know, it just means it's not worthwhile. You wouldn't be listened to, and actually, then you would not have the opportunity to be part of the conversation, so you know and that's what's felt most uncomfortable, I suppose.*"

P9: "*which ones can I let go of and which ones can I fight…. Yeah it's hard."*

In the face of trying to challenge discrimination participants described how their awareness of the immensity of the problem within systems meant they feel as though their agency is removed and they are instead undermined and entirely subject to the will of their organisation:

P5: *"I suppose that sense of kind of powerlessness and helplessness, I suppose…you know that actually your, there's a system here that can do what it likes with you and you don't necessarily have any control over that, and that is fundamentally a really destabilising way of relating to a kind of organisation or a system*."

When the most powerful positions in the organisation are occupied by people of certain backgrounds who will want to protect their privilege, as in most organisations in the UK, participants did not have hope for any change:

P9: "*Ultimately, NHS Trusts will protect, they'll protect leaders, you know, leaders up top. <Mhmm> Uh leaders who are in, you know from a different background to myself and I just thought, is there any really point in this?"*

For one participant, claiming their marginalised identity made them feel empowered. However this power was also felt to come with the risk of other people perceiving them with distrust:

> P1: "*You kind of get a power. You get listened to, so it's double edged, but you can also, uhm? Probably, people are wary of you, as well*"

Potential costs to relationships were considered both in relation to the person being challenged, as well as individuals directly impacted by discrimination, and whether at times too much consideration for the person being challenged was given:

> P11: "*But then as my colleague talked … she said, but by not saying anything it makes me feel uncomfortable because you haven't considered my comfort over there. And I thought, oh yes, you're right. I've been privileging the wrong person's comfort*."

3.2.2.2 It's "about the relationships involved"

This subtheme reflects participants' ideas around the utility of existing leadership models, the importance of context, psychological safety and compassion as foundations for challenging issues of privilege and discrimination. Participants spoke about leadership in terms of their own personal and professional development as well as its importance for the development of employees as individuals and their relationships with one another.

Several leaders spoke about how existing models and frameworks of leadership do not capture their experiences of leadership:

> P4: "*you can write and read about leadership in this context, but it doesn't quite always feel like that when you're doing it. [laughs]*"

Leadership models were not considered to capture the dynamic process of individuals acting according to their own values and in response to others':

> P9: "*you develop your own in line with your own personal values, your own views, your own teams that you're working in*."

Participants talked about creating a context of psychological safety for others as being a key consideration in opening up conversations about discrimination:

P3: "*models of creating curiosity and questioning and that people were able to do that in safe space so that people … don't feel like they're going to be criticised for it, that we actually actively welcome that*."

P8: "*if something gets missed or they don't like something that they're able to open a conversation about it … difference of ideas and, uhm, difference of opinions, difference of experience are all safe to discuss hopefully*."

Participants also valued having separate spaces for themselves where they could have conversations about privilege and discrimination free of a sense of judgement to be able to practice talking about discrimination:

P11: "*I sort of have this peer group, peer supervision group, which I think is really helpful. It's just a place to unpack a little bit and to have permission to not get it right and to sort of be still working it out… if you think you have to get it right, you'll never get started, so it's a bit about, yeah, how do I fumble through and how do I keep fumbling through? And how do I keep doing it?"*

P5: "*having colleagues who I've been able to almost kind of rehearse those conversations with … it enables you to go into more public sort of settings and have those conversations. Having an idea in your head of this, I understand how I can talk about this in a way that feels safe.*"

Others felt that speaking out about discrimination has always been part of them and their identity that they have carried through with them to how they are as leaders:

P9: "*I think I've just done it. I think it just, being the brown female and you're, it's always on your lens. It's never not to there. <Mhmm> It's always there. I think a [religion] you're an activist anyway, because that's what the religion has come from, fighting for justice so, it's part of me, as in the style of leadership that I've always had like, talking about, yeah, stuff that's really important and you know leadership, oppression, discrimination, racism, sexism, all isms. That's important*."

In relation to themselves, some participants spoke of concern about how they would be perceived by others if their response to discrimination was considered wrong or clumsy:

> P3: "*being really honest, I think there are times when I think I'm as a white person, I'm scared that I might say it, get it wrong that I might if I ask something or say something that it might be, it might come across in a way that I don't intend it to... can I ask that? Is that OK? Do I want, does this person want to have this conversation with me or not?"*

It was felt that in a leadership role this needed particular consideration under the sense of pressure to do things well:

> P5: "*There is a fear of you know being tripped up saying the wrong thing inadvertently offending people, and I think that is one of the things that stops us having those conversations and talking about those things, I think I certainly recognise that in myself"*

In further efforts to mitigate these concerns, many participants spoke of how they found developing good relationships with people and being gentle in their approach to conversations to be an important foundation:

> P11: *"it is often about the relationships involved*"

> P3: "*you have to, you have to have that warm, collaborative relationship to start with. Otherwise…that's not going to work is it*."

> P10: "*Because I have quite a good relationship with them, they'll accept it from me. But when another member of my team or a colleague that I work with does it he won't accept it. So I know that I have to make sure that I'm not sick or away…I have got the ability to go look, this is having a psychological impact what you do"*

Developing relationships with people was also seen by some participants as a useful way of deepening interest in and broadening their own understanding of experiences of discrimination they did not have:

> P5: "*having the opportunity to get to know people in that sort of setting, you know, just gave me an insight and gave me a, uh, a wish to kind of look at that as an issue and to speak about that as an issue that I don't*

think I would have had otherwise. I think it's only once you really get to know people closely that that sort of rings true to you in a way"

While others acknowledged that their privilege might get in the way of developing relationships:

> P4: "*people can't probably don't feel like they can be honest because there's a power imbalance there."*

Furthermore, it was considered important to support staff in their ability to interact with one another around discrimination as staff experiences were considered to have an impact on service user experiences:

> P3: "*you can't work effectively with people if your staff are not well looked after*"

Where the discriminatory behaviour of one team member was challenged, a participant talked about how this seemed to have a ripple effect across a team. They described how, previously people had refused to work with an individual and there was high staff turnover and the team was now experiencing a better retention rate:

> P10: "*that team had a really high recruitment issue originally before I joined and I've been there for four years now and we've not lost a member of staff in four years, three years. <Mhmm> Which is good going when we were losing, like people would refuse to work in that team because of this member of staff. And so I guess I've asked what's different and we were talking about it the other day 'cause I was thinking about this with somebody that was on, very close to leaving, and they were going, you've changed him. And I'm like, I haven't really, and they're like, but because I called that out, it creates change*."

However experiences of discrimination also meant it felt difficult for some participants to build and maintain necessary relationships:

> P5: *"I think it made it difficult to have relationships with some of these people 'cause I needed to build relationships with them actually 'cause that was the only way to turn this around. But you know, knowing that they had been saying these venomous things about me behind my back*

and kind of treating me as if I was just a kind of object to be cast about, you know that's hard, and not an easy thing to do."

3.2.3. Theme 2: Fitting the leadership mould

In this main theme, participants talked about how the problem of discrimination in CP is no different to other professions or may even be worse. People who are white and do not challenge discrimination were considered more likely to be accepted as leaders in a culture where politeness is more highly valued.

3.2.3.1. "Clinical psychology is no different"

Participants described how the "*constant kind of juggle of competing demands*" (P7) to contend with made it difficult to give their attention to thoughtfully addressing privilege and discrimination:

> P9: "*So you end up, you know, working mindlessly*"
>
> P8: "*there's a lot of doing, much less reflection and time to think … it's nice to think about it, but I'm sorry you're getting it a little bit undigested*"

Some participants talked about how increasing the number of people of differing backgrounds might mean it would be easier to bring about change, as "*then you can have those people really driving the change*" (P2). Some participants said that people who have experienced discrimination are better placed to speak out as they can bring their lived experience which would be more impactful than naming something as discriminatory:

> P4: *"the most powerful thing that anybody could do is to explain, rather than me saying that I think something is inappropriate. If I, if there was some example that could be drawn on that you know, would, I feel that would be more, more powerful or more impactful*."

It was felt, however, that CP, when compared with other professions is not doing as well to recruit people from a wide range of backgrounds:

> P4: "*the diversity that I see when I attend meetings. It's still not within my own profession."*

Others spoke of their own personal experience of meeting people with a variety of backgrounds, including some experiences of reciprocal mentoring

programmes which helped them to remain aware of the challenges other people may experience but may not have experienced themselves:

> P6: "*being part of the dominant culture I'm just so oblivious to the cultural communication difficulties that might be going on for people from other cultures like it's very hard even when you're trying to have a consciousness of that to even be aware of such that some of the issues that might be going on when you just haven't had very much experience of feeling othered, being othered*"

Furthermore, one participant expressed concern that CPs are not aware of their own privilege:

> P2: "*some people in the team who were just like, well, I don't think I'm really privileged at all and you're just like, Oh my God. [laughs] Like, you're a white male. You literally couldn't be any more privileged. Just complete, head in the sand like, just no idea whatsoever. But some of these people, you just wonder if they should even be clinical psychologists"*

Despite living in diverse local communities where their colleagues should come into contact with people of a variety of backgrounds, one participant noted this variety of backgrounds did not appear to impact on the makeup of staff working in services. Nor did their colleagues appear to have developed a greater awareness, understanding or willingness to listen and acknowledge their own bias and racism:

> P2: "*I live in [place] which is almost 50% Black and ethnic minority, like non white British people of colour in this population here…Why is it that there aren't many people of different backgrounds in these senior positions? Uhm? And I used to ask those questions. Still do ask those questions. And I remember just getting a lot of really just pained expressions. And not really any, [laughs] not really any answers, but a complete denial about the fact that there might be system, a systematic and unconscious bias and racism. A complete, complete denial. Uhm, when I raised that, and I would raise that, and I do still raise it and people are still uncomfortable."*

Access to published evidence and knowledge about racism meant that participants felt they were more likely to be listened to when they spoke up about racism, instead of being dismissed as being emotional when they tried to share their stories and experiences of racism:

> P11: "*And I think not having the language it makes it and not having the research makes it really hard to not just sound angry and passionate and emotional, and I think again, British culture is not to be ru-, not to be passionate, to be dispassionate <Mhmm> and objective and kind of clinical. So unless you've got the research and the language to back it and then the allies you just don't even bother because you just sound like you're yeah, mad, angry whatever*."

> P2: "*the snowy white peaks document was a bit of a revelation as well, just in the fact that it actually backed it all up with statistics. Uhm? And it was something that people couldn't wriggle away from. <Mhmm> Because it was there, clear, that this was happening. And that psychology, clinical psychology was no different*."

3.2.3.2. A kind of a fringe position, a bit of a maverick

Many participants talked about their own and others' perceptions of what leaders should and should not do, as well as who a good leader is. Talking about privilege and discrimination in psychological theories and models and the workforce, while becoming more commonplace, was experienced as something that was seen as radical and a potentially extreme view at odds with evidence-based practice:

> P5: "W*e're a very white middle class profession, but we don't really kind of acknowledge that, or talk about that. I think that is, that there's some change in that, but certainly you know five years ago and still now in some quarters, you know the idea that our theories and models are built around a very particular way of seeing the world that comes from a very particular cultural group essentially, that would be seen as a kind of fringe or marginal position and a bit maverick, and a bit strange, and you know not to get in the way of getting on and doing CBT"*

One participant talked about being perceived as incompetent by others for attempting to lead in a more collaborative, less hierarchical way where knowledge of every kind was valued:

> P10: "*I've demonstrated leadership from a not knowing stance, not a knowing stance so that therefore means that I can quite often appear like I'm maybe somebody that doesn't get it 'cause I'm trying to not know it… And therefore it can make me sometimes maybe be perceived as a bit incompetent by somebody that would expect me to know something when I probably do know it, but I'm wanting to reinforce that other people know this stuff*."

There was a sense that the use of certain words such as 'racist', while possible among family, they are less acceptable at work and could potentially be considered unprofessional and provocative:

> P4: "*You're not feeling that you are wearing some sort of professional hat where you need to maintain a respectful boundary with people. Maybe in your family you just feel little bit more disinhibited and more able just to tell someone to shut up if they're saying something that you think is sexist or racist. And being able to, feeling more able to use words like that, that yeah, that feel quite inflammatory themselves, but accurate, but being, but feeling like you're able to speak more openly maybe*."

Several participants said their "*professional boundaries were …questioned*" (P1) for challenging discrimination, while another participant described how they were told they were exaggerating the work that they were doing to advocate on behalf of their clients for their own personal gain:

> P7: *"weekly meetings with commissioners and actually I was talking to them more often than that. Uhm, and when I was saying this to the managers who are making a decision about the role, they basically said to me, well, you're, you know promoting your role to or you're… exaggerating the responsibility that you hold to ensure that you get this grading*"

Participants talked about how their work to challenge discrimination is not understood by their senior colleagues, nor is it valued as part of their leadership role:

> P7: "*I definitely didn't have any sort of power or voice, and I think the people who did were more senior managers and leaders, were two white men who didn't really understand, three white men, so I think didn't understand the work that we did and didn't value it*"

Instead, participants felt that challenging discrimination is something viewed by their organisations as going above and beyond the minimum job requirements, suggesting it is not considered integral to their work:

> *P7: "all of this work is on top of my day job, which is complicated enough*."

Given the lack of understanding and interest perceived from more senior leaders, it was queried whether the same requirements aimed to address discriminatory recruitment procedures such as having greater diversity on recruitment panels are applied to the recruitment of senior leaders:

> P4: *"we have a requirement to have somebody from ethnic, an ethnic minority at every panel. Well, did they do that here in the hospital when they employed the new chief executive? Who's on the panel? Who's making the decisions? … how are we recruiting people to the most senior roles? How are we ensuring that this is sort of coming from the top down as well?"*

3.2.3.3. Leadership culture stops you challenging

Participants talked about the ways in which they experienced the gatekeeping of leadership through the application of the English culture of politeness:

> P5: *"A polite English way of not letting other people in"*

This politeness, was described as a means to end a conversation among very senior NHS leaders about racism in the workforce and instead direct the conversation to a different topic which meant that the conversation got stuck:

> P5: "*having a conversation with my group of kind of 8d leads about what were we going to do about, you know about race, racial equality in our workforce…and I thought that we should … get together a kind of project to look at this particularly. And there was, you know, polite rejection of that idea. People steered the conversation back to, men on training courses or… we can't just think about one sort of difference, you have to think about all of them in a way that sort of paralysed the whole conversation*."

When talking about their experience of discrimination as a supervisor, one participant spoke about how their feedback did not matter, they were not part of conversations and information about their trainee was not shared with them and that this lack of response is part of a culture of maintaining discrimination:

> P12: *"the trainees I'd supervise it just, they didn't need to listen to me, that's how it felt. And then what I said to the course didn't matter. I wasn't even privy to like end of placement document, so, like these sort of things, I think are absolutely awful, but uhm there's a very British, I think there's a very British thing of just this silence, like not responding, actually*."

Several participants thought modelling vulnerability was meaningful in terms of supporting others to learn to respond to discrimination and tolerate the discomfort individuals may feel while having conversations about discrimination:

> P8: "*I'm in a position of power, so therefore it's easy for me to make myself vulnerable in a certain way, but still make it safe for them and model that the kind of it's OK to not know and model that this feels uncomfortable and painful but we're still gonna do it anyway?"*

Participants also talked about needing to be careful in their role not to appear too vulnerable as this may make employees feel it is difficult to share their problems:

> P8: "*sharing a bit about myself so people don't experience me as a bit of a robot, but also keeping at, making sure that what I do share is digested and safe enough so that the people I'm working with don't then think that I'm too vulnerable that they can't bring anything to me*"

Creating a culture of leading with compassion, not just kindness, but being aware and willing to do something to support someone's difficulties was talked about as creating necessary conditions in which to challenge and be challenged, despite challenges potentially being an uncomfortable experience for all parties.

> P9: *"So everybody tends to think, actually compassion is the same as kindness, it isn't. Compassionate is about the awareness that there are difficulties and the willingness to do something about them, you know, and sometimes that's difficult in leadership, because actually ultimately somewhere along the line sometimes decisions are made, you like to be, involve everybody, well sometimes there could be variance in agendas. So there will be, you know, ruptures in people's minds."*

3.2.4 Theme 3: Leadership roles and responsibilities

For some participants, taking up a leadership position came with a sense of power and authority while others experienced a battle to be given a leadership position and a continued need to fight through their experiences of discrimination while carrying out their leadership role. There were divergent experiences and perspectives on the limits of and how to use a leadership role. Participants talked about the need to integrate the personal and the professional in order to be authentic leaders.

3.2.4.1. People doing the same job and the parity is different

Participants talked about divergent experiences and perceptions in terms of their progression into leadership roles, and the factors that affected their ability to carry out their role.

For some, leadership was something they assumed would be part of their role and felt comfortable with:

> P11: "*just feeling like I belonged in that position*"

> P7: "*I never really questioned it. It was something that I always wanted"*

Participants suggested that having leadership role models in family members inspired them on their journey to leadership, while for others drawing on feminist discourses around gender equality, formal and informal learning helped build their confidence in their ability to take on a leadership role:

P7: *“having those sorts of role models in my family, who, people who were taking leadership positions in public service I guess, yeah, was sort of inspirational to a degree… I have had lots of opportunities to be in those sorts of positions… even sports teams or you know, things at school or at university”*

P6: “*I have a masters in organisational psychology… and then the ideas I get … a lot of sort of Brené Brown stuff around leadership”*

P3: “*Probably just my feminism, I guess. [laughs] A fundamental feminism, which I know is supposedly old-fashioned these days. But you know, I grew up when feminism was really important, and you know, equality, uhm, and being heard as a woman. So I think I've just sort of had that burning kind of value of, I'm a woman, and I deserve to have as big a voice as a man.”*

Some participants suggested that those in leadership positions are less likely to experience discrimination than those in clinical or more junior roles:

P3: “*I've seen it more in terms of supervising people’s clinical work or supervising supervisors and then discussing dilemmas around that*”

P6: “*the more discriminatory feeling experiences happen pre leadership roles, they're all, they're all the like, oh, there's a you know, like oh, there's a group of four young assistant psychologists, we call them the what's it babes*”

One participant thought that there has been some shift in privilege and discrimination when they reflected on their own personal leadership journey in comparison to people they saw as older than themselves. They suggested that gender inequality is not something that has been a barrier in their career and is perhaps a thing of the past:

P4: “*I've met lots of women in senior leadership roles in psychology who are at retirement age or coming up to retirement age who've clearly had a very different experience*”

While working in parallel with a racialised and visibly religious colleague, one white and non-visibly religious participant observed how they appeared to be afforded a greater degree of leniency by others when it came to making

mistakes or errors. These discrepancies were attributed to their observable differences in terms of race and religion:

> P11: "*I'm allowed to make mistakes and I can just say I'm really sorry and I can be very charming about it and I will get away with a lot"*

At the same time, for some participants, the idea that being in a leadership position might be associated with privilege was not one they felt applied to them:

> P9: "*that's a hard one for me to think about, because actually I don't think I've had that privilege*"

Indeed, for some participants, leadership is something they suggested having had to work harder for than other people they see in similar roles to themselves with less experience:

> P9: "*my journey hasn't been like the easiest one in terms of, yeah, thinking I've had privilege. It's been the opposite even in that, through the position I'm in now I've had to fight <Mhmm> while actually other people are in positions with less years experience, um, which yeah, you just sit there thinking, yeah, I wonder what that's about? You know, people doing the same job and the parity is different. What's that about?"*

Furthermore, participants described how being in a leadership position has not brought an end to their experiences of racism and continued sense of scrutiny:

> P9: "*it never ends…You constantly feel as if you're in the courtroom being judged or assessed, that you have to get things right 'cause if you don't, actually people see you as incompetent or not worth it."*

> P2: "*I still think I experience discrimination, or I certainly have done. Uhm? I just think, [laughs] just thinking of another example of like another really senior person, who kept getting me and the one other woman of colour mixed up. [laughs]…we don't look anything alike. And I was just like in my head, I was thinking, just, this is just ridiculous. Uhm? We don't even have, similar names or anything like that. It was just the whole classic, yeah, just casual everyday racism. Uh, so yes. Still experiencing discrimination. Absolutely."*

P12: "*When I became a supervisor, I noticed I wasn't respected in the same way that I had felt that my supervisors were. <uh-huh> And I did feel that was I was being treated differently"*

In addition to this, participants talked about experiencing discrimination on the basis of gender, sexuality, mental health and professional status. One participant also talked about their experience of discrimination based on the people they were advocating on behalf of:

P7: "*I actually think I was discriminated against because of the client group that I serve."*

It was suggested that having people in senior positions available for support contributed to leaders' development and capacity to continue in their roles in the face of discrimination:

P9: "*Oh my God, um good supervision. Good line management. I have a mentor that's been absolutely fantastic and I've got a good peer network around me where I can talk about this stuff. I mean if I didn't have any of that I think you'd get into no leadership positions 'cause it's hard*."

However, it was also noted that such mentors and role models are sparse within a profession dominated by white people:

P2: "*When I got my job as consultant clinical psychologist in [specialism], I couldn't think of a single other person of colour and woman in that role. That I knew. I couldn't think of a single one. There was [name] in [London], who was head of health psychology. I remember when I met her, I was just like, oh my God. [laughs] There are people who are in really senior leadership positions. She was really inspiring*"

While considered helpful, it would appear difficult to network with potential mentors:

P2*: " I'm sure there's probably more, but you just never hear of them, and certainly not in [specialism] psychology, which is about as blonde and white as you can get."*

3.2*.4.2. Using the position of leadership*

This subtheme reflects how leaders perceived the limits and remit of their role. Some participants who otherwise described feeling comfortable in a leadership role, noted the discomfort and uncertainty they felt when faced with discrimination. Others suggested having a clear sense that challenging discrimination was part of their role and were clear about steps they had taken to address discrimination.

Participants talked about how leaders might be welcomed into situations where they can use their leadership position and power they associate with it to advocate for service users:

> P1: "*This community, this early intervention team, they were all kind of, seemed to be intent on justifying why they were keeping this person in hospital. Uh, I mean by saying just that question, kind of got the psychiatrist trying to defend, uh, her behaviour, uh, and, it created a bit of a shift. And I could only have done that from my position of power and when I left, it was like, oh thank you for coming."*

While some participants talked about being comfortable in a leadership position and using their voice on the one hand:

> P6: "*I definitely mean, there can be a bit of an idea that women psychologists are quite tentative, in stating a position, and I guess that hasn't fitted with my own ideas about being quite assertive… I've got plenty of privilege, which is just sliding me into leadership in more of a comfortable way"*

They also described feeling very uncomfortable about responding to discrimination on the other:

> *P6: "I mean, yeah, I try and engage… it's so cringey, it's definitely examples of like trying, but feeling like, uh, I haven't quite got the language to make it land"*

Including outside a work environment:

> P6*: "talking at parent, PT forums* [laughs*] and stuff is probably the sharp end of like* [mimics gagging]"

There was some suggestion that sometimes participants did not feel confident about using their position due to worries about the boundaries of their role and responsibilities, and that their motives and actions might be considered racist:

> P7: "*when does me stepping up be me actually overstepping and uhm, you know, getting into a space that I don't need to be getting into, as a sort of white saviour.*"

Some participants suggested that a certain level of seniority, beyond that of the participants, was perhaps required for initiatives and responses to discrimination to be truly effective. There were suggestions that this could legitimise the time that individuals need to address discrimination, inspire individuals to speak about discrimination and explore some of their fears around it:

> P11: "*it needs to be a certain level of seniority because, you know everyone's got too much on so if they have to privilege certain pieces of work over another in their prioritisation, if their manager doesn't give them permission to, it's an add on and it's not gonna have the same effect…you need a certain number of people in senior positions who are supportive*"

> P7: "*we have a reflective space … I am in in the race equity task force and one of the senior managers is. Both white women … our clinical director who's a white woman came to it and it's the first time she's been to any of the things… and I just thought it was really meaningful, her being there and not just being there but actually speaking up and taking a stance… And I think that's when leadership has you know, meaning for people as well, I think when people in those senior positions do, you know, I guess, put themselves out there and potentially even take risks, I think it's really important*"

Others suggested this authority might come from having clear policies about how they should respond to issues of discrimination:

> P8: "*Let's make sure that we've got a pretty robust policy about how to respond to aggression of any kind, be it homophobic, racial, you know, whatever*"

Some participants suggested that their leadership vision may not always fit with that of the wider system:

> P10*: "I lead by my own example, but not maybe by the wider systems example*

In such instances they would use their position in line with their beliefs:

> *P10: "I'm going to use my position to say no, this isn't OK what you're saying"*

One participant suggested that it is also the role of psychologists to use their position to advocate for service users and staff, and that while they believed that other psychologists would also do this, their experience of speaking up for other staff being so noticeable indicated otherwise to them:

> P5: "*something I think we do importantly for people who use our services, you know, we try and then put their voice into conversations… but I think you can do that same thing for staff. I remember once… one of the nurses said to me, you know, you're the only person who goes into these meetings and speaks up for us, and I'm sure that wasn't entirely true. I'm sure lots of other people did that, and I'm sure I was pretty imperfect at doing it, but … I thought you know that means a lot that that seems to have been noticed.*"

While another participant suggested that they had successfully implemented their own recruitment strategy and the culture they fostered enabled effective responses to discrimination:

> P9: "*I think it's the team that I've brought in and I think it's the people that I've recruited. I think it's the style of leadership that I have that actually it's a, this isn't about, you know, making you know, maybe it's about making others leaders. <Mhmm> Yeah, getting everybody on board of having responsibility, duty having integrity. That's what it's about."*

3.2.4.3. You can't split the personal and the professional narrative

This subtheme drew together participants' indications that their personal experiences affect how they respond as a leader. This was discussed in terms

of their experiences contributing additional challenges, as well as motivating their choice of leadership approach.

Participants talked about how their backgrounds and personal experiences shaped their approach to leadership, something they felt was potentially at odds with narratives about professionalism requiring personal experiences be separated from the professional role:

> P9: "*in our religion we talk about actually just being true to yourself. I think you have to be an authentic leader. I think people talk about having a split between the personal and professional narrative, I don't think you can split that, I don't think it's as easy as that. I think actually, how do you lose parts of yourself that are important."*

One participant suggested that although their position of leadership might lead others to expect them to have a certain degree of confidence and power, they did not necessarily have an internal sense of confidence even if they managed to convey a sense of confidence in their interactions with others:

> P2: "*I don't feel it on the inside, but I do know the perception so you know people will take it, I can speak quite coherently, can speak I can sound as if I know what I'm talking about. I think I'll sound like I've got some authority.*"

However this participant went on to suggest that maintaining the facade of confidence and challenging discrimination takes its toll, that it is not possible to do so continuously and it is necessary for them to step away from it at times:

> P2: "*after that few years where I was just like I just can't be bothered to do this…I did have a bit of a break"*

Having previously spoken about their sense of feminism, confidence in their position, and their own manager, one participant described how their experience of discrimination was responded to.:

> P3: "*And because I've got such a good relationship with my own manager, my own boss, I was able to talk to her about that and just say, this happened. And she noticed it… and it was dealt with incredibly well actually and I think I think the men were actually a bit mortified. I don't think they, I think it was one of those things where they weren't aware*

that that's what they were doing. They were just being men. They, I don't mean, I just sorry, I don't mean that in a disparaging way, but I just think that they'd sort of hadn't realised that that's how it had, how the dynamics had developed?"

They went on to suggest that having to address their own experience of gender-based discrimination directly would be difficult. This observation appeared to occur to them for the first time during our conversation

P3*: "oh I should slightly cringe having that conversation with them. [laughs] Interesting, that, isn't it? I would. [laughs] I'd feel uncomfortable about that, yeah*."

By exploring and getting in touch with their own personal experiences, another white participant discussed how this helped them come to understand a split which had occurred in a team with a racialised colleague. While they suggest that the split occurred due to a difference in approaches, the participant also questioned how those different approaches had developed and indicated a belief that race, and racialisation had a role in how their differing approaches had developed:

P8: "*we were split by the team not because of race, but it made it an easy split to make… 'cause of certain different approaches and I know that her experiences, growing up had meant that she had had to sort of survive or approach difficulties by being a certain way, and whereas the difficulty, that completely different set of difficulties that I'd faced that were, you know much less of a difficulty, but I'd learned by, surviving or responding in a sort of make myself small and approachable and everything is OK and not challenge anything kind of way which was opposite to each other"*

Other participants also shared how aspects of their experiences, such as being othered, unusual beliefs and ableism inform how they think about and might respond to situations as a leader:

P11: "*I'm from [place] and I always had a sort of being on the outside position <Mhmm> that's been quite a strong influence and an experience*

of having a different view from everyone around us sometimes, and… so I think in some ways that makes me think about different perspectives"

> P3: "*my own son has additional needs, and so I've also experienced it from a, uh, point of view of a parent and so you know, thinking about you know, the world that they, they are in and how, how they are responded to. So I think all of that comes through."*

Some participants suggested that while they may appear to hold a lot of privilege in some instances, their frequent experiences of being othered is a key aspect to their approach to leading in a collaborative and compassionate way:

> P10: "*I might look like a white male, but I actually have a lot of difficulty with certain things. <Mhmm> And being in a position of being othered, it is quite common to me … I have quite a big authentic-, thing about accessing services for people that struggle to engage, and experiences of systems saying, no you can't do that"*

They went on to describe how the experience of being othered influenced their approach to leading in a compassionate and collaborative way:

> P10*: "I quite often think about compassion when I think about leadership. And leaning in and letting the system be vulnerable rather than fighting against exposing and looking through threat."*

> P1: "*I've been interested in quite, radical thinking like Paolo Freire, uh…Theatre of the oppressed. I've looked, because of my own experiences of discrimination and being a bit undervalued or being, uh treated in the mental health system and given, a diagnosis…that's made me very sensitive about, how to do things differently and more collaboratively, more of a partnership model rather than a top-down domineering approach"*

Participants talked about how their own experiences of discrimination have not only made them more mindful of the struggles others may face, but also enabled them to consider situations from another's point of view, how it might be affecting them and how they then might be able to support that individual towards their goal despite any struggles they may experience along the way:

> P12: "*knowing what it feels like to be the person that you're working with and having that like degree of empathy so that you can think about, what must it feel like for this person in this role? What must it feel like for this person in this position or, you know, are you limiting them? Are you helping them achieve their potential?*"

Some participants suggested that their leadership approach to challenging discrimination was not just based in and motivated by their individual personal experiences, but also due to potential worries and fears for their children and loved one's future experiences:

> P2: "*And then you just, you do think, it's so cheesy, I just want things to be different and want things to be different from my daughter. I don't want things to be the same for her*"

4. DISCUSSION

The conclusions of the analysis will be outlined in this chapter and explored in relation to the research questions given in the introduction, with reference to relevant literature. While the study did not set out to focus on specific aspects of identity in relation to leadership, some themes were found to be predominantly represented by white participants and racism was the primary form of discrimination discussed by participants. These differences in relation to the experiences of leaders will be discussed. A critical evaluation of the study will be given, including personal reflections and limitations. Lastly, clinical and research implications of the study will be considered.

4.1. Findings in Relation to the Research Questions and Literature

4.1.1. How do leaders define their leadership style and approach to issues around privilege and discrimination?

Though the study set out to explore how participants defined their leadership style and approach to issues around privilege and discrimination, people talked more about their personal experiences of discrimination with limited reference to existing leadership theories and frameworks (Gomez, 2015), implying their lack of utility in practice (Power et al., 2017). In contrast with research indicating completion of leadership programmes led to individuals feeling more confident as leaders (Percival & Best, 2019), there was a sense that, how leadership is defined in the literature and on training courses did not fit with participants'

experiences. Consistent with existing conceptualisations of leadership, this appeared to result in participants relying heavily on their own personal experiences to inform their leadership approach (Gomez, 2015; L. J. Gordon et al., 2015).

The dynamic approach to leadership found was reflected in existing research, as participants described how ongoing negotiation in relationships with others, drawing on compassion (West, 2021) was key to their approach to leadership (Grint, 2010; McCray et al., 2018; Phillips & Norman, 2020). Primarily white participants contributed to this theme and felt it was necessary and helpful to have separate, psychologically safe spaces in which to develop skills necessary to navigate these relationships. There was a sense that, as a leader, participants felt a heightened sense of risk to themselves (personally and professionally) and others should they “not get it right”. These concerns are reflective of Whiteness and ‘white guilt’ where silence and avoidance due to fear of the ‘other’, upsetting people, and not recognising how their own privilege serves to uphold hierarchies and oppressive practices (DiAngelo, 2012; Keating et al., 2002; Wood & Patel, 2017). Participants recognised a need to move away from this towards positions of ‘safe uncertainty’ (Mason, 1993). Racialised participants talked about the challenge of speaking out (Salway et al., 2016) about discrimination as part of their usual everyday experiences, likely compounded by silence of their white counterparts (Wood & Patel, 2017). Furthermore, building the good working relationships considered necessary for change to occur with those who have been discriminatory was difficult and thus the ability to drive change is not available to all individuals in the same way (Burgess, 2022). While the concepts of psychological safety, empathy and compassion were considered conducive to challenging discrimination, this suggestion would appear to be primarily for the benefit of those in positions of privilege (DiAngelo, 2018) and potentially at considerable emotional cost to those who are marginalised and minoritised (Gorski & Erakat, 2019). This perhaps reflects the white-centric nature of the literature, the conceptualisation of leadership essentially as an instrument of Whiteness with the aim of preserving hierarchy, privileging positivist paradigms and resulting epistemic injustice (Fricker, 2009).

The idea that leaders who challenge discrimination are ‘mavericks’ was predominantly represented by white participants and perhaps represents the novelty of this position to those accustomed to privilege and unaccustomed to the potential accumulated impact of racism in all its forms (Eichstedt, 2001). White individuals whose antiracist views otherwise mean they feel alienated from family and communities may also gain important points of interpersonal and political connection through their activist role and therefore benefit from their ‘maverick’ identity (Case, 2012). Nonetheless, despite calls to promote equality (West et al., 2017), participants felt that when it came to challenging discrimination, they were seen as provocative, radical, incompetent, unprofessional or unconventional leaders (Salway et al., 2016). Equality, or a social justice stance which emphasises collaboration, non-expert positions, talking about prejudice, resistance and survival of oppression, being receptive to reflecting on power and privilege (Afuape & Hughes, 2016) would appear to be at odds with dominant leadership discourses. Leadership in a work setting implies power and access to a higher level of resources and opportunities, while a follower has no such powers, fewer resources and opportunities (Winter, 2019). Thus, leadership might be conceptualised as part of the fabric of cultural practices which sustain the hierarchies central to Whiteness. In this case, equality and social justice initiatives could be considered a threat to Whiteness and attempts made to quash them construct social justice behaviours as incompetence (L. J. Gordon et al., 2015) and unprofessional (Salway et al., 2016). Indeed, participants interviewed felt that leaders more senior to them neither understood nor valued a leadership approach which challenged discrimination (Percival & Best, 2019). Equality discourse and efforts to empower staff with the capacity, skills and legitimacy to drive changes (Martin & Waring, 2013) are aimed more at those in institutionally lower hierarchical positions while those who are in positions of authority are rarely held to account (Percival & Best, 2019). Keeping less privileged staff busy with an impossible task ensures that nothing changes, for “the master’s tools will never dismantle the master’s house” (Lorde, 1984c).

A small number of participants talked about the importance of leadership culture (Percival & Best, 2019), noting the dominance and deleterious effect of cultures of politeness and silence, key tools of Whiteness in disavowing individuals’

awareness of oppression and their own complicity (Morgan, 2021). A leadership approach which models vulnerability, willingness to sit with discomfort and perhaps even to be perceived as rude or disliked (Lorde, 1984b) was favoured.

This study adds to the literature critiquing competency-based leadership frameworks (McCray et al., 2018), critiques of leaders as exemplary individuals, or hero discourses (L. J. Gordon et al., 2015; McCray et al., 2018; Percival & Best, 2019). It also adds to the argument for compassionate leadership but indicates a need to critically examine how individuals conceptualise compassion alongside their roles and responsibilities. It is all very well to aim to create cultures of psychological safety, but *who* is it safe for and what do we *do* with the conversations this opens up?

4.1.2. In what ways do leaders' personal identity (experiences of privilege and discrimination) influence their approach to leadership?

Predominantly white participants talked about feeling confident and able to easily identify with being in a leadership position (L. J. Gordon et al., 2015) as they drew on discourses about people like them in leadership and past opportunities for leadership. Participants also drew on first wave feminist discourses focused on equality with men, which fails to address the oppression faced by racialised and otherwise marginalised women (Crenshaw, 1991; Lorde, 1984a). This was reflected in comments that people in senior positions do not experience discrimination, as it perhaps reflects their own experience of privilege as white individuals.

Predominantly racialised participants could quickly recall personal experiences of discrimination, despite being in formal leadership roles. Racialised participants noted in particular the importance of the presence and accessibility of other racialised people in senior positions with whom they could identify and potentially find the psychological safety necessary to discuss their experiences and personal challenges as a marginalised and minoritised individual (Bond, 2010). Participants talked about how their experiences of discrimination have meant they have had to work harder to gain a formal leadership position (L. Gordon, 2019), as well as indicating the emotional and professional toll that ongoing discrimination takes (Salway et al., 2016). Indeed, concern about

professional and personal repercussions led one participant to withdraw part of their transcript and another to request not to continue speaking about their discriminatory experience. These accounts speak to the problems inherent in the unspoken assumption throughout the leadership literature that anyone designated a leader is operating with the same degree of authority and risk as all other leaders (Phillips & Norman, 2020; Salway et al., 2016).

Predominantly white participants described how, despite feeling comfortable and confident that leadership is part of the role of a psychologist (L. J. Gordon et al., 2015), they avoided or struggled to use their position to challenge discrimination (McCray et al., 2018). Worries about being labelled as racist themselves appeared to be a factor. Others suggested their hierarchical position meant they did not hold sufficient influence or sway for their intervention to make a difference (Percival & Best, 2019). Participants' discussion of their context and how they perceive it to limit the scope of their influence as leaders (L. J. Gordon et al., 2015) suggests a perception of powerlessness relative to the system. A fear was perhaps implied that challenging discrimination crossed a line which would risk their privileged position as a leader and instead, the responsibility for this risk was seen as sitting with other parts of the system. This dissonance between some participants' perception of their authority to lead and their authority to challenge discrimination (Salway et al., 2016) highlights the incongruence of dominant leadership discourses, which position leaders as individuals with greater power and knowledge (L. J. Gordon et al., 2015), and calls for leaders to promote equality, where equality impinges on the sense of power and superiority that leaders may wish to retain. As Whiteness seeks to create fear, divide individuals and preserve power for the few, the potential strength in naming and uniting in difference is missed. Individuals may educate themselves about oppression without engaging with their internalised oppressor (Freire, 1993) or combatting discrimination. Limiting their involvement may allow individuals to feel like change-makers while also facilitating their oppressor role (L. Gordon, 2019; Tuck & Yang, 2021). In contrast, one racialised participant clearly outlined strategies they had successfully implemented to tackle the impact of systemic racism on recruitment of people with minoritised and marginalised backgrounds. Taking action and using their position of responsibility to address discrimination

was seen as inherent in their role. It would suggest challenging discrimination was felt, by some, to cross a line which could risk the privileged position of leader and was a risk not all participants were willing to take, consistent with literature demonstrating how white individuals take fewer risks than racialised individuals in response to racism (Gorski & Erakat, 2019). Reverting to hierarchical structures to authorise work around discrimination speaks to the problems inherent in dominant leadership discourses which appear to be at odds with the stated intention of challenging discrimination. It would further suggest that where individuals seek authority externally within systematically discriminatory institutions, discrimination will be perpetuated. Moreover, the reliance on hierarchy highlighted, by participants primarily in formal leadership positions who self-selected to participate in this study, is at odds with the continued calls for inclusive leadership practice to be embedded as the responsibility of all leaders (NHS England, 2022b).

Consistent with positioning theory (Davies & Harré, 1990), when it came to confidently responding to discrimination, some participants gave clear accounts of how their personal lives and experiences were entwined with their leadership approach. While white participants primarily talked about discrimination as something that happens to other people, some also described how their experiences of being othered based on nationality/politics, sexuality, ableism, or mental health influenced their leadership style. In contrast, racialised participants' initial responses when asked about discrimination were about their own personal experiences of being discriminated against both historically and on an ongoing basis despite their formal leadership positions. There was an underlying sense that for leaders who experience discrimination themselves, authenticity came with an additional task of needing to convey confidence they did not always feel they had. Furthermore, the burden of having to hide the personal impact of discrimination while carrying on with their job and potentially facing other discriminatory situations meant that some participants talked about the need for breaks from challenging discrimination (Chen & Gorski, 2015).

For some participants, there was a sense of leaders being 'good' (L. J. Gordon et al., 2015) which left little room for individuals to balance the identity of oppressor, or negative identities with positive constructions of self (Eichstedt, 2001). The literature to date has been largely silent on the matter of the

inequalities faced by marginalised and minoritised individuals, describing challenges faced by leaders without distinguishing between privileged-identity and marginalised-identity leaders and their interactions within organisations (McCray et al., 2018; Monkhouse et al., 2018; Percival & Best, 2019; Phillips & Norman, 2020).

4.1.3. What are the barriers and facilitators for leaders of responding to issues around privilege and discrimination?

Overall participants identified more barriers than facilitators for responding to issues of privilege and discrimination.

While predominantly white participants implied hope for change due to the impact of Black Lives Matter discourses on individuals' readiness to engage in conversations around discrimination (Prochaska & DiClemente, 1983), others expressed frustration at individuals' lack of willingness to acknowledge their privilege and wider change (McInnis, 2020; Patel & Fatimilehin, 2005; Wood & Patel, 2017). It was felt that existing structures and support available to leaders is insufficient, while leadership training courses do not fit with leaders' realities (Percival & Best, 2019; Power et al., 2017). Given that there remains a strong organisational cultural hierarchy (Percival & Best, 2019; Phillips & Norman, 2020), which is resistant to change (Percival & Best, 2019), and particular discourses and sources of knowledge are privileged over others (Finn, 2008), it is perhaps unsurprising that efforts to encourage equality without altering organisational structures have only a limited effect (NHS England, 2022b).

Where leaders have continuing experiences of discrimination, the risk of i) the emotional and physical toll of their own experiences; ii) the impact on their working relationships, and iii) other covert repercussions combined with the potential absence of safe and trusted supervisors or mentors (McCray et al., 2018), meant participants often felt they faced difficult decisions about which incidents of discrimination to challenge and not to challenge (Salway et al., 2016). All racialised and some other participants disclosed having left at least one job due to their experiences of discrimination. Concerns about upsetting others, professional consequences (Percival & Best, 2019) for themselves and their relationships with others, and being clumsy were primarily cited by white

participants as barriers to responding to discriminatory issues and is consistent with existing literature demonstrating that despite antiracist convictions, white activists take fewer risks (Case, 2012). One white participant’s reflection about privileging the feelings of the person being challenged over the feelings of the person experiencing discrimination highlighted that even when individuals believe they are challenging discrimination they can still simultaneously be operating within the confines of and thus upholding discriminatory structures (Gorski & Erakat, 2019).

Discrimination is woven systemically and permanently into the history and present of all aspects of society and thus not solvable by the use of monitoring, task setting and assurance provision (Phillips & Norman, 2020). Instead, building and establishing warm, collaborative relationships with others (McCray et al., 2018), compassion and psychological safety were suggested primarily by white participants as being key to developing willingness to experience vulnerability, the capacity to challenge and for challenging discrimination. However, racialised leaders and others who experience discrimination do not always have the luxury of good relationships and psychological safety (Burgess, 2022). When experiences and conversations about inequality are simply part of everyday life, where is the additional support for these individuals? Furthermore, it was suggested by some participants that the potential for change was limited when the most senior positions are occupied by white people who wish to protect their own privilege.

Participants talked about how their workload left little time to reflect on and respond to discrimination (Phillips & Norman, 2020) and dismay CPs are not already aware of their own privilege (Ahsan, 2020). Primarily white participants suggested that hearing or being in proximity to personal stories of discrimination could support leaders to consider privilege and discrimination (Patel, 2010; Salway et al., 2016). This contrasted with other participants stating that despite living in a racially diverse area the senior people in their organisation are still primarily white and that the same is true for psychology more broadly. Participants indicated that having access to published data and language around discrimination made it harder for white people to dismiss the existence of institutional racism (Phillips & Norman, 2020). This suggests that representation alone is insufficient to address institutional discrimination and

that instead, current CPs need to examine their own relationship to discrimination before any meaningful change can occur.

Dominant leadership culture appeared to be synonymous with Whiteness. Participants' suggestion that the English culture of politeness was interwoven with leadership and used to gatekeep and shut conversations down, fits with ideas around Whiteness preserving the dominance of those socially racialised as white through the production (and reproduction) of systemic rules and norms (DiAngelo, 2018). Dismantling Whiteness and inequalities by modelling vulnerability, tolerance for sitting with discomfort and compassion (West, 2021; West et al., 2017) were perceived to facilitate others' engagement with difficult conversations (Grint, 2010). However, it was also suggested that modelling these could potentially be destabilising for others' sense of their privilege. This indicates that a compassionate approach in response to inequality is likely to also need to draw on learning from antiracist approaches (Ahsan, 2020; Patel, 2021).

Cultivating compassion was indicated as facilitating not just a willingness to do something in the face of difficulties but was also implied to be necessary for leaders to have for themselves when making and in the aftermath of difficult decisions (de Zulueta, 2016). This perhaps also points to the enormity of the challenge of institutional discrimination and the impossibility for individual leaders (Phillips & Norman, 2020; Salway et al., 2016) to have effective responses to all instances of discrimination.

An authentic leadership approach was suggested to be facilitative of challenging discrimination, in particular where leaders felt they had personal experiences of discrimination they could draw on to help them understand the challenges others faced. One participant noted their motivation to persist with the work was a desire for things to be different for future generations. However, the personal and professional impact of the work along with personal experiences of discrimination meant participants experienced burnout and felt unable to continue to sustain their activism (Chen & Gorski, 2015).

Overall, the study findings are consistent with the existing literature while also adding new insights and raising further questions about leadership in relation to privilege and discrimination.

4.1.4. Process-based aspect of the interviews

Several participants commented that they did not ordinarily have time or opportunities to reflect on privilege and discrimination at the end of the interview. Indeed, it was suggested that taking part was a decision with the explicit purpose of making time to think about discrimination.

Speaking from personal experience

White participants primarily talked about discrimination in relation to teams, systemic and institutional processes. Some could not recall any instances of either personal or observed experiences of discrimination. This may be understood within the psychodynamic literature as the unconscious impulse to focus on the 'other' and not wanting to know, or resisting, the feelings raised by knowledge about one's own role, or complicity (Lowe, 2013). While these participants would mention ideas about being brave enough to talk about discrimination, even in the anonymous space of a study with another white person it felt too risky to discuss their personal experiences. Indeed, some wondered whether those with the most privilege are ready to have conversations about discrimination.

Conversely, though my race was discernible from my photo next to recruitment posters, some minoritised participants may not have felt entirely comfortable to share their personal experiences in depth with me as a white person. There may have been real and understandable concern that my reaction to and interpretation of their experiences could perpetuate their experiences of racism.

Given both the apparent distant relationship with discrimination for some participants and the potential risk of speaking with a white person for others, I wondered what motivated participants to take part in the research. It may have been a helpful to explore participants' motivations for taking part in the study.

Participant reflexivity

At the end of the interview, how participants had experienced the interview process was explored using reflexive questioning to better understand their experience.

Primarily racialised participants reflected that it would have been nice to have had more of a two-way conversation. I wondered whether, given their senior positions, the participants were not used to being the ones answering questions. But also, given my being white, I wondered whether a sense of uncertainty or potential lack of a sense of safety about how their responses were being received, what was ok to say, or how their responses would be reported triggered this reflection. This comment possibly also implied that with the lack of clarity and elusiveness of the concept of leadership that it could have been useful to explore the topic and its challenges together in an effort to make more sense of it. Indeed, several participants reflected that they did not feel as though they had spoken much about leadership as it is quite confusing, and they spoke more about discrimination.

Primarily white participants indicated that it had been an uncomfortable experience at times. Some were aware they had not previously thought in as much depth about discrimination and reflected that they did not know what they were going to say or what they thought until asked about it in the interview. Despite this, they were able to talk at length. Participants spoke of feelings of regret and embarrassment about actions that had, or had not, been taken.

4.2. Critical Evaluation

Using Yardley's (2000) evaluation criteria outlined in the methodology, a critical evaluation of the study is outlined below with an attempt at interweaving reflexive thinking throughout. Some specific limitations of the research are also discussed.

4.2.1. Sensitivity to context

By exploring the existing research on leadership, as well as literature on discrimination in healthcare settings the study demonstrates sensitivity to context and has identified a gap on leadership approaches to issues of privilege and discrimination among CPs. I was also aware of the wider context of the Covid-19 pandemic at the time the study was being conducted in addition to the

recent Black Lives Matter protests and increase in conversations about race in the media and social groups.

I considered participants' racial, cultural, religious, sexual identity, mental health, and disability backgrounds, and how my (perceived, ambiguous, or otherwise) position as either an insider or outsider may have hindered or facilitated more discussions, around racism and striving for antiracism for example (Hayfield & Huxley, 2015). While my race, religious, sexual identity, mental health nor disability background were explicitly disclosed, my whiteness was visible to all and my cultural background could be inferred from my name and accent (Arai & Thoursie, 2009). However, some participants may have been unaware of my Irishness.

In some interviews with white participants the use of comments such as "you know" implied reassurance seeking about the validity of ideas shared, as well as assumptions on the part of participants that I would agree with their views. In my researcher role and aware of potential effects of racial distress (DiAngelo, 2018) for participants as they discussed race and racism, I was mindful to be encouraging of participants to lean in to this discomfort while also neither validating nor invalidating their views and experiences.

Conversely, in interviews with racialised participants I frequently had the sense that participants looked at me as a white person and did not trust that I would truly listen to, understand, or represent their painful experiences and accounts of resistance in the face of oppression (McClelland, 2006). I had an acute awareness of my role and ethical responsibilities that the interview process was not experienced as another discriminatory and invalidating event. With this in mind, I aimed to respond first as another human being, and second as a researcher. However, this may have resulted in fewer questions and less exploration of some areas.

Overall, throughout interviews I aimed to make participants feel at ease by developing rapport (Dempsey et al., 2016). Verbal utterances, reflecting and summarising to demonstrate listening, reminding participants only to share what felt comfortable to share, that it was possible to take breaks, checking in whether participants were comfortable to continue and debriefing with each participant afterwards were used to achieve this.

4.2.2. Commitment and rigour

I immersed myself within the data during transcription and analysis over five months (Braun & Clarke, 2021c), in literature and peer reflections on racism, demonstrating in-depth engagement and commitment to the topic. Alongside struggling with my confidence as a novice researcher, this being an emotionally challenging and demanding time for me, I felt overwhelmed with the process as I worried about doing justice to the participants' voices. A gap in supervision, a period of uncertainty around continuity of supervisor, my own Whiteness, and a sense of responsibility to represent the complexity and variation within hitherto unrepresented participant experiences in the leadership literature compounded these feelings. With good supervision, engaging in individual reflection, continual examination of my thinking and interpretation of the literature and data, in addition to recursive use of the iterative TA process (Braun & Clarke, 2006), I developed my competence (Yardley, 2000) in order to generate and refine the themes.

I used supervision throughout the research process to ensure design and implementation rigour. Individual, in-depth interviews and recruitment of a cross-section of CP leaders ranging in age, gender, race, and experience (Olsen, 2004) ensured sufficient detail to support comprehensive qualitative analysis.

For the assessment of research quality, I sought out recent publications on current thinking, assumptions and issues in TA, as well as ensuring the methodology and analysis is in line with a reflexive approach to TA (Braun & Clarke, 2019, 2021a, 2021b, 2021c, 2022; V. Clarke & Braun, 2021a, 2021b).

4.2.3. Transparency and coherence

The study aims and methodology were compatible with a critical realist epistemology and were a good fit with inductive reflexive TA for a rich qualitative exploration of leadership approaches to issues of privilege and discrimination (Yardley, 2000). Situating the results within previous literature also aimed to provide a clear account of the findings. In supervision and peer discussions, the coherence of interpretations and themes was explored.

Outlining the epistemological position, clear documentation of each step of the research process and provision of example coded extracts in Appendix 11 and

12 aimed to provide transparency. Using supervision and a reflective journal I endeavoured to be alert to the effect of my assumptions, actions, and status as a white trainee CP throughout. Further transparency has been offered by outlining my position and reflections on the research process in the introduction, methods, a journal extract (Appendix 9), in this section, and further thoughts shared below.

The consideration of participants' context and aspects of their identity was helpful to locate participants and is required within a critical realist epistemology. The demography questions chosen were informed by the protected characteristics under the Equality Act, 2010 with the aim of locating participants' experiences of privilege and discrimination. However, the questions used and in particular the use of categorical questions is at odds with a critical realist and CRT framework. By its nature, a demography form imposes a set of social identity categories on participants rather than allowing them to freely identify themselves according to their own framework. By using questions with categorical options for responses, I further imposed a binary framework for these social identity categories. It may have been more appropriate to ask more open questions or allow participants to identify the aspects of their identity that they felt was salient to them.

4.2.4. Impact and importance

The study aimed to highlight previously unexplored and unheard experiences and narratives about discrimination and leadership within Clinical Psychology. It is the first known study to explore leadership approaches to issues of privilege and discrimination from CPs' perspectives. The research aims to illuminate the gap in the literature around leaders' responses to issues of privilege and discrimination, from the point of view of CPs.

The clear indication of actions necessary for staff recruitment, development and retention demonstrate the utility and impact of the research, in addition to offering potential routes to move the profession towards anti-discriminatory practice (see 5.3.1.). It is intended to disseminate the findings through publication in a research journal in addition to sharing the research via conferences and more accessible informal learning routes such as podcasts.

4.2.5. Reflexivity

Reflexivity is at the core of ethical research (Attia & Edge, 2017) and requires personal, epistemological, and critical language awareness (Willig, 2013) to ensure conscious decision-making insofar as possible (Ross, 2017). Endeavouring to make conscious decisions and develop my awareness of decisions made around the research, I kept a reflective journal and used supervision.

Personal reflexivity

My relationship to leadership, racism and other forms of discrimination was shaped by socio-political and personal events of the last three years. The GTiCP conference, Black Lives Matter protests and Covid-19 pandemic amongst other events influenced my thinking, interpretations and how I have presented the information in this report. I noticed that the leadership literature appeared to be based in an assumption about leaders as a homogenous group.

Reflecting on my own personal journey, I realised that part of my interest in exploring leadership was sparked by the awareness of the expectation for me to position myself as a leader while at the same time struggling to see myself as a leader. At the same time, I recognised my assumption that those who are in positions of leadership would have answers and solutions. During the course of the research, continued teaching, reading, and experiences, my position and views on leadership have changed, in the sense that I find myself in an even more difficult relationship with the concept of leadership than ever before. The process has led me to see leadership as an additional mechanism or tool of Whiteness for the maintenance and protection of privilege and power, as the notion of leadership intrinsically positions leaders as having greater power. Within clinical psychology, I have come to understand the drive for leadership as a drive to justify and sustain the position of clinical psychologists within a multidisciplinary hierarchy and organisational pay structures at odds with the ethical standards we are professionally bound to uphold. I now aim to be guided by ethics grounded in a Human Rights framework, to see each individual as bringing their own unique experiences, strengths, ideas, solutions and knowledge, which, when shared, can be to all of our advantages. From this perspective, future training and development programmes should place less emphasis on leadership and instead aim to support individuals to i) develop the

confidence to be guided by their values and ethical standards; ii) to recognise their own capacity to develop and implement solutions; iii) while also working in genuine collaboration with others in recognition of their unique skills, experiences and knowledge.

As a white researcher, I was aware that racialised and other marginalised participants may not feel comfortable speaking with me, and this could impact the richness of the data. Indeed, one racialised participant kept their camera off for most of the interview, only turning it on again for debriefing at the end. I attempted to manage these issues in how I spoke about the aims of the research, introduced and set up the interviews. As a trainee CP I drew on clinical skills used in a therapeutic setting in an attempt to make participants feel comfortable. However, this may have limited my use of probing questions. Though I took a critical analysis of the literature and data, I also needed to reflect on blind-spots that could perpetuate discriminatory ideas, oppression and inadvertently marginalise the voices I aimed to centre.

Participants' worry about 'getting it right' and experiences associated with feelings of shame also had the potential to impact the richness of the data due to my hesitance to probe further. Participant feedback on this was sought (see 4.2.2.). My supervisor and I reflected on our respective racialised and white identities and personal experiences impacting our assumptions about CP leaders, and these are likely to have impacted on the data analysis and results.

My familiarity with one participant should be considered in relation to data collection and the analysis process. Four years had elapsed since I last had contact with the participant and thus, I was able to take a curious stance towards their views. My potential position as an in-group member also possibly allowed that participant to feel comfortable, enabling open exploration of personal and professional challenges and vulnerabilities.

I noticed strong thoughts, feelings and physical responses to what some participants said in interviews, and again while transcribing. Listening to participants talk about discrimination, hearing about their actions, thoughts, feelings, experiences or sometimes an apparent lack thereof, was emotive. While I felt hopeful that participants were trying to consider discrimination, I also worried whether my responses colluded with the idea that what they were doing

was enough or unconsciously upheld racism and thus the research might inadvertently serve to perpetuate discrimination. This impacted on coding and initial theme development. I noticed a reluctance to code data highlighting a racist approach to leadership as well as being drawn to quote particular participants and their experiences in the analysis. I was conscious of a desire not to offend participants in the report, not to centre Whiteness and the gap in my understanding of some participants' experiences.

I noticed my assumption that people in leadership positions should have answers. Through engagement with the literature, supervision, reflection both with peers and individually my relationship to the concept of leadership changed during the course of the research. The predominant concept of leadership espoused in the literature appears inherently bound up in Whiteness, with a seeming inability to separate leadership from a sense of authority (Obholzer, 1994) and hierarchy. Instead, I have come to think perhaps we need to find our own answers, using creativity, trying to do things differently to those who have gone before us while guided by our ethics.

Discussions with participants on privilege and discrimination proved complex and at times challenging as a white researcher where discussions predominantly concerned race and discrimination. On the one hand, I noticed a strong reaction in myself where I had a sense that participants had little direct personal experience of discrimination or insight into their complicity with discrimination and talked about discrimination as something that happens to other people, with little personal investment in dismantling the structures that uphold discrimination. When we have people in these positions of power who are not aware of their privilege, what does it say for addressing discrimination? I noticed a tension in these discussions, how I felt cautious to press these participants further in the interviews, in my interpretation and reporting of their responses due to worry that participants might feel they had somehow been misled in their participation in the research. While I was cautious not to collude with or perpetuate Whiteness, I believe my concern about how participants might use their power could impact on my position as a doctoral candidate meant these interviews and analysis did not always go into the depth that was warranted. On the other hand, I was aware that discussions with people for whom experiences of discrimination are a common experience in their day to

day lives felt different. I sensed an understandable cautiousness in participants' responses and a strong sense of my responsibility not to perpetuate discriminatory experiences in the interviews. These factors inevitably shaped the conversations, meaning that I potentially missed important aspects of participants' experiences, did not explore particular themes in the interviews or the analysis with sufficient depth. These polarising experiences were not unpredictable, and it was with these possibilities in mind that, as a white researcher, I hesitated to say this was a study exploring leadership and whiteness and chose to recruit a broad sample of participants to speak about discrimination in general. These decisions and my approach to exploring this topic, including the decision to recruit a broad sample of participants reflect my knowledge and experience at the outset of the research. I had not fully anticipated such stark disparities in my experience as a researcher, nor the influence of power and privilege on the analysis. I noticed my assumptions about who would volunteer to participate in research on privilege and discrimination and their insight and ability to examine and discuss their own power, privilege and discrimination. I did not clarify enough the position that I would take in the research, whether I would be an observer or active participant. Perhaps a more active position would have been more in line with my approach and at the same time my position has evolved through the course of my learning journey while conducting this research. I chose thematic analysis because the literature is so sparse, when perhaps a discourse analysis or interpretive phenomenological analysis would have been more fitting.

Epistemological reflexivity

A critical realist epistemology meant participants' responses were taken as a true reflection of their thoughts and experiences. I was cautious to be neither judgemental nor dismissive of participants' accounts. Considering participants' socio-political and cultural background is also necessary. Thus, I was aware of the challenge of how I interpreted participants' words, for example through the lens of Whiteness and potentially in a way that they were not aware of (Stainton Rogers & Willig, 2008). Overall, theme development and the analysis have

been more heavily influenced by my experiences, ethical and political positions, than epistemology and ontology.

Critical language awareness

The linguistic constructs used within the research questions and how this may have affected participants' responses was carefully considered together with my supervisor. However, my interpretation of participants' responses may have been implied by my follow up questions to participants (Appendix 15). Although I was reluctant to use terms I found problematic, I aimed to use participants' language and preserve their meaning. The use of direct quotes aimed to maintain the participants' meaning despite my language influence on the creation of themes.

While I found the structure of semi-structured interviews useful, my reliance on this structure in early interviews perhaps limited more extensive exploration of ideas. I was able to develop my ability to think about probing questions to open up conversations and clarify my understanding of what was being said using a reflective journal and thus the confidence to adopt a curious and appreciative stance within the scope of the interview schedule.

4.2.6. Strengths & limitations

Participants self-selected and were recruited through social media and existing networks. This may have led to respondent bias, as those who chose to take part perhaps felt more interested in and able to take a more active approach to consideration of privilege and discrimination as part of their leadership role. Individuals who do not feel they can risk challenging discrimination may have been less likely to respond to a research advert titled 'Leadership, privilege and discrimination'. Themes within the study did however indicate participants who took part felt able to challenge discrimination at some times and not at others. While one participant was previously known to me, the risk of associated sampling bias was limited.

I reflected together with my supervisor that participants were primarily white, some were male, and that some talked about never having experienced

discrimination. The demographics represented broadly reflect the profession (DCP, 2015). Given discourses around leadership and that men are over-represented in formal CP leadership positions relative to the workforce it was considered whether men were more likely to see themselves as leaders. Those who had no experience of discrimination perhaps reflect the fact that CP is dominated by white women and therefore white women are less likely to experience marginalisation. Regardless of whether an individual has personal experience of discrimination, it is the duty of all CPs to challenge discrimination and thus useful to understand the role that privilege, and discrimination can play in choices of action and inaction.

The decision not to recruit only white participants was an attempt to avoid centring Whiteness. In discussion with my supervisor, I considered and reflected on the challenge of being a white woman interviewing racialised participants only. Asking participants to define their identity only based on race, to fragment themselves would perpetuate the restrictions imposed by Whiteness (Lorde, 1984a). It was considered unlikely that many racialised participants would have felt comfortable to speak with me. Those that would, may only have given thin accounts due to feeling uncomfortable. Due to my Whiteness, I could neither claim to be able to offer participants a safe interview experience nor to explore their experiences sensitively and thoroughly. The decision to recruit more broadly offered participants the opportunity to choose which or multiple aspects of their experiences they might feel comfortable to bring and discuss in depth.

The study aimed to explore the views of CPs of any background who identify as having a leadership role. A broad stance in terms of background and definition of leadership was taken due not only to the dearth of research in this area, but also in recognition of the intersectional, multiplicity and fluidity of identities that individuals hold and, in an attempt, not to undermine the understanding of identity as multiple – a concept at odds with the construct of authentic leadership, based on knowing your authentic self (Zoonen, 2013). Delineating divergent experiences in the discussion attempted to address the risk of this approach homogenising experiences and discounting the challenges faced by racialised and otherwise marginalised individuals. I recognise that my privileged identities can make it difficult for me to recognise and understand the nuances

described by some participants in this study. As a white, abled, cis-gender heterosexual female, perhaps I was not the best person to conduct this research.

My inclusion of a research question on barriers and facilitators which shape leadership experiences and practices in relation to privilege and discrimination can give the impression that leadership experiences and practices are binary and linear in nature. The question appeared to be largely interpreted by participants in that way and elicited individualised answers. When instead, leadership experiences and behaviours are a result of complex systemic influences on leaders and their responses to issues around privilege and discrimination. Moreover, power operates to prevent people who work in different ways to what is traditionally defined as leadership to obtain and retain formal positions of hierarchical power. Future research should explore barriers and facilitators from a systemic lens more explicitly.

Socio-political context

The study was advertised from November 2021 to January 2022. The Covid-19 pandemic and recent Black Lives Matter protests highlighted disparities among healthcare workers and in the general population and brought conversations about racism and discrimination to the fore. Several participants linked these events with raising their awareness of racism and discrimination and some spoke specifically about how their organisation had allocated budget to address systemic inequalities, though such conversations had potentially become less prominent by this time. I considered that social and professional pressure may have prompted some individuals to take part. Conducting this study at another time may have resulted in a very different set of data.

While participants made limited reference to Covid, the resultant adaptation to online working meant participants were all familiar with the online interview format. Conducting interviews online may have meant that nuances of tone and body language were lost, however online interviews also offered the possibility of different kinds of interactions (Braun et al., 2017). Indeed, several participants commented that they find it easier to have conversations about anti-racism in an online space. Paradoxically, perhaps communicating online via

computer facilitated engagement by allowing some participants to present a particular facet of their identity (Zoonen, 2013) the ‘good’ part of themselves (Lowe, 2013), while for others it maintained a sense of environmental control facilitative of the sense of psychological safety (Newman et al., 2017). Furthermore, it allowed for recruitment of participants across a wider geographical area.

This context is important to consider within a critical realist epistemology.

4.3. Implications of the Research

The research findings indicate that CP leaders tend to draw on personal experiences when responding to discrimination in a dynamic, context dependent process. The barriers and facilitators of responses have implications for clinical practice, training, policy and future research.

4.3.1. Individual level

There has been an undeniable 'moment' across Eurocentric nations, of thinking about racialisation. But what will happen once this moment has passed? Who will carry on the work in CP? Will the work be carried on?

Leadership training and culture may serve to reproduce oppressive practices. This study offers further evidence that diversity initiatives under the banner of ‘widening access’ at pre-training level (Cape et al., 2008; Health Education England, 2022; SLAM, 2022; Turpin & Coleman, 2010) are insufficient to address the continued legacies of slavery and colonialism veiled in the language of equality and diversity within CP (Wood & Patel, 2017). There is not only a need to support minoritised and marginalised individuals to access and progress in their career post-qualification but also to reiterate calls to examine the foundations of psychological theories, methods and practices, and challenge ourselves personally and professionally to deliver ethical practice (Afuape & Hughes, 2016). In addition, further critical engagement with the concept of leadership is needed alongside recognition of the specialised social justice knowledge held by those who are marginalised (Tribe et al., 2014).

For individuals to develop the depth of understanding necessary to contribute to anti-discrimination movements and get in touch with internalised oppressive

discourses, their own complicity with oppression, explore their embodied experience and sit with that discomfort there is likely to be additional support needed. The creation of facilitated 'safe spaces' for people to be able to discuss their personal experiences of discrimination, 'practice' having conversations about discrimination and opportunities for peer support can help to, a) support those directly impacted by discrimination and b) help to develop individuals' confidence to talk about and respond to discrimination. Simultaneously, individuals must be willing to collaborate with and defer to marginalised individuals especially where their lived experience of marginalisation is central to the discrimination at hand, stepping up and making themselves vulnerable rather than relying on institutionally discriminatory hierarchies, practices and policies (Tribe & Bell, 2018). Action is more likely to occur where challenges are reconstructed by focusing on small wins and accepting that change happens in stages (Weick, 1984).

Additionally, networking opportunities for those who are minoritised and marginalised can provide valuable peer support, mentoring opportunities and safety from oppressive views; invalidation of their perspectives as marginalised individuals; frustration about unwillingness of others to take action when needed; white fragility; and exploitation which may exacerbate the threat of burnout (Gorski & Erakat, 2019). The lack of such support risks undermining the effectiveness of social justice movements (Gorski & Erakat, 2019).

A recruitment emphasis on values based in social justice and exploration of how individuals conceptualise their privilege is essential and should be seen as core to clinical psychology. This requires commitment from service managers and supervisors to make anti-racism and social justice integral to supervision. A compassionate approach (Gilbert, 2010) can help foster a conducive environment for the exploration and development of these skills (West et al., 2017).

4.3.2. Service level

CPs cite their training as equipping them well for leadership roles, but does it? Participants describe being overwhelmed despite many having also attended formal leadership training in addition to their psychology training. Decolonisation of the CP training curriculum and leadership training pose a potential solution (Wood & Patel, 2017). On the other hand, it is suggested that due to the

emotional, embodied nature of the work of responding to discrimination (Bhui, 2014) a training emphasis on developing the ability and capacity to experience the full range of responses to injustice is needed. According to David Campbell, due to the challenge of creating reflective spaces in organisations, more active ways to intervene are also required (Barratt, 2013).

The desire for ‘safe spaces’ within which to explore one’s own relationship to discrimination and potential responses to it is frequently cited among those who have less experience of discrimination (Lowe, 2013), something not afforded to those who experience discrimination. The invitation to engage with an embodied, emotional relationship to privilege and discrimination can leave individuals feeling overwhelmed within and in the face of systems they cannot change. Therefore, it is crucial that course tutors, placement supervisors and all other qualified CPs consider such exploration as an intrinsic part of their role as educators, supervisors and professionals as their influence will persist for several decades. The apparent lack of scrutiny that comes with increased power and potentially even greater capacity to intentionally or otherwise harm is also vital to consider (Adetimole et al., 2005). Without wanting it to become a tick-box exercise, a commitment to change within themselves through regular engagement in reflective practice around issues of power need to become part of continuing professional development required for professional accreditation.

The need for peer networks for marginalised individuals is also highlighted by this research. These are often developed informally and take place at the personal expense and commitment of individuals. A leadership approach to discrimination could protect the time and resources within individuals’ job plans to engage with such spaces, not just within individuals’ employing healthcare organisation, but also across professional networks.

Furthermore, services need to critically appraise their use of informal leadership roles or risk exploiting their staff in lower levels of organisational hierarchies, over-represented by individuals from marginalised groups, and further scaffolding institutional discrimination. Services should provide individuals with sufficient training, resources and organisational authority to carry out any leadership tasks in collaboration with colleagues and service users.

Addressing these issues around leadership and discrimination may help staff retention and recruitment with additional implications for improved quality of care for service users (Burgess, 2022; Tribe & Bell, 2018).

4.3.3. Policy level

The BPS Division of Clinical Psychology practice guidelines require simply an understanding of the nature and history of racism (BPS, 2017), without any further indication of how to develop this. The development of explicit guidelines and training requirements for CPs, both trainees and qualified, with respect to privilege and discrimination is required to inform practices and procedures that can shape and reinforce equality (ACP-UK, 2022). Furthermore, given the lack of leadership literature in relation to privilege and discrimination found across healthcare this call extends to the Health and Care Professions Council (HCPC) and NHS England. This would require individuals within the BPS, HCPC and NHS to also adhere to these guidelines, as well as examination of existing procedures and practices.

4.3.4. Research

The study adds to literature exploring Whiteness in the profession (Ahsan, 2020; Basset, 2021; Ong, 2021) from a leadership perspective. Based on the results, there are several further studies worth conducting.

While an insider researcher position has been argued to provide the opportunity to conduct more ethical research which centres the often marginalised voice of participants (Bridges, 2001; Kanuha, 2000), this assumes homogeneity of experiences and thinking (Kanuha, 2000) based on a single identified characteristic (Bridges, 2001). To consider identity within a dichotomous framework oversimplifies the positions of both the researcher and the participant in relation to each other, as both are rarely one or the other (Griffith, 1998) and denies the complexity and multiplicity of identities and the ways in which they intersect (Fish, 2008). A study using a participatory action research (PAR) methodology may be a useful method of researching the intersectional experiences of CP leaders across a range of geographical locations. This would give voice to and allow for more consideration of marginalised identities and

experiences, providing greater nuance, depth and richness of data. This data could be influential in deconstructing the leadership role and support more targeted training and development opportunities. It may also be interesting to examine the power implications of how leadership, privilege and discrimination is talked about by CP leaders through Foucauldian Discourse analysis (Willig, 2013). Further research in this area could help address discrimination faced by both CPs, service users, their families and communities.

4.4. Conclusion

Good leadership is considered central to greater equity within healthcare services, however the concept of leadership lacks nuance within the literature, has changed over time and it is unclear what leadership in the face of discrimination looks like from the perspective of CPs. This study aimed to explore leadership approaches to issues of privilege and discrimination from the point of view of CPs. It has outlined, at times divergent, ideas about what leadership approaches look like in response to discrimination, how personal experiences interact with these approaches as well as some of the factors that are barriers to and facilitators of taking action.

One overarching theme (‘We have been talking about this for 20 years’) and three main themes were identified using TA: ‘Personal and professional risks and challenges’, ‘Fitting the leadership mould’, and ‘Leadership role and positions’. These themes build on the research base to provide a unique, more nuanced account of CPs’ experiences as leaders. The results suggest a lack of clarity about the concept of leadership which was talked about more as an ongoing dynamic negotiation of relationships sometimes within the context of discriminatory experiences. Participants talked about how the structures of Whiteness affect their (in)actions as leaders, while acts of resistance grounded in collective and collaborative leadership approaches enabled them to effect change. When considering actions in response to discrimination, predominantly white participants spoke of their worry about the risk of repercussions to themselves in terms of working relationships. Participants suggested needing to make difficult choices about whether to adhere to their personal values, at odds with leadership culture invested in maintaining its own privilege.

The results suggest a need for CPs to engage in personal and uncomfortable self-reflection on their practices and approaches in order to develop the in-depth understanding necessary to address discrimination. Engaging with these issues is likely to be of benefit not just to those within the profession, but also to the service users, families, communities, and colleagues we serve and work alongside. While this is not a discrete piece of work, but part of a ‘wicked’ set of issues, participants in the study described examples of initiatives that have been effective in terms of dismantling discriminatory processes. Although the problem of discrimination is impossible for individual CPs to solve, further initiatives and collaborative approaches of this kind allow fewer opportunities for discrimination.

I was struck by individuals’ resistance, the gaps in depth of understanding about discrimination that remain, especially among individuals who would consider themselves as antiracist, and the polarity in responses to discrimination. It prompted me to continually interrogate myself, my assumptions and approach to the research. The results highlight that continuing conversations about discrimination are necessary despite the challenges.

Moreover, I was humbled and honoured to be trusted with the personal experiences of all participants who shared their thoughts and feelings with me.

It is important to note that I wished neither to erase nor invalidate the experience of racialised individuals by including people of all backgrounds in the study. By acknowledging the multiplicity of identity, it was attempted to add to knowledge about and increase awareness of the necessity and possibilities for collaborative approaches to dismantling discrimination from a position of solidarity.

5. **REFERENCES**

Abdulrahman, S. (2020, August 3). *Do black lives matter in the NHS?* The BMJ. https://blogs.bmj.com/bmj/2020/08/03/sahar-abdulrahman-do-black-lives-matter-in-the-nhs/

Abimbola, S. (2019). The foreign gaze: Authorship in academic global health. *BMJ Global Health*, *4*(5). https://doi.org/10.1136/bmjgh-2019-002068

ACP-UK. (2022). *Equity, diversity and inclusion: Context and strategy for clinical psychology*. Association of Clinical Psychologists UK. https://acpuk.org.uk/wp-content/uploads/2022/03/EDI-Strategy-Document-ACP-UK-Mar22-v1.pdf

Adetimole, F., Afuape, T., & Vara, R. (2005). The impact of racism on the experience of training on a clinical psychology course: Reflections from three Black trainees. *Clinical Psychology Forum*, *48*, 11–15.

Afuape, T., & Hughes, G. (Eds.). (2016). *Liberation practices: Towards emotional wellbeing through dialogue*. Routledge.

Ahsan, S. (2020). Holding up the mirror: Deconstructing whiteness In clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 45–55.

Akala. (2019). *Natives: Race and class in the ruins of empire*. Two Roads.

Alimo-Metcalfe, B. (2013). A critical review of leadership theory. In H. S. Leonard, R. Lewis, A. M. Freedman, & J. Passmore (Eds.), *The Wiley-Blackwell Handbook of the Psychology of Leadership, Change, and Organizational Development: Leonard/The Wiley-Blackwell* (pp. 15–48).

Arai, M., & Thoursie, P. S. (2009). Renouncing personal names: An empirical examination of surname change and earnings. *Journal of Labor Economics*, 127–147.

Attia, M., & Edge, J. (2017). Be(com)ing a reflexive researcher: A developmental approach to research methodology. *Open Review of Educational Research*, *4*, 33–45. https://doi.org/10.1080/23265507.2017.1300068

Bailey, S., & Burhouse, A. (2019). From super-hero to super-connector, changing the -leadership culture in the NHS. *Future Healthcare Journal*, *6*(2), 106–109. https://doi.org/10.7861/futurehosp.6-2-106

Banister, P., Bunn, G., Burman, E., Daniels, J., Duckett, P., Goodley, D., Lawthom, R., Parker, I., Runswick-Cole, K., Sixsmith, J., Smailes, S.,

Tindall, C., & Whelan, P. (1994). *Qualitative methods in psychology: A research guide* (2nd ed.). Open University Press.

Barratt, S. (Ed.). (2013). Evolving applications of systemic ideas. Towards positioning and polarities: David Campbell in interview with Charlotte Burck. In *Positions and Polarities in Contemporary Systemic Practice*. Routledge.

Bass, B. M. (1985). Leadership: Good, better, best. *Organizational Dynamics*, *13*(3), 26–40. https://doi.org/10.1016/0090-2616(85)90028-2

Basset, F. (2021). What's whiteness got to do with it? *Journal of Critical Psychology, Counselling and Psychotherapy*, *21*(1), 6–13.

BBC. (2022). 'Toxic culture' of abuse at mental health hospital revealed by BBC secret filming. *BBC News*. https://www.bbc.com/news/uk-63045298

Bell, D. A. (1980). Brown v. Board of Education and the interest-convergence dilemma. *Harvard Law Review*, *93*(3), 518–533. https://doi.org/10.2307/134054

Bergen, N., & Labonté, R. (2020). "Everything is perfect, and we have no problems": Detecting and limiting social desirability bias in qualitative research. *Qualitative Health Research*, *30*(5), 783–792. https://doi.org/10.1177/1049732319889354

Bhaskar, R. (1978). *A realist theory of science*. Harvester Press.

Bhui, K. (2014). Can race and racism be acknowledged in the transference without it becoming a source of therapeutic impasse? In *Elements of Culture and Mental Health: Critical Questions for Clinicians*. Royal College of Psychiatrists. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=1118293

Bhui, K. (2016). Brexit, social division and discrimination: Impacts on mortality and mental illness? *British Journal of Psychiatry*, *209*(2), 181–182. https://doi.org/10.1192/bjp.209.2.181

BMA, J. (2020). *'We stand in solidarity' – BMA statement on Black Lives Matter*. The British Medical Association Is the Trade Union and Professional Body for Doctors in the UK. https://www.bma.org.uk/news-and-opinion/we-stand-in-solidarity-bma-statement-on-black-lives-matter

Bolden, R. (2004). *What is leadership?* Centre for Leadership Studies, University of Exeter.

Bond, S. (2010). Putting a face to institutionalised racism: The challenge of introducing a live-supervised training programme for black social workers in a predominantly white institution. In C. Burck & G. Daniel (Eds.), *Mirrors and Reflections: Processes of systemic supervision*. Karnac.

BPS. (2010). *Clinical psychology leadership development framework*. British Psychological Society: Division of Clinical Psychology. https://shop.bps.org.uk/clinical-psychology-leadership-development-framework

BPS. (2014). *Code of human research ethics*. British Psychological Society.

BPS. (2017). *BPS practice guidelines (Third Edition)*. British Psychological Society. https://cms.bps.org.uk/sites/default/files/2022-06/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf

Brathwaite, B. (2020). Black lives matter and the disparities and risk of COVID-19 in BAME nurses. *British Journal of Healthcare Assistants*, *14*(7), 318–320. https://doi.org/10.12968/bjha.2020.14.7.318

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021a). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2021b). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*. https://doi.org/10.1037/qup0000196

Braun, V., & Clarke, V. (2021c). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2022). A not-so-scary theory chapter—Conceptually locating reflexive thematic analysis. In *Thematic Analysis. A Practical Guide* (pp. 157–193). SAGE Publications Inc.

Braun, V., Clarke, V., & Gray, D. (2017). Innovations in qualitative methods. In B. Gough (Ed.), *The palgrave handbook of critical social psychology* (pp. 243–266). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-51018-1

Breen, R. L. (2006). A practical guide to focus-group research. *Journal of Geography in Higher Education*, *30*(3), 463–475. https://doi.org/10.1080/03098260600927575

Bridges, D. (2001). The ethics of outsider research. *Journal of Philosophy of Education*, *35*(3), 371–386. https://doi.org/10.1111/1467-9752.00233

Brohi, N., Mehmood, S., Erri, M., Mushtaque, T., Shah, I., & Khuhro, M. (2021). Compassionate leadership is key to success: Role of servant leadership style in predicting employees trust in leadership, psychological safety, and turnover intention. *Ilkogretim Online*, *20*(5), 5662–5672. https://doi.org/10.17051/ilkonline.2021.05.641

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Burgess, R. A. (2022). Working in the wake: Transformative global health in an imperfect world. *BMJ Global Health*, *7*(9). https://doi.org/10.1136/bmjgh-2022-010520

Burnham, J. (2018). Developments in social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In Krause, I-B. (Ed.). *Culture and reflexivity in systemic psychotherapy*. (pp.139-160. Routledge.

Burns, J. M. (1978). *Leadership*. Harper & Row.

Campbell, D. (2022). Thérèse Coffey scraps promised paper on health inequality. *The Guardian*. https://www.theguardian.com/politics/2022/sep/29/therese-coffey-scraps-promised-paper-on-health-inequality

Cape, J., Roth, A., Scior, K., Thompson, M., Heneage, C., & Du Plessis, P. (2008). Increasing diversity within clinical psychology: The London initiative. *Clinical Psychology Forum*, *190*, 7–10.

Carter, K., & O'Reilly, M. (2016). *Is IAPT damaging clinical psychology? -* The British Psychological Society. https://www.bps.org.uk/psychologist/iapt-damaging-clinical-psychology

Case, K. (2012). Discovering the privilege of whiteness: White women's reflections on anti-racist identity and ally behavior. *Journal of Social Issues*, *68*, 78–96. https://doi.org/10.1111/j.1540-4560.2011.01737.x

Chamberlain, K. (2014). Epistemology and qualitative research. In P. Rohleder & A. C. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 9–28). Macmillan International Higher Education.

Chen, C. W., & Gorski, P. C. (2015). Burnout in social justice and human rights activists: Symptoms, causes and implications. *Journal of Human Rights Practice*, *7*(3), 366–390. https://doi.org/10.1093/jhuman/huv011

CHPCCP. (2021). *Equal opportunities data for 2021 entry*. Clearing House for Postgraduate Courses in Clinical Psychology. https://www.clearing-house.org.uk/sites/default/files/2022-05/Equal%20opportunities%20data%20for%202021%20entry.pdf

Clarence, E., & Painter, C. (1998). Public services under New Labour: Collaborative discourses and local networking. *Public Policy and Administration*, *13*(3), 8–22. https://doi.org/10.1177/095207679801300302

Clarke, S., & Garner, S. (2009). *White identities: A critical sociological approach*. Pluto Press. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=3386535

Clarke, V., & Braun, V. (2021a). Tips on writing a qualitative dissertation or thesis, from Braun & Clarke—Part 1. *Edpsy.Org.Uk*. https://edpsy.org.uk/blog/2021/tips-on-writing-a-qualitative-dissertation-or-thesis-from-braun-clarke-part-1/

Clarke, V., & Braun, V. (2021b). Tips on writing a qualitative dissertation or thesis, from Braun & Clarke—Part 2. *Edpsy.Org.Uk*. https://edpsy.org.uk/blog/2021/tips-on-writing-a-qualitative-dissertation-or-thesis-from-braun-clarke-part-2/

Coghill, Y. (2019). When will we see more diverse nursing leadership? *British Journal of Nursing*, *28*(1), 62–63.

Collins, E., Owen, P., Digan, J., & Dunn, F. (2020). Applying transformational leadership in nursing practice. *Nursing Standard*, *35*(5), 59–66.

Cozijnsen, L., Levi, M., & Verkerk, M. J. (2020). Why industrial methods do not work in healthcare: An analytical approach. *Internal Medicine Journal*, *50*(2), 250–253.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

Daiches, A. (2010). Clinical psychology and diversity: Progress and continuing challenges: A commentary. *Psychology Learning & Teaching*, *9*(2), 28–29. https://doi.org/10.2304/plat.2010.9.2.28

Dalal, F. (2002). *Race, colour and the processes of racialization: New perspectives from group analysis, psychoanalysis and sociology*. Routledge.

Dalton, S. D. (2020). Flapjack or jackboot? Reflections on leadership styles for the COVID-19 pandemic. *BMJ Leader*, *4*(3). https://doi.org/10.1136/leader-2020-000270

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*(1), 43–63. https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Dawes, D., & Handscomb, A. (2005). *A literature review on team leadership*. European Nursing Leadership Foundation. http://www.nursingleadership.org.uk/publications/teamreport.pdf

DCP. (2015). *Clinical psychology UK workforce project*. Scribd. https://www.scribd.com/presentation/291856635/CLINICAL-PSYCHOLOGY-UK-WORKFORCE-PROJECT

de Zulueta, P. C. (2016). Developing compassionate leadership in health care: An integrative review. *Journal of Healthcare Leadership*, *8*, 1–10. http://dx.doi.org/10.2147/JHL.S93724

Delbridge, R., & Ezzamel, M. (2005). The strength of difference: Contemporary conceptions of control. *Organization*, *12*(5), 603–618. https://doi.org/10.1177/1350508405055937

Delgado, R., & Stefancic, J. (Eds.). (2013). *Critical race theory: The cutting edge*. Temple University Press. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=1210896

Dempsey, L., Dowling, M., Larkin, P., & Murphy, K. (2016). Sensitive interviewing in qualitative research. *Research in Nursing & Health*, *39*(6), 480–490. https://doi.org/10.1002/nur.21743

Department of Health. (1989). *'Working for patients' white paper*. Department of Health. https://navigator.health.org.uk/theme/working-patients-white-paper

Department of Health. (1997). *The new NHS: Modern, dependable*. The Stationery Office Ltd.

Department of Health. (2000). *The NHS plan: A plan for investment, a plan for reform.* HM Government. https://webarchive.nationalarchives.gov.uk/20130124064356/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118522.pdf

Department of Health. (2004). *NHS the strategic health authority: Race equality guide 2004: A performance framework*. https://jstor.org/stable/community.28327588

Department of Health. (2006). *Our health, our care, our say: A new direction for community services*. HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

Department of Health. (2007). *The NHS modernisation agency*. https://webarchive.nationalarchives.gov.uk/ukgwa/20090501182614mp_/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/Browsable/DH_4907637

Department of Health. (2008a). *A high quality workforce: NHS next stage review*. Department of Health. https://webarchive.nationalarchives.gov.uk/ukgwa/20130105063355mp_/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_085841.pdf

Department of Health. (2008b). *High quality care for all. NHS next stage review: Final report*. Department of Health.

Department of Health. (2008c). *Modernising medical Careers*. Department of Health. https://publications.parliament.uk/pa/cm200708/cmselect/cmhealth/25/25i.pdf

Department of Health. (2009). *Inspiring leaders: Leadership for quality*. Department of Health.

https://www.aemh.org/images/AEMH_documents/2018/16_Inspiring_leaders_Dept-of-health.pdf

Department of Health. (2010). *Equity and excellence: Liberating the NHS.* HM Government.

Department of Health. (2012). *Liberating the NHS: Developing the healthcare workforce*. HM Government. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216421/dh_132087.pdf

Department of Health. (2022). *Direct and indirect health impacts of COVID-19 in England: Emerging Omicron impacts*. GOV.UK. https://www.gov.uk/government/publications/direct-and-indirect-health-impacts-of-covid-19-in-england-emerging-omicron-impacts/direct-and-indirect-health-impacts-of-covid-19-in-england-emerging-omicron-impacts

Department of Health and Social Care. (2019). *The NHS Long Term Plan*. Department of Health and Social Care. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

Department of Health and Social Security. (1973). *National Health Service Reorganisation Act 1973*. Department of Health and Social Security. https://www.legislation.gov.uk/ukpga/1973/32/enacted

DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy*, *3*(3), 54–70.

DiAngelo, R. (2012). *Nothing to add: A challenge to white silence in racial discussions*. *2*, 1–17. https://marypendergreene.com/wp-content/uploads/2020/01/Nothing-to-Add-Published.pdf

DiAngelo, R. (2018). *White fragility: Why it’s so hard for white people to talk about racism* (Reprint edition). Beacon Press.

Eddo-Lodge, R. (2018). *Why I’m No Longer Talking to White People About Race* (1st ed.). Bloomsbury Publishing.

Eichstedt, J. L. (2001). Problematic white identities and a search for racial justice. *Sociological Form*, *16*(3), 445–470.

Equality Act. (2010). *Discrimination: Your rights*. GOV.UK. https://www.gov.uk/discrimination-your-rights

Evans, D. (2022). So close to love: Compassionate leadership in healthcare. *British Journal of Healthcare Management*, *28*(4), 1–8. https://doi.org/10.12968/bjhc.2021.0135

Exworthy, M., Powell, M., & Mohan, J. (1999). Markets, bureaucracy and public management: The NHS: Quasi-market, quasi-hierarchy and quasi-network? *Public Money & Management*, *19*(4), 15–22. https://doi.org/10.1111/1467-9302.00184

Fernando, S. (2017). How 'race' began, and the emergence of psychiatry and clinical psychology. In *Institutional Racism in Psychiatry and Clinical Psychology: Race Matters in Mental Health* (pp. 11–38). Springer International Publishing AG. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=5042239

Finn, R. (2008). The language of teamwork: Reproducing professional divisions in the operating theatre. *Human Relations*, *61*(1), 103–130. https://doi.org/10.1177/0018726707085947

Fish, J. (2008). Navigating queer street: Researching the intersections of lesbian, gay, bisexual and trans (LGBT) identities in health research. *Sociological Research Online*, *13*(1), 104–115. https://doi.org/10.5153/sro.1652

Ford, J. (2005). Examining leadership through critical feminist readings. *Journal of Health Organization and Management*, *19*, 236–251. https://doi.org/10.1108/14777260510608961

Foster, S. (2017). Compassionate leadership counts. *British Journal of Nursing*, *26*(12), 715–715. https://doi.org/10.12968/bjon.2017.26.12.715

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust public enquiry: Executive summary.* Stationery Office (TSO).

Freire, P. (1993). *Pedagogy of the oppressed* (30th anniversary ed). Continuum.

Fricker, M. (2009). *Epistemic injustice: Power and the ethics of knowing*. University Press.

Gibb, C. (1947). The principles and traits of leadership. *The Journal of Abnormal and Social Psychology*, *42*(3), 267–284.

Gilbert, P. (2010). *The compassionate mind*. Constable.

Gomez, R. (2015. *Building a preliminary model of the transformational process of how clinical psychologists may evolve into compassionate leaders: A*

grounded theory investigation. [Doctoral thesis, Salomons Christ Church Canterbury University]. http://create.canterbury.ac.uk/13920/1/Rosemary_Gomes_MRP_2015.pdf

Goodwin, N. (2000). The National Leadership Centre and The NHS Plan. *British Journal of Healthcare Management*, *6*(9), 399–401. https://doi.org/10.12968/bjhc.2000.6.9.19307

Gordon, L. (2019). Managing self, managing others: What does owning one's perspective add to leadership when you are a black woman in the NHS? In M. McIntosh, H. Nicholas, & A. H. Huq (Eds.), *Leadership and Diversity in Psychology: Moving Beyond the Limits* (pp. 118–127). Taylor & Francis Group. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=5704054

Gordon, L. J., Rees, C. E., Ker, J. S., & Cleland, J. (2015). Dimensions, discourses and differences: Trainees conceptualising health care leadership and followership. *Medical Education*, *49*(12), 1248–1262. https://doi.org/10.1111/medu.12832

Gorski, P. C., & Erakat, N. (2019). Racism, whiteness, and burnout in antiracism movements: How white racial justice activists elevate burnout in racial justice activists of color in the United States. *Ethnicities*, *19*(5), 784–808. https://doi.org/10.1177/1468796819833871

Griffith, A. I. (1998). Insider / outsider: Epistemological privilege and mothering work. *Human Studies*, *21*(4), 361–376.

Griffiths, R., Bett, M., Blyth, J., & Bailey, B. (1983). *Griffiths Report on NHS.* HM Government.

Grint, K. (2000). *The arts of leadership*. Oxford University Press. https://static1.squarespace.com/static/5df3bc9a62ff3e45ae9d2b06/t/5e28652f63f0e31fb8b54c28/1579705668236/Arts+of+Leadership.Grint.EBS.pdf

Grint, K. (2010). Wicked problems and clumsy solutions: The role of leadership. In S. Brookes & K. Grint (Eds.), *The new public leadership challenge* (pp. 169–186). Palgrave Macmillan UK. https://doi.org/10.1057/9780230277953

Ham, C. (2014). *Reforming the NHS from within: Beyond hierarchy, inspection and markets*. The King's Fund.

Harrison, S. (1988). *Managing the National Health Service: Shifting the frontier?* Springer.

Haycock-Stuart, E., & Kean, S. (2012). Does nursing leadership affect the quality of care in the community setting? *Journal of Nursing Management*, *20*(3), 372–381. https://doi.org/10.1111/j.1365-2834.2011.01309.x

Hayfield, N., & Huxley, C. (2015). Insider and outsider perspectives: Reflections on researcher identities in research with lesbian and bisexual women. *Qualitative Research in Psychology*, *12*(2), 91–106. https://doi.org/10.1080/14780887.2014.918224

Health Education England. (2022). *Action plan to improve equity of access and inclusion for Black, Asian and Minority ethnic entrants to clinical psychology training*. https://healtheducationengland.sharepoint.com/sites/MHPe/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FMHPe%2FShared%20Documents%2FPsychological%20Professions%2FNHS%20Funding%20Psych%20Professions%2FExternal%20Comms%20Updates%2FNovember%202021%2FAction%20Plan%20to%20Improve%20Equity%20of%20Access%20and%20Inclusion%20for%20Black%2C%20Asian%20and%20Minority%20Ethnic%20Entrants%20to%20Clinical%20Psychology%20Training%2Epdf&parent=%2Fsites%2FMHPe%2FShared%20Documents%2FPsychological%20Professions%2FNHS%20Funding%20Psych%20Professions%2FExternal%20Comms%20Updates%2FNovember%202021&p=true&ga=1

Health Foundation. (2021). *Unequal pandemic, fairer recovery.* The Health Foundation. https://www.health.org.uk/publications/reports/unequal-pandemic-fairer-recovery

Hewison, A., & Morrell, K. (2014). Leadership development in the English National Health Service: A counter narrative to inform policy. *International Journal of Nursing Studies*, *51*(4), 677–688. https://doi.org/10.1016/j.ijnurstu.2013.08.004

Hewison, A., Sawbridge, Y., Cragg, R., Rogers, L., Lehmann, S., & Rook, J. (2018). Leading with compassion in health care organisations: The development of a compassion recognition scheme-evaluation and

analysis. *Journal of Health Organization and Management*, *32*(2), 338–354. https://doi.org/10.1108/JHOM-10-2017-0266

Hewison, A., Sawbridge, Y., & Tooley, L. (2019). Compassionate leadership in palliative and end-of-life care: A focus group study. *Leadership in Health Services*, *32*(2), 264–279. https://doi.org/10.1108/LHS-09-2018-0044

Hofmeyer, A., & Taylor, R. (2021). Strategies and resources for nurse leaders to use to lead with empathy and prudence so they understand and address sources of anxiety among nurses practising in the era of COVID-19. *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, *30*(1/2), 298–305.

Horrell, B., Stephens, C., & Breheny, M. (2015). Online research with informal caregivers: Opportunities and challenges. *Qualitative Research in Psychology*, *12*(3), 258–271. https://doi.org/10.1080/14780887.2015.1040318

Hutchinson, M., & Jackson, D. (2013). Transformational leadership in nursing: Towards a more critical interpretation. *Nursing Inquiry*, *20*(1), 11–22. https://doi.org/10.1111/nin.12006

Ifekwunigwe, J. O., Wagner, J. K., Yu, J.-H., Harrell, T. M., Bamshad, M. J., & Royal, C. D. (2017). A qualitative analysis of how anthropologists interpret the race construct: How anthropologists interpret the race construct. *American Anthropologist*, *119*(3), 422–434. https://doi.org/10.1111/aman.12890

Iqbal, M. (2019). *Increasing diversity in the workforce: Exploring experiences of diversity issues that affect clinical psychology careers* [University of Liverpool]. https://livrepository.liverpool.ac.uk/3065156/1/201227092_Nov2019.pdf

Kalra, V. S., Abel, P., & Esmail, A. (2009). Developing leadership interventions for black and minority ethnic staff: A case study of the National Health Service (NHS) in the U.K. *Journal of Health Organization & Management*, *23*(1), 103–118. https://doi.org/10.1108/14777260910942588

Kanuha, V. K. (2000). ‘Being’ native versus ‘going native’: Conducting social work research as an insider. *Social Work*, *45*(5), 439–447.

Keating, F., Robertson, D., McCulloch, A., & Francis, E. (2002). *Breaking the circles of fear: A review of the relationship between mental health*

services and African and Caribbean communities. The Sainsbury Centre for Mental Health.

Kendi, I. X. (2019). *How to be an antiracist*. Random House Publishing Group.

Kline, R. (2014). *The 'snowy white peaks' of the NHS: A survey of discrimination in governance and leadership and the potential impact on patient care in London and England.* University of Middlesex. https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf

Kline, R. (2015). *Beyond the snowy white peaks of the NHS?*. Race Equality Foundation.

Kotter, J. P. (1990). What leaders really do. *Harvard Business Review*, *68*(3), 103–111.

Kumar, R. D. C. (2013). Leadership in healthcare. *Anaesthesia & Intensive Care Medicine*, *14*(1), 39–41. https://doi.org/10.1016/j.mpaic.2012.11.006

Lawrence, B. D. (2021). *An avoidable crisis: The disproportionate impact of Covid-19 on Black, Asian and minority ethnic communities.* (p. 29).

Learmonth, M. (2014). Who doesn't want to be a leader? Leaders are such wonderful people comment on "Leadership and Leadership Development in Healthcare Settings - A Simplistic Solution to Complex Problems?" *International Journal of Health Policy and Management*, *4*(1), 45–47. https://doi.org/10.15171/ijhpm.2015.03

Lorde, A. (1984a). Age, race, class, and sex: Women redefining difference. In *Sister outsider: Essays and speeches* (pp. 114–123). Penguin Classics.

Lorde, A. (1984b). *Sister outsider: Essays and speeches*. Penguin Classics.

Lorde, A. (1984c). The master's tools will never dismantle the master's house. In *Sister outsider: Essays and speeches.* (pp. 110–113). Penguin Classics.

Lorde, A. (1984d). The uses of anger: Women responding to racism. In *Sister outsider: Essays and speeches:* (pp. 124–133). Penguin Classics.

Lowe, F. (2013). Thinking space: The model. In *Thinking space: Promoting thinking about race, culture, and diversity in psychotherapy and beyond* (1st ed., pp. 11–34). Karnac. https://doi.org/10.4324/9780429483974-2

Macpherson, W. (1999). *The Stephen Lawrence Inquiry*. Stationery Office.

Malterud, K., Siersma, V., & Guassora, A. D. (2015). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *1*, 1–8. https://doi.org/10.1177/1049732315617444

Mann, R. D. (1959). A review of the relationships between personality and performance in small groups. *Psychological Bulletin*, *56*(4), 241–270. https://doi.org/10.1037/h0044587

Mannion, R., Davies, H., Harrison, S., Konteh, F., Greener, I., McDonald, R., Dowswell, G., Walshe, K., Fulop, N., Walters, R., Jacobs, R., & Hyde, P. (2010). *Changing management cultures and organisational performance in the NHS*. National Institute for Health Research Service Delivery and Organisation Programme.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., & Grady, M. (2010). *Fair society, healthy lives.* UCL Institute of Health Equity. http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

Marnoch, G., McKee, L., & Minnie, N. (2000). Between organisations and institutions. Legitimacy and medical managers. *Public Administration*, *78*, 967–987.

Martin, G. P., Currie, G., & Finn, R. (2009a). Reconfiguring or reproducing intra-professional boundaries? Specialist expertise, generalist knowledge and the ‘modernization’ of the medical workforce. *Social Science & Medicine*, *68*(7), 1191–1198. https://doi.org/10.1016/j.socscimed.2009.01.006

Martin, G. P., Currie, G., & Finn, R. (2009b). Leadership, service reform, and public-service networks: The case of cancer-genetics pilots in the English NHS. *Journal of Public Administration Research and Theory*, *19*(4), 769–794. https://doi.org/10.1093/jopart/mun016

Martin, G. P., & Learmonth, M. (2012). A critical account of the rise and spread of ‘leadership’: The case of UK healthcare. *Social Science & Medicine*, *74*(3), 281–288. https://doi.org/10.1016/j.socscimed.2010.12.002

Martin, G. P., & Waring, J. (2013). Leading from the middle: Constrained realities of clinical leadership in healthcare organizations. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *17*(4), 358–374. psyh. https://doi.org/10.1177/1363459312460704

Mason, B. (1993). Towards positions of safe uncertainty. *Human Systems: The Journal of Systemic Consultation and Management*, *4*, 189–200.

Maxwell, J. A. (2012). *A realist approach for qualitative research*. SAGE.

McClelland, L. (2006). Social inequalities formulation: Mad, bad and dangerous to know. In *Formulation in psychology and psychotherapy*. https://doi.org/10.4324/9780203087268-13

McCray, J., Warwick, R., & Palmer, A. (2018). Impressions of action and critical action learning: Exploring the leadership development of senior doctors in an English healthcare organization. *International Journal of Training and Development*, *22*(1), 69–85. https://doi.org/10.1111/ijtd.12119

McInnis, E. M. (2020). An African psychology perspective on White Supremacy within UK clinical psychology. *Journal of Critical Psychology, Counselling and Psychotherapy*, *20*(3), 5–15.

McIntosh, M., Nicholas, H., & Huq, A. H. (2019). *Leadership and diversity in psychology: Moving beyond the limits*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=5704054

McIntosh, P. (2009). White privilege and male privilege. In S. Shaw & J. Lee (Eds.), *Women's voices, feminist visions: Classic and contemporary Readings* (4th ed., pp. 28–40). McGraw-Hill. http://www.rowanfirstyearwriting.com/uploads/1/2/9/3/12938517/white_privilege_and_male_privilege.pdf

Midlands Partnership Foundation Trust. (2020). *Black Lives Matter: Midlands Partnership Foundation Trust*. https://www.mpft.nhs.uk/about-us/latest-news/black-lives-matter

Milner, A., Nielsen, R., & Norris, E. (2021). Brexit and European doctors' decisions to leave the United Kingdom: A qualitative analysis of free-text questionnaire comments. *BMC Health Services Research*, *21*(1), 188. https://doi.org/10.1186/s12913-021-06201-0

Ministry of Health. (1969). *The report of the committee on senior nursing staff structure. The Salmon Report* (pp. 268–278). Her Majesty's Stationery Office.

Mintah, R., Ong, L., Johnson, T., & Nagra, S. (2020). *Racism is not entertainment*. Psychologists for Social Change. http://www.psychchange.org/racism-is-not-entertainment.html

Mintzberg, H. (1973). *The nature of managerial work*. Pearson.

Mohan, J. (1996). Accounts of the NHS reforms: Macro-, meso- and micro- level perspectives. *Sociology of Health & Illness*, *18*(5), 675–698. https://doi.org/10.1111/1467-9566.ep10934530

Mohdin, A., Walker, P., & Parveen, N. (2021). No 10's race report widely condemned as 'divisive'. *The Guardian*. https://www.theguardian.com/world/2021/mar/31/deeply-cynical-no-10-report-criticises-use-of-institutional-racism

Monkhouse, A., Sadler, L., Boyd, A., & Kitsell, F. (2018). The Improving Global Health fellowship: A qualitative analysis of innovative leadership development for NHS healthcare professionals. *Globalization & Health*, *14*(1). https://doi.org/10.1186/s12992-018-0384-3

Morgan, H. (2021). Whiteness: A problem for our times. *British Journal of Psychotherapy*, *37*(3), 469–483. https://doi.org/10.1111/bjp.12648

Morrell, K., & Hewison, A. (2013). Rhetoric in policy texts: The role of enthymeme in Darzi's review of the NHS. *Policy & Politics*, *41*(1), 59–79. https://doi.org/10.1332/030557312X645801

Morrison, T. (1998). *Toni Morrison—Interviewed by Jana Wendt* (Australian Broadcasting Corporation (ABC), Interviewer) [Australian Broadcasting Corporation]. https://www.youtube.com/watch?v=WoTELoC8Q0M

National Institute for Health Research. (2013). *New evidence on management and leadership*. Health services and delivery research programme. https://www.journalslibrary.nihr.ac.uk/downloads/research-programmes/HSDR/New-Evidence-on-Management-and-Leadership.pdf

Newman, A., Donohue, R., & Eva, N. (2017). Psychological safety: A systematic review of the literature. *Human Resource Management Review*, *27*, 521–535. https://doi.org/10.1016/j.hrmr.2017.01.001

Newnes, C. (2011). Toxic Psychology. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: Psychiatry, psychology and the human condition* (pp. 211–225). Palgrave Macmillan UK. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=797941

NHS England. (2012). *Compassion in practice*. https://www.england.nhs.uk/wp-content/uploads/2014/12/london-nursing-accessible.pdf

NHS England. (2014). *Building and strengthening leadership: Leading with compassion*. https://www.england.nhs.uk/wp-content/uploads/2014/12/london-nursing-accessible.pdf

NHS England. (2022a). *Coronavirus » Addressing impact of COVID-19 on BAME staff in the NHS*. https://www.england.nhs.uk/coronavirus/workforce/addressing-impact-of-covid-19-on-bame-staff-in-the-nhs/

NHS England. (2022b). *Leadership for a collaborative and inclusive future*. Department of Health & Social Care. https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

NHS England. (2022c). *London NHS reflects on two years of Covid-19*. https://www.england.nhs.uk/london/2022/02/05/london-nhs-reflects-on-two-years-of-covid-19/

NHS Leadership Academy. (2011). *Clinical leadership competency framework*. NHS Leadership Academy. https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf

NHS Leadership Academy. (2019). *Inclusion: The DNA of leadership and change*. NHS Leadership Academy.

NHS Leadership Academy. (2022a). *Building leadership for inclusion – Leadership Academy*. https://www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/blfi-2/

NHS Leadership Academy. (2022b). *Inclusion, equality and diversity – Leadership Academy*. https://www.leadershipacademy.nhs.uk/resources/inclusion-equality-and-diversity/

NHS Leadership Academy. (2022c). *Leadership Academy – Better leaders, better care, brighter future*. https://www.leadershipacademy.nhs.uk/?repeat=w3tc

NHS Leadership Centre. (2004). *NHS leadership qualities framework: A good practice guide*. NHS Institute for Innovation and Improvement.

NICE. (2012). *Methods for the development of NICE public health guidance (third edition)*. NICE. National Institute for Health and Clinical Excellence.

NICE. (2022). *History of NICE: Who we are*. NICE. https://www.nice.org.uk/about/who-we-are/history-of-nice

Nicola, M., Sohrabi, C., Mathew, G., Kerwan, A., Al-Jabir, A., Griffin, M., Agha, M., & Agha, R. (2020). Health policy and leadership models during the COVID-19 pandemic: A review. *International Journal of Surgery*, *81*, 122–129. https://doi.org/10.1016/j.ijsu.2020.07.026

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Open University Press. https://www.vlebooks.com/Product/Index/314192?page=0

Nottinghamshire NHS Leaders. (2020). *A statement from Nottingham and Nottinghamshire's NHS leaders—Black Lives Matter*. Nottinghamshire Healthcare NHS Foundation Trust. https://www.nottinghamshirehealthcare.nhs.uk/latest-news

Obholzer, A. (1994). Authority, power and leadership: Contributions from group relations training. In A. Obholzer & V. Zagier Roberts (Eds.), *The unconscious at work: Individual and organizational stress in the human services*. Routledge.

Oborn, E., Barrett, M., & Dawson, S. (2013). Distributed leadership in policy formulation: A sociomaterial perspective. *Organization Studies*, *34*(2), 253–276. https://doi.org/10.1177/0170840612473552

Odusanya, S. (2017). *The experience ofqQualified BME clinical psychologists: An interpretative phenomenological and repertory grid analysis*. https://doi.org/10.18745/th.17471

Office for National Statistics. (2020). *Regional ethnic diversity*. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest#ethnic-diversity-by-area

Oliver, D. (2020). Covid-19 has shown the value of local and clinical NHS leadership. *BMJ*, *370*, m3532. https://doi.org/10.1136/bmj.m3532

Olsen, W. (2004). Triangulation in social research: Qualitative and quantitative methods can really be mixed. In M. Holborn (Ed.), *Developments in sociology* (Vol. 20). Causeway Press Ltd.

Ong, L. (2021). *White clinical psychologists, race and racism* [Professional Doctorate, University of East London]. https://doi.org/10.15123/uel.89y81

Onyett, S. (2007). *BPS new ways of working for applied psychologists in health and social care—Working psychologically in teams*. The British Psychological Society. https://cms.bps.org.uk/sites/default/files/2022-

07/BPS%20New%20Ways%20of%20Working%20for%20Applied%20Psychologists%20in%20Health%20and%20Social%20Care.pdf

O'Reilly, D., & Reed, M. (2010). 'Leaderism': An evolution of managerialism in UK public service reform. *Public Administration*, *88*(4), 960–978. https://doi.org/10.1111/j.1467-9299.2010.01864.x

Owens, P., & Glennerster, H. (1990). *Nursing in conflict*. Macmillan. https://link.springer.com/book/10.1007/978-1-349-11177-0

Patel, N. (2010). Plus ça Change, Plus C'est la Même Chose? Commentary on Turpin and Coleman. *Psychology Learning & Teaching*, *9*(2), 30–31. https://doi.org/10.2304/plat.2010.9.2.30

Patel, N. (2011). The psychologisation of torture. In M. Rapley, J. Moncrieff, & J. Dillon (Eds.), *De-medicalizing misery: psychiatry, psychology and the human condition* (pp. 239–255). Palgrave Macmillan UK. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=797941

Patel, N. (2019). *Racism is not entertainment*. Psychologists for Social Change. http://www.psychchange.org/racism-is-not-entertainment.html

Patel, N. (2021). Dismantling the scaffolding of institutional racism and institutionalising anti-racism. *Journal of Family Therapy*, *n/a*(n/a). https://doi.org/10.1111/1467-6427.12367

Patel, N., & Fatimilehin, I. (2005). Racism and clinical psychology: Has anything changed? *Clinical Psychology Forum*, *48*, 20–23.

Patel, N., & Keval, H. (2018). Fifty ways to leave …… your racism. *Journal of Critical Psychology, Counselling and Psychotherapy*, *18*(2), 61–79.

Percival, A., & Best, S. (2019). Does leadership development alter the perspectives of NHS managers? *British Journal of Healthcare Management*, *25*(2), 85–91. https://doi.org/10.12968/bjhc.2019.25.2.85

Phillips, N., & Norman, K. (2020). A case study of frontline nurse leadership informed by complex responsive processes of relating. *Journal of Clinical Nursing*, *29*(13/14), 2181–2195.

Pilgrim, D. (2014). Some implications of critical realism for mental health research. *Social Theory & Health*, *12*(1), 1–21. https://doi.org/10.1057/sth.2013.17

Power, A., Allbutt, H., Munro, L., Macleod, M., Kennedy, S., Cameron, D., Scoular, K., Orr, G., & Gillies, J. (2017). An evaluation of experiences

and views of Scottish leadership training opportunities amongst primary care professionals. *Education for Primary Care*, *28*(3), 159–164.

PPN. (2020). *Leadership and management in the psychological professions: Discussion paper*. Psychological Professions Network. https://se-ppn.nhs.uk/resources/ppn-kss-publications/38-leadership-and-management-in-the-psychological-professions-discussion-paper/file

Prajapati, R., Kadir, S., & King, S. (2019). Dealing with racism within clinical psychology training: Reflections of three BAME trainee clinical psychologists Riddhi Prajapati, Sanaa Kadir & Sadé King. *Clinical Psychology Forum*, *323*, 20–24.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, *51*(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390

Reeve, D. (2012). Psycho-emotional disablism in the lives of people experiencing mental distress. In J. Anderson & H. Spandler (Eds.), *Distress or disability? Proceedings of a symposium held at Lancaster Disability 15-16 November 2011* (pp. 24–29). Centre for Disability Research, Lancaster University. https://eprints.lancs.ac.uk/id/eprint/69661/1/ReeveChapter2012a.pdf

Ross, L. E. (2017). An account from the inside: Examining the emotional impact of qualitative research through the lens of “insider” research. *Qualitative Psychology*, *4*(3), 326. https://doi.org/10.1037/qup0000064

Ryde, J. (2019). *White privilege unmasked: How to be part of the solution*. Jessica Kingsley Publishers.

Saidi, A. M. O. A., Nur, F. A., Al-Mandhari, A. S., Rabbat, M. E., Hafeez, A., & Abubakar, A. (2020). Decisive leadership is a necessity in the COVID-19 response. *The Lancet*, *396*(10247), 295–298. https://doi.org/10.1016/S0140-6736(20)31493-8

Salway, S., Ghazala, M., Turner, D., George, E. T. H., Carter, L., & Gerrish, K. (2016). Obstacles to ``race equality’’ in the English National Health Service: Insights from the healthcare commissioning arena. *Social Science & Medicine*, *152*, 102–110. https://doi.org/10.1016/j.socscimed.2016.01.031

Seewoodhary, J. (2021). Black Lives Matter: Tackling racial and ethnic inequalities in diabetes health care. *Practical Diabetes*, *38*(3), 26–30. https://doi.org/10.1002/pdi.2338

Silverman, D. (2013). *Doing qualitative research: A practical handbook* (Fourth edition.). Sage.

SLAM. (2022). *Aspiring clinical psychologists access acheme—South London and Maudsley*. https://slam.nhs.uk/aspiring-clinical-psychologists-access-scheme

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist*, *60*(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16

Smithson, J. (2007). Using focus groups in social research. In P. Alasuutari, L. Bickman, & J. Brannen (Eds.), *The SAGE Handbook of Social Research Methods* (pp. 356-371.). Sage.

Smoot, K. (2020, June 29). White people say they want to be an ally to Black people. But are they ready for sacrifice? *The Guardian*. https://www.theguardian.com/commentisfree/2020/jun/29/white-people-ally-black-people-sacrifice

Spiliopoulos, G., & Timmons, S. (2022). Migrant NHS nurses as 'tolerated' citizens in post-Brexit Britain. *The Sociological Review*. https://doi.org/10.1177/00380261221092199

Stainton Rogers, W., & Willig, C. (2008). *The SAGE handbook of qualitative research in psychology*. SAGE.

Stevens, S. (2020). *NHS England » Personal message from Sir Simon Stevens on Black Lives Matter and health inequalities*. https://www.england.nhs.uk/2020/06/personal-message-from-sir-simon-stevens-on-black-lives-matter-and-health-inequalities/

Stoller, J. K. (2020). Reflections on leadership in the time of COVID-19. *BMJ Leader*, leader-2020-000244. https://doi.org/10.1136/leader-2020-000244

Storey, J., & Holti, R. (2013). Towards a new model of leadership for the NHS. *NHS Leadership Academy*.

Streeton, A.-M., Kitsell, F., Kung, M., Oo, M., Rowse, V., Wadd, V., & Shere, H. (2021). The Improving Global Health Programme—Leadership

development in the NHS through overseas placement. *BMJ Global Health*, *6*. https://doi.org/10.1136/bmjgh-2020-004533

The King's Fund. (2011). *The future of leadership and management in the NHS: No more heroes*. The King's Fund. https://www.kingsfund.org.uk/sites/default/files/future-of-leadership-and-management-nhs-may-2011-kings-fund.pdf

The King's Fund. (2012). *Leadership and engagement for improvement in the NHS – Together we can*. The King's Fund. https://www.emerald.com/insight/content/doi/10.1108/lhs.2012.21125daa.009/full/html

Tomkins, L., & Simpson, P. (2015). Caring leadership: A Heideggerian perspective. *Organization Studies*, *36*(8), 1013–1031. https://doi.org/10.1177/0170840615580008

Tong, K., Peart, A., & Rennalls, S. J. (2019). Reframing our stories: Addressing barriers faced by Black people trying to access a career in clinical psychology. *Clinical Psychology Forum*, *323*, 14–19.

Tribe, R., & Bell, D. (2018). Social justice, diversity and leadership. *The European Journal of Counselling Psychology*, *6*(1), 111–125. https://doi.org/10.5964/ejcop.v6i1.145

Tribe, R., Weerasinghe, D., & Parameswaran, S. (2014). Increasing mental health capacity in a post-conflict country through effective professional volunteer partnerships: A series of case studies with government agencies, local NGOs and the diaspora community. *International Review of Psychiatry*, *26*(5), 558–565. https://doi.org/10.3109/09540261.2014.918025

Tuck, E., & Yang, K. W. (2021). Decolonisation is not a metaphor. *Tabula Rasa*, *38*, 61–111. https://doi.org/10.25058/20112742.n38.04

Turpin, G., & Coleman, G. (2010). Clinical psychology and diversity: Progress and continuing challenges. *Psychology Learning & Teaching*, *9*(2), 17–27. https://doi.org/10.2304/plat.2010.9.2.17

Vance, C., & Larson, E. (2002). Leadership research in business and health care. *Journal of Nursing Scholarship*, *34*(2), 165–171. https://doi.org/10.1111/j.1547-5069.2002.00165.x

Vince, R. (2008). ‘Learning-in-action’ and ‘learning inaction’: Advancing the theory and practice of critical action learning. *Action Learning: Research and Practice*, *5*(2), 93–104. https://doi.org/10.1080/14767330802185582

Vincent, S., & O’Mahoney, J. (2018). Critical realism and qualitative research: An introductory overview. In C. Cassell, A. Cunliffe, & G. Grandy, *The SAGE handbook of qualitative business and management research methods: History and traditions* (pp. 201–216). SAGE Publications Ltd. https://doi.org/10.4135/9781526430212.n13

Wainwright, T. (2014). Ethics column: The governance and influence of clinical psychology: Professional ethics and the Francis report. *Clinical Psychology Forum Special Issue: The Francis Report*, *2014*, 5–9.

Webster, C. (1988). *Problems of health care; The National Health Service before 1957* (1st Edition). Stationery Office Books.

Webster, C. (2002). *The National Health Service: A political history*. Oxford University Press.

Weick, K. E. (1984). Redefining the scale of social problems. *American Psychologist*, *39*(1), 40–49.

West, M. (2021). *Compassionate leadership: Sustaining wisdom, humanity and presence in health and social care*. Swirling Leaf Press.

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T., & Lee, A. (2015). *Leadership and leadership development in health care: The evidence base*. The King’s Fund. https://www.kingsfund.org.uk/node/90575

West, M., Eckert, R., Collins, B., & Chowla, R. (2017). *Caring to change. How compassionate leadership can stimulate innovation in health care*. The King’s Fund.

West, M., Eckert, R., Steward, K., & Pasmore, B. (2014). *Developing collective leadership for health care*. King’s Fund.

Whomsley, S. (2014). Compassion, organisations and leadership. *Clinical Psychology Forum Special Issue: The Francis Report*, 46–48.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Willig, C. (2016). Constructivism and ‘the real world’: Can they co-exist? *QMiP Bulletin*, *21*. https://openaccess.city.ac.uk/id/eprint/13576/1/

Winter, L. A. (2019). Power and privilege in psychology: Can we have egalitarian leadership? In M. McIntosh, H. Nicholas, & A. H. Huq (Eds.),

Leadership and Diversity in Psychology: Moving Beyond the Limits (pp. 85–93). Taylor & Francis Group. http://ebookcentral.proquest.com/lib/uel/detail.action?docID=5704054

Wood, N., & Patel, N. (2017). On addressing ‘Whiteness’ during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291.

WRES. (2019). *NHS workforce race quality standard.* https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

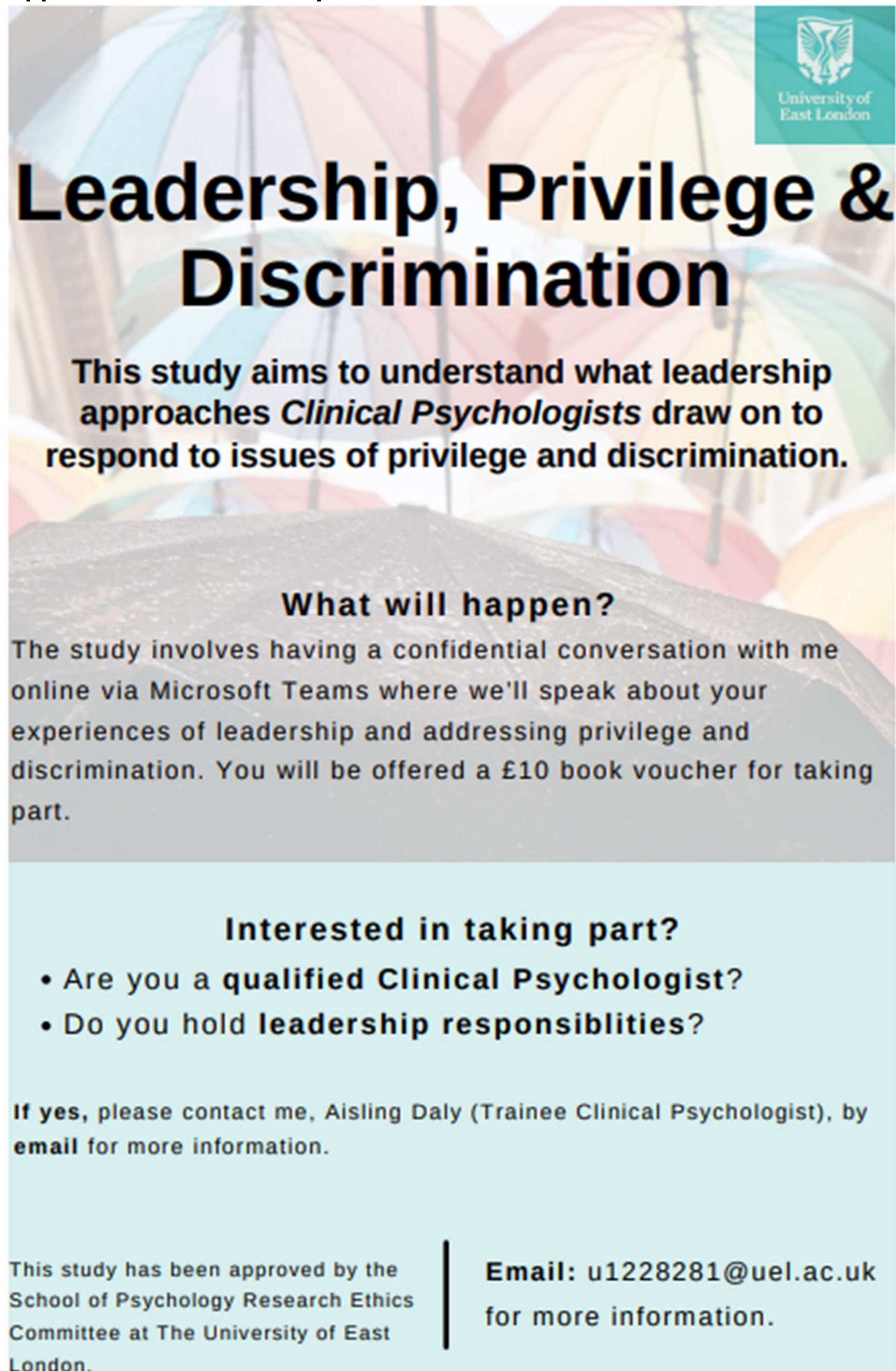
WRES. (2021). *Workforce race equality standard report 2021*. https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf

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

Zoonen, L. (2013). From identity to identification: Fixating the fragmented self. *Media, Culture & Society*, *35*, 44–51. https://doi.org/10.1177/0163443712464557

6. APPENDICES

Appendix 1: Recruitment poster



Appendix 2: Participant information sheet

Participant Information Sheet

Leadership, Privilege and Discrimination

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 doctoral level student 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. I am interested in exploring the leadership approaches clinical psychologists draw on in response to issues of privilege and discrimination.

What is the research?

I am conducting research into leadership approaches to privilege and discrimination, as defined by clinical psychologists who are in formal or informal leadership positions.

I am interested in how you define your leadership approach to issues of privilege and discrimination, what the barriers to and facilitators of this are, as well as how your personal identity may affect this.

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?

You have been invited to participate in my research as someone who fits with the kind of people I am looking for to help me explore my research topic. I am looking to involve qualified clinical psychologists who are in formal or informal leadership positions.

I emphasise that I am not looking for 'experts' on the topic. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will participating involve?

If you agree to participate in this study, you will be asked to take part in a 60-90 minute interview via Microsoft Teams, at a time and location that is convenient and confidential for you.

Before the interview, I will verbally confirm with you about what is involved, and you will be asked to sign a written consent form. This consent form will confirm that you have read this information sheet and agree to take part in the study. The interview will involve some questions about your experiences of leadership in response to issues of privilege and discrimination, and it will be like having an informal chat. I will record the interviews with on Microsoft Teams on a password-protected non-networked laptop, so that I can give an accurate representation of your views when writing up the research as well as taking some notes. I will also ask you to complete a demographics questionnaire.

I will not be able to fully compensate you for taking part in the research but can provide a £10 voucher as a token of appreciation. I would very much appreciate the time that you take to share your experiences with me, and I hope that this study will improve staff and client experiences in future by improving understanding in this area.

As the research progresses, you may be asked to attend another interview to follow-up certain themes raised in the study. You are again free to decide whether or not you participate in a re-interview if asked to attend, and should not feel coerced.

Are there any risks?

The interview is not designed to cause distress, however speaking about personal experiences may be difficult to do and can potentially raise upsetting feelings.

Please be aware that you do not have to share anything you do not feel comfortable with. You are also free to take a break during the interview, can decide to finish the interview at another time, or withdraw from the interview completely at any time without there being any disadvantages or consequences for you.

If you do feel distressed during the interview, you are welcome to discuss this with me. However, please note that I will be unable to provide counselling or therapy.

If there are any concerns around your safety, this is something that I may raise with you and we can explore your support options. Immediate safety concerns may need to be discussed with my supervisor. Contact details about organisations who offer support will be provided to all participants.

Taking part will be safe and confidential

Your privacy and safety will be respected. Direct quotes from your interview may be included in the write-up, however care will be taken to make sure this is anonymised.

If there are any serious concerns about your experiences, this will be discussed with my supervisor and steps may be taken to raise concerns. If this is the case, this will be discussed with you and you will be kept informed.

I will ensure that your safety and privacy are protected throughout the study. I will do so by removing your name and/or any identifying details from the write up after the interview. This includes the thesis itself, as well as any resulting publications, conference attendances or presentations.

The only instance in which I would need to break this confidentiality is if I think that there is a risk to you, or to someone else. If this is the case, I will do my best to try to discuss this with you before contacting anyone else.

You can choose to skip any question by saying ‘pass’, and you can end the conversation at any time, without having to provide me with a reason for this.

What will happen to the information that you provide?

Once I have recorded your interview on the password protected device it will be uploaded to the University of East London’s secure computer network and deleted from the recording device as soon as possible. I will transcribe the interview word-for-word in a secure location, removing any potentially identifying information. Your transcript file will be password protected and stored on the secure system. The audio recording will be deleted as soon as transcription of the interview is complete.

Consent forms and any other personal details collected will also be password protected and stored separately and securely on this system. Only I will have access to this storage base.

I will not include your name or any other identifying details in any reports that I write up. Your anonymised data will be seen by my supervisors and the people who grade my thesis at the University of East London. The transcripts of the interview will be analysed to identify themes around the leadership approaches

clinical psychologists draw on in response to issues of privilege and discrimination as well as how their personal identity affects this. Direct anonymised quotes from your interview may be included in the write-up of the study.

Transcripts of the interviews will be kept for three years following completion, in keeping with data management procedures. The transcripts will be stored securely in a password-protected file and my supervisor will have sole access to them. After this period all data will be deleted.

The final write-up will be available in the University of East London’s open-access research database. The study may also be disseminated in a research journal, presentations, reports or social media after my thesis is complete.

What if you want to withdraw from the study?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within one week of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like any further information about my research, or if you have any questions or concerns, please do not hesitate to contact me.

Aisling Daly, Trainee Clinical Psychologist,

University of East London

Email: u1228281@uel.ac.uk

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

Email: m.qureshi2@uel.ac.uk

Or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.patel@uel.ac.uk

Appendix 3: Demographics questionnaire

Demographic Questionnaire

Please answer the following questions:

1. **What is your age?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

2. **How many years since you qualified as a clinical psychologist?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

3. **How would you describe your role as a leader?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

4. **Aside from clinical psychology training, have you ever completed any leadership training?**

   Please select one

   ☐ Yes ☐ No ☐ Prefer not to say

   If yes, please specify

5. **How do you identify with respect to gender?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

6. **How would you describe your sexual orientation?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

7. **How would you describe your ethnic background?**

   Please specify below or select the box if you prefer not to say

   ☐ Prefer not to say

8. **Do you speak any languages, other than English?**

Please select one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

9. **Do you consider yourself to have a disability?**

Please select one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

10. **Do you have dependents?**

Please select one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

11. How would you describe your socioeconomic background?

Please specify below or select the box if you prefer not to say

☐ Prefer not to say

12. Do you identify as spiritual or religious?

Please select one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

13. Do you belong to a religious group?

Please select one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

Appendix 4: Consent form

Consent Form

Please type your initials in the box to confirm your agreement and consent to each statement.

I confirm that I have read the information sheet dated 11/08/2021 (version 2.0) for the above study and that I have been given a copy to keep.

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation in the study is voluntary and that I may withdraw at any time, without providing a reason for doing so.

I understand that if I withdraw from the study, my data will not be used.

I understand that I have 1 week from the date of the interview to withdraw my data from the study.

I understand that the interview will be recorded using Microsoft Teams.

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity.

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission.

It has been explained to me what will happen to the data once the research has been completed.

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me.

I understand that the thesis will be publicly accessible in the University of East London's Institutional Repository (ROAR).

I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me.

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. ☐

I agree to take part in the above study. ☐

Date: ______________________

Appendix 5: Ethical approval

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: Rachel Tribe

SUPERVISOR: Maria Qureshi

STUDENT: Aisling Daly (Resubmission)

Course: Prof Doc in Clinical Psychology

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 amendments required *(for reviewer)*:

There are some methodological issues which will need to be discussed with the supervisor to ensure that the trainee achieves the standard expected at doctoral level. There are no ethical issues. I wish the trainee every success with the project.

Major amendments required *(for reviewer)*:

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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): Aisling Daly*
Student number: u1228281

Date: 18/10/2021

(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 /

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)*: Prof Rachel Tribe

Date: 1.10.21

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

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Appendix 6: Ethics application form

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

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.

Your details

1.7 Your name: Aisling Daly

1.8 Your supervisor's name: Dr Maria Qureshi

1.9 Title of your programme: Professional Doctorate in Clinical Psychology

1.10 UEL assignment submission date (stating both the initial date and the resit date): Initial submission date: May 2022
Resit date: August 2022

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.

1.11 The title of your study: **Leadership, Privilege and Discrimination**

Introduction

Even before the Covid-19 pandemic in January 2020, the NHS faced a staffing crisis related to vacancies, sickness absence, staff turnover and stress levels with damaging consequences for staff health, performance and patient safety (West, 2021). Scandals of care failure (Francis, 2013), increasing reports of discrimination and less access to opportunities at work reported by people with minoritised and marginalised backgrounds (NHS England, 2020) have led to urgent considerations of leadership in NHS systems. The drive for parity between mental and physical health treatments (Department of Health, 2011), contemporary challenges for the NHS including managing chronic illness, changing expectations of multiple stakeholders, changing workplace structures, (Hartley et al., 2008) acknowledge the need for leadership. The leadership approach required to address the issues of privilege and discrimination underlying these issues however, is unclear.

Working definitions of leadership

Leadership and management are terms used interchangeably with respect to the NHS and theory. Since the inception of the NHS in 1948 there has been a

lack of clarity about how leadership was being defined. In NHS discourse leadership was initially termed “administration”, then termed “management”, then “leadership” (Martin & Learmonth, 2012).

In the 1960s, policy shifted away from administration towards management (Hewison & Morrell, 2014) and aiming to promote clinician leadership (Ham et al., 2011; Porritt, 1962). NHS reorganisation in 1974 encouraged involvement of multi-disciplinary teams in management decisions, sometimes with the effect of minimal decision-making (Ham et al., 2011). The Griffiths Report (Griffiths et al., 1983) challenged this, and it led to the establishment of autonomously functioning tiers of management accountable to a board (Kumar, 2013) . The introduction of internal market mechanisms and competition in the NHS as part of Conservative government reforms (Propper et al., 2008) was seen as strengthening managerialism, with management and control remaining centralised (Goodwin, 2000). More collaborative approaches were proposed by a Labour administration in 1997 in attempts to move away from unhelpfully bureaucratic command-and-control mechanisms (Clarence & Painter, 1998; Exworthy et al., 1999).

A shift in the concept of leadership from a management role to a quality that could exist across the system from senior to junior frontline workers emerged in the early 2000’s (Martin & Learmonth, 2012). Clinical professionals increasingly moved into strategy and management roles (Veronesi et al., 2013), and policy changes began to advocate for practitioners leading and shaping services (Department of Health, 2000, 2006, 2010, 2012). This led to the development of various leadership training initiatives and the need to draw on a well-researched evidence base (Storey & Holti, 2013).

Theoretical Considerations in NHS Healthcare Leadership

Leadership theory and literature applicable to healthcare was commonly developed in a business context (Dawes & Handscomb, 2005), mainly theoretical or descriptive and with limited evidence of improved patient care or enhanced patient performance (Vance & Larson, 2002).

Trait theories state that leadership consisted of personal, innate qualities generalisable across professions (Alimo-Metcalfe, 2013). These have been countered by reviews indicating a definitive set of traits could not be identified (Gibb, 1947; Mann, 1959).

Transactional leadership, conceptualised as focused on the process of controlling, organising and short-term planning (Bass, 1985), was not straightforward to implement in the NHS. Transformational leadership, where leaders and followers interact to mutually encourage motivation and morality (Burns, 1978) became increasingly associated with more patient-centred care. With this moral dimension in transformational leadership (Bolden, 2004), it seemed a better fit with a values-based NHS. However the model is based on research samples reflective of a dominant group of existing leaders, limiting generalisability (Alimo-Metcalfe, 2013; Kline, 2015).

More recently, shared, collective or distributed leadership ideas have gained popularity as they value inclusivity and collaboration (Oborn et al., 2013), prioritise collaboration across organisational silos and create work culture where high quality healthcare can be delivered (West et al., 2014). Compassionate leadership, defined as attending, understanding, empathising and helping (West et al., 2017), is argued to be a solution to a crisis of leadership in the NHS and ideal to address inequalities (West, 2021). Yet the model is also based on homogenous research samples.

Privilege & Discrimination

Personal and social identities intersect in any given context, affording different levels of social, cultural and economic power and privilege depending on a person's gender, geography, race, religion, age, ability, appearance, culture, class/caste, education, employment, ethnicity, spiritualty, sexuality or sexual orientation (Burnham, 2018; Crenshaw, 1991). Those with minoritised and marginalised identities are more likely to experience prejudicial treatment, poorer physical and mental health (Marmot et al., 2010). Under the Universal Declaration of Human Rights (UDHR, 1948) healthcare professionals are required to address social inequalities, discrimination and stigma which arise from privilege and discrimination.

Conceptual Issues and Gaps in Literature

There is no agreed definition of leadership, and no shared understanding of effective methods for leadership approaches to privilege and discrimination. Perceptions of leadership are reported to vary between patients and staff (Singh et al., 2018) relative to a person's cultural background and previous experiences (Taylor et al., 2017). In other words, leadership is subjective, shaped and influenced by the environment and objects in which it is situated (Cronin et al., 2010). How healthcare professionals in positions of leadership define their leadership approach to issues of privilege and discrimination is, as yet, unclear.

Rationale

How people in leadership positions respond to issues of privilege and discrimination affect both staff and patients in all healthcare settings. This study will focus on the perspectives of clinical psychologists as there is limited research in this area and due to ongoing calls from within the profession to tackle inequalities (Ratele & Malherbe, 2020; Rosebert et al., 2019; Wood & Patel, 2019).

Aims

This study aims to explore clinical psychologists' leadership approaches to privilege and discrimination, the barriers and facilitators of responding, and whether and how their personal identity interacts with how they respond.

Clinical Relevance

Clinical psychologists are ethically and duty-bound to uphold and protect individuals from discrimination at all levels within healthcare systems, in relation to individuals, within small teams or across organisations and policy development. By exploring the barriers and facilitators of leadership responses

to privilege and discrimination, this study aims to strengthen leadership resources and responses to issues of privilege and discrimination.

1.12 Your research question:

- How do leaders define their leadership style and approach to issues around privilege and discrimination?
- In what ways do leaders' personal identity (experiences of privilege and discrimination) influence their approach to leadership?
- What are the barriers and facilitators for leaders of responding to issues around privilege and discrimination?

1.13 Design of the research:

Epistemology

A critical realist position will be adopted for this study. This ontological and epistemological stance is suitable for this study as it allows that concepts such as 'leadership', 'privilege', 'discrimination' and 'clinical psychology' exist, while acknowledging, that our understanding of these is influenced by culture and time (Bhaskar, 1989). It allows for greater understanding of concepts, which do not exist independent of our perception, taking into account different contexts (Oliver, 2011). This is appropriate for the current study because while acts of leadership may not be directly observable, the effects of the presence or absence of leadership can be felt by individuals who may define leadership differently based on their personal experiences.

Design

This is a qualitative study, consisting of individual, 60-90 minute audio-recorded semi-structured interviews. Individual interviews are likely to provide a rich data source, allowing participants to speak more confidently about their experiences (Carruthers, 1990) than focus groups.

1.14 Participants: Up to 12 qualified clinical psychologists who identify as being in positions of leadership either formal or informal, are currently employed as a clinical psychologist in the UK and able to provide written informed consent.

1.15 Recruitment: Participants will be recruited using a snowballing method through social media and email to contacts known to the researcher (Appendix I). A secure email address will be provided for potential participants to request further information about the research and to opt-in.
Participants who are known to the researcher may be excluded from the study as familiarity may inhibit their participation.

As the study progresses, theoretical sampling will be used to elaborate on ideas and develop these further. As a result, some participants may be requested to re-interview to feed back initial analyses, check current themes and gather supplementary data.

1.16 Measures, materials or equipment:

Semi-Structured Interview Proforma

1. What does leadership mean to you?
   Prompt – What has helped you to think about leadership in this way? - Have there been any experiences which have shaped your thinking on leadership? (e.g. Training, professional life, cultural, spiritual, religious, family views, friends' views, media).
2. What does a leadership response to issues around privilege and discrimination look like to you?
   Prompt – What would you expect to hear from a leader? What would you expect to see?
3. What are:
   a. the barriers to responding to issues of privilege and discrimination?

b. the facilitators of responding to issues of privilege and discrimination?

4. How do aspects of your identity, your personal experiences of privilege and discrimination, effect your approach to leadership?
5. How do your personal experiences of privilege and discrimination effect your ability to respond to issues of privilege and discrimination? Prompt – What are the barriers? What are the facilitators?
6. Is there anything else you would like to add about your views on leadership approaches to privilege and discrimination that I have not asked?
7. Before we finish, given all we've talked about, I just want to revisit one of the first questions I asked, which is how do you personally define leadership? (In light of our discussion, what does leadership mean to you?)

Demographic Questionnaire

Please answer the following questions:

6. **What is your age?**

   Please specify below or tick the box if you prefer not to say

   ☐ Prefer not to say

7. **How many years since you qualified as a clinical psychologist?**

   Please specify below or tick the box if you prefer not to say

   ☐ Prefer not to say

8. **How would you describe your role as a leader?**

   Please specify below or tick the box if you prefer not to say

   ☐ Prefer not to say

11. **Aside from clinical psychology training, have you ever completed any leadership training?**

    Please tick one

    ☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

12. How do you identify with respect to gender?

Please specify below or tick the box if you prefer not to say

☐ Prefer not to say

13. How would you describe your sexual orientation?

Please specify below or tick the box if you prefer not to say

☐ Prefer not to say

14. How would you describe your ethnic background?

Please specify below or tick the box if you prefer not to say

☐ Prefer not to say

15. Do you speak any languages, other than English?

Please tick one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

16. Do you consider yourself to have a disability?

Please tick one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

17. Do

Please tick one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

18. How would you describe your socioeconomic background?

Please specify below or tick the box if you prefer not to say

☐ Prefer not to say

20. Do you identify as spiritual or religious?

Please tick one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

22. Do you belong to a religious group?

Please tick one

☐ Yes ☐ No ☐ Prefer not to say

If yes, please specify

1.17 Data collection:

Participants will be recruited using a snowballing method through emailing contacts known to the researcher and circulation of a recruitment poster on social media (Appendix I & II). Potential participants will be provided with a secure email address to request further information about the research and to opt-in.

The participant information sheet (Appendix III) will be emailed to participants, at least one week before their scheduled interview, allowing participants time to consider their participation fully, and to withdraw from the study.

Participants who are known to the researcher may be excluded from the study as familiarity may inhibit their participation.

As the study progresses, theoretical sampling will be used to elaborate on ideas and develop these further. As a result, some participants may be contacted by email to feed back initial analyses, check current themes and gather supplementary data.

1.18 Data analysis:

Thematic analysis (Braun & Clarke, 2006) will be used to analyse data from a critical realist position. Thematic analysis was chosen as it allows the flexibility to reflect reality as well as to unpick the surface of reality and deemed a good fit for the research aims, to capture what participants have to say about the leadership experiences. Rather than generating themes from a data-driven (inductive) or a theory-led (deductive) approach, a dual deductive-inductive approach will enable the researcher to approach the data with awareness of existing literature but also be open to new ideas and concepts (Joffe, 2012). This avoids the repetition of previous research and facilitates the production of new knowledge.

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.

1.19 Will participants data be gathered anonymously?

No, this will not be possible due to data being gathered by interview.

1.20 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)?

The confidentiality of participant information will be maintained throughout the study and beyond. Any identifying information will be removed from transcripts. Samples in the thesis and any future publications will be referred to using an anonymous code, in order to ensure anonymity (BPS, 2014).

1.21 How will you ensure participants details will be kept confidential?

Data will be anonymised at the point of transcription, and the transcripts will be stored in password protected files on the password protected secure UEL network. Direct, anonymised, quotes may be used in the write up of the study and participants will be informed of this prior to participating.

Participants will be informed that if concerns are raised during the interview around their safety or workplace experiences, confidentiality will be broken, and this will be discussed with research supervisors as a minimum.

1.22 How will the data be securely stored?

Following interviews, participants' audio files and transcripts will be saved on the researcher's password protected laptop within their UEL OneDrive cloud service, as .docx files which will be encrypted. The laptop will be a personal, non-networked, laptop with a password only known to the researcher.

Audio files and transcripts will be stored in separate locations; the audio files on the H: Drive post-transcription, in a separate and encrypted folder from the consent forms. Audio recordings will be deleted once transcribed.

1.23 Who will have access to the data?

Only the researcher, research supervisors and examiners at UEL will have access to the data.

1.24 How long will data be retained for?

Transcripts will be retained for three years following study completion, in keeping with data management procedures (UEL, 2019).

Informing participants

Please confirm that your information letter includes the following details:

1.25 Your research title: ✓

1.26 Your research question: ✓

1.27 The purpose of the research: ✓

1.28 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ✓

1.29 That participation is strictly voluntary: ✓

1.30 What are the potential risks to taking part: ✓

✓

1.31 What are the potential advantages to taking part:

1.32 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked): ✓

1.33 Their right to withdraw data (usually within a three-week window from the time of their participation): ✓

1.34 How long their data will be retained for: ✓

1.35 How their information will be kept confidential: ✓

1.36 How their data will be securely stored: ✓

1.37 What will happen to the results/analysis: ✓

1.38 Your UEL contact details: ✓

1.39 The UEL contact details of your supervisor: ✓

Please also confirm whether:

1.40 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

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

No, because this is a qualitative study using interviews. The confidentiality of participant information will be maintained throughout the study and beyond. Whilst risk issues are not predicted as likely (see UEL Risk Assessment Form, Appendix IV), participants will be informed via the participant information sheet that in the event of risk to themselves or others, their confidentiality may need to be compromised in order to access the required support.

Any identifying information will be removed from transcripts. Samples in the thesis and any future publications will be referred to using an anonymous code, in order to ensure anonymity (BPS, 2014).

1.42 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?
Yes, in the form of redeemable book vouchers to the value of £10 per participant. This is a token gesture and effort to recognise the imbalance of power and the contribution of the time given by participants.

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.

1.43 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?
Participants will be informed that the interview may raise distressing feelings prior to providing consent. Should participants become distressed, space to discuss this will be provided and all participants will be given a debrief sheet which includes contact details of support organisations.

Whilst risk issues are not predicted as likely (see UEL Risk Assessment Form, Appendix IV), participants will be informed that if concerns for their safety or regarding their workplace experiences are raised in the interview, confidentiality may need to be compromised. This would be in order to access support and would be discussed with research supervisors as a minimum.

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

Working from home there is a risk of fatigue due to insufficient breaks. Planning sufficient gaps in between interviews to allow for breaks, debriefs to participants and for researcher to debrief to supervisor may minimise this risk. It is possible that interviews may cause psychological distress for the researcher and this will be discussed with the research supervisor in planned supervision.

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

Helpline numbers have been provided for Samaritans, Rethink Mental Illness Advice Line, MIND, Black Minds Matter, MindOut, Black and Minority Ethnics in Psychiatry and Psychology, Black, African and Asian Therapy Network. These organisations provide both general emotional support as well as organisations which provide emotional support and networking opportunities specifically for people who identify as having minoritised and marginalised backgrounds.

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

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:

This research will take place online only.

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

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.

Disclosure and Barring Service (DBS) certificates

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

NO

1.49 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: ☐

1.50 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: ☐

1.51 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.

Other permissions

2. 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.

2.1

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.

2.2 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

2.3 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?

N/A

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

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.

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: Aisling Daly

Student's number: u1228281 Date: 24.07.21

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

Appendices

Appendix I: Message to researcher's contacts:

Dear colleague,

As a part of my doctoral thesis, I would like to invite qualified clinical psychologists to take part in individual interviews. The title of my thesis is: "Leadership, privilege and discrimination".

Participation will involve a 60-90 minute interview and completion of a demographics questionnaire, conducted remotely using Microsoft Teams. The interview will involve an informal discussion of ideas about leadership, privilege and discrimination in clinical and professional settings. The interview will be audio recorded. Upon transcription, all data will be anonymised and the recordings will be deleted. Participation will be anonymous.

Please circulate the attached poster within your social networks. I can be contacted directly on my university email at u1228281@uel.ac.uk by anyone interested in taking part and I will send the participant information sheet for further information. Interviews will be arranged directly with me.

Should you require any further information, please do not hesitate to email me.

Kind regards,

Aisling Daly, Trainee Clinical Psychologist, University of East London

u1228281@uel.ac.uk

Supervised by Dr Maria Qureshi, Lecturer, University of East London

m.qureshi2@uel.ac.uk

Appendix II: Recruitment poster

Leadership, privilege and discrimination

This study aims to understand what approaches clinical psychologists draw on to respond to issues of privilege and discrimination.

The study involves having a confidential conversation with me online via Microsoft Teams where we'll speak about your experiences of leadership and addressing privilege and discrimination. At the end of the interview you'll be offered a £10 book voucher.

If you're a qualified clinical psychologist, currently employed and in a (formal or informal) leadership position, I'd like to invite you to take part. *I would like to interview 12 clinical psychologists

Please contact Aisling Daly at u1228281@uel.ac.uk for more information.

This study has been approved by the School of Psychology Research Ethics Committee at The University of East London.

Appendix III: Participant Information Sheet

Participant Information Sheet

Leadership, privilege and discrimination

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 doctoral level student 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. I am interested in exploring the leadership approaches clinical psychologists draw on in response to issues of privilege and discrimination.

What is the research?

I am conducting research into leadership approaches to privilege and discrimination, as defined by clinical psychologists who are in formal or informal leadership positions.

I am interested in how you define your leadership approach to issues of privilege and discrimination, what the barriers to and facilitators of this are, as well as how your personal identity may affect this.

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?

You have been invited to participate in my research as someone who fits with the kind of people I am looking for to help me explore my research topic. I am looking to involve qualified clinical psychologists who are in formal or informal leadership positions.

I emphasise that I am not looking for 'experts' on the topic. You will not be judged or personally analysed in any way and you will be treated with respect.

You are quite free to decide whether or not to participate and should not feel coerced.

What will participating involve?

If you agree to participate in this study, you will be asked to take part in a 60-90 minute interview via Microsoft Teams, at a time and location that is convenient and confidential for you.

Before the interview, I will verbally confirm with you about what is involved, and you will be asked to sign a written consent form. This consent form will confirm that you have read this information sheet and agree to take part in the study. The interview will involve some questions about your experiences of leadership in response to issues of privilege and discrimination, and it will be like having an informal chat. I will record the interviews with on Microsoft Teams on a password-protected non-networked laptop, so that I can give an accurate representation of your views when writing up the research as well as taking some notes. I will also ask you to complete a demographics questionnaire.

I will not be able to fully compensate you for taking part in the research but can provide a £10 voucher as a token of appreciation. I would very much appreciate the time that you take to share your experiences with me, and I hope that this study will improve staff and client experiences in future by improving understanding in this area.

As the research progresses, you may be asked to attend another interview to follow-up certain themes raised in the study. You are again free to decide whether or not you participate in a re-interview if asked to attend, and should not feel coerced.

Are there any risks?

The interview is not designed to cause distress, however speaking about personal experiences may be difficult to do and can potentially raise upsetting feelings.

Please be aware that you do not have to share anything you do not feel comfortable with. You are also free to take a break during the interview, can decide to finish the interview at another time, or withdraw from the interview completely at any time without there being any disadvantages or consequences for you.

If you do feel distressed during the interview, you are welcome to discuss this with me. However, please note that I will be unable to provide counselling or therapy.

If there are any concerns around your safety, this is something that I may raise with you and we can explore your support options. Immediate safety concerns may need to be discussed with my supervisor. Contact details about organisations who offer support will be provided to all participants.

Taking part will be safe and confidential

Your privacy and safety will be respected. Direct quotes from your interview may be included in the write-up, however care will be taken to make sure this is anonymised.

If there are any serious concerns about your experiences, this will be discussed with my supervisor and steps may be taken to raise concerns. If this is the case, this will be discussed with you and you will be kept informed.

I will ensure that your safety and privacy are protected throughout the study. I will do so by removing your name and/or any identifying details from the write up after the interview. This includes the thesis itself, as well as any resulting publications, conference attendances or presentations.

The only instance in which I would need to break this confidentiality is if I think that there is a risk to you, or to someone else. If this is the case, I will do my best to try to discuss this with you before contacting anyone else.

You can choose to skip any question by saying ‘pass’, and you can end the conversation at any time, without having to provide me with a reason for this.

What will happen to the information that you provide?

Once I have recorded your interview on the password protected device it will be uploaded to the University of East London’s secure computer network and deleted from the recording device as soon as possible. I will transcribe the interview word-for-word in a secure location, removing any potentially identifying information. Your transcript file will be password protected and stored on the secure system. The audio recording will be deleted as soon as transcription of the interview is complete.

Consent forms and any other personal details collected will also be password protected and stored separately and securely on this system. Only I will have access to this storage base.

I will not include your name or any other identifying details in any reports that I write up. Your anonymised data will be seen by my supervisors and the people who grade my thesis at the University of East London. The transcripts of the interview will be analysed to identify themes around the leadership approaches clinical psychologists draw on in response to issues of privilege and discrimination as well as how their personal identity affects this. Direct anonymised quotes from your interview may be included in the write-up of the study.

Transcripts of the interviews will be kept for three years following completion, in keeping with data management procedures. The transcripts will be stored securely in a password-protected file and my supervisor will have sole access to them. After this period all data will be deleted.

The final write-up will be available in the University of East London's open-access research database. The study may also be disseminated in a research journal, presentations, reports or social media after my thesis is complete.

What if you want to withdraw from the study?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated data, provided that this request is made within one week of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like any further information about my research, or if you have any questions or concerns, please do not hesitate to contact me.

Aisling Daly, Trainee Clinical Psychologist,

University of East London

Email: u1228281@uel.ac.uk

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

Email: m.qureshi2@uel.ac.uk

Or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.patel@uel.ac.uk

Appendix III: Consent Form

Consent Form

I confirm that I have read the information sheet dated 26/03/2021 (version 1.0) for

the above study and that I have been given a copy to keep.

(**NB**: all consent forms should show the date on which they were agreed and have a version number in order to keep track of any changes that might occur over the course of the study).

I have had the opportunity to consider the information, ask questions and have

had these answered satisfactorily.

I understand that my participation in the study is voluntary and that I may withdraw

at any time, without providing a reason for doing so.

I understand that if I withdraw from the study, my data will not be used.

I understand that I have 1 week from the date of the interview to withdraw my data from the study.

I understand that the interview will be recorded using Microsoft Teams.

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity.

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission.

It has been explained to me what will happen to the data once the research has been completed.

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me.

I understand that the thesis will be publicly accessible in the University of East London's Institutional Repository (ROAR).

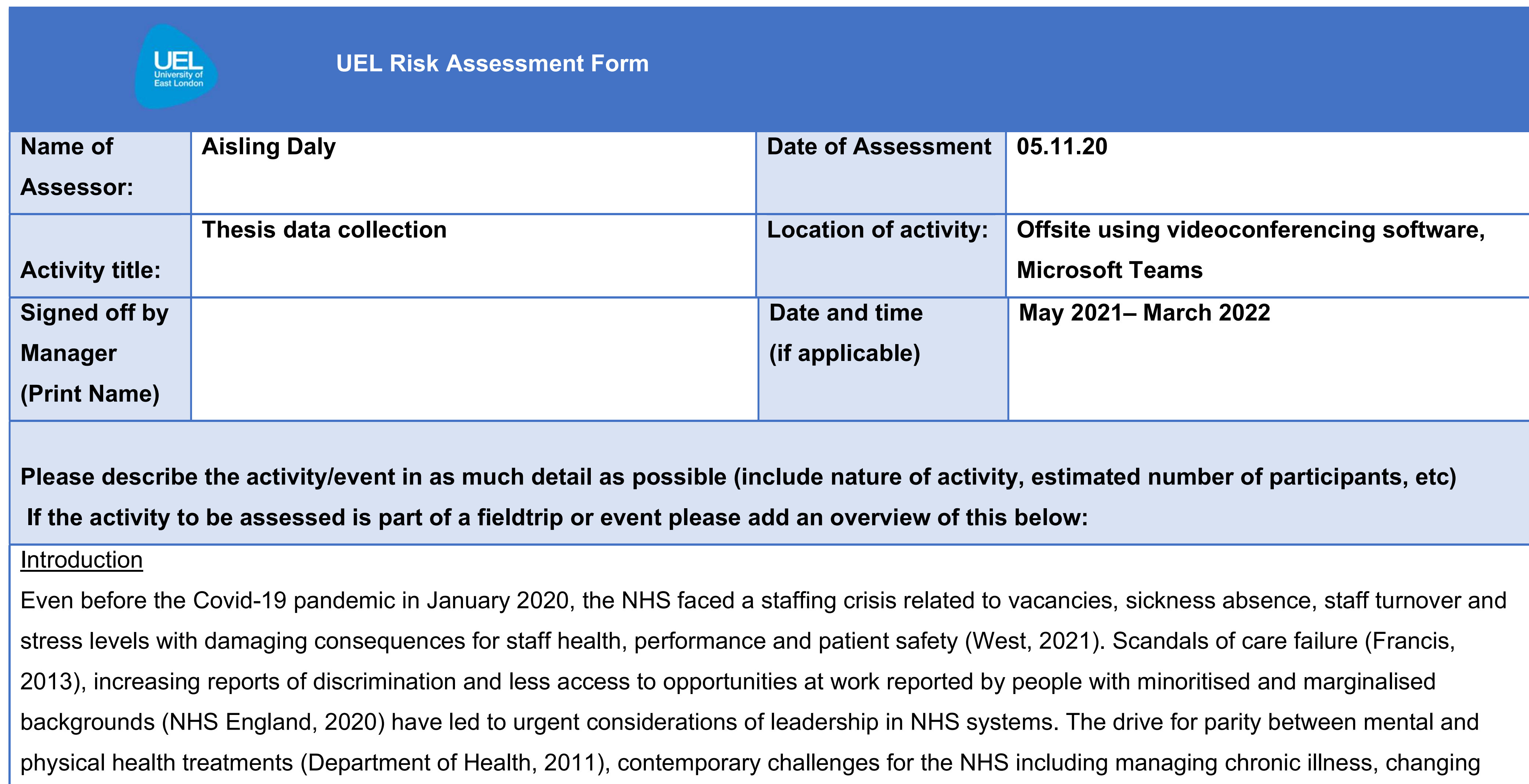
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and

academic journals resulting from the study and that these will not personally identify me.

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.

I agree to take part in the above study.

Appendix IV: Risk Assessment Form



UEL Risk Assessment Form			
Name of Assessor:	**Aisling Daly**	**Date of Assessment**	**05.11.20**
Activity title:	**Thesis data collection**	**Location of activity:**	**Offsite using videoconferencing software, Microsoft Teams**
Signed off by Manager (Print Name)		**Date and time (if applicable)**	**May 2021– March 2022**
Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc) If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:			
<u>Introduction</u> Even before the Covid-19 pandemic in January 2020, the NHS faced a staffing crisis related to vacancies, sickness absence, staff turnover and stress levels with damaging consequences for staff health, performance and patient safety (West, 2021). Scandals of care failure (Francis, 2013), increasing reports of discrimination and less access to opportunities at work reported by people with minoritised and marginalised backgrounds (NHS England, 2020) have led to urgent considerations of leadership in NHS systems. The drive for parity between mental and physical health treatments (Department of Health, 2011), contemporary challenges for the NHS including managing chronic illness, changing			

expectations of multiple stakeholders, changing workplace structures, (Hartley et al., 2008) acknowledge the need for leadership. The leadership approach required to address the issues of privilege and discrimination underlying these issues however, is unclear.

Working definitions of leadership

Leadership and management are terms used interchangeably with respect to the NHS and theory. Since the inception of the NHS in 1948 there has been a lack of clarity about how leadership was being defined. In NHS discourse leadership was initially termed “administration”, then termed “management”, then “leadership” (Martin & Learmonth, 2012).

In the 1960s, policy shifted away from administration towards management (Hewison & Morrell, 2014) and aiming to promote clinician leadership (Ham et al., 2011; Porritt, 1962). NHS reorganisation in 1974 encouraged involvement of multi-disciplinary teams in management decisions, sometimes with the effect of minimal decision-making (Ham et al., 2011). The Griffiths Report (Griffiths et al., 1983) challenged this, and it led to the establishment of autonomously functioning tiers of management accountable to a board (Kumar, 2013) . The introduction of internal market mechanisms and competition in the NHS as part of Conservative government reforms (Propper et al., 2008) was seen as strengthening managerialism, with management and control remaining centralised (Goodwin, 2000). More collaborative approaches were proposed by a Labour administration in 1997 in attempts to move away from unhelpfully bureaucratic command-and-control mechanisms (Clarence & Painter, 1998; Exworthy et al., 1999).

A shift in the concept of leadership from a management role to a quality that could exist across the system from senior to junior frontline workers emerged in the early 2000’s (Martin & Learmonth, 2012). Clinical professionals increasingly moved into strategy and management roles (Veronesi et al., 2013), and policy changes began to advocate for practitioners leading and shaping services (Department of Health, 2000, 2006, 2010, 2012). This led to the development of various leadership training initiatives and the need to draw on a well-researched evidence base (Storey & Holti, 2013).

Theoretical Considerations in NHS Healthcare Leadership

Leadership theory and literature applicable to healthcare was commonly developed in a business context (Dawes & Handscomb, 2005), mainly theoretical or descriptive and with limited evidence of improved patient care or enhanced patient performance (Vance & Larson, 2002).

Trait theories state that leadership consisted of personal, innate qualities generalisable across professions (Alimo-Metcalfe, 2013). These have been countered by reviews indicating a definitive set of traits could not be identified (Gibb, 1947; Mann, 1959).

Transactional leadership, conceptualised as focused on the process of controlling, organising and short-term planning (Bass, 1985), was not straightforward to implement in the NHS. Transformational leadership, where leaders and followers interact to mutually encourage motivation and morality (Burns, 1978) became increasingly associated with more patient-centred care. With this moral dimension in transformational leadership (Bolden, 2004), it seemed a better fit with a values-based NHS. However the model is based on research samples reflective of a dominant group of existing leaders, limiting generalisability (Alimo-Metcalfe, 2013; Kline, 2015).

More recently, shared, collective or distributed leadership ideas have gained popularity as they value inclusivity and collaboration (Oborn et al., 2013), prioritise collaboration across organisational silos and create work culture where high quality healthcare can be delivered (West et al., 2014). Compassionate leadership, defined as attending, understanding, empathising and helping (West et al., 2017), is argued to be a solution to a crisis of leadership in the NHS and ideal to address inequalities (West, 2021). Yet the model is also based on homogenous research samples.

Privilege & Discrimination

Personal and social identities intersect in any given context, affording different levels of social, cultural and economic power and privilege depending on a person’s gender, geography, race, religion, age, ability, appearance, culture, class/caste, education, employment, ethnicity, spiritualty, sexuality or sexual orientation (Burnham, 2018; Crenshaw, 1991). Those with minoritised and marginalised identities are more likely to experience prejudicial treatment, poorer physical and mental health (Marmot et al., 2010). Under the Universal Declaration of Human Rights (UDHR, 1948) healthcare professionals are required to address social inequalities, discrimination and stigma which arise from privilege and discrimination.

Conceptual Issues and Gaps in the Literature

There is no agreed definition of leadership, no shared understanding of effective methods for leadership approaches to privilege and discrimination. Perceptions of leadership are reported to vary between patients and staff (Singh et al., 2018) relative to a person's cultural background and previous experiences (Taylor et al., 2017). In other words, leadership is subjective, shaped and influenced by the environment and objects in which it is situated (Cronin et al., 2010). How healthcare professionals in positions of leadership define their leadership approach to issues of privilege and discrimination is, as yet, unclear.

Rationale

How leaders respond to issues of privilege and discrimination affect both staff and patients in all healthcare settings. This study will focus on the perspectives of clinical psychologists as there is no known research in this area and ongoing calls from within the profession to tackle inequalities (Ratele & Malherbe, 2020; Rosebert et al., 2019; Wood & Patel, 2019).

Aims

This study aims to explore and shed light on clinical psychologists' leadership approaches to privilege and discrimination, barriers and facilitators of responding, whether and how their personal identity interacts with how they respond.

Clinical Relevance

Clinical psychologists are ethically and duty-bound to uphold and protect individuals from discrimination at all levels within healthcare systems, in relation to individuals, within small teams or across organisations and policy development. By exploring the barriers and facilitators of leadership responses to privilege and discrimination, this study aims to strengthen leadership resources and responses to issues of privilege and discrimination.

Your research question:

- **How do leaders define their leadership style and approach to issues around privilege and discrimination?**
- **In what ways do leaders' personal identity (experiences of privilege and discrimination) influence their approach to leadership?**
- **What are the barriers and facilitators for leaders of responding to issues around privilege and discrimination?**

Design of the research:

Epistemology

A critical realist position will be adopted for this study. This ontological and epistemological stance is suitable for this study as it allows that entities such as 'leadership', 'privilege', 'discrimination' and 'clinical psychology' exist, while acknowledging, that our understanding of these concepts is influenced by culture and time (Bhaskar, 1989). It allows for greater understanding of concepts, which do not exist independent of our perception, taking into account different contexts (Oliver, 2011). This is appropriate for the current study because while acts of leadership may not be directly observable, the effects of the presence or absence of leadership can be felt by individuals who may define leadership differently based on their personal experiences.

Design

This is a qualitative study, consisting of individual, hour-long audio-recorded semi-structured interviews. Individual interviews are likely to provide a rich data source, allowing participants to speak more confidently about their experiences (Carruthers, 1990), than focus groups.

Participants: Qualified clinical psychologists who identify as being in positions of leadership either formal or informal, are currently employed as a clinical psychologist in the UK and able to provide written informed consent.

Recruitment:

Participants will be recruited using a snowballing method through social media and email to contacts known to the researcher (Appendix I). A secure email address will be provided for potential participants to request further information about the research and to opt-in.

Participants who are known to the researcher may be excluded from the study as familiarity may inhibit their participation.

As the study progresses, theoretical sampling will be used to elaborate on ideas and develop these further. As a result, some participants may be requested to re-interview to feed back initial analyses, check current themes and gather supplementary data.

In case of difficulties with recruiting a sufficient number of participants, the participant pool may be widened to include any mental healthcare professionals.

Approximately twelve participants will be recruited to the study, as data gathered from twelve hour-long interviews are understood to approach data and theoretical saturation (Guest et al., 2006).

A semi-structured interview schedule and demographics form will be compiled. The questions selected will be informed by previous research and experts by experience, while allowing space for participants to share their experiences.

Interviews will last approximately one hour and be conducted remotely via videoconferencing to comply with Covid-19 guidelines. This will also enable participants to be wherever is most convenient, and thus help them feel at ease (Potter & Hepburn, 2005). A password-protected recording device will be used to record interviews. Recordings will be transcribed verbatim.

Data analysis:

Thematic analysis (Braun & Clarke, 2006) will be used to analyse data from a critical realist position. Thematic analysis was chosen as it allows the flexibility to reflect reality as well as to unpick the surface of reality and deemed a good fit for the research aims, to capture what participants have to say about the leadership experiences. Rather than generating themes from a data-driven (inductive) or a theory-led (deductive) approach, a dual deductive-inductive approach will enable the researcher to approach the data with awareness of existing literature but also be open to new ideas and concepts (Joffe, 2012). This avoids the repetition of previous research and facilitates the production of new knowledge.

Overview of FIELD TRIP or EVENT:

Approximately 12 individual interviews will be conducted remotely using Microsoft Teams, videoconferencing software. Participants will be in a location of their choosing, with advice to make sure it is a safe and confidential space. Interviews will be centred around how participants define leadership approaches to privilege and discrimination.

Guide to risk ratings:

a) Likelihood of Risk	b) Hazard Severity	c) Risk Rating (a x b = c)
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

	Hazards attached to the activity						
Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**

Risk of participants becoming distressed during the interview.	Participants	Interview questions designed to minimise risk of distress. Participants will be informed of the nature of the interview prior to the interview. Information about support available will be provided in the	1	1-3	1	Researcher to inform participants that if any concerns about their safety arise, confidentiality may need to be breached in order to access support for the participant.	1
Working from home – risk of fatigue, insufficient breaks.	Researcher	Plan sufficient gaps in between interviews to allow for breaks, debriefs to participants and for researcher to debrief	1	1	1	Researcher to inform supervisor of interviews scheduled to ensure opportunity to debrief available if necessary.	1
Risk of researcher becoming distressed .	Researcher	Supervisor available to debrief after interviews.	1	1	1		1

Appendix 7: Debrief information

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on leadership, privilege and discrimination. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

I would like to remind you that your data will be stored securely, and any information that you have given that will be included in my thesis, and any resultant publications, will be anonymised. This means that your name and any identifying information will be removed completely.

If for any reason you would like to withdraw from the study, you can do this within one week of the interview date. After this, it will not be possible to remove your data from the final write up, but all identifying information will be removed as explained above.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

Samaritans
Website: https://www.samaritans.org
Tel: 116 123 (freephone)
Email: jo@samaritans.org

Rethink Mental Illness Advice Line
Website: http://www.rethink.org/about-us/our-mental-health-advice
Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: online contact form

Mind
Website: www.mind.org.uk
Tel: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463
Email: info@mind.org.uk

Black Minds Matter
Website: https://www.blackmindsmatteruk.com
Email: blackmindsmatteruk@gmail.com

MindOut (LGBTQ+ Mental Health Support)
Website: https://mindout.org.uk
Tel: 01273 234839
Email: info@mindout.org.uk

Black and Minority Ethnics in Psychiatry and Psychology (networking group)
Website: www.bippnetwork.org.uk
Email: info@bippnetwork.org.uk

Black, African and Asian Therapy Network (network and therapy)
Website: www.baatn.org.uk
Email: connect@baatn.org.uk

If any of the issues that we have discussed are having an impact on your ability to work, please speak to your manager, who will give you information regarding contacting the occupational health department in your trust.

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

Aisling Daly, Trainee Clinical Psychologist, University of East London
Email: u1228281@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor:

Dr Maria Qureshi, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: m.qureshi2@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee:
Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Appendix 8: Interview schedule

Many thanks for taking the time to take part in this interview.

Have you read the information sheet and signed the consent form?

Demographics

Just to remind you, the interview should take about one hour, and we can take a break whenever you need.

I will be asking questions in order to explore your views and experiences of leadership, privilege and discrimination. If you don't feel comfortable in answering a question, just say 'pass' and we will move on. I will be recording this interview using Microsoft Teams, so that I can concentrate fully on what you are saying and will be able to take some notes if I need to. There are no right or wrong answers, and as this is a confidential space, please feel free to share openly and honestly around your views and experiences.

Are you still happy to take part in the interview? Are you ready to begin? Ok, I'll start recording

1. [Share the competency framework for leadership (NHS Leadership Academy, 2011)] –

You may be familiar with this, the current NHS clinical leadership competency framework . What are your thoughts on how leadership is defined? How does this understanding of leadership fit with the roles/work that you do? How are you enacting some of these roles/activities?

2. What has influenced your understanding of your role in leadership?

    a. Does your background, your identity and experiences, influence how you lead? If so, how? Why?
    b. Does your training, self-study or reading influence how you lead? If so, how? Why?

3. Often in leadership roles there may be a position of privilege – can you think of a time when this was relevant for you and how you became aware of your privilege?

    a. What was this like for you?
    b. What does this mean for you?

4. Can you tell me a about a time when you faced any kind of discrimination in your leadership role?

    a. What was this like for you?
    b. What does this mean for you? Was anyone else aware?
    c. (If not already discussed) How do you make sense of how privilege and discrimination work in your role? And their impact on (interviewee example)

5. (If not already discussed) Can you describe a time when you witnessed privilege and/or discrimination in your leadership role/work? You don't have to say in detail what happened, but I am interested in how it was responded to, or not.

    a. Did anyone respond? How did you respond?
    b. What was that like for you, why?
    c. To what extent do you think the response(s) led to meaningful change (and for whom)?
    a. How do you know if the response is meaningful? And meaningful to whom? (superficial/tokenistic responses)
    b. How and when do responses lead to change?

6. When you face a situation/issue relating to privilege/discrimination, what enables you to respond (or gets in the way of responding)? How does this help/not?
    a. What else helps you to think about and engage with these issues, and to respond, and why/how?
    c. Can you tell me about other contexts outside of your leadership role – what allows you to engage with these issues? What holds you back? What has helped you move past these challenges? Are there some contexts where it is easier, which ones, why?

7. Is there anything else you would like to add about your views on leadership approaches to privilege and discrimination that I have not asked? Or any final reflections you would like to add?

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General Prompts

- Could you tell me more about that?
- Is there anything else you would like to add?
- How did that affect you?
- What do you mean?
- Can you give me an example?
- Did you notice that at the time, or just on reflection?

Many thanks for taking the time to speak with me today. It has been very useful hearing your views.

Debriefing: How do you feel about our conversation today? Is there anything that bothered you? Do you have any questions?

*Provide debrief sheet.

This debrief sheet includes my details if you have any questions, or if you would like to withdraw your interview data from the study. This would need to be done within one week from now, as beyond then I will have begun analysis and won't be able to withdraw the data. I have included some numbers of support organisations, in case you feel that you would benefit from support or a space to discuss anything that came up today further. Thank you again for your time and effort in taking part in this study. I will send a voucher by email.

Appendix 9: Reflective journal extract following transcription of interview 4

Talks a lot about things from other people's perspectives. Seems reluctant to speak about their own experience. I wonder what that's about? Talking about the leadership programme, sounds like they didn't offer their thoughts there either. It's almost as if all of these things are happening separately outside of this individual and they do not see themselves as part of what is happening. I wonder how much they have considered their role, experiences and feelings and how they have shaped their responses?
I wonder do they see me as another white British person with a wealthy family? In my experience, white British people are often blind to me being Irish and assume that because I am white I am also British. I find that annoying as my name and accent are quite clearly Irish. It feels like a symptom of the colonial project, to erase history, Whiteness, and its atrocities which have shaped the relationship between our countries, language, educational and other opportunities
Saying, you've got to be brave enough while saying that some people may not feel like they have the safety to risk things - they don't really seem to be able to acknowledge how they are contradicting themselves? Saying that more marginalised people need to be the ones to speak up and share their stories for people to really understand, but also not acknowledging that marginalised people are more likely to be in lower banded positions and therefore perhaps not feeling like they have the safety to say anything.
Something about psychologists being better at, or more equipped to have conversations about and challenge privilege and discrimination than other healthcare professionals? - this contrasts with the idea that other professions are more diverse - is it that the participant finds it easier to talk to other people who look like them about discrimination?

Appendix 10: Transcription Conventions- Adapted from Banister et al. (1994)

Symbol	Used to denote
…	Pause
[inaudible]	Inaudible piece of transcript
[laughs] [sighs]	Notable non-verbal action by the participant
(…)	Some speech removed (no more than 40 words)
<>	Brief interruption to conversation

Appendix 11: Sample coded extract A

P5: Suppose, I don't know. I mean, I suppose, you know, at like, a, your classic kind of outpatient psychology service, where you know you you have a group of staff who who have a a good amount of control really about what work they're doing, there are kind of mechanisms in place to, you know, choose which referrals you will see yourself, which referrals you won't see, you have very good supervision structures to kind of help you deal with that. You know it's not that that work is not incredibly challenging and difficult, and you know when, there was a time you know after qualification where I was really doing that kind of, you know, learning about being an adult psychologist and therapists and seeing you know six people a day every day, and you know that was mind blowingly tough in its own different way. But I think it does, it's still I suppose a sort of work where you generally, there are boundaries around what you're doing, and you've got some control over over what's going on as a as a service and as individuals, and I think psychologists typically in the NHS have tended to keep at a little bit of a distance from, you know, from the inpatient wards from the A&E departments, you know, from those bits of the NHS that are really public facing, much more unpredictable sometimes, where there's much more, you know violence and very acute ill health and things like that. And that's the sort of stereotype I suppose of psychologists that you know they might waltz onto the ward for half an hour and then you won't see them for dust and they're never around when difficult things are happening. I mean, that is an unfair stereotype to some extent, but I think yeah, my experience was that yeah, you know, mix it, you know getting to know those ward teams and and working really closely with them and doing things like the staff support and reflective practice groups where you actually really hear a bit about what it's like to be working in those settings, it's sort of, I don't know, I suppose it humanizes those, you know, people who you otherwise might see as another group, you know, of the ward staff who you don't really know, you're not, you've never really met them. You know, I think, once you do know those people by name, and you know about their family life and what's going on, you know it just gives you a different sort of window, I suppose, into understanding their experience. And that in turn, I suppose, gives you a sense of what you know, the the disconnect that there can sometimes be between the very senior leadership of an organization and that reality at ground level, and kind of how that lands, and how that really has an impact on people's lives.

Appendix 12: Sample coded extract B

was working by myself, essentially in a district General Hospital, but it was just things like going out and seeking meetings with people like chief execs or deputy board members and things like that. So forming strategic relationships with people and uhm, offering to write things or getting in touch with other clinical psychologists in leadership positions to find out what they did and whether or not I needed to do something similar and that was how I kind of did it, I think. Uhm, and then, yeah, just like asking to like shadow people or just calling up. [laughs] Once, I'm was just calling up like the head of pediatric psychology in [place] and was like I'm in this service and I just kind of need some help. [laughs] How do I do this? <Mhmm> Uh, so I feel that that was how I managed to sort of get the experience as well, and the, 'training'. And and then, just in terms of my personal background, I don't know whether there was anything specific I guess I, I've tried to be sort of confident in my own abilities. Uh, and uh. Conscious of things about like being sort of assertive without being aggressive and just trying to get my point across and trying to be diplomatic but also learning how to stand my ground if I needed to. Uhm? I think I might be like that. It's just in my general personality anyway, and I maybe that's stood me in good stead in relation to the job.

Researcher: Mhmm. Was there anything else you want to add on that, sorry?

P2: No, I don't think so. I was just saying thinking about the fact that my, that my mom was always really encouraging of me and just, you know, really wanted me to do well. But she didn't have the opportunity to go to university, and I think that she was, really gutted by that really, uhm? And I didn't necessarily feel any pressure, but she was just like you've got all these opportunities and you, you know you could do it. Uhm? <Mhmm> She did also say that it was going to be more difficult because I was like a woman and I'm not white. Uh, and I'm not from a wealthy background, she's a single parent. <Mhmm> Uh, two brothers as well and she was working and looking after them as well. But UM. She did give me. I don't know how but she just she did give me self belief. That it was possible. So I think that helped. You have to be confident to a point, I think, to have those

Outside work
Gaslighting
Stand my ground if needed
Diplomacy
Something you have to do alone
Can't rely on others
Disappointing
Innovative and dynamic
Developing relationships with people
social constructionism is unhelpful when it comes to racism
Existing models do not capture leadership
Delivering services
Incremental, slow change
Developing as a leader
Need for rest, breaks. Tiring, exhausting work
Keeping in touch with personal values
Personal toll of challenging discrimination
Bridging the gap between university and DClin training
Disrupting with gentle challenges
Coding Density
Confident, self belief

Appendix 13: Sample early thematic map

Major Theme	**Sub-themes**
Theme 1: Managing own and others' relationships	1. Having the confidence to respond
	2. Judging the efficacy of a response
	3. Supporting others
Theme 2: Impact of hierarchical structures	4. Hierarchical structures reinforce discrimination
	5. Bridging the divide
Theme 3: Fitting the Leadership Mould	6. Who is likely to be able to challenge
	7. Whose voices are heard
	8. "It's turtles all the way down"
	9. Who gets to be a leader
Theme 4: Personal Risks & Challenges	10. Worry about impact on personal and professional relationships
	11. Personal toll

Appendix 14: Thematic map of study including contributing participants

Overarching Theme : We have been talking about this for 20 years		**Participants:** P4, P6, P8, P5, P12, P2, P3
Major Theme	**Sub-themes**	**Participants**
Theme 1: Personal risks and challenges	1. Challenging discrimination gets me "enemies"	P10, P12, P1, P4, P12, P2, P7, P9, P5, P1, P11
	2. It's "about the relationships involved"	P4, P9, P3, P8, P11, P5, P10
Theme 2: Fitting the leadership mould	1. "Clinical psychology is no different"	P9, P8, P4, P2, P6, P11
	2. A kind of a fringe position, a bit of a maverick	P5, P10, P4, P7
	3. Leadership culture stops you challenging	P5, P12, P8, P9
Theme 3: Leadership roles and responsibilities	1. "People doing the same job and the parity is different"	P11, P7, P6, P3, P4, P9, P2, P12, P10
	2. Using the position of leadership	P1, P10, P5, P8, P6, P7, P11, P9
	3. You can't split the personal and the professional narrative	P9, P2, P11, P3, P10, P1, P12, P8

Appendix 15: Sample demonstrating critical language awareness

also, we just don't have a very diverse workforce [laughs] as well. So yeah, we both on the one hand, hopefully we will be quite sensitive to being culturally sensitive and inclusive. On the other hand, we're massively failing because we've got a very un-diverse [laughing] workforce, so I yeah I can't think of anything for that.

Researcher: You mentioned before, thinking and engaging with ideas around privilege and discrimination. I'm just wondering what enables you to engage with issues around privilege and discrimination.

Appendix 16: Change of title ethical approval

CHANGE OF TITLE REQUEST FORM

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

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

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

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☐

Details	
Name of applicant:	**Aisling Daly**
Programme of study:	**Prof Doc in Clinical Psychology**
Title of research:	**Leadership, Privilege & Discrimination**
Name of supervisor:	**Dr Maria Qureshi**

1

October 2021

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	Leadership, Privilege & Discrimination
New title:	A qualitative exploration of clinical psychologists' experiences as leaders of intersectional power and its impact on their responses to privilege and discrimination
Rationale:	The title change is requested as part of viva amendments.

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

Student's signature	
Student: (Typed name to act as signature)	**Aisling Daly**
Date:	**13/03/2023**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested in the viva.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**15/03/2023**	