CLINICAL PSYCHOLOGY AND MORAL DISTRESS

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ABSTRACT

Background: Decision-making practices are complex and within the process ethical dilemmas can present themselves. When a healthcare professional feels unable to provide the care that their ethical code deems ‘best’ for a patient, moral distress can arise. Moral distress is a phenomenon originating in, and most explored within, nursing; it captured the compromised ethical integrity nurses experienced when they were institutionally constrained from acting in accordance with their professional values. This study is believed to be the first in the United Kingdom to explore the concept of moral distress with Clinical Psychologists.

Methods: A Thematic Analysis was carried out on data collected from semi-structured interviews with 14 Clinical Psychologists working to provide mental health support to adults in the United Kingdom’s ‘socialised’ healthcare system, the National Health Service.

Results: Three superordinate and six subordinate themes emerged from data analysis. These spoke to the patterns in participants’ experiences of ‘Being in Services’ and the constraints on their attempts to ‘Do the Right Thing’ whilst observing ‘Cultural Harm’. A theme concerning ‘Power’, it’s ‘Top-Down’ enforcement, and the participants’ attempts at ‘Resistance’ followed. The final theme spoke to the role of ‘Professional Identity’ and the consequences of morally distressing experiences, such as the intent to leave a role or the NHS itself. Mechanisms for managing the values conflicts are also identified.

Conclusions: Clinical Psychologists in this study were regularly constrained from working in alignment with their personal and professional values by institutional practices. The impact of this on the participants’ own psychological wellbeing was significant.

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LIST OF ABBREVIATIONS

AMH	Adult Mental Health
BPS	British Psychological Society
CMHT/s	Community Mental Health Team/s
CP/s	Clinical Psychologist/s
HCP/s	Healthcare Professional/s
HCPC	Health and Care Professions Council
MD	Moral Distress
MH	Mental Health
NHS	National Health Service
NICE	National Institute of Clinical Excellence
TA	Thematic Analysis
UK	United Kingdom

1. CHAPTER ONE: INTRODUCTION

This chapter outlines the core components of this research project: the complexities of decision-making in healthcare, the presence of ethical dilemmas within this process, and the potential production of ‘moral distress’ as a result. The relevance to clinical psychology is introduced, including the impact of the current National Health Service (NHS) context. A scoping review of the literature on moral distress is presented and what we do not yet know is considered, giving rise to the focus for this project and the research questions.

1.1. Decision-Making

Decision-making in healthcare is situated in the broader context of human decision-making. The extensive literature around this topic includes work by Tversky and Kahneman whose 1981 paper explored the framing of decisions and the psychology of choice. In both daily life and the social sciences, explanations and predictions of people's decisions are often based on the presumption of human rationality. Debates about the definition of rationality continue, but a consensus generally exists around the need for choices to be coherent and consistent to be considered rational. However, there are ‘decision problems’ in which these requirements are systematically violated which Tversky and Kahneman (1981) understand through “the psychological principles that govern the perception of decision problems and the evaluation of options” (Tversky & Kahneman, 1981, p. 453). Key to this is recognition that a decision-maker’s frame is in part controlled by their formulation of a problem and in part by their habits, the norms they have adopted, and their personal characteristics.

Tversky and Kahneman’s studies with university students and faculty, and with physicians too, identified a common phenomenon: “choices involving gains are often risk-adverse and choices involving losses are often risk-taking" (Tversky & Kahneman, 1981, p. 453); the decision-problems were identical but their differing frames produced a significant shift, a reversal in preference. Tversky and Kahneman (1981) concluded that the psychological concepts that influence the understanding of decision problems and the calculation of probability and outcomes induce predictable variations in choice when the same problem is phrased in different ways. Reversals of choice can be seen in decisions concerning monetary implications, both hypothetical and real, as well as concerns about the loss of human lives. The dependency of preferences on the wording of decision problems calls into question the idea of rational choice. Relatedly, making choices in 'risky contexts', when the consequences cannot be known means mentally accounting for the acceptability level of outcomes with varying probabilities – a negative outcome being perceived as an expected cost, or an 'uncompensated loss', for example (Kahneman & Tversky, 1984). Additionally, this loss aversion has been identified as one explanation for the general bias in systems which favour the status quo (Kahneman, 1991).

In a healthcare context there is a need to manage uncertainty during decision-making processes, and necessary trade-offs in doing so. Making judgements under uncertainty, however, generally calls for a reliance on heuristics ('mental shortcuts') and bias (Tversky & Kahneman, 1974), which is often economical and typically effective but can lead to systematic, and foreseeable, errors. The framing of choices again is impactful, informing someone considering a medical intervention that they have a 10% chance of death is meaningfully different to a 90% chance of survival (Kahneman, 1991).

Also not considered in the rationality theory of choice is the role played by conflict during decision-making. When a decision-maker does not know how to navigate the cost-benefit, value-risk trade-off, or the analysis of instantaneous satisfaction versus future discomfort, conflict naturally arises for them (Tversky & Shafir, 1992). Being uncertain about the implications of one's decisions complicates conflict resolution, which is further disrupted by the expectation of dissonance or regret. Tversky and Shafir (1992) therefore argue that conflict not only affects the psychological condition of the decision-maker, but also influences the actual choice made.

Gigerenzer (1996) explored the difficulties people have with understanding and utilising probability in decision-making and advocated for a heuristic approach to decision-making in medicine (Marewski & Gigerenzer, 2012), teaching physicians effective heuristics – ‘simple’ decision strategies. The heuristics-and-biases framework described above suggests people regularly make systematic errors through their decisions and judgment of probability, Marewski and Gigerenzer (2012) meanwhile proffer the ‘fast-and-frugal heuristics’ framework for understanding how reliance on this simplicity can produce smart action. In their framework, rational thinking occurs when correspondence criteria are met, rather than the coherence criteria named in the ‘normative’ definitions of rationality that Tversky and Kahneman spoke to. Marewski and Gigerenzer (2012) noted a tendency of physicians in the United States to employ a defensive heuristic - “err on the safe side” – in fear of litigation, and ultimately over-diagnose and ‘overtreat’, engaging in practices that are not the best options for their patients. They argued that a change to the system and the environment can support physicians in relying on heuristics that benefit the patient, such as the use of fast-and-frugal decision-trees. In the ‘real world’ and in medicine, where uncertainty reigns, people can and should, they say, rely on heuristics which can make transparent, accurate decisions, using less resources than complex, information-saturated strategies. Support for the utility of fast-and-frugal approaches to decision making includes work by Smith & Gilhooly (2006) on responses to ‘depression’ presentations in primary care.

Overall, the human decision-making literature tends to suggest that people use (attend to, gather, and interpret) information in a style that confirms their decisions about others, rather than examining them. Psychotherapists are not expected to be free of this trap, indeed studies have identified a similar reliance on confirmatory strategies (Pfeiffer et al., 2000). The ‘Practice Guidelines’ published by the British

Psychological Society (BPS) in 2017 state aims around defining good practice for all psychologists and offering guidance for decision-making; they add a caveat that no guidance document can take the place of a psychologist's own professional judgement (British Psychological Society, 2017). Within their guidance however there is a reflective section on the "various competing biases" (BPS, 2017, p. 11) that can influence decision-making which psychologists should be aware of, so that they may "think through dilemmas" (BPS, 2017, p.11). These biases include confirmation bias, dissonance, and loss aversion as above; the work of Tversky and Kahneman (1974) is cited. Beyond cognitive biases, the Guidelines also note the influence of motivation: "the original reasons for undertaking the profession may change or be challenged due to fatigue or experience within the profession which may affect the psychologist's viewpoint" (BPS, 2017, p. 11); a recognition, however brief, that psychologists' experiences of clinical practice and decision-making can be taxing and dually impacting.

1.1.1. Evidence-Based Practice

Decision-making in the NHS operates on multiple levels, beyond the individual intervention to departmental, organisational, management levels; professional (influence of research), societal (influence of the media), and regulatory and commissioning levels. Funding and resource allocation are issues that are often prioritised and create conflict.

The National Institute for health and Care Excellence (NICE) state that their recommendations arise from an analysis of the benefit-harm trade-off referred to above, alongside their judgement of evidence for interventions (National Institute for Health and Care Excellence, 2021). They too make note of the level of certainty afforded to their decision-making. It is of course imperative that we consider the hierarchy of evidence NICE propagates and how it reflects the economic priorities above. The British epidemiologist Archie Cochrane is often cited as the originator of what has come to be known as Evidence-Based Practice (EBP). Cochrane (1972) argued that the limited nature of healthcare resources requires their allocation be determined by the evaluated effectiveness of interventions and services.

Randomised Controlled Trials (RCTs) are often said to be the ‘gold standard’ in clinical research; in these RCTs interventions are assessed under tightly controlled, ideal circumstances. What is then not known is how effective these interventions will be in real, clinical settings (Cartwright & Munro, 2010) leading to a divide between research and practice. Subsequently, the dominance of EBP and its reliance on RCTs in mental health (MH) provision has prioritised what is valued by commissioners and service-providers, and in doing so has limited service-user choice and autonomy.

Facts and data are intended to aid us in making sensible decisions, but we must consider the basis on which these knowledge claims are produced, and the value-laden nature of their conception. Not all evidence is equal, a hierarchy exists here in an exercise of power. “Evidence-based medicine … has and confers both epistemic and moral authority” (Kerridge, 2010, p. 365) but we must consider whose values and interests are served by EBP, and the potentially compromising experience of providing healthcare dictated by EBP.

‘Shared decision making’ has also been named as one of the six key parts of the NHS Long Term Plan’s aim around personalised care (NHS England, 2019). However, what may be the best option for an individual patient may not be an economically viable decision for the healthcare service. Similarly, whilst collective thought and shared decision-making within a multidisciplinary team is often encouraged with regard to the input of multiple perspectives and knowledges, it does not necessarily ensure moral validity within a decision-making process; teams may reach a consensus, but the decision still may not be in the patient’s best interest, resource prioritisation dominating for example.

While classical approaches to understanding decision-making tend to focus on rationality and information processing, it is important to recognise that in many areas of life (not just healthcare) decisions have a moral and ethical context and consequences. Kahneman (1991) acknowledges that the psychological study of decision making and judgement under uncertainty has preferred to invoke cognitive or psychophysical terminology, whilst the emotional and social factors of these experiences have been relatively neglected. In practice, decision-making processes, morality, and emotion can be considered to collide during what we refer to as ethical dilemmas.

1.2. Ethical Dilemmas

When I speak of morality in this thesis, I am referring to the principles that govern the distinction between right and wrong, or good and bad behaviour. Conversations concerning the moral principles that govern a person's behaviour or the conduct of an activity are aided by ethical rules. Ethical clinical practice is said to be core to the foundations of all healthcare professions, with the overarching commonality being to do no harm and centre the welfare of patients, but the integration of personal and professional values can be a complex one (Kimball, 2018), contending with the multifaceted trade-offs identified above. Ethical principles in practice are concerned with protecting the rights, dignity and welfare of patients and service-users. Much of these principles grew from previous abuses and unethical research carried out by public health services (such as the ‘Tuskegee Syphilis Study’, Kampmeier, 1974); by physicians (such as those involved in Nazi human experimentation, Annas & Grodin, 1992; Strous, 2007); and psychologists (such as the use of deception by Milgram, 1963).

Colnerud (1997) invites us to make distinctions between ethical problems, ethical conflicts, and ethical dilemmas. An ethical problem arises when an immediate solution to a situation is not found but can be through assistance. An ethical conflict occurs when two or more interests collide, a solution requiring compromise between these, and an individual perceives a violation of their sense of right and wrong (Moser, 1988). An ethical dilemma entails deciding between two or more options, each of which has less-than-ideal moral consequences. (Rathert et al., 2016).

In a workplace, the ethical environment reflects the organisation's "procedures, policies, and practices with moral consequences" (Martin & Cullen, 2006, p.177). Norms and standards for ethical decision-making and behaviour permeate expectations for workers and the ethical environment of the organisation impacts which ethical issues are prioritised and what criteria should be employed during ethical decision-making. Work by Rathert et al. (2009) found that nurses who perceived their work environment to be a caring and ethical one reported increased psychological safety and organisational commitment.

It is important to recognise that the differing professions operating in our healthcare system each belong to differing regulatory and professional bodies (such as the General Medical Council; Nurse and Midwifery Council; Health and Care Professions Council; British Association for Counselling and Psychotherapy; BPS), and each of these hold their own principles and guidelines their clinicians should abide by. However, these may not always be consistent, and prioritisation of issues is likely to vary. Indeed, moral conflicts can arise due to differing, and at times conflicting, values and perspectives held between members of a team but also patients and their families (Landau, 2000). These differences will then impact the process of choosing a course of action, contributing to ethical dilemmas, where certain values and perspectives 'win out'. These ethical dilemmas can act as precursors to moral distress (Fourie, 2015).

As the largest clinical workforce in the NHS (The Nuffield Trust, 2020) and worldwide, nurses also dominate the literature on clinical ethical dilemmas. This may be due to their availability, their exposure to distress due to hands-on daily patient contact, and/or concerns about recruitment and retention. Intensive Care Units (ICUs) are often the focus of studies in this area, where nurses are regularly exposed to ethical conflict particularly in regard to administering ineffective treatments like analgesia (Falcó-Pegueroles et al., 2016). These researchers designate ethical conflict an internal problem but highlight the significant influence of environmental conditions and found that when nurses are involved in decision-making they are protected from such ethical conflicts. A scoping review of the ethical elements in nurses' prioritisation of care by Suhonen et al. (2018) found that when prioritisation involves rationing nurses can compromise their patients' right to healthcare and this conflicts with the nurses' values, personal and professional, leading to consequences for patient and nurse.

In psychiatric nursing, Lützén et al. (2010) identified an association between moral sensitivity, moral climate, and moral stress having collected questionnaire data from 49 psychiatric nurses in Sweden. The environmental moral climate contributed to these nurses' experiences of moral stress, stress which was mediated positively or negatively by moral support. They therefore encourage us to consider clinical ethical issues through a focus upon healthcare structures and management, and the values they uphold.

1.3. Burnout

Burnout is a widely acknowledged issue in the public services sector and has been validated as a concept over the years through the production of standardised measurements (Malach-Pines, 2005; Maslach et al., 1996). Occupational stress and resultant burnout are often spoken of in the context of increasing workloads, staff shortages, and reducing resources (Rossi et al., 2012). These experiences generally co-exist and produce physical and psychological exhaustion, disassociation from work and job dissatisfaction (Kim et al., 2011; Nissly et al., 2005).

An integrative review (Gribben & Semple, 2021) of the factors contributing to burnout for nurses working in the NHS' oncology services identified two broad themes: an 'inability to thrive', workplace burnout originating from organisational barriers; and 'personal perspectives influencing burnout’. The demands of an ever-increasing workload, lack of time to provide good care, and staff shortages contributed strongly to the first theme, as well as the state of the workplace culture. The second theme spoke to inconsistent findings on the relationship between individual demographics, personal attributes, and burnout. There were also inseparable influences of the oncology context on these nurses’ burnout experience. The authors conclude that organisations should share the responsibility for confronting burnout, but the suggested strategies do centre individualised ‘wellness’ in the name of resilience.

O’Connor et al. (2018) conducted a systematic review and meta-analysis of burnout in MH professionals. They identified workload and work relationships as key determinants for a burnout experience that incorporated high levels of emotional exhaustion (40%); depersonalisation (22%); and a lowered sense of accomplishment (19%). Factors appearing to protect these professionals from burnout included clinical autonomy, regular supervision, cultural fairness, and role clarity. Interestingly, community mental health team (CMHT) staff appeared more vulnerable to burnout than those operating in more specialist teams; it is suggested this is due to specialist staff experiencing greater autonomy.

There are conceptual difficulties to be noted however, and questions have been raised as to the distinction between the state of burnout and clinical depression, for example; a review into this overlap by Bianchi et al. (2015) attempts to speak to this. Following a systematic literature review, they argue that the empirical evidence for burnout as a distinctive entity is inconsistent and its characterisation has been impeded by a lack of clinical observation. They suggest the instruments developed for measuring burnout (referenced above) have contributed to the confusion.

Having reviewed the models for and issues related to decision-making, one notices necessary trade-offs as points of tension, particularly where there is conflict with professional codes of ethics and individual moral values and intuitions.

1.4. Moral Distress

Despite its conceptual ambiguity, burnout talk is common in healthcare spaces. A lesser known concept is moral distress. Moral distress (MD) is a term originally coined in 1984 by Andrew Jameton, an American ethicist. As above, distress amongst healthcare workers is often discussed through the concepts of ‘burnout’ and ‘stress’, which Jameton acknowledged as relevant but insufficient for what he was concerned with. Jameton (1984) more specifically examined the ethics of nursing and described MD as arising from situations where a person knows what the right thing to do is, but that course of action appears impossible due to institutional constraints. An example of nurses being constrained from translating moral choice into moral action, compromising their values and code of ethics, includes the inability to ensure a patient is comfortable due to staffing levels impacting on which tasks take priority during a shift (Rodney, 2017).

Wilkinson (1987) furthered the definition of MD by describing “the psychological disequilibrium and negative feeling state” (p. 16) felt by nurses in these scenarios. Nathaniel (2002) expanded the concept to speak to an embodied, at times painful, experience where a “person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about the correct action” (p. 9). When healthcare professionals (HCPs) are unable to practise in accordance with their ethical standards, they can feel powerless, angry, and guilty (Meltzer & Huckabay, 2004; Schwenzer & Wang, 2006). In other words, MD arises when personal or institutional factors (values or policies, for example) prevent us from taking what we deem to be morally justifiable actions (McCarthy & Gastmans, 2015). Zuzelo (2007) encourages us to consider that these feelings of guilt, frustration, and anger arising as MD often do so because clinicians lack the necessary power or resources to respond as they see fit.

A more recent definition has been provided by Varcoe et al. (2012), who refer to “the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards” (p. 59). A decision reached following a dilemma has compromised a person’s professional and/or personal moral integrity, and the actions agreed do not align with their individual moral judgement of the dilemma, and/or their code of ethics (Fantus et al., 2017). Compromised integrity within MD is often associated with burnout and the intention to leave a position in healthcare (Hamric et al., 2012; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Piers et al., 2012). Indeed, the significant physical and emotional experience of MD has been linked to the loss of qualified HCPs and career dissatisfaction (Hamric, 2000; Pauly et al., 2009). Above and beyond other workplace pressures, MD is linked to job dissatisfaction, weariness, and turnover (DeTienne et al., 2012).

MD is said to contextually occur interactionally, between individuals and workplaces which are financially constrained and have increasingly ill patients, and a workforce that incorporates differing power dynamics amongst its personnel (Musto et al., 2015; Varcoe et al., 2012). This is a context in which ethical conflicts between clinicians and their organisations are rife, and often centre around the impact of scarce resources upon patient care, disagreement regarding organisational policy and procedure, and a sense of leaders ‘turning a blind eye’ (Gaudine et al., 2011). MD can be considered an ‘ethical canary’ (Somerville, 2004), warning us something is significantly amiss, in need of systematic reform.

Oliver (2018), a medical consultant, shares their thoughts on how MD touches all who work throughout the NHS and cites staff surveys which have highlighted declining morale in association with pressure and staff shortages. He notes the growing interest in ‘resilience training’ for the NHS workforce and is not convinced by this as an evidence-based solution, nor as one that adequately responds to what he sees as unacceptable working conditions. Oliver suggests that we might begin by naming the MD in our system, rather than seeking to hide it or diminish it.

A few authors have spoken to the potential for MD to do good through the prompting of self-reflection and enhanced moral sensitivity (Carse &

Rushton, 2017). Tigard (2019) argues that whilst many of the effects of MD are undeniably negative, the experience can serve to reveal and affirm what matters to us as moral agents and under certain circumstances, permit important moral maturation and highlight a person's character. Similarly, improved organisational ethics support is posited as an opportunity for workers to learn and grow from their experiences of ethical dilemmas and conflicts, should mechanisms such as ethics committees be accessible and supported (Rathert et al., 2016).

Numerous authors have raised concerns about our current lack of adequate understanding of MD, it's conceptualisation and delineation (Fourie, 2015; Tigard, 2018). These conceptual demands can and should be considered. However, the concept of MD remains worthy of investigation, not least because of its tendency to reveal structural issues and highlight the political dimensions of professional practices as ethical concerns (Weinberg, 2009). The threat to patient safety from the moral disengagement of a healthcare system and its clinicians also calls for inquiry (Hyatt, 2017).

Throughout the process of this thesis, the world has been experiencing the coronavirus disease 2019 (COVID-19). Healthcare has substantially changed in this time and the distress of HCPs has been broadcast. These HCPs have been facing moral and ethical dilemmas of a heightened intensity and frequency. Garros et al. (2021) suspect that beyond the challenges of care during COVID-19, HCPs will be experiencing MD as resources become scarcer, for example. Pre-pandemic, the MD literature was saturated with end-of-life conflicts and the dilemmas of providing sub-optimal treatment because of a lack of resources (a significant, institutional-level constraint). Garros et al. (2021) encourage a paradigm shift, moving away from 'simplifying' distressed HCPs as solely exhausted (in the style of burnout narratives) to consider the problematic environments they are being expected to survive.

In summary, the body of literature on MD has continued to grow over the last 40 years as MD has come to be more acknowledged as a problem within healthcare settings, posing a threat to the moral integrity and wellbeing of clinicians and patients alike, and the quality of services delivered and received. The contents of this empirical research literature will be explored later in this chapter.

1.4.1. Burnout Revisited

Having introduced MD, it is perhaps useful to revisit burnout and consider their similarities and differences. Within the literature, burnout is often framed as one consequence of MD (Hamric et al., 2012; Meltzer & Huckabay, 2004). Other authors have expressed concerns that MD may at times be inaccurately categorised as occupational stress or burnout (Fantus et al., 2017). Definitions of occupational stress do not include reference to ethical dilemmas or morally compromising situations, instead they cite “the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker” (National Institute for Occupational Safety and Health, 2021, p. 6). Distinctions between burnout and MD have been offered in response, burnout identified as an experience that does “not entail a lack of ethical integrity or personal value incongruence” (Fantus et al., 2017, p. 2284).

Occupational stress, burnout, and MD may be experienced by HCPs because of similar institutional constraints. What distinguishes these experiences is the extent to which the consequences derive from a moral event; that is, when institutional constraints such as funding and workload produce ethical dilemmas whereby the resultant decision conflicts with a HCPs values (personal and/or professional), or integrity (Fantus et al., 2017).

1.4.2. Moral Efficacy and Moral Courage

Moral efficacy as a concept is derived from Bandura’s theory of self-efficacy (Hannah et al., 2011) and states that beyond the influence of moral knowledge and reasoning, moral conduct is influenced reciprocally by intrapersonal characteristics, the external environment, and specific behaviours that an individual selects. Self-efficacy is brought into the discussion on MD by

Rathert et al. (2016) as they believe individuals' ability to persevere in the face of hardship is highlighted in this theory.

Moral efficacy is also argued to be an influencer on moral courage, that which supports an individual in converting their moral ideals into actions regardless of pressures to be subservient (May et al., 2003). A key component of moral courage is what Rathert et al. (2016) refer to as moral voice, which they differentiate from the concept of feeling psychologically safe to speak up to instead the “voice of agency, to act with courage, conviction, and capacity” (Edmonson, 2010, p. 4).The general notion of moral courage (‘the courage of your convictions’) has permeated our culture for some time and it follows that people may feel distressed by a perceived failure to speak up around something they believe to be wrong.

1.5. Clinical Psychology

The Clinical Psychologist’s (CP’s) role within the NHS’ provision of psychological care generally involves clinical practice, research, and leadership responsibilities which may all require varied approaches (Barkan, 2018). Understanding interpersonal dynamics within care organisations, developing shared understandings of complex issues, and facilitating multidisciplinary teamwork are all common concerns for CPs (Reiss & Kirtchuk, 2009). The ethical dilemmas that CPs face are evidently complex. Factors to consider are free and informed consent, confidentiality, professional boundaries, competency, cross-cultural practices, and social justice (Truscott & Crook, 2004). CPs can turn to their professional body’s code of ethics for guidance; here the principles and values of the professional community are articulated.

O’Donohue & Henderson (1999, p. 10) spoke of the “epistemic and ethical” duty a psychologist holds and of the imperative need to attain the highest possible level of theoretical and empirical knowledge, which must then be utilised in the most ethically appropriate manner (Barkan, 2018). This tension between empirical knowledge and ethical practice may require more consideration in application once the means of producing and disseminating empirical knowledge is deconstructed.

1.5.1. Power and Knowledge

Power as a concept in our Western society is defined in terms of control; that which has power has the ability to control people and things, influence them and exert authority. Many forms of power exist: legal power, economic and material power, and coercive power to name a few (Johnstone & Boyle, 2018). When a profession is closely affiliated with societal knowledge and is depended upon by other groups, its ethical practice becomes especially relevant (Pettifor, 2004). CPs are certainly such a profession, producing knowledge through research and disseminating it, often as truth, with their powerful titles as Doctors attached; this is one way in which CPs may differ from general nurses, for example.

CPs have amassed valued qualifications, knowledge and networks which afford them social and cultural capital, enhanced by their titles which denote expertise and status. They have access to and can wield ideological power, influencing the control of language, meaning, and perspective (Johnstone & Boyle, 2018). Hagan and Smail (1997) encouraged psychology to engage in ‘power-mapping’ to consider the full implications of taking seriously the workings of power upon an individual’s social environment, how psychological distress can result from social power operating upon a person. This power is not created in a vacuum, away from clinical psychology, rather clinical psychology plays a role in reproducing ideas and concepts, and CPs are not immune from experiencing this as people themselves.

The knowledge CPs have attained through their training is likely to include frameworks for understanding human behaviour and subsequent distress, such as Social Identity Theory (Tajfel &

Turner, 1979), a theory speaking to how people develop a sense of who they are based on their group membership(s) and source their pride, self-esteem, and sense of socially belonging from these groups. People divide into categories, such as castes, generations, and races; more relevant to this thesis however may be how HCPs might separate into groups of their own: ‘psychiatric nurses’, ‘psychiatrists’, and/or ‘psychologists’, ‘ward teams’ and ‘external consultants’, ‘inpatient’ and ‘outpatient’ staff – an ‘us and them’ that intensifies during times of stress or conflict. Understanding a theory such as this may afford psychologists the ability to make sense of any distress they may feel in their occupational setting when they are outside of a dominant group and not adhering to the norms of that group, such as practices which pathologize and medicate distress.

Additionally, Ecological System’s Theory (Bronfenbrenner, 1977) is taught widely on clinical psychology doctorate courses, providing CPs with an understanding of how the influential, layered systems within a person’s environment will shape their experiences of being in the world. Again, this offers psychologists a framework for meaning making regarding what it’s like to be part of a system, one which is impacted by others, and why ethical dilemmas may present, and then why they may be distressing. These theories are simply two examples of the knowledge psychologists may be equipped with, which may alter their experience of moral distress, how it is felt, understood, and managed.

1.5.2. Values: Personal and Professional

A person’s own values and moral code are developed and shaped through multiple contexts and group memberships. The values upheld by one’s family, for example, are likely to influence what matters to the self, alongside cultural norms, religious teachings, and that which is promoted through media. Children are taught to ‘do the right thing’, but what this is will likely differ from household to household and person to person. ‘Doing the right thing’ is contextual and therefore often subjective. Philosophies and principles deployed by psychologists are often influenced by Judeo-Christian ethical traditions (Knapp & VandeCreek, 2007), which raises questions as to whether it is indeed ethical for psychologists to apply the standards of Western morality to clients originating from other cultures. As a British, 'socialised' healthcare system, one might assume that the NHS has been built upon Westernised ideas of universal ethics. However, despite two NHS HCPs being born and raised within a Western culture, they may still have individual differences in their personal values and have different responses to a patient who discloses the wish to terminate a pregnancy based on differences in religious beliefs or personal experiences as parents, for example, despite a professional code perhaps advocating for the same response from both HCPs. Beliefs vary even with the same culture (Knapp & VandeCreek, 2007), and the boundary between personal and professional may not always be as distinct as desired.

Hadjistavropoulos et al. (2003) compared the ethical ideologies of (Canadian) psychologists with those of physicians and found the psychologists to be influenced by their code – more so than physicians – and less influenced by the views of their family or peers or religion. Psychology also exhibited a greater tone of duty (over utility) than medicine did. The researchers say that the reduced relativism noted in psychologists may support more consistent ethical decision making. However, despite professional ethics in general being produced through internal consensus, individual psychologists are ultimately alone when making moral choices in clinical practice. Different professions may therefore experience MD differently, through the violation of values based upon different personal and/or professional perspectives.

Alongside the Judeo-Christian ways of thinking which are privileged within the NHS context, the dominance of EBP (as spoken to earlier in this chapter) has implications for how clinical psychology has, as a profession, presented and developed itself.

> The scientist-practitioner model has traditionally been advocated for amongst several clinical psychology training programmes, promoting the idea that CPs should be equally as competent as researchers as they are clinical practitioners. EBP having come to underlie decisions about provision and funding of healthcare in the NHS has meant that a clinical psychologist who aligns themselves with the values of EBP is likely to be more comfortable operating in our current system. CPs who position themselves differently however, for example as critical practitioners who draw on research evidence from a more pluralistic and pragmatic manner, aware of the limitations of positivist methods, are likely to experience conflicts between what they feel is important and what the system, advocating for EBP, values.

Our healthcare system can ill afford the consequences of MD, and burnout. The psychological impact of stress at work is significant; a poll of primary care workers found that 43% of this staff force had considered leaving their post, or already had; 21% reported having developed a MH problem; and 8% expressed suicidality (Mind, 2016). A ‘staffing crisis’ in the NHS is often written about (Brown, 2019; Hazlegreaves, 2019; Kaidi & Atun, 2017; Mundasad, 2017) with authors warning that the future of the NHS is in jeopardy. Numerous explanations for staff shortages have been put forth, including the argument that the NHS has been staffed according to what it can afford rather than what the population it serves needs (Mundasad, 2017). More people leaving the NHS than joining impacts everyone at every level – economic, therapeutic, and occupational; it creates an inconsistent care-experience for patients and a chaotic workplace for clinicians, which only adds to the probability of people leaving (Hazlegreaves, 2019). The implementation of the NHS Long Term Plan (LTP) (NHS England, 2019) is expected to be hindered by the on-going deficits in the workforce (Buchan et al., 2019), despite it being framed as an opportunity to address workforce issues.

Clinical psychology is far from immune to retention challenges. A commentary on the LTP by the Division of Clinical Psychology expresses disappointment at a lack of attention to the psychological professions and a wish for acknowledgment of how many staff are experiencing the NHS as a difficult place to work, considering the retention issues (Lavender, 2019). Attempts to address the struggle to retain junior doctors have included raising the medical school enrolment cap and increasing locum posts (Kaidi & Atun, 2017); interestingly, clinical psychology appears to be employing similar strategies, increasing the number of training placements and advertising more vacancies as ‘bank’ posts. These (expensive) solutions are attempts to recruit, not retain; they do not address why clinicians, across all professions, are ‘dropping out’ of the NHS. Calls for action on the retention challenge, at the organisational level, have been sounded (Bell & Breslin, 2008; Varcoe et al., 2012).

1.5.3. Clinical Decision-Making

The complexities of decision-making as a human and as a HCP apply to CPs too. Clinical work for a CP includes decision-making regarding assessment, formulation, and treatment and therefore the issue of decision-making is at the forefront of a psychologist’s competence (Tracey et al., 2014). Practitioner psychologists are registered with and regulated by the Health and Care Professions Council (HCPC); their Standards of Proficiency (2015) include items addressing the making of ‘effective’ clinical decisions and are intended to be complimented by the BPS Practice Guidelines (2017) which assert that through their extensive ‘theory to practice’ training, psychologists can draw on a variety of sources of information and experience to make a clinical decision. They go on to state that what separates a psychologist from other therapeutic practitioners is their “ability to access, review, critically evaluate, analyse and synthesise data from a psychological perspective” when engaging in decision-making (BPS, 2017, p.10).

We may therefore come to understand that continuous decision-making, seeking to resolve repeated dilemmas, is inherent to the psychologist’s role (Scaturo & McPeak, 1998). This is undoubtedly an intricate process that calls for the integration of experience, (evidence-based) knowledge, and the unique qualities of the client and the practitioner (Barkan, 2018); the self-evaluation of a practitioner’s work is therefore strongly advocated for in the Practice Guidelines. Several texts have thus been published as clinical decision-making guides, to support ‘best practice’, and claim to speak to achievable, accurate and concrete clinical decision-making (Magnavita, 2016). One could argue, however, that the above does not clearly distinguish CPs from other healthcare workers and therefore the experience of decision-making and its consequences is likely to be similar for CPs as with others.

1.5.4. BPS Code of Ethics and Conduct

Fantus et al. (2017) note that MD may operate differently across healthcare professions due to differences in each discipline’s code of ethics and their distinct responsibilities. The ethical considerations governing therapeutic interventions should underpin decision-making in clinical practice, and the BPS Code of Ethics and Conduct (2018) encourages psychologists to ensure they have an awareness of their limitations as a professional. However, membership with the BPS is voluntary for psychologists and so the extent to which an individual psychologist is signed up to this code likely varies.

1.6. Systematic Reviews of Moral Distress

Systematic reviews of the literature on moral distress have highlighted that most studies on the experience have been conducted with general nurses; a bibliometric analysis by Lamiani et al. (2017) placed the prevalence at 71%. These studies (for example, work by Austin, 2007; Corley, 2002; Hamric, 2000; Tiedje, 2000) have demonstrated a significant prevalence of MD in nursing, particularly within settings such as end-of-life care and the decision-making processes therein. Most research on MD has been conducted within acute physical healthcare settings, finding that MD is also experienced here by physicians, pharmacists, and occupational therapists (Førde & Aasland, 2008; Schwenzer & Wang, 2006; Sporrong et al., 2006).

Sanderson et al.'s (2019) systematic review of the MD literature found it to most often be framed as an individual experience although power and hierarchies in the workplace are referenced. They identified that the numerous definitions of MD that have developed over time have limited the usefulness of studying MD, but go on to suggest a redefinition of their own: “ethical unease or disquiet resulting from a situation where a clinician believes they have contributed to avoidable patient or community harm through their involvement in an action, inaction or decision that conflicts with their own values” (Sanderson et al., 2019, p. 195).

What we know, broadly speaking, about MD is that it arose as a phenomenon in the context of nursing, more specifically end-of-life nursing, and speaks to the experience of being unable to act in accordance with one’s moral judgement (Rodney, 2017). It has been distinguished from other forms of emotional distress through an identification of its threat to HCPs moral agency and integrity (Hamric, 2012), the consequences of which including desensitisation and attrition. Causes of MD have varied but generally include challenges in decision-making, excessive workload, and conflict with colleagues; all of which have been barriers to providing the care nurses viewed as best for their patients. What is more unknown is how people manage this experience. The presence and prevalence of MD in other contexts, such as MH settings and professions, is also less explored.

1.7. Scoping Review of Moral Distress

A scoping review of the current literature on moral distress (within healthcare settings) was performed. A scoping review should explore the extent and quality of existing research on a particular issue, as well as its fundamental concepts and identify any gaps in the literature. (Arksey & O'Malley, 2005; Peters et al., 2015).

1.7.1. Literature Search Strategy

Using the keywords, published, peer-reviewed work was searched for across electronic databases including EBSCO (PsycInfo, PsychARTICLES, CINAHC); Academic Search Complete; and Google Scholar. The terms 'moral distress', 'psychology', 'burnout', 'ethical dilemmas', and 'decision-making' were used individually and in combination with one another. Following abstract readings, articles considered relevant were obtained in their full text and incorporated into the review. These tended to speak to the emotional component of clinician's experiences or considered the constructs and contexts that impacted upon these experiences. Citation searches were also carried out and the reference lists of key papers were hand-searched. The search took place between July 2020 and February 2021. This process is outlined in Appendix A.

A total of 5921 articles were identified through the search, 1156 were screened, 97 duplicates were removed, and 80 full texts accessed; 14 articles remained and are spoken to in the scoping review below. Reasons for exclusion included a sole focus on paediatric settings; exploration of MD outside of a healthcare context; being written in a language other than English; and full texts not being available. Theses and dissertations, unpublished, were also excluded. The 80 full texts were downloaded and organised using the reference management software Zotero. Due to the scarcity of literature examining the moral experience of CPs in the UK, papers speaking to this outside of the UK were included. This process is illustrated in a chart based on Peters et al., (2015) in Appendix B.

1.7.2. Nursing

As referred to above, the concept of MD has its origins in nursing and subsequently most of the literature on MD has been carried out with nurses. Nursing studies identified through the scoping review follow.

de Veer et al. (2013) were concerned with the determinants of MD in everyday nursing practice and carried out a cross sectional correlational questionnaire survey in The Netherlands. Their participants were general nurses working in acute care hospitals, nursing homes, and elderly home care; n=365. The nurses completed an initial questionnaire centred around job characteristics and satisfaction, followed by a MD questionnaire (of their own design) three months later. Their results included ten situations with the highest intensity of MD scores, the most morally distressing for these nurses being times when there is a discrepancy between what a patient wants and what their family wants (M=2.54; SD=0.94). Disagreeing with a doctor (regarding intervention, diagnosis, or discharge), believing it is not in the client's best interest, and witnessing improper behaviour in a colleague followed closely behind. Each of these three situations appeared to reflect the nurses' sense of responsibility to their patients being compromised. MD was also higher particularly for nurses who recognised a lack of time for providing their patients with care. A Pearson product moment correlation coefficient identified that nurses who were less satisfied in their job (r= -.34, p <.000) were experiencing higher MD levels. Individual characteristics (such as age and years of experience) held no significant relationship with these nurses' experiences of MD. Leadership style was identified as an additional situational trigger of MD and the authors call for organisational level interventions for reducing MD levels.

An American survey into the predictors of moral distress in nurses was carried out by Rathert et al. (2016) who sought to build upon previous descriptive research by testing a comprehensive model, underpinned by Social Learning Theory (Bandura, 1977), examining the work environment and intrapersonal variables that may influence MD. Within an acute hospital they surveyed the nursing staff and reported a response rate of 45% (n=290). More than half of their respondents said they had ethical difficulties on a monthly to daily basis. The impact of five independent variables on MD and moral voice were investigated using structural equation modelling. These were: the frequency of ethical dilemmas and conflicts; moral efficacy; ethics communication; ethical environment; and organisational ethics support.

Their findings demonstrated that the frequency of ethics concerns and organisational ethics support have significant independent effects on MD. Moral voice entirely moderated the relationship between moral efficacy and MD, and somewhat mediated the relationship between organisational ethics support and distress, according to a bootstrapping analysis. Their results also suggested that organisational ethics support is possibly one important factor affecting both ethics voice (indirectly) and MD (directly), and following a supplemental analysis found that organisational ethics support moderated the moral efficacy-moral voice-moral distress relationship in that when organisational support was low, moral efficacy was negatively related to MD via moral voice. Rathert et al. (2016) concluded that whilst the elimination of ethical dilemmas is likely impossible, healthcare organisations may find that by improving their nurses’ moral efficacy they will support moral voice and thereby reduce MD. Having ethics resources available was not enough, the nurses needed to be supported in making use of them.

The high rates of MD in the nursing experience have been explained through their hands-on obligations which include often performing lifesaving or life-ending interventions, actively provided or withheld (Fantus et al., 2017). Further work in The Netherlands by Lokker et al. (2018) explored more qualitatively the MD experiences of nurses, specifically those working with palliative sedation. The Netherlands had eight years earlier introduced national guidelines for palliative sedation. The researchers interviewed 36 nurses from primary care, hospital, and nursing home settings and used a constant comparative analytic method. An overarching theme of ‘pressure’ emerged. The MD experience of these nurses was related to feeling constrained and unable to act in their patient’s best interest, from their view. This regularly included not being able to offer sedation to patients they believed required it because a physician disagreed, and as a nurse they were with the patient and their family, observing their pain, far more closely than the physicians. Conversely, the nurses described a pressure to act too soon, initiate sedation for the family rather than the patient. Powerlessness appeared central to their experiences of distress; the nurses felt they could assess their patient’s needs but did not have the authority to ensure they were met. Lokker et al. (2018) suggest some of this MD could be alleviated through a focus on improving communication between nurses and physicians and ensuring that the guidelines for the decision-making process around palliative sedation were ingrained to a greater degree.

Forozeiya et al. (2019) noted that the growing literature base around MD in nurses had not given much credence to how the nurses were coping with this distress. They interviewed seven nurses working in intensive care (ICU) in Canada, the majority of whom had limited ICU experience. An interpretative descriptive approach was taken, and a thematic analysis conducted. A common experience for these nurses was engagement in practices which did not appear overall helpful to their patients and one of the four themes described was ‘going against what I think is best’; this incorporated being in a position in which they had to do what their physicians or patients wanted and believed was best rather than what they themselves did. This conflict led to negative emotional experiences for the nurses, and they spoke of feeling angry, awful, and traumatised. The consequences extended to a withdrawal from their own family and friends, and not wanting to go into work – they debated reducing their working hours or leaving their ICU posts. These nurses also viewed MD as being inherent to their job, the denial of patient autonomy being a reoccurring concern and physicians often perceived as deceiving families, something the nurses had to witness with little power to intervene. The authors identified a dynamic process wherein these nurses would both turn toward and turn away from their MD, needing to avoid and distance themselves, at times by calling in sick, or seeking out connection with (ICU specific) colleagues who could relate and affirm their experience. The researchers noted a risk of moral disengagement for nurses who had not found ways of coping but stressed this is an organisational issue, not to be individualised, time and space to access support and reflection as a prerequisite.

1.7.3. Moral Distress Scales

Commonly found in the MD literature is the Moral Distress Scale-Revised (MDS-R), a 21-item scale devised by Hamric et al. (2012) to measure levels of MD. Six versions exist, catering to adult and paediatric clinicians; nurses; physicians; and other HCPs. The 21 items are scored via a Likert scale (0-4), across two dimensions: frequency, and the intensity of the disturbance. Total scores range from 0-336. The MDS-R concludes by enquiring about intent to leave a position and has three possible responses: “no, I’ve never considered quitting or left a position”; “yes, I considered quitting but did not leave”; and “yes, I left a position”. Hamric et al.’s (2012) original reliabilities for the MDS-R produced Cronbach of 0.89 for nurses and 0.67 for physicians; use by Allen et al. (2013) later reported Cronbach reliabilities ranging from 0.88 to 0.95. Epstein et al. (2019) revised the MDS-R further following an evaluation of the data produced by 22 studies and a review of 14 other publications. They produced a 27-item scale now named the Measure of Moral Distress for Healthcare Professionals (MMD-HP) and describe it as appropriate for use in all acute settings. It is recommended the MMD-HP replace the MDS-R.

1.7.4. Multidisciplinary Studies

As referenced above, much of the research into MD has taken place within the field of nursing. Studies exploring the concept with other healthcare professions have emerged in more recent years. One institution-wide survey conducted in the U.S.A. by Whitehead et al. (2015) collected completed MDS-Rs from 592 clinicians working at a tertiary medical hospital. This was the largest survey of MD amongst multiple disciplines yet. They found MD to be present in all their professional groups (nurses; physicians; social workers; pharmacists; therapists; chaplains), with significantly higher levels found in those who had direct patient care. Their Cronbach reliability was stated to be 0.90 for nurses, 0.88 for physicians, and 0.90 for other providers. The highest-ranked sources of MD here were witnessing lesser quality patient care due to poor communication or a lack of continuity. Echoing some of the previous nursing studies, clinicians working in adult and ICU settings reported higher levels of MD than those in paediatric or non-ICU settings. Higher levels of MD were also reported by clinicians with end-of-life care training than those without, and a similar correlation was found for clinicians who had departed their roles or were considering doing so compared to those who had never thought about leaving their positions. Participants who had never considered quitting had the lowest average MDS-R scores. Whitehead et al. (2015) concluded that whilst differences in experiences and perspectives may exist, MD was a common experience for clinicians, regardless of their profession. It is of note however that 67% of survey respondents were nurses. This variability in causes of MD between professions has been noted by a number of studies. Hamric and Blackhall (2007) for example, note that whilst nurses found it morally distressing to allow students to practice painful procedures in order to attain their competency, physicians did not. MD may present differently across the disciplines perhaps due to differing responsibilities and differences in the code of ethics for each profession (Fantus et al., 2017).

1.7.5. Moral Distress and Experience

Whitehead et al. (2015)'s above study found no significant relationship between scores on the MDS-R and length of time in a profession or current post. A Canadian study by Dodek et al. (2016) conversely found just that. This was an ICU specific survey however, and there is some agreement that the MDS, revised and original, is more sensitive to the ICU context as this is where it originated. Dodek et al. (2016) distributed the MDS-R to 13 ICUs in British Columbia and conducted a multivariate, hierarchical regression to examine the relationship between MD scores, demographic characteristics (age, gender, years of experience), and intention to leave. They received a more equal response rate across nurses, physicians, and other HCPs (social workers; pharmacists; therapists); however, as the largest of the professional groups nurses were once again the most represented profession. Physicians, considered to have the highest authority on decision-making, reported lower levels of MD than the other professions and therefore control appears an important moderator. The highest ranked items associated with MD were related to budgeting constraints and end-of-life dilemmas. The multivariate analyses highlighted age as being inversely associated with MD, but only amongst the non-nurses and non-physicians, whilst years of experience was directly associated with MD but only for nurses. For all except the physicians, MD scores were found to directly relate to tendency to leave an ICU job. This study sought to understand which characteristics of health professionals are independently associated with MD, and looked less to the ethical climate of the systems they are operating in.

Physicians are often implicated in the MD experience of other clinicians. Work by Lomis et al. (2009) explored the MD of medical students in the U.S. through a descriptive review of the students' case reflections. Recurrent themes were identified following an analysis of 192 case reports which were categorised as exhibiting higher or lower levels of MD based on tone and content. The researchers report that 67% of the cases were identified as highly distressed and that the most common problem within these submissions centred around communication problems, with patients and other HCPs. The hierarchical organisation of healthcare was implicated here, preventing trainees from speaking up. Students who took action (spoke up) experienced lower levels of distress. Following communication, themes arose around problems with unprofessional behaviour (of senior physicians); systems of care (access and continuity inside and outside the institution); severe illness (death, ICU, prognostic uncertainty); medical error (near misses and complications); role models (positive and negative); and student action (regret of inaction). As students, these participants appeared to take up a liaison position between patients and physicians, questioning what they observed but unsure how to respond to concerns. The authors conclude that MD-generating situations are identifiable and to support the trainees' development this distress should be more readily addressed. Forums for discussion were notably absent but valued by participants, and a culture change seemed necessitated for improved communication.

In Australia, Crane et al. (2013) interviewed 14 medical doctors (most of whom were specialists) regarding their experiences of MD, doing so due to the decision-making autonomy afforded to doctors in the healthcare system. Their interviews incorporated the items from the MDS. Four themes were identified, the first being that MD arose for these doctors because of institutional constraints impacting their autonomous experience of decision-making. However, over half of these doctors were not morally distressed by such events, assigning the limitations of care to the system and not themselves. A mixed experience arose with Crane et al.'s participants, some of whom reported significant feelings of guilt and shame around their decision-making, such as instances where a patient's suffering was prolonged due to attempts to keep them alive. Others though did not assign moral significance to such errors in judgement. The final theme concerned a delayed onset of MD, the distress arising in retrospect, an example being of having performed an abortion which was felt to violate a moral framework later when the doctor had their own children. Notably, however, only two participants produced this theme and so the authors argument for adjusting the definition of MD to exclude a necessity for a moral conflict to be identified in advance of experiencing the distress is not entirely convincing from these results only.

1.7.6. Moral Distress and the Crescendo Effect

The Dodek et al. (2016) survey described its finding on MD being directly associated with years of experience (in nursing) as providing evidence for the 'crescendo effect' (Epstein & Hamric, 2009). The suggestion is that MD builds over time and unresolved MD endures even once the moral conflict has dissipated, leaving a moral 'residue' that means recurrent experiences of MD can intensify and escalate, and may have a lasting impact on professional practice (Epstein & Delgado, 2010). Subsequent experiences accumulate and over time the effect can desensitize workers to the moral aspects of a situation, leading to disengagement (Bandura, 2012). "Repeated experiences of moral distress indicate deeper, systemic problems of poor communication, inadequate collaboration, and perceived powerlessness resulting from hierarchical structures" (Epstein and Hamric, 2009, p. 338); the hierarchical structures are a significant factor in this complex process, ones that are certainly pertinent to UK healthcare provision.

1.7.7. Moral Distress and Mental Health

When referring to 'therapists' in their category of 'other HCPs', the studies above are speaking of physio therapists; respiratory therapists; occupational therapists etc. Psychologists are not traditionally included in these studies which are being conducted in North American physical health settings, where psychologists do not appear to be integrated into medical teams. MH services and psychological provision may hold specific challenges, such as the tension between individualised aetiology and the impact of social context and inequalities.

The reoccurring finding surrounding considerably higher levels of MD in nurses than physicians is perhaps accounted for by nurses' greater familiarity with patients and the power hierarchy found in most healthcare organisations, where the care is directed by physicians and the fundamental characteristic of MD that is powerlessness can arise (Musto et al., 2015). Psychologists typically become similarly familiar with their patients, developing a detailed understanding of a patient's past and present circumstances. Psychologists can be in more powerful positions than nurses however, greater weight afforded to them due to their professional title, and therefore an interesting comparison can arise, psychologists taking up space somewhere between nurses and physicians. Through the scoping review a small number of papers were identified investigating MD within MH settings. Notably, one study by Austin and colleagues (2003; 2005; 2008) had produced numerous publications; this was a Canadian hermeneutic phenomenological study using individual interviews to explore the lived experience of MD with psychiatrists, psychiatric nurses, social workers, and psychologists. Each discipline of 6-9 participants engaged in a dialogue with a researcher from the same discipline. A publication of the social work findings could not be located, but three studies by the researchers pertaining to the other three professions are spoken to below.

First, Austin et al. (2003) described psychiatric nurses experiences of MD, who cited a lack of resource (staffing; time) producing dispiritedness, and a lack of respect and acknowledgment for staff and patients alike which was significantly diminishing their sense of being able to provide good care. The nursing staff named anger, frustration, and sadness in response to being unable to meet the needs of their patients due to what was lacking. The nurses also spoke to a dehumanisation of patients and staff, no one being known in their entirety but rather becoming a diagnosis (patients) or part of a machine (nurses). Noticing this and becoming distressed by it was deflected by the institution when it was named – ‘do your best’ not feeling a sufficient response. These nurses had sworn to devote themselves to caring, but this responsibility had become an individual liability, they had not been afforded the necessary power and control to safely attend to their responsibilities, and the researchers emphasised the need for health institutions, and society, to make the necessary resources available to nurses so they may fulfil their commitment to competent and ethical practice.

Secondly, Austin et al. (2005) described the MD as experienced by psychologists in their study. The paper is interestingly titled ‘To Stay or To Go, To Speak or Stay Silent, To Act or Not To Act’. These psychologists spoke to events during which their integrity felt compromised and identified factors such as team conflict, interdisciplinary disputes, and institutional demands as contributing to this. Congruent to Godkin’s (2000, cited in Austin et al., 2005) suggestion that humans often notice an ethical issue has arisen based on pain in the ‘gut’, the psychologists here described having horrible, intolerable feelings including anger, shame, grief, embarrassment and sadness. Mechanisms by which to manage this MD, deployed by the psychologists, included taking a stand or acting secretively (afraid of repercussions); engrossing themselves in the therapeutic work; aligning with colleagues for support; remaining silent (to avoid alienation); or leaving their post. The psychologists spoke of a reoccurring self-questioning of their ability to make change, of noticing a feeling of ‘hitting a brick wall’ and reaching a point at which perseverance seems futile. Leaving though, was just as hard as staying.

Finally, Austin et al. (2008) explored psychiatrists' experience of MD, who reported wrestling to 'do the right thing' for their patients in the context of a societal system which lays demands, perceived as unrealistic, upon the psychiatrists' expertise. A difficulty with certainty arose here, an expectation that the psychiatrists can and should make sure decisions about coercive treatment and assessments of danger. This expectation was felt to be unrealistic and removed from the complexity of an uncertain reality. However, psychiatrists have been identified "as the most powerful non-government decision-maker" (Austin et al., 2008, p. 91) with the ability to take a person's freedom and liberty away (Robitscher, 1980; cited in Austin et al., 2008). MD arose for these psychiatrists in the context of this balancing act, the responsibility society places upon them to care for vulnerable people with reduced autonomy, whilst shouldering accountability around public protection. These roles were often in conflict, seemingly more so as the psychiatrists found themselves increasingly facing a pressure to fit social ills into the medical model through which much of Western society makes sense of distress (Austin et al., 2008).

One MD study identified through the scoping review was carried out closer to home, with Irish psychiatric nurses. Deady and McCarthy (2010) interviewed eight psychiatric nurses working within acute care settings and carried out a thematic analysis in line with Pope et al.'s (2000) guidance. They describe their findings as confirming the presence of MD and the situations which gave rise to MD for these psychiatric nurses were segmented into three categories: "professional and legal conflict; professional autonomy and scope of practice; and standards of care and client autonomy" (Deady & McCarthy, 2010, p. 5). Sharing an opposing view, challenging a clinical decision, was difficult for these participants who did not feel valued or that any change would come from it, and the client's needs were deprioritised. Similarly, their position as nurses who spent extended periods of time with their clients was not valued enough to influence clinical decision-making. Thirdly, the witnessing of substandard (by their measure) care, which they had little power to influence across all levels of their MH system, was distressing. Participants felt the impact of this upon both their professional and personal lives and described feeling frustration, anger, guilt, and depression which followed them home and endured over extended periods. Their strategies for coping included attempts to adapt to the culture, deny there is a problem, establish a separate moral code for work, and/or leave their job. As with other studies, participants here reported their organisations being inadequately aware of or supportive of the moral challenges in clinical practice.

Musto et al. (2021) explored how multidisciplinary healthcare providers in Canadian acute MH settings navigate ethical dilemmas and mitigate MD. They used Grounded Theory to analyse documents, observations, and interview data with participants working across inpatient and emergency departments. All participants were regulated health professionals, predominately psychiatric nurses (N=14), but also medics (N=2), social workers (N=3), occupational therapists (N=2), and registered nurses (N=6). They found that a constant source of MD for these participants was what they named ‘systemic inhumanity’, “a fundamental inability in the healthcare system to respond consistently with respect, dignity, and compassion towards people struggling with MH issues” (Musto et al., 2021, p. 2461). Barriers to humane practice had been written into the system’s policies. To manage this, their participants ‘risked vulnerability’, striving to practice ethically whilst balancing organisational processes and professional obligation. This risk included ‘pushing back’ (acting strategically, holding onto professional identity) and ‘working through team relationships’ (identifying boundaries, strategising). Musto et al.’s work was one of the few papers identified which considered the impact of socio-political factors like austerity measures on ethical practice, and how this undermined participants' moral enactment. The decision making of their HCPs was also understood as being challenged by how austerity had shaped their clinical environments. Moral agency and the role of action was identified as a key influence of MD, with a dynamic and relational component; participants who were helped by others in their organisation to enact moral agency avoided becoming 'stuck' in MD. The researchers concluded that such an embodied and dynamic process called for interventions across the micro, meso and macro levels with a shared responsibility for change. Institutions, organisations, individuals, and regulatory bodies must work collaboratively, they say, to implement practices which allow values to be enacted and foster moral agency to humanise care.

Baker Collins and Cranmer-Byng (2018) too focused upon the structural constraints, such as restrictive policies, which contribute to MD. Theirs was a study based in Ontario, Canada in which interviews were conducted with 15 case managers (social workers) whose environment they described as having undergone a neo-liberal restructuring, which impacted their ability to practice in accordance with the social justice values integral to the profession. MD was not the original focus of these interviews but was elicited as the participants spoke of the systemic conflicts they were facing as they attempted to navigate a restrictive programme alongside the complex needs of their clients. Interview data was analysed thematically, and two overarching themes were presented: contributory systemic and contextual factors leading to MD, and the participants attempts to cope, including through resistance. This first theme referred to a lack of time to meaningfully be with their clients due to substantial caseloads and burdensome data reporting requirements. They expressed the erosion of a therapeutic relationship related to this, and the impact this had on their experience of ethical decision-making. Their resistance spanned smaller, typically disguised, acts of rebellion to more openly resistant micro-acts. They tried to 'lessen the damage' by being strategic around the timing of their decision-enforcement, and proactively sought out more meaningful engagement with their clients in hope of waylaying the system's rigid distancing of client and professional.

1.7.8. Neglected Areas

A small number of studies have examined MD within MH care, with recent additions from psychiatric settings (Deady & McCarthy, 2010; Lützén et al., 2010). Only one publication identified during the scoping review dealt singularly with the MD experiences of psychologists (Austin et al., 2005) and these were psychologists operating in a Canadian MH system. No investigations into MD with CPs in the UK were found. CPs in the UK's NHS are operating within settings where the resources are low, and the demand is high. They too are likely to regularly face ethical dilemmas and have fluctuating decision-making autonomy which may conflict with their sense of duty to care and compromise adherence to the code of ethics they subscribe to (not necessarily the BPS').

In a review of the three decades worth of research on moral distress, Rodney (2017) acknowledges some of the criticisms of the concept itself and suggests ways for it to be moved forward. She recommends there be increased investigation of MD in more diverse practice areas, beyond acute contexts like critical care to focus more on MH, community, and long-term care. Rodney also encourages researchers to consider the reciprocity between organisations and individuals, examining MD through a relational ethical lens. Psychologists are perhaps a group well suited to considering the interconnectedness between people and structures. MD has been identified as more prevalent in clinicians who work with adults (Whitehead et al., 2015) and so CPs providing care to adults may be a group to begin investigations with.

1.8. Relevance and Rationale

The ideological power and social and cultural capital held by clinical psychologists necessitates an investigation into the presence of moral distress within the profession. The leadership path CPs are encouraged to follow, to a different degree than other MH HCPs in the NHS, also provides reason to research MD specifically with CPs, an awareness of personal values being key to effective leadership (DCP Professional Standards Unit, 2010), and leaders being in a position to dictate an organisation's – in this case a healthcare system's – values and principles.

To my knowledge, the concept of MD has not been explored with CPs in the UK. Much of the MD research has been conducted in North America, and a study in the NHS (a 'socialised' healthcare system) is warranted. Doing so may refine our understanding of this psychological experience and might additionally tell us something about the way our profession is currently operating – how aligned our aims are with our actions, how we fit into the healthcare system, and what values and beliefs exist about what psychology 'should' be doing. Additionally, conversations about morality within healthcare are particularly salient in this time of an international pandemic. Engaging with this study topic as a clinical psychology issue is consistent with the BPS's ethical commitments and the profession's broader claims to be concerned with ethical conduct (British Psychological Society, 2018; Butchard & Greenhill, 2015; Kinderman, 2007).

1.9. Research Questions

1. What situations or experiences can make psychologists feel their personal or professional values are compromised?

2. How do clinical psychologists experience conflicts between their values and institutional procedures, and how do they attempt to manage them?
3. What is the nature of the conflict and how is it experienced?

2. CHAPTER TWO: METHODS

This chapter will summarise the epistemological position taken, and the research methodology used during the research process. The data collection procedure and method of analysis will be defined and justified, with ethical concerns considered.

2.1. Epistemological Position

Through ontology we consider our beliefs about the nature of reality, and in taking an epistemological stance we make claims about the production of knowledge. A researcher's epistemological position is the conceptual framework from which all research begins and is consequently key in understanding the way the research has been designed, carried out, and interpreted (Willig, 2012; 2019).

It is therefore important to share my own positioning in this thesis as a critical realist (Bhaskar, 2008). The limitations of relativism and positivism influenced the emergence of critical realism as a philosophical position, limitations such as the rigidity of acknowledging only that which is 'proven' through math or science. Critical realism theorises that there is a reality existing independently from our minds, but it is one we cannot be in direct contact with. There are real mechanisms (such as biology) producing phenomena which we can observe and know of, but we accept that our ability to discover the world is limited.

In the social sciences, critical realism allows us to understand social affairs as having a complex composition, centred around social structures, their origins, and the human capacity for reflection. Language supports us in constructing our social reality, but these creations are themselves constrained by the inescapable material world (Riley et al., 2007). Operating within clinical psychology, as a critical realist, means exploring scientific and technical concepts within the conditions (cultural, historical) through which they emerged (Pilgrim & Bentall, 1999). It is our theories of reality, the claims we make about it, which are socially constructed. The theories and methods presented within this thesis have been shaped by social forces and influenced by a variety of stakeholders and agendas.

In this study I will be working within the tangible, substantial reality of healthcare provision, in which some conditions (principally physical health) will have material underpinnings while others (principally mental health) will be subject to a greater degree of social construction and mediation. This reality will be explored in the context of ideas surrounding morality, which are socially, culturally, and historically mediated. To understand the experiences of the CPs in this study we must acknowledge the physical reality of providing psychological support to the national population (resource limitation, institutional procedures) and the socio-historical production of morality, ethics, and "moral distress". Similarly, the concept of distress itself is socially and historically mediated; manifestations of distress and people's experiences of it will vary, but we do not seek to deny the lived reality of this distress (Pilgrim & Bentall, 1999).

Critical realism pursues the production of a philosophy that we can live by (Bhaskar & Hartwig, 2016), which aligns with this study's aim to support clinical practice. However, whilst this research may describe the reality of its participants, the methods utilised to explore their experiences of moral distress have been influenced by established socio-cultural assumptions (Willig, 2012).

2.2. Methodological Approach

This thesis is qualitative in design as it seeks to explore, describe, and interpret the experiences of CPs by obtaining rich, 'thick' accounts. This research in interested in the impact and management of ethical dilemmas in clinical psychology practice, if these experiences equate to moral distress, and hopes to complement the largely quantitative literature on moral distress. A review of this existing literature on moral distress identified significant contributions from the nursing profession but very few investigations of the concept within clinical psychology, none having been produced in the UK. The UK of course has its own cultural idiosyncrasies and historical context for healthcare provision and an understanding of whether moral distress is present in our profession, in our national health service context, is perhaps particularly important given the 'retention problem' (Buchan et al., 2019).

2.2.1. Thematic Analysis

I sought to describe and interpret the views of participants, and identify any patterns in the data, whilst accounting for context, values, and varying experiences. Thematic analysis (TA) is a method "for identifying, analysing and interpreting patterned meanings or themes", (Braun & Clarke, 2006, p. 79) and does not make a priori assumptions, which supports this study's efforts to explore ethical dilemmas whilst leaving space for a moral grounding to potentially emerge. The flexibility afforded by TA lends itself to an exploration of meanings shared by participants and coherently aligns with a critical realist epistemological positioning (Nowell et al., 2017).

TA can be utilised with almost every form of qualitative data, including interview data (Braun & Clarke, 2006). It is important to note however that when analysing interview data through TA I am generating an outsider account rather than inhabiting a lived experience. When I use the term 'experience' in this study I am enquiring about what it is like for these participants to work through these dilemmas, and experience the emotional impact of them, whilst trying to navigate a decision-making process. TA pays attention to the language participants use and where they place themselves in relation to others; it is attentive to language, but it does not give language centrality in the manner that discourse analysis may (Paltridge, 2012), for example. TA allows for a systematic structuring of the data and produces a reading of the material, that is an interpretation of the data developed by a researcher and their supervisor, which does not make claims to truth (Nowell et al., 2017). An inductive approach is undertaken here, the analysis not being driven by any predetermined theory or framework (Patton, 1990), allowing the themes to identify more closely with the data.

I am conscious of the writings of Kerry Chamberlain on methodolatry (Chamberlain, 2000) and the tension between description and interpretation. Chamberlain commented on the dominance of thematic analyses of interview data in qualitative research, and the tendency for portions of transcripts to be shared as though they speak for themselves. I therefore intend to go beyond description to interpretation and work in ‘discovery mode’ (Becker, 1993) to interpret what is happening in the interviews in a more meaningful manner.

Additionally, I note the criticisms of TA by some researchers who declare it ‘unsophisticated’, in the shadow of Discourse Analysis or Interpretive Phenomenological Analysis, for example. This may however speak to the risks of descriptive applications of TA referred to above, rather than being a critique of TA’s internal validity. To monitor my own application and ensure reflexivity during the analysis process Braun and Clarke’s (2006) checklist for ‘good’ TA will be drawn upon.

2.3. Participants

Participants in this study were practicing CPs, working within the NHS and providing psychological support to adults. Research by Guest et al. (2006) found that the point by which saturation is achieved within interview data is at the 12th participant and this served as a guide for my sample size aim of 8-15 participants; however, I do acknowledge that their work was completed in a different context, that of Grounded Theory, and do not intend to claim that reliability can be achieved through a number alone. Ultimately, 14 participants provided data for this study.

2.3.1. Inclusion Criteria

The inclusion criteria for this study were as follows:

- Qualified CPs
- CPs who are practicing in the UK, in the NHS
- CPs who are providing psychological support to adults

All participants were screened on first contact to ensure the above criteria were met. Several people were excluded during screening due to them no longer working in the NHS, or only working with children, for example. These criteria were in place to ensure the data not be confused by a mix of participants working with clients who have reduced capacity during decision-making processes (e.g. children) or participants who face different constraints due to not working in the dominant healthcare institution in the UK (the NHS).

2.3.2. Sampling

Purposive sampling was employed, participants being selected according to the above criteria, relevant to the research questions (i.e. that participants be practicing CPs). Snowball sampling (Robson, 2002) was also in place, with participants passing on the details of the study to others within their personal and professional networks who may have been interested.

2.3.3. Recruitment

Participants were recruited primarily through advertising on social networking platforms, namely Twitter and Facebook, where there is a closed group for UK CPs which at the time of writing has approximately 6,000 members. The poster shared for advertising purposes can be seen in Appendix C. Recruitment also occurred through informal networks, friends and acquaintances sharing the poster advertising the study with those they thought may meet the criteria. Once screened, each participant was emailed a copy of the Participant Information Sheet and encouraged to ask me any questions via email. If participation was agreed, a date and time to hold the interview was organised. All communication with participants, throughout the research process, has been electronic.

2.3.4. Sample Characteristics

Extensive demographic information for participants in this study was not gathered as this was not directly relevant to the research questions. What is known is the gender, age range, nationality, years of experience, geographical location and work setting of each participant. Of the 14 CPs who participated in an interview five (36%) were men and nine (64%) were women. All but one participant was aged between 30 and 50, the former being in their early 60s. All but one participant was British, the former being American. Eleven participants were White; three described themselves as People of Colour. The participants had 131 years of qualified clinical psychology practice between them. Their years of experience had a mean of nine, mode and median of six, and a range of 29. Two participants worked in Wales, where there are of course some differences in the commissioning structures of mental healthcare compared to England, where the other 12 resided. Of these 12, a majority worked in the south of the country. Work settings included CMHTs (4); inpatient units (3); complex physical health (3); early intervention (2); and secondary care therapy services (2).

2.4. Data Collection

To address the research questions, descriptions of experiences were required and so methods such as focus groups or individual interviews were viable. Discussions about ethical clinical practice are complex and potentially sensitive, exploring the morality of one’s profession may perhaps rather be done with some anonymity. Focus groups additionally posed logistical issues (finding suitable dates and times for all, for example) and there were concerns around power relations (junior psychologists perhaps needing to safeguard their reputations in front of seniors). Therefore, the most appropriate method of collecting data for this study appeared to be individual interviews, which would be semi-structured to allow for elaboration and clarification.

Data was collected between August and October 2020. Due to COVID-19 restrictions interviews were conducted over videocall via Microsoft Teams. Each interview was audio-recorded on an encrypted digital audio recording device, in addition to the internal recording within Microsoft Teams.

2.4.1. Interview Procedure

Conducting the interviews online via videocall required some additional considerations around privacy and confidentiality, ensuring that participants felt comfortable to speak from where they were, and knowing that from where I was too that they would not be overheard; to this end, I wore earphones during each interview and checked if interruptions were expected. Consent forms were emailed to each participant at least 24 hours prior to their interview date and time, returned via email also, and an opportunity to discuss this was in place at the start of each interview. Each participant was given the opportunity to ask any questions before the interview commenced, and permission to record was obtained before the digital audio recording device or Microsoft Teams was set to do so. Once the interview began, questions were asked one at a time and responses – including emotional state – were monitored. As the interviews neared an end, each participant was asked again if they had any questions and there was space for reflection after the recording was stopped to allow for an ‘unwatched’ debrief where the experience of the interview was shared. Each participant received a follow-up email after their interview containing a ‘debrief sheet’ (Appendix D) with information on support available and a reminder of their right to withdraw before analysis began. A time of one hour was allocated for each interview; interview lengths ranged from 31 to 62 minutes.

2.4.2. Interview Approach

A semi-structured interview schedule was devised and can be seen in Appendix E. An interview schedule being in place does risk restricting a participant’s freedom; however, a semi-structured design meant each interview was guided by the schedule but not rigidly dictated by it. The flexibility afforded by a semi-structured interview also meant meanings could be clarified, follow-ups proffered, and the order of the questions could vary depending on the direction the participant had taken. In devising the interview schedule a light framework was drawn upon wherein more general questions about the participant opened the interview, progressing onto broader questions on the topic at hand, before seeking example-based responses, participants being asked to recall a clinical case and a decision they had to make regarding an ethical dilemma, to ground the conversation in something more tangible. Broadly, the interview schedule covered: the professional values of clinical psychology; relationships between personal values and professional requirements; occasions participants had been unable to provide the support they thought would be ‘best’; the impact of ethical dilemmas on the experience of being a CP; and the relationship between power and ethical decision-making. The schedule was piloted prior to interviewing the first participant and revisions were made to address the research questions more closely. The interview schedule is designed to primarily ask open questions and avoid leading questions; occasionally closed questions were utilised to probe and clarify when required. Although I did not adopt a therapeutic approach, I was aware that the interview could be emotionally taxing and so did take an empathetic and non-judgemental stance.

2.4.3. Transcription

Interviews were transcribed verbatim in their entirety; audio recording having begun after each participant consented to the Microsoft Teams function and the digital audio recording device being turned on. Transcription was carried out manually, from the audio file produced by the digital audio recording device. The video file from Microsoft Teams was used to cross-check, if there was uncertainty about what was heard on the audio file. Questions were included in the transcript and below in some of the extracts as illustrations for themes, to fully represent the interaction and provide context. What participants say is important, but it must be understood as a response to what was asked. Each interview was transcribed within a week of it taking place, and a semantic level of transcription has been employed, following adapted conventions advocated for by Banister et al. (2011). Laughing, inaudible moments, and crying have been noted as well as any lengthy pauses, across all transcripts. This thesis did not seek to examine rhetorical devices nor speech patterns and so the transcription format required no further sophistication, such as that proposed by Jefferson (in Lerner, 2004). A transcription key, describing the notation system used can be seen in Appendix F.

2.5. Ethical Considerations

2.5.1. Ethical Approval

Ethical approval for this study was granted by the School of Psychology Research Ethics Committee within the University of East London on 22nd July 2020 (Appendix G).

2.5.2. Informed Consent

The Participant Information Sheet (Appendix H), shared with all participants at the point of expression of interest, included details of the study title; the purpose of the research; the nature of participation; the study’s voluntary nature; and emphasised their right to cease participation and/or withdraw their data. Information on how their data will be managed was also included. There was no compensatory incentive offered for participation in this study, nor any deception involved. Consent forms (Appendix I) were shared and signed prior to each interview commencing.

The interview topic, ethical dilemmas and moral distress, is expected to be an emotive one however I sought to be transparent about what the interview would entail through the advertising poster, information sheet, and screening conversations. Collecting the data via individual interviews also allowed for monitoring of a participant’s response to the questions so that a pause or adaption could be made if indicated.

During recruitment I reflected on an assumption of mine that my participants – CPs – would be knowledgeable of the thesis processes and noted a concern about my communication regarding procedures appearing patronising. However, I maintained a common protocol throughout recruitment and ensured there was space and time for discussion about the information sheet and consent form, where questions could be posed, and clarifications offered.

2.5.3. Risk

When considering the risk of participation I was wary of demoralising clinicians through their participation, encouraging them to talk about what they might rather avoid thinking about (potentially unethical clinical practice) in order to be able to continue practicing in these systems, and also wondered about threats to participants’ self-image through internal appraisal (Allmark et al., 2009). To attempt to counter this I reviewed the interview schedule to ensure questions were open and participants would have control over how they responded. Additionally, as a trainee I considered the potential complications of recruiting a CP working as a supervisor in the North Thames region, the possibility of us encountering one another after the research is completed. All participants were aware of my trainee status and the location of my training programme and gave informed consent. The risk to myself appeared minor, perhaps some awkwardness due to the trainee-qualified CP dynamic, but considerations on how my relationship with the profession could have been impacted are below.

2.5.4. Confidentiality and Anonymity

In this study participants' data is not being gathered anonymously; their names, email addresses, and faces are now known to me. To ensure their anonymity in this thesis, and any dissemination, each participant has been given a pseudonym, applied from the point of transcription. Participants are aware that quotes, verbatim extracts, from their interview may be used in the thesis and any potential publication. Participants' names and contact details have been stored separately and securely away from the data, and all identifying information was permanently deleted once analysis began. Through each pseudonym only gender should be assumed by the reader when extracts are presented.

2.5.5. Data Management

With all interviews taking place electronically, data was recorded within Microsoft Teams (audio-visual) and on an encrypted digital audio recording device. Access to the Microsoft Teams recordings is automatically restricted to myself only; each video was downloaded immediately after the interview was completed and transferred to my University of East London OneDrive cloud storage account, along with the audio file. Once transferred, the audio file was deleted from the digital audio recording device. The transcriptions were also stored in password-protected files on a password-protected computer and on the password-protected cloud storage, OneDrive. Once the thesis has been submitted and examined all recordings will be securely deleted and only the anonymised transcripts retained; these will be destroyed up to two years after submission of the thesis. The research supervisor and I will be the only people able to access the data. However, the supervisor will see the data only in its anonymised form. The study's documents explained the above to all participants.

2.5.6. Dissemination

The findings of this study and its report will be summarised and shared with those participants who requested a copy be sent to them post examination. For those who did not request this post-interview, I will contact them to ask if they would like a copy once available. I will additionally offer to discuss the summary with each participant. The thesis will be made available for viewing on University of East London's research repository. I plan to submit the study for wider publication and hope that all those invested in the profession of clinical psychology will find it an interesting, usefully challenging read.

2.6. Analytical Approach

The analysis procedure adhered to Braun and Clarke's (2006) six stages for TA, which are outlined below.

2.6.1. Stage One: Familiarisation with the Data

Multiple readings of the transcripts served to build familiarly with the data and the accounts therein.

2.6.2. Stage Two: Generating Initial Codes

Transcripts were then more closely examined for pertinent information, details which were noted in the margins. Here the data was segmented into meaningful units, identifiable through labels or names – codes. An inductive TA was employed and so the codes were derived from the raw data. The software programme 'NVivo' aided the organisation and systemisation of these codes. An example of a coded extract can be seen in

Appendix J and a list of the initial codes developed is available in Appendix K. A spider diagram for each participant was created, incorporating the codes from their transcript, to support identification of reoccurrence across the data set, an example is in Appendix L.

2.6.3. Stage Three: Searching for Themes

The next step was to begin linking the codes together and notice any patterns within them to generate early themes from 'meaningful groups' of codes. Braun and Clarke (2006) define a theme as being a construct through which we capture "something important about the data in relation to the research question" (p. 82) and so a semantic and conceptual reading of the data was undertaken. Further spider diagrams were drawn up to illustrate the grouping of prevalent codes and begin identifying themes.

2.6.4. Stage Four: Reviewing Themes

A cyclical process of reflection and revision followed. Superordinate and subordinate themes (subthemes) were distinguished, whilst I repeatedly returned to the data to ensure that there remained a connection between the themes, codes, and quotes and therefore that the analysis was grounded in the data. The internal homogeneity and external heterogeneity of these themes was assessed in collaboration with the supervisor, undergoing a reviewing of their ability to represent, meaningfully, the dataset (Patton, 1990). An example of thematic map refinement can be reviewed in Appendix M.

2.6.5. Stage Five: Defining and Naming Themes

A refinement of the themes followed, adjusting the titles of the themes and their framing, collapsing, and restructuring until a final thematic map was produced; this is presented in Chapter Three.

2.6.6. Stage Six: Producing the Report

To ensure coherence and rigour, pertinent data extracts are presented in Chapter Three illustrating each theme and subtheme in an analytic narrative. A discussion then follows as to the implication of these interpretations.

2.7. Reflexivity

2.7.1. Personal Reflexivity

Personal reflexivity speaks to the extent to which a researcher's beliefs, values, and experiences shape the research (Willig, 2019). Inductive thematic analysis requires interpretations be made of the data, and these interpretations are made by the researcher – the researcher takes on the role of interpreter, and therefore we must acknowledge the impossibility of separating the researcher from the research and examine the relationship between the researcher and their interpretations – the research. I am the researcher; I am the interpreter. I am a White British woman in my late 20s, from a working-class and care-experienced background, in my final year of a clinical psychology doctorate programme. I have academic requirements to attend to, whilst working as a Trainee CP. I therefore stand quite closely to the issues being explored in this research project, clinically, ethically, personally. This is an investigation of the moral state of a profession I am about to enter as an almost-peer for my participants. I had expectations about what I may learn from my participants, having worked and trained in similar clinical settings and having experienced ethical dilemmas in practice of my own.

2.7.2. Epistemological Reflexivity

Epistemological reflexivity speaks to the extent to which the research questions, study design, and method of analysis have influenced the outcomes (Willig, 2012; 2019). When analysing and interpreting the data in this study, my position as a critical realist created a lens through which I identified patterns, and themes. The results of this study were influenced by what I had read about the topic of moral distress previously, and by the narratives around ‘burn out’ which we are all so saturated in when working in the NHS. There is perhaps also a generational reading, my perception as a member of the incoming graduating class of CPs influencing how I asked questions during data collection, and how I read the data now.

3. CHAPTER THREE: RESULTS

3.1. Thematic Map

Three themes and six subordinate (sub) themes were identified during analysis. Figure 1. presents a summary of these themes and their subthemes.

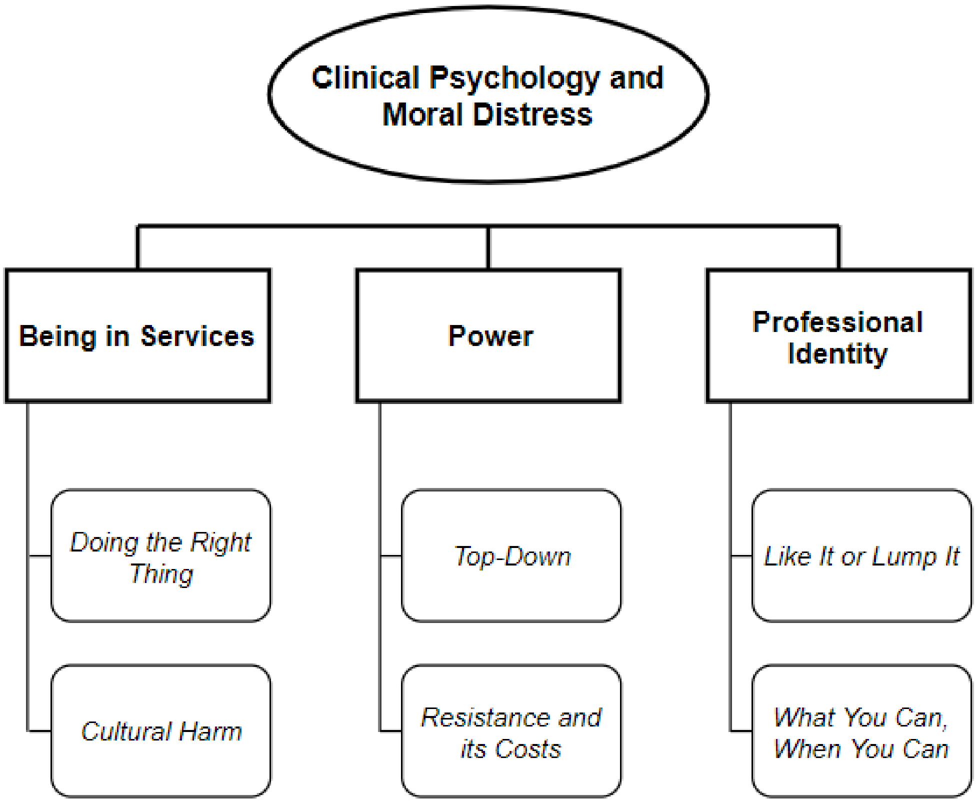


Figure 1.: Overview of themes and subthemes derived from a thematic analysis of the interview data.

3.2. Theme One: Being in Services

Participants' experiences of ethical dilemmas were situated within the context of their positions as CPs operating within a nationalised health service, a public body with a duty to care and a duty to safeguard. These duties, at times, conflicted with one another, and obligations to an individual client and their therapeutic needs were complicated by the system's policies, procedures, and/or practices. This produced difficult decision-making experiences and the CPs spoke to a push-and-pull resource tension, struggling with the demand, and ideas about the NHS being a machine.

> "It feels like there's a lot more compromising to be made and a lot more difficult decisions to be made" (Lucy, 59-60).

Waiting lists and targets are prioritised and the CPs notice the impact this has on patient choice and care, the therapeutic relationship not given due weight. This violates what the CPs believe is important but part of the experience of being in their services – in these systems – is a 'letting go' of ideals.

> "… ultimately my voice can only stretch so far. So, I have had to kind of let my own values be pushed to the back" (Bina, 59-60).

3.2.1. Subtheme: Doing the Right Thing

A subtheme arose concerning service gaps in the system and the inaccessibility of what does exist, how 'wrong' this feels, and how feeling an ethical obligation to 'do the right thing' can lead CPs to 'go the extra mile.'

Participants shared a dilemma around how inaccessible services are by design, that getting in the door itself is a hardship for many and that it requires a client to be presenting with a very specific level of need or distress, a little or a lot, a binary of extremes. For the many people who are assessed as presenting with more moderate levels of distress no service exists to accept them and they 'fall through the gap' unless they are capable (financially and otherwise) of turning to the private sector for help. There is a strong sense of how 'wrong' this is, and the CPs had no confidence that the clients they assess, and do not meet their service criteria, would have another service to turn to.

> "… you sort of have to be the right amount of unwell to get a service. If you are ill enough that you're thinking of killing

> yourself, you'll get taken on … if they aren't unwell enough to be thinking of killing themselves or they have enough protective factors in place, they don't get taken on by secondary care … often IAPT isn't enough so they just fall through the gap and it's only if they have access to enough funds to pay for private therapy, which is expensive, that they can get that help. That doesn't seem right to me at all" (Jem, 64-65; 72-75).

Participants expressed a reoccurring difficulty wherein a client has an identifiable need but is rejected by the wider service criteria and the opportunity to help is taken from the CP. It may not be ethical in fact for their service to see them, perhaps due to the need being for long-term trauma-focused therapy and the service being brief in design, but the awareness of no alternative space existing for the client means they don't 'belong' anywhere.

> "… you can see that there's a need, but you know that it isn't your service that can fill that, and you know that there isn't anywhere else for them to go, and that's really frustrating and comes up again and again and again" (Lucy, 210-213).

The interface between services was identified as dysfunctional and frustrating for the CPs too; attempts to attain the 'right' support for a client is often unsuccessful and leave the CPs with a dilemma around providing support in the 'wrong' setting.

> "… trying to get people linked into community mental health teams, for example … you refer them, and nothing happens, or they eventually get some kind of assessment and then told that they don't meet criteria … I think if anything within our service we over-do or over-treat or give more than we're actually supposed to do on paper" (Glen, 204-210).

CPs providing MH support in physical health settings in particular reported an experience in which they plug the gaps, clients coming into their service for a medical condition and this being their opportunity to have their psychological needs attended to, having not been able to access this elsewhere. For the CPs this meant working to ensure that they provided a service within the boundary of their competence and engaging with additional work to do so. They may be seeing a client due to their HIV status for example, but the client's need is around disordered eating, and having not been able to access specialist 'eating disorder services' the CP feels a responsibility to provide what they can in this regard, but first must equip themselves with the skills beyond what is usually required in their role.

> "… sometimes people come to hospital having been unable to get services elsewhere … history of not being able to get therapy, despite her best efforts … so it put me under an ethical obligation to do quite a bit of reading about the treatment so that I would not be operating outside my area of competence" (Dariusz, 88; 92-93; 96-97).

The dangerousness of a bounce-back-referrals culture in the system was also highlighted, the consequences of overloaded services feeling pressured to reject and maintain a tight remit being significant risk of harm to the clients.

> "I'm seeing someone who has very complex needs because no one else will see him, over and above the call of duty … you end up having to try to pick up those pieces, try to advocate for them and in this case we got there and luckily his overdose wasn't successful, but it so easily could have been" (Glen, 233-237).

The CPs also spoke to how pressured services 'water down' interventions, which can leave clients blaming themselves for 'not doing well enough in therapy' when the fault lies with the reduced provision of service.

> "I'm aware that I don't have an ethical duty to go an extra mile for patients, but I feel that my values take me to that

> place, I see people whose lives have been horrendous and I think that mental health services are in a really difficult place and we have things like waiting list targets pulling us towards offering less and less to people and I just won't do it" (Lydia, 68-72).

Participants identified that their own services were implementing barriers to access to manage the resource-demand pressure and spoke of punitive action being taken to manage waiting lists, rejecting the people who were often most in need and citing their difficulty as the reason for denial (e.g., instability), exclusionary policies being weaponised paradoxically. CPs attempts to challenge this were threatening and experienced as an attack on the system's efforts to cope, resulting in denigration of the CPs themselves.

> "… we were already having to make decisions about how to manage waiting lists and how to keep them manageable and that involved putting in structures that did undoubtably make it harder for people to access services" (Lucy, 90-92).

> "I felt like policies were being applied inconsistently and they wanted to deny this person access to a service, and I felt that was really unfair … I was seen as argumentative" (Darla, 152-155).

An uncomfortable hypocrisy was noted by participants, in which there is a societal and political promotion of good MH but no sufficient scaffolding structures through which services can meet the promises made.

> "So, on one hand we're advocating mental health and we're talking about World Mental Health Day and we're trying to invite people in to address their mental health needs- I think we have to ask the question, are we fully equipped to even meet these needs of the people that are walking through those doors, the volume of people?" (Bina, 218-221).

3.2.2. Subtheme: Cultural Harm

A second subtheme arose concerning the issues and challenges related to, and arising from, the gaps and access difficulties described above. This subtheme speaks to the consequences of such issues, the harm that occurs through, and is reproduced by, the system. This harm arises at the level of the individual and beyond and is linked to the way the system is organised (its oversight, time pressures, its narrow focus) and operates (hierarchically, powerfully).

Participants identified themselves, personally and professionally, as valuing patient-centred care. This value was frequently compromised through the dehumanising attempts to manage the demand-resource difficulty, during which a client is stripped of their personhood.

> Kerrie: “In those compromises is there anything that's being lost?”
>
> Lucy: “The thing that springs to mind that I immediately wanted to say, and then I didn’t want to say it because I almost don’t want to say it out loud is that the thing that’s been lost is the client as the individual” (62-64).

People become numbers; clients become targets and clinicians become a means through which targets can be met.

> “… it feels really horrible to me as a person, as a psychologist, but ultimately people are bed numbers” (Kat, 153-154).

This was felt to be something that has developed over time, the client’s individuality eroding with the ever-increasing focus on numbers and the creeping commercialisation of a nationalised health service. For the CPs this brought forth a questioning of their place in the system.

> “… there is this dilemma of being in a career where it’s now turning into- rather than client-focused it’s more number

> crunching, no time to really see the client for who they are" (Bina, 125-127).

The politicisation of the NHS was also considered to contribute to this removal of personhood, positioned as an entity bigger and more important than those it's meant to serve.

> "… politicians talk about the NHS in such a politicised way and it's really depressing because what you lose then is actual people, who need support and need help" (Jem, 344-346).

This erosion was illustrated by the loss of agency felt by clients and CPs, for example clients being prescribed group therapy and clinicians being asked to withhold individual therapy regardless of clinical opinion, directed by service restraints rather than NICE guidance. The participants felt this pressure to not give what they thought would be best was cruel and unfair, the wants of the service influencing decisions beyond the needs of the clients. The connection between the CPs and their teams was further severed as they were left needing to defend and advocate for their client, rescue them from the service itself. Services being run to meet their own needs does not work, however, and in the long-term the demand is not managed at all.

> "… and then you're wondering why they're back, but it's because you haven't actually addressed their issues you've addressed the goals of the service rather than the client" (Bina, 191-193).

The personhood of CPs themselves was also invalidated, conformity promoted, and difference rejected, instructing clinicians to assimilate.

> "I think there's such an emphasis on following certain models and no space to kind of be different and I think when you are someone who perhaps is seeing differently, I feel like that's quite hard because then you become

> faceless or invisible and just another kind of cog in a machine rather than a real person” (Asmita, 68-71).

‘Do no harm’ was another core principle specified by these CPs. The systems they were operating within and their cultural practices were felt to threaten this integral value regularly. The norms were relational and systemic and practices such as providing ‘ECT for anxiety’ were identified as overwhelmingly difficult to witness and challenge.

> “… just the whole ethos of the place, the whole culture … practice was seen as normal and good but did not feel ethical and did not feel right and did not feel like best practice to me and did not feel like we were helping people in the best way that we could, it felt like we were harming people (.) quite regularly” (Rupert, 118-122).

This witnessing of poor clinical practice was a significant shared experience, one that left CPs felt powerless to combat, but there was an understanding as to why it may occur: multidisciplinary colleagues often pushing clients away out of fear, under pressure. The ‘cliché’ of crisis services encouraging suicidal clients to have a cup of tea or run a bath was offered as an example of when no framework for thinking is utilised, in a context where the consequences can be so catastrophic, but the staff-experience is one so overwhelmed that the CPs extended compassion to their colleagues with less access to the training and resources (supervision; frameworks for understanding) that the CPs themselves had.

> “I think one of the biggest ethical dilemmas that people face at the moment is watching colleagues provide something that you think is substandard at best, and at worst is doing harm … they’re doing is stuck in a system that holds a really horrible narrative about people that need help”” (Lydia, 382-384; 450).

Participants also spoke to the wider, societal influences on their ability to do their jobs the way they would wish to, and how our healthcare system can reinforce inequalities and social determinants of distress. The current functioning of the NHS does not allow these CPs to practice in accordance with social justice values.

> "… social justice ought to be part of our professional values because I don't see how we can help people when they're distressed without paying proper attention to the systems that arguably contribute to and maintain that distress" (Jem, 28-31).

The CPs referenced Maslow's 'hierarchy of needs' (Maslow, 1943) and the dilemma around providing therapy to clients whose social circumstances are such unstable states – unsafe housing, sanctioned income benefits – that it may in fact be unethical to engage in a psychotherapy, but the alternative is perceived as 'nothing', no support whatsoever, the CPs experiencing a sense of powerlessness to do much about the former. There is a continuous cost-benefit analysis, attempting to calculate what could provide some benefit for the client, alongside what it is they would like help with.

> "… we're ultimately trying to help them to manage a situation that they shouldn't be in and I think it's around the social care structure that's around people. I think our society has been decimated in terms of people's safety nets … it's that really basic concept of Maslow's hierarchy of needs, that bottom tier of things just isn't being met" (Lucy, 106-110).

These social inequalities, affecting an overwhelming amount of the clients these CPs encounter, are experienced as barriers to the clinical work, preventing CPs from using (and clients making use of) their core therapeutic skills. The most impactful intervention for one CP would be to effect political change that could have a more macro-level impact by aiding the housing budget, for example.

> "I think as a psychologist it's very difficult to do meaningful work when you are sending somebody back home to cockroach-ridden, temporary accommodation … we're talking Maslow's hierarchy here … get the Tories out and increase the housing budget in [borough] and that would have the best impact on mental health, in my opinion" (Duncan, 185-187; 189; 192-193).

The profession of clinical psychology itself is not considered innocent. A lack of diversity in identities and subsequent discriminatory practices is named and considered for its own role in maintaining how inaccessible our services are for the many.

> "I'm also aware that at a sort of deeply embedded, sort of systemic level of course there is prejudice … I'm aware that we're a very white profession, I'm aware that most of my clients are white. So, I am aware that inherent in what we do somewhere along the line we're not getting it, we're not managing to serve all the people in our community. So, in terms of social justice I like to hope that at a personal level there are things I do to try and tackle that but professionally and systemically I think there are probably things that we're doing that are maintaining the injustice, and I hate it and it sits really uncomfortably" (Jem, 83-93).

The impact of political weaponizing of the NHS was revisited in this context of the damage done to clients and CPs when a deliberate underfunding occurs. A pained workforce makes poor decisions, and everyone suffers. One participant spoke to the narratives that follow 'scandals of abuse' in healthcare which individualise the problem and produce recommendations, legislations, and training which never address the systemic cause.

> "… and you know when they say about 'oh the NHS isn't meeting it's targets' well, no, yeah, that's because you've

> underfunded us quite severely, and then the implication, or the way it can be easily interpreted, is it’s because we’re not working hard enough or we’re doing a poor job and it really sickens me … what I see is the impact of a system where everyone’s stressed, everyone’s underfunded, undertrained, under-resourced. So, you’ve got staff that feel powerless and trapped and take it out on people they shouldn’t … it comes from a place of being dragged down and dragged down and dragged down and I think that’s how these bad decisions get made” (Jem, 346-358; 364-5).

Powerful emotional content is elicited here, the CP is sickened. Strong emotion – anger in particular – arises even for the most senior and experienced of CPs who feel at a loss regarding influencing change and culture. There was a consensus that the client suffers whilst the system’s stasis is prioritised; CPs reassured themselves that they can only make change from within but this belief waivers as the challenges persist.

> “I feel that what we’re doing at the moment is privileging our relationship with the system, feeling that that’s for the greater good, that if we’re in it at least we can influence somewhere, but over the service-user experience. As experienced as I am, I still haven’t found a way to grasp that” (Lydia, 396-399).

3.3. Theme Two: Power

Joining and working in these systems is an emotional experience for the CPs. The frustration of attempting to navigate the dilemmas explored above, and the powerlessness expressed, can lead to a difficulty moderating the emotional impact upon the self and subsequent clinical practice.

> “It’s hard, it’s hard to be a psychologist sometimes when you’re working in psychiatry and not be outraged” (Drew, 94-5).

Navigating the aetiological tensions amongst teams and the extent to which psychological formulation is welcomed has led these participants to dread attending meetings, expecting their input will be rejected and their advocacy for the client unsuccessful. These premonitions are physiologically strongly felt.

> “When you’re predicting that there’s going to be a conflict, you get anxiety symptoms don’t you … right in your chest” (Drew, 201-2).

The impact of being joined with other professionals who appear to be rigidly engaging with unethical practices, and that sense of therefore not being able to trust your colleagues, was experienced by numerous participants as a betrayal, an abandoning of the core values of the ‘helping professions’, and a threat to one’s own integrity.

> “… it’s devastating … it can feel like a big betrayal… suddenly you feel very unsafe, you feel very much on your own, and yeah it affects your motivation and everything, how you feel in the job, how you are feeling within the profession” (Rupert, 103; 106; 109-111).

Demoralisation, despondency, and despair were threaded through the participants accounts. The CPs were also conscious of their own privilege if they themselves had ‘escaped’ similar experiences to their clients, such as poverty, and were left with a survivor’s guilt, unable to pull their socially disadvantaged clients to safety.

> “That sense of powerlessness can be really quite depressing I think, it’s hard not to get completely deflated” (Lucy, 136-7).

Numerous CPs named an uncomfortableness with speaking on these dilemmas; it felt safe to do so only due to the protections afforded by anonymisation. What we’re allowed to admit about the state of NHS MH services and their inaccessibility appeared particularly troublesome, a difficulty admitting the concessions CPs have made to their preferred ways of practicing, and fears around the future of the profession.

> "I'm glad you said this is anonymised … I don't think it is controversial, but I probably wouldn't be allowed to say it and be named for it … so I feel a bit anxious about saying it" (Jem, 63; 66-67).

> "I'm noticing that this is harder to talk about than I thought it would be … even though I know I'm anonymous, I'm noticing I'm anxious right here [points], there is a knot in my stomach that feels like I'm saying something that I shouldn't be saying" (Lucy, 150; 329-331).

Perceived compromised integrity was a significantly distressing experience for the CPs. Examples included being forced to implement a plan that felt not true to their value of patient-centred care, senior staff enforcing a decision that both the clinician and client experienced as threatening. For the CPs this often felt like an alarm bell, bringing forth anxiety around these instances being repeated.

> "The job that we do is emotionally demanding and trying to do it in a way that maintains your own integrity and the professional and personal values that we all came into this profession wanting to live out, it's really tiring and I'm not sure it should be quite that tiring" (Jem, 372-376).

The relentless need to protect their integrity is exhausting and impacts on the wellbeing of the CPs to a significant degree. Their awareness of how clients' whole lives are impacted by the decisions of others, and the CPs powerlessness to intervene, can cause great alarm for their own psychological wellbeing.

> "… it felt devastating … my colleagues really noticed; they were like 'are you alright? You're not your usual self, what's going on?' And I think this case in particular highlighted that dilemma in the system … this problem in general, it wasn't just a one-off thing that could be resolved it was this issue, now with real life consequences for this woman's freedom and her wellbeing … it was that again and again with other cases … felt a bit maddening, it felt like I was going a bit crazy" (Rupert, 220; 222- 227; 251).

A concern for what CPs are made to do by complying with the institutional procedures emerged, their formulation of a client's history lending itself to an understanding of what harm they may be replicating.

> Kerrie: "How did it leave you feeling?"
>
> Asmita: "I felt quite sad for her, and I felt angry about who I was becoming in relation to people in her early life, I'd let her down … and these ideas of kind of coming into the profession and doing no harm and having integrity in what you do I think that was completely at odds with what I was doing in the moment" 148-151).

3.3.1. Subtheme: Top-Down

The CPs sense of power was relative. They shared a belief that whilst their managers were the conduits for everyday systemic frustrations, they were ultimately enforcing something that was produced from above them. The 'hands tied' narrative reoccurred throughout the dataset and was framed as 'par for the course'. The experience of having decisions overruled, the therapeutic relationship not being given weight when faced with waiting times for example, was nonetheless a hard one to bare, particularly when the impact on the client was witnessed.

> "… but my hands were tied ultimately, I couldn't make that decision and I'm now sitting on the side-line watching this client disengage. It's difficult" (Bina, 104-5).

The overarching need to manage waiting lists with limited resources pushes ethical decision-making to the side, or below, and that is a precedent set by the very highest of boards.

> "I think it comes down higher up … so I think people's hands are tied when it comes to ethics and morality, I don't think that's been thought about much higher up and I think that comes from politics" (Asmita, 93-97).

The potential for local change therefore feels scare, efforts often thwarted by the power holders and a mandate for change withheld, resulting in no movement on the ground. The ‘concrete ceiling’ is impenetrable and the cultural resistance to reflection and difference is maintained.

> “But because the power comes from higher up you’ve got this kind of- it’s not a glass ceiling, it’s a concrete ceiling. Until people in control, people in charge, want to acknowledge that there is a different way of thinking, you can’t get the staff on board” (Drew, 152-155).

By virtue of being a client, receiving a service, power is imbalanced. When considering clients’ positions in society too, their trauma and complex needs, it feels unjust to these CPs to be offering such limited services, unable to verbalise their wish to provide the client with more when that’s what they believe the client needs, leaving the client to interpret the problem as inside them.

> “… colluding essentially with this idea, leaving the patient feeling like it’s their fault when it’s something that’s going on higher up” (Asmita, 104-5).

Ultimately, for these CPs power and change feels very much out of reach, uncaring, and non-responsive. The client’s resultant experience perhaps not too dissimilar. There is agreement that at the most macro of levels a powerful message exists which acts as a barrier to the therapeutic work of CPs: distress is pathological, and healthy people contribute to our economy.

> “It is about society isn’t it, that actually if as a society we give messages about not tolerating distress, that we feel better and we should be happy and we should have stuff, and this kind of capitalist view of the world” (Lydia, 465-467).

3.3.2. Subtheme: Resistance and its Costs

Participants sought to manage their emotional experience of ethical dilemmas through advocacy; advocating for what they felt was best for the client, and in turn advocating for their own needs to be met by finding a way to live out their values in practice. This was often framed as fighting back against the oppressive structures of the NHS system and MH services, going into battle with those with more power who they expected to shout them down

> “I went into this meeting expecting a fight on my hands” (Drew, 212).

The witnessing of poor clinical practice described in ‘Subtheme: Cultural Harm’ can require CPs to enact moral courage and engage in internal safeguarding reporting that requires the CP to withstand backlash from their team, and anger from their management when they’re scrutinised. One CP understood the anger and aggression they experienced through Social Identity Theory, they were outside of the social group, not engaging with the group’s norms, and this meant enduring an attack from within one’s own team, with the dispiriting potential for no good to come of it.

> “… when I had to take it to a higher level in the Trust there was a lot of anger from my team and I got somewhat rejected from the team … the whistle-blower ends up kind of falling on their sword … you end up feeling a little bit empty” (Drew, 251-256).

This is a battle for what matters to the CPs: personhood, patient choice; one that meant not submitting to what does not feel right.

> “… fighting for that, rather than just going along with what I am required to do” (Asmita, 141-2).

The CPs recognised limits to their power and their influence but resolved to resist.

> "… it really worries me, I'm not quite sure what to do about it other than fight it as best I can at the level I can" (Jem, 243).

However, challenging the harmful narratives and working to influence a culture change is emotionally demanding and requires the CPs to actively choose to do so.

> "… I take a deep breath and I challenge … but you do really have to fight. You have to really actively pay attention to it and it's exhausting, it's really tiring, and I think that's part of it, it's the fatigue of it all. You have to make a decision every day to do battle" (Jem, 370-373).

Taking this stand comes with a risk, of rejection and attack from the system, a rebuke that encourages CPs to think twice about staying with this ethical stance, but the risk appears necessary if CPs hope to maintain their personal and professional values.

> "I think when you do take a stand or kind of bring up morality or ethics about the work that we're doing and whether things are kind of in line with the party line of the service I think you can get a little backlash … there's a pressure to kind of conform or adhere to very business-like, kind of neo-liberal ideas that are driving therapies … to me, becoming a psychologist was what I described before about kind of the integrity with which you go into the profession but I think there's a real tension for me that somehow I'm having to kind of fight for that a lot, and that can feel quite exhausting" (Asmita, 55-6; 59-63).

Fighting against these pressures to deny a service, provide less yet do more is a continuous battle, it drains them, but the CPs agree the alternative is unbearable.

> Kerrie: "What's it like to push back against that pressure?"

> Lydia: “… it’s not easy but I ask myself all the time what would the alternative be and the alternative would be offering a bit of a [expletive] service to loads of people and pretending that that’s psychology, and it isn’t” (108-110).

3.4. Theme Three: Professional Identity

When considering the alignment of personal and professional values, and the extent to which these are facilitated in clinical practice, a difficulty for these CPs was identified surrounding embodying the profession. A primary concern was the ownership of clinical psychology’s Code of Ethics and Conduct, written by the BPS, an organisation CPs are not required to subscribe to, and yet set the standard for clinical psychology ethical practice.

> “I mean, there’s like the BPS guidelines and there’s the HCPC as the registering body but that’s always felt very messy to me, cause I was a member of the BPS but decided to leave … but the HCPC does not have a psychology code of ethics, the Code comes from the BPS, it’s a BPS document, developed by the BPS, updated by the BPS, overseen by the BPS, so that feels very messy … the BPS sort of oversees what it means to be a psychologist and what is deemed sort of ethical and good practice as a psychologist, so that feels very messy and I think problematic” (Rupert, 36-40; 44-50).

Concerns regarding the representation of clinical psychology through the BPS were also voiced, some participants anxious about an atmosphere of acceptance surrounding the increased medicalisation of clinical psychology (for example the debates around psychology prescribers), whilst others were alarmed by the lack of presence of thought for ethical dilemmas in BPS communications.

Ethical dilemmas, and the often inherently political nature of them, were not felt to be a headline issue for the profession’s leadership but for these CPs there is a real wish for the profession to come together on this and speak more openly about moral conflicts, combat the taboo, and consider these real, everyday issues psychologists are facing, alone.

> “… shows a dilemma in the profession, this confusion around who is our governing body and who is the leadership within the profession, and then this huge dissatisfaction with them … and then just feeling on an individual level like you are very much left on your own in these unethical sort of quandaries that you’re having to negotiate and feeling like that is not really even on the BPS agenda” (Rupert, 396-405).

The perception of CPs as upstanding, inherently moral clinicians was considered unhelpful, setting CPs up to fail when they can’t hold back their human messiness. The instruments used during the doctoral course selection process contributed to this narrative of CPs’ superior ethical judgement.

> “When you are applying to do clinical psychology you have to do these kind of situational judgement tests to get onto different courses and that kind of gives you this idea that psychologists must be very moral, must have lots of integrity, must be very noble and have like the best judgements and I think that’s not real, psychologists are messy and they’re complicated, they get things wrong, and I just wish that we would kind of sit with that a bit more and acknowledge that” (Asmita, 183-189)

Engaging with ethical dilemmas regularly, together, is not something these CPs felt was occurring. The experience was very much an isolated, individualised one, with little collective thought as to the emotional impact on CPs. Multiple participants suggested supervision was a space in which this could be more proactively welcomed.

> “I think actually we probably don’t as a profession reflect on the moral dilemmas enough, on the ethical dilemmas enough … it almost needs to be a supervision agenda item … I’m not sure- apart from this- that I’ve ever really spoken about some of the-

> about how uncomfortable it feels, it’s [spoken about] more from a practical point of view” (Kat, 392-393; 399-403).

The rigidity some CPs experienced around what is a psychologist’s job, how they should be spending their time, contributed to the participants’ sense of helplessness. A more community-focused framework offers flexibility, allowing CPs to act in accordance with their values.

> “… there is so much we can and should be doing, from voting to lobbying to writing letters to speaking out on social media where appropriate, and then all the way through to our day-to-day clinical work and advocating for the people we support” (Jem, 528-530).

Participants often placed their hope for change in the new generation of CPs and the push for diversifying training recruitment. This reliance however seems to stem from the idea that to change the system we must be in it but negates the responsibility of the leaders perpetuating problems; the new generation cannot overhaul the profession without a mandate, and action, from the top.

> “I think there’s this huge drive now with people entering the profession to kind of do something different or to make it more varied or diverse and I think they’re missing the point, change should be coming from people from the top because they’re the ones sustaining the problem, it’s not the people with less power” (Asmita, 260-263).

3.4.1. Subtheme: Like It or Lump It

The consequences of experiences spoken to in Themes One and Two, and the professional disconnectedness noted in Theme Three, are stark. Eleven out of the fourteen participants shared a dilemma around remaining in their posts, and/or in the NHS. Three had left previous posts for reasons relating to Subtheme: Cultural Harm. Another three had begun to do part-time work outside of the NHS and framed this as necessary for their wellbeing, private practice providing the opportunity to work in line with professional values (such as ‘the client as an individual’). They commented on having to leave the NHS to do work they can be proud of and protect their identities.

> “… something shifted within the NHS, within psychology. So, it’s almost a case of you either stick at it and lump it, or you leave” (Bina, 130-131).

There was talk of entering posts with hopes of ‘turning things around’ but when constrained by structure and hierarchy being unable to make full use of their skills and training some felt defeated; an accumulative effect was noted by all.

> “I think there’s probably this background erosion of my sense of efficacy, I won’t deny that I’m leaving this service in four weeks and that’s one of the reasons I’m going” (Duncan, 228-229).

But leaving the NHS is not an easy or simple choice, for some this too would feel unethical, and their patients would be left with no advocate.

> “If that’s one way to deal with the ethical dilemma, is to leave, then where does that leave all those patients who don’t have someone fighting their corner?” (Sara, 248-250).

Concerns linger however as to what the system does to these CPs, how when faced with such powerful structures clinicians who may have previously held strong ethical convictions can be corrupted. Jem points out that psychologists too can fall foul to conformity.

> “… just how different we are as psychologists compared to how we thought we were going to be and that can cause some kind of cognitive dissonance” (Lucy, 227-230).

> “I feel like ‘am I getting sucked further into a system, am I going to end up, honestly, being corrupted by it?’ I worry that I’ll get to a point where I buy into the stuff that I currently disagree with” (Jem, 327-329).

Participants said the retention problem epitomises what is going wrong in the system and they see no attempts to retain them. Changes to banding structures and the emphasis on leadership positioning for CPs has resulted in a loss of clinical experience which used to be disseminated; participants mourned the loss of nurturing support from those above them. Junior CPs had witnessed seniors become exhausted and ask themselves ‘is this worth it’ and were left wondering when they too would reach a stage of ‘enough is enough’, their relationship with the NHS and it’s MH provision becoming too strained, taking too much from them. The CPs expressed guilt and pain for even considering leaving, referencing the privileged position afforded to CPs who are paid to train by the NHS, but they anticipate having to walk away, reaching a point where their need to survive takes precedence.

> “You kind of end up in this strangely abusive relationship with the NHS, it has given me so much, so many opportunities that I would have never had … so I am incredibly grateful but at the same time it’s like, well, when is enough enough? When is what it’s taking from me equal to or greater than what I’ve got from it? I feel a bit tearful thinking about that … it kind of feels like a bit of a betrayal (.) on both sides” (Lucy, 266-267; 271-274).

> “I’ve got all these ideas about wanting to work in the NHS but now I’m thinking for my own mental health I can’t. I can’t keep working in this way …It doesn’t fit with my values, I’m trying to work in a way that does but it feels like a fight every time … it’s exhausting, it’s really tiring, and I can’t feel like this at this stage” (Asmita, 197-206).

Being in these services does something quite destructive to the CPs, the system’s dysfunction getting inside them, putting them in a position that they need to leave, escape, to be safe and well.

> “… I needed to change that job, I remember describing I felt like I was in crisis again and again and I think that was part of the service, the acute service- it’s a crisis service but I ended up feeling I was in crisis working there and I think that was about the system” (Rupert, 281-284).

Changing jobs appeared to be a compromise the CPs made to keep them in the NHS, a system they felt they needed to be in in order to protect their ‘socialist’ values; but the system itself was not living up to these and was in fact getting in the way of the CPs attempts to do so, and in turn taking something from them. Participants (notably the women) also voiced concerns about how remaining in the NHS, burning out and detaching from their values, affects their ability to parent too, to be a good friend, a good partner, and so it was not just themselves they needed to protect.

> “… socialism’s always been a really, really, really core part of my values and personality for as long back as I’ve been politically aware … and I have found myself thinking in the last year about what it might be like to do some private work (4) and it makes me shudder now but … I just cannot imagine myself doing this fulltime when I’m 66, 67, I’d just be a husk, there wouldn’t be anything left of me” (Lucy, 244-251).

> “… thinking how hard it is to be in this position at this stage of my career and having at least another 30 years ahead of me, how can I sustain my values in a place that isn’t really enabling that but kind of taking them away” (Asmita, 76-79).

3.4.2. Sub-Theme: What You Can When You Can

Participants employed several strategies to try and keep themselves in the NHS, in their posts, to manage the emotional impact and the damage done to their ideals. This included trying to ‘do what you can when you can’; ‘standing your ground’ and challenging decisions that seem inappropriate; and choosing to keep fighting – for their patients and for themselves. They spoke of holding onto ‘little wins’ and ‘golden moments’; capitalising on windows of opportunity for working in line with their values; and finding allies in the system.

> “…even if it’s a little seemingly insignificant thing it’s at least better than nothing, or better than an alternative which is no service” (Kat, 283-285).
>
> “the bottom line is finding a values-based approach to working that works for you and being reflective about that” (Drew, 85-89).
>
> “… you have to make a stand, you have to choose” (Jem, 472).

Attempts to resist bending to cultural norms and subsequent burnout included enforcing boundaries around taking a lunch break, for example.

> “So, I sort of see it as part of my responsibility to myself and to my clients to make that decision to go and have a break, it’s all those kinds of micro-decisions isn’t it?” (Sara, 272-275).

Multiple CPs cited engagement with clinical psychology social media commentary as keeping them away from complacency. Others contextualised their experience to make sense of it and assign responsibility for their distress externally.

> “’Okay, I’m feeling this not because there’s something wrong with me, but I’m feeling these things because there’s something wrong with the system’” (Rupert, 260-1).

Having forums through which to stay connected to values, and each other, seemed important for sustainment. In Wales, no psychologist is alone in their service and these CPs voiced a concern for their English colleagues, a worry that when alone conformity becomes likely.

> “When I was trained, the first thing we were told was ‘you’re trained to hold a different voice and a different narrative, that’s your job and you need to find a way to sustain that” (Lydia, 335-337).

Numerous (women) CPs noticed they had to work to go against their more ‘well-behaved’ temperaments to become assertive and ‘bolshy’, bending the rules, challenging the power at play and being ‘naughty’ to maintain their integrity and keep their values alive. Writing supporting letters to housing departments was one task that offered the CPs some reassurance.

> “I’ve discovered a rebellious streak … I’ve always been quite good at towing the line. So, actually for me to push against that is quite anxiety-provoking … it sort of feels like I’m breaking the rules or challenging the rule-makers, which I am, for good reason, but it doesn’t sit quite comfortably. But I suppose it feels more wrong to compromise my own integrity” (Jem, 280-1; 285-289).

However, a common ‘strategy’ employed was detachment, cutting off to carry on. One CP expects her trainee self would be mortified by this, another spoke to noticing their supervisor do the same, and when they bring dilemmas to them it reconnects them in a devastating fashion: there’s validation but little solution.

> “I think to manage in that environment you have to kind of detach from it” (Rupert, 245).

Using supervision, having informal rants, and ‘sticking their necks out’ to keep aligned with one’s values was not enough; there came a tipping point in which disengagement was the only survival mechanism.

> “There has to be a degree of blocking as well, and I can see the argument for that not being skilful, but you have to

> because if I engage with this fully all the time I can’t cope with it, it’s too much” (Jem, 432-434).

Two CPs spoke to an internal debate regarding their passion for the profession, the taboo of it being ‘just a job’ but reflected on how it can become such when you are up against an ‘inefficient, traumatising, bureaucratic machine’.

> “… ‘it’s just a job’ and yeah, I’ve just been kind of just wondering really how much of that is a kind of defensive distancing and how much of it is just kind of the reality for me” (Duncan, 271-2).

4. CHAPTER FOUR: DISCUSSION, EVALUATION, AND IMPLICATIONS

4.1. Aims Revisited

The aims of this study were twofold. First, to explore the concept of moral distress with CPs who are operating within the UK's 'socialised' healthcare system. Second, to develop an understanding of this psychological experience, how it is produced in this context and the impact it has on the CPs. To my knowledge, this study is the first examination of MD with UK CPs; it is hoped the results of this study can contribute to the literature surrounding ethical clinical practice for UK CPs and bring the emotional experience into the fore.

In the previous chapter, three overarching themes and six subthemes were presented following a TA of interview data from 14 CPs. Whilst the presentation of the themes suggests a distinct nature, there is interaction between them all.

4.2. Summary of Findings

Participants' experiences of ethical dilemmas, and the emotive aspect of managing these, were situated within their services, their systems. They experienced conflicts between their personal and professional values and the institutional practices which constrained them. Always striving to 'do the right thing' the CPs were frequently hindered in their ability to help by the gaps in service provision, and the inaccessibility of that which does exist. They could not help some clients because their service criteria would not allow them entry, but there was no alternative service to offer them and so some rebellion was required of the CPs, finding a way to offer something rather than nothing. The pressure on these systems meant services were rejecting and denying clients a service, applying policies inconsistently, and the CPs were left powerless, unable to do anything other than witness this.

The culture of these systems was described by the participants as harmful. Clients were stripped of their personhood and assigned a numerical category, a dehumanising attempt to manage the imbalance of demands and resources whilst a socialised healthcare system experiences ever-increasing commercialisation. Clients and clinicians alike lost agency, the services' need to survive prevailing above patient choice and control. Participants expressed concern for their own future practice, how they may be corrupted by the system and what their conformity may mean for their clients, their energy for fighting against the system being depleted.

For many, what got in the way of them doing their therapeutic job the way they wanted to were the impoverished circumstances in which their clients were stuck. Poor housing, lack of financial aid, the basic needs were not being met for many and the powerlessness the CPs felt around combatting this was a significant source of frustration and distress. Being in services also meant fighting against aetiological frameworks and business models through which clients were no longer considered to be whole people; this type of 'treatment' was experienced by the CPs as a betrayal of the helping-professions' core values.

Throughout the participants' accounts there was despondency, despair, demoralisation in response to how immovable cultural practices seemed. There was a shared exhaustion, a continuous fight to maintain one's integrity, a relentlessness that tired the participants beyond what seemed acceptable. The CPs were powerfully impacted by the ethical dilemmas they were facing time and time again, to the extent the systems hurt them too. Rupert, for example, shared how "it felt like I was going a bit crazy" (line 251), and Lucy worries that staying in the NHS will leave her "a husk" (line 251).

Advocacy was championed by most of the participants as a means by which to manage the dilemmas and the threat to the self. This required the participants to fight, to challenge the system they were a part of, this a battle for what matters to the CPs and the clients they were trying to help. The limits to their power however often meant ‘doing what you can when you can’, and the extent to which this was satisfactory varied.

A key theme arose concerning the ethos of clinical psychology, its ethical priorities, and a lack of coherence as a profession regarding this. Participants raised concerns around who is determining the profession’s ethical and professional values - an organisation currently and publicly in turmoil (Dixon, 2021) - and what role the professional body plays in embedding these.

Most participants spoke to the retention dilemma in the profession, their deliberations around remaining in the NHS or leaving for private practice often framed as an attempt to be in control of their impact, being able to work as the psychologist they want to be. Contemplating leaving the NHS was painful too, a position they never expected to find themselves in, a complex relationship having developed between the CPs and the NHS. To leave would be to abandon the clients that could not access help privately. To leave would be to abandon the CP’s own egalitarian views. To leave would be to betray the organisation that trained them. But, to stay risked further deterioration in the CPs own mental health. To stay risked remaining powerless and unable to use their full set of skills to truly help. To stay risked becoming what they fear, perpetuating harm.

4.3. Discussion of Findings

4.3.1. Integrity

When asked what comes to mind when thinking about the professional values of clinical psychology half of the participants immediately named ‘integrity’; person-centred care and ‘do no harm’ closely followed as the key components of their professional identity. They described how this integrity was compromised in their accounts. Varcoe et al.'s (2012) definition of MD situated this compromised moral agency as a core component of the MD experience. Multiple previous studies (Hamric et al., 2012; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004; Piers et al., 2012) identified an association between compromised integrity and leaving a healthcare post, a relationship that was spoken to with the CPs here too. Indeed, the findings herein support the distinction between MD and burnout provided by Fantus et al. (2017), burnout being a phenomenon not concerned with ethical integrity whereas this is central to the MD experience, as illustrated by the CPs.

MD, as an occupational phenomenon, is grounded in disruption to professional identity (Austin et al., 2005). Integrity seemed to be central to much of how the CPs framed their experiences. What we mean by integrity is therefore important to consider; it is likely to entail moral uprightness, being whole and in an uncorrupted state. It's literal definition speaks to honesty and holding strongly onto moral principles which you do not veer from (Cambridge Dictionary, 2021). Integrity can be such an embodied entity that we attend to it more so when it is threatened or thwarted (Zahavi, 1999). Austin et al.'s (2005) investigation of MD with Canadian psychologists referenced the 'need to be able to look in the mirror', which was echoed by the CPs here who noticed that their younger selves would not like what they saw of their current practice, and the detachment they engaged with allowed some temporary reprieve from facing this.

4.3.2. Compromising Situations

The CPs felt their personal and professional values were most often compromised by the current state and structure of the NHS's MH provision. This was not a finding that closely replicated previous literature on MD but rather spoke to the specific UK healthcare context wherein a 'socialised' system is at the mercy of government funding and commissioning decisions which have significant consequences, barriers going up to prevent large groups of people (with more 'moderate' needs) from accessing services which are broadly mild (IAPT) or severe (CMHT).

What does follow previous studies however is the experience of feeling compromised by what one witnesses. In Whitehead et al.'s (2015) multidisciplinary survey, witnessing ‘diminished care’ ranked highly as a source of MD and poor communication was implicated. The CPs in this study echoed this, citing tension amongst professionals with differing aetiological frameworks, whose formulation of a client appeared pathologising or uncompassionate to the CPs, leading to concerns about what care their clients were receiving. Attempts to navigate this, explore their colleague’s thinking, were often frustrating and the culturally embedded narratives seemed immovable, resulting in repeated cycles of (perceived) inefficient care.

4.3.3. Experiencing Values Conflict

The CPs’ personal and professional values were aligned, many referenced this being what brought them into the profession, but in clinical practice these values are constrained, and the CPs felt a pressure to comply, toe the line, violate their own standards and principles in order to keep the service going. This idea around working ‘for the good of the many’ seemed a fallacy, perpetuated to keep the CPs going. The needs of the service, its economics, and its own anxieties, wiped out the needs of the clients; the CPs could empathise with their managers, who were experiencing constraints too, but ultimately experienced what they enforced as a threat to their integrity.

The CPs named despair, despondency and disheartenment, all of which seemed linked to their sense of powerlessness – a fundamental characteristic of MD (Hamric, 2012; L. C. Musto et al., 2015). The resultant exhaustion reflected the dispiritedness noted by Austin et al. (2003)

The role of control was also implicated; Dodek et al.'s (2016) study found that their physicians – holding the highest authority on decision making and therefore the most ‘in control’ – expressed the lowest levels of MD. The CPs were seeking autonomy and control, so they may practice in line with their values, and this led to the consideration of private practice for some.

The fear of conformity, voiced by the CPs, concerning who they could become should they remain in this system much longer was not something discovered in the scoping review as a feature of MD but it logically follows as a consequence; when our professional integrity is compromised and we do not like how we are being made to practice, we might worry where this will lead and what kind of psychologist one might become. The women in the sample also shared concerns around how, with the personal and professional being so linked, this transformation into something less-compassionate, less-human/more-machine, would impact on their whole person too, their family and friends.

4.3.4. Managing Conflicts

The CPs attempts to manage the conflicts between their values and the institutional procedures centred around resistance, resisting the oppressive structures and the attempt to force the CPs out of alignment. This was framed as a battle, a fight a CP had to choose to enter in to. This finding brought forth ideas about moral courage and Rathert et al.'s (2016) work; the extent to which the CPs could persevere and motivate themselves to challenge what is constraining them and their clients, in the face of such adverse circumstances, is their moral-efficacy, which in turn influences moral courage – converting their intentions into actions, despite the pressure to be subservient. Holding onto 'golden moments' and 'little wins' seemed to aid this perseverance.

However, there was consensus amongst the CPs that these compromising experiences and the distress that follows has an accumulative effect – a crescendo effect perhaps (Epstein & Hamric, 2009); a moral residue than lingers and gathers, a reminder of having not abided by one's own moral standards. Detachment was deployed as a means of protecting the CPs from this crescendo, desensitising them to the moral aspects of their impact (Bandura, 2012). Some CPs expressed a discomfort with this disengagement, whilst others viewed it as a necessity borne from the reality of current NHS practices.

The ultimate mechanism by which the CPs could manage their MD experience was to leave their job or leave the NHS. However, leaving the NHS itself was fraught with moral implications. Three participants did not consider employing such a strategy, and notably had more years of experience. Two of these gave less emotive accounts of their ethical dilemmas and expressed a more external locus of control, assigning the responsibility for ethical practice more so to their service and systems than themselves. The third was in a powerful position and had more influence on their system's practices than the majority of the sample. The MD levels of these three participants appeared lower, or perhaps 'more managed'; indeed Whitehead et al. (2015) found that MD is lower in clinicians who have never considered leaving a position.

4.3.5. NHS Principles and Values

Associated with integrity are ideas about 'doing the right thing' and so we should consider what that looks like and its location within individual value systems. In producing a charter of principles and values (Department of Health and Social Care, 2021), the NHS tells us what they think it means to 'do' healthcare right. These principles include ensuring the patient is at the heart of all the NHS does, something that was certainly countered in this dataset, where the stripping of personhood dominated accounts.

A difficulty arises therefore when clinicians operating in the NHS system, who enter it believing their own values are aligned with the NHS', find that its practices are compromising the extent to which one can 'live out' their values. Indeed, one CP wonders how she can sustain her values in a system that is not enabling them but rather is taking them from her, despite having declared itself to be aiming for something entirely opposite.

The concept of moral injury becomes pertinent here. “Moral injury is the damage done to one’s conscience or moral compass when that person perpetrates, witnesses, or fails to prevent acts that transgress one’s own moral beliefs, values, or ethical code of conduct” (The Moral Injury Project, 2021, p. 1). The CPs are at risk of moral injury through the disruption to their belief in the NHS’s capacity to act in an ethical, and just, manner (Drescher et al., 2011). The failure of leadership to uphold principles when the stakes are so high, and the betrayal described by the CPs, implicates the BPS too.

4.3.6. Research Questions

Having discussed the key findings in relation to the literature, from which the research questions arose, we can consider the extent to which these have been answered. The reader is invited to consider these research questions as interconnected.

1. What situations or experiences can make psychologists feel their personal or professional values are compromised?
2. How do clinical psychologists experience conflicts between their values and institutional procedures, and how do they attempt to manage them?
3. What is the nature of the conflict and how is it experienced?

Witnessing care perceived to be substandard, dehumanising, and dictated by funding restrictions compromised the CPs in this study and their integrity. The pressure to engage with procedures which perpetuate culturally harmful narratives and practices further distressed these CPs, leaving them despondent and despairing the state of the system. Managing this was a challenge for most, they spoke of having to grab hold of whatever moments of good practice they were able to employ and find allies to keep their values alive. Commonly, the CPs reached a point in which they needed to distance themselves from the unfairness, unjustness they were noticing. Most of the CPs had left previous posts, or were considering doing so, in an attempt to move into a position which allowed them to work in line with their values. Some felt it was inevitable they would need to leave the NHS, to be able to do work they could be proud of but also to support their own psychological wellbeing and protect themselves from transforming into something unrecognisable.

4.4. Critical Evaluation of the Research

The variety of qualitative approaches employed in research require diverse methods for assessing validity; Yardley's (2000) criteria are consistent with a critical realist positioning and are spoken to below.

4.4.1. Sensitivity to Context

This study has been contextualised through the existing MD literature, and in the NHS, a healthcare system unlike those found in previous studies, with its own stated core values. Working in services with powerful hierarchies, using medical models, encourages the individualisation of distress, clients', and clinicians'. Attention to the intersecting social, relational, cultural, and power-based embodied experiences supports a more contextualised account. During analysis sensitivity to context was also sought though careful selection of quotations across the breadth of participants, their perspectives, and experiences.

4.4.2. Commitment and Rigour

Commitment to the project has been evidenced via my immersion in the subject matter and the literature base during the scoping review of Chapter One, and by gaining insights through empathic alignment with the participants. Engagement with the topic was enhanced experientially through my placements as a Trainee Clinical Psychologist, in settings not dissimilar to the participants'. Rigour has been demonstrated though the extensive process of carrying out a thematic analysis, detailed attention given to the content of each interview. This TA was completed over a four-month period, guided by formal and informal supervision, the latter being peer-led.

4.4.3. Coherence and Transparency

From design to completion, the research questions were returned to at every stage of the process in an attempt at attaining coherence of the thesis. Developing the themes through discussion with the supervisor also aided coherent identification of patterns and illustrating these with data extracts is an attempt to support the reader in sharing in this. I have attempted to present a transparent description of the analytic procedure in Chapter Two and the results of this in Chapter Three included verbatim extracts. I have also endeavoured to demonstrate the resultant themes via a range of participant accounts. Transparency is additionally demonstrated via researcher reflexivity, explored later in this chapter.

Spencer and Ritchie (2011) provide additional principles by which we can review the study, and these follow:

4.4.4. Credibility

I attempted to ensure this study was plausible and credible by firstly presenting the proposal and rationale to clinical psychology colleagues in my network, who responded with interest and reported that the emotional experience of navigating ethical dilemmas was one they were often having to attend to alone, and out of working hours. An exploration of MD with CPs therefore appeared appropriate and relevant. A pilot interview with a fellow trainee CP confirmed that the concept of MD resonated, even at the trainee level. Discussions with clinical supervisors also provided space for reflections on the variety of ways in which MD could be experienced by CPs and supported the development of the interview schedule.

Regarding the credibility of the results, Braun and Clarke (2006) present criterion for conducting a ‘good’ TA, via a 15-point checklist. This criterion stretches across all stages of the process, from transcription to report writing, and I feel confident I have met each of these 15 points by, for example, producing themes that are distinctive and coherent (criteria 6), and born fundamentally from the data following an interpretative process (criteria 7). Although it is suggested one-word theme titles be avoided the priority is that titles be concise and suggestive of meaning, which I believe has been achieved despite ‘Power’ being such a one-word title – an organised story about the data follows (criteria 9), with language and concepts utilised (criteria 15) being consistent with a critical realist positioning (Braun & Clarke, 2021).

4.4.5. Epistemology

As per Willig (2019), I have sought to emphasise the importance of a coherent relationship between the study’s epistemological and methodological assumptions. A critical realist positioning facilitated contextualised accounts which considered the material reality of a CPs role and duty. For example, participants spoke to the reality of target-driven, resource-constrained service provision and these experiences were given more nuance when grounded in the socio-political context of a socialised healthcare system where power operates. I acknowledge critiques of critical realism, including concerns around meaning being derived from the researcher’s perspective rather than the participants’ (Sims-Schouten et al., 2007). To address this, transcripts have been revisited throughout the theme refinement process to ensure any analytic claim is grounded in the data and participants’ reports, whilst attending to the broader ‘socialised healthcare’ context.

4.4.6. Analysis

Thematic Analysis provided a flexibility that allowed me to address material and contextual issues within the themes, aligned with a critical realist position. It does however rely on participants providing a ‘whole’ account of their experience; that which is not voiced cannot be analysed and incorporated into the overall understanding of MD produced.

4.5. Research Strengths and Limitations

4.5.1. Sample

This study includes data from 14 CPs, operating in adult mental health settings at tier 2 or above. Each of their services, and their experiences, are situated in differing commissioning and local government contexts. Although I sought to recruit UK CPs, there is no representation from Northern Ireland or Scotland. Remote data collection however perhaps allowed those who would not normally have time to attend or to travel to participate; this also allowed for a broader geographic reach. Following the work of Guest et al. (2006) on saturation, Ando et al. (2014) also found 12 interviews to be a sufficient sample size for identifying the key elements of a phenomenon, when conducting TA specifically. However, as these authors note in their study too, two of my participants opted to keep their camera off and it is not known the extent to which this will have influenced coding.

Recruitment occurred via social media and word of mouth, which does limit the reach somewhat to people in those networks. We could assume that particular CPs would be attracted to engaging in a research project such as this, CPs who had an opinion on the topic and had ‘more’ experience of ethical dilemmas than most perhaps. Some participants did indeed express a hope that their engagement with the study could lead to changes in the profession, that this unspoken distress CPs are experiencing might be brought to the table for discussion, beyond how to manage ethical dilemmas to what is it like to be in systems where you are restrained from carrying out ‘best practice’ and acting with integrity. The invitation to participate in research, the framing of the study during recruitment, and the subsequent semi-structured interview schedule does come together to create an artificial context through which questions and answers are positioned in a certain frame (Potter & Hepburn, 2005). However, asking participants about values conflicts did not enforce a moral framework, although it will have closed down other ways of talking about experiences (such as those less focused on the CP's emotional experience and more on clinical management).

Several CPs got in touch after coming across the recruitment poster but did not meet inclusion criteria as they no longer worked in the NHS; it would nonetheless be interesting to know what drew them to volunteer to participate, and this is perhaps something for future research to consider.

Participants included nine women and five men, which approximately equates to the gender ratio in the UK clinical psychology profession (Baker & Nash, 2013). A representative sample regarding race and ethnicity was a more complex endeavour due to the risk of compromising confidentiality. It is well documented (Division of Clinical Psychology Racial and Social Inequalities in the Times of COVID-19 Working Group, 2020; Wood, 2020; Wood & Patel, 2017) that clinical psychology has a 'diversity problem', particularly regarding Whiteness, and concerns about their ethnicity making them identifiable may have discouraged a number of UK CPs from responding to the recruitment advert. One participant indeed raised this concern, a query as to how I would protect her as one of the few Asian psychologists she knew of in the UK. I resolved to not present demographics in their totality; each participant's gender, ethnicity, location etc. is not shared in conjunction with each other as when combined could make them identifiable. Demographic information is presented at the group level. Differences in race and ethnicity are not commented on within analysis or indeed this discussion, the sample size being too small for any meaningful distinctions to be made. However, it would be remiss of me to not consider how the isolation participants described may be ten-fold for CPs who are already marginalised due to their race or ethnicity.

4.5.2. Transcription

Potter and Hepburn (2005) raise a concern regarding an inability for the wealth of human responses to be wholly captured through transcription. Through transcription we lose the expressions of emotion that aren't voiced, that which is conveyed through tone and inflection, and the bodily movements suggestive of uncomfortableness or anxiety. I attempted to capture some of this by employing a form of transcription which noted gestures and halted speech but was aware when a few participants became tearful that I would struggle to fully encapsulate this in written form.

4.5.3. Video Interviews

As referenced above, two participants kept their cameras off, impacting my felt sense of rapport and ability to observe their reactions to questions. All had opportunities to withdraw, however.

Participants were engaging with data collection from the comfort of their own homes, which we may assume provided greater safety and security for disclosure, as well as greater convenience. It is possible that had the interviews been conducted in-person, on work or university grounds, participants' ability to name and speak on such distressing topics may have been impeded. Remotely conducting the interviews may also have helped to manage the trainee-qualified dynamic as we were in 'neutral territory'.

4.5.4. Generalisability

Quantitative studies' aim of generalisability is incompatible with the qualitative methodology of this research. As broad a range of CPs as accessible produced the themes in this study but due to the scarcity of comparable UK clinical psychology studies on MD we cannot confirm nor refute previous findings. These findings therefore serve to provide an illustration of how MD may present in clinical psychology in the NHS and somewhat build upon previous MD research and wider discourses, in the context of institutionalised practices and procedures, to produce ‘vertical generalisability’ (Johnson, 1997).

It is important to note that data collection took place August – October 2020, 6-9 months into the COVID-19 pandemic. Participants were working in NHS settings, experiencing the impact of COVID-19 on the delivery of healthcare and their ability to do their jobs, the adaptations required, and so their contributions are likely to have been influenced by this. Nevertheless, when participants did refer to COVID-19 they did so to point out that it had only exacerbated pre-existing systemic difficulties in their services.

4.6. Contribution and Importance

The value and relevance of a research project, its ability to advance theory, policy, and/or practice can be spoken to in terms of its contribution (Spencer & Ritchie, 2011). Considering the sample described above and the limits of generalisability, this study does not attempt to represent the MD experiences of all CPs working in the UK’s NHS. This is a relatively unexplored area with UK CPs and so I hope that by sharing the experiences of these 14 CPs in England and Wales the current study provides a valuable insight into what may be an important but largely unspoken difficulty in the profession.

A ‘retention issue’ in the NHS is well known, and spoken to in Chapter One, but writing on this is predominantly focused upon nurses and physicians. A retention difficulty in clinical psychology is acknowledged far more anecdotally, less ‘research’ as to its causes conducted. This study may provide some understanding as to why CPs struggle to stay in posts, or in the NHS. The literature on staffing issues suggests that burnout, exhaustion, and depression – precipitated by working conditions

– cause clinicians to ‘quit’. Participants here reported similar experiences, an overwhelming tiredness developing out of a relentless fight to stay aligned with one’s values, battling a system that is constraining moral action, and the impact this has on their own psychological wellbeing. Systems in crisis ultimately produce workers in crisis. I hope this study also goes someway to acknowledge the significant impact that working in these systems has on its clinicians.

It is evidently important that moral practitioners with vast clinical experience remain in our systems, disseminating their skills, to be utilised and valued by colleagues and clients. It seems an ethical imperative that the system, its leaders and associated professional bodies, try to retain ethically conscious clinicians for the benefit of patients. Perhaps things would improve if the NHS was able to live more completely up to its stated principles and values.

MD may present differently in CPs than in other HCPs for a variety of reasons. As referenced in Chapter One, CPs have amassed frameworks for understanding – such as Social Identity Theory, deployed by one participant here – to support them in making sense of the distress their clients, but also they themselves, can experience. Their knowledge contributes to the power they hold, occupationally. However, the results of this study suggest that whilst this knowledge and power may provide the CPs with the means for understanding their experiences of MD, and how these have been systemically produced, their power was not sufficiently protective; it did not keep the MD at bay. Clinical psychology doctoral programmes additionally often train CPs to focus upon societal contexts and systems and so the awareness of being compromised regarding one’s ability to support social justice, for example, may be more in reach for CPs. Many doctoral courses also take up a political stance, although within the profession debates continue regarding how explicitly political, or neutral, the profession should be (for example, Rahim & Cooke, 2019; Randall, 2020).

The broad conceptualisation and delineation of MD has not been directly dealt with in this study. What this study may add to our understanding of MD as a concept however concerns what happens when an organisation, with moral roots (universal healthcare for all), compromises itself and in turn its workers. Working with an MD framework may be efficacious in that it brings the emotional experience of moral and ethical dilemmas to the fore, having identified that CPs are often not ‘allowed’ to do so, focusing more on the practical components of these, with little space for acknowledging that psychologists too need support. They are not the morally superior agents that situational judgement tests, for example, may suggest. Ideas about CPs taking on a ‘moral compass’ position and working to ‘do the right thing’ do imply some morally superior ideas about the profession, which may have been brought to the fore by myself as a researcher who is also an incoming CP. It is important to note therefore that a small number of participants did not describe themselves as morally distressed, however they were engaged with personal and professional detachment. This should not necessarily imply a bad or morally dubious fraction of CPs but rather connects to ideas about ‘good and bad’ systems and what it is like for HCPs to operate within them. Most people agree that the NHS is a fundamentally ‘good’ system due to its core component being the provision of free healthcare, however it is also accused of being institutionally racist (NHS Race and Health Observatory, 2020), for example, and so a binary of good and bad should not be enforced on the CPs navigating this system.

4.7. Implications

Here I present three levels at which the current study may suggest recommendations for action, but I believe these levels are interactive and likely to influence one another

4.7.1. Clinical

The emotive aspect of ethical dilemma management, and the consequences of a negative experience of this, are significant enough to warrant more meaningful consideration in clinical practice. This may mean incorporating thoughts on this across the breadth of a CP’s career, beginning with doctoral training programmes where explicit acknowledgment of the tension between organisational, clinical, and personal values and responsibilities might be helpful for attending to what can become ‘divided loyalties’ for a CP. Increasing the awareness in clinical practice of such experiences, through a MD lens or otherwise, could help to foster collective thought and skill development, combatting the isolated experience the CPs described, framing the issue as the relational one it is, and helping CPs stay connected to their values together. This thread could continue through reflective practice, line management, and supervision, should the emotive component of these difficult decision-making tasks be given as much credence as the practicalities currently are.

4.7.2. Research

As the first study to explore MD with UK CPs, future researchers may wish to replicate this study, literally or through shared aims.

Based on the questions I am left with following this study, our understanding of MD in clinical psychology might be furthered by an examination of what was only mildly touched on in this report – the differences in experiences described by the participants with significantly more experience; two participants had over 20 years’ experience, nine participants had 10 or less and there did seem to be some moderating factor at play, but I cannot speak to this specifically as it was not individually investigated.

A comparison of MD experiences with CPs in the UK operating in organisations other than the NHS (such as charities) may also be of worth, potentially adding to our understanding of the operation of institutional constraints upon MD.

The significant influence of multidisciplinary colleagues’ narratives and actions upon the CPs experience of ‘witnessing’ might also call for a study of how these dilemmas are spoken about within teams, perhaps a conversational analysis, to look towards change-based interventions at the meso level.

4.7.3. Policy

At a more macro level, the CPs implicated the social care structure as hindering their ability to live and work by their values. Commissioning and government funding are also impacting upon what it is that CPs and their services can and cannot offer, leading to the ‘gaps and access’ issues. Some CPs suggested that clinical psychology should therefore be more concerned with lobbying practices, engaging with the fight for social justice, as it otherwise impedes individual therapeutic work. Other CPs however expressed not having the fight left in them for such ‘extra-curriculars’, the current system not leaving any space for CPs to do more than their contracted contact hours and sessions. Nonetheless, (revived) environments which enable CPs to act in line with their values and ethics are perhaps the answer to combatting the powerlessness and despair that can take hold (Morgan et al., 2019).

The Long Term Plan (NHS England, 2019) aims to address the issue of a ‘gap’ between primary and secondary care but mostly plans to do so by reorganising the current services, restructuring a struggling system rather than engaging in a deep, cultural reform. The reports of the CPs in this study suggest that the latter is warranted.

The BPS may also wish to consider how its policies and guidance on ethical conduct and ethical decision-making are not held in mind by the CPs in this study to any significant degree; these participants were not drawing directly from BPS publications for support in managing such issues. The ‘messiness’ of a voluntary-membership organisation setting the standard for UK CPs may not quickly nor easily be resolved, but with matters of ethics being so integral to the profession, and healthcare more broadly, this is certainly something that will need further thought.

4.8. Reflective Review

This thesis as presented is a product of the researcher and must be viewed as such (Nightingale & Cromby, 1999; Willig, 2019).

4.8.1. Personal Reflexivity

I conducted this study as a Trainee CP with experience of NHS MH services and being somewhat in the profession, but as I completed analysis I drew closer to qualifying and more thoroughly taking up a place in the system I am critiquing.

I had assumptions as to what I would hear from my almost-peers. I expected frustration and ideas about limited autonomy, providing prescriptive models for set amounts of time. The latter constraint arose minimally; most participants reported having clinical autonomy, being in control of what they deliver to a client, but this was not protective enough when they witnessed so many clients unable to get into the service and the clinical room in the first place, or make use of it once there.

An interest in ethical decision-making had developed through my own experiences of working in services, as a support worker, an assistant practitioner, a psychological wellbeing practitioner, and as a trainee CP; across primary and secondary settings, inpatient and outpatient, that sense of not being able to help people in the way I wish I could was ever-present. It is of course somewhat demoralising to hear from my participants that it does not go away once I qualify, but also somewhat relieving to know my seniors can and do still resist and challenge the system when and where they can.

The doctoral course itself furthered an approach which centres power and political influences upon the work of CPs. These experiences and lenses through which I conceptualise issues will have influenced my analysis, despite all attempts at rigour. I believe I remained aware of this throughout the research process however and I was vigilant to the impact of my own assumptions, checking back to ensure interpretations linked to the data. Nonetheless, it was I who saw patterns in the data and named them, and so my subjective engagement with the data cannot be denied (Braun & Clarke, 2006).

4.8.2. Power

There are implicit power differentials between researcher and participant (Ringer, 2013), and for myself and the participants here there were particularly interesting, alternating power imbalances; I as the researcher held power, but as a trainee CP faced with qualified CPs power felt like it was exchanged between us at different stages of the research process. As an interviewee, participants may have felt a need to respond in the most helpful way for me, as qualified CPs being interviewed by a trainee they may have felt either self-assured or assessed. My impression was the former, most were relaxed and conversational, expanding and elaborating without prompting, often including humour. I note however a concern some participants voiced, not wanting to 'put me off' the profession; they were aware of my trainee status and the demands of a thesis and ending training too and so may in fact have held back some of their more severe or existential dilemmas in an attempt to protect me; an ironic moral principle invading this research space on MD.

4.9. Concluding Comments

MD is a well-researched topic within nursing literature, although debates about its conceptualisation remain. In this study MD was explored with Clinical Psychologists in the UK's NHS for the first time. In this context ethical dilemmas arose in, and were complicated by, systemic difficulties in the NHS's MH structure. Being in these services, observing and becoming enmeshed in culturally harmful practices leaves CPs conflicted as to how to do the right thing, and just what that right thing is. The powerful hierarchies in these services are at times stifling, forcing compromise, and the CPs have to repeatedly find the will – the moral courage – to resist, but this comes with a cost. Participants' relationship with their professional identity was threatened; they felt unsupported by their professional body with this distressing ethical problem, and to manage at times needed to morally disengage from their everyday working reality. The alternative for most was to change jobs, but an inevitable departure from the NHS loomed in many CP's futures; this a painful decision but one the CPs felt was necessary for their personal and professional selves to survive.

5. REFERENCES

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A., & Tod, A. M. (2009). Ethical issues in the use of in-depth interviews: Literature review and discussion. *Research Ethics*, *5*(2), 48–54. https://doi.org/10.1177/174701610900500203

Ando, H., Cousins, R., & Young, C. (2014). Achieving saturation in thematic analysis: Development and refinement of a codebook. *Comprehensive Psychology*, *3*(4), 1–7. https://doi.org/10.2466/03.CP.3.4

Annas, G. J., & Grodin, M. A. (1992). *The Nazi doctors and the Nuremberg Code: Human rights in human experimentation.* Oxford University Press.

Arksey, H., & O’Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Austin, W. (2007). The ethics of everyday practice: Healthcare environments as moral communities. *Advances in Nursing Science*, *30*(1), 81–88. https://doi.org/10.1097/00012272-200701000-00009

Austin, W., Bergum, V., & Goldberg, L. (2003). Unable to answer the call of our patients: Mental health nurses’ experience of moral distress. *Nursing Inquiry*, *10*(3), 177–183. https://doi.org/10.1046/j.1440-1800.2003.00181.x

Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2008). The balancing act: Psychiatrists’ experience of moral distress. *Medicine, Health Care and Philosophy*, *11*(1), 89–97. https://doi.org/10.1007/s11019-007-9083-1

Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemermeyer, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. *Ethics & Behaviour*, *15*(3), 197–212. https://doi.org/10.1207/s15327019eb1503_1

Baker Collins, S., & Cranmer-Byng, S. (2018). “Things I cannot change”: Moral distress in the implementation of Ontario Works. *Canadian Social Work Review*, *35*(2), 5–24. https://doi.org/10.7202/1058477ar

Baker, M., & Nash, J. (2013). Women entering clinical psychology: Q-Sort narratives of career attraction of female clinical psychology trainees in the UK. *Clinical Psychology & Psychotherapy*, *20*(3), 246–253. https://doi.org/10.1002/cpp.788

Bandura, A. (1977). *Social learning theory*. Prentice Hall. http://www.asecib.ase.ro/mps/Bandura_SocialLearningTheory.pdf

Bandura, A. (2012). On the functional properties of perceived self-efficacy revisited. *Journal of Management*, *38*(1), 9–44. https://doi.org/10.1177/0149206311410606

Banister, P., Bunn, G., Burman, E., Daniels, J., Duckett, P., Goodley, D., Lawthorn, R., Parker, I., Runswick-Cole, K., Sixsmith, J., Smailes, S., Tindall, C., & Whelan, P. (2011). *Qualitative methods in psychology: A research guide* (2nd ed.). Open University Press.

Barkan, M. (2018). *Psychologists’ experiences of decision-making in clinical work: A thematic analysis* [Doctoral dissertation]. University of East London.

Becker, P. H. (1993). Common pitfalls in published grounded theory research. *Qualitative Health Research*, *3*(2), 254–260. https://doi.org/10.1177/104973239300300207

Bell, J., & Breslin, J. M. (2008). Healthcare provider moral distress as a leadership challenge. *Journal of Nursing Administration Healthcare Law,* *Ethics, and Regulation*, *10*(4), 94–97. https://doi.org/10.1097/NHL.0b013e31818ede46

Bhaskar, R. (2008). *A realist theory of science*. Routledge.

Bhaskar, R., & Hartwig, M. (2016). *Enlightened common sense: The philosophy of critical realism*. Routledge.

Bianchi, R., Schonfeld, I. S., & Laurent, E. (2015). Burnout–depression overlap: A review. *Clinical Psychology Review*, *36*, 28–41. https://doi.org/10.1016/j.cpr.2015.01.004

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. (2021). 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

British Psychological Society. (2017). *Practice Guidelines: Third Edition*. https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines%20(Third%20Edition).pdf

British Psychological Society. (2018). *Code of ethics and conduct*. Ethics Committee of the British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*(7), 513–531.

Brown, L. R. (2019, February 19). *NHS staff turnover has reached ‘critical’ levels, think tank warns*. People Management.

https://www.peoplemanagement.co.uk/news/articles/staff-turnover-critical-levels-think-tank-warns

Buchan, J., Charlesworth, A., Gershlick, B., & Seccombe, I. (2019). *A critical moment: NHS staffing trends, retention and attrition* (p. 38). The Health Foundation.

Butchard, S., & Greenhill, B. (2015). Giving clinical psychology a backbone. *Clinical Psychology Forum*, *276*, 16–22.

Cambridge Dictionary. (2021). *Integrity*. https://dictionary.cambridge.org/dictionary/english/integrity

Carse, A., & Rushton, C. H. (2017). Harnessing the promise of moral distress: A call for re-orientation. *The Journal of Clinical Ethics*, *28*(1), 15–29.

Cartwright, N., & Munro, E. (2010). The limitations of randomized controlled trials in predicting effectiveness. *Journal of Evaluation in Clinical Practice*, *16*(2), 260–266. https://doi.org/10.1111/j.1365-2753.2010.01382.x

Chamberlain, K. (2000). Methodolatry and qualitative health research. *Journal of Health Psychology*, *5*, 285–296. https://doi.org/10.1177/135910530000500306

Cochrane, A. L. (1972). *Effectiveness and efficiency: Random reflections on health services*. Nuffield Provincial Hospitals Trust.

Colnerud, G. (1997). Ethical dilemmas of psychologists: A Swedish example in an international perspective. *European Psychologist*, *2*(2), 164–170. https://doi.org/10.1027/1016-9040.2.2.164

Corley, M. C. (2002). Nurse moral distress: A proposed theory and research agenda. *Nursing Ethics*, *9*(6), 636–650. https://doi.org/10.1191/0969733002ne557oa

Crane, M. F., Bayl-Smith, P., & Cartmill, J. (2013). A recommendation for expanding the definition of moral distress experienced in the workplace. *Australasian Journal of Organisational Psychology*, *6*, 1–9. https://doi.org/10.1017/orp.2013.1

DCP Professional Standards Unit. (2010). *Clinical Psychology Leadership Development Framework*. https://www.bps.org.uk/sites/bps.org.uk/files/Member%20Networks/Faculties/Leadership/Clinical%20Psychology%20Leadership%20Development%20Framework%20-%20BPS%20%282010%29.pdf

de Veer, A. J. E., Francke, A. L., Struijs, A., & Willems, D. L. (2013). Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey. *International Journal of Nursing Studies*, *50*(1), 100–108. https://doi.org/10.1016/j.ijnurstu.2012.08.017

Deady, R., & McCarthy, J. (2010). A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care*, *46*(3), 209–220. https://doi.org/10.1111/j.1744-6163.2010.00260.x

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

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

Division of Clinical Psychology Racial and Social Inequalities in the Times of COVID-19 Working Group. (2020). *Racial and social inequalities: Taking* *the conversations forward*. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Racial%20and%20Social%20Inequalities%20in%20the%20times%20of%20Covid-19.pdf

Dixon, H. (2021, April 25). Exclusive: British Psychological Society faces Charity Commission probe. *The Telegraph*. https://www.telegraph.co.uk/news/2021/04/25/exclusive-british-psychological-society-faces-charity-commission/

Dodek, P. M., Wong, H., Norena, M., Ayas, N., Reynolds, S. C., Keenan, S. P., Hamric, A., Rodney, P., Stewart, M., & Alden, L. (2016). Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. *Journal of Critical Care*, *31*(1), 178–182. https://doi.org/10.1016/j.jcrc.2015.10.011

Drescher, K. D., Foy, D. W., Kelly, C., Leshner, A., Schutz, K., & Litz, B. (2011). An exploration of the viability and usefulness of the construct of moral injury in war veterans. *Traumatology*, *17*(1), 8–13. https://doi.org/10.1177/1534765610395615

Edmonson, C. (2010). Moral courage and the nurse leader. *The Online Journal of Issues in Nursing*, *15*(3), 11. https://doi.org/10.3912/OJIN.Vol15No03Man05

Epstein, E. G., & Delgado, S. (2010). Understanding and addressing moral distress. *The Online Journal of Issues in Nursing*, *15*(3). https://doi.org/10.3912/OJIN.Vol15No03Man01

Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics*, *20*(4), 330-342.

Epstein, E. G., Whitehead, P. B., Prompahakul, C., Thacker, L. R., & Hamric, A. B. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics*, *10*(2), 113–124. https://doi.org/10.1080/23294515.2019.1586008

Falcó-Pegueroles, A., Lluch-Canut, M. T., Martínez-Estalella, G., Zabalegui-Yarnoz, A., Delgado-Hito, P., Via-Clavero, G., & Guàrdia-Olmos, J. (2016). Levels of exposure to ethical conflict in the ICU: Correlation between sociodemographic variables and the clinical environment. *Intensive and Critical Care Nursing*, *33*, 12–20. https://doi.org/10.1016/j.iccn.2015.10.004

Fantus, S., Greenberg, R. A., Muskat, B., & Katz, D. (2017). Exploring moral distress for hospital social workers. *The British Journal of Social Work*, *47*(8), 2273–2290. https://doi.org/10.1093/bjsw/bcw113

Førde, R., & Aasland, O. G. (2008). Moral distress among Norwegian doctors. *Journal of Medical Ethics*, *34*(7), 521–252. https://doi.org/10.1136/jme.2007.021246

Forozeiya, D., Vanderspank-Wright, B., Bourbonnais, F. F., Moreau, D., & Wright, D. K. (2019). Coping with moral distress: The experiences of intensive care nurses: An interpretive descriptive study. *Intensive and Critical Care Nursing*, *53*, 23–29. https://doi.org/10.1016/j.iccn.2019.03.002

Fourie, C. (2015). Moral distress and moral conflict in clinical ethics. *Bioethics*, *29*(2), 91–97. https://doi.org/10.1111/bioe.12064

Garros, D., Austin, W., & Dodek, P. (2021). How can I survive this? Coping during the COVID-19 pandemic. *Chest*, *159*(4), 1484–1492. https://doi.org/10.1016/j.chest.2020.11.012

Gaudine, A., LeFort, S. M., Lamb, M., & Thorne, L. (2011). Ethical conflicts with hospitals: The perspective of nurses and physicians. *Nursing Ethics*, *18*(6), 756–766. https://doi.org/10.1177/0969733011401121

Gigerenzer, G. (1996). On narrow norms and vague heuristics: A reply to Kahneman and Tversky (1996). *Psychological Review*, *103*(2), 592–596.

Gribben, L., & Semple, C. J. (2021). Factors contributing to burnout and work-life balance in adult oncology nursing: An integrative review. *European Journal of Oncology Nursing*, *50*, 101887. https://doi.org/10.1016/j.ejon.2020.101887

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. https://doi.org/10.1177/1525822X05279903

Hadjistavropoulos, T., Malloy, D. C., Sharpe, D., & Fuchs-Lacelle, S. (2003). The ethical ideologies of psychologists and physicians: A preliminary comparison. *Ethics & Behaviour*, *13*(1), 97–104. https://doi.org/10.1207/S15327019EB1301_11

Hagan, T., & Smail, D. (1997). Power-mapping—I. Background and basic methodology. *Journal of Community & Applied Social Psychology*, *7*(4), 257–267. https://doi.org/10.1002/(SICI)1099-1298(199709)7:4<257::AID-CASP428>3.0.CO;2-P

Hamric, A. B. (2000). Moral distress in everyday ethics. *Nursing Outlook*, *48*(5), 199–201. https://doi.org/10.1067/mno.2000.110564

Hamric, A. B. (2012). Empirical research on moral distress: Issues, challenges, and opportunities. *HEC Forum*, *24*(1), 39–49. http://dx.doi.org/10.1007/s10730-012-9177-x

Hamric, A. B., & Blackhall, L. J. (2007). Nurse-physician perspectives on the care of dying patients in intensive care units: Collaboration, moral distress, and ethical climate. *Critical Care Medicine*, *35*(2), 422–429. https://doi.org/10.1097/01.CCM.0000254722.50608.2D

Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare Professionals. *AJOB Primary Research*, *3*(2), 1–9. https://doi.org/10.1080/21507716.2011.652337

Hannah, S. T., Avolio, B. J., & Walumbwa, F. O. (2011). Relationships between authentic leadership, moral courage, and ethical and pro-social behaviours. *Business Ethics Quarterly*, *21*(4), 555–578. https://doi.org/10.5840/beq201121436

Hazlegreaves, S. (2019, January 18). How can the NHS address the current staff retention crisis? *Open Access Government*. https://www.openaccessgovernment.org/nhs-staffing-retention-crisis/57201/

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

Hyatt, J. (2017). Recognizing moral disengagement and its impact on patient safety. *Journal of Nursing Regulation*, *7*(4), 15–21. https://doi.org/10.1016/S2155-8256(17)30015-7

Jameton, A. (1984). *Nursing practice: The ethical issues*. Prentice-Hall. https://repository.library.georgetown.edu/handle/10822/800986

Johnson, R. (1997). Examining the validity structure of qualitative research. *Education*, *118*(2), 282–292.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: An alternative nondiagnostic conceptual system. *Journal of Humanistic Psychology*, *1*(18). https://doi.org/10.1177/0022167818793289.

Kahneman, D. (1991). Judgement and decision making: A personal view. *Psychological Science*, *2*(3), 142–145.

Kahneman, D., & Tversky, A. (1984). Choices, values, and frames. *American Psychologist*, *39*(4), 341–350.

Kaidi, A., & Atun, D. R. (2017, August 16). Fixing the Recruiting and Retention Problems in Britain's NHS. *Harvard Business Review*. https://hbr.org/2017/08/fixing-the-recruiting-and-retention-problems-in-britains-nhs

Kampmeier, R. H. (1974). Final report on the "Tuskegee Syphilis Study". *Southern Medical Journal*, *67*(11), 1349–1353. https://doi.org/10.1097/00007611-197411000-00019

Kerridge, I. (2010). Ethics and EBM: Acknowledging bias, accepting difference and embracing politics. *Journal of Evaluation in Clinical Practice*, *16*(2), 365–373. https://doi.org/10.1111/j.1365-2753.2010.01412.x

Kim, H., Ji, J., & Kao, D. (2011). Burnout and physical health among social workers: A three-year longitudinal study. *Social Work*, *56*(3), 258–268. https://doi.org/10.1093/sw/56.3.258

Kimball, P. (2018). *When professional and person values collide: A thematic analysis of counselling students' developmental journey through an ethics course* [Dissertation, Liberty University].

https://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=2906&context=doctoral

Kinderman, P. (2007). Human rights and applied psychology. *Journal of Community & Applied Social Psychology*, *17*(3), 218–228. https://doi.org/10.1002/casp.917

Knapp, S., & VandeCreek, L. (2007). When values of different cultures conflict: Ethical decision making in a multicultural context. *Professional Psychology: Research and Practice*, *38*, 660–666. https://doi.org/10.1037/0735-7028.38.6.660

Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of Health Psychology*, *22*(1), 51–67. https://doi.org/10.1177/1359105315595120

Landau, R. (2000). Ethical dilemmas in general hospitals. *Social Work in Health Care*, *30*(4), 25–44. https://doi.org/10.1300/J010v30n04_03

Lavender, T. (2019). *The NHS Long Term Plan: DCP Commentary*. Division of Clinical Psychology. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/The-NHS-Long-Term-Plan.pdf

Lerner, G. H. (2004). *Conversation analysis: Studies from the first generation*. John Benjamins Pub. Co. https://search.ebscohost.com/login.aspx?direct=true&scope=site&db=nlebk&db=nlabk&AN=253163

Lokker, M. E., Swart, S. J., Rietjens, J. A. C., van Zuylen, L., Perez, R. S. G. M., & van der Heide, A. (2018). Palliative sedation and moral distress: A qualitative study of nurses. *Applied Nursing Research*, *40*, 157–161. https://doi.org/10.1016/j.apnr.2018.02.002

Lomis, K. D., Carpenter, R. O., & Miller, B. M. (2009). Moral distress in the third year of medical school; a descriptive review of student case reflections. *The American Journal of Surgery*, *197*(1), 107–112. https://doi.org/10.1016/j.amjsurg.2008.07.048

Lützén, K., Blom, T., Ewalds-Kvist, B., & Winch, S. (2010). Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nursing Ethics*, *17*(2), 213–224. https://doi.org/10.1177/0969733009351951

Magnavita, J. J. (2016). *Clinical decision making in mental health practice.* American Psychological Association. https://doi.org/10.1037/14711-000

Malach-Pines, A. (2005). The Burnout Measure, Short Version. *International Journal of Stress Management*, *12*(1), 78–88. https://doi.org/10.1037/1072-5245.12.1.78

Marewski, J., & Gigerenzer, G. (2012). Heuristic decision making in medicine. *Dialogues in Clinical Neuroscience*, *14*(1), 77–89.

Martin, K. D., & Cullen, J. B. (2006). Continuities and extensions of ethical climate theory: A meta-analytic review. *Journal of Business Ethics*, *69*(2), 175–194.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *The Maslach Burnout Inventory* (3rd ed.). Consulting Psychologists Press.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396.

May, D. R., Chan, A. Y. L., Hodges, T. D., & Avolio, B. J. (2003). Developing the moral component of authentic leadership. *Organizational Dynamics*, *32*(3), 247–260. https://doi.org/10.1016/S0090-2616(03)00032-9

McCarthy, J., & Gastmans, C. (2015). Moral distress: A review of the argument-based nursing ethics literature. *Nursing Ethics*, *22*(1), 131–152. https://doi.org/10.1177/0969733014557139

Meltzer, L., & Huckabay, L. (2004). Critical care nurses' perceptions of futile care and its effect on burnout. *American Journal of Critical Care*, *13*(3), 202–208. https://doi.org/10.4037/ajcc2004.13.3.202

Milgram, S. (1963). Behavioral Study of obedience. *The Journal of Abnormal and Social Psychology*, *67*(4), 371–378. https://doi.org/10.1037/h0040525

MIND. (2016, August 11). *Mind finds 'worrying' levels of stress among primary care staff*. MIND. https://www.mind.org.uk/news-campaigns/news/mind-finds-worrying-levels-of-stress-among-primary-care-staff/

Morgan, H. C. M., Randall, J., Lyons, A. J., Oliver, S., Saffer, J., Scott, J. M., & Nolte, L. (2019). Pebbles in palms: Counter-practices against despair. *Psychotherapy and Politics International*, *17*(1), 1–10. https://doi.org/10.1002/ppi.1481

Moser, M. R. (1988). Ethical conflict at work: A critique of the literature and recommendations for future research. *Journal of Business Ethics*, *7*(5), 381–387.

Mundasad, S. (2017, January 19). NHS staff shortages: Why so persistent? *BBC News*. https://www.bbc.com/news/health-38640068

Musto, L. C., Rodney, P. A., & Vanderheide, R. (2015). Toward interventions to address moral distress: Navigating structure and agency. *Nursing Ethics*, *22*(1), 91–102. https://doi.org/10.1177/0969733014534879

Musto, L., Schreiber, R., & Rodney, P. (Paddy). (2021). Risking vulnerability: Enacting moral agency in the is/ought gap in mental health care. *Journal* *of Advanced Nursing*, *77*(5), 2458–2471. https://doi.org/10.1111/jan.14776

Nathaniel, A. (2002). Moral distress among nurses. *Ethics and Human Rights*, *1*(3), 3–8.

National Institute for Health and Care Excellence. (2021). *Making decisions using NICE guidelines*. NICE. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/making-decisions-using-nice-guidelines

National Institute for Occupational Safety and Health. (2021). *Stress... At work*. Centers for Disease Control and Prevention. https://www.cdc.gov/niosh/docs/99-101/pdfs/99-101.pdf

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

NHS Race and Health Observatory. (2020, April 1). *NHS Race and Health Observatory's response to the report of the Commission on Race and Ethnic Disparities*. https://www.nhsrho.org/news/nhs-race-and-health-observatorys-response-to-the-report-of-the-commission-on-race-and-ethnic-disparities/

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. McGraw-Hill Education (UK).

Nissly, J. A., Barak, M. E. M., & Levin, A. (2005). Stress, social support, and workers' intentions to leave their jobs in public child welfare. *Administration in Social Work*, *29*(1), 79–100. https://doi.org/10.1300/J147v29n01_06

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847. https://doi.org/10.1177/1609406917733847

O'Connor, K., Muller Neff, D., & Pitman, S. (2018). Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants. *European Psychiatry*, *53*, 74–99. https://doi.org/10.1016/j.eurpsy.2018.06.003

O'Donohue, W., & Henderson, D. (1999). Epistemic and ethical duties in clinical decision-making. *Behaviour Change*, *16*(1), 10–19. https://doi.org/10.1375/bech.16.1.10

Oliver, D. (2018). Moral distress in hospital doctors. *BMJ : British Medical Journal*, *360*, 1–2. https://doi.org/10.1136/bmj.k1333

Paltridge, B. (2012). *Discourse analysis: An introduction* (2nd ed). Continuum.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed). Sage Publications.

Pauly, B., Varcoe, C., Storch, J., & Newton, L. (2009). Registered nurses' perceptions of moral distress and ethical climate. *Nursing Ethics*, *16*(5), 561–573. https://doi.org/10.1177/0969733009106649

Peters, M. D. J., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015). Guidance for conducting systematic scoping reviews. *International Journal of Evidence-Based Healthcare*, *13*(3), 141–146. https://doi.org/10.1097/XEB.0000000000000050

Pettifor, J. L. (2004). Personal reflections on 60 years of psychology: Many roads to truth. *Canadian Psychology*, *45*(1), 11–15.

Pfeiffer, A. M., Whelan, J. P., & Martin, J. M. (2000). Decision-making bias in psychotherapy: Effects of hypothesis source and accountability. *Journal of Counseling Psychology*, *47*(4), 429–436. https://doi.org/10.1037/0022-0167.47.4.429

Piers, R. D., Van den Eynde, M., Steeman, E., Vlerick, P., Benoit, D. D., & Van Den Noortgate, N. J. (2012). End-of-life care of the geriatric patient and nurses' moral distress. *Journal of the American Medical Directors Association*, *13*(1), 80-e7. https://doi.org/10.1016/j.jamda.2010.12.014

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

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *BMJ : British Medical Journal*, *320*(7227), 114–116.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, *2*, 281–307. https://doi.org/10.1191/1478088705qp045oa

Randall, J. (2020). *Surviving clinical psychology: Navigating personal, professional and political selves on the journey to qualification*. Routledge.

Rathert, C., Ishqaidef, G., & May, D. R. (2009). Improving work environments in health care: Test of a theoretical framework. *Healthcare Management Review*, *34*(4), 334–343. https://doi.org/10.5465/ambpp.2008.33659871

Rathert, C., May, D. R., & Chung, H. S. (2016). Nurse moral distress: A survey identifying predictors and potential interventions. *International Journal of Nursing Studies*, *53*, 39–49. https://doi.org/10.1016/j.ijnurstu.2015.10.007

Reiss, D., & Kirtchuk, G. (2009). Interpersonal dynamics and multidisciplinary teamwork. *Advances in Psychiatric Treatment*, *15*(6), 462–469. https://doi.org/10.1192/apt.bp.107.004796

Riley, S. C. E., Sims-Schouten, W., & Willig, C. (2007). The case for critical realist discourse analysis as a viable method in discursive work. *Theory & Psychology*, *17*(1), 137–145. https://doi.org/10.1177/0959354307073156

Ringer, A. (2013). Researcher-participant positioning and the discursive work of categories: Experiences from fieldwork in the mental health services. *Qualitative Studies*, *4*(1), 1–20. https://doi.org/10.7146/qs.v4i1.8126

Robitscher, J. B. (1980). *The powers of psychiatry*. Houghton Mifflin. https://repository.library.georgetown.edu/handle/10822/785510

Robson, C. (2002). *Real world research: A resource for social scientists and practitioner-researchers* (2nd ed). Blackwell Publishers.

Rodney, P. A. (2017). What we know about moral distress. *The American Journal of Nursing*, *117*(2), S7–S10.

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curtolo, C., Tansella, M., Thornicroft, G., & Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, *200*(2), 933–938. https://doi.org/10.1016/j.psychres.2012.07.029

Sanderson, C., Sheahan, L., Kochovska, S., Luckett, T., Parker, D., Butow, P., & Agar, M. (2019). Re-defining moral distress: A systematic review and critical re-appraisal of the argument-based bioethics literature. *Clinical Ethics*, *14*(4), 195–210. https://doi.org/10.1177/1477750919886088

Scaturo, D. J., & McPeak, W. R. (1998). Clinical dilemmas in contemporary psychotherapy: The search for clinical wisdom. *Psychotherapy: Theory, Research, Practice, Training*, *35*(1), 1–12. https://doi.org/10.1037/h0087726

Schwenzer, K. J., & Wang, L. (2006). Assessing moral distress in respiratory care practitioners. *Critical Care Medicine*, *34*(12), 2967–2973. https://doi.org/10.1097/01.CCM.0000248879.19054.73

Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Psychology*, *17*(1), 101–124. https://doi.org/10.1177/0959354307073153

Smith, L., & Gilhooly, K. (2006). Regression versus fast and frugal models of decision-making: The case of prescribing for depression. *Applied Cognitive Psychology*, *20*(2), 265–274. https://doi.org/10.1002/acp.1189

Somerville, M. A. (2004). *Ethical canary: Science, society, and the human spirit*. McGill-Queen's Press - MQUP.

Spencer, L., & Ritchie, J. (2011). In pursuit of quality. In Harper, D., & Thompson, A. R. (Eds.). *Qualitative research methods in mental health and psychotherapy* (pp. 225–242). John Wiley & Sons, Ltd. https://doi.org/10.1002/9781119973249.ch16

Sporrong, S. K., Höglund, A. T., & Arnetz, B. (2006). Measuring moral distress in pharmacy and clinical practice. *Nursing Ethics*, *13*(4), 416–427. https://doi.org/10.1191/0969733006ne880oa

Strous, R. D. (2007). Psychiatry during the Nazi era: Ethical lessons for the modern professional. *Annals of General Psychiatry*, *6*(1), 8. https://doi.org/10.1186/1744-859X-6-8

Suhonen, R., Stolt, M., Habermann, M., Hjaltadottir, I., Vryonides, S., Tonnessen, S., Halvorsen, K., Harvey, C., Toffoli, L., & Scott, P. A. (2018). Ethical elements in priority setting in nursing care: A scoping review. *International Journal of Nursing Studies*, *88*, 25–42. https://doi.org/10.1016/j.ijnurstu.2018.08.006

Tajfel, H., & Turner, J. (1979). An integrative theory of intergroup conflict. In Austin, W. G., & Worchel, S. (Eds.). *The Social Psychology of Intergroup Relations* (pp. 33–37). Brooks/Cole. http://ark143.org/wordpress2/wp-content/uploads/2013/05/Tajfel-Turner-1979-An-Integrative-Theory-of-Intergroup-Conflict.pdf

The Moral Injury Project. (2021). *What is Moral Injury*. https://moralinjuryproject.syr.edu/about-moral-injury/

The Nuffield Trust. (2020, February 29). *The NHS workforce in numbers*. https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers

Tiedje, L. B. (2000). Moral distress in perinatal nursing. *The Journal of Perinatal & Neonatal Nursing*, *14*(2), 36–43.

Tigard, D. W. (2018). Rethinking moral distress: Conceptual demands for a troubling phenomenon affecting health care professionals. *Medicine, Health Care and Philosophy*, *21*(4), 479–488. https://doi.org/10.1007/s11019-017-9819-5

Tigard, D. W. (2019). The positive value of moral distress. *Bioethics*, *33*, 601–608. https://doi.org/10.1111/bioe.12564

Tracey, T., Wampold, B., Lichtenberg, J., & Goodyear, R. (2014). Expertise in psychotherapy: An elusive goal? *American Psychologist*, *69*(3), 1–12. https://doi.org/10.1037/a0035099

Truscott, D., & Crook, K. (2004). Psychologists' duty to protect. *The CAP Monitor*, *Winter*(18), 1–4.

Tversky, A., & Kahneman, D. (1974). Judgment under uncertainty: Heuristics and biases. *Science*, *185*, 1124–1171.

Tversky, A., & Kahneman, D. (1981). The framing of decisions and the psychology of choice. *Science*, *211*, 453–458.

Tversky, A., & Shafir, E. (1992). Choice under conflict: The dynamics of deferred decision. *Psychological Science*, *3*(6), 358–361.

Varcoe, C., Pauly, B., Webster, G., & Storch, J. (2012). Moral distress: Tensions as springboards for action. *HEC Forum*, *24*(1), 51–62. http://dx.doi.org/10.1007/s10730-012-9180-2

Weinberg, M. (2009). Moral distress: A missing but relevant concept for ethics in social work. *Canadian Social Work Review*, *26*(2), 139–151.

Whitehead, P. B., Herbertson, R. K., Hamric, A. B., Epstein, E. G., & Fisher, J. M. (2015). Moral distress among healthcare professionals: Report of an institution-wide survey. *Journal of Nursing Scholarship*, *47*(2), 117–125. https://doi.org/10.1111/jnu.12115

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

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in* *psychology, Vol 1: Foundations, planning, measures, and psychometrics.* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

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

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

Wood, N., & Patel, N. (2017). On addressing 'Whiteness' during clinical psychology training. *South African Journal of Psychology*, *47*(3), 280–291. https://doi.org/10.1177/0081246317722099

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

Zahavi, D. (1999). *Self-awareness and alterity: A phenomenological investigation*. Northwestern University Press.

Zuzelo, P. (2007). Exploring the moral distress of registered nurses. *Nursing Ethics*, *14*(3), 344–359. https://doi.org/10.1177/0969733007075870

6. APPENDICIES

6.1. Appendix A: Literature Search Strategy

The search criteria for this scoping review was determined by the contents of the narrative review and the inclusion criteria for this study. An initial search was performed across several databases to refine search terms. Using the keywords, published, peer-reviewed work was searched for across electronic databases associated with psychology, sociology, philosophy and ethics, and medicine. These databases included EBSCO (PsycInfo, PsychARTICLES, CINAHC); Academic Search Complete; and Google Scholar. The terms ‘moral distress’, ‘psychology’, ‘burnout, ‘ethical dilemmas’, and ‘decision-making’ were used individually and in combination with one another. Following abstract readings, articles considered to be potentially relevant were obtained in their full text and incorporated into the review. Those considered relevant tended to speak to the emotional component of clinician’s experiences or considered the constructs and contexts that impacted upon these experiences. Citation searches were also carried out and the reference lists of key papers were hand-searched. The search took place between July 2020 and February 2021.

A total of 5921 articles were identified through the search, 1156 were screened, 97 duplicates were removed, and 80 full texts accessed; 14 articles remained and are spoken to in the scoping review. All papers identified by the search, meeting the inclusion criteria, were downloaded and organised using the reference management software Zotero. Reasons for exclusion included a sole focus on paediatric settings, exploration of MD outside of a healthcare context, not relating to clinical practice, being written in a language other than English, and full texts not being available. Theses and dissertations, unpublished, were also excluded. Due to the scarcity of literature examining the moral experience of clinical psychologists in the UK, papers speaking to this outside of the UK were included. Similar experiences may be described in papers not included, due to their publication in ‘grey literature’ for example, however I sought to explore all literature dealing with the concept of moral distress itself.

The questions guiding this scoping review were:

- What current understanding of ‘moral distress’ in clinical practice is there?
- What is the clinical psychology experience of ‘moral distress’?

The following search terms were used concurrently with the terms “moral distress”, and/or “burnout” with the Boolean operators ‘AND’ and ‘OR’:

- Psychology
- Ethical dilemmas
- Decision-making

Limiters included:

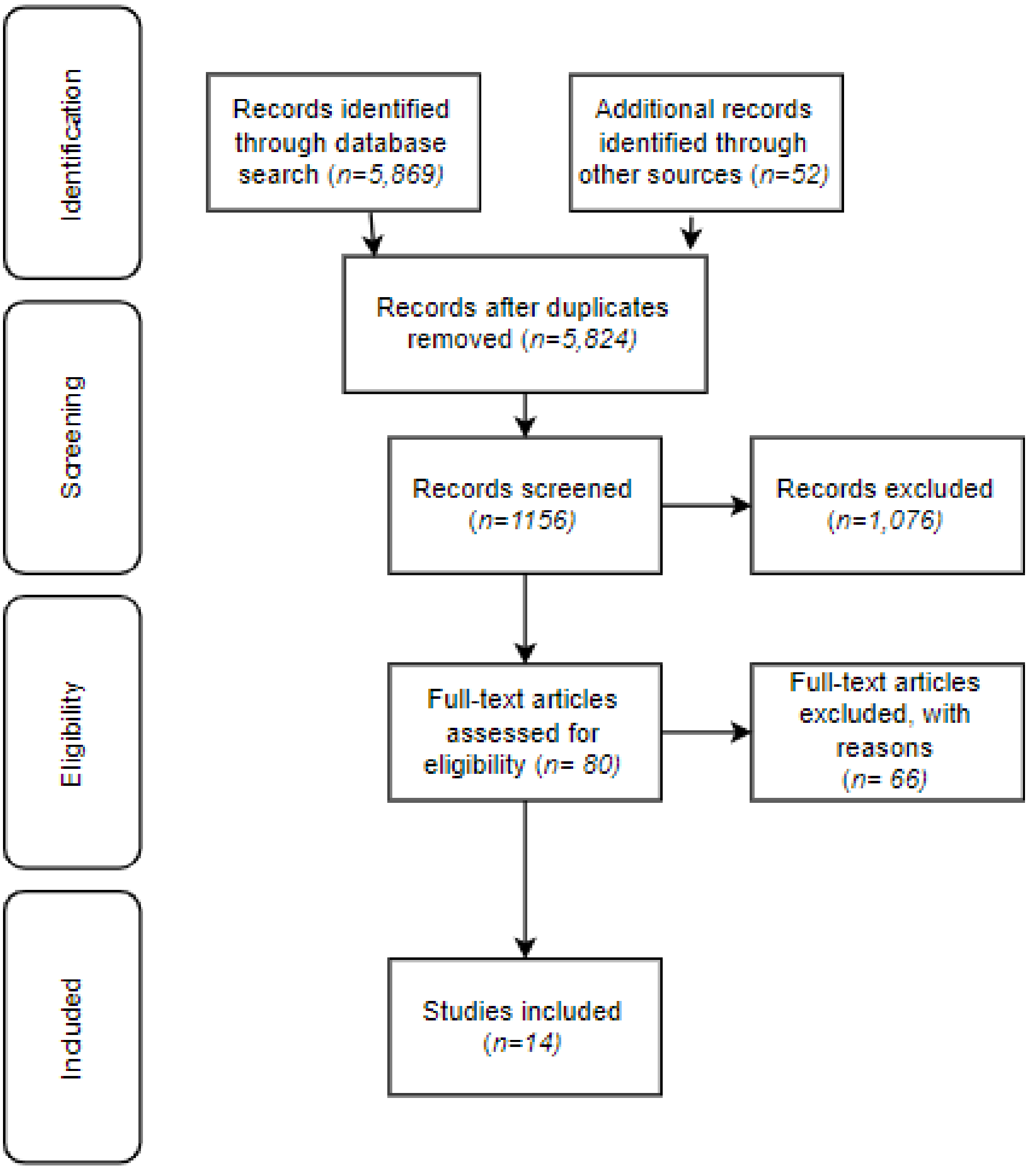
- Title and abstract only
- English language only

The following databases were used for the search:

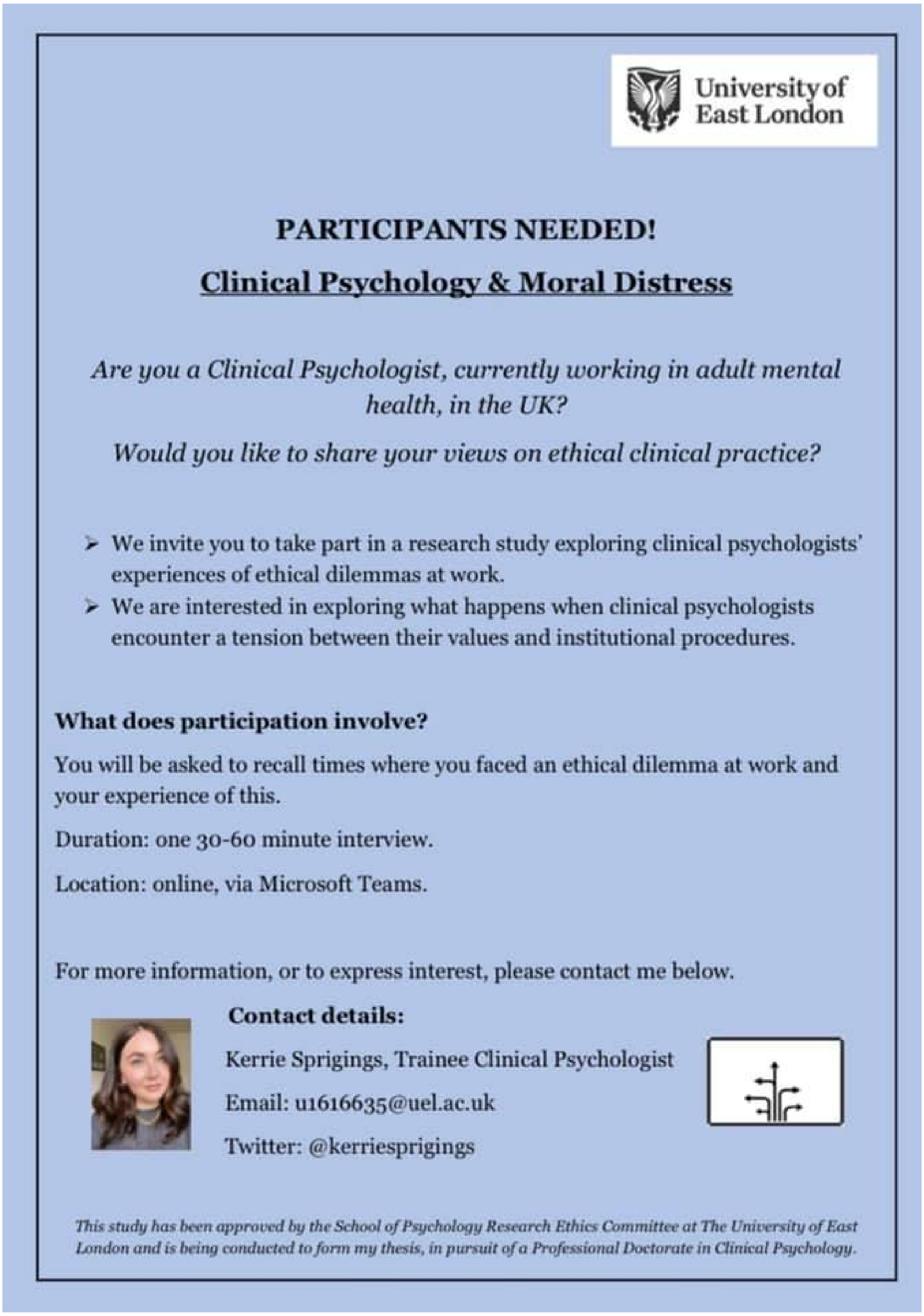
- EBSCO: PsychINFO, PsychARTICLES, Academic Search Complete, and CINAHL
- Science Direct
- Google Scholar
- Open-source research repositories included the UEL Research Repository

6.2. Appendix B: Scoping Review Process

Illustrated by a chart adapted from Peters et al. (2015).



6.3. Appendix C: Recruitment Poster



University of East London

PARTICIPANTS NEEDED!

Clinical Psychology & Moral Distress

Are you a Clinical Psychologist, currently working in adult mental health, in the UK?

Would you like to share your views on ethical clinical practice?

- We invite you to take part in a research study exploring clinical psychologists' experiences of ethical dilemmas at work.
- We are interested in exploring what happens when clinical psychologists encounter a tension between their values and institutional procedures.

What does participation involve?

You will be asked to recall times where you faced an ethical dilemma at work and your experience of this.

Duration: one 30-60 minute interview.

Location: online, via Microsoft Teams.

For more information, or to express interest, please contact me below.

Contact details:

Kerrie Sprigings, Trainee Clinical Psychologist

Email: u1616635@uel.ac.uk

Twitter: @kerriesprigings

This study has been approved by the School of Psychology Research Ethics Committee at The University of East London and is being conducted to form my thesis, in pursuit of a Professional Doctorate in Clinical Psychology.

6.4. Appendix D: Debrief Sheet

PARTICIPANT DEBRIEF SHEET

‘Clinical psychologists and moral distress’.

Thank you for participating in my research study on ‘clinical psychologists and moral distress’. This letter offers information that may be relevant in light of you having now taken part.

What if you have been negatively affected by taking part?

It is not anticipated that you will have been negatively affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that participating 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 helpful for obtaining information and support:

- You can locate your local IAPT (Improving Access to Psychological Therapies) service online https://www.england.nhs.uk/mental-health/adults/iapt/ or ask your GP to refer you
- SANE: a UK-wide charity offering emotional support and information via their helpline, textcare, and online support forum http://www.sane.org.uk 0300 304 7000 (4:30pm – 10:30pm daily)

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

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

Kerrie Sprigings, email: u1616635@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact my research supervisor, Dr Kenneth Gannon, at the School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: k.n.gannon@uel.ac.uk

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

6.5. Appendix E: Semi-Structured Interview Schedule

Semi-structured Interview Schedule

'Clinical psychology and moral distress'.

Beginning the interview: revisiting consent, confidentiality, and right to withdraw. Set time limit and offer to answer any questions before proceeding.

> Your involvement with this study, and the data you provide, will remain confidential. Only my supervisor and I will have access to the data, and my supervisor will view your data only once it has been anonymised and you have been given a pseudonym. You have the right to withdraw from the study, and this interview, at any time and with no repercussions. I ask only that you withdraw before analysis of the data begins on February 1st 2021. We have up to an hour allotted for today, do you have any questions before we begin?

Opening questions:

- How long have you been a qualified clinical psychologist?
- What adult mental health setting do you currently work in?
- Do you have any managerial responsibility?
- What comes to mind when you think about the professional values of clinical psychology?
  - Are these enshrined anywhere?
- Can you tell me about the relationship between your own personal values and what is required of you in your professional role?

Example situation:

- During your career, have there been times you have been unable to provide the support you felt would be most 'right' or ethical?
  - Can you give me an example?
  - What was 'getting in the way'?
  - What value or principle was compromised?
  - What was your emotional experience of this?
  - How did you resolve this?
  - Were you satisfied with the outcome? Why/why not?
  - Would 'should' have been done different?

- Are there particular situations that arise in your workplace that compromise your values?
- What is it like to experience this conflict between your values and the institution's procedures?
- How do you manage this?

General experience:

- Is your experience of being a clinical psychologist impacted by such ethical dilemmas? If yes, in what way?
- To what extent do you draw on moral or ethical principles when making decisions about clinical care?
  - Do you think psychology colleagues do similarly?
- On a day-to-day basis, what supports your ethical practice?
- Where does the responsibility for ensuring psychology is ethical lie?
- What amount of power to affect decisions would you say you have?
- Have you had any experience with clinical ethics committees?

6.6. Appendix F: Transcription Notation Key

(.) Pause

(seconds) timing of significant pauses in number of seconds

[inaudible] inaudible section of recording

[laughter] laughter during the interview

[text] clarifying information, context or interruptions

… Indicates removal of text not relevant to the quote / point

6.7. Appendix G: Ethical Application and Approval

UNIVERSITY OF EAST LONDON
School of Psychology

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

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

1. Completing the application

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

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

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

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

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

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

1.6 The following attachments should be included if appropriate:

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

2. Your details

2.1 Your name: Kerrie Sprigings

2.2 Your supervisor's name: Dr Kenneth Gannon

2.3 Title of your programme: Professional Doctorate in Clinical Psychology

2.4 UEL assignment submission date (stating both the initial date and the resit date): May 2021

3. Your research

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

3.1 The title of your study: 'Clinical psychology and moral distress'.

3.2 Your research question:

What situations or experiences can make psychologists feel their personal or professional values are compromised?
How do clinical psychologists experience conflicts between their values and institutional procedures and how do they attempt to manage them?

3.3 Design of the research: qualitative methodology will be employed in order to gather in-depth accounts of individual perspectives on the research questions.

3.4 Participants: participants will be qualified clinical psychologists working in adult mental health services.

3.5 Recruitment: snowball sampling will be employed for recruitment. The study will be advertised on social media platforms with requests for relevant networks to share it onward, and also sent to personal social networks for distribution. Participant Information Sheets will be sent to any interested party by email; these include my email address and prospective participants will be encouraged to email me if they have any queries.

3.6 Measures, materials or equipment: due to the current COVID-19 situation and social distancing measures, interviews will take place via video call on Microsoft Teams and so a laptop or smartphone will be required. Interviews can be recorded within Teams and also, as a back-up, onto a password-protected Dictaphone. These files will be then be transferred to and stored on a password-protected computer in encrypted folders. They will be backed-up and saved to my University of East London OneDrive cloud storage account. If required and if possible a transcription pedal will be obtained from the University's Psychology department technicians. The software programme 'NVivo' will aid organising coding during analysis.

3.7 Data collection: semi-structured interviews will be conducted on a one-to-one basis, lasting approximately one hour each. They will take place remotely, as described above; I will offer to hold interviews over the phone, should participants not wish to attend a video call. Participants will be asked to recall a clinical case and a decision they/the team had to make regarding an ethical dilemma, to ground the discussion and questions in a concrete context.

3.8 Data analysis: thematic analysis will be employed for the interpretation of participants' data, seeking to identify any patterns or themes within their interviews in order to answer the research question. I will follow the Braun and Clarke (2006) process for coding.

4. Confidentiality and security

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

4.1 Will participants data be gathered anonymously? No.

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

Participants will be advised that they are not required to answer all questions during the interview if they do not wish to. During transcription all participants will be given pseudonyms and no identifying information will be kept once analysis begins.

4.3 How will you ensure participants details will be kept confidential?

Participant names and contact details will be stored separately and securely from the audio files and transcripts and password protected. Names and contact details will be retained until the analysis has begun and then will be permanently deleted. They will not be linked with the analysis and will not appear in any outputs, including the thesis.

4.4 How will the data be securely stored?

The audio recordings and the transcriptions will be stored in password-protected files on a password-protected computer and password-protected cloud storage – OneDrive, University of East London account. Recordings will be transferred from the Dictaphone to the computer and OneDrive immediately after each interview and will then be deleted from the Dictaphone. Once the thesis has been submitted and examined the recordings will be securely deleted and only the anonymised transcripts retained.

4.5 Who will have access to the data?

Myself, and my research supervisor Dr Kenneth Gannon, will be the only people able to access the data. However, Dr Gannon will see the data only in its anonymised form.

4.6 How long will data be retained for?

All transcripts will be destroyed two years after submission of the thesis; other data will have been deleted before this (see above).

5. Informing participants

Please confirm that your information letter includes the following details:

5.1 Your research title: ☒

5.2 Your research question: ☒

5.3 The purpose of the research: ☒

5.4 The exact nature of their participation. This includes location, duration, and the tasks etc. involved: ☒

5.5 That participation is strictly voluntary: ☒

5.6 What are the potential risks to taking part: ☒

5.7 What are the potential advantages to taking part: ☒

5.8 Their right to withdraw participation (i.e., to withdraw involvement at any point, no questions asked ☒

5.9 Their right to withdraw data (usually within a three-week window from the time of their participation ☒

5.10 How long their data will be retained for: ☒

5.11 How their information will be kept confidential: ☒

5.12 How their data will be securely stored: ☒

5.13 What will happen to the results/analysis: ☒

5.14 Your UEL contact details: ☒

5.15 The UEL contact details of your supervisor: ☒

Please also confirm whether:

5.16 Are you engaging in deception? If so, what will participants be told about the nature of the research, and how will you inform them about its real nature. NO

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

Please see 4.3 to 4.6 above

5.18 Will participants be paid or reimbursed? If so, this must be in the form of redeemable vouchers, not cash. If yes, why is it necessary and how much will it be worth? NO

6. Risk Assessment

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

6.1 Are there any potential physical or psychological risks to participants related to taking part? If so, what are these, and how can they be minimised?
The topic of the interviews may be an emotive one, which may cause some emotional distress, however I am being transparent about what we will be discussing and so participants should not be caught off guard and by collecting the data via interviews I can monitor a participant's response to the questions

and cease the interview if I suspect it may be too difficult, or offer breaks if that would be helpful.

6.2 Are there any potential physical or psychological risks to you as a researcher? If so, what are these, and how can they be minimised?
When asked to discuss a specific ethical dilemma they have faced during their interview what a participant shares may be emotional distressing for me to hear. I will seek to manage this through supervision.

6.3 Have appropriate support services been identified in the debrief letter? If so, what are these, and why are they relevant?
The debrief letter includes weblink for locating local IAPT services and the SANE helpline. The information for an organisation that supports clinical psychologists with lived experience of poor mental health will be added if permission granted by the group.

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

Data collection is occurring remotely, online via video calls and telephone

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 cor NA d:

6.5 Does the research take place outside the UK? If so, where? No.

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

However, please also note:

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

to be signed by the Head of School. However, if not deemed low risk, it must be signed by the Head of School (or potentially the Vice Chancellor).

- Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.

7. Disclosure and Barring Service (DBS) certificates

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

YES / [✓ **NO**]

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

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

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

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

7.4 If participants are under 16, their information letters consent form, and debrief form need to be written in age-appropriate language. Please tick to confirm that you have done this ☐

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

understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children click here.

8. Other permissions

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

9.1

YES / [✓ 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. *This is what I will be doing
- IRAS approval is not required for research involving NHS employees when data collection will take place off NHS premises, and when NHS employees are not recruited directly through NHS lines of communication. This means that NHS staff can participate in research without HRA approval when a student recruits via their own social or professional networks or through a professional body like the BPS, for example.

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

[✓ YES] / NO

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

YES / **<u>NO</u>**

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

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

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

9. Declarations

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

Student's name (typed name acts as a signature): KERRIE SPRIGINGS

Student's number: Date: 15/07/2020

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

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Hebba Haddad

SUPERVISOR: Kenneth Gannon

STUDENT: Kerrie Sprigings

Course: Professional Doctorate in Clinical Psychology

Title of proposed study: Clinical psychology and moral distress

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)*:

3.4 – (roughly) how many participants?

Major amendments required *(for reviewer):*

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

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

Student's name *(Typed name to act as signature):* Kerrie Sprigings
Student number:

Date: 01.08.2020

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

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

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

YES

Please request resubmission with an adequate risk assessment

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

☐ HIGH

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

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

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

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

Date: 22.07.20

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

6.8. Appendix H: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

‘***Clinical psychology and moral distress’.***

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 some time to read the following information carefully.

Who am I?

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

What is the research?

I am conducting research exploring clinical psychologists’ experiences of ethical dilemmas in their practice.

Why have you been asked to participate?

You have been invited to participate in my research as you are a clinical psychologist working in adult mental health in the UK. I am not looking for ‘experts’ on the topic of ethics, you will not be judged or personally analysed in any way, and you will be treated with respect.

What will your participation involve?

If you agree to participate, we would carry out an interview which would last approximately one hour. The interview is intended to be similar in manner to an informal conversation but will be audio recorded. You will be asked to recall clinical cases where you or your team faced an ethical dilemma; I will then ask you questions regarding your experience of this.

Due to the COVID-19 restrictions, interviews will take place over Microsoft Teams.

Will what you say remain confidential?

Yes, your privacy and safety will be prioritised. The interview will be audio-recorded and transcribed, and in the transcript you will be given a pseudonym. You are not required to answer all questions asked and you can stop the interview at any time. In the event you tell me that you or someone else is at risk of harm I may need to let someone else (e.g. my supervisor) know but, if possible, I would try to discuss this with you first.

What will happen to the information that you provide?

The audio recording and the transcripts will be stored in password-protected files on a password-protected computer and password-protected Cloud storage - OneDrive. No-one other than my supervisor will have access to these files, and they will not know your name. When I write my thesis, I may use quotes from your interview but you will only be referred to by a pseudonym and nothing that might identify you will be included; the same will apply to any subsequent articles or reports published.

Your name and contact details will be stored separately (and securely) from the audio files and transcripts; these files will be destroyed two years after the completion of the study. The data gathered for this study will be retained in accordance with the University's Data Protection Policy.

What if you want to withdraw?

You will be free to leave the interview at any time and may also ask any questions throughout the process. There is the potential for some distress, were you to find the topic of discussion difficult, however I aim to support you during the process and it is hoped your participation may help to increase our understanding of the topic whilst providing an interesting opportunity to talk about your views.

You should not feel under any obligation to take part in this study and are free to withdraw from the research at any time without explanation, disadvantage or consequence. However, I must ask that you contact me to withdraw before analysis of the data begins on 1st February 2021.

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.

Contact details

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

Kerrie Sprigings, email: u1616635@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact my research supervisor, Dr Kenneth Gannon, at the School of Psychology, University of East London, Water Lane, London E15 4LZ. Email: k.n.gannon@uel.ac.uk

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

6.9. Appendix I: Consent Form

CONSENT TO PARTICIPATE

‘Clinical psychology and moral distress’.

Please tick to confirm you have read and understand the following:

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

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

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

Participant’s name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s signature

………………………………………………………………………………………..

Researcher’s name (BLOCK CAPITALS)

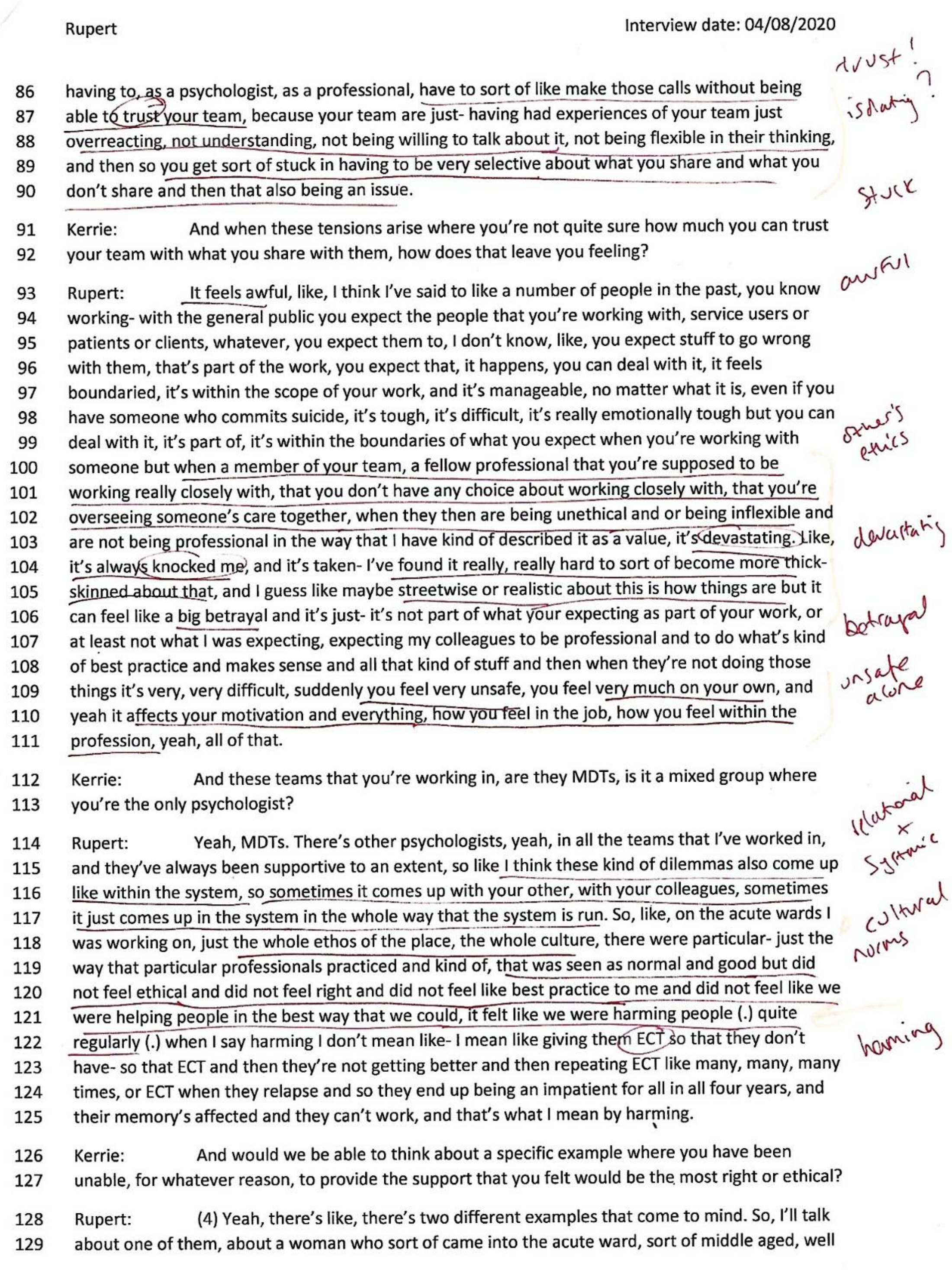
KERRIE SPRIGINGS

Researcher’s signature

…………………………………………………………………………………………

Date: ……………………………

6.10. Appendix J: Coded Extract



Rupert Interview date: 04/08/2020

having to, as a psychologist, as a professional, have to sort of like make those calls without being able to trust your team, because your team are just- having had experiences of your team just overreacting, not understanding, not being willing to talk about it, not being flexible in their thinking, and then so you get sort of stuck in having to be very selective about what you share and what you don't share and then that also being an issue.

distrust!

isolating?

stuck

Kerrie: And when these tensions arise where you're not quite sure how much you can trust your team with what you share with them, how does that leave you feeling?

Rupert: It feels awful, like, I think I've said to like a number of people in the past, you know working- with the general public you expect the people that you're working with, service users or patients or clients, whatever, you expect them to, I don't know, like, you expect stuff to go wrong with them, that's part of the work, you expect that, it happens, you can deal with it, it feels boundaried, it's within the scope of your work, and it's manageable, no matter what it is, even if you have someone who commits suicide, it's tough, it's difficult, it's really emotionally tough but you can deal with it, it's part of, it's within the boundaries of what you expect when you're working with someone but when a member of your team, a fellow professional that you're supposed to be working really closely with, that you don't have any choice about working closely with, that you're overseeing someone's care together, when they then are being unethical and or being inflexible and are not being professional in the way that I have kind of described it as a value, it's devastating. Like, it's always knocked me, and it's taken- I've found it really, really hard to sort of become more thick-skinned about that, and I guess like maybe streetwise or realistic about this is how things are but it can feel like a big betrayal and it's just- it's not part of what your expecting as part of your work, or at least not what I was expecting, expecting my colleagues to be professional and to do what's kind of best practice and makes sense and all that kind of stuff and then when they're not doing those things it's very, very difficult, suddenly you feel very unsafe, you feel very much on your own, and yeah it affects your motivation and everything, how you feel in the job, how you feel within the profession, yeah, all of that.

awful

other's ethics

devastating

betrayal

unsafe alone

Kerrie: And these teams that you're working in, are they MDTs, is it a mixed group where you're the only psychologist?

Rupert: Yeah, MDTs. There's other psychologists, yeah, in all the teams that I've worked in, and they've always been supportive to an extent, so like I think these kind of dilemmas also come up like within the system, so sometimes it comes up with your other, with your colleagues, sometimes it just comes up in the system in the whole way that the system is run. So, like, on the acute wards I was working on, just the whole ethos of the place, the whole culture, there were particular- just the way that particular professionals practiced and kind of, that was seen as normal and good but did not feel ethical and did not feel right and did not feel like best practice to me and did not feel like we were helping people in the best way that we could, it felt like we were harming people (.) quite regularly (.) when I say harming I don't mean like- I mean like giving them ECT so that they don't have- so that ECT and then they're not getting better and then repeating ECT like many, many, many times, or ECT when they relapse and so they end up being an impatient for all in all four years, and their memory's affected and they can't work, and that's what I mean by harming.

relational × systemic

cultural norms

harming

Kerrie: And would we be able to think about a specific example where you have been unable, for whatever reason, to provide the support that you felt would be the most right or ethical?

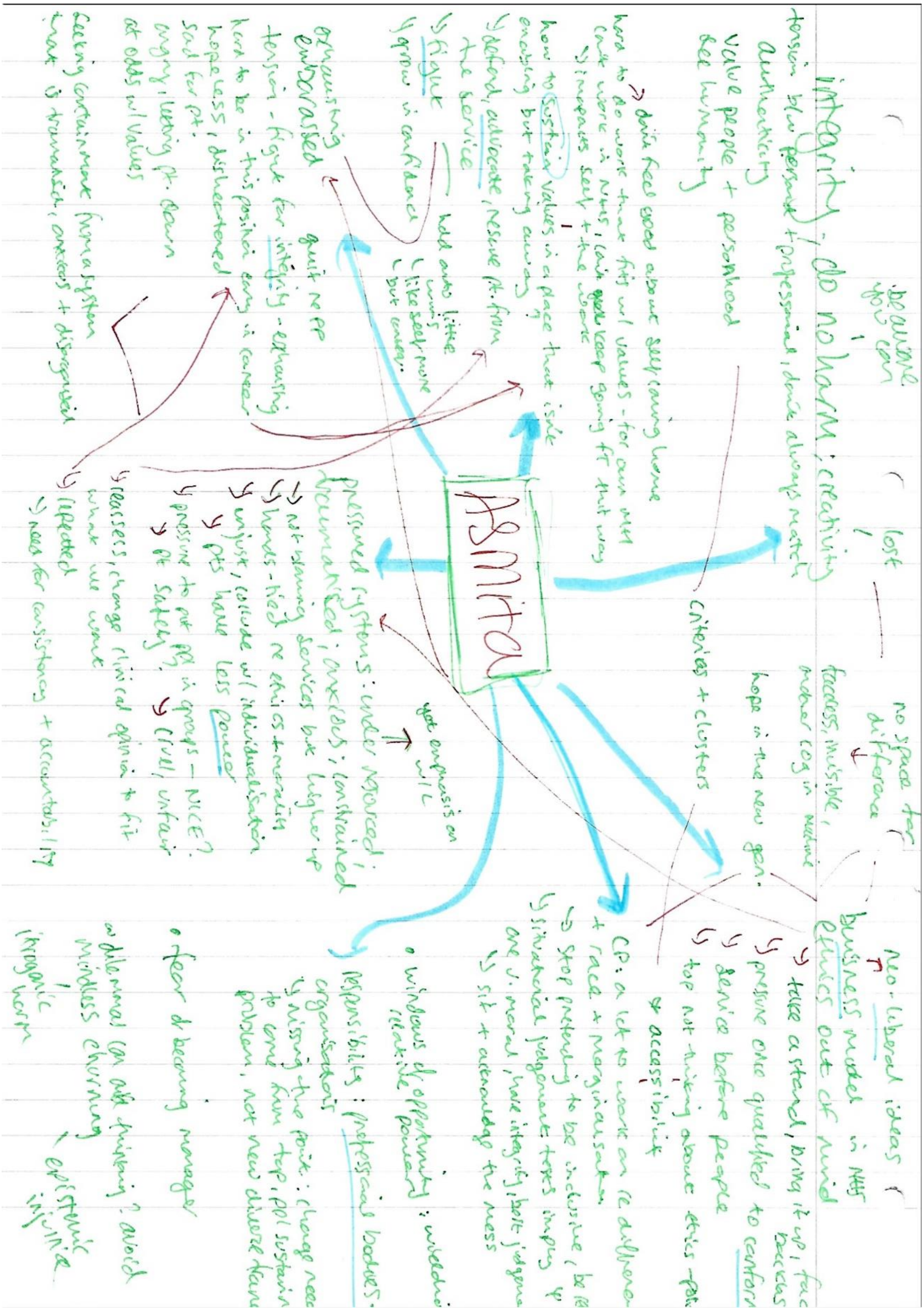
Rupert: (4) Yeah, there's like, there's two different examples that come to mind. So, I'll talk about one of them, about a woman who sort of came into the acute ward, sort of middle aged, well

6.11. Appendix K: List of Codes

Codes	
Obligation	BPS guidelines
Responsibility	HCPC registration
Idea of CPs a moral	BPS ineffective org
Learning experiences narrative	Frustration with BPS
Professions track record	BPS Code of Ethics, binding?
Ethics is taboo, political	BPS as authority, yet voluntary membership
No cohesion, individual readings	Problematic; messy
Dilemma in the profession	Leadership confusion and dissatisfaction
Psychology prescribers	Uncomfortable changes in profession
Force/coercion to be something other	CPs as cheap psychiatrists, handmaidens
Integrity	Want to help
Respect	Authenticity, genuineness
Do no harm	Advocacy
Confidentiality	Valuing personhood
Trustworthiness	Seeing humanity
Accessibility	Honesty
Person-centred care	Reflection
Therapeutic relationship	Competent decision-making
Adherence to guidelines	Evidence-based practice
Doing the right thing	Kindness and compassion
Collaboration	Client as expert
Diversity	Critical lens (NICE, diagnostics)
Socialism	
Need for change from the top	Waiting lists
Overwhelmed	MDT culture
Traumatised systems	Under-resourced
Ethics out of mind	Services not for service-users
Medical model	Psychiatric power and influence
Unethical practice of others	Inflexible thinking
Stuck-ness, repetition	Dis/trust within MDT
Cultural norms & harming	Dilemmas in system; dilemmas between people
ECT	On your own, isolated, lone fighter
Litigious society and defensive practice	Consequences for patients
Change unwanted, threatening, resisted	Impact on sense of job & profession
Crisis	Management mandate
Patients not humans	The unconscious at work
Practice as taught	Dysfunctional systems
Fight	Service's moral compass
Advocate	Marginalisation
Predict, expect conflict	Witnessing unethical practice / non-evidence decisions
Power imbalances	Patient exp of power
Splits	Causality and formulation tensions
Concrete ceiling	Preference for shortcuts
Whistle-blower's unwanted	Mistreatment of patients
Angry management	Outdated
Covertness	Ethical high road not taken

Deprivation	Reciprocal attacks
Aggression	NICE guidelines
NHS machine	Compromising decisions
COVID as exacerbator	Manage pressure by implementing barriers
Social care	Maslow’s hierarchy
Weighing up	Ethics of providing therapy during instability
Struggle	Powerlessness
Maddening	Hopelessness
Betrayal	Trying your best
Not sustainable	Just survive, carry on
Embarrassed	Detach, cut off, to manage
Ethical pull to keep going	Distance for self-preservation
Pressure to conform	Fight
Faceless, invisible, voiceless	Exhausting
Unjust	Cruel, unfair
Sadness	Anger
Letting patient down	Disheartening
Guilt	Scared
Compassion burnout	Over values overshadowed
Moderating self, outrage, behaviour	Family & relationships suffer
Anxiety, physically felt	Shouted down
Rejection	Dread, premonitions
Signed off, stress	Nothing changes, left empty
Painful, uncomfortable	Worry
Horrible, crap	Demoralising
Tearful	Mortifying, but reality
Cognitive dissonance	Slog
Intent to leave NHS	Draw of private practice
Reality/state of NHS	Leadership posts
Not sustainable	Accumulative effect
NHS business model	Neo-liberal ideas
Fight	Cog in a machine
Values not enabled, taken away	Hope for new generation
Collusion	Practice at odds with values
Keep trying, or leave	NHS bad for own mental health
Experience of Trust	NHS as identity marker
Awareness of privilege	Survivor’s guilt (class)
Depressing	Deflating
Fear of who may become	NHS years like dog year
Not CP thought they’d be	Hard to speak on
NHS takes vs NHS gives	Tipping point, walk away
Wield power in line with values	Jump on opportunities to work in values
ACT; CFT; social identity theory	Hold onto little wins/golden moments
Values-based approach	Recheck, rebalance, reconnect
Confidence building	Standing ground
Channel anger, make things better	Find allies
Small, local, change	Witness psychology working
Naughty, bend rules	Boundaries of what CPs ‘supposed’ to do
Sheepish vs grandiose	Suppression

6.12. Appendix L: Participant Spider Diagram



6.13. Appendix M: Thematic Map Refinement