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Professional Doctorate in Clinical Psychology

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Clinical Psychologist’s accounts of personal distress experienced within the profession: a discourse analysis

MAEVE LYNCH

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ABSTRACT

This study is concerned with ways that clinical psychologists construct the clinical psychologist's experience of distress, in relation to their professional identity, and the implications these constructions have for their social practices in relation to personal distress. Nine qualified clinical psychologists in practice in the NHS were interviewed using a semi-structured interview approach. Data from these interviews was analysed using a discourse-informed approach to Thematic Analysis. Three overarching themes were formed: psychologist's distress is constructed as part of the human condition, work with distress as a difficult and skilled practice, negotiating dilemmas of professional identity and role. These themes are discussed with reference to the socio-cultural and historical context of the profession of Clinical Psychology. In dialogue with literature and research pertaining to clinical psychologist's distress and help-seeking, and broader aspects of the institutional and professional context. Findings supported the view that the ways contemporary clinical psychologists in the NHS are positioned by language, social practices, and institutions can function to constrain clinical psychologists from talking about personal distress and accessing support. However, findings also indicated that there is scope in the contemporary clinical psychologist professional identity for resistance to discourses and practices that limit space for clinical psychologists to acknowledge their own vulnerability. Implications for Clinical Psychology practice and further research are considered. In conclusion, it is suggested that the acknowledgement of a human vulnerability by clinical psychologists can create the conditions for individual and collective action to respond to distress experienced by clinical psychologists, and their colleagues, in the NHS.

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1. **CHAPTER ONE: INTRODUCTION AND LITERATURE REVIEW**

1.1. Introduction

This thesis is concerned with ways in which clinical psychologists construct the clinical psychologist's experience of distress, in relation to their professional identity, and the implications these constructions have for their ways of being in relation to personal distress. Distress has been described as central to the work of the clinical psychologist by the British Psychological Society's (BPS) Division of Clinical Psychology (DCP). A DCP document entitled *The Core Purpose and Philosophy of the Profession* states: "Clinical Psychology aims to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and data" (Toogood, 2010, p.2). The original short document of the same name defined the purpose of the profession in the same way, and in terms of the functions: assessment, formulation, intervention, evaluation, and research (DCP, 2001). Thus, the work of the clinical psychologist has been defined, by the DCP, as having the intention to reduce distress and promote wellbeing through the carrying out of these functions within the health service. In the 2010 document, the listed functions of the clinical psychologist was expanded to include: transferable skills, personal and professional skills, communication and teaching skills, and service delivery skills (Toogood, 2010). The expansion of the functions of the clinical psychologist, over the ten years between documents, reflects a developmental change in the way the profession has come to define the means of achieving its stated purpose over time, with an increasing emphasis on functions that indicate an expectation that clinical psychologists will work within teams, and on skills denoting suitability for leadership positions within the health service.

The question that this thesis seeks to address is the scope that the professional identity of clinical psychologist allows for clinical psychologists to think about, and act in relation to, personal distress. Firstly, some of the dominant ways of conceptualising distress in the broader social context will be reviewed. This is followed by an exploration of the clinical psychologist's professional identity in terms of roles, with a particular interest in the scope each role allows for consideration of personal distress experienced by the clinical psychologist. Subsequently, the ways in which clinical psychologist's distress has been spoken about in literature, the public domain, and research will be considered. Lastly, existing research in the area will be reviewed, and perceived gaps in the evidence-base that prompted this study elaborated.

1.2. What is Distress?

Distress is a nebulous term, chosen for this research for its polysemic nature. In everyday talk, it can be used to refer to a broad range of human experiences of physical or emotional suffering. Synonyms for distress in the Oxford English Dictionary include: "anguish, suffering, pain, agony, ache, affliction, torment, torture, discomfort, heartache, heartbreak" ("Distress", 2019). In a mental health context, the term distress usually refers to experiences that might otherwise be called mental illness or psychopathology (Cromby, Harper & Reavey, 2013).

In the field of science, distress is thought about using models. As a body of knowledge and a clinical practice, the models of distress drawn on by Clinical Psychology are many and varied. These models construct distress in various ways, perhaps privileging different aspects of the experience of distress. Clinical psychologists learn about these models in their professional training and in interaction with other professionals in professional life. Constraints of space preclude consideration of all models of distress. As such, key overarching models will be considered in brief. It should be noted that, in contemporary clinical practice, clinical psychologists may draw on a number of models simultaneously and consider interactions (e.g., the Biopsychosocial model).

1.2.1. Somatogenic Model

The somatogenic model is perhaps the oldest model of distress. This model posits that distress is caused by the body. Ancient Greeks hypothesised various bodily causes of distress, for example, an imbalance of humors in the body (Simon, 1978). The modern-day medical model is an example of a somatogenic model. Distress is commonly conceptualised as psychopathology within a medical model framework and categorised into various psychiatric disorders according to symptoms (Cromby et al., 2013). As distress is hypothesised as caused by the imbalance of chemicals in the brain, the main treatments prescribed by this model are calculated to effect change in physiology, such as psychotropic medications prescribed to affect brain chemistry.

1.2.2. Psychogenic Model

According to the psychogenic model, distress arises out of the mind. The events that happen in the world are considered by this model, but the individual's interpretation of experience is privileged in hypothesising causes of distress.

Psychoanalysis is perhaps the oldest example of a psychogenic model, conceptualising distress as arising out of an unconscious conflict in the mind of the individual and the mind's attempts to manage this conflict through the operation of unconscious psychic defence mechanisms (Milton, Polmear & Fabricius, 2011). In a broad sense, a treatment based on a model informed by psychoanalytic theory entails the therapist helping the patient to become conscious of, and work through, the psychic conflicts that are hypothesised to be causing their distress (Milton et al., 2011). Transference and countertransference are key concepts in psychoanalytic theory. Transference is a hypothesised unconscious process through which the client's relationship with a significant attachment figure is transposed onto the relationship with the therapist (in the client's mind), countertransference is the hypothesised unconscious response of the therapist to the client (Lemma, 2003).

Cognitive Therapy is also an example of a psychogenic model, but one with a conceptualisation of distress very different from that of Psychoanalysis. While the existence of the unconscious is the central premise of Psychoanalysis, Cognitive Therapy does not theorise unconscious processes. Cognitive Therapy is heavily influenced by Stoic philosophy and the key technique, the rational weighing up of evidence for thoughts or beliefs, is modelled on the reputed practice of the Stoic philosopher Socrates (Robertson, 2010). An individual's distress is hypothesised to be caused by the way they are interpreting their experience (rather than the experience itself, as such), and that it can, thus, be managed by the rational weighing up of evidence by the individual to change their view of experience (Beck, 1976; Greenberger & Padesky, 1995).

1.2.3. Sociogenic Model

In this model, distress is viewed as caused by environmental and social influences, including an individual's social location (e.g., abuse, poverty and oppression), adverse life events, and interactions with other people.

Behaviourism could be considered the first sociogenic model, as distress is conceptualised as the outcome of behavioural learning (Cromby et al., 2013). Classic behavioural approaches restricted their theorising and intervention to that which could be directly observed; thus, the mind was not theorised. The focus in behavioural treatment is on observing and changing client behaviour to facilitate new learning and, thereby, reduce distress and improve functioning (Wolpe & Lazarus, 1966).

Systemic Family Therapy is another example of a sociogenic model of distress. Distress is conceptualised as the product of a system, a symptom of relationships and communication between members of the system (Dallos & Draper, 2010). Intervention is usually at the level of the system (i.e. the family) as, according to this model, systemic change is required to change an individual's experience of distress (Dallos & Draper, 2010).

1.3. Professional Identity

1.3.1. The Birth of a Profession

Clinical Psychology in Britain is a relatively young profession with a history that spans some 80 years. The history of British Clinical Psychology is the history of an academic discipline that evolved in a cultural and philosophical context dominated by empiricism and pragmatism, subsequently moving into an applied setting (Hall, Pilgrim & Turpin, 2015). Throughout the 20th Century, Clinical Psychology in Britain was a white middle-class male-dominated profession, with white men occupying the majority of leadership roles (Pilgrim & Patel, 2015). Clinical psychologists have offered a critique of the (white, western) patriarchal forms of leadership and knowledge that dominated the profession's beginnings (Nicolson & Ussher, 1992). It has been posited that dichotomies between mind and nature, reason and feeling, masculine and feminine, were embedded in the discourse of science and, hence, in the discourse of the applied science of psychology (Keller, 1985). In the 21st century, the majority of the Clinical Psychology workforce are white middle-class women (Patel, 2015), but women continue to be underrepresented in senior Clinical Psychology roles (Islam & Schlosser, 2016). Black and minority ethnic groups are also hugely underrepresented in the profession (Pilgrim & Patel, 2015). At the time of the profession’s beginnings and throughout its early years of development, the dominant British cultural script regarding personhood prised fortitude, stoicism, and restraint, with the metaphor of the stiff upper lip and the emblem of the British bulldog exemplifying cultural constructions of resilience (Furedi, 2002).

1.3.2. What is Professional Identity?

Social action was once viewed as governed by identity, with individual identity conceptualised as an essential, socialised, internal psychic phenomenon (Benwell & Stokoe, 2006). A Postmodern turn in the social sciences, while not disputing a relationship between social action and identity, has radically re-conceptualised identity as a public phenomenon, a construction or performance that takes place in discourse, social action, and embodied conduct (Benwell & Stokoe, 2006). Davidson and Patel (2009) suggest that the professional identity of the clinical psychologist can be understood as shaped by the way clinical psychologists are described and positioned in language, by social practices, and social institutions.

The identity of the clinical psychologist will be explored further with a consideration of Clinical Psychology roles and the constructions of professional identity these roles imply, with particular reference to the space these constructions allow for consideration of the emotional experience of the psychologist.

1.4. Clinical Psychology Roles and the Personhood of the Psychologist

The history of the profession is intertwined with the history of the National Health Service (NHS) of the United Kingdom, as the birth and development of the profession is coterminous with the birth and development of this institution. The NHS has both nurtured and shaped the profession over the years, offering unique opportunities and constraints as the main employer of clinical psychologists and the funder of Clinical Psychology training programmes (Richardson, 2015). As the profession has developed over the years since its inception, clinical psychologists have occupied various roles within the NHS. Rather than these roles sequentially replacing each other, the profession has broadened over time, incorporating all of these roles.

1.4.1. Psychometric Tester

Clinical psychologists initially specialised in assessment and diagnosis using psychometric tests. Eysenck initially believed that clinical psychologists, as applied scientists, should stick to assessment and diagnosis using scientific tests and not be involved in the provision of therapy (Eysenck, 1952). A number of tests were developed by clinical psychologists, including tests of intelligence (Weshler, 1949) and of personality (Eysenck, 1964). Clinical psychologists are involved in testing to this day, particularly in older adult services, child and adolescent mental health teams, and services for people with a learning disability (Hubbard & Hare, 2015). Psychologists apply these tests to compare the performance of an individual client to population norms or, in the case of personality tests, to diagnose the structure of what is conceptualised as an internal, stable, context-independent character of an individual: the personality. The point has been made that psychometric tests legitimise binaries, dichotomies between the normal and the abnormal, the mad and the sane (Hubbard & Hare, 2015). The tester is constructed as the classic (male) scientist, rational and objective in their application of a scientific test. It follows that the personhood or emotional experience of the psychologist has not been considered relevant in this role.

1.4.2. Scientist Practitioner

Schon (1983) suggests that, in establishing a respectable standing within a society, most professions lay claim to a knowledge base supported by positivist science. Clinical Psychology, building on their established niche in psychometric testing, continued along the path established by this role and defined themselves as scientist-practitioners with unique credentials in the application of psychological science to human problems (Pilgrim & Treacher, 1992). This model was socially validated in successive government reports that lead to the increasing autonomy and expansion of the profession (e.g. The Trethowan Report, 1977). A survey of qualified and trainee clinical psychologists in the UK, in 2001, concluded that the majority of those surveyed continued to endorse the scientist-practitioner model (Kennedy & Llewelyn, 2001).

As a model of professional practice for psychologists, the scientist-practitioner model has been the subject of criticism as well as strong endorsement (Lane & Corrie, 2006). It has been posited that the attention to the personal necessary to support the development of self-knowledge and a capacity to manage emotional experience, qualities considered central to the capacity to care by psychotherapists (Gilbert, Hughes & Dryden, 1987), are constrained for the clinical psychologist by the scientist-practitioner model. Pilgrim and Treacher (1992) proposed that the scientist-practitioner model constructed the psychologist as an “omniscient scientist who is not himself (male pronoun used advisedly DP/AT) a possible object (or subject) for scientific investigation” (p.130). They declared, at this time, that there was a crisis in the profession of Clinical Psychology as trainees were being inducted into a profession which had a “macho tradition of the scientist-practitioner [which] precludes any real discussion of vulnerability” (p.139). Mollon (1989) posited that scientism was utilised as a psychic defence by the profession to defend against the emotional impact of working with people in pain, resulting in a fraudulent identity for the clinical psychologist, an identity based on a fantasy of omnipotence in which personal distress is denied. He suggested that an alternative way for the clinical psychologist to build professional identity is a slower process of learning, developing skill and understanding through the acknowledgement and struggle with emotional pain, but that this process requires space for the psychologist to acknowledge emotional responses and feelings of inadequacy (Mollon, 1989).

1.4.3. Psychological Therapist

However, clinical psychologists are not, strictly speaking, psychotherapists. Parry (2015) differentiates the two professions by the range of theories clinical psychologists, as the “ultimate pragmatists” (p.184), tend to draw on in research and practice.

In the early days of the profession, there was a tension between psychologists who championed Behaviourism, such as those working at the Maudsley Hospital, and those who were influenced by Psychoanalysis, many of whom were based at the Tavistock Clinic (Pilgrim & Patel, 2015). Hans Eysenck at the Maudsley Hospital initially reviled psychotherapy, considering it unscientific and ineffective (Eysenck, 1952). In 1958, he was to endorse Behavioural therapy, a therapy that he believed had an empirical rather than a theoretical basis (Eysenck & Gwynne-Jones, 1958). By the 1960s, therapies based on behavioural science became widely disseminated by clinical psychologists, carving out an expert role for clinical psychologists in therapeutic practice in the NHS (Parry, 2015). However, despite strong opposition from within the profession, and it's being somewhat inimical to the British philosophical and cultural context at the time, psychoanalytic theory and practice was to retain a foothold in Clinical Psychology as a model of psychotherapeutic practice (e.g., Lemma, 2015), and a framework for critique of the mainstream tradition in psychology (e.g., Henriques, Hollway, Urwin, et al., 1998). From the 1980s onwards, the range of therapeutic models available to the profession grew exponentially, coming to include humanist and experiential therapeutic approaches, such as Carl Rogers's Person-Centred Therapy (Rogers, 1961), a therapy based on constructivism: Personal Construct Therapy (PCT: Butt, 2008) and, therapies unpinned by a social constructionist epistemology: Narrative Therapies (e.g., White, 1989).

Despite the broad range of psychotherapeutic approaches available, a hybrid of Behavioural Therapy and Cognitive Therapy, Cognitive Behavioural Therapy (CBT), was to emerge as the dominant form of psychotherapy available through the NHS in the 21st Century (Marks, 2015). Current BPS standards for Clinical Psychology course accreditation state that clinical psychologists should have the "ability to implement therapeutic interventions based on knowledge and practice in at least two evidence-based models of formal psychological interventions, of which one must be Cognitive Behavioural Therapy" (BPS, 2019, p.17). In the 21st century, so called 'Third-wave' cognitive behavioural therapies were developed, including Acceptance and Commitment Therapy (ACT: Hayes, 2004), Mindfulness-Based Cognitive Therapy (MBCT: Segal & Teasdale, 2018), and Compassion-focused Therapy (CFT: P. Gilbert, 2010). These approaches draw on evolutionary theory to normalise experiences of distress and are more process-focused, promoting mindfulness and acceptance of emotional experience, with key techniques based on Buddhist meditation practices (Hayes, 2004).

Due to constraints of space, this review will content itself with a brief exploration of the CBT approaches and two of the other (arguably most influential) therapeutic orientations, with particular reference to the constructions of the therapist, and therapist emotional experience, allowed by these frameworks.

Behavioural and Cognitive approaches

The classic behavioural therapist is constructed as the (male) scientist, objective and rational in the application of techniques such as reinforcement schedules and exposure. Classic Behaviourism does not consider the person of the therapist beyond thinking about their application of technique and the behaviour they are modelling for the client (Wolpe & Lazarus, 1966). The cognitive therapist is also constructed as a scientist, an expert, who, ideally in collaboration with the client, formulates an understanding of the maintenance of the client's distress by (what are judged to be) dysfunctional client thoughts and behaviours, designing behavioural experiments to test these thoughts and behaviours, and alternatives (Greenberger & Padesky, 1995). Historically, the person of the therapist and their emotional experience was not accorded much attention in CBT theorising. Where therapist emotional responses have been considered, they have been considered with a view to therapist self-management of these responses (Sudak, Codd, Ludgate et al., 2016). Judith Beck (2011) recommends that the therapist engage in self-scanning when working with clients with more complex difficulties. The aim of this scanning is for the therapist to detect changes in their own thinking, emotions, behaviour, or physiology that are evoked by interactions with the client (an application of the CBT model to therapist experience) so that they can self-manage these responses, through the application of the CBT technique to themselves (Beck, 2011). James Bennett-Levy (2003) calls this self-management practice self-practice/self-reflection (SPSR), and it has been suggested that the practice of SPSR can substitute for personal therapy for the therapist (Chigwedere, Thwaites, Fitzmaurice et al., 2018).

The Third-wave CBT approaches share some similarities with the parent frameworks, but with some notable differences. As with classic Behavioural Therapy, the therapist is constructed by ACT discourse as a teacher and a model of behaviour for the client (Luoma, Hayes & Walser, 2007). However, practices of self-disclosure[1] by therapists are allowed, should these practices be considered helpful to the client (Luoma et al., 2007). A similar construction of the therapist as 'model' for the client is produced by CFT discourse. Kolts and Hayes (2016) advise that the CFT therapist should "serve as a living embodiment and model of this compassionate self" (p.42), to be perceived by clients "both as competent helpers and as real human beings who have sometimes struggled with some of the very things that trouble them" (p.42).

Overall, self-reliance is promoted within a CBT framework. Both for the client, who after a short period of therapy should be skilled in applying the CBT techniques to themselves, no longer needing the therapist, and for the therapist, who is expected to be skilled in self-management of their own emotional experience.

Psychoanalytically-informed approaches

At the other end of the spectrum are the therapies that draw on psychoanalytic theory. Within a psychoanalytic tradition, the therapist is expected to have their own 'neurosis': an unconscious constellation of unconscious conflicts and defences, causative of distress and problems in living, to be explored in intensive personal therapy (Milton, Polmear & Fabricius, 2011). Freud originally considered countertransference, conceptualised as: "a result of the patient's influence on [the analysts] unconscious feelings" (1910/1964a, p.144), as an impediment to therapy to be overcome by the analyst who should function as a mirror of client experience (Freud, 1912/1964b). However, the concept has undergone a series of radical revisions since Freud's time, and contemporary psychoanalytic theorists agree that counter-transference phenomena are an inevitable concomitant of therapy and, furthermore, are of crucial importance, as an

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[1] Therapist self-disclosure is a term that has been used within the literature to refer to the therapist telling the client that they have personal experience of distress (with distress often framed as mental health problems), and, more broadly, to refer to the therapist sharing any aspect of their personal experience with a client (Ruddle & Dilks, 2005)

invaluable source of information about the client's internal world (Sandler, Dare, Holder et al., 1992). However, while the conceptualisation of therapist emotional responses in psychoanalytic theory changed, the echoes of Freud's (1912/1964b) mirror construction of the therapist have persisted in the recommendation that the therapist not display their emotional reactions to the client, as this could interfere with the development of the client's transference (Sandler et al., 1992). A common construction of the therapist in psychoanalytic discourse is therapist as maternal figure, involved in a process of holding and maternal reverie in their work with the client, who is required to have a healthy dependence on them as the source of containment (Sandler et al., 1992). Containment is conceptualised as a process that entails the therapist tolerating the client's emotional experience without retaliation, and offering explanations of their distress (called interpretations) from an expert position (Sandler et al., 1992). Contemporary relational psychoanalysts depart somewhat from this view as, in addition to considering transference and countertransference dynamics crucial, they stress the importance of the dynamics of a co-constructed intersubjective relationship between analyst and client to the therapy process (Benjamin, 2004), and "value a greater mutuality and humanness in the treatment relationship" (Bridges, 1999, p.293).

Systemic approaches

Therapists of the Milan school, the earliest tradition of systemic psychotherapists, were psychoanalysts who departed from this tradition, rejecting a focus on the de-contextualised individual, and their intrapsychic world, in favour of a view of the individual in a relational context within the world (Cromby et al., 2013). Therapists were urged to aspire for neutrality initially, by treating all interpretative positions as equally valid and resisting a pull to align with any individual perspective (Cecchin, 1987). The concept of neutrality was subject to critique and evolved into the ideal of a therapist who maintains a stance of curiosity, holding all perspectives, all views of reality, lightly (including their own) and being open to, and curious about, alternative perspectives (Cecchin, 1987). In contemporary theory and practice, self-reflexivity (Burnham, 1993), a process in which the therapist considers how their socially constructed personhood informs therapeutic work, is a core aspect of therapeutic practice. Supervision is considered a space for reflection, including a reflection on the personhood of the therapist and the emotion evoked by the work, particularly in work with clients with a history of trauma (Smith, 2012).

1.4.4. Reflective-Scientist Practitioner

It has been suggested that the roots of the professional identity in the British philosophical traditions of empiricism and pragmatism disabled reflection on practice for clinical psychologists in the early days of the profession (Pilgrim & Treacher, 1992). However, over the years, as Behavioural Therapy became Cognitive-Behavioural Therapy, integrating a greater focus on cognition, the behaviourist wholesale rejection of an inner life became less tenable. In recent years, theory imported from a teaching and education setting: reflective practice (Schön, 1983), has been embraced by the profession. The reflective-practitioner model has joined the scientist-practitioner model in underpinning the construction of the clinical psychologist identity in BPS standards for Clinical Psychology course accreditation, which states that trainees should be trained to develop "clinical and research skills that demonstrate work with clients and systems based on a scientist-practitioner and reflective-practitioner model" (BPS, 2019, p.8). In the 21st century, the declaration was made that Clinical Psychology was in the middle of a paradigm shift toward a reflective-practitioner model (Stedmon, Mitchell, Johnstone et al., 2003).

As with many other concepts and practices in Clinical Psychology, and reflecting the pluralism of the profession in approaches to therapy, reflective practice is a concept that has been interpreted in various ways by clinical psychologists. Some interpretations draw on psychoanalytic theory in talking about: "attending to the patient within us" in understanding process issues in therapy (O'Loughlin, 2003, p.24). Some appear to consider systemic factors in talk about the need for the system to offer "emotional and cognitive space" for the psychologist, to facilitate reflection (Paula, 2003, p.28). Within the majority of these constructions, attention to the relationship between the work and the self of the psychologist is validated to some degree (Lavender, 2003).

1.4.5. Leader

The review and introduction of new pay and conditions for service for (almost all) NHS staff as set out in *Agenda for Change* (Department of Health, 2003) worked in favour of the profession. Clinical psychologists were given high bandings relative to other professional groups, further increasing the power of the profession within the health service. However, it has been suggested that this also put increasing pressure on the profession to prove its worth, relative to colleagues in the health service on a lower banding (Hall, Pilgrim & Turpin, 2015). In 2007, the DCP produced the guidance *Leading Psychological Services* to encourage clinical psychologists at all levels to take up leadership roles in the NHS. The *Clinical Leadership Competency Framework* produced by the NHS lists self-awareness and self-management as key personal qualities required of the NHS leader (NHS & Academy of Medical Royal Colleges, 2010). The BPS emphasises relationality in the observation that: “Contemporary leadership styles are generally more aligned to working within a team or a system rather than being directive” (BPS, 2017, p.15). Reflecting on the leadership competencies that the contemporary NHS demands, Pam Skinner suggests that clinical psychologists as a professional group possess the personal qualities, values, and skills in relationship building, reflectiveness, and emotional awareness that make them ideally suited to leadership in the contemporary NHS (Skinner, 2011). Steve Onyett (2012) agrees that clinical psychologists are well suited for leadership roles, constructing the clinical psychologist as a professional with the strong relational competencies and the emotional intelligence[2] required by leaders in today’s pressured NHS. Drawing on psychoanalytic notions of personal vulnerability, he also suggests that, in exercising leadership, clinical psychologists should also seek to understand their shadow side[3] in “achieving personal wholeness as a leader or anyone exercising power” (p.15). Antebi (2012) has recommended clinical psychologists for leadership on the basis that good leaders require emotional intelligence to “model the culture, the tone, and the right behaviours expected” of staff within the organisation and to have the

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[2] Goleman (1998) defines emotional intelligence as a combination of self-awareness, the capacity to manage one’s own emotions, and social awareness.

[3] The shadow side is a Jungian concept, one that refers to aspects of the self that are repressed or rejected by the individual as unacceptable (Casement, 2006)

“robustness” and “resilience” to welcome interpersonal conflict (p. 22). Moyes (2012) agrees that “personal resilience” is a key quality of clinical psychologists as “calm, strong, admirable, moral leaders” (p. 28).

1.5. Contexts in which the Idea of Clinical Psychologist’s Distress has been Spoken About.

While it could be said that the personhood of the clinical psychologist has become an increasingly legitimised consideration within the profession of Clinical Psychology over the years, talk of clinical psychologist’s distress has continued to be somewhat circumscribed. Some of the ways in which clinical psychologist’s distress has been considered by the profession over the years will be reviewed, with a brief consideration of the implications for the profession.

1.5.1. Personal Therapy

Personal therapy, central to the theory and practice of psychotherapy, has historically been a contentious issue for the profession of Clinical Psychology (Gillmer & Marckus, 2003). The case has been made that there is insufficient evidence to justify making personal therapy a requirement (Macran & Shapiro, 1998). However, the view that it is not a question of empirical evidence has also been asserted, in the argument that it is a moral imperative that the clinical psychologist, as someone charged to care for others, undertake personal therapy (Hughes & Youngson, 2009). Mollon (1989) suggested that Clinical Psychology training traditionally (naively in his opinion) assumed that psychologists “should somehow be healthy enough, well-adjusted enough not to need help themselves as if psychologists and their clients have to be kept in clearly differentiated categories” (p.10). It could be argued that there is some evidence for this distinction being made between clinical psychologists and their clients in professional guidance where personal distress experienced by the clinical psychologist is presented as a possibility, rather than an inevitability. For example, in the BPS accreditation guidelines that put the onus on courses to give trainees assistance in obtaining help “if” they experience “stress or psychological disturbance” (BPS, 2019, p.45).

1.5.2. Supervision

Conversations about supervision have also entailed some consideration of the possibility of clinical psychologist distress. Scaife (2003) advocates that supervision should be a safe space for the supervisee to share anxieties, feelings of inadequacy, and mental pain in order to inform the work of therapy. However, it has been suggested that the safety of talk of distress by the supervisee in this space cannot be assumed. Shiela Youngson, reflecting on her experience of training supervision in the 1970s, stated that: “if personal feelings and emotional responses to the work were mentioned, usually this was taken to be a sign of over-involvement at best and inappropriate emotional liability at worst” (Hughes & Youngson, 2009, p.17). Pilgrim and Treacher (1992) suggested that the availability of supervision as a space in which personal issues, and emotional responses to the work, can be discussed by the clinical psychologist is dependent on whether the supervisor “has been trained within a model which legitimises the exploration of difficult personal issues” (p.124).

The current DCP guidelines on supervision advise that supervision can provide a reflective space in which “strong emotions” and “a high level of personal disclosure[4]” are likely and that a good relationship between supervisor and supervisee is, therefore, crucial (Dooley & Peyton-Lander, 2014, p.7). These guidelines advise that supervision should offer support and a space for the supervisee to reflect on the personal impact of the work, but caution that clear boundaries are necessary to delineate supervision from personal therapy. It should be noted that, according to these guidelines, the primary purpose of supervision is “to ensure the safety and quality of care and treatment for service users” (p.4). Hence, supervisors have a regulatory role in addition to a development role and a duty to consider “concerns about fitness to practice” when hearing expressions of distress by their supervisees (Dooley & Peyton-

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[4] Disclosure is the term most commonly used in literature and research to refer to a psychologist’s talk about their personal experience, including experiences of distress. This term is used advisedly here and elsewhere in the thesis to reflect its use in the literature and research under discussion. It should be noted that this terminology has particular implications. Disclosure in common parlance evokes the notion of the sharing of secret or hidden information (see “Disclosure”, 2021). As such, this language contributes to a particular construction of distress, and of the process of talk about distress by psychologists.

Lander, 2014, p.9). Furthermore, the DCP recognise that the formative and normative aspects of supervision are becoming more dominant, subjugating the traditional reflective space component of supervision, because of the increasing emphasis in healthcare systems on performance management (Dooley & Peyton-Lander, 2014).

1.5.3. Personal Development

The concept of personal development emerged in the context of the conversation within the profession about reflective practice, and initiatives within training courses to support trainees to develop the capacity to reflect on their practice. Sheikh, Milne and MacGregor (2007), who proposed a model for Personal Professional Development (PPD) for training courses, suggested that PPD helps trainees to develop their reflective abilities, enhances their self-awareness, and builds their resilience. In 2004, there was an increased emphasis given in the accreditation criteria for Clinical Psychology training on learning outcomes for PPD (BPS, 2004). These criteria have been interpreted in various ways by different courses, with differing emphases on the personhood of the psychologist and potential for personal distress. According to Hughes and Youngson (2009), from the Leeds training programme, personal development brings the personhood of the clinical psychologist back to the centre of the work. They suggested that strong emotion will be evoked in the trainee engaging in PPD. In Leeds PPD groups, trainees are encouraged to share aspects of their personal ‘selves’, a process that trainees have reported various levels of comfort with in course feedback (Hughes & Youngson, 2009). Mearns (1997) opined that it is extremely useful to take part in a group where “it is permissible to articulate feelings of inadequacy, incompetence, helplessness, and shame in the knowledge that such feelings will be respected and understood, and will not be taken as signs of weakness or professional uselessness” (p.26). However, Mearns speaks from the Counselling Psychology perspective, a discipline that has historically placed a greater emphasis on personal development in training. Hughes and Youngson (2009), reflecting on Mearn’s statement, have suggested that Clinical Psychology trainees, who may have less experience engaging in reflection and talking about the self, may be more inclined to find this experience threatening. Gillmer and Marckus (2003) reported that one of the themes from a workshop on PPD attended by the seventeen Clinical Psychology training courses was that “PPD necessarily invites a deconstruction of self during training, which is in direct conflict with the super-competent image demanded of trainee applicants” (p.20). Woodward, Keville and Conlan (2015) reported that trainees described a number of benefits of PPD, including increased self-awareness, greater self-acceptance, and a greater willingness to bring the personal self, including talk about emotional experiences, into the professional domain. Participants in their study reportedly constructed this talk of the personal in professional contexts as a process that facilitates reflective practice, but also as relational risk-taking, with the risk being that this talk may be considered unacceptable by others in the professional context (Woodward et al., 2015).

1.5.4. Self-Care

Clinical psychologist’s distress has also been spoken about in conversations, literature, and guidelines utilising a discourse of ‘self-care’. Much of the literature base for practices stemming from the self-care concept originates in the USA, and it is a concept linked to the concept of impairment in this literature (e.g., Barnett & Cooper, 2009; O’Connor, 2001; Sherman & Thelen, 1998). Self-care has been described, in moral and ethical terms, as an imperative, on the basis of its theorised link to competence in the practice of professional care for others (e.g., Norcross & Barnett, 2008; Wise, Hersh & Gibson, 2012). The DCP guidelines for practice produced in 1995 referenced self-care in relation to safeguarding fitness to practice, putting the onus on the clinical psychologist to monitor the effects of the work on their psychological and emotional wellbeing, and to take action where there is a risk of their personal wellbeing negatively affecting their professional practice (DCP, 1995). The BPS Practice Guidelines similarly framed self-care as a professional obligation (BPS, 2017). Myers, Sweeney, Popick and colleagues (2012) defined self-care as the use of strategies by the individual that promote psychological or emotional wellbeing, strategies they conceptualised within an individualist framework as: “sleep, exercise, use of social support, emotion regulation strategies, and mindfulness practice” (p.57). Wise and colleagues (2012) mobilised a discourse of ethics to promote the practice of Mindfulness Meditation as a form of self-care. They recommended Mindfulness Meditation as a way for the psychologist to increase their awareness of internal experience, with a view to increasing their motivation to engage in other self-care activities, such as exercise, time with loved ones, and time in nature (Wise et al. 2012). A large systematic review found support for the practice of mindfulness in reducing distress and improving some aspects of work performance and some indices of wellbeing (i.e. job satisfaction) in healthcare workers (Lomas, Medina, Ivtzan et al., 2018). However, the researchers noted that the quality of the studies was inconsistent. In the UK context, there is some support for the utility of a mindfulness group in promoting a self-care culture among Clinical Psychology trainees during training (Hemanth & Fisher, 2015).

1.5.5. Talk of Clinical Psychologist's Distress in the Public Domain

Personal therapy, reflective practice, and supervision are spaces less public, with talk of personal distress by clinical psychologists kept private or confidential to some degree. Over the years, a number of clinical psychologists have chosen to make public their experiences of personal distress in social and mainstream media. Clinical psychologists have spoken about having been users of mental health services prior to professional training and of experiencing, and accessing treatment for, personal distress post-qualification (e.g., Chadwick, 1997; Hughes, 2016; May, 2000; McCourt, 1999). These psychologists have emphasised that their personal experience of distress informs and enriches their work as clinical psychologists. The BPS guidance on disability (Harper, Rowlands & Youngson, 2006) validates this position and advises training bodies that increasing access for individuals with a history of personal psychological distress can enrich the profession, as individuals with lived experience of distress and its treatment can offer a unique insight to their colleagues. While there have been many voices raised in support of these narratives of personal experience of distress shared by psychologists, it should be noted that the reception to sharing of experiences of personal distress by members of the profession is not overwhelmingly positive. In a letter to *The Psychologist*, one clinical psychologist described these narratives as personal confessions and stated his view that material of this nature was unworthy of publication (Lindsey, 2017).

Clinical psychologist's distress has increasingly been a topic of interest in mainstream and social media in recent years, perhaps spurred by the dissemination and discussion, through BPS social and print media, of the findings of a BPS/New Savoy partnership survey reporting high levels of depression in psychological therapists working in the NHS (Barnett, 2016). These have tended to be different types of narratives, with less emphasis on the experience of distress as helpful in the work. An anonymous clinical psychologist, practising in the NHS at the time, wrote a piece for *The Guardian* newspaper speaking about how difficult it is to be depressed while in practice as a psychologist (Anonymous, 2016, Feb. 9th). In another piece in the same newspaper, clinical psychologists Jay Watts and Anne Cooke profess to be unsurprised by the finding of the 2016 wellbeing survey (Cooke & Watts, 2016, Feb.17th). They propose that psychologists working in the NHS are distressed because caring in the NHS is under attack from relentless targets and the prioritisation of these targets over the wellbeing of staff by managers.

1.5.6. Constructions of Distress in Mental Health Professionals in Research

A negative impact of the work on mental health professionals has been conceptualised as 'compassion fatigue', 'vicarious traumatisation', 'stress', and 'burnout' in the literature.

Compassion fatigue is conceptualised as a post-traumatic stress reaction that occurs in mental health professionals who work routinely with clients who have had traumatic experiences (Figley, 1995, 2002). For Figley (2002), "compassion is to bear suffering" (p.434), and compassion fatigue is an inability in the professional to continue to bear the suffering of clients in the course of the therapeutic work (Figley, 2002). The term compassion fatigue is sometimes used interchangeably with the term vicarious traumatisation. Vicarious traumatisation is described as a constellation of experiences in the clinician that resemble the expression of distress that attracts a diagnosis of Post-Traumatic Stress Disorder within a psychiatric model, i.e. intrusive re-experiencing of traumatic material, avoidance, and hyperarousal (McCann & Pearlman, 1990).

Stress is defined by the Oxford English Dictionary as "a state of mental or emotional strain or tension resulting from adverse or demanding circumstances"

(“Stress”, 2019). Burnout is a term used to describe a particular type of work-related stress response in professionals who work in people-oriented professions. Burnout was defined by Maslach (1982) as the experience of chronic exhaustion, de-personalisation and emotional distancing, accompanied by a feeling of failure or a sense of reduced personal accomplishment. Maslach (1982) hypothesised that individuals who work in the caring professions are more likely to experience burnout because of the routine exposure to the suffering of others and highly emotional situations, a hypothesis that has parallels with the conceptualisation of clinician distress as a traumatic stress response to exposure to the distress of others. It has been suggested that the nature of a psychologist’s role predisposes them to experiencing burnout because it entails a heightened sensitivity to people, a need to prioritise other’s needs over their own, and the tolerance of intense emotion coupled with the withholding of personal emotional responses (O’Connor, 2001). However, subsequent conceptualisations of burnout have placed more emphasis on wider systemic factors. Maslach and Leiter (2008) proposed six work environmental sources of burnout: work overload, lack of control, insufficient reward, perceived unfairness, breakdown of community, and values conflict. The demand-control model of burnout (Karasek, 1979) theorised that high strain jobs, defined as jobs high on demand and low on control (with control defined by the factors skill discretion and decision authority), are most likely to cause a mental strain on employees. Johnson and Hall (1988) included the dimension of social support, hypothesising that high control can buffer an employee against high demand in the work context when there is also high social support. Successive reviews have found support for this model (Häusser, Mojzisch, Niesel et al., 2010; Stansfeld & Candy, 2006; van der Doef & Maes, 1999).

1.6. Review of Existing Research

1.6.1. Search Strategy

The databases ‘Psycinfo’, ‘Psycarticles’, and ‘Medline’ were searched using the search terms: “Stress" OR "Chronic Stress" OR "Environmental Stress" OR "Occupational Stress" OR "Post-Traumatic Stress" OR "Psychological Stress" OR DE "Social Stress" OR "Stress Reactions" OR DE "Stress Management" OR DE

"Stress Reactions" OR DE "Compassion Fatigue" OR DE "Vicarious Traumatization" AND "clinical psychologists" or "clinical psychology" OR "Mental Health Workers". The search was limited to results in the English language from peer-reviewed journals. Literature pertaining to a non-UK context was excluded. Additional relevant references within these texts returned by these searches were also sourced.

The searches were also run with the inclusion of the search terms "Anxiety" and "Depression", but the inclusion of these terms returned an unworkable number of texts pertaining to the work of clinical psychologists with clients experiencing anxiety and depression, irrelevant to this study. As such, these terms were omitted in subsequent searches.

1.6.2. Distress in Mental Health Workers: Prevalence Estimates

There is evidence that levels of distress are higher for health professionals working in the NHS than for any other professional group (Borril, Wall, West et al., 1998), and that mental health professionals, i.e. psychiatrists, psychologists, nurses, and social workers are at particularly high risk for experiencing burnout (Onyett, Pullinger & Muijen, 1997; Thomsen, Soares, Nolan et al., 1999). In 2016, an NHS staff survey reported that 37% of respondents reported feeling unwell due to work-related stress, 41% of NHS staff in mental health services (Barnett, 2016). Although not directly comparable, as the operationalisation of the construct of distress in measurement differs, these surveys would seem to suggest that the prevalence of distress in NHS workers is higher than in the general population. The Adult Psychiatric Morbidity Survey (APMS) reported that approximately 17% of adults (19% of women) surveyed in England met the criteria for a common mental disorder, i.e. anxiety or depression (McManus, Bebbington, Jenkins et al., 2016).

1.6.3. Distress in Clinical Psychologists: Prevalence Estimates

There is a dearth of research investigating distress in clinical psychologists as a professional group specifically. As a whole, existing studies suggest that UK clinical psychologists experience levels of distress comparable with the levels of distress reported for other mental health professionals. In 1996, Cushway and Tyler reported on a series of studies of stress and coping in British clinical psychologists carried about between 1992 and 1996. They reported the finding in earlier studies that 30% of their sample of clinical psychologists reached caseness[5] on the General Health Questionnaire (GHQ: Goldberg & Williams 1988) (Cushway & Tyler, 1994). In later studies, they reported that 40% reached caseness on the same measure (Cushway & Tyler, 1996). A systematic review of seven studies investigating stress and coping in UK clinical psychologists concluded that up to four in ten clinical psychologists reported personal distress at a level that indicated the presence of a diagnosable mental health problem[6] (Hannigan, Edwards & Burnard, 2004).

There is some evidence that the lifetime prevalence of distress is higher for clinical psychologists than population norms. In recent study of 678 qualified UK clinical psychologists, 62.7% of respondents reported experience of a mental health problem, either in the past or at the time of survey completion (Tay, Alcock & Scior, 2018). The reported lifetime prevalence of distress (as diagnosable mental health problems) among adults in the UK is 41% (Mental Health Foundation, 2016).

An early study that assessed levels of stress in British Clinical Psychology trainees reported an estimated prevalence of psychological problems, assessed using the GHQ-28, of 59%, with 75% describing themselves as moderately or severely stressed (Cushway,1992). In subsequent studies, high percentages of Clinical Psychology trainees reported significant problems in the areas of self-esteem, anxiety and depression: 25% of 183 trainees in a study by Kuyken, Peters, Power and Lavender in 1998; and 41% of 364 trainees in a study by Brooks, Holtum and Lavender in 2002. In a recent survey of 348 Clinical Psychology trainees, 67% of respondents reported experiencing a mental health problem over the lifespan (a binary choice, with trainees asked to select the problem from a list of psychiatric diagnoses), with 29% reporting this as a current problem at the time of survey completion (Grice, Alcock & Scior, 2018).

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[5] Caseness refers to psychiatric caseness – whereby, if the respondent presented in a medical or mental health setting, reporting these experiences, they would be likely to receive further attention from professionals (Jackson, 2007).

[6] The term ‘mental health problem’ is used here and in the subsequent section to reflect its use in the research under discussion. It should be noted that this term has particular implications for the way distress is constructed as it is a term often used alongside terms that medicalise distress such as ‘mental illness’ and ‘disease’ (e.g., Knapp, 2003; Layard, 2017).

A survey of NHS staff published in 2016 reported that 46% of psychology professionals described themselves as depressed, with 25% reporting a long-term chronic condition (Barnett, 2016). Furthermore, 70% of respondents reported finding their job stressful, and 49.5% reported considering themselves a failure. These findings show a slight increase from a survey of NHS psychology professionals in 2014, in which 40% of respondents reported feeling depressed, and 40.2% reported feelings of failure (Rao, Clarke, Bhutani et al., 2017). In a 2017 survey, there was a slight decrease in reported levels of depression (43%) and feelings of failure (42%), but it should be noted that the lowest levels of reporting were also in 2017 (Rao et al., 2017). Clinical psychologists formed the largest proportion of respondents (48.5%) in these surveys (Rao et al., 2017). In a recent survey of 298 NHS psychological therapists investigating burnout[7], 78.9% of respondents were classified as suffering from high burnout and 58.1% were classified as experiencing high disengagement from the emotional experience of clients (Johnson, Corker & O'Connor, 2020).

While these studies appear to support a conclusion that distress in trainee and qualified clinical psychologists is a significant problem, results should be interpreted with caution. There are significant issues entailed with a self-report method of data collection and the survey methods utilised by all of the studies. Self-selection and reporting biases should be taken into consideration in interpreting results. In addition, direct comparison is complicated by the differing constructions of distress utilised in various studies and the differences in the way these constructs were operationalised in measurement.

1.6.4. Theorising Causal Factors

There is evidence from US studies that organisational factors play a greater role in burnout experienced by mental health professionals than individual factors, particularly in the context of roles involving high patient contact, with work pressures and low control consistently found to correlate with burnout (Lasalvia, Bonetto & Bertani, 2009; Schulz, Greenley, Brown et al.,1995). Lasalvia and colleagues (2009) found support for the demand-control-support model of

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[7] This study utilised the Demerouti & Bakker (2008) model of burnout, a two-factor model conceptualising burnout as a psychological syndrome whereby psychological therapists feel emotionally exhausted by their work and emotionally disengaged from their clients.

burnout in a study with community-based mental health staff. They reported that the best predictors of burnout were roles with higher levels of face-to-face contact with patients and three organisational factors: workgroup cohesion, perceived fairness, and control.

There is some evidence from the series of studies of stress and coping in UK psychologists by Cushway and Tyler (1994, 1996) that organisational stressors for qualified clinical psychologists are similar to those reported by other professional groups in the NHS, namely: pressure of workload, lack of resources, interpersonal conflict with other professionals, and poor communication and management within the organisation. Experienced psychologists reported less stress than less experienced psychologists in their series of studies. However, levels of stress were found to decrease for men with an increase in grade, but not for women. The researchers theorised that this was due to multiple role strain for women, who were likely to have more responsibilities in the home context. They reported that client factors, such as client distress and client behaviour, were particular stressors for clinical psychologists, but that professional self-doubt or uncertainty about effectiveness in the role was the largest individual factor predicting psychologist distress (Cushway & Tyler, 1996). A review of seven studies of stress and coping in UK clinical psychologists concluded that there is evidence that the factors: client characteristics, excessive workloads, professional self-doubt, and poor management all contribute to higher stress levels in clinical psychologists (Hannigan et al., 2004).

1.6.5.Theorising Individual Differences in Distress and Coping

Acknowledgement of the experience of stress by the psychologist and an active attempt to manage stress was the approach to coping most strongly associated with lower levels of stress in the Cushway and Tyler (1992, 1994, 1996) series of studies. Talking to a friend or colleague was the coping strategy most frequently cited as helpful by their respondents and was negatively correlated with stress. Conversely, a reliance on avoidance coping strategies involving denial or refusal to acknowledge stress was correlated with higher levels of stress (Cushway & Tyler, 1996). The review by Hannigan and colleagues (2004) concluded that active coping strategies that entail disclosure of personal distress and help-seeking are the most effective approaches to stress management for clinical psychologists.

Brooks and colleagues (2002) reported that trainees who had personality traits[8] that indicated a reduced likelihood of seeking support from others or attempting to exercise control over their environment were more likely to report suffering from anxiety, depression, and low self-esteem. In a longitudinal study, trainees who reported experiencing demands as manageable and having more access to support at time one reported less avoidance coping, less anxiety and depression, and higher self-esteem at time two (Kuyken, Peters, Power et al., 2003). Specifically, access to support in the home was associated with less avoidance coping by trainees at work, and less avoidance coping had a positive moderating effect on levels of anxiety, depression and self-esteem (Kuyken et al., 2003). Increased access to social support in the workplace was associated with trainees reporting a greater sense of control and less avoidance coping in the workplace, and achieving lower scores for anxiety and depression, and higher scores for self-esteem (Kuyken et al., 2003).

In study with 298 qualified psychological therapists, higher quality supervisory relationships were associated with lower levels of emotional disengagement from clients but not lower levels of emotional exhaustion (Johnson et al., 2020), a factor that previous studies have linked to demand (Miller, 2018). The quality of supervisory relationships was measured using the safe base subscale of the Short Supervisory Relationship Questionnaire (S-SRQ: Cliffe, Beinart, & Cooper, 2016). The safe-base subscale purports to measure the extent to which the supervisee experiences the supervisory relationship as safe, respectful, and collaborative (Cliffe et al., 2016).

1.6.6. Barriers to Accessing Support

While available research indicates the value for clinical psychologists of taking an active approach to coping with distress, including the use of both formal and informal social support, it has been suggested that talking to others about personal distress and help-seeking are not straightforward propositions for

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[8] As assessed using the The Millon Index of Personality Styles (MIPS) (Millon, 1994)

clinical psychologists. Walsh and Cormack (1994) reported that the clinical psychologists they interviewed perceived the idea of disclosing distress and seeking support as psychologically threatening, in part due to a perceived conflict between the experience of personal distress and the values of their profession and the health service organisation. Hannigan and colleagues (2004) concluded from their review that "powerful organisational and professional factors may act in ways that inhibit the capacity of psychologists to seek and obtain support for stress at work" (p.243). A subsequent study by Charlemagne-Odle, Harmon and Maltby (2012) provided further support for this conclusion. The clinical psychologists they interviewed reported that fears about being stigmatised by colleagues for experiencing distress, and the perceived need to maintain an appearance of coping, make it difficult for them to talk to others about the experience of personal distress. The researchers concluded that the barrier to disclosing distress and help-seeking is such that, if the psychologist's distress goes undetected by others, they may attempt to persevere in the same conditions, despite the impact of personal distress on their effectiveness at work (Charlemagne-Odle et al., 2012). Researchers proposed on the basis of their findings that clinical psychologists experience a conflict between their role or identity as a clinical psychologist, and the experience of distress and help-seeking (Charlemagne-Odle et al., 2012).

Grice, Alcock and Scior (2018) reported that the perceived stigma associated with a mental health problem coupled with what they referred to as maladaptive perfectionism (conceptualised as a quality of the individual) predicted whether trainee clinical psychologists would disclose their experience of distress to others. Tay and colleagues (2018) found that the qualified clinical psychologists in their study who had not told anyone about their experience of a mental health problem (11% of their sample) reported higher levels of self-stigma, indicating that they stigmatised themselves for having a mental health problem. These respondents also scored higher for feelings of shame about their experience of distress, and were more likely to report anticipating negative consequences for self-image (public and private) and career if they talked to others about experiencing mental health problems or engaged in help-seeking (Tay et al., 2018). Tay and colleagues (2018) reported that their study participants were more likely to have spoken to a friend or family member about personal experience of a mental health problem. However, almost half of those who reported experience of a mental health problem had talked about the experience in a work setting. Contrary to the researcher's initial hypothesis, formulated on the basis of evidence from research carried out with samples from the general population, rates of disclosure and help-seeking did not differ for clinical psychologists between those who reported mental health problems they classified as more stigmatised (i.e., psychosis/bipolar disorder), and those they classified as less stigmatised (i.e., anxiety/depression) (Tay et al., 2018).

1.7. Rationale for the Current Study

Distress is central to the work of the clinical psychologist. While the work of clinical psychologists with the distress of others has received much research attention to date, comparatively little attention has been accorded to the consideration of clinical psychologist's personal experiences of distress and distress management. Research evidence available, and anecdotal evidence from social and mainstream media, suggests that distress is a significant issue for members of the profession of Clinical Psychology. There is also evidence that there are factors that complicate the acknowledgement of personal distress by clinical psychologists and help-seeking. This research hopes to further the understanding of the experience of personal distress by clinical psychologists in the NHS by exploring the discursive resources that clinical psychologists draw on to construct distress experienced by clinical psychologists and how discourses drawn on shape social practices.

1.7.1. Research Questions

- How do participants construct a clinical psychologist's experience of distress in relation to their professional identity?
- How do the discursive resources drawn on shape their accounts of how psychologist distress has been responded to and how they think it should be responded to?

2. CHAPTER TWO: METHODOLOGY

In this chapter, the epistemological and ontological positions underpinning this research are outlined, including the key assumptions made in the adoption of these positions. Subsequently, the procedure followed in seeking ethical approval, recruiting participants, and collecting data is elaborated. This is followed by a detailed description of the approach to data analysis. Lastly, the reflexivity concerns that have been an important consideration throughout the study will be introduced, as will evaluation criteria for the study, both of which receive further consideration in chapter four.

2.1. Epistemology and Ontology

2.1.1. Critical Realism

The epistemological and ontological positions adopted in this study are consistent with the three elements of Critical Realism, as expounded by Pilgrim (2020).

First and foremost, it is ontologically realist. Ontology can be defined as the study of being and existence in the world (Burr, 1998). To adopt a Critical Realist ontological position is to allow for an independent reality to the natural world and our social structures, a reality that exists outside of our understanding of it and has real causal effects (Pilgim, 2020). This study is ontologically realist in the assumption that there is a reality to the experience of distress, and in the attribution of causal effects to an independently existing reality, though it is acknowledged that the historical and cultural context will shape participant's understandings, experience of, and relationship with this reality, including how distress is experienced.

Secondly, it is epistemologically relativist. Epistemology can be defined as the philosophy of the nature of knowledge, of what it is possible to know, and how we can know it (Willig, 2013). Critical Realism assumes an ontological reality, but that this reality can only be known through the imperfect lens of our sensory capacities as social beings (Bhaskar, 1997). As such, it is assumed that all knowledge is partial and subject to revision (Chamberlain, 2015). Thus, Critical Realism problematises claims of any kind of direct access to reality, including claims of access to objective truths about the nature of being and existence in the world (Bhaskar, 1997). This relativist epistemological position, consistent with some moderate Social Constructionist positions, encourages suspicion of taken-for-granted understandings of the world, thereby opening up space for curiosity about our knowledge of the world as human beings. Knowledge, both theoretical and taken-for-granted understandings of the world, is understood to be socially constructed, objectified, institutionalised, and internalised by human beings through processes of primary and secondary socialisation into a historically and culturally defined symbolic world (Berger & Luckmann,1966/1991). Thus, human subjectivity is hypothesised to be constructed by social processes, and involved in the active construction of social reality in collaborative, dynamic, social processes (Berger & Luckmann, 1966/1991). Reciprocal habitual patterns of behaviour by actors are theorised to become institutionalised, accepted as ‘the way things are done’, with this institutionalisation acting as a mechanism of social control operating to sustain a particular social order (Berger & Luckmann, 1966/1991). Knowledge, as truth, is taken to be the currently accepted ways of understanding the world, in a particular historical and cultural context, and, as these socially constructed ‘truths’ dictate what it is permissible for human beings to do, and to do to others, the social construction of reality is considered inextricably bound up with social action and power relations (Burr, 1995). While not attributing reality in its entirety to these constructionist processes, this study accords with Gergen (1985) in the view that the way people describe and explain the world (including themselves), through language, is social action that functions to sustain particular patterns in a given social reality, to the exclusion of others. This study adopts an epistemologically relativist position in its concern with the construction by participants of the social reality they inhabit in the role of clinical psychologist in the institution of mental healthcare in the NHS, and the focus on the ways that these constructions of social reality structure their lived experience in this context, by facilitating or limiting, enabling or constraining, what can be said and done by the clinical psychologist (i.e., ‘ways of being’).

The third element proposed by Pilgrim (2020) is the notion of judgemental rationality, which is the idea that human beings are capable of the evaluation of knowledge claims, and of making moral and rational judgements. The notion of judgemental rationality provides a basis for the attribution of a constructive role to discourse, as knowledge, while also allowing space for a subject with agency who can weigh up the ‘truths’ at their disposal and make choices as regards social action. Thus, clinical psychologists are conceptualised as both “determined and determining beings” (Pilgrim, 2020, p.25), products of socialisation processes but also subjects with agency who actively contribute to the construction of social reality.

2.2. Procedure

2.2.1. Ethical Approval

The University of East London Research Ethics Committee granted ethical approval for the study (appendix A). Ethical issues were an important consideration in this study, as in all qualitative research which entails “researching private lives and placing accounts in the public arena” (Birch, Miller, Mauthner et al., 2002, p.1). Participants were provided with information on the study at two time-points, once prior to expressing interest and again prior to the interview. A participant de-briefing sheet, with sources of support for psychological distress, was sent to each participant after their interview (appendix B). Interviews were anonymised at the point of data collection and deleted from the dictaphone after transfer to the researcher’s password-protected computer. Participants were initially differentiated by number (i.e., CP 1) and assigned pseudonyms in the latter stages of data analysis. Participant’s names were not linked to the data at any point.

Ethical research practice was viewed as an ongoing process of reflection and openness to tensions, ambivalences and dilemmas in the areas of informed consent, confidentiality, consequences of the research, and role of the researcher. These areas were conceptualised as “fields of uncertainty” rather than areas in which ethical questions could be considered resolved at the point of research design (Brinkman & Kvale, 2017, p.261). The topic could be considered a sensitive topic, and the community of clinical psychologists in the UK a relatively small and well-connected community. When sampling from a smaller and more well-connected population the risk of breaching confidentiality is considered greater (Damianakis & Woodford, 2012). One participant contacted the researcher after the interview to express concern about her identity being reconstructed from demographic, training, and employment information in combination with quoted material. Morse (2008) made the point that, in qualitative research, numerous identity tags linked with pseudonyms and quotations can threaten anonymity. Taking these factors into consideration, the choice was made to report more general demographic information about participants and to use ranges rather than exact figures for each specific participant. Any reference to specific courses, specific services, localities, or individuals in the data was substituted at the point of transcription.

2.2.2. Recruitment

A purposive sampling method was used to recruit nine clinical psychologists currently practising in the NHS. A number of factors were taken into account to make the decision about sample size. Constraints of time and resources, and the awareness that a larger amount of data could preclude a deep, complex engagement with the data (Onwuegbuzie & Leech, 2005), were balanced against the need to gather sufficiently rich data for the study to be considered to make a useful contribution. Braun and Clarke (2013) have recommended that the anticipated richness of data should be a consideration in deciding the amount of data required. It was anticipated that a sample of clinical psychologists would provide relatively rich data, as clinical psychologists are a population of academics accustomed to speaking about and reflecting on experience, and the topic was anticipated to be of personal relevance to participants. This study was considered exploratory, one that aimed to indicate rather than conclude, and the analytic approach inductive, requiring a depth of analysis that was anticipated to be more time and labour intensive. A smaller sample size has been recommended in qualitative studies of this nature (Crouch & McKenzie, 2006). While this study does not adopt a discourse analytic method, as such, there was an interpretative phase to the analysis informed by discursive theory, which was anticipated to be more labour intensive, and smaller sample sizes are recommended in studies using discourse analytic methods (Georgaca & Avdi, 2012). Additionally, the concept of saturation was reflected upon in considering the relationship between sample size and sufficiently rich data, with saturation defined as the point at which carrying out further interviews fails to generate new information (Sandelowski, 1995). An empirical study investigating sample size and saturation in qualitative research, found that saturation was reached in twelve interviews, and basic meta-themes were present in six interviews (Guest, Bunce & Johnson, 2006).

A sample size of 9, while small for a study using Thematic Analysis (TA), is comparable to some published TA studies in similar areas of interest or drawing from similar study populations. For example, a study of paranoia in a student population with a sample of seven (Harper & Timmons, 2019) and a study exploring experiences of mandatory personal therapy in professional training with nine trainee clinical psychologists (Ivey & Corné Waldeck, 2014).

Participants were recruited through an invitation posted by the researcher on the social media site Twitter (appendix C), which included a link to the participant invitation letter (appendix D). Inclusion criteria were broad as it was anticipated that recruitment to the study would be difficult. As previously noted, the topic was judged, in dialogue with supervisors and peers, to be sensitive. Furthermore, the sample was drawn from a population who are time-pressured. Individuals currently working in the NHS as clinical psychologists for at least one year were invited to participate. The sample was expected to be homogenous with respect to the fact that they were all clinical psychologists working in the NHS at the time of the study, with some variation expected within that but not specifically recruited for. Given the dearth of previous research in the area, it was difficult to predict variables that it might be important to seek variation on. Discussions did take place early on in supervision as to whether to recruit for clinical psychologists who self-identified as having lived experience of distress. It was decided, as this concept is sometimes linked in the literature to experience of distress that has attracted a functional diagnosis, this could constitute a pre-narrowing of the definition of the construct of 'distress', a concept purposefully chosen for its polysemic nature.

2.2.3. Participants

The clinical psychologists who opted to participate in the study were all female. Seven participants defined their ethnicities as White British, two as Asian British. Age ranges: 25-35 (3), 36-45 (4), 45-60 (2). Length of time in practice as qualified clinical psychologists: < 2 years (1), 3-9 years (4), 10-20+ years (4). Four participants worked in London or surrounding areas, and five worked in other parts of Britain. Settings participants worked in included: forensics, neuropsychology, community mental health, physical health, and mental health. Including Clinical Psychology courses that participants had trained on and those they had been involved with as members of the course team, participants had lived experience of ten different Clinical Psychology training courses.

2.2.4. Data Collection

Each participant was given the option of being interviewed one-to-one by the researcher at a venue of their choosing or via Skype. One interviewee chose to be interviewed at her home, one at a coffee shop, one at the university campus, the remaining six over Skype. Of the six interviewed over Skype, five were at home at the time of the interview, and one was in her workplace. Interview duration was between one hour and one hour thirty minutes.

A semi-structured approach to interviewing was used, using an interview schedule developed in consultation with supervisors and colleagues (appendix E). As the study was exploratory, and due to the dearth of research in the area, the questions were intentionally broad and open to interpretation by the interviewee. They were designed to evoke descriptions of the clinical psychologist’s role and identity, descriptions of distress (both generally and as experienced by clinical psychologists), and to elicit participant’s ideas about helpful responses to distress experienced by clinical psychologists. The decision to ask broad questions was also taken with the awareness that more detailed questions could orient participant’s reflections in a particular way and position them in relation to certain constructs (Fairclough, 2014). Questions were also minimal to allow flexibility for the scope of the interview to broaden or change in response to emergent interview material. Prompts or follow-up questions aimed to follow the participant’s order and phrasing and focused on encouraging reflection, asking for clarification, and requesting explanation and illustration of concepts and metaphors used. Overall, the researcher intervened as little as possible so as not to interrupt the flow of the participant’s ideas. As each interview was conceptualised as a novel intersubjectively created context, and the interview questions were not designed to elicit particular types of responses, the interview schedule was not piloted, over and above discussion with supervisors and colleagues.

Interviewees were forthcoming and reflective, and a comfortable and easy rapport was established between researcher and interviewee early on in each interview. It was indicated that interviewees positioned the researcher as a colleague by their regular use of phrases such as "*you know*" and the assumption that the researcher understood psychological terms and concepts used. This was most likely an advantage in terms of establishing rapport, but possibly a disadvantage in terms of generating richer descriptions of concepts and terms. The researcher tried to maintain an awareness of this positioning throughout and to make a point of asking for explanations and illustrations of terminology and concepts used by participants. It was noted that participants who were interviewed at home appeared particularly forthcoming in their interviews. This was commented on by one participant, and reflected on by the researcher in light of concerns about protecting participants anonymity.

Data was recorded on a dictaphone and transcribed using a system of Jefferson Lite by the researcher in accordance with the conventions set out by Parker (1992). Adopting this style allowed certain key non-linguistic elements to be retained without the depth necessary for a conversation analysis. In extracts re-produced in the results section, (..) indicates a pause and (…) indicates omitted material.

2.3. Analytic Approach

2.3.1. Thematic Analysis

As the study was exploratory in nature a more flexible method was considered more appropriate. A method that would allow the researcher to move from a more descriptive macro view of the whole data set, to a focus on specific areas of interest in the data set, identified as the analysis developed, with a view to a deeper, more interpretative analysis of these areas of interest. Thematic Analysis (TA) is considered a method rather than methodology, as it does not provide a theoretically driven framework for data analysis (Terry, Hayfield, Clarke et al., 2017). This flexible method, which enables the reporting of thematic patterns across a sample, allows the researcher to make interpretations of the data that aim to construct a picture of the reality of the research participants (Joffe, 2012). In this study, interpretation of the data was informed by post-structuralist theory and discursive analytic traditions, resulting in an approach to data analysis that has been described by Braun and Clarke (2013) as a constructionist form of TA. A constructionist approach to data analysis was considered a good fit with the relativist epistemological assumptions, and offered scope for the consideration of how the topic was interpreted by participants and how ideas drawn on constructed their social realities.

Other methodologies were considered. A Foucauldian Discourse Analytic approach (FDA) would have been compatible with the aim of the study to explore the construction of clinical psychologist's subjectivities within the social context of the NHS through discourse, and would have allowed a consideration of the historical and cultural conditions of the production of these subjectivities, and a focus on the operation of power. However, this methodology does not allow much space for the agency of social actors, as subjectivity is conceptualised as constructed by the impress of power, through the operation of hegemonic discourse, on social actors (Willig, 2013). Discursive Analysis could have offered a methodology for an exploration of the subjectivity of the clinical psychologist as constructed in interaction (Wiggins & Potter, 2020), allowing for a consideration of agency in social processes. However, a traditional discursive approach does not readily allow the same consideration of the macro socio-political power relations (Weatherall, 1998). Furthermore, the use of both of these methodological frameworks necessitates that a specific focus is taken from the outset of the analysis, based on specific research questions, and, in the case of FDA, the clear identification from the outset of objects to be deconstructed (Braun & Clarke, 2013). As such, both of these analytic approaches were considered incompatible with the exploratory nature of the study. A phenomenological approach would have been a good fit with the exploratory nature of the study, and could have offered a depth to the understanding of the subjective experiential aspects of clinical psychologist's distress. However, this approach was considered incompatible with the relativist epistemological position, with research questions that operate on the assumption of language as constructive rather than reflective, and with the study's aim to go beyond representations of experience to de-construct the social reality presented by participants. Furthermore, this study was intended to contribute to a reflexive critique of the profession of Clinical Psychology. It has been suggested that some phenomenological methodologies, such as Interpretative Phenomenological Analysis (IPA), do not lend themselves to a reflexive critique of the discipline of psychology, as they tend to privilege the psychological over socio-cultural interpretation (Braun & Clarke, 2013).

2.3.2. Discursive Theory

Post-structuralist theorists, most notably Foucault, proposed that psychological theories, such as theories of child development, of madness, badness, and personality, play a formative role in constructing the objects and subjects they claim to explain (Foucault, 1961/1965,1969/1972). From this perspective, language does not simply describe, but rather constructs our social and psychological reality through the operation of discourses, or systems of meaning, available within a given socio-cultural historical context (Georgaca & Avdi, 2015). These shared systems of meaning make available ways of seeing and ways of being, with implications for what may be done and are, as such, strongly implicated in the exercise of power (Willig, 2015). It has been argued that the discourses of psychology have shaped historicised subjectivities, producing a particular understanding of 'self' (Rose, 1999). Rose (1985, 1999) asserts that the 'psy-professions' (i.e., psychology, psychiatry, psychoanalysis) perform a powerful regulatory function in society by dictating how individuals understand themselves and act upon themselves, in essence how they govern themselves. This self-governance, which is the operation of power through discourse that constructs the regime of the self, stems from the relationship between meaning-making and action. Talk and action are theorised to support and reinforce each other in the construction of subjects and objects, with the discourses drawn on in the construction of reality making certain actions possible, and actions in turn reinforcing the reality constructed through discourse (Willig, 2015). Parker has argued that discourses offer "an array of subject positions, and discursive complexes contain specifications for the types of object and shapes of subjectivity" (Parker, 1992, p.245). Parker (1992) defines a subject as a particular type of object, a sense of self made available by a discourse, that an individual can step into or reject. Davies and Harré (1990) argue that subject positions are a key consideration in discursive practice, stating that “the constitutive force of each discursive practice lies in its provision of subject positions” (p.5). They describe positioning as inherently relational, as we position ourselves, and are positioned by others in relation to other people. Furthermore, they propose that there are culturally, socially, politically understood meanings attached to subject positions and, thus, subject positions facilitate, or even demand, certain behaviours, and as a subject position is associated with certain rights and duties, each subject position has moral consequences (Davies & Harré, 1990).

The ‘psy-professions’ are theorised to have been themselves disciplined by the emergence of the regimes of selfhood they have played a key role in inventing and perpetuating (Rose, 1998). Poststructuralist theory offers a way of thinking about the social and psychological realities of clinical psychologists, their subjectivities (ways of thinking and feeling) and their social practices. A discursive approach facilitates the mapping of the discursive environment inhabited by the clinical psychologist, with a view to understanding the various ways professional identity can be constructed in this discursive environment and how these constructions shape the experience of, and ways of relating to, personal distress.

Foucault has been critiqued for theorising a subject without agency (Hall, 2004). This study adopts an Althusserian view in thinking of professional identity as constructed through available discursive resources by the mechanism of interpellation, with clinical psychologists hailed by the ideologies, or discourses, embedded in their professional cultural context and experiencing the consequences of ideologies drawn on. From this perspective, interpellation is conceptualised as “a seductive power” (Hall, 2004, p.88) rather than a deterministic force. The Althusserian perspective allows for a view of an agentic subject as proposed by Pilgrim (2020). Davies and Harré (1990) align with this view, conceptualising subjects as choosing subjects who bring their own subjective lived histories to bear on their responses to how they are positioned, and how they position themselves in the narratives constructed in conversation. Hollway (1984) makes the point that without some notion of agency we are left with discourse determinism, which does not account for why people take up a position in one discourse rather than another. The consideration of power in analysis was at the level of the individual, the institution, and the broader social context. The institution (i.e., the Clinical Psychology profession, the mental health system) is considered to exert power in the creation of the discursive world of the clinical psychologist, particularly as regards determining the dominant discourses of this world, but the clinical psychologist is considered to have agency in choosing or investing in the various available discourses, and the subject positions they offer, in the construction of their professional identity. From this perspective, identity is a construction "in-process" (Belsey, 1985, p.169), always under construction in a process never completed, and the subject in-process is considered a site for resistance and change.

2.3.3. Analytic Phases

TA is conceptualised as an iterative, fluid, and recursive process (Terry, Hayfield, Clarke et al., 2017). A number of stages in the analytic process are elaborated, but it should be noted that these stages were not strictly linear. The process was iterative, with movement back and forth between stages during the process of analysis.

Phase 1: Immersion and distance- treating the data as data.

Analytic engagement with the data set began with a process of immersion in the data through listening to the audio files and transcribing the data. This process was progressed with a reading and re-reading of the entire transcribed data set, with an initial consideration of semantic and latent meaning and a noting of potential points of analytic interest. This facilitated a position of immersion and distance in relation to the data (Braun & Clarke, 2013).

Phase 2: Complete coding

Coding commenced with a complete coding of the data set, by hand, with an emphasis on more data-derived codes initially, progressing to more researcher-derived codes as the analysis developed (see appendix F). A complete coding of the data set was considered an appropriate place to start as to commence with selective coding, as would be common in a pattern-based discourse analytic approach, the researcher must know what they are looking to code before they begin (Braun & Clarke, 2013). As the study was exploratory in nature with broad research questions, this complete coding was a way to identify the features of interest, instances, that were then more selectively coded for in subsequent stages.

Phase 3: Selective coding- coding the text in light of the research question, informed by discursive theory.

In the selective coding phase, the emphasis shifted to researcher-derived codes (see appendix G) bringing a theoretical understanding of language as productive to look beneath the surface of the data and consider how language was producing particular versions of reality (see appendix H). The discursive analytic phase of the analysis, informed by Parker (1992) and Willig (2015), focused on the following.

- Discursive object(s): Coding was informed by the discursive object(s) of interest in this study. The main discursive object was ‘distress’, and the text was coded for explicit and implicit references to distress. The clinical psychologist and the profession of Clinical Psychology were also considered discursive objects for the purposes of coding the data. Codes represented the diversity of ways the discursive objects(s) were constructed in the text.

- Discourses: The discourses drawn on by speakers constructing the object(s) were considered. Parker’s (1992) definition of discourse as: “a system of statements which constructs an object” (p.4) guided the process. A number of questions were asked to facilitate the consideration of discursive resources. For example: what picture of reality does this discourse present? How does this discourse connect with other discourses? Contradictions between different ways of describing something were considered through reflection on alternative discourses that could be used, and the differences and similarities in the objects as constituted by these discourses.

- Subject positions: Following Davies and Harré (1999), subject positions offered by discursive resources utilised were considered. Of particular interest was the position the speaker took up/was offered, in what narrative, and how this positioned them in relation to others. Images, metaphors, and analogies used were noted, and the ‘ways of being’ assumed or invoked by these rhetorical devices. The power, rights, and responsibilities of the various subject positions were reflected upon.

- Practices: The opportunities for action opened up or closed down by the discourses drawn on were reflected on, with reference to the subject positions they made space for. The kinds of action made possible and disallowed by subject positions were considered, including who has the right or responsibility to perform these actions.

Phase 4: Review of codes and development of candidate themes

Codes were reviewed, with a return to the data set to check that there were sufficient codes to capture the patterning of meaning and diversity within the data. Codes that captured similar ideas were merged and some codes discarded (see appendix I). Codes that appeared to cluster together were collated in a similar place, initially on Nvivo, then also in word files to facilitate the inclusion of researcher interpretative notes. Additional coding took place as the analysis took shape, and some previously identified instances were rejected as no longer centrally relevant to the emerging narrative of the analysis. The analysis worked from codes to consideration of broader patterns of meaning across the data set and central organising concepts. Similarities and differences in ways of constructing the object/s, and the patterning of discursive meanings across the data set, were considered in the development of themes. A theme was defined as capturing something important about the data, with reference to the research questions (Braun and Clarke, 2006). This phase entailed a return to source material numerous times to check that the grouping of codes in developing themes was a good fit with the broader narrative of a participant’s interview. Themes were considered provisional at this stage.

Phase 5: Review of themes

Candidate themes were reviewed and assessed as to whether they could be considered a good fit with the coded data and to reflect meaning across the whole data set, with a view to constructing an explanatory framework of the themes judged to be most important (Willig, 2013). Questions suggested by Braun and Clarke (2013) aided in the review of themes and revision:

- Is this a theme or a code?
- Does this theme tell me something useful about my dataset and the research questions?
- What are the boundaries of this theme?
- Is there enough meaningful data to support this theme?
- Is the theme coherent?

Phase 6: Refinement and naming of themes

The focus and scope of each theme was defined, themes were named, links between themes and networks of meaning were constructed. This process also entailed a return to individual codes and coded data extracts, which facilitated the writing of brief summaries of each theme.

Phase 7: Production of an analytic narrative of the analysis.

At this stage, the consideration was the overall story that the themes could be said to tell about the topic. Relevant literature was re-considered at this point, and further literature sourced. The question of the operation of power through discourses drawn on was revisited, including who benefits or loses from the operation of a discourse.

2.4. Reflexivity

2.4.1. Personal Reflexivity

As qualitative research concerns the construction of meanings, it is considered crucial that the researcher give careful consideration to what their identity contributes to the process (Willig, 2013). No qualitative researcher can be outside the process. As the researcher, I have considered my ‘self’ central to the construction of the meanings in this study. As a trainee clinical psychologist, I am part of the professional group I am researching. My interest in this topic stems from personal experience working in the NHS, entrenched in practices and discourses about distress in training and the NHS context, and with my own lived experience of distress. Qualitative research has been characterised as an immersive process (Nelson & Prilleltensky, 2010), and I was already immersed in the context that I was researching to a degree. This could be considered a position of advantage as regards my familiarity with the discursive world inhabited by my participants. Discourses can be thought of as the institutionalised use of language, which can occur at the level of discipline (Davies & Harré, 1999). As pointed out by Parker (1992), discourses that operate within psychology may have a different meaning to those outside of this professional culture. However, the contribution of my professional identity and pre-existing relationship with this discursive world to the construction of meaning needed careful consideration. I considered the contribution that my professional identity, as viewed by participants, could make to the creation of the context for data collection, the political and moral commitments that my participants may have assumed from my Twitter account, and the UEL training course, and my contribution to the dialogue in the interviews. I considered these as influences that could lead participants to view the interview as a particular sort of occasion, invoking particular discourses to the exclusion of others. Considering positioning as relational, I endeavoured to maintain an awareness of my contribution to positioning participants in our conversations, how participants positioned me, and my relationship and response to being thus positioned. Reflexive fieldnotes, which included reflection on my identity, and affective responses, were made after each interview and during the process of analysis. These notes formed part of a reflective log (appendix J) and contributed material for reflective discussions with supervisors and colleagues.

2.4.2. Epistemological Reflexivity

Epistemological relativism has been critiqued on the basis of value neutrality and impotence to bring about social change. An extreme relativist position has relativistic consequences insofar as it claims that different social forces lead to the construction of a multiplicity of different realities, with no construction of reality having any claim to be more valid than another (Parker, 1998). As such, entirely relativistic truth claims have the potential to paralyse social activity at best, and at worst, to sabotage principled resistance to abuse of power and oppressive practice within a discipline (Burman, 1990). However, this study uncoupled epistemological relativism from an anti-realist ontology, adopting instead a subtle realist ontology, and assuming judgmental rationality. This allowed for the theorisation of a subject with agency, a subject who is embodied and shaped by the social world, but capable of reflection and choice (Elder-vass, 2012). It has been posited that, as a discursive perspective draws attention to the flexible nature of personal and social being, it is a means of social critique and social change (Willig, 1999). Given the assumption of multiple competing social realities by epistemological relativism, the main concern is how to respond to this epistemological relativity (Willig, 1998). In direct contradiction to the notion of value neutrality, Willig (1998) suggests that researchers be informed by their political views in their choice of what to study, as the researcher who is interested in the workings of discourse must rely on their political views to choose which objects to deconstruct and which alternative constructions to suggest in their place. As the analysis in this study proceeded from more data-driven coding to more researcher-derived coding, a coding influenced by discursive theory, reflection by the researcher on political views, hypothesised to influence analytic choices, became a relevant consideration, explored in the reflective log and discussed in supervision.

2.5. Evaluation Criteria

The means of evaluating quality in qualitative research is an ongoing debate. The assumption of multiple competing social realities, as opposed to one objective reality, means that the criterion of validity needs to be re-conceptualised, with reflexivity foregrounded in order to provide information on the context of the production of meaning by the researcher (Lather, 1993). Continuous reflection by the researcher is considered an important aspect of the process of qualitative research (Harper, 2006). Reflexivity was an ongoing process throughout this project to trace my influence on meaning-making, and will be further elaborated on in chapter 4. In light of the relativist interpretations made in this study, the question of rigour was particularly pertinent to making the case that the interpretations, and the insights that stemmed from them, were more than simply arbitrary (Chamberlain, 2015). Spencer and Richie (2011) suggest that evaluation of qualitative research should be done according to the principles contribution, credibility and rigour. These principles will structure the evaluation of the quality of this research in chapter 4.

3. CHAPTER THREE: ANALYSIS AND DISCUSSION OF THEMES

In this chapter, the analysis of the interview data is presented, organised into themes. The analysis focused on the examination of discursive resources drawn on, the subject positions they made available and implications for ways of being clinical psychologists, and a consideration of power. Data extracts are used to support and illustrate analytic interpretations.

Figure 1: Table of themes:

Themes	**Psychologist's distress is constructed as part of the human condition**	**Work with distress as a difficult and skilled practice**	**Negotiating dilemmas of professional identity and role**
<u>Subthemes</u>	Distress as a normal human response	Distress as inherent to the role of the clinical psychologist	Distress in the context of supervision
	Psychologists are expected to be superhuman	Training as a context for the socialisation of ways of being with emotional experience	Managing distress in the team context

3.1. Psychologist's Distress is Constructed as Part of the Human Condition

Participants mobilised a range of discourses to construct a social reality in which there is a group of humanity, of which psychologists are part, and a continuum of distress, which any human being can experience in difficult circumstances. Discourses constructing distress as part of the human condition were mobilised in resistance to discourses producing distress as a pathological or marginal experience, taboo for 'experts' who are expected to be immune to distress and able to exert a superior control over distress experience.

3.1.1. Distress as a Normal Human Response

Being human was constructed by participants to mean inevitably experiencing distress, with distress described by all participants as a given for human beings. Both Paula and Clare linked distress to "*life stages*", constructing distress as part of a developmental process of life. Michelle described the experience of distress in life as "*a very healthy normal process*". These discursive resources produced distress as a natural human experience that does not necessarily indicate a need for professional intervention. Bereavement and loss (unavoidable experiences in the human life) were given by most participants as examples of life experiences expected to provoke distress for human beings, reinforcing the notion of a universality to the experience of distress. All participants explicitly positioned psychologists (including themselves) as members of the human race, for whom distress in life is inevitable, for example, Sophie stated:

> *We are all human, we're all gonna experience distress*

This discourse of distress as an aspect of the human condition was reminiscent of a Humanist discourse, as it appealed for recognition of a universal, natural, human experience (Copson, 2015); and also, of the evolutionary discourse that operates in Third-wave CBT approaches (as reviewed in ch.1.) to produce distress as a universal human experience. Three participants explicitly stated that training in CFT offered validation for a (described as pre-existing) view that we are all humans who all experience distress. The construction of distress as a non-pathological human experience was also achieved by participants through the mobilisation of a sociogenic discourse that produced distress experienced by human beings as a response to difficult experience in the external world. A sociogenic discourse operated in participant's talk about NHS staff distress to produce the NHS work context as a causal factor for a collective experience of distress. Michelle, among others, explicitly stated a causal connection between the NHS work context and NHS worker's experiences of distress:

> *a lot of NHS employees are distressed because, because of the working environment*

Two participants referred to whole staff teams who are "*burnt out*" in some services. While the concept of burnout can operate to individualise distress, by locating the distress in the individual worker, participants concurrently resisted the individualising effects of the concept by presenting these types of experience as the norm in these service contexts. Staff experience of distress in the NHS was described by three participants as a state of being "*overwhelmed*", talk that evokes notions of experience that is too much for a person to bear.

The positioning of themselves as 'human' was also achieved by a number of participants through descriptions of their own distress as experience felt in the body, and by all participants through the use of lay language to describe their own distress. While this discourse constructed distress in various ways, there was a consensus in using the word distress to refer to a broad spectrum of unpleasant human emotional experience. Participants used metaphors that constructed distress as a messy or dirty feeling: "*a bout of feeling pretty shit*" (Sarah), "*feeling a little bit rubbish*" (Rebecca); discourse that invited the positioning as victim of something bad or unpleasant: "*suffering*" (Rachel); and metaphors that indicated depth and fear of falling: "*low days*" (Louise), "*that terrifying staring into an abyss feeling*" (Anna). As illustrated by these descriptions, distress experience was represented by participants as occurring along a continuum of intensity. Sarah explicitly minimised the relevance of the professional identity in talk about psychologists experiencing distress:

> *Yeah, I think it's, you know, it's what human beings experience, that, in my mind, I don't think there's a difference. I think if you are having, if you are in psychological distress, it doesn't matter whether you're a psychologist, or, or whatever, I think. When things are hard, things are hard.*

In the above extract, Sarah would appear to be resisting an implicit discourse that differentiates psychologists from other human beings on the basis of susceptibility to distress experience. It has been suggested that a dichotomous way of thinking about professionals and the recipients of their services is pervasive throughout the mental health services (Richards, 2010), and four participants explicitly described the dichotomisation of mental health professionals and people who use their services as ubiquitous within the mental health service. Sophie, Louise, and Michelle in talk about a process they called "*othering*". Rebecca in talk about 'us-and-them' thinking that presented these as dichotomising notions as institutional features of longstanding:

> *there are very strong us-and-them narratives which are very deep-seated and rooted and like very old*

It has been suggested that professional caring that entails the construction of distress as pathology supports a dichotomisation of mental health professionals and service users by positioning the recipient of care as ‘other’ (Johnstone, 2000; Laurance, 2003). Sophie made this link by describing processes of “*othering*” as occurring through the use of diagnostic terms by staff, to refer to clients, in “*casual conversation*”. This language presented the pathologising of distress as unremarkable, an accepted norm within the social context. Paula’s description of the mental health services as “*pathologising of life*” also presented the pathologising of distress as endemic, and concurrently called into question the marginality of distress experience, through the substitution of the word life for a word denoting distress. A number of participants disclaimed psychology’s role in the construction of distress as pathology, suggesting that psychologists use psychological theory in an attempt to counter the pathologising of distress. For example, Rachel, in talk about her role within a team:

> *I suppose we're striving to promote psychological theories and ideas, em, to non-psychological staff, so having a, helping everyone to have a good understanding of distress from a sort of non-pathologising position*.

As Rachel was speaking about work with a hospital team, we might infer that it was the medical discourse she was implicating in the production of distress as pathology. However, this splitting of medical and psychological discourses, with the association of the production of distress as pathology with medical discourse alone, was not a consensus. Paula described the pathologising of distress within the mental health system as a process that clinicians, including herself, cannot avoid being party to, by virtue of the nature of the treatments on offer:

> *you are inherently within kind of a system that is, that does pathologise people's, people's distress in a way. I think it, it, kind of sometimes locates it in the individual, and it’s, I think we almost have to, almost in a way, do that in order to be able to offer the, the interventions that we have on offer.*

She went on to describe the recognition of commonalities in affective experience with clients as creating an openness to a risk for psychologists that they will view their own distress as pathological:

> *You can start to think, you know, gosh, these things we pathologise in*

> *others I have some of these within myself.*

Paula’s talk is suggestive of dichotomisation of psychologists, who do the pathologising, and recipients of their services, whose affective experience is pathologised, and implied that the recognition of experience that challenges this binary can be disturbing for the psychologist, a notion also reflected in the talk of a number of other participants. Notably, her talk located the pathology inside the individual, implicating the previously referenced individualising models of distress, operating in the self-to-self relating of the psychologist to produce distress as pathological. Participants occasionally mobilised a medical discourse to describe past experience of distress. Sarah mentioned having a phobia, Sophie referred to having panic attacks, Michelle and Anna described themselves as having been depressed. However, standard professional intervention to treat distress, the social practice this discourse commonly dictates, was not referenced as sought out. Anna was in an ongoing process of Psychoanalysis but did not frame this as an intervention that treated her distress, stating that she did not know why her distress had resolved.

3.1.2. Clinical Psychologists are Expected to be Superhuman

Participants described being positioned by others, and also positioning themselves at times, as people expected to be less susceptible to distress than other human beings. Two participants used the word “*immune*” to describe the expectations that others have of the clinical psychologist’s susceptibility to distress. This term is suggestive of a medical discourse that constructs distress as illness or disease and a positioning of the psychologist as akin to medical expert, a positioning often juxtaposed in a binary relation with the patient position in medical discourse. In the following account, the positioning of the psychologist as ostensibly superior, “*superhuman*”, is presented by Michelle as, paradoxically, disempowering by virtue of the assumptions of invulnerability and the social practices (or rather exclusion from supportive social practices) this positioning entails:

> *There’s this assumption that you’re a psychologist, you'll be sorted, like you won't need any extra help or support because, yeah, I don't even know why, like because somehow, you're this kind of superhuman immune*

> *to the same, I don't know, to emotions, or kind of em [laughs] to being upset by things, or to needing extra support when things are tough*

A number of participants described the expectation that psychologists should have a superior ability to manage distress, without recourse to help from others, as linked to assumed knowledge. This association evokes Foucault's (1975/1977, 1980) coupling of the terms knowledge-power in his theorisation of the disciplinary power of the expert in modernity. Two participants described (but concurrently resisted) a notion of distress as controllable in constructing distress as "*shit*", implying a messy bodily process that the psychologist should be able to control and keep private. The notions of control and processing in Louise's talk of distress management evoked a technical or mechanistic process:

> *you should have your own shit under control, em, that it should all be processed, sorted, neatly boxed off, kind of you know you should know how to cope with, life, I guess.*

As reviewed in chapter one, the Stoic notions underpinning the CBT model operate on the premise that emotion can be understood through the application of technical knowledge and controlled, by rational means, once one has the required knowledge. Both Sarah and Paula described assumptions of superior knowledge-power as made in personal as well as professional contexts. Paula's talk called into question the notion of a separation between personal and professional identities for psychologists in the minds of others, including her family:

> *I think even sometimes my parents have said oh you are a psychologist you should know, know better [laughs]*

The laughter accompanying the statement made by Paula (and Michelle in the first extract) could be interpreted as performed resistance to the notion of invulnerability to distress in the form of an invitation to the researcher to join in viewing this notion as comical. However, there was a suggestion that a dismissal of this expectation of reduced vulnerability to distress is not necessarily easily achieved by psychologists. Anna constructed her experience of distress in talk that presented the professional identity as intertwined with personal identity, with experience of distress constructed as failure across both professional and personal identities, and a feeling of shame described as accompanying the experience, and constraining talk to others about her distress:

> *Actually, I lost all will to tell anyone anything, and I was also so, so caught up with so much shame around how I felt like I'd messed everything up and em been a bad psychologist, bad mother, bad wife, everything, that I really didn’t, I just couldn't face telling anyone.*

Rebecca’s talk also implied a construction of distress as shameful experience operated in the social context. She presented a fear of being viewed negatively by others as a powerful constraint on talk of personal distress by the psychologist:

> *I think people are shut up, we don't talk about certain things because we don't want to be shamed by others, and I think that plays out in lots of settings or seen negatively in the eyes of others or in the mind of others, or feel we are being*

Wetherell (2013) argues that emotion is bound up with local moral orders, and according to Dalal (2018), “Metaphorically speaking, shame is the mechanism which entices us back towards and into ruling norms.” Talk of feeling shame, and fear of being shamed by others as constraining talk of personal distress by psychologists, constructed the experience of distress as the transgression of a social norm for psychologists. Deviance from a social norm has been linked to processes of stigmatisation (Helmus, Schaars, Wierenga et al., 2019), and four participants referred to distress as experience that is “*stigmatised*” for the psychologist. Paula described psychologists as prone to stigmatising themselves, indicating that similar normative processes operate in the psychologist’s self-to-self relating. Louise’s talk constructed the profession of Clinical Psychology as one with a normative prohibition against members experiencing distress deeply embedded:

> *I think it just feels ingrained in the profession that somehow you are not supposed to, you know that that’s only, that’s not what somebody might experience*

Rachel’s talk implied a dichotomisation of people who can cope and have secure attachments and people who are not able to cope and/or do not have secure attachments, with psychologists positioned as people expected to be in the former group:

> *We feel like we shouldn't be like this, and we should be, you know, better able to cope with it or be people with secure attachments, you know*

Robbins (2015) has pointed out that binary thinking not only creates boundaries between people but posits that one group are inherently superior to the other, and, “For classes of things to be true binary opposites, they must be mutually exclusive.” (p1). Michelle’s talk about what may happen if a psychologist acts in ways that would appear to challenge a binary between psychologists and their clients, communicating loudly about needs that are unmet due to systemic issues (implying distress or difficulties coping), evoked Foucault’s (1982) theory of the regulation of individual conduct through dividing practices. Foucault (1982) posited that through these normative practices the subject is divided within himself (sic), i.e. mind/body, or divided from others, i.e. sane/insane:

> *And actually, that irony I suppose is that I think as a psychologist if you do start to shout about it it's then that kind of, you know, what’s the matter with them kind of, that’s seen as quite, em, worrying probably, or quite dangerous, or em meaning you’re not fit for your job or that you need time out.*

Foucault (1976/1980) proposed that confessional practices, i.e. practices entailing the ‘confession’ of personal experience, are also implicated in the regulation of individual conduct, as rituals for the production of ‘truth’ about the self. Both Sophie and Sarah used the word “*admit*” to describe talking to others about struggles to cope, constructing this talk as a confession of prohibited experience. Sarah linked this prohibition to the positioning of the psychologists as ‘expert’:

> *I think if you work in mental health services, as a, you know, kind of positioned as an expert in mental health kind of interventions, you know I think it can be difficult to, to admit, and I use that word consciously, eh, to a wider framework, that there are struggles*.

However, practices of speaking about the self, to trusted others, have also been conceptualised as ‘technologies of the self’, a means of acquiring a self-knowledge proposed to be central to taking care of the self (Foucault,1988). Seven participants reported that they had engaged in some form of talking therapy at some point during their career. Louise constructed psychotherapy as means of acquiring self-knowledge. However, her talk also implied a split between self-knowledge and a need for care. She presented psychotherapy as a practice that could be justified in the professional context as a self-knowledge project, but not as an acknowledgement of susceptibility to distress, or a form of help-seeking, as such:

> *I just, you know, just wanted to know myself more, em, and that, that was true but almost noticing I needed to justify it as you know it's not that I'm like, I don't know, unwell, or it's not that I'm kind of struggling really*

Sophie referenced a discourse of experts-by-experience, discourse that seeks to disrupt a dichotomisation of psychologists and service users, by constructing personal experience of distress as valuable within the mental health services. However, she problematised this discourse as one paradoxical in its effects in practice, as it can be mobilised in a professional context to support and perpetuate division and categorisation:

> *almost all of those conversations still kind of assume there's, therefore, a difference, that kind of there’s still an us and them in that of well there’s experts by experience, and there’s experts by whatever the other one is, and there’s kind of somehow still something different about clinical psychologists who've experienced mental health distress and clinical psychologists who haven't, and I suppose for me that still feels not that helpful, of there just shouldn't be any kind of distinction*

As indicated in the extract to follow, it was suggested by a number of participants that talk about a continuum of distress experiences by psychologists is what is required to de-stigmatise psychologist’s experiences of distress. Sarah constructed the prohibition against speaking about distress as a systemic issue in her use of the metaphor of the #Metoo movement[9]:

> *We know it's not possible for people to go through life and not have (laugh) some sort of crisis of some description, so where are those, where are those experiences, where are people talking about them, you know. So, I guess that's, that's somewhere to start, is that, a kind of, you know, psychological distress me too kind of campaign*

The use of this metaphor constructed the action required as political or politicised action, based in solidarity, opening up an activist position for psychologists who speak about personal distress. Clare juxtaposed a psychologist's self-management of emotion (an expectation she validated to some degree) and talk about distress as political action, also inviting the activist subject position for the psychologist who speaks about distress as a systemic issue:

> *I think we have a role to try and manage our own emotions as much as we can, but we also have a much bigger political role in saying the way that services are set up is shite (laughs)*

3.2. Work with Distress as a Difficult and Skilled Practice

Experience of distress by the clinical psychologist in the context of clinical work was also normalised by participants, and, although framed as difficult experience, not negatively connoted, but used to make a case for emotional support for psychologists in performing their role, access to which they presented as constrained by systemic priorities and dominant discourses. Participants positioned themselves as advocates for the normalisation of distress experience, with a view to increasing access to relational support for psychologists, both in training and in qualified practice.

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[9] The #Metoo movement is a social movement against sexual abuse and sexual harassment – whereby, women have spoken publicly about their experiences of abuse by men in more powerful social positions. Its main aim is to break the silence about these experiences, and empower women through solidarity to challenge the power imbalances that support sexism and racism (Gill & Rahman-Jones, 2020, July 9th)

3.2.1. Distress as Inherent to the Work of the Clinical Psychologist

Both Rebecca and Louise used the word "*inherent*" to describe the relationship between distress and clinical work, language that constructs distress as a permanent, or essential, characteristic of clinical work. There was a consensus in constructing the work with others experiencing distress as demanding and potentially distressing for the psychologist. This was explicitly stated by participants and also achieved in talk that presented a picture of the clinical work as entailing contact with the distressing lived experience of other people. Sophie used the term "*vicarious traumatisation"* to describe the effect of the clinical work on psychologists over time, a concept that produced contact with client distress as causative of psychologist distress. Similarly, Michelle's use of the word "*exposed*" constructed psychologists as vulnerable to harm from the distress of others:

> *you are exposed to so much, kind of distress and trauma on a day-to-day basis and how can that not impact on you, kind of, you know, that if it doesn't impact on you that almost in itself is a bit of a worry or a bit of a concern*

However, there was a consensus in constructing the exposure to distressing experience as an inevitable concomitant of good practice as a psychologist, as indicated in the above extract. Although there were slightly different accounts of this process, clinical practice was described as necessitating a sustained openness to emotional experience as the basis for the work of helping others with distress. Therapeutic work with clients was constructed by five participants using the psychoanalytic discourse of 'containment'. This discourse produced the clinical work as a relational-affective process entailing the taking in of the client's emotion, by the psychologist, in order to help the client to manage their emotional experience. Rebecca's use of a feeding metaphor, and talk of developmental processes, evoked psychoanalytic theory's maternal construction of the therapist subjectivity:

> *The work we do is about trying to sit with people and somehow digest or somehow sort of tolerate their emotions, digest it and give them back in a*

> *sort of understandable way and start to sort of develop people's capacity to think.*

Psychoanalytic discourse produced the psychologist as both receptacle for distress, and expert manager and interpreter of distress, allowing participants to claim an epistemic authority. The power accorded to the clinical psychologist by this discourse could be described as a pastoral power, which has been defined as a power to tend to others through "knowledge of the conscience and an ability to direct it" (Foucault, 1982, p.783).

Knowledge, as psychotherapeutic discourse, dictates how a psychologist should arrange their relationship with others as a condition for the social practices of professional caring, specifying appropriate subject positions for the psychologist and those they relate with in their role (Guilfoyle, 2005). The origins of the containment discourse is in the theorisation of the mother-infant relation by the psychoanalyst Wilfred Bion, theorised as a relation in which there is only one subject (the infant) and an object (the mother) who provides the function of containment for the infant (Bion, 1962). As such, this discourse invites an explicitly asymmetrical positioning, with the psychologist positioned as ‘expert-container’, with primary responsibility for the control of emotional experience, and the client in the complementary ‘dependant-contained’ position, reliant on the psychologist for the management of their emotional experience. However, there was also some resistance to the ‘expert’ position that a container-contained discourse invites. Anna’s talk implied a problematisation of the ‘expert’ position, and she made a case for the value of personal psychotherapy as a process that provides lived experience of distress that challenges a positioning of the psychologist as inherently different to the client:

> *…having experienced being a patient, or really struggling, which I think is, is uniquely important […] maybe it gives you some humility and some appreciation of the depths people can experience and, and stops you positioning yourself as an expert.*

Furthermore, a number of participants made a case for a human-to-human relating in clinical practice, as a form of relating required for feelings of empathy for the client, feelings they described as crucial in therapeutic work and constrained by dichotomising notions. In human-to-human relating, also called 'I-Thou' relating (Buber,1958), the person being related to is recognised to be as fully human as ourselves, in contrast to a de-humanising form of relating enabled by othering processes (Buber, 1958). Paula constructed feelings of empathy as based in acknowledgement of a shared humanity:

> *I mean, I think it's just personally it's just helpful not to hold kind of a polarised attitude of there's this world where there are the people that struggle and the people who don't. Yeah. Just because I think that, that makes our, that would make our job really hard. It would make it actually very hard to empathise and sympathise*.

The psychoanalytic concepts of transference and countertransference were mobilised by five participants to produce the psychologist's own emotional experience as useful to the therapeutic process, while also need to be controlled by the psychologist in interaction, as illustrated in Michelle's talk about clinical practice:

> *I think you have to be able to use, like with, you know, transference and countertransference, and being present and using what you are feeling, but equally not allow that to maybe dominate the room or kind of, em, turn it into all about you and your feeling on it*

The balance of managing one's own emotion, while still having access to it, was described by Michelle as the psychologist keeping their own emotion in a box "*but not a locked box*", constructing personal emotional experience as something that must be boundaried, contained within an internal space by the psychologist, but kept accessible. Five participants also mobilised a containment discourse to describe their supportive function as supervisors, and three to describe their emotion management function in teams. In talk about providing a containment function for staff teams, Rachel used the metaphor of a box to construct management of emotional experience as a boundarying of emotion, similarly differentiating this process from suppression of emotional experience entirely:

> *I talk about containing so physically like a box shape, so kind of em helping things to be a manageable size so they don't feel too big, but equally not squashing them down so just having a, a sort of boundary, em,*

> *that, that then can help the person or the people who you're relating to, to feel that it's manageable*

There was a consensus in constructing the internal space for holding emotion as one with limited capacity, and this notion was used to make a case for access to institutionally-legitimised space for emotion to be released by the psychologist. Participant’s talk indicated adverse consequences both personally and professionally for the psychologist who does not have access to a legitimised space at work to release this emotion. Paula constructed emotion held internally as a liquid that can “*stagnate*” inside you if not released, talk that constructs holding emotion inside for too long as unhealthy for the psychologist. Clare stated that internally-held emotion continues to “*build and build*” and is carried home to affect home life if there is not a “*proper outlet*” at work. Louise’s talk implied a reduced capacity for clinical work in the absence of a space for the psychologist to release emotion held internally:

> *there’s no space to take someone else’s feelings unless you clear out some of your own*

Four participants made a case for legitimised space for emotional support by mobilising a psychoanalytic discourse of anxiety-defence, common in psychoanalytic studies of emotion management in organisations (e.g., Menzies Lyth, 1959; Obholzer, & Roberts, 1994). This discourse produced dichotomising practice in clinical work as defensive emotion management practice, occuring in the absence of alternative ways for the clinician to manage the emotional demands of the role. Michelle’s talk about this defensive emotion management practice constructed emotion as dangerous, validating the notion of a clinician’s need to be protected:

> *If the distress is very strong and it feels very, very dangerous can, it can probably, quickly result in either complete othering of the person that they are working with, as a way of protecting themselves against those feelings, or…*

Rebecca gave an account of disconnection from client emotional experience happening, as a non-volitional defence, in a service where she had limited access to relational support to help her to manage the emotional demands of the work:

> *just feeling unable to sit with or manage anybody else's distress that I was working with, and actually very quickly in a very scary way actually I think becoming very, very, cut off and disconnected from the people I was working with*

Overall, participant's constructions of their role and identity validated an openness to emotional experience and a need for emotional support in the role. However, there was a tension evident between these constructions and the way the service (and/or training course -to be discussed in a subsequent theme) was described as constructing the psychologist's role and identity, in some institutional contexts. Rebecca metaphorically implied that an institutional construction of the psychologist's identity can negate notions of the possibility of an affective response in the clinician, and construct their clinical role as a mechanistic or technical process:

> *the idea that you should be able to just sit and do therapy like a robot, em, person after person after person, and not be affected, and not feel, and services that sort of perpetuate this narrative that, you know, this is just what we do and its, it's fine*

A number of participants linked the devaluing of space for emotion by the institution to a prioritisation of numerical indicators of success over care of people by the institution. Sophie described the emphasis on performance management as constraining the space for reflection that clinicians need:

> *so what gets paid attention to are KPI's* [key performance indicators] *so that's what everyone pays attention to, and reflective space will get pushed right down the agenda, and that space that we need to think gets pushed down*

The prioritisation of activity over reflection in particular service contexts was constructed by Rebecca and Anna as defensive systemic practice, using discourse evocative of Menzies Lyth's (1988) notion of systemic defences against intolerable emotion, a psychoanalytic discourse that produced the constant activity and de-valuing of time for reflection as a practice that is (unconsciously) defending against intolerable emotion, by shutting down spaces for contact with emotional experience. Rebecca's construction of her distress in this context as feeling "*uncontained*" evokes notions of a systemic failure to meet caregiving responsibilities toward clinicians:

> *thinking about services where I felt uncontained actually they've been where the distress has been really high, and the system has sort of perpetuated this inability to think, so this idea that we need to be seeing people back-to-back to back, we need to, we can't be having enough like, supervision is very limited, or it doesn't happen and almost like to be able to sit and think with and tolerate the distress is so unbearable, so the day just gets jam-packed*

Seven participants spoke of increasing power, with increasing seniority, to influence systemic practices. They spoke of involvement in strategic service planning, staff supervision and training of staff teams. However, Anna positioned herself as protector of relational reflective spaces, talk that presented a picture of these spaces as under threat:

> *...slotting in and protecting these actual spaces like a reflective practice group or like clinical supervision.*

Paula described making time for reflective practice groups as "*harder to justify*" in qualified practice, talk that presented these practices as a low priority and implied that the decisional authority was located elsewhere. She went on to emphasise the hierarchal nature of the system, positioning clinicians as dependant on "*management*" for their decision-making power within the system.

While supportive practices were in the main constructed as relational practices, five participants did mention self-care. They primarily constructed self-care, in lay language, as taking breaks during the workday, and establishing boundaries between personal and professional life, to allow time for things other than work. Sophie spoke of "*putting boundaries around your work*", constructing work as something that must be fenced in/kept in its place in order to care for the self. However, this establishment and maintenance of boundaries, including taking breaks, was presented by a number of participants as an aspirational goal, rather than standard practice, due to the performance-oriented culture of the NHS.

Furthermore, three participants described an increasing systemic pressure to work longer hours with increasing seniority.

3.2.2. Training as a Context for the Socialisation of Ways of Being with Emotional Experience

There was a consensus in constructing the training context as one of high demand, and distress experienced by trainees as inevitable to some degree, but a lack of consensus on whether training socialises trainees to manage distress and demands in a helpful way. This lack of consensus may reflect diversity in training practices, and overall ethos, between the various training courses. Some participants described trainee distress as amplified by a training context of high demand coupled with low support in practice (some suggested the support existed on paper), a context that negates messages about the importance of self-care practice that requires time away from work. Four participants suggested that a strategy of pushing through and ignoring distress is the strategy socialised pre-training, reinforced during training, and continued into qualified practice. Rachel, who experienced a physical health crisis post-qualification, described distress throughout training as an embodied experience that she only saw as problematic in retrospect:

> *a simmering level of, you know simmering background kind of noise of distress, that em, I just accepted and felt was acceptable*

She used a discourse of judicial punishment, or devotional suffering, to position the psychologist as consistently relatively powerless within the system, fortunate if reasonable expectations are set by others:

> *You flog yourself to get onto the course, and then you flog yourself throughout the course, and then you might end up in a job where you, there’s an expectation that you will flog yourselves*

Rachel’s talk constructed inattention to experience of distress and pushing oneself to perform as an accepted norm for the trainee. Sarah described this norm as produced by a longstanding socialisation practice for work in the NHS, authorised by those in power, a category she positioned herself in, in reference perhaps to her history of involvement in training:

> *I used to think it kind of set you up to manage the eh, in terms of stamina wise, to manage the pressures of the NHS, and then I was like, well, like, is that even ok? I mean why are we doing that, you know, that shouldn't be ok either, you know actually, em, you know kind of we are therapying people to be kind of overworked (laugh) and unsupported [...] you know it's not ok, because then we are perpetuating something in that system and we are, something is permissible*

Sarah's description of the socialisation process as "*therapying*" invites a construction of the training process as an expert intervention, positioning the trainee in the (less powerful) client position in relation to the training course. The majority of participants constructed the relationship between training courses and trainees as hierarchical but dynamic, with trainees entering the course with pre-socialised ways of being in relation to their own emotional experience, usually through work within the health service, and courses responsible for either reinforcing or challenging this way of being in training practices. Six participants suggested that courses actively recruit people who have developed a strategy of not attending to or not showing distress to perform in such a way as to secure a training place. Rachel echoed Rebecca's use of the metaphor of the robot, a metaphor that implied a construction of the clinical psychologist's role as technical or mechanistic and, in this instance, implied an absence of emotionality was the ideal for recruiters:

> *...they were trying to seek people who maybe were a bit more like robots, it felt.*

Louise suggested that the experience of personal distress was not constructed as an expected aspect of the clinical psychologist's role in the training context:

> *I think that as a whole, training courses are not set up to acknowledge that distress is a part of what we might experience when we hear everybody else's distress all day, every day.*

Michelle differentiated between the performance of managed emotional experience by the psychologist, which she described as socialised during training, and a sharply contrasting hidden subjective internal experience:

> *I guess part of training is probably how you, you know, how to do the swan thing of sitting with a client appearing very calm, whilst inwardly paddling furiously and thinking oh my god, what am I doing, or what shall I do about this, or that's really hard to hear or, you know.*

Michelle's use of the metaphor of the swan suggested that there is an expectation that psychologists will appear serene and keep their emotional experience under the surface. A number of participants talked of receiving both explicit and implicit messages from the course that expression of distress was not expected or acceptable by psychologists in the training context.

Three participants linked the recruitment of trainees with a particular way of being in relation to distress, and the failure of training courses to offer trainees adequate support to manage the emotional impact of the work, to a discourse that constructs resilience as an internal quality of the individual, indicated by the absence of an emotional response to adversity. There was a consensus that an alternative form of resilience, one based in an awareness of emotional experience and the capacity to talk about this experience to others, is what training courses should be trying to foster, as this is what is required to sustain clinical psychologists in qualified practice. This was referred to as "*a flexible resilience*" by Michelle and contrasted with a stoic form of resilience that she constructed as something fragile, "*brittle resilience*", that would be shattered by distressing experience in practice over time. Participants suggested that this alternative form of resilience could be developed through access to psychotherapy and the provision of relational spaces on training that allow trainees to express vulnerability.

Participants constructed access to relational reflective spaces on training as a valuable aspect of professional development in two key ways. Firstly, as these spaces encourage trainees to connect to their internal experience, to allow for the development of a level of comfort with personal vulnerability, which they presented as conducive to improved self-care. Four participants, who stated that they did not have access to helpful reflective spaces during training, described personal therapy they engaged in after completing training as a space for the development of a subjectivity that allowed a different way of being in relation to their own emotional experience. A process they felt they should have been able to undertake on training. Secondly, these spaces, particularly reflective practice groups, were constructed as valuable in developing a professional subjectivity that allows talk about personal emotional experience to others, facilitating a form of resilience located in relationships that allow the expression of vulnerability. The alternative form of resilience constructed by participants evoked the notion of relational resilience (Jordan, 2004), conceptualised as a resilience built through growth-fostering relationships that depart from the construction of relationships in terms of binary oppositions and separateness, with the denial of vulnerability and illusory self-sufficiency this entails. Reinforcing the notion of a resilience embedded in relationships as valuable, all participants referred to friendships with psychologists they had trained with as an important source of informal support post-qualification. Two participants described reflective spaces they experienced on training as supportive in developing an awareness of personal vulnerability and allowing the development of capacity for a resilience embedded in relationships once qualified. However, Paula also presented the reflective practice group as an experience she did not feel positively inclined towards at the time:

> *As much as I hated going there* [reflective practice group], *I think there was this real recognition that it was a course that was trying to offer something for you in the way of time to think, reflect, develop personally, and that gave the very clear message that you, you can maybe talk about things that are difficult and I think that those kind of things are also really helpful when you are working as a qualified psychologist.*

A number of participants described trainees as resistant to talking about their emotional experience in groups, as a practice perceived as dangerous. For example, Michelle’s talk emphasised notions of risk:

> *I think that's very threatening and there is always trainees who really, really don't want to do that, that does not feel like a very safe thing to do at all*

Louise proposed that reflective spaces require a different type of subjectivity, one that trainees, who had been socialised into self-reliance, needed to be supported to develop in a consistent staged process:

> *It's almost like you have to work down that hierarchy, maybe you have to start with thinking about someone else, and then you can think about the environment, and then you can think about where you sit in that environment, and maybe that's about unpicking that kind of strategy of self-reliance stage by stage. But that I think, for a lot of trainees, that's been quite hard, so being able to own it, and yet if you don't have it from day one of a course that that's what we do here, I think it's, you can't just introduce a reflective practice group at some point and expect people to be able to sit comfortably with their own feelings. I think it needs to be out there, but it's difficult.*

This talk presented the reflective practice group as a space in which counter-conducts can be developed, i.e. performances that disrupt hegemonic norms (Foucault 1981/2000). In this case, norms that support a denial of personal vulnerability and encourage self-reliance. However, Louise emphasised the discomfort of this process for the trainee and positioned the course as more powerful, responsible for explicitly setting alternative social norms in a more directive way.

3.3. Negotiating Dilemmas of Professional Identity and Role

Negotiating professional identity and role in professional relational contexts was presented as dilemmatic for clinical psychologists, as discourses that operate in these contexts to produce role and identity invite subject positions that embody conflicting or contradictory affective and social practices. Thus, the performance and combining of the subjectivities available to clinical psychologists was presented as a complicated process. Talk about experience of distress by the psychologist was presented as a relational risk, amplified in the supervisory context by the construction of supervision as surveillance, and in the team context by the expectations attending seniority within a team.

3.3.1. Distress in the Context of Supervision

There was a consensus that supervision that allows talk of struggle and emotional experience, by the supervisee, is an important support to the psychologist in their work and can sustain the psychologist in a challenging role, but also that this form of supervision is not reliably available to all psychologists. Supervision was constructed as serving a surveillance function (that may or may not be benign) by all participants at some point, perhaps unsurprisingly given that this is the primary function accorded to supervision in policy documents. Safety was a frequently referenced concept in talk about supervision, and there was a consensus in describing the nature of the relationship as a key factor determining the extent to which it is safe for a supervisee to speak about their emotional experience. In addition to using the word relationship to describe supervision, a number of participants mobilised discourse that emphasised the relational-affective aspects of supervision. For example, Louise referred to the supervisory relationship as a "*secure attachment"* and Sarah as a "*secure base*", concepts that also evoke notions of security vs insecurity in asymmetrical relationships. Three participants emphasised the importance of human responses indicating care for them, as a person, from their supervisor as the basis for their feeling of safety in the relationship. Sophie was exceptional in her use of a lay discourse to construct supervision as a human-to-human relationship, and she constructed the supervisory relationship as a space in which expression of strong emotion was safe. She constructed her distress as a normal human vulnerability, positioning herself as having similar needs to a client in terms of responses to her distress:

> *Yeah, yeah, that you trust that you can be vulnerable in front of em, and I think that's, that is the biggest thing I think, I would say, in my experience, is that there is someone that you can go and who will say, you know, let's make a cup of tea, let's sit down, let's talk about it. I mean, it's not rocket science because it's what we know, if we speak to the people who use our services, they all say, look I, what I really want is someone I can sit down and talk to and trust, we're not different, we're not different.*

Sophie's talk presented resistance to dichotomising notions as facilitative of less restricted emoting practice for the supervisee. Rebecca constructed the supervisor who is unsafe to speak to about personal emotional experience as someone who is inclined to practice based in dichotomising notions:

> *supervisors perhaps who have been more along the orientation of a bit us*

> *and them*

Similarly, Paula constructed an unsafe supervisory space as one in which an admission of "*struggling*" would be unsafe, likely to invite a judgemental type of surveillance by the supervisor. Clare referred to the supervisor functioning as a "*safety net*", and Sarah spoke of the supervisor being able to "*catch anything I didn't notice*" with regards to personal experience of distress. This discourse, producing distress as dangerous, and supervision as a form of risk management, evoked notions of surveillance and of distress as the potential for impairment. Both constructed the surveillance function as benign, supportive. However, Clare elsewhere referenced concerns about perceived fitness to practice as a reason that the psychologist may not talk openly about emotional experience, implying a dilemma entailed in the dual-construction of supervision as surveillance and support.

Clare stated that supervision should not become "*pseudo-therapy*" and indicated, as did a number of other participants, that talk of personal and emotional experience by the supervisee dictates this boundary between supervision and therapy. However, the clear boundaries delineating personal therapy from supervision that the DCP propose should exist (DCP, 2014) were presented by participants as difficult to define in practice. Foucault (1982) theorised that the operation of power can be seen when an inspecting gaze is interiorised by the subject who then comes to exercise surveillance over themselves, becoming their own overseer and self-regulating in accordance with the demands of the social context. This self-regulation was presented as a process complicated for psychologists by a lack of clarity about the demands of the supervisory social context. Michelle spoke about trying to figure out, in her early years of practice as a psychologist, how much she was "*allowed*" to share about her emotional experience, constructing talk of emotional experience as something that may or may not be permitted. Rebecca constructed the supervisory relationship as a context in which the rules or norms are unclear (although she suggests otherwise):

> *I think there are different ideas in terms of what's appropriate for supervision and what's not perhaps, and I think there are things that are, I*

> *think there's, there is a very clear boundary as well between, you know, supervision and therapy and how you use both appropriately, em, and that it's hard and I think there's often a bit of a panic in terms of what's ok to talk about, what's not ok to talk about what will, I don't know.*

Her repetition of the word "*appropriate*" indicated a social norm, but one constructed as mercurial, and her description was suggestive of a nebulous threat should she fail to correctly judge a boundary between the practices of supervision and therapy. Two participants predominantly mobilised a container-contained discourse to describe the supervision process. This discourse validated the expression of strong emotion in supervision, and allowed a positioning for the supervisee that entitled them to a supported vulnerability, and expert help to manage their emotional experience. Michelle's talk produced access to supervision that can offer containment as dependant on a sense of safety in the supervisory relationship, and systemic priorities:

> *obviously you have supervision and you kind of hope that's a safe space in which to do that, but I know a lot of people who either don't feel that safety with their supervisor or, you know, supervision gets cancelled or moved or other things are prioritised.*

Sophie was unusual in describing reliable access to an emotionally supportive supervisory relationship, even with an increase in seniority. Three participants described the emotionally-supportive supervisory space as harder to find with an increase in seniority. Louise indicated that there is less of an expectation (from self and others) that the psychologist will need this type of supervisory space as they move up the hierarchy and that the priorities of supervision can shift:

> *the emotional bit probably has been missing from that because the, the focus has been strategic*

However, there was a consensus that with increasing seniority, the need for emotional support in the role does not decline. Two of the three participants who did not have access to supervision that allowed talk of emotional experience constructed personal therapy as an alternative relational space to freely express, and make sense of, their emotional experience. Louise framed the expectations that the same emotional support would not be as necessary with seniority as an expectation based in an association of seniority with a reduced emotional experience:

> *…somehow because you are in that senior post, that you are not supposed to feel things anymore (laughs)*

Her laughter suggests a framing of this expectation as comical or ridiculous.

3.3.2. Managing Distress in the Team Context

Participants primarily used a lay language, for example, "*chat*" (Sophie), "*rant*" (Clare), "*moan*", "*grumbles*" (Paula), to describe talk about emotion with colleagues in the MDT, language constructing conversations about emotion in the team context as more casual or informal human interactions. Four participants presented relationships with colleagues as spaces that offer space for a more 'human' subjectivity in talk about having a laugh with colleagues and speaking about topics other than work. Clare referred to conversations about distressing experience, with colleagues, as happening over a cup of tea (as Sophie had in speaking about her supervision), strengthening the construction of these spaces as informal and the positioning of both parties as fellow-humans, rather than professionals, with reference to a more domestic setting:

> *I think the types of places where you can have a bad session and then go and have a rant and a cup of tea with someone, for me that's a much more supportive, and that's I think how you do the more distressing work long-term.*

As illustrated in the above extract, and in common with descriptions of the function of good supervision, relationships with team members that allowed talk of emotional experience were constructed as serving a sustenance function for the psychologist working in emotionally challenging contexts. Sarah referred to this as "*a kind of team resilience situation*", discourse that produced resilience as a quality of a group rather than an individual. A number of participants constructed the MDT team as a supportive community, offering the psychologist a position of belonging, embeddedness, connectedness to others as a team member. For example Louise, who also mobilised a discourse of risk to emphasise the clinician's need for support within the team:

> *The work that we do is very demanding, as you know, and really there is something about you can work in incredibly demanding settings but if, but if you feel supported, if you are not alone, if there is a sense of belonging and connection to your team members and you feel that they've got your back, and you've got someone to talk to and that you are not left alone with high-risk situations.*

Six participants juxtaposed practising alone, a practice produced as dangerous by a risk discourse, with having someone to go to after a distressing experience, someone to talk to and think with, someone who would offer validation of emotional experience and support. One participant (who did not work in an MDT context at the time of the study) problematised the 'expert' position, as one desired by others, but not conducive to the establishment of relationships for the one positioned as expert:

> *…and really be part of the teams and embedded in them rather than a kind of roving expert who arouses a lot of envy or suspicion*.

With the use of profanity and lay language, and talk of fallibility, Rebecca emphasised a positioning of herself as 'human' in relationships with team members:

> *em, what makes for good colleagues I think, people that, I think there's something about having people that you're working with where the relationship is sort of good enough that it's ok for it not to be ok, so if you've like really fucked something up, or you've had a really shit day, em, and you've done something awfully wrong, or just been a rubbish therapist that day*

Rachel also constructed access to these supportive team relationships as dependent on being able to perform a 'human' subjectivity but presented the revealing of human vulnerability by the clinician as a risk. Similarly, Louise described not talking about personal experience in teams as a defensive emotion management practice:

> *…you know people have to keep themselves separate because that's the only way to keep yourself emotionally safe*

The notion of talk about emotional experience as boundary work, and of norms as unclear or disputed, was reflected on by Sophie, who, like Rebecca, used the word "*appropriate*", implying a risk of breaching social norms or rules:

> *so to talk about your own distress in a work context, even though it might be work-related, I think some people would not feel was, wouldn't be comfortable with, or wouldn't feel was appropriate, so I suppose it's where do you put those markers between what you share and what you don't share in a work context*

Sarah endorsed a construction of clinical psychologist as professional that requires the limitation of talk of the personal, presenting crossing a boundary between personal and professional as practice that may undermine her professional identity:

> *I think there's some kind of level of professional impression management, you know. I mean I have anyway, I, you know, It's, em, I just think it's you know, it's just being professional really having a professional boundary.*

There was a suggestion that the pressure to distinguish oneself from other staff increased with seniority. Parker (1992) proposed that social structure provides the pre-condition for positioning in discourse, and two participants described a positioning as 'container-expert' linked to their seniority within teams. The container-contained dynamic has been critiqued on the basis that, as a theorised subject-object relation, it constrains the subjectivity of the container in the dynamic (in this case, the psychologist), thus constraining intersubjective relating (Benjamin, 1990). Two participants in particular described a positioning as 'container-expert' as one that constrained their intersubjective relating in teams. The positioning as 'container-expert', responsible for the care of others, dominated Michelle's descriptions of her relationships with the staff team. She also described the management of a demand for care from others, by setting boundaries, as complicated by a conflict with the values of her professional identity:

> *yeah, of being able to assert some kind of boundary, and I guess trusting that that doesn't mean that that makes you a crappy psychologist or that like somehow you are saying you don't care*

Michelle’s construction of her professional identity here evokes Foucault’s (1982) notion of pastorship as a salvation-based form of power grounded in the provision of love and it has been suggested that pastorship values commitment to those being cared for to the point of self-sacrifice (Hook, 2003). In line with this notion of self-sacrifice, a number of participants described not prioritising, or as Sophie framed it, “*neglecting*” (an antithetical notion to self-care), their own needs in order to meet the needs of others. As illustrated in the following extract, Rachel mobilised a discourse of distress as something that must be controlled and not shown by the psychologist, in order to offer the containment function in a multidisciplinary team:

> *you might be the highest-paid person in that team, and you almost have to park your own distress at the door to manage the other professionals, em, you know so to be containing for others, to be seen as being able to cope and to manage, in order to keep other people afloat you know*

Her description evoked an image of risk and positioned her as responsible for providing safety for the team through a performance of coping that entails not showing her emotional experience. However, both Michelle and Rachel also struggled with this construction of psychologist as ‘container-expert’, who cannot show emotion, resisting it at times utilising a discourse of shared humanity and a Behaviourist discourse of modelling. Michelle spoke about a plan to try to perform a more ‘human’ subjectivity, to establish a different dynamic with the team in her next role (she was due to change jobs):

> *actually, it’s an opportunity to model that it’s alright to have days where you're feeling sad or feeling stressed or feeling anxious that, kind of, its ok to talk about that, to acknowledge that*

In the above extract, Michelle uses the behavioural discourse of modelling to justify the expression of emotion, by the senior psychologist, by re-inscribing it as the performance of leadership.

4. CHAPTER FOUR: DISCUSSION AND CRITICAL REVIEW

In this chapter the analytic findings are considered, in dialogue with relevant literature and empirical research, and situated in the historical and socio-cultural context of the Clinical Psychology profession in the UK. The questions of reflexivity and of the evaluation of the quality of the research are re-considered. Lastly, some implications of the findings for research and practice are presented.

4.1. Discussion

Broadly speaking, the picture presented by participants in this study was resonant with the conclusion drawn by previous authors that organisational and professional factors function to constrain clinical psychologists from acknowledging their own distress and accessing support (Hannigan et al., 2004; Walsh & Cormack, 1994). In talk about clinical psychologist's experiences of distress, including their own, study participants emphasised the clinical psychologist's humanity and minimised the relevance of the professional identity. However, they also constructed the experience of distress as inherently bound up with the clinical psychologist's professional identity and role. Both constructions, clinical psychologist as 'human' and clinical psychologist as 'container-expert', were mobilised in the service of attempts to create space for acknowledgement of clinical psychologist's experiences of distress and to make a case for supportive social practices for clinicians in the NHS.

4.1.1. Research Questions Re-visited

4.1.1.1. How do participants construct a clinical psychologist's experience of distress in relation to their professional identity?

Participants in this study described distress as stigmatised for the clinical psychologist. They talked of feelings of shame linked to experiences of distress, and of fear of being viewed differently by colleagues as inhibiting the psychologist's talk of personal distress. These findings are consistent with the conclusions drawn by previous researchers that stigma, and concerns about adverse consequences arising from talk about personal distress in a professional context, are implicated in constraining clinical psychologists from talking about their experiences of distress and seeking support (Charlemagne-Odle et al., 2012; Grice et al, 2018; Tay et al., 2018). The construction of distress as stigmatised and shameful for the psychologist can be understood with reference to the socio-historical and discursive context of the construction of the clinical psychologist's professional identity, and the perpetuation of particular representations of reality, and subjectivities, in the discourses and practices of the present context of the clinical psychologist in the NHS.

Stigma, Dividing Practices, and Dichotomising Notions

Foucault (1962/1987) opined that psychologists draw on qualified forms of science to give them the knowledge-power to engage normalisation practices. Rose (1998) proposed that these disciplinary practices also shape the subjectivity of members of the psy-professions. Norms are a key consideration in understanding stigma as stigmatisation can be described as a process in which a particular condition is judged by an individual or group to deviate from a norm, evoking negative emotional and behavioural responses toward those judged to be deviant (Helmus et al., 2019). Dividing practices entailing the classification, categorisation, and division of human beings function to construct norms (Foucault, 1961/1965,1982). The origins of Clinical Psychology in psychometric testing root the profession in classification practices that legitimise binaries (Hubbard & Hare, 2015). Diagnostic classification systems, produced by a medical discourse, are powerfully constitutive of pathology and normality and can be considered one of the primary means through which power operates in the past, and present, mental health service context (Pickersgill, 2012). A consistent finding of prior research into distress using discourse analytic methods has been the ubiquitousness of a medical discourse that constructs distress as mental illness (Georgaca, 2014). Clinical Psychology has been described as historically complicit in the dominance of a medical discourse in the mental health system in order to retain their professional power and status (Boyle, 2011). Newnes (2004) has suggested that three stances are open to clinical psychologists towards a medical discourse and the practices it legitimates: compliance, eclecticism, and radical opposition. Newnes (2004) observed that historically the profession has tended toward either compliance, i.e. using psychiatric terminology to label clients, or eclecticism, i.e. not using diagnoses but not actively challenging the medicalisation of distress. The position adopted by participants in this study can be characterised as somewhere between eclecticism and the third option: radical opposition, i.e. the promotion of an alternative (de-medicalised) understanding of distress (Newnes, 2004).

Another effect of the classification and categorisation of human beings is the formation of groups, with attendant minimisation of within-group differences and exaggeration of between-group differences (Turner, 1987). Throughout, participants in this study struggled with discursive practice that produces the clinical psychologist as different from other human beings on the basis of susceptibility to distress, a struggle that indicated the operation of dichotomising discursive practice within their social context. In the institution of mental health care dichotomising discursive practices, also known as 'us-and-them' thinking (Helmus et al., 2019; Richards, 2010) and 'othering' (Carroll, 2016; Maccallum, 2002), construct a group of 'us' the mental health care professionals, bearers of the clinical gaze that objectifies the ‘them’ (Foucault, 1963/1973), i.e. the people subjected to, and subjugated by, the clinical gaze. Dichotomising discursive practice, othering, has been defined as a powerful subjectification process, a process that forms the subjectivity of those positioned as ‘other’ and also of those who occupy the position of the hegemonic subject in relation to this discursively defined other (Thomas-Olalde & Velho, 2011). Thus, the dichotomisation of mental health professionals and service users can be theorised as having a formative influence on the subjectivity of clinical psychologists, irrespective of their positioning in this discursively defined dichotomy. Dichotomising discursive practices were presented by participants as endemic in the professional and institutional context of the clinical psychologist. They presented these dichotomising discursive practices as problematic in terms of clinical practice, and as strongly implicated in circumscribing space for clinical psychologists to acknowledge and talk about their personal experiences of distress.

It could be argued that the effects of the operation of dichotomising discursive practices in the formation of the professional identity of the clinical psychologist can also be seen in the qualitative study by Charlemagne-Odle and colleagues (2012). Their participants reported that experiences of personal distress conflicted with ideas of what is allowable, or expected, as a clinical psychologist, their own ideas and the profession’s. Comparisons with the findings of Tay and colleagues (2018) is complicated by the implications of the construction of distress as 'mental health problems' in their study. However, it could be argued that the effects of the construction of distress in terminology that evokes notions of distress as pathology, coupled with the operation of dichotomising discursive practice in the social context of study participants, explains their finding that the likelihood that clinical psychologists would tell someone about their distress was found to relate to self-stigma, and perceived stigma, but not the nature or severity of the distress as conceptualised in diagnostic terms (Tay et al., 2018). Stigma is associated with the construction of distress as mental illness (Georgaca, 2014), and the dichotomisation of people as either mentally ill or healthy serves to create and perpetuate the stigmatisation of distress (King, Brophy, Fortune et al., 2020). Construction of distress as mental illness, and the dichotomisation of clinical psychologists and others with regards to susceptibility to distress, arguably operates to construct all distress as stigmatising for the clinical psychologist, not necessarily certain expressions of distress more than others.

Resistance to Dividing Practices and Dichotomising Notions

The emphasis placed by participants in this study on a positioning of themselves as human beings, and the mobilisation of discourse that constructed distress as an aspect of the human condition, can be interpreted as resistance to the pathologisation of distress, and to their subjectification by dichotomising discursive practice operating within the social context. This resistance, occurring at the site where power operates, is the process of resistance as theorised by Foucault (1982). Participants drew on a range of discourses in the service of this resistance. Including Behaviourism, providing support for the view that the profession's origins in Behaviourism facilitates a de-pathologising perspective (Smail, 1995), and Humanism. While not explicitly a focus in the training of clinical psychologists, Humanism has historically offered a counter to the de-humanising positivist and empiricist agendas that have dominated the practice of mainstream psychology (Parker, 1999; Tudor, 2015) and circulates in the socio-cultural context as a result of the influence of the psy-professions in modernity (Parker, 2002; Rose, 1985). Humanist discourse may have particular appeal to clinical psychologists whose defining feature as a profession, David Smail (1995) has observed, is a tendency to *side with* their clients. Smail (1995) proposes that this feature has been shaped by largely situational rather than discursive factors, i.e. by the location of the profession in the context of a public health service, the characteristics of the people they help, and their relative lack of formal power in this system compared with psychiatrists. The mobilisation of a CFT discourse by study participants, to enable a positioning of themselves as 'human', suggests that the emergence of Third-wave Cognitive Behavioural approaches has also offered clinical psychologists a discursive resource to construct distress as a normal aspect of human experience. Third-wave approaches (in their original forms at least) do not use a discourse of psychiatric diagnosis and are not, as such, as heavily implicated in dividing practices. However, it should be noted that these approaches stop short of radical opposition to the medicalisation of distress by labelling themselves ‘transdiagnostic’ treatments (e.g., P. Gilbert, 2009; Hayes, Strosahl & Wilson,1999).

The medicalisation of distress within the institution of mental healthcare has been problematised by a number of authors. There are books devoted to this topic (e.g., Rapley, Moncrieff & Dillon, 2011; Speed, Moncrieff & Rapley, 2014). Dichotomising processes have been described as underpinning the stigmatisation of the recipients of mental health services (Richards, 2010), and professionals with lived experience who work in them (King, Brophy, Fortune et al., 2020; Rhodes, 2020). This study can be considered an original contribution to the literature as it illustrates the effects of the pathologisation of distress and dichotomising discursive practices on a professional group who are in a powerful social position in the institution of mental healthcare, clinical psychologists, and some of the discursive resources that can be drawn on in this context to resist subjectification by these discursive practices.

The Clinical Psychologist as 'Expert' in Emotion Management

While resistance to the pathologisation of distress and dichotomising discursive practice was more overt in participant's talk, there was a process of subjectification by a discourse that appeared more difficult for participants to resist. A discourse that constructed the clinical psychologist as someone who should, by virtue of their power-knowledge, have a superior capacity to manage personal distress. Findings of this study resonated with the conclusions drawn by

Charlemagne-Odle and colleagues (2012) that “being seen as a coper” (p.249) is perceived as important by clinical psychologists, and with van Der Merwe's (2019) observation, stemming from her research into emotion management by psychologists in Australia, that psychologists are expected to be a model of the "perfect, worked over, emotionally limber self" (p.37). Participant's descriptions of the expectations that they and others had of their superior capacity to cope would seem to eschew the passive patient positioning invited by the medical model (Georgaca, 2014). Conceivably this could be attributable to the aforementioned dichotomising discursive practices and the positioning of the clinical psychologist, as ‘expert’ in mental health, in an ostensibly superior group with regards to distress. However, participant's talk about these expectations in this study also suggested the concurrent and interactive effects of the operation of a discourse that responsibilises the sufferer in the management of their distress, with particular implications for what is expected of the ‘expert’.

Rose (1998) has argued that theoretical approaches in psychology share a common normativity in their construction of the individual as the self-contained locus of thought and action, responsible for their own behaviours and (mis)fortunes, i.e. the "unitary, individual, rational subject" (Venn, 1998, p.146) who has traditionally been the subject of mainstream psychology. He has opined that psychotherapeutic and medical discourses all individualise, de-contextualise, pathologise, and mystify distress (Rose, 1998). However, as regards the responsibilisation of the sufferer in the management of distress the discourse of the CBT psychotherapeutic approaches is most strongly implicated. Dalal proposes that the key notion contained in a CBT discourse is the following: "it is believed that you should be able to choose and determine what you feel and think. If you feel depressed say, then it is because you have not yet understood how to take control of your inner life." (2018, p.6). Thus, the ‘expert’ is produced by this discourse as someone expected to have a superior capacity to control their internal experience. Furthermore, in an influential UK government report by Lord Layard promoting CBT (Layard, 2006), happiness is produced as a state that all human beings should be able to achieve, with sufficient effort, irrespective of contextual or historical factors. Where happiness is constituted as a normal and achievable state and, by virtue of the responsibilisation of the individual in the management of emotional experience becomes a moral imperative, all suffering is, by default, constructed as dysfunctional and a moral failing (Dalal, 2018). Notably, feelings of failure associated with the experience of distress were reported by a participant in this study, and, as reviewed in chapter one, have been reported by large numbers of psychological therapists, who also report distress, in NHS surveys. It has been suggested that the profession of Clinical Psychology in the UK have strongly affiliated themselves with the CBT paradigm (Dalal, 2018). An observation that would seem to be borne out by the status of CBT as a mandatory competency in the professional training of clinical psychologists. As such, it could be argued that this expectation of a superior capacity to cope, based in superior knowledge, is an example of the disciplining of the psy-professions by the regimes of selfhood they have played a role in inventing and perpetuating (Rose, 1998).

It could be argued that the psychoanalytic construction of ‘expert’ carries a similar expectation of a superior capacity to manage distress experience, in the clinical encounter at least. However, the case could be made that this expectation is offset by the notions that the therapist will have their own neurosis and experience countertransference (as outlined in ch.1), and by the legitimisation of spaces for the therapist to receive emotional support, or containment, themselves (Berman, 2000; Stewart, 2002). The discourse of Third wave CBT approaches, mobilised by participants to allow a 'human' subject position for the psychologist, while perhaps appearing to be a rupture or change in systems of thought at first examination, does not allow an escape from the 'expert' position that carries the expectation of a superior capacity to manage distress autonomously. Similar to Behaviourism, these approaches expect the therapist to 'model' the ideal way of being for others (as outlined in chapter one), with any experience of distress safely located in the past, an expectation that implies a construction of the therapist as someone with a superior ability to manage their emotional experience.

Resistance to a Techno-Scientific Construction of Professional Identity and Role

It has been suggested that the marriage of the objective stance of science and the intersubjective healing role of practice in the clinical psychologist identity has been fraught with tensions from the beginning (Cheshire & Pilgrim, 2004). The discourse of science has historically been credited with constraining space for clinical psychologist vulnerability (Pilgrim & Treacher, 1992). More recently, the point has been made the tenuous balance that had been achieved between intersubjective, more intuitive, perspectives and the more technical, ostensibly more scientific, approaches in the formation of the clinical psychologist identity has been increasingly threatened by a drive for clinical psychologists to be defined as evidence-based practitioners (Dudley, 2017). Particularly in the context of a health service that privileges a form of evidence that gives CBT, a technical approach allied with more positivist iterations of science, an advantage over more intersubjective or intuitive psychotherapeutic approaches (Dalal, 2018; Guilfoyle, 2019). Participants in this study used the power-knowledge contained in their reflective-practitioner identity, and, with what could be argued was the intersubjective practitioner identity, to resist an institutional construction of their work as a technical process, performable by an automaton. A construction of their role and identity they presented as invalidating their emotional experience, and de-prioritising social practices that they presented as crucial in helping them to sustain their work. A number of study participants mobilised psychoanalytic discourse to construct a professional subjectivity that enabled particular stances and practices in relation to emotional experience. The psychoanalytic discourse constructs clinical work as a relational-affective process, and legitimates ongoing attention to the therapist's emotional experience in supervision practices (Milton et al., 2011). Though the stances enabled by this discourse, systemic factors contributing to worker distress could be elaborated, and emotional support for clinicians legitimised. However, psychoanalytic discourse, while useful in this context as a source of knowledge-power, was also presented by participants as a discursive framework that offered some constraints. The construction of the clinician as 'container-expert' risked re-producing an expert-patient dichotomy and constraining space for intersubjective relating. Furthermore, it was indicated that the power accorded by the 'container-expert' construction of professional identity, which could be characterised as a pastoral power (Foucault, 1982), may invite expectations of self-sacrificing practice by the clinical psychologist for the wellbeing of others.

Emotional Control and Leadership

There was some resistance to the effects of subjectification by discourse that constrained intersubjective relating, by participants in this study, with regards to clients and team members. However, these effects appeared harder to resist with an increase in seniority. It could be argued that this is due to the combined and interactive effects of subjectification by psychoanalytic, cognitive-behavioural, and neoliberal discourses constructing the subjectivity of the 'leader' in the NHS. The case can be made that these discourses function to support and reinforce each other to close down space for talk of vulnerability, particularly for more senior clinical psychologists, in the construction of the leader as someone who should exercise a superior control and restraint as regards their own emotional experience. It has been suggested that the capacity to monitor and control one's emotional experience is a marker of high status in a neoliberal society (Froyum, 2010; Ilouz, 1997) and that emotional control is symbolic capital as a marker of professionalism (Ilouz, 1997). As previously noted, the CBT construction of ‘expert’ carries similar expectations, and the rise to dominance of the CBT psychotherapeutic approaches has been attributed to their good fit with the modern neoliberal agenda (Hall, Pilgrim and Turpin, 2015). The NHS leadership framework’s construction of the NHS leader as someone with strong capacities for self-awareness and self-management suggests that the capacity to manage emotional experience in a self-reliant fashion is a valued form of cultural capital in the contemporary NHS. The discourse of resilience mobilised by some clinical psychologists in the promotion of clinical psychologists for leadership (e.g., Antibi, 2012; Moyes, 2012) would seem to imply what participants suggested is a problematic construction of resilience, i.e. a stoic-type individualist construction of resilience that entails a denial of vulnerability and dependency needs.

This study can be considered an original contribution to the literature in its illustration of the operation of psychotherapeutic and neoliberal discourse in the construction of the subjectivity and role of the clinical psychologist in the contemporary NHS. In particular, in the illustration of the discursive construction of the clinical psychologist as ‘expert’ or ‘leader’ who should exert a superior control over their emotional experience; a construction that has implications for clinical psychologists in terms of talk about their own distress and access to supportive social practices within the institutional context.

4.1.1.2. How do the discursive resources drawn on shape their accounts of how distress has been responded to and how they think it should be responded to?

The reluctance to seek support from others, strategies of self-reliance, and attempts to persevere at work despite the experience of distress (Brooks et al., 2002; Charlemagne-Odie et al., 2012) were presented by participants as practices supported by hegemonic discursive structures and institutional practices. Descriptions of the institutional context by participants in this study echo Charlemagne-Odle and colleagues (2012) participant's descriptions of a culture of long working hours and skipped lunches in NHS organisations. Dominant discourses in the institutional context construct reality through the representations of it that they offer, the social practices these representations dictate, and truth effects that embody the realities as defined by these representations (Opie, 1997). Overall, the findings of this study provide support for the view that a neoliberal ideology, with its emphasis on productivity, the location of responsibility for distress and recovery in the individual, and denial of dependency needs, has had an adverse effect on service providers in the mental health services (Jackson & Rizq, 2019; Watts, 2017, Nov.4th).

Self-care and the Repudiation of Dependency

There is mounting evidence that all NHS workers are expected to work to tighter and tighter performance targets (Felstead et al., 2013), and this picture of the NHS context was reflected in participants talk. Neoliberal subjectivity has been described by Layton (2009) as a form of subjectivity that encourages manic activity, devalues caregiving, and denies the interdependence of human beings and human dependency needs. Study participant's talk of the emphasis on activity over reflection, the de-valuation of supportive practices, and the promotion of an individualist form of resilience entailing self-reliance in the management of emotional experience, in institutional contexts, suggested that this form of subjectivity was valorised in many of these contexts.

The various psychotherapeutic discourses allow, warrant, or dictate a range of social and material practices and constrain or de-legitimise others. The dominant psychotherapeutic model in the NHS, CBT, does not legitimise spaces for emotional support, instead aligning with a neoliberal ideology in the promotion of self-reliance in the management of a de-contextualised, individualised, distress experience (Jackson & Rizq, 2019). Individualising constructions of distress also dominate in literature and research on clinical psychologist distress (i.e. burnout, stress, mental health problems - as reviewed in ch.1.). The BPS Practice Guidelines (2017), while attributing a role to a supportive other, would appear to accord with the promotion of self-reliance, to a degree, in their direction that: "within their CPD plans and supervision psychologists should consider self-care and how they can maintain their own wellbeing." (p.12). Inevitably, the location of distress within the individual orients people and institutions to seek individualistic solutions to distress (Coles, 2010), and the discourse of self-management invites the repudiation of a need for dependency on others (Benjamin, 1990). Creating a discursive context supportive of practices such as the prioritisation of formative and normative aspects over restorative functions of supervision (Dooley & Peyton-Lander, 2014). Skovholt and Trotter-Mathison (2011) construct care of others as being in direct competition with self-care in their tome *The Resilient Practitioner*, and recommend various self-management techniques in addition to cautioning clinicians against co-dependant relationships. Dattilio (2015) places the responsibility for distress management squarely on the shoulders of the individual psychologist, describing psychologists as hypocritical in their resistance to using the self-care strategies they teach their clients, such as cognitive restructuring, mindfulness and maintaining a balanced lifestyle. Notably, the strategies he suggests are primarily those of CBT or Third-wave approaches. Mindfulness meditation, a core practice of Third-wave CBT approaches, has been widely promoted of late as a way of reducing NHS worker's distress (Lomas et al., 2018; Marx, Strauss & Williamson, 2014; Wise et al., 2012). It has been argued that Mindfulness Meditation is a neoliberal iteration of the original Buddhist meditation practice, stripped of the traditional ethical and moral basis (Purser, 2019). In this form, the meditation practice has been described as practice that responsibilises the individual in distress management, encouraging them to look inwards for the causes of distress, discouraging critical thinking and social action to address external causes of distress (Purser, 2019). The case has been made that the dominant discourse of resilience in the mental health services operates similarly to shift focus from social-contextual factors causative of distress to internal, individual factors (Harper & Speed, 2012). Study participant's descriptions of what they presented as a problematic construction of resilience that operates in the institutional context evoked what has been described by Joseph (2013) as "embodied neoliberalism" (p.38). A construction of resilience that privileges autonomy and self-reliance, locating strength or weakness in the individual, and effectively diverting attention away from the examination of systemic factors (Joseph, 2013). Participants presented the expectation that they should manage distress autonomously as one that constrains their access to help. Similarly, participants in the study by Charlemagne-Odle and colleagues (2012) described the notion that, as psychologists, they should manage distress autonomously as one that delayed them seeking help.

This study can be considered an original contribution to the literature in its illustration of the role of discursive structures that individualise and de-contextualise distress in the creation of a social context in which access to supportive practices are constrained for clinical psychologists, and practices such as perseverance in attempts to meet demand, and inattention to embodied signs of distress, are supported.

Making a Case for Supportive Practices – Clinical work as Emotional Labour

Previous research has reported that psychologists describe the seepage of emotional experience from their professional lives impacting on their personal lives and that they engage in various self-care strategies outside of work hours to make them better professionals (van der Merwe, 2019). Arguably indicating that the pressure to be self-reliant in emotion management eats into personal time. Participants in this study constructed self-care as the setting of boundaries to protect their personal time. Overall, the case made by study participants for access to spaces in which talk of their emotional experience is legitimised is in line with one of the most consistent findings of research on psychologist distress to date, pertaining to the value of social support in moderating clinical psychologist's experiences of distress (as outlined in ch.1.). Notably, participants in this study emphasised the role of social support in the work context, rather than the personal context, in sustaining clinical psychologists in their professional roles in the NHS. They resisted the construction of their work through discourse that supports self-reliant practices of emotion management by constructing distress as an inherent and unavoidable aspect of their work. This construction of clinical practice accords with research suggesting that the nature of a mental health professional's role, a role involving sustained contact with the distress of others, increases vulnerability to distress (Cohen & Collens, 2013; Knight, 1997; Moore & Cooper, 1996; Tehrani, Colville & Fraser, 2020). The way that study participants constructed their clinical practice and the importance they placed on having a connection to emotional experience (their own and the clients) reflected the concept of deep acting in Hochschild's (2012) theory of emotional labour. Hochschild proposed that social situations have particular feeling rules associated with them, i.e. rules that dictate the emotions that the social actors should feel or display in that context. She differentiated between surface acting, i.e. the outward performance by the social actor of the emotion the situation is believed to demand, and deep acting, i.e. a practice that entails the social actor endeavouring to induce these emotions (Hochschild, 2012). However, participant's constructions of their clinical practice departed from Hochschild's (2012) theorising of emotional labour as a practice dictated solely by organisational demands. In line with Virkki's (2007) research on emotional labour in caring work, participants presented deep acting as a practice central to their professional identity, personally invested in as a source of professional and moral competence.

From studies with psychiatric nurses, there is evidence supporting a link between the surface acting dimension of emotional labour[10]and burnout, particularly emotional exhaustion (Mann & Cowburn, 2005; Schmidt & Diestel, 2014; Zammuner & Galli, 2005). This finding has led researchers to suggest that training and practices should be in place to support deep acting in caring work (Mann & Cowburn, 2005; Schmidt & Diestel, 2014). Formal and informal relational practices that support the capacity for deep-acting were the types of

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[10] As measured by the Emotional Labour Scale (ELS: Brotheridge & Lee, 2003)

practices that participants made a case for, as practices that can respond to, and to a degree ameliorate, clinician distress stemming from the emotional labour entailed in the clinical role.

Formal and Informal Supportive Practices

Supervision was presented by study participants as a crucial form of formal support for the clinical psychologist at all levels of training and experience. There was a strong consensus between participants descriptions of the basis for 'good' supervision and the DCP's (2014) description of the quality of the supervisory relationship as crucial. The notion that the supervisor provides containment for the supervisee is reflected in this policy document, with a supportive and containing relationship between supervisor and supervisee cited as factors promoting satisfaction with supervision (DCP, 2014). Participant's representation of teams as a potential source of informal emotional support resonates with findings that psychologists who do not work in teams report higher levels of psychological distress and lower job satisfaction than those who work in teams (Carter & West, 1999), and with the finding that experiences of friendship and emotional support within a team are associated with high staff satisfaction (Mickan, 2005; Opie, 1997; Onyett, 2003).

Study participant's construction of relational reflective practices, that allow space for emotional experience, as a means of reducing the likelihood that a disconnection from emotional experience will occur resonates with the finding that supervision that the supervisee experiences as safe, emotionally supportive, and collaborative is associated with a reduced likelihood of emotional de-personalisation for psychological practitioners (Johnson et al., 2020). Notably, in Johnson and colleague's study, the quality of the supervisory relationship did not moderate emotional exhaustion. As reviewed in chapter one, there are a number of studies providing evidence that organisational factors, including demand and pressures of workload, are related to clinician distress (Cushway & Tyler, 1994, 1996; Hannigan et al., 2004; Lasalvia, Bonetto & Bertani, 2009; Schulz, Greenley, Brown et al.,1995). Clinician's experience of emotional exhaustion, in particular, has been linked to demand in other studies (Miller, 2018; Steel, Macdonald, Schröder et al., 2015). The findings of this study also implicate demand, and a culture in which taking breaks is not supported, in the creation of a context that limits clinical psychologist’s options for managing work-related distress. However, there is evidence that social support in the workplace leads to reduced avoidance coping and a greater sense of control, which has a positive moderating effect on experiences of distress (Kuyken et al., 2003). This may be attributable to the potential for social support to validate emotional experience and link affective experience to context, reducing the likelihood that emotional experience discordant with dominant social norms will be constructed as dysfunctional by the individual and facilitating action in the external world to ameliorate distress (Thoits, 1985).

This study can be considered a contribution to the evidence-base indicating that formal and informal relational-affective practices in the workplace, that offer space for clinical psychologist’s emotional experiences, are important considerations in thinking about systemic ways to respond to clinical psychologist’s distress in the NHS.

Access to Formal and Informal Supports as Unreliable

However, access to spaces that offer emotional support was presented by study participants as dilemmatic and carefully negotiated by clinical psychologists. Study findings accord with research providing evidence that relational reflective spaces on training can be experienced as conflictual and distressing by trainees (Hughes & Youngson, 2009; Knight, Sperlinger & Maltby, 2010; Woodward et al., 2015). Participants in this study agreed with the conceptualisation of these relational reflective practices on training as entailing a deconstruction of self for the trainee (Gillmer & Marckus, 2003). However, they presented this 'self’ as a neoliberal subjectivity, that it would be useful to de-construct to build a form of resilience that will sustain trainees in qualified practice. Furthermore, findings of this study indicate that similar dilemmas and constraints on talk about personal distress exist for qualified psychologists, a finding in line with the conclusions drawn through research with populations of mental health professionals with lived experience of distress (King et al., 2020). Amplified, in the team context, one might assume, by discourses that operate within the NHS to construct the clinical psychologist as ‘expert’ or ‘leader’. Arguably, legitimised space for clinician emotional experience may function to offset the demand for self-sacrifice or self-restraint that a subjectification that accords the clinician pastoral or leadership power demands. However, study participant's suggested increasing barriers to accessing both formal and informal emotional support with increasing seniority. A circumstance that may go some way towards explaining the finding that psychological practitioner wellbeing does not increase in the UK with age, experience and years of service (Summers, Morris, Bhutai et al., 2020), in contrast with findings in the Australian (Di Benedetto & Swadling, 2014) and the US mental healthcare contexts (Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert, Stevanovic, & Hunley, 2009).

Technologies of the Self or Confessional Practices?

The case has been made that supervision and reflective practice can be conceptualised as modes of surveillance and confessional practices that operate to discipline the professional (T. Gilbert, 2001). It could be argued, on the basis of the findings of this study, that the distinction between these relational reflective practices as 'technologies of the self', that promote care of the self, or 'confessional practices', that have a disciplinary function, is determined by the relation of power, and the discourses that structure these practices. Foucault (1976/1980) theorised that confessional practices take place in the context of a hierarchical binary relationship, as he suggested is usual in social practices structured by a psy-professions discourse (Foucault, 1963/1973). If discourses that pathologise distress and support the othering of those who experience distress structure professional relationships, talk about vulnerability by the clinician is likely to be constructed as the confession of potential for impairment, inviting surveillance from those in more powerful positions (Peterson, 2017). In this study, both container-contained and human-to-human relationships with supervisors were presented as facilitating the use of this relationship by the supervisee as emotional support. The container-contained relation can be construed as a hierarchical binary relation. However, supervision practice as structured by psychoanalytic discourse allows some space for supervisee emotional experience. The point has been made that a continuum view of distress, i.e. the view that every human being will inevitably experience distress, to varying degrees, enables talk about personal experience of distress by clinicians within mental health services (King et al., 2020). It could be argued that a continuum view of distress produces relationships as more symmetrical ‘human’ relationships through resistance to dichotomising notions and dividing practices. Notably, in this study, a construction of distress as an aspect of the human condition, and the positioning as ‘human’ for the clinical psychologist, allowed talk of emotion in supervision and access to informal support from colleagues with a team.

This study can be considered to make a contribution to a reflective examination by the profession of Clinical Psychology of the nature and use of formal and informal supportive practices by clinical psychologists, in training and qualified practice.

4.2. Critical Review

4.2.1. Limitations of the Research

The generalisability of the findings is considered limited by the small, self-selected nature of the sample. The recruitment method and the nature of the research questions may have led to a sample homogenous in significant ways. In particular:

- Recruitment using the social media site Twitter may have led to the recruitment of a sample homogenous in terms of their values or political views. Twitter is not used by all clinical psychologists and is perhaps more likely to be used by those with a greater interest in public debates about mental health and social activism. Furthermore, while I had not previously posted on Twitter, I had in the past 'liked' posts by others. This provided information to participants about my interests and views and, in combination with the context of my training course, perhaps positioned me as a 'critical psychologist' creating a particular context for the conversation in interviews.
- The sample was not diverse in terms of gender. The case could be made that the nature of the research questions created barriers to participation for male psychologists. It has been suggested that hegemonic constructions of male gender identity in a Western society offer additional

constraints as regards talk about personal distress (Brody & Hall, 2016). Furthermore, primary socialisation processes (in childhood) are theorised to play a formative role in emotional socialisation and interact with the secondary socialisation that takes place in the formation of a professional identity (Cahill, 1999). Thus, discourses that operate in primary socialisation to construct gender identity, i.e. femininity as nurturing, masculinity as rational, may operate to bias the nature of discourses internalised in secondary socialisation, contributing to a male psychologist professional identity that differs in significant ways from a female psychologist professional identity.

4.2.2. Quality Evaluation

The quality of the research will be considered according to the principles of contribution, credibility and rigour set out by Spencer and Richie (2015).

4.2.2.1. Contribution

According to Spencer and Richie (2015), research can be considered to have contributed if it advances knowledge or understanding of policy, practice, or theory. This study aimed to make a contribution as a critical pedagogy to facilitate reflection on sites of oppression and resistance for clinical psychologists. Following Nikolas Rose (1998), the hope was that by rendering the historical contingency of the clinical psychologist's construction as professional 'selves' more visible these constructions are opened up for interrogation and transformation. Critical reflection by clinical psychologists has the potential to disrupt unwelcome or oppressive identities (Davies, 2008). Thus, the research is intended to be emancipatory for the profession (Parker 2015), in the sense of facilitating reflexivity, and opening up spaces for new practices, in relation to personal distress. This can be framed as a process of 'conscientisation' of the professional group, i.e. the development of a critical awareness of oppression that creates an impetus for social change (Freire, 1968/1972). Conscientisation is a concept developed with reference to work with the most oppressed groups in society. However, while clinical psychologists are implicated in institutions and practices that can be considered oppressive, they can also feel oppressed by these same institutions and practices (Larner, 1999). As Freire (1968/1972) has pointed out, even those considered by others as oppressors are also oppressed within an oppressive system.

4.2.2.2. Credibility

I have aimed to fulfil this criterion in a number of ways. Firstly, with reading post-structuralist theory, as extensively as time allowed over the past three years, to ground my interpretation in theoretical understanding. The analysis was discussed with my supervisor at a number of points during the analytic process, which included a review of data extracts. He also provided feedback and critique on drafts of my analysis, to ensure that my analysis was grounded in the data.

4.2.2.3. Rigour

A rationale for the development of the research questions and the method chosen is provided in chapter 2, in addition to a detailed outline of the steps taken in the analytic process. A list of initial codes (appendix G) and an excerpt of coded interview data (appendix H) provide an audit trail of the analytic process. Seale's (1999) conceptualisation of objectivity as an attempt to step back from the data as much as possible was held in mind. Reflexivity was enhanced by the use of a reflective log (appendix J) throughout the research process and conversations with peers, colleagues, and supervisors.

4.2.3. Learning

Maintaining faithfulness to a relativist epistemological position proved more difficult than initially anticipated. As someone with experience of the contexts described, who has had a long and intense period of secondary socialisation into the symbolic universe that the participants drew from in constructing their experience, I found their constructions of reality personally compelling. I often found myself drawn away from a relativist epistemological position to a more epistemologically realist view of the social context constructed by participants in their talk. When it came to the data analysis, I initially struggled to step back from and treat psychological theory, in particular psychoanalytic concepts such as containment, as discursive constructions. The interpretative stage of analysis was anxiety-provoking, as I was aware that my interpretation of the data could potentially depart in ways from the story told by study participants themselves. I struggled with the sense that I was invalidating participant’s experience through relativist interpretations by treating their experience as less 'real', and with the sense that I was privileging my voice over theirs in interpretation. Confidence was an issue, as might be expected with a novice researcher, and initially, my coding was more descriptive than interpretative, and I was frequently pulled into the personal narratives away from a focus on the questions the research was attempting to address. I found that I ended up discarding or amending a number of my initial codes (appendix I). Through this process, I learned the value of consultation with others, including my supervisor, colleagues, and people outside the psychology profession, to help me to achieve a distance from knowledge that I had been accustomed to treating as ontologically real.

4.2.4. Reflexive Review

4.2.4.1. Personal Reflexivity

Over the course of the research process, certain aspects of my identity came to the fore in my reflective log:

- My Irish identity: please see the reflective journal excerpt (appendix J)
- My gender identity and gendered discourses of emotional expression. I identify as a feminist and have read quite widely on the topic. As such, feminist discourse structures my subjectivity, and my practices, to some degree.
- My training and employment background (as secondary socialisations), including postgraduate training in CBT, an MSc in psychoanalytic theory, and a training in Clinical Psychology on a course aligned with a critical psychology position.
- My own history of distress, in the context of training and work in the NHS, and my investment (time/money/emotional) in two years of personal Psychoanalysis (a process of secondary socialisation into this particular symbolic universe and a lived experience of being a 'patient') and what this meant for the way I constructed distress, supportive practices, and my professional identity.

The relevance of these aspects was considered throughout, but this did not entirely negate their influence. To give an example from the interview process, at one point, I asked: *And in what way did the therapy, sorry I shouldn't assume, did the therapy help in that*? Despite the correction, the question orients the interviewee to my position, thus creating a particular context for their response. While I intentionally kept questions broad and intervened as little as possible, my personhood and my positioning co-created the context of each interview. My embodied presence and communications through body language, leaning forward etc., when I made notes and when I did not, could have informed participants about my positioning in discourse, irrespective of whether I explicitly positioned myself linguistically (Ellingson, 2009).

4.2.4.2. Epistemological Reflexivity

Embodied experience is an aspect of experience particularly pertinent to the field of mental health and to developing understandings of distress (Georgaca, 2014), and one of the limitations of analytic interpretation that focuses on discourse stems from its emphasis on language and meaning, which can have the effect of making it difficult to give fuller consideration to materiality and embodied experience (Nightingale & Cromby,1999). Margaret Wetherell's affective practice theory (2012, 2013) could have provided an additional theoretical framework for an analysis of discourse, with a view to taking extra-discursive experience into account without divorcing these embodied experiences entirely from discourse.

Furthermore, choice or investment in particular discourses, and the subject positions these discourses allow, is not theorised as simple or necessarily conscious (Hollway, 1989). It has been argued that any understanding of the formation of identity requires an account of the unconscious investment that a given individual has in taking up a particular position in discourse, as opposed to other available positions (Hollway,1984, p.238). Layton (2006, 2009) suggests that normative unconscious processes pull an individual to maintain and reproduce hegemonic ideological norms in the process of consolidation of what these norms suggest is the right kind of identity. According to Layton (2009), as these norms can be causative of distress unconscious collusion with them functions to maintain distress. Adaptations to the analytic approach adopted in this study modelled on the psychoanalytically-informed approach to discourse analysis by Frosh, Phoenix and Pattman (2003) or Hollway and Jefferson (2000) could have allowed for an account of unconscious investment in subject positions. It has been suggested that a psychoanalytic approach is not necessarily incompatible with a critical realist position (Pilgrim, 2020).

4.3. Implications

4.3.1. Research

There is a dearth of research investigating clinical psychologist's experiences of distress, and more is warranted. On the basis of this study's findings, the following specific recommendations for further research can be made:

- Further quantitative research into NHS worker distress and access to supportive practices is merited. Including research investigating levels of access to relational reflective and supportive practices for clinical psychologists and other staff in the NHS, systemic moderators that enable and constrain access, and the relationship between access to these practices and worker wellbeing.
- Available research and literature, as reviewed in chapter one, indicates similar levels of distress in allied mental health professional groups, and there is evidence that there may be similar barriers to help-seeking for other professional groups that work in mental health (Galbraith, Brown & Clifton, 2014; Garelick, 2012). Collective participatory research practices (Nelson, & Prilleltensky, 2010) to explore norms for social and emotional practice, and systemic factors related to NHS worker distress, could provide a basis for collective action to address distress experienced by NHS workers.
- Further qualitative research exploring trainee and qualified clinical psychologist's experiences of relational reflective and supportive spaces is merited. It has been suggested that reflective practice groups like PPD are difficult for trainees to make use of, particularly trainees from a minority ethnic background (Goodbody & Burns, 2011). Furthermore, it has been argued that these practices have the potential to contribute to the perpetuation of social inequalities, and hegemonic norms, through the

privileging of white western discourses in these contexts (Goodbody & Burns, 2011). As such, the use of these spaces by trainees and qualified psychologists from minority ethnic backgrounds, and the exploration of alternative more ethnically and culturally diverse discourses to inform these practices, merits particular attention.

- There was some diversity in the study sample as regards ethnicity. However, the implications of this aspect of difference was not explored. Such an exploration is merited in future research, particularly as it has been reported that Asian-British psychological practitioners in the NHS report a higher level of wellbeing than their White-British colleagues (Summers et al., 2020).

4.3.2. Practice

4.3.2.1. Clinical Psychologists

The following practice recommendations can be made:

- That clinical psychologists consider radical action in relation to dichotomising discursive practice and discourse or practice that perpetuates the pathologisation and de-contextualisation of distress. There is evidence that supervisors and senior clinicians play a pivotal role in communicating the norms for emoting by staff in mental health services, including norms for talk about lived experience of distress (Peterson, 2017; Harris, Leskela & Lakhan, 2019). Clinical psychologists can take the lead in promoting a culture that does not stigmatise distress by promoting a continuum view of distress in mental health services (King et al., 2020).
- Clinical psychologists can engage in self-care, and model good self-care practice for other staff, by taking regular breaks during the workday and protecting their personal time by resisting pressure to work over their contracted hours.
- While not dismissing the value of self-management techniques entirely, it is recommended that the potential for a discourse of self-management to contribute to the creation of a context that constructs the experience of distress as failure and constrains help-seeking is held in mind, particularly by clinical psychologists who are supporting other staff or providing

training for staff teams. It is recommended that clinical psychologists take the lead in promoting mutual care and dependence on others in addition to self-care in organisations, i.e. by advocating for protected time for supervision, psychotherapy, peer support and relational reflective practice.

- That clinical psychologists find or create spaces, for example, in supervision, peer supervision or peer support groups, that support the exploration of the discursive construction of personal-professional identities and practice implications of these constructions. Collective externalising conversations could facilitate psychologists to give an account of the effects of discourses, norms, and practices on their lives (White, 1991). The location of the problem of psychologist distress in the external world has the potential to provide a solid basis for individual and collective action to address professional and systemic factors contributing to clinical psychologist distress in the NHS.
- That clinical psychologists advocate for, and participate in, collective multi-disciplinary reflection on the norms for emotional and social practice that have acquired a truth status for mental health professionals, as people located in a similar discursive context. It has been argued that challenging the de-contextualisation and pathologisation of distress, and building worker resilience, requires what Foucault (1982) called a transversal resistance, based in solidarity between workers from different disciplines and collective ethics (Guilfoyle, 2005; Reynolds, 2011).

4.3.2.2. Policy Makers

As a population-level intervention that guides behaviour and supports people and institutions to make choices, policy has the potential to have a powerful influence on people’s personal and professional lives (Ruggeri, 2017). Policy implications of this study at the service level and the societal level are considered, with reflection on the role of the clinical psychologist in policymaking at these levels:

Service level

In 2016, it was reported that over two-thirds of NHS trusts did not have plans or policies in place to support staff wellbeing (Hacker-Hughes, Rao, Dosanjh et al., 2016). A search I carried out for policies published online by the Mental Health

Foundation Trusts in London and surrounding areas revealed that some trusts still may not have policies in place that pertain to supporting staff wellbeing at work, even when the idea of a policy to support staff wellbeing at work is defined more broadly. Some trusts have published policies that pertain to supporting staff with stress (e.g., The Tavistock and Portman Mental Health Foundation Trust, 2019; The Central and North West London NHS Foundation Trust, 2018) and review of these policies indicated that they could be interpreted as policies for supporting staff wellbeing at work.

Clinical psychologists, as senior clinicians, can take an active role in enquiring about and contributing to the review, and if necessary the development, of policy to support staff wellbeing in their respective services. The NHS Health and Wellbeing Framework (NHS, 2018) is recommended as a helpful reference for this process, with some caveats. A discourse encouraging self-management of distress by staff would appear to be privileged in the sections: *Upskilling Staff and Line Managers* and *Access to Interventions*. It is suggested that the discourse of self-management could be tempered by an emphasis on recommendations in the section that pertains to systemic factors in this framework: *Create a Healthy and Supportive Working Environment*. Additionally, there is a suggestion in this framework that senior managers should be trained to notice “signs and symptoms of poor mental health” in staff (NHS, 2018, p.47). This discourse would appear to support, or at least align with, a construction of distress as pathology and has overtones of surveillance. An awareness of the language used to describe distress, and proposed interventions, and the implications of language chosen is also recommended. The *Managing Psychological Wellbeing at Work Policy* produced by the East London Foundation Trust (2017), a trust rated as outstanding by the Care Quality Commission (CQC) in 2018, can also be recommended as a useful example of a service-level policy to support staff wellbeing. Of particular note is the use of the demand-control-support model (Johnson & Hall, 1988) to inform and structure the policy and the linking of the policy to a Work-Life Balance Policy, a move that underlines the trust’s commitment to supporting their staff to balance work with other aspects of life.

Societal level

Ideally, service-level policy initiatives would be supported by government policy initiatives. While services can work to implement policy that protects existing staff from work-related distress, these service-level policies do little in practice to reduce the demand on mental health services, and are likely to have little impact on a capacity to meet demand that relates to staffing levels. A wealth of research provides evidence that social inequality has a powerful effect on psychological and physical health (Cromby et al., 2013; Marmot, 2010; Pickett & Wilkinson, 2010; Read & Sanders, 2010). Social policies in the areas of housing and welfare, and policies that support community development approaches to distress, have the potential to reduce demand for mental health services in the longer-term by impacting on levels of distress at a population level (Psychologists Against Austerity, 2015; Harper, 2016). In the short-to-medium-term capacity to meet demand in mental health services could be increased by an increase in staffing levels in mental health services. Government policies that aim to increase staffing levels, including policies that improve the pay and conditions of staff in the NHS to attract and retain people in these public service roles, are merited.

There are increasing opportunities for psychologists to be involved in social policymaking, in-directly through communications to their representatives in the BPS (BPS Public Policy Team, 2019), and more directly through links with their local MPs, commissioners and policy makers. The concept of 'wellbeing' has recently come back on the government's policy agenda (Perriard-Abdoh & Murray, 2020). However, all policy is ideological at some level (Ruggeri, 2017), and the process of policymaking commonly starts from the existing perspectives and preferences of decision-makers (Perriard-Abdoh & Murray, 2020). Walker, Speed and Taggart (2018) argue for a view of policymaking as a politically-motivated process, proposing that psychological research only has the potential to inform policy development when it aligns with current political interests. They offer the Increasing Access to Psychological Therapies (IAPT) as an exemplar of this argument, a programme aligned with the Governments of the time's neoliberal ideological position. Neoliberalism still holds sway in political systems in the UK, although it has been argued that the Covid-19 pandemic provides the impetus for a change in ideology (Saad-Filho, 2020). The findings of this study are difficult to interpret in a way that would align with neoliberal political interests.

However, when a direct influence on policymaking is unlikely, another avenue open to clinical psychologists is involvement in social activism, in solidarity with others affected by the same social problems (Walker et al., 2018). It is recommended that clinical psychologists work in solidarity with NHS colleagues and service users to influence policy at the government level, engaging in lobbying and other forms of social activism. Networks such as Psychologists for Social Change (http://www.psychchange.org/#) provide opportunities for psychologists at all levels to be involved in the application of psychology to policy making and political action.

4.3.2.3. Training Programmes

The following recommendations can be made for training programmes:

- The promotion of open communication by trainees, course staff, and supervisors about their own vulnerabilities and psychological wellbeing to challenge the stigma associated with mental health difficulties within the profession, as recommended by Grice and colleagues (2018).
- That PPD is given a high priority on training and the process carefully considered. Smaller groups (10-13) with facilitators trained in group processes have been recommended (Knight et al., 2010). Michael White's (1991) deconstructive method could provide a framework for the development of these spaces as usable spaces for talk about emotional experience by trainees. White (1991) suggests that a process of opening up reflection on ways of being that shape our existence creates space for choosing alternatives. Additionally, Windslade’s (2002) discourse analytic method for exploration of the subjectivities produced by the various psychotherapeutic discourses, developed for professional identity development work in counselling trainee groups, could be adapted for clinical psychologist trainee groups.
- That there is careful consideration by training courses as to whether there is a preference for recruitment of people who perform a stoic-type resilience over trainees who are open about experiences of personal distress and can contribute to discussions supporting a continuum view of distress in these contexts. The DCP practice guidelines on Clinical

Psychology Training and Disability (Harper et al., 2006) is recommended as a useful resource for training courses in this regard.

4.3. Conclusion

A recently published DCP briefing paper validates a continuum model in thinking about clinical psychologist’s distress stating "People in the Clinical Psychology profession can experience mental health difficulties at any (or all) stages of their career." (Hogg & Kemp, 2020, p.1). When distress is seen as part of the human condition and the humanity of clinical psychologists is acknowledged this statement seems obvious. Yet the authors clearly felt it was a statement that needed to be made. The ways that clinical psychologists in the NHS have been positioned by language, social practices, and institutions has complicated the acknowledgement of a shared human vulnerability by clinical psychologists, creating constraints to clinical psychologist’s ways of being in relation to personal distress. However, as illustrated by this study, the clinical psychologist professional identity offers scope for a variety of stances and practices in relation to distress, including distress experienced by clinical psychologists themselves. Stances and practices that align with current institutionally-validated discourses and practices, and those that could be construed as counter-conducts that create space for new ways of ways of being in relation to distress. Foucault (1982) described resistance as "not to discover what we are, but to refuse what we are" (p.216). When resistance is conceptualised as the fracturing of the limitations imposed by normalising identity categories the contested knowledge base of Clinical Psychology, and the profession’s struggle to reach a consensus on what the profession does and why (Cheshire & Pilgrim, 2004), is revealed as a strength. Butler (2015) conceptualises acknowledgement of vulnerability as "a condition of resistance'" (p.184), and it is through acknowledgement of vulnerability that space can be made for a resistance to professional and institutional factors that constrain space for clinical psychologist’s experiences of distress. By acknowledging a shared human vulnerability and the mutual interdependence of human beings, clinical psychologists can help to open up space for improvisation in professional identity performances, and create a basis for the solidarity required for collective action to bring about transformative change in healthcare organisations, and wider society.

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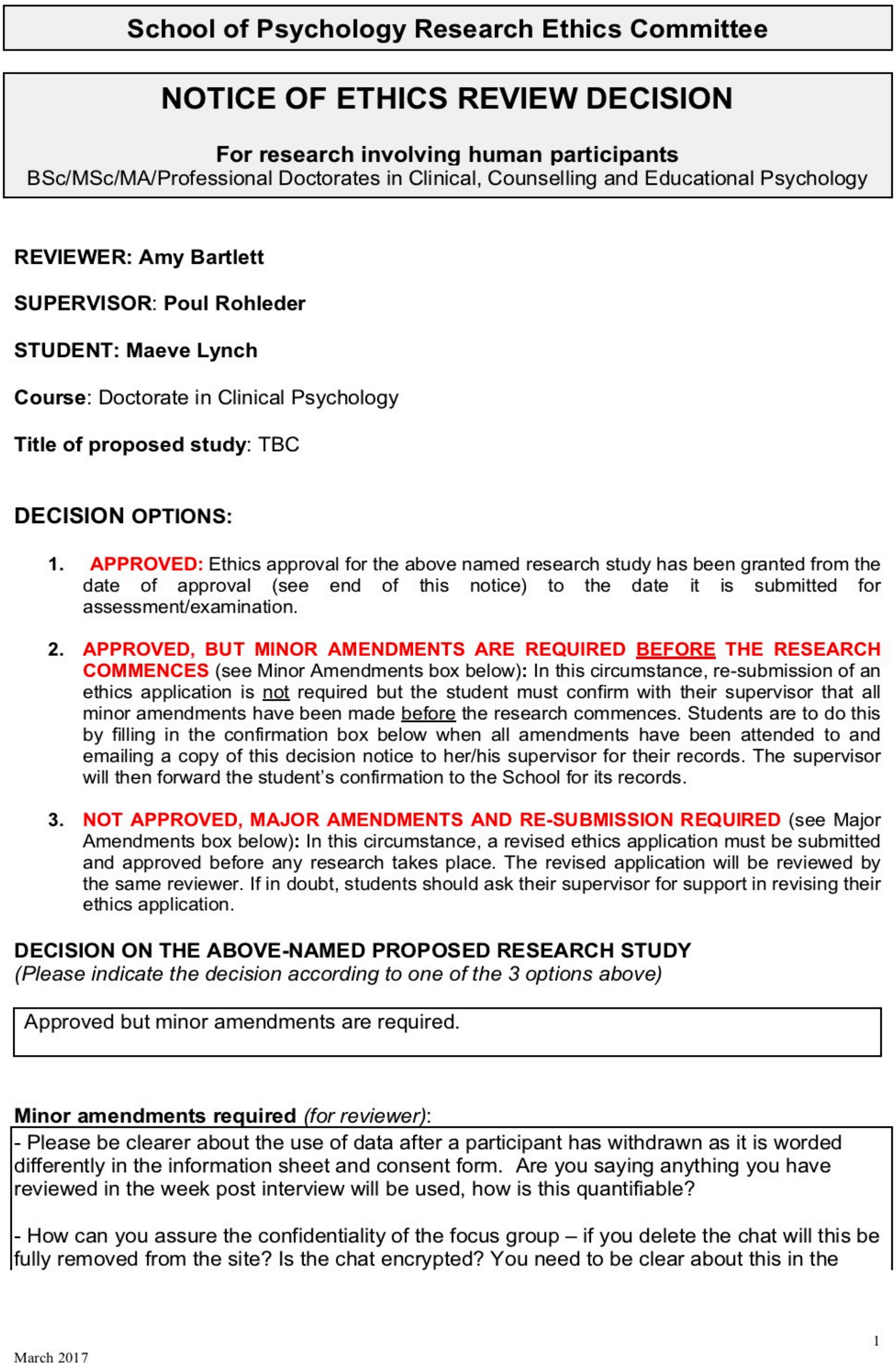
APPENDIX A: Ethics review decision letter



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: Amy Bartlett

SUPERVISOR: **Poul Rohleder**

STUDENT: Maeve Lynch

Course: Doctorate in Clinical Psychology

Title of proposed study: TBC

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)

Approved but minor amendments are required.

Minor amendments required *(for reviewer)*:

- Please be clearer about the use of data after a participant has withdrawn as it is worded differently in the information sheet and consent form. Are you saying anything you have reviewed in the week post interview will be used, how is this quantifiable?

- How can you assure the confidentiality of the focus group – if you delete the chat will this be fully removed from the site? Is the chat encrypted? You need to be clear about this in the

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information sheet along with more details about the focus group e.g. how long following the interview will this commence.

- Please be clear about the storage of the Dictaphone recordings i.e. will they be downloaded after each interview and then deleted from the Dictaphone; if not, how will the Dictaphone be stored, is it encrypted?

- Please make this sentence clearer so that participants can easily understand - *'Participation in the focus group is voluntary and should you not wish to participate the value to the study of your participation in the interview will not be compromised in any way.'* E.g. …if you do not wish to participate, this will not affect the interview data unless you choose to withdraw from the study.

- Q25 - Please consider the impact of the interviews on you and what support you will access.

- Please attend to the phrasing of the first line of the 'Why have you been asked to participate?' on the information sheet. E.g. ….as someone who may have knowledge/experience in the area I hope to explore.

- Please be clearer about who you are aiming to recruit and make this explicit in the adverts and information sheet. You talk about a particular group of people within the remit of psychological distress and state 'not only' but do not state who you are looking for: those who feel they have experienced psychological distress personally; those who feel that they have witnessed this in others; those who feel they have no experience.

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: Maeve Lynch
Student number:

Date: 08.05.2019

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

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

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

YES / NO

Please request resubmission with an adequate risk assessment

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

☐ HIGH

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

☐ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

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

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

Date:

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

RESEARCHER PLEASE NOTE:

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

APPENDIX B: Participant de-briefing sheet

PARTICIPANT DEBRIEFING INFORMATION

Thank you for taking the time to participate in this study.

Data will now be analysed using a discursive approach which aims to identify the discourses in the interactional and socio-cultural world of the Clinical Psychologist, the way in which these discourses construct the professional identity of Clinical Psychologist, and the implications of this construction of identity for the experience of personal distress by the Clinical Psychologist.

You are free to with draw your data at any point up to the commencement of the data analysis, one week from now.

I plan to disseminate the study findings through publication in psychology journals and presentation at psychology conferences.

It is hoped that the study will contribute to positive changes within the profession, stemming from the profession itself, changes that will increase the wellbeing of Clinical Psychologists and also by extension benefit their clients.

If you have been distressed by this interview and would like some support with this distress the following options are available in your area:

Option 1: For a non-judgemental listening service call the Samaritans on 116 123

Option 2: Contact your GP for referral to an NHS primary care mental health Service

Option 3: Source private psychotherapy, for example through one of the following websites:

- British Association of Counselling and Psychotherapy: https://www.bacp.co.uk/search/Therapists
- The British Psychotherapy Foundation: http://www.britishpsychotherapyfoundation.org.uk/Find-a-Therapist
- The British Association for Behavioural and Cognitive Therapies. https://www.babcp.com

- Institute of Psychoanalysis: http://www.psychoanalysis.org.uk/find-ananalyst.

[This is selection of websites that offer options for sourcing private counselling or psychotherapy. It is not intended to be exhaustive or an endorsement of any particular modality, clinician or practice]

In the case of a crisis **Call 111** - if you urgently need medical help or advice but it is not a life threatening situation. **Call 999** - if you or anyone else is in immediate danger or harm. You can also speak with your GP or go to your Go to your nearest Accident and Emergency department (A&E). You can search for your local department through the NHS Choices website If there any questions that you would like to ask or concerns that you would like to share please give me a call on or contact me by email on

If there any questions that you would like to ask or concerns that you would like to share please give me a call on or contact me by email on

APPENDIX C: Twitter post

CALL FOR CLINICAL PSYCHOLOGISTS CONCERNED ABOUT DISTRESS EXPERIENCED WITHIN THE PROFESSION.

Are you a Clinical Psychologist working in the NHS?

Could you give up 1- 1.5 hrs of your time to participate in a research interview?

Further info:

https://drive.google.com/file/d/1zbnr9xN0Sm-5JXBL6QMatr9-

Thank you

APPENDIX D: Interview schedule

PARTICIPANT INVITATION LETTER

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

Who am I?

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

What is the research?

I am conducting a psycho-discursive study of Clinical Psychologists working in the NHS with a view to gaining a greater understanding of the profession and their experience of working in the context of the NHS.

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

Why have you been asked to participate?

You have been invited to participate in my research as someone who fits the kind of people I am looking for to help me explore my research topic. I am looking to interview Clinical Psychologists that work either full or part-time in the NHS and have been in post for at least one year.

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

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

What will your participation involve?

If you agree to participate you will be asked to participate in two interviews to talk about being a Clinical Psychologist. The interviews can take place at a location and at a time that suits you. It is anticipated that they will last for 1 to 1.5 hours. The approach adopted for the interview is a ‘Free Association Narrative Interview approach’ with space for you to speak uninterrupted and some open questions. The second interview will be a ‘follow-up’ interview comprising of questions to follow-up on material discussed in the first interview and to discuss any further thoughts you had after the first interview. Interviews will be audio-recorded and transcribed by me.

I will not be able to pay you for participating in my research but your participation would be very valuable in helping to develop knowledge and understanding of the profession of Clinical Psychology and the experience of being a Clinical Psychologist in the NHS.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

- You will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.
- You will not have to answer all questions asked of you and you can opt to stop your participation at any time

What will happen to the information that you provide?

What I will do with the material you provide will involve:

- Personal contact details will be stored in an encrypted file on a password protected computer

- Your name and contact details will not be linked to the interview data. All interview data will be anonymised by the use of pseudonyms.
- Anonymised interview data will be stored on a password-protected computer.
- Supervisors and examiners will have access to anonymised data contained within the thesis.
- It is hoped that the anonymised data will form part of a paper that will be published and that the finding of the study will be presented at psychology conferences.
- Your contact details will be deleted once the data analysis is complete. Interview recordings will be deleted after the award of the degree.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. However, if you withdraw I would reserve the right to use material that you provide up until the point of my analysis of the data.

Contact Details

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

RESEARCHER NAME & UEL EMAIL

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

Email: [supervisor's email]

or

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

(Email: m.finn@uel.ac.uk)

APPENDIX E: Interview schedule

Interview Schedule

1. What comes to mind when you think of Clinical Psychology?

2. Can you tell me about your role as a Clinical Psychologist in the NHS

3. What do you understand by ‘psychological distress’?

4. What comes to mind when you think of a Clinical Psychologist experiencing psychological distress?

    - Have you any had experience of personal psychological distress?
    - Can you tell me about any experience that you have had of colleagues who have experienced personal psychological distress?

Prompts:

Can you tell me more?

Can you tell me what happened…and then…

Can you tell me what you mean by?

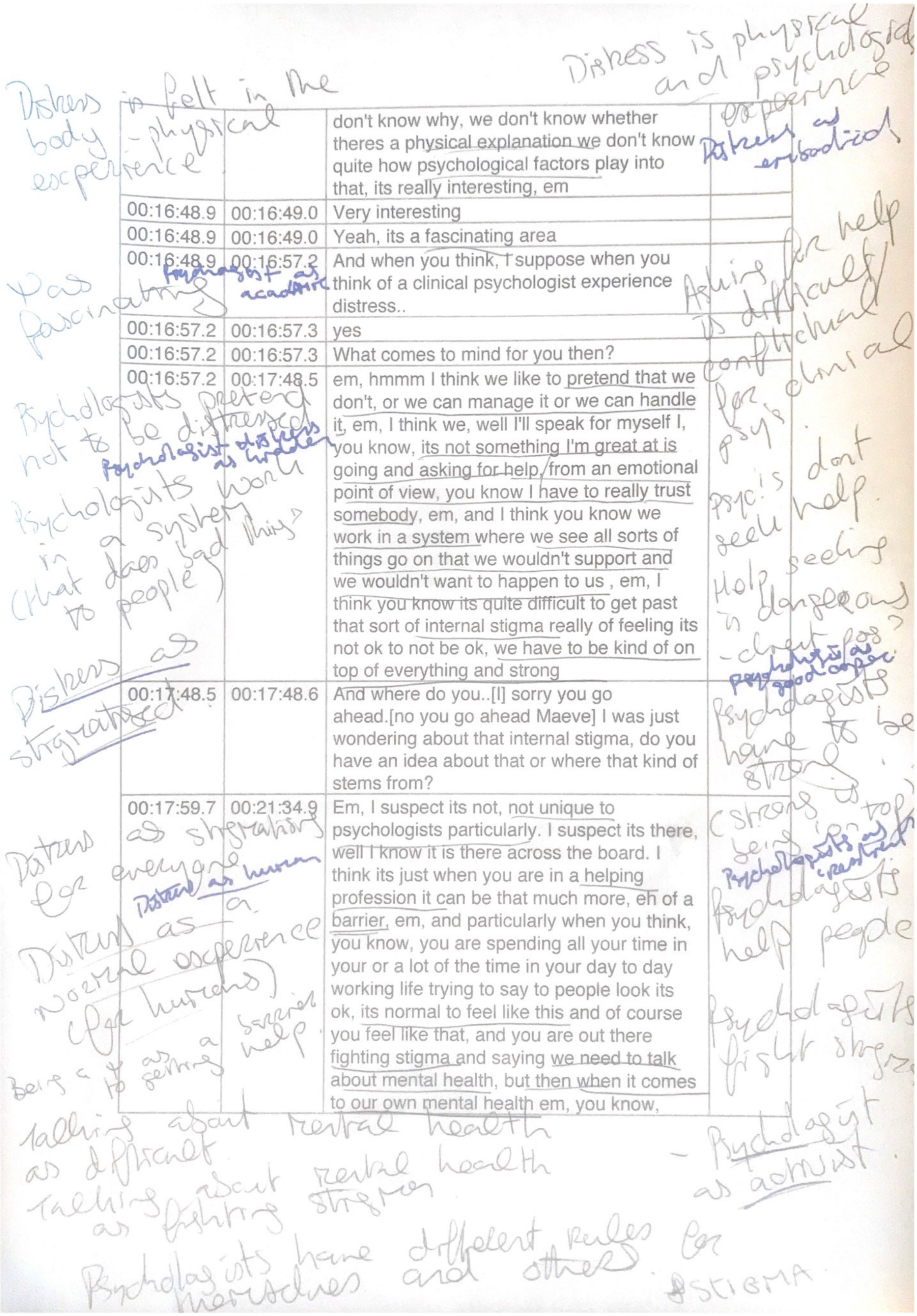
Can you describe?

Metaphors/analogies - explore

Request examples

6. Can you tell me your thoughts on ways that the likelihood of experiencing personal psychological distress could be reduced for clinical psychologists in the NHS… and/or approaches that may be helpful in alleviating such distress if experienced.

APPENDIX F: Example of complete coding (by hand)



		don't know why, we don't know whether theres a physical explanation we don't know quite how psychological factors play into that, its really interesting, em	Distress as embodied!
00:16:48.9	00:16:49.0	Very interesting	
00:16:48.9	00:16:49.0	Yeah, its a fascinating area	
00:16:48.9	00:16:57.2	And when you think, I suppose when you think of a clinical psychologist experience distress..	
00:16:57.2	00:16:57.3	yes	
00:16:57.2	00:16:57.3	What comes to mind for you then?	
00:16:57.2	00:17:48.5	em, hmmm I think we like to pretend that we don't, or we can manage it or we can handle it, em, I think we, well I'll speak for myself I, you know, its not something I'm great at is going and asking for help, from an emotional point of view, you know I have to really trust somebody, em, and I think you know we work in a system where we see all sorts of things go on that we wouldn't support and we wouldn't want to happen to us , em, I think you know its quite difficult to get past that sort of internal stigma really of feeling its not ok to not be ok, we have to be kind of on top of everything and strong	
00:17:48.5	00:17:48.6	And where do you..[I] sorry you go ahead.[no you go ahead Maeve] I was just wondering about that internal stigma, do you have an idea about that or where that kind of stems from?	
00:17:59.7	00:21:34.9	Em, I suspect its not, not unique to psychologists particularly. I suspect its there, well I know it is there across the board. I think its just when you are in a helping profession it can be that much more, eh of a barrier, em, and particularly when you think, you know, you are spending all your time in your or a lot of the time in your day to day working life trying to say to people look its ok, its normal to feel like this and of course you feel like that, and you are out there fighting stigma and saying we need to talk about mental health, but then when it comes to our own mental health em, you know,	

Distress is felt in the body - physical experience

Distress is physical and psychological experience

Psychologist as academic

Ψ as fascinating

Asking for help is difficult/conflictual for psy's clinical

Psychologists pretend not to be distressed

Psychologist distress as hidden

Psychologists work in a system (that does bad things to people)

Psyc's don't seek help

Help seeking is dangerous - client pos?

Psychologists as good exper

Psychologists have to be strong (strong & being on top)

Distress as stigmatised

Distress as stigmatising for everyone

Distress as human

Distress as a normal experience (for humans)

Being a Ψ as a barrier to getting help

Psychologists as 'creatt'

Psychologists help people

Psychologists fight stigma

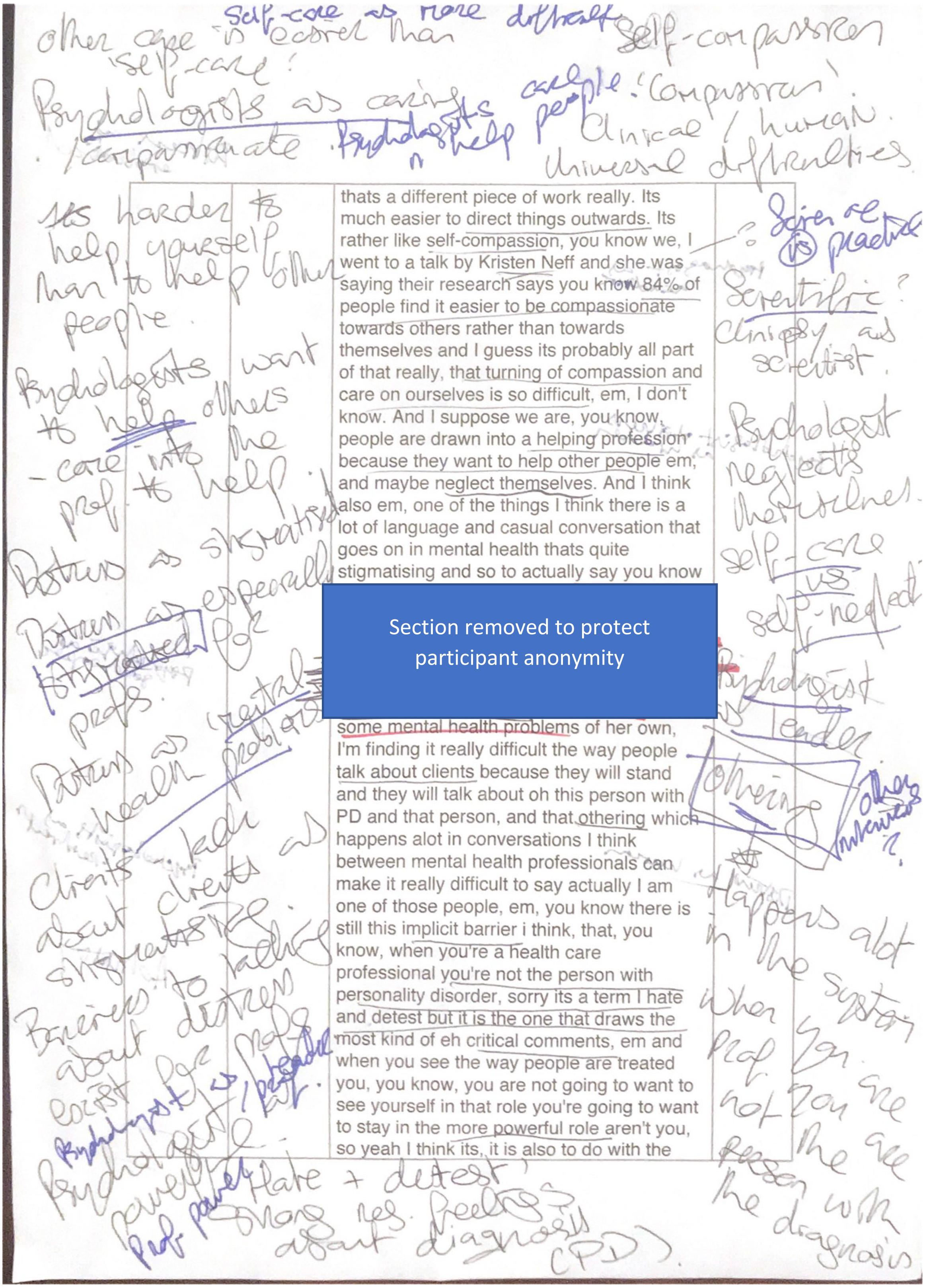
Talking about mental health as difficult

Talking about mental health as fighting stigma

- Psychologist as activist.

Psychologists have different rules for themselves and others.

STIGMA



other care is easier than self-care!

Self-care as more difficult

Self-compassion

Psychologists as caring / compassionate. Psychologists help people

capable people 'Compassion' Clinical / human. Universal difficulties

thats a different piece of work really. Its much easier to direct things outwards. Its rather like self-compassion, you know we, I went to a talk by Kristen Neff and she was saying their research says you know 84% of people find it easier to be compassionate towards others rather than towards themselves and I guess its probably all part of that really, that turning of compassion and care on ourselves is so difficult, em, I don't know. And I suppose we are, you know, people are drawn into a helping profession because they want to help other people em, and maybe neglect themselves. And I think also em, one of the things I think there is a lot of language and casual conversation that goes on in mental health thats quite stigmatising and so to actually say you know

Section removed to protect participant anonymity

some mental health problems of her own, I'm finding it really difficult the way people talk about clients because they will stand and they will talk about oh this person with PD and that person, and that othering which happens alot in conversations I think between mental health professionals can make it really difficult to say actually I am one of those people, em, you know there is still this implicit barrier i think, that, you know, when you're a health care professional you're not the person with personality disorder, sorry its a term I hate and detest but it is the one that draws the most kind of eh critical comments, em and when you see the way people are treated you, you know, you are not going to want to see yourself in that role you're going to want to stay in the more powerful role aren't you, so yeah I think its, it is also to do with the

Its harder to help yourself than to help other people.

Psychologists want to help others - care into the prof to help.

Distress as stigmatised

Distress as especially stigmatised for profs.

Distress as mental health problems

Clients talk about clients as stigmatising.

Barriers to talking about distress exist for profs

Psychologist as powerful / Psychologist as leader / powerful. Prof power

Science vs practice

Scientific? Clinician and scientist.

Psychologist neglects themselves.

self-care vs self-neglect

Psychologist as leader

Othering

others [illegible] ?

Happens alot in the system

When prof you are not the person with the diagnosis you are the [illegible]

Hate + detest! Strong neg. feelings about diagnosis (PD).

APPENDIX G: Initial researcher-derived codes

Code
CP as human
CP as professional - boundaries
CP as expert - container
CP as leader
CP as empathic
CPs as a heterogenous group
CP as helper
CP’s as academic
CP as reflective practitioner
CP as advocate for reflective space for others
CP brings multiple perspectives
CP as responsible for others
CP as self-reliant
CP as immune
CP as activist
CP as anti-diagnosis
CP works with trauma
CPs leaving the NHS
CP as pastor – self-sacrificing
CP as robot – institutional construction
CP helps others to reflect
CP as slave
CP as soldier
CP as constrained from talk about distress
CP as superior coper
CP use individualist models -pathologising
CP as objective, rationale
CP normalises distress
CP’s as more thought than feelings
CP contains MDT colleagues
CP has a service development role
CP as isolated expert
CP needs to be open to distress
CP power within the system as limited
CP ignores embodied responses
CP has no permission to talk about distress
Distress as inherent to the work of the CP
Distress as held in an internal space with limited capacity
Distress as human experience
Distress as embodied

Distress affects functioning
Distress as a response to life difficulties
Distress as caused by experience in the external world
Distress as managed relationally
Distress as something you must tolerate (clinical work)
Distress as something to be controlled
Distress as hidden (by professional)
Distress as inherent to the work of the CP
Distress as something to be understood
Distress as embodied threat response
Distress as stigmatising (gen)
Distress as stigmatising (CP)
Distress as shameful
Distress as feeling of pointlessness
Distress as struggles
Distress as unpleasant experience
Distress as feeling overwhelmed, unbearableness
Distress as mental health problems
Distress as feeling powerless
Distress as frightening/horrifying
Distress shuts down thinking – no outlet
Distress as prohibited - norms
Distress as something to be understood through reflection
Distress as something that builds over time
Distress as traumatising
Distress as a liquid
Distress as pathologised (norm)
Distress as impairment
Distress as existential distress – values conflict
Distress as something you push through
Distress as the breakdown of a coping strategy
Distress as something you take in
Stigma in self-to-self relating
Peer relationships as important
Dichotomisation psychologists/others
Dividing practices
Client position as dangerous
MDT – sense of belonging
Personal and professional -boundaries
Self-care as time boundaries
Self-care requires systemic support
Space as relational – facilitating environment
MDT rel.s. as human connection
Training as distressing

Containment as practical help (supervisor)
Supervision as holding - containment
MDT staff distress as a collective experience
Talk of distress as relational risk
Talk of distress as informal
Emotion as a resource
Talking about distress depends on the quality of the relationship
Reflective space as key to managing emotion
Training as a socialisation into practices of relating to emotion
Understanding as requiring reflective space
Team relationships as supportive – sustenance
Training provides insufficient preparation for exp. of distress
Talking about distress requires systemic support
Talk of distress by CP as shocking to others
Mercurial norms for emoting
Self-reliance as problematic resilience
Supervisors offer practical guidance
Human responses to distress as important
Resilience as problematic (‘robustness’)
Reflective space under threat
Reflective space as relational
Emotional experience as something accepted/acknowledged or cut off (othering)
Managing demand from the system – boundaries personal/professional life
Clinpsy as a striving profession
Empathy as central to the work
Clinical work requires attention to own emotional exp
Internal experience as something you connect to
Internal space with limited capacity - containment
Systemic support for managing demand as fortunate
The system pathologises distress
Pathologisation of distress (norm)
Relationship to emotion/emotion practice as socialised
Trainees are socialised pre-training
Courses recruit for Stoic resilience
Compassion/empathy
Relationships outside of work as important
Modelling a different way of being -showing vulnerability
Courses as different, variable
Training as needing to normalise distress
Peer rels as support
Supervision as emotional support - sustenance
Self-care as time away from work

Personal therapy as an alternative space for emotional dev
Different way of being - modelling vulnerability and coping
Need for validation in expressing emotion
MDT rels allow a different way of being (human)
Othering as a defence
Training courses should foster friendships
Supervision must be safe
Bad experience of supervision (unsafe)
System prioritises targets/performance
NHS context as overwhelming
Resilience – Stoic
Supervision as a relationship
Relational space for emotion less available with seniority
Reflective space as avoided
Training encourages emotional avoidance
Emotion not spoken about openly on training
Seeking help as difficult for CP’s
Training and emotional development
Professional context as unsafe for disclosure of distress
Talk of distress as talk of vulnerability
Talk of distress as confession
Use of reflective space as difficult
Use of reflective space as learned/socialised
Supervision as surveillance
Supervision is not therapy - boundaries

APPENDIX H: Transcript excerpt with coding

Please note:

- This except is selected from a later point in the interview (~17 minutes) to protect participant anonymity. The earlier part of the interview contained the most potentially identifiable information (i.e. description of the participant's service context and role). One additional segment of text containing information that might have compromised anonymity has also been removed.
- This is presented as an example – all codes utilised for each segment of data are not necessarily shown

Speaker	**Transcript**	**Coding -examples**
Researcher	And when you think, I suppose when you think of a clinical psychologist experience distress..[CP: yes] What comes to mind for you then?	-
Clinical Psychologist	em, hmmm I think we like to pretend that we don't, or we can manage it or we can handle it, em, I think we, well I'll speak for myself I, you know, its not something I'm great at is going and asking for help, from an emotional point of view, you know I have to really trust somebody, em, and I think you know we work in a system where we see all sorts of things go on that we wouldn't support and we wouldn't want to happen to us , em, I think you know its quite difficult to get past that sort of internal stigma really of feeling its not ok to not be ok, we have to be kind of on top of everything and strong	CP as superior coper Distress as hidden (by the professional Distress as something to be controlled CP as self-reliant Dividing practices Client position as dangerous Distress as stigmatising Stigma in self-to-self relating Resilience - Stoic
Researcher	And where do you..[I] sorry you go ahead.[no you go ahead Maeve] I was just wondering	-

	about that internal stigma, do you have an idea about that or where that kind of stems from?	
Clinical Psychologist	Em, I suspect its not, not unique to psychologists particularly. I suspect its there, well I know it is there across the board. I think its just when you are in a helping profession it can be that much more, eh of a barrier, em, and particularly when you think, you know, you are spending all your time in your or a lot of the time in your day to day working life trying to say to people look its ok, its normal to feel like this and of course you feel like that, and you are out there fighting stigma and saying we need to talk about mental health, but then when it comes to our own mental health em, you know, thats a different piece of work really. Its much easier to direct things outwards. Its rather like self-compassion, you know we, I went to a talk by Kristen Neff and she was saying their research says you know 84% of people find it easier to be compassionate towards others rather than towards themselves and I guess its probably all part of that really, that turning of compassion and care on ourselves is so difficult, em, I don't know. And I suppose we are, you know, people are drawn into a helping profession because they want to help other people em, and maybe neglect themselves. And I think also em, one of the things I think there is a lot of language and casual conversation that goes on in mental health thats quite stigmatising and so to	Distress as stigmatising (gen) CP as helper Distress as stigmatising (for CP) CP's normalise distress Distress as a human experience Dichotomisation psychologist/others CP as academic Compassion/empathy CP as human CP as pastor- self-sacrificing CP as helper The system stigmatises distress Pathologising distress (norm) Dividing practices Dichotomisation psychologist/others

	actually say you know when you are with colleagues.. [section removed to protect anonymity] ..they will stand and they will talk about oh this person with PD and that person, and that othering which happens alot in conversations I think between mental health professionals can make it really difficult to say actually I am one of those people, em, you know there is still this implicit barrier i think, that, you know, when you're a health care professional you're not the person with personality disorder, sorry its a term I hate and detest but it is the one that draws the most kind of eh critical comments, em and when you see the way people are treated you, you know, you are not going to want to see yourself in that role you're going to want to stay in the more powerful role aren't you, so yeah I think its, it is also to do with the context we are in because for all the talk about de-stigmatising, I seem to remember that time to change had a look at this and found that actually while attitudes in the general population had improved in mental health they'd actually gone backwards and people were being more stigmatising and not less, so as, if you are there as someone with a dual-identity, if you want to call it that, its very hard to fess up and go well actually I have significant mental health problems myself because the language and the attitudes people use are, you know, they're not, em, positive, or even neutral, you know the underlying tone is often	CP’s as anti-diagnosis Dichotomisation of psychologists/others CP as professional - boundaries Talk of distress as relational risk Dichotomisation of psychologists/others Client position as dangerous Dividing practices Distress as stigmatising (gen) Distress as mental health problems Talk about distress as confession Dichotomisation psychologists/others Distress as stigmatised (gen)

	very critical and negative em, we have alot of work to do	
Researcher	And when you say dual-identity what do you mean would you mind telling me a bit about that?	
Clinical psychologist	Well I suppose its, it is a term that you see where people say, you know, I'm a healthcare professional but I'm also a user of mental health services or I also have my own mental distress eh, as I say again I use it in inverted commas really as a shorthand eh because I guess its probably more than dual there's probably multiple identities that we have but I guess those two can be the eh, sometimes the most difficult to bring together, and you know I think, I'm not sure that we are very good at understanding what people need in order to support their mental health at work, em, and i don't, I mean, I don't know, I mean I've not had any negative experiences myself but I've heard from colleagues who've had negative experiences sometimes when they've shared something about their own kind of mental issues or distress eh people don't always get a supportive response	Dichotomisation psychologist/others Dividing practices CP brings multiple perspectives Dichotomisation psychologist/others Distress as prohibited (norms) Distress as stigmatising (gen) Client position as dangerous Talk about distress as a relational risk
	[section removed to protect participant anonymity]	
Researcher	But psychologists too can experience this barrier to speaking about..[Oh Yes]..distress?	CP as constrained from talk about distress
Clinical psychologist	Yes, yes, definately, definately. I mean I went to, [removed] and Natalie Kemp was there talking about her experiences, em and you know she speaks extremely eloquently	CP as activist Modelling a different way of being– showing vulnerability

APPENDIX I: Discarded initial codes - examples

Code	Action	Rationale
• Distress requires practical solutions - boundaries	Discarded	Unfocused code – content unclear
• Talk of distress as risky	Broken down into a number of codes i.e. • Talk of distress as talk of vulnerability • Talk of distress by CP as shocking to others • CP as immune • Dichotomising practices	Too broad
• Dual-identity discourse	Replaced by: • Dichotomisation psychologists/others	Too narrow, and overly descriptive.
• Distress as a signal/communication – unattended to	Replaced by: • Distress as embodied threat response	Did not capture the content succinctly
• CP's need to shout to get help/support	• Dichotomisation psychologists/others	Too narrow and descriptive
• CP's have an ethical responsibility to notice distress	Replaced by: • Distress as impairment • CP as responsible for others	Too narrow and descriptive, did not capture the underlying constructions of distress, and the CP identity that underpin this expectation of responsibility.
• CP's who shout as incompetent, childlike • Distress as seen by others as weakness/incompetence	Replaced by: • Dividing practices	Too narrow and overly descriptive
• CPs must negotiate for reasonable demands	Replaced by: • CP power within the system as limited	Overly descriptive

APPENDIX J: Reflective Log (excerpt)

Interview with CP 4: A good rapport was established early on. Interview felt intimate, with the participant talking like she was talking to a friend or close colleague. Setting in participants home, at the weekend, talk of kids at intervals when they could be heard in the background. Perhaps the participant felt more comfortable and revealed more that she would have otherwise [note this participant expressed concerns afterwards about anonymity, perhaps she felt the more intimate context lead to her revealing too much - evokes strong feelings about protecting participant's anonymity] I experienced feelings of admiration for the participant, identification, feelings of similarity based in shared experience, it was hard to stand back from the narrative in the interview, and I was conscious of making an effort to maintain a focus on prompts that encourage clarification and elaboration.

Re: participant “wearing heart on sleeve”/being told that she is too emotional – strong feelings of identification with this relationship with emotional experience. My Irish identity- a difference I have noticed between UK and Irish cultural contexts is the permission to express emotion. Emotion seems to be considered a more private experience in the UK, with public expression of emotion considered “awkward”. The Implication seeming to be that showing feelings is not ok, not acceptable? “Wearing heart on sleeve”.. this has negative connotations? Origins in medieval times jousting, in jousting presumably wearing one's heart on ones sleeve meant one could be easily killed. Associations with weakness, in men. Discourses of masculinity/femininity? Clinpsy and patriarchal discourse? Are there other references to display of emotion as unacceptable? Display as unacceptable vs having the feeling as unacceptable. Emotion as internal experience vs emotion as a communicated experience. Distress and struggling and emotion seem to be used interchangeably.I recall, in a work context, a colleague describing a client voicing angry feelings as “having a paddy”. I remembered thinking at the time that ‘paddy’ were what Irish people were called in England, linked to colonial racialisation. Irish people seen as too emotional by English standards or norms? Too angry? Because anger was de-contexualised/de-historicised? The term Paddy bring to mind ‘Paddywagon’ i.e. police van – discipline/law and order. How do these associations, indicative perhaps of a particular relationship to the norms for emoting in a UK cultural context influence my relationship to and interpretation of the data? But I have also been socialised not to show my emotions more in accordance with these norms, i.e. not expressing strong emotion in public, not cursing. To perform in a more ‘socially acceptable way’ Professionalism? Psa encourages free expression of emotion only in circumscribed circumstances. Anger in particular is an unacceptable emotion?