

Psychological therapists' wellbeing in the context of IAPT-
NHS: A Foucauldian Discourse Analysis.

Paula Bermúdez Otero

1527420

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Abstract

This study set out to gain in depth and critical understanding of how psychological therapists working in IAPT-NHS services construct the concept of their wellbeing at work. Foucauldian Discourse Analysis (FDA) was used to identify the available discourses mobilised by these practitioners and map out their impact on subjectivity and practice, as well as the role of the specific NHS-IAPT context.

Ten psychological therapists working in IAPT services across two East London NHS Trusts were interviewed, using a semi-structured interview which also featured a visual task to elicit information. The interview narratives were analysed using FDA through the lens of a moderate social constructionist position.

The analysis identified four main discursive constructions of wellbeing: (1) *wellbeing as an individual responsibility*; (2) *wellbeing as a collective responsibility*; (3) *wellbeing as self-actualisation*; and (4) *wellbeing as productivity*. Each presented a picture of duality and contradiction, delineated by the subject positions made available. Notably, for the first two constructions, the subject positions of *responsible* and *irresponsible* alternated between the individual and the service, with particular impact on the ability to voice wellbeing difficulties at work. Subject positions of *the good/ideal therapist* and *the good employee*, corresponding to the latter two constructions, were mediated by the introduction of IAPT as a sub-context. IAPT was constructed as an inflexible, target-driven system in which participants seemed unable to hold both *the good/ideal therapist* and *good employee position*, resulting in a constant tension that seemed to only be resolved by giving up one of the two positions.

The conclusion addresses the benefits of approaching the issue of psychological therapists' wellbeing at work beyond the individualistic, neoliberal perspective, with particular recommendations to: (1) direct more funding to protect the NHS's therapeutic function, preventing further expansion of the market discourse into mental health services; (2) promote congruence between policies and practices at work, aligned with a collectivist perspective of wellbeing where both the individual and the system share responsibility and support; and (3) increase IAPT's flexibility to adapt appropriately to diversity.

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Abbreviations

BPS: British Psychological Society

CBT: Cognitive Behavioural Therapy

CQC: Care Quality Commission

CoP: Counselling Psychology / Counselling Psychologist

ELFT: East London Foundation Trust

FDA: Foucauldian Discourse Analysis

HCPC: Health Care Professions Council

IAPT: Improving Access to Psychological Therapy

IPA: Interpretative Phenomenological Analysis

NELFT: North East London Foundation Trust

NHS: National Health Service

NICE: National Institute of Clinical Excellence

ONS: Office for National Statistics

PWP: Psychological Wellbeing Practitioner

SWB: subjective wellbeing

UEL: University of East London

UK: United Kingdom

WHO: World Health Organization

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Chapter One: Introduction

1.1. Chapter One Overview

This first chapter aims to introduce the reader to the topic of psychological therapists' wellbeing working in Improving Access to Psychological Therapies (IAPT) services in the National Health System (NHS) in the United Kingdom (UK). I start by introducing the wider context of this research, including the NHS's recent history and IAPT, and the increased interest in the topic of wellbeing. Following this, my personal interest in the topic, my position and terminology used throughout this thesis will be discussed. I then present the literature review, including the search strategy; this begins with the main dilemmas regarding the definition of wellbeing, then expands on the available research in wellbeing, including subjective wellbeing, psychological therapists and wellbeing, wellbeing at work and the current state of psychological therapist's wellbeing in NHS-IAPT services. A reflection on the limitations of the reviewed literature follows, leading into the rationale for the study and its relevance to Counselling Psychology (CoP). The chapter concludes by outlining the study's aims and the research questions.

1.2. Current context in the NHS

The NHS was created in 1948, with the vision that healthcare should be offered to everyone regardless of their wealth. Since then, the NHS has become one of the world's largest workforces. It is generally identified with the medical model, traditionally focused on pathology, the use of diagnostic categories and medication (Golsworthy, 2004; Larsson, Brooks & Loewenthal, 2012; Woolfe, Strawbridge, Douglas & Dryden, 2010). Following the economic crisis in 2008, a significant proportion of the world appeared to be 'shaken' by it. This seemed to be followed by ongoing measures of austerity implemented across Europe as a potential way of 'solving' the problem. Clarke and

Newman (2012) offer a critical analysis of the economic crisis in which they argue that what originally appeared to be a located financial problem originating in banks seemed to be transformed into a global fiscal crisis and a political issue. They explain that after the crisis, the focus seemed to be changed from re-establishing the stability of the market, to distributing blame and responsibility; this means that instead of concentrating on what they believe to be the cause of the economic crisis (banks' risky strategies), the spotlight seemed to be placed on the 'expensiveness' and 'inefficiency' of the public sector and welfare state, which in turn seemed to present the problem as 'government debt' that could then be solved by cutting spending (austerity).

In this context, several authors have pointed to the increasing pressures on the NHS, describing a situation in which the NHS seems to be expected to provide care to more people with fewer resources, in a context of constant changes and re-structuring (Gilbert, 2015; Rao, Bhutani, Clarke & Sanjivan, 2016; Sizmur & Raleigh, 2018). For instance, the NHS Five Year Forward View promised £22 billion of efficiency savings by 2020 (NHS, 2014), and the Health and Social Care Act 2012 was approved, enabling private companies and non-profit organisations to compete for healthcare contracts against the NHS. This seemed to create a situation where NHS provision appears to be continuously squeezed and placed in precarious conditions—lacking the resources to cope with the challenges of an increasing demand of mental health services (in part possibly due to the impact of the economic crisis on people's mental health)—whilst the private sector could be seen as making profit by selecting those areas of healthcare that are 'easier' and 'cheaper' to deal with, which could then be leaving the NHS to attend to the most challenging and expensive cases (Willis, 2015).

Following this, the NHS could be seen as having no choice but to appear 'inefficient', seemingly confirming the initial 'diagnosis of the problem', yet perhaps missing the point that this might not be the original problem, but the consequence of the 'attempted

solutions’ acting as a ‘self-fulfilling prophecy’ (Merton,1957). Thus, in a context where we seem to have accepted that the financial problem is now a problem of government debt, NHS mental health services appear to have started to redirect their efforts to show the ‘cost-efficiency’ of the services provided, as a possible way to survive and ‘compete’ against private companies (Care Quality Commission (CQC), 2015; NHS, 2014).

1.2.1. Improving Access to Psychological Therapies (IAPT)

Following a report from the economist Richard Layard (Layard et al., 2006), IAPT was created to improve “not only the health and well-being of the population but also promote social inclusion and improve economic productivity” (Department of Health, 2007, p. 4). Thus, a major preoccupation of IAPT was to help people who were receiving benefits get back to work. The vision involved helping the government save money in the long term whilst creating a programme that provided cost-effective treatments to the requirements of the National Institute for Health and Care Excellence (NICE). NICE is committed to randomised control trials (RCT) to support evidence-based practice—a quantitative methodology, from a positivist perspective, that has received numerous criticisms (e.g. Carey & Stiles, 2016; Mulder et al., 2018; Perez-Gomez, Mejia-Trujillo & Mejia, 2016), yet is still regarded as the ‘golden standard’.

Thus, IAPT has elicited controversial reactions; whilst the majority of professionals acknowledge its positives regarding easier access to psychological treatment for a greater number of people (Clark, 2011; IAPT, 2012; Rao et al., 2016; We need to talk coalition, 2013), IAPT has also been critiqued because of its target-driven culture and approach to evidence-based practice, which emphasises the use of diagnostic categories, standardised treatment protocols, and favours Cognitive Behavioural Therapy (CBT) over other therapeutic approaches (McCann, Granter, Hassard & Hyde, 2015; Rao et al., 2016; Rizq, 2011;2012; Scott, 2018b; 2018c; We need to talk coalition, 2013; Woolfe et al., 2010).

Tensions between IAPT-trained staff and non-IAPT psychological therapists have been explored in the literature (Alston, Loewenthal, Gaitanidis & Thomas, 2014; Mason & Reeves, 2018), and several reports highlight the high turnover and high levels of staff burnout in IAPT services, which places them at the epicenter of staff wellbeing struggles (Rizq, 2011; Scott, 2018a; Steel, Macdonald, Schröder & Mellor-Clark, 2015; Walklet & Percy, 2014; Westwood, Morison, Allt & Holmes, 2017).

1.3. Increased interest in wellbeing

Psychology has been traditionally influenced by the medical model, focused on the study of psychopathology and the absence of health. It was in the 1960s that Psychology started to focus on prevention and the study of wellbeing, coinciding with a more stable economy and secure society (Ryan & Deci, 2001). During this period, Humanistic Psychology emerged as an alternative to Behaviourism and Psychoanalysis, bringing a new perspective to the understating of human experience, characterised by a focus on self-actualisation, growth, and wellbeing (Du Plock, 2010). In 1998, Positive Psychology was introduced by Martin Seligman, unifying a significant group of researchers who had been studying wellbeing for years. This consolidation aimed to encourage a shift of focus from Psychology's traditional emphasis on pathology towards human potential and promotion of flourishing (Seligman & Csikszentmihalyi, 2000).

In 2010, UK Prime Minister proclaimed the government's interest in measuring the nation's wellbeing. A year later, the Office for National Statistics (ONS) stopped using Gross Domestic Product to evaluate the country's progress and instead introduced a measure of wellbeing, including subjective and objective measures, with 10 different domains, counting social context and relationships, amongst others (ONS, 2011; Everett, 2015). This signaled the increasing presence of wellbeing in political, commercial, academic and psychological discourses (La Placa & Knight, 2014; Smith, 2019).

With Positive Psychology predominating in research into wellbeing, its presence in society and in academia has grown exponentially, with more than 3000 studies published on the topic since the 1960s (Carlisle & Hanlon, 2007). In this way, its rise in popularity has been variously received; White (2017) identifies different positions taken by authors regarding the increasing focus on wellbeing; firstly, those who support it, believing that it provides an excellent opportunity for human realisation (Helliwell, Layard & Sachs, 2017; Seligman, 2011); and secondly, those who critique it, arguing that it encourages excessive focus and pressure on the self, whilst removing proper attention from the quality of the welfare provision offered (Ahmed, 2010; Cromby, 2011; Davies, 2015; Ehrenreich, 2009; Held, 2002; Sointu, 2005). I agree with White's (2017) stance on this matter, as she argues for a combination of valuing the focus on wellbeing but also being critical of it; thus, I value the move to prevention in the NHS and the acknowledgement of the importance of subjectivity and notions of wellbeing (in accordance with the humanistic underpinnings of CoP; Cooper, 2009; Orlans & Van Scoyoc, 2009), whilst also adopting a critical approach to this matter, questioning the potential negative consequences of focusing excessively on the individual and disregarding social structures.

1.4. My personal interest in the topic

My interest in psychological therapists' wellbeing in the NHS was born from my own experience working as a psychological therapist in an IAPT service. After some time working there, I started noticing feelings of stress and burnout negatively impacting my experience at work, as well as my life outside work. I remember feelings of shame when I started sharing 'my struggles' with other close colleagues, and of surprise when they started disclosing similar feelings. I soon started to observe colleagues and our conversations at the office; I sensed that we were certainly not the only ones struggling,

yet it remained a shameful unspoken experience. It was not until I read the staff NHS survey (2015) reporting increasing levels of stress, burnout and depression in psychological professionals and a report by The Wellbeing Project Working Group Joint Initiative between the British Psychological Society (BPS) and New Savoy Conference (Rao et al., 2016) highlighting their concern for the situation, that I realised that this was a wider problem.

In our current society, characterised as it is by its dizzying speed, ‘having time to think’ almost feels like a privilege. Thus, informed by my CoP training, I wanted to use my thesis as an opportunity to ‘capture’ the moment and engage with the topic of wellbeing in a reflective and critical way, to hopefully inform future decision-making in the best interest of our professionals and health care services.

1.5. Positioning and terminology

Throughout this research I adopt a moderate social constructionist (Willig, 2012) critical-ideologist (Ponterotto, 2005) approach, influenced by Critical Psychology (Parker, 1999b) and grounded in the humanistic value base at the core of the CoP profession (Cooper, 2009; Kasket, 2012). This means that I aim to adopt a critical stance on the topic, through the deconstruction of language and the ‘taken-for-granted truths’ that are being used in our society, institutions and profession. Further explanation of my ontological, epistemological and axiological position and methodology will follow in chapter 2.

I have written this thesis using the first person to transparently acknowledge and embrace my positionality, which is essential to ensure quality in qualitative research (Georgaca & Avdi, 2012; Harper, 2012; Willig, 2013). By this, I aim to transmit that this thesis is a construction, and not an ‘objective or detached’ account, which can be implied when writing solely in the third person.

I have used single quotation marks to highlight the socially constructed nature of particular terms or to question their use, though due to the limited nature of this thesis I could not further explain their nuances. I have used *italics* for new terms introduced as part of my own analysis. Finally, I decided to use ‘wellbeing’, without including the other available forms (well-being and well being) to facilitate reading.

1.6. Literature review

1.6.1. Literature search

To ensure a complete search of the topic, PsychoInfo, Academic Search Complete, Science Direct and Scopus were examined. Papers, books and relevant articles were initially filtered through an initial reading of abstracts. I conducted searches in May 2016, August 2018 and December 2018, using all available combinations of the following terms in pairs:

- Psychologists OR therapists OR psychotherapists OR clinicians OR counselors OR mental health personnel
- Well-being OR wellbeing OR well being OR wellness
- Discourse analysis OR discourse
- Improving Access to Psychological Therapies OR IAPT
- National Health Service OR NHS

1.6.2. Definitions of wellbeing in the literature

The concept of wellbeing has been defined in various ways and by different disciplines. Philosophers have been interested in wellbeing for centuries, originally discussing it within the philosophy of ethics, mainly related to moral conduct as a means to a ‘happy’ living (Haybron, 2008). Economists have also studied wellbeing for more than a century

(Oades & Mossman, 2017), traditionally focusing on studying it through the assessment of wealth and consumption. In 1946, the World Health Organization (WHO) referred to wellbeing in their definition of health, producing increasing interest and debates around the concept; WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946, p. 2). Since then, professionals from different fields have become increasingly interested in understanding the concept of wellbeing further, including sociologists, economists and, more recently, psychologists (La Placa & Knight, 2014).

Currently, there is no agreed definition of wellbeing and it is commonly referred to throughout the literature as a controversial and complex construct (Dodge, Daly, Huyton & Sanders, 2012; Ryan & Deci, 2001). Traditionally, it has been approached from two perspectives, still present in the research: hedonism and eudaimonism (Dodge et al., 2012). The hedonic perspective is based on the concept of subjective wellbeing (SWB), understood as pleasure or happiness (Diener, Lucas & Oishi, 2005). Conversely, the eudaimonic perspective is based on the idea of the fulfillment of the “true self” (Ryan & Deci, 2001, p. 146), understood in terms of an individual finding meaning through reaching their full potential, and measured through concepts of autonomy, mastery, personal growth, life purpose, relatedness and vitality.

Some authors have classified the available literature in wellbeing according to three categories (Dolan & White, 2007; Jongbloed & Andres, 2015): (1) those who link wellbeing to desire-fulfillment, focused on ‘wanting’, highly present in the economic literature (Griffin, 1986; Harsanyi, 1982); (2) those portraying wellbeing as pleasure over pain, focused on ‘liking’ (from the hedonic tradition) (Bentham, 1978); and (3) those who link wellbeing with people’s needs, including eudaimonic approaches regarding the need for meaning and purpose, and the objective list theory that conceptualises basic needs as “basic objective goods” (Rice, 2013, p. 197), including loving relationships, autonomy,

meaningful knowledge, pleasure and achievements (Grix & McKibbin, 2016; Rice, 2013).

Nonetheless, there are additional approaches to wellbeing that do not seem to be captured by these categories. For example, Prilleltensky's (2012) model of 'wellbeing as fairness' places conditions of justice at the societal, physical, intrapersonal and interpersonal level as fundamental influencers of community, personal, interpersonal and organisational wellbeing. Sen proposed a model of capabilities to define wellbeing, placing the ability to 'do' or 'be' at its centre, explaining how this 'capability' does not reflect directly the person's ability, but their opportunity (or freedom) to action them (Sen, 1999); it emphasises how this freedom, although inherent to the individual, is significantly shaped by the socio-economic-political context and conceptualises wellbeing as the 'real' freedoms or opportunities people have to achieve a life that they value and have reason to value (Nussbaum, 2011; Sen, 1999). Moreover, White offers an alternative perspective to wellbeing which has resonated with me due to its relational nature and its emphasis on constructing people as subjects (White, 2018; 2017). She suggests referring to wellbeing as 'relational wellbeing', proposing 'wellbeing' as a sort of energy that develops through relationships, as opposed to residing within the individual, also supported by La Placa & Knight (2017). White acknowledges individual processes as important yet emphasises the significance of looking at contextual issues to approach the current wellbeing deficit.

These examples show the complexity of this topic and the attendant challenges this brings in terms of defining wellbeing. Dodge et al. (2012) talk about this challenge and offer a new definition with the intention of making it universal, optimistic and easy to measure. They refer to wellbeing as a dynamic process that represents an equilibrium between individuals' physical, social and psychological resources and the challenges they encounter, stressing the important role of appropriate challenges as a source of growth. However, critical perspectives warn of the dangers of seeking and proclaiming a universal

definition of wellbeing (Afuape, Hughes & Patel, 2016). It is argued that although a general conceptualisation of wellbeing can facilitate its measurements and commodification (as argued by Dodge et al. 2012), it dismisses the importance of culture, context and individual subjectivity, usually benefiting a westernised perspective that can be then imposed on others.

This relates closely to the theory of discourse and power at the core of this research project; Foucault (1980; 1982) talked about ‘modern power’ being intertwined with dominant forms of language (what is presented and accepted as ‘truth’; dominant discourses) that are ratified in our day-to-day interactions. As Afuape et al. (2016, p. 38) state, the potential danger of a universal definition is that “ideas that we come to accept as true can constrain our ability to live by our personal values and thus be oppressive”. This critical awareness is also at the core of my CoP values of appreciating diversity and standing up for social justice issues (Bradley, Werth & Hastings, 2012; Cooper, 2009; Orlans & Van Scoyoc, 2009). Subsequently, at this stage I hold an open mind towards this concept and rather than searching for a ‘definite/accurate definition’, I understand that wellbeing may mean different things to different people, depending on their context.

1.6.3. Research in wellbeing

1.6.3.1. Subjective wellbeing (SWB)

SWB has become one of the preferred measures of wellbeing in Psychology and other fields (Graham, 2011; Jen, 2017; White, 2017), with numerous studies focused on measuring, predicting and controlling this construct. Influenced by Bentham’s (1776) utilitarian approach to wellbeing focused on pleasure, SWB refers to “a person’s cognitive and affective evaluations of his or her life” (Diener et al., 2005, p. 63) and it involves positive emotions, high levels of life satisfaction and absence of negative mood.

Due to SWB's individualistic focus and the increasing material wealth of Western societies, following the first studies published at the beginning of the 20th century, SWB research grew exponentially as a way of satisfying people's interest in pursuing a 'good life' (Diener et al., 2005). Although SWB was created in Positive Psychology to advocate for a wider focus on personal strengths rather than the traditional emphasis on 'weakness and mental illness', it has been questioned as a measure of wellbeing (Henderson & Knight, 2012; Moor & de Graaf, 2015; Ryan & Deci, 2001; Ryff & Dinger, 1998) and has also been critiqued for its affinity with neoliberal market discourses (Smith, 2019; White, 2018, 2017).

Beyond the 'accuracy' of wellbeing as a measure, I am more interested in the potential implications of such construction. For instance, Smith (2019) eloquently explains how SWB dismisses interpersonal aspects in favor of presenting a view of the self as autonomous and independent. White (2017) also argues that since SWB has become an economic and social marker, happiness has come to represent 'what people desire'; therefore, positioning people as consumers measuring their lives' subjective success, seemingly creating an ideal scenario for people to develop 'false selves' (Winnicott, 1965). Consequently, many authors critique the SWB-influenced construct of 'wellbeing' prevalent in our society (e.g. Ahmed, 2010; Cabanas, 2016; Carlisle & Hanlon, 2007; Held, 2002; Scott, 2015; Smith, 2019; Vittersø, 2013; White, 2018, 2017). For instance, Cabanas (2016) discusses how 'happiness' has turned into a new 'moral regime', allocating responsibility and reinforcing an individual and consumerist ideology; he argues that this approach turns citizens into 'psytizens', meaning that people become 'psychological clients', who self-govern and make consumption choices to 'manage' their own wellbeing.

1.6.3.2. Wellbeing and psychological therapists

Regarding psychological therapists' wellbeing, several themes were identified in the available literature: (1) intrinsic hazards of the profession; (2) factors influencing wellbeing; (3) wellbeing as an ethical issue; and (4) individual interventions to improve wellbeing.

1.6.3.2.1. Intrinsic hazards of the profession

Skovholt (2001) describes the inherent risks of the caring professions, particularly the fundamental challenge of continuously attaching and separating from clients. He stresses that difficulties generally arise from our hopes and expectations of change and the barriers we encounter from them. He describes 20 hazards that cover different topics, such as working with difficult emotions, the impossibility of sharing successes with others due to confidentiality, frustrations because of our own limitations or the client's situation, and exposure to uncertainty, amongst others.

Additionally, Lawson, Venart, Hazlet & Kottler (2007) found that the fundamental abilities needed to develop a trusting and safe therapeutic relationship, can also place therapists at risk of compassion fatigue, burnout and secondary traumatic stress. Whilst Dattilio (2015) compares psychological therapists to police officers and firefighters, amongst others, in terms of the high level of stress experienced in the psychological profession due to the nature of the work, which involves continuous exposure to suffering and to "psychologically toxic situations" (Dattilio, 2015, p. 393). Similarly, Johnson et al. (2018) highlight specific characteristics of the work that makes us more vulnerable to stress and burnout than other healthcare professions; these include: prolonged 'emotional labour' with unwell clients, exposure to violence, and work with people who do not want to be treated (e.g. involuntary detentions) or may harm themselves and/or commit suicide.

1.6.3.2.2. Factors influencing wellbeing

1.6.3.2.2.1. Type of clients and caseload

Studies using surveys and quantitative measures have targeted therapists to find correlations between type of clients and workloads and their impact on the therapists' wellbeing, finding that workload, severity and nature of clients' presentations are factors to be considered and balanced. For example, Lawson (2007) conducted a national survey measuring wellness and impairment, finding that having a varied caseload protects counsellors from burnout, which is consistent with Young and Lambie's (2007) findings about the negative impact of constantly working with severe presentations, such as working with addictions or victims of abuse (Ducharme, Knudsen & Roman, 2007). He also found that seeing an elevated number of clients was associated with burnout, which is also supported by Lee, Seong, Kissinger and Ogle (2010).

1.6.3.2.2.2. Psychological therapists' characteristics

Other research has focused on the clinicians' themselves. Studies have reported that psychological therapists are at great risk of stress based on their personal vulnerabilities, sense of perceived invincibility to mental health difficulties and reluctance to seek help due to social stigma, anticipated risks and fear of emotion and self-disclosure (Barnett & Cooper, 2009; Barse, McMinn, Seegobin & Free, 2013). Moreover, some authors have portrayed psychological therapists as disregarding their own self-care (Dattilio, 2015; Figley, 2002; Walsh, 2011).

Furthermore, Barnett (2007) talks about unconscious drives that attract psychological therapists to the profession, connecting with the widely known concept of the wounded healer, first used by Jung, referring to the potential for developing genuine empathy with

clients' painful experiences from our own suffering; Barnett's findings suggested that therapists who were subjectively and objectively aware of 'their own wounds', were well able to help others. Yet there is still debate around this topic; for example, Gentry, Baranowsky, and Dunning (2002) stated that people who choose the Psychology career may have been wounded in the past, making them more vulnerable to distress, and they assert that all health professionals will experience burnout sometime in their careers. Conversely, Collins and Long (2003) found that when therapists had worked through difficult past experiences, this could protect against burnout and aid positive growth, which is supported by Martin (2011) who invites therapists to truly accept their wounds to become better clinicians. Similarly, Schonau (2012) supports the potential of the wounded healer, through her qualitative study looking at how therapists grow through their life experiences. Her findings suggest that life events helped clinicians appreciate their fallibility and develop a more personal therapeutic relationship bringing about personal and professional growth.

Thus, this section shows a tension in psychological/psychotherapeutic research and practice, whereby therapists' characteristics/abilities have been portrayed as our potential but also as our vulnerabilities.

1.6.3.2.3. Wellbeing as an ethical issue

Psychological therapists' wellbeing has also been referred to as an ethical issue in the literature, based on the impact that our own wellbeing could have on the quality of work. Barnett, Baker, Elman and Schoener (2007) refer to it as an "ethical imperative" (p. 604), emphasising that psychological therapists should engage with the previously described challenges in order to deliver good quality of care and not cause harm to clients. Similarly, Wise and Gibson (2012) support the notion of self-care as an ethical imperative, linking it to professional competence, and Dattilio (2015) argues for a critical

relation between ethics, competence and self-care. Furthermore, our Practice Guidelines (BPS, 2017) recommend taking responsibility for our own self-care to maintain our wellbeing, and this is also included in the Professional Practice Guidance of both the Division of Counselling Psychology and the Health and Care Professional Council (HCPC) as “fitness to practice” (Division of Counselling Psychology, 2005, p. 3; HCPC, 2016, p. 11). This underlines the significance of this topic, not only in clinical practice but also in the research, as it places psychological therapists under significant pressure to monitor and maintain their wellbeing as an ethical duty.

1.6.3.2.4. Individual interventions to improve wellbeing

A significant number of studies focused on interventions to cope with the stresses of the profession and to maintain and/or improve wellbeing. Research has supported personal therapy (Barnett, 2007; Linley & Joseph 2007; Stevanovic & Rupert, 2004), supervision (Barnett, 2007; Drouet Pistorius, Feinauer, Harper, Stahmann & Miller, 2008; Linley & Joseph 2007), group support (Jordaan, Spangenberg, Watson, & Fouche, 2007), co-workers (Ducharme et al., 2007), Acceptance and Commitment interventions (Reeve, Tickle & Moghaddam, 2018), and mindfulness (Di Benedetto & Swadling, 2014; Zarbock, Lynch, Ammann, & Ringer, 2015) as appropriate strategies to help clinicians deal with the intrinsic and external hazards of their work to improve their wellbeing.

Self-care strategies have also been a significant recommendation for psychological therapists, with numerous research projects, articles and books focused on this (Corey, Muratori, Austin, & Austin, 2018; Dattilio, 2015; Drouet Pistorius et al., 2008; Guy, 2000; Hensley & Schultz-Duncan, 2017; Kottler, 2011; Moye, 2017; Pakenham, 2015; Skovholt, 2001; Skovholt & Trotter-Mathison, 2011; Wise, Hersh, & Gibson, 2012). Thus, self-care strategies are recommended to healthcare staff, encouraging them to meet their personal and family needs, whilst promoting physical, psychological and spiritual

health (Brownlee, 2016; Mills & Chapman, 2016). Similarly, several authors have also developed self-care models for psychological therapists in order to maintain wellbeing and professionalism throughout our careers (Barnett & Cooper, 2009; Norcross & Guy, 2007; Stevanovic & Rupert, 2004; Walsh, 2011; Wise et al., 2012;). Nevertheless, a participant in Brownlee's (2016) qualitative study of seven counsellors, made an interesting remark about their perception of self-care, stating that however important they perceived self-care to be, they also associated it with feelings of self-indulgence, selfishness and guilt, making it difficult to prioritise their self-care.

1.6.3.3. Wellbeing at work

Another area widely present in the literature was in relation to wellbeing at work, with several authors highlighting the importance of investing in staff wellbeing, due to firstly its positive impact on performance, productivity and client outcomes (Black, 2008; Boorman, 2009; Bryson, Forth, Stokes & NIESR, 2014; Francis, 2013; Fith-Cozens & Cornwell, 2009; Hancock & Cooper, 2017; Kersemaekers et al., 2018; Lee, Seo, Hladkyj, Lovell & Schwartzmann, 2013; Maben et al., 2012; Miller, 2016; West & Dawson, 2011), and secondly its economic impact, in terms of associating staff wellbeing issues with extra costs to healthcare institutions (Department of Health, 2010; Knapp & Iemmi, 2014; West & Dawson, 2011;).

Consequently, guidelines to promote wellbeing at work have been published by the BPS (Weinberg & Doyle, 2017), NICE (2009, 2016), and NHS-related organisations, such as NHS England (2016) and NHS Employers (2015, 2018). For instance, in March 2018, NHS Employers conducted the first 'Health and Wellbeing conference' to talk about mental wellbeing across NHS England and published new frameworks to improve staff wellbeing at work, establishing the importance of staff wellbeing in the NHS agenda. Their latest publications (e.g. Workforce Health and Wellbeing Framework, NHS

Employers, 2018) include a description of organisational enablers and interventions to improve health and wellbeing at work; when referring to the organisational enablers, they acknowledge the importance of cooperation between service structures, management and staff, and they promote structural changes to support staff wellbeing at work (including leadership and management, data and communication and healthy working environments). When referring to health interventions, the need for an individual assessment is highlighted, followed by self-management, prevention and specific interventions; this includes interventions related to mental health (e.g. counselling), musculoskeletal health (e.g. physiotherapy) and lifestyle (e.g. smoking cessation and exercise). Similarly, The National Collaboration Centre for Mental Health (2018) released 'The IAPT Manual' with a specific section for staff wellbeing, highlighting the importance of a supportive culture, the right working environment, supervision, and training, amongst others.

Following this, numerous 'wellbeing initiatives' have been introduced (e.g. Blake & Gartshore, 2016; Blake & Lloyd, 2008; Blake, Suggs, Coman, Aguirre & Batt, 2017; Blake, Zhou & Batt, 2013; Flint, et al., 2016), yet studies that have evaluated the implementation of wellbeing programmes have pointed to significant challenges, including structural factors (Quirk, Crank, Carter, Leahy & Copeland, 2018) and the neoliberal, reductionist nature of such programmes, which attempt to monitor and measure wellbeing, compromising its holistic multi-layer nature (Dooris, Farrier & Frogett, 2018). Spence (2015) raised an interesting point regarding the lack of engagement in 'well-intentioned' programs to improve staff wellbeing, highlighting the importance of involving staff in the process, whilst listening to what is meaningful to them. Moreover, Johnson et al.'s (2018) review of the literature on mental healthcare staff wellbeing points to the minimal effects of wellbeing interventions, both at the individual and organisational level, and they highlight the importance of attending to the underlying

reasons for the difficulties before providing ‘reactive solutions’. These critiques point to the importance of attending to relationships and context in order to deliver meaningful interventions, which is at the heart of CoP values (Cooper, 2009).

1.6.3.4. The current situation of psychological therapists’ wellbeing in the IAPT-NHS

Since the ‘Francis Report’ (Francis, 2013), which identified malpractice and a culture of blame and harassment in the NHS, numerous studies have continued to report high levels of distress in mental health professionals (Gilroy, Carroll & Murra, 2002; Hill et al., 2006; Morse, Salyers, Rollins, Monroe-DeVita & Pfahler, 2012; Pope & Tabacknick, 1994; Ukens, 1995;). For instance, NHS staff surveys (2015, 2016, 2017) have reported a consistent figure of 40% of respondents feeling unwell due to work-related stress, and several authors have indicated the high prevalence of burnout and distress in IAPT psychological staff (McAuley, 2010; Rizq, 2011; Scott, 2018a; Steel et al., 2015; Walklet & Percy, 2014; Westwood et al., 2017).

Moreover, Rao et al. (2016, 2018) have reported a consistent prevalence of distress in the psychological workforce over the last four years. Their discussion paper (Rao et al., 2016) has greatly inspired my current study, as they took a critical approach to psychological therapists’ wellbeing at work. Although they do not explicitly state their epistemological stance, they report their intention to look for causal links and establish correlations to better understand the situation and develop new measures, fitting within a quantitative paradigm and resonating with a critical realist approach. Their methodology involved sending The Staff Wellbeing Questionnaire to mental health professionals registered with regulation bodies, measuring social, personal and work wellbeing, including several closed questions and a section for open comments. They followed a similar methodology to a survey carried out in 2009, with the aim of measuring wellbeing and comparing it

with previous results and the general population, though their sample of mainly heterosexual white British female participants (88.9% white British, 88.7% heterosexual and 80.3% female) and Band 7 workers may suggest a limited profile of participants.

Their 2016 research found that most respondents reported good social wellbeing and satisfaction at work; however, increasing levels of stress and a doubling of reported harassment and bullying were reported. 70% reported their job as stressful, 46% reported symptoms of depression, and almost 50% described feelings of failure. Only 10% of their comments were positive, and the negative included issues with working towards targets, supervision, continuing professional development, not being valued, limited time for reflection and preparation/formulation, and low morale and blame culture, amongst others (Rao et al., 2016). Following this, Rao's team organised a focus group to think about the potential impact on clinicians, clients and services, and launched a Charter for Psychological Wellbeing and Resilience with the purpose of rebalancing the current direction of the NHS, claiming an urgency to support the wellbeing of psychological staff.

Additionally, the team continued to measure psychological therapists' wellbeing each year, reporting an increase in depression (from 40 to 48%) and feelings of failure (from 42% to 46%) in 2015 and 2016, with a slight decrease in 2017 (down to 43% and 42% respectively). In the 2017's open comments, the target-driven culture remained a top concern, followed by feeling less depressed yet more hopeless, anxious and stressed, and the lack of leadership and containment. Expressions of the desire to leave the NHS and reference to complaints and a culture of fear and threat, amongst others, were also higher (Rao et al., 2018). Thus, Rao's team continued to show a concerning picture regarding the psychological workforce.

1.6.4. Limitations in the available research

A significant part of the literature and research found in relation to wellbeing was interested in measuring, predicting, increasing and/or improving ‘wellbeing’, frequently aligned with a positivist epistemology, using quantitative approaches, with few qualitative studies or mixed methods. For example, Schrank et al., (2015) conducted a study looking at staff perceptions of factors influencing their own and their clients’ wellbeing, using Thematic Analysis from a positivist realist stance. The use of qualitative methods from a positivist realistic perspective seems to disregard the essence of the methodology, which does not aim to seek ‘truth’ and regards subjectivity and reflexivity as fundamental (Braun & Clarke, 2013). Similarly, four out of the five recent systematic reviews that examined the literature on wellbeing at work had only focused on quantitative studies (Carolan, Harris & Cavanagh, 2017; Ivandic, Freeman, Birner, Nowak & Sabariego, 2017; Nielsen et al., 2017; Robertson, Cooper, Sarkar & Curran, 2015), showing the limited nature of the research in this area.

Research using quantitative methodologies and positivist epistemologies tend to portray their findings in ‘universal’ and ‘generalisable’ terms. Consequently, the issue of not having a shared definition of wellbeing presents an important limitation for quantitative research. Dodge et al., (2012) and Allin (2007) also highlighted this limitation, as they warn about how most researchers approach wellbeing from a multidimensional perspective, meaning that different terms can be used for wellbeing or different meanings attributed to it. Thus, it was noted that a significant number of the quantitative studies used ‘health’, ‘happiness’ and ‘wellbeing’ interchangeably, raising questions about the ‘validity’ of the findings. This is not surprising, considering that even The Oxford English Dictionary defines wellbeing as “...the state of being healthy, happy, or prosperous; physical, psychological, or moral welfare”. Nevertheless, Jongbloed and Andres (2015) argued that research on wellbeing and happiness shows that they are not the ‘same

concept'. To better understand Canadian people's conceptualisations of wellbeing and happiness, they conducted a mixed-method study using a sequential exploratory design, consisting of semi-structured interviews and thematic and statistical analysis. Their findings highlighted that wellbeing and happiness were constructed as two separate and fluid concepts, suggesting that happiness is a part of wellbeing, but that it does not completely capture its meaning. This points out the potential problems in research where both have been used interchangeably, adding to the question of what was really being 'measured'.

Further methodological limitations of the literature have been highlighted by a recent systematic review (Ivandic et al., 2017) which looked at studies published in English and German between 2000 and 2016 regarding interventions for increasing wellbeing at work. They included RCTs and quasi-experimental studies that assessed interventions evaluating the impact on participants' wellbeing. They concluded that due to the studies' methodological limitations, there was no consistent evidence on the effectiveness of brief stress management interventions, relaxation, mindfulness or medication. Additionally, they noted that all the studies reviewed focused on evaluating individual-level interventions, which could reflect a disregard for contextual and external aspects linked to staff wellbeing at work. Indeed, they suggested that policy-makers need to create appropriate legislation to guarantee that employers invest in measures to improve their staff's wellbeing, rather than placing the onus solely on the individual. These limitations suggest that regardless of the vast literature on wellbeing, there is still scope to approach the topic from a different perspective that has been generally overlooked, particularly in terms of bringing a qualitative approach looking beyond the individual.

1.7. Rationale for the study and relevance to Counselling Psychology

Though the area of psychological therapists' wellbeing has been highly researched, it nonetheless becomes apparent that there is a disconnection between the available knowledge and guidelines, and people's experience of their own wellbeing at work, setting a scene whereby those professionals responsible for supporting people experiencing mental health difficulties are themselves reporting similar issues at work. Furthermore, recent systematic reviews show that the proposed interventions to tackle these difficulties do not seem to help (Dreison et al., 2016; Ivandic et al., 2017; Johnson et al., 2018), leading to a paradoxical situation for psychological professionals, who find their wellbeing squeezed by growing demands and targets (Gilburt, 2015; Rao et al., 2016; Sizmur & Raleigh, 2018), whilst their organisational discourse seems to convey that 'they value staff wellbeing' (e.g. NHS England, 2016; NHS Employers, 2015, 2018 NICE, 2009).

As CoPs, we know from our clinical practice that tensions and 'ruptures' in therapeutic relationships are not necessarily disadvantageous (Clarkson, 2003), but moments to learn about ourselves and our clients, providing an opportunity to work through difficulties and generate transformation (Safran & Muran, 2000). Thus, I propose that we use this moment to critically reflect on the current processes to deepen understanding of our engagement with them. Furthermore, the relevance of this research project intensifies when the current socio-cultural moment is considered; a time when politics and policy-makers are considering wellbeing as an important aspect to develop in our society and decisions are made based on research findings (Bache, 2015; NHS England, 2016, NHS Employers, 2015, 2018; NICE, 2009). Thus, I believe that introducing an alternative approach to research in wellbeing could be of value to CoP and all allied psychological/psychotherapeutic professions. By embracing a critical perspective,

focusing on deconstructing ‘taken-for-granted’ knowledge, I aim to elucidate the presupposed ways of constructing wellbeing that relate to professionals’ subjectivity, and consequently, to the system and our clients.

Finally, following Willig (2013), I don’t believe that my perspective is the only valuable approach to wellbeing. Instead, I believe that diverse perspectives and methodologies have different value, and when brought together, can help us develop a more multifaceted understanding, which embraces the pluralistic stance at CoP’s heart (Cooper, 2009). Thus, I propose that researching psychological therapists’ wellbeing in IAPT-NHS services from a moderate social constructionist perspective, paying attention to the constructive nature of language beyond the individual, may offer a different perspective and thereby make a valuable contribution to the field.

1.8. Aim of this Research

The present study aims to contribute to the body of knowledge regarding staff wellbeing in the NHS (particularly IAPT) by approaching the topic with different lens and focusing on different phenomena. Specifically, this study’s aim is not to focus on measuring levels of staff wellbeing, or to design or evaluate the implementation of guidelines to enhance wellbeing, as these are abundant in the available literature. Instead, this study’s aim is to gain in-depth and critical understanding of how psychological therapists construct their own wellbeing at work (IAPT-NHS) and its implications for subjectivity, paying special attention to the use of language and its relation to the specific workplace context. With this, I hope to facilitate a new conversation about wellbeing and make a meaningful contribution to knowledge and practice about wellbeing for the clinical professions.

1.9. Research questions

The overarching research question is:

- How do Psychological therapists construct their own wellbeing in the context of IAPT-NHS?

With two sub-questions:

- What are the implications of these constructions for subjectivity?
- What difference does the particular context of the NHS Trust make, if any, to the above?

Chapter Two: Methodology

2.1 Chapter Two Overview

This chapter presents a reflection on epistemological and methodological choices, followed by information regarding the research procedure, covering ethics, participants and recruitment, data collection and the analytic approach. The chapter concludes with a description of the evaluation criteria and reflexivity.

2.2. Positioning of the research: Epistemological and ontological considerations

To ensure rigour and trustworthiness in qualitative research, it is important to present a clear epistemological position, which will also provide the grounds to establish the appropriate evaluation criteria (Willig, 2013). Thus, I will now explain my rationale for adopting a moderate social constructionist position/critical-ideologist, whilst embracing the CoP humanistic underpinnings.

For this, I start by acknowledging my position as a CoP. I regard CoP as a unique profession within the Psychological field. CoP tends to promote an open and curious approach towards knowledge and human beings and it is strongly grounded in humanistic values (Cooper, 2009; Douglas, Woolfe, Strawbridge, Kasket & Galbraith, 2016; Kasket, 2013; Orlans & Van Scoyoc, 2009). These values motivate professionals to be honest, committed and interested in the subjective experience, whilst embracing the idea of empowering and being welcoming to others (Cooper, 2009; Kasket, 2013). But this humanistic value-base is only a part of the essence of CoP; I have also come to understand our discipline as holding a resilient and critical stance. We are encouraged through our training both in research and practice to engage in deep debates and tensions while holding an open mind (Douglas et al., 2016; Kasket, 2013). For this, it seems crucial to

have the ability to approach our clinical and research practice both with a ‘scientific’ mind, using different theories to inform formulations or to critically appraise literature, but also, with the capability to manage the uncertainty of challenging our own views and taken-for-granted knowledge.

Accordingly, I have also engaged critically and reflexively with the different paradigms concerned with the nature of existence (ontology) and the way knowledge is produced (epistemology), as well as the place of values in the process (axiology). As these concepts are highly abstract, it is not surprising to find several conceptual maps of them. Thus, I have decided to focus on Ponterotto and Willig’s categorisations, which helped me develop an understanding of my own position and methodological choices. Ponterotto (2005) draws on Lincoln and Guba’s (1985) ideas to refer to positivism, postpositivism, constructivism-interpretivism and critical-ideological paradigms, whilst Willig (2012) writes about realist, phenomenological and social constructionist approaches along a continuum, with variations within each approach.

Thus, Ponterotto’s positions (2005) could be further categorised into two clear groups: positivist and postpositivist on the one hand, and constructivist-interpretivist and critical-ideological on the other. This separation into broader groups makes it easier for me to position myself within the latter group, as I believe in ‘reality’ as co-constructed and dependent of its context; therefore, I do not believe that there is only one ‘truth’ but multiple ‘truths’. The constructivist-interpretivist paradigm thus seems to fit nicely with how I understand the world and knowledge, as well as my clinical practice, where I believe that the core aspect of the therapeutic process is the therapeutic relationship. Yet, the constructivist-interpretivist paradigm seems slightly limited, as it assumes that individuals construct reality within their minds, whereas critical-ideological approaches offer a broader perspective, acknowledging the role of the social and historical context.

Regarding axiology, I acknowledge that, as a clinician and researcher, I bring my values into both my research and practice. Whilst in clinical practice it seems that my approach sits better with the idea of ‘bracketing’ my values (leaning towards a constructivist-interpretivist approach), in research, acknowledging that I have hopes and values is a fundamental part of the rationale for choosing my specific topic and methodology, more in line with a critical-ideological stance. Despite my growing commitment to this approach, I am aware of my positivist/postpositivist historical background. Shifting paradigms is a difficult process, especially when considering the current socio-political-economic context, governed by a neoliberal capitalist system that tends to reduce social phenomena to the individual level (Parker, 2015). I therefore value reflexivity and continuous dialogues with peers and colleagues as a way of challenging myself to be aware of these influences and potential dilemmas.

Following this critical stance towards the status quo, it seems important to reflect on the ontological dimension. For this, I find Willig’s (2012) categorisation useful to identify myself as a ‘moderate social constructionist’ in contrast to a ‘radical’ position. This has been a process, which started by noticing how my training as a CoP had led me towards the relativist side of the continuum, opening new perspectives and possibilities. As Potter (1998) explains, relativism encourages resistance to ‘settlement’ and it works well with critique, plurality and multiplicity of voices, which seems to align with the CoP values previously described. Nevertheless, a tension arises when I relate this stance to my desire to bring about change with this research project, requiring the acknowledgement of the power/knowledge relation (Foucault, 1980) and its oppressive ‘real’ effect (Parker, 1998), which is better facilitated by a critical realist (moderate) stance (Willig, 2012). For instance, when thinking about ‘subjective concepts’, such as wellbeing or oppression, the relativist position strikes me as unable to make a strong argument to advocate for change, standing on the side of the ‘marginalized or oppressed’ by the system. Parker (1999a)

refers to this as “apolitical individualism” (p. 73), and he strongly defends how a critical realist stance enables the understanding of institutional and historical structures of power. Similarly, Burr (1998) reflects on this dilemma and states that in order to justify advocating a specific view over another, we need to have some notion of reality. I agree with her view, especially when she argues the impossibility of stepping outside of our own value system, located as it is in our specific history and cultural background. She suggests that we might only be able to make interpretations and choices from within this system and aim to engage with them critically and reflexively to make informed decisions. I therefore believe that from a critical realist (moderate) standpoint I will be better equipped to conduct this project, paying attention to ‘non-discursive’ aspects such as context and policies (Sims-Schouten, Riley & Willig, 2007).

2.3. Methods and Research Design

2.3.1 Rationale for using Foucauldian Discourse Analysis (FDA)

According to the aims and research questions of this project, the type of knowledge needed to answer them, my epistemological, axiological and ontological position, I believe that Foucauldian Discourse Analysis (FDA) could offer an appropriate method to conduct this research.

To make this decision, I also considered Interpretative Phenomenological Analysis (IPA) and Thematic Analysis (TA) as qualitative methods that focus on giving voice to participant’s meaning making (Braun & Clarke, 2013; Joffe, 2012; Larkin & Thompson, 2012). Nevertheless, IPA was discarded based on its limitation to consider socio-cultural context (Braun & Clarke, 2013), and although TA was compatible with my research position and it is considered ‘easy’ to learn for novice researchers (Braun & Clarke, 2006), it was discarded because this project’s originality lays on the uniqueness of its analysis, which aligns better with Discourse Analysis.

Within UK Psychology, there are two main approaches to the study of discourse, Discursive Psychology and FDA (Coyle, 2007; Willig, 2013). Of the two, FDA seems better equipped to look at the world as having a structural reality, consistent with a moderate social constructionist approach. Thus, as explored in Chapter 1, most of the research in wellbeing has been interested in measuring and controlling ‘wellbeing’, showing an excessive focus on the individual whilst mostly disregarding the context and social impact of power and structural aspects. FDA offers an alternative to this, bringing a qualitative critical approach and turning attention to the constructive nature of language. Moreover, FDA emerged in a socio-cultural context of dissatisfaction with the political system (Arribas-ayllon & Walkerdine, 2014). This strikes me as especially relevant, when considering the current climate where movements against the current political establishment are increasing (e.g. Syriza in Greece, ‘15 M’ in Spain or Brexit in the UK). This may indicate a growing dissatisfaction with the system from a large part of the population, including myself, which could have driven my interest to step outside the individual and consider the macro level and issues of power, facilitated by FDA.

2.3.2 Foucauldian Discourse Analysis

FDA is a form of Discourse Analysis highly influenced by Michel Foucault’s ideas (Arribas-ayllon & Walkerdine, 2014). It is considered a post-structuralist method, linked with social constructionist and critical approaches (Willig, 2013). Thus, FDA focuses on the use of language and how this constructs the object of which it speaks, or in other words, how it constructs ‘social reality’ (Foucault, 1972; Willig, 2013). Accordingly, FDA adopts a critical stance towards the language we use and the ways in which we understand others, ourselves and the world, as well as the actions that we are expected, and not expected to perform. Language is therefore understood as a constructive tool and not as a reflection of ‘reality’ or ‘truth’ (Arribas-ayllon & Walkerdine, 2014; Coyle,

2007). FDA aims to unpack ‘taken-for-granted’ concepts and constructive processes through looking into the available discourses that people deploy to construct an object or subject, to then understand the ‘ways-of-being’ or ‘ways-of-seeing’ the world that the speaker can embody (Willig, 2013). In other words, discourses require that the person who deploys them takes a ‘subject position’ that inevitably has implications for the individual and society at two levels: firstly, affecting the individual subjective experience and one’s sense of self, and secondly, both enabling and restricting the actions that the individual can or is expected to carry out (Georgaca & Avdi, 2012; Willig, 2013).

To understand the task of FDA, we need to clarify what it is meant by ‘discourse’. Foucault defined discourse as “constituted by a group of sequences of signs, in so far as they are statements, that is, in so far as they can be assigned particular modalities of existence” (Foucault, 1972, p. 107). Parker (1992) refers to it as a system of statements that together construct an object, and Burr (1995) states that there is no one definition of discourse that can encapsulate its meaning, and she goes on to explicitly incorporate images, metaphors, stories and meanings to its definition, bringing depth and creativity into it, adding that “it refers to a particular picture that is painted of an event (or person or class of persons), a particular way of representing them in a certain light” (p. 48). My approach to ‘discourse’ considers it a systematic set of metaphors, images and ways of representing, thinking and talking that together construct a specific object. Furthermore, discourses are understood as operating within the socio-cultural context, irrespective of the person’s intentions and/or awareness (Georgaca & Avdi, 2012). Discourses provide a way to communicate that serve as ‘building blocks’ for institutions (e.g. medicine, psychology, science), forming a mutual relationship in which institutions create discourses and practices that they both disseminate and legitimise, creating a cycle of reinforcement. Consequently, discourses involve an irrevocably enmeshed relationship with power, as discourses make available certain versions of reality of personhood whilst

possible alternatives are marginalised. This means that discourses represent the ways in which phenomena can or cannot be talked about (Willig, 2013), also stabilising the specific types of ‘self’ that it is possible to be (Foucault, 1982).

This is linked to the concept of positioning and subject positions (Davies & Harré, 1990; Harré & Van Langenhove, 1999), through which an individual’s actions are located within a particular social category that enables or inhibits particular self-constructs. In other words, “when an individual is constructed through discourse, s/he is accorded a particular subject position within that discourse, which brings with it a set of images, metaphors and obligations concerning the kind of response that can be made” (Coyle, 2007, p. 103). The person can then accept (fulfilling the obligations) or resist the positioning. This exemplifies the core relationship between knowledge and power assumed in FDA, based on the idea that knowledge is operated through discursive practices and the adoption of specific subject positions, which control and regulate people’s actions (Coyle, 2007; Willig, 2013). Nevertheless, Foucault challenged the ‘traditional understanding’ of power, usually conceptualised as limiting or prohibiting, as he added that power is both enabling and constraining at the same time (Foucault, 1982). This important concept underpins the motivation for this research (in that my power as a researcher may enable alternative perspectives on the matter of wellbeing).

The importance of power becomes more evident when we identify that certain discourses and subject positions are privileged in our current time and context. These are considered ‘dominant discourses’ and they privilege versions of social reality that legitimate existing power and social structures, which in turn, validate and reinforce the dominant discourses, creating a ‘vicious cycle’. Discourses can become so ‘entrenched’ in our lives that it can be a paramount challenge to become aware of them, as they become “common sense” (Willig, 2013, p. 130). Nonetheless, discourses are not eternal, and as Foucault

highlighted in his unique work, discourses are linked to history and institutions. Thus, in the analysis of discourse it is important to understand structures of power and politics that are not only implicated in the maintenance of dominant discourses but also in the oppression of 'alternative discourses'. Finally, FDA is also concerned with the relationship between available discourses, subject positions and people's subjectivity (people's thoughts, feelings and their experiences), as well as what they may do (practices) and the context (material conditions) in which the experience may take place (Willig, 2013).

2.3.3 Limitations of FDA

An important limitation of FDA, especially in the context of embodying CoP humanistic values (e.g. balancing power differentials), is that FDA tends to lack meaningful involvement of the research participants (Georgacas & Avdi, 2012). Based on the previous explanation regarding the taken-for-granted nature of language, FDA has an important interpretative nature, as participants tend to not be aware of their own assumptions or ideologies (Harper, 2003). Consequently, FDA does not use participant validation processes commonly employed in other qualitative approaches, since it makes no sense to ask participants to validate what they may not be aware of (Coyle, 2000). Consequently, several authors have highlighted that FDA is a product of the analyst's choices and interpretations; this is because FDA does not use a standardised methodological process (Arribas-ayllon & Walkerdine, 2014; Willig, 2013), which, especially in the context of a novice researcher (as in my case), can lead to confusion and a lack of confidence to make interpretations and evaluate our work (Harper 2003; Harper, O'Connor, Self & Stevens, 2008; Morgan, 2010).

Bearing in mind this lack of both participant involvement and standardised methodological process, I decided to offer my participants the opportunity to check their

transcripts to give them some power and I clearly communicated the analysis' interpretative nature, so they could make an informed decision to participate. Similarly, I opted to follow Willig's six steps of analysis as guidance, to gain clarity in the research process and facilitate a 'good enough' analysis, as referred to by Harper (2003).

2.4 Procedure

2.4.1 Ethical considerations

This research has been registered with the University Quality and Standards Committee, and ethical approval was sought and received before starting recruitment. Ethical approval was received by the University of East London's School of Psychology Research Ethics Committee (Appendix A) and the University Research Ethics Committee (Appendix B). As my participants were psychological therapists working in the NHS, additional NHS ethical approval was required. The study was registered and authorised on the Integrated Research Application System to seek approval from the NHS Health Research Authority (Appendix C). Following this, Research and Development departments of the two NHS Trust from which I recruited my participants were contacted for local ethical approval (Appendix D & E).

Following the UEL Code of Practice for Research Ethics (2015), the BPS Code of Ethics and Conduct (2018) and BPS Code of Human Research Ethics (2014), there are four ethical principles to guide behavior and decisions through the research process. These are: respect, competence, responsibility and integrity. Therefore, based on these principles, I provide an explanation of the ethical considerations applied to this project, including a reflective account of ethical challenges experienced as an insider researcher throughout the following sections: ensuring informed consent, protecting anonymity and ensuring confidentiality, and planning and considering health and safety for both participants and researcher.

2.4.1.1 Informed consent

To ensure respect, responsibility and integrity (BPS, 2018), participants who expressed interest in the study were emailed an invitation letter with the relevant information including the study's purpose, use of the results and researcher role (see appendix F). Immediately prior to the interview, participants were given the invitation letter again, offered time to ask questions, and reminded of their right to withdraw from the study at any time during the three weeks following the interview without disadvantage and with no obligation to provide a reason. They were also informed that after the three-week period, their data would be analysed as an anonymous part of the collective body of data.

During our conversations prior to signing the consent forms and starting the interviews, it became clear that most participants, particularly those who worked in the same service as me, were concerned about my role as a researcher and their anonymity and confidentiality. In this way, I found myself recurrently explaining before starting the interviews, that I was an 'independent researcher', meaning that this project was born from my own initiative within my training as a CoP at UEL; with this I intended to clarify that although I was recruiting through work (NHS-IAPT), this study was not connected to my role at work, and therefore the NHS was not overseeing my study, apart from providing ethical approval for it to take place. This explanation was often followed by participants' expression of surprise and relief (i.e. one of my participants said "oh! Is this really not going to be reported to the managers at work? Can I really say what I think here?"). Once the independence of the study was established, a significant number of participants asked me direct questions about the protection of their anonymity (further explained in section 2.4.1.2.), as they shared some concerns about the possibility of their employers finding out about them taking part in the study and having access to their views/thoughts and experiences regarding their wellbeing at work.

These concerns seem to resonate with Foucault's concepts of 'surveillance and control' and his theory of Panopticism (Foucault, 1976, 1981). Foucault based these ideas on Jeremy Bentham's circular prison with an observation tower in the centre, designed in such a way that prisoners could be observed at all times, without them knowing when they were being observed. Foucault argued that this form of permanent 'invisible' surveillance, promoted that people would start 'policing/monitoring' themselves (self-discipline) and others. This in turn, seems to create a constant sense of being under 'the gaze': assessed against certain standards by which one could be 'punished' or 'rewarded', establishing what one is 'allowed/normal' or 'not allowed/abnormal' to express and/or be in a particular context/society. Thus, the previously described concerns, from both my participants and myself as an insider researcher, could be showing how these mechanisms of power may be operating at work.

Accordingly, I believe that having these conversations with my participants was an important process in my research, to provide a clear and safe frame to conduct the interviews and to potentially help my participants feel less constraint to talk about their views and experiences of wellbeing at work. In this way, only after participants had expressed their understanding and agreement with the research terms were they asked to sign the consent form (Appendix G).

2.4.1.2 Confidentiality and Anonymity

To protect anonymity and ensure confidentiality, participants have been referred to by pseudonyms throughout this thesis, including their transcripts, and all identifiable information has been removed and/or altered. Moreover, I offered participants the option of reviewing their transcripts prior to the analysis, with the intention of giving them more control and power over their data whilst ensuring their safety and anonymity. Three out of the ten participants asked to review their transcripts, which we arranged through non-

work email communication. On reflection, the choice of using non-work emails, could be linked with a shared sense of feeling under constant ‘surveillance’ at work (both me and my participants), in this case, through new technologies. Foucault (1976) described how individuals become ‘docile bodies’ through constant surveillance, constricting individuals’ freedom to think and behave ‘out of the norm’ (representing the power of the ‘gaze’). Perhaps this could also be linked with the idea of constructing this research as ‘a form of resistance’ (challenging the status quo). Ussher (2000) talks about how authors who challenge the establishment tend to feel ‘scrutinised’, thus, as an inside researcher, I may have shared my participants’ concerned position of feeling observed as behaving ‘out of the norm’, particularly from my employer’s perspective (further reflection on the impact of this in the research process can be found in section 4.3.2.).

In this way, it seemed important to also clarify with my participants that transcripts were stored safely in a locked cupboard and the audio recordings in a password protected document on a laptop kept within the researcher’s home. Similarly, participants were informed that audio recordings and transcripts would only be read or listened to by myself and my supervisors and audio recordings will be destroyed upon completion of the study; however, the anonymised transcripts will be kept securely as outlined in the consent form for five years after the interview, in accordance with the Data Protection Act (1998), allowing for its use in future publications arising from this research.

2.4.1.3 Protection of participants

A risk assessment was conducted and there were no specific risks identified in relation to participating in this study, however, the research could evoke emotional responses, and this was monitored. The burden of participating was also minimised by only sending one email with no follow-ups. Interviews were arranged at a convenient time and place for participants, they were mostly held at their workplace; however, bearing in mind

participants' safety, particularly in relation to their concerns about their employer's 'gaze' (Foucault, 1976), an alternative location at UEL facilities was offered to some participants who did not feel comfortable to discuss their experiences at their work place. Thus, participants' safety and privacy were ensured, and interviews took no longer than 80 minutes.

2.4.1.4 Debriefing

As it was acknowledged that the nature of the research could evoke emotional responses, participants were offered time to debrief following the interview. The aim was to ensure that they felt comfortable with their experience, and they were also given a debrief letter (Appendix H) containing further information about the study and a list of organisations that could offer support, both personally and professionally. At the end of the interview, most participants wanted to know a bit more about my own position in the research; they often asked me about my own view on the matter, and in some cases, they asked me about my own experience at work. I explained my critical approach to the topic and intention to look at wellbeing beyond the individual, and in some cases, (particularly where participants had significantly opened up about their negative experiences at work), I also chose to share with them my personal experience of struggling with my own wellbeing at work, with the hope of normalising these feelings and experiences. This seemed to help my participants feel at ease, perhaps establishing a solidarity and human connection, beyond the researcher-participant relationship.

2.4.1.5 Health and safety of the researcher

To ensure my safety during the interviews, I organised a system with my supervisor and colleagues where I informed them of the location and duration of the interviews. I communicated when I started and finished them, as well as when I had safely left the building (see Field Work Risk Assessment in Appendix I).

2.4.2 Participants and recruitment

2.4.2.1 Participant selection criteria

Following Willig's (2013) recommendations for qualitative research doctoral projects using FDA, I recruited a sample of 10 participants from two different NHS London Trusts: six from East London NHS Foundation Trust (ELFT), and four from North East London NHS Foundation Trust (NELFT). The NHS Trusts were selected on the basis of practical reasons such as location and obtaining NHS ethical approval, as well as the level of staff satisfaction in their most recent CQC evaluations. In order to consider whether differences in staff satisfaction would relate to the available discursive resources used to construct wellbeing, I selected one local Trust with high levels of staff satisfaction—in which I was working, also facilitating ethical approval and recruitment—and an additional local Trust, with lower staff satisfaction levels (CQC, 2016a, 2016b).

Within qualitative research, and specifically FDA, participants are selected purposively because they can offer insight into a particular experience within a specific context, in this case, their wellbeing working in IAPT-NHS services. Therefore, the sample was selected purposively and derived from two mental health Trusts across IAPT services. Nevertheless, in order to ensure recurrence of significant themes and concepts (Harper, 2012), a relatively homogenous sample was selected through the inclusion criteria. Participants were thus psychological therapists (1) working in IAPT-NHS; (2) who have face-to-face contact with clients; (3) who have worked in IAPT for at least one year; and (4) employed by the NHS full-time or part-time. The final criterion was included to exclude agency staff; agency workers tend to change working environment often, which could have impeded engagement with the organisation.

2.4.2.2 Recruitment

After gaining ethical clearance, an initial email was sent to Psychology Team Leaders within the two different NHS trusts (ELFT and NELFT), who were asked to cascade the email to their teams of psychological therapists with the participant invitation letter attached. Advertising material was also displayed in different working environments with contact details of the main researcher and research supervisor for interested therapists to contact them (see appendix J). When participants showed interest in taking part in the study, a conversation by phone or email was offered to clarify questions and obtain informed consent. In the case that the potential participant did not meet the inclusion criteria, this was communicated during this initial conversation, sensitively explaining the reasons to avoid further disappointment.

It seems important to reflect that I recruited participants from a Trust (ELFT) where I was working as a Trainee Counselling Psychologist. Thus, aware of the possible ethical dilemmas related to feelings of obligation or coercion on the part of participants who may have had prior contact with me, I did not directly approach any potential participants, and instead I disseminated information about the study via email and posters, with no follow-up to non-responders.

2.4.2.3 Profile of participants

A total of 10 participants from ELFT and NELFT were interviewed. Following the inclusion criteria, they were all psychological therapists, including two Clinical Psychologists, two Psychotherapists, four CBT therapists, one Psychological Wellbeing Practitioner (PWP) and one Assistant Psychologist; most of them held a Band 7 job, whilst two were Band 5 and two Band 8a. Similarly, all were employed by the NHS and had been working in their IAPT service for a minimum of a year, though the length of service varied from one to seventeen years. Likewise, participants' years of experience

as psychological therapists varied from two to seventeen years. Finally, only four participants reported having worked in a different Trust.

In relation to the demographics of the sample, six were females, whilst four were males. Their ages ranged between 25 and 55, and four identified themselves as White British, three as Asian British, two as White Irish and one as Mixed Raced.

Table 1. Participants' profile

ID	Pseudo-nym	Gender	Ethnicity	Age	Role	Band	Years in the Trust	Experience as a Psych. Therapist	Work in other Trust?
1	Andrea	Female	White British	31	Clinical Psych.	Band 7	3 years	9 years	Yes
2	Brenda	Female	Asian British	26	Assistant Psych.	Band 5	5 years	2 years	No
3	Carol	Female	White Irish	33	Psycho-therapist	Band 7	1 years	3 years	No
4	David	Male	White British	51	CBT therapist	Band 8a	3 years	8 years	Yes
5	Fabian	Male	Asian British	37	CBT therapist	Band 7	9 years	13 years	Yes
6	Eve	Female	White Irish	28	CBT therapist	Band 7	3 years	5 years	No
7	Gerald	Male	White British	31	CBT therapist	Band 7	4 years	4 years	No
8	Heidi	Female	Mixed Raced	55	CBT therapist & Psycho-therapist	Band 7	17 years	17 years	No
9	Indigo	Female	White British	35	Clinical Psych.	Band 8a	4 years	11 years	Yes
10	Jaden	Male	Asian British	28	PWP	Band 5	1 year	2 years	No

2.5 Data Collection

Informed by Foucault's theory of discourse (Foucault, 1972) and my moderate social constructionist position (Willig, 2012), it was my intention to select a data collection procedure that could help me access the discourses deployed in relation to wellbeing at work, involving my participants' ways of talking, thinking and representing the subject

of study. For this, I decided to use a semi-structured interview featuring a visual task, the rationale for which is explained below.

2.5.1 Semi-structured interview

Qualitative interviews are considered effective methods to elicit information and obtain in-depth data regarding participant's views and attitudes, in contrast with other approaches (Byrne, 2004). It is therefore important to highlight that participants' accounts during the interviews, in line with my epistemological position, will not be considered as a direct reflection of their experiences. As Kitzinger (2004) explains, participants' accounts can only be understood as a form of discourse, representing a current culturally available way of talking about their experience. Thus, the interview is not seen as a tool to obtain 'truth'; instead, it is a tool by which both participants and researcher engage in a dialogue about the topic, co-constructing its meaning, and would therefore need to be understood and approached as such.

Potter and Hepburn (2005) warned about the 'overuse' of interviews in the Psychology field, advocating for naturalistic forms of data collection. I therefore aimed to find ways in which to create a more naturalistic encounter to facilitate the flow of the conversation, leading me to explore the world of visual methods—an emerging area in qualitative psychology research that offers significant benefits in the data collection process (Willig, 2013; Reavey, 2011).

2.5.2 Visual methods

In the context of my interest in engaging participants in a more creative and naturalistic way, I had several conversations with lecturers and my research supervisor, in which we discussed how, based on their experience, psychological therapists tend to provide 'well-rehearsed' narratives in interviews, especially when asked about concepts that they use within their professional capacity, such as 'wellbeing'. Though FDA is not as concerned

with the richness of data as other qualitative methods (Coyle, 2007), it is still essential to facilitate engagement with participants to co-construct enough significant data for the analysis and, therefore, to be able to answer the relevant research questions (Langdridge, 2009; Willig, 2013). Following this, I considered different visual methods, and I was inspired by the photo-elicitation technique that has been strongly advocated in qualitative research (Reavey, 2011; Harper, 2002; Harrison, 2002), identifying the following strengths. Firstly, it has the potential to elicit different information beyond verbal questions, facilitating the disruption of “well-rehearsed narratives” (Reavey, 2011, p. 6). Secondly, it has been found to provide an avenue to participants’ taken-for-granted assumptions (Marvasti, 2004). Finally, it promotes a collaborative process in which the meaning is co-constructed between participant and researcher, helping to redress the interview’s power imbalance (Nunkoosing, 2005; Harper, 2012; Willig, 2013), resonating with the CoP humanistic value-base (Cooper, 2009; Kasket, 2012). Subsequently, variations of the technique were explored, such as asking participants to bring their own photographs, objects or materials, as well as asking them to draw, or presenting them with pictures, amongst others. Whilst acknowledging the benefits regarding engagement and potential empowerment of participant by using object elicitation, photo-elicitation, photo-production or photovoice (Reavey, 2011; Willig, 2013), based on my participants’ characteristics as busy professionals, I chose the most practical option to reduce further burden on them and facilitate recruitment (see Appendix K for reflective notes on this decision).

Thus, I developed a visual task to elicit information in an original way. The visual task consisted of presenting participants with OH-Cards and asking them to construct a story (or anything they wanted) that could represent their wellbeing at work. The OH-Cards (Resilio Deck) are a collection of Emilie Marti’s paintings, created with the purpose of eliciting information and evoking people’s stories (Bolgeri, 2007). The Resilio Deck has

been particularly designed in relation to everyday life pressures, as well as resilience and wellbeing (see a sample in Appendix L). They have been referred to as metaphoric associative cards, meaning that they have no fixed value or interpretation, making them appropriate to use across cultures and ages to elicit information in qualitative work (Popova & Miloradova, 2014). They have been used in different professional areas, such as Education and Pedagogy, Business and Workplace, Social Studies and Counselling—including dramatherapy, art therapy and trauma work, amongst others (Atkinson & Wells, 2000; Ayalon, 2008;).

Using OH-Cards as an eliciting tool in the context of research has not been found in the available literature. Nevertheless, there is significant proof on their usefulness in therapeutic contexts (Atkinson & Wells, 2000; Ayalon, 2008; Gatineau, 2010; Moore; 1999; Popova & Miloradova, 2014) and supervision (Lahad, 2000), which suggests their potential transferability to the research context. The literature supports the value of OH-Cards in facilitating interpersonal interaction and exploration of the person's meaning making process and its relation to the social environment (Popova & Miloradova, 2014). Furthermore, the OH-Cards have not been associated with any specific theoretical approach and can be used within different epistemologies and approaches in Psychology (Jacome, 2012). They are considered a multimodal tool, involving a visual and a narrative aspect, which can help facilitate data to identify available discourses.

Thus, I believe that the visual task facilitated the elicitation of material that may have been missed in word-alone interviews (Harper, 2002). It also brought a novel quality to the research, which made it more attractive to participants, who appeared curious and enthusiastic about engaging in a more 'creative' research task, as they reported it as an enjoyable activity that provided them with an opportunity to reflect on their own experience of wellbeing at work.

2.5.3 Pilot Interviews

The interview schedule was designed around three main areas: (1) a warming up section with general background questions; (2) the visual task focused on discussing the construction of their wellbeing at work; and (3) open questions to offer ‘windows of power’ to my participants, in which they were asked about their recommendations for others at different levels (see Appendix M). After the visual task, depending on how much we had already covered, I also decided to introduce a question about their thoughts, if any, regarding the recent surveys reporting increasing levels of distress in mental health professionals (e.g. NHS, 2015). This was decided following a reflection on the purpose, implications and coherence of this question with my epistemological position (see Appendix N for reflective notes). Thus, it was considered that whilst the introduction of this question could have the risk of being regarded as ‘slightly leading’, or as presenting a specific ‘reality’, the question was still presented in an open enough way for participants to choose their own engagement with it. It was also placed towards the end of the interview, meaning that participants would have had the opportunity to discuss wellbeing in their preferred way. Finally, I considered that the benefits of introducing the task (potentially reducing stigma and normalising difficulties at work) could outweigh the negatives (possible focus on negative experience).

Once the interview schedule was developed, pilot interviews were conducted to test interview schedule with two colleagues who worked at different IAPT services. From this, I noticed that participants seemed very willing to talk about their experiences of wellbeing at work. I soon realised that most of my questions were being answered by participants almost without prompt, providing me with a useful opportunity to practice a more naturalistic conversation and to develop my confidence and familiarity with my interview. The most significant learning was in relation to the visual task. I found that it was better to carry out the visual task early in the interview because the cards seemed to

elicit feelings that could leave participants feeling unsettled. Thus, having the visual task first, followed by further prompts and open-ended questions, finishing with a more ‘empowering’ section, seemed to enable rapport and useful information, whilst leaving participants contained. This was important to me because it is aligned with my values, but also because it my ethical duty to ensure the safety of my participants (BPS, 2018, 2014).

A second decision made in relation to the visual task was in relation to the number of cards provided to participants. During the pilots I noticed that giving participants all the cards seemed to become a distraction, hindering their focus on using the cards to represent their wellbeing. Consequently, I decided to present 39 cards from the 99 available to facilitate the flow of the interview. The selected cards were intended to contain a balance of stress and resilience-related cards; as they are subject to our interpretation, no further rationale was felt needed for their selection.

2.5.4 Interviews

Interviews were conducted both at participants’ workplaces and UEL facilities. Once we were both settled in the room, I started by checking if they had read the invitation letter and if they had any questions, which in such case we would discuss. I then explained, clarified and offered a chance to ask questions about confidentiality, after which I asked them to read and sign the consent form. After this I started my two recording devices and used the visual task and semi-structured interview to facilitate the conversation. Interviews lasted between 50 and 80 minutes, depending on the participants’ pace and engagement with the topic. When most of the questions had been discussed, participants were offered the opportunity to add anything they considered relevant before finishing the interview. Once the interview concluded, I turned off the two recording devices, took

a picture of the card composition¹ and consent was reviewed. After this, I provided them with a debrief form and we had a brief conversation about their experience of the interview, whilst offering them the opportunity to ask any further questions. After each interview I wrote reflective notes, including relevant thoughts or feelings I had during the interview and non-verbal communication that seemed relevant. I also tried to note any relevant conversations we had before the interview, such as specific concerns about confidentiality.

2.5.5 Transcription

The 10 interviews were transcribed verbatim. The transcription code followed was adapted from Jefferson (2004) and Edwards and Potter (1992), to facilitate readability and understanding of the interaction, whilst also presenting some more fine-grained features, such as pauses (short and long), contextual information, elongations and overlaps. The transcription convention used can be found in Appendix O. All identifying information was omitted or altered, and pseudonyms were allocated. Finally, three participants agreed to review their transcripts before analysis, so they could be in control of their data anonymity.

2.6 Analysis

There is no ‘right’ way of conducting FDA. Foucault himself was against prescribing a way of how things should be or done (Foucault, 1994) and FDA has been traditionally approached as a set of ideas and techniques that researchers apply in accordance with their research aims. Nevertheless, aware of my position as a novice researcher and new to Foucault’s ideas, I have decided to follow Willig’s six stages of analysis; these have not been followed as a linear process, but as a useful indication to ensure that attention

¹ A picture of the cards was taken with the initial view of potentially analysing it. Yet this was not included in the analyses presented in this thesis.

was paid to the different aspects of analysis (Willig, 2013). Willig's stages enable the identification of discursive resources used, the subject positions, and their implications for subjectivity and practice (see Appendix P for my own adaptation).

Thus, I conducted the first stage of analysis (discursive constructions) on all the interviews first, before moving on to the following steps. In this way, I familiarised myself with all transcripts, through listening and re-reading them to identify the relevant discursive constructions. For this, I started by highlighting all the parts in the interview where participants refer to the concept of 'wellbeing' both implicitly and explicitly (to then do the same regarding 'professional therapists' and 'IAPT'). Before moving to the second stage, I wrote all the discursive constructions on a piece of paper for each of the participants (see example in Appendix Q). There were times when I was able to notice other aspects of the analysis as I was making sense of the discursive constructions. This was mostly the case, in relation to noticing potential subject positions and/or subjectivity; these aspects stood out for me when for example participants included subjects within their talk about wellbeing (i.e. "I've definitely been to blame myself for") and/or when they talked about responsibility or judgements, like 'being good or bad'. Accordingly, I allowed myself to make notes of this as I noticed them (see Appendix R for an example of my process of analysis).

Once I had conducted the first stage for all interviews, I created a mind map to summarise and visualise the discursive constructions that were repeated across interviews (see Appendix S). This activity helped me engage with the discursive constructions differently; this meant that I was able to see all the discursive constructions identified through the 10 interviews on the same piece of paper, which allowed me to start noticing when perhaps some discursive constructions were linked, and when perhaps they were in contraposition to each other (i.e. neoliberal/individualistic discourse versus collectivist discourse). Following this, I decided to start exploring in more detail the remaining stages

recommended by Willig (2013), only on those discursive constructions that had been repeated across interviews. Thus, according to Willig's second stage (emerging discourses), I located the discursive constructions previously identified within wider discourses of society. The third stage followed closely (action orientation), where I paid attention to the discursive contexts within which the different constructions were deployed, to explore motivations around the particular constructions, and issues of power were considered. The fourth step (positioning) involved identifying the possible subject positions into which participants placed themselves or others. Stage five (practice) focused on exploring the relationship between discourses and practice; this step was closely linked to subject positions, focusing on what could or could not be done from the different subject positions. Finally, the sixth (subjectivity) was in some ways the most speculative one, as it focused on exploring the consequences of taking up different positions in the subjective experience of my participants.

During the process of analysis, I consulted and shared my progress, including my mind maps, with both my research supervisors, as well as with peers and a mental health professional from the NHS familiarised with FDA, to ensure reflexivity and quality of my research, especially in the context of my inexperience with the method.

2.7 Ensuring Quality

Yardley (2008) and Willig (2013) recommend specific criteria to ensure quality in qualitative research. Willig (2013) stated that each research should be evaluated based on its epistemological and methodological choices and Yardley (2008) recommends following four principles, which have guided my design and process. Further commentary on their evaluation will follow in section 4.3.

Thus, ensuring quality in FDA involves: (1) showing coherence and transparency through clear and detailed explanation of the process, including transparent descriptions and

reflections upon methodological choices; (2) showing sensitivity to the multiple contexts involved in the research, through engagement with the literature and reflection on the impact of the research-power relationship; (3) ensuring commitment and rigour through appropriate consideration and engagement with the data and analysis; and finally, (4) ensuring usefulness of the findings, addressed in sections 4.5-4.7, which expand on the implications, recommendations and relevance of this research, however, it is the reader who ultimately establishes the interest, value and usefulness of this research.

2.8 Reflexivity

Reflexivity is a fundamental aspect of qualitative research. It refers to the researcher's awareness of their role and impact as co-constructing the process of research. Willig (2013) discusses two types of reflexivity: epistemological reflexivity concerned with the assumptions connected to the researcher's epistemological position (view of the world and knowledge) and its implications in the research process; and personal reflexivity, which focuses on the researcher as an individual, involving being aware of how our aims, beliefs, values and past experiences, may influence the research process, as well as how the research may have an influence on the researcher. Thus, I have intended to show my embedded reflexivity throughout this thesis (explicitly expanded in section 4.3), whilst also having frequent discussions with my research supervisors, peers, and other related professionals, as well as keeping a reflective research diary to facilitate the awareness that defines it, as encouraged by Coffey and Atkinson (1996). See Appendices K, N, Q, R & S as examples of reflexivity.

Chapter Three: Analysis and Discussion

3.1 Chapter Three Overview

This chapter presents the analysis and discussion of how psychological therapists working in IAPT-NHS services construct their wellbeing at work. This has been structured around the contraposition of four main constructions of wellbeing, presented in pairs. With this presentation I hope to give the same visibility to both dominant and counter-discourses, to also discuss their implications for practice and subjectivity. Thus, the first part will focus on *wellbeing as an individual responsibility* versus *wellbeing as a collective responsibility*. The following section will present *wellbeing as self-actualisation* versus *wellbeing as productivity*; these two ways of constructing wellbeing will be also explained in relation to the construction of IAPT services and the subject positions of *good and bad employee* and *good and bad therapist*, which I argue, relate in a contradictory way (i.e. *good therapist* equating *bad employee* and vice versa).

It is important to highlight that the discourses presented in this chapter do not represent all the discourses deployed throughout the interviews. For example, most participants seemed to construct *wellbeing as a subjective felt sense* that is fluid and shifts depending on different aspects; as this construction seemed to reflect the subjective nature of wellbeing, which is contained within all discursive constructions (Willig, 2013), I decided to expand further on the previously four outlined because they seemed most relevant in the context of my research aims to answer the research questions. Thus, this analysis is my own 'de-construction' and 're-construction' of the data, informed by my own context. See appendix S for visual mind-maps of the different constructions of wellbeing identified through analysis.

Accordingly, participants are not seen as necessarily consciously constructing wellbeing in the way presented here, but rather it is through their talk that available resources to

construct wellbeing at work can be identified. Finally, with the aim of facilitating the reader to consider the validity of the data (Yardley, 2008), I have included longer extracts and/or explanation of the conversation prior to the quotes, when possible.

3.2 Wellbeing as an individual responsibility vs as a collective responsibility

This first section of the analysis focuses on two discursive constructions identified in participants' talk. *Wellbeing as an individual responsibility* was identified as a dominant discourse, reproduced by both institutions and individuals, whilst *wellbeing as a shared responsibility* seemed to act as a counter-discourse, providing a way of resisting the dominant discourse and entailing distinct implications regarding the allocation of blame and subjectivity. I will now present both constructions and their implications under two artificially 'separated' subheadings, to then discuss their interplay in section 3.2.3.

3.2.1. Wellbeing as an individual responsibility

Wellbeing as an individual responsibility constitutes a dominant discursive construction, which entailed talking about wellbeing as a 'task' for the self, requiring a need for self-awareness and self-care practices. Thus, participants drew on a conceptualisation of wellbeing as dependent on their own actions and not on others or their contexts. This can be noticed in the following extract.

Extract 1:

P: Yeah, yeah. And can I ask you, what does wellbeing at work mean to you?

Jaden: What does wellbeing at work [low tone of voice] Erm (.) I think it's about knowing, being self-aware (.) knowing what helps (.) what, what triggers (.) what makes your wellbeing worse (.) and knowing what to do to make it better. You don't get better by default, you don't, you don't keep well just because of (.) by default, you have to make the effort to:: manage your wellbeing, erm. (Lines 386-389)

Extract 1 conveys wellbeing as an obligation of the individual that requires both self-awareness (“knowing what helps, what triggers, what makes your wellbeing worse”) and “effort to manage it”. Jaden’s reference to ‘not getting better by default’ and his reference to a need for effort, seems to portray wellbeing as a commodity that can be achieved through effort (Atkinson, 2013), resonating with the idea of ‘meritocracy’, firstly introduced by Michael Dunlop Young in 1958, where wellbeing results from individual achievement and effort (merit).

Constructing *wellbeing as an individual responsibility* seems to resonate with a neoliberal discourse which constructs subjects as accountable for all aspects of their lives, closely linked with individualism and meritocracy (Litter, 2018). This implies that people are expected to use their power and resources on themselves, encouraged to be self-aware, self-care and self-improve. Thus, individuals are constructed as independent of the state and others, and expected to be ‘entrepreneurs’ within a ‘competitive’ environment, under the premise that one’s own efforts and achievements would lead to deserved rewards, creating an ‘illusion of justice’—“whoever performs best, justly deserves the highest reward” (Mijs, 2016, p. 17). This discourse could be seen as ‘motivational’ for individuals, prompting people to make more efforts to achieve and become productive in pursuit of a fair compensation (i.e. improving or maintaining their own wellbeing), which could be linked with participants’ references to self-care practices. Self-care practices involved participants talking about the importance of taking breaks and leaving work on time (e.g. Andrea, 323; Brenda, 103-104; Eve, 556-558), setting boundaries (e.g. Carol, 334-337; Eve, 329-332; Heidi, 390), finding and maintaining balance (e.g. David, 626-627; Fabian, 451; Indigo, 185), and engaging in specific practices, such as meditation, mindfulness and/or yoga (e.g. Andrea, 331; Brenda, 99-106). The next extract follows a section of the interview in which Brenda had begun to discuss how she had been trying to balance the clinical and more ‘admin-like’ tasks at work.

Extract 2:

P: So, kind of taking care of yourself and doing things outside work

Brenda: I might even do it during the day (.) If I find myself (.) finding myself really stressed out during the day (.) I may go to take (.) a 5 minutes break and just walk around (.) the:: building (.) I may go and take a bit of fresh air (.) just standing on a window and get my fresh air, or I may actually just engage in a little bit of mindfulness(.) I feel like it's necessary to not only do it outside of work but at work (.) because that's when my stress is up (.) yeah? (Lines 102-106)

Brenda enumerates some self-care practices and uses the word “necessary”, which could refer to the aspect of this discursive construction that places certain obligations on the individual to monitor and look after oneself. This way of talking seems to convey her sense of responsibility, showing that she is aware of what she needs and when she may need to apply it, as expected of subjects within the neoliberal discourse (Wilson, 2007). Subsequently, Eve also seems to deploy this discourse through her response to my question about what wellbeing at work meant to her.

Extract 3:

Eve: ... Erm:: wellbeing could be about (.) you know (.) having those (.) really, I know it's very cliché, but really having those breaks, you know, having those, kind of a:: (.) those, you know making sure you have your lunch (.) making sure you're leaving on time:: and then get to that point (.) Erm:: yeah:: (Lines 555-558)

Eve's language seems to indicate that it is oneself, not others, who must ensure these practices happen (i.e. “making sure you have your lunch”). The fact that Eve talks about these practices as “very cliché” could also reveal the dominant quality of this discourse, showing that it may be ‘overused’. Western society, and especially the UK's government, institutions and social life are embedded in this way of thinking. For instance, a British newspaper's opinion article wrote of neoliberalism and the government that “they knew no other way of thinking or doing: it had become common sense” (Jaques, 2016). In this

way, participants could be seen as reproducing and maintaining this dominant institutional discourse.

On top of self-care practices, participants also talked about the need for psychological therapists' self-awareness (i.e. Eve, 627; Gerald, 470-473) as part of *wellbeing as an individual responsibility*. Extract 4 presents Andrea talking about caring professionals 'forgetting' about their own care and wellbeing; she talks about this in the context of the NHS, where professionals can find it hard to focus on their own care, as they have to care about others.

Extract 4:

Andrea: ...Erm:: (.). I wonder you know, I think there's often an (.) an issue in (.) NHS services in general, not even in just mental health services, but (.) obviously there is such a focus on (.) clients and (.) patients and their care and wellbeing, and I think that we as professionals often forget (.) about our own (.) we kind of almost, like (.), slightly put out ours to the side in order to focus on theirs. Erm::, so::, yeah (.) it doesn't, it doesn't help. (Lines 427-430)

To 'forget' is a verb that could be initially understood as an 'involuntary' process, yet Andrea seems to describe it as an action that the individual does—"we kind of slightly *put ours to the side* in order to focus on theirs". This may convey the neoliberal obligation placed on individuals to be in charge of their mental processes as a part of being self-aware and to be able to look after oneself (Parker, 2015; Rose, 1999). Furthermore, in extract 5, Carol refers to this through the visual task by talking about 'having a lot in her mind'.

Extract 5:

Carol: Yeah::, so that can be frustrating but not necessarily work related, it's just [laughs],erm, I suppose:: this side [pointing to cards 1 to 11] kind of is a bit of the struggles that you may face or feeling like there is a lot on your mind::, kind of it's always turning, I guess sometimes you do feel like you've got a 100 things in

the air::, erm, sometimes it does feel like a bit like a toggle or:: [laughs] (.)
Between, erm:: (.) [sighs], trying to do your job as much as you can, but there's
obviously limitations of the service, your own limitations (.) and it just feels
sometimes like (.) you're being pulled in every direction, erm::, and I think that
there's just unnecessary paperwork::, and that sometimes you can feel snowed
under on, depending on (.) your paperwork that you can do... (Lines 159-164)

Throughout extracts 4-5, self-awareness seemed to be talked about as the ability to know oneself to then control mental processes (i.e. memory, focus), constructing the individual as responsible for them. Self-awareness was portrayed as a condition for self-care and maintenance of wellbeing, which appeared to be constructed in competition with external demands (i.e. care for others (Andrea) and paperwork (Carol)). Moreover, participants seemed to link lack of self-awareness with negative impact on wellbeing, as an excessively occupied mind appeared to involve that their wellbeing would suffer.

Carol's words "it just feels sometimes like you're being pulled in every direction" could also be linked with increased demands on the individual, as part of the expansion of the neoliberal discourse in our society. Wilson (2007) explains how the excessive emphasis on the individual risks omitting the social aspect of our human life, mistakenly placing all the responsibility of social problems on the individuals, converting wider problems into 'self-care' issues. Thus, people feel responsible for many more aspects of life, which, with the potential alienation and negation of interdependence characteristic of neoliberal ideas, could be linked with a negative impact on wellbeing. So, if the population in general, based on the expansion of the dominant neoliberal discourse, is expected to take more responsibility, it would be reasonable to suppose that the expectations placed on those working in the caring professions would be significantly heavier, bringing up the question of 'who cares for the carers'.

Self-awareness and self-care practices resonate with Foucault's concept of technologies of the self, as techniques that enable individuals to regulate and transform themselves to

reach “happiness, purity, wisdom, perfection or immortality” (Foucault, 2000, p. 225). In this way, therapists’ conduct could be seen as governed through these particular practices (self-examination and self-care practices), through which they become self-disciplining subjects. This was present in participants’ talk about self-examination (i.e. Heidi: 390; Brenda: 198-192), which was closely linked to the allocation of blame on the individual, both by others (i.e. managers, service) and themselves. Accordingly, deploying *wellbeing as an individual responsibility* constructed psychological therapists as the ones responsible and to blame for their wellbeing. Extract 6 seems to show Andrea’s negotiation of the allocation of responsibility through her talk; this was following the discussion of the visual task and my question about what wellbeing at work meant to her.

Extract 6:

Andrea: I think, you know, as::, as therapists and psychologist, we are notoriously bad:: at looking after ourselves. And:: I think that I have been sometimes like that in the past and I’ve definitely been to blame for myself of, but I think that I’ve learnt from quite early on when, when I was in my assistant role, about the::, the importance of boundaries (.) to protect your own wellbeing. About like leaving at 5, and I’ve never believed in this kind of work ethic of (.) everyone working till half past five, just to show that they are putting in a bit more effort, I think you know, “you are paid until 5, work till 5, you’ve got another life”. Erm::, and so I was always quite good at that, and actually initially when I came into this service I started to (.) bring other people into that, and would get everyone to sit down at lunch together, and have lunch together and, and then the more I got pulled into this kind of perfectionist system, the less it’s been able to be (.) maintained. And I’ve definitely noticed, my wellbeing (.) seriously slip, but it’s not (...) again (.) things have been pointed, I’ve raised (.) up how kind of stressed I’ve been and that my wellbeing has been affected, and it’s very much a sense of “well, it’s your responsibility to make sure you take your lunch break, it’s your responsibility to leave at 5” (Lines 320-329)

Andrea’s extract exemplifies all the components that have been explained so far, starting with self-care practices (i.e. leaving at five, placing boundaries and having lunch with

others), then referring to the importance of self-awareness by stating “I’ve definitely noticed my wellbeing seriously slip”, followed by showing an aspect of evaluation and allocating blame on the individual (i.e. “I’ve definitely been to blame for myself”). At this stage it could be argued that constructing *wellbeing as an individual responsibility* opens up the two subject positions of *responsible* and *irresponsible*; Andrea seems to take the position of *responsible*, through her talk about particular practices of self-care, her ability to notice her own wellbeing slip and raising this with the service. Yet, Andrea reports that her attempt to share it was rejected and responsibility seems to be placed back on her by the service. This could show the oppressive aspect of the dominant discourse of *wellbeing as a solely individual responsibility*, subjugating any attempt to include others in it, and making psychological therapists alone carry all the weight of their own wellbeing.

Thus, those who were to experience difficulties with their wellbeing would be positioned as *irresponsible*, and those difficulties would be constructed as ‘their own fault’. This would elicit feelings of guilt and shame, making it difficult for participants to be able to speak up about their struggles and seek/receive support, which could have the effect of therapists feeling isolated and deteriorating even more their wellbeing.

For instance, Eve talks about noticing that her colleagues are not vocal about their own potential wellbeing struggles, in contrast to her own experience of being vocal.

Extract 7:

Eve: ... I am very vocal (.) and I am very outwards about (.) what (.) how I feel in my wellbeing, and I know a lot of people aren’t, people just slip off, and they just go (.) or:: they just leave::, or they go on long term leave::, or sick leave (.) and I am very open to say “I am burning out, or I am tired, I’m::, you know::” and I am seeing it in my own person, I am becoming pessimistic, and I am (.) moaning and I am:: doing all these things.

P: And how is it for you? How is that like, how does it impact (.) you that you are:: outspoken and other people are not::

Eve: Well it makes me feel that I am the only problem, the only person with the problem (.) but it's not true, because then::, you know I just think (.) it's not true because (.) you hear it back in other ways:: (.) you know::, or you::, or they leave, you know what I mean?, erm::, or they::, or they, take career breaks:: or, that's about it, yeah::... (Lines 624-632)

The way Eve talks shows how within the discourse of *wellbeing as an individual responsibility*, being vocal about their own wellbeing seems to be problematised (“it makes me feel that I am the only problem”); however, she then quickly explains that others are ‘quietly’ struggling too, as she sees people leaving the service constantly. This could show how, within the *irresponsible position*, neither option (being vocal or quiet) seems to help people ‘get out of this position’. Consequently, the high volume of people leaving the service (high turnover) was discussed by almost all participants (i.e. Andrea, 297-316; Carol, 228-235; David, 83-123) as a way to cope with the current situation (escape), often related to the construction of IAPT services as inflexible (further explanation in section 3.3.3.).

In this context, it is not surprising that psychological therapists may be reporting high levels of depression and anxiety at work (Rao et al., 2016; 2018), also problematised within our society and mainstream Psychology. For example, Psychology has conducted extensive research on the ‘internal and external locus of control’, initially developed by Rotter (1966), concluding that people with a higher internal locus of control² experience less stress at work (see for example Chen & Silvethorne, 2008; Nazariadli, 2017; Ogolla, Aloka & Raburu 2016); this research could evidence how the discourse of *wellbeing as an individual responsibility* operates throughout our profession. Alternatively, critical

² Internal locus of control means that people attribute their life events to internal variables such as their own capacity, their effort and responsibility (Rotter, 1966).

psychologists have discussed the social function of ‘depression’ and ‘anxiety’ within a system of social control that is centred on self-regulation; a context where life events are understood as a psyche problem rather than political or contextual (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1994). Furthermore, Gilbert (2006) also talked about depression in this way, explaining the down-regulation of positive emotions as an adaptive response to unsupportive and competitive environments. This could provide a different interpretation to the experiences of participants at work, not necessarily as an individual fault, but perhaps as an adaptive response to their working conditions in IAPT, which doesn’t seem to be conducive for good practice, as it is further explained in section 3.3.3.

In summary, this section presented my discussion of the dominant discursive constructions of *wellbeing as an individual responsibility*, which resonates with a wider neoliberal discourse. This included constructing wellbeing as a task for the individual, including self-awareness, self-care practices and an inevitable element of self-examination, which was closely linked with the allocation of ‘blame’ on the individual, corresponding with a subject position of *irresponsible*. Thus, I argue that this subject position may be linked with feelings of guilt and shame in psychological therapists who may be struggling with their wellbeing, making it difficult for them to be vocal and reach out/seek help. In this way, experiencing distress at work seems to be problematised, and participants seemed to be reproducing institutional discourse that maintains and reinforces the dominant discourse, turning them into self-disciplining subjects. Nevertheless, as Foucault explained in 1982, where there is power, there is the option for resistance; therefore, through the interviews, it also became apparent the availability of a counter-discourse through which participants seemed to resist the construction of *wellbeing as a solely individual responsibility*, by constructing it as a *collective responsibility*, explained in the subsequent section.

3.2.2. Wellbeing as a shared/collective responsibility

The construction of *wellbeing as a shared or collective responsibility* was conveyed by participants' talk about wider issues, including the service and their relationships with others, not only themselves. This included speaking about the impact of decreasing resources in the NHS, the importance of having good supervision, and supportive relations with others. In this way, although all participants seemed to assume their own share of responsibility for their own wellbeing, they also talked about it as dependent on external factors that were interrelated.

For example, returning to extract 6, its last part showed the availability of this alternative discourse, which permitted Andrea to talk about her own wellbeing differently. As Andrea started talking about the influence of the IAPT culture as putting her wellbeing in jeopardy (in her case, through the influence of a 'perfectionist service'), she changed the subject in her talk about wellbeing, saying "the less *it's* been able to be maintained", depersonalising 'who has to maintain it'. At this stage, Andrea seems to be deploying a different construction of wellbeing at work, in which wellbeing is not *solely* an individual responsibility, as she seemed to allude to the service's responsibility to do something to help once she had raised her issue. Following this, Andrea's talk shows the oppressive power of *wellbeing as an individual responsibility* (dominant discourse), as she explains how her shift towards a collective discourse is met with the service's use of the dominant discourse, aiming perhaps to place the subject back in the *responsible vs irresponsible* position—"it's your responsibility to make sure you take your lunch break, it's your responsibility to leave at 5". This seems to negate the interdependent aspect of constructing *wellbeing as a shared responsibility*, by which one exists not in isolation but in relation to others. Thus, wellbeing would not be one's sole responsibility but a process in which we are all interconnected. This resonates with the following extract, where

Indigo talks about wellbeing as a service's responsibility in response to my question of what wellbeing at work meant to her.

Extract 8:

Indigo: ...I think in this (.) country [laughs] erm, they take quite a:: (.) m-, a view that, you know, more:: is better, almost? When actually (.) if you look at Scandinavian countries, for example, or (.) France, for example, where::, actually, they make sure that staff have lunch breaks (.) and they even , I can't remember what country is, but they finish early and (.) they, or emails have to go off at like five o'clock and things, erm (.) And actually, they find, I think it's some French companies (.) that people work more efficiently (.) cause actually in the U.K., we are not working very efficiently [laughs] erm, and I think (.) this well- (.) not having (.) good wellbeing at work and thinking about (.) erm (.) work isn't just expecting them to do more with less resources (.) Because then in the reality of the government and there's been cuts, that's, that's the reality, but (.) were expecting (.) staff to do more:: (.) And that is gonna just have an impact on burnout and stress (.) and wellbeing, and people are gonna leave. And we're seeing it with the nursing profession, for example (.) erm, you know, people leaving (.) and (.) not, erm (.) you know (.) then, having a lack of, kind of nurses (.) or::, then you have lots of abs-,erm, people off sick (.) and that's not gonna be good for::, kind of (.) targets. So I think the, erm (.) more of the bigger picture needs to be looked at, rather than (.) just the narrow kind of "we have to meet targets" [laughs] (Lines 366-377)

Indigo's talk about the importance of having lunch breaks seems to be different from participants' quotes in the previous section. She talks about practices in other countries where perhaps wellbeing at work may be approached differently, and she says "*they* make sure that staff have their lunch breaks", conveying that it is the service's responsibility to facilitate and ensure that employees take their breaks. This is a significant change from the previous construction, changing the subject from the individual to the service, constructing the individual as not solely responsible. Moreover, Indigo seems to construct 'poor wellbeing' as resulting from unhelpful working conditions where staff are expected

to do more with less, referring to “impact on burnout and stress”. It is also interesting that Indigo’s wider talk about wellbeing seems to include references to other caring professions, such as nursing, which could show the collectivist aspect of this construction going beyond the individual and understanding issues as social problems that affect caring professions, and not problems of the particular person, or even profession. Similarly, Fabian talks about the pressure on targets and the need to perform as a cause of anxiety and distress below.

Extract 9:

Fabian: ...more distress now than I was (.) you know, 5 years ago (.) Erm::, Am I any better managing it? I am not sure [laughs] But I know I am definitely a lot more (.) distressed, but maybe I am just, used to being so distressed, you know? Erm::, in terms to what contributes to it (.) I really don’t think it is to do with the complexity of patients, I don’t, I know that’s the easiest one to fall to, because I kind of enjoy:: (.) it’s not just working with patients, working with complexities, you know? Erm, if I didn’t, I wouldn’t be here in the first place [chuckles], erm::, I think what leads to the distress, and I feel like anxiety even, you know? Is:: all those targets, is all those (.) erm (.) need to perform, you know, which just::, it doesn’t sit very nicely unfortunately, yeah. (Lines 511-516)

Thus, Fabian also talks about distress at work, naming contextual issues (complexity of patients, targets and pressure to perform) as potential causes. This construction seems to allow participants to voice negative experiences easily, as the ‘reasons’ are not placed within the individual but are constructed as shared. This way of constructing wellbeing seemed deployed by some participants in the sections of their interviews where they voiced their negative experiences regarding their own wellbeing or others’ (i.e. Andrea, 327-329; Jaden, 96-99). Thus, although neoliberal discourse seems to advocate and aim for maximum individual freedom, in regard to the construction of wellbeing, it is interesting to note that the neoliberal discourse did not seem to allow participants to use their voices freely at work, perhaps as a result of the excessive ‘responsibilisation’ of the

self (Rose, 1999) typical of this discourse. Conversely, a collectivist or socialist discourse, which places the focus on our interrelations with others and our contexts instead of on individuals alone, encouraging people to take responsibility for others to benefit the group, seemed to allow participants to use their voices more freely.

Moreover, constructing *wellbeing as a collective or shared responsibility* also included participants' talk about financial pressures, such as cuts and budget reductions in the NHS, when talking about staff wellbeing problems. Subsequently, David talked about services being underfunded in response to my question regarding the recent NHS surveys, prior to the extract, I had prompt him to tell me more.

Extract 10:

David: That:: (.) we're::, we're quite lucky in IAPT services that we are fairly well protected from cuts, but from what I hear about people working on wards:: (.) wards and secondary care services (.) and potentially care services and stuff(.) they had a lot of cuts, so people are not being able the jobs that they really wanna do::, in terms of kind of actually help people, they are just managing stuff or barely managing stuff all the time (.) there's probably a lot more:: (.) I think that I heard someone say that there's a lot more kind of (.) assaults and stuff (.) and stuff like that on wards:: (.) and all of these things going on (.) and, generally on those situations as well, because of how systems are and how people are (.) things started going wrong (.) and (.) NHS tends to say "oh we will investigate this properly, we are not blaming individuals" but people end up being blamed for stuff(.) it may be locally their fault (.) I know that maybe they didn't follow some procedure but really is because (.) something is going above that, and they are not getting staff (.) those sorts of things. (.) I would say that's probably (.) why the stress levels have gone up/ (Lines 551-559)

In this extract, David names the dynamic of blaming the individual for systemic problems (part of the dominant discourse), and he links this with increasing distress. This way of talking shows the presence of both discourses described so far, and also seems to show how the NHS tends to perhaps 'use' the collective discourse ("NHS tends to say we will

investigate this properly, we not blaming individuals”) yet, it acts according to the individual one (“but people end up being blamed”). This contradiction between the ‘verbal’ and ‘actions’ was referred to in several other interviews (i.e. Andrea, 339-342; Brenda, 30-39; Carol, 433-436; Fabian, 398-418; Heidi, 516-564) and was often linked with a negative impact on staff wellbeing, based on the frustration evoked. Further explanation will follow in section 3.2.3.

Another important aspect of constructing *wellbeing as a shared responsibility* was present in participants’ talk about their teams, their relationships at work and the importance of communication. The following extract presents Heidi’s response to my direct question about what wellbeing at work means to her. She starts her response by stating that wellbeing is “how I can take care of myself” (Heidi, 481) alluding to the dominant discourse, and she then adds that it involves not only taking care of herself, but also thinking about her colleagues; the extract begins just after she starts talking about her concern for her colleagues and supervisor.

Extract 11:

Heidi: ...So, I think is team wellbeing, as well. Not just, I am in a bubble, managing to take care of myself, and (.) you know, stuff everyone else (.) It’s, it’s, you know (.) “how can we do things together?” Sometimes going out, or having lunch, I always have lunch, always, whatever's happening, I would always have my half an hour lunch (.) erm (.) at, away from my desk, I never have lunch in my desk, ever (.) And I (.) I do try and encourage people not to do that (.) because I think it's so important, you still have to eat (.) you have to get away (.) and I may take a walk, get a coffee::, erm:: (.) So I think it's so imp-, it is really important (.) erm:: (.) (Lines 492-497)

Heidi’s talk about relationships and others seems to construct them as constitutive of subjectivity–wellbeing (White, 2017), and her talk about “team wellbeing” resembles core socialist concepts such as shared ownership and ‘solidarity’. Similarly, Carol’s

response to what wellbeing meant to her included referring to 'people checking people in', which could show glimpses of this discourse, through conveying a sense of interdependence.

Extract 12:

Carol: Wellbeing at work, [sights] it's difficult, because, you know, you are at work every day so you don't [laughs] it's hard to differentiate that, but, you know, wellbeing at work it's kind of (.) I feel like it's, it's, it's people checking people in (.) and:: (.) having a space to say whether you are struggling or not (.) . Erm:: (.) I think it's people feeling happy in their job, to a certain degree, you know, it depends on, if they like their role (.) erm:: (.) wellbeing at work (.) feeling like you matter sometimes? ... (Lines 396-399)

Similarly, participants talked about the importance of their supervision at work, including references to the time and space for supervision, as well as the quality of the supervisory relationship. For example, Gerald talks about his experience of clinical supervision as being too focused on clinical cases, instead of offering him space to reflect on and process other aspects of his work.

Extract 13:

Gerald: Yeah. And there just (.) there isn't much (.) time (.) for self (.) reflection. That's what, I think that's really what it comes down to (.) is:: I have to, I have my own self-reflection but (.) in a::, in a, structured (.) constructive (.) way, erm, like we have our line (.) we have our case or clinical (.) supervision, erm:: (.) and there is, my supervisor tries to allow for a little bit of "how are you feeling and that" (.), but (.), but the, the, the crux of it is really (.) "what are you doing with these patients, how well are you getting on with them, where are you going with this and that?" Erm, as opposed to just a space to just sort of say "how (.) how are you feeling?", to help you process it all. It's just like this (.) 10 o'clock patient, 11:00 o'clock patient, 12 o'clock that's back and it's, quite over time it can build up, I guess. (Lines 122-128)

Gerald seems to be referring to his own responsibility to self-reflect, implying a construction of the self as *responsible*, yet he also adds a need for a relationship and a space where in relation to others, he could reflect on and process aspects of his work. This way of talking shows elements of collectivism, where the individual is not expected to manage on its own, but in relation to others. Subsequently, Jaden talks about his “brilliant experience” in his IAPT service, following my question about how he finds working there.

Extract 14:

Jaden: Erm, yeah, I mean, I read a lot about (.) a lot of IAPT forums, about how other people get on and things like that, and (.) they really struggle with (.) erm, being sort of (.) micromanaged (.) unreachable targets, erm (.) just feeling like (.) lack of supervision (.) erm, all of these sort of things, there:: (.) sometimes they work with complexities too much sometimes (.) But I (.) I get none of those problems here (.) Erm, I’ve got (.) we always have at least one duty supervisor, on site, and it’s not just like a senior PWP its, at least, one of the clinical managers here (.) erm, so there’s always at least one around (.) if you ever need, kind of ad hoc supervision (.) or just to talk to even (.) erm, and I do get frequent supervision with my supervision, he is really good (.) erm, in providing that (.) erm. (Lines 43-48)

Jaden’s account seems to be constructing wellbeing at work as a consequence of the context; he refers to management, targets, supervision and type of clients as a service responsibility that directly affects people’s experiences of wellbeing at work. His account emphasised the availability, frequency and quality of his supervision as a fundamental aspect of his positive experience, which conveys the importance of supervision, a task provided by the service and involving at least two people, instead of being focused only on what the individual does. This shows a way of talking about wellbeing that involves interaction with others and emphasises the quality of these interactions as an important component of wellbeing.

Thus, talking about *wellbeing as a collective/shared responsibility* opened different possibilities and set of obligations for participants. This construction allowed sharing responsibility and ‘blame’ with others, without ‘asphyxiating’³ subjects by making them feel solely responsible for their own wellbeing in a perhaps ‘hostile’ environment (an explanation of IAPT’s construction will follow in 3.3.3). Understanding wellbeing as something created, shaped and maintained in relation with others seemingly allowed participants to support each other, normalise their experiences (reducing blame, guilt and shame) and be more vocal. This construction seems to resonate with White’s (2017) proposal of ‘relational wellbeing’; it identifies people as subjects instead of objects, which acknowledges the importance of individual processes, yet it emphasises our relational nature as human beings, whereby contextual issues are included, and have to be attended to when considering wellbeing. Therefore, in contrast to constructing *wellbeing as an individual responsibility*, being vocal at work would not necessary reflect ‘individual failure’ but ‘systemic failure’. This seems to provide subjects with a different experience in which they seemed less inundated by negative feelings, facilitating a sense of solidarity and interdependence between colleagues which in itself seemed to improve the subjective experience of wellbeing at work.

Nonetheless, participants who deployed this discourse also seemed to report feelings of frustration (Eve, 457-471; Fabian, 41-418; Indigo, 230-237). This was normally present in relation to their experience of ‘not being heard’ and finding that the system would not share the responsibility with them, remaining closed to feedback and seemingly denying interdependence with their employees. Deploying a collective construction of wellbeing could be seen as resisting the dominant discourse of *wellbeing as an individual responsibility*, which in turn encountered the oppression of the dominant discourse aiming

³ I decided to use this word to reflect the accounts of some participants who talked about their wellbeing at work through the use of a metaphor that involved “keeping your head above water” or “drowning” (i.e. Brenda, 153-156, 412; Gerald, 204-205; Jaden, 300-302;).

to ‘quiet’ employees (Lorde, 2007) by placing the focus and responsibility back onto the individual (i.e. extract 6, when Andrea was told “this is your responsibility”).

In summary, this section presented the counter-discourse of *wellbeing as collective/shared responsibility*, which resonates with a wider collectivist or social discourse. This included constructing wellbeing in relation to others and wider issues, including the lack of resources in the NHS, team support and supervision. Constructing *wellbeing as a shared responsibility* seemed to allow participants to be vocal about their struggles, as I argue that potential issues with their wellbeing were no longer constructed as ‘one’s fault’, but as a contextual issue. This could be seen as facilitating a sense of solidarity and shared ownership between psychological therapists that seemed to improve their wellbeing at work. Yet, it was also discussed that feelings of frustration could be elicited when participants experienced the oppression of the dominant discourse in response to their attempts to share responsibility for their wellbeing. Thus, throughout the quotes presented in this section, both discourses seemed to be present, and I reflect on the relation between them in the following section.

3.2.3. Individual versus collective- the interplay

This section maps out and discusses the interplay of the two discourses presented thus far. It specifically focuses on how system/service/managers (people in positions of authority) are shown to be using aspects of the collective discourse, often with the purpose of transmitting a message that implies that ‘they care about their employees’ wellbeing’, yet it became clear that their actions seldom match their words. Instead, institutional actions appear to be often more aligned with a discursive construction of *wellbeing as an individual responsibility*, which implicitly requires individuals to continue to take sole responsibility for their wellbeing at work. The following two extracts present sections of conversations showcasing this contradiction.

Prior to Carol's extract she had started talking about a recent meeting in her service where they discussed wellbeing at work.

Extract 15:

Carol: ...it just feels like [laughs] they are saying these things, but they are not acting. So for example::, It's, people talk about training opportunities, people talk about (.) like flexible working hours, too, which I asked for, not got- not gotten, yet it's partly something that they are really providing people, so I kind of sit there and go "It's all talk (.) sometimes" and I know that, I think that they are trying to, but it just doesn't seem to get enough around. (Lines 81-84)

Prior to Fabian's extract, he has started talking about a recent meeting with his line manager after he had been off sick, which was required by his service's regulations. In this extract, Fabian himself is pointing to the discrepancy between words and action, and I had just paraphrased his account before he continued talking.

Extract 16:

Fabian: ... fact that she is:: kind of trying to support you, but actually not (.) cause she is not, she is not taking me as a:: person [talks cautiously], which is kind of, she just went through (.) sc-, scripts, if you like, yeah, so the illusion that they are trying to support you is there, because you know (.) erm, all the boxes are ticked, and she gave me an opportunity to explain myself, she gave me, she offered me the support, and all these things were there (.) and I'm pretty sure she'll write it up and send it to me to sign and send back to her, and I am pretty sure that they'll be like, you know, did they offer you stress management support, and obviously, they did, it wasn't appropriate, but they did, so::, they are ticking the right boxes::, it's just not supporting you::... (Lines 565-570)

The discrepancy between 'what is said' and 'what is done' that is highlighted in this extract is an important example of the common interplay between these two discourses in participants' talk. If *wellbeing as an individual responsibility* is the dominant discourse (in terms of being openly supported by institutions), this poses the question of how this tallies with institutions verbally using a more collective discourse on wellbeing.

Foucault's (1980) notion of power emerges here as useful lens to better understand this interplay, as he talked about techniques of power as fundamental to maintaining the wider mechanisms of power that function in our society.

How, then, might we better understand the use of the collective discourse for the benefit of institutions as a technique of power? One way to approach this is to follow it through and see their intention of creating an "illusion" of togetherness and solidarity at work (as Fabian says, 530), echoing some recent shifts in leadership policy, where such techniques of power are used to emphasise horizontal leadership involving more people and teams. For instance, the NHS has started to implement 'people participation programmes' (NHS England, 2017) and their NHS Leadership Academy (2013) lists 'inspiring a shared purpose' and 'leading with care' as two key dimensions of good leaders. Thus, the NHS could be seen as deploying the *collective discourse of wellbeing* rhetorically, to comply with these initiatives that have been supported by research, although their actions do not correspond with it. A possibly naïve interpretation could be that the service lacks the resources to fully invest in their staff wellbeing and the explanations for this discrepancy lie in these financial constraints and prioritisation of targets over staff's wellbeing. However, the fact that the techniques of power reinforce their authority seems a more credible explanation for the discrepancy. Furthermore, another option could be to view these initiatives (i.e. NHS England, 2017; NHS Leadership Academy, 2013) as not belonging within a collective discourse but as a mechanism of power to govern behaviours from a distance (Arribas-Ayllon & Walkerdine, 2014). Thus, by alluding to shared responsibility and willingness to care for each other, the service could make employees feel 'looked after' without actually having to act. Taking this further, asking people to share their concerns, could be interpreted as yet another way of encouraging the individual to take responsibility for their own wellbeing, as a way of self-managing or 'problem solving', which in turn directs the blame back onto the individual. Thus,

although it seems that the service recognises the impact of external factors on their employees, their actions do not correspond with this, and based on the inherent power relations of this context, workers feel left with only two options: leave the service or ‘adapt’ to the rigid environment and self-regulate, perpetuating the dominant discourse of ‘wellbeing as an individual responsibility’ at the cost of their own wellbeing.

3.3. Wellbeing as self-actualisation versus wellbeing as productivity

This second section is more fluid and complex because the different discursive constructions that follow are significantly intertwined. It begins by explaining the construction of *wellbeing as self-actualisation* within a humanistic discourse, which leads to the construction of the *good/ideal therapist*. This subject position appeared to clash with the construction of IAPT, which seemed to provide new lens to construct *wellbeing as productivity*; this offered two possible subject positions (*the good and bad employee*) that related contradictorily to the *good and bad therapist* positions (e.g. *good employee equating bad therapist*).

3.3.1. Wellbeing as self-actualisation

An important way of constructing wellbeing across all interviews was conveyed by participants’ talk about being congruent with their sense of self—“being able to be your own person” (Jaden, 363), and being able to grow, learn and flourish as a person and professional. Thus, to encapsulate these two aspects, I’ve decided to call this discursive construction *wellbeing as self-actualisation*, hoping to reflect both ‘authenticity/congruence’ and ‘growth’ as aspects of this construction. My choice of the word ‘self-actualisation’ comes with the awareness of its strong links with a humanistic discourse, particularly Humanistic Psychology, which conceptualised humans as organisms with an inherent drive to grow and self-actualise (Rogers, 1951). Thus, the humanistic discourse assumes growth as a basic human need that when “stopped”

(Fabian, 241), “stunted” (Brenda, 240), or “crushed” (Jaden, 419) would negatively impact wellbeing. Similarly, in Humanistic Psychology, the concept of authenticity or congruence has been portrayed as a core element that facilitates self-actualisation, by enabling individuals to behave consistently with their sense of self, connected to their ideal-self (as Andrea mentions, 376-379). Thus, this discursive construction resembles the traditional eudaimonic perspective on wellbeing (Ryan & Deci, 2001), describing wellbeing as the fulfilment of the self, according to one’s true values, and therefore encompassing both congruence and growth.

In the following extract, Fabian appears to construct wellbeing as being congruent with one’s purpose and meaning.

Extract 17:

P: Yeah, so what do you think is related to::, you know, having a good week or feeling better or not?

Fabian: Many things, I think but overall it is, erm:: (.) I think the thing that continues to happiness for me, anyway, contributes to me feeling pleased with what I've done (.) is ultimately knowing, you know, you’ve kind of genuinely (.) done something meaningful for a patient (.) if I see a patient kind of (.) you know:: making sense of something or achieve something, and that's always a nice thing, regardless of (.) what umbrella that comes under (.) under the umbrella of twelve sessions or six sessions, you know, once that’s done you feel really good about it (.) erm::, because that's part of why you're here in the first place, you know you are working for the NHS, you are working in this kind of (.) role if you like (.)...
(Lines 103-109)

Fabian’s language resembles that of humanistic discourse; he talks about ‘genuineness’ (one of Roger’s conditions) in the context of congruence, and also seems to diminish the importance of ‘targets’ in favour of quality or experience (i.e. “regardless of what umbrella that comes under, the umbrella of twelve sessions or six sessions”) prioritising meaning and purpose (“because that’s part of why you’re here in the first place”).

Similarly, in the following extract, Jaden talks about this in relation to feeling in control; he talks about how he is given freedom to make decisions and work in the way he wants. This exchange was during our exploration of the cards he had selected for the visual task; Jaden had just shared that he felt 90% in control at work, which helped him avoid feeling overwhelmed or flooded.

Extract 18:

P: And if you were to complete that a bit::, in control of?

Jaden: Oh, erm:: (.) [sighs] just my work, how I do it, how I see my clients, what I do with them (.) erm (.) and just how I manage all the aspects of work (.) it's, it's all up to me (.) there's no one to tell me what to do, unless I asked them what to do [chuckles] erm (.) so you feel like your own person, you feel (.) I don't know::, you feel respected, because they let you do that all yourself. (Lines 360-363)

Jaden's talk about his sense of control and its link with being "your own person" seems connected to how employees are treated in his service. In his case, the environmental conditions seem to provide freedom that allows people to behave according to their values and capacities, which resonates with Sen's model of capabilities (1983). Furthermore, this way of talking suggests that the individual *is in relation to* their environment and that wellbeing is linked with feeling respected 'to be who you are'; to be given autonomy to "manage all the aspects of work" seems to show respect for employees' authenticity at work, resembling humanistic discourse. Thus, although this discourse places significant importance on the individual, humanistic discourse also considers the context as important. For instance, Jaden's talk resonated with Roger's ideas that appropriate environmental conditions should be provided for an individual to self-actualise (Rogers, 1961).

Another aspect of *wellbeing as self-actualisation* in participants' talk was the role of growth and learning:

Extract 19:

Fabian: I think clinically, it is, as I said, it is satisfying, erm, in terms of::, kind of, you know, learning new things, is always satisfying, because you're always having to learn new things, you know, you cannot not learn new things, so I think that part is really really interesting (.) Yeah, and it's rewarding (.) But I think just like (.) the way (.) just like I am expressing it now really, I think it's just clouded by so many unfortunately negative things [chuckles] that such good things that we're learning and doing, doesn't flourish, erm::.... (Lines 235-238)

Extract 20:

Brenda: I feel like (.) it (.) it will be an issue for everyone because, although maybe some of them might be at a position where they feel like they have reached growth, they may still wanna be challenged. (.) There might still be more that they wanna do and that it could still become impacting them. But (.) I think that the most important thing from all of this is (.) if:: your growth is really kind of stunted (.) then you are not able to give quality of care to your clients. (.) and that doesn't have to be career growth, like I said, it could your own personal growth and being able to look after yourself (.) to, to really give something to your patients... (Lines 403-408)

Fabian talked about learning as positive (linked to his wellbeing), whilst also making reference to negative things at work not allowing it to "flourish". Brenda also seems to construct wellbeing as directly related to her own growth at work (i.e. Brenda,15), and like Fabian, she also indicates negative influences that can hinder growth. Thus, both participants seem to be deploying the wider humanistic discourse through their references to growth and flourishing. Within self-actualisation, growth appears to be constructed as a process that encompasses both personal and professional growth (Brenda: "that doesn't have to be career growth, like I said, it could be your own personal growth"). Moreover, both participants' talk about growth included a sense of this being stopped or

negatively affected (Fabian: “doesn’t flourish”; Brenda: “your growth is really kind of stunted”), raising the question of who or what stunts growth. Jaden seems to talk about this below; the extract comes after I asked Jaden about his view on the potential impact of the workplace on staff wellbeing (positive or negative) and Jaden had started to talk about the importance of the system’s culture, referring to his service prior to recent structural changes.

Extract 21:

Jaden: Yeah, so that, that, that culture, that system (.) would have a massive negative impact on people (.) because they feel that they can’t change anything (.) it’s a system crushing them down (.) so then, obviously they are gonna get out, whereas (.) I don’t feel that oppression (.) there is no oppression (.) in this place (.) erm (.) the, the, it, it enables you to thrive (.) in your own way, and make your own journ-, not journey, but like (.) make your own week up, in terms of how you do your job (.) erm (Lines 418-421)

Jaden refers to the system’s culture as something that can “crush them [employees] down”. This seems to imply that without any sense of control, psychological therapists may feel oppressed (“they feel that they can’t change anything”), which I argue resonates with the humanistic critique of capitalist systems regarding their dehumanisation and alienation of people (Fromm, 1941, 1956). It is interesting how Jaden then contrasts this with his own experience, as he talks about how, he doesn’t feel this “oppression”, which in turn “enables you to thrive”. Thus, the service’s culture seems to be portrayed as having the power to both ‘enable’ and ‘oppress’ staff wellbeing, resembling Foucault’s concept of power (1982). Allusion to the power relations between the service and employees was also present in other interviews, through references to ‘the excessive pressure to meet targets’ and ‘not being heard’ being oppressors of their growth and authenticity (e.g. Fabian, 73-76; Indigo, 233-237).

Consequently, constructing *wellbeing as self-actualisation* raises the question of what growth and congruence might ‘ideally’ look like for this particular group. This could be considered closely related to the two subject positions made available through this discursive construction: the *good or ideal therapist* and the *bad therapist*, which I consider next (section 3.3.2). I argue that when psychological therapists are unable to be congruent with their own values (resonating with *the ideal therapist*) or they feel that their process towards becoming a *good therapist* is being impeded, their wellbeing may be negatively affected.

3.3.2. The good/ideal therapist⁴

The *good/ideal psychotherapist* was constructed in participants’ talk as a professional who: (1) thinks, reflects and is able to express their feelings and opinions to others; (2) is able to work autonomously, with an independent mind and ability to make decisions; and (3) cares about their clients and wants to help them, prioritising clients’ wellbeing over targets. An interesting aspect of participants’ talk about *the good/ideal therapist* is that this construction was often made in opposition to their construction of IAPT. I will now present extracts and commentary on participants’ constructions of *the good/ideal therapist*, before discussing their construction of IAPT in section 3.3.3. This is an artificial ‘separation’ to favour clarity in the presentation of the analysis and discussion, although the interplay of this discursive construction will become apparent through the quotes and discussion.

Subsequently, Gerald and Eve talk about ‘thinking and reflecting’ as fundamental elements of their profession, in opposition to the construction of IAPT.

⁴ Based on the limited nature of this thesis, I have decided to mainly explain the ‘good or ideal therapist’, as the bad would be the opposite of this.

Extract 22:

Gerald: ... Psychology as a, as a, as a field is (.) kind of (.) the bread and butter of it, it's:: (.) reflection (.) erm, yeah, I think that's possibly something that's lacking, you know, in IAPT services. Just, it ff:: feels, like this, the hamster wheel, that's constantly going. (Lines 141-143)

Extract 23:

Eve: ...we don't think, we don't think, we just do (.) we do, do, do, do and do, we don't think (.) and I think (.) that's not good in the Psychology profession, cause we think, that's what we are supposed to be doing, we need to be thinking (.) and I think that IAPT doesn't think we do, you know::... (Lines 647-649)

Extracts 22-23 refer to “Psychology” (Gerald) and the “Psychology profession” (Eve), to talk about the importance of ‘thinking and reflecting’ for good practice. However, as mentioned above, participants’ talk about *the ideal therapist* often involved talking about a constant conflict with the environment (IAPT services), almost constituting poles of the same continuum (i.e. thinking versus doing). In this way, Gerald’s talk equating the lack of reflection in IAPT to being in a “hamster wheel, that’s constantly going”, suggests a ‘factory-like’ environment (mentioned by Fabian, 230; Heidi, 160-166). This also seems to be present in Eve’s words, “we just do, we do, do, do, do and do” and “I think that IAPT doesn’t think we do [think]”, perhaps suggesting that individuals are expected to function as objects (where thinking is not valued or necessary) instead of being treated as subjects (human beings). In this way, IAPT seems to be portrayed as an environment that may alienate people at work (see section 3.3.3).

Back to the construction of the *good/ideal therapist*, participants’ talk also included an element of being able to work autonomously, able to have an independent mind, contribute and make decisions. The following extract comes after Andrea had started talking about how she had always been invited to think and contribute as a Psychologist

in her career, explaining that this helped her feel valued and respected; just before this intervention, she had mentioned that this was not the case anymore at her current IAPT and, following my reflection of her account, she replied by quoting her service's words:

Extract 24:

Andrea: “You are not a manager, you are not here to::, to have an impact on (.) the ways things run or question anything, just get on with it”

P: Gosh, so how was that for you?

Andrea: Erm, I think (.), that felt really:: challenging. I'm::, I think, I feel like in my past experiences I've been very much shaped to (.) speak up and, and, and in my training as well, you know, you are always invited to, to keep talking, so::, so really:: really hard, I guess.... (Lines 250-253)

It is interesting to notice how I reacted after she shared the service's words with me; my surprise or even disapproval of these words perhaps shows my position within the same field as my participant (see section 4.3 for further reflexivity). Furthermore, Andrea's talk seems to construct IAPT as the oppressor of her identity as a Psychologist. Implicit in this construction is the fact that each psychological therapist would have an 'independent mind' that is valuable for others. Nonetheless, IAPT seems to be constructed as denying this uniqueness, not interested in people's thinking, but their capacity to 'do', which in turn seems to bring up negative feelings for the employee. Indigo seems to use the same discursive resources to talk about the *ideal/good therapist* in contraposition to IAPT.

Extract 25:

P: So how do you think that, that impacts? Because you said that, you know, I think that not being heard is mostly the issue::, how do think that, that impacts you::, or your wellbeing at work?

Indigo: I think it (.) I said earlier, in terms of your confidence (.) as a (.) as a therapist but also, you know, you're:: trained to be an autonomous practitioner

and (.) it's kind of, they are taking the autonomy away (.) and the decisions::.. And then you feel quite helpless (.) as well, erm::, about change I guess...(Lines, 238-243)

Both Andrea and Indigo refer to their training as a potential origin of this construction, forged at universities and maintained by regulatory professional bodies, such as the BPS and HCPC, amongst others. For instance, their practice guidelines include autonomy as a core competence to develop and maintain throughout and after qualification (BPS, 2017; HCPC, 2015). Moreover, Indigo contrasts this with her experience of being deprived of this autonomy by not being able to make decisions and not being heard. She explains that, as might be expected, this impacts her subjectivity, by affecting her confidence and evoking feelings of helplessness.

Furthermore, *the good/ideal therapist* was also constructed as someone who cares about clients and wants to help.

Extract 26:

Fabian: ...you know, because one of the reasons why we're here is because we like helping people and (.) doing things for people and sometimes that just means (.) you know, that not everyone is the same (.) some people need a few more sessions, some people need less and you know, the fact that the flexibility isn't there, doesn't make it easy. (Lines 56-58)

Fabian refers to psychological therapists as 'we', explaining that 'we' like helping people, and contrasts the need to adapt to clients in order to help them with the lack of flexibility that he experiences in the service, describing this as difficult. This way of constructing *the good therapist* as wanting to help perhaps indicates a vocational attribute that is often present in the 'caring/helping professions' (i.e. Kovacsne, 2007; Skovholt, 2001).

In summary, this section presented the construction of *the good/ideal therapist* as a professional who thinks and reflects, and who has been trained to work autonomously,

speaking up and making decisions, with a vocation to help others. Furthermore, participants' talk about *the good/ideal psychological therapist* was often connected to their experience of not being able to 'be in this way', showing the frustration of their attempts to be *good therapists*, which could result in poor wellbeing. Accordingly, participants' talk seemed to construct *the good/ideal therapist* in opposition to the construction of IAPT, further explained below.

3.3.3. The construction of IAPT

All participants, whether from ELFT or NELFT, constructed IAPT in a consistent way: as a system that is (1) primarily focused on meeting targets, prioritising quantity over quality of care; (2) inflexible, unable to accommodate difference; (3) fast paced; and (4) lacking resources, yet constantly asking more from their employees. Both Trusts had experienced management re-structuring, yet in this respect some difference was noticeable between NELFT and ELFT: firstly, participants from ELFT but not NELFT talked about a 'perfectionist system' where they were asked to meet 100% of targets, and secondly, participants from NELFT, more so than ELFT, seemed to emphasise the 'changing' nature of their services through regular re-structuring. These differences did not appear to impact the wider construction of IAPT, so I will now focus on discussing IAPT as a wider system, without differentiating between Trusts.

The following extracts present a construction of IAPT as inflexibly target-driven.

Extract 27:

David: ... So, for example (.) there's targets we have to reach about how long we're allowed to keep people within the service before (.) you know (.) how long (.) yeah(.) about how long people can wait before they're seen for the first therapy appointment (.) and if they wait too long it looks bad on our statistics (.) but if people are coming into the service (.) and they say "oh I want an evening

appointment, I don't mind waiting another 3 months and that's okay, it don't bother me at all as soon as I get an evening appointment" (.) that could be potentially fine for us (.) but because it looks bad in our statistics we are not supposed to do that (.) So we have now been restricting things for the patients (.) because it was something from outside the service (.) which is really just to do with people (.) having an inflexible idea about how to count something (.) cause you could potentially say "okay if anyone makes that request again, you just count them out of those figures (.) or you, when you're doing your figures or something"... (Lines 215-223)

Extract 28:

Indigo: ... I guess sometimes it, it feels like you're (.) running against the tide (.) [laughs] [points to card 6] in the sense that (.) erm, you, you know, you're (.) trying to do things to:: (.) in the best interests in the patient (.) but sometimes that, you know (.) isn't (.) heard (.) and, or other priorities (.) are more important, like targets (.) or:: (...) admit tasks that seem (.) a bit pointless, sometimes (.) (Lines 263-625)

Extracts 27 and 28 show how IAPT is constructed as inflexible, prioritising targets over quality of care for patients. Participants' talk about targets as "pointless" (Indigo) or as being "potentially fine for us, but because it looks bad in our statistics we are not supposed to do that" (David) could show the conflict between IAPT and *wellbeing as self-actualisation* and the *ideal therapist*, where congruence, autonomy and caring for clients were seen as central; we could argue that an inflexible system inhibits autonomy, and prioritising targets inhibits authentic practice (i.e. valuing quality of care over quantity).

Moreover, targets are talked about as measurable statistical goals to be evaluated (David: "how long people can wait"; "if they wait too long it looks bad on our statistics"), resembling a business economic discourse, where actions are organised around outcomes and resources. This can also be noticed in the following extracts, where IAPT is constructed in relation to increasing demands alongside decreasing resources.

Extract 29:

Gerald: ... I know this isn't just this service, I know from colleagues that I have in other services, I know that it's, it's::, it's kind of pervasive across IAPT services, really. It's just this (.) the vast majority have this (.) culture of (.) pushing, pushing, pushing for more and more (.) contacts. And (.) and I, I, yeah, I just think it's very draining for clinicians. It can be, very draining... (Lines 105-108)

Extract 30:

Indigo: ...Because then in the reality of the government and there's been cuts, that's, that's the reality, but (.) we're expecting (.) staff to do more:: (.) And that is gonna just have an impact on burnout and stress (.) and wellbeing, and people are gonna leave... (Lines 372-374)

Extracts 29-30 talk about IAPT services in relation to resources and demands, resonating with the economic and business discourse, yet they present an inverted logic (more demands with fewer resources), which seems to place workers under unrealistic pressures (Gerald: "culture of pushing, pushing, pushing for more and more"). This 'illogical' situation of asking more with less (Indigo: "there's been cuts, that's the reality, but we're expecting staff to do more") resonates with Strecker's (2011) definition of 'exploitation of labour', by which workers are placed under unfair and unrealistic expectations, within an imbalanced power relation. As Indigo mentions, it might only be expected that these conditions would negatively affect staff wellbeing.

Beyond ongoing increases in demands, another component of the construction of IAPT present in participants' talk was 'it's fast pace':

Extract 31:

Heidi: ... I don't know, it looks more like a factory, you just, it just feels like, "I can't remember the names of my clients (.) all the time". Erm::, it's like, it's quicker, the pace is much quicker. See one person::, review after six, 12 sessions

or continue or not continue, discharge, next client. It's like if you are fitting in the next client even you before you finished, and I think is the thinking, I don't have any, I don't have time to think (.) about my clients (.) really (.) apart from (.) the time I put aside (.) for supervision (.) which I try to put aside, at least an hour, to think about the clients I want to bring (.) and that's the only time I really think about my clients (.) otherwise is just "go, go, go, go, go, go" (.) I feel it's fast paced, I feel the pace is much faster... (Lines 160-166)

Extract 32:

Eve: ... I think that in the NHS, it's, it's more emotionally draining (.) it's quite demanding (.) and (.) and the, the workload it's, it's, it's, yeah, it's quite (.) robotic I find it as very fast paced... (Lines 27-28)

These extracts seem to construct IAPT as fast paced; statements like "it looks more like a factory", or "it's quite robotic" seem to present IAPT as focused on 'doing', rather than thinking or caring. Similarly, participants' talk is reminiscent of the dehumanisation and alienation discussed above in relation to how IAPT was constructed as the oppressor of *wellbeing as self-actualisation* (obstructing congruence and growth). Indeed, the IAPT context seemed to facilitate an alternative construction of wellbeing that will be further explained in section 3.3.5; a construction that resonated more with the economic business discourse and that also seemed to fit well with the construction of *wellbeing as an individual responsibility*, both under the umbrella of the neoliberal discourse.

In summary, this section has presented my discussion of how the construction of IAPT resonates with a wider business economic discourse and how this seems to be oppositional to the construction of *wellbeing as self-actualisation* and the position of the *good/ideal therapist* within a humanistic discourse. This involved constructing IAPT as inflexible, fast-paced, prioritising targets over quality of care, and lacking resources yet constantly demanding more from their employees. I argue that this construction of IAPT oppresses the *good/ideal therapist*, which in turn may have a negative impact on psychological

therapists' wellbeing. For a visual juxtaposition of construction of *the good/ideal therapist* and *IAPT*, please see table 2.

Table 2. The ideal therapist vs IAPT

<i>The good/ideal therapist</i>	<i>IAPT</i>
<p style="text-align: center;">Thinks & reflects</p> <p>...the Psychology profession, cause we think, that's what we are supposed to be doing, we need to be thinking... (Eve, 648)</p> <p>...Psychology as a, as a, as a field is (.) kind of (.) the bread and butter of it, it's:: (.) reflection (.)... (Gerald, 141-142)</p>	<p style="text-align: center;">Fast paced & focused on doing</p> <p>...IAPT (.) does, IAPT doesn't think... (Eve, 646)</p> <p>...that's the only time I really think about my clients (.) otherwise is just "go, go, go, go, go, go" (.) I fell it's fast paced... (Heidi, 165-166)</p>
<p style="text-align: center;">Works autonomously</p> <p>...As a therapist but also, you know, you're:: trained to be an autonomous practitioner... (Indigo, 240-241)</p>	<p style="text-align: center;">Inflexible</p> <p>...I guess what feels like is more challenging about the work, erm, is (.) around (.) the, the set up and the, the::, the kind of the pressure on targets, and recovery and (.) getting a certain number of people in per week, feels like it's (.) very specific and quite pedantic (.), umm, to a point that I think that it doesn't feel like there is much flexibility there... (Andrea, 39-41)</p>
<p style="text-align: center;">Cares about clients—wants to help</p> <p>...Because, you know, we want to all give quality of care to our patients (.) erm, but often (.) giving that quality of care... (Brenda, 20-21)</p>	<p style="text-align: center;">Prioritises targets—more concerned with numbers, statistics</p> <p>...I guess the idea of IAPT in general. That (.) it is about (.) target orientation, so, reaching these targets, thinking about quantity rather than the quality of the service you are delivering... (Brenda, 357-358)</p>

3.3.4. The construction of the ideal/good therapist & IAPT- the interplay

This section will focus on discussing further the opposition between the construction of IAPT and the subject position of the *ideal/good therapist*, now focusing on possibilities that this conflict leaves to psychological therapists working in IAPT services, this being (1) leaving the service, or (2) adapting to the environment. Subsequently, the option of ‘adapting to the environment’ will be explored, leading to the introduction of the final construction of wellbeing presented in this thesis, *wellbeing as productivity* (3.3.5).

Subsequently, Andrea constructs IAPT in opposition to the *good/ideal therapist*.

Extract 33:

Andrea: ... I:: started to become increasingly worried about this set up. In terms of, my own, who I was as a person and my identity. Because (.) I, I felt like if I stay in this particular environment for too long, I’m gonna forget what it’s like to (.) contribute and to, it’s gonna completely change the way that I am as a practitioner. And I don’t want to be::, I don’t want to be a wall flower, I don’t want to be someone who just (.) gets on with it. I like to challenge, I like to (.) change things up...yeah. So I kind of talk about just being a ‘cog in the wheel::, just kind of get on with it do your daily grind::... (Lines 259-263)

Extract 33 constructs IAPT as the oppressor of the *ideal/good therapist*, threatening the therapist’s identity (“I felt that if I stay in this particular environment for too long, I’m gonna forget what’s like to contribute and it’s gonna completely change the way that I am as a practitioner”). Andrea’s references to not wanting to “be a wall flower” or “a cog in the wheel”, could indicate her attempts to resist a new subject position offered by IAPT services (*the good employee*, which I will explain further on section 3.3.6.). Thus, in the context of IAPT, it seems that those in the position of *the good/ideal therapist* are left with two options: (1) to leave the service and remain true to the *good/ideal therapist construction*, or (2) to remain and adapt to IAPT, distorting the *good/ideal therapist*

construction (be a “cog in the wheel”). Following, Eve talks about this making reference to ‘adapting to survive’.

Extract 34:

Eve: ... you just have to adopt (.) or adapt, sorry adapt, and::, and adjust (.) and:: the more you moan about it, the more you fall behind, so you just have to:: (.) keep up with it and:: (.) survive, survive, survive the IAPT world [smiles] that could be a good (.) quote [chuckles] (Lines 655-657)

Talking about ‘adaptation to survive’ seems to resemble an evolutionary discourse where only those who adapt to the environment are able to endure. This means that the subject must change and let go of certain parts or ways of behaving, in order to become a good fit for the environment (Darwin, 1859). Thus, participants’ construction of *wellbeing as self-actualisation* and *the ideal/good therapist* don’t seem to fit with the environment (IAPT). This seems to be linked with participants’ constructed experiences in IAPT as a ‘constant battle’ or ‘fight to survive’ (see table 3 for some quotes from participants about this). Accordingly, the IAPT context seems to create the conditions to ‘extinguish’ *wellbeing as self-actualisation* and *the ideal/good therapist*, bringing about a different wellbeing discourse with two new subject positions, explained in the following section.

Table 3 Experience of IAPT as ‘a fight to survive’

<p><i>Running against the tide</i></p>	<p>... I guess sometimes it, it feels like you're (.) running against the tide (.) [laughs] [points to card 6] in the sense that (.) erm, you, you know, you're (.) trying to do things to:: (.) in the best interests in the patient (.) but sometimes that, you know (.) isn't (.) heard (.) and, or other priorities (.) are more important, like targets (.) or:: (...) admit tasks that seem (.) a bit pointless... (Indigo, 263-265)</p>
<p><i>Meandering through the forest</i></p>	<p>... getting through the week [laughs], sometimes it kind of just feels like (.) I don't know if each one of these represents a patient (.) or a client, and you kind of like that, okay so there is one, and you're, you're meandering your way through then, through the forest, until eventually you get the week (.), the end of the week which perhaps which lead to this again [laughs]... (Gerald, 297-299)</p>
<p><i>A tug-of-war</i> <i>A constant battle</i></p>	<p>So, yeah, that’s one of the cards, and the tug-of-war, I guess, that I talked about before:: it always feel like a constant battle (.) trying to do your thing, you know, erm, even trying to do things for yourself, you know, erm, like asking for things like flexibility and stuff like that, feels like (.) abnormal, feels out of the norm,</p>

<p><i>A tug-of-war</i></p> <p><i>A constant battle</i></p>	<p>So, yeah, that's one of the cards, and the tug-of-war, I guess, that I talked about before:: it always feel like a constant battle (.) trying to do your thing, you know, erm, even trying to do things for yourself, you know, erm, like asking for things like flexibility and stuff like that, feels like (.) abnormal, feels out of the norm, so it always feels like a tug-of-war [pointing to card 3]</p> <p>(Fabian, 275-277)</p>
<p><i>Choppy waters</i></p> <p><i>A constant battle</i></p>	<p>.... So I kind of talk about just being a 'cog in the wheel::, just kind of get on with it do your daily grind:: erm, I guess, again this kind of::, (.) maybe it isn't such a different card, maybe I could get rid of that, but it's just this sense of with the kind of the choppy waters, and just feeling like it's a constant battle, and something that you are out in the middle of the sea, and you never quite reach land::, erm::, (.) that umm, yeah, that you are just you never ever catch up...</p> <p>(Andrea, 263-266)</p>

In summary, this section has presented my discussion of the incompatibility of *IAPT* and *the good therapist* aligned with a humanistic discourse, as I argue that the construction of *IAPT* only leaves two options for those positioned as *good/ideal therapists*; (1) to leave *IAPT* and remain as *good therapists*, or (2) to adapt to *IAPT* and give up the position of *good/ideal therapists* in order to survive. In this way, as the construction of *IAPT* resonates with an economic business discourse, this also seems to be linked with a new construction of *wellbeing as productivity*.

3.3.5. Wellbeing as productivity

Participants seemed to reproduce an institutional discourse of *wellbeing as productivity*. I refer to this as an institutional discourse because it seems to be primarily produced by *IAPT* services and managers who, in positions of authority, represent the voice of their employers, yet it also resonates with our capitalist society and government. This discourse was conveyed by participants' talk about being effective and efficient at work, including an element of control and surveillance, as participants talked about 'being watched' and "avoiding the red hand" (Gerald, 317) or 'being finger pointed' (Andrea, 209-211).

Thus, this construction seems to resemble a prevalent narrative on the literature linking wellbeing to productivity (e.g. Black, 2008; Boorman, 2009; Bryson et al., 2014; Kersemaekers et al., 2018) resonating with neoliberal business economic discourses; these wider discourses are focused on the individual and linked with the use of surveillance, by which people are valued in relation to their productivity, with the potential of reducing subjects into objects. In this case, *wellbeing as productivity* required psychological therapists to take the subject position of *good* or *bad employee*, based on their ability to produce (meet targets). Thus, NHS-IAPT services seem to be themselves reproducing this wider discourse, as if the NHS had subordinated to the market, whereby it could be argued that the focus is no longer ‘to provide healthcare to everyone regardless of their wealth’, but to function as a profitable business.

Thus, an element of *wellbeing as productivity* involved participants’ talk about their ability to meet targets.

Extract 35:

Gerald: ... me, personally, is when I (.) it can start getting me, a bit (.) deflated and down. Thinking "well (.) I, I'm not (.) making I feel like I'm not making the progress with people that I should be. And when you've got to hit certain targets and move to recovery rates and things like that... (Lines 69-71)

Gerald’s talk shows how wellbeing has been constructed as being efficient and effective at work, as he states: “I’m not making the progress with people that I should be”, and he refers to having to “hit certain targets”. Moreover, constructing *wellbeing as productivity* also included a constant sense of ‘being observed’ and potentially judged if not behaving ‘as expected’:

Extract 36:

P: And what was this referring to [pointing to card 9]?

Gerald: I guess that's trying to avoid the big red hand, erm:./

P: /What is the big red hand?

Gerald: To me the big red hand is kind of (.) "you:: (.) are doing something wrong::, you're in trouble, you:: aren't doing your job right (.), you're::, erm::, you::, you kind of stand out as (.), as, erm::, as one to watch, I guess in a negative sense it's that, you're not, yeah, you're (.) I guess, "We're watching you" kind of thing... (Lines 316-321)

Extract 37:

Andrea:...I see other people working late, but no one will talk about it, no one will say anything about it, because they are all so worried (.) that they will be, that the finger will be pointed at them as (.) not performing, not keeping up with the, erm, I feel like I try to take a bit of a risk in just being honest, because I felt, this is an unworkable situation (.) I need to stand up and say something (.) but in doing that (.) ended up being pointed out as (.) the one that wasn't performing (.) because no one else will say anything/ (Lines 208-212)

Extract 36-37 resonate with the concepts of surveillance and control explained by Foucault (1976, 1981). Thus, participants' talk could suggest that their behaviours at work are regulated through surveillance (Gerald: "we're watching you") and discipline (Gerald: "trying to avoid the big red hand" or Andrea: "finger pointed at them"). With the presence of constant observation, Foucault (1976) argued that individuals internalise the sense of control and become 'docile bodies'. The following extract shows Heidi's talk about what it meant for her to "want to get better" in this context.

Extract 38:

P: Umm, and when you say "I want to get better", what do you mean there?

Heidi: I want to be more efficient, I want to::, erm, you know, if, if let's say I've got to perf-, maybe a bit of perfectionism in there, and then I've got to do everything perfectly, I want to be able to let go of that, and just do what's::, and be okay with it, it's good enough, rather than "I've got to cross every t and dot in every (.) sentence", or write::, you know (.) if I am sending a text, do I have to, do

I have to put a, do I have to (.) put a capital (.) C, a capital for the person's name
(.) I do that, but actually, do I have to that? that's looking at it very sort of simply
(.) Does it matter? (.) yeah:: (.) Being more efficient (.) getting what I need to do
done (.) Learning how to do it (.) more efficiently. (Lines 338-344)

This extract constructs *wellbeing as productivity*, by referring to Heidi's 'willingness to get better'—to become more efficient at work—and one inevitably wonders whose words these are. Heidi talks about a conflict between wanting to do things well (alluding to being perfectionist) and she contrasts it with wanting to be able to 'get things done'. Thus, Heidi seems to be reproducing an institutional discourse, by which employees must self-manage to be productive, for which the management of time is fundamental. This could be considered a consequence of the constant presence of surveillance, now internalised by employees, which leads them to self-regulate and behave as 'it is expected' (efficiently and effectively).

Consequently, constructing *wellbeing as productivity* seems to place the value of the person on their productivity. Accordingly, participants' talk often included an evaluation of their performance ('failing versus achieving'), so that when unable to meet their targets, they feel negative feelings, such as feeling like a failure. Subsequently, Carol talks about her experience within this construction.

Extract 39:

Carol: So, when you perform, and you perform well, so you can get up in the high 90s. You still feel like you've failed because you haven't reached the target. So:: (.) that's probably one of the most challenging things, that you always feel like you've set up to fail. (Lines 49-50)

It is interesting how Carol seems to attribute the 'failure' to the system, as she stated, "you always feel like you've set up to fail", yet she still experiences feelings of failure, because she has not been able to meet the service's expectations of her. Subsequently,

wellbeing as productivity offered two subject positions, which I will explain in the following section.

3.3.6 The good and bad employee

Hoping to capture the expectations that are placed on psychological therapists in IAPT services, I have decided to call these subject positions *the good and bad employee*. *The good employee* is a worker who is productive, can use their energy to fulfil their duties at work, and prioritises meeting targets over their own personal or professional values. Participants refer to this as ‘getting on with the job and not complaining’.

Subsequently, Carol seems to talk about these two subject positions, as she seems to take *the good employee* position.

Extract 40:

Carol: ...yeah, obviously people would love to have a change (.) but (.) you know, you, you’re actually really limited and they are well aware that people struggle with performance, I am not gonna keep bringing it up, I am not gonna keep pushing myself and put myself into that position (.) where I am always fighting for something that I don’t feel I am gonna get anywhere with (.) So I am just thinking like “okay, I am here to do my job, my job is x, y and z”, I do that (.) I make sure I am okay (.) and that, you know, colleagues or whatever are okay to a certain extent [laughs], but (.) beyond that I am not gonna push (.) for something that I know:: (.) could go beyond (.) our managers or the head management of the service, like (.) that’s only an example but (.) you know (.) that kind of thing.
(Lines 212-218)

Carol’s talk seems to construct those who ‘complain and fight’ as *the bad employees*; those who waste time (don’t use it well) trying to voice their views with the aim of changing something that “could go beyond the head management”, implying that this would be almost impossible to change. Carol’s talk seems to allude to an attitude of ‘accepting and adapting to the environment’, resonating with the evolutionary discourse

mentioned in section 3.3.4. In this way, it could be argued that adapting to IAPT involves taking the position of the *good employee*, one who to survive must do what is expected of them (subjugate to the dominant institutional discourse).

Returning to the last part of extract 33, Andrea’s talk seemed to show resistance to this dominant discourse and the subject position of *the good employee* in order to remain true to her identity (positioned as *ideal/good therapist*). Resisting the *good employee position* involved alluding to “being a cog in the wheel” or a “wall flower”, seemingly constructing the subject as an object. In this way, there seems to be a paradoxical relationship between subject positions, whereby it seems impossible to be both *the good employee* and *good therapist* at the same time. In this case, Andrea seemed to adopt the *good therapist position* as someone who ‘resists, fights or complains’ with the hope of changing things, behaviours and attitudes that within *wellbeing as productivity* are constructed as evidence of using resources inefficiently and being therefore ‘unproductive’. See figure 1 for a visual representation of these conflicting subject positions.

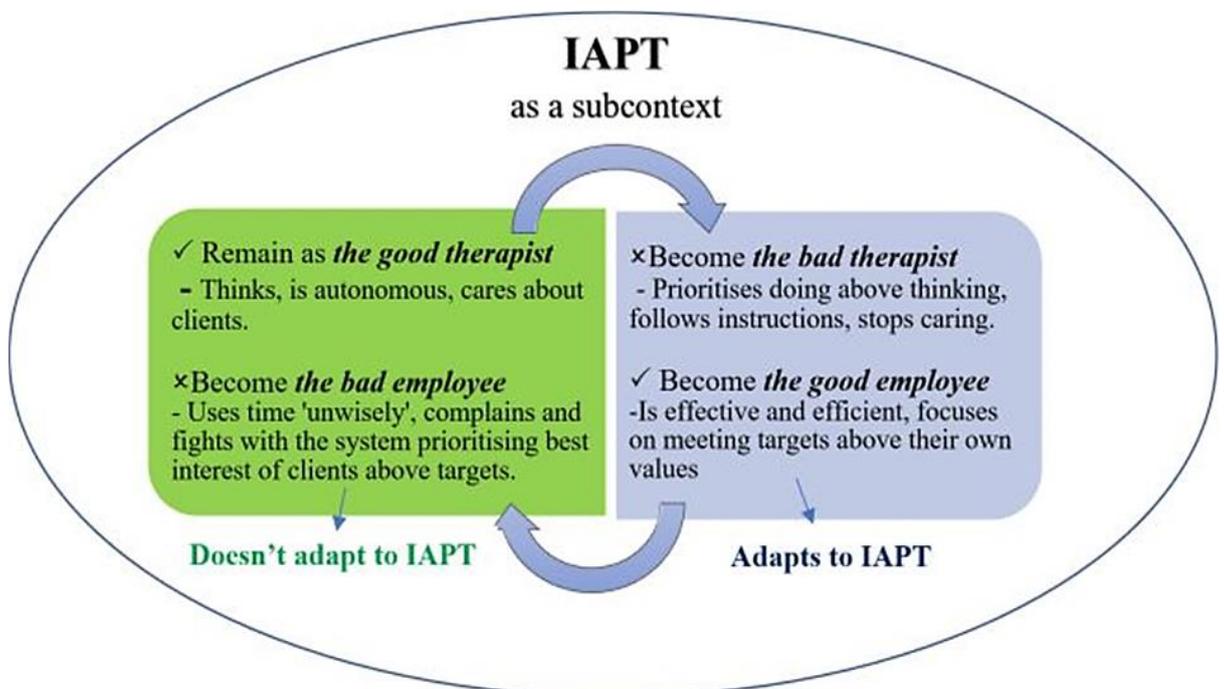


Figure 1. Conflict of subject positions

Similarly, returning to Extract 36, Eve seemed to construct ‘moaning’ as a way of becoming inefficient, unable to ‘be on top of things’ and meet targets, linked with the *bad employee* (“the more you moan about it, the more you fall behind”). Thus, to take the position of the *good employee* within *wellbeing as productivity*, one has to give up the position of the *good/ideal therapist*. For a visual comparison, see figure 1 and/or return to table 2, in which IAPT’s characteristics correspond with *the good employee*.

It seems, then, that the current construction of IAPT forces participants to choose between retaining their identity as *the good/ideal therapist position* and thereby become *the bad employee* or adapting to the market business model of IAPT to become the *good employee* and thereby sacrificing the *good therapist position*. This seems to indicate that under the current situation in IAPT services in the UK, psychological therapists must suffer with the tensions of these contradictory constructions, which would potentially impact negatively on staff wellbeing at work.

In summary, this section presented the last construction of *wellbeing as productivity*, which resonates with a wider economic neoliberal discourse, and involves performing effectively and efficiently at work alongside a component of permanent control and observation. I have argued that this construction seemed to open up two subject positions—*the good and bad employee*—that coincided with adapting to and adopting the institutional discourse. Accordingly, the *good employee* was portrayed as someone able to do their job effectively, prioritising targets and managing time well, which in turn seemed to entail sacrificing the *good/ideal therapist position*. I conclude that, doomed to suffer the tensions of these contradictory constructions, the wellbeing of psychological therapists in UK IAPT services may also suffer.

Chapter Four: Summary, Evaluation and Implications

4.1 Chapter Four Overview

This chapter starts by revisiting the research questions to discuss and summarise the main findings. It continues with a section on reflexivity and a critical review and evaluation of the study. Implications and recommendations for research and practice, and the relevance for CoP are then discussed, ending with a final summary and conclusion.

4.2. Research questions and analysis summary

The aim of this research was to gain in depth and critical understanding of IAPT-NHS psychological therapists' constructions of their wellbeing at work, also exploring their impact on subjectivity and the relevance of context. To facilitate clarity, the main findings will now be summarised and discussed according to each research question.

4.2.1 How do psychological therapists construct their own wellbeing in the context of IAPT-NHS?

Through the analysis four main discursive constructions were identified: (1) *wellbeing as an individual responsibility*; (2) *wellbeing as a collective responsibility*; (3) *wellbeing as self-actualisation*; and (4) *wellbeing as productivity*.

From these four main discourses, *wellbeing as an individual responsibility* and *wellbeing as productivity* can be considered dominant based on their recurrence across interviews, but most importantly, based on their endorsement by those in power. Both discourses resembled a wider neoliberal discourse, portraying wellbeing as primarily dependent on the individual's actions and resulting from each person's achievements and effort, which resonates with individualism and meritocracy. Accordingly, individuals are constructed as independent 'entrepreneurs', encouraged to self-govern and manage their wellbeing

through certain practices, analogous to the highly critiqued market discourse linked to notions of SWB (Smith, 2019; White, 2018, 2017; Cabanas, 2016). This was seen in participants' talk about self-care practices in *wellbeing as an individual responsibility*, and in their accounts about working efficiently and effectively to meet targets within *wellbeing as productivity*.

Additionally, both constructions included an element of surveillance that could serve as a form of control and regulation of participants' behaviours, seen in participants' references to self-examination and self-awareness within *wellbeing as an individual responsibility* and to being "watched" and avoiding the "red hand" within *wellbeing as productivity*. Accordingly, these discursive constructions of wellbeing have the potential to reduce subjects to objects; as McNay (2009) argues, neoliberal discourse encourages people to perceive and relate to themselves in terms of the notions of productivity and economic interest, also linked with the increasing literature on wellbeing and productivity at work (e.g. Bryson et al., 2014; Hancock & Cooper, 2017; Kersemaekers et al., 2018; Miller, 2016). Thus, these ways of constructing wellbeing deflect attention from the system and discourage reliance on others. They have the potential to subjugate and alienate the individual through surveillance and judgement, techniques of power that have an impact on people's psychology (feeling like a failure, guilt, and shame) whilst simultaneously problematising wellbeing issues at work (further explored later in relation to subjectivity).

Conversely, *wellbeing as a collective responsibility* and *wellbeing as self-actualisation* appeared to act as counter-discourses providing resistance to the previous dominant discourses. Constructing *wellbeing as a shared responsibility* involved reference to wider issues beyond the individual (i.e. NHS lack of resources, team support and supervision), and constructing *wellbeing as self-actualisation* involved placing the focus on growth and congruence instead of productivity. Both constructions of *wellbeing as a collective*

responsibility and *wellbeing as self-actualisation* acknowledge the importance of the individual whilst simultaneously portraying the environment and interconnectivity as fundamental, promoting the construction of people as subjects instead of objects, beyond economic rationality; this resembles White's (2017, 2018) work on 'relational wellbeing' associated with collectivist discourses.

4.2.2. What are the implications of these constructions for subjectivity?

Each of the four main discursive constructions of wellbeing presented in the analysis provide a picture of duality and contradiction. Firstly, *wellbeing as an individual responsibility* and *wellbeing as a shared/collective responsibility* presented a continuous switch between individual and shared duality regarding who is *responsible* or *irresponsible* for employees' wellbeing. From the *collective construction of wellbeing* it was the system which wore the label of *responsible* or *irresponsible*, whereas from the *individual construction of wellbeing* the label of *responsible* or *irresponsible* was enforced on the individual.

Moreover, a point of tension between these two constructions became apparent in the reported gap between the service's talk and actions, similar to the gap identified through the literature review between guidance and people's experiences. Participants' talk pointed to the service deploying a *collective construction of wellbeing*, implying that they care about their employees' wellbeing, according to the current wellbeing guidelines (NHS Employers, 2015, 2018; NHS England, 2016; NICE, 2009). Yet, the service's actions were not congruent with this construction, as sole responsibility was placed back on the individual, meaning that if psychological therapists were experiencing wellbeing difficulties at work, this must be their fault. This in turn means that employees become caught up in this incongruence, potentially impacting their wellbeing negatively.

Secondly, *wellbeing as self-actualisation* and *wellbeing as productivity* showed a constant duality between *good* and *bad employee/therapist*, articulated by the introduction of IAPT as a new sub-context. This duality alternated from who is 'good' or 'bad' depending on who was doing the talking; from the construction of *wellbeing as self-actualisation* the *ideal/good therapist* is someone who cares about clients, thinks and voices their opinions, and IAPT is seen as oppressing the *good therapist*. Instead, when IAPT is doing the talking, and *wellbeing as productivity* is mobilised, it is the *good therapist* who is a *bad employee* for not adapting to its environment (IAPT), through which voicing their views and thinking is constructed as a way of wasting time, and therefore being inefficient.

In terms of subjectivity, psychological therapists' wellbeing at work is related to the available subject positions. Accordingly, when *wellbeing as an individual responsibility* was deployed, psychological therapists were constructed as agents in charge of their own behaviours and states. This provided a motivational force to take care of oneself and practise self-awareness and self-examination, linked to the position of *responsible*. Yet if participants were to experience wellbeing difficulties, they were placed in a position of *irresponsible*, associated with feelings of guilt and shame. This made it difficult for psychological therapists to vocalise and therefore seek help, such that their wellbeing could deteriorate. Similarly, when *wellbeing as productivity* was deployed, participants were regarded as *good* or *bad employees* depending on their ability to comply with their work demands; thus, within the current pressurised NHS context (i.e. increasing demands with less resources) workers would be continually positioned as the *bad employee*. This links to Sen's wellbeing model of capabilities (1999) that places the focus not necessarily on an individual's abilities, but on their opportunities to practise them; thus, considering the current context, constructing *wellbeing as individual responsibility* and/or as

productivity seemed to constrict participants' possibilities to 'be' or 'do', especially in the face of difficulties, which could perpetuate a negative experience of wellbeing.

Conversely, when *wellbeing as a collective responsibility* was deployed, the positions of *responsible and irresponsible* were externalised and shared with the service (also including the individual). This in turn allowed participants to vocalise their difficulties, normalise their experiences and increase solidarity, improving their experiences of wellbeing at work. Similarly, the construction of *wellbeing as self-actualisation* emphasised growth, learning and authenticity, which seemed to motivate therapists to take the position of the *ideal/good therapist* as a professional who thinks, reflects and practices autonomously in the client's best interest, aiding with the profession's natural hazards. When this position was impeded, participants' talk showed frustration and a potential negative impact on their wellbeing at work. This appeared to be linked with their construction of IAPT which oppressed their opportunities to be *the ideal/good therapist* (further discussion will follow below).

4.2.3. What difference does the particular context of the NHS Trust make, if any, to the above?

The role of the NHS Trust context in therapists' constructions of wellbeing at work was insubstantial compared to the IAPT context. Beyond ELFT workers talking about a 'perfectionist system' and NELFT workers referring to constant changes in their services, participants' talk varied little in terms of Trust-related available discursive resources to construct wellbeing at work. Instead, it was the context of IAPT that seemed important. IAPT's characteristics provided particular material structures and discursive practices that created a consistent construction across Trusts. IAPT was constructed as an inflexible, target-driven system that seemed to resemble a 'pre-fabricated factory' unable to accommodate difference; following this, the 'pre-fabricated walls' could be seen as

being constructed by the particular protocols and ways of talking (discourses) that guide IAPT services, in an inflexible manner.

Accordingly, I argue that IAPT 'is changing' how people think about being a therapist and an employee in mental health services, as well as their wellbeing at work. Hence, *wellbeing as self-actualisation*, seemed to be formed in training institutions, maintained by professional bodies. Although IAPT offers inhouse training to PWP's and CBT Therapists, all but one of my participants had been trained elsewhere prior to working in IAPT. Thus, participants seemed to already have an identity as employees and therapists, mostly aligned with *wellbeing as self-actualisation*, which seemed to be placed at risk in the context of IAPT through the neoliberal economic business discourse, immediately placing the focus on accomplishments and measurements (*wellbeing as productivity*). This resonates with Clarke and Newman's (2012) critical analysis following the economic crisis, as they argued that the financial problem was transformed into a political issue, whereby the NHS was placed under scrutiny and high pressure to become 'efficient' as a way to 'solve' the problem, providing the financial discourse a way into the health system. Moreover, IAPT's purpose of improving economic productivity in the population (Department of Health, 2007), shows its engrained affinity to the market discourse.

Thus, in this context, I argue that psychological therapists found themselves in a position where if they wanted to remain in the system, they had to adapt to it. This was shown in participants' references to their experiences as a *constant fight* and/or *battle for survival* that required the alteration of the *ideal/good therapist* linked to *wellbeing as self-actualisation*. This means that to survive IAPT, psychological therapists have to adapt their construction of therapist and employee, prioritising meeting targets (*wellbeing as productivity*) and taking the new positions of the *good* and *bad employee*, according to their productivity at work. This movement towards efficiency in mental health services significantly resonates with Ritzer (1993)'s concept of 'McDonaldisation', as he warned

about the dangers of replacing thinking with targets, efficiency and social control, at the expense of the healing element of human relations.

The conflict shown here was based on the opposition of these two constructions: if participants adapted and prioritised targets (be *the good employee* within *wellbeing as productivity*), they would inevitably be unable to be congruent with their values of caring about clients above meeting targets (be the *ideal/good therapist* within *wellbeing as self-actualisation*). Thus, the current situation seems to point to a permanent conflict for IAPT psychological therapists, where it is impossible to be both a *good therapist* and *good employee*, based on their contradictory constructions. Following this, IAPT seems to be driven by a market discourse that poses the risk of eradicating the construction of the *good/ideal therapist*. This leaves a scenario where, on the one hand, those who adapt to IAPT have to abandon the *ideal/good therapist* position as a way of reducing the tension experienced at work, by accepting that by focusing on meeting targets, quality of care may be compromised. On the other hand, those who prevailed as *good therapists* reported feeling watched and singled out at work, which could influence their own wellbeing, talking about leaving the service as their only option.

4.3. Reflexivity

4.3.1. Epistemological Reflexivity

Transparently reflecting on my authorship in the construction of this research is a fundamental aspect of quality in qualitative research (Willig, 2013). Based on my interest in the topic and influenced by my CoP training, this thesis emerged from a critical perspective on the current status quo, which motivated my chosen epistemological position and methodological choices, including the post-structuralist method of analysis—FDA—that from a moderate social constructionist (Willig, 2012) critical-ideologist (Ponterotto, 2005) position could assist me to critically deconstruct how

psychological therapists construct their own wellbeing in IAPT-NHS services and their impact on subjectivity. Therefore, it is important to acknowledge that my position and methodological choices together with my previous experiences, values and personal beliefs have shaped this research process, which is in itself one of many possible discursive constructions, conducted in a particular time and context (Foucault, 1982). Consequently, I acknowledge that different researchers and/or methodological approaches would have offered alternative views on this matter; for instance, the data could be analysed using IPA to explore participants' lived experiences of wellbeing at work to provide further insight into this area.

4.3.2. Personal Reflexivity

Through the process of conducting this research I embarked on a journey where, as a novice researcher and trainee CoP, I was discovering both myself as a clinician and as a researcher using FDA. One significant point of personal reflexivity was regarding my critical position in relation to my research. As previously stated, my motivation to design and conduct this research emerged from my own personal experience struggling with my wellbeing working in IAPT, which later met with my evolving professional role as a researcher, through which I could approach this topic from a different position. This new position involved having the power to separate myself from the dynamics and then be able to observe, analyse and make recommendations from the researcher's position. Consequently, through the research process I paid special attention to my own position through constant reflection and discussion with peers. Hence, I was able to notice my fluctuation in this position; Harper (2003) talks about how when novice researchers conduct FDA, during the analysis, they necessarily 'divorce' and separate themselves from the participants for a while. It was during this time that I noticed that my critiques came easily and forcefully; as I felt distant from the 'social reality' (people), I was able

to identify a ‘shameful intention’⁵ to ‘oppress’ the current dominant discourses that I was interpreting as perpetuating the current situation, linked perhaps to my ‘new privileged position’ in relation to this research (Chizhik & Chizhik, 2002).

This shifted significantly, when writing up my analysis, perhaps motivated by being back in touch with the ‘social reality’ in which I live and work. I almost went to the opposite end of the spectrum, writing without confidence and in an apologetic way, typical of novice FDA researchers (Harper 2003; Harper et al., 2008; Morgan, 2010), yet perhaps also linked with the fear of being seen as a “troublemaker” (Palmer & Parish, 2008, p. 287) and being scrutinised (Ussher, 2000), typical in authors who challenge the establishment in the context of advocating for social justice issues. It was in discussion with my peers that I reconnected with my original purpose and CoP values; to facilitate a new conversation about wellbeing that could bring about change. Thus, the focus was replaced on how I could best reach my audience, including people in positions of authority, as to facilitate a new conversation, all parties would have to be involved without feeling undermined. Subsequently, I was able to take a balanced viewpoint, in which my privileged position as a researcher could enable me to facilitate the awareness of taken-for-granted knowledge that may be in use to construct the current notions of wellbeing at work that are impacting psychological therapists’ subjective experiences.

Moreover, as a non-English white woman, I am often positioned as an ‘outsider’ in relation to others in this country, which tends to allow me to ask more questions to unpack meaning in a natural way. Thus, through this research I could hold both an ‘insider/outsider’ position: being an ‘outsider’ in this country but an ‘insider’ in IAPT

⁵ I say ‘shameful’ to capture my initial feelings when I identified and reflected on my own oppressive intention. This was fundamental in understanding the power dynamics that can take place even when deeply committed to CoP values of balancing power and social justice. With this, I hope to normalise and encourage other novice researchers to share their experiences and learn from them as part of the research process.

services. Six of my participants worked in the same IAPT service as I did, thus I was holding a dual role as colleague/researcher, in which I was also immersed in the same culture as them, so I was familiar with their language and potential nuances that could help me both build rapport and generate useful conversation to address my research questions. Conversely, I also had to be extra careful in not assuming or leading based on my own experiences or views (Pillow, 2003). It was interesting that each of the other four participants who worked in other IAPT services asked me before or during the interview whether I had worked in IAPT, which in turn established my familiarity with the system and its culture. I was positively surprised throughout my interviews by my participants' level of disclosure; I believe this could be linked both with my 'insider/outsider position' providing me with an useful point of access (Berger, 2014; Finlay, 2000), and with the use of the visual task that facilitated conversation through the use of metaphors, images and stories.

4.3. Evaluation and critical review

This section will present a critical evaluation of the study, in the context of quality criteria recommended for qualitative research informed by Yardley (2008) and Willig (2013), attending to issues of coherence and transparency, sensitivity to context, rigour, reflexivity and usefulness of the findings.

4.3.1. Coherence and transparency

To ensure coherence and transparency, I have intended to present a congruent and consistent line of argument across all components of this research by constantly returning to my initial aims and research questions, in the context of a moderate social constructionist position. Furthermore, in my commitment to transparency I have explicitly described and reflected upon my rationale for each methodological choice that has defined this research, including the design, collection and analysis of data. I have

provided long extracts when possible and provided context to quotations presented to support the analysis and discussion and following Yardley's (2008) recommendation I have also kept a paper trail throughout the research process, (see appendices K, N, Q, R & S for examples).

4.3.2. Sensitivity to context

Sensitivity to context requires awareness of the multiple contexts involved in the research (Yardley, 2008) to ensure that the meaning generated is new and not pre-stipulated. To ensure this, chapter 1 demonstrates awareness of the literature and the social context (sections 1.2 & 1.6), whilst awareness of the research relationship, my own position and issues of power have been addressed throughout the thesis, particularly in the reflexivity sections (sections 1.4 & 4.3). Consequently, I aim to assure the reader that the findings presented have been constructed during the process of completing this thesis. I would say that my analysis started with the literature review, through which I became aware of a dominant discourse of *wellbeing as an individual responsibility*, as other critical authors have also pointed to this (Cabanas, 2016; Smith, 2019; White, 2018, 2017); thus, I had anticipated that I would probably find this in my participants' talk. What I had not anticipated was the counter-discourse of *wellbeing as a shared responsibility*, particularly as it also contained the individual as responsible. It was only through revisiting the data on numerous occasions that I was able to see this aspect of the discursive construction. Similarly, I was also struck by the contradiction between *good employee* and *good therapist*, especially when, through the analysis of their implications, I noted that those who took the *good employee* position seemed better able to adapt to the environment and experience less tension at work (though not without costs).

4.3.3. Rigour and commitment

Rigour and commitment starts with an appropriate consideration and engagement with the research, and Yardley (2008) states that this is shown through careful consideration of data and in-depth analysis. For this I considered a sample size of 10 participants across two different Trusts, to represent breadth in experience and service context within IAPT services. Aware of being a novice researcher and the implications for the development of my skills, I sought regular supervision, especially when conducting analysis, and made use of peers and articles about novice FDA researchers (e.g. Harper et al., 2008). To ensure in-depth engagement with the topic and analysis, I had discussions with experienced professionals familiar with Foucault's work and methodology, as well as with therapists working in the NHS. Evidence of my active engagement with analysis can be found in appendices Q, R & S, which illustrate different stages of my analysis before arriving at the final version here presented.

4.4.4. Limitations and recommendations for future research

This study had limitations based on the methodological choices made that, although informed by deliberate rationale, also precluded other aspects from consideration. For instance, FDA has its limitations in exploring participants' lived experiences and in tending to 'take the power away' from participants, as it is the researcher who interprets the data (Coyle, 2000; Georgacas & Avdi, 2012; Harper, 2003). Thus, using IPA could offer an interesting perspective on psychological therapists' lived experiences of wellbeing at work, representing their voices more (Larkin & Thompson, 2012). Moreover, although I believe that the use of visual methods within the one-to-one interview served its function well (further explained in sections 2.5.1-2.5.4), focus groups could have facilitated even more naturalistic conversations; having more participants in the room could have minimised the researcher's influence and allowed more nuances in

the interaction of discourses. Similarly, ethnography or video diaries could go one step further to capture the day-to-day realities that group or individual interviews may miss (Pini & Walkerdine, 2011).

Another limitation relates to the demographics of the sample. To obtain a wide range of accounts and ensure presence of dominant discourses, participants were recruited with a range of contextualising features such as gender, age, ethnicity, background experience and training; however, these features were not specifically considered during analysis. Instead the analysis was guided by my research questions that focused on constructions of wellbeing and the importance of context. Consequently, further research focusing on the role of any of these contextualising features in the constructions of wellbeing would be relevant, for example attending to the place of training (i.e. therapists trained in IAPT may deploy and take different subject positions, as *wellbeing as self-actualisation* may not have been dominant in their training). Similarly, another recommendation would be to investigate how those with authority in the Trust (managers, supervisors or commissioners) construct therapists' wellbeing, including responsibility.

Although I was aware that our professional training can also direct which discourse we may habitually draw upon, I decided to keep my inclusion criteria open, and none of my participants happened to be CoPs. This did not seem problematic, because my intention was not to investigate the specifics of professional training in relation to wellbeing, and I was interested in reaching a wider audience to open a new meaningful conversation about wellbeing. Nonetheless, a recommendation for future research could involve conducting a similar project with CoPs, in order to gain further insight into the particular discursive resources made available to the profession.

4.5. Implications and recommendations

There are three key areas of focus in terms of the practical implications of this research. Firstly, considering the current socio-political climate in the UK, with Brexit and the ongoing austerity measures and the privatisation movement shaping the NHS (e.g. CQC, 2015; NHS, 2014; Social Care Act, 2012), it is only to be expected that levels of uncertainty and anxiety would increase in the population, including mental health staff. Moreover, NHS services continue to undergo re-structuring, placing people's jobs at risk, and the business and economic discourses continue to permeate the service, signifying the McDonaldisation and marketisation of mental health services. Thus, it is crucial to become aware of how certain discourses place people in even more complicated positions, especially when experiencing wellbeing difficulties. In particular, when *wellbeing as an individual responsibility* and *wellbeing as productivity* are deployed, these place therapists in the *irresponsible* and *bad employee* position, making it even harder for them to address any wellbeing difficulties at work, eliciting feelings of failure, guilt and shame. As these were the dominant discourses, services may find that their psychological therapists struggle with their wellbeing silently, with the potential impact that this would have on clients and colleagues.

The shift towards the individual could be seen as a 'liberating process', where individual autonomy is promoted and valued, and even Foucault (2008) advocated 'ethics of the self' as the main way of resisting social control. Nevertheless, McNay (2009) warns that in modernity it is through our 'autonomy and individuality' that social control is perpetuated; as a complex paradox, it is within our individual freedom and autonomy—which encourages us to self-monitor and become 'entrepreneurs' of our lives—that we are controlled. Therefore, responses/solutions focused on the individual, although well intended, can only reinforce the current situation. Thus, to generate genuine social change, we have to prioritise responses that embrace 'solidarity'.

Accordingly, a first recommendation would involve the encouragement of the collective/shared discursive construction of wellbeing through verbal, written and social practices in IAPT services. *Wellbeing as a collective/shared responsibility* was seen to provide a normalising sense of permission to vocalise difficulties, seek and receive support that could overall improve wellbeing at work. Moreover, participants' talk showed a gap between the service's narratives and actions in relation to this discursive construction. Thus, to reduce this tension and improve wellbeing at work, increasing social practices and structures that could promote such congruence would be encouraged. A practical way of doing this could involve protecting practices and spaces that facilitate staff coming together, as well as thinking and reflection, growth and development, and mutual support. Some examples might include protected reflective practice meetings, protected time to prepare cases, debriefings, and social gatherings. These practices tend to involve tasks that are difficult to 'measure' and seem to have been the first spaces to disappear following IAPT's recent restructurings. Thus, I hope that this research can emphasise the value and importance of these spaces and practices to promote a collective/shared construction that involves both individuals and services sharing responsibility for wellbeing at work.

A second implication relates to the construction of IAPT as a target-driven, inflexible service unable to accommodate difference, in opposition to the *ideal/good therapist* who values authenticity and growth as fundamental components of wellbeing. This direct clash between business economic discourses (*IAPT-wellbeing as productivity*) and humanistic discourse (*wellbeing as self-actualisation*) creates a constant tension to the detriment of psychological therapists' wellbeing, which seems to only be solved by leaving or adapting to IAPT. Consequently, another recommendation would be to encourage flexibility in IAPT in order to adapt to the diversity of both staff and clients. I suggest that these could

be done at the level of policy, service guidelines and through local leadership, by prioritising formulation-led treatment over standardised protocols.

Thirdly, the creation of IAPT seems to signify a shift in mental health services toward business/economic discourses (e.g. cost-effective treatments, efficiency savings) and a positivist epistemology, where things must be measured and controlled to be valuable (e.g. RCTs to recommend ‘evidence-based’ treatments). Indeed, my findings show how this shift towards financial business discourses in mental health services can significantly impact psychological therapists and their idea and provision of therapy. This presents a concerning picture where a ‘mechanical’ approach towards therapy is promoted, potentially treating people as objects. This McDonaldisation and marketisation process in mental health clashes with the constructions of *wellbeing as self-actualisation and wellbeing as a shared responsibility*, whereby thinking, congruence, meaning and subjectivity are fundamental, implying a negative prospect for psychological therapists’ wellbeing at work.

Moreover, this neoliberal push could be seen as pervading not only mental health services, but also training institutions, where financial pressures are increasingly shaping the delivery of training (Cleary, 2018; Friedman, 2003; Lauder, 2006), signifying the expansion and dominance of the neoliberal discourse across institutions. This poses the question regarding the future of our profession if the neoliberal market discourse continues to impregnate our training and work institutions. In response to this, I can only warn against the continued expansion of such discourse into psychotherapy/psychological services, which comes through material realities such as budget cuts, austerity measures and continued pressures to meet increasing targets with fewer resources. Hence, these research findings can add strength to a wider message supporting that the protection of the welfare state and the NHS as a public service is worthwhile, not only because when we look at other countries where health services are mostly private, such as the USA,

economic spending is doubled whilst the care provision is worse than in the UK (The Commonwealth Fund, 2014), but also because we are seeing how this negatively impacts the wellbeing of the professionals in charge of caring for those in need in our society.

Thus, a final recommendation would involve the protection of the therapeutic purpose of psychological/psychotherapy professions above financial agendas in the NHS. This could entail (1) reducing bureaucratic procedures, and (2) claiming more funding for mental health services, to allow public services to reorganise their priorities and construct working spaces where professionals can focus on providing quality of care instead of fulfilling statistical market expectations.

4.6. Relevance to Counselling Psychology

The findings and conclusions of this research may be relevant to all psychological therapists working in IAPT-NHS services, including CoPs. Moreover, based on CoP's strong humanistic value base, its commitment to social justice and its focus on the therapeutic relation (Bradley et al., 2012; Cooper, 2009; Donati, 2016; Orlans & Van Scoyoc, 2009;), I argue that our profession could potentially be one of the most affected by the neoliberal shift in the NHS, as it may oppress our values and flexible/tailored way of working. Nonetheless, I also believe that CoP may be in a unique position to use our voice and expertise to bring about change, without oppressing any involved part.

4.7. Conclusions

This research project was motivated by the recent reports of increasing levels of distress in NHS mental health professionals (NHS, 2015, 2016, 2017; Rao et al., 2016, 2018). Thus, despite the large volume of existing research on wellbeing, this study has aimed to approach this topic from a different perspective, turning the attention to the constructive function of language. Through the critical lens of FDA from a moderate social constructionist position, this study has investigated how psychological therapists working

in IAPT-NHS construct their wellbeing at work, together with their implications for subjectivity and the role of context.

My findings suggest that the view of approaching psychological therapists' wellbeing from a marketised, individual perspective is not only ineffective, but also likely to be part of the problem. They find support in the published research that critiques the neoliberal discourse applied to wellbeing (Ahmed, 2010; Cabanas, 2016; Cromby, 2011; Davies, 2015; Dooris et al., 2018; Ehrenreich, 2009; Held, 2002; Smith, 2019; Sointu, 2005; White, 2018, 2017) and to mental health services (McCann, Granter, Hassard & Hyde 2015; Rao et al., 2016; Rizq, 2011, 2012; Scott, 2018a, 2018b; Shorrock, 2011; We need to talk coalition, 2013; Woolfe et al., 2010), as well as in numerous groups and initiatives such as 'Keep our NHS Public', 'Public services for People not Profit' and 'Psychologists Against Austerity', amongst others.

Consequently, a wider perspective on this matter is encouraged, understanding the impact of context and language to action alternative 'solutions' for psychological therapists' wellbeing in IAPT-NHS services. This would involve: (1) directing more funding to NHS services and reducing beurocratic procedures to protect the NHS therapeutic function, preventing the expansion of the neoliberal market discourse into mental health services; (2) promoting congruence between policies, leadership and practices at work, aligned with a collectivist perspective of wellbeing, where both the individual and the system/team share responsibility and support; and (3) increasing IAPT's flexibility to appropriately adapt to employees' and service users' diversity.

From the researcher's 'privileged position', it has been my intention to bring awareness and invite others to consider the power of these taken-for-granted constructions of wellbeing. It is hoped that, through sharing these findings with IAPT services, training institutions, professional bodies, and psychological therapists, a different conversation

about wellbeing may be facilitated, creating spaces for us to come together and promote solidarity.

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Appendix A: Notice of Ethics Review Decision (UEL)

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: David Harper

SUPERVISOR: Martin Willis

COURSE: Professional Doctorate in Counselling Psychology.

STUDENT: Paula Bermudez Otero

TITLE OF PROPOSED STUDY: "What's happening with Psychological Therapists' wellbeing working in the NHS?" A Foucauldian Discourse Analysis of Psychological Therapists' construction of their own wellbeing working in the public sector (NHS).

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 WITH MINOR AMENDMENTS

Minor amendments required (*for reviewer*):

1. In the information letter there is a reference to the need to exclude people who cannot give informed consent or who need an interpreter. Since presumably the letter will only be sent to therapists all of whom meet these criteria I think it is probably unnecessary and could be deleted to avoid confusing potential participants.
2. In the information letter (second page, first para) there is reference to you contacting support contacts or personal therapists. Again, given the population I think it is unnecessary to suggest contacting them directly and might also concern potential participants (who might worry you will contact them without their consent).
3. In the information letter (second page, para 5) the sentence explaining that you retain the right to use anonymised data is not as well phrased as it is in the ethics application and consent form. Please rephrase so the meaning is clearer.

Not a requirement but you may wish to correct the typo in the titles of the posters – it should read 'wellbeing in the NHS' not 'at the NHS'

Major amendments required (for reviewer):

N/A

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

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

MEDIUM

LOW

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

N/A

Reviewer (Typed name to act as signature): David Harper

Date: 16 Feb 2017

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

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

Student's name (*Typed name to act as signature*): Paula Bermudez Otero
Student number: u1527420

Date: 20/02/2017

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

PLEASE NOTE:

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

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>

Appendix B: Confirmation of UEL Sponsorship



25th April 2017

Dear Paula,

Project Title:	"What's happening with Psychological Therapists' wellbeing working the in the NHS?" A Foucauldian Discourse Analysis of Psychological Therapists' construction of their own wellbeing working the in the public sector (NHS)
Researcher(s):	Paula Bermudez Otero
Principal Investigator:	Paula Bermudez Otero

I am writing to confirm that the application for the aforementioned NHS research study reference **223451** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **25th April 2021**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

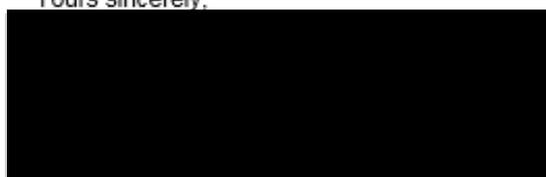
Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,



Research Integrity and Ethics Manager
For and on behalf of
Dr Lisa Mooney
University Research Ethics Committee (UREC)
Research Ethics
Email: researchethics@uel.ac.uk

Appendix C: HRA Letter of Approval



Health Research Authority

Miss Paula Bermudez Otero



Email: hra.approval@nhs.net

19 April 2017

Dear Miss Otero

Letter of HRA Approval

Study title: "What's happening with Psychological Therapists' wellbeing working in the NHS?" A Foucauldian Discourse Analysis of Psychological Therapists' construction of their own wellbeing working in the public sector (NHS).

IRAS project ID: 223451

Protocol number: 1527420

Sponsor: University of East London

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *“After HRA Approval – guidance for sponsors and investigators”* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is 223451. Please quote this on all correspondence.

IRAS project ID	223451
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Yours sincerely

Kevin Ahmed
Assessor

Telephone: [0207 104 8171](tel:02071048171)

Email: hra.approval@nhs.net

Copy to: *Ms Catherine Fieulleateau, Sponsor Contact, University of East London*
Ms Mabel Sali, R&D Contact, Noclor Research Support
Dr Martin Willis, Academic Supervisor, University of East London

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Advertising material 2 docs]	1	20 March 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance 1]	1	14 February 2017
Interview schedules or topic guides for participants [Interview schedule & visual material]	1	20 March 2017
IRAS Application Form [IRAS_Form_28032017]		28 March 2017
IRAS Application Form XML file [IRAS_Form_28032017]		28 March 2017
IRAS Checklist XML [Checklist_28032017]		28 March 2017
Other [Statement of Activities]	1	18 April 2017
Other [Schedule of Events]	1	18 April 2017
Participant consent form [Consent Form]	2	13 April 2017
Participant information sheet (PIS) [Invitation Letter]	2	13 April 2017
Referee's report or other scientific critique report [Scientific report]	1	20 March 2017
Research protocol or project proposal [Research protocol/Project proposal]	1	20 March 2017
Summary CV for Chief Investigator (CI) [CV for Chief Investigator]	1	20 March 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.*

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Ms Catherine Fieulleateau
 Tel: 0208 223 6683
 Email: researchethics@uel.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	A71-1 states that this is a single site study, where it is in fact multi-site. A76-3 states that the University insurance will cover conduct of the study. As this study involved NHS staff, NHS indemnity will also cover conduct.
2.1	Participant information/consent documents and consent process	Yes	The sponsor amended the PIS and Consent form to align with HRA Approval standards.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites. The sponsor is not requesting, and

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			does not require any additional contracts with study sites.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. No study funding will be provided to sites, as detailed at Schedule 1 of the Statement of Activities.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

<i>This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.</i>
<p>All participating NHS organisations will undertake the same study activities. There is therefore only one study site 'type' involved in the research.</p> <p>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.</p> <p>If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.</p>

Confirmation of Capacity and Capability

<i>This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.</i>
<p>NHS organisations in England that are participating in the study will be expected to formally confirm their capacity and capability to host this research.</p> <ul style="list-style-type: none"> • Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) section of this appendix. • The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

<i>This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).</i>
<p>The sponsor has assessed that the Chief Investigator will be responsible for all study activities at study sites.</p> <p>GCP training is <u>not</u> a generic training expectation, in line with the HRA statement on training expectations.</p>

HR Good Practice Resource Pack Expectations

IRAS project ID	223451
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This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Where arrangements are not already in place, network staff (or similar) undertaking any of the research activities listed in A18 or A19 of the IRAS form (except for administration of questionnaires or surveys), would be expected to obtain an honorary research contract from one NHS organisation (if university employed), followed by Letters of Access for subsequent organisations. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm enhanced DBS checks, including appropriate barred list checks, and occupational health clearance. For research team members only administering questionnaires or surveys, a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix D: Research and Development Approval- ELFT

IRAS 223451 Confirmation of Capacity and Capability at East London NHS Foundation Trust

HUSAIN, Faisal (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) <faisal.husain1@nhs.net>

Fri 19/05/2017 15:45

Inbox

To: NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) <contactnoclor@nhs.net>; Paula BERMUDEZ OTERO <ul527420@uel.ac.uk>; Research Ethics <researchethics@uel.ac.uk>; Aneta Tunariu <a.tunariu@uel.ac.uk>;

Cc: ROLLINGS-KAMARA, Emmanuel (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) <emmanuel.rollings-kamara@nhs.net>; JARRETT, Sacha (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) <sacha.jarrett@nhs.net>;

2 attachments (639 KB)

223451_SL45_Letter_of_HRA_Approval_20170419.pdf; FINAL 223451 Statement of activities v1 18042017.pdf;

Dear Catherine,

RE: IRAS 223451. Confirmation of Capacity and Capability at East London NHS Foundation Trust.

Full Study Title: Psychological Therapists' construction of their own wellbeing at work.

Latest HRA Approval Date: 19/04/2017

Site PI/LC: Paula Bermudez Otero

This email confirms that East London NHS Foundation Trust has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

East London NHS Foundation Trust agrees to start this study on a date to be agreed when you as sponsor give the green light to begin. Please ensure the R&D office and local CRN contacts are provided with this date.

If you wish to discuss further, please do not hesitate to contact us.

As specified in the HRA Approval, Letters of Access for the research team are required and should be arranged prior to the relevant team members conducting any study interventions.

Please note, in line with national HRA approvals process, you will no longer receive an NHS R&D Approval/Permission letter.

Kind regards

Faisal Husain
On behalf of East London NHS Foundation Trust

Faisal Husain
Costing and Contract Assistant

Tel
Email Faisal.Husain1@nhs.net
Website <http://www.noclor.nhs.uk>
Twitter [@NoclorResearch](https://twitter.com/NoclorResearch)

Noclor Research Support
1st Floor, Bloomsbury Building, St Pancras Hospital,
4 St Pancras Way, London NW1 0PE

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RESEARCH SUPPORT

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1/2

Appendix E: Research and Development Approval- NELFT



Research and Development Office
North East London NHS Foundation Trust,
1st Floor Maggie Lilley Suite,
Goodmayes Hospital,
Barley Lane,
Goodmayes,
Essex, IG3 8XJ

19/06/2017

Dear Paula Bermudez Otero,

Letter of access for research

As an existing NHS honorary contract you do not require an additional honorary research contract with the North East London NHS Foundation Trust. We are satisfied that such checks as are necessary have been carried out by your employer. This letter confirms your right of access to conduct research through the North East London NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 19/06/2017 and ends on 31/08/2017 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct activities associated with such projects as you have received authorisation confirmed in writing from the Research and Development Director of the North East London NHS Foundation Trust. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to the North East London NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this Trust, in particular that of an employee.

While undertaking research through the North East London NHS Foundation Trust, you will remain accountable to your employer East London NHS Foundation Trust but you are required to follow the reasonable instructions of your nominated manager Dr Elisa Aguirre in this Trust or those given on her behalf in relation to the terms of this right of access.

You must act in accordance with the North East London NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer East London NHS Foundation Trust is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

You are required to co-operate with the North East London NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other

health and safety legislation and to take reasonable care for the health and safety of yourself and others while on North East London NHS Foundation Trust premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998.

Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

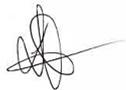
The North East London NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by the North East London NHS Foundation Trust in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

Please also ensure that while on the premises you wear your NHS ID badge at all times, or are able to prove your identity if challenged. Please note that this Trust accepts no responsibility for damage to or loss of personal property.

If your circumstances change in relation to your health, criminal record, professional registration or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform your employer through its normal procedures. You must also inform the Research and Development Department and your nominated manager in North East London NHS Foundation Trust.

Yours sincerely



Sandeep Toot

Research and Development Deputy Director,
North East London NHS Foundation Trust

Appendix F: Participant Invitation Letter

IRAS Project ID: 223451
Version 2: 13/04/2017



PARTICIPANT INVITATION LETTER

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)

Paula Bermúdez Otero (u1527420@uel.ac.uk). Dr Martin Willis (M.Willis@uel.ac.uk)

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology course at the University of East London.

Project Title

“What’s happening with Psychological Therapists’ wellbeing working in the NHS?”
A Foucauldian Discourse Analysis of Psychological Therapists’ construction of their own wellbeing working in the public sector (NHS).

Project Description

The aim of this research project is to explore how psychological therapists working in the NHS construct the concept of their own wellbeing at work with the hope to inform further changes in the system and for the results to be published.

The interview will consist of two stages; it will start with a task where I will ask you to use some visual cards (the OH-Cards) to construct a story that could represent your own wellbeing at work. We will then have some time to discuss this together to then move into some questions to explore your views on the topic.

In order to participate, you need to be a qualified psychological therapist employed full-time or part-time by the NHS, working face to face with clients and have a minimum of one year of experience working in the NHS.

There are no specific risks linked with participating in this study, nevertheless, we are aware that the research could evoke emotional responses. At the end of the interview you will be given a debrief form that contains further information about the study and a list of organizations that could offer support and guidance. Similarly, in the event that during the interview I became worried about risk to yourself or others, I will need to stop the interview and address ways to keep you or others safe, following the BPS code of ethics and conduct (2009).

Interviews will last approximately 60 minutes and will take place at your workplace or another alternative confidential location, whichever you prefer. The researcher will ensure that any alternative location will allow for privacy and safety. Interviews will be audio recorded and transcribed, and pictures will be taken of the arrangement of the OH-Cards during the visual task for posterior analysis.

Confidentiality of the Data

To protect anonymity and ensure confidentiality, participants will be referred to by pseudonym in the transcript. The transcripts will be stored in a locked cupboard and the audio recordings will be stored in password protected documents on a laptop and kept within the researcher's home. Audio recordings and transcripts will be read by myself and my supervisor.

Data arising from this interview will be used anonymously, and selective quotes will be anonymised to support the analysis. You have the right to withdraw from the study at any time without disadvantage to yourself and without being obligated to give any reason within the first 3 weeks following the interview. If you chose to withdraw following the 3 week-period, the researcher reserves the right to use your data anonymously in the write-up of the study and in any further analysis that may be conducted.

Once the study is completed, audio recordings will be destroyed and the anonymised transcripts will be kept securely for a maximum of 5 years after the interview takes place, in accordance with the Data Protection Act (1998), allowing for its potential use for future publications arising from this research.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. Following the interview, you have the right to withdraw at any time within three weeks by emailing the researcher, without disadvantage to you and without being obliged to give any reason. Withdrawing from the project will mean that all your data will be electronically and physically destroyed by the researcher, and none of the information provided will be used. After the three-week period, the interview will be analysed as an anonymous part of the collective body of data.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Prior to the interview, I will arrange an initial phone call or email communication in which we will discuss whether this study is suitable for you and to make interview arrangements.

Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor: Dr. Martin Willis, School of Psychology, University of East London, Water Lane, London E15 4LZ., 0208 223 2946, M.Willis@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,
Paula Bermudez Otero
23rd February 2017

Appendix G: Consent form

IRAS Project ID: 223451
Version 2: 13/04/2017
CONSENT FORM



UNIVERSITY OF EAST LONDON

Consent to participate in a research study

“What’s happening with Psychological Therapists’ wellbeing working in the NHS?”
A Foucauldian Discourse Analysis of Psychological Therapists’ construction of their own wellbeing working in the public sector (NHS).

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

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

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason within the first 3 weeks following the interview. I also understand that should I withdraw following the 3 week-period, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant’s Name (BLOCK CAPITALS)

.....

Participant’s Signature

.....

Researcher’s Name (BLOCK CAPITALS)

.....

Researcher’s Signature

.....

Date:

Appendix H: Debrief form

Version 1: 20/03/2017



UNIVERSITY OF EAST LONDON

Debrief information

“What’s happening with Psychological Therapists’ wellbeing working in the NHS?”
A Foucauldian Discourse Analysis of Psychological Therapists’ construction of their own wellbeing working in the public sector (NHS).

Many thanks for taking the time to take part in this study.

The aim of the research study was to gain deeper understanding on the process of how Psychological Therapists are constructing their own wellbeing in the context of their workplace (NHS) using Foucauldian Discourse Analysis. This means that I will pay special attention to the use of language and positioning within the different discourses available and its relation to the workplace context.

Wellbeing is a concept that has been increasingly researched and recognized within our society. Nevertheless, and despite the research to date regarding wellbeing, recent reports inform of decreasing levels of mental wellbeing in the general population (ONS, 2016) and increasing levels of stress, burnout and depression in mental health professionals (The Wellbeing Project Working Group Joint Initiative between the British Psychological Society (BPS) and New Savoy Conference (NSC), 2016). This sets a scene where the professionals who are responsible for supporting people who are experiencing mental health difficulties are, themselves, reporting similar issues in their workplace (mental health services). Consequently, a gap has been identified between the theory and practice, in terms of the promotion of wellbeing on the one hand and the experiences of the population and mental health professionals on the other. I therefore intend to research this issue in depth, with the aim of better understanding the disconnection between theory and practice, by shedding light on the importance of wellbeing and facilitating collaborative understanding of how mental health professionals are experiencing and managing their own wellbeing within their work context.

The use of visual methods and a semi-structured interview was selected as a way of eliciting information from participants, and whilst I had some prompt questions I wanted to ask, I also wanted to allow for the interview to adapt to your own experience.

Following the interview, the data gathered will be only handled and analyzed by me the researcher. Please note that if you wish to withdraw from this study you may do so until data analysis starts, 3 weeks after your interview. Please be assured that your personal details will be made anonymous in the final version of the study.

The objectives of analyzing discourses on notions of wellbeing at work would be to critically examine the presenting discourses and how language conveys them whilst looking at the impact, if any, that the workplace context creates. This could potentially enhance understanding of this matter, prompting further discussions and research in the field. I hope that the critical approach to this matter could help to inform policy and facilitate further changes from a different perspective, in which I aim to balance power imbalances by paying attention at the specific context and structures.

If you feel you have further concerns or if you experience any emotional distress, now or in the future please remember to refer to your usual sources of help and support such as your supervisor or personal therapist.

Please refer to the contact information below for further support:

- BPS Directory of Chartered Psychologists:

An online source of professional psychologists. www.bps.org.uk/e-services/find-a-psychologist/directory.cfm

- BACP (British Association for Counselling and Psychotherapy)

BACP is a membership organization that sets standards for therapeutic practice. Their online directory can be used to locate a professional counsellor, who will usually charge for their services. Tel: 01455 883300 (to locate a professional counsellor)

- Samaritans

Samaritans provide emotional support 24 hours a day, 265 days a year. Website: www.samaritans.org. Phone: 116 123 (UK)

- Mind (National)

Promotes the views and needs of people with mental health problems. Phone: 0300 123 3393 (Mon-Fri, 9am-6pm) Website: www.mind.org.uk

Additionally, I would like to provide the following resources for **further support and guidance regarding issues at work:**

- NHS Employers:

If you are concerned about something you are experiencing or seeing at work, please find clear and useful information about how to raise a concern in the following link: <http://www.nhsemployers.org/your-workforce/retain-and-improve/raising-concerns-at-work-and-whistleblowing/information-for-nhs-staff>

- Whistleblowing Helpline:

The national Whistleblowing Helpline provides free, independent and confidential advice to all staff and contracted workers within health and social care. While the helpline cannot investigate concerns on behalf of individuals, it can provide invaluable advice on whether your concern is indeed whistleblowing and to talk you through the process to ensure it is followed correctly. They are also able to advise on how you can escalate the concern with a relevant prescribed body if needed.

To speak to a helpline advisor, **call 08000 724 725 between 8am and 6pm Monday to Friday**. An answer machine and ring-back service is available for calls outside of these times. Alternatively, you can email enquiries@wbhelpline.org.uk.

○ Public Concern at Work:

Public Concern at Work, is a whistleblowing charity, which is the leading authority in the field. They provide confidential advice to individuals with whistleblowing dilemmas at work.

Website: <http://www.pcaw.org.uk/individual-advice>

Phone: 020 7404 6609

○ Health and Care Professional Council (HCPC):

HCPC is the regulatory body for health care professions. Here you can find more guidance and information. <http://www.hcpc-uk.org/complaints/>

We hope you found the study interesting and we thank you again for taking part and contributing to research in the area.

If you have any other questions, please do not hesitate to contact us at the following:

To contact me, the researcher:

Paula Bermudez Otero
University of East London
Email: u1527420@uel.ac.uk

To contact the supervisor of this study:

Dr Martin Willis
University of East London
Email: M.Willis@uel.ac.uk

Appendix I: Field Work Risk Assessment

Humanities and Social Sciences: Field Work Risk Assessment

Name: Paula Bermudez	School: Psychology
Student number: u1527420	Director of Studies: Dr Martin Willis
Thesis Title: <i>'What's happening with mental health professionals' wellbeing working in the NHS?'</i> A Foucauldian Discourse Analysis of Psychological Therapists' construction of their own wellbeing working in the public sector (NHS).	
Fieldwork location: Interviews will ideally take place at participants' workplace (NHS Trust). Alternative location would be offered if they prefer it, in which case UEL Stratford Campus would be offered.	Type of Fieldwork: Interviews
Proposed dates or periods of Fieldwork: January 2017 – August 2018	
Potential hazards or risks:	<i>(rate high medium or low)</i>
1. Risk of emotional distress	low risk
2. Physical harm to researcher	low risk
3. Disclosure to researcher	low risk
4. Risk of fire or other hazards	low risk
Potential Consequences for each hazard: <i>(please continue on a separate sheet if necessary)</i> 1) Emotional distress to the participant or interviewer Participant may become distressed due to the conversations asked by the interviewer. This may cause short-term emotional upset. Interviewer may become distressed as a result of the content of participants' responses. This may also have a short-term impact on the interviewer.	
2) Physical harm to researcher The study does not involve physical components. To ensure my safety during the interviews, I will ensure that I organise a system with my supervisor and other available people (i.e. other colleagues) where I will inform them of where I will be conducting the interviews and will communicate when I start and when I finish them and I have safely left the building.	
3) Disclosure If there is the case that the participant discloses unethical behaviours that places others at risk. I will need to raise a concern and contact their supervisor, as following our code of ethics and conduct (BPS, 2009). This information is included in the participants' invitation letter.	

4) Risk of fire or other hazards

In the case of a fire, evacuation procedures for the site will be adhered to. These procedures will be discussed briefly with participant when interviews commence.

Controls in place for each hazard in order of likely risk: *(please continue on a separate sheet if necessary)*

1. Emotional distress

- Participant will be informed of their right to take a break or withdraw
- Researcher will consult supervisor for any issues that involve disclosure or distress for the participant and personal therapist to discuss any more personal impact, as well as keep a reflective journal.

2. Physical harm to researcher

- Supervisor and colleague would be informed of my interview schedules and location and I will notify them at the start and end of each interview.
- Researcher will raise alarm and contact nearest staff member

3. Disclosure

- Participants will be allowed to withdraw data
- They would be provided with a debrief form with further support services which they can access

4. Risk of fire or other hazards

- Researcher will immediately terminate the interview.
- Fire protocol for each NHS Trust or UEL will be followed. Moreover, the researcher will ensure to be informed in advance of the health and safety rules (i.e. fire drills, exits etc.) and will inform the participants in advance of the interview of any planned events.

By signing this document, you are indicating that you have consulted the policy and have fully considered the risks.

Signature of Student:

Paula Bermudez Otero

Date: 30/1/2017

I agree to the assessment of risk in relation to this project.

Signature of Director of Studies:

Martin Willis

Date: 31/01/17

Appendix J: Advertising material



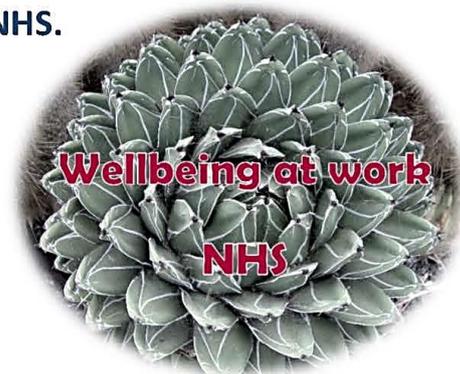
Version 1: 20/03/2017

PARTICIPANTS NEEDED FOR RESEARCH ON

Psychological Therapists' construction of their own wellbeing in the NHS.

Have you been working in the NHS for at least one year?

Do you have face to face contact with clients?



Would you like the opportunity to talk about your experience of your wellbeing at work with an independent researcher?

In order to participate, you will need to attend 1 interview where we will talk and do some visual tasks regarding your own wellbeing at work. All interviews are confidential and your participation will be anonymous. Your participation would involve only 1 session of approximately 60 minutes.

For more information about this study, or to take part, please contact Paula Bermudez at: U1527420@uel.ac.uk

Supervisor Dr. Martin Willis, School of Psychology.

Email: M.Willis@uel.ac.uk

This study has been reviewed by, and received ethics clearance through the Research Ethics Committee, University of East London. If you would like to complain about any aspect of the study, please contact the Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk.



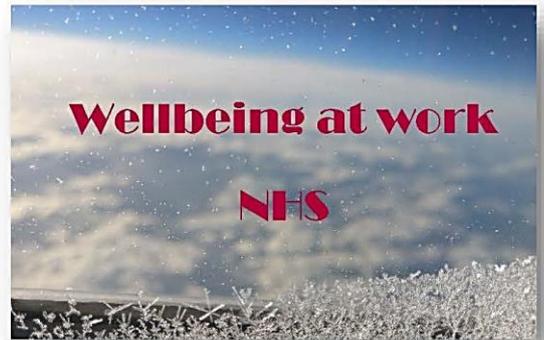
Version 1: 20/03/2017

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Have you been working in the NHS for at least one year?

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In order to participate, you will need to attend 1 interview where we will talk and do some visual tasks regarding your own wellbeing at work. All interviews are confidential and your participation will be anonymous. Your participation would involve only 1 session of approximately 60 minutes.

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Appendix K: Reflective notes on visual methods strategy

Research Diary:

Entry 09: Considerations to decide visual methods strategy.

Asking participants to bring material (objects/photo/other) to the interview:

PROS ✓	CONS ✗	CONSIDERATIONS/Questions
<p>- Allows participants to take an active position in research (they can think carefully about what they wish to photograph and why, which can be empowering for participants. (Del Busso, 2011).</p>	<p>- May seem complicated or another task that they do not have time to do (busy participants), may affect recruitment.</p>	<p>- Could I make this optional? And if people do not want to do it, or feel that they do not have the time, allow them to still participate and maybe discuss what got in the way of doing it?</p> <p>- Practical problem: Try to facilitate the process: a. Throwaway camera b. Can use any electronic device and we will transfer them to a tablet, where we could both see them. (Easiest?)</p>
<p>It may help to prompt thoughts regarding the context/environment. Can create a link between the world of the participant and the researcher as they can allow the researcher to see glimpses of the participant's world (Willig, 2013).</p>	<p>Prosser and Loxley (2008), claim that there is a danger that using photos in interviews would encourage participants to talk about what they believe to be the researcher's chosen meaning, instead of the participants chosen meaning.</p>	<p>☞ One of the aims of my study is try to balance power imbalance and being able to look at the context in the area of wellbeing- sharing responsibility- looking at it as a system.</p> <p>☞ What are the implications of this intention? Should I make this explicit on my information sheet?</p>
<p>It could help elicit further discussion and provide richer data.</p>	<p>Could this also bring difficulties to get NHS approval for the research? ☞ Make them feel more exposed? Would it be implications regarding photographing the workplace. What if they want to photograph a colleague, or a boss?</p>	<p>Ethical considerations. ☞ Informed consent. ☞ If other people in the pictures I will not publish or use them for dissemination.</p>
<p>Potentially allow for higher engagement and active position on participants. Elicit further information.</p>	<p>Practical difficulties, ethical implications: ☞ NHS ☞ Confidentiality ☞ Camera, pictures, device ☞ recruitment</p>	<p>How to get around the obstacles and what to ask: ☞ make it optional? ☞ Facilitate the process ☞ Take pictures or bring objects that could capture your <i>experience of wellbeing at your workplace</i>.</p>

Me providing the (objects/photo/other) to the interview:

PROS ✓	CONS ✖	CONSIDERATIONS/Questions
<ul style="list-style-type: none"> - Less difficulties for participants. - It will potentially not interfere with the recruitment. 	<ul style="list-style-type: none"> - Reduces the possibility of their active position in research. 	
<ul style="list-style-type: none"> - It could help to elicit further discussion and provide richer data. 	<ul style="list-style-type: none"> - I would need to select the materials. <p>With the practical implications of what to present, rationale behind each picture or form of visual presentation.</p> <p>Are there any assumptions on what I would choose to present?</p>	<ul style="list-style-type: none"> ☞ Potentially choosing a picture will bring the same challenge as presenting a research question. ☞ I could use cards that are used in therapy (OH-cards), abstract, and from there have a conversation. <ul style="list-style-type: none"> ☞ About OH-cards: research papers on the benefits of using them in therapy. Nothing found on research context yet. ☞ France and Lawrence (1993) talk about how they can facilitate interpersonal exploration in the context of therapy. ☞ What exactly am I going to ask? <p>Chose pictures or objects that could represent/capture your <i>experience of wellbeing at your workplace.</i></p>
<p>Less ethical and practical implications:</p> <ul style="list-style-type: none"> ☞ NHS ☞ Confidentiality ☞ Camera, pictures. ☞ Recruitment <p>Elicit further conversation and information.</p>	<p>Potentially less active engagement, may move them away from context.</p>	<p>Question of which materials to use and question to ask.</p> <ul style="list-style-type: none"> ☞ OH-cards? ☞ Chose pictures or objects that could capture your <i>experience of wellbeing at your workplace.</i> ☞ HOW Many?

☞ **Decision:**

At this stage it seems to me that using OH-cards could be a great option, as it reduces potential practical and ethical problems, whilst it still allows to elicit information in a creative way where to address the research question.

This task of the interview would be mainly focused on understanding how participants construct their own wellbeing at their workplace.

However, it may also touch and relate to the rest of the questions, as how they position themselves in relation to the available discourses and touch on specifics of their particular trust.

☞ ***How these decisions relate to my epistemological position and method of analysis?*** *Moderate Social constructionist using FDA.*

I believe that using visual methods is compatible with my current epist. position and method of analysis, as discourse is not understood as mere text, but everything that can have

meaning, therefore images are also included. However, it is not the purpose of this task to analyse the specific images but use them as a resource to facilitate further exploration of how they construct and understand the concept of wellbeing at work.

As I understand that the process of meaning making is a social construction, I believe that through using these materials participants would be talking about their interaction and positioning within their particular context. And therefore, the analysis of our further exploration of the chosen images can be done in the same way as following an open question.

☞ *Next step:* to research about the OH-Cards and design the visual task.

Appendix L: Sample of Resilio OH-Cards used



Appendix M: Interview Schedule

Interview Schedule

Start **introducing the interview**, frame, confidentiality, recording, right to withdraw and explain the structure of the interview.

- ✓ Questions & sign consent form

Move to some **warming questions to build rapport**:

- Demographics: Age, gender, ethnicity
- What is your role? Band?
- How long have you been working in this Trust? And as a psychological therapist?
- Prompt: Have you worked in others Trusts before?
- How do you find working here?

Introduce the **visual task**:

- We have some cards here, I would like to ask you to have a look at them and construct a story that could represent your wellbeing at work. You can use as many cards as you want. After a few minutes I would like you to share your story with me and I may ask you a few questions to make sure I understood it well. Is that alright?
 - If they ask about further details- leave it open and general. I will not provide examples.
 - During the visual task, try to explore and use prompts following the participants' comments.

If the participant does not mention specific areas, I would use the following questions and the same prompts as if it comes up naturally.

- **Questions:**
 1. What does wellbeing at work mean to you?
 2. From your own perspective, would you say that there is anything especially characteristic of this working environment?
 - a. Prompt: How do you feel about it?
 - b. Prompt: What do you think that is the impact, if any, of this on you?
 3. From your experience, what do you think is the impact that the workplace has on your own wellbeing, this could be positive or negative impact?
 4. What difficulties, if any, do you encounter at your workplace that you feel impact your wellbeing?

- a. Prompt: how do you see this as a difficulty for you?
 - b. Prompt: How is that for you?
 - c. Prompt: How do you deal with them?
 - d. Prompt: From your own experience, what is the impact, if any, of these (tension/difficulties) on your own wellbeing?
5. What support, if any, do you encounter at your workplace that you feel impact your wellbeing?
- a. Prompt: How do you see this as a support for you?
 - b. Prompt: How is that for you? / How do you experience them?
 - c. Prompt: From your own experience, what is the impact, if any, of these enablers on your own wellbeing?

-
6. A recent **survey from the NHS** reported increasing levels of distress in mental health professionals. What are your thoughts about this?

-
- **If it was up to you, what and how would you change to improve wellbeing at work?**
 - **What would you advise to people who are designing and thinking about measures to improve wellbeing at work?**
 - **What would you advise to others that are struggling in this situation?**
 - Is there **anything else that you think that is important** for me to know that we covered today?

-
- ✓ Many thanks for your time
 - ✓ Give debrief form

-
- Prompts throughout the interview:
 - Ask for **examples** - Could you give me an example?
 - Ask for **more information**- Could you tell me a bit more about that?
 - Ask **about idiosyncratic meaning**- What does _____ mean to you?

Appendix N: Reflective notes about interview questions

Research Diary:

Entry 11: Reflection on introducing the NHS staff survey on the interview.

☞ Why do I want to introduce this task?

I thought about this because I believe that presenting this survey could offer a chance to deepen into the topic and/or normalize difficulties or struggles in potential participants and facilitate thoughts on the topic of study.

I believe that mentioning the results, could invite participants to talk in general, as they can refer to the experience in that way, rather than at an individual level. I think that this could be helpful, specially based on the reports of the ‘bullying culture’ (Francis, 2013) and the possible stigma around talking in first person about experiencing distress at work.

I thought that introducing this at the end of the interview, when we could have already developed a bit more of ‘trust’, and the person could feel a bit more comfortable. This could facilitate the discussion of delicate and potentially stigmatised feelings or experiences, if any.

☞ What are the implications of introducing this? What could be the implication or possible impact that this could have on interviewees?

By introducing these survey results I may be leading participants to focus on distress and I may be facilitating a space to ‘complain’ or to extend on negative experiences, rather than positive experiences.

However, as this is presented at the end of the interview I think that the leading effect gets minimised, as we have spent the majority of the time talking about both positive and negative aspects that influence their wellbeing, how they understand it and what it means to them.

At the same time, based on the question I ask with the survey “what are your thoughts about this?” I believe that they can also say that they disagree or that they do not feel represented by the survey; I am not asking a direct question where the only answer is focused on negative experiences (i.e. asking for moments where they felt distressed). The following question is open and general, allowing them to choose their focus and direction.

Similarly, if they chose to engage with the negative aspect of the experience, I believe that this could provide rich information about the specific topic of interest for my research

and this could bring an opportunity for them to feel that they can express views that otherwise, they may not have the space or chance to do.

↳ *What is the implication for my epistemological position?*

It could be seen as if I am offering this results as a ‘reality’ (NHS survey results), this could be conflicting with my current epistemological position—‘moderate social constructionist/critical-ideologist. This means that I understand that data cannot directly reflect ‘reality’; however, we can make sense of people’s meaning making through interpretation (Willig, 2012). Furthermore, I understand that the process of meaning making is a social construction, and therefore the study of this construct in another social and historical context would be different (Harper, 2012).

However, following Vivien Burr’s discussion on realism vs relativism, I agree with what she says: “without some notion of truth or reality, how can we justify advocating one view of the world over another, and one way of organizing social life?” She argues that, “since we cannot ever step outside our own culturally and historically located value systems, perhaps we must (and can only) make such judgements from within this system and defend them regardless of their inevitable relativism. While we must acknowledge that our values are culturally and historically specific, we are nevertheless able to examine them critically and to make an informed judgement about the appropriateness of our values based upon our knowledge of the reality that lies behind social phenomena”.

Therefore, I can stand behind the survey results, as aware of their relativity, I chose to use them to be able to explore this topic and hopefully, by being aware of my own assumptions and culturally shaped views, critically analyse the data of the interviews to bring enhance awareness on this topic.

At this point, I could continue developing this argument, but I think that I have reached a position where I am comfortable: It seems that my final positioning is that I am inclined to introduce it.

I think that it could have the risk of being seen as ‘slightly leading’, as it chooses to focus on a specific ‘reality’; however, is still open enough for participants to choose their own direction and engagement with the topic, it is at the end of the interview, and the benefits (reduce stigma, normalize) could outweigh the negatives (focus on negative experience).

Appendix O: Transcription convention

Transcription convention	
(.)	Short pause
(...)	Long pause (more than 3 seconds)
[. . .]	Material omitted to ensure confidentiality and/or text extracted due to poor quality of recording.
::	Elongation
[text]	Clarifying information regarding subtleties of the communication (such as use of irony or significant non-verbal gestures)
/	To indicate interruption of the other speaker

Appendix P: Adaptation of Willig's FDA 6 stages of analysis

FDA ANALYSIS:

Stage 1: Discursive constructions

- Familiarize with the text (read, re-read, listen to audios)
- Identify and highlight all parts of the text where participants refer to 'wellbeing', 'psychological therapist' and 'NHS' in the interview (explicitly and implicitly).
- **AIM: To identify different ways that participants construct the discursive objects.**

Stage 2: Discourses

- **AIM: To locate the discursive constructions within wider discourses in society.**

Stage 3: Action orientation

- Pay attention to the discursive context in which the different constructions are deployed.
- Exploring the gains and motivations linked with specific ways of constructing a particular object in a particular context.
- *What is gained from constructing the object in this particular way, in this particular point within the text?*
- *What is the function and how does it relate to other constructions produced in the surrounding text?*
- **AIM: To identify what may be the function of the discursive construction.**
(* Could this be a stage where consideration of **institutions and power implications** could be considered- why institutions are supported or oppressed by each discourse, and which 'type' of people would gain or lose by the employment of a particular discourse (Parker).

Stage 4: Positioning

- Involves identify the subjects constructed by the discourses
- Identify the subject positions that participants place themselves or others
- Each subject position has: (1) structure of rights, (2) obligations, (3) and possibilities of action (with power implications).
- **AIM: To identify the subject positions that each discursive construction offers.**

Stage 5: Practice

- Focuses on exploring the relationship between discourses and practice.
- Based on the identification of subject positions, focus on the actions or practices that are opened or closed by them.
- **AIM: To identify what can or cannot be done within each subject position.**

Stage 6: Subjectivity

- Focuses on the relationship between discourse and subjectivity.
- Explores the consequences of the particular ways of constructing the objects and subject positions.
- **AIM: To identify what can be felt, thought and experienced within the identified subject positions.**

how they experience themselves & the world.

Appendix R: Example of the analysis process

This is a snapshot of my process of analysis following Willig’s guidance (2013), without strictly adhering to the suggested order. I have used a section of Andrea’s transcript in which I was conducting the first stage of analysis (identifying discursive constructions of wellbeing) and I allowed myself to make notes of other aspects of the analysis that I was noticing. With this snapshot, I hope to illustrate more in detail the non-linear process of FDA that I embraced throughout the analysis of my data.

I used different colours to highlight sections of the transcript according to the scheme I presented in Appendix S, to facilitate posterior stages of making sense of the data as a whole.

317	P	Right, so if looking at this, you know, and I guess that the question was about wellbeing, so how would you understand, how do you
318		understand your wellbeing at work? What does it mean to you? And you know, we could base it on this, or not, you know
319		whatever it comes.
320	A	I think, you know, as::, as therapists and psychologist, we are notoriously bad:: at looking after ourselves . And:: I think that I have
321		been sometimes like that in the past and I’ve definitely been to blame for myself of, but I think that I’ve learnt from quite early on
322		when, when I was in my assistant role, about the::, the importance of boundaries (.) to protect your own wellbeing . About like
323		leaving at 5, and I’ve never believed in this kind of work ethic of (.) everyone working till half past five, just to show that they are
324		putting in a bit more effort, I think you know, “you are paid until 5, work till 5, you’ve got another life”. Erm::, and so I was always
325		quite good at that, and actually initially when I came into this service I started to (.) bring other people into that, and would get
326		everyone to sit down at lunch together, and have lunch together and, and then the more I got pulled into this kind of perfectionist
327		system, the less it’s been able to be (.) maintained . And I’ve definitely noticed , my wellbeing (.) seriously slip, but it’s not (...) again
328		(.) things have been pointed, I’ve raised (.) up how kind of stressed I’ve been and that my wellbeing has been affected, and it’s
329		very much a sense of “ well, it’s your responsibility to make sure you take your lunch break, it’s your responsibility to leave at 5”

Stage 1: Discursive Constructions

“Wellbeing as....”

- (1) (Line 320) Wellbeing as looking after ourselves (*)⁶ *you can be good or bad at this/ blame is allocated in relation to this*
- (2) (Line 322) Wellbeing as something that you have to protect (placing boundaries)/ *Protect against?*
- (3) (Lines 323-326) Wellbeing as certain practices (leaving at 5, have lunch with others)

⁶ I used (*) to point to moments where I noticed aspects that could indicate subject positions.

- (4) (Line 326-327) Wellbeing as against the perfectionist system (perhaps certain practices, from previous construction, against the perfectionist system)
- (5) (Line 327) Wellbeing as something that you can notice “seriously slip”
- (6) (Line 327) Wellbeing as something that has to be maintained (requires effort? /actions, linked to (2), (3)?)
- (7) (Line 328-329) Wellbeing as something that can be affected by stress
- (8) Lines 328-329 Wellbeing as something that can be raised (not sure about this one)
- (9) Lines 328-329 Wellbeing as something that is affected by certain practices (*) *Who’s responsibility is this?*

Note: So far, I am wondering whether (2) have to protect and (3) certain practices are part of the same construction (1) wellbeing as looking after oneself?

Stage 4: Positioning

It seems that in this section there is a dynamic of allocation of blame and responsibility. It seems that lines 320-322 present a potential construction of ‘wellbeing as looking after oneself’ and of ‘wellbeing as an individual responsibility’. Thus, the participant seems to be deploying this construction by which she judges/evaluates/regards herself as ‘bad’ (“we are notoriously bad”) and also seems to place blame on herself (“I’ve definitely been to blame for myself”).

This seems to point to two potential subject positions:

- (1) SP: ‘good’ vs ‘bad’
- (2) SP: ‘responsible’ vs ‘irresponsible’

I wonder if Andrea is taking the ‘responsible/good’ position. It’s interesting how she shifts her language at the end of the intervention- maybe she is trying to share the responsibility with the system? This makes me think about potential implications for ‘action orientation’

Stage 3: Action Orientation

Towards the end of her intervention, lines 328-329, it seems that she could be placing or sharing responsibility with the service, perhaps by saying that she has “pointed this out and raised it up” she is trying to explain that even though she is having difficulties, she is still responsible, and she has tried to seek help, or support?

It is interesting that she says that the service is saying back to her that “it’s your responsibility”. This could be indicating a negotiation of responsibility, and it makes me wonder whether this is touching on the potential existence of conflicting wider discourses.

Stage 2: Discourses

It seems that a wider discourse of individualism vs collectivism could be at play here.

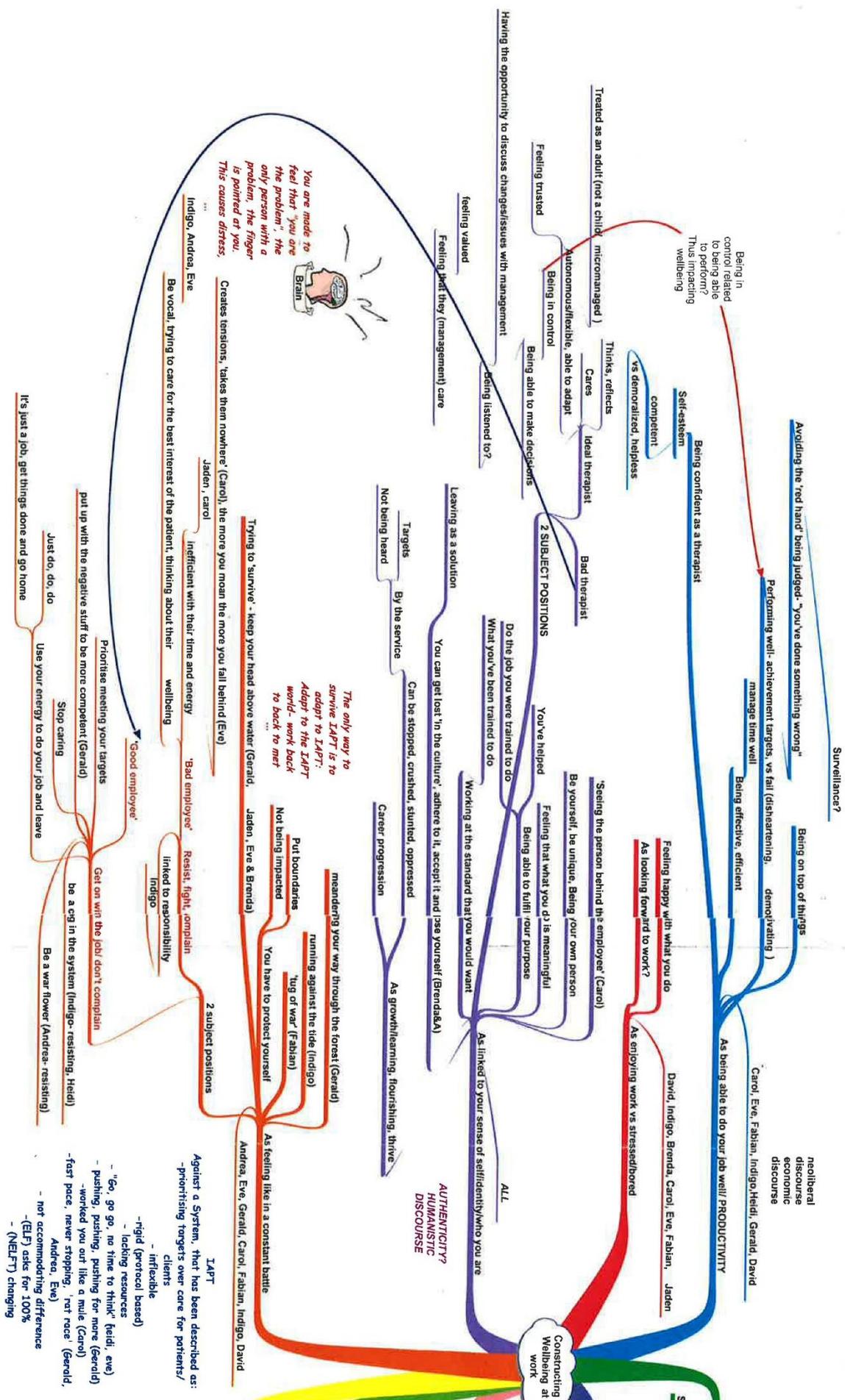
This makes me wonder about the implications for practice and subjectivity of this construction.

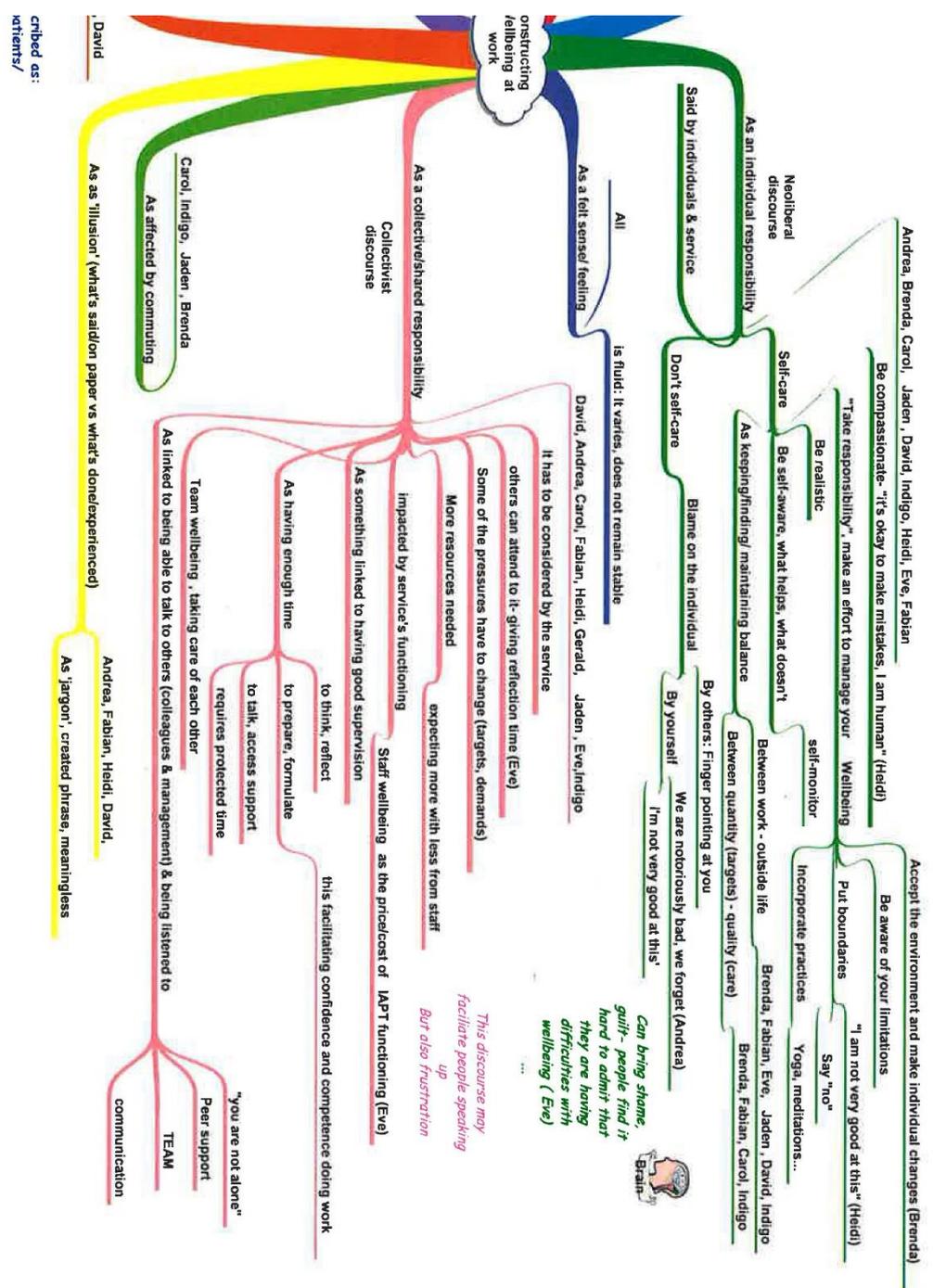
Stage 5: Practice

From this extract it seems that the actions opened for the participant are: to take care of herself, take responsibility of her wellbeing by looking after herself, leaving on time, taking her own breaks... Yet, it could be possible that trying to raise and share issues with others could be closed (being told back “it’s your responsibility)- not allowed.

Stage 6: Subjectivity

Andrea talks about “shame” and being “bad” at looking after ourselves, which could indicate aspects of her subjectivity in relation to this discursive construction- element of evaluation/judgement. Moreover, one could speculate about how frustrating and lonely it may be to be having difficulties at work and feel that when you are trying to verbalise it and seek help, you are told that “well it’s your problem”.





cribbed as:
 ndrea, Brenda, Carol, Jaden, David, Indigo, Heidi, Eve, Fabian
 Be compassionate- "it's okay to make mistakes, I am human" (Heidi)
 "Take responsibility", make an effort to manage your wellbeing
 Be realistic
 Be self-aware, what helps, what doesn't
 As keeping/finding/ maintaining balance
 self-monitor
 Put boundaries
 Incorporate practices
 Yoga, meditations...
 "I am not very good at this" (Heidi)
 Say "no"
 Yoga, meditations...
 Accept the environment and make individual changes (Brenda)
 Be aware of your limitations
 "I am not very good at this" (Heidi)
 Say "no"
 Yoga, meditations...
 We are notoriously bad, we forget (Andrea)
 I'm not very good at this
 Can bring shame, guilt - people find it hard to admit that they are having difficulties with wellbeing (Eve)
 This discourse may facilitate people speaking up but also frustration
 Staff wellbeing as the price/cost of IAPT functioning (Eve)
 It has to be considered by the service
 others can attend to it- giving reflection time (Eve)
 Some of the pressures have to change (targets, demands)
 More resources needed
 expecting more with less from staff
 Impacted by service's functioning
 As something linked to having good supervision
 to think, reflect
 to prepare, formulate
 to talk, access support
 requires protected time
 Team wellbeing, taking care of each other
 As having enough time
 As linked to being able to talk to others (colleagues & management) & being listened to
 this facilitating confidence and competence doing work
 "you are not alone"
 Peer support
 TEAM
 communication
 As as 'illusion' (what's said/on paper vs what's don/experienced)
 As 'jargon', created phrase, meaningless
 Andrea, Fabian, Heidi, David,
 David
 Carol, Indigo, Jaden, Brenda
 As affected by commuting
 As as 'illusion' (what's said/on paper vs what's don/experienced)
 As 'jargon', created phrase, meaningless