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Moral injury and NHS talking therapies: psychological therapists and their experiences of moral challenges - a reflexive thematic analysis

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Moral Injury and NHS Talking Therapies: Psychological Therapists and Their Experiences of Moral Challenges - A Reflexive Thematic Analysis

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Dedication

I want to dedicate this project to Siobhan, my partner in life. Without her unwavering support, kindness, and patience, it would not have been possible.

Abstract

The current study investigates how psychological therapists experience morally challenging events when working in NHS Talking Therapies (formally IAPT) and why these events may occur. The theory of Moral Injury was used as the guiding theoretical concept to make sense of participant's experiences, and a Reflexive Thematic Analysis was adopted as the methodology of choice. From this, five themes were generated: (1) *The Setting: Introducing the Moral Territories;* (2) *The Threat: Invasion of the Moral Territories*; (3) *The Battle: Experiences of the Invasion*; (4) *The Resistance: Strategies used to Survive*; and (5) *The Context: Age of Clinical Tyranny*. An additional three sub-themes were also generated: (1) *Relational Hill;* (2) *The Failed Strategy;* and (3) *The Power of Togetherness*. The data supports Moral Injury as a distinct theoretical model and indicates it to be a helpful and applicable theory in understanding the moral difficulties experienced by psychological therapists in NHS Talking Therapies. Furthermore, the current research suggests this population may be at risk of Moral Injury. To understand *why*, links are made between (a) the moral conflicts identified by participants and (b) the wider socio-political landscape. As such, this study draws attention to the contemporary shifts in the art and science of psychotherapy and how neo-liberalism, the division of labour, and workplace alienation may be related to such shifts.

Contents

Table of Abbreviations

MI	Moral Injury
pMIE	Potentially Morally Injurious Event
MIE	Morally Injurious Event
pMRE	Potentially Morally Reparative Event
MD	Moral Distress
PTSD	Post-Traumatic Stress Disorder
IAPT	Improving Access to Psychological Therapies
NHSTT	NHS Talking Therapies (formally IAPT)
DCoP	Division of Counselling Psychology
BPS	British Psychological Society
VA	Veterans Affairs
HCP	Health Care Professional
MP	Moral Psychology
NICE	National Institute for Health and Care Excellence
GSH	Guided Self-Help
CBT	Cognitive Behavioural Therapy
HIT CBT	High Intensity Cognitive Behavioural Therapist
PWP	Psychological Wellbeing Practitioner
ICBT	Internet Cognitive Behavioural Therapy
CR	Critical Realism
TA	Thematic Analysis
RTA	Reflexive Thematic Analysis
QCA	Qualitative Content analysis
IPA	Interpretative Phenomenological Analysis
GT	Grounded Theory
DA	Discourse Analysis
WS	Work Stress

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CHAPTER ONE
Introduction

Background

My introduction to the theory of moral injury (MI) felt like a strike of lightning. Comparable to the final puzzle piece, it 'fit', and I resonated with its ideas. This connection was not random but a consequence of circumstance. At the time, I was a trainee psychotherapist and psychologist working in a busy NHS Talking Therapies (NHSTT) service (formally known as IAPT). Three years later, disillusioned and discouraged, I felt beaten down. I kept being told I had burnout - a reasonable deduction given the fast-paced nature of the role. However, it felt like *more*. I noticed the meaning of burnout became elastic, overused, and diluted – more like a diagnostic dustbin than a carefully considered framework matching my experience. The connotations of burnout implied a lack of resilience, something *within* me requiring change. Thus came the lightning strike, a short article by Talbot and Dean (2018) titled: "Physicians aren't burning out. They're suffering from moral injury".

Talbot and Dean argued the term burnout is over-applied in the American healthcare system. Physicians were not having a crisis of resilience; instead, it was because the system did not allow them to *help* in the way they were trained. Restrictive and rigid protocols combined with target-driven health care placed physicians in a position of feeling unable to do *what is right*. Not only did they risk burning out, but their actions were inconsistent with their moral framework, from "being unable to provide high-quality care and healing in the context of health care" (Talbot & Dean, 2018, para. 6).

Unable to do *what is right* and unable to provide *high-quality care* and healing, these ideas struck powerful chords and added shape to my feelings. I felt unable to help my clients in the way I was trained: a healer being denied the tools to heal, a helper who felt helpless. It was not long before my interest in MI became academic: could the experiences described in the article occur in the NHS? What about NHSTT? This sparked the genesis of the current study,

a research journey defined by many hiking trails, a few complex woodland diversions, the occasional pitfall, and one unprecedented global pandemic.

The pandemic significantly impacted how researchers and authors interfaced with MI. Previously, it was applied mainly to military populations, with the pandemic forcing the theory to experience a proverbial growth spurt. It was thrust into the public consciousness and became foregrounded in the discourse of health care professionals (HCP) who endured the heavy burden of navigating impossible moral scenarios.

Reflections

An underlying assumption of this work is that any drive towards knowledge production is partly fuelled by the researcher's interests. My relationship with the topic of MI is no different. Much of my clinical experience has involved working with complex trauma - an area I am drawn to due to personal experiences - and MI as a trauma theory is an extension of that interest. Therefore, it is a value-laden pursuit that rejects the positivist claim one can separate facts from values. I believe that as researchers, we are part of that which we observe, and to investigate a phenomenon, we must also examine ourselves: our assumptions, experiences, values, biases, and prejudices. Equally, one must consider one's geo-historical situation, an important consideration given the COVID-19 pandemic. Therefore, the impact of the pandemic on the theory of MI cannot be abstracted from this work, nor my engagement with its review of literature. Similarly, my position as a researcher cannot be divorced from my previous experience in NHSTT, nor my current position as a psychotherapist and trainee psychologist in an NHS psychiatric hospital. Both roles have equipped me with insider knowledge and perspectives.

Navigating the Thesis

The reader can expect a two-part review in Chapter Two: part one will include a summary of the literature on MI - which is used as the guiding theoretical concept for the current study, and part two will introduce NHSTT - its aim, history, and a review of its critiques. The reader will then be guided through the methodological approach to the study in Chapter Three, including its philosophical assumptions, study design, and ethical considerations. Chapter Four summarises the themes and sub-themes generated from the analysis. Finally, in Chapter Five, the reader will be directed through the discussion, followed by the current study's relevance to the profession of counselling psychology, its limitations, and suggestions for future research.

A Quick Note on Terminology

The frequency in which I use terms such as 'healthy', 'anxiety', 'PTSD', 'burnout', 'depression', and other descriptors of human experience is not indicative of my endorsement of the ontology of these terms, nor their status as pathology or illness. Instead, my commitment to using these terms is for the sake of linguistic ease and readability. When I cite a specific diagnostic term, I point to the vaguely defined cluster of behaviours, feelings, and thoughts that, when put together, the medical model constitutes a diagnosis instead of unique indicators of human experience.

Research Aims and Research Questions

The current study aims to explore the morally challenging experiences of psychological therapists working in NHSTT. To achieve this, the theory of MI was used as the theoretical framework to guide and make sense of participants' experiences. Equally, space was made in the analysis to generate novel insights that could contribute to the overall field of MI and pave the way for understanding the moral aspects of working clinically in NHSTT. Therefore, two questions guide this investigation:

(1) Primary question: How do therapists experience morally challenging events when working in NHS Talking Therapies?
(2) Sub Question: Why might therapists experience morally challenging events when working in NHS Talking Therapies?

The first question is exploratory, and the latter is explanatory. Taken together, they provide a detailed account of participant experiences while also exploring causal explanations.

Relevance to Counselling Psychology

The Division of Counselling Psychology (DCoP) outlines a list of values. The first value, being reflective scientist-practitioners, highlights the *responsibility* of counselling psychologists to both consume and conduct meaningful research. The current state of healthcare requires empirical contributions from researchers committed to a reflective and nuanced understanding of a system where the realities of suffering - and the tools needed to address such suffering - risk being overlooked or disavowed. This is symptomatic of the industrialisation of target-driven healthcare that has become riddled with pre-occupations of efficiency, diagnosis, and quantification. By offering a detailed and rich account of frontline therapists, this study provides an alternative and more detailed language to better understand experiences of moral difficulties in NHSTT.

Aligning with another commitment of the counselling psychology profession – that is, leading and influencing the design and delivery of innovative policies and services, the current study also aims to contribute to research encouraging the re-evaluation of mental health services and how psychological therapists are managed and supported.

CHAPTER TWO
Literature Review

Part 1: Moral Injury

A History

Moral Injury, a trauma theory, was developed in the early 1990s by American psychiatrist Jonathan Shay. At the United States Department of Veterans Affairs (VA), a service providing healthcare to military veterans, Shay was interested in the experiences of soldiers who fought in the Vietnam War and was inspired by Homeric philosophy to formulate and communicate his theory of MI (Shay, 1991).

Not satisfied with the diagnosis of post-traumatic stress disorder (PTSD), Shay explored alternative explanations for a soldier's experience of profound moral transgressions. Referenced as a "soul wound", Shay described MI as deteriorating one's character, ambitions, ideals, and capacity to trust (Shay, 2012), resulting in the "shrinkage of the social and ethical horizon" (Shay, 1991, p. 577).

Shay argued PTSD inadequately adjusted for the moral and ethical implications of war – a conviction still maintained today (Denov, 2022). In separating the two constructs, Shay (2014) outlined the primary emotions associated with PTSD as *fear*, *horror*, and *helplessness*, and for MI, *guilt, shame,* and *anger*. Thus, PTSD occurs from a loss of *safety* and MI, a loss of *trust*.

PTSD vs Moral Injury

Both MI and PTSD develop after an acutely distressing experience where affective changes, social/interpersonal difficulties, and psychobiological problems occur (Jinkerson, 2016; Shay, 2012, 2014). This can lead to avoidance behaviours, substance misuse, nightmares, insomnia, suicidal ideation/behaviour, and the re-experiencing of distressing memories (Brake et al., 2017; Bryan et al., 2014; Nichter et al., 2021; Schwartz et al., 2022; Smigelsky et al., 2020). One study suggests a comorbid diagnosis of MI and PTSD increases the risk of suicide

(Bryan et al., 2018), with evidence indicating MI may predict PTSD (Jinkerson & Battles, 2019; Papazoglou et al., 2020a). Others have found a statistically significant relationship between MI and poor mental health (Hall et al., 2021; McEwen et al., 2021, 2022), and some authors argue that the outward behavioural changes caused by MI can closely mirror those found in traumatic illnesses, such as PTSD (Atuel et al., 2021).

However**,** research has identified and operationalised MI as a distinct and *alternative* model of trauma (Atuel et al., 2020, 2021; Barnes et al., 2019; Bryan et al., 2018; Jinkerson, 2016; Nickerson et al., 2015). Aetiologically, PTSD and MI differ: PTSD is an acute response to trauma that has a significant physiological component from life-threatening - or inescapably stressful - event(s) (Van der Kolk, 2015) that perpetuate inaccurate fear appraisals and does *not* always include shame and guilt as part of the presentation (Jinkerson, 2016). Alternatively, MI is *not* always a consequence of acute physiological distress but the actions of self or others that violate one's moral code. Hence, MI can occur in the absence of physiological arousal, and PTSD is not always synonymous with shame and guilt. In their dual-pathway model, one team of researchers suggest PTSD occurs from disturbances in one's emotional, cognitive, and physiological processes. In contrast, MI comes from disturbances in identity, character, and virtues (Atuel et al., 2021). One study by Bryan et al. (2018) indicates that difficulty sleeping and nightmares were closely linked with PTSD, whereas the experience of anger was more strongly correlated with MI. Furthermore, a team of researchers exploring the neural correlates between MI and PTSD found that MI had distinct anatomical responses (Sun et al., 2019).

Although separating MI and PTSD is important when framing both as separate and unique traumatic models, it is worth noting that a qualitative study by Williamson et al. (2020) found MI can be experienced following both ethically challenging *and* life-threatening situations, so-called 'mixed' events. This is particularly important as it supports Shay's (1991, 2014) original assertion that MI can also be a consequence of life-threatening events, a feature neglected in

later theoretical iterations where physical arousal was not considered a part of the MI construct (Litz et al., 2009).

Definitions

The research landscape around MI is replete with definitional confusion – a topic later explored in more detail. However, two leading definitions have informed almost all conceptions of MI. According to Shay's (2012) original typology, MI is defined as (1) a betrayal of *what is right*, (2) by someone who holds *legitimate authority*, and (3) in a *high-stakes situation*.

In 2009, MI started to gain scientific attention, beginning with a seminal publication by Litz et al. (2009). In their preliminary framework, MI is defined as "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 697).

Both definitions share similarities but diverge in meaningful ways. Litz and colleagues' definition underscores the *self* as perpetrator – adding an intrapsychic dimension. In contrast, Shay's definition locates itself in the social system and accentuates the *power holder* as violator. These differences mark a point of contention in the MI literature (Hollis et al., 2022; Molendijk et al., 2022): the latter contextualises the morally injurious experience and the former, with its foci on the *self*, frames MI as pathogenic and erupting from a cognitive failing to reconcile moral dissonance (Litz et al., 2009). Notably, many researchers have omitted Shay's emphasis on betrayal-based transgressions due to its political connotations (Hodgson & Carey, 2017; Molendijk et al., 2022)

The framing of MI as a uniquely intrapsychic phenomenon (rather than a social one) influenced the direction of theory development, with many operationalising MI in terms of perpetration rather than betrayal-based conceptions (Hollis et al., 2022; Molendijk et al., 2022). Jinkerson's (2016) diagnostic typology for a MI 'syndrome' is one example of this – a model that more recently has garnered empirical support (Jinkerson & Battles, 2019; Roth et al., 2022).

To meet the diagnostic threshold for MI, Jinkerson reports one must present with a history of exposure to morally injurious events (MIE), a presentation of guilt, and a minimum of two symptoms originating from the primary or secondary symptom clusters. The elevation of guilt in his nosology of MI is notable. Guilt has neurological and adaptive roots in human evolution and supports pro-social behaviours that decrease the likelihood of violating social norms or harming others (Gilbert, 2003; Zefferman & Mathew, 2020). In turn, this presupposes a transgression by the individual and excludes betrayal-based explanations of MI. Despite attempts made to consider betrayal-based alternatives (Atuel et al., 2020, 2021; Bryan et al., 2016; Drescher et al., 2011; Marks et al., 2021; McCormack & Riley, 2016; Nash & Litz., 2013; Nash et al., 2013; Richardson et al., 2020; Schwartz et al., 2022), Jinkerson's privileging of guilt points to the wider tendency to report on perpetration-based interpretations (Hollis et al., 2022; Molendijk et al., 2022).

The following is a focused review of the key MI literature spanning three periods: pre-pandemic (2009-2020), mid-pandemic (2020-2022), and post-pandemic (2022-2023). This format is deliberate, as it intends to contextualise the current research and draw attention to the notable contours of change spanning the past 15 years.

Shifting Landscapes

Pre-Pandemic (2009-2020)

Before the pandemic, MI had only existed within the domain of social science for 11 years, and researchers primarily focused on MI in military populations. Over time, a burgeoning literature was developed whereby almost *all* descriptions of MI included guilt, shame, anger, and loss of trust in self, other, or transcendental beings (Jinkerson, 2016; Litz et al., 2009; Richardson et al., 2020; Shay, 2012; Talbot & Dean, 2018). Additional symptoms include spiritual/existential crisis (Conway, 2014; Drescher et al., 2011), depression, anxiety, intrusive thoughts, and alcohol or substance misuse (Battles et al., 2018; Currier et al., 2015a; Stein et al., 2012) with some suggesting an association between suicidal thoughts and behaviours and MI exposure (Bryan et al., 2014; McCarthy, 2017).

A study by Molendijk (2018) analysed 80 qualitative interviews with Dutch veterans, leading to the identification of three key themes: (1) *value conflicts*, such as choosing one life over another; (2) *morally overwhelmed/detached*, which explored psychological defences – such as temporary moral disengagement used to safeguard oneself against human suffering; and (3) *senselessness*, where soldiers may grapple with the tension between the rhetoric of political leaders and society, while personally feeling their experiences of suffering promote little meaning.

Molendijk's study was significant in two ways. First, half of the sample had not experienced combat, suggesting MI was not specific to combat exposure. Secondly, it foregrounded how moral beliefs may exist in tension. This prospect of competing values has important implications for the NHSTT therapist, where a commitment to following the boundaries in one's role *and* doing what is right for the patient may come into conflict. Equally, incongruences may be felt between perceptions of one's role as a therapist and an organisation's expectations (e.g., the so-called 'gold standard' of care).

Adopting an interpretative phenomenological analysis, McCormack and Riley (2016) explore seven former police officers' lived experiences. All seven had been discharged due to PTSD. The themes presented lean heavily into betrayal-based conceptions of MI, such as a loss of trust in the organisation, feelings of betrayal and rejection from a lack of support, and a general breakdown in the "policing family" from accumulative exposures to traumatic experiences. As a piece of qualitative research, it succeeds in outlining an explorative and contextualised account of moral challenges external to the military and foregrounds the active role of institutions (Shay, 2014).

From here, some significant similarities between police officers and NHSTT therapists can be identified: (1) both may face chronic or acute trauma exposure experienced directly or vicariously (McCormack & Adams, 2016), (2) both professions are expected to inhabit similar qualities – such as the ability to be unaffected by the distress encountered in their roles, and

(3) both rely heavily on a hierarchical system that some may perceive as rigid and unsupportive.

Pivoting away from the military and frontline police officers is a qualitative pilot study by Murray et al. (2018), where the lens of MI was used to investigate the lived experiences of a small population of medical students. This was the first study to consider MI as a secondary trauma in a healthy working population and positioned MIE within the social system (Shay, 2014), such as witnessing traumatic events, accessing resources, and receiving appropriate support. Naturally, being a pilot study with a small sample size, its findings were exploratory. Before the pandemic, it supported the assertion that MI could occur in alternative populations and sat alongside similar research on adult refugees (Hoffman et al., 2018, 2019; Nickerson et al., 2015) and social workers (Haight et al., 2016). Crucially, the moral events cited were not limited to medical students but can be found in frontline professionals *across* health-care systems, including the NHSTT therapist who is exposed to repeated trauma narratives, has limited resources at their disposal, and may not always have access to appropriate organisational support.

Mid-Pandemic (2020-2022)

Twenty-twenty marked the year the theory of MI began to attract significant attention, largely in response to the Covid-19 crisis. Many authors continued to address the impact of MI in different contexts and across populations. Some further researched military personnel (Jamieson et al., 2020; Nazarov et al., 2020; Nichter et al., 2021; Ragin, 2020; Usset et al., 2020; Williamson et al., 2020) and police officers (Papazoglou et al., 2020a; Papazoglou et al., 2020b), with one team of researchers developing an evolutionary theory of MI (Mohsin et al., 2020). Others considered MI amidst spiritual leaders (Greene et al., 2020), with one commentator arguing a *collective* MI in response to the murder of George Floyd (Barbot, 2020). Another team of researchers explored the causal link between climate anxiety, government betrayal, and MI (Marks et al., 2021).

Due to growing interest, more efforts were made to explore tailored treatment options (Capone et al., 2021; Cenkner et al., 2021; Murray & Ehlers, 2021; Williamson et al., 2021), and MI also entered psychoanalytic discourse, where Freud's (1923/2019) structural model of the mind was adopted to understand MI experienced by nurses during the pandemic (Lesley, 2021).

The population where the theory of MI most proliferated was the frontline healthcare professionals (HCP) of the world. They had to manage the disastrous onset of a global pandemic that required a shift *away* from patient-centred ethics to public health ethics (Hossain & Clatty, 2021). In turn, this prompted some authors to declare MI in healthcare an *invisible epidemic* (Dean et al., 2020).

Moral Injury and the Healthcare Worker

Although there was some debate about the applicability of MI in healthcare – mainly due to the lack of a consensus definition and limited research (Cartolovni et al., 2021), with one author citing MI as a misplaced term in healthcare (Asken, 2019) – as a theory, it still became widely applied and generated an increasing awareness of the moral impact of the pandemic on HCP.

The first major study to explore the impact of COVID was by Wang et al. (2020). A large-scale quantitative analysis was conducted to determine the psychometric properties of the Moral Injury Symptom Scale-Health Professional (MISS-HP), adapted from a measure designed by Koenig et al. (2019) initially focusing on military personnel. The study was conducted in China, with 583 nurses and 2,423 physicians participating. Out of the 3006 total participants, 20.4% met the criteria for MI, with the authors concluding the MISS-HP as a valid and reliable measure.

One sub-sample of note is the 8% of psychiatrists. The field of psychiatry is the closest to the professions of counselling, psychotherapy, and psychology. Therefore, a psychiatrist's experience of MI and potentially morally injurious events (pMIE) is of consequence when considering the role of the NHSTT therapist. Unfortunately, little insight into *how* psychiatrists

– or other HCPs – experienced MI was given or what specific areas of their work gave rise to such experiences.

Following on from Wang and colleagues' study was a team of researchers who conducted a similar quantitative analysis with the aim of further developing the MISS-HP's psychometric properties (Mantri et al., 2020). Of the 181 healthcare workers assessed, 7.8% met the criteria for a MI diagnosis and further supported the MISS-HP as a reliable and valid measure. Similar to the previous study, some limitations make understanding the data difficult. However, both studies were key to placing MI firmly on the proverbial map for healthcare workers.

Further exploring the link between MI and HCPs, Roycroft et al. (2020) suggested MI is caused by *moral distress* (MD), which occurs when one feels unable to act on what they believe is right - an idea originally proposed by Talbot and Dean (2018), echoed by Meacham (2019), and supported by Litam and Balkin (2021). The accumulation of *moral residue* - the feelings and self-judgements remaining after a moral stressor - increases MD (Epstein & Hamric, 2009) and limits one's capacity to tolerate additional moral dilemmas, potentially resulting in MI. Not having the time to process moral stressors is a risk factor; therefore, having opportunities to debrief within a trusted team is considered protective – an idea initially proposed by Shay (2014) and supported by Murray et al. (2018) in their study on medical students. The authors' use of MD is important, as it exemplifies the definitional confusion underpinning MI as a construct.

Moral Injury vs Moral Distress

Moral distress – a term originating from the field of nursing – was first coined by Jameton (1984) and refined by Wilkinson (1987). Jameton defined two stages of MD: (1) feelings of anger, frustration, and anxiety when one is in conflict with others' values, or broader institutional restrictions, and (2) the distress experienced when one's initial distress is not acted on. The overlap is apparent as both models address moral tensions. However, for conceptual clarity, distinguishing between the two is an important task (Čartolovni et al., 2021; Papazoglou et al., 2020b).

Moral distress emerges from moral frustration (Litz & Kerig, 2019) in the context of organisational restrictions, and can lead to negative feelings and psychological disequilibrium (Čartolovni et al., 2021). Contrastingly, MI originates from deeper emotional wounding – from moral failings occurring in or outside of the workplace – with long-lasting changes in the perceptions of oneself, others, and the world. As the wording of these two theories imply - 'distress' and 'injury', the former is considered less severe than the latter, with both theories representing individual points on a continuum (Litz & Kerig, 2019; Webb et al., 2024). Moral distress, therefore, may become MI, with the boundary being placed at the point where accumulative *distress* becomes *injurious*.

Dzeng and Wachter (2020) argued that the dominant focus on healthcare as a business over a human right places HCPs in morally difficult positions, resulting in a growing disparity between professional ethics and reality. Although MI and MD have been discussed, these scenarios may also increase the risk of burnout, another conceptually similar model.

Moral Injury vs Burnout

Burnout is characterised by cynicism, exhaustion, and reduced professional efficacy (Maslach & Leiter, 2008) from chronic exposure to unsustainable levels of stress. Whereas MI is a breakdown in one's moral interior. Put simply, burnout does not adequately adjust for the threat to an individual's integrity in the same way as MI (Meacham, 2019). In some cases, MI may make one more vulnerable to, or further compound, symptoms of burnout (Papazoglou et al., 2020b). Equally, this relationship may also play out in reverse where burnout is an etiopathogenic factor in the development of MI or other difficulties (Carmona-Barrientos et al., 2020; Dzeng & Wachter, 2020; Mikolajewska, 2014). Placing the spotlight more specifically on the NHSTT therapist, as a profession there are parallels with so-called 'high-risk-of-burnout' professions (Johnson et al., 2005). For example, the conveyor belt of clients an NHSTT therapist supports, with limited resources, strict protocols, target-driven pressures, limited autonomy, and minimal time between sessions, may cause moral frustration and thus a build-up of moral residue/distress, increasing the risk of MI.

As suggested in Chapter One, labelling someone as 'burnt out' may be more likely when they are, in fact, morally injured (Kopacz et al., 2019; Talbot & Dean, 2018). Akin to perpetration-based conceptions of MI, over attributing burnout to peoples' experiences may risk decontextualising them (Meacham, 2019).

One critical feature shared between MI and the above models is they are all a response to either acute, or chronic stressors - with burnout considered an 'advanced' or 'extreme' form of stress (Johnson et al., 2005). Therefore, understanding what stress *is*, becomes an important task.

Moral Injury, Stress, and Work Stress

Also known as 'occupational' or 'job stress', the field of work stress (WS), and stress more broadly, is vast and well developed. The current aim is not to provide an extensive review of this area, but outline some of the theoretical fundamentals, and how they may relate to MI. Similar to MI, establishing a consensus definition of WS is both an important, but challenging task - not least because of the scale of the phenomenon, the diversity in how it is experienced, and its universal applicability (Akanji, 2013; Dewe & Trenberth, 2004). However, before grappling with the concept of WS, first the construct of *stress* requires attention.

Typically, stress "is commonly perceived in terms of general physiological and psychological reactions that provoke adversarial mental or physical health conditions when a person's adaptive capabilities are overextended" (Akanji, 2013, p. 73). Over time, theories of stress have been formulated in a variety of ways: either as a response (e.g., stress from the point of one's psychological reactions to stressors), a stimulus (e.g., features of one's environment as the cause of disturbance), or a stimulus-response interaction. When examining stress as an outcome between the interaction of an individual and their work context - the so-called 'interactionist' approach - it can be more precisely defined as "the consequences of a structural lack of fit between the needs and demands of the individual and his/her environment" (Cooper & Cartwright, 1997, p. 7).

When framing WS as both stimulus and response, Lazarus and Folkman's (1984) influential 'transactional theory' is of value, as it examines how one evaluates – or appraises – potentially stressful events (*primary* appraisal), and the subsequent mobilisation of coping strategies (*secondary* appraisal) to either extinguish, accommodate, or reduce stressors. Thus, the transactional theory inspects the relationship between workers and their environment and how through workers' assessments of their workplace, appraisals of potential stressors are made. Why an individual may experience WS includes, but is not limited to: work overload, having limited control or autonomy, excessive time pressures, role conflict, role ambiguity, role confusion, and poor working conditions; consequently, it is generally accepted that intense or prolonged stress can lead to negative outcomes, which may include poor mental and physical health, burnout, absenteeism, reduced work accomplishment, and higher turnover rates (Akanji, 2013).

The theories of stress, and WS more specifically, provide an important foundation for the theory of MI, which has been referred to as a "stressor-linked problem" (Litz & Kerig, 2019, p. 342). If a stressor is appraised as morally threatening or dangerous (i.e., a potentially morally injurious event) due to it involving an act of moral violation - perpetrated by the self, other, or legitimate authority - then feelings of guilt, shame, anger, and a loss of trust may occur. This description echoes that of Farnsworth et al. (2017), who suggest an event becomes injurious if "an individual perceived that an important moral value has been violated by the actions of self or other" (p. 392).

In the case of the current research, it may be helpful to conceptualise the relationship between WS and MI as: psychophysiological stressors arising from the perceived structural mismatch between an individual's moral needs and the demands of their work environment, resulting in the immediate or eventual overwhelm of adaptive coping capabilities. Similarly, MD could be framed as: a psychophysiological reaction to perceived frustrations and tensions between one's morals and the values of others or wider institution, along with the accompanying assessment that these stressors are not being resolved or acted upon.

Post-Pandemic (2022-2023)

Before the pandemic, ideas on MI were less established. However, through an inflation of interest, there is now a flourishing field of discourse. Recently, MI has been explored in emerging adults with child welfare backgrounds (Haight et al., 2022), climate change (Henritze et al., 2023) forensic psychiatry patients (Roth et al., 2022), young refugees (McEwen et al., 2022), human trafficking (Haralson, 2023), LGBTQA+ communities (Jones et al., 2022), speech-language therapists (Nagdee & Andrada, 2022), and veterinary professionals (Williamson et al., 2022). It continues to be researched in healthcare settings (Hagerty & Williams, 2022; Kok et al., 2023; Nelson et al., 2022; Rushton et al., 2022; Weber et al., 2023; Williamson et al., 2023a), including HCP in secure mental health hospitals (Morris et al., 2022a, 2022b; Webb et al., 2023).

Scholars have continued to broaden research in the police (Doyle et al., 2023) and military arenas (Denov, 2022; Hinkel et al., 2023; Maguen et al., 2023; Molendijk et al., 2022; Williamson et al., 2023b). One team established an empirically based, military-informed definition of MI (Richardson et al., 2022), further strengthening the theory's face validity and pushing the field closer to an agreed-upon definition.

The diversification of research outlined above is emblematic of a growing interest in adopting MI theory as a heuristic for understanding the complex and layered experiences of those exposed to moral challenges. However, some limitations remain.

Limitations, Gap in the Literature, and Contribution

The 'Moral' in Moral Injury

Morality as a concept has a long and rich history, one often omitted from the literature on MI, which largely exists in a vacuum of psychiatric and psychological discourse - despite theories on morality being arguably more developed in the sibling disciplines of philosophy, theology, evolutionary science, anthropology, and moral psychology.

This failure to integrate other perspectives on morality is a significant drawback for the theory of MI, which has not gone unnoticed (Atuel et al., 2020; Hollis et al., 2022; Molendijk et al., 2022). These observations sit alongside the notable imbalance between betrayal-based and perpetration-based conceptions and how this may restrict MI discourse and fail to address social and political dynamics (Atuel et al., 2020; Hodgson & Carey, 2017; Hollis et al., 2022; Kinghorn, 2012; Molendijk, 2018, 2019, 2022; Wiinikka-Lydon, 2017).

Moral Psychology

The field of moral psychology (MP) has a rich lineage, rooted in two key areas: (1) the work of Jean Piaget, where the corresponding field of developmental psychology began to study how children acquired moral concepts and moral reasoning; and (2), the synthesis of neurological, evolutionary, and social-psychological research in the 1990s that became focussed on the study of moral emotions (Haidt, 2008).

As a discipline, MP bridges MI, morality, and the adaptive role of moral emotions (Gilbert, 2019; Nesse, 2019). Although some definitions differ (Buss, 2019; Haidt, 2012), the consensus within the field of MP supports morality as a fundamentally *social* phenomenon that facilitates collaboration, cohesion, and group survival (Farnsworth et al., 2014; Gilbert, 2003; Haidt, 2012). This broadly overlays with Shay's (2014) original social-hierarchical definition and thus demands greater consideration of contextual factors contributing to the experience of MI.

Extending the theory of MI beyond the constraints of perpetration-based interpretations is an important task of the current study that heeds the call "for interdisciplinary, context-sensitive research on moral injury" (Molendijk et al., 2022, p. 750). By divorcing the individual from their moral community – that is, the NHSTT therapist from their organisational, social, and broader political context – then one risks decontextualising, diluting, and oversimplifying the typology of MI rather than seeing it as a complex and multi-layered scientific theory (Atuel et al., 2020, 2021; Evans et al., 2020; Molendijk et al., 2022).

In addition to providing a thread between MI, morality, and moral emotions, MP also grapples with fundamental concepts that have implications for conceptually expanding and positioning the theory of MI. Examples of note include: assessing the relationship between chronic stress and moral decision-making (Caviola & Faulmuller et al., 2015; Zhang et al., 2018); considering how morality may change across the lifespan (Killen & Dahl, 2018); determining whether moral judgement is driven by intuitive or deliberative processes, or both (Van den Bos, 2018); distinguishing between what is 'wrong' and what is 'bad', and the place of moral clarity (Nichols, 2018; Wiltermuth & Newman, 2018); linking the role of empathy in moral emotion (Zaki, 2018); differentiating between moral and non-moral emotions (Gina-Sorolla et al., 2018; Valdesolo, 2018); conceptualising the relationship between personal identity and the moral self (Strohminger, 2018); expanding on the relationship between moral intolerance and moral 'objectivity' (Goodwin, 2018); and considering moralisation and the tendency towards blame (Alicke et al., 2018; Schein & Gray, 2018).

Although an exploration of the abovementioned areas is not the aim of the current study, they remain significant in highlighting the multifaceted nature of morality as an age-old concept, and how positioning the theory of MI in relation to other, more developed examinations of morality is an essential task for ensuring conceptual clarity and theoretical legitimacy.

Defining Ethics, Morality, Values, and Norms

Similar to drawing the conceptual boundaries around PTSD, MI, MD, burnout, and stress, when collating the frameworks of ethics, morals, values, and norms under one umbrella it becomes necessary to distil their distinct theoretical properties. The fields commonly attached to these frameworks – such as philosophy and moral psychology – encompass ideas dating back thousands of years and stretch far beyond the scope of the current research. Therefore, a deep analysis of these terms is not the aim, but rather the focus is to provide a rudimentary outline of their differences.

Outside of formal academic enquiry, the terms 'ethics', 'morals', and 'values are often used interchangeably. Broadly, 'ethics' - also known as moral philosophy - is an arm of philosophy

that seeks to systematically reflect on, and tackle questions on morality (Khatibi & Khormaei, 2016). One specific branch of ethics significant to the current study is *professional ethics*, which specify the "special codes of conduct adhered to by those who are engaged in a common pursuit" (Chowdhury, 2018, p. 1). For example, in the field of psychotherapy and psychology, these may include the professional ethical frameworks outlined by the United Kingdom Council for Psychotherapy (UKCP) and the Health Care and Professions Council (HCPC).

Rooted in the Latin word *moralitas* – referring to character, manner, and proper behaviour – the term 'morality' signals to the differentiation of the decisions, actions, and intentions of an individual that distinguishes them as either being proper, or improper. Simply put, *morality refers to the attitudes, beliefs, and views of a society, a group, or an individual*. A functionalist, multi-disciplinary perspective from the field of moral psychology defines moral systems as "interlocking sets of values, practices, institutions, and evolved psychological mechanisms that work together to suppress or regulate selfishness and make social life possible" (Haidt, 2008, p. 10). Moreover, 'norms' outline a standard of behaviour based on mutually shared psychological expectations, attitudes, and beliefs within a society and can be classified as either social (e.g., tipping a waiter) or moral (e.g., avoid causing harm to others) (FeldmanHall et al., 2018). And lastly, 'values' are connected to individual attitudes and beliefs that guide behaviour.

In sum, *ethics* is the systematic study of what is considered right and wrong; *morality* is the view of a society, group, or individual about what is right and wrong; *norms* represent clusters of formal or informal rules or laws in a given society or group that reenforce acceptable behaviours; and *values* are linked to an individual's beliefs and actions that motivate and guide their behaviour.

Moral Injury and Definitional Confusion

The field of MI can be challenging, both in terms of not having an agreed definition (Griffin et al., 2019; Hodgson & Carey, 2017; Molendijk et al., 2022) and its overlap with other trauma and wellbeing models (e.g., PTSD, burnout, and moral distress). Richardson et al. (2020) poignantly foregrounded this issue by conducting a systematic review of MI definitions, which raised notable inconsistencies and a need for definitional clarity to support future research.

Twelve primary definitions were established after conducting a comprehensive review of 124 articles. Most cited was the perpetration-based definition by Litz et al. (2009) across 96 articles, and only 18 articles referred to Shay's (2012) betrayal-based definition. Richardson and colleagues concluded that "moral injury has a multifaceted definition at best and was a definitionally confusing construct at worse" (p. 582). Only two of the 12 definitions were empirically supported, which speaks to the wider conceptual fragmentation of MI as a theory. Consequently, this raises questions about face validity, reliability, and credibility, which threaten its legitimacy as a construct, thus calling for definitional clarity (Atuel et al., 2020; Griffin et al., 2019).

Defining Moral Injury for the Current Study

The definition used for the current study accounts for both betrayal and perpetration-based conceptions while capturing the multifaceted nature of MI. It is broad enough to apply within or outside military populations, and it strikes a balance between both Shay's (2012) and Litz et al. (2009) definitions:

> Moral injury is a trauma-related syndrome caused by the physical, psychological, social and spiritual impact of grievous moral transgressions, or violations, of an individual's deeply-held moral beliefs and/or ethical standards due to: (i) an individual perpetrating, failing to prevent, bearing witness to, or learning about inhumane acts which result in pain, suffering or death of others, and which fundamentally challenges the moral integrity of an individual, organisation, or community, and/or (ii) the subsequent

> experience and feelings of utter betrayal of what is right caused by trusted individuals who hold legitimate authority (Carey & Hodgson, 2018, p. 2).

As a definition, it has been praised as both comprehensive and "useful in research aiming to include contextual dimensions of moral injury" (Molendijk et al., 2022, p. 746).

The Positivist Elephant

If one was to take an aerial view of the field of literature on MI, one might observe a dominant positivist thread woven between recent publications (Hagerty & Williams, 2022; Mantri et al., 2020; Nazarov et al., 2020; Nelson et al., 2022; Rushton et al., 2022; Schwartz et al., 2022; Usset et al., 2020; Wang et al., 2020) – which connects to a much larger tapestry of historic quantitative presence within the existing literature (Atuel et al., 2020; Griffin et al., 2019; Jones et al., 2022).

A risk of having theory disproportionately influenced by quantitative methodologies – particularly those with clinical implications – is the possibility that quantitative approaches based on positivist philosophical assumptions sacrifice complexity, socio-political context, and nuance for reductionist, binary, and arbitrary modes of understanding, which can result in the medicalisation of ethical behaviour and pathologising of adaptive human emotions.

To this point is a recent article by Dobos (2023) arguing for the use of pharmacological interventions to 'prevent' MI in soldiers. He considers the use of Propranolol (a substance used to block stress hormones) to blunt soldiers' emotional experiences when enacting transgressive behaviours on others – thus mitigating MI. Similarly, Adderall is also suggested due to its increase in concentration and purported upregulation of positive affect when undertaking a task – even if it is otherwise perceived negatively. He claims by weakening a soldier's aversive emotional experience, they become insulated against the acute shame and guilt experienced in MI. Dobos then moves from a discussion on numbing pharmaceuticals to what he describes as "morality-altering" interventions – that is, testosterone boosters and oxytocin (the so-called 'love hormone') - which, when administered may generate a utilitarian

bias and increase one's sense of achieving the 'greater good' while strengthening in-group allegiance and out-group hostility. Although the author creates space in his thesis to consider the ethical parameters of his suggestions, his assumption that the moral complexity of humans can be of-set by pharmaceutical interventions is symptomatic of the omnipresent threat of the over-medicalisation of distress, and the pathologising of internal experience at the expense of systemic considerations.

When a particular area of conceptual interest is dominated by one form of methodological application, then the lens of theoretical and clinical interpretation may become unhelpfully narrowed, leaving little room for the contribution of alternative frameworks of knowledge (Hollis et al., 2022; Jamieson et al., 2020; Jones, 2020). Shay's original use of the word 'injury' over 'disorder' - a deliberate manoeuvre to mitigate the risk of stigmatising and medicalising the experience of MI (Ragin, 2020), suggests he anticipated the theory might come up against such challenges. However, this important detail risks erasure as the theory grows beyond the parameters of Shay's initial contributions.

The details of *how* HCPs experience MI are minimal, thus demanding further qualitative analysis (Atuel et al., 2020; Weber et al., 2023). However, it should be noted some recent qualitative efforts have been made (Doyle et al., 2023; Jones et al., 2022; Richardson et al., 2022; Roth et al., 2022; Williamson et al., 2020), including mixed-method analysis (Hagerty & Williams, 2022; Nelson et al., 2022). Therefore, the current study aims to contribute to this modest qualitative presence and distil the moral challenges experienced by NHSTT therapists – a population that, to date, has not been studied through the lens of MI theory.

Part 2: NHS Talking Therapies

NHS Talking Therapies is the world's largest, publicly funded, evidence-based psychological care implementation. With national dissemination beginning in 2008, there are now over 200 services in England. Since the introduction of national statistics in 2012, there have been roughly 7.5 million referrals between 2012 and 2020, with the service approximating 1.25 million referrals annually (Wakefield et al., 2021). Therapy is offered based on a client's

severity of need via a stepped-care treatment model informed by recommended evidence-based therapies from the National Institute for Health and Care Excellence (NICE).

Clients are commonly offered low-intensity guided self-help (GSH), which is informed by principles of Cognitive Behavioural Therapy (CBT) and delivered by Psychological Wellbeing Practitioners (PWPs) who provide low-intensity standardised evidence-based interventions. If GSH proves unsuccessful, a more formalised CBT treatment is conducted by a qualified or trainee CBT therapist. Other therapies offered include Couples Counselling for Depression, Eye Movement Desensitisation and Reprocessing (EMDR), Counselling for Depression, Interpersonal Psychotherapy, Mindfulness-Based Cognitive Therapy, and Behavioural Couples Therapy. From these, CBT is the most utilised modality, making up 92% of the therapeutic offer (NHS England, 2022).

A recent annual report on the use of NHS services shows that 1.81 million referrals were made between 2020 and 2021, of which 1.24 million accessed services and 664,087 completed treatment. The average length of treatment was 7.9 sessions, and 50.2% reached recovery (NHS Digital, 2022), representing the lowest level of recovery in five years. For those who met the recovery threshold, much remains unknown about the durability of treatment in the long term (Kellet et al., 2021).

A History

In the last two decades, a new type of politics has emerged, focusing on science to increase citizens' wellbeing. The government became aligned with Aristotle's observations on ethics and politics. This was a significant shift from liberalism to a neo-Aristotelian philosophy. The latter concludes that attention to the flourishment of societies' citizens is the primary purpose of government – that is, to provide what Aristotle termed the good life, to give an opportunity to EU *zēn*, which, when translated, means *to live well* (Aristotle, 350 B.C.E/2021). Aristotle believed that as a species, we share the same biological nature and that to fulfil that nature, we need to flourish.

Under the Labour government at the latter end of the 1990s, British policy became heavily influenced by neo-Aristotelian political philosophy. This direction was further carved out in 1998 by Demos, a British think-tank that produced a collection of essays called *The Good Life* (Christie & Nash, 1998). These essays encouraged a change in political priorities, with concerns of flourishing and virtue at their core. It was not long before there was cross-party support for neo-Aristotelianism and its potential implications on broader society, thus beginning the politics of wellbeing, the aim of which was to elevate citizens to new states of happiness and health.

The newly fertilised soil of neo-Aristotelianism created the optimal conditions for the seeds of neoliberalism to grow and thrive. A multidimensional political philosophy with an extensive history and competing definitions, neoliberalism reappeared in the late 20th century with substantial implications for society and its subsequent structuring around economic incentives, focus on individualism, and the reduction of distress to facilitate greater productivity. Scholarly work has often explored neoliberalism through Marxist or Foucauldian theory, and landing on an agreed definition has been, and remains, a point of political and theoretical contention.

Alongside the emergence of neo-Aristotelianism and neoliberalism was the growing interest in the cognitive science of wellbeing in the 1960s, which then increased in popularity in the 1990s leading to the major support of cognitive behavioural psychology, positive psychology, and economics, professing it was possible to measure life satisfaction and happiness. This supported the dissemination of an 'objective truth', a truth where the government no longer feared accusations of imposing a moral or ethical order. Instead, they could justify their claims on wellbeing with scientific 'evidence' (Evans, 2018).

The Architects of NHS Talking Therapies

A meeting between Lord Richard Layard, an economist with neo-liberal and utilitarian leanings and specialisation in the economics of employment, and Dr David Clark, a leading British CBT practitioner, led to the development of NHSTT. A new kind of mental health service was promised, one with an overarching economic focus: to get sufferers of anxiety and depression

back to work and to reduce the financial strain incapacity benefits had on the country (London School of Economics and Political Science, 2006). On paper, alleviating misery while saving money made sense. However, as with any ideology – especially those that come up against human complexity – the gap between theory and reality is vast, with evidence suggesting, despite positive economic claims, the cost of NHSTT is at least five times greater than initially projected (Scott, 2018a).

The 2005 Labour Party's manifesto swiftly adopted Layard's and Clark's plans for NHSTT and officially launched the service nationwide in 2008 with the vision of helping millions recover from anxiety and depression (Layard & Clark, 2014). Given the shift to neo-Aristotelianism and the growing evidence that wellbeing could be measured, Clarke's claims of a 50% recovery rate in those with anxiety and depression using CBT (Layard & Clark, 2014) were rapidly absorbed and reinforced by NICE's approval of CBT to treat anxiety and depression. Armed now with convincing rhetoric underscored by 'objective' science, the government could roll out plans supporting the necessary flourishment of its citizens.

Critique of NHS Talking Therapies

Since the genesis of NHSTT, a growing presence of socio-political commentary has emerged, with commentators often falling into one of two camps: for or against. As a service, the success of its nationwide application and re-formulation of mental health provisions justifies some acknowledgement. It is rare to see something theoretically proposed become eagerly supported by key policymakers, government bodies, and senior NHS personnel.

Throughout its evolution, NHSTT has become the subject of global attention, stamped with a seal of quality that other health services aspire to. In their book *Thrive*, Layard and Clark (2014) coined it the "great humanitarian project" (p. 207). It successfully helped the NHS prioritise scientific evidence (Pickersgill, 2019) and revitalised a sector plagued by long waiting times and inconsistent treatment delivery while making therapy accessible to large areas of the population (Binnie, 2015; London School of Economics and Political Science, 2006).

Given the highlighted relationship between poor mental health and economic damage, it made 'sense' to form an accessible service armed with evidence-based treatments delivered to ameliorate suffering. This reasoning is echoed in several interviews with policymakers conducted by Pickersgill (2019), with one interviewee citing NHSTT as "the sensible thing to do" (p. 636), given the circumstances. Weber (1905/2002) coined this method of deduction "rationalization", a term linked to the growing proliferation of markets and bureaucracy. It is the use of criteria to assist in rational decision-making in combination with calculable economic efficiency. However, despite all good intentions, NHSTT's economic motivations marked the beginning of something far more insidious: a culture where *worklessness* became synonymous with *worthlessness* (Scanlon & Adlam, 2010).

In a world where the seductive forces of reductionism bring comfort to many in a complex world, it is not unreasonable to title NHSTT as a *sensible* solution. However, one might ask: who *defines* 'sensible', and who are the *real* benefactors of such sensibilities? These questions, in one shape or another, are tentatively – and at times quite boldly explored by those who challenge the NHSTT model, often at the risk of being branded 'anti-progressive' (Watts, 2016).

Rosemary Rizq, a counselling psychologist, explored the cultural, clinical, and political challenges caused by NHSTT. Through the elegant application of Freudian ideas, Rizq assigns NHSTT as responsible for *the perversion of care,* an endemic issue forming part of a broader, more systemic problem of *fetishisation* within NHS governance systems (Rizq, 2012). Simply put, the changes made due to NHSTT have seen the NHS distance itself from the complexity of managing the suffering, vulnerability, and dependence found in society. Thus, enabling mental health services the privilege of avoiding emotional realities of pain and suffering in replacement of policies, protocols, and target outcomes: a justifiable accusation given that NHSTT clinicians work to an average of 7.9 sessions (NHS Digital, 2022). To this point, treatment lengths have been suggested as contraindicated in meeting the needs of a

high percentage of clients – particularly those falling in the complex range (Griffiths & Griffiths, 2015; Martin et al., 2022).

One example of NHSTT's commitment to data and protocols is the systematic use of measures such as the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder (GAD-7), and Work and Social Adjustment Scale (WSAS) questionnaires in every session. These data are collated to determine the effectiveness of treatment while also reflecting a therapist's overall performance. Data also forms part of a broader requirement guided by service targets, contributing to annual national statistics. A recent study found the administration of measures across five services was deemed impersonal, inflexible, and inconsistent. From this, the authors recommend practitioners should "move from administering outcome measures as a stand-alone exercise aiding discharge, to one of focusing on item changes… as a constituent part of the therapeutic encounter" (Faija et al., 2022, p. 834).

The privileging of measures and protocol above the clients' psychological needs, Rizq (2013) cites, is not reflective of reality but rather is a "virtual reality". The *fetishisation* of governance systems and auditing protects us from intolerable feelings of helplessness brought on by the limits of our capabilities when faced with trying to help people in psychological distress. Rizq suggests that this virtual reality necessitates an act of *disavowal*, where one simultaneously admits something while also disowning it. In this case, the denial is manifest in the clinical and cultural consequences brought on by the rigid application of measures and protocols impacting therapists, clients, and the wider landscape of mental health (Bermudez Otero, 2019; Binnie, 2015; Douglas et al., 2016; Mason & Reeves, 2018; Pickersgill, 2019; Rizq, 2012, 2013; Scott, 2018; Steel et al., 2015; Watts, 2016). Despite this, these consequences are ignored – or disavowed – due to top-down rhetoric and a professional desire to be seen as conforming and complying. Being part of this virtual reality lends itself to a distortion of emotional reality, where the quality of clinical work is reflected through auditing rather than *being with* clients.

Bevan and Hood (2006) caution against relying too heavily on measurements, which they suggest can lead to *reactive gaming* - that is, abusing the rules of a system designed to protect

it. As such, with NHSTT's emphasis on Key Performance Indicators (KPIs), it runs the risk of pushing service personnel towards reactive gaming. Binnie (2015) writes of his observations from working in NHSTT, where he witnessed data gaming to satisfy commissioners. Often, the priority is to reach a specific target instead of considering what the target represents, and can be manipulated to reflect optimal KPIs: a “blatant example of fudging the statistics” (Binnie, 2015, p. 6).

Ritzer (1992) termed the increasing, highly controlling, bureaucratised systems in contemporary social living “McDonaldization”, a hat tilt to the food industry predicated on efficiency, quantification, and control: a template now adopted in education and medicine. The prevalence of McDonaldization in healthcare, Strawbridge (2016) notes, causes the process of therapy to become minimised, with little respect for the complexities involved. Instead, this minimisation creates a focus on fidelity to manualised treatments, quantification of data, and diagnoses. Thus, NHSTT is akin to what Binnie (2015) calls a “therapy factory” (p. 3). This is an appropriate observation given NHSTT's allegiance to the medical model, where treatment delivery is based on psychological distress being pathological rather than a dimension of human experience (Mason & Reeves, 2018). Privileging this perspective of the human condition risks organising distress into arbitrary symptom clusters while underestimating and simplifying more complex presentations. One recent study supports this, concluding the current NHSTT training and delivery framework may be insufficient in meeting the needs of a sweeping percentage of complex referrals (Martin et al., 2022).

Therapist Wellbeing

The above critiques of NHSTT promote a position of healthy scepticism and encourage one to consider how an over-reliance on policies, protocols, and outcomes may impact the wellbeing of therapists – with one commentator reporting “they [NHSTT] operate like a totalitarian Communist regime concerned with ideology, operational matters, production quotas, and waiting times” (Scott, 2023, para. 4). Watts (2016) explores this very issue, reflecting on her experience of supervising dozens of staff: “These experiences have all led

me to believe that IAPT operates in a virtuality focusing on performativity and surveillance rather than real encounters between clinician and patient" (p. 87). This facilitates an environment that places significant strain on the clinician. Although Watts' statement is anecdotal, there is further evidence suggesting concerns for those working in NHSTT are warranted (Baker, 2020; Bermudez Otero, 2019; Martin et al., 2022; Owen et al., 2021; Turnpenny, 2019).

A collaboration between the British Psychological Society (BPS) and the New Savoy started in 2014 to explore clinician wellbeing in mental health services. Since then, data has been published from 2014 to 2019 across primary and secondary mental health services. In the 2017 survey, which had a sample of 1678 respondents, 43% indicated they felt depressed, and 42% felt like a failure, with some of the biggest contributing factors being burnout (recall the tendency for burnout to be used in place of MI), low morale, and stress. Catherine Jackson addresses this survey in her article *Slaves to the Machine*:

> "The overall picture it consistently reveals is of a stressed and distressed workforce, driven to depression, self-doubt and job change by the constant pressure to meet demanding targets despite inadequate staffing, not enough time to work genuinely therapeutically with clients, and not enough management support and professional supervision. The surveys reveal a culture described as lacking compassion for staff and clients alike" (Jackson, 2019, para. 1).

When treatment does not go to plan, it is not uncommon for the blame to lie with the therapist (here we find a crossover over with perpetration-based conceptions of MI), who, herself, is under more monitoring and pressure than any other therapist in history (Watts, 2016). This is partly because the type of CBT practised focuses heavily on short-term manualised techniques for change and primarily looks to control and alter cognitive processes. This modality requires rigid adherence as treatments are time-limited, in turn disallowing the client space to explore their process while also limiting what the therapist can offer outside of the prescribed protocol – blocking the most basic of relational contact (Lamph et al., 2021; Proctor

et al., 2021): something I have come to label the *disenfranchised relationship*. The top-down pressures - affecting both clients and staff prompted one commentator to conclude that NHSTT is in need of radical reform (Scott, 2018b, 2021).

Rigid treatment protocols, manualised therapies, reduced clinical contact, increased monitoring and surveillance, these modifications to the art and science of psychotherapy are symptomatic of a broader trend in the field of mental health care: one that moves away from psychotherapy as a craft, towards a division of labour focussed on reproducible and standardised clinical outcomes, often facilitated by less skilled workers. Satran's (2022) article on the automation of psychotherapy speaks to this point. Drawing on the Marxist framework, Satran argues the role of the human therapist is being controlled and minimised in a way previously unseen. His primary thesis centres on the newly developed Internet Cognitive Behavioural Therapy (ICBT) provision rolled out in Israel and strongly modelled after the UK's NHSTT service. A cost-effective and rationalistic modality, ICBT focuses on shortening the time a therapist spends with their client (roughly 20 minutes per week), with the clinician's role limited to remotely guiding their clients through self-help material.

A similar concept to ICBT can be found at the bottom 'step' of the NHSTT stepped-care model, where clients are introduced to some form of guided self-help – either online or via a workbook – before being progressed (if proven ineffective) to the next 'step' for more direct treatment. Moreover, the NHS (including some NHSTT provisions) has adopted its own form of 'distance' therapy, coined Typed Cognitive Behavioural Therapy. Claiming to be as effective as face-to-face therapy (ieso, 2021), Typed CBT is a text-based service where clients are guided through self-help materials to manage feelings of depression, anxiety, and other mental health difficulties.

In an analytical autoethnographic study, Richard Mason observed the challenges of working in NHSTT, focusing on the ideological tension between counsellors and trained CBT practitioners (Mason & Reeves, 2018). He writes of this tension creating an us-and-them dynamic, where one is pressured – despite modality, training, and qualifications – to train in

CBT as a matter of workplace survival. Mason writes: “My sense of loss and uncertainty led to a decision. I realised that IAPT was not going to accommodate me, so I had to accommodate IAPT, or leave” (Mason & Reeves, 2018, p. 674). This notable inequity between High Intensity (HIT) CBT therapists and counsellors is not limited to philosophical and theoretical stances but also manifests through pay disparities where CBT therapists are often higher pay bands when compared to their counsellor colleagues (Leavesley & Shakespeare, 2023).

The clinical modality taught to HIT CBT and PWP trainees and prescribed by NHSTT is drawn mainly from ‘second-wave’ CBT because it is quicker and easier to teach and conditions one view of the human mind (Watts, 2016). This is despite notable drops in its effectiveness and recovery rates as a modality when compared to other therapies (NHS Digital, 2022). It strongly focuses on cognition and, in its manualised form, leaves little room for the relationship, contrasting with more traditional ‘second-wave’ or ‘third-wave’ CBT, which better uses relational and behavioural components (Hayes, 2016). This type of CBT has been compared to and is reminiscent of Foucault’s *disciplinary power*, where a person (in this case, a client) is made a disciplined subject – a *good citizen* – through the subtle application of power by the state (Foucault, 1982/2019; Watts, 2016). However, I believe it is not too radical to suggest that the NHSTT therapist is also subject to such comparisons (a topic discussed in Chapter Five).

The rigidity of manualised CBT, along with the ascension of performance data, means supervision consists of an analysis of numbers associated with treatment, an encounter where performance is privileged over the relational contact between two people. This is further compounded by the NHSTT contract, which goes through competitive bidding processes between local mental health services. A system that encourages manipulation of data and strategic clinical manoeuvring to ensure contract acquisitions. In turn, recovery scores are prioritised, and if these remain suboptimal, then the therapist is made to bear the burden of blame for failing treatment fidelity. With this top-down pressure in mind, it is not shocking to

learn of significant turnover rates among the NHSTT workforce (NHS England, 2016), with up to a quarter leaving in the first three years (Watts, 2016).

Reflections

As indicated in Chapter One, this research was a value-laden pursuit, one with roots in both my personal and professional history that cannot be decontextualised from the final product. Personally, my stance towards systems of power is influenced by experiences growing up under the poverty line, as a minority, and spending a period of my childhood in foster care. Overtime, I became increasingly sensitive to perceived inadequacies within power structures (albeit unknowingly at the time). This pattern played out throughout schooling, where I would push back against boundaries and the authorities that placed them, sadly resulting in multiple suspensions and eventual expulsion.

These early experiences consolidated a preoccupation with the concepts of 'right' and 'wrong', 'good' and 'bad', and the confronting of how people could be 'good', while also being capable of 'bad'. This confusion was magnified by having a parent I idealised (good), while also falling victim to their capacity for harm (bad). I was often exposed to morally transgressive experiences, either by me or others; I struggled to reconcile the fact that everything was framed as 'good' or 'bad', while feeling these terms were inadequate in describing a complete picture of me and others. Therefore, it would be reasonable to assume these early experiences contributed to my intellectual interest in morality, and thus the theory of MI more specifically.

Professionally, my cautiousness and scepticism of systems began to take shape less through acting out, and more through reflection as I increased my capacity to wrap language around experience. Following my undergraduate degree, I worked in the charity sector supporting children, young people, and adults with mild-to-moderate mental health difficulties. Although the work felt meaningful, it was guided by strict protocols and

debilitating funding cuts. Feeling helpless and frustrated, I decided the only way I could make change, or at the very least get my foot through the door, was to get a 'Dr' title in front of my name.

After successfully applying to a doctoral programme, I secured my first placement in an NHSTT service. It did not take long to realise it suffered problems similar to those I had seen previously. But the stakes felt higher, not least because the client group was more distressed. At the time, we were being urged to consider research ideas on the training, so I decided to channel my feelings into the development of the current research. I felt this achieved two things, (1) it allowed me to overcome feelings of helplessness by *doing* something, and (2), the research could contribute a new narrative that expands the conversation on *how* stress is framed for therapists working in NHSTT.

It is sensible to assume, therefore, that my reading of the literature was also influenced by my personal and professional context. For example, in the MI literature, I was particularly inspired by Shay's original work because of its contextualised focus and at times struggled with other contributions that failed to consider social-political factors, or were more medicalised and quantitative (however, it should be noted these tendencies may have also been reenforced in part by the critical nature of psychotherapy and counselling psychology as disciplines). Similarly, I also noticed a gravitation towards more critical accounts of NHSTT; therefore, I became mindful of ensuring my personal and professional experiences were not the driving force behind my approach to the evaluation of literature.

CHAPTER THREE
Methodology

Epistemology and Ontology

My philosophical position assumes reality is largely mind-independent, and knowledge production can reflect *something* present in reality. However, I do not propose an unmediated, direct truth to reality where universal laws are assumed without *epistemic humility* (Pilgrim, 2019). Instead, I believe knowledge is stratified, complex, and a consequence of many seen and unseen intersecting processes. Thus, I hold a position advocating the fallibility and limits of knowledge.

I reject a strictly realist, positivist position due to its focus on universal laws, problematic and shallow determinants of causation, and the assumption that knowledge can be accessed objectively. Equally, I position myself away from purely social constructionist relativist assumptions where discourse, meaning, and experience are encouraged as part of knowledge production, but in doing so, can overlook causal explanations (Fryer, 2022a; Pilgrim, 2019). In other words, it neglects the pursuit of explanatory conclusions to determine *why* a particular discourse, meaning, or experience may occur and *how* research can influence meaningful change.

To reconcile the above while establishing internal coherence between my research focus and chosen methodology, I have situated this research through the lens of critical realism (Bhasker, 1975/2008; Bhasker & Hartwig, 2016). Critical realism (CR) grounds itself within a realist ontology from a ‘critical’ stance and gives way to a mild epistemic relativism – that is, knowledge is produced and articulated within historical, cultural, and social contexts, as opposed to regression-based models of cause-and-effect. Moreover, CR critiques traditional positivism on the grounds that the observer cannot be separate from the observed, a counterclaim to positivist theorists who presuppose a straightforward, unmediated relationship between the world and how we perceive it. Thus, the post positivist – and subsequently the CR – express that scientific enquiry can only come to imperfect conclusions about the state of

reality (Guba & Lincoln, 1994), an understanding inevitably mediated through the generation of theory (Pilgrim, 2019)

Critical realism considers the context in which research is gathered while factoring other variables, such as human discourse and social power that mediate the relationship between human curiosity and scientific endeavour (Gorski, 2013) without sacrificing causal explanations or actionable outcomes. This sacrifice can be observed in more traditional social constructionist paradigms that caution against ontic realism and, in doing so, risk radical relativism.

Design

Thematic Analysis

Broadly speaking, Thematic Analysis (TA) supports the production of knowledge represented by themes and descriptive codes, allowing researchers to make sense of specific phenomena (Braun & Clarke, 2006; Willig, 2013). On its own, it does not represent a singular method but rather a diverse range of knowledge production approaches spanning the paradigmatic landscape. These approaches can fall within a ‘Big Q’ framework (underpinned by qualitative norms, values, assumptions, tools, and techniques), a ‘Small q’ framework (the use of qualitative tools underpinned by a positivist or post positivist paradigm), or a ‘Medium Q’ framework (situated more centrally on the Big Q-Small-q spectrum).

The Thematic Analysis ‘Family’

Braun and Clarke (2021a), in their latest compendium on TA, outline a tripartite typology organised around different forms of TA, where an exploration of the philosophical assumptions and analytic procedures are used to demarcate different variations. These classifications include reflexive TA (Big Q), coding reliability TA (Small q), and Codebook TA (Medium Q), respectively.

Coding Reliability TA

Coding reliability TA (Boyatzis, 1998) is an approach unified by (post) positivist commitments to reliability and unbiased, objective truth-seeking, either explicitly manifest or implicitly implied. Reliability is established through structured adherence to the use of a coding frame, and subjectivity is something to be managed - to reduce bias and ensure reliability - rather than adopted as a research tool.

Codebook TA

Codebook TA, by contrast, values researcher subjectivity and does not encourage a positivistic emphasis on reliability. It shares many values underpinning qualitative research but adopts a structured coding process by establishing a coding frame before or after analysis. The ensemble of characterologically similar approaches that fall under a codebook TA often go by different names, with two of the more widely used being framework analysis (Srivastava & Thomson, 2009) and template analysis (King, 2012).

Reflexive Thematic Analysis

Reflexive thematic analysis (RTA) – the chosen method for the current research, deviates from other forms of TA with its focus on complex and nuanced exploration of meaning and understanding; theoretical, technical, and philosophical flexibility; prioritisation of researcher reflexivity; and its focus on immersion and depth to the data – while also creating space and distance from it. These features also share an affinity with critical realism. Unlike its methodological cousins, RTA parts with any use of coding framework which may risk the research process becoming mechanistic and constraining the interpretative and analytic process.

Reflexive thematic analysis lies upon a bed of qualitative values and sits within a Big Q framework. It outlines six phases that form part of the analytic process. These phases do not represent a linear climb to conquering the analytic objective but are – and should be – taken recursively, with the researcher oscillating between different phases at different stages of their

research journey. This allows the analytic and interpretive process to be engaged more flexibly and at greater depth than other forms of TA while also interrogating the role of the researcher as *part* of the research, not separate from it.

The flexibility of an RTA method challenges the researcher to apprehend and interrogate their assumptions on the nature of reality and how they come to know it: in short, a consideration of the 'ologies (Malterud, 2016). This also includes one's axiological assumptions, which RTA largely adjusts for through its emphasis on subjectivity and reflexivity. When done effectively, this flexibility promotes a harmonious and coherent relationship between methodological, theoretical, and philosophical assumptions.

The flexibility of an RTA allowed this research to be philosophically underpinned by CR and theoretically informed by MI. It offered tools to stay close to participant experiences while giving space for me to situate these experiences theoretically within the wider socio-political context. An RTA supports both inductive and deductive orientations to the data and exploratory and explanatory conclusions from the data.

Thematic Analysis and Critical Realism

When considering the relationship between an RTA and CR, it should be noted that the primary authors of RTA identify themselves as mainly practising within a constructionist, relativist framework (Braun & Clarke, 2021a). However, as stated previously, CR challenges purely constructionist positions as they privilege language and discourse over casual insights. As a philosophy, it does not discount the importance of language. Instead, it avoids taking it to its purely relativist conclusion, where ontology risks being missed, and research can become delimited in its opportunity to generate causal conclusions and actionable outcomes (Fryer, 2022b; Pilgrim, 2019). Interestingly, despite this tension, CR has been documented as the most utilised philosophical approach when using an RTA (Braun & Clarke, 2021a). This is likely due to the flexibility of an RTA as a model, and when applied appropriately, showcases the complementary nature of the two approaches.

Both RTA and CR strongly advocate for critical engagement with philosophy when conducting research, as without this, one risks stepping into the trap of epistemic and ontic fallacies (Braun & Clarke, 2021a; Pilgrim, 2019). A common error in research, epistemic fallacies occur when one conflates the proverbial map with the territory – that is, flawed beliefs or conclusions emanating from statements on reality that are reduced to statements of our knowledge of it. Adopting a position of epistemic humility is necessary to avoid such faulty conclusions, which cautions one against the fallibility and partiality of knowledge. Similarly, ontic fallacies come from using faulty reasoning to describe a dimension of reality, such as seeking evidence to promote one's own view of the world. In this case, the abstract becomes the concrete – that is, because a term of reference for something exists (e.g., theories of flat earth or some biological theories of mental health), it, therefore, equates its existence with reality.

Both RTA and CR recognise the fallibility of universal laws sought after and espoused by positivist research and acknowledge the limits of direct, 'objective' contact with reality. However, CR takes this further with its theories on open and closed systems, transitive and intransitive dimensions of reality, and focus on events, experiences, and causal mechanisms (Bhasker, 1975/2008; Pilgrim, 2019).

The CR theory of experiences, events, and casual mechanisms - and the importance of considering these in research - supported the current research to value the discursive accounts of participants and what they experienced (events and experiences) while also holding space for *why* these experiences may have occurred (the causal mechanisms). This formula is considered necessary to produce good quality research and, more specifically, underpins a crucial feature when using a CR-informed TA (Fryer, 2022a).

Of note, my use of 'events', 'experiences', and 'causal mechanisms' is deliberate and shifts *away* from using the domains of 'the actual' (actual aspects of reality that occur, whether observed or not), 'the empirical' (the observable aspects of reality), and 'the real' (parts of reality both beneath and beyond the actual and empirical domains) (Bhasker, 1975/2008).

Here, I align with the critiques of Fryer and Navarrete (2022), who suggest that the former helps clarify and better orientate researchers, whereas the latter can obfuscate and disorientate them. In their paper, the authors conclude: “for a scientific researcher that understands the differences between *experiences*, *events,* and *causal mechanisms* we cannot see any extra insights that come from adding the three domains [the actual, real, and empirical] of reality. They’re redundant.” (Fryer & Navarrete, 2022, p. 2).

Critical Realist Approaches to Thematic Analysis

Critical realism considers the establishment of causal mechanisms as crucial to the research process and, when applied to qualitative research, challenges the long-standing assumption that it cannot produce causal insights (Bhasker, 1975/2008; Fryer, 2022a). Historically, qualitative research projects often attend to the *exploratory* rather than the *explanatory* (however, it should be noted that grounded theory can also explore causal processes, a topic discussed in more detail later) (Creswell, 2009). In contesting this, CR approaches to TA therefore argue for the following: “social scientific research should both communicate and represent people’s experiences (exploratory experiences) and then move on to produce causal explanations that allow us to understand, and potentially to intervene in, these events (explanatory research)” (Fryer, 2022a, p. 16). Therefore, although an RTA is the primary method used in this research, inspiration has been taken from newly developed models offered by Fryer (2022a) and Wiltshire and Ronkainen (2021) on conducting a CR-informed TA.

There is significant overlap between the RTA model outlined by Braun and Clarke (2021a) and the CR approaches to TA developed by Fryer (2022a) and Wiltshire and Ronkainen (2021). However, the primary point of divergence is in their conclusions. Reflexive thematic analysis uses the concept of *storytelling* to describe the analytic process (Braun & Clarke, 2021a) and emphasises the generation of “interpretative stories about the data” (Braun & Clarke, 2019, p. 594) as the purpose of research, likely originating from its more constructivist routes. However, while still valuing the place of language and experience, a CR-informed TA

advocates for the outcome of research to also address causal explanations (Bhasker, 1975/2008; Fryer, 2022a; Wiltshire & Ronkainen, 2021) and cautions against prematurely cutting the research process short by only reporting on experiences.

Because the current research attempts to shed light on an under-explored corner of the MI literature (i.e., therapists in NHSTT), it is necessary to start with events and experiences – that is, the *exploratory* (Fryer, 2022a). However, in holding the CR foundations of this study in mind, I have outlined an additional causal research question to meet the *explanatory* function of the research that considers why participants may have experienced these events.

Other Methods of Analysis

Reflexive thematic analysis is just one method among a compendium of other methods and methodologies within qualitative research. Providing an overview of all of these goes far beyond the scope of this project. However, I will offer a sketch of the more common methods and methodologies and explain why they were *not* used.

Before continuing, it is important to distinguish the difference between a 'method' and 'methodology'. Methodologies are theoretically informed research designs that are 'pre-packed' – that is, they come equipped with theoretical and methodological features that guide the researcher. Examples of pre-packed methodologies include Grounded Theory (GT), Interpretative Phenomenological Analysis (IPA), and Discourse Analysis (DA).

Conversely, a 'method' is theoretically independent, meaning the scaffolding of theory is negotiated separately. Theory-independent methods include TA and Qualitative Content Analysis (QCA). However, the theoretical independence associated with methods can sometimes conflate them with being atheoretical and, therefore, lacking in sophistication and analytic power, a controversial and contested position within the literature. This premise has supported the (misguided) belief that methodologies are superior to methods. However, there is much overlap between the analytic outputs of both, serving the counter-argument that methodologies are *not* constitutionally better than methods: a point well established and

defended elsewhere (Braun & Clarke, 2021b; Chamberlain, 2012). In keeping with this distinction, I will subscribe to the use of "method(ologies)" when referring to either a method or methodology from this point on.

Reflections

When designing a research project, my own experience leads me to agree with the following: "there is rarely one ideal method – or methodology – for a research project" (Braun & Clarke, 2021b, p. 38). Researchers engage with method(ologies) in several ways and for several reasons. This may include selecting a method(ology) for pragmatic or conceptual purposes or because it feels comfortable or familiar. Equally, a particular method(ology) may be selected because it has been popularised within a researcher's academic institution. However, despite the method(ology), what remains is the importance of 'methodological integrity' (Levitt et al., 2017) – that is, that the method(ology) *fits* with the research purpose and philosophical structure.

Qualitative Content Analysis

Qualitative Content Analysis is concerned with identifying themes (Burla et al., 2008; Vaismoradi et al., 2016). Variations of a QCA closely resemble a TA. However, unlike RTA, QCA has been framed as 'atheoretical' rather than theoretically flexible. Theoretical underpinnings are seldom discussed, and positivist assumptions can be implicitly or explicitly introduced into the research process, examples of which may include using tools to adjust for researcher subjectivity or using inter-coder agreement to determine reliability. It is also considered a method primarily used for producing more descriptive analysis (Cho & Lee, 2014) and has been suggested as the "least interpretative of the qualitative analytic approaches" (Braun & Clarke, 2021b, p. 4). Because the current research looks beyond a descriptive analysis, and my philosophical position challenges the notions of researcher objectivity and

empirical methods of 'reliability', QCA was deemed unsuitable for this current project. Furthermore, I find the atheoretical assumptions underpinning QCA particularly problematic, as it implies a position of theoretical neutrality that challenges my philosophy and personal sentiments - that is, one cannot escape the influence of theory, values, and other contextual factors (Bhasker, 1975/2008; Braun & Clarke, 2021a).

Grounded Theory

Grounded Theory is similar to TA in that it aims to identify categories of meaning through coding, considers the positioning of the researcher (in more constructionist versions), and is concerned with the identification and contextualisation of social processes. However, unlike TA, its primary aim is to generate a substantive theory (i.e., a contextualised theory as opposed to a grand theory positing universal laws) from an analysis that is 'grounded' in the data. When used in its abbreviated form (occasionally referred to as 'GT-lite' where sample sizes are smaller), it can produce a similar analysis to TA (Braun & Clarke, 2021b). For this reason, GT was RTA's most significant competitor when considering the current study's method(ological) direction.

Grounded Theory vs Reflexive Thematic Analysis

Grounded Theory can be used in quantitative and qualitative research and exists on a theoretical spectrum ranging from Glaser's (1992) positivist adaptation, Strauss's modified design informed by symbolic interactionism (Strauss & Corbin, 2015), to Charmaz's (2014) constructivist rendition. With its focus on events, experiences, and causal explanations, it can be seen as broadly overlapping with CR.

One essential feature of GT is its use of ethnographic data, a powerful approach to contextualising participants' experiences. However, given the environmental limitations of the pandemic – which occurred during the current study's design – this critical feature of data collection would have been negated. Naturally, this factored strongly into my decision-making when exploring the practical limitations of choosing a method(ology) and pushed me towards

an RTA. An RTA accommodated the practical limitations (i.e., quarantine rules and remote working) of conducting research at the time while offering the tools to conduct a meaningful data analysis with space for exploratory and explanatory functions.

Equally, GT takes an inductive approach to analysis, allowing the construction of theory *from* data. Therefore, a purely inductive orientation would not have been compatible with my research design, as MI was the theoretical 'filter' used to make sense of participant experiences. As such, a method(ology) primed for both inductive *and* deductive investigations was required.

Lastly, the function of the current research was not focused on generating a novel theoretical framework. Grounded Theory, therefore, would not have served the study's overall aim. However, through some modifications to the research design, I recognise that a GT adaptation could offer a unique and equally meaningful perspective on the current study (see limitations and future directions).

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (Finlay, 2011; McLeod, 2011; Smith & Fieldsend, 2021), much like an RTA, values the place of subjectivity in the research process. Equally, both share similar means of knowledge production through the identification of themes. When a small sample is used, the results of a phenomenologically informed TA compared to an IPA are similar (Braun & Clarke, 2021b). An IPA aims to generate and interpret a detailed and rich account of participants' experiences. However, it often fails to deepen our understanding of *why* such experiences occur and *why* there may be differences between individual phenomenological accounts (Willig, 2013). Therefore, it has a reputation for interpreting, describing, and documenting experience rather than exploring contributing factors or causal mechanisms, a criticism some IPA methodologists have also echoed (Brocki & Wearden, 2006; Smith, 2011). For this project, I intended to document the experience while also exploring *why* the experience could be occurring. My aims were, therefore, guided by research

questions and a philosophical position which do not restrict the analysis to explorations of personal experience alone, thus making an IPA incompatible with the study design.

Discourse Analysis

Discourse Analysis frames language as a performative and active social practice, and much like its method(ological) cousins, can vary in its application, ranging from more fine-grained explorations of language practice used in conversation analysis (Madill et al., 2001) on the one end, to the broader focus on discursive productions adopted in poststructuralist discourse analysis (Gavey, 1989) or interpretative repertoire analysis (Wetherell & Potter, 1992) on the other. Some outputs of DA - particularly more pattern-based iterations - can closely resemble an RTA. However, the current research was *not* aimed at an exploration of language alone. Although the study of participants' language was necessary and formed part of this analysis, it was insufficient to meet the overall objectives. Furthermore, the strong lineage of poststructuralist and constructionist ideas found in some versions of DA run contradictory to the philosophical assumptions grounding this study, where reality is largely mind-independent and assumed to exist beyond the territories of language.

Participant Recruitment, Interviews, and Data Collection

Recruitment Process

This study recruited eight participants. Emails with a recruitment flyer (Appendix E) attached with instructions on how to sign up were distributed to therapists working in – or had previously worked in – NHSTT. This was done internally via the Metanoia Institute or externally across different NHSTT services. Once the recruitment phase ended, all participants were screened over the phone. As part of this call, participants were asked to briefly describe the experience(s) they felt related to the current study, including the impact. To alert the participants of the potential risk of distress from participating in the study, each was asked how they would feel discussing their accounts in more detail and were encouraged only to proceed if they felt comfortable. For those participants who met the criteria, a day and time

was arranged for the formal interview. Once informed consent (Appendix A) was obtained, semi-structured interviews (Appendix D) were conducted in a confidential location over Zoom.

Inclusion Criteria

Participants had to be trainee or qualified therapists (level four or above) with a minimum of one year of experience working in an NHSTT service. A year minimum was deemed necessary as it was felt to be adequate time to become settled in their role and integrated into the established work culture. Those with a minimum of one year needed to experience one or more of the scenarios listed on the recruitment flyer to pass the screening stage.

Exclusion Criteria

Therapists who had worked for less than one year in NHSTT were not included in the current study for the above reasons. Furthermore, Psychological Wellbeing Practitioners (PWP), a relatively new edition to the NHSTT workforce, were also excluded from the research as they are not trained therapists but instead receive one-year post-graduate training to provide low-level Cognitive Behavioural Therapy for mild psychological symptoms (Green et al., 2014).

Data Collection and Transcription

All semi-structured interviews were conducted over Zoom and audio recorded. Each interview was transcribed verbatim using transcription software (Otter transcribing software), and every transcript was reviewed separately to ensure accuracy. All data was stored on an encrypted hard drive and, when not in use, placed in a locked safe. Once the interviews were fully and accurately transcribed, the data was coded. All participants were allowed to withdraw their data at any stage before the analysis commenced. No participants opted to do this.

Demographics

Participant Number	1	2	3	4	5	6	7	8
Pseudonym	Sally	Jenny	Katherine	Nina	Tracy	Sophie	Alex	Claire
Gender	F	F	F	F	F	F	F	F
Ethnicity	White British	White British and Black Jamaican	White British	White British	White British	White British	White British	Chinese
Age	53	53	39	64	39	56	31	34
Level of Clinical Qualification	Diploma in Counselling	Masters	Masters	Diploma in Psychodynamic Counselling	Diploma in Humanistic Counselling	Doctorate	Doctorate	Level 7 HIT CBT
Length of Time in NHS Talking Therapies	10 Years	2 Years	10 Years	7 Years	19 Months	8 Years	13 Months	3 Years
Still Working in NHS Talking Therapies?	No	Yes	No	No	No	No	No	Yes
Interview Duration	28:15	1:00.45	41:19	25:51	36:24	57:02	36:04	30:12

Phases of Analysis

Because the framework of this analysis was informed by an established theory (moral injury), a theory-driven analysis of the data (i.e., deductive orientation) was used to guide the coding and theme identification process. This was coupled with a mild inductive orientation, allowing for the generation of additional insights and causal explanations. Data was engaged with at both the semantic (meaning was explored at the explicit, surface level) and latent levels (meaning was explored at the implicit, underlying level). As per the practice of RTA (Braun & Clarke, 2006, 2021a), the inductive-deductive and semantic-latent boundaries are blurry. Therefore, it is more accurate to conceptualise both orientations as existing on a spectrum, where the researcher inevitably fluctuates between different positions at different stages of analysis. Allowing for this flexibility reflects a critical attitude of the counselling psychology profession: one of pluralism. A 'both-and' position embracing the value of multiple stances to knowledge production (Douglas et al., 2016) while also corresponding with the philosophical commitment of CR (Bhasker, 1975/2008; Pilgrim, 2019).

Reflections

When one embarks on a research journey, it is unlikely to be smooth: pitfalls and obstacles will arise and should be expected. Anticipating my relationship with the research to be calm at some points and tumultuous at others allowed me to be open to the possibility of revising and adjusting the analysis with the evolution of the study – including knowing when to take a step back, slow down, and have a break (something I confess is difficult for me). This also included a critical engagement of my own subjectivity, as I was *part* of the research process, not separate from it. Therefore, any changes were monitored, documented, and reflected upon using a reflexive journal, an essential part of conducting an RTA (Braun & Clarke, 2021a).

Below, I have outlined the six phases of an RTA analysis and a corresponding description of *how* I approached each phase throughout the research process. Here, I aim to offer the reader an overview of each stage while also expanding on what the analytic process looked like. Each stage is unique and separate, but their relationship is not strictly linear. Instead, they are recursive, and one has the freedom to move between phases as and when necessary.

From beginning to end, the entire analytic process spanned six months (August 2022 - January 2023). Both hard copy and electronic formats were utilised when analysing the data. For me, the tactile feedback of physically moving codes and themes on a surface allowed for a different interaction with the data compared to electronic methods. The physical environment also played a key role. I engaged with much of the analysis away from my regular environment in the idyllic French countryside, where I am fortunate to have regular access. Stepping outside the competing pressures of day-to-day life, devoid of distraction, inspired significant shifts in energy and mood that provided psychological space to fully engage with the analytic process.

Phase One: Dataset Familiarisation

Phase Overview

Phase one involves an immersion in the dataset to build a deep and intimate knowledge of it. It requires a dance between two positions, one of immersion and closeness to the data, and the other of distance and critical engagement. Facilitating both these positions is the recording of thoughts related to the data.

Phase in Action

In my journal, I reported “excitement” and “apprehension” as I started my analytic journey. The 11th of August 2022 marked my transition into phase one. After formatting each transcript for readability, I began immersing myself in the data to explore the diversity of meaning and potential patterning across datasets. This involved reading through (electronically) and listening to each transcript from beginning to end multiple times. To reduce the chance of privileging some data over others - particularly in light of my own experience working in

NHSTT- I actively engaged in self-reflection throughout the familiarisation phase. This came in the form of documenting my thoughts, feelings, and ideas, which allowed for the interrogation of any potential biases or assumptions.

As phase one unfolded, I combined immersion with a more deliberate analytic approach. Broadly put, this required a move away from passively absorbing information to active analytic engagement with information-as-data. I began asking myself deeper questions and exploring patterned meaning within and across datasets (Appendix J). To support the *analytic sensibility* required for this – that is, the ability to occupy an interpretative and inquiring position to data – I undertook a broad reading of the MI literature. This helped me capture the theoretical landscape to achieve an informed analysis.

A running commentary of thoughts, feelings, and ideas was documented for each transcript (Appendix I), which acted as the building blocks for producing codes and themes. Some of these explored linkages between the data and the theory of MI, and others addressed more novel features. Before transitioning to phase two, I comprehensively interrogated any tentative conclusions or assumptions from the familiarisation process. I did this in dialogue with myself via the reflexive journal (Appendix H), where potential analytic directions were illustrated, combined with a cross-examination of my thoughts, feelings, and ideas. Before moving on, I also ensured I could broadly recall key analytic observations from memory - a helpful indicator proposed by Braun and Clarke (2021a) to determine when to move to the next phase.

Phase Two: Data Coding

Phase Overview

In phase two, the researcher systematically reviews each data item and the entire dataset. Any data relevant to the research question(s) is tagged with a *code label.* Coding is an organic process, meaning codes may evolve, be discarded, or require refinement throughout. Coding can be inductive or deductive, semantic or latent, or both.

Phase in Action

As I entered phase two, I documented some frustrations. I described the first wave of coding as “messy and chaotic” and felt “deskilled” given the enormity of the task at hand. However, I eventually found my coding rhythm and developed 72 codes. I realised there were some overlaps, which prompted me to modify the parameters of some codes. Some were discarded as they represented interesting features of the data but were not directly related to addressing the research question. I developed a spreadsheet separating all codes into columns to organise the codes and my thoughts. The columns were arranged to illustrate the code label and any subsequent revisions to that label. This is so I could monitor - at a glance - the evolution of codes over time.

From here, I refined and defined the codes into meaningful units reflecting distinct features in the data. Before completing my final wave of coding, I had a break from analysing. I described my experience as unable to “see the wood through the trees”, so creating some distance from the process felt important. On returning, I was filled with renewed energy and optimism. After two rounds of coding, followed by measuring the established coding for consistency and diversity of meaning, I started to move to phase three.

Phase Three: Initial Theme Generation

Phase Overview

Phase three sees the researcher begin generating initial themes from the coded data. Themes develop from clustered patterning observed across the dataset and orbit around a central organising concept. Codes are aggregated into *candidate* themes, which require deeper exploration and reflection before the final theme is settled. Themes can be organised into overarching themes (an umbrella concept connected to different themes), regular themes (captures something meaningful from the dataset), and subthemes (represent a singular feature of a theme).

Phase in Action

Entering phase three filled me with excitement, and I was eager to shape my analysis further into themes. I began to move from working electronically (a relief after many days of staring at a screen) to writing each code on small cards (Appendix K). By doing this, I experienced a sense of play - attempting to cluster labels into candidate themes while embracing a creative and flow-like state. I was mindful to hold any potential themes 'loosely' to allow space for refinement while equally being vigilant to not mistake themes for topic summaries.

At this point, I sensed an urgency within me, a desire to *sprint* and get through the analysis. I recognised this can be a personal pattern of mine: forever in pursuit of the finish line while forgetting about the journey. Stemming from a place of anxiety and impatience, I made a point of reflecting on this pattern further in my journal. By doing this, I was able to consciously slow down and avoid limiting the analysis. Although this was difficult at times, I feel it greatly benefited the generation of themes which could be thoughtfully considered rather than impatiently developed.

After formulating candidate themes, I had to consider the place of subthemes and overarching themes. Intuitively, I felt the liberal use of subthemes or an overarching theme would be unhelpful and may overcomplicate the analytic space. This intuition was consistent with the advice offered by Braun and Clarke (2021a), who caution against adding structural complexity over analytic depth. Rather, the placement of overarching themes and subthemes should be well-considered and used sparingly. With this in mind, I opted to dispense with any overarching theme and settled on a modest number of subthemes. As I neared the end of this phase, I had several candidate themes primed for the next theme development phase.

Phase Four: Theme Development and Review

Phase Overview

Phase four invites the researcher to re-engage with all code extracts and the complete dataset to test the quality of initial clustering and determine if there is room for more sophisticated developments. Quality checks for themes include (1) ensuring they address the research

question(s), (2) they are built around a core concept (to avoid topic summaries), (3) are rich and diverse and clearly represent key ideas, (4) are not too multi-layered or fragmented, and (5) are distinct from each other, with clear boundaries and a central focus.

Phase in Action

After another much-needed break, I entered phase four with more confidence. I re-visited my table of code extracts and found ample opportunity to collapse and redefine some codes to achieve greater internal consistency within the candidate themes. After making these changes, I updated my tangible hard copies and engaged in more 'play', moving codes into clusters and clusters into candidate themes - experimenting at will. At this point, I had tentatively settled on four themes, which were subsequently developed and quality-checked. I was satisfied that these themes were not topic summaries, were rich and diverse, reflected critical features of the data, and had clear boundaries with a central organising concept.

Phase four also marked the point where I began considering how I wanted to communicate my analysis - the story I wanted to tell. Inspired by MI's military foundations, it felt apt to use the metaphor of a battle. Through this 'battle', a story could unfold, pointing the reader to critical features of the analysis. Having this metaphor helped to organise my thoughts. It made me realise something was missing from the story: the themes I had so far illustrated covered the exploratory aim of the study but not the explanatory. Using the story as an anchor, I could make sense of the experiences involved in the battle but not *why* the battle was happening.

Thus came the generation of a fifth theme. However, after some initial development, I hit an analytic block. Ideas were circling in my mind, but I had great difficulty shaping them in any meaningful way. I realised talking the fifth theme through with a colleague might be helpful. To ensure I was not trying to massage the data to address the explanatory function of the study, I invited my colleague - who had extensive experience conducting a TA – to skim over the data I had organised for this final theme. Through their valuable and thoughtful feedback, I was able to shape my thinking, allowing me to develop the explanatory fifth and final theme of the study further.

As I was nearing the end of this phase, I felt confident that no shortcuts had been used and that all efforts had been made to engage fully and meaningfully with developing my candidate themes.

Phase Five: Theme Refining, Defining, and Naming

Phase Overview

Phase five engages the researcher in continued refinement of their themes, including settling on theme names. Defining a theme name consists of writing a paragraph clarifying the theme while illustrating its key features and central organising concept. The researcher is also prompted to consider their analytic argument and the format of their analysis in preparation for the write-up.

Phase in Action

I started this phase by defining my themes. To ensure each theme was well-defined, precise, high-quality, and had a central organising concept, I experimented with writing an abstract for each (Appendix G). This was critical as it focused my attention on each theme and how I could communicate its key features. From here, I could name each theme according to the key features of a ‘battle’.

By having each theme defined and named, the analytic argument and format started to take shape. I wrote about feelings of “excitement” from nearing the end of the analysis. However, this was juxtaposed with feelings of “fear” at the final product not being “good enough”. My oscillations between states of cautious confidence and fearful insecurity became increasingly notable. Fortunately, I was able to stabilise these swings by interacting reflectively with my journal and through extensive conversations with my research supervisor and peers, who offered a compassionate and reassuring space for my concerns. Seeking the support and wisdom of others helped me to move on to the next phase and avoid unproductively and obsessively re-addressing previous parts of my analysis in pursuit of unattainable perfection.

Phase Six: Writing Up

Phase Overview

Writing is a key feature of the analytic process in an RTA. Writing up the analysis is not final but part of the process and aims to outline the analytic claims and arguments. In writing up the analysis, further opportunities are made for refinement, where the researcher can make changes before the final submission.

Phase in Action

I found collecting and synthesising all the information and writing about it the most challenging part of the project. I could not fathom how to complete the monumental task that was *writing up*. As I look back on this final phase, I now realise the difficulties I faced were generated by me. My expectation stood between me and reason. I committed to breezing through the write-up, lamenting this intention in the following journal entry: “I love writing, so I think this will be the easiest bit for me”. I can now say the person writing that sentence was unprepared for the reality of this phase. As I progressed through the first half of the write-up, I danced a delicate line between good health and burnout, often finding myself on the latter side. I learnt quickly that writing up was not a quick process but demanded patience and time. Initially, I did not want to heed this warning. However, reality demanded I listen, as aggressively approaching the write-up alongside life-pressures was unsustainable. What ensued was a period of grief and shame as I dispensed with the expectations I could not meet. On reflection, this dose of reality was the most important thing to happen. It forced me to dig deep and address the internal conflict generated from the writing process. It made me recognise that there was more to life than writing and studying, that my health needed prioritising, and that I could achieve a balance with time, patience, and consistency. This new outlook allowed for the second half of the write-up to take a healthier pace, making room for new ideas and insights as I refined my writing style and how I would like to present my analytic claims and arguments. Because my writing process was recursive, I often revisited different Chapters at different times, allowing me to modify and update information as I progressed to ensure overall consistency.

Ethical Considerations

This research received ethics approval from the Metanoia Research Ethics Committee on July 23, 2021 (appendix F), and it is compliant with the Code of Human Research Ethics set out by the BPS (British Psychological Society, 2021).

The recruitment email stipulated that it was okay not to participate in the study to mitigate any concerns candidates had about feeling pressured to participate. Before consenting, participants were informed on how their data would be stored and subsequently used. Equally, the limits of confidentiality were discussed, and their right to withdraw at any stage up to the point of analysis was clarified. Upon completion of the interviews, participants were debriefed. All participants were told they would have access to a copy of the study upon successful completion of the thesis.

As part of my ethical responsibility, I attempted to anticipate any short or long-term implications a candidate may encounter from participating. Short-term implications may have included guilt, shame, and anger, which are primary experiences of MI outlined by Shay (2012). Moreover, feelings of anxiety, depression, and intrusive thoughts (Battles et al., 2018; Currier et al., 2015b) may also have resulted from participation. For this reason, being aware of the potential power dynamics, paying attention to pace, and adopting a relational stance to the interview was critical in allowing research participants the space to talk without feeling pressured or coerced.

Reflecting on the literature, loss of trust in self or others is also an experience aligned with MI (Litz et al., 2009; Shay, 2012). Therefore, the potential long-term consequences may have included a loss of trust in one's ability as a therapist or a loss of trust in their organisation, which could have consequences on a participant's career and relationship with their organisation. Moreover, engaging in the current study could have placed participants in an uncomfortable position where they felt their loyalty to an organisation was being challenged. Although it was not possible to account for or prevent *all* potential risks, I endeavoured to reduce the chances of any long-term consequences by having a debrief (Appendix C),

appropriately signposting, being prepared to stop the interview if necessary, and building trust and a culture of feedback where participants were allowed to voice any concerns they may have had. With this in mind, participants *were* psychological therapists, making it likely they had greater insight that acted as a protective factor against managing any distress from participating in the study.

Quality in Qualitative Research

Frameworks for assessing quality – or trustworthiness – in qualitative research have been widely established (Guba & Lincoln, 2005; Levitt et al., 2017; Lincoln & Guba, 1985; Morrow, 2005; Tracy's, 2010; Yardley, 2008) and more specifically when conducting an RTA (Braun & Clarke 2006, 2021a, 2021c). Determining quality markers for qualitative research differs markedly from quantitative research, where establishing validity, objectivity, reliability, and generalisability (Winter, 2000) are the goals. However, be it quantitative or qualitative, quality remains key for determining if the results of one's research are worthy of attention by researchers, policymakers, practitioners, and the wider public domain.

To ensure the current study met the expected standards of quality and trustworthiness in qualitative research, Braun and Clarke's (2006, 2021a, 2021c) quality criteria for conducting an RTA were considered, alongside Tracy's (2010) criteria for establishing excellence in qualitative research. This twofold approach allowed me to 'zoom' in and out of the current research so it could be assessed in its application of a qualitative model (i.e., RTA) and as a piece of qualitative research.

Braun and Clarke's Checklist for Good Reflexive TA

Virginia Braun and Victoria Clarke outlined a 15-point quality 'checklist' in their seminal paper on conducting a TA in psychology (Braun & Clarke, 2006). Since then, this has been updated (Braun & Clarke, 2021a). As is common in other areas of their work, caution is given when engaging with their quality checklist to avoid "evoking 'dos and don'ts' and 'right and wrong' ways to do TA – rules to be obeyed" (Braun & Clarke, 2021a, p. 268). Rather, they encourage researchers to see TA not as a recipe but as an adventure. They balance their notions of

quality on researchers' reflexivity, depth of engagement, and theoretical knowingness instead of the positivistic target of establishing accuracy, consensus, and reliability.

In heeding Braun and Clarke's warning, I was mindful of my pull towards structure and certainty when assessing for quality. As such, I aimed to counterbalance this with a purposeful focus on creativity, immersion, thoughtfulness, and insight, all of which underpin their quality criteria (Braun & Clarke, 2021a). These criteria can be broadly divided into five categories addressing different phases of the analytic process: (1) transcription, (2) coding and theme development, (3) analysis and interpretation (in the written report), (4) the overall analysis, and (5) written report.

Six additional strategies were used in the analytic process to enhance quality further and promote an open and curious relationship with the data (Braun & Clarke, 2021a). These included (1) the use of a reflexive journal, (2) ensuring the analysis was conducted over an extensive period (to avoid premature closure), (3) gaining additional insight on the analysis from others (this included peers and a research supervisor), (4) carefully considering theme names (to avoid topic summaries), (5) researching good quality RTA publications (for comparative examples), and (6) maintaining a comprehensive audit trail.

Tracy's "Big Tent" Criteria

Sarah Tracy, a United States organisational researcher and teacher of qualitative methods, developed eight criteria that "provide a common language of excellence for qualitative research and a useful pedagogical compass" (Tracy, 2010, p. 849). Her "Big Tent" criteria include (1) a worthy topic (topic of significance), (2) rich rigour (appropriate research design), (3) sincerity (the use of reflexivity and transparency), (4) credibility (use of a 'thick' description), (5) resonance (the research influences or affects readers), (6) significant contribution (contributes to the wider literature), (7) ethical (procedural, situational, and relational ethics considered), and (8) meaningful coherence (research achieves its purpose, and is theoretically coherent). These criteria are transtheoretical and, much like RTA, are flexible enough to be applied to a diverse spectrum of qualitative projects.

Impact Statement

All efforts have been made to respect the accounts of each participant while attempting to situate their experiences within the broader social context. Therefore, this study may have an impact beyond the academic institute in which it was written. Considering causal explanations means wider socio-political narratives were addressed as part of the research's output. Furthermore, participant experiences have been linked to the governance of NHSTT. This particular focus may be seen as valuable and refreshing by some or unhelpful and critical by others. However, my view here aligns with a fundamental position of counselling psychology and critical realism: the role of the social scientist is to conduct research that opens up different ways of producing, engaging, and interpreting knowledge, all of which may challenge grand narratives. Research, therefore, *should* have an impact. Dare I say, it should (respectfully) *disrupt* the norm, and as Tracy (2010) proclaims: "[research should address] issues that shake readers from their common-sense assumptions and practices" (p. 841).

Speaking Engagements

During the write-up, I was invited to attend two speaking engagements where I could present my findings. Presenting one's research is a critical part of the dissemination process, so I eagerly agreed and was honoured to discuss my research at the University of Oxford for their first-year Clinical Psychology Doctorate students (June 2022) and the NHS for a cohort of Advanced Clinical Nursing Practitioners (January 2023). Both were successful and invaluable experiences. Upon completing this thesis, I will continue to present and publish its findings.

CHAPTER FOUR
Analysis

Summary of Themes and Sub-Themes

THEME NUMBER	THEME TITLE	SUB-THEME
1	THE SETTING: INTRODUCING THE MORAL TERRITORIES	RELATIONAL HILL
2	THE THREAT: INVASION OF THE MORAL TERRITORIES	THE FAILED STRATEGY
3	THE BATTLE: EXPERIENCES OF THE INVASION	
4	THE RESISTANCE: STRATEGIES USED TO SURVIVE	THE POWER OF TOGETHERNESS
5	THE CONTEXT: AGE OF CLINICAL TYRANNY	

Navigating the Analysis

Method of Transcribing

Braun and Clarke's (2021a) guidelines for transcribing data were used. Each participant is referred to using a pseudonym. Any identifiable information – such as names of counties, towns, cities, or specific NHSTT services, was changed or altered to preserve confidentiality. These measures were pertinent to the recruitment process as almost all participants expressed concerns about being identified. In some cases, words have been added or edited for clarity, brevity, and readability, with care taken to preserve the overall meaning. The appearance of three full stops in brackets (...) indicates my editing of an extract. When squared brackets are shown […], I have added words for clarity. Some words have been <u>underlined</u> to reflect an emphasis placed on a word by a participant. In instances where a speaker reflects

on the thoughts or speech of another person - or their own thoughts and feelings from the past – the use of 'inverted commas' is displayed. If a particular part of a transcript could not be transcribed due to inaudibility, the following is used: ((inaudible)).

The reader will be introduced to each theme in numerical order. A theme overview is outlined, followed by an analysis. All extracts are indented and formatted differently to the wider text to enhance readability. The use of a dash – is used to symbolise the transition from the body of text to an extract.

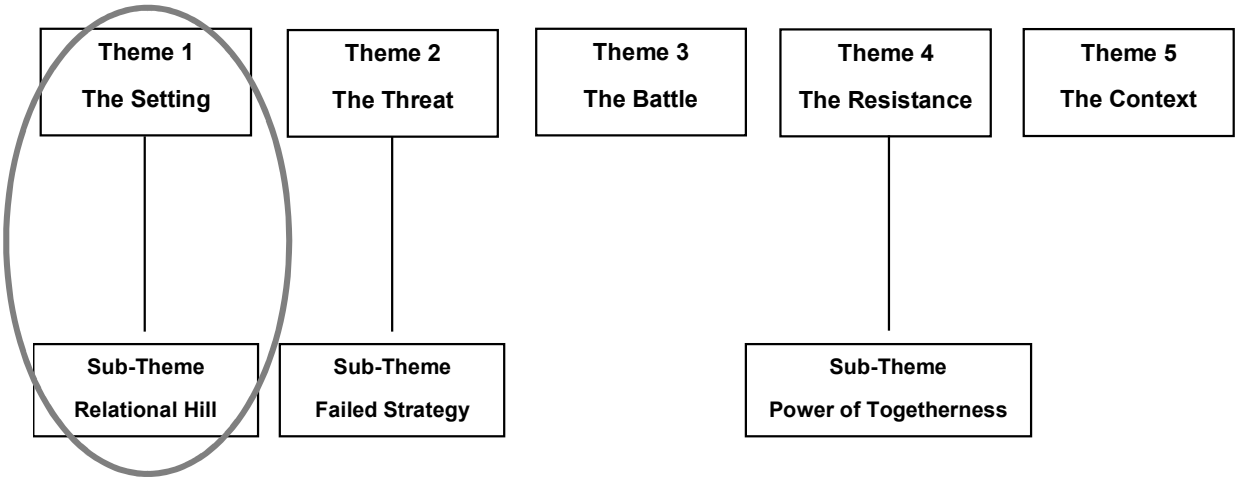
Use of Terms

The words "morals" and "values" are used interchangeably throughout. Early in the interview process, I noticed participants found it difficult to conceptualise their experiences by only using the term "morals". However, when the term was used alongside "values", some participants could better reflect on and clarify their experiences. The interview schedule was guided by the defining features of *morality* outlined in Chapter Two. As such, when either the term "morals" or "values" are used henceforth, this should be interpreted as a reference to the general attitude, belief, or view about what is felt to be right or wrong.

At the time of conducting the interviews, NHS Talking Therapies was known by its original name: Improving Access to Psychological Therapies (IAPT). Between the recruitment phase and the write-up, the NHS rebranded. Both brands are used interchangeably throughout the analysis. In the body of the text, I have opted to use 'NHSTT'. However, throughout the extracts, participants used 'IAPT'.

Analysis

Theme 1 - The Setting: Introducing the Moral Territories



Theme Overview

Theme one maps out the proverbial moral landscape – that is, the configuration of participants' morals and values within the context of their roles as therapists in NHSTT. As an exercise, participants found this difficult as it meant distilling and articulating core professional and personal morals. The types of morals expressed were diverse and often reflected key professional values underpinning the counselling and psychotherapy professions. These included doing what is best for the client (client-centredness), speaking out, working within one's clinical competency, integrity, doing no harm, authenticity, taking a holistic approach to client care, and working with the therapy relationship. The latter moral – prioritising the therapy relationship, was particularly salient across the dataset and, as such, became its own sub-theme.

Theme Analysis

When highlighting Alex's morals, she referenced client-centredness as a fundamental dimension, which she linked to her training. Having this moral being regularly transgressed made it difficult for her to uphold, representing a tension between a key professional humanistic value taught in her clinical training and the reality of working in NHSTT –

> If I think about it, in terms of what kind of morals were transgressed, I guess it is (…) those kind of fundamental things certainly that you get taught in the counselling psychology training, (…) that client centredness and doing what's in the best interest

> of the client is quite difficult – I guess it often gets, well it feels like it was always getting transgressed in (…) IAPT. (…) So yeah, (…) there's a lot of tensions throughout and kind of knowing that those values are being transgressed is difficult.

Another participant, Tracy, builds on Alex's reflection by linking a failure to practice in a client-centred way to the administration of outcome measures -

> I (…) felt with doing the forms week after week (…) disrupted the client's process because they have such a short opportunity to come to therapy anyway and then you're taking it up with these wretched forms every single week, which I get, you know, can be useful measures when somebody is at risk, but often it would just become a real irritation for the client because [it's] not what they need to be focusing on. So I think overall, it's a sense of (…) forms were becoming the centre of the therapy, rather than the client's issues (…) being the focal point. And [the] therapy revolves around the questionnaires rather than around the client.

Tracy goes on to reflect on the pressure she felt to persuade clients to rate the measures in a way that was not truly representative of how they felt, which, for her, contradicted the clinical value of client-centeredness –

> to (…) actively persuade them [the client] that they might be feeling something other than [what] they actually were. It didn't feel it didn't always feel client-centred. (…). I guess it doesn't really align with maybe you know client knows best.

Tracy goes into further detail, this time connecting the focus on administering measures to the top-down pressure of meeting targets, which, for her, encouraged the use of language to prompt clients into scoring more favourably - an act referred to later in Chapter Five as *psycho-compulsion* (Friedli & Stearn, 2015) - further indicating the tension between following protocol and upholding her moral commitment to client-centred practice –

> There were some issues which I wrestled with, or my conscience wrestled with, one of which was how we approached the outcome measures for the GAD7 and PHQ9 with patients-clients (…). There was pressure (…) each time you went to supervision, to be showing that your client scores were improving (…). And you were being actively encouraged to use a lot of I guess, sort of real positive psychology to word things in a certain way (…), it almost felt like coercion. A little bit like manipulating the language in order to get the right answer in order for them to score themselves lower than perhaps they might do had I, you know, how you just maybe just worded things as they are on the forms.

In her ten years of NHSTT work, Katherine also felt that upholding the value of client-centred practice was difficult. By defining clinical practice with outcome measures, Katherine felt there was a failure to adjust to a client's subjectivity –

> It's not valuing like the person's subjectivity. It (…) parallels the measures that you use with clients. It's like the numbers matter. But what about the person?

For Katherine, there was a recognition that she could not work with the full scale of client complexity in her role, but this did not mean that a client-centred approach should not happen. However, maintaining this value in the fast-paced, high-stress environment of NHSTT was difficult –

> I think it's around (…) how we view people as human beings like, are they people that are like us, that are struggling? And there's all sorts of complex difficulties that come up and, and it's not about [how] we can work on them all, but like seeing them as a person and thinking what is in their best interest.

Following on from the moral of adopting a client-centred approach was the importance of seeing clients not just as one-dimensional but as multifaceted and complex. The diagnostic emphasis of the medical modal, which NHSTT heavily relies on, created moral tension for Katherine when it came to taking a holistic approach to her work –

> Some practitioners were not really seeing the client in a more holistic way. And it was like I was becoming more and more aware of like, you know, oh, they've got (…) a bit of GAD [generalised anxiety disorder], or they've got their social anxiety or you know, do BA [Behavioural Activation] with them, but they'd have so many complex issues (…) they were struggling with that I became quite annoyed that people were viewing clients in that way.

Keeping with this is Sophie's experience of the medicalisation of distress and the limitations of diagnostic categories. The pervasiveness of medicalised discourse in NHSTT is manifest in Sophie's account, where the word "patient" unintentionally entered her reflections – a word more commonly associated with the medical model. Sophie was quick to notice this as it likely represented its own moral tension in the interview, a minor perpetration-based transgression against the more client-centred language used in her clinical work –

> So it just feels like we're shoehorning these guys [clients] into boxes that don't allow us to care for patients, that don't really help (…). I actually don't use the word 'patients', but I just did, it's strange.

Next, Sophie describes her attempts to speak out when she felt her morals were being violated. This dynamic is interesting, as it exemplifies the layers of one's moral framework. For Sophie, when one moral was transgressed, the activation of another moral - *speaking out* - was activated to preserve the original morals under threat: *client-centredness* and *doing no harm*. The situation giving rise to this orbited around issues of risk management –

> But if I've got the skills and if I think that it can help them better than what I'm doing at the moment with their [risk] protocol to have, to have the freedom to do that to help the client this is the bottom line (…) help them and don't cause them harm and do (…) what I think is right to – it's a really difficult thing, certainly as a counselling psychologist my responsibility to challenge behaviours in the organization that I feel are making it hard for clients and myself, trying to do that, even though you know you're going to get shut up beaten down and pathologised and scapegoated for it, you know, I struggled with that for quite a while wanting to speak up and having a voice for something that I felt was right and sensible. But not being heard. So that moral challenge was: speaking up for what I thought was right and challenging the organisational assumptions, I suppose.

The above moral of speaking up was also shared by Claire, who felt a commitment to speak up against data manipulation in her service. She described the conflict between being an NHSTT trainee and upholding her morals –

> When I joined (…) the first team, I somehow accepted (…) I'm a small potato, even though (…) I don't think that's right. And I genuinely don't believe that's right. But I don't feel I'll be taken seriously. (…) And how would I know, sort of [how to] position myself in a service? I guess, in a way, I feel I wasn't brave enough to really stand up for my own value saying: 'we shouldn't do that'.

At this stage, I invited Claire to consider what values were transgressed when she became aware of the manipulation of data in her service –

> Yeah, I think the strongest one always come into my mind is integrity. So it's through our training, clinical practice and throughout my whole career, integrity is like the fundamental value, I feel it's so important.

Jenny also cited the moral of *integrity* alongside *authenticity*. These morals were identified when she reflected on the lack of consideration given to the client allocation process. In the extract below, Jenny discusses her experience of being allocated a client beyond her clinical competency as a trainee, representing a threat to her *integrity* and commitment to *authenticity*. By not adequately informing the client of Jenny's competency, she suggests there was a lack of transparency that did not align with her morals –

> If I'm a client of IAPT, then I have a certain expectation, I think, or at least I think I would if I was a client of IAPT, a certain expectation of who I'm going to get as a therapist. And I suppose what was what was violated is that, I mean, obviously, it's made clear that the person's a trainee, but you know, I also appreciate that when a client comes to IAPT, you know any client that comes for any therapy, that, you know, they just want help, you know, they're not necessarily looking at the small print of your qualifications or your title. And I suppose there's something about <u>authenticity</u> and <u>integrity</u> in it to me. (…) Was there a transparency enough in who he [the client] was being offered. That fitted with my integrity. I suppose that's the moral, really, if I'm honest.

Sub-Theme: Relational Hill

Sub-Theme Overview

'Relational Hill' encompasses participants' emphasis on the therapy relationship in their work and the difficulties they face upholding their commitment to it. In the fields of counselling and psychotherapy, the therapy relationship is well established as a key component of therapeutic change. The frequency with which it was cited indicates its importance as a key professional moral. However, the demanding and restrictive culture of NHSTT made upholding this moral difficult.

Sub-Theme Analysis

Katherine offered a glimpse into some of the tensions that can arise when one is training as a psychotherapist and working in NHSTT – specifically, the philosophical tensions regarding the *therapy relationship*. Katherine found it difficult to infuse her psychodynamic training with the culture of NHSTT as she felt she received insufficient support from supervision –

> I felt like I was learning about all these new aspects of therapy, but I didn't really have anyone to nurture that within the [NHS Talking Therapies] clinical work. So I did have my placement, which was separate, where I could work more aligned with the philosophy of what I was learning more psychodynamic theory and about, like more about the relationship. And I suppose, like sitting with the uncertainty of where things will go in a session, but in IAPT, so then didn't know how to integrate what I was learning into that clinical work. Or if I did, I felt like I wasn't getting supervision for it.

Similarly, Sally introduced her challenge of upholding the therapy relationship from her time in NHSTT. In her service, counsellors were sub-contracted and paid episodically (paid per treatment rather than per session or salaried), and if the client reached recovery – that is to say, reached 'caseness' via a reduction in their scores, then counsellors would be financially bonused. Sally felt the financial incentive to reach recovery impacted the *therapy relationship* in a morally challenging way. Her account reflects themes of unfairness, implying therapists should be seen for what they offer rather than whether or not they reach an arbitrary score. Below, she reports –

> The bit where I really found it just unacceptable was when it was episode payment [paid per episode of treatment], but then they [the service] were expecting you to go to 12 sessions if they [the client] haven't improved enough, which then means that your

> actual hourly pay is going right down. And then that has an implication on how many sessions (…) you offer that client over the therapist, suddenly there's this, there's this bit about what the therapist is being paid, coming into the therapeutic relationship, and I just did not like that at all. (…) it's just wrong for that to come into the relationship (…) you're (…) with your client for 50 minutes you're putting all your heart and soul into it and all of your experience and all of your knowledge, you're putting it all in there that 50 minutes should be worth just what you've done (…) not whether somebody got better.

In Jenny's case, she felt the *therapy relationship* became compromised due to a lack of support on how to manage a safeguarding concern. Reporting on her failed efforts to seek support within her service, a primary concern for Jenny became about the relationship once the safeguarding concern was acted on, and in her narrative, there is a strong sense of the importance of the relationship being unacknowledged by the system. Acting on safeguarding is a professional duty for all clinicians, whether they work in NHSTT or not. Therefore, this represents a tension that may exist in many clinical contexts, where an ethical commitment to acting on safeguarding transgresses one's moral commitment to the therapy relationship –

> So there were people around that could say, oh, 'you need to talk to this person', or 'this is the web address' or whatever. But I didn't feel I had anyone in the service on that day, where I [could have] sat for half an hour and just talked about the, like, the actual process, you know, and my fears around the impact on the relationship with my client. I didn't get that that day.

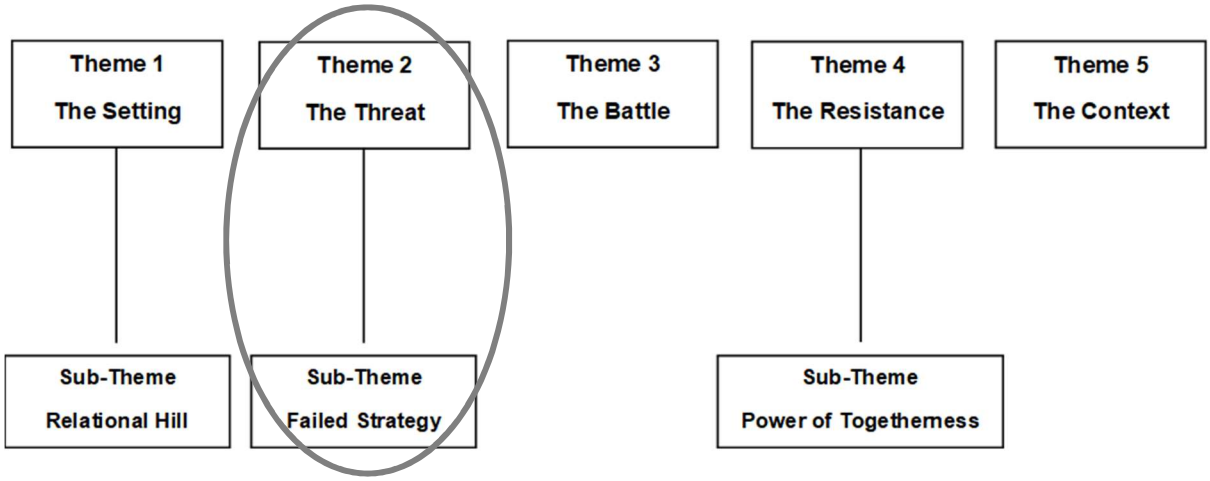
The moral complexity of navigating risk management protocols was also echoed by Sophie, who discussed her experience with a client that required a referral due to elevated risk levels. Sophie spoke of how the risk protocols in place abruptly cut off the *therapeutic relationship*, creating a restricted focus on administration rather than working with the relationship, a problem she reports is worsened by caseload pressures and is antithetical to good risk management –

> Our instructions were, as soon as we made the referral, we have to, we have to stop working with them [the client], which is, in my view, cutting off therapeutic relationship, the lady (…) had just had a baby, I felt really strongly about this. (…) So the pressures that you know [of] having the caseload is in direct, in direct conflict with the reality of needing the time and the headspace not only to make therapeutic alliances – because that is a safeguarding action in itself. It's not the paperwork isn't safeguarding, it's how you can help that person, reduce their risk and reduce the things that are causing their risk, which therapy in a good trusting relationship can do, obviously, there are limitations I understand.

Similarly, for Alex, adherence to her service's safeguarding and risk protocols also challenged her ability to uphold a moral commitment to the *therapeutic relationship*. This came in the form of a case of historic sexual abuse that was disclosed in treatment. As per protocol, Alex had to report this disclosure to the police despite having no clear details of the incident or perpetrator. In addition to a breakdown in the therapy relationship, she felt it to be re-traumatising for the client –

> So basically, we didn't have a name, or, you know, an address [or] any information about the perpetrator, other than it was an old, an old colleague, so we don't have any information, she's not going to tell us, she was not going to tell the police. So (…) there's going to be no outcome that's going to be beneficial for that client. The only outcome is box ticking that we've done this. So it [is] senseless, in the sense that it didn't help her. It was more damaged – well it broke the therapeutic relationship we were building, it was more traumatising for her. And she then had to go through the process of starting again with a new therapist. Police have spent their time, and again they were, the police had their own process (…) but because of what had been reported, they said they had to do a home visit (…) within a certain amount of time, so everyone was just following protocols that didn't help anyone. Which you know, they're there for a reason, I guess, but not sure it needs to be so black and white really.

Theme 2 - The Threat: Invasion of the Moral Territories



Theme Overview

Theme two encompasses the specific *events* that transgressed or challenged participants' morals. These spanned across betrayal-based and perpetration-based violations, and reflect the complex moral matrix participants navigated within their services. Using the lexicon of MI, theme two explores participants' potentially morally injurious events (pMIE).

Theme Analysis

For Sally, the act of having to manage tensions between earning enough money as a sub-contracted counsellor and offering her clients more sessions was the event that gave rise to moral challenges –

> This value that could be transgressed would be that: 'well, I'm not going to offer you more sessions because I don't think you're going to make me enough money' (…). That's the bit that feels really wrong (…). I don't want to feel like that because that's just awful. And that's not my values about anything.

The precarious balance between money and morals is further echoed by Nina, who recalled her counselling service bidding for the NHSTT contract as a matter of organisational survival –

> We had to make an application because we needed the IAPT work for the organization to continue viably with-you know, financial reasons.

More traditional counselling organisations often embraced longer-term treatments, sometimes even open-ended. However, by securing the NHSTT contract, Nina and her colleagues had to adjust to a different type of work –

> Yeah, we were forced into it. Yeah. We were forced into doing short term work, because we didn't have any money to keep the business going.

Nina spoke to the tensions that had occurred between her morals: her commitment to helping people was challenged by the practicalities of running a counselling service. Therefore, to preserve her commitment to the organisation and ensure a viable provision was offered, she had to compromise on what 'helping' looked like, which philosophically deviated from the therapeutic offer of NHSTT.

For Katherine, the tension between morals and money arose because of the need to upskill in CBT. This was despite the difficulties experienced between the philosophy of NHSTT and her own clinical training. As discussed in Chapter Two, being absorbed into a CBT modality was not uncommon and often left many clinicians choosing between philosophically uprooting from their own way of practising or having to seek work elsewhere –

> But I think that the more that I stayed in IAPT alongside the training, the more difficult it became really. And I got a bit frustrated with the way that things were done. But then I did decide to train in CBT properly as a high-intensity therapist, but that was mainly because of a financial move to get a bit more money and reduce my hours (…). So I was kind of straddling both.

Another participant, Claire, wonderfully portrays the pressure between money and morals in the upcoming extract. For her, this tension became apparent when choosing between a service she knew manipulated statistics, but because of this, was more financially secure due to the likelihood of renewing their NHSTT contract. Or, a service that was honest in its portrayal of the figures but less financially secure as it did not repeatedly reach targets. For Claire, committing to her values of professional integrity outweighed financial security –

> Yeah I guess (…) it's down to [the] individual (…). Do you want (…) personal financial security against your personal value your professional value (…) like integrity? (…) everyone have this kind of anxiety, but I probably I would like to choose the latter. And that's why I stayed in the current team, I just feel that it's more important.

Below, we return to Jenny's experience, where the act of being allocated a client she felt was outside her clinical competency represented a key betrayal-based event, as it transgressed her moral commitment to both integrity and authenticity –

> There's something about him [the client] (…) expecting one thing, possibly, and getting another. And I think that's morally what I find really uncomfortable, the idea that you're not getting what you signed up for.

Jenny goes on to describe another MIE from working with a client, where she templated trust, integrity, and authenticity in the therapy relationship, but due to the disclosure of a safeguarding event, had to uphold her ethical duty, thus transgressing her morals in the process –

> I'd given her [the client] myself (…) given her a picture of me that is someone who is true to their word, authentic, says what they mean. Weirdly, one of the very first things she said of a therapist was someone that wasn't 'airy fairy or artsy fartsy', which I think is really funny. And we asked about that, and she came back to it right at the very end of the time we work together. And it just felt that I'd gone against that a bit, you know, that that I'd. Yeah. That I'd kind of broken her trust.

Below, Jenny continues, clearly grappling with her own moral conflict. On the one hand, she could identify with the importance of disclosing safeguarding incidents, but on the other, she speaks to the moral weight of making the decision –

> I think it was trust and I appreciate that there's a time and place for that in terms of clinically. And it absolutely isn't about breaking trust. It's about safety. But where I went to with it. And what I struggled with was this sense of having broken her trust.

Similarly, for Alex, breaking confidentiality to manage risk was necessary. However, the MIE was having to act on a safeguarding concern knowing it would compromise the relationship and obstruct the work. Alex felt if there was someone else to carry out the safeguarding issues, then it would allow the therapy relationship to remain intact –

> There were children at risk. So I was always going to do the referral, the referral needed to be done. I think it was, I guess, (…) it violated the therapy the trust in the therapeutic relationship when I think things can be approached in a different way. You know, by there being someone else who does that [safeguarding reporting]. Yeah. So that could still have been done. And, you know, then in our session, she could probably have, you know vented to me about it, but it wouldn't be that I've done it. So, yeah, I guess it

> just kind of compromised the therapeutic relationship, and meant that that person didn't get therapy.

For Sophie, conforming to a "one-size-fits-all" approach to risk management represented the moral conflict. The following extract offers insight into circumstances where betrayal and perpetration-based violations can act in tandem. In Sophie's case, the organisation's risk protocol was the betrayal, and personal adherence to the protocol was the perpetration –

> So, the first kind of encounter that I had that caused me some disturbance was having to deal with risk. So it (…) may not be that much to do with IAPT, but it might be to do with the desire of the organisation to be seen (…) ticking all the boxes. But nevertheless, the context of IAPT in terms of the restrictive scope (…). So basically, the one-size-fits-all approach, (…) I think was the thing that caused problems.

Another pMIE experienced by clinicians was managing caseloads of complex clients. For Katherine, her commitment to being client-centred and holistic was challenged when faced with the high rate of complex cases she had to work with –

> And there's all sorts of complex difficulties that come up and, and it's not about we can work on them all, but like seeing, seeing them as a person and thinking what is in their best interest? That's like the moral bit for me. Because (…) it felt like sometimes people were getting desensitised. I think even I got desensitised when I was on duty, and you'd have like, be doing lots of assessments and assessing risk and everything. You kind of don't see the person anymore, because you're just so stressed. So I think actually, well, there's a moral issue there then around looking after the staff as well, I think, and wellbeing of staff because I feel like it was trickling, the stress was trickling down.

Despite Katherine's moral commitment to client-centred and holistic practice, the pressure in her role promoted a psychological detachment from her clinical work, thus representing a betrayal-based violation, particularly regarding a lack of support. Alongside this was also a perpetration-based violation from being unable to uphold her own clinical morals.

Similar to Katherine, Jenny also spoke of managing complex presentations but connected them to the limitations of short-term work. In the below excerpt, she challenges the appropriateness of short-term work for complex presentations –

> I think, I feel really exhausted, absolutely exhausted. And again, in part, I think that's down to the year (…). But I also think it's because the clients I've had are just incredibly complex that I'm working with. And it's very difficult. One thing I haven't mentioned, but

> this whole idea of the complexity of the clients and their presentations and short-term work, which is a whole other area, you know, which also, I think would be morally sometimes I question, you know, are these clients right for a short term pathway?

Below, Jenny builds on her point by illustrating a pMIE. A powerful sense of guilt is located in her narrative as she describes identifying the complex needs of her client, but not being able to do *what is right* –

> Another client I had had multiple personalities, (…) I think probably an underlying dissociative disorder, where on any given week he was coming with one side of his personality and it was trying to decide who I was working with. And again, you know, I had 20 weeks with him and it felt, I mean, he was desperate to work with me for longer. And he couldn't, you know.

She goes on to describe more examples where the treatment length was contraindicated –

> This was a woman with complex trauma, somebody else who had a history of child abuse, and a domestic violence situation, you know, that's a lot to deal with, in 15 weeks.

Participants regularly referenced the difficulties of managing large caseloads of complex clients who were not suitable for NHSTT. Having small treatment windows to reach recovery while also upholding a clinical commitment to helping their clients often resulted in moral tension. For Sally, being an EMDR therapist meant clients were disproportionately allocated to her because they did not respond to other treatments. This left her dealing with an accumulation of complexity while also being expected to meet the same treatment targets. The event Sally described was not being able to meet unrealistic standards and then feeling as though it was her fault –

> Actually, probably the worst bit, (…) I just done my EMDR training, and I was given clients for EMDR. But in actual reality, they were the clients who just hadn't responded to anything else. And they seemed to be <u>the</u> most complex clients and they weren't just a simple PTSD, (…). They have multiple, multiple problems going on. And yeah, I still had to function in that same system of: 'right, you've got 8 to 12 sessions, and you're gonna get paid by results and fix them' and yeah, so their scores were not improving fantastically compared to if I had an easy CBT case. So just the moral bit, the injury there makes you feel like you're bad at your job, because you're getting I'm being given like the most complex clients. And then you're not even being rewarded for that work, even though you're doing harder work than other things that you've ever done.

Another participant, Tracy, also experienced the challenge of being pushed to meet targets with clients who were not suitable for short-term work -

> And it just felt morally and ethically wrong to me. Partly because, you know, a lot of these patients being referred into the service, were really in need of long-term therapy, and all we can offer them is six sessions. Generally, six sessions is a sort of window into therapy, or a taster. (…) if somebody is coming in with a score of like, 27 to start with, or even 24-25 on the PHQ9 to start with, it feels (…) pretty unrealistic that they're going to get down to a score of nine in six sessions. And yet, we were being encouraged so much (…) to meet the targets.

Here, she goes on to describe the pMIE of offering someone a provision unlikely to make a difference. From her training in trauma therapy, Tracy could outline the importance of going at the client's pace, showing a preference for working "where somebody is at". However, she contrasted this with the reality of her role, where target pressures and short treatment lengths restricted her preferred way of practising and, for some clients, may have made things worse –

> If someone's in the depths of despair, and they've been in the depths of despair for months, I'm not going to get them out of the depths of despair in six weeks, in such a way that they're actually going to be able to sustain that. So it feels a little bit like it (…) putting a sticking plaster on, on things (…). I'd much rather kind of work with where somebody is at. And I guess, with all the trauma therapy training that I've done (…) you know, [you] become more and more aware of that need to go at the client's pace. Whereas this really felt like I'm trying to, you know, I'm trying to get (…) them to run before they can walk. So that doesn't sit comfortably with me, like you're trying to push them to feel better faster than they naturally are inclined to. And, you know, in doing that, if someone's coming with a history of trauma, then that just (…) created backdraft.

Following, she connects these experiences with her reason for leaving, due to the moral conflict of manipulating clients to score more favourably on their measures. Tracy's process of leaving could be interpreted as an attempt to preserve the moral whole. Unable to make meaningful changes in how she practised - leaving her vulnerable to an accumulation of moral difficulties – the best way to offset further moral transgressions was to retreat.

> It just felt manipulative at times. I think that's what I'm left with, I feel that it's not proper therapy. And that's partly why I left. I (…) felt with the doing the forms week after week (…) often disrupted the client's process because, they have such a short opportunity to come to therapy anyway and then you're taking it up with these wretched forms every single week.

Sub-Theme: The Failed Strategy

Sub-Theme Overview

Many of the events experienced as transgressive against participants' morals arose from the inability to uphold their moral ideals - that is, a *failed strategy* from being *unable to do what is right.* As a sub-theme, it implicitly underpins many of the moral conflicts cited above. The inability to enact on what one feels is *right* strongly connects to the limitations of the NHSTT system and is a symptom of target heavy healthcare systems more broadly. Following are participants' reflections on *not* being able to act on what is right – which is to say, not being able to uphold their morals of providing high-quality care in line with their training. This sub-theme is particularly important, as it connects with the wider literature on moral difficulties and healthcare systems.

Sub-Theme Analysis

In Sally's reflection, she powerfully evokes a sense of personal moral failing, a pMIE, from not being able to offer the care needed to clients –

> I feel really bad that I've let them [the clients] down (…) the system is not letting me do what I would like to do.

Sally goes on to reflect further -

> I think sometimes the bit where somebody needs secondary care, (…) morally, there's some bits there that are bad, well I felt awful, IAPT basically saying you can't have this person, that was another reason for leaving as well, because it was starting to go down that line of if there's any domestic abuse, we can't see them, if there's any history of childhood sexual abuse, you can't see them, you know, they started really drilling down into: 'oh, we can't help' (…). And then you kind of go: 'nearly everybody's got some sort of history of something'. And, you know, as soon as they [the client] come for their assessment: 'oh, sorry, we can't help you anymore'. Yeah, that kind of stuff is awful to feel like you've got to tell a client: 'I'm sorry, I can't help you. Because you've just told me about sexual abuse, I'm gonna have to refer you on', that feels morally wrong. And that that's a terrible thing to do to a client.

In the next example, Jenny's attempts to do *what is right* were outweighed by the stream of clients who needed longer-term treatment. Despite recognising the limitations of her role, Jenny still had difficulties of being in a system not designed to treat complex issues. This

placed her in a position where she was unable to help many of her clients in the way she wanted to, likely representing an accumulation of moral distress –

> That's really hard to contain in such a short-term therapy framework, (…) I've probably worked with about 20 clients, (…). And I would say, only two or three have come in with what I would say are issues that felt containable, easily containable, within 15 weeks. (…) And I think it really taps into that, the idea that these people, these people that come into IAPT need support and need help. And the system isn't there to support them in the way that they need. (…) I get that that's the system, you know, that it's the NHS, that funding is tight, that it's oversubscribed, that you know, whatever you want to attribute to it, but morally, that is so uncomfortable for me that, you know, someone who has an absolute need for that help for that therapy. And that need is far greater than 20 weeks, or 15 weeks.

Similarly, Nina also reported on the limits of not being able to do *what is right* due to short-term treatments -

> And the main problems for me were the limits of session numbers, and knowing that clients needed more help, but [being] unable to give that.

When invited to offer more detail, she presented a potent image. Nina addressed her inability to help despite being trained to do so. And how short treatment lengths not only shut down the client but also shut her down. As she reflected, there was a sadness to her description of not being able to "reach the end" with her clients and help in the way she needed to. Her use of language evoked a sense of 'done to' by the system, which in turn placed clients in a position to be 'done to' by her, thus representing both betrayal and perpetration-based transgressions –

> It was about not being able to help in the way that I wanted to. And that hurts, it's quite difficult. (…) Because that's what I was trained to do to help people and to have an ending, you know, have a start, and an ending. And an ending that's forced, is one that's been drawn to an end very quickly. And it's almost like I'm closing someone down. And also, it's closing me down, you know, forcing me to end this work. (…) it's almost like that you give them a false sense of security in that sense. Because a lot of times I was only able to help for a little bit. I couldn't, I couldn't reach the end with them. It wasn't possible.

Another participant, Katherine, connected short-term treatments to the expectation from services to meet certain milestones, which pressured clinicians to focus more on targets. For

Katherine, these events contrasted with her person-centred philosophy, where doing *what is right* is being able to follow the client's lead rather than imposing her own -

> But what I found hard was (…) on the CBT training, they would talk in very idealistic terms about treatment for social anxiety, by session 12 you'd get here. And so then I think that then it could have put a pressure on me to feel like I need to treat them [the client] or get to this certain point. And I don't think that's right, because that's more about me than it is about the client.

Keeping with Katherine's point, Sophie went on to critique how "successful" treatment was defined in her service, and the conflict this generated -

> It's the narrowness of how they [NHSTT] define what an effective and successful services that is responsible for causing the stress and this moral injury and being asked to help the client with tools that I think doesn't help the client - you know, it's just wasteful. Wasteful.

Sophie's above use of "moral injury" - despite the term not being used at any point throughout the interview process – indicates that as a theory, it may be helpfully applied to understand the moral tensions experienced by therapists working in NHSTT. In the above example, it was the misalignment between how Sophie defined a successful treatment and how her service defined success.

Following is Tracy, who also spoke of the conflict between what she felt was right and the NHSTT framework; as a consequence, this left her feeling that what she could offer was not in her client's best interest –

> I would find myself butting up against the framework. And just (…) wanting to give the client more feeling like they want to have something different (…) the therapy wasn't often done in their best interests.

Even when Tracy was able to provide a helpful treatment, she felt the restrictive treatment lengths meant any meaningful therapeutic gains did not last. Below, she suggests having more flexibility in how many sessions offered could have made a difference –

> There were other occasions – when I felt that I was kind of in the midst of a really good piece of work (…) And, you know (…) give them another six sessions, we could make some real progress here, something that might actually stay with them, rather than, you know, again, it's this kind of sticking plaster effect: it'll stay on for a little bit, and

> then they'll, you know, because their patterns are so entrenched they'll revert to default setting.

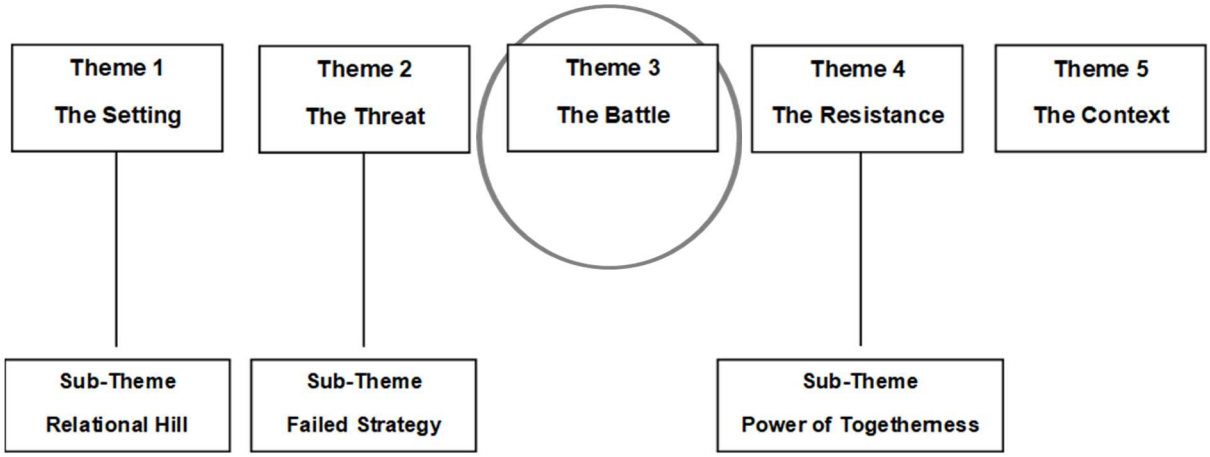
Another participant, Alex, describes the pressure she felt to practice in a particular way. Not only did this prevent her from doing *what is right*, but it also meant she actively practised in a way that clients may not have found helpful. Here, she refers to the use of CBT and how she attempted to be more flexible in sessions to offer a different experience but also highlighted that it was not always possible –

> You're kind of pressured to work in a way that, you know, is not the best way to work with that client. Obviously, there's wiggle room in the actual sessions. (…) yeah, it's fairly rigid what you can offer. So yeah, I guess in that sense, it's just like this is what I can apply here in these sessions, you know, with some wiggle room, you know, if it's workable, knowing that it's not going to help some of those clients.

Alex continues, this time referring back to her previous example of a MIE, where following protocol meant calling the police regarding a disclosure of historic sexual abuse. She knew this was unhelpful for her client and that it acted against what she felt *was right*. Her reflections offer another good example of morals existing in tension: one where there was an ethical commitment to following the rules of her organisation, which contrasted with her moral commitment to do *what is right* –

> I was having to do something that I didn't agree with. (…) you know, I was having to follow through with something that I knew wasn't going to go well, and wasn't gonna be helpful. It was stressful.

Theme 3 - The Battle: Experiences of the Invasion



Theme Overview

Theme three unpacks participants' experiences of morally challenging events, drawing its boundaries around the central concept of *how* they experienced their morals being transgressed, violated, or challenged. Naturally, this is a continuation of the first two themes, which outlined the types of morals and the pMIE. Participant experiences were diverse and largely reflected the experience of moral violations put forward by the theory of MI. These include losing a sense of trust in oneself or the system, not feeling valued or good enough as a therapist, feeling unsupported and burnt out, or, when exploring emotions more specifically, feeling angry, frustrated, ashamed, guilty, humiliated, or hopeless.

Theme Analysis

When reflecting on her experiences managing the tension between money and the therapy relationship, Sally reported feeling unsupported and undervalued by her agency. She talked of how the focus became more about saving money and meeting targets than valuing the work of its therapists –

> It's not being valued or supported by your agency at all. So that's morally that's wrong, because you should feel safe in your job and feel like someone's got your back.

Next Sally goes onto to describe the lack of pride she felt in her role as a counsellor. She connected this to not feeling good enough, knowing that what she offered was inadequate –

> You don't feel very proud of doing your job when you're working in that kind of system, actually, (…) I didn't feel any pride in that, you know, it's just you know, because it's not good enough, basically.

Reflecting on her emotional experience, she described a sense of guilt from being unable to act on what she felt was right. This exemplifies how clinicians may be left with difficult emotions because of betrayal-based violations –

> Yeah, guilty. Actually, I think there's guilt. Yeah, just, yeah, you just feel like you could have done a better job if the system would let you do a better job and you kind of know what you could do. But you're not allowed to do it. Because yeah, the system won't let you.

Sally goes on to link a lack of pride, feelings of being undervalued, and her guilt to burnout. Her use of the term burnout is interesting, as it reflects the term's popularity in healthcare systems. However, as previously stated, it risks implying the individual is at fault and decontextualises their experience. As I have argued elsewhere, the theory of MI may be a more accurate proxy. In Sally's case, the *system* was preventing her from doing what she felt was right, an important oversight if only looked through the lens of burnout –

> Feeling undervalued feeling like you're not performing at your job, and all that kind of stuff (…) I think that leads to counsellor burnout in IAPT, so most people who've worked in it for quite a long time, they don't all speak highly of it.

In concluding how moral transgressions made her feel, Sally likened her sense of being undervalued and taken advantage of to feeling "like a mug". Her narrative evokes a sense of personal failing, and maybe some underlying anger, from having continued to stay in a system that she lost trust in –

> Well you feel like a mug actually, I think you feel like (…) why would you let someone to do that to you? And it's almost like your pride in yourself and your self-esteem, you're thinking: 'why, I'm worth more than this'. (…) Part of your head is going: 'but I am I am good at my job and I am really experienced (…) I know what I'm doing. I know my stuff. I've done so much training now, I've been on the planet a long time' it's that (…) logic. And then the other side of you sort of feels like: 'well, what a mug you are for going – still doing that'. And so for every week that you carry on, I don't think that's good for your self-esteem at all, I don't think that's good for (…) feeling good about your work.

For another participant, Jenny, it was having to report on a safeguarding that compromised the therapy relationship and went against her values of honesty and integrity, which inspired strong feelings of anxiety. Although implicit, within her narrative there appear to be other emotions, such as anger and guilt, and her anxiety is maybe a manifestation of these experiences (in her interview, she disclosed anxiety is often a cover for other more difficult emotions) –

> I felt that I'd let her down. I'd broken her trust, (…) there was a sense of I'd say one thing, but I was doing something else. So I suppose it does fit again, with integrity and honesty. (…) I suppose my main emotion after (…) was really, really severe anxiety, you know, I was really anxious.

Next, she moves on to reflect more specifically on anger. She refers to a compromise in healthcare, which has connotations of a betrayal-based transgression, as she represented an extension of the very system that restricted her from preserving her moral commitment to help in the way she felt was right –

> It makes me really angry (…) that this is true of any health provision within the NHS, you know, that there isn't enough money to give people who need care, be it physical health issues or mental health issues. There's just, you know, the resource too scarce. And yeah, that makes me angry, you know, that makes me really angry that there's a compromise. And that isn't comfortable for me.

Moving on, Katherine also experienced anger. Her anger was a response to feeling undervalued in her role. Tasked with developing a group-based intervention, Katherine and her colleagues committed themselves to the project for months before it was unexpectedly "scrapped". Again, this conjures up images of being 'done to' by the system with little-to-no explanation, or as Katherine puts it, "collaboration" –

> I used to get really angry actually, like towards the end, because I can remember they wanted to implement a group program at step 3. So (…) we spent ages like developing the groups and everything. And then (…) eight months later, they scrapped it because (…) the commissioners maybe wanted something else, or there wasn't enough people getting into the groups. Again, it was a bit like: 'well, we've put all this effort in, but then we're not even giving it a chance'. And then we're just told that it's being scrapped. So I think the collaboration was missing. And then I think you end up feeling (…) like our works not really being valued. We're not being seen, maybe a bit like the clients like we're not kind of being seen as people.

Katherine also connected her anger to the system's focus on outcome measures, particularly when in supervision, which she likened to being at “school”. Her reflections speak to a sense of disempowerment and infantilisation in her role and how the lack of nurturing generated feelings of anger –

> Just like feeling, like angry about it. And a bit like, it’s a bit like you’re at school, and it’s a teacher that’s just telling you what to do rather than nurturing.

Although she could eventually accept the philosophy and limitations of NHSTT, Katherine remained uncomfortable about the privileging of outcome measures above all else, connecting this to broader feelings of hopelessness –

> And so I kind of get it [need for measures] but I feel like when (…) the stats and everything takes over. That’s when I got a bit (…) hopeless.

For another participant, Nina, feelings of anger arose from the pMIE of not being able to offer more sessions. She provided a potent example of how short treatment lengths could impact the client and violate her ability to help and act on *what is right*. The below extract depicts both perpetration and betrayal-based transgressions -

> Yeah, the frustration I suppose led to feelings of anger. (…) it was hard to let people go (…), I’ve had people [client’s] hanging on to me, you know, and crying at the end.

In the case of Alex - where the police were informed after her client disclosed historic sexual abuse - she cited the protocol as “counterintuitive”, as it harmed more than helped. Feeling forced to do something she did not agree with left her with feelings of frustration and anger –

> I don’t know why IAPT have this really kind of… I don’t know, just kind of counterintuitive just process that you have to follow when it’s not going to help anyone. So yeah, quite angry. And yeah, kind of frustrated.

Although feelings of anger were common for many participants, other emotional experiences were also referred to. In the case of Tracy, her relationship with the outcome measures became difficult if she failed to reach recovery. The service’s focus on targets often left her feeling like she was doing something wrong, accompanied by feelings of not being good

enough. This is an apt example of how an organisation's unrealistic standards can create a culture of self-blame in their staff –

> And, and and then again, you feel I've done something wrong and I'm not, you're not doing – I'm not doing a good enough job.

It was the pressures of meeting recovery scores in supervision and feeling she was coercing clients to score more favourably that also induced feelings of shame and embarrassment. Her experience of shame is an important one, as it is a key ingredient in the experience of MI. Again, this extract parallels both Katherine's and Sally's previous reflections, where the clinician is positioned in a betrayal-based, 'done to' position, resulting in a transgression of their own morals –

> They [supervisors] would induce just a sense of shame. Shame or embarrassment – which is kind of on the spectrum of shame, isn't it? Just, you feel like: 'ahh, I'm a crap practitioner' or 'I'm not good enough', you know, sort of playin' to your negativity bias, I guess. And yeah, it's shame, I think (…) And if I feel I'm coercing them to answering, maybe not quite authentically, then that's not really great.

Tracy goes on to expand on her point in an important way, linking her feelings of shame and guilt to the funnelling of coercion from the top down. Having enacted this sense of coercion on her clients by encouraging lower scores, she reported feelings of shame and guilt –

> I guess I'd feel frustrated with (…) the framework, in proceeding with what we're been asked to do. It's almost like the sort of coercion gets passed on. And (…) I'd feel that sort of sense of (…) shame and guilt.

Next, another participant felt shame because she did not feel good enough after being allocated a client. She felt that the client was outside her competency, transgressing morals of integrity and authenticity by the service, which did not consider her level of experience at the time. When invited to consider her emotional experience during treatment with this client, Jenny reported –

> In terms of emotionally (…) I think there was a lot of shame (…), the fact that you know, I wasn't a good enough therapist for him.

In the case of Claire, her feelings of guilt came from working in a service responsible for data corruption, a violation of her commitment to clinical integrity. Although Claire never actively manipulated any of her own data, she felt culpable by extension. Her experience is a compelling example of a betrayal-based violation and how an organisation's transgressive act can transgress an individual's morals –

> When I see these kind of bureaucracy issues, (…) if you think about data corruption, and just make me feel I don't know [like I am] being one of them, you know [a] sense of guilt. (…) because my background was working on research. And I really respect (…) how accurate the data is.

Another participant, Alex, reflected on how her safeguarding case that required police involvement existed alongside other safeguarding issues from her caseload. These incidences accumulated over time, resulting in what she described as burnout. However, given the chronic transgressive nature of following the safeguarding protocols, there may have been an element of moral distress and MI to her burnout experience. Below, she talked about doing what she was "supposed to do", which appeared to act against her, a process of disavowal where she was working in one way but implicitly felt another. This appeared to be symbolic of a wider discrepancy between the goals of NHSTT: a culture purporting low intensity and high volume that deviated significantly from the realities of the role –

> Because I was following what I was supposed to do, I was ending up with all of these police reporting things. (…) But yeah, [there had] been an accumulation of a couple of safeguarding things, police reporting things…

Alex continues –

> I was definitely burnt out by the end, (…) the whole point of IAPT is (…) you see a high volume of clients (…) who aren't so complex. I was seeing a high volume of clients with a lot of complexity on top of police reporting, safeguarding, you know.

In addition to feelings of hopelessness, anger, and shame, some participants also lost trust in themselves and the system. For Sally, the focus on recovery ratings generated feelings of doubt in her own clinical competencies –

> You start to feel like (…) you're not as good as you were like a few years before ((inaudible)) that's what the statistics are telling you. But actually, it's their system and the processes that have made that happen, because I was one of the most experienced counsellors there. (…) I know for a fact friends of mine who worked in IAPT have just completely left it, and they've burned out. One of my friends have given up completely, because her confidence in her work was totally destroyed.

Sally connected her point to the infantilisation she experienced in her role. This strongly echoes Katherine's previous reflection, which made similar parallels: "*(…) it's a bit like you're at school, and it's a teacher that's just telling you what to do rather than nurturing"* –

> Not treating your staff like adults, either, (…) making you feel deskilled, like children, and then rewarding you badly for it.

Pivoting from losing trust in self to losing trust in the system, Sophie reported on the disparity between the claims of CBT and her experience of using it. Her reflections here are powerful, as they describe the tension between being told one thing and feeling another, reducing her confidence in the system. This extract also offers an insight into the fear Sophie grappled with when wanting to preserve her moral framework by *speaking out* or challenging the wider systemic narrative -

> I was being told that the CTSR [a competency framework for qualifying in high-intensity CBT] is at the front of all knowledge about good therapy, but in my view, it's not relational therapy, it's not Person Centred therapy, it's not, you can't be human in it. So (…) dehumanising me, as a therapist you know, trying to maintain my humanity and the client's humanity. So I was kind of being drawn into this tick box, the robotic interpretation of what good therapy is, but also thinking: 'it's not true'. You know, really wanting to stand up for something that is just not true, I'm being pulled into this lie, this fantasy. (…) And then kind of, because I have to follow that, first and foremost, the fear is that I'm going to be – I'm going to lose my job, or I'm going to be told I'm bad or I'm dangerous.

Below, she unpacks her feelings in more detail and explicitly references a lack of trust. Sophie also points to a parallel process, highlighting that her feelings were most likely also felt by the clients –

> A helplessness. I mean, probably a lot of the things that the clients feeling, actually, you know (…) helplessness and anger, frustration, lack of trust. You know, bit of dread, bit of doom you know, probably a lot of what the clients are feeling, you know

She goes on to report a collision of different emotional experiences and the need to collude with the system to avoid repercussions, drawing a parallel with systems of power that demand conformity –

> I felt lost, I felt confused. I felt… undermined, I felt shaky. I felt stressed (…). Disillusioned, disappointed, again a lack of trust and having to kind of almost put a mask on so I didn't piss off my supervisor [and] the organisation (...) Angry, I mean… it was more fear. I felt fearful.

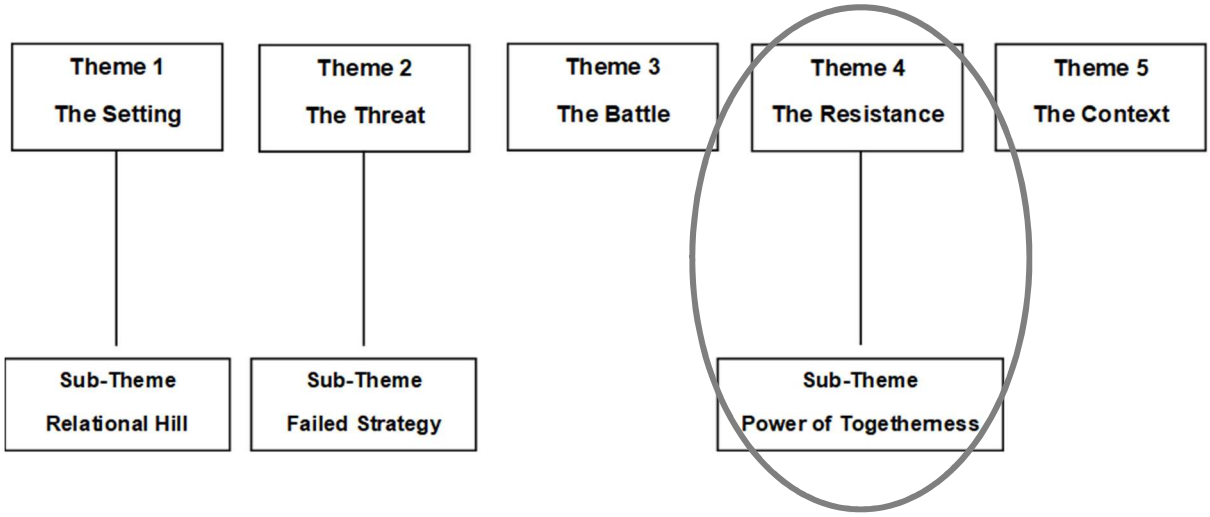
The "disillusionment" cited by Sophie also underpinned Claire's loss of trust in her organisation. Learning of the gaming of statistics, she questioned whether this transgression was generalisable to other services. And in doing so, considered whether it was taken seriously –

> If they [IAPT service] violate one important value like that [manipulating statistics], what about the others? Right, you know, the other kind of NHS [services] (…) issues that just make you feel, are they taking them seriously?

Here, her doubts were founded on personal experience, where she observed no efforts to stop the manipulation of data in her service. Her loss of trust can be connected to the tacit feeling of hopelessness in the following passage –

> The saddest part is nobody stepped in and they still carry on, as far as I know, it's still you know, working quite well in their system. And nobody seems to care. So that's the issue I feel, of what should be done, you know, some, that situation should be resolved, either by now, or at least in the process, or at least those people should be, you know, challenged, but no bodies challenging them, it just make you feel it doesn't really matter, maybe they don't care.

Theme 4 - The Resistance: Strategies used to Survive



Theme Overview

Theme four details the deployment of strategies used to manage and cope with moral threats. Coping strategies included: attempting to preserve and uphold one's moral system by speaking up for *what is right*, looking for the positives to better tolerate the negatives, advocating for or protecting the client from the system, or leaving the organisation entirely.

Theme Analysis

For Sally, it was the repeated messages of not being good enough, particularly when working with complex clients, that was her catalyst for change –

> If you get – that's all you get is those complex clients and the system is telling you: 'oh well, they haven't improved enough and you're only worth 10 pounds an hour for this job', then that's telling you you're not very good at your job. I don't know, that's kind of how I felt with that. I just thought: 'I'm out, I can't do this anymore'.

Sally attempted to preserve her morals by speaking out in her organisation before leaving. Although it was not enough to keep her in the role, her experience offers an example of how one set of morals, *speaking up*, can be enacted when other morals are transgressed as a means to preserve one's wider moral system –

> Well, my way of coping was to go and tell them [that] I don't like working in IAPT anymore and tell them (…) what [did] they expect to happen for the amount of sessions and the way that the system (…) doesn't work. So yeah, so I suppose (…) tell them what I think and then to leave, that's how I coped, really.

Sally compares her experience working in NHSTT to volunteering for free in another therapy service. Being able to preserve her morals in this service, where she felt valued for her work, was experienced as more meaningful than working in her NHS role, where she was paid but felt taken advantage of. For Sally, being able to use the full scope of her clinical expertise offered respite from her NHS role –

> Yeah, so I just think it just takes, it takes all the enjoyment out of going to work because when I first started at IAPT and I did used to enjoy it, and then when it got to the point where I'm working for [another counselling service], and I'm donating my time for free, and I feel more valued there than when I'm going to work and getting paid, I'm happier about doing this stuff for nothing than you are feeling that you're, you're being erm – yeah, taken advantage of. I think that's, that's not good, then when you're starting to feel you're being taken advantage of every day going into work, you shouldn't be going anymore. So that's when I left.

Opting to leave was also a strategy used by Alex, whose experience of managing an increasingly complex caseload of safeguarding issues – particularly the one with police involvement, was enough for her to reconsider her future with NHSTT. In the following extract, she gestures at the futility of speaking up in the system, discovering the only strategy to preserve her morals was to leave –

> IAPT is very structured, it is clear cut, even though people don't always seem to follow it. But (…) I don't feel I can work in a service where I don't, I'm gonna like not do what I'm supposed to do. But if I don't agree with what's to be done, you know, what can I do really? Other than leave.

However, before leaving, one tactic Alex used to uphold her morals and attempt to do *what is right* for her clients was to integrate some flexibility in her CBT treatments. In her reflections, she speaks to this but hints at it still not being enough, which prompted her to open up a private practice where she had more scope to practice flexibly -

> You're kind of pressured to work in a way that, you know, is not the best way to work with that client. (…) I didn't just stick to the protocol, because it was there. But yeah (…) that's one of the main reasons that I now work (…) in a private kind of integrative practice, (…) just [for] the freedom to actually go with what the client needs and what's helpful for the client and to have a bit of flexibility.

For some, the act of speaking up against their service often landed on deaf ears (recall the act of not having one's distress acted upon is a feature of moral distress). When asked how she coped, Nina offered another child analogy, referencing the anger and feelings of rejection arising from not being heard. Her description ends with a powerful sense of helplessness and disempowerment from learning that challenging the system was futile –

> Well, rejection. Well, I suppose it looks into the child part of you, doesn't it? Anger, rejection. But not resistance because there was no point.

Feelings of helplessness were also shared by Katherine, who, in an attempt to preserve her morals by speaking out, came to learn it had very little impact –

> I just think that I gave up a bit (…) working in that environment a bit like what's the point? Like, what's the point in bringing these things up if (…) I'm just not heard?

However, similar to Alex, Katherine attempted to navigate the complex line between following protocol and meeting the client's needs. Below, she offered an example of how she would stray from protocol with some clients during her CBT training. The commitment to upholding her clinical morals was prioritised over fidelity to treatment, and offered her a way to manage moral tensions –

> But I kind of had to navigate giving them what they wanted [assessors on CBT course], but also being aware of not doing exactly how they were saying because it didn't fit with that client. I don't know how I really navigated that but – probably by not getting great scores on the CBT course. But I didn't really care. I was just doing it to get through.

Another participant, Claire, also felt dejected after attempting to speak up about the data manipulation in her service, learning it made no difference. Here, she refers to the theory of learned helplessness. Established in the late 1960s, this theory demonstrated the impact of repeated aversive stimuli on subjects, resulting in an acceptance of helplessness. As a theory, it has been applied to many different psychosocial arenas. However, when applied to Claire's experience, is telling of the degree of helplessness experienced in her role, despite the deployment of tactics - such as speaking out to preserve her morals –

> I mean, in a way, because we talked about it, then later on, I don't really see any changes, and I don't really see any way or possibility it will change. And they just make you feel (…) [there is] no point of discussing [it], becoming a little bit like learned helplessness.

However, before speaking out, she relied on a different strategy as a trainee: repressing her feelings about the moral tensions she experienced. This was because she felt less secure with her trainee status, foregrounding concerns about job security. Nonetheless, as she became more experienced and confident, she could acknowledge her feelings, which pushed her to act on the moral tensions by speaking out. She described more of a willingness to make sacrifices to uphold her morals and explicitly referenced her engagement with the current study as a platform to do this –

> Before [as a trainee], even though I probably had emotions, like frustration, sadness, and guilt. But because (…) of [a] more fundamental threat like: 'would I get a secure job? Would I be able to continue with my training?' (…) I somehow can suppress my emotion like: 'don't think about that's not quite important right now'. But when you become more mature and more confident, you feel: 'yeah, I'd probably have more bargaining power. I have the kind of position maybe I can speak up for something'. And yeah, just for example, taking this project [the current study]. If, if you talk to me back in 2018, I don't know if I will actually accept this kind of project, because I will have concerns. Now I feel (…): 'I know I may lose something, but I guess I'm willing to take the sacrifice'

Sometimes, participants' tactics to speak out came in the form of advocacy. For Jenny, learning of the complexity of some of her clients, she would push for more sessions. Although many participants have referenced helplessness and disempowerment in their role, it is important to note they still had more power than their clients, and Jenny's reflections provide an important recognition of this –

> Um, well by the fact that I mean, for instance, at the moment, I'm working with one client who has a historic diagnosis of complex PTSD, but actually came into the service more with depression and anxiety as a result of lockdown. But obviously, once you start working together, what comes up is, you know, a lot to do with the trauma that led to the complex PTSD diagnosis. And I'm working with her longer term (…) because I kind of fought for that [and] said, look: I think, [she is] someone who [would] really benefit from longer therapy.

Similarly, for Nina, she would pursue more sessions on behalf of her clients. Equally, she would also "think ahead" in her treatments to manage clients' expectations and prepare them for the realities of short-term work. Below, she talks about minimising the difficulty for her

clients. However, it is likely by managing her client's expectations, she was also managing her own, which helped to mitigate the impact of moral violations –

> So it was, you know, getting a feel of the client quite quickly into the sessions. And then thinking, trying to think ahead (…) and then trying to minimize the difficulty for the client at the end. And also then trying to get more sessions for them.

For some, how they made sense of and formed meaning in their roles helped them to better tolerate their moral tensions. In the case of Sally, it was learning to focus on what she could do rather than what she could not that helped her to cope –

> [I was] always thinking 'well at least this client is getting some help for nothing for free' (…) so that was always my way of counterbalancing all of the bad feelings about going to work.

Similarly, for Jenny, although she could acknowledge the limitations of what was possible in her role, there was a recognition that at least something was being offered. This counterbalance likely acted as a buffer against the helplessness, guilt, shame, and feelings of sadness expressed –

> I just feel really – yeah, just felt really defeated and sad actually if I'm honest. Yeah, <u>not enough</u> is a word that comes up, you know, morally, it's not enough. You know, we're offering something, thank God. But it's not enough.

Nina goes on to also speak of a similar contrast between the therapeutic provision not being enough but also concluding it was better than giving nothing –

> That's all they get [the clients] is (…) the experience from the NHS. You know, something was better than nothing.

A comparable tension was then expressed by Alex, who acknowledged the benefit of more people getting access to therapies while challenging the one-size-fits-all philosophy of NHSTT. Below, she makes an important link between the transgression of values and the tendency for other clinicians to balance their time between NHS work and private practice –

> And yeah, you know that you're working with people who otherwise would not be able to access therapy. So, you know, that's really great to be part of that. At the same time, it's not a one-size-fits-all all and you kind of have to be able to provide that (…) to operate in that way. So yeah, (….) there's a lot of tensions throughout and kind of knowing that those values are being transgressed is difficult. And I can fully see why a lot of people seem to do part-time NHS part-time private practice. Yeah, to get that balance.

Additional perspectives suggest some participants were able to make meaning from their difficult experiences and highlight important areas of growth. For Jenny, working in NHSTT exposed her to a high-stress environment, which built resilience and increased her confidence –

> How has it [IAPT] impacted me? I just think it's (…) toughened me up, actually, in an odd sort of way. Maybe a bit more resilient. Allowed me, as I say, allowed me to believe that I can do it.

Similarly, for Tracy, exposure to the fast-paced nature of her service supported clinical growth and taught her about the wider healthcare system. Describing it as "real therapy", Tracy refers to how it caters to those who would otherwise not have the resources to afford private therapy –

> My supervisor taught me, the whole experience taught me a lot about, about the profession, about working in the NHS, I'm hugely grateful for that experience, and getting (…) the experience of writing lots of letters, referral letters, discharge letters, crisis plans, you know, kind of understanding primary, secondary, tertiary care. And it felt like real therapy to me in one respect, because sometimes private therapy can feel a little bit like you know,(…) it's for those who have [money]. So, yeah, no, I really did enjoy it on the whole – it had its frustrations, but on the whole, a very good and informative experience.

For Katherine, looking to make positive change from inside the NHS offered a meaningful and protective strategy to manage her moral stress -

> I am passionate about working in the NHS, because I think if you've got a different philosophy, you can influence in subtle ways. (…) for example, when I was doing some supervision with the PWPs, (…) I was bringing in the importance of the relationship and, and so I think there's subtle ways that you can kind of influence.

Lastly, Tracy referred to the skills she developed, pushing her to focus on providing her clients with the best care despite the limitations. Although she eventually left, focusing on how to navigate the system and control what was within her power likely helped her to better tolerate the moral tensions before leaving -

> But on the on the other hand, it (…) did teach me a lot about the importance of a tight framework and sticking to that, and really focusing in the therapy, because you've got so few sessions, it was quite liberating in a way, because you knew that you couldn't deal with X, Y, and Z you can only deal with X in this session (…). So it's quite freeing in a way. And it just keeps you on your toes. You know, there's, there's, there's nothing

> wishy-washy about it. You don't have the beauty of unlimited sessions. (…) I want to give them the best experience (…) possible, I suppose

Sub-Theme: The Power of Togetherness

Sub-Theme Overview

A key strategy for managing moral conflicts was connecting and speaking with others. Often cited across the dataset, many participants found this helped them think through their conflicts and reduce overall tension.

Sub-Theme Analysis

For Jenny, the stress and lack of support in her role pushed her to rely more on her clinical peer group. Describing herself as someone where reaching out can be difficult, learning to tap into this support system became an essential form of coping –

> I've learned to use resources in a way that perhaps I hadn't before. So for instance, I have a fantastic peer supervision group, who I've worked with now for two and a half years, who I feel were really supportive of one another. So for instance, with the safeguarding issue that I talked (…) about, because all my supervisors were away. And I wasn't able to get (…) the support I needed. I actually did put a WhatsApp out to my peers and say: 'look, has anyone got half an hour? I really could do with just talking this over, please.' Which for me, is quite, you know (…) that's doing something quite different for me. So I've learned to acknowledge when I can't do something.

Another participant, Katherine, also referred to the importance of having supportive colleagues who could relate to the difficulties of her role. Although she avoided overly explicit forms of rebellion against her management, she admitted to more covert resistance –

> Well just like, I suppose I was always a bit rebellious (…) I wouldn't be outwardly rebellious because I think I know what I've got to do to keep a job and to get on with people. But (…) I'd (…) go talking to like, other colleagues and seek out people that feel the same and just be a bit rebellious against the management. But I think that kind of gives you a sense of like, belonging, and somewhere to go to vent.

For Nina, having a trusted supervisor outside her service along with colleagues she could talk to added a protective layer against the moral challenges in her role -

> You [were] supported by supervision. And oh, you're comrades, you know, yeah. The other counsellors around would sort of talk about it.

When invited to discuss ways she coped in her role, Sophie reflected on the importance of connecting with colleagues, particularly when it came to validating her experiences. In the

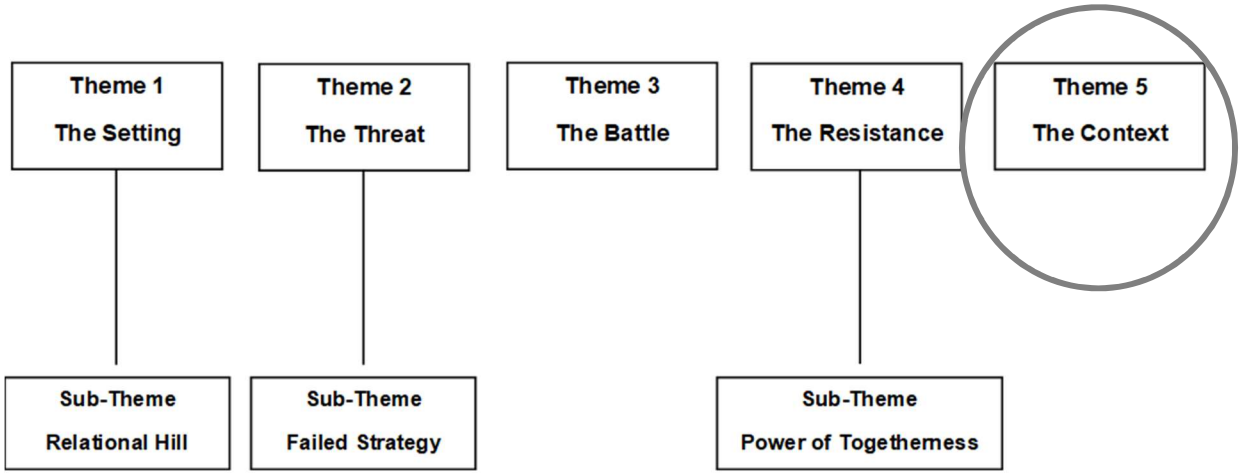
following extract, connecting to others sits alongside a plethora of strategies Sophie deployed to keep herself psychologically and morally safe –

> [the] biggest thing I'd say is to ask my colleagues, first to gain kind of validation: 'am I the only one? Because I was feeling I'm going mad' (…). Have peer supervision, so share with my colleagues – find out that, that they also feel the same way. (…) I just [would] kind of canvass my colleagues, and tried out a few of the things, you know, which included kind of hardening myself off to my supervisor a little bit, which err, not bringing stuff to my supervisor (…), really trying to separate myself off from work […]. And (…) just really just living for the weekends. Do a little bit of private practices as well, so, […] that I wasn't just defined by IAPT and those experiences. (…) I gave up trying to challenge the system. (…) I couldn't do that, which is something I would have done, always used to do it, that's my tendency to challenge the system, but gave up on that. So really, it was just ways to duck and dive, you know, standard stuff that therapists do to save themselves. You know, trying to keep my head under the radar. Just make sure I fulfil the kind of caseload stuff, just trying to keep out of harm's way, dodge the bullets.

Lastly, Claire referred to the importance of talking with like-minded colleagues and finding a platform to express her concerns - such as the current study, which supported her to fight for a profession that aligns with her values –

> But you know, like talking to my colleagues and talking to you, find a platform, I'm more willing to share my experience. And (…) when you speak up for something (…) you always have a certain level of risk (…) but I guess I'm sort of made peace with myself, (…) I'm happy to take on this kind of potential risk, because I want to (…) work in a profession, which I feel [is] consistent with my personal values. So I guess I feel more comfortable now.

Theme 5 - The Context: Age of Clinical Tyranny



Theme Overview

Theme five *zooms out* and contextualises participants' experiences within the wider NHSTT system. During the interviews, the language used by participants often evoked a sense they were navigating an authoritarian or oppressive system. Many participants referred to the power of the system and its heavy reliance on rhetoric. Others spoke to the constant monitoring and surveillance of clinical activity, while some addressed the top-down projection of blame and responsibility on frontline staff.

Theme Analysis

For Jenny, the size of the broader organisation became more apparent from working only one day a week. There is a sense of intimidation that comes with her use of the word "beast", one that implicitly positions her as powerless and NHSTT as powerful -

> The idea of being isolated being one person who pops up one day a week, felt even more pertinent, you know, when I'm doing it here in my study on my own, without that huge sort of kind of beast of the infrastructure of the NHS you know.

Below, she builds on her above point, commenting on the lack of recognition for the skillset of individual clinicians. Rather, there is a sense of 'sameness' assumed. Again, she uses the adjective "beast" to position the system as something with power. Notably, Jenny's point indicates a parallel process: many participants highlighted the limitations of NHSTT's one-size-fits-all philosophy to clients. However, Jenny's experience suggests something similar

may happen for clinicians, where an assumption is made that all clinicians share the same skillset, and that this can be applied equally –

> I think sometimes it's just an acknowledgement of not everybody is as qualified as the next person (…) within the systems. And, you know, IAPT's a massive, massive beast of an organisation. And I think there's something about part of me thinks that they almost need to recognise that what that means to someone like me, who is literally in there once a week.

Reflecting on the safeguarding incident that left her feeling unsupported by her organisation, Jenny offers another metaphor to describe the scale of NHSTT. Again, she implicitly places herself in a position of powerlessness, and her experience evokes a sense of isolation and confusion –

> And morally, I get that it was the right thing to do [report the safeguarding]. (…) but it just felt like a very sledgehammer hammer approach to what had been shared. I suppose it was that one time where I felt like a really small fish in a very, very large sea.

For Nina, when referencing the system, she paints a particularly powerful image arousing themes of power and powerlessness and a sense of being 'done to' by something beyond her control. In her analogy, the system is the "parent", and she is the "child". Interpreting her analogy further, the caution given to not officially "moan" about her experiences resembles the authoritative parental figure that disallows authentic emotional expression from their child –

> Yeah, yeah, that's a parent [the system] I'm the child, you do what you do (…) you don't, don't moan about it. Not officially anyway.

In Sophie's case, the system's power was not as explicitly referenced. During the interview, she raised a concern that her identity might be discovered by talking about her experiences. This concern was not unique to Sophie and was raised by almost *all* participants during the screening phase of the study. This implies there were shared concerns regarding potential repercussions. Moreover, these concerns were still raised despite six out of eight participant's no longer working in NHSTT -

> So had some training delivered […] on therapeutic drift and talking about [this] I mean, (…) [I'm] nervous about this being – because it might be tracked back to me.

In her interview, she referred to the size of NHSTT, citing it as a “juggernaut”: a compelling word used to describe a powerful and overwhelming force. Sophie also challenged the legitimacy of its claims as a service, suggesting it offers one thing but does another. Here, she likens this discrepancy to being “gaslit” due to the system not owning its limitations, clinicians are then pushed to feel they are the problem –

> This machine of IAPT – this juggernaut of IAPT – it claims something that it doesn’t really do. And then and then if you’ve got kind of organizational dynamics, then they’re trying to kind of put stuff on you. So it’s, so it’s a feeling of being almost gaslit. I think that there’s something wrong with me. But the system doesn’t wanna own that actually, it’s not a gold standard system at all.

Sophie goes on to link the system's limitations to its rhetoric around the purported efficiency and effectiveness of its protocols. In her case, this was regarding a safeguarding incident, prompting her to challenge the discrepancy between what was claimed and the reality of the situation. However, in doing so, she came away feeling unheard and “pathologised” –

> So I ended up speaking to the clinical lead about it [the safeguarding concern]. (…) the outwards view is: ‘oh there’s a really good smooth system here’. But my reality was that there wasn’t. And then when I spoke to the clinical lead, he said: ‘that there must be some miscommunication’. But actually, he wasn’t willing to say, you know, to actually admit that aspects of this squeaky clean risk process was not actually very smooth, and resulted in me having, you know, having to work really late one night, very anxious, because I was doing my own kind of risk assessment, which I trust, and then I was having to do a whole load of other stuff that I didn’t believe was about risk, I believed it was about the organisation’s desire to cover its tracks (…). I spoke to clinical lead about this as I did this (…). But I felt as though I was pathologised. It’s just that I wasn’t doing it properly.

Sophie goes on to illustrate another example of what she described as gaslighting, directly relating it to the disparity between rhetoric and reality –

> So a lot of us clinicians have to drift [deviate from protocol in sessions] because the clients don’t fit the model. And you know in a team meeting once I said something about (…) fitting the client to the protocols, and (…) the clinical lead said: ‘oh, we never do that’. And I’m thinking: ‘yes we do, yes we do’. Because we can’t treat them for both anxiety and depression at the same time. So don’t lie, please. So again, gaslighting (…).

Below, Sophie concludes with two powerful statements. She draws parallels between the purported claims of her service and a "fantasy" – one she felt a pull to be complicit in. Rather than being a service held up by its own clinical merit, she describes NHSTT as having power and explicitly refers to feeling like she was up against the "Firm" and, if challenged, worrying that something bad would happen. As an extract, it echoes the perspectives offered by other participants about the power associated with the system and gives a more contextualised understanding of why betrayal-based transgressions are likely to occur -

> I'm being pulled into this lie, this fantasy. That just doesn't help clients and stresses me out as well. Same thing as I said before. (…) And then kind of, because I have to follow that, first and foremost, (…). You know – this is a lie. This is a fantasy. It's not able to own up and claim the weakness because it's so allied to this gold standard. You know, this conviction of the CTSR is a good measure of you know good CBT. But it is not, but it's got power. And I just feel you you're against the Firm really, it's like the Firm and something bad is going to happen to you if you challenge it.

Sophie continues –

> I'm very interested in the top-down pressures. IAPT has got so much power, organisations are trying to deliver the gold standard model because they think their gonna (...) win the tenders, they think they're going to get, you know, glowing reviews from NHS England, but it's just all a load of superficial bullshit. It's not to do with the wellbeing of the clients and (…) there's not enough flex in the model to allow for the outliers (…).There's so much experience out there, so many counsellors that, you know, could do the NHS work, do it competently. They don't need to do a counselling for depression training course.

Another participant, Sally, further echoed Sophie's criticisms of the dislocation between the claims made in her organisation and the reality of the role. Being a sub-contracted counsellor, she spoke to the tension between staying in the organisation or risk going private. For counsellors who were unable to take the financial risk of leaving, they became stuck in the system where they were left holding blame and responsibility –

> So that dilemma is: (…) feel kind of taken advantage of by the by the agency that you're working for or do you take the plunge and just go private and hope you're gonna attract enough clients to you to be able to pay your bills. So there's this sort of pressure that gets put onto the counsellor, (…) you're (…) sucked into this hamster wheel of you just accept whatever you're told to do, and the conditions of the job, you just have to accept them, because that's just how it is. And it's improving standards or whatever. But it's, it's not <u>improving standards</u>, its saving money, and putting the risk onto the counsellors then the agency doesn't have to lose any money on someone that needs more

> sessions, the counsellor loses the money. And it just, you don't – yeah, it's not being valued or supported by your agency at all.

Sally also spoke about the excessive monitoring and surveillance of her clinical activity, and how it was the persistent invasion of emails that left her feeling deskilled. Again, the dynamic of a parent-child relationship - conjuring themes of a power imbalance - is used as the anchoring reference –

> With all of the emails and all of the (…) communications are horrible, the hundreds of [emails] like, you're always (…) being spoken to like children with the communications [in] bold capital letters and emails with: 'this hasn't been done properly'. (…) just not treating your staff like adults, (…) making you feel deskilled, like children.

In Katherine's case, it was her organisation's approach to monitoring performance outcomes. In an attempt to create competition, her organisation would send out all of the clinicians' performance outcomes via email –

> Because I felt like then we were being judged on our performance, but not, but not in a way that was helpful, like: 'okay, bring those stats to the supervision, and let's discuss them', it was more like, let's put them all on a piece of paper and email them out. Almost like creating competition between therapists (…). I just felt it was quite a dictatorial way of doing it.

In the case of Sophie, her experience of being monitored came from conducting over-the-phone assessments. Because of strict inclusion criteria, she often found herself wanting to help clients navigate the risk questions and ensure they would be accepted for support. However, trying to meet the client's needs while adhering to protocol was difficult for Sophie because of assessments being recorded –

> Some of the calls were recorded as well. So you're always kind of aware someone is looking over your shoulder and monitoring what you're doing. So I'm just sitting there thinking: 'please don't say you've got a plan' [for suicide]. And just trying to clarify, is that intensity of feeling? Or is that intention? And almost trying to say to them: 'well, you know, if the intention is over five out of 10, you know, we would be told that you're not really IAPT suitable'. So just trying to get them to understand why I need them to rate it under five out of 10. Because it's like intention, and you're suffering, rather than you're going to do it.

Another participant, Claire, worked in two different NHSTT services and observed how a difference in management style impacted how the service was run. Here, she compared how

one manager with a more business-orientated style focussed heavily on ensuring staff met their targets. It also happened to be the service that manipulated their data to secure contracts. She contrasted this with the service she opted to remain in, which was led by a manager with a clinically orientated style who focussed more on the experience of the clients -

> Yeah, I noticed certain things, which is (…) how they run a services that are highly related to the personal style of the service lead. So I noticed I only worked in two services (…) and notice the one who manipulated the service data, the service lead seems (…) they were working using very business bio model, and very target driven (…) even the supervision styles [was always] checking on your, your sort of, if you have managed your target and how to make sure the service target is met.

Reflecting on NHSTT more broadly, Jenny went on to challenge the system's ability to help people in the right way. In doing this, she acknowledges wider systemic issues regarding funding and oversubscription in the NHS –

> These people that come into IAPT need support and need help. And the system isn't there to support them in the way that they need. And that makes me morally I have, you know, I get that that's the system, you know, that it's the NHS, that funding is tight, that it's oversubscribed, that you know, whatever you want to attribute to it, but morally, that is so uncomfortable for me that, you know, someone who has an absolute need for that help for that therapy. And that need is far greater than 20 weeks, or 15 weeks. And that need is not going to be met in secondary care, because they're not severe enough.

Keeping to Jenny's point, Alex provides a more detailed description of how the system misses the client's needs, referring to the problematic inclusion criteria. Below, she challenges the clinical approach of isolating one problem area, which fails to consider wider difficulties – such as trauma and personality issues. Her commentary offers a window into how frontline clinicians are left morally vulnerable because of wider systemic assumptions on mental health and the human condition. For Alex, this is exacerbated by the lack of appropriate provision elsewhere, leading to the oversubscription of NHSTT –

> My sense about IAPT in general, is that (…) they [the client] might (…) tick the boxes for depression or anxiety. But actually, it's complex trauma or personality issues. But because you can, you know, in theory work on the anxiety, or the depression they've been put through, but obviously, it's a lot more complex than that. And I guess just my understanding is there isn't enough room in other services. So people end up in IAPT. (…) I don't have anything against IAPT, it's there because it's it's needed. It serves a

> function, but I think (…) most of the NHS is being overwhelmed and (…) isn't necessarily workable anymore.

Continuing with the theme of broader systemic issues is the participants' experience of the top-down projection of responsibility from a system unable to address its own limitations. Sally speaks to this below, connecting the running of her service with counsellors absorbing increasing levels of stress –

> The way the services are managed (…) leads to the counsellors (…) picking up like the stress of the work more and feeling undervalued feeling like you're not performing at your job, and all that kind of stuff.

For Katherine, it was a lack of staff support combined with a high turnover of assessments – akin to that of a therapy factory (Binnie, 2015) – that led to the accumulation of projected stress –

> I think even I got desensitised when I was on duty, and you'd have like, be doing lots of assessments and assessing risk and everything. You kind of don't see the person anymore, because you're just so stressed. So I think (…) there's a moral issue there then around looking after the (…) wellbeing of staff because I feel like it was trickling, the stress was trickling down.

The projection of stress made it difficult to be present with clients and put a dent in the armour of team cohesion, a likely protective factor against moral difficulties. Here, Katherine continues –

> If someone knew you're going into a difficult session (…) I always experienced that people would be actually like: 'are you okay?' Although (…) as time went on, and it got more stressful, those periods where people are so busy, I think that [support] gets missed a bit. (…) I think the team was supportive to each other. But (…) as the pressure from the top came down I think it made (…) everyone (…) quite stressed.

In Tracy's case, the pressure placed on supervisors would then increase pressure on therapists. Below, we can observe her referring to a culture of punishment for those failing to meet targets, connecting this with the performative pressure services are under to win contracts -

> If we weren't meeting those target numbers (…) you know, the supervisor's knuckles would get wrapped, and then supervision, the trainee's knuckles would get wrapped. And so there was pressure (…) each time you went to supervision, to be showing that

> your client scores were improving, there was an upward trajectory. (…) So, you know, there was pressure (…) so that they would keep (…) the contract year on year.

Below, Tracy continues by referring to a cascading of coercion through the system. Notably, it is at this stage she reports concerns of whistleblowing. This appears to be emblematic of the position NHSTT occupies in participants' minds, one where concerns of power and punishment are strong enough to elicit anxiety when discussing their personal experiences for the current study –

> It's almost like the sort of coercion gets passed on. And I'd feel that sort of sense of guilt or shame (…), as I said the other day [during the screening phone call], this does feel a little bit like whistleblowing – of doing them a disservice.

Lastly, the factors at play regarding the top-down projection of stress were well articulated by Sophie –

> You know, therapists try to protect clients, that's what we will try to do. The line managers try to protect us. You know, from my research (…) I know that anxiety comes down the line and it gets projected right down. (…) So the squeeze is really coming at the coal face, the line managers are trying to protect staff, (…) we don't want them to get into trouble, but (…) you don't get heard – you don't get listened to.

Conclusion

The above analysis gives voice to the complex dynamics between therapists and systemic processes and how this is partly enacted at the interface between a therapist's moral commitments to *what is right* and the restrictions imposed on them in pursuit of this aim. This indicates to important implications for the increasing bureaucratisation of healthcare and how it is experienced and tolerated by those on the frontline working with high levels of distress. The following Chapter aims to further unpack these themes and explore them in greater detail.

Reflections

Early in the research process, I had to grapple with the art of semi-structured interviewing. Having not done it before, the only frame of reference I had was my clinical experience. Quite quickly, I realised it was *not* a clinical encounter and adjusted my style accordingly –

research supervision was particularly helpful here. It felt strange to interview participant's whose experience I strongly resonated with, where the urge to collude felt strong at times. I sense this is where my clinical training helped - that is, the skill of *staying out of the way*, which allowed participants both the time and space to reflect on their experiences, while also giving me space to regulate and bracket mine.

Looking back, I feel conducting online interviews - a consequence of the pandemic - helped moderate some of my anxieties around the process of interviewing, and made interviewing, audio recording, and transcribing a much more integrated process, while also allowing the opportunity to interview people much further afield: where having to physically travel long distances would have potentially hindered and extended the recruitment process. However, I do also wonder if the practical benefits of remote interviews may have sacrificed certain intersubjective features of an in-person format - particularly given the restricted scope of bodily cues one has access to remotely compared to in-person encounters, where you have greater access to additional channels of communication (e.g., verbal, non-verbal). As many clinicians would agree, there is a substance to in-person encounters that simply cannot be replicated online. It is uncertain how, and if, the data collected and subsequent analysis would be different if interviews were in person, but it is certainly an important point to consider.

Given MI was the guiding theory in the current research, I approached the data - along with the identification of codes and themes - from a specific vantage point. For example, I assumed if NHSTT therapists did experience moral challenges, then there would be a logical succession to the process: first, there would have to be a set of morals, and then there would need to be a transgressive event. From here, there would be a response by way of thoughts, feelings, and behaviours, and then an effort to cope with this. And finally, I was sensitive to insights that could shed light on *why* these moral experiences may occur in the first place. This deductive skew towards the data meant other, more data-driven

insights may have been missed. Equally, it cannot be said with complete certainty that *positivism creep* - in this case, falling victim to looking for ultimate 'truths' – did not partly influence data analysis.

Nearing the end of the analysis, I found many of the potential theme names I was considering had a military substance to them. Reflecting at the time, I connected this tendency to my interest in Shay's original work. As noted previously, I resonated with his early contributions, and it became clear this influenced my stance to theme names. Therefore, I decided to open myself up to this, highlighting a number of reasons: (1) I felt it would provide a structure to the write up process, and better guide readers of the analysis (2), the idea of an 'invasion' was provocative – adding a creative flare – and (hopefully) captured the phenomenological nature of having one's morals violated or transgressed, and (3) I wanted to give a subtle 'hat-tilt' to the origins of the MI theory, and Jonathan Shay by extension, as without him this research would not exist.

CHAPTER FIVE
Discussion

Introduction

This research investigated how psychological therapists working in NHSTT experienced morally challenging events (the exploratory dimension) and why these events may occur (the explanatory dimension). Using Moral Injury (MI) as the guiding theoretical framework and an RTA as the methodological instrument of choice, five distinct themes were generated from eight interviews with psychological therapists across different services.

All participants reported a constellation of morals, many of which were in tension with the expectations of their service. This spanned across multiple domains, including the therapy relationship, use of psychometrics, manipulation of data, and risk management. Participants' moral experiences gave way to a series of difficult emotions, which for many was enough to leave the job to pursue something more aligned with their morals.

The data also gave rise to organisational and political forces that dictate clinical expectations and policy, driving a culture incongruent with psychological therapists' personal and professional values. A culture influenced by neoliberal sentiments and propelled by an increasing reliance on efficiency, division of labour, alienation, hyper-reductionism, quantification, replicability, and surveillance. Participants often referenced the difficulties of navigating the political and organisational complexities of their roles, particularly at the interface of what helping looked like.

The following is a more detailed discussion of each theme. The first four themes address the study's primary question: exploring *how* participants experienced and navigated moral challenges. The fifth and final theme addresses the secondary question: to consider *why* therapists may have encountered such challenges in their roles. As the study concludes, key findings and their relevance to counselling psychology are discussed. Limitations and suggestions for future research are also explored.

Theme 1 - The Setting: Introducing the Moral Territories

This study represents the first attempt to explore and distil the moral ingredients of psychological therapists working in NHSTT. The assumption that therapists navigate challenging moral experiences is implicit in the research question. The data supports this and points to a constellation of morals and values that reflect the counselling and psychotherapy profession more widely. We can observe the humanistic influence of *client-centredness* and *authenticity* (Rogers, 1967), both fundamental components taught in most therapy training as a key requisite to good clinical practice. Similarly, participants placed significant value on the establishment and maintenance of the *therapy relationship*, which supports empirical findings demonstrating the importance of a strong therapeutic alliance in clinical practice (Gelso & Carter, 1994, 1985; Norcross & Wampold, 2011; Paley & Lawton, 2001; Wampold, 2015).

The frequency with which the therapy relationship was cited by participants - including the challenges from transgressing it - suggests it has important moral properties and thus represents a unique insight on its own terms. Given the ever-increasing industrialisation of healthcare (Binnie, 2015; Ritzer, 1992; Rizq & Catherine, 2019; Satran, 2022; Strawbridge, 2016), this has important implications for psychological therapists working in NHSTT, but also other therapy services where upholding one's clinical commitment to the therapy relationship may be disrupted by systemic restrictions.

The therapy relationship is a well-documented dimension of clinical practice and is significant in the process of meaningful therapeutic change. This study supports the inference that being unable to create or maintain a clinical environment conducive to building a robust relationship - resulting in what I have labelled *the disenfranchised relationship* - may have a negative impact on both the therapist and the client. It also supports data suggesting NHSTT is inadequate at meeting the needs of a high percentage of clientele (Griffiths & Griffiths, 2015; NHS Digital, 2022), including for more complex presentations which necessitate a longer period of time to establish a strong working alliance (Martin et al., 2022): something not well

suited to the average treatment length of 7.9 sessions (NHS Digital, 2022). It may also offer an additional perspective on recent annual recovery rates of 50.1% (NHS Digital, 2022).

Another insight generated from the study suggests multiple morals can exist in tension, which supports Molendijk's (2018) findings challenging the assumption morals are linear. For some participants, this was present when managing risk. As a therapist, there is an ethical and moral commitment to risk management. However, for some, this competed with the participant's commitment to the therapy relationship, creating moral tension. It should be noted that this situation is not unique to NHSTT but therapists more broadly, where safety and risk have to be negotiated with other clinical commitments, such as the therapy relationship. However, what was unique about those working in NHSTT was how risk was managed - which was perceived as more reactive, defensive, and rigid. Some participants felt NHSTT risk management protocol could unnecessarily challenge the therapy relationship, creating irreparable ruptures, indicating NHSTT risk protocols may make it more difficult for therapists to effectively manage risk and the relationship simultaneously, something one participant implied could *increase* risk.

Along with client-centredness and the therapy relationship, participants also placed moral value on working within one's clinical competency, speaking up, having integrity, and doing no harm. These morals are strengthened or adopted when becoming a therapist and represent key ethical requirements dictated by the field's regulatory bodies. Therefore, the current study highlights a significant tension between competing expectations for the NHSTT therapist: pulled between a moral commitment to their clients and the clinical expectations of the service.

Theme 2 - The Threat: Invasion of the Moral Territories

At the time of writing, the current study is the first to explore and organise events giving rise to moral difficulties in a cohort of psychological therapists. It supports the concepts of *potentially morally injurious events* (pMIE) and *morally injurious events* (MIE) as helpful heuristics to frame these experiences. Equally, evidence of both betrayal-based (Shay, 2012) and perpetration-based conceptions (Litz et al., 2009) were shared by participants (and in one

case, the term “moral injury” was used *by* a participant), further supporting the theoretical framework of MI as a potentially helpful construct when considering the moral experiences of therapists working in NHSTT.

Of note was how exposure to MIE generated a sense of being unable to do *what is right*. Being unable to do what is right marks the first step in Shay’s (2012) definition and strongly supports the application of MI in healthcare settings (Hagerty & Williams, 2022; Kok et al., 2023; Litam & Balkin, 2021; Mantri et al., 2020; Meacham, 2019; Morris et al., 2022a, 2022b; Murray et al., 2018; Nelson et al., 2022; Roycraft et al., 2020; Rushton et al., 2022; Talbot & Dean, 2018; Wang et al., 2020; Weber et al., 2023; Williamson et al., 2023a). Here, we can recall Talbot and Dean’s (2018) definition: “The moral injury of health care is not the offence of killing another human being in the context of war. It is being unable to provide high-quality care and healing in the context of health care” (p. 2). Like medical personnel, psychological therapists are trained to care and heal those in distress. However, based on the current data, there appears to be a divergence in what ‘helping’ can look like. This may create scenarios where therapists are restricted in exercising *what is right* according to their morals. This study, therefore, supports the notion that exposure to pMIE is not unique to those in medical disciplines but is also experienced by those in psychological professions.

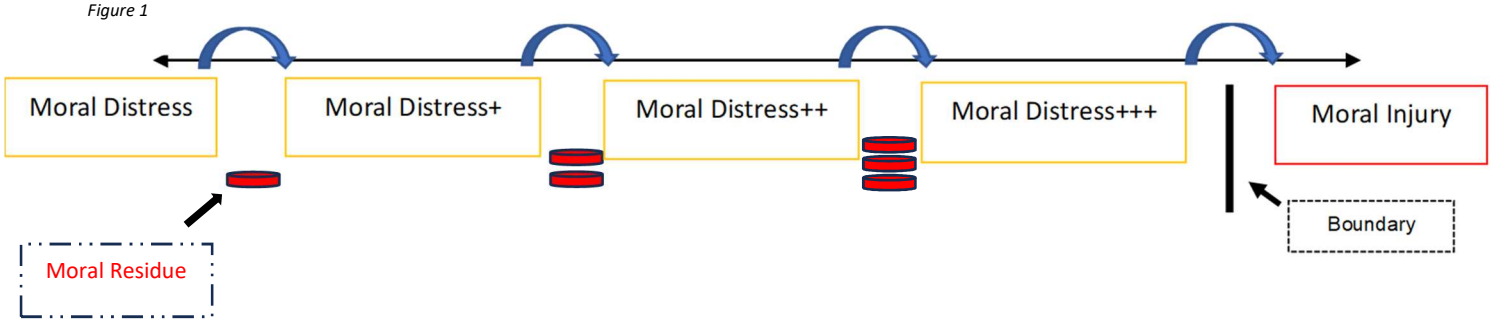
Moral Injury and Moral Distress

Unlike the more acute moral scenarios found in military populations, the current study indicates events may only become morally injurious after repeated moral stressors. This suggests research on moral distress (MD) may *also* be helpful when making sense of the current data. As discussed in Chapter Two, the roots of MD (Jameton, 1984; Wilkinson,1987) originate from the nursing profession and can lead to negative feelings and psychological disequilibrium from (1) a conflict with others’ values, or broader institutional restrictions, and (2) the difficulties experienced from not having one’s initial distress acted on. To this point, the current study supports the proposal that MD could be a contributing factor to MI (Grimell & Nilsson, 2020; Litz & Kerig, 2019; Roycroft et al., 2020; Webb et al., 2024). This pattern is

observable in the data, where tension did not come from participants only experiencing one or two moral stressors, but many.

Epstein and Hamric (2009) describe the chronicity of moral stressors as the 'Crescendo Effect', referring to the accumulation of *moral residue* that metastasises into MD. In light of the current data, the following diagram (see *Figure 1*) takes Epstein and Hamric's formula further and proposes a tentative relationship between moral residue, MD, and MI. It also factors in the temporal differences, as Grimell and Nilsson (2020) highlighted, with MD indicating a short-term reaction and MI a long-term one.

Figure 1



The current study, therefore, supports MD and MI as related but separate and unique theoretical frameworks (Grimell & Nilsson, 2020; Litz & Kerig, 2019). This is critical given the confusion found in the literature when defining MI (Griffin et al., 2019; Hodgson & Carey, 2017; Molendijk et al., 2022) and the importance (and challenge) of delineating it from alternative frameworks (Cartolovni et al., 2021; Papazoglou et al., 2020b). Teasing out the relationship between MD and MI in the abovementioned way allows for a greater and more nuanced understanding of moral experiences, and supports Grimell and Nilsson's (2020) integrative model where MI and MD are fused for the purposes of gaining a greater understanding of moral experiences.

The data also offers some conceptual clarity, supporting the operationalisation of MI as an alternative and distinct theoretical model in its own right (Atuel et al., 2020, 2021; Barnes et al., 2019; Bryan et al., 2018; Jinkerson, 2016; Nickerson et al., 2015). However, the current

data is not exhaustive, therefore I agree with others (Meacham, 2019; Riedel et al., 2022) who have highlighted the need for further research exploring the relationship between MD and MI and, more specifically, whether untreated MD in therapists working in NHSTT may lead to MI.

Theme 3 - The Battle: Experiences of the Invasion

The literature is replete with research linking MI with poor mental health (McEwen, 2021). Although the current study did not explore mental health outcomes specifically, the data supports evidence of both betrayal-based (Shay, 2012) and perpetration-based (Litz et al., 2009) transgressions in participants' experiences, along with a constellation of emotional responses which closely correlate with multiple definitions of MI (Carey & Hodgson, 2018; Jinkerson, 2016; Litz et al., 2009; Richardson et al., 2020; Shay, 2012).

Perpetration or Betrayal?

As discussed in Chapter Two, Shay's (2012) original conceptualisation of MI prioritised betrayal-based transgressions that contextualised the individual and firmly placed them in the social-hierarchical system - framing the power holder as violator. However, Litz and colleagues' (2009) definition decontextualised the individual's experience by emphasising perpetration-based conceptions. This decontextualisation of the individual marked an important point of divergence between both models, with perpetration-based conceptions dominating much of the subsequent research (Hollis et al., 2022).

However, the current study suggests that both betrayal *and* perpetration conceptions play an important role when considering the moral experiences of therapists working in NHSTT. It is concordant with literature arguing against the privileging of one (perpetration) over the other (betrayal), as this fails to adjust for the social-political dimensions of MI (Atuel et al., 2020; Hodgson & Carey, 2017; Hollis et al., 2022; Kinghorn, 2012; Molendijk, 2018, 2019, 2022; Wiinikka-Lydon, 2017).

Claire poignantly demonstrated the value of adjusting for betrayal-based conceptions in Chapter Four. Her betrayal-based experience involved her learning the service manipulated

data to inflate their recovery scores. This transgressed her sense of integrity, brought up feelings of shame, guilt, anger, and loss of trust, and forced a questioning of her professional commitments. One explanation for why Claire's organisation may have done this can be found in the 'McDonaldization' of healthcare (Ritzer, 1992), which demands a focus on efficiency, quantification, and reproducibility. Organisations predicated on the strict adherence to quantification become vulnerable to 'reactive gaming' (Bevan & Hood, 2006). Therefore, the current study suggests NHSTT is also vulnerable to this and raises important ethical questions. Furthermore, Claire's experience indicates that data manipulation in NHSTT may negatively interact with a clinician's moral framework, representing a unique betrayal-based transgression.

If the current study focused solely on perpetration-based transgressions, then experiences like Claire's would have been missed. This would be unhelpful as the current data suggests that adjusting for the political and social domain (betrayal-based transgressions) is critical to understanding *why* therapists may come up against moral challenges. Thus, it supports wider criticisms that omitting betrayal-based conceptions may restrict and skew the landscape of MI research (Atuel et al., 2020; Hollis., 2022).

The Moral Emotions

Almost all descriptions of MI include guilt, shame, anger, and loss of trust in self and/or others (Jinkerson, 2016; Litz et al., 2009; Richardson et al., 2020; Shay, 2012; Talbot & Dean, 2018). When reflecting on their responses to MIE, participants reported feelings of shame, guilt, anger, and a lack of trust in self and/or their service. These were centralised around perpetration and betrayal-based moral transgressions – strongly supporting the current theoretical understanding of MI. Notably was the place of anger in participants' experiences, which supports Bryan et al. (2018) study showcasing anger as highly correlated with MI. The data also supports Williamson and colleagues' (2020) study that found MI may arise not just from life-threatening situations but also ethically challenging ones - so-called 'mixed' events. Interestingly, the data indicates some participants used additional descriptors when reflecting

on their responses to MIE, such as humiliation, not being 'good enough' and feelings of hopelessness.

The Place of Humiliation in Moral Injury

There is little-to-no empirical research linking humiliation with MI. However, the wider literature has regularly cited humiliation as playing a pivotal role in moral suffering (Atuel et al., 2021; Currier et al., 2015b; Hollis et al., 2022; Rothbart & Poder, 2017; Shay, 1991, 2012). Closely related but distinct from shame, humiliation is an important moral emotion that supports us to negotiate our place in the social world, and when activated, can lead to social and moral suffering and has powerful effects on one's sense of worth, value, and power (Gilbert, 2019).

Unique to this study is the humiliation generated by the NHSTT system. The theory of *systemic humiliation* addresses the relationship between humiliation and a system. It can be understood as a set of rules, norms, or behaviours that impact a specific population by directly or indirectly affecting their thoughts, behaviours, and sense of self (Rothbart & Poder, 2017). A by-product of this is a sense of inferiority, powerlessness, and weakened self-esteem, which can promote power imbalances. This is a valuable theory to help make sense of the relationship between systems and humiliation, as participants regularly revealed a sense of powerlessness from attempting to uphold their moral framework by speaking up and expressing their concerns but coming away feeling unheard, invalidated, infantilised, and powerless to make meaningful change for themselves or their clients. Note the lack of support from those in charge also represents a risk factor for MI (McCormack & Riley, 2016; Riedel et al., 2022; Shay, 2014; Weber et al., 2023; Williamson et al., 2020). Here, we can trace the precipitating steps necessary to developing a loss of trust in self (the therapist) and/or others (the system), which is central to the MI experience (Litz et al., 2009; Shay, 2012).

Despite being a moral emotion, one reason for the exclusion of humiliation in popular models of MI is the privileging of perpetration-based conceptions (Hollis et al., 2022). Humiliation requires an *other*, but when transgressions are only explored through the lens of perpetration,

the *other* is abstracted from the narrative. Therefore, the current study indicates the place of humiliation within the theory of MI is of some importance, particularly when contextualising the individual within a system that may challenge their existing moral framework.

Not 'good enough'

Appraising oneself as not 'good enough' or losing faith in one's clinical effectiveness appears to be a meaningful outcome of therapists struggling to uphold their moral framework within NHSTT. When a system cannot tolerate its limitations, then those working on the frontline risk becoming proxies for holding institutional responsibility and blame (Baker, 2020).

The notion of an individual being labelled as the problem rather than considering the place of their environment is embraced by Thomas (2019) in his concept of *malignant individualism*. This is defined as the imposition of "individualised and interiorised explanations of misery, hopelessness and despair, [that] fails to recognise the role of social and political contexts of poverty and destitution that people are powerless to change" (Rizq & Catherine, 2019, p. 25). Thomas challenges the utility of the 'science' of happiness, positive psychology, and CBT in government policy and healthcare, including NHSTT. Akin to perpetration-based conceptions of MI, positive psychology privileges intrapsychic explanations of human distress over their contextual alternatives. Thomas weaves his concept with Marxist, Foucauldian, and neoliberal theory to illustrate the limitations of the current state of mental health care, arguing positive psychology, the 'science' of happiness, and CBT all represent tools equipped by the state to control and manage the unemployed.

Evidence of the limitations of the so-called 'science' of happiness can be found in the current data, where participants report on their systematic use of clinical measures to monitor 'recovery' (or lack thereof). Thomas argues that when there is no improvement, the client is blamed for the problem rather than the intervention. However, the current study argues that malignant individualism may also extend to the therapist, who is under extraordinary pressure to meet recovery targets and is socialised to deliver 'evidence-based' care defined by binary

explanations of human suffering supported by 'science'. Explanations which appear incongruent with therapists' moral framework. When the therapist inevitably fails to help or do *what is right*, they are blamed as the problem rather than the system or intervention. This decontextualisation of the individual can also be observed in the closely related concept of burnout.

Moral Injury, Burnout, and the NHSTT Therapist

Findings from theme three raise the topic of theoretical clarity. Burnout was referenced by some participants due to the high-volume, high-turnover pace of NHSTT and is defined by cynicism, exhaustion, and reduced professional efficacy from chronic exposure to high levels of stress (Maslach & Leiter, 2008). In Chapter One, I refer to burnout as a "diagnostic dustbin". Here, my views intersect closely with Talbot and Dean's (2018), who suggest physicians are not burning out but instead are morally injured: a statement - this study suggests - may also apply to therapists working in NHSTT. Although the current study's aim was not focused on the relationship between MI and burnout, some tentative inferences can be made.

The current study supports a likely relationship between MI and burnout. However, how this relationship unfolds remains uncertain. As hypothesised in Chapter Two, the relationship between MI and burnout may be bidirectional depending on the individual and their context. One may give rise to the other or be experienced simultaneously. Someone may experience chronic, unsustainable levels of distress that decrease their capacity to cope, in turn making them more vulnerable to MI. Equally, someone may experience MD and MI, leaving them vulnerable to higher levels of burnout.

As highlighted previously, burnout may significantly reduce wellbeing rates and increase turnover rates for therapists working in NHSTT (Jackson, 2019; NHS England, 2016). The current data support this but also suggests MI could be an alternative and important framework to consider as it contextualises the individual within a social-hierarchical system (Shay, 2012), but also highlights different phenomenology (or symptoms) that may be overlooked if defined as 'burnt out'. Similar to MD, the current data points to both models as likely helping frame

therapist experiences. However, in alignment with Talbot and Dean's (2018) position – this study cautions against applying the burnout construct too widely, as it risks misunderstanding the individual and overlooking wider causal explanations. This suggests future research to better understand the relationship between burnout and MI is a worthy endeavour, as both appear to play unique roles in the experience of therapists working in NHSTT.

Themes 1-3: Moral Injury & NHS Talking Therapies

As per the chosen MI definition for this study, an individual must have "deeply-held moral beliefs and/or ethical standards" (Carey & Hodgson, 2018, p. 2). Given the morals outlined by participants in theme one - which are supported and reinforced by academic institutions and professional regulatory bodies - defining therapists' morals as "deeply held" appears both necessary and sufficient. Theme two supports MIE and pMIE as helpful heuristics for understanding the types of events resulting in "grievous moral transgression, or violations" (Carey & Hodgson, 2018, p. 2). Finally, theme three points to a series of emotional responses participants faced from pMIE that correlate with the theory of MI while also highlighting humiliation as a potentially helpful addition to the MI construct. Taken together, themes one to three strongly support the theory of MI as both a helpful and applicable model in understanding the moral difficulties experienced by therapists working in NHSTT.

Theme 4 - The Resistance: Strategies used to Survive

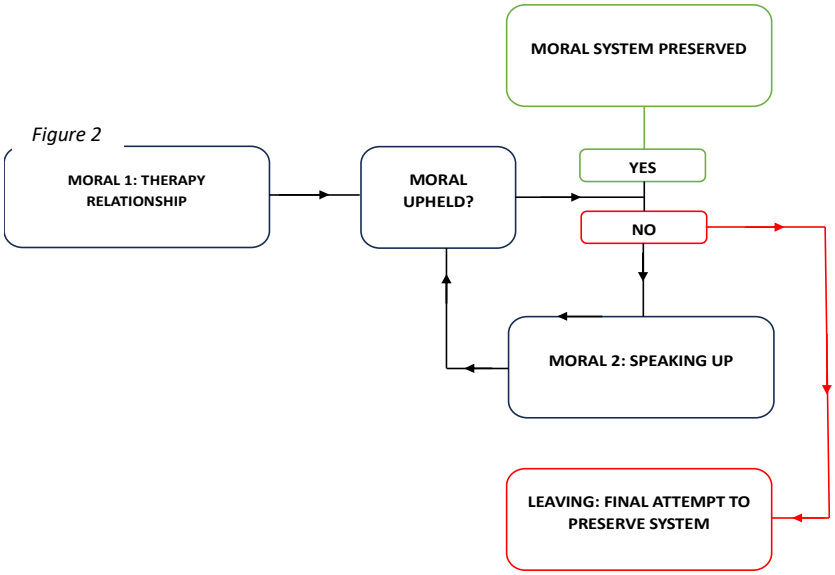
The current study marks a first attempt to understand what strategies therapists working in NHSTT use to manage, mitigate, and navigate moral conflict. When encouraged to reflect on this, participants articulated various coping strategies. These included an attempt to protect their clients from the system, speaking up for what is right, focussing on the positives, reaching out to trusted colleagues, balancing time between the NHS and private practice, or leaving the organisation entirely.

Moral Preservation

One noteworthy pattern was how therapists negotiated specific dynamics of their moral systems. As discussed in theme one, there is supporting evidence that morals are not linear

but can exist in tension. Building on this interplay between morals is how participants attempted to preserve their moral systems following a transgression. A primary example is found when examining the relationship between participants' moral duty to the therapy relationship and their commitment to speaking up for what is right. The transgression of the former resulted in the activation of the latter, suggesting one key way therapists preserve the failing of one moral (therapy relationship) is by enacting another (speaking up for what is right) in an attempt to preserve the moral whole (see *Figure 2*). However, if speaking up was unsuccessful, the therapist's final efforts to preserve their moral system involved leaving the service entirely.

Figure 2



Before leaving, many therapists remained in their roles for considerable periods of time. For some, balancing their time between NHSTT, private practice, or volunteering in a service more aligned with their morals was critical to off-setting moral tensions. Another notable strategy was the value of connecting with trusted others, such as a supervisor, work colleague(s), or an external peer group. Based on this, participants having a space to discuss the experience and frustrations of their roles appeared protective. The insulation provided from

adequate support has been highlighted elsewhere in the literature as a protective factor against moral difficulties (Atuel et al., 2021; Dale et al., 2021; Hossain & Clatty, 2021; Litz et al., 2009; McCormack & Riley, 2016; Murray et al., 2018), and the current study supports this. However, the data also suggests this may not be sufficient in the long term, as in the end six out of eight participants left their services. One potential explanation may be the helplessness participants experienced from realising they could not align the system with their morals, which would require significant systemic change.

Having a Platform

For Claire, she had a choice to remain in her service, where the pay was less, or move back to her previous service, where data was being manipulated. She resonated with the integrity of the honest service, so she stayed, and with this, a moral harmony was achieved. However, being aware that other services were gaming their data still created some tension, and one way she attempted to manage this was by participating in the current study, which offered her a "platform" to voice her concerns. Although other participants were not as explicit in their reasons for participating, it is possible the difficulties experienced during their time in NHSTT had left some moral residue. Therefore, having an opportunity to align with their moral commitment to speaking up for what is right – or what they perceived as not *right* – about their time in NHSTT may have been a key motivator to engaging in the current study, something I have termed a *potentially morally reparative event* (pMRE).

Risk Factors

The current study suggests having adequate support is protective. However, for many participants, this support was external to their services. A lack of institutional support is regarded a risk factor for MI (McCormack & Riley, 2016; Riedel et al., 2022; Shay, 2014; Weber et al., 2023; Williamson et al., 2020), which can generate a loss of trust in self and the wider system. Despite participants' best attempts to utilise coping strategies, it appears chronic moral stressors combined with a lack of institutional support eventually degraded the effectiveness of these strategies, resulting in many participants leaving. Again, this may offer

an additional lens to understanding the high turnover rates in NHSTT services (NHS England, 2016; Watts, 2016).

The literature reports on a range of risk factors for developing MI. However, risk factors for therapists developing MI have yet to be explored outside of this study. Therefore, it is helpful to consider factors from alternative professions which may apply to the therapist working in NHSTT. The first of these factors is age (Williamson et al., 2020), with therapists younger in age potentially being at a higher risk of MI. Closely related to age is a therapist's level of experience (Rushton et al., 2022), which may result in them struggling to navigate moral experiences earlier in their career. Moreover, a therapist's level of preparedness for the moral risks of their role may be a meaningful consideration (Hossain & Clatty, 2021; Shay, 2014; Williamson et al., 2020); having inadequate preparation for managing moral complexities – particularly in training – may result in novice therapists being more vulnerable to MI. Lastly is a therapist's self-esteem economy, with poorer self-esteem being a potential risk factor (Litz et al., 2009; Strelan, 2007). Although these were not explored in the current study, they represent worthwhile areas of enquiry in future research, which will aid in more precisely determining individual MI risk factors for therapists working in NHSTT and similar organisations.

Summary of Protective Factors

Following is a list of proposed protective factors generated from the current study, which may support therapists working in NHSTT to better manage moral challenges:

1. A support network, be it a supervisor, work colleague(s), or peer group, appears to be a significant protective factor. However, if therapists feel unsupported by the organisation, then this may not be enough to significantly mitigate moral difficulties. Therefore, appropriate institutional support may be an essential ingredient in warding off moral injuries.

2. Clinical inflexibility appeared to generate moral tensions for therapists. This suggests that having a greater sense of agency and clinical flexibility could help better offset moral difficulties, as there would be more alignment between their moral framework and expectations of the organisation.
3. Working part-time between NHSTT and private practice (or another service with more clinical flexibility) appeared meaningful for therapists when resolving moral difficulties. For some, working in NHSTT taught valuable skills and clinical resilience. Therefore, balancing between roles could support therapists in developing clinically from working in NHSTT while also providing an alternative outlet where a fuller commitment to their morals is possible.

Theme 5 - The Context: Age of Clinical Tyranny

So far, the explorative ingredients of the current study have been considered. However, theme five pivots towards the explanatory, with efforts made to contextualise the therapist's experience within the social-political domain. Broadly, it strongly depicts the role of institutional power and how it seeps through the architecture of NHSTT. One clear feature is how participants explicitly (or implicitly) reflected on their experiences of organisational power (see below):

	Quote
Jenny	"beast of the infrastructure of the NHS"
Jenny	"I felt like a really small fish in a very, very large sea"
Nina	"that's a parent [the system] I'm the child"
Sophie	"This machine of IAPT – this juggernaut of IAPT"
Sophie	"but it's got power. And I just feel (…) you're against the Firm really and something bad is going to happen if you challenge it."
Katherine	"I just felt like it was quite a dictatorial way of doing it"
Sally	"making you feel deskilled, like children".
Tracy	"almost like the sort of coercion gets passed on"

These excerpts represent only some of the ways participants made sense of the power structures at play. Other meaningful observations included: (1) the use of organisational

rhetoric – which often contradicted the realities of the job and created a sense of "gaslighting", (2) the exaggerated role of monitoring and surveillance of clinical activity, (3) the dominating top-down pressures and subsequent cascading of blame, coercion, and responsibility on to frontline staff, (4) participants' attempts to covertly navigate and resist the system, and (5) the collective concerns expressed early in recruitment about participating in the current study, and the fear of being identified as whistle-blowers or dissenters. To better understand these insights, examining the social-political drivers is necessary. In doing so, I aim to grapple with the hazy image of *why* therapists are being exposed to MIE and bring it into greater focus. To do this, the conceptual frameworks of neoliberalism, Foucault, and Marxism are probed and inspected for causal explanations.

Neoliberalism

As highlighted in Chapter Two, the dominant political philosophy of neoliberalism re-emerged in the late 20th century, influencing many different corners of society - the least of which was how society cared for and perceived the mentally unwell and economically disadvantaged. This had great implications on how we view human relationships, our capacity for compassion, and our ability to engage with and tolerate the suffering of others. Harvey (2005) outlined three important features of neoliberalism: (1) its emphasis on individualism and relegation of collective responsibility, (2) its impact on democracy and social justice, and (3) a focus on expertise and technology.

Thomas's (2019) previously discussed theory of malignant individualism illustrates this ideological focus on individualism, aptly capturing the interiorised explanations of distress imposed on an individual at the exclusion of their context. Individual freedom is therefore privileged over collective responsibility. Therefore, the ideal neoliberal subject is the competitive go-getter, the 'striver', who achieves success by embracing personal responsibility and templates this for the rest of society. By contrast, any failure becomes personal, the responsibility of the individual who is decontextualised from exterior adversity. Thus, a fertile

territory is cultivated, forming two moral camps: those who think and live ‘correctly’ and those who do not.

Neoliberalism also supports the government in claiming responsibility for increasing the wellbeing of its citizens. Inspired by utilitarian political theories, this gave the state licence to utilise the ‘science’ of positive psychology and manualised CBT in service of a more happy and productive society while re-enforcing the narrative that distress is an interiorised phenomenon capable of being changed through rationality, alterations in cognition, and objective evaluations of the self – the roots of which can be found in philosophical empiricism. To this point is Atkinson’s (2016) assertion that modern capitalism leverages ‘happiness’ as its most valued sales pitch, as it threads the individual’s need for success with money and anchors it with their desire to be happy. Through a delicate sleight of hand, neoliberalism creates conditions of misery for many while simultaneously marketing solutions to overcome such misery with the promise of happiness. Here, we can begin to observe the influence of politics on psychological professions and how positive psychology and therapies, such as manualised CBT, may be used as political tools to manage and control citizens in the service of employment, productivity, and efficiency (Loewenthal & Proctor, 2018).

Foucault

The French philosopher and political activist Michel Foucault significantly influenced contemporary understandings of the nature of power. Included are his theories on *governmentality* (Foucault, 1978/2019), which further unpacks the position of individualism in neoliberal theory, the creation of neoliberal subjects, and how these relate to psychological therapies. The 1970s marked the point when Foucault’s conceptualisation of power changed. Rather than only formulating power as a form of oppression and subjugation – something more aligned with the political discourse of Marxism (Thomas, 2019) – Foucault considered how power could be productive, creative, and positive. On the one hand, power can suppress and conceal the truth, but on the other, it can be utilised to develop discourses of truth and leveraged to assert one description of truth against another (Bracken et al., 2007). One

example is the ‘truth’ generated from decades of scientific research advocating for the importance of the therapy relationship in the process of meaningful change, which comes up against manualised therapies in NHSTT proclaiming the ‘truth’ of prioritising cognition and rationality.

By studying prisons and asylums (Foucault, 1975/2020), Foucault generated his theory of *disciplinary power*. Here, Foucault asserted that following the Enlightenment came a shift in how power was exercised. Before, power was directed through the restriction and/or punishment of individuals’ physical bodies, whereas following the Enlightenment came greater efforts to persuade members of society to discipline themselves – thus, a shift to individualism. Along with this new way of conceptualising the human condition came the creation of disciplines such as psychotherapy, psychology, and psychiatry, all tools that the government can leverage to enact disciplinary power. Specific examples of this may include the deployment of positive psychology and CBT – particularly the manualised CBT interventions found in NHSTT – in the formation and preservation of the neoliberal subject and surveillance of the self through ‘normalisation’ techniques (Loewenthal & Proctor, 2018; Proctor, 2008; Thomas, 2019).

Although the word “government” was used in different ways by Foucault (Gordon, 1991), within the current context, it refers to the *conducting of conduct* – that is, the implementation of regimes that impact, guide, and shape the conduct of others. This form of governmentality manifests on many levels, one of which is at the level of interpersonal relationships, particularly when control or guidance is involved (e.g., the therapy relationship). Therefore, a key concern of governmentality is the intersection between an individual and the state and the state's operation of power to coax an individual to conform to their assigned duties (e.g., the genesis of NHSTT to get people back to work). To achieve this, the state employs a host of tools and technologies – what Foucault (1982/2019) referred to as *technologies of the self* – with the aim of supporting freedom. However, this ‘freedom’ exists only within the borders imposed by

particular discourses, laws, rules, and statements of 'science' arranged by institutions to (re)configure subjectivity. Critical to this idea is the technology of psychotherapy and psychology to enact specific knowledge that promotes obedience and conforming of the individual subject in the pursuit of upholding neoliberal values. Similar interpretations are further echoed in the scholarship offered by anthropology and sociology, which argue psychotherapy is an elitist practice wielded as a tool to systematically normalise social disparities, conformity, and de-politicisation (Furedi, 2004; Rose, 1998).

By combining neo-liberal philosophy with Foucault's theories of governmentality, disciplinary power, and technologies of the self, we can begin to understand the wider motivations leading to the development of NHSTT and the challenges within. One interpretation is that top-down forces wield the therapist as a tool to communicate particular 'regimes of truth' (Foucault, 1975/2020) or imposed psychological explanations - what Friedli and Stearn (2015) call *psycho-compulsion*. These explanations are justified by statements of 'science' promoting rigid and restrictive conceptions of human distress. Not only is the client on the receiving end of this power, but the current findings also suggest the psychological therapist is, too. When a therapist operates within these borders - especially when trained in alternative 'regimes of truth' - there is a powerful clash between their morals and the clinical expectations of the service.

Marxism

Karl Marx exerted significant influence as a revolutionary socialist and enormously impacted political, intellectual, and economic history. A broad analysis of Marx's work is not the intention of this Chapter, nor would it be possible within the scope of this thesis. However, I feel that not exploring some of Marx's contributions would do a great disservice to the current research, as he put forward some key ideas - such as the *division of labour* and *alienation* - that are applicable to the current study.

Division of Labour

When inspecting different corners of society, one often faces the realities brought on by the division of labour, where complexity is chiselled down into basic units and assigned to less skilled workers. According to Marx, the rationality behind humans' organised production sets them apart from the rest of the animal kingdom. As such, one cannot be defined as separate from one's labour. Marx's concept of production had implications for many domains of human life and, as an idea, was central to his framework. He occupied a hostile position towards the division of labour as he argued it gave way to the emergence of competitive boundaries between people, where lines of division create class differences. Without these economic classes, the state would become obsolete and no longer used as an instrument for social control, wielded by occupants of one class to subjugate those of another.

The implications of the division of labour related to the discipline of psychotherapy were briefly explored in Chapter Two, where Satran's (2022) work on the automation of psychotherapy was referenced. To recap, Satran pulls on the Marxian framework, arguing the role of the human therapist is being controlled and minimised in a way previously unseen. To further his point, he supports his argument by directing it to the newly developed Internet Cognitive Behavioural Therapy (ICBT) provision in Israel, templated after the UK's NHSTT service. Satran argued the condensing of clinical contact to 20 minutes per client is evidence of the division of labour to less skilled workers for increased efficiency, standardisation, and reproduction. A move he highlights, away from *craft* towards *industrialised labour*. In his first volume of Capital (Marx, 1867/2023), Marx correlates the reduction of craft with the early stages of capitalism, where highly skilled craftsmen began to gather in one place under one employer. Ordinarily, the control exercised by the employer is relatively limited, and traditionally speaking, this is the same for the psychotherapist, who, in turn, preserves the craft of psychotherapy along with the clinician's morals. However, the role of the employer can be taken to greater extremes - NHSTT being one example - where flexibility devolves to rigidity as the therapist experiences less and less control or autonomy over their role.

The notion of craftsmanship is explored further by Pye (2019), who addresses the dichotomy of *risk* versus *certainty* as it pertains to workmanship. Satran (2022) introduces the field of psychotherapy to Pye's argument, noting psychotherapy could be seen as a workmanship of risk. Here, *risk* means the somewhat tumultuous journey of becoming a psychotherapist: an expensive process with its own risks, one with multiple obstacles on its path. Still, it is worthwhile as the end result is a skilled practitioner. However, the emergence of more industrialised forms of healthcare - which promote evidence-based treatments, standardisation, and quantifiable outcomes - Satran argues, is a sign of the profession's move away from the workmanship of risk to one of *certainty*. As the current study suggests, the craftsmanship of psychotherapy still exists - demonstrated by participant's efforts to uphold the tradition of their discipline despite the limitations placed on them. However, this was an increasingly arduous task for participants, as their craft became regularly violated and streamlined by the dominating force of market pressures and the division of labour.

Alienation

Marx's theory of alienation (Marx, 1844/1988) attempts to unpick the impact of capitalism on how workers begin to experience human life as worthless or meaningless as their right to think and govern is deprived, and the opportunity to gain value from their own labour is restricted. Marx observed this during the Industrial Revolution, where he witnessed owners of factories benefiting from great wealth at the expense of those who worked within them. These workers were referred to as "hands", as their value only resided in the repeated use of their 10-digit instruments (Meacham, 2019), separated from the satisfaction and process of completing the product, along with reasons for doing it as creative agents, Marx labelled this type of work *alienated labour*.

When referring to alienation, Satran writes: "work becomes routine, tasks become monotonic, and workers lose interest in their work, eventually becoming alienated from it. The end-point of the process is replacement by a cheaper and less skilled work force" (Satran, 2022, p. 9).

This observation is reflected in the NHSTT structure, largely comprised of psychological well-being practitioners (PWPs) and high-intensity CBT therapists (HITs), which require significantly less time to train than a traditional psychotherapist. Less skilled workers are trained in specific therapy protocols, often manualised to enhance standardisation and replicability.

Meachan (2019) adopts Marx's four types of alienated labour as the "metaphor through which to examine the kind of moral distress suffered by medical students" (p. 6). The four layers of alienated labour - that is, the individual worker is alienated from (1) the process, (2) the product, (3) the work, and (4) themselves and what it is to be human - are outlined, and Meachan considers these types of alienation as having implications on the relationship between accumulated moral distress and moral injury. In her paper, the 'product' is the patient, and moral distress accumulates as healthcare workers go through each layer of alienation within a system that ignores their lived experience. Meachan puts forward a convincing argument that she applies to the medical profession, one that can also be translated to the therapist working in NHSTT. Here, we can identify a combination of key ingredients and how they result in the alienation of the skilled NHSTT psychotherapist, as they slowly become unable to uphold their morals nor fully practice their craft, all while feeling powerless to make meaningful change. For many participants, this eventually led them to leave, where they were often replaced by less-skilled workers, but not before experiencing chronic moral challenges.

Notably, out of the eight participants recruited for the current study, only two remained in their organisation, one of whom was a high-intensity CBT therapist. This suggests their training may have better prepared them to work within the NHSTT system, whereas others were trained in more relational modalities that appeared to be in greater conflict with the system. The fact this study attracted more clinicians from these modalities indicates an incompatibility between their training and NHSTT, which may lead to greater moral conflict. Equally, the presence of the HIT CBT therapist - albeit only one - suggests these conflicts may also extend to those trained to work within NHSTT.

Conclusion

As this discussion edges closer to its conclusion, it becomes clear that power plays an important role in the NHSTT therapist's world. When one considers the motivations and subsequent consequences of a neoliberal ideology, along with the contributions of Foucault and Marx, a picture begins to emerge of a deep division carved in society between the motivations of the state and those experiencing psychological distress. Particularly when what constitutes ‘distress’, ‘health’, and ‘normality’, is determined and defined by those positioned to enforce such ‘truths’ with epistemic certainty. The NHSTT therapist finds themselves stuck in a precarious victim-perpetrator dichotomy, where they are an extension of a system recruited to absorb, retain, and enforce particular narratives at the expense of relationality and clinical flexibility - powerless to enact meaningful change, both within their role and at times with their clients. Over time, their morals and values begin to decompensate as they realise the clinical scope of their role is restricted in a way that becomes incongruent with the immediate needs of service users, a perpetration against doing *what is right* that is experienced by therapist and client.

Summary of Key Findings

Following is a synopsis of the primary findings from the current study:

1. The findings indicate that psychological therapists working in NHSTT *do* experience moral challenges. Among others, two key causes of moral conflict appear to come from difficulties upholding the *therapy relationship* - suggesting it has distinct moral properties - and doing *what is right*. The “disenfranchised relationship” is coined to capture the challenges of establishing a therapy relationship within the NHSTT system.
2. Potentially morally injurious experiences (pMIE) and morally injurious experiences (MIE) appear to be helpful constructs when attempting to understand the moral experiences of the NHSTT therapist.
3. The data supports moral injury (MI) as a distinct theoretical model. It also indicates that MI is a helpful and applicable model for understanding the moral difficulties experienced by

psychological therapists working in NHSTT. This supports complementary findings arguing that MI is not only specific to those exposed to life-threatening events but also ethical ones.

4. The current study supports literature cautioning against the privileging of perpetration-based conceptions of MI. Rather, balancing this with betrayal-based conceptions is strongly indicated - as per Shay's (2012) original model - as it contextualises the individual's experience and positions them within the social-political domain. Equally, this study acknowledges the risk of omitting the 'moral' in moral injury and argues for greater integration of sibling disciplines (e.g., moral psychology, philosophy, sociology, anthropology) within the MI construct.
5. Although future studies are needed, it can be tentatively inferred that psychological therapists working within the constraints of the NHS system more broadly (not just in NHSTT) may face similar moral difficulties. Equally, this may also extend to other healthcare roles.
6. The study supports moral distress (MD) and MI as separate and distinct theoretical frameworks. Furthermore, it suggests an important relationship between the two, where MD is likely a precursor to MI. Thus, considering both models may offer a fuller and more nuanced understanding of moral experiences.
7. The current data demonstrates that *humiliation* may have an important role within current theories of MI.
8. The current findings highlight a likely relationship between MI and burnout – however, further research is needed. It also supports Talbot and Dean's (2018) concerns that MI risks being mislabelled as burnout.
9. Strategies used to navigate moral conflict included protecting clients from the system, speaking up for what is right, focusing on the positives, reaching out to trusted colleagues, working part-time in the NHS alongside a more clinically flexible role, and leaving the organisation entirely.
10. Participants demonstrated complex internal dynamics when attempting to preserve their morals. For example, when one moral is transgressed (the therapy relationship), efforts

were made to resolve this by activating another moral (speaking up). Failing this, many participants left their organisation to preserve the moral whole.

11. Participating in the current study appeared to offer an important platform for participants to speak up and voice their moral experiences. Although further research is needed, this suggests having a platform to speak up could act as a kind of moral resolution, or as I refer to it, a "potentially morally reparative event" (pMRE).
12. The current study indicates that a lack of institutional support and clinical inflexibility may be MI risk factors. Combining these risk factors with chronic moral stressors appears to degrade the effectiveness of coping strategies, resulting in a high turnover of staff - as highlighted by six out of the eight participants eventually leaving.
13. Three protective factors against MI were outlined: (i) access to appropriate institutional support, (ii) having greater clinical flexibility, and (iii) combining one's NHSTT role with alternative clinical work more aligned with one's morals.
14. Lastly, neoliberal theory, along with the contributions put forward by Foucault and Marx, appear to be valuable frameworks for understanding organisational power and *why* psychological therapists working in NHSTT may experience moral difficulties.

Contribution to the Field

The current study contributes to the field of counselling psychology and psychotherapy in the following ways:

1. One critical takeaway is that psychological therapists may be exposed to varying levels of moral conflict and MI based on their clinical context. This is significant as moral conflict from the therapist's perspective is rarely considered or articulated. Therefore, the current study offers a linguistic aid – that is, a more precise language that clinicians can use and apply to their own clinical experiences.

2. The current study offers a valuable theoretical contribution as it draws attention to the relatively new theory of MI. A key counselling psychology value speaks to the importance of challenging universal 'truths' while seeking a more nuanced understanding of phenomenon.

This study achieves this by showcasing the theory of MI and its implications for psychological therapists working in NHSTT. In doing so, it challenges and cautions against the over-application of burnout – which risks decontextualising the individual – while making room for the phenomenology of both perpetration and betrayal-based conceptions of MI. Additionally, these insights better equip therapists with the knowledge to explore and separate MI, MD, or burnout in their clients - and in themselves - to determine the most helpful way to make sense of their experiences.

3. As the first study to explore moral experiences within a population of NHSTT therapists, it indicates this particular cohort of professionals may be at risk of MI. This is of significance as many counselling psychologists and psychotherapists often find themselves in NHSTT, either in a placement or paid role. Therefore, this study offers clinicians an opportunity to better consider the realities of working in NHSTT. For those clinicians who go on to occupy a role, the insights offered from this study may support them in safeguarding themselves from moral difficulties.

4. The current study highlights the importance of therapists receiving appropriate levels of support from within NHSTT, further opening up opportunities to better understand their experiences and safeguard against moral conflict.

5. The current study opens up an important avenue for future researchers, particularly in investigating MI risk and protective factors for psychological therapists. Furthermore, it points to the need for clinical training to more comprehensively include MI within its curriculum to inform and prepare therapists for the moral complexities of their role in the future.

6. Although the theory of MI has grown in popularity, the current study has opened up a space to further 'pull' the theory into the disciplines of counselling psychology and psychotherapy. In turn, this will generate greater awareness of a theory with important clinical implications for therapists and clients alike.

7. On an explanatory level, the current study draws further attention to the contemporary shifts in the art and science of psychotherapy due to the division of labour and alienation and how this may have moral consequences for frontline clinicians in NHSTT. In doing so, it highlights the importance of preserving the essence of psychotherapy in a fast-changing world.

Limitations and Suggestions for Further Research

Every research project not only has to consider its contributions and strengths but also its limitations. In this regard, this study is no different. Following is a list of identified limitations alongside a number of proposals for potential future research which could enrich the current area of study:

1. The inclusion criteria dictated that psychological therapists with at least one year in an NHSTT service were eligible to participate. There were no restrictions on modality, allowing for diverse clinical expertise ranging from high-intensity CBT therapists to psychotherapists and psychologists. Although this allowed for the casting of a wide net, it did so at the exclusion of modality-specific differences when considering moral difficulties. For instance, the current study included one high-intensity CBT therapist alongside seven clinicians trained in more traditional relational modalities. Although preliminary, the data does indicate some possible differences, particularly when considering the level of preparedness for working in NHSTT. Therefore, future research that is more sensitive to modality-specific differences could yield important findings.
2. Another limitation of the current study included the homogenous research sample (i.e., all female). Furthermore, all interviews were remote. Therefore, future research could consider conducting in-person interviews with a more heterogenous sample, which may provide additional insights.
3. The scope of the current study allowed for MI risk and protective factors to be considered, but not comprehensively. As outlined previously, additional factors to consider in future research may include the therapist's age, experience, level of preparedness for moral difficulties, and self-esteem management.

4. The current study attempted to define different experiences that led to moral conflict, what the MI literature classifies as morally injurious events (MIE) or potentially morally injurious events (pMIE). As a study, it has broken new ground in this area, but future research is needed to corroborate these findings while considering other pMIE within the profession. Furthermore, the terms “disenfranchised relationship” (i.e., the difficulties of upholding the therapeutic relationship) and “potentially morally reparative events” (i.e., experiences that could repair moral difficulties) were coined in this study. As conceptual terms, they require scrutiny to determine their utility and validity within the wider MI literature. I am eager for this, and I invite any and all feedback.
5. The data indicates that an important relationship between moral distress (MD) and MI may exist. Therefore, further research is needed to more precisely understand the dynamic between these two theories, particularly if unresolved MD increases the risk of developing MI. Similarly, further exploring how burnout is mediated between MD and MI is worthy of equal consideration.
6. Similar to examining the events that may lead to moral conflict, the current study also explored therapists' strategies to defend against these conflicts. Expanding on this territory may help determine effective strategies that support therapists to better manage moral difficulties and remain in NHSTT.
7. Although the current study made efforts to identify explanatory factors for participants' moral experiences, which included the contributions of Marx, Foucault, and the excavation of neoliberal theory, these are only a handful of interpretations. Therefore, caution should be given to restricting the current data to only these insights at the exclusion of others. For example, other interpretations that were not considered might include inspecting therapists' experience through the lens of *organisational resistance* or *labour surveillance*. These are fascinating areas of study that could offer valuable insights. Equally, taking a more psychodynamic perspective by exploring the mobilisation of psychological defences that help an individual manage moral conflict could offer an alternative, but equally compelling perspective. Some efforts have been made to study organisational resistance

and defence mechanisms (Bovey & Hede, 2001). However, this has yet to be done through the lens of MI and psychological therapists.

8. As argued in Chapter Two, bridging the gap between the theory of MI and other disciplines where theories of morality are significantly more developed (e.g., moral psychology, philosophy) is a crucial task for future researchers, and the construct of MI more broadly.
9. A Reflexive Thematic Analysis (RTA) is only one way to generate research insights. Therefore, other qualitative method(ologies) may provide alternative and equally valuable perspectives. Correspondingly, the design of larger-scale quantitative, or mixed-method designs would help determine the scalability of the current findings. For example, 'qualitatively-driven mixed method' approaches (Frost, Dempsey, & Foley, 2023) or the increasingly popular field of online survey studies that capture both quantitative and qualitative data (McBeath, 2023) would support this aim. The production of both qualitative *and* quantitative data would demand greater attention and is more likely to spark the flame of meaningful change at the level of policy.

Conclusion

The ultimate aim of the current study was to investigate how psychological therapists experience morally challenging events in NHSTT and why these events may occur. As the participants poignantly illustrated, there is a complex array of moral events encountered, which suggests that the theory of MI is a meaningful and valid model for understanding a therapist's moral experiences. Although the population under study was a limited sample of psychological therapists working in an NHSTT service, important questions are raised on whether the current research findings generalise to wider NHS services, headlining the importance of future research exploring the relationship between clinical practice and moral conflict. Furthermore, the findings indicate the current models of practice in NHSTT may be causing harm to clinical staff. As discussed, these models have political roots that make it difficult for therapists to feel they have control over their roles. Therefore, highly skilled psychotherapists and psychologists leave or are deterred from working in the NHS. This is a particularly tragic reality, as the NHS

is often the only point of access for those with the highest needs. If clinicians feel they are unable to do *what is right*, then not only do we risk a morally injured workforce, but we risk failing those who come to us at their most vulnerable.

Final Reflections

The *scientist-practitioner* is a defining pillar propping up the identity of the counselling psychologist. The meeting of these two words, fused by the hyphen that joins them, is frequently encountered by the counselling psychology neophyte. Repeatedly underlined and highlighted in their textbooks, they attempt to integrate the concept of the scientist-practitioner into their professional identity, initially with little success. In my experience, the practitioner part tends to come first as one navigates different clinical placements, learning the complexities of the human condition from those brave enough to entrust me with their experience. I first learnt to be the *practitioner* without its *scientist* - that is, until I was faced with the doctoral thesis.

For me, this thesis was a demanding undertaking. I attempted every which way to conquer it, at times naively looking for shortcuts, a response to my own impatience and feelings of inadequacy. It was a humbling experience; I learned quickly that there were no shortcuts or such a thing as perfection. I learned I could throw everything I had at it, but it would only make a small dent and that these efforts would ultimately sacrifice my health and wellbeing. I learned the process demanded patience and time. These were the lessons taught, and after thwarted efforts to resist them, I finally succeeded in internalising and embodying them. This project has been much more than finalising my doctorate: it has been a life-altering enterprise.

As I end, I am reminded of the 'good work' project (Gardner et al., 2001), which advocates for the pursuit of 'good work' in a changing world enveloped in competitive market forces and epistemological tensions. Work that is ethically pursued, provoking to its practitioners,

and defined by excellent quality are the principles driving ‘good work’. These are compatible with the commitment of the counselling psychologist, who is governed by a philosophy focused on context, reflexivity, ethics, and professional development (Rafalin, 2010). The current project has been my attempt to produce ‘good work’, a challenging but meaningful goal where every effort was made to uphold these guiding principles. My greatest hope is these efforts have been fruitful and that what has been produced offers something of value to both the clinical and scientific community.

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Appendices

Appendix A: Consent Form

Consent Form

Participant Identification Number:

Title of Project: Therapist experiences of morally challenging events when working in an IAPT service.

Name of Researcher:
Craig Abex
Metanoia Institute
13 Gunnersbury Avenue
London, Ealing, W5 3XD
Email – craig.abex@metanoia.ac.uk

Please initial box

1. I confirm that I have read and understood the information sheet dated .....for the above study and have had the opportunity to ask questions. 1
2. I understand that my participation is voluntary and that I am free to withdraw permission to use data at any time up to the point the researcher begins analyses. 2
3. I agree that this audio tape bears my name and may be listened to by a designated auditor. 3
4. I agree that my non-identifiable research data may be stored in the National Archives and be used anonymously by others for future research. I am assured that the confidentiality of my data will be upheld through the removal of any personal identifiers. 4
5. I understand that my interview may be recorded and subsequently transcribed. 5
6. I understand that in any report on the results of this research, my identity will remain anonymous. This will be done by changing my name and disguising any details of my interview which may reveal my identity or the identity of people I speak about.
7. I agree to take part in the above study. 7
8. I understand that this consent form and original audio recordings will be retained on an encrypted memory stick stored in a secure safe until the exam board confirms the results of the dissertation. 8
9. I understand that I am free to contact any of the people involved in the research to seek further clarification and information 9

Name of participant _____ Date _____ Signature _____

Researcher _____ Date _____ Signature _____

'Completion of this questionnaire is deemed to be your consent to take part in this research.

Appendix B: Participant Information Sheet (PIS)

Participant ID Code:……

SECTION 1

1. Study title: Therapist experiences of morally challenging events when working in an IAPT service.

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

I am exploring how therapists experience instances that may challenge their personal and professional morals and values while working in an IAPT setting. These tensions can occur when one feels unable to act on what is felt to be right in a situation.

4. Why have I been chosen?

It is important that we assess as many participants as possible, and you have indicated that you are interested in taking part in this study. I need seven to eight participants who are qualified therapists (level 4 or above) and have worked in an IAPT organisation for a minimum of one year.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you do decide to withdraw from the study, then please inform the researcher as soon as possible, and they will facilitate your withdrawal. If, for any reason, you wish to withdraw your data please contact the researcher within a month of your participation. After this date, it may not be possible to withdraw your individual data as the results may have already been published. However, as all data are anonymised, your individual data will not be identifiable in any way.

6. What will I have to do?

- You will only be invited to one interview which will take 60 minutes. The overall research project will take one year to complete between the years 2021 and 2022.
- I will send you an invitation via email with a link for a password-protected video meeting on Zoom at a date and time convenient for you. The interview will be audio-recorded. All the recordings will then be encrypted and stored on a password protected memory stick.
- At the time of your interview, I will record your audio consent for the research by reading the consent form. As part of this,I will pause after each consent item to give you space to audibly confirm your agreement.
- As part of the interview, you will be asked a series of questions designed to explore your experiences and what impact they had on you. At any stage, you can request the interview be stopped or paused. Furthermore, you are also free to decline a particular question in the interview.
- As previously stated, the interview will be audio-recorded. All audio will then be transcribed, so any analyses conducted is based on accurate material. Confidentiality is ensured by substituting your name with a code known only to me and by avoiding the transcription of any details about your academic affiliation. Audio recordings are encrypted, password-protected, and accessible only to me until my research dissertation is formally assessed, at which point they will be destroyed.
- Any data produced from my doctoral thesis may be published in the form of journal articles and conferences at a later date. If needed, I will contact you to clarify certain aspects of your interview. However, you do have the right to refuse any further involvement in the research.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What are the possible benefits of taking part?

We hope that participating in the study will help you. However, this cannot be guaranteed. The information we get from this study could support the re-evaluation of how therapists are managed and supported within IAPT organisations. It may also provide valuable data on how therapists manage moral challenges.

8. What are the possible disadvantages of taking part?

The possible disadvantages of participating include:

- You may share sensitive information, which could leave you feeling vulnerable and exposed;
- Some of the questions asked may stir up difficult thoughts and feelings that could leave you feeling emotionally vulnerable;
- There is a possibility of unprofessional or unethical practice being disclosed when responding to some questions should any exist.

To reduce any possible risk:

- All participant data will be confidential with appropriate procedures put in place to maintain confidentiality (please see **Section 9** for details);
- In the unlikely event, you were to share a concern about part of my research, I will address this with my research supervisor. If there was a serious concern about a potential ethical or safety issue, an investigation would be conducted by the Metanoia Institute/Middlesex University Research Ethics Committees and may be reported to the Health & Care Professions Council.
- Should you feel any distress that links to the topic covered in this research, I would encourage you to consult with one of the following services:

- Mental Health Matters – 0800 107 0160 24/7 helpline
- Crisis Support Team – 03002220123 24/7 helpline
- Samaritans - 116 123 (freephone number) 24/7 support line (www.samaritans.org)
- SPARK - www.sparksupport.co.uk - online peer support group for everything and anything related to mental health.
- Shout – text 'SHOUT' to 85258 – 24/7 helpline

9. Will my taking part in this study be kept confidential?

The research team has put a number of procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data. For example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password-protected computer. All information you provide will be treated in accordance with the UK Data Protection Act.

10. What will happen to the results of the research study?

The results of this study will be written up as a doctoral thesis. Once the thesis has been successfully submitted, I may wish to use it for the purpose of publications or presentations. However, the data will only be used by members of the research team and at no point will your personal information or data be revealed.

11. Who has reviewed the study?

The study has received full ethical clearance from the Metanoia Institute Research Ethics committee (MREC), who reviewed the study.

12. Contact for further information

If you require further information, have any questions or would like to withdraw your data then please contact:

Researcher

Craig Abex
Metanoia Institute
13 Gunnersbury Avenue
London, Ealing, W5 3XD
Email – craig.abex@metanoia.ac.uk

Research Supervisor

Dr Miya Khera
Email: mayakhera@gmail.com

Thank you for taking part in this study. You should keep this participant information sheet as it contains your participant code, important information and the research teams contact data.

Appendix C: Debrief Sheet

Thank you for taking part in this research. I appreciate the time you have given and hope you found it interesting. If you have any questions now, or in the future, do not hesitate to contact my supervisor or me. I hope your experience was comfortable, and you were not distressed at any stage. If you were distressed and feel that you would benefit from some support, please find a resource list below:

- Mental Health Matters – 0800 107 0160 24/7 helpline
- Crisis Support Team – 03002220123 24/7 helpline
- Samaritans - 116 123 (freephone number) 24/7 support line (www.samaritans.org)
- SPARK - www.sparksupport.co.uk - online peer support group for everything and anything related to mental health.
- Shout – text 'SHOUT' to 85258 – 24/7 helpline

Researcher: Craig Abex

Email: craig.abex@metanoia.ac.uk

Phone: 07818599280

Research supervisor details

Name: Dr Maya Khera

Email: mayakhera@gmail.com

Appendix D: Interview Schedule

Interview Schedule

Participant ID:
Interview Date:
Age:
Gender:
Ethnic Background:
Length of time In IAPT:
Currently Working in IAPT: Y/N
Type of Qualification:

Introduction

"Thank you for agreeing to participate. To begin, I would like to take the opportunity to go over some areas of the information sheet to give you the space to answer any questions you might have."

Outline details of the Information Sheet

"Do you have any questions about what I just read?"

"As part of this process, I would also like to ask for your permission to audio record our interview. This is to ensure that I have accurate data so that I don't make assumptions about your responses or opinions during the data analysis."

Consent - verbally go through each item

***RECORD**

"The current research aims to explore your experience of working in an IAPT service. It's very important for me to get a detailed and rich account of your experiences. For part of the interview, I have prepared some questions and based on your answers, I may ask some additional questions. My aim throughout is to listen closely to your experiences."

"Do you have any questions?"

"The interview will take roughly 60 minutes. There is a possibility it may briefly go over, is that okay with you – do you have anywhere to be?"

"When asking the below questions, be mindful of experiences that align with feelings of anger, shame, guilt, anxiety, depression, and loss of trust in self and others. Explore these experiences further if they emerge.

Questions

1. Could you please tell me how long you've worked in IAPT and describe your overall experience?

"As you know from the flyer and our brief telephone conversation, this research is interested in morally challenging events, which brings me onto my next question: would you be able to re-articulate the morally challenging event you shared with me over the phone. This time, I am really interested in the detail, so please don't worry about talking too much":

2. How would you describe your experience of being in a situation where your sense of right and wrong was challenged?

   Prompts: *What were the key moments that felt morally challenging for you? Was there anything that stuck out for you about this experience? What was the value of yours that was violated?*

3. How or in what way do you feel this experience impacted you?

   Prompts: *What emotions would you use to describe the impact? Did these experiences have an impact on your work – if so, how? If not, how did you stop them having an impact? Did you ever lose faith in your role, profession, or organisation, if so, how? What was that experience like for you?*

4. How would you describe your experience of coping, or trying to cope, with the moral challenges you have spoken of today?
   Prompts: *Did you ever consider seeking support? If yes, what was your experience like? If no, was there something that prevented you?*

"Okay, so we're just coming to the end of the interview. Thank you so much for your time. However, before we finish":

5. Is there anything more you would like to add about what you've told me today?"

Appendix E: Recruitment Flyer

I am researching the experiences of trainee or qualified therapists (level four or above) who have worked in an IAPT organisation for a minimum of one year.

The interview will take up to one hour via Zoom. You will only be encouraged to talk about experiences you are happy to share and will not be forced to reveal anything you do not wish to. To qualify for the study, you will need to have encountered one or more of the following experiences related to your work as a therapist within IAPT.

- Experienced an event where you were unable to do what you felt was *right;*
- Had an experience, or experiences, where your sense of right and wrong was challenged by something you did, or something someone else did;
- Had an experience, or experiences, that made you lose faith in your role, profession, or organisation.

If you are interested in participating, and meet one or more of the above criteria, then an initial screening call will be arranged to determine if your experience meets the criteria for the current study. As part of the call, and to determine eligibility, you will be asked to very briefly describe your experience/event, what impact it had on you, and how you feel about discussing it as part of a formal research interview.

This research forms part of my doctoral research in Counselling Psychology and Psychotherapy at the Metanoia Institute. If you are interested in taking part or have any questions, please email me at craig.abex@metanoia.ac.uk

Please note: emailing does not commit you to participate in the study

Research supervisor details

Name: Dr Maya Khera
Email: mayakhera@gmail.com

Appendix F: Ethics Approval

METANOIA INSTITUTE
13 Gunnersbury Avenue
Ealing, London W5 3XD
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Craig Liam Abex
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

23rd July 2021
Ref: 23/20-21

Dear Craig,

Re: Therapist experiences of morally challenging events when working in an IAPT service

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,

Dr Julianna Challenor
Director of Studies DCPsych
Faculty of Post-Qualification and Professional Doctorates

On behalf of Metanoia Research Ethics Committee

Appendix G: Example of Theme Definitions/Abstracts

Theme 1: Values

The boundary for theme 1 maps out the proverbial 'moral landscape', with the core being what shape participants' morals and values take within the context of their roles as therapists in an IAPT system. Across the dataset, participants found it challenging to reflect on their specific morals, largely because discussions on morals were experienced as quite abstract. Therefore, some morals are semantic and obvious, requiring *less* interpretation, and others are more latent, needing *more* interpretation. The types of morals/values are diverse, including therapist autonomy, doing what's best for the client (client-centredness), transparency, working within one's clinical competency, authenticity, integrity, and the importance of the therapy relationship. The moral that centralised the therapy relationship was particularly salient across the dataset and, as such, became its own sub-theme.

Interestingly, there is also evidence of tensions *between* participants' morals, which adds to the diversity of the theme. To explore *how therapists experience morally challenging events when working in IAPT*, one needs to understand what specific morals are in play. Therefore, this theme is pertinent to the overall analysis and marks the beginning of the story.

Theme 2: Transgression

Similar to the first theme, theme 2 is a cornerstone of the overall analysis: to understand how clinicians in IAPT experienced morally challenging events, it is necessary to unpack *what* the events were. Therefore, theme 2 contextualises and describes the events that transgressed, violated, or challenged the participants' morals. The violations experienced take many forms, reflecting the complexity of morality more broadly. Theme 2 explores types of transgressions, and challenges the idea that morals follow a linear structure. That is, the data reflects the tensions between two morals held simultaneously and how morals can be transgressed by the individual, or by an*other* (i.e. the system). One dimension of this theme was salient enough to become a sub-theme, which orbits around the idea of being unable to *do what's right* for the client.

Theme 3: Participant's Experience of Transgression

In continuing to unpack therapists' experiences of morally challenging events in IAPT, theme 3 draws its boundaries around the central concept of *how* participants experienced their

Appendix H: Sample of Reflexive Journal

Entry 11 – 11th August 2022

Today is the day I begin my process of analysis. I realised the transcripts would probably benefit from being reformatted, to allow for a number system and coding system to be integrated. I am in the middle of this now, and just completed 040's transcripts. There are so many exchanges in this piece, over 50! Meaning I was a lot more active in the interview than the previous ones. Reflecting on who the participant is, I think I know why. She was difficult to interview, and she felt quite passive aggressive in her accounts. I wonder if she was relying heavily on defences, such as splitting and denial. This made it difficult to truly connect with her, and thus I compensated by becoming much more active than I usually would. It's interesting, because going through this particular transcript elicits a strong reaction from me, I find myself getting exasperated and frustrated with her narrative. It's important I am aware of this when it comes to coding this particular data unit.

I have re-familiarised myself with the definitions of moral injury. I think I need to start engaging with the literature again, which will support my familiarisation process and critical engagement with the data items. I have to admit, the idea of reading, and re-reading, the data set is not filling me with joy!

Entry 12 – 12th August 2022

I have now gone through 3 transcripts as part of the familiarisation process. It's interesting to see what comes up, but I am also becoming more aware of how easy it is to only comment on information that resonates with my personal experiences of IAPT. I am needing to bracket regularly. One strong thread throughout is this sense of not being seen, or valued in IAPT services. At this stage, I'm not finding too much that directly links to moral injury as a construct. But I do also wonder how much is playing out in the implicit. By gut tells me there would be more linkages with the construct of MI, but people become quite emotional or defensive, which lock away emotions of shame, guilt, could anger, and lack of trust. I think they are also concerned about being seen as whistle-blowers. Furthermore, morals, values, ethics, however we word it, I think the participants found it hard to connect or make sense with something so abstract.

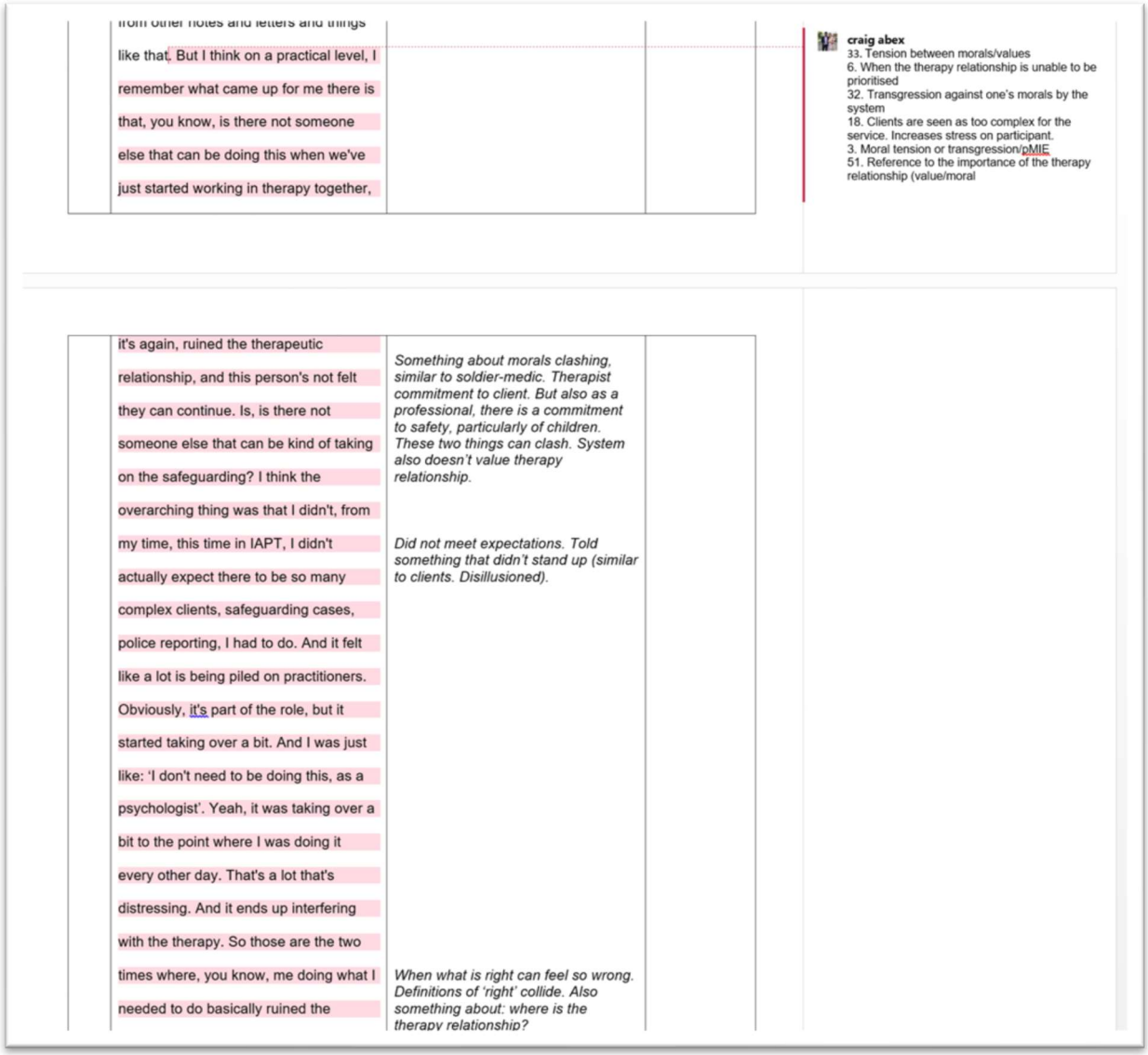
Reading through 040's transcript felt jarring and strange. She appeared to spend so much time justifying herself, or defending against difficult feelings. There was a distortion of reality, the use of psychological defences that has made my countertransference quite strong. And for some reason, I have a very powerful reaction to her. I seem to get annoyed by most things she says, and the tone of her voice. I feel like there was maybe a power struggle between us.

Entry 13 – 13th August 2022

Today, I am feeling tired as I try to familiarise myself with the data. It feels laborious, and not very exciting. And unlike yesterday, I feel like I have lost 'grip' on my understanding of analysis. I realise this is a normal experience. But it does not make it any easier to feel. It makes me feel a little useless… and stupid. Braun and Clarke are incredible writers, and I don't think they could be any clearer. I am inspired by them; but in the shadow of such expertise, I can't help but feel comparatively useless in my skills.

Appendix I: Examples of Early Stages of Analysis

The left column represents the transcript, the middle my comments, and to the right are potential codes labels. Three examples are given.



from other notes and letters and things

like that. But I think on a practical level, I remember what came up for me there is that, you know, is there not someone else that can be doing this when we've just started working in therapy together,

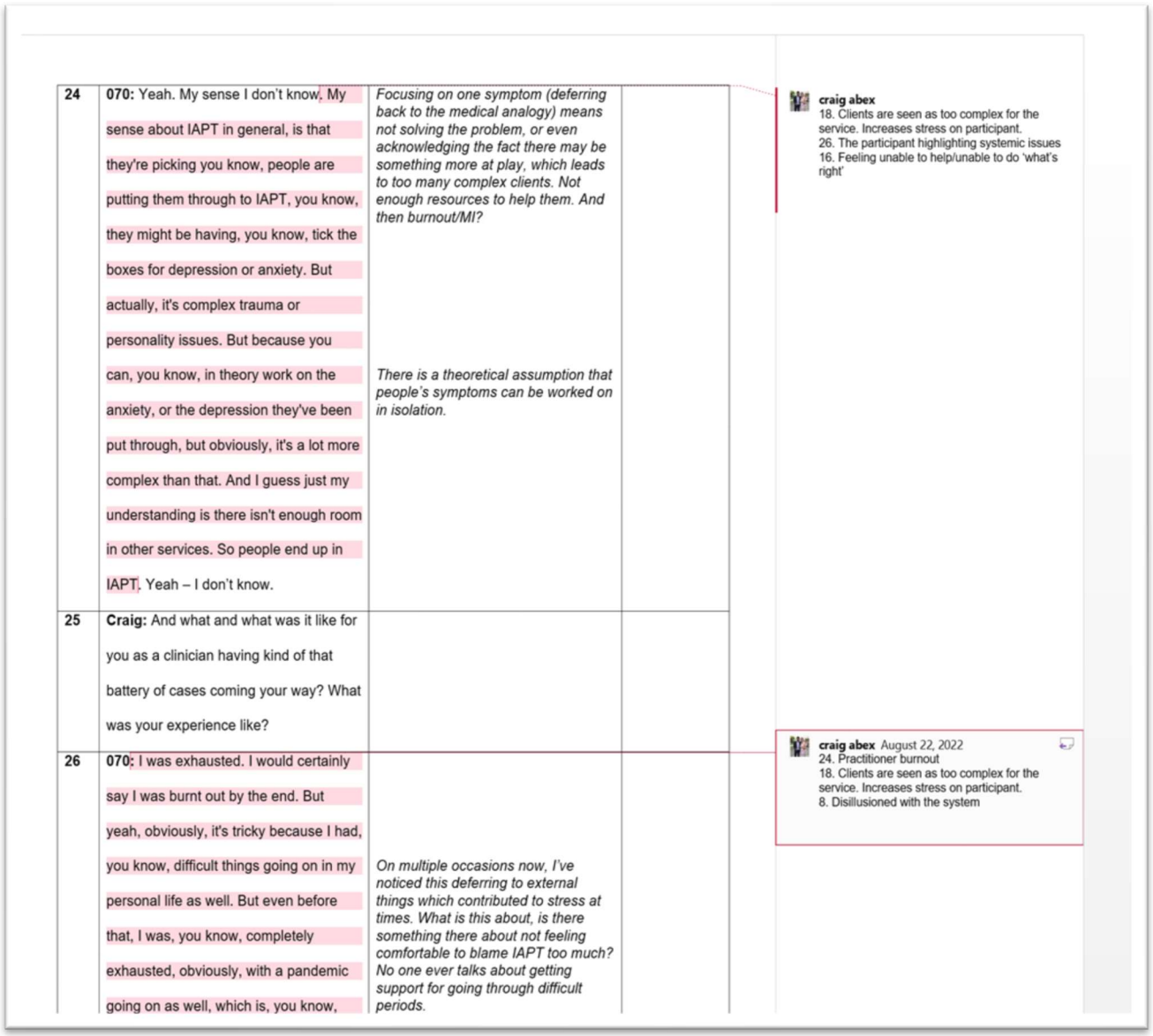
craig abex
33. Tension between morals/values
6. When the therapy relationship is unable to be prioritised
32. Transgression against one's morals by the system
18. Clients are seen as too complex for the service. Increases stress on participant.
3. Moral tension or transgression/pMIE
51. Reference to the importance of the therapy relationship (value/moral

it's again, ruined the therapeutic relationship, and this person's not felt they can continue. Is, is there not someone else that can be kind of taking on the safeguarding? I think the overarching thing was that I didn't, from my time, this time in IAPT, I didn't actually expect there to be so many complex clients, safeguarding cases, police reporting, I had to do. And it felt like a lot is being piled on practitioners. Obviously, it's part of the role, but it started taking over a bit. And I was just like: 'I don't need to be doing this, as a psychologist'. Yeah, it was taking over a bit to the point where I was doing it every other day. That's a lot that's distressing. And it ends up interfering with the therapy. So those are the two times where, you know, me doing what I needed to do basically ruined the

Something about morals clashing, similar to soldier-medic. Therapist commitment to client. But also as a professional, there is a commitment to safety, particularly of children. These two things can clash. System also doesn't value therapy relationship.

Did not meet expectations. Told something that didn't stand up (similar to clients. Disillusioned).

When what is right can feel so wrong. Definitions of 'right' collide. Also something about: where is the therapy relationship?



24	**070:** Yeah. My sense I don't know. My sense about IAPT in general, is that they're picking you know, people are putting them through to IAPT, you know, they might be having, you know, tick the boxes for depression or anxiety. But actually, it's complex trauma or personality issues. But because you can, you know, in theory work on the anxiety, or the depression they've been put through, but obviously, it's a lot more complex than that. And I guess just my understanding is there isn't enough room in other services. So people end up in IAPT. Yeah – I don't know.	*Focusing on one symptom (deferring back to the medical analogy) means not solving the problem, or even acknowledging the fact there may be something more at play, which leads to too many complex clients. Not enough resources to help them. And then burnout/MI?* *There is a theoretical assumption that people's symptoms can be worked on in isolation.*	
25	**Craig:** And what and what was it like for you as a clinician having kind of that battery of cases coming your way? What was your experience like?		
26	**070:** I was exhausted. I would certainly say I was burnt out by the end. But yeah, obviously, it's tricky because I had, you know, difficult things going on in my personal life as well. But even before that, I was, you know, completely exhausted, obviously, with a pandemic going on as well, which is, you know,	*On multiple occasions now, I've noticed this deferring to external things which contributed to stress at times. What is this about, is there something there about not feeling comfortable to blame IAPT too much? No one ever talks about getting support for going through difficult periods.*	

craig abex
18. Clients are seen as too complex for the service. Increases stress on participant.
26. The participant highlighting systemic issues
16. Feeling unable to help/unable to do 'what's right'

craig abex August 22, 2022
24. Practitioner burnout
18. Clients are seen as too complex for the service. Increases stress on participant.
8. Disillusioned with the system

	records. So their recovery rate, their discharge rate looks really good on paper. And that's the secure their place before other services, which are honest, you know, doing the job are meant to be done. And they probably for long term, they lost their competitive position, and it's quite unfair. So the way I just later on much later on, I start to think about, especially the longer I work in this kind of profession, I just feel, start to doubt because you know, integrity is almost the fundamental value of this kind of service or for psychotherapy in general. If we couldn't even be honest with our own data it just make you feel a bit disheartened.	*Not showing the whole truth. Under the stats are issues of manipulation. It's a misrepresentation of information, and skews outcomes.* *Fairness vs unfairness. Honestly vs dishonesty* *Disillusionment. Grinds one down. Trust less and less over time. Over time one sees the cracks. Possibly an expectation the IAPT system would uphold integrity and values. This would be a common response. It's easy to have faith. It's easy to want to have faith in a larger system (like parents)/ Benevolence.* *Assumption that integrity is the value underpinning services, and profession. Being dishonest about targets and KPIs is not in line with integrity.*	
5	**Craig:** And when thinking about these, these kinds of examples and these experiences you went through, are you able to pin down what it is that made you feel		

Appendix J: Example of Familiarisation Notes from Across the Data Set

- There is a sense of helplessness across the dataset. Although the interviews were cautiously approached by many of the participants, I feel it also acted as a platform to speak up and be heard regarding some of the difficulties experienced in IAPT. A forum to articulate experiences; some participants were passionate about continuing to challenge the system.

- The funnelling down of stress through the system is another potential theme. This could lead to workplace survival which impacts relationships within the team (i.e. less support) and between client and therapist (i.e. more pressure on treatment fidelity which decentralises the relationship). Many participants referenced the top-down stress and how it impacted those on the proverbial frontlines.

- Not feeling good enough in one's role – is often a consequence of the procedures present in the system, such as wellbeing measures or risk measures. This hit to one's professional self-esteem sometimes came about from not being able to help in a way that felt 'right' (because the system wouldn't allow it) or because the therapist was not meeting a 'gold standard' in their work (such as decreasing scores or working with very complex clients with the same framework as not so complex clients). The therapist would take the blame instead of the system taking responsibility for the limitations of achieving a 'gold standard' (referenced as a "fantasy").

- The feeling of knowing what a client might need, but being unable to provide it because it falls outside the parameters of the IAPT system, appears to be a common occurrence from the data. This is firmly in line with Talbot and Dean's work on physicians and the idea that one is trained to help, but if the system prevents this, it can lead to moral injury – which, they argued, is often mistaken for burnout. I wonder to what degree this occurs within IAPT.

- Almost all participants started the interviews reflecting positive experiences in IAPT, regularly linking it to professional growth, developing new skills, and increasing one's resilience. Some participants also praised being part of a system that allows more people to access support. Interestingly, many participants would also acknowledge the strain on the NHS system and how limited it is in terms of resources. This would often be raised after offering an alternative to how the system could have worked better (using their particular examples as points of reference). They sometimes referred to

Appendix K: Example of Physical Analysis of Codes and Themes