An Interpretative Phenomenological Analysis of Counselling Psychologists' Experiences of Stress in NHS Child And Adolescent Mental Health Tier 3 Work Settings

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Abstract

The aim of this study was to identify and understand counselling psychologists' individual experiences of stress in NHS Child and Adolescent Mental Health Services Tier 3. The qualitative methodology of interpretative phenomenological analysis (IPA) was used to allow the emergence of each participant's idiographic, personal experiences of the phenomenon of stress in their work settings, and the meaning each ascribed to it.

Data was collected from seven counselling psychologists (six females, one male) permanently employment by NHS CAMHS. Each participant was individually interviewed on two separate occasions with a period of up to six months between interviews. Each semi-structured 60-minute interview was digitally timed, audio-recorded, transcribed in full, and analysed using IPA. All first interviews were conducted in person on NHS site locations. Some of the second interviews were done over Skype video at participants' NHS sites or in person and the same protocol was observed as in the first interviews. Fourteen interviews were collected in total.

A systematic analysis of the transcripts identified fourteen sub-themes which merged into four super-ordinate or master themes: (1) Impact of NHS changes on CAMHS Tier 3 work settings, (2) Therapy room impact, (3) Counselling psychologists' well-being and morale, and (4) Professional identity issues.

The findings showed that all the counselling psychologists were experiencing intense stress in their working lives. The study took place in the political context of National Health Service (NHS) reform and austerity based economic restructuring which is

ongoing. Counselling psychologists believed such economic cuts caused contextual changes in CAMHS settings which brought new stressors into their working lives. Their experiences of stress were similar to factors consistently identified in organisational stress research as burnout risk factors or burnout itself. As a result of the increased stress, they expressed either a desire to leave their posts or they were already seeking work elsewhere. Participants also shared stress experiences related to professional identity issues involved in being the relatively new and only other psychology discipline working and competing for jobs in NHS CAMHS Tier 3.

In many cases, a mitigating factor of the stress was a sense of meaning derived from their relationships and work with mentally unwell young people. Given the importance of the therapeutic relationship as a conduit for successful therapeutic outcomes, research on how best to support and protect against occupational stress experienced as impacting the early intervention work of NHS CAMHS counselling psychologists is an area for future research.

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Chapter 1: Introduction

In this introduction, I summarise the aim of the research, the specific research question, and the relevance of it. I give an overview of the origins, definitions, and current context of the concept of stress for mental health professionals' experiences in their work environments.

The overarching aim of this study was to explore stress as experienced by counselling psychologists specifically in National Health Service (NHS) Child and Adolescent Mental Health (CAMHS) Tier 3 work settings. Central to this research was to locate, understand, and present an understanding of how stress was being meaningfully experienced by them in their daily working lives.

My research question about individual worker's stress experiences was borne out of my professional time in CAMHS Tier 3 and Parent Infant Mental Health Services Tier 3. When I started working there in 2007, I was the only counselling psychologist in both services with two multi-disciplinary teams of psychiatrists, clinical psychologists, psychiatric nurses, child psychotherapists and psychiatric social workers. Both services were in the same NHS Trust. In the perinatal service, my title as Highly Specialist Parent-Infant Psychotherapist & Psychologist involved using awareness of unconscious dynamics to facilitate healthy bonding in parent-infant relationships. In this sensitive dyad, unconscious primal anxieties are constantly triggered in their most raw form in the infant and the caregiver. When a baby arrives, it is normal for a parent to experience the return of some of their own infantile anxieties. On the positive side, this can facilitate the caregiver's sensitive attunement into the infant's psyche. However, when the primary caretaker is vulnerable, suffering with mental health issues or holds relational trauma, a

resurgence of their own infantile anxieties from their original parent relationship or other relational wounds can seem overwhelming, be unconsciously relived, and if unprocessed, can be projected onto the baby. Unconsciously, the baby can be experienced as threatening to the parent's psyche. The dysfunctional dynamic can interrupt and undermine the parent-infant bonding process. The therapist tries to help the parent to gently become aware of, identify, process and contain such unconscious anxieties and remove obstacles to healthy parent-infant attunement. This facilitates a healthy parent-infant bond and a containing relational experience for the infant. This work gave me insight into how powerful primal infantile anxieties can resurface in containing or caregiving adults during times of stress. In CAMHS work, the therapist functions as a containing adult to the mentally ill child. My PPIMHS work helped me practice and understand how necessary it is to process unconscious projections that the therapist can internalise from traumatised or depressed mothers or babies. For example, if there is a persistent lack of attunement from the primary caregiver to the baby, a therapist can leave the therapeutic space feeling anxious about the baby, and unable to relax that the child is being sufficiently emotionally contained. Sometimes this unprocessed projection experienced as stress, worry, or anxiety can be further projected onto colleagues in everyday work relationships and played out in the work environment. Bion proposed that unprocessed projections from the mentally ill or traumatised child or adult can manifest in a therapist's thoughts and behaviours. In my CAMHS work, I noticed a high level of stress amongst some colleagues in the team who would sometimes become highly irritated with other colleagues or upset in heated team meetings. Reflecting on the complexity of child and adolescent cases presenting with

comorbidity, systemic problems, and transgenerational and relational trauma in the CAMHS setting, I wondered if therapists noticed stress being evoked in them by the chronic nature of cases, and how or if this was experienced. I began to wonder how workplace stress was triggered by unprocessed clients' unconscious projections or if unconscious projections from the therapy room were left unprocessed within the therapist and therefore relayed into the working environment and replayed in colleague relationships. Therefore, I initially set out to explore how therapists experienced the trauma presented to them in the therapy room and how they reflected upon it, processed it or if they could reflect on whether remnants of unprocessed relational trauma might be projected into the work milieu. However, as the research got underway the study changed course solely because of the data presented by the participants. Without exception, they wanted to speak about stress in terms of how work changes were affecting their client work and how this rippled into many aspects of their working life. This both surprised and humbled me as a researcher. The data seemed to take on a life of its own.

Without exception, each participant emphatically stated their stress levels had escalated exponentially due to the nature of NHS restructurings which reduced the time and energy they could give to clients. The data began to emerge, as participants from the various CAMHS teams focused mainly on experiences of stress as being related to ongoing workplace changes enforced by government restructurings and cuts. The participant information consistently moved towards the impact of restructurings on their lives and client work. They emphasised how the client-therapist relationship was being increasingly undermined by outside forces and the work and meaning were being

undermined.

1.1 Research question

The specific research question asks what individual counselling psychologists experienced as stress or consistently stressful in NHS CAMHS Tier 3 work settings. Fundamental to this was capturing the meaning ascribed to these stress experiences by counselling psychologists who are a relatively new professional addition to multi-disciplinary NHS CAMHS teams.

1.2 Why is it important to ask this question?

The research is important because it highlights the relevance of context in understanding human experiences of stress. It explores experiences of stress in the context of frontline child mental health NHS work environment settings. At the time of this research, there was no information in the literature about counselling psychologists' experiences of working in NHS CAMHS. Most of the research I located on counselling psychologists working with mentally ill young people came from international sources, particularly the USA. When I studied to become a counselling psychologist, none of my fellow students were interested in working in CAMHS, as they felt more drawn to adult work. During my training, I found placements in CAMHS T3 as well as adult primary care. This research project was undertaken to offer an insight into the lived experiences of stress and the influence of contextual factors within this setting. It aims to inform the knowledge base about the complexity of counselling psychologists' experiences and

working lives by providing qualitative data. *"The element of 'lived' experiences draws our attention to the conditions under which these experiences unfold*" (Askegaard & Linnet, 2011, p. 397).

1.3 Research orientation

I used a postmodern point of reference used when exploring individuals' lived experiences of stress, seeking the unique reality of each individual. The research was humanistic, explorative and interpretive in nature.

1.4 Research method

I employed interpretative phenomenological analysis (IPA) to engage with the data. Data were accumulated through in-depth individual interviews. After each recorded interview with the participants, I transcribed their interviews verbatim and applied IPA to those verbatim transcripts. The experiences were carefully allocated into super-ordinate themes and sub-themes. All of the themes identified are detailed in Chapter 4. The comparative analysis of themes represents a co-construction of the researcher's reality and the participants' realities. I discuss the research method more detail in Chapter 3.

1.5 The research in brief

I embarked on a national search for potential participant counselling psychologists working in NHS CAMHS Tier 3. Search outlets I used included the Division of

Counselling Psychology's (DCoP) research website; the British Psychological Society's (BPS) website; counselling psychology forums on the internet; the DCoP annual conference; Continuing Professional Development events at the BPS; the NHS; through word of mouth; cold calling NHS Trusts; NHS networks; and counselling psychology programmes' graduate alumni networks.

The qualitative methodology of IPA was used to analyse the data collected from seven recruited chartered counselling psychologists. Data collection involved fourteen face-to-face interviews. Each participant completed two intensive, face-to-face, semi-structured audio-recorded interviews. The interviews were designed to allow the emergence of each participant's idiographic, lived experience of the phenomenon of stress and the meaning each person ascribed to it in the context of their work setting.

In summary, the research findings revealed the participants' experiences of stress, and the sources of their stress. Repeatedly they pointed to experiences of their humanistic work with children being impeded. The stress was expressed as being triggered by CAMHS changes which brought a new discourse into the work setting and caused conflict between attending to client care and working through high administration workloads. Service changes were experienced as interfering with the functioning and purpose of the client work. Counselling psychologists felt pressured to place the organisational needs above the child's needs. They detailed experiences of high stress levels which seemed to parallel the syndrome of burnout in terms of its risk factors and consequences. This included job dissatisfaction, role conflict, less support (supervision and consultation), lowered morale, increased illness, absenteeism, turnover intentions and turnover. They also shared other stressors related to being the only other

psychology discipline working in and competing for jobs in NHS CAMHS Tier 3. As a relatively new addition to CAMHS, counselling psychologists also believed the DCoP was not knowledgeable about the work setting expectations and they would have preferred a more supportive interaction with the Division.

1.6 Tier 3 Child and Adolescent Mental Health Service

CAMHS Tier 3 consists of a multi-disciplinary team of psychologists, psychiatrists, child psychotherapists, family therapists, psychiatric nurses, social workers and medical secretaries based in local community clinic settings. It provides a specialised service for children (up to 18 years) with severe, complex, and persistent mental health disorders. Referrals come through every day for children and young people suffering with comorbid and complex mental health difficulties affecting their everyday functionality. Most of the mental health presentations are chronic, deeply entrenched and complex. Families are often highly dysfunctional. Presentations of suicidal ideation with or without intentions, plans, previous attempts and self-harming are regular types of referral requiring containment and crisis intervention. Many young people present with Autism Spectrum Disorders and comorbid mental health problems, learning difficulties, attention deficit hyperactivity disorder, and neglected and looked after children.

A significant gap exists in the literature on counselling psychologists' practice and stressors in child mental healthcare. At the time of this research, there were no published studies on counselling psychologists' stress experiences in CAMHS Tier 3, NHS. This investigation used the methodology of IPA which was chosen to best allow

complexities and idiographic stress experiences to emerge. Because of the homogeneous counselling psychologist population sample and work setting type, some similarities were expected to arise across participants' experiences. However, it was unexpected to discover so many commonalities in the stress experiences and the challenging nature of the problem. The chapter begins with a description of stress and factors evidenced as being likely to potentiate stress and burnout in the workplace.

1.7 Presentation of the study

This study consists of the following chapters:

Chapter 2 begins by contextualising the research. This includes information regarding stress in the workplace and chronic stress or burnout. Fundamental aspects of occupational stress and burnout are discussed. The concept of burnout, including its definition and historical development, is also explored. The differences between stress and burnout are explained.

Chapter 3 focuses on IPA, the research methodology used in this study. The essential aspects of the research design, sampling, data collection and data analysis are discussed. Issues relating to validity are discussed as well as ethical considerations in the research process.

Chapter 4 explores and extrapolates the findings of the study with specific reference to themes identified in the data analysis. As is the primary aim of this research study, the lived experiences of the participants are represented.

Chapter 5 provides the discussion and conclusion to the study. An integration of the themes from the data analysis and the relevant literature is offered to explain the findings.

Chapter 6 begins with a brief description of burnout interventions, and suggestions for an intervention type. Following that is an evaluation of the study in terms of strengths and limitations, and recommendations for further research are suggested.

Chapter 2: Literature Review

In this chapter I bring together the general claims about work-related stress and burnout, then look at evidence about stress and burnout in healthcare and mental healthcare professionals, particularly psychological therapists.

2.1 Reviewing the literature

My search for research literature on stress and burnout took place in several different areas. I used the Middlesex University Library databases and e-journals; the British Psychological Society (BPS) website online resources of EBSCO Psychology and Behavioural Sciences; PsychINFO, Royal College of Psychiatrists e-journals; Royal College of Nurses e-journals; NICE, British Medical Journal; Mendeley; Deepdyve, Endnote, Google Scholar, and ResearchGate.

In the literature searches I first used the simple keywords ‘stress‘, and burnout’, before expanding the search with key phrases relevant to my inquiry into counselling psychologist stress in CAMHS. Examples include ‘counselling psychologist stress’, ‘counselling psychologist burnout’, ‘psychologist stress’, ‘psychologist burnout’, ‘workplace stress’, ‘workplace burnout’, ‘mental healthcare worker stress’, mental healthcare worker burnout’, ‘healthcare worker stress’, ‘healthcare worker burnout’, ‘organisational stress’, ‘organisational burnout’, ‘organisation change and stress’, ‘organisational change and burnout’, ‘effects of burnout’, burnout predictors’, ‘stress resilience’, ‘resilience burnout’, ‘NHS change and stress’, ‘NHS change and burnout’, ‘nurses and burnout’, ‘nurses and organisational change’, ‘public sector stress and

burnout', 'psychiatrist stress, 'psychiatrist burnout', 'NHS burnout', 'NHS stress', 'CAMHS stress', 'CAMHS burnout', 'stress in child mental health,' burnout in child mental health', 'psychologist stress in child mental health', 'stress in child healthcare', GP mental health.

The literature on burnout and stress is extensive. However, my search produced little information on counselling psychologist stress and burnout, although there were more numerous studies on healthcare professionals' stress and burnout. Fewer results were found on mental healthcare workers' stress and burnout and some of these were based in Europe. Initially, searches like 'GP mental health' tended to yield UK results about GP's input into patients' mental health, however, more recently this has changed with more studies available now. There was a good deal of information about GPs' and health workers' stress based on studies in the USA. Having found so many sources of information, I organised the most relevant journals by downloading them and storing them on my computer under relevant folder names or in some downloaded research apps including Mendeley, Deepdyve and Endnote. I would highly recommend that any such storage apps are backed up with a second storage system. The literature search produced very few phenomenological studies on general stress and burnout or stress and burnout resilience. My searches showed far more quantitative studies on stress and burnout than qualitative studies.

2.2 What is work-related stress?

Work-related stress has been defined as *"a pattern of emotional, cognitive, behavioural*

and physiological reactions to adverse and harmful aspects of work content, work organisation and the working environment. It is a state characterised by high levels of agitation and distress and often feelings of not coping" (Diamantopoulou, 2002, p. 3).

2.3 Organisational stress

Work-related stress is one of the leading occupational health problems in the European Union (Health and Safety Executive [HSE], 2004). In the United Kingdom, work-related stress, depression or anxiety accounted for 44% of work-related ill health and 57% of working days lost, in 2017/18. The occupations and industries reporting the highest rates remain consistently in the healthcare and public sectors of the economy. The primary cause of work-related stress, depression or anxiety is workload (in particular, tight deadlines, too much work or too much pressure and responsibility). Other factors identified included a lack of managerial support, organisational changes at work, violence and role uncertainty (lack of clarity about the job or uncertainty about what the worker is meant to do) (HSE, 2019).

In the United Kingdom, the average prevalence rate for work-related stress, depression or anxiety across all industries was 1,320 cases per 100,000 workers over the three-year period 2016/17 – 2018/19. In the industry of human health and social work, work-related stress issues accounted for 2,120 cases per 100,000 workers and in education there were 1,940 cases per 100,000 workers. It is worth noting that, in both cases, the rate was statistically significantly higher than the average for all industries (HSE, 2019).

The notion of psychosocial workplace risk factors pertains to individual subjective perceptions by workers regarding aspects of the organisational work that carry emotional value (for example, perceived job demands and degree of support from managers or co-workers) (Rick, Thomson, Briner, O'Regan, & Daniels, 2002). Psychosocial workplace risk factors have been grouped into the following categories: demands (workload, work scheduling, work organisation, job design and physical environment); control (lack of authority); support (appropriate proactive and reactive support, failure to match people's skills with their job, failure to take account of other individual factors); relationships (poorly designed/managed procedures for eliminating damaging conflict at individual/team level such as bullying or harassment); role (role conflict, inappropriate levels of role ambiguity, inappropriate levels of responsibility); change (lack of planned and active strategy for change, poorly designed/managed strategies, lack of appropriate consultation with employees about the change, lack of appropriate support for employees, poorly designed/managed new ways of working or new technology) (Rick et al., 2002).

2.4 Burnout as a unique syndrome

Burnout is included in the 11th Revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon rather than a medical condition (World Health Organisation [WHO], 2019). It is however widely recognised and can be characterised as a syndrome with three dimensions related to work: exhaustion, negativism or cynicism and reduced efficacy (Graveling, 2020).

Research indicates that job burnout may cause psychological distress (Jain, Lall, McLaughlin, & Johnson, 1996), and has been confused with depression. However, depression often undermines many areas of an individual's functionality in life whereas burnout tends to be specific to occupational functioning which diminishes when away from the activity of work (Maslach, Schaufeli, & Leiter, 2001). Burnout is understood to be an occupational stress syndrome which reflects workers' attributions about specific qualities of the social context of work in which they are meaningfully involved (Leiter & Durup, 2007). The burnout construct is considered to be different from other constructs involving job dissatisfaction, fatigue, occupational stress and depression. Although some of the literature can be vague about the difference between compassion fatigue and vicarious trauma in mental health work, burnout is widely accepted as being a separate construct in itself (Canfield, 2005; Dunkley & Whelan, 2006; Figley, 1995). Secondary traumatic stress (STS) involves a range of factors such as experience, personal trauma history and coping style influence vicarious traumatisation and compassion fatigue (Dunkley & Whelan, 2006). Whereas job burnout tends to arise from the longterm consequences of extreme job demands very often in human services professionals (Cieslak, Shoji, Douglas, Melville, Luszczynska, & Benight, 2014). Compassion fatigue is considered to be a psychological response to frequent and intense contact with traumatised clients and is triggered by chronic exposure to the traumatic content of trauma survivors' experiences (Elwood, Mott, Lohr, & Galovski, 2011). The symptoms can be similar to Post-Traumatic Stress Disorder (PTSD). Whereas most researchers agree that burnout is a response triggered by chronic exposure to a matrix of occupational stressors in the work environment. The symptoms

are emotional exhaustion, depersonalisation, or a lack of personal accomplishment (Cieslak et al., 2014).

2.5 How work-related stress experiences are perceived

There are variations in the definition and description of stress. Work-related stress has been described as "*the response people have when presented with work demands and pressures that are not matched to their knowledge and abilities, and which challenge their ability to cope*" (Leka, Griffiths, & Cox, 2003, para. 3). This description seems restrictive and based on individual differences, thereby implying inadequacy or failure of the worker. However, a view put forward by Lazarus and Folkman (1986) is that stress is a relationship (`transaction') between individuals and their environment. "*Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well being and in which the demands tax or exceed available coping resources*" (Lazarus & Folkman, 1986, p. 63). The phrase *"exceed available coping resources"* moves away from an external value judgement about the individual's 'ability' to cope as in the Leka et al. (2003) definition above. It suggests that feelings of not coping can be a reaction to factors in the working environment such as unavailable resources, which undermine the individual's coping strategy. The transactional definition offers complexity and suggests that stress is not a result of the individual alone but rather an interaction between the individual and the environment. This person-environment relationship results from "*appraisal of the confluence of the social and physical environment and personal goals, beliefs about self and world, and resources*" (Lazarus, 2000, p. 665).

The study of the influence of individual differences such as personality, lifestyle and individual vulnerability has dominated occupational stress research. Research on the effect of organisational resources and activities and how these can trigger exposure to prolonged stress and burnout have received less attention, as have the worker's meaningful representations of the work environment or its psychological climate (Martin, Jones, & Callan, 2005).

Lazarus, a veteran in the study of stress research, takes a process-centred holistic line of enquiry with an epistemological, ontological and theoretical outlook. He takes into account individual differences but only as part of the complexity of the stress response.

In the cognitive-phenomenological theory of stress and coping, Lazarus focuses on the meaning the person draws from their interaction with the work setting. The approach centres on "*the relational meaning an individual constructs from the person-environment relationship*" (Lazarus, 2000, p. 665). It posits that discerning stressful events begins with a cognitive and affective appraisal of those events and the mix of personal and environment resources that are accessible to the individual in attempts to cope with it (Lazarus, 1999; Lazarus & Folkman, 1984). Cognitive appraisal depends on the meaning given to an event in the occupational environment (Lazarus & Folkman, 1984).

The idea that primary appraisal is when people evaluate how a particular situation or stressor affects their well-being or stress levels is central to his theory. If determined to be stressful, they make two further judgements. They appraise their a) perceived control of the situation and b) efficacy expectations (or confidence) in their own ability to cope adequately with that particular stressor (Folkman, 1984).

Historically, much previous research on burnout considered it a problem which was located in the individual rather than a normal human response to an organisational deficit or obstruction (Maslach & Leiter, 1997). Many studies on burnout in mental health settings have focused on individual socio-demographic factors (Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Prosser, Johnson, Kuipers, Szmukler, Bebbington, & Thornicroft, 1996) or individual differences, predispositions or personality traits (Deary, Agius, & Sadler, 1996). Later research included organisational sources of stress as central to understanding the concept. These indicate that burnout can develop, for example, when working relationships or organisational support changes in a way that is felt to be unacceptable to the workers, or is in conflict with their values (Leiter & Maslach, 2004). There is a growing body of evidence suggesting that although individual differences can occur in stress perception, the majority of workers' experiences of job stress can be triggered by environmental stressors interacting with each other (Cox, Griffiths, & Rial-Gonzalez, 2000). Generally, research agrees that burnout is an individual syndrome mediated by the occupational or working context, and organisational factors have a stronger influence on burnout than personal factors (Maslach & Goldberg, 1998; Maslach et al., 2001). Organisational-environmental variables are stronger predictors of burnout than individual differences (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). The experience of stress can vary widely even in identical situations for different reasons. The severity of job stress depends on the magnitude of the demands being made and the individual's sense of control and decision-making latitude within this (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001).

Lazarus (2000) acknowledged studies that were carried out by Tennen, Affleck, Armeli,

and Carmel (2000) on arthritis sufferers, stress and coping in which the researchers longitudinally investigated potential multi-layered stress factors within- and across-person. This helped to gather microanalytic data in a process-centred, holistic way, all offering a richer insight into the stress phenomenon. In research on caregivers of patients suffering and dying from AIDS, Folkman, Moskowitz, Ozer, and Park (1997) used questionnaires but their main source of data included detailed, in-depth interviews and observations which revealed poignant emotional reactions of the caregivers as well as their coping mechanisms. Psychologists studying stress need to accurately portray the behavioural expressions and experience of emotions in stress and what this means in their particular milieu. They need to take into account the causes and the organised (synthesised) whole that comprises the parts and show antecedents and consequences and especially, focus on how people appraise and construct relational meanings about stress (Lazarus, 2000).

2.6 The link between stress and burnout

It is largely accepted that burnout develops from exposure to chronic occupational stress. The chronic nature of the stress arises particularly when needed resources are persistently unavailable in the face of increasing demands or pressure on the individual. If they were available, these resources could reduce, alleviate or mediate against the stress (Karl & Fischer, 2013).

Chronic exposure to occupational stress causes burnout (Awa, Plaumann, & Walter, 2010). Burnout is a psychological syndrome in response to chronic occupational stress

(Maslach et al., 2001). Burnout is a stress phenomenon which occurs in working life (Maslach et al., 2001) and can have serious consequences for psychological well-being, health, organisations and the economy. Psychiatrist Herbert Freudenberger (1974) originally conceptualised ‘burnout’ as a set of symptoms resulting from repeated experiences of chronic stress. He described these symptoms as frustration, emotional exhaustion, and physical fatigue.

In the past, there were two distinct approaches to burnout. Freudenberger understood it through a clinical framework also describing burnout as a *“mental disorder that is mainly caused by personal characteristics such as intrapersonal conflicts, dysfunctional personality traits or cognitions and wrong coping patterns”* (Schaufeli, 2003, p. 2). This was assessed and treated through observation, diagnosis, psychotherapy and various individual treatments including rehabilitation. Social psychologist and researcher Christina Maslach took a scientific approach and understood it as a syndrome with *“interpersonal, social and organisational factors as the root causes of burnout”* (Schaufeli, 2003, p. 2). In the early 1980s, burnout self-report measures were introduced with the most notable being the Maslach Burnout Inventory. Interpersonal stressors such as relationships between the healthcare or mental healthcare worker and patients, and between the worker and colleagues and/or family members and the effect of burnout on each was investigated (Maslach et al., 2001). Researchers such as Cherniss (1980) focused more on the relationship between organisational factors and burnout.

The concept of burnout was first investigated in populations who worked in human services and healthcare work settings (Maslach, Jackson, & Leiter, 1996) and

professions involving demanding interpersonal interactions with the public (Maslach et al., 2001). Interestingly, there is no discrete consensus amongst researchers as to what constitutes the construct of burnout (Bakker, Demerouti, & Sanz-Vergel, 2014), and it has been criticised for lacking a comprehensive theoretical framework (Schaufeli & Buunk, 2003). Neither stress nor burnout are clearly defined concepts (Pines & Keinan, 2005). Cox (1985) wrote, "*the concept of stress is elusive because it is poorly defined. There is no single agreed definition*" (p. 1). Maslach et al. (2001) defined burnout as "*a prolonged response to chronic emotional and interpersonal stressors on the job*" (p. 397). Hobfoll and Shirom (2000) viewed it as a consequence of exposure to chronic job stress. Schaufeli and Enzmann (1998) defined burnout as "*a special type of prolonged occupational stress that results particularly from interpersonal demands at work*" (p. 8). It is generally accepted that burnout was conceptualised in stress research and is a psychological syndrome emerging as a response to chronic stressors in the area of working life (Maslach & Leiter, 2016; Maslach et al., 2001; Shirom, 2003).

Burnout is generally referred to as a work-related syndrome with a construct of emotional exhaustion, depersonalisation and reduced sense of personal accomplishment that can develop in mental healthcare or healthcare workers and the helping professions as a result of chronic exposure to work-related stress (Maslach & Leiter, 2016; West, Dyrbye, & Shanafelt, 2018). The three key dimensions of the burnout response are: 1) an overwhelming emotional exhaustion; 2) feelings of cynicism and detachment from the job or depersonalisation; and 3) a sense of ineffectiveness or lack of accomplishment. The significance of the three-dimensional model is that it clearly places the individual stress experiences within a social context and involves the

person's concept of both self and others and in their work environment (Maslach & Leiter, 2016).

2.7 Burnout and meaning

Folkman and Moskowitz (2000) posited that meaning is implicated in the appraisal of stress. The personal significance of a stressful situation is determined by the meaning assigned to it. The appraised meaning of stressful encounters shapes the emotions that the individual experiences. "*Appraised situational meaning contrasts with global meaning which refers to more abstract, generalized meaning related to people's fundamental assumptions beliefs, and expectations about the world and the self in the world"* (Folkman & Moskowitz, 2000, p. 651).

The literature suggests that burnout can occur when the worker is unable to derive meaning from their work, whereas resilience is linked to being able to access a sense of meaning in life (Gustafsson & Strandberg, 2009; Pines, 2002). Thus, the cause of burnout may be in the individual's need to believe their life is meaningful and their activities are useful and relevant. As Victor Frankl stated, *"The striving to find meaning in one's life is the primary motivational force in man"* (Frankl, 1976, p. 154). Burnout is often related to a lack of significance at work. When the sense of significance is restored, the burnout problem tends to resolve (Pines, 2002). As counselling psychology is based on the philosophy of humanism, the relational and person-centred meaning of the work is primary. If this is prevented from its expression in the work setting, then obtaining a sense of existential significance in the work may be impeded.

This can trigger heightened stress or burnout. Pines and Keinan (2005) have shown there is a higher correlation between burnout and the meaning of work than between burnout and stressors in the work context. Burnout is the index of the dislocation between what people are and what they have to do. *"It represents an erosion in values, dignity, spirit, and will, an erosion of the human soul"* (Maslach & Leiter, 1997, p. 17).

2.8 Burnout and values

The risk of burnout appears to be higher when workers are in states of perceived value dissonance with their organisation. The better the fit between the individual workers and organisational values, the higher the work engagement and the lower the risk of professional burnout (Dylag, Jaworek, Karwowski, & Kozusznik, 2013). Maslach and Leiter (1997) stated that value misalignment is one of the key risk factors for job burnout and decrease in work engagement. But there is ambiguity on which particular values are more susceptible to this misalignment. Many research findings lack a commonly shared theory on values and there is little integration leading to better understanding of findings (Dylag et al., 2013). Various value instruments are used to determine values based on personality traits and organisation-specific value systems (Schwartz, 2012). However, there is no dominant value measure and values change cross-culturally (Schwartz, 1999). It is therefore logical to suggest that capturing values and understanding better their role in burnout may require a qualitative methodological approach. This can perceive and identify the experiences of the worker's values as a subjective construct which varies depending on personal and professional identity. This type of information can enrich the knowledge base on the roles and inter-relationship of

values and meaning in organisational burnout.

2.9 Values and workers' complexity

Graves believed that no individual or organisation is subject to one value system but is simultaneously influenced by at least three. These are the previous dominant (value) system, the current dominant system, and the next emerging value system. Graves (1970) stated that *"The psychology of the mature human organism is an unfolding or emergent process marked by the progressive subordination of older behavioural systems to newer, higher order behavioural systems"* (p. 133). Graves's Emergent Cyclical Levels of Existence Theory (ECLET) is a 20-item assessment measure that has been widely used for identifying and assessing values. Based on existential philosophy, it was developed and constructed using an early grounded theory approach by Graves (1970). Its construct is based on extensive qualitative research.

Burnes and Jackson (2011) utilised the ECLET measure which is standardised but with qualitative and existential theoretical underpinnings. It has been widely used to assess values. The researchers investigated values with proposed organisational change interventions in a sample of two groups of participants from public sector and private sector work settings. They found that participants agreed with the changes if they were aligned with their values as assessed by the measures. The findings showed that value alignment influences the intention of employees to respond positively to and implement directives on organisational change. The researchers also showed that value alignment is an important determination in whether organisational change interventions are

accepted, in theory, by employees. Despite this, there was one participant in the public sector group who vehemently disagreed with the organisational change intervention for his team (charity/public sector group). It was expected his values would align with the proposed change intervention but they clearly did not. This is important because: 1) his lone voice supports the argument for use of a more complex, idiographic capturing of individual values so that each experience is recorded and is treated as a unit of feedback. Although the study was based on qualitative content analysis, it is still a limited construct for capturing subjective experiences; 2) it highlights the limitations of Ipsative measures (list of questions with a choice between two extreme answers for each), which ignore complexities and which can sway the choices on closed-questionnaire answers on any given day (as, for example, in attribution theory, where an individual's choices and perceptions are temporarily or permanently swayed or affected by a recent event); and 3) more importantly, there was only feedback on how the change intervention seemed, in theory, to align or misalign with the participants' values. There was no opportunity to seek information on how participants experienced or engaged with the change intervention on a daily basis. It remained unknown if or how everyday tasks, pressures, job role or sense of self-efficacy were experienced by individuals in their work settings as a result of the changes.

2.10 Models of stress and burnout

2.10.1 The Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is the most frequently used measure of burnout and was designed to assess the burnout in healthcare workers (Maslach & Jackson, 1981; 1986). Originally, it was based on qualitative research methods but became modified over time.

As the most widely used model of the burnout construct, it places stress experiences in a social context. The model's three dimensions indicating burnout responses are: 1) emotional exhaustion such as depleted energy, fatigue, feeling worn out, loss of idealism, feeling there is nothing left to offer patients; 2) depersonalisation or cynicism, which refers to a loss of idealism, psychological withdrawal from patients and/or the workplace, and less tolerance for patients; and 3) reduced personal accomplishment or inefficacy, referring to reduced productivity, feelings of ineffectiveness in helping patients, and low morale (Maslach & Leiter, 2016; West et al., 2018). The dimensions are further detailed below.

2.10.1.1 Emotional exhaustion

Emotional exhaustion refers to feelings of being over-extended and depleted of one's emotional and physical resources in work (Maslach et al., 2001). A key aspect of the burnout syndrome is increased emotional exhaustion. As emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological and physical level (Maslach, Jackson, & Leiter, 1997).

2.10.1.2 Depersonalisation

Depersonalisation refers to an unfeeling and impersonal response towards others (Maslach et al., 1996). Depersonalisation or cynicism represents the interpersonal

context dimension of burnout. It includes negative, cynical attitudes and feelings towards clients. The authors perceived that the development of depersonalisation in an individual seemed to be related to the experience of emotional exhaustion (Maslach et al., 1997).

Emotional exhaustion (depletion of emotional resources) and depersonalisation (development of negative, cynical attitudes towards service users) are considered to be the two core symptoms of burnout (Shirom, 1989) and show the most robust relationships with work-related stress (Schaufeli & Enzmann, 1998).

2.10.1.3 Reduced personal accomplishment

A third dimension of burnout is lack of personal accomplishment. This component represents the self-evaluation dimension of burnout. It refers to feelings of incompetence and a lack of achievement and productivity at work (Maslach et al., 2001). It is the tendency to negatively evaluate one's work with recipients (patients or clients) and is accompanied by feelings of insufficiency (Schaufeli & Buunk, 1996). Reduced personal accomplishment or reduced efficacy refers to a sense of ineffectiveness and lack of accomplishment. It is associated with feelings of self-doubt and negative self-evaluation and is likely to occur in mental health therapists whose self-esteem is contingent on their work performance (Teater & Ludgate, 2014).

2.10.1.4 The MBI and measuring burnout

The first forms of the MBI as a measuring tool were used with healthcare professionals (Maslach Burnout Inventory Human Services Survey [MBI-HSS]; Maslach & Jackson, 1981; 1986) and teachers (Maslach Burnout Inventory Educators Survey [MBI-ES];

Maslach & Jackson, 1986). Both the MBI-HSS and MBI-ES became widely used and their factorial validity has often been tested with studies offering divergent results. The MBI-HSS's three-factor structure has been validated on samples of healthcare professionals (Hallberg & Sverke, 2004) and social workers (Kim & Ji, 2009).

2.10.2 Job demands-resources (JD-R)

The job demands-resources (JD-R) model assumes that burnout occurs regardless of the type of occupation when job demands are high and job resources are constricted. It is such working conditions that lead to energy depletion and eventually depress the workers' motivation (Demerouti et al., 2001).

The JD-R model states that jobs which are high on demands but low on occupational resources can trigger burnout in employees. It proposes that the development of burnout follows two processes. In the first process, demanding aspects of work (i.e., extreme job demands) can lead to constant overexertion eventually causing exhaustion. In the second process, it claims a lack of resources interrupts the ability to meet the demands, which exasperates the worker and leads to withdrawal behaviours from work. The long-term consequence of this withdrawal is shown to be disengagement from the work setting altogether (Demerouti et al., 2001). The JD-R model states that workers with highly demanding jobs but who have low job control can suffer burnout and decreased well-being (Karasek, 1979). The model claims that job control is a specific resource that can mitigate against the negative effects of high job demands. Having

control or autonomy in the job has been associated with job satisfaction and better psychological health (Leiter & Maslach, 2009).

2.11 Burnout and caring professions

Most discussions on burnout emphasise contact with people and the factors that make contact particularly difficult or emotionally stressful, and much of the burnout literature to date deals with the helping professions (human services, healthcare, education) (Maslach, 1982). Working with demanding patients and families with unrealistic expectations for treatment was found to be related to psychiatrists' recurring feelings of depersonalisation and exhaustion (Maslach et al., 2001). In addition to emotionally demanding patient contacts, it has been shown that lack of time to plan and prepare work, frequent interruptions, and responsibility in the absence of decision-making power can be important stressors in the healthcare profession (International Labour Organisation [ILO], 2016).

2.11.1 Burnout and frontline workers

Research has shown that professionals working in specialist areas at the frontlines of mental healthcare and healthcare are among the highest at risk of burnout (Dyrbye et al., 2017). NHS CAMHS Tier 3 is a specialist service at the frontline of child mental health. Attention is turning to burnout as a critical issue for mental healthcare service delivery. It can lead to less effectiveness in professionals and poorer treatment outcomes (Johnson, Hall, Berzins, Baker, Melling, & Thompson, 2018; Priebe et al.,

2004). It can also precipitate staff turnover and the expense incurred as a result of staff loss and recruitment. Burnout is especially gaining increasing attention as a relevant and increasingly serious problem in a time of ongoing cuts to services and consistently increasing patient numbers and demand. This may have serious implications for child mental health services which are already in a state of financial shortage and are less resourced than adult mental health. In comparison to healthcare, adult mental healthcare is itself under-resourced, and child mental health is even less resourced and funded. Burnout is an ongoing and acute problem for workers in human services (Cherniss, 1980) and it can undermine service delivery in community mental health settings and clinics.

Healthcare professionals are perceived to be particularly vulnerable to occupational stress and the negative effects of stress-related conditions (Edwards & Burnard, 2003). Sutherland and Cooper (1990) saw a relationship between healthcare professionals' stress and lack of continuity of patient care and poor patient engagement. Furthermore, stress has been associated with frontline workers' burnout, physical illness, absenteeism, poor morale, high staff turnover, and reduced efficiency (Acker, 2010; Dahl, 2011; Demerouti et al., 2001; Maslach & Leiter, 2016). Poorer well-being and higher burnout are associated with poorer quality of patient care and safety, less effective interventions, higher absenteeism, and higher turnover rates in mental healthcare services (Johnson et al., 2018).

Organisational stress has been widely researched among healthcare and mental healthcare professional groups - clinical psychologists (Cushway & Tyler, 1999), occupational therapists (Sweeney & Nichols, 1996), and nurses (Kipping, 2000).

Organisational stress has been linked to decreased mental health in medical students (Tyssen, Vaglum, Gronvold, & Ekeberg, 2001), and suicide in young General Practitioners (GPs) (Richings, Khara, & McDowell, 1986). In physicians, it has been associated with disrupted personal relationships (Gallegos, Bettinardi-Angres, & Talbott, 1990). Decreased attention, reduced concentration and sleep (Askenasy & Lewin, 1996) and poorer decision-making skills (Klein, 1996; Lehner, Seyed-Solorforough, O'Connor, Sak, & Mullin, 1997) have all been linked to occupational stress and burnout.

2.11.2 Burnout and mental healthcare workers

Burnout rates for mental health workers show a trend of being in the moderate-to-high levels and mental health workers are at higher risk of burnout than the general working population (Dennis & Swartz, 2015; Kumar, 2007). Although some research has shown that healthcare professionals share the highest burnout rates (Shanafelt et al., 2012), other researchers found that mental healthcare staff reported even higher rates of burnout and decreased well-being than healthcare staff (Ackerley, Burnell, Holder, & Kurdek, 1988; Johnson et al., 2018; Vredenburgh, Carlozzi, & Stein, 1999).

Burnout is a formidable impediment to productivity and patient care. Numerous studies have shown that organisational stress is related to negative consequences for an individual's physical and psychological health (Dewe, O'Driscoll, & Cooper, 2010; Schabracq, Winnubst, & Cooper, 2003). Workers subjected to high job demands but who have little control over their work have also been shown to be at increased risk for cardiovascular disease (American Institute of Stress, n.d.). Mental healthcare workers

experiencing burnout may struggle to provide good quality treatment to their patients (Cherniss, 1980).

Up to 67% of mental health providers are estimated to have chronic burnout levels (Morse et al., 2012; Rohland, 2000). In community mental health work settings, burnout is strongly implicated in increased organisational costs due to absenteeism, turnover, recruitment and new staff training (Rollins, Salyers, Tsai, & Lydick, 2010; Schaufeli, Bakker, & Van Rhenen, 2009). It affects mental healthcare delivery because it destabilises the workforce in mental health services, and affects the continuity and quality of care received by patients (Lasalvia & Tansella, 2011; Priebe et al., 2004).

2.11.3 Psychologists and burnout

Therapeutic psychologists in mental healthcare have been observed as being a population particularly committed to their work and more likely to be at risk of work-related stress and burnout compared to healthcare and other professionals (Ackerley et al., 1988; Johnson et al., 2018; Vredenburgh et al., 1999). Mental healthcare staff reporting higher rates of burnout not only highlights a possible threat to the safety and quality of patient care but also financial costs to services as higher rates of sickness absence are triggered and turnover of staff ensues (Hall et al., 2018).

2.12 Work setting risk factors for burnout in psychologists

Other research found evidence that work setting type can be a significant predictor of

burnout in psychologists (Senter, Morgan, Serna-McDonald, & Bewley, 2010). For example, those in public sector settings are 64% more likely to report stress as the leading hazard of concern at work compared to 48% of workers in the private sector (Blaug, Kenyon, & Lekhi, 2007).

Studies have claimed that psychologists employed in the public sector are more likely to develop burnout than psychologists in the private sector (Ackerley et al., 1988; Boice & Myers, 1987; Vredenburgh et al., 1999). In public sector mental health workers, burnout has been considered to be prevalent, driving up costs in regard to absenteeism, training, turnover, and recruitment (Gilbody, Cahill, Barkham, Richards, Bee, & Glanville, 2006). This may be partially due to the changing environment of healthcare and the growth of managed care, which have introduced new work stressors (including economic uncertainties, ethical challenges, increased workload, loss of professional autonomy, and increased caseloads) (Rupert & Morgan, 2005).

Although the ILO (2016) reported that the level of emotionally demanding client contact hours increases stress levels, this was not substantiated by other studies such as the following. Using the standardised MBI research tool in a population of 521 counselling psychologists across the USA, Vredenburgh et al. (1999) found that the highest levels of burnout existed in public sector work settings, whereas those in private practice reported lower levels of burnout. Their analysis revealed that the type of work setting contributed significantly to a variance in professionals' depersonalisation of clients. In replicating Ackerley et al.'s 1988 study, Vredenburgh et al. (1999) showed that the type of practice setting was predictive of burnout. Interestingly, the findings also showed a positive correlation between client load and the counselling psychologists' sense of

personal accomplishment. The higher the client load, the greater was their sense of personal accomplishment. The suggested explanation was that a higher client load offered counselling psychologists the perception of increased opportunity to help others, thereby increasing feelings of personal accomplishment and mitigating against feelings of depersonalisation and emotional exhaustion. The researchers also proposed that in private practice, counselling psychologists enjoyed the extra remuneration brought in by clients. The study showed no significant relationship between client load and the burnout dimensions of emotional exhaustion or depersonalisation of clients, therefore implying that an increased client load was not in itself a trigger for burnout. There has yet to be found a consistent finding across the literature on the relationship between caseload and stress.

Also using the MBI, several themes were identified by Maslach and Goldberg (1998) as features within the psychologists' workplace settings which can trigger the onset of burnout. Burnout can be triggered, for example, if: a) there is an imbalance between the demands on the psychologist and the resources available to meet those work demands within the workplace; b) stressors in the work environment are chronic, occurring over a long period of time without respite; and c) the workplace produces ongoing conflict. The latter can be a conflict between the various demands placed upon the individual clinician; between colleagues; or client-related conflict or notably, a values conflict (Maslach & Goldberg, 1998).

Potential risk factors for burnout in counselling and clinical psychologists in the public sector were reported by Rupert and Morgan (2005). In addition to the Maslach Burnout Inventory (MBI), they used an expanded version of the Psychologists' Burnout

Inventory-Revised (PBI-R) (Ackerley et al., 1988), along with demographic surveys and the Farber and Heifetz (1981) two-and-a-half-hour semi-structured interview on sources of satisfaction and stresses in therapeutic work (modified version). They found that factors predictive of burnout included psychologists' sense of a loss of control over their work activities, for example, through working longer hours; spending more time in administrative and paperwork activities; seeing few direct-paying clients; and dealing with more negative client behaviours. The research also revealed that psychologists in independent practice settings perceived themselves as having greater control over their work activities and thus having flexibility to adjust hours, work tasks, and client types which helped to reduce the likelihood of burnout.

All three studies above attempted to examine the relational aspects associated with psychologists' burnout in their work settings. Although the Rupert and Morgan (2005) study added a more layered approach to investigating risk factors for chronic stress and burnout in the work setting, the authors stated in their conclusion, *"burnout is a multi-determined phenomenon that cannot be predicted on the basis of work-related variables alone. However, some work characteristics may be seen as potential risk factors*" (Rupert & Morgan, 2005, p. 550). Professional identity (as a work characteristic), for example, can encompass professional and/or personal values, and meaning which may be variables to include. As with Lazarus, Rupert and Morgan's assertion is further support that the phenomenon of chronic stress and burnout is complex and multi-faceted.

2.13 Work setting and counselling psychologists' burnout

Although Vredenburgh et al.'s sample was large, comprising 521 doctoral level counselling psychologists from a variety of settings (including universities, private sector, in-patient hospitals, community mental health centres, etc.), the study was not longitudinal nor qualitative and offered minimal insight from the sample into reasons underpinning the resulting relationships (Vredenburgh et al., 1999).

For example, the study did not show how perceived high or excessive client loads could impact the sense of accomplishment. The authors did not investigate other organisational factors that could affect the counselling psychologists' perception of their client load and sense of accomplishment (e.g., resources or lack thereof such as time allotted to client therapy versus administration load).

2.14 Predictors of burnout

The vast majority of burnout research has focused mainly on predictors, with studies highlighting occupation- or work-related factors as the strongest ones (e.g., Alarcon, 2011; Lee & Ashforth, 1996). The JD-R model (Demerouti et al., 2001) is the dominant approach in explaining the predictive role of occupational factors in burnout development. The model looks at the balance between demands and resources. Its core assumption is the tension between job characteristics that require a sustained effort and elicit physical or psychological costs (i.e., demands) and goal attainment or high functioning (i.e., resources). High demands and insufficient resources trigger an energy expenditure process with health-damaging costs (i.e.,

burnout). Optimal resources prompt a motivational process which fosters positive outcomes (i.e., engagement, low cynicism). The model has been supported by other research that is cross-sectional (Llorens, Bakker, Schaufeli, & Salanova, 2006), longitudinal (Hakanen, Schaufeli, & Ahola, 2008), and meta-analytic (Nahrgang, Morgeson, & Hofmann, 2011) among diverse occupational roles. Excessive job demands are the strongest predictor of health impairment which, in turn, predicts medical absence; in contrast, high job resources predict high dedication and low turnover intentions (intention of leaving employment) (Bakker, Demerouti, & Schaufeli, 2003). Use of the JD-R has shown that excessive job demands trigger exhaustion, and lack of appropriate job resources leads to cynicism (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003; Demerouti et al., 2001).

In healthcare professionals, researchers agree that dealing with high workloads under time pressure (Pisanti, van der Doef, Maes, Lazzari, & Bertini, 2011); caring for demanding patients (Escriba-Aguiar, Martin-Baena, & Perez-Hoyos, 2006); and having higher nurse-patient ratios (Gunnarsdottir, Clarke, Rafferty, & Nutbeam, 2009) affect levels of emotional exhaustion (Maslach et al., 2001). A lack of structural empowerment (Laschinger, Wong, & Grau, 2013) or social support (Prins, Hoekstra-Weebers, Gazendam-Donofrio, Van De Wiel, Sprangers, Jaspers, & van der Heijden, 2007) contributes to healthcare professionals' cynicism, which is also a predictor of and a correlational factor in burnout.

2.15 Impact of chronic stress on healthcare professionals and their clients

The impact of work-related cumulative stress which can precipitate burnout is multi-dimensional. For example, burnout can spark other psychological issues such as anxiety, irritability, and depression, physical symptoms and behavioural reactions (e.g., alcohol and drug misuse) (Duquette, Kerovac, Sandu, & Beaudet, 1994). In patient-related work, physicians, residents, and nurses affected by burnout are more prone to substance misuse (Moustou, Panagopoulou, Montgomery, & Benos, 2010; Oreskovich et al., 2012), depression (Hakanen & Schaufeli, 2012), insomnia (Vela-Bueno et al., 2008), and high rates of suicidal thoughts (Shanafelt et al., 2012; van der Heijden, Dillingh, Bakker, & Prins, 2008). The performance of hospital institutions can be greatly impacted by burnout due to increased turnover intentions (Leiter & Maslach, 2009), absenteeism (Davey, Cummings, Newburn-Cook, & Lo, 2009), or early retirement intentions (Linzer, Visser, Oort, Smets, McMurray, & de Haes, 2001). Most of these studies were based outside of the UK where healthcare worker stress has been in focus. Perhaps healthcare professionals outside of the UK are more willing to talk about mental health problems triggered by work stress, and are less worried about any potential consequences of their disclosures. The consequences of burnout on health professionals' clients or patients can lead to increased patient risk, and can even predict serious medical and practice errors (Shanafelt et al., 2012). Work-related stress and burnout have also been associated with diminished empathy and engagement within patient-professional relationships (Pastore, Gambert, Plutchik, & Plutchik, 1995). Burnout in psychologists, specifically, has been correlated with self-reported low patient care feedback (Shanafelt, Bradley, Wipf, & Back, 2002). Therefore, the effects of

chronic stress, the repeated experience of which leads to burnout (Freudenberger, 1974), can be catastrophic for the caring professional as well as the vulnerable patient.

2.16 Capturing stress

As aforementioned, a large amount of the research on burnout and coping with burnout is based on questionnaires and cross-sectional studies. Critical of the tendency in burnout research to apply reductive thinking rather than address its complexities, Lazarus (2000) was sceptical of the use of questionnaires for measuring transactional stress, and of research claiming to be predictive. He further criticised cross-sectional studies as only demonstrating correlations, not causality, and factor analysis as reductionist (Lazarus, 2006). He believed most methods used to research stress give limited information, not allowing for analysis into the complexities (social, emotional, physical, cognitive, and relational) underpinning individual stress. This study aims to encompass some of these missing elements by using qualitative methods to investigate idiographic experiences of stress in a distinct occupational setting.

As noted previously, Lazarus and Folkman (1984) viewed the experience of stress as a transaction between individuals and their environment ('transactional model'). The transaction results from an imbalance between demands and the perceived ability or resources to cope with those demands. Lazarus's transactional approach is based on the *"relational meaning that an individual constructs from the person-environment relationship"* (Lazarus, 2006, p. 42). Stress researchers, he stated, should make efforts *"to produce a rich, full, contextual portrait of our research participants. I assert that we*

need to go back to a much more idiographic perspective and seek rich in-depth descriptions of the lives of individuals" (p. 42). He believed the approach should be person-centred, with a combination of intra-individual and inter-individual experiences making it "*possible to construct relational meanings, which refer to the significance for the individual of what is happening in the person-environment relationship, the most important aspect of which is interpersonal"* (p. 12). Perhaps unwittingly, Lazarus makes a good case for the use of IPA methodology, as its humanistic philosophy can allow insight into social, emotional, physical, cognitive, and relational complexities of experiential stress.

Chapter 3: Methodology and Procedures

3.1 The choice of method for analysis

Offered below is a brief background on the philosophical underpinnings of the methodology chosen for this research, including:

- phenomenology
- hermeneutic phenomenology
- interpretative phenomenological analysis

I also outline reasons supporting my choice of IPA for this study, including some critiques of the methodology.

Please note that, given the confines of this document, the philosophical outline and discussion are condensed. However, references are provided if the reader would like to pursue more information.

3.1.1 Phenomenology

Phenomenology is a philosophical approach to the study of human experience, of what this experience is like, and of what makes it meaningful to the individual (Smith, 2011; Smith, Flowers, & Larkin, 2009).

There are numerous branches of phenomenology and contributors to its philosophy. The movement emerged in the first half of the twentieth century with Edmund Husserl (Husserl, 1907/1990).

3.1.2 Hermeneutic phenomenology

The branch most associated with IPA is hermeneutic phenomenology. Hermeneutic phenomenology is not only concerned with the human experience of a phenomenon but also the interpretation of this experience. Within hermeneutic phenomenological research, the researcher is conscious of their own biases and views and their interactivity within the dialogue of inquiry and with the participant. This process continues throughout the research, during data collection, in reflections during and afterwards, and whilst interpreting the data. Therefore, the interpreter/researcher and the phenomenon being studied are combined together (Dowling, 2007).

3.1.3 Intentionality

Phenomenology originated from the ideas of philosopher Edmund Husserl. Husserl (1859-1938) is often referred to as the father of phenomenology and is associated with transcendental phenomenology. Empiricism in science, he believed, was not the only way of achieving an understanding of the world (Husserl, 1907/1990). He endorsed the importance of capturing individual lived experience as the way forward. However, he contended that the essence of an individual's experience is pre-reflective and without interpretation. This was known as the concept of *intentionality*, referring to his view that immediate, conscious experience of the world happens before it has been thought about (Husserl, 1907/1990).

In terms of research, Husserl believed the participant's experiences should be studied in isolation from their contextual factors (Dowling, 2007). He suggested experience is not

about meaning, but about a consciousness that is lived and captured in ‘moments’ in its pure form, with no associated meaning. An experience is an immediate, conscious state that occurs within an individual as they place their momentary focus or ‘intentionality’ on an object, thought, or concept – before reflection gives it meaning (Smith & Smith, 1995). In addition, he proposed that in order for the true essence of an individual’s lived experience to unfold, pre-conceived ideas must be put aside, an approach known as *bracketing* or *epoche* (Moustakas, 1994). In essence, the experience is studied devoid of contextual factors which would give the experience meaning. In research, therefore, the researcher provides a description of the participant’s experience but without assigning meaning, in the sense that the data are presented and analysed pre-reflection before being categorised (McConnell-Henry, Chapman, & Francis, 2009).

Evolving from Husserl’s concepts, Heidegger, a student of Husserl, offered his alternative theory of hermeneutic phenomenology. This is based on the concept of *dasein* (Heidegger, 1962), according to which an idiographic experience is perceived through the filters of contextual factors, including environmental and historical context and socio-cultural background.

Heidegger (1962) believed that for the lived experience of the individual to be understood fully, context and time were important, as an experience was idiographic because of the meaning assigned to it by the individual. His hermeneutic cycle states the sum of the parts is understood in the context of the whole of the parts, and the whole is understood in the context of its parts. In other words, an experience is a phenomenon infused with meaning drawn from contextual factors (temporal, spatial, cultural, bio-chemical, etc.). An experience is an interpreted occurrence of

consciousness. This also applies to the researcher's interpretation of the individual's idiographic experience.

In scientific research, Heidegger (1962) also viewed bracketing differently. To him, it is not possible for the interpretive research to be free of the researcher's judgment or influence. He believed the researcher is as legitimate a part of the research as is the participant, because both are constructing reality from their experience of being in the world. Interpreting phenomena is reliant on previous knowledge and understanding for both the participant and the researcher, and the researcher should be conscious of their biases. The researcher's role involves making sense of the participant making sense of their experience:

> "*Understanding is never without presuppositions. We do not, and cannot, understand anything from a purely objective position. We always understand from within the context of our own disposition and involvement in the world."* (McConnell-Henry et al., 2009, p. 10)

It is this acknowledgement of experiential meaning and the interactivity of interpreter bias with the research that underpins the major theoretical concepts in IPA research and interpretative/hermeneutic phenomenology.

Hans-Georg Gadamer (1900-2002) was a student of Heidegger. He expanded on Heidegger's ontological (or existential) views of what it means 'to be', by proposing that understanding is achieved only through language and openness to the perspectives of others (McConnell-Henry et al., 2009). There is a Heideggerian-Gadamerian tradition that represents an ontological understanding of a person's sense of 'being-in-the-world'.

This refers to the belief that everyday existence cannot be isolated from intersubjective, relational, and temporal influences (Evans & O'Brien, 2005; Gadamer, 1975). IPA also draws on the work of Merleau-Ponty and Schleiermacher (Smith et al., 2009). It is worth noting that Husserl, Heidegger, Gadamer, and the other philosophers did not offer research methodologies as such, but provided a philosophical groundwork upon which methodologies were later developed (McConnell-Henry et al., 2009).

Other philosophers continue to debate the issues. For example, Giorgi argues that bracketing is properly done in the analysis phase of the phenomenological research and is not appropriate while interviewing, when closeness with the other must take priority (Drew, 2004).

In this research project, the view was held that the role of bracketing depends upon the aim of the researcher and the methodology used. Bracketing would defeat the purpose of the IPA methodology. Therefore, I maintained constant vigilance over my own pre-conceptions and biases. I tried to notice and monitor these and how they might positively stimulate or negatively affect the unfolding data during the interviews; during post interview reflections; and during data analyses.

3.1.4 Choice of IPA methodology

Qualitative research requires the researcher to discover the passion in a research topic (Chenail, 2011). I was very mindful of eminent stress researcher, Lazarus, who, despite the many studies in the field of stress, has criticised the research for lacking in depth. He called on researchers to embrace and capture the complexities of stress (Lazarus,

2000). I understood that the work settings and profession of the participants were complex. Therefore, a methodology was needed that could capture multi-faceted dimensions of stress, if they existed, within this sample population, along with the processes underlying the lived experiences of their working lives. Smith and Osborn (2008) stated IPA is *"...especially useful when one is concerned with complexity, process or novelty*" (p. 53).

In looking at IPA as a possible methodology for the research, it was exciting to discover that it aims to capture the complexity of a participant's lived experience, and promotes continually reflecting upon researcher-interpreter bias. I was encouraged by the similarity of the interviewing process to an intense person-centred, humanistic, therapeutic session, and the post-reflection required thereafter (in both). I felt it would facilitate a fluid and organic interaction between the participants and myself, and allow reflection upon communications during and after the interviews.

The application of IPA is *"a two stage interpretation process which combines an empathic hermeneutics with a questioning hermeneutics, thus consistent with its phenomenological origins"* (Smith & Osborn, 2008, p. 51). The sample population were counselling psychologists. I am also a counselling psychologist, and the IPA process seemed congruent with this profession's empathic, person-centred, reflexive philosophy. I thought counselling psychologist participants would feel at ease with the familiarity of this approach too. Also, I felt it would give the participant the floor and allow him or her to develop their own unique momentum in imparting their lived experiences. I felt enthused by IPA as it mirrored many aspects of how I already work humanistically with clients, so I felt I had a good understanding of it. I refer here mainly to the person-

centred focus; the multi-dimensional engagement of active listening, interpretation, self-reflection upon my interpreter biases; and attunement to affective communications. I thought the IPA framework would not impose anything upon the participants' accounts of their own lived experiences. In keeping with this concern, IPA seemed to be a progressive methodology not least in challenging me, as a researcher, to constantly reflect upon the interaction between my own biases and the data. Van Manen (1988) seamlessly encapsulates this point:

> *"The simple phenomenological precept (is) to always try to understand someone from his or her situation... The phenomenological approach asks of us that we constantly measure our understandings and insights against the lived reality of our concrete experiences, which, of course, are always more complex than any particular interpretation can portray*." (van Manen, 1988, p. 8).

3.1.5 Some criticisms of IPA

Willig (2008) identifies some limitations of IPA, stating that talking about an experience does not adequately describe the experience. In my view, this verges on obfuscating the point that IPA is not designed to just elicit and listen to the spoken word It aims to interpret the meaning within the individual's spoken descriptions. In attempting to access *"the participant's personal world"* (Smith, 1996, p. 218), as a researcher, I took into account the effect of the participant.

> *"IPA has a theoretical commitment to the person as a cognitive, linguistic, affective and physical being and assumes a chain of connection between*

> *people's talk and their thinking and emotional state. At the same time IPA researchers realise this chain of connection is complicated – people struggle to express what they are thinking and feeling… and the researcher has to interpret people's mental and emotional state*" (Smith & Osborn, 2008, p. 54).

Willig (2008) states that IPA excludes participants without good verbal language skills. I believe this viewpoint represents a common misconception about IPA in the literature. For example, Baillie, Smith, Hewison and Mason (2000) argue that interpretations of experiences are bound by participants' abilities to articulate their thoughts and experiences adequately. However, in ascribing meaning to descriptions, surely it is not the proficiency of language used that is as important as the meaning imparted by use at the available language level. If Willig (2008) and Baillie et al. (2000) were correct, this would imply that a five-year-old child cannot verbally describe his phenomenological experience with, say, Thomas the Tank engine. In playing with Thomas daily, listening to stories, seeing videos and pictures, and indeed talking to Thomas (as he may do in play), his phenomenological experience is relevant as is age-appropriate language to describe it. In such a case, it is up to the researcher to be familiar with pertinent issues (such as the normal language and nuances of that age group, Thomas 'the phenomenon', etc.), and to design an appropriate topic guide. I think such arguments risk placing hasty limitations on this methodology's reach in capturing meaning presented within an individual's idiographic language. Ironically, my role as researcher risks being overlooked. As a researcher, my familiarity with the normal language and nuances therein of the counselling psychologist or therapist in CAMHS must surely be relevant in understanding and interpreting meanings within speech.

Narrative portrayal is very important, with the final examinations resulting in a detailed interpretative analysis of themes (Brocki & Wearden, 2006). However, a narrative is also idiographic and laced with individual nuances. The focus in IPA, therefore, is on interpretation of meaning within the spoken narrative rather than on construction of language or social discourses (Flowers, Duncan, & Knussen, 2003). IPA is not merely a thematic analysis tool. The aim of IPA is to explore in detail the processes through which participants make sense of their own experiences, by looking at the respondent's highly individualised account of the processes they have been through (Chapman & Smith, 2002; Smith, 2004).

Some criticisms may assume that spoken language is the only means of communication within a verbal exchange or narrative. All participants' verbal language was studied in the context of the whole of their communication (for example, non-verbal body language, sighs, hesitations, facial expressions, tonality, general presentation of affect).

Smith and Osborn (2008) state that IPA may be unsuitable for use in studies with children only because they recommend IPA interviews should proceed uninterrupted. Perhaps they might reconsider this, as even with adults avoiding interruptions in interviews is not always possible. I see this as Smith and Osborn placing limits on IPA and the researcher, perhaps prematurely. For example, a scientist-practitioner experienced in communicating with children has a skill base in interpreting the age-appropriate language and verbal narratives of a child whilst being mindful of interpreter bias. Perhaps this is an area in which IPA research will evolve further, and I would like to explore it myself.

Malim, Birch, and Wadeley (1992) state that IPA is not a suitable research tool because, whilst applying IPA to understanding the wholeness and uniqueness of the individual, generalisations across cases are not practicable. Malim et al. (1992) state that idiographic studies are potentially subjective, intuitive, and impressionistic. I disagree and believe this is a misunderstanding of the research tool. Qualitative and IPA researchers tend to think in terms of theoretical transferability rather than empirical generalisability. Therefore, by gaining insight into the individual, insight into the whole can also be achieved (Smith et al., 2009). Moreover, transferability is supported when commonalities and divergences are found in cross-case analyses through rigorous IPA methodology process applications (Pringle, Drummond, McLafferty, & Hendry, 2011).

3.1.6 Why choose IPA?

IPA aims to uncover phenomena that may not have been previously identified by researchers or presented in the existing theories (Shaw, 2001). In this way, IPA can be referred to as data driven rather than theory driven. If new data are unveiled, then they can be added to pre-existing theories to extend them further or used as the basis of a new theory. This is highly beneficial as it has been sourced from those experiencing the phenomena. It offers a flexible, open-ended approach (Brocki & Wearden, 2006). Brocki and Wearden (2006) and Smith (1999) state that IPA analysis requires close interaction between the researcher and the text, as the researcher attempts to comprehend the presented account whilst at the same time using their own ‘interpretative resources’. Smith (2004) goes on to say that the quality of the final analysis is determined by the level of personal analytic work done at each stage of the analytical process.

As I sought to find the best methodological fit for the goals of this study, I particularly considered the methodologies of thematic analysis, grounded theory and content analysis, and briefly thought about discursive analysis before choosing IPA. Grounded theory has some commonalities with IPA, in that the data can be analysed on different levels which are abstracted into categories (Willig, 2008). Like IPA, grounded theory takes an interpretivist approach so the researcher enquires into real-life situations, and looks at the lived experiences of participants. Both grounded theory and IPA collect and analyse data from participants' perspectives. In addition, researchers are expected to acknowledge and maintain awareness about how their own biases and pre-conceived ideas can influence the work (Starks & Brown-Trinidad, 2007). Grounded theory and IPA are different in that grounded theory aims to develop a theory or a hypothesis to explain the data. It allows the bottom-up *"emergence of theory from data"* (Willig, 2008, p. 44). Glaser and Strauss's objectivist grounded theory is based on positivism but moved away from the dominant deductive and hypothesis-test approach to an inductive, theory-building method of inquiry from data (Glaser, 2014). A later, modified version of this is the social constructionist grounded theory approach. This posits that the meanings of phenomena are shaped through social interactions and context and can change over time (Charmaz, 2014). However, I was not seeking to build a theory from the data analysis; rather, I was pursuing the meaning ascribed by participants to their experiences of a phenomenon: work stress.

Although grounded theory can limit its data collection to participant interviews, it can also include other sources of data such as diaries, historic literature, images, and research. A process of 'constant comparison' is used to contrast all participants' data

with other available data to uncover any contradictory cases which might challenge the emerging theory. This could have worked against my study rather than supporting it. Challenging idiographic meanings and experiences may invalidate or denigrate the individual's lived experiences. I did not want to challenge the participants' experiences to support a theory, rather I wanted to capture their experiences and, if anything, uphold their validity. As in IPA, the goal was to allow the process to be *"collaborative, emphasising that the participants were the primary experts"* about their own experiences (Alexander & Clare, 2004, p. 82).

Furthermore, the aim of grounded theory is to develop an explanatory theory of how a basic social process occurs in certain environments (Glaser & Strauss, 1967). Within this approach, knowledge of social realities is achieved through careful observation of behaviour and speech practices (Starks & Brown-Trinidad, 2007). It examines the 'six Cs' of social processes (causes, contexts, contingencies, consequences, co-variances, and conditions) to understand the patterns and relationships among these elements in the data analysis (Strauss & Corbin, 1998). Alternatively, IPA does not use set criteria such as the 'six Cs' in developing an explanation of the data. I did not want to use pre-established social criteria in examining the data. I wanted to examine the data for the information which organically emerged and to continue this organic development throughout the analysis. Indeed, in retrospect, the analysis developed its own style and flourished as if it had a life of its own. Possibly because of the use of *"minimal probes"* in the interviews (Smith & Osborn, 2008, p. 63), the analysis seemed to allow the unfolding of participants' own criteria, which was supported and reinforced by them across each other's cases.

I also considered content analysis, which makes use of categories that are defined before the data analysis commences. The categories are designed to be mutually exclusive. Pre-defining categories before the analysis, I believed, would establish a strong research bias. Pre-set categories could only have been an obstacle to maintaining open-mindedness and curiosity for the participant and myself in the eliciting and interpretation of individual phenomenological experiences (Dey, 1999). I also realised that content analysis was not designed specifically to capture first-person accounts of personal experiences. IPA was more appropriate to capture this.

I briefly considered discourse analysis which investigates the role of language in participants' descriptions of their experiences. It looks at how experiences and environments are socially constructed through the use of language (Gergen, 2001). Like IPA, it allows for the exploration of nuances in verbal expressions, body language, and facial expressions, and recognises that the researcher and the participant are *"only co-participants in the project of making sense of the world and our experience of it"* (Harre & Gillett, 1994, p. 21). IPA acknowledges that a function of the researcher is to be interpretative and to access meanings the participant assigns to their cognitive and emotional interactions with the world (Smith et al., 2009), rather than to be descriptive. However, it was not my intention to explore the specific role of language in descriptions of experiences (Pringle et al., 2011; Smith et al., 2009), as in discursive analysis. Although language played an important role in capturing meanings, the study was not about the task or design of language used in descriptions, and I did not want the study to become about how language defines meaning. My study process had to be about engaging with the participant in a reflexive, interactive, humanistic, gentle way which

allowed an experience to unfold in its complexity. This could include emotion, cognition, behavioural aspects, and psychosocial or contextual factors, depending on what the participant expressed. However, I was not embarking on an examination of the role of language in a research interview.

Of the methodologies I considered it seemed there were especially strong similarities between IPA and Thematic Analysis (TA). In considering TA as a possible option, my subsequent decision not to use it was based on several thoughts mainly regarding the suitability of the phenomenology methodology and usefulness in capturing idiographic experiences and meanings, and subsequently the sample size recommended.

TA is “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p. 79). TA is not tied to any one epistemological or theoretical approach and this can allow more flexibility for the researcher.

IPA methodology is informed by phenomenology and hermeneutics and facilitates an especially detailed examination of lived experience. Although both TA and IPA can analyse the participant’s world view while reflecting on the bias of the researcher, one of the main characteristics of IPA is that it offers an idiographic focus on lived experience (Eatough & Smith, 2008) whereas TA does not. Therefore, although TA can choose a phenomenological epistemology it does not share IPA’s idiographic focus. It has been suggested that with the application of TA there is a potential to focus more on description which offers limited interpretative value (Braun & Clarke, 2006). IPA has a focus on both the unique characteristics of individual participants (the idiographic focus) and on patterning of meaning across participants. Some researchers view thematic analysis as more of an analytic strategy rather than a sophisticated stand-alone method

due to its process ambiguity (Mills, 2014). Others see TA as a methodology used for identifying, analysing and reporting patterns or themes within data which offers a 'theoretically flexible approach that can 'be considered as a method in its own right' (Braun & Clarke, 2006, p.77). Although it is underpinned by epistemological flexibility and can be used for many types of research, TA appears to often rely on a more descriptive generation of common themes based on the choice of language rather than gaining an understanding of the complexity and variations of the experience itself, as enabled by the more detailed and interpretative approach of IPA (Willig, 2008). Furthermore, although TA examines themes, IPA procedures are different in that they involve a detailed idiographic focus on the analysis of each case and thereafter exploring developing themes across cases (Braun & Clarke, 2013).

At the time of my research, counselling psychology training in the UK was more adult than child based. I was the only one of my classmates during my training who actively worked in CAMHS, and I knew there may be relatively few numbers of counselling psychologists elsewhere in NHS CAMHS settings. Therefore, I had to consider that however limited the sample size, the methodology had to help me explore information from participants in the most concentrated way possible. I needed a methodology that could accommodate a relatively smaller sample if necessary. IPA could offer this because of its idiographic and interpretative focus on each individual case or participant. TA generally recommends a larger sample number than IPA.

I was aware that TA has some history of phenomenological research in the social and health sciences (Langdridge, 2007), I chose IPA because of its suitability for use in in-depth analysis in a smaller sample size which is recommended to support a more

idiographic focus. I felt IPA was the best choice as it promotes interpretation of nuances which could potentially be missed by TA (Eatough & Smith, 2008). Furthermore, the idiographic nature of IPA and the interview process seemed in-keeping with my own person centred counselling psychology identity, as well as that of the participants.

For this study, I believed IPA to be most suited to the goals of the project as it is concerned with the phenomenology of participants' experiences. The process involved in IPA aims to hold the integrity of participants' subjective accounts (Flowers, Hart, & Marriott, 1999). IPA guides the researcher to be consistently aware that research is a dynamic process (Smith, 1996), understanding that participants' experiences *"depend on and are complicated by the researcher's own conceptions*" (Smith, Jarman, & Osborn, 1999, pp. 218-219). This must be remembered whilst interpreting and *"making sense of that other personal world"* (Smith et al., 1999, p. 219).

IPA is based on three theoretical areas of philosophy: phenomenology, hermeneutics, and idiography. It originates from the philosophical ideas of Edmund Husserl. He conceived it as the pursuit of the essence of experience, during which an abstract stance should be maintained when researching actual experiences. Building on this, IPA draws on the more context-conscious, existential phenomenology of Heidegger (Sherman, 2009) and the work of Merleau-Ponty (Chaplin, 2001), Gadamer (Regan, 2012), and Schleiermacher (Schleiermacher, 1838/1998).

3.2 Participant recruitment

Full ethical approval for the study was granted by Metanoia Institute, the National Research and Ethics Committee (NREC), and the Research and Development Departments of participating NHS Trusts. (Please see Appendices 1-3 for all relevant documentation pertaining to ethical approval.) NHS Trusts were approached through their Research and Development (R&D) departments for permission to interview potential anonymous participants. A summary of how the participant data were collected and the complex process of analysing the data are presented. Participants were recruited between April 2011 and January 2012.

3.2.1 Participant criteria

The data collection involved purposive homogeneous sampling of seven participants (interviewed twice, i.e., fourteen interviews) working in CAMHS Tier 3 settings from various NHS Trusts in England. Participants were required to be counselling psychologists of any age and gender, who currently or recently worked in NHS CAMHS Tier 3 as permanent or temporary employees. I actively scouted for participants nationally through the DCoP research website, the BPS website, through counselling psychology forums on the internet, the Anna Freud graduate alumni, Continuing Professional Development events at the BPS, NHS and other sites, through word of mouth, via NHS networks and counselling psychology programmes' graduate alumni networks. See Table 1 for the demographics of the participant sample. See also Appendices 4 and 5 for the letter to universities and the call to participants respectively.

Seven participants were recruited and they agreed to participate in two separate interviews. In the design of my research, I wanted to have two interviews for the following reasons: The second interview were conducted in the interests of obtaining deeper levels of data. It gave participants an opportunity to add any issues or afterthoughts they may have wished to disclose once they had processed cognitions from the first interview (Smith & Osborn, 2008). Furthermore, it would be an opportunity for them to elaborate on, confirm, or disconfirm the meanings found in the previous interview, and allow me to question them for clarification. The second interview allowed both the participant and me to reconnect, and allowed the interviewees to see if any changes in their situations had occurred which might affect their stress levels. In IPA, the researcher can *"use the master list of themes obtained from a first interview to identify more instances of these themes in subsequent interviews, while also being alert to the possibilities of new themes"* (Biggerstaff & Thompson, 2008, p. 221). It is also possible to start the data collection again with the second or later interviews, and produce a list of themes for each interview to be drawn together into a consolidated list. Whichever the choice, new themes are tested against earlier data (Biggerstaff & Thompson, 2008).

Table 1

Demographics of Sample

Participant*	Gender	Age (years)	Ethnicity	Time employed by NHS CAMHS Tier 3
Michael	Male	47	White British	9 years
Ayesha	Female	42	Asian Indian	10 years
Emma	Female	33	White British	5 years
Tash	Female	32	Asian British	8 years
Diane	Female	43	Black British	10 years
Christina	Female	48	White British	10 years plus
Laura	Female	38	White British	7 years
Average		40		8.4 years

*Potentially identifying details have been changed to help protect anonymity.

A total of one male and six female counselling psychologists participated in this research. All agreed to be interviewed twice by me, yielding fourteen interviews in total. Participants ranged in age from 32 to 48, with the average age being 40 years. At the time of the first interviews, all participants were in permanent employment in NHS CAMHS Tier 3 community clinics.

In consideration of ethnicity, the UK is a multicultural country and there is great ethnic diversity in the NHS workforce. Ideally, psychology research should reflect the diversity of our culture and conditions. The DOH's research governance framework states that available research evidence should reflect diversity in our society (RGF 2.2.7). Even though my sample size was small, I was fortunate to have found ethnic differences in participants which reflects some ethnic diversity in the NHS CAMHS workforce. I would

have preferred to include more diversity as different ethnic and diverse groups should feel represented in counselling psychology research, not least because this embraces its person-centred, humanistic ethos. There is so much diversity in the UK including race, ethnicity, disability, gender, sexual orientation, age and class, and I acknowledge that qualitative researchers cannot always reflect such diversity in each of their samples, especially smaller samples (Allmark, 2004). Furthermore, it would be interesting to explore whether background, diversities and multicultural differences have a role in how stress is experienced in NHS CAMHS. This could be an area for future research in CAMHS counselling psychologists.

3.2.2 The semi-structured interview

One of the most common qualitative research strategies is interviewing, acknowledges Mason (2002), who states an unstructured interview is *"a misnomer because no research interview can be completely lacking in some form of structure"* (p. 62). Although the interviews were semi-structured, an interview schedule was developed in advance. This allowed me to prepare by thinking through areas to cover in the time allotted with participants. Furthermore, an interview schedule allowed the wording of any sensitive or more personal questions to be constructed with care (Smith, 1995).

I identified areas to cover in the interview to try and encompass the investigation of individual participants' experiences of stress in their working lives in CAMHS Tier 3 settings. This involved experiences identified as being attributed to client-related stressors, professional relationships, and general experiences and resources in their workplace setting.

Literature surrounding the relationship between anxiety and stress in NHS mental healthcare professionals and counselling psychologists was reviewed to inform the development of the interview schedule (Loretto, Popham, Platt, Pavis, Hardy, MacLeod, & Gibbs, 2005). I was acutely aware that care must be taken when working with pre-existing theoretical frameworks to avoid imposing them on new material. Although IPA does not prohibit the use of pre-existing knowledge, I was conscious that pre-existing interpretations should not be allowed to colour the emergence of new data from the participants.

Once potential participants had been found, I made contact by e-mail and then phone. The initial telephone contact was a formal introduction between myself and the participant. The purpose of the research was explained verbally, and a debriefing about informed consent was offered. Thereafter, an information sheet was e-mailed to participants, along with a consent form for their perusal. Once they agreed to participate, an interview time and place was decided over the phone, and I convened with each participant individually at an NHS site. There, they were again presented with copies of the information sheet and consent form, and I explained the research purpose.

The interview schedule only guides the interview and does not dictate it. The aim is to try and enter the psychological and social world of the participant with gentle inquiry. Therefore, it should be noted in this methodology that the participants were able to introduce issues which I had not considered or expected. In this relationship, the participant is perceived *"as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story"* (Smith & Osborn, 2008, p. 59). This can sometimes lead to a novel, unpredictable outcome.

The semi-structured interview facilitates rapport and empathy, allows greater flexibility of coverage and allows the interview to go into novel areas, and tends to produce richer data. It is useful in attempts to establish rapport with the respondent, gives the interviewer freedom to probe interesting areas that arise, and allows the interview to follow the respondent's interests or concerns (Smith & Osborn, 2008). However, semi-structured interviews reduce the control the researcher has over the situation, take longer to carry out, and are harder to analyse than other interview types (Smith & Osborn, 2008).

3.2.2.1 Initial interview

Upon meeting, the participant was provided once again with a detailed information sheet and a consent form (see Appendices 6 and 7 respectively). The participant was given plenty of time to read the information sheet. A verbal explanation was given about a) the purpose of the research, b) confidentiality, and c) how Duty of Care could affect this. The latter aimed to support proper understanding of informed consent. The participant was asked if they had any questions.

Participants were reminded that they were free to withdraw at any point during the interviews, without prejudice, and their data would be immediately deleted. Participants were also advised that if they preferred not to answer particular questions, they were free to decline at will. They were reassured that my academic supervisors at Metanoia Institute would be the only other individuals who may request access to their raw data throughout the research process. In any case, these data would be anonymised first to protect their identity, so that only I would know who they were.

In keeping with the IPA approach, participants were informed there were no right or wrong answers, as I was interested in their own unique and individual experiences. It was explained that, given the scarcity of research about counselling psychologists in this particular work setting and the NHS in general, whatever data unfolded in the interviews were already unique and could only give a helpful voice to an area as yet without a strong voice. The assertion was factual, and was also mentioned so as to defuse any pressure participants might have felt to live up to their perceptions of my expectations. It was also said in an attempt to anticipate and diffuse participants' pre-existing theoretical frameworks about stress and psychologists. It was natural that some participants would feel apprehensive about the interview for these and various other reasons, such as the formality of it, being audio recorded, and the work-related subject matter. Therefore, it was my responsibility as the researcher to alleviate anxiety and be responsive to perceived discomfort (Smith, 1995).

Participants were advised that the audio interviews would be transcribed at a later time, and that any identifying information provided by them would be pseudo-anonymised, modified, coded, or deleted to protect their identities within the data. They were advised that all their data would be kept safely, password-protected, and then securely destroyed after I completed the work in accordance with Metanoia Institute's protocols. All participants confirmed their agreement to participate and they were amenable to commence with the interviews. When they said they were ready, the audio recorder was switched on, and the individual interviews commenced.

3.2.2.2 The interview process

Individual interviews were carried out with each participant at NHS sites. Questions posed within the interviews were generally open-ended to allow a distinctive, individualised train of thought from the participant. It was attempted to offer liberal time lapses to allow the participant to finish answering questions before another was asked. Closed questions were sometimes used to encapsulate or clarify what the participant had said so as to aid my understanding. Probing questions were used to aid my insight into the participant's experiential world, e.g., *"How does that feel for you?"* or *"What does that mean to you?"*. The interviews took on the feel of a humanistic therapist-client session which seemed congruent with the IPA methodology. The IPA methodology allowed the participant's experiential world to unfold, and therein lay the necessity for me to give the floor over to the participant whilst gently interrogating and containing the process. Second interviews were done five to six months after the first interviews. Please see Appendix 8 for the interview schedule.

3.3 Carrying out the study

3.3.1 Preliminary coding

Each interview was audio recorded using a digital voice recorder. Participant interviews ran up to 60 minutes each. All interviews were transcribed verbatim. The coding process is outlined below.

Analysis of a single transcript was entirely completed before moving onto another.

I engaged with and read the first transcript in its entirety whilst listening to the audio recording of the interview. This method helped to a) keep the transcript alive; b) bring me back into the moment with the participant to support accurate context and de-contextualisation; c) prompt my recall of the participant's nuances within the interview; d) totally immerse in the data to further access and safeguard the integrity of the participant's experiences; and e) support thoughtful yet flexible application of the IPA methodological framework.

I typed notes in the margin of each transcript. I set up both an iPages table and later an Excel document to record emerging preliminary themes, tonalities, and post-interview impressions as they unfolded in the analysis. Each transcript was then re-read whilst listening to the audio recording up to three times in total. This helped me become very familiar with the data, record further observational notes, and get a deeper sense of each participant's psychological world and their life experiences at work. Finally, a break was taken from analysing the transcript and another transcript was taken on, and the process was repeated. Each transcript was read again with a refreshed and open-minded approach. After the break, there was a significant familiarity with the transcript, a bit like meeting up with an old friend once more.

The transcript was read multiple times as emerging themes were observed and noted. I became extremely familiar with each transcript.

3.3.2 Exploratory phase and descriptive comments

In this initial exploratory phase, key words, explanations, repetitions, and phrases used were noted. I then noted what the participant seemed to be describing at face value level.

3.3.2.1 Linguistic comments

Linguistic comments such as tonality, metaphors, repetitions, sighs, pause, hesitancy, fluency, and other functional aspects of language were noted.

3.3.2.2 Descriptive themes

I gleaned a descriptive theme from each statement or set of statements in the transcript. These descriptive themes aimed to capture the *"descriptive core of comments which have a clear phenomenological focus and stay close to the participants' explicit meaning"* (Smith et al., 2009, p. 83). Therefore, the aim was to describe the core of the participant's testimony (in a section of the transcript) whilst showing a *"clear phenomenological focus"* of their experience and what was important to them (Smith et al., 2009, p. 83).

3.3.3 Finding emergent themes within the transcript

This phase of the analysis aimed to reduce the volume of the data into themes that are unfolding, whilst maintaining the data's complexity and integrity (Smith et al., 2009). This phase involves working primarily with the initial notes rather than the transcript itself. However, I worked mostly with the transcript as well as the notes, in attempts to uphold the participant's meaning and overall perspective. Smith et al. (2009) support

flexibility and state that *"Literature on IPA has not prescribed a single method for working with data",* but espouses *"a healthy flexibility in matters of analytic development"* (Smith et al., 2009, p. 79).

The aim was to capture the crucial points of a section of the transcript text whilst understanding the influence of the whole text on that section. In keeping with Smith et al.'s (2009) suggestion, I attempted *"to produce a concise and pithy statement of what was important in the various comments attached to a section of the transcript"* (p. 91). This gave a sense of the emergent theme. I followed this and found it helpful, as it challenged me to clearly condense those sections of the data (i.e., the participant's statement(s)) into relevant points whilst keeping the sense of the participant's statement(s) intact.

Emerging themes were gleaned from each transcript in succession. This process was, at times, challenging and intense, and relied upon my capacity for perceptive insight. The themes extracted from the data were grouped into clusters which represented a similar topic or theme.

Reflection upon my own interpretative bias, perceptions, and processes was a necessary practice (Smith et al., 2009) and a constant habit. I often left the themes, then returned on a later day to view them with a refreshed mindset. Occasionally, this led to a change being made in the theme emphasis. Sporadically, such a change seemed necessary if I had spent too long immersing in the data and needed distance to avoid over-analysis.

3.3.4 Identifying patterns of emergent themes in each participant's data

This was a process I carried out at least four times. Firstly, each transcript section or quote which represented an emergent theme was written on a post-it note and stuck onto the wall and floor of my workspace. The aim here was to give me an overview and good spatial representation of the data to help identify patterns across the transcripts more easily, and the ability to move the themes around to explore how they related to each other (Smith et al., 2009). The transcript sections were then titled using a coded name for the participant. I was able to place the relevant transcript sections and quotes under the heading of a relevant emergent theme.

3.3.5 Identifying super-ordinate themes

Emergent themes that seemed similar were clustered together (by grouping the post-its together), and this is how a super-ordinate theme (or cluster name) unfolded. Similar emergent themes were grouped together under a draft super-ordinate theme title, which later developed into a final super-ordinate theme.

3.3.6 Identifying patterns of emergent themes across cases

During this process of abstraction (Smith et al., 2009), I printed out relevant quotes/sections of all transcripts assigned to emergent themes and super-ordinate themes and pinned them onto very large aeroboard panels to give an expansive surface. The sections and quotes were assigned code names and had transcript line numbers. The idea of laying out this information was a) to see any connections across

the cases; b) to identify the most forceful themes across the cases; and c) to allow re-organising and re-labelling of themes as appropriate. Some of the quotes and themes had shared concepts. Therefore, this encouraged a process of further abstraction and reduction. *"Some of the best IPA has this dual quality – pointing to ways in which participants represent unique idiosyncratic instances but also shared higher order qualities"* (Smith et al., 2009, p. 101). This process was also very time consuming, as the higher-order thoughts within parts of the transcripts that held duality were considered and teased out so as not to lose the integrity and sense of the participants' meanings. (Please see Appendix 9.)

3.3.7 Identifying super-ordinate themes across cases

Super-ordinate themes that had previously been identified in each transcript were subject to modification as they melted in with or stood apart from the others across the cases. The process was the same as that explained in the previous section above.

3.3.8 Final super-ordinate and sub-themes

After a long process of micro-analysis, abstraction, and reduction, a table of super-ordinate and sub-themes was produced (see Table 2). This showed a description of higher-order (super-ordinate) themes and clusters of sub-themes which were nested within them.

3.3.9 Data movement along the way

Excel spreadsheets detailing selected sections of each participant's transcript, emergent, and super-ordinate themes were compiled as part of the process of the analysis (see Appendix 10 for samples of this work.)

3.4 Trustworthiness

Assessing the validity, transferability, and generalisability of qualitative research has been in debate for some time (Barbour, 2007; Dixon-Woods, Shaw, Agarwal, & Smith, 2004), mainly by advocates of positivism. However, Smith et al. (2009) proposed that the validity and rigour of IPA studies are supported by researchers being open to external audit (Koch, 2006) and providing an audit trail of the research process and the decision-making processes therein (Akkerman, Admiral, Brekelmans, & Oost, 2006). This fits in with Casey and Murphy's (2009) proposal of using more than one method of data collection (e.g., interviews supported by journaling the process, journaling the decisions involved). However, the function of auditing aims to ensure that the account produced is a credible one, but not the only credible one (Smith et al., 2009), as IPA aims to provide an authentic account of a participant's idiographic experience within a particular time, space, and situational context.

To assist in attending to the rigour and credibility of the process, I enlisted the help of two inter-raters. One was a counselling psychology doctoral student from Metanoia Institute who looked at the final themes and associated transcripts. The other was a psychologist who had previously worked in a CAMHS setting for several years as a

researcher. The latter read all the transcripts, and viewed the themes and sub-themes and the allocated transcript sections. Each was familiar with IPA.

In the final analysis stages, the transcript sections and the analysis details in Excel and Word formats were privately e-mailed to each inter-rater. Each transcript section was assigned to the relevant sub-themes of the super-ordinate themes. Any participant-identifying information had been removed. Additionally, any documents shared were password-protected, the passwords being sent in separate communication (by e-mail or phone). The raters were asked to scrutinise the transcript analyses in terms of their relevance to the sub-themes and make notes in red ink with their criticisms and suggestions. Verification of my data evaluation and analysis was requested by myself. Inter-rater agreement occurred on approximately 98% of super-ordinate themes and sub-themes. Some of the participants' quotes could have been assigned to more than one theme (as previously stated). Inter-rater agreement was approximately 98% on the allocation of those particular multi-dimensional quotes. One rater was in general agreement with the work, with the exception of one quote which the rater thought was ambiguous. I had previously been unsure whether to leave this quote in but had not discussed this with the rater. Therefore, I was reassured and thankful that the rater pointed it out. I agreed with the rater and took the quote out.

Within IPA there is a recognition that the methodology in an interview between a researcher and participant and the interpretation produced is referred to as "inter-rater reliability" (Smith. J, 1999). Yardley (2011) highlights the importance of judging validity in IPA by looking at the questions asked, methodology used and interpretation applied.

The other rater believed the themes had captured the data accurately. However, she made one suggestion about how participants' personal circumstances outside of work might affect sensitivity to stress in the workplace, and this might be a factor to consider (see Appendix 11 for sample email correspondence). I was grateful for this advice and contemplated on it. During recruitment, I had not made any suggestion to potential participants that personal stressors would be a question topic. However, upon reflection, I felt given the open and person-centred nature of the interviews and the participants' responsiveness to me that they may have spoken of personal stresses affecting their tolerance to workplace stress or their general stress levels if they felt inclined to do so. Also, I was mindful of the allotted timeframe I had with each participant. As my colleague had agreed with the accuracy of the themes and did not view personal stress factors as in way undermining of the study, I decided the decision to speak about personal issues affecting ability to cope with workplace stress should remain at the discretion of the participants and this may be an area to be included in future counselling psychology stress research (see Appendix 12 for samples of this work.)

The concept of validity is not a single, fixed, or universal concept, but *"rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects"* (Winter, 2000, p. 1). Lincoln and Guba (1985) state that *"Since there can be no validity without reliability, a demonstration of the former is sufficient to establish the latter"* (p. 316). Patton (2001) refers to the researcher's ability and skill in any qualitative research and states this reliability is a consequence of the validity in a study.

To ensure meeting the criteria of reliability outlined in the quantitative tradition has *"involved substituting new terms for words such as validity and reliability to reflect interpretivist conceptions"* (Seale, 1999, p. 465). These include terms such as quality, rigour, and trustworthiness (Davies & Dodd, 2002; Lincoln & Guba, 1985; Seale, 1999; Stenbacka, 2001). Lincoln and Guba (1985) state that the issues quantitatively discussed as validity and reliability are realistically translated into qualitative work as sustaining the trustworthiness of a research report. The idea of discovering truth through measures of reliability and validity is replaced by the idea of *trustworthiness* (Mishler, 2000) which is *"defensible"* (Johnson, 1997, p. 282) and establishes confidence in the findings (Lincoln & Guba, 1985). Seale (1999) proposes that to ensure reliability in qualitative research, examination of trustworthiness is crucial, as the *"trustworthiness of a research report lies at the heart of issues conventionally discussed as validity and reliability"* (p. 266).

A good qualitative study can help us *"understand a situation that would otherwise be enigmatic or confusing"* (Eisner, 1991, p. 58). Reliability is a concept used to evaluate quality in quantitative study with a *"purpose of explaining"*, while the quality concept in qualitative study has the purpose of *"generating understanding"* (Stenbacka, 2001, p. 551). Davies and Dodd (2002) argue that the application of the notion of rigour to support reliability and validity in qualitative research should differ from quantitative research. By *"accepting that there is a quantitative bias in the concept of rigor, we now move on to develop our reconception of rigor by exploring subjectivity, reflexivity, and the social interaction of interviewing"* (Davies & Dodd, 2002, p. 281). To support this process of rigour, I kept a journal. I wrote about my observations and thoughts

immediately after the interviews and during the data analysis. I monitored my thoughts and reactions to the data, as well as my observations of and reactions to the participants. My aim was to engage fully in a reflexive process to sustain the rigour of the methodology. Furthermore, my own self-examination was necessary so as not to minimise in any way my co-construction potential in the interview process.

3.5 Ethical approval

Having sought and gained ethical approval from Metanoia Institute and Middlesex University for this study, ethical approval was then sought from the Health Research Authority's NHS NREC. A detailed application was made electronically through the Integrated Research Application System (IRAS), which is an online system for applying for permission to conduct health and social care/community research in the UK. Following this, I received a letter inviting me to attend an interview. There, I presented my research proposal and all documentation pertaining to it, and defended it in front of a panel of eleven ethics committee judges at the London and City Road National Research Ethics Service (NRES) Research Ethics Committee (REC) 1 at Moorfields Eye Hospital, 162 City Road, London, EC1V 2PD, United Kingdom. The committee granted approval of the study by letter.

3.6 Ethical considerations

I adhered to the NHS Confidentiality Code of Practice Guidelines (DoH, 2003), the 2003 Data Protection Act, the BPS Code of Ethics and Conduct (BPS, 2009), the BPS Code of Human Research Ethics (BPS, 2014), and Metanoia Institute Codes and Procedures

(Metanoia Institute, 2013). The issue of confidentiality and the right to withdraw from the study at any time was made clear prior to participation (BPS, 2014). Written and verbal informed consent was requested from the participant. Prior to this, by phone, e-mail and then again in person, information was given to participants to explain the nature of the research; its objectives; how the interview would be carried out; and how the data would be subsequently used. Before commencing the interviews, participants were fully debriefed and encouraged to ask questions in order to complete their understanding of the research. Participants were advised against using identifiable material in the interviews, however they were also reassured that confidentiality would be strictly maintained during the process of information gathering, data analysis, and writing up of the study. Any material which could potentially identify a participant would be removed from the final report. The interview data were pseudo-anonymised with a code or index only known to me. Collected and recorded data were kept in a locked cabinet so as to keep any identifying details confidential. Participants were told they would be offered a summary of the research once it was completed.

I tried to ensure that participants felt confident they had the freedom to voice their concerns and questions, withdraw their consent at any stage, or register their protest if they felt uncomfortable about disclosing sensitive information during the interviews. It was important for the process to be person-centred and for the participants to feel in control and not be put on the spot. They were made aware that if they had any concerns, they could contact my supervisors at Metanoia, whose contact details were on the information sheet given to them in advance.

Because of the nature of the research, I was mindful that feelings of anxiety and stress may be aroused during the interviews. I approached this work sensitively and used therapeutic skills, as necessary, to ensure that the participant was contained and left the interview in a calm space. I had decided to recommend therapeutic support if necessary, and be accessible to the participant post interview, if there was any requirement for further containment. If there had been concern about the mental state of a participant, I would have sought outside intervention. I made each participant aware that I had a Duty of Care to them, which meant I would need to break their confidentiality if they disclosed that they or someone else was unsafe or in danger. This would only be done to assist in keeping them safe.

It is worth noting that, despite being assured of confidentiality (including the Duty of Care clause) before the interviews commenced, the majority of participants sought my reassurance about identity protection (usually after the interview). This was not a flaw of the research process. Rather, there was a sense of anxious concern about job security amongst some, and a sense of intimidation about being identified as speaking out of agreement with their service management teams. This apprehension seemed congruent with participants' concerns that unfolded during the interviews. Because of this salient anxiety, and the fact that some of the Trusts involved employed only a few counselling psychologists (and in some cases just one), I believed it was necessary to withhold publishing the identity of the Trusts involved from the research document. This would protect participant confidentiality and anonymity. I discussed the issue first with my academic supervisor who supported this ethical concern. However, the identity of participating Trusts is available to my academic supervisors at Metanoia Institute.

I was initially very conscious of the similarity of my profession and work setting type to those of the participants. As IPA is a methodology grounded in the hermeneutic phenomenological philosophy, I was keen that the emphasis on reflexivity and possible researcher bias, as well as the application of the double hermeneutic cycle, would be enough to support me in upholding the integrity during the participants' data collection, analysis, and presentation.

Chapter 4: Analysis and Findings

4.1 Overview of chapter

In this chapter I outline the results from the interpretative phenomenological analysis of counselling psychologists' experiences of stress in NHS CAMHS Tier 3. In-depth, transcribed audio interviews were conducted, then meticulously analysed using IPA qualitative methodology. From the full transcripts, four main super-ordinate themes were identified, each of which was substantiated by sub-themes. Table 2 presents a master table of super-ordinate themes and subordinate themes. Each super-ordinate and subordinate theme has been expanded upon in this chapter, using verbatim examples from participants and written up in narrative form. The verbatim excerpts also demonstrate interrelation across themes. However, the participants' extracts were chosen if they were interpreted to be the most appropriate example of the sub theme. In presenting the verbatim extracts some minor changes have been made to improve readability. Minor hesitations, word repetitions and utterances such as "well, um, uh" have been removed unless deemed relevant. Dotted lines (...) indicate less relevant material is missing from the extract. All identifying information has been removed or changed. Alias names have been used to protect the anonymity of participants.

The timing of the interviews coincided with some recent organisational changes occurring in the NHS because of budget cuts which were being filtered into CAMHS teams. The cuts began in 2008 and have been ongoing. Although there is a gap of up to six months between each of the participants' two interviews, this made little difference to the content except to confirm issues raised by participants in the first interviews. In

some cases, the second interviews demonstrated how the participants' initial concerns were validated through time. A total of fourteen interviews were carried out.

The findings present examples of the raw data which most clearly demonstrate analytical points. Interestingly, although the participants interviewed provided individual portraits of phenomenological experiences, the findings of the study show similarities and parallels across the participants. This was notable given that the participants were selected from different CAMHS teams in various parts of England. It was unexpected but, in retrospect, seems like an organic outcome given the changes sweeping through the NHS, nationally. The findings are presented with some contextualising paragraphs to help the reader relate them to the framework of the study. This approach is appropriate for a qualitative study (University of Southern California, 2021). The conceptual framework can be found in the Introduction section of this report.

Below is a table which shows how sub-themes are nested within super-ordinate or master themes. These illustrate the themes of the stress experiences for each participant. Therefore, there are four over-arching master themes of stress experiences with sub-themes under each one. This section reports on the super-ordinate themes derived from the analysis. Four super-ordinate themes were found, each with a number of sub-themes, summarised in Table 2.

Table 2

Table of Themes

Super-ordinate Themes	**Sub-themes**
1. Impact of NHS Changes on CAMHS Tier 3 Work Settings	4.1.1 More business led, less client focused
	4.1.2 Limited time for complex Tier 3 cases
	4.1.3 Higher administration workload conflicting with client work
	4.1.4 Experiencing devaluation of psychology
2. Therapy Room Impact	4.2.1 Emotional availability for clients
	4.2.2 Practitioner values and client-led care
	4.2.3 Reflective practitioner with less reflection time
3. Counselling Psychologists' Well-being and Morale	4.3.1 Stress-related illness
	4.3.2 Threats to job security
	4.3.3 Thoughts on leaving and turnover
4. Professional Identity Issues	4.4.1 The new psychologist in CAMHS
	4.4.2 Experiences of professional discrimination
	4.4.3 Division of Counselling Psychology support
	4.4.4 Where meaning lies

4.2 Impact of NHS changes on CAMHS Tier 3 work settings

All participants identified the impact of NHS organisational changes on their CAMHS Tier 3 work as the foremost issue continually increasing their stress levels in each of their work settings. In posing some general, non-specific questions about their current experiences of stress in the workplace, each participant quickly focused their attention on recent NHS organisational changes. Each spoke at length, detailing how the changes caused increased stress on a daily basis. The changes seemed to have greatly impacted and re-structured many aspects of their previous working lives in CAMHS. Each participant imparted anxiety about these adjustments, which were experienced as being less client centred and more business-centric. This is further detailed in the paragraphs below.

Further stressors resulted from the impact these changes had on therapy room dynamics. This presented significant stressors for the counselling psychologists because they felt it restricted them and interfered with their humanistic work and values. As the findings go on to show, the impact of the changes including participants' sense of the de-prioritisation of client-centred work; and their view of devaluation of their expertise (as well as that of their colleagues) had a direct impact on their stress levels, well-being and morale. It also came through in the data that the counselling psychologists interviewed seemed to be a group dedicated to their humanistic value system and profession-specific values.

4.2.1 More business-led, less client-focused

Each participant reported they felt increasingly stressed. They attributed this to NHS organisational changes and restructurings imposed upon their services and their day-to-day work activities. They experienced the introduction of a business-led focus being driven through their CAMHS teams. They shared the similar view that their service's focus moved further away from client-centred care towards a business-centric care provision, based on meeting targets, outcomes, auditing, and presenting as economically valid for commissioners' approval. They felt this represented a shift in culture and a significant difference in the discourse of child mental health from quality of care to cost-driven care. Their reported experiences seemed to reflect a change in culture. This sub-theme includes information about a decreased focus on client-led needs and an increased focus on producing quantifiable outcomes; more business-driven management style; and shaking up of management teams, with the introduction of non-clinical managers making unilateral decisions about psychological care without prior discussions with psychologists. This affected their practitioner work and, in turn, threatened client care quality.

Counselling psychologist (who is also a clinical psychologist) Michael expressed his feelings about a change in focus within his CAMHS team. He felt that number crunching had become the primary goal in his NHS service, and the clients' therapy needs were not taking priority.

> *Michael: "A changing discourse is coming in and culture... it's not about quality of the therapy work, it's reaching monthly targets... It's reductive... and all about numbers now." (Interview 1)*

Ayesha was interviewed before she left the NHS to work in a private paediatric hospital. Her experience seemed to replicate Michael's as she experienced clients having less importance in the Trust. With some emotion, she shared that cost cutting and reaching targets were prioritised above supporting the provision of quality of care for vulnerable children and families. Management no longer placed clients' therapy needs first.

> *Ayesha: "Nowadays, the work is so target driven. Families aren't valued anymore in CAMHS. Saving money and... covering your back is... families come last." (Interview 2)*

Diane echoed a similar quality-of-care experience in her interview.

> *Diane: "We often say this cost cutting is turning us into the Tesco of mental health. A one-stop shop. Loading as many clients off the waiting list as fast as possible." (Interview 2)*

Christina's similar experience of clients being deprioritised was most prevalent for her in the management of her service. She said she felt discouraged at times because in the past she had been a leading member of the management team before her service was restructured. Now, in the same team, new non-clinical managers exercised their authority to make decisions without necessarily listening to the clinical opinions of the psychologists.

> *Christina: "We had clinical managers but the Trust don't want clinical managers now. They're separate from clinicians. The new management don't always check with clinicians before making decisions. And, they're not the best decisions*

clinically. Only what's best money-wise. You feel demotivated at times." (Interview 1)

Similarly, Laura experienced radical changes in her CAMHS management team structure. She said her NHS Trust put non-clinical managers in position. She observed that clinical decisions were often made unilaterally for the psychology team but without much or any consultation with the psychologists. She believed higher NHS management directives now insisted on a more calculative mindset based on tallying up numbers. She observed this was happening without adequate consideration of complex factors such as social, ethical, or interpersonal dynamics which were likely to affect mental health outcomes.

Laura: "There are radical changes going on in the management of things... I think with that a change in philosophy... now it's accounting and business... They're cost driven... and don't have experience of sitting with a client in a room. They make decisions, no discussion." (Interview 1)

Emma echoed comparable experiences in her CAMH service. She noticed a shift in culture, which changed the management team discourse to one referring to productivity instead of person-centred care.

Emma: "Too many people are running the show with not much clinical input. So you get these scenarios where managers are concerned with productivity really but not understanding what's helpful to the clients… to get a better outcome for them. In meetings they talk about money and 'getting bums on seats'. The bums on seats are children." (Interview 1)

Tash expressed that, although her management team took on board the clinical advice of psychologists, she believed their hands were tied by higher management in the Trust. The latter's focus and directives, she said, were about reaching pre-assigned targets and achieving outcomes quickly, and quality of client care was not addressed within this. She felt it created a conflict of interests in the system.

> *Tash: "We're leaning towards a Foundation Trust so we have to generate income, so everything is about income. The Trust is leaning more towards performance-pay... if we meet our targets and contacts, you know, we'll be rewarded but if we don't within a certain amount of time, we'll be penalised." (Interview 1)*

Clearly, within these quotes, there is the common experience in the participants' work settings of an increasing emphasis on reaching targets and performing to a higher quantitative standard. This, however, ignored the capacity to offer a high-quality standard of client care while reaching for the higher quantity. This was evidenced through their experiences of a changed management style to more business-type decision-making practices, and a discourse which referred to vulnerable children as targets to reach, numeric outcomes to achieve, and getting 'bums on seats'.

4.2.2 Limited time for complex Tier 3 cases

Within this study, over half of the participants (four out of seven) expressed concern about a drive towards time-limited therapy as a means of maximising the capacity to see clients and reduce waiting lists in their CAMHS Tier 3 services. The participants

believed time-limited therapy was unhelpful to a client population of children with complex and chronic mental health problems. Some were concerned about clients being rushed too quickly towards discharge before they were ready, with the likelihood of the need for a re-referral to CAMHS in the future. This would mean going through the referrals process once more and joining a new waiting list and this would only apply if they were motivated to seek therapy again and try to gain entry to the service which would take some time. Two of the participants said they were aware of a leaning towards time-limited therapy in their CAMHS teams. At the time of interviewing, it had not been imposed upon their community clinics, although they heard it was possibly coming.

> *Ayesha: "We have a certain number of sessions to do... There's pressure to discharge the clients and take on new clients... Sometimes I haven't finished the piece of work but there's pressure to close... and you know this family are going to refer to us again. It's a way of manipulating waiting list numbers, I think." (Interview 1)*

Similarly, Emma felt time-limited therapy for complex Tier 3 cases who often presented with comorbidity (an individual presenting with more than one mental health disorder) was not usually workable. The only option for clients to obtain further treatment was to then seek re-referral to the service after discharge.

> *Emma: "We're following a (therapy) model which is six to eight sessions. We argue it doesn't work... but we're restricted. Unfortunately, then we have to discharge that child. And you know their issues weren't resolved… and they'll probably come back again." (Interview 1)*

Laura's experience of time-limited therapy raised her concerns for the more vulnerable young people who came to the community clinic for help. She feared they would become marginalised by the time-limited therapy framework offered in her CAMHS team.

> *Laura: "There's pressure to be time limited with sessions and to be more, kind of, goal focused in therapy. I think with some clients, they're too vulnerable. They can't articulate therapy goals. They need a space. So to put limits on that I feel is wrong. The more vulnerable kids will be marginalised." (Interview 2)*

Christina understood that the introduction of time-limited therapy was pushed forward in her team as part of a new management strategy. She felt this overruled a client-centred approach for the sake of reaching targets and managing waiting lists and budgets.

> *Christina: "Managers quote numbers at us and say, 'We don't care how long you work or how you do it but we need you to do this many sessions per week, and we need this many people in and out by this time." (Interview 1)*

Their own discretionary professional authority about client care was, psychologists felt, being ignored by their management teams. In some cases, a new model of time-limited therapies was being implemented across the board despite the protestations of psychologists. This appeared to ignore the psychology team's judgement and the complex dynamics of psychological client care.

Feeling compromised as a counselling psychologist was Tash's experience. There was a drive in her service to do fewer therapeutic sessions, she said, even if the

psychologists opposed it. She felt this approach to therapy was compromising her practice and potentially unhelpful to the client.

> *Tash: "There are times where I do feel our skills and our status of being a counselling psychologist (are) being compromised. We're more often expected to do short-term therapy. A quick CBT approach on certain issues that we don't feel would work." (Interview 2)*

4.2.3 Higher administration workload conflicting with client work

Another stressor attributed to the impact of NHS reforms in the work setting was reported as being the considerable rise in psychologists' administrative workload. There was a general similarity amongst participants' experiences that the amount of time and energy necessary to complete these tasks was becoming overwhelming. Administration loads increased to a level where psychologists struggled to find time to engage adequately with their therapeutic role. The resulting conflict was being highly stressful for them.

When first asked about the most stressful part of his work, without hesitation Michael exclaimed*, "The admin!"*. He explained that the intensity of the client presentations and the active containment of risk with at-risk children should have been the biggest stressor of his job. However, he felt the burden of ever-increasing administrative expectations was overtaking this. It caused him the most stress in his work setting. He expressed frustration throughout his narratives that administrative tasks competed with his clinical time, daily.

> *Michael: "The admin! We've got all this paperwork. The admin side has definitely increased. That's the biggest stressor and it competes with my clinical time. I think 'that' stress has increased in recent years. And the admin keeps increasing." (Interview 1)*

Diane said she was accustomed to a stressful work setting, having practiced in forensic settings for a number of years before her role in CAMHS. She felt she had a high threshold for stress, and she also actively engaged in personal and professional stress management activities. She introduced stress management gatherings in her CAMHS team based on mindfulness therapy. However, there was no time for this any longer. In our second interview, she presented with a noticeable air of fatigue and seemingly worn-down acceptance. She was anxious to share her opinion on the biggest stressor in her working life, and that administrative tasks were gradually overwhelming her psychology practice work. She said she had been anxious to speak with me again.

> *Diane: "I understand the importance of the paperwork and clinical documentation, and especially in an ever-increasing time of safeguarding et cetera, but having a balance would help... to do the job I trained for, to actually practice as a psychologist." (Interview 2)*

In her Trust, Ayesha had a similar experience of her client work time being disrupted.

> *Ayesha: "Sometimes, I go in (to work) early and finish late but I never seem to catch up. I never seem to catch up. It's really hard to stay on top of the client work as well as the admin." (Interview 1)*

Tash seemed aggrieved that the administrative tasks and paperwork were demanding much of her time to the point where she struggled to find sufficient time for her client work. Consequently, she felt the standard of the therapeutic work was suffering.

> *Tash: "I feel less able to do efficient clinical work... and it's more paperwork." (Interview 1)*

Christina's experience was similar in her work setting. She spoke of struggling to fit the new administrative work demands into her day. She felt frustrated by increased non-clinical work tasks. She felt these were usurping her practitioner time.

> *Christina: "I have less time in terms of having more and more demands to meet... and they're non-clinical demands…" (Interview 1)*

This lack of time for client-related work was recounted as being a result of the NHS changes. This was also identified by Laura. Her daily experience was that her NHS Trust's imposed administration tasks were so time consuming, they consistently diverted her time and attention away from her client work.

> *Laura: "There's a thrust towards outcomes and being thorough and getting the admin finished, you know. Sometimes, I think within all of that, it's hard to say, 'This is hard!'... The admin pulls me away from the clinical work." (Interview 1)*

Emma's experiences were similar, as she reported that her Trust's change initiatives introduced the model of the Children's and Young People's Improved Access to Psychological Therapy (CYP-IAPT) into her team. This increased her administrative burden. Working through the administration tasks and dealing with a higher volume of form filling with the client(s) was preoccupying her to the point where she felt challenged

to find space for her therapy-focused work. Because of the stress caused by this conflict, she began to *“hang on to”* the form-filling tasks she had to do. She said they represented a certainty she could achieve. This was in contrast to her client work, which she felt she could no longer complete to a good enough standard of quality. This was demeaning for her professionally and personally. The administration seemed more important to the survival of the service, she said.

> *Emma: “Our service introduced the CYP-IAPT model in a big way. Now there are forms to fill in with every client. Making sure I have all the forms with me in the room... it takes up time. It’s the only certain thing I can, kind of, hang on to... If I can’t do that, then I can’t support the service.” (Interview 1)*

There was clearly a high level of stress being experienced because of increased administrative tasks which competed with the client work. This seemed to demonstrate the existence of a value conflict. There was a sense of hopelessness as participants experienced client-centred, psychological work being obstructed.

4.2.4 Experiencing devaluation of psychology

There was a strong sense amongst several of the participants that the role of the psychologist practitioner in CAMHS was being devalued and denigrated in their Trusts. Some participants experienced management indifference to psychology opinion; playing down of the psychologists’ skill base; and devaluing of the profession’s financial worth.

The role of psychology was being strategically undermined, Michael felt, and a distance was coming into multi-disciplinary work and communication within the team. Michael felt that psychologists and the team's multi-disciplinary colleagues were being fragmented.

> *Michael: "Psychologists have been, I feel, and our roles are being depleted. There's a lack of really listening to us. It's just dividing, you know the old saying 'divide and conquer'? I think what's happening is that the multi-disciplinary team is being strategically divided." (Interview 2)*

Devaluing psychology as a profession was part of a wider cost-cutting agenda to justify replacing psychologists with less qualified and cheaper staff, Ayesha believed. She observed an attacking and persecutory language developing against psychologists in her CAMHS team, and psychologists were feeling personally besieged.

> *Ayesha: "The Trust's idea is to employ mental health practitioners who are less qualified but cheaper. They're talking about psychologists being expensive and replacing them. So colleagues feel it's an attack on them personally because people in the Trust are openly saying, 'What do the psychologists do anyway?' " (Interview 2)*

Higher management within her Trust was demonstrating an active disregard for all psychologists' expertise, Diane said. Although she offered her thoughts and input in meetings, this was not acknowledged by her management.

> *Diane: "I've accumulated a lot of clinical expertise throughout the years, I'm here to help the client. The management view is 'Give your opinion if you must'. Not just with us but with the clinical psychologists too." (Interview 2)*

Christina believed there was a strategy in progress, based on cutting costs in her service. She believed the Trust was driving through an agenda to employ less qualified mental health workers to replace psychologists. She sensed that management were out of touch with the complexities of psychologists' work in general, and this was supporting the minimisation of the profession of psychology.

> *Christina: "I think psychologists are seen as expensive and they can get other people to do the job just as well. The thinking seems to be psychologists only do CBT and they think you can get other people to do it just as well. And that's the idea. I don't think it's true but this is what's happening." (Interview 2)*

Emma experienced a similar set of circumstances in her service. She said there was pressure on psychologists to justify their worth. She believed a cost-cutting agenda was obscuring informed thinking about the skill base of psychology in child mental health. She observed that there was a distorted perception about the therapeutic clout of CBT, especially by non-psychologists and management.

> *Emma: "I feel psychology is being questioned. We had to justify why people should spend money on psychologists when nurses could be trained in CBT and employed cheaply." (Interview 2)*

Tash believed that saving money was the strategic rationale in her Trust and 'expensive' psychologists were being targeted. She felt there was a backlash against psychology, which was filtering down from NHS higher management in the Trust due to financial concerns.

Tash: "All of this... is having an impact against psychologists the most, because we're perceived as being the most expensive professionals to have. So there's a lot of talk about down-banding some of the psychologists, and capping it to save money. Not having so many psychologists within one team." (Interview 2)

4.3 Therapy room impact

Concern was raised that the organisational changes increased the workload, so much so that the ability to work relationally with clients was negatively impacted. All participants imparted their specific experiences of how they were required to work in ways they deemed as incongruent with their values as client-centred psychologists.

4.3.1 Emotional availability for clients

Increasingly, Michael felt challenged to be fully present in the therapeutic dyad with his child and family clients. He reasoned this was a result of being over-stretched by a high caseload along with the rising level of administration tasks, including extensive form-filling activities with the clients. The ability to practice effectively as a clinician was being impaired. He was experiencing (as were his colleagues, he said) being over-stretched by his workload. He experienced this as a consequence of pressure imposed by the Trust to demonstrate productivity. He was worried that the situation would only change under dire circumstances or if a client suffered. Elsewhere in the transcripts, Michael described his client work as being the most meaningful part of his job. Therefore, the

increasing struggle to be mentally and emotionally available for the clients was a source of profound frustration for him.

> *Michael: "It's a systemic flaw... almost like an epidemic that's happening. Clinicians have not been allowed to do the work they should, and have been overworked. There will be a knock-on effect on a client… I do think, the way things are going." (Interview 2)*

Echoing Michael's experience, Diane explained that her fatigue and distraction were the consequences of being over-extended by a growing administration workload which competed with her therapeutic work. She disclosed that she struggled, at times, to fully engage in the therapeutic dyad.

> *Diane: "When you have so much to do in a day, you get tired, distracted and then you're struggling to be fully present for the client... to be honest." (Interview 2)*

Ayesha's situation resonated with Diane's. Diminished emotional availability in the therapy session, she believed, was a consequence of being over-stretched by mounting administration tasks and client work. She said she felt preoccupied, and noticed herself becoming a little less tolerant with clients.

> *Ayesha: "I think it has impacted negatively on my client work. In terms of being emotionally available for a client, yes, my level of tolerance is less. Definitely, that's going to affect the quality (of the session)." (Interview 2)*

Laura expressed that increasing demands on her time restrict her ability to read client notes and be fully present in sessions. At times, she was unable to slow down enough to tune into the relational dynamics emerging in the clinical therapeutic space.

> *Laura: "You know, it'd just be helpful to have time to read through the client notes before the session. Last week, I forgot whether my client was taking GCSEs or A levels (Interview 2). You know, and I felt bad. But also I need to slow down enough to tune into my own awareness of patterns emerging in relational issues in the dyad." (Interview 1)*

Similarly, Emma noticed that increasing administrative work demands on her time impacted her clinical proficiency in the therapy room.

> *Emma: "I've gone into sessions and not been fully prepared. I hadn't time to reflect on what I did the last time, and now the client is sitting in front of me again. Feels like I'm just treading water." (Interview 1)*

Tash noticed that the stress of her workload affected her energy for the clients and caused her to doubt her therapeutic effectiveness.

> *Tash: "Sometimes I've felt like I can't give one hundred per cent to the client today. Then it's, 'Okay! Go in there and do it'. I feel I'm not doing justice to the clients... working like this. I think, 'Am I actually helping?' " (Interview 1)*

4.3.2 Practitioner values and client-led care

Ayesha noticed how clients were increasingly referred to in her Trust in dehumanising ways. She felt clients were becoming objectified in her service and increasingly referred to as 'targets', 'outcomes' to achieve, and numerical units to record. As a result, she felt

the need to be vigilant in maintaining her client-centred focus and humanistic grounding. She experienced her identity as a client-centred psychologist being stripped away.

> *Ayesha: "Sometimes I felt I was working against my belief of valuing the subjectivity of the clients and their own world view. I had to remember to stay grounded in humanistic values." (Interview 1)*

Michael felt strongly that the *"enforced changes"*, as he described his Trust's organisational changes, imposed a reductionist structure on his client work. Similarly to Ayesha, this was to the point, he felt, where the individual client, as a whole, was being disassembled by quantitative measures. He believed these quantitative measures were designed to support a management system based on productivity and faster throughput of clients. He expressed that his Trust expected psychologists to approach child therapy in a targeted, goal-oriented way but which ignored the complexity of mental health problems. He felt that, for example, having to carry out an identity check with the clients or family and ask to see a passport was incongruent with his humanistic values as a counselling psychologist. He felt this immediately devalued the client and his function in the relationship.

> *Michael: "For counselling psychologists, the client relationship is highly prized. Now there are forms to fill in with clients. I check if they've brought a passport and council tax bill. I feel like a bank clerk." (Interview 1)*

Diane believed the practice of counselling psychology involved the transfer of energy and empowerment within the therapeutic space. The client picks up the psychologist's energy in the therapy room, she said, and the therapeutic relationship is the conduit for

client-led empowerment. Therefore, the therapist must feel empowered and grounded in their own right and bring that energy into the therapeutic space, she explained. She was anxious about changes in her service because she felt any sense of disempowerment would impact her therapy work.

> *Diane: "I've got a strong political and social conscience, and that comes across in who I am in certain ways, you know, empowerment of clients. And of myself and colleagues. Not too many managers may like it. The work environment and therapy... one impacts the other, you know, because we're all human, we're not robots." (Interview 2)*

Using similar language, Laura described an example of how she felt she was being used to impose a new NHS organisational structure upon clients. Consequently, she felt that sometimes she had to actively practice against her humanistic values and ignore client choice.

> *Laura: "If a client doesn't show up for their session, we have to contact them twice every fortnight by phone. This feels like I'm imposing the NHS on the client, which goes against my humanistic values. It undermines the client's autonomy. They choose not to come." (Interview 1)*

Laura felt her Trust was enforcing a tick-box exercise designed for auditing purposes so as to demonstrate how the service prioritised risk prevention. In reality, her experience was that the particular activity she described above was intrusive to the client.

Emma felt she was becoming de-skilled. She believed her work was forced into more superficiality because of pressure to move clients through her CAMHS quickly. This was

to achieve the prerequisite targets and outcomes as set out by management. She thought the organisational changes interfered significantly with her ability to be client centred in her psychology work. She experienced feeling de-skilled as she was forced to work in increasingly superficial ways with clients.

> *Emma: "It's really difficult and de-skilling... because there's not much time to think or plan ahead. I know I'm only scratching the surface with clients." (Interview 1)*

These situational experiences seem to describe how the behaviours of psychologists were changing to achieve NHS reform. The methods of reform experienced were felt to negatively affect how the counselling psychologists work, the effectiveness of the therapy, and the client's progress. Participants seemed to be experiencing NHS changes as undermining their ability to stay with their client-centred values and continue working in a client-centred way.

4.3.3 Reflective practitioner with less reflection time

In this sub-theme, participants reported having insufficient time to reflect on their client cases because of increasing workload demands on their time. For some participants, this crossed over into clinical supervision. Some participants explained that reflection upon client cases in supervision was sidelined in favour of management-related discussions about targets and outcomes and their daily productivity.

A sense of deprivation came through in Diane's experience of maintaining a reflective stance in her work. She referred to the unmet *"need"* for time and space to consciously

process *“this type of work”*, suggesting that the level of need and risk of this client population required reflection time. She found this was less available to her now. Her demeanour was calm but her verbal expression was strong as she referred to her clinical supervision as being taken over by business and administrative issues, which were now invading her previously allotted formal reflective space. The language was perhaps suggestive of wanting to escape from an infection which was spreading into a formerly protected or quarantined space for herself and her clients.

> *Diane: “With this type of work, you need thinking space. To think about the clients, to think about the work. You know, targets and outcomes, they should be separate conversations... line management issues, they’re talked about in supervision now.” (Interview 1)*

Christina observed an increasing disregard for reflective client space in her service. She felt that management-related discussions were dominating her clinical supervision. In an expression of both irritation and resignation, she sighed as she related her experience that management-related issues often took over her clinical supervision. This left little time for reflection on client cases.

> *Christina: “Even in supervision, the client gets squeezed out. The boundaries are crossed. Yes, then very little time is used for client reflections. Reflective team discussions about clients are no longer a priority. Nobody has time.” (Interview 2)*

A stressed supervisor discussing management business issues has sometimes crossed the boundaries into Ayesha’s supervision. There was a sense her supervision space became more pressurised, with less opportunity to decompress and reflect on client

work. She thought this was because of pressure on the supervisor to monitor the psychologist's administration work. Apparently, such issues had initially been part of the service manager's responsibilities but were now being delegated to the clinical supervisor to address in supervision. Sometimes, Ayesha noticed her supervisor presenting as more stressed, and this added to her own experience of stress.

> *Ayesha: "Supervision is sometimes mixed up with admin monitoring. And there is less time for case reflection. Sometimes my supervisor has talked about her own work stress. And yeah, it added to mine (stress)." (Interview 1)*

The overall increased workload demands, Michael observed, were allowing insufficient time and space for him to continue being a reflective practitioner.

> *Michael: "I think the time to reflect has become a lot less. So this notion of the reflective practitioner, I don't think it's getting any kind of space now." (Interview 2)*

The same kind of experience was imparted by Laura. Mounting administration demands and tasks accelerated her pace in work. There was a need to work harder and faster, which brought a sense of chaos and emergency. She would like more clinical reflection time but she felt this eluded her. Even in the writing up of her client session progress notes, she could only find time to make hurried entries.

> *Laura: "I'd like more time to reflect but it feels like I'm on the back-foot sometimes. I feel I'm... like I'm fire-fighting, doing back-to-back sessions and running from thing to thing." (Interview 1)*

In another vein, Emma said she was discouraged by her management from engaging in practitioner reflection time. She believed there was an expectation to accept she was being paid to see clients, and not seek out reflective discussions with colleagues about her cases. This was stressful for her because, she believed, it increased her own vulnerability as a psychologist holding challenging cases in her mind.

> *Emma: "It sort of felt frowned upon… trying to get a case reflection meeting together. There was a comment that the money is being spent on me seeing clients. Then I'm left with some cases going around in my head and not much access to group reflection." (Interview 1)*

Tash echoed these experiences. She noticed that time allocated to business meetings increased, while time allocated to team meetings for case discussions decreased.

> *Tash: "You know, there are more business meetings in the service which I'm expected to attend. For example, we used to have more team case discussions... those meetings tapered off... so there's less reflective time... we're supposed to be a team." (Interview 1)*

4.4 Counselling psychologists' well-being and morale

This super-ordinate theme comprised participants' experiences of where meaning is derived in their work and experiences attributed to NHS changes of stress-related illnesses, threats to their job security, and devaluation of psychology in CAMHS. These factors seem to have stressed and demoralised participants to the point where they

have actively considered leaving the NHS altogether and have sought employment outside of CAMHS Tier 3.

4.4.1 Stress-related illness

Most of the participants suffered more bouts of illness which they directly attributed to work-related stress. Some stated their health had suffered in the past year because they were overwhelmed by substantially increased workloads and heightened occupational stress levels. This was due to the change initiatives activated in their CAMHS teams, they believed. Also mentioned was observing an upsurge of absenteeism as their colleagues became ill.

As previously mentioned, Diane was the only participant who said she was actively engaging in stress management activities in her first interview. However, in the second interview, she stated that organisational changes had overwhelmed her working life so much, that she scrambled to get everything done daily. She said the past few months, particularly, had been the *"most stressful"* in her career. It was stressful to the point where she was diagnosed with a number of illnesses, including Irritable Bowel Syndrome. Her doctor suggested making a formal diagnosis of a stress-related illness and recommended she take some sick leave. However, she did not want to carry this through because she did not want this on her occupational health records, in case it would affect her career in the future.

> *Diane: "It was an extremely stressful year for me... I think it's probably the most stressed I've ever been at work. The GP offered to sign me off with stress. I was*

very close but I didn't in the end. That's the overriding thing, I didn't want it on my health records." (Interview 2)

The recent changes in work practices caused Ayesha to feel overwhelmed, yet she was anxious about the consequences of taking time off when stressed. In the past, she would usually have opted to take a few days of annual leave to help her re-balance and recover from stress she experienced at work. She noticed increasing numbers of her colleagues were taking sick leave and she said morale was low in her service.

Ayesha: "The Trust put pressure on people and morale was low. Quite a few people got sick and needed time off. When it got too much, I'd take two or three days off to centre myself." (Interview 1)

Tash was one of two participants who openly referred to experiencing 'burnout'. She believed the increased workload associated with a quick throughput of clients had been impacting her energy and immune system. Unusually for her, she said, she had experienced more frequent illnesses in the past year. Historically, she rarely took more than three days of sick leave at any given time. She admitted working whilst feeling unwell.

Tash: "It transfers into your body. I've been more tired. My immune system was low. This past year, I've caught colds and a chest infection. I think it's stress. I've worked when I haven't been feeling ok… you take time off and work piles up." (Interview 2)

Christina was clear that changes in the team were so stressful that they caused her to become ill. She was strongly opposed to some of the changes and their impact on the

team, and felt frustrated at being unable to prevent them. This seemed particularly hard for her because previously she had been an active management team member. However, now she was no longer able to protect her colleagues from changes which impacted their stress and job demands. She eventually tried to let go of her concerns for the sake of her health and peace of mind.

> *Christina: "My stress is the changes in management... I was out for a couple of weeks because it made me ill. I had to go through it to come to terms with the fact that I can't do anything about it. I've had to let it go." (Interview 1)*

Michael had taken no time off for any stress-related illnesses. Nevertheless, he had felt stressed and discontented with the Trust. Like Christina, he did not wish to go into details but indicated that he felt badly treated by his Trust and this was related to the changes. It had caused a difference in him, and he felt more negative now, and angry.

> *Michael: "I think because of the changes that have happened... and because of maltreatment, I've become more disgruntled. Angry. There has been some change (in me)." (Interview 2)*

Laura was a second participant who referred to 'burnout' consciously and not in the abstract. She felt *"close to burnout"* at times and she believed this was related to changes in her service. Laura revealed being very stressed in her work setting. She sought personal therapy to help her cope with work stress and her feelings about her work.

Laura: "At times I've been close to burnout… It comes and goes. I'm surviving. I went into therapy... and I still dip into it at times just to help me function in the job." (Interview 2)

4.4.2 Threats to job security

Five of the seven participants spoke of threats of job loss from management in their teams if they did not conform to changes in their NHS Trusts.

Tash described a sometimes dictatorial and threatening management style in her team. A stressful part of her working life, she explained, was the threat by management of potential job loss. Tash and her colleagues were frequently reminded, she said, that unless they conformed to the new organisational expectations, they could lose their jobs.

Tash: "We're threatened with the risk of losing our jobs. So that part becomes stressful. At the end of the day, we're told this is what the Trust wants and if we don't do it, we could lose our jobs." (Interview 1)

Laura echoed Tash's account by sharing her experience of increased pressure to comply and conform to NHS changes. Earlier on, she had spoken of a significant shake-up in her management team. She felt her job security would be undermined unless she complied with the service. She felt it was no longer safe to express any contrary points of view to her management team.

> *Laura: "Now it feels if you don't do what they want, you're out. I think that's felt widely across the team. It feels difficult to raise any concerns. It isn't safe. There's pressure to comply." (Interview 1)*

When the changes initially came into her service, Ayesha subsequently lost some of her experienced psychologist colleagues who had to re-apply for their jobs. Their posts were either left vacant or filled with cheaper, less experienced, non-psychology staff. She talked about the unsettled atmosphere permeating throughout her team of meeting targets, of pay cuts, or job loss.

> *Ayesha: "There was this constant threat of meeting targets or end up losing our jobs. Some very experienced psychologists lost their jobs or had to re-apply for them." (Interview 1)*

In a similar vein, Christina suggested that if she continued to challenge the service changes or her management team, this would be regarded unfavourably and would not be to her advantage.

> *Christina: "Things have changed in my job. I didn't have a choice. I can't talk about that. At first, I tried to challenge it but... let's say, it wasn't in my best interests to do that anymore. You have to choose your battles carefully." (Interview 1)*

Michael also felt there is a threat hanging over job security in his CAMHS team when his management team tried to enforce new cuts and changes.

> *Michael:* "*They told us we're lucky to have our jobs. And we need to reach their targets." (Interview 1)*

4.4.3 Thoughts on leaving and turnover

All of the participants shared thoughts about leaving their Trust or the NHS altogether. Their reasons were uniformly related to a sense of overwhelming stress, and feeling their Trusts' implementation of changes was no longer in alignment with the values inspiring their work with children.

When we last spoke, Ayesha had decided to leave her Trust. She was about to resign and work in the paediatric department of a private hospital. She trained first as a clinical psychologist and then later as a counselling psychologist. She preferred the latter, and said she was more invested in its humanistic philosophy.

> *Ayesha: "It's been very difficult. The restructuring left the team with very low morale. I've seen psychologists crying in the corridor over having to re-apply for their jobs. I found another job and I'm leaving." (Interview 1)*

Like the other participants, Tash came across as a highly organised, hard-working professional who had been fighting for CAMHS clients against certain service changes. However, the toll on her health and morale had been high in the past year, she said. She was intending to leave the NHS completely to work in the private sector.

> *Tash: "I would like to ultimately leave the NHS completely. I'm giving myself six months to a year." (Interview 2)*

Diane's value system was very much aligned to helping children and families unable to afford private care. However, she was contemplating reducing her NHS CAMHS work, and had thought about this regularly.

> *Diane: "I think about it every week... Going into private practice or at least doing half-and-half. I'd still like to work in the NHS. I still want to offer a service to people who can't afford private, that's where my heart is." (Interview 1)*

When I first interviewed Emma, there was no mention of her wanting to leave her job. However, six months later, when we spoke again, she had already handed in her resignation and was about to start working for another Trust, not in CAMHS but in NHS Adult services.

> *Emma: "I've just left CAMHS. They wouldn't reduce my hours. With the level of admin and, you know, I'm a mum and I wanted to reduce my hours. Eventually, I left." (Interview 2)*

A sense of loss seemed to permeate Laura's thoughts about her service and possibly leaving her CAMHS team. She missed the cohesion her team used to enjoy. She experienced the new management team as unsupportive. She believed the changes had been drastic and, as a result, many of her CAMHS team colleagues had already left, while others were actively job seeking.

> *Laura: "I'm looking for a different job. I miss how things used to be. I think it's felt across the team. Some colleagues have left, and I know others who are looking around for jobs." (Interview 2)*

As a direct result of the stress imposed by the changes, and the pressure this put on his therapeutic work, Michael said he felt unhappy enough to leave his job. However, he would only do this if a suitable and secure position arose. He was keeping his eye on the job market but found nothing he wanted to pursue as yet. He felt the economy was

still restricting his choices. Like Ayesha, Michael was highly qualified as both a counselling psychologist and a clinical psychologist in CAMHS Tier 3 work.

> *Michael: "I think with the economic climate, there aren't many permanent jobs, they're normally fixed-term contracts, maternity cover, or locum positions. So I think economics dictates whether myself or other people will leave the Trust but… there's a lot of dissatisfaction and people working here out of necessity. The problems are the same across the NHS." (Interview 2)*

Christina had a strong ethical concern about private practice fees for children and families with mental health problems. She said it was against her value system to charge for private care when many people had already paid for the NHS through the tax system. Interestingly, she also appeared to impart a lack of confidence, which seemed inconsistent with her years of experience at management level. Perhaps this was evidence of how recent events had depleted her inner resources and, as she said, *"My sense of self is lost".*

> *Christina: "I think about leaving all the time. I don't agree with private practice... I don't feel it's right to go into private practice. I don't feel people should have to pay when we've got the NHS. And secondly, I'd be scared to take the chance. I don't know if I'd make enough money." (Interview 2)*

There was a clear thread running through all the transcripts connected to the high stress levels experienced because of the new administrative workload. The participants' value systems, professional identities, and the meaning they derived from the client-centred care were, they believed, being undermined and challenged. There was tension in

maintaining a sense of balance as there appeared to be competition between the new NHS demands and client-centred work.

4.5 Professional Identity Issues

This super-ordinate theme covered stresses and resources experienced whilst counselling psychologists were trying to break into NHS CAMHS and during their time there. Experiences of professional discrimination were revealed, along with issues surrounding their professional identity. Participants also related their impression of a lack of support from the Division of Counselling Psychology (DCoP), which some assumed was due to a lack of understanding about the complexity of child mental health.

4.5.1 The new psychologist in CAMHS

Participants experienced their professional identity in CAMHS as not being understood by others. Clients, preoccupied with their mental health issues, only noticed that counselling psychologists were ‘psychologists’. Participants found colleagues had little awareness about the differences between clinical and counselling psychologists. Some participants felt strongly about building their identity as a counselling psychologist specifically, and wished to keep it alive.

Michael's consistent experience, in his service, was that the differences between counselling psychology and clinical psychology were not understood. His multi-disciplinary team tended to mix up both disciplines, treating them as one and the same.

> *Michael: "I think quite a few don't understand the differences. Because they don't understand the differences, they actually mix them up." (Interview 1)*

Emma had a similar experience.

> *Emma: "I'm the only counselling psychologist in the Trust so they call me a clinical psychologist, and just forget I'm not. I have to remind them." (Interview 1)*

Ayesha felt she was treated as a clinical psychologist and was expected to operate from this frame of reference. This led to her feeling professionally isolated and lonely in her work setting.

> *Ayesha: "I feel isolated. I'm supposed to identify myself to clients as part of the clinical psychology group. The team expect the same thing that a clinical psychologist provides. Even my payslip says I'm a 'clinical psychologist' although I'm employed as a counselling psychologist." (Interview 1)*

Christina felt very clear about her own professional identity with her team. Interestingly, how she chose to work made her feel different not just from the clinical psychologists, but from other counselling psychologists.

> *Christina: "I work very similarly to the clinical psychologists in my team and differently to other counselling psychologists. I've got a leg in both camps. For*

> *example, I've no problem doing psychometric testing. The other counselling psychologists here won't do them." (Interview 1)*

Likewise, Laura maintained a very clear focus on her professional identity and how she wanted to develop it. She noticed that other counselling psychologists seemed less focused on this.

> *Laura: "Some counselling psychologists don't have a clear identity whereas I feel I have. But I've worked on that over time. I've purposely sought out counselling psychologists as supervisors... to hold on to the core of my professional identity." (Interview 1)*

Diane's experience was that neither her colleagues nor her clients could distinguish between either type of psychologist. She cautioned that, in not maintaining a clear focus on professional identity, the work setting will take over and shape it for the worker.

> *Diane: "People don't know the difference between us. Our identity is shaped by where we're placed, and who's been supervising us. So, unless you're paying particular attention, you won't even realise it's being shaped for you.*" *(Interview 1)*

Although Tash was holding onto her professional identity, she did not see much future for counselling psychology in the NHS. She believed the professional identity would be more respected in the private sector.

> Tash: *"I try to integrate with the team. I'm still holding onto my title as being a counselling psychologist… I think in terms of the NHS, it's gonna probably die out as a profession, and I think people will start to do a lot more in the private*

sector because there's more job satisfaction, and there's more respect for you as a psychologist... more so than the NHS." (Interview 1)

4.5.2 Experiences of professional discrimination

Negative professional discrimination was experienced by six of the seven participants, they reported. Some witnessed it being openly expressed in the NHS, whilst others felt it was more implicit and subtle.

Michael experienced discrimination against his profession in an NHS job interview. He believed this type of discrimination still exists in the NHS.

Michael: "I went for an NHS job interview and the interviewer said, 'The problem with counselling psychologists is that they speak many languages but are fluent in none'... Clinical psychologists are preferred by the NHS." (Interview 1)

More recently, Tash had a similar experience to Michael's. She felt humiliated and discouraged by the attitude of an NHS job interviewer towards counselling psychologists.

Tash: "I had an NHS interview before I got this job. One of the interviewers was scathing about counselling psychologists. Basically, he said I should go back and do the clinical psychology training. Like what I've done wasn't worth it." (Interview 1)

Within her own team, Laura felt discriminated against because of her profession. She believed it was deeply entrenched in the NHS to favour and value clinical psychology above other psychology disciplines.

> *Laura: "Recently, a post came up within my CAMHS team. My manager told me not to apply because they were looking specifically for a clinical psychologist. I was shocked. I felt betrayed. I'd thought we were equal in my team... For us, professional discrimination does exist." (Interview 2)*

Ayesha did not want any implicit discrimination against her profession to take hold. She actively fought against this in how she portrayed her professional identity in the workplace.

> *Ayesha: "Sometimes they refer to me as the 'counsellor' and it feels degrading. So, I'm careful not to portray myself as just a therapist because I do much more than that." (Interview 1)*

Emma had witnessed discrimination from clinical psychologists in her team. She overheard colleagues expressing their belief that counselling psychologists were not real psychologists.

> *Emma: "I used to overhear clinicals saying to assistant psychologists, 'Oh, don't apply for counselling psychology... You're not a true psychologist if you're a counselling psychologist', and I think, at that point, I felt that I needed to speak up. So, I would speak up to them." (Interview 1)*

Christina, who integrated her work so that she had *"a leg in both camps"*, observed that clinical psychologists were perceived as representing the gold standard of psychology in

the NHS. Her view was that counselling psychologists had not yet earned the same respect.

> *Christina: "I still think counselling psychology is seen to be second class, not so much by my CAMHS team but in the Trust generally. I think clinicals are seen to be the best." (Interview 2)*

4.5.3 Division of Counselling Psychology support

All of the participants experienced the DCoP as failing to support their professional identity in CAMHS and the NHS job market. Some believed the DCoP was out of touch with child mental health. They felt there was little support around the competitiveness existing between clinical and counselling psychologists for NHS CAMHS jobs. The following is a sample of the experiences related by participants.

Laura seemed disappointed with DCoP support and experienced them as being out of touch with NHS CAMHS work. She thought they had little awareness of the type of work this setting expects.

> *Laura: "The Division of Counselling Psychology doesn't support our identity in the NHS. We're on our own. They probably don't even know what we do and how we work in CAMHS." (Interview 1)*

Christina, who had held a management position in her service, said she made efforts to help the DCoP support professional identity in CAMHS. However, she was frustrated by what she perceived to be the DCoP's lack of forward movement.

> *Christina: "I don't see any kind of movement coming out from the Division except information about their accounts. Employers don't always know that a counselling psychologist can apply for a clinical psychology post. The Division should do more to address that. To make it equal." (Interview 1)*

Tash was disappointed by the DCoP, feeling they did not support counselling psychologists in CAMHS. She felt they were not helping to elevate the professional identity on to an equal status with CAMHS clinical psychologists.

> *Tash: "The Division should be aware and understand that there's big competition between counselling and clinical psychology for NHS jobs. I don't think they do enough to help us become recognised as equal with clinical psychologists." (Interview 1)*

Similarly, Emma said she tried to encourage the DCoP to be more supportive and aware of the competition existing between counselling and clinical psychologists in the NHS job market. She seemed disappointed that the DCoP did not have a stronger presence.

> *Emma: "I've been trying to be part of the Division to encourage the (job) ads to be more about applied psychologists rather than clinical psychologists (in the NHS). I wish there was more of a presence of counselling psychology, but the Division does nothing." (Interview 1)*

Michael shared his disappointment in what he viewed as a lack of DCoP interest in child mental health. He gave an example of how he experienced this perceived lack of interest filtering down to the accredited training courses. He made efforts to offer

supervised CAMHS trainee placements to counselling psychology programmes, and said he called the programmes and wrote, but "*They never get back to you".*

> *Michael:* "*The Division is quite weak... it hasn't embraced child mental health to the extent it should. So, I do feel this has influenced the whole discipline. It has some blame for that. The training has been more adult focused. I've contacted colleges offering placements but they never get back to you." (Interview 1)*

Diane believed the DCoP were not raising the profession's profile enough. She perceived there was a lack of knowledge amongst NHS employers about counselling psychology. Some NHS Trusts, she said, still advertised for clinical psychologists only and had little familiarity with counselling psychology. She cited an example.

> *Diane: "NHS Trusts still advertise for clinical psychologists only. I enquired about a clinical psychology job. I explained my skills and experience were relevant. The consultant psychologist didn't really know what counselling psychologists do… but after talking, she encouraged me to apply. I really feel the DCoP could do more for us." (Interview 1)*

Ayesha experienced the DCoP as being less productive than the Division of Clinical Psychology.

> *Ayesha: "There are always policies and procedures coming out from the Division of Clinical Psychology but nothing from our side, except accounts and flyers about elections. Meanwhile, you still see NHS posts advertised just for clinical psychologists." (Interview 1)*

4.5.4 Where meaning lies

All participants believed their professional core values reflected their own personal humanistic ethos. They stated that they placed a high value on the client-therapist relationship. They shared that upholding the worth of this relationship brought meaning to their work.

Laura found meaning in her ability to relate to children and adolescents and her belief in their potential to change.

> *Laura: "I think I feel more hopeful with children. That things can still change. On a personal level, I can relate well to adolescents. It's part of who I am. It's meaningful to me." (Interview 1)*

Michael's belief was, he said, that meaning as applied to his client work was in relationally caring for others as well as possible.

> *Michael: "It took me a long time to become a psychologist and I've tried to protect that as best I can, so that I get meaning from my work... (It) is that I've been able to care for my clients as best I can... (Interview 1). I don't think I get as much meaning as I used to, but it's still there and I fight for it on a daily basis." (Interview 2)*

Christina spoke of finding meaning in her work through seeing her clients' mental health improving. In a wider organisational context, being person-centred provided the meaning in her work. She experienced meaning in offering a conciliatory and containing approach in her client and colleague relationships.

> *Christina: "I think the sense of meaning comes when I see the client improving and getting better. And when I'm able to contain worries in the team in a way so feelings aren't as negative. That gives me meaning." (Interview 1)*

Emma also experienced finding meaning in her client-centred work within the NHS. She explained that her own person-centred, humanistic values originally drew her to the profession. Her philosophy involved attempting to maintain awareness of the relationship dynamic, and being attuned and sensitive to the impact of the psychologist's communication with the clients.

> *Emma: "Meaning is very much about being in the room with a client, and what drew me to the profession, and I value that. Self-awareness, my self-concept, how I understand myself and my impact on others, and how others impact me." (Interview 1)*

Diane illustrated how finding meaning in her work was deeply entwined with her personal values. She said she had a strong, empathic, humanistic sense of self and values. She explained finding relational meaning in empowering others whilst maintaining the integrity of the client-led relationship dynamic.

> *Diane: "Personally, I have a strong political and social conscience, and I find meaning in empowering clients, myself, and colleagues despite what's going on in the service and the world. Meaning for my professional self and my personal self are based on the same things." (Interview 2)*

For Tash, meaning in her work came from helping children through the process of positive change and emotional recovery. The meaning depended on her ability to

connect to the client, empathise, and see the world from their experiential perspectives, she explained. She humanised the unwell client and focused on the person rather than allowing the illness to cloud this.

> *Tash:* "*When you meet vulnerable teenagers, and after a few sessions they open up about the sadness in their lives… Meaning comes from relating at that level, understanding things from their world view, as opposed to just seeing them as someone with an illness." (Interview 1)*

Ayesha's sense of meaning in her work reflected her own personal values which, she said, made life meaningful to her in general. However, she added that life in the NHS was taking away her autonomy and her creativity with clients, and this was stifling her relational work. The restrictions made it more difficult to find meaning and purpose in her NHS CAMHS work, she said.

> *Ayesha: "I think the values of equality, a sense of people deserving the best help you can offer. Yeah, that reflects my sense of meaning in my work and also in my life generally. But I've been asking myself lately, 'What's the purpose in all this?'" (Interview 1)*

Chapter 5: Discussion

In this study, counselling psychologists' experiences of stress showed striking similarities to both risks and consequences of job burnout as shown in stress and burnout literature. The findings highlight how NHS restructurings and cost cutting changes were identified by participants as creating increasing daily stress. The stresses were experienced as hindering psychology practice with the introduction of a dehumansing management discourse about children, higher administration loads including electronic record keeping and auditing processes which often diverted their focus and time away from the mental health work at hand. Other stresses experienced were challenges in establishing, maintaining, and distinguishing professional identity and holding onto a sense of meaning in the work of counselling psychology with children. The study goes on to explore the stresses and how they could pose a threat to effective early intervention work in child mental health.

The stressors experienced by the counselling psychologists as comparable to burnout risk factors comprised: less inclusion in decision making, high administration workloads leading to role conflict and role overload, less dedicated supervision time and case reflection time, professional identity issues, devaluation of their profession, job insecurity, client care challenges and a change in management discourse perceived as an organisational value change. The stress experiences which were similar to the consequences of burnout included: decreased well-being, more incidences of illness, increased absenteeism, reduced emotional engagement with clients, turnover (resigning/leaving the job), and turnover intentions. Finding such parallels between the

counselling psychologists stress experiences in CAMHS and the burnout risk and consequences in the literature was an unexpected outcome of the study.

5.1 Burnout recap

Leaders in the field of burnout, Maslach and Jackson's research mostly involved professions working in human services such as social healthcare, mental healthcare, social work, and teaching. Maslach (1982) defined burnout as a psychological syndrome which occurs in professions involved in working with people in challenging situations. It is characterised by (a) emotional exhaustion (feeling overburdened and depleted of emotional and physical resources); (b) depersonalisation (a negative and cynical attitude towards others); and (c) a diminished sense of personal accomplishment or inefficacy (Maslach, Jackson, & Leiter, 2010). Work demands in public sector mental health services and, in particular, increased administrative workloads can lead to burnout (Green, Albanese, Shapiro, & Aarons, 2014). It is a serious syndrome not just causing worker distress and undermining personal fulfilment but also weakening the financial performance and productivity of organisations. It is associated with a range of adverse outcomes for mental health services and service users (Morse et al., 2012; Salyers et al., 2015).

5.1.1 Organisational change and stress

In this study, all of the counselling psychologists attributed the majority of their stress experiences to the effects of changes imposed upon their CAMHS teams, which altered

their daily working practices. Much of the stress involved managing the conflict of increasing and competing daily job demands which posed obstacles to their professional client-centred practice. There were also concerns about a value shift in the management teams within their services. The restructurings were filtered down into their teams by higher management in their NHS Trusts.

Organisational change and how it is managed have been identified as one of the six main risk factors of adverse occupational stress in stress management standards (HSE, 2005). Also included are role ambiguity, job demands, lack of support, strained work relationships, and loss of job control (HSE, 2005).

In support of counselling psychologists' experiences of changes obstructing their client practice, the literature has identified the effects of organisational change as potentially causing difficulties in professional practice. For example, implementation of change can increase job demands and subsequently cause role conflict and role overload, job insecurity, less inclusion in decision making, client care problems, less supervision time and fewer colleague consultation opportunities (social support). It is these burnout risk factors and their consequences which can cause gaps in service delivery, quality-of-care issues, and financial implications for a service, thus potentially undermining early intervention work in child mental health. The chronic stress or burnout related to organisational change management is multidimensional and complex, and places the stress experiences in a context.

5.1.2 Organisational change and burnout

Chronic stress or burnout can be experienced following changes in an organisation or the nature of the work (Schabracq, 2003). Stressors which have been documented in the workplace as leading to burnout can be introduced or exacerbated as a result of organisational change (Day, Crown, & Ivany, 2017). For example, organisational change can cause uncertainty and anxiety about potential negative outcomes of the change, such as job losses or reduced autonomy and role ambiguity (Smollan, 2015). For employees, coping with occupational change is referred to as extra job demands which require more effort. As such, change comes at a cost (Day et al., 2017) but especially when the demands are not supported by adequate resources to fulfil those demands. The latter issue was a salient point of stress for these counselling psychologists in their CAMHS teams.

To further support their experiences, evidence shows that during organisational change lack of participation in decision making, inadequate organisational support (such as supervision and colleague consultations), increased workload, role ambiguity (Smollan, 2015), and job insecurity can trigger burnout in employees (Noblet, 2006).

5.2 The perception of CAMHS changes

Counselling psychologists' stress in their work settings was not stated as being a normal anxiety response to general change nor as factors experienced as the normal stressors inherent in patient contact, such as exposure to emotional suffering, suicidal ideation and traumatic life events (Sjølie, Binder, & Dundas, 2015). Rather, they referred to the effects of the type of change system implemented in their teams. They

identified this as having an increasingly business-led, less client-focused ethos causing a perceived shift in work setting values and posing obstacles to congruent, client-centred psychological practice. As a result of the NHS and public sector cuts, it has been well documented that CAMHS teams and resources have been depleted. Information gleaned from this research gives an insider's view into how counselling psychologists' working practices in child mental health, and individual stress levels have been negatively affected.

5.2.1 Background to the changes and cuts in CAMHS Tier 3

These are challenging times for NHS child mental healthcare services. The NHS in England caters to a population of 54.3 million and employs around 1.2 million people. NHS England treats over 1 million patients every 36 hours (NHS England, 2016b). In order to address budget deficits caused by the 2008 financial crash and subsequent economic crisis, the UK Government introduced austerity measures. Although it pledged to protect the NHS budget, funding for mental health services decreased by 8% in real terms between 2010 and 2015 and 2,100 beds were lost due to the closure of NHS mental health facilities during the same period (Kerasidou & Kingori, 2019).

Having stated they would offer a 1% increase in funding to the NHS, the real government funding increase is just 0.2% per year when adjusted for inflation specific to the NHS. This does not match the annual 4 per cent increase in patient demand pre-Covid 19 pandemic. Amongst other cuts in public spending, there has been a £200 million funding cut in Local Authority public health budgets which fund or partially fund

community mental health services, including CAMHS (partial funding) (Patients4NHS, 2016). Cuts in social care and welfare spending have also increased pressure and demand on the NHS.

The NHS has faced significant difficulties in the delivery of high-quality patient care during a time of severe financial constraints and workforce shortages (Addicott, Maguire, Honeyman, & Jabbal, 2015; Dunn, McKenna, & Murray, 2016). NHS Trust annual financial accounts revealed that approximately 40 per cent of mental health Trusts had budget cuts in cash terms from 2012 to 2015, rising to almost 50 per cent between 2015 and 2016 (Gilburt, 2016, 2018). Resources have been heavily constrained and pruned, patient demand on services has continued to grow regardless of an NHS financial deficit of more than £500 million for 2017/18 (Ham, 2018; Murray, Jabbal, Maguire, & Ward, 2018).

In order to cut expenditure, services have undergone restructurings and development of new service delivery models; they have also been subjected to productivity pressures and increased expectations to compete for commissioner funding. In the meantime, the number of children seeking help from CAMHS in England more than doubled between 2017 and 2019 (Schraer, 2019). However, only 25% of children needing specialist mental health services have accessed them (National Audit Office, 2016). It is not clear if this statistic acknowledges the many children turned away from CAMHS after attempted access, due to gatekeeping because of dwindling resources within teams already stretched to cope with increasing patient demand. A recent report by England's children's commissioner stated that the biggest constraint on improvements to accessing mental health treatment appeared to be spending decisions made locally and

nationally. On average local CCG areas spend less than 1% of their overall budget on children's mental health and 14 times more on adult mental health services (Children's Commissioner, 2021). This seems to add further credence to the stresses experienced by counselling psychologists walking the tightrope between attending to increasing patient demand and continued cuts to services.

5.2.2 NHS reform

The stated aims of the NHS reform are to improve quality of care, clinical efficiency and cost effectiveness, illness prevention support, and development of NHS control away from the government (devolution of power) and improved patient access. In effect, the reform aims to get the NHS to achieve improved service efficiency and quality of care but with fewer resources and smaller budgets (NHS England, 2016a).

The Mental Health Five Year Forward View and Long-Term Plan promises to deliver timely, high-quality mental health support. This includes the expansion access to mental health therapies by 2023/24 so that an additional 380,000 people per year can access support for mental health disorders. It also expects to expand services and work with schools and colleges so that an additional 345,000 children and young people aged 0-25 can access comprehensive support each year. The plan undertakes to offer 100% coverage of 24/7 mental health crisis care provision. Thus, all children and young people experiencing a mental health crisis are projected to have access to crisis care 24 hours a day, seven days a week accessible via an emergency telephone number, NHS 111. Furthermore, the NHS is expected to provide a single point of access to services

with little delay. People with moderate-to-severe mental illnesses will have access to better quality care across community teams, have greater choice and control over the care they receive, and be supported to lead fulfilling lives in their communities (NHS England, 2019). However, the independent research body and health think tank, the Kings Fund observed that much of the NHS is in the thrust of a workforce crisis including mental health services but the NHS Forward Plan does not address issues of recruitment, retention or workforce capacity (Murray, 2018).

The stated aims of the NHS reform are to improve quality of care, clinical efficiency and cost effectiveness, illness prevention support, and development of NHS control away from the government (devolution of power). In effect, the reform aims to get the NHS to achieve improved service efficiency and quality of care but with fewer resources and smaller budgets (NHS England, 2016a).

The Royal College of Psychiatrists commissioned a study which showed numerous problems in (adult) mental health services. These included inadequate availability of patient care, disparity in access to evidence-based therapies, lack of clarity in outcomes expected, and inconsistency in leadership quality (Crisp, Smith, & Nicholson, 2016). The Department of Health's (DoH) initiative of overall NHS change and service re-design was previously put forward by the Labour government in the NHS Plan (DoH, 2000). It states that NHS change was overdue and the responsibility for transforming the health service rested with all those employed within it (Hewison, 2012). The Plan explicitly committed the NHS to an approach towards service re-design that *"mirrors the change management approach taken in much of the private sector"* (DoH, 2000, para. 6.14). The previous Conservative–Liberal Democrat Coalition government (2010-2015)

introduced further modifications to the Plan in the document *Equity and Excellence, Liberating the NHS* (DoH, 2010). This states that the government's values are aligned to, and in support of, NHS values as outlined in the NHS Constitution. In summary, the paper sets out the government's proposals in relation to the future of the NHS, covering the areas of: NHS values; arrangements for greater choice and control for patients and the public; greater focus on quality and outcomes as measures of success; the need to empower professionals and providers of service; commissioning by GPs and practice teams; the role of a new NHS Commissioning Board; the role of Foundation Trusts, Monitor and the Care Quality Commission; and the need to achieve very significant efficiency savings and reduce NHS management costs.

With the intention of activating these changes, the Health and Social Care bill was passed in 2012. Interestingly, patient safety was mentioned only once in the Act (in clause 281) and only in reference to the abolition of the National Patient Safety Agency. The Act confirms a commitment that the *"continuous improvement of the quality of services, more specifically the effectiveness of services and the quality of the experience of patients are principles enshrined in the Health and Social Care Act 2012 and in the NHS Constitution"* (Royal College of Nursing, 2015, para. 4). Thus, it states that quality of care and service effectiveness are the main principles upon which the Act is based.

5.2.3 Health and Social Care Act of 2012

Six key aspects of the Health and Social Care Act aim to assist in achieving the

proposed changes. The six aspects focus on Clinical Commissioning Groups (CCGs), public health, health and well-being boards, economic regulation, quality regulation, and service providers (NHS and private). To date, Primary Care Trusts (PCTs) and Special Health Authorities have been abolished. Instead, 211 CCGs have been set up in England, each commissioning care for an average of 226,000 patients. Every one of the 8,000 NHS GP practices in England is now part of a CCG, and all general practices are required to become local CCG members (The King's Fund, 2016). The CCGs contract the majority of NHS services for their patients. These include CAMHS treatment, elective hospital care, rehabilitative care, urgent and emergency care, most community health services, mental health and learning disability services, and private sector healthcare – the latter being commissioned often to help reduce waiting lists. The CCGs must answer to an NHS Commissioning Board (NCB), which is independent of the government. The NCB is responsible for disseminating the £100 billion NHS budget to the CCGs, who disseminate it to Trusts and services. The NCB calculates and allocates practice budgets to CCGs, and holds them to account for contractually defined quality standards, based on the Quality and Outcomes Framework and evidence of patient outcomes (The King's Fund, 2010). As part of the reforms, NHS services (such as specialist CAMHS Tier 3) must now apply to CCGs for their NHS budget allocations. Evidence of patient outcomes and other audit-based outcomes achieved by each individual CAMHS Tier 3 service must be provided (The King's Fund, 2016). Such evidence is gathered through new service procedures which involve auditing, outcome measures and administrative practices performed by mental healthcare professionals.

5.2.4 The change system and burnout

My research supports existing evidence that NHS workers have experienced chronic stress levels since the implementation of restructurings based on austerity measures (Hutchinson & Purcell, 2010). Closer performance management and the need for accountability have placed pressure on teams by increasing their range of responsibilities and their workload and subsequently, increasing stress levels (Kelliher & Parry, 2015; Meier & Hill, 2007). Evidence has been found that the practices driven by the cost cutting changes can produce negative work outcomes and stress in the public sector, which are likely to impair performance (Kelliher & Parry, 2015). Since the introduction of austerity policies work has been defined by pressure to reach targets, more patient demand and longer hours for NHS frontline staff. Increased feelings of burnout and of being devalued and demoralised were reported as a part of their everyday experience (Kerasidou & Kingori, 2019).

5.3 The need for CAMHS early intervention

In the UK, 50% of mental illnesses in adult life (unrelated to dementia) is estimated to start in childhood, before the age of 15 years, and 75% of mental illnesses start before the age of 18 years; suicide is the leading cause of death in young people (Mental Health First Aid England, 2020). In the United States, the statistics are similar, with half of Americans experiencing a diagnosable mental health problem with the first onset by age 14 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). The UK has one of the worst child mortality rates in Western Europe, with nearly 2,000 excess deaths a

year compared to the best performing country, Sweden (Royal College of Paediatrics and Child Health, 2014).

Evidence from a national case audit of children's deaths in the UK found that high numbers of children who died from suicide did not have any contact with mental health services. One thousand 10- to 28-year-olds die each year as a result of self-harm, suicide, or abuse (specifically, physical assault). In 34 years, the number of child and adolescent deaths due to intentional injuries and self-harm did not decline since 1980 (Royal College of Paediatrics and Child Health, 2014).

The proportion of under-16s experiencing mental health disorders (including anxiety and depression, as well as behavioural disorders and hyperactivity) increased from 11.4% to 13.6% between 1999 and 2017. One in eight (12.8%) 5- to 19-year-olds presented with at least one mental health disorder when assessed in 2017. Specific mental health illnesses were grouped into four broad categories: emotional, behavioural, hyperactivity, and other less common disorders. Emotional disorders (such as depression, anxiety, and PTSD) were the most prevalent type (8.1%) experienced by 5- to 19-year-olds in 2017 (NHS Digital, 2018a).

5.3.1 Child mental health and funding

Mental illness is the single largest cause of disability in the UK. One in four adults suffers with a mental health problem. The cost to the economy is estimated to be around £105 billion annually – roughly the cost of the entire NHS budget (Mental Health Taskforce, 2016). Despite this, only 13% of the NHS budget goes towards mental

health, even though mental illness accounts for over a quarter of the total burden of illnesses on the economy.

The situation is more dismal for child mental health which is often referred to as the ‘Cinderella of Cinderella services’ with only 6% of mental health funding being allocated to children and young people’s services (Royal College of Psychiatrists, 2014). Most of the DoH documentation regarding NHS changes focuses on the NHS as a healthcare provider for physical illness. In governmental policy terms, adult mental health has been the poor relation of healthcare. Child mental health has received even less priority despite the critical developmental importance of childhood and adolescence (Royal College of Paediatrics and Child Health, 2015).

Services such as CAMHS Tier 3 are commissioned by clinical commissioning groups (CCGs). Young Minds recently published data obtained through Freedom of Information requests, showing that 77% of CCGs who submitted data had frozen or cut their CAMHS budgets between 2013-14 and 2014-15 (34 reported having cut budgets, and 40 reported having frozen their budgets) (Young Minds, 2018).

5.3.2 Impact of austerity cuts on child mental health

Before the Covid pandemic, child poverty, homelessness, and food poverty were on the increase and were mainly implicated in the rise in infant mortality and mental health problems in the poorest areas of England and there a clear link has been found between poverty and poor mental health (Marmot et al., 2010). The impact of austerity was reported as having severely damaged the provision of mental healthcare with cuts

to services (UN Committee on the Rights of Persons with Disabilities, 2016). Evidence shows that growing up in or living in poverty is associated to the onset of mental illness (Marmot et al., 2010).

The effects of the Covid pandemic on employment and poverty are predicted to be ten times greater than that of the 2008 financial crisis (OECD, 2020). So far, there is evidence of increased financial strain on families, and this along with the government enforced lockdown have been damaging to the development and mental health of children (Department for Education, 2021).

In attempts to stabilise the economy, the government has increased its spending as a response to the Covid pandemic. However, concerns have been raised that long term planning and government policy to pay back this increased expenditure may lead to even more cuts to local authorities and mental health services which will affect deprived children disproportionately (BMJ, 2021).

5.3.3 Impact of pandemic on child and adolescent mental health

More than 21.7% of 17- to 22-year-olds with a probable mental disorder reported they had not sought help due to the pandemic (Vizard et al., 2020). At the beginning of the Covid-19 pandemic lockdown (March 2020) referrals to NHS mental health services fell but this was quickly followed by a sharp increase (Price, 2020). Since it began, many young people have been experiencing increased anxiety and depression (Hefferon et al., 2020). A Young Minds (2020) survey showed that 83% of young people with existing mental health issues reported a decline in their mental health since the pandemic.

There has also been a rise in the number of young people accessing online mental health platforms and apps. Between January and May 2020, the charity Childline delivered almost 7,000 counselling sessions to children with concerns directly related to COVID-19 (Hefferon et al., 2020). In a report eight months after Covid lockdown began, children and young people with an existing mental health disorder were more likely to say lockdown had made their lives worse (Vizard et al., 2020). During lockdown, widespread school closures, lack of peer interactions and social activity has been isolating for young people. In trying to fulfil the need for social connection, many young people have increased their use of online social networks. This has the potential to be a risk factor to mental health as use of such platforms increase the probability of exposure to bullying, exploitation and other menacing influences on social media. Children and young people experiencing loneliness during lockdown were three times more likely to develop depression once lockdown ends. Community services, such as CAMHS, offered online support and video sessions as an alternative to meeting in person where possible during the lockdowns. This had its own issues for people who had problems with privacy, access to technology and anxiety about talking on the phone or via video calls (Young Minds, 2020).

For many young people already facing hardships such as abuse, domestic violence and problematic family relationships, have worsened during lockdown left them in a situation of increased isolation and vulnerability (NSPCC, 2020). In being separated from the physical proximity of teachers and the community, they were out of sight of and without access to those who might observe or notice any concerning presentations, behaviours and see or hear signs of increased need, neglect or mental health struggles.

Subsequently, there was less opportunity for identifying, tracking and intervening in mental health and safeguarding issues. Children with disabilities and those who live and work on the streets were particularly vulnerable (United Nations, 2020).

5.3.4 Deteriorating child mental health and service provision

There have been many national media news reports and government discourse about the impact of the pandemic on the NHS healthcare system. However, far less emphasis has been placed on the impact upon NHS child mental health services.

There are growing concerns about deteriorating mental health among children and young people, and the inadequacy of service provision which needs investment and funding to cope (BMJ, 2021).

Anne Longfield, the children's commissioner for England, warned at the start of 2021 that the already stretched NHS CAMHS services do not have the capacity to cope with the impact of the Covid-19 pandemic on children (Children's Commissioner, 2021). However, cuts to child mental health services are ongoing. As an example, it was reported recently that Lewisham's Child and Adolescent Mental Health Service (CAMHS) (partially funded by NHS and the local authority) which had, like most CAMHS, endured years of cuts was now fighting another funding cut of £250,000. The proposed cut was part of £40million cuts planned over the next three years. The council said its hands were tied because of years of Government austerity (Kilraine, 2021).

The children's commissioner has warned that the damage to children's mental health caused by the Covid crisis could last for years without a large-scale increase in funding

and resources for children's mental health services. In a report, it was emphasised that the number and rate of children being referred to NHS mental health services continues to rise (Children's Commissioner, 2021).

Risks to young people's mental health such as poor living conditions, increased hardship due to parental unemployment, reduced access to education, loss of social interaction, and reduced access to health services have risen since the pandemic. The full consequences of these situations are yet to unfold. It is expected there will be more cuts to mental health services in the future as the government tries to repay its Covid expenditure (BMJ, 2021). This is likely to intensify the stresses upon counselling psychologists in CAMHS who, as frontline mental health workers, are already among the highest at risk of burnout (Dyrbye et al., 2017). Neither does this not augur well for catching child mental illness early.

5.3.5 Why CAMHS early intervention is vital

An untreated mental illness leaves the individual vulnerable to more severe development of the disorder, and eventually the mental illness can become resistant to treatment (Kessler et al., 2010). 70% of children and adolescents who experience mental health problems have not had appropriate interventions at a sufficiently early age (Children's Society, 2020). About half the population will meet the criteria for a mental health disorder sometime in their life, with first onset usually in childhood or adolescence. Interventions aimed at prevention or early treatment need to focus on the youth (Kessler et al., 2005).

Evidence-based early intervention mental health work is important in arresting and containing mental health illnesses in children across the UK. Economic analysis indicates that early intervention service provision could save the NHS approximately £5,000 per patient each year and produce good clinical outcomes for patients (Marwaha, Thompson, Upthegrove, & Broome, 2016). Early investment in disadvantaged children and early prevention are more cost effective than later remediation. Economically, the rate of return is estimated to be better than at later times in the life cycle (Doyle, Harmon, Heckman, & Tremblay, 2009).

A serious mental health disorder causes limitations to an individual's ability to carry out daily activities and is associated with high rates of work disability, suicide attempts, and psychosis. On average, a person with a chronic mental health problem endures three months of the year when unable to function normally in daily activities. Individuals with one untreated mental illness are at a high risk for developing a second one (comorbidity). In the United States of America, nearly half (45 per cent) of those with one mental disorder meet the criteria for two or more disorders. In a European study with 6 million Danish participants, comorbidity within mental health disorders was shown to be pervasive (National Institute of Mental Health, 2021).

Untreated child and adolescent mental health disorders are associated with school failure, teenage pregnancies, unemployment, divorce, separation, and violence (Khan, 2016). It has been well documented that early intervention access and effective treatment of cases can prevent severe functioning problems in later life. Therefore, the smooth service delivery of CAMHS, which is an early intervention mental health service,

is important in terms of mental illness treatment and prevention perhaps now more than ever.

5.4 How burnout can undermine early intervention service delivery

Burnout in mental health workers has been associated with turnover intentions and turnover (Salyers et al., 2017; Rollins et al., 2010; Schaufeli et al., 2009). In my research, counselling psychologists had been considering leaving their services or were just about to leave due to increasing and multi-layered stress experiences in CAMHS. It is generally agreed that turnover of professionals who decide to leave a service due to work-related stress compromises mental healthcare teams by potentially causing staff shortages and instability in patient care (Holmberg, Sobis, & Carlström, 2016).

Furthermore, when staff leave a service, there is evidence that it affects the continuity and flow of service delivery (Rollins et al., 2010) and can put pressure on remaining staff in terms of extra work. In addition, recruitment and training costs are incurred.

5.4.1 Organisational change and burnout

As aforementioned, organisational change and how the change is managed are recognised risk factors for stress and burnout (HSE, 2004). Changes can introduce burnout or drive up existing stress levels into burnout syndrome, especially when changes are made to the nature of the work (Schabracq, 2003; Day et al., 2017). As counselling psychologists experienced the disruption of therapy room dynamics and client interactions because of service changes, these stated changes to the nature of

the work seem relevant to the burnout literature. Implementation of organisational changes associated with frontline staff experiencing increased stress and burnout can occur due to an overall loss of resources, such as decreasing autonomy, less involvement in decision making, less stimulating work, less time with supervisors, and less authority over their work (Dubois, Bentein, Mansour, Gilbert, & Bédard, 2014). Restructurings, mergers, and downsizing can result in higher levels of job demands, role ambiguity, and job insecurity (Smollan, 2015), which are all risk factors for burnout, and all reported by counselling psychologists as stressors since restructurings were introduced into their CAMHS teams.

5.4.2 Burnout and its effects on patient safety

Not only can service delivery become impaired in its functioning when burnout contributes to employee absences, lateness, reduced job performance, and increased turnover (Dyrbye & Shanafelt, 2011) but also quality of patient care and increases in patient-related errors, decreased empathy and patient satisfaction have been associated with burnout (Dyrbye & Shanafelt, 2011). This is costly to service providers in terms of finances and quality and continuity of patient care (Durning et al., 2013). Evidence shows that burnout can negatively affect quality of patient care and patient safety in the NHS (Hoge, Terhakopian, Castro, Messer, & Engel, 2007; McCray, Cronholm, Bogner, & Gallo, 2008; Salyers, Bonfils, Luther, Firmin, White, Adams, & Rollins, 2017) and decrease patient satisfaction (Dyrbye & Shanafelt, 2011).

Considering the potential consequences of burnout on patient safety, it is concerning that 69% of full-time NHS psychological therapists in the UK are estimated to have

burnout (Westwood, Morison, Allt, & Holmes, 2017). The fact that this sector is less well funded and resourced than healthcare may be a contributing factor. In mental health care services, poorer well-being and higher burnout are associated with poorer safety and quality of patient care, less effective interventions, higher absenteeism, and higher turnover rates (Johnson et al., 2018).

A higher number of hours spent on administrative tasks with higher numbers of patients seen per day and feeling less supported were all factors associated with higher burnout levels in UK healthcare staff. Hall et al. (2019) also showed how higher burnout levels were associated with the increased likelihood of a near miss in the previous three months, such as prescription errors and communication errors. Stressed workers are more likely to make poorer decisions and judgements (Johnson et al., 2018), and to rely on cognitive biases which can skew clinical decision-making processes (Hall et al., 2018).

5.4.3 Illness, burnout, and patient experiences

In 2016, figures showed that mental healthcare staff took more sick days than healthcare staff in acute Trusts. Work-related stress is higher, with 41% of mental healthcare staff reporting feeling unwell due to stress in one year compared with 35% of healthcare staff in other acute Trusts (NHS Digital, 2018b). Reduced well-being, absenteeism, mental health and health problems of workers (Acker, 2010; Dahl, 2011) can be traced to burnout and these are costly to services (including employment of locum cover staff) and can destabilise patient outcomes. Counselling psychologists

stated that they had experienced reduced physical and emotional well-being since organisation changes increased their stress experiences.

Burnout has been linked to increased risks to, and poor experiences for patients. The chronic symptoms of sustained stress and burnout can affect the behaviours of staff and their relationships with colleagues and patients. Heavy workloads and staffing shortages are associated with patient dissatisfaction. Staff shortages can mean that necessary tasks are not always performed for patients and burnout can lead to an increased risk of errors which can ultimately affect patient outcomes (Hall, Johnson, Watt, Tsipa, & O'Connor, 2016) and undermine a positive experience in mental health care services. Stress related emotional withdrawal from clients and from the organisation (disengagement) also risk disrupting work quality with patients. Therefore, the effects of chronic stress have the potential to be catastrophic for patients, professionals and services.

5.5 Discourse and organisational change

In my study, within the super-ordinate theme of ‘Impact of NHS changes on CAMHS Tier 3 work settings’ and its sub-themes, counselling psychologists discerned the work setting as becoming more business led and less client focused. They found this stressful as it seemed to be out of harmony with their professional values and their normal expectations of NHS values. Counselling psychologists also described the way in which stress impacted their experience of themselves in therapeutic encounters.

A recurring concern and stressor experienced by counselling psychologists was the effect of NHS changes on client-centred care. A new emerging business discourse in the work setting was perceived to dehumanise the children. They were referred to as ‘targets’, ‘outcomes’, ‘numbers’, ‘contacts’, and ‘bums on seats’. In their narrative flows, participants sometimes juxtaposed this new management vernacular against patient care language. For example, “*Management are more concerned with productivity than what’s helpful to clients*”; “*Work is so target driven... it’s about saving money and families come las*t”; and “*In meetings they talk about money and ‘getting bums on seats’. The bums on seats are children”.*

There is a language associated to management philosophy and a cultural transformation (Al-Assaf & Schmele, 1993). Czarniawska-Joerges and Joerges (1988) noted that metaphors, labels, and even platitudes identify changes taking place in an organisation, often helping to understand, impart and even implement those changes.

Swales and Rogers (1995) suggested that a key sign of tangible change in an organisation is that its language is changing; it is through this language change that “*meaning is created and action becomes possible*” (p. 224). Meaning is important here as these changes seemed to bring a value tension into the counselling psychologists’ work settings. Gilbert (2005) described it as a value tension between cost of care and the values inherent in quality of care which polarised professional and managerial discourses in the work environment. As counselling psychologist, Michael expressed, “*A changing discourse is coming in and culture... It’s reductive... and all about numbers now”.*

To the counselling psychologists, the discourse reflected a change in the meaning inherent within the daily work processes of improving child mental health. It seemed these processes were becoming embedded with quality-monitoring mechanisms. The colonisation of professional activity by managerial discourse was perceived to be producing a context where professional activity is defined by audits, reaching targets, and monitoring or 'managerialism' (Gilbert, 2005). Power called this a displacement in the terms of government discourse from service-specific values of care to more abstract, financial and quantitative categories (Power, 1996, p. 13).

Counselling psychologists commented on a culture of quantitative contacts and targets being introduced as part of the service changes and, along with this, a discourse of business-related auditing and monitoring activities. They found this stressful because the discourse and processes seemed to convert the activities of client care from socially dynamic relationships into objectified and quantitatively manageable products (Gilbert, 2005). Organisations tend to be primarily concerned with efficiency and profitability whereas professionals, especially in the caring professions, tend to care mainly about providing quality of care as defined by their profession, which often takes precedence over cost or revenue considerations (Freidson, 2001). In this case, the CAMHS management teams were perceived as engaging in cost cutting and monetary-based reductive thinking regarding mentally unwell children, at the expense of profession-defined quality of psychological care, thinking and practice.

5.5.1 Value conflict and change

My research findings suggest counselling psychologists have been managing a

stressful conflict between a changed and organisationally dominant discourse of measurability and productivity and the value system, ethical guidelines, and original organisational values to which professionals originally chose to align their identities (Maslach & Leiter, 2016; Swales & Rogers, 1995).

According to Maslach and Leiter (1997), burnout is more about value conflicts than it is about work demands. When there is a value conflict in the work setting or a conflict between individual values and those supported by the managing systems, employees will find themselves making a trade-off between work they want to do and work they have to do. The implications are stressful enough to lead to burnout (Maslach & Leiter, 2016). Values are the ideals and motivations that originally attract many professionals to seek employment in the NHS. Thus, values can be the motivating connection between the worker and the work setting which extends beyond the exchange of effort for financial compensation. Organisational values are articulated in mission statements and websites and included in induction and training sessions (Ryan, 2005). Therefore, they are an active part of working life. The values enshrined in the NHS Constitution encompass: Working together for patients; Respect and dignity; Commitment to the quality of care; Compassion; Improving lives; and Everyone counts (DoH, 2009). In addition, according to the *Employee Engagement and NHS Performance* paper, the NHS pledges that "*all staff will be empowered to put forward ways to deliver better and safer services for patients and their families"* (West & Dawson, 2012, p. 7). Therefore, this perceived change in values discerned by a change in the managing system of their services was stressful to the counselling psychologists. As Laura asserted, *"there's been a change in the management, and... a change in philosophy... it's become very*

cost driven. They don't have experience of sitting in a room with a client".

Organisational values are frequently experienced and seen in language that is used in the managing system. Martin (2002) showed how jargon both defines a culture and shapes it. For example, in researching corporate mergers and acquisitions businesses, the author noted that the informal, everyday use of terms such as 'shark', 'ambush', 'stud', 'cupid', and 'afterglow' reflected themes of violence and sex. "*Metaphors tap the emotional aspects of life in particular kinds of organisations and industries, alluding to emotions that may not be socially acceptable to express more directly"* (Martin, 2002, p. 80).

The findings support established research identifying workload and values as organisational risk factors implicated in burnout. During organisational change, if the change interventions are not congruent with the employees' value systems, a misalignment of values can affect professional identity, and also lead to burnout (Du Plessis, Visagie, & Mji, 2014; Dylag et al., 2013). Value misalignment is one of the key risk factors for job burnout and work disengagement (Maslach & Leiter, 1997).

Value alignment between organisations and their employees is regarded as important in organisational research. Many researchers agree that organisational culture is substantially about values (Duck, 1993; Kabanoff, Waldersee, & Cohen, 1995; Ryan, 2005). Dylag et al. (2013) showed an increase in occupational burnout and decrease in work engagement and job satisfaction under conditions of perceived discrepancy between individual values and organisational values. A number of studies have shown that when personal and organisational values are incongruent, insecurity and disengagement from the work ensue and cynicism develops about the working

environment, leading to turnover and absenteeism. In contrast, value alignment between the organisation and the worker reassures employees and fuels work engagement (Dylag et al., 2013; Maslach & Leiter, 1997). Studies highlighting ethical, value, or professional misalignments in the workplace leading to burnout and its consequences of turnover intentions, stress-related illness, and diminished quality of care (Maslach & Leiter, 2016) support but their experiences but may not augur well for the CAMHS counselling psychologists in this study.

5.5.2 Meaning and the client relationship

Arguably, it was partially the counselling psychologists' advocacy of the child-centred approach which underpinned their distress about some of the changes in the work setting. In the sub-theme of 'Where meaning lies', it seems evident that counselling psychologists found meaning in helping children overcome their problems. They seemed to be highly perceptive to the delicate sensitivity of the child-therapist relationship, and valued being effective in their child work: "*Meaning comes from relating, understanding things from their world view, as opposed to just seeing someone with an illness"; "Meaning is... about being in the room with a client, and what drew me to the profession"; "Sense of meaning is when I see the client improving and getting better"; "Fundamentally, the meaning is in relating to others"; "I relate well to adolescents. It's part of who I am"; "That I've been able to care for my clients as best I can... it's still there and I fight for it on a daily basis".* It can be seen in these quotes how the counselling psychologists find meaning in relating to children as individuals in their own right and allowing them the space to open up and express themselves. Seeing the

children as individuals trying to survive and work through the phenomena of mental illnesses, and viewing the relationship as being the conduit of this process, it is highly regarded in their approach. They seem to be protective of the relationship and distressed by the impact of the service changes which were to them out of context with client-centred values.

In terms of reaching positive treatment outcomes, the relationship between therapeutic alliance and outcome has been shown to be the most robust factor across treatment modalities and clinical presentations (Castonguay & Beutler, 2006). This suggests that, in the interests of the effectiveness of early intervention mental health treatment, the therapeutic space should be keenly protected. However, counselling psychologists reported negative impacts in the therapy room as a result of stress during organisational change and due to the change method systems.

5.5.3 Role conflict and early intervention

Counselling psychologists in this research stated that heavily increased administrative tasks were so time consuming to the point where time for client work was being eclipsed. Expanding administrative duties competing with increased job demands and diminished resources (Demerouti et al., 2001) typically sets up a situation which causes role conflict and role overload and the worker's ability to finish the necessary tasks is undermined. In such a work setting the organisational climate can become increasingly stressful (Glisson et al., 2008) and may further contribute to the experience of burnout.

Increasing administrative work rivalling time allocated to client work was a main source of stress for all the counselling psychologists. Their expressions of frustration included: *"I understand the importance of the paperwork and clinical documentation, and especially in an ever-increasing time of safeguarding. but having a balance would help... to do the job I trained for, to actually practice as a psychologist".* Consequently, the counselling psychologists were left with a sense of inefficacy (also a dimension of burnout): *"I never seem to catch up"; "It's really hard to stay on top of the client work as well as the admin"; "I feel less able to do efficient clinical work... and it's more paperwork"; "I have less time in terms of having more and more demands to meet... and they're non-clinical demands…"*. It was clear the participants felt torn between the client work and supporting the service by completing the administration tasks. This appeared to represent role overload and role conflict, but also a conflict between new restructured organisational needs and the client care.

In many cases, the therapy sessions felt reduced to a tick-box routine to meet management targets and produce numerical outcomes (Curtis et al., 2012). Tension between counselling psychologists' client work and the reality of the change system's expectations had fostered role conflict and role overload, which are both implicated in burnout (Green et al., 2014; Maslach et al., 2001). Attempting to balance the competing demands was so exhausting as to leave counselling psychologists feeling psychologically depleted and, in some cases, less prepared for their client therapy sessions. The emphasis on record keeping and auditing *"diverts attention away from critical aspects of the clinical process such as timelines and clinician empathy"* (Hopkins, 1996, p. 418).

5.5.3.1 Therapy room impact and early intervention

Within the super-ordinate theme of ‘Therapy room impact’ it can be seen how work stressors impacted participants’ experience of themselves in the therapeutic encounter.

Depletion of emotional energy in the therapy room is a feature from this study particularly resembling the ‘emotional exhaustion’ factor in the burnout literature. Emotional exhaustion is a principal dimension of the burnout concept (Maslach et al., 1996), and is viewed as the driving force behind the syndrome (Leiter & Maslach, 2003). Conversely, emotional engagement is a positive, fulfilling, work-related state of mind that is characterised by vigour, dedication, and absorption in one’s working life (Schaufeli & Bakker, 2004). Rizq (2012) described mental health workers’ relational disengagement from clients as a consequence of continued pressure to focus more on producing quantifiable and measurable service delivery outcomes, and this involved more administrative work for the practitioner. Here, the participating counselling psychologists experienced a state of mental exhaustion and, consequently, noticed a depletion in their psychological availability for clients in the therapy room (Green et al., 2014; Linley & Joseph, 2007).

Although the counselling psychologists did not express feeling cynical towards clients (a dimension of burnout), their exhaustion often left them too rushed to offer their full psychological presence in the therapy dyad. In mental healthcare, ongoing experiences of high job demands have been evidenced as risk factors for emotional exhaustion in professionals (Demerouti et al., 2001). Exhaustion can prompt emotional and cognitive distance from work as a way to cope with the overload (Maslach et al., 2001). Juggling the demands of a caseload with increasing administrative tasks has meant that some of

the counselling psychologists offered a less attentive presence in the therapeutic space. Tash openly described her experience: *“There have been... days I’ve felt like I can’t give one hundred per cent in the therapy. Working like this, ‘Am I actually helping?’*”. The latter sentence also points to a red flag for burnout potential as it expresses a sense of doubt in her professional efficacy. The reduced personal accomplishment dimension of burnout refers to a decline in feelings of achievement and competence at work (Bakker & Demerouti, 2014). Along with pressure to attend to competing work demands which increased due to the introduction of higher levels of administration, Tash felt bad about her resulting mental tiredness. Subsequently, she questioned her effectiveness in the therapeutic space, and seemed to personalise the depletion of energy caused by the struggle of competing demands.

Michael felt this also: “*Clinicians have not been allowed to do the work they should, and are being overworked. There is a knock-on effect on clients”.* It was felt that completing administrative and non-clinical tasks had to be prioritised. Consequently, Emma felt ill prepared as she entered some of her sessions because she had been preoccupied completing non-clinical tasks: *“I’ve gone into sessions and not been fully prepared... I hadn’t time and now the client is sitting in front of me again. Feels like I’m just treading water*”. Again, the latter sentiment exposes a sense of lack of efficacy shown to play a prominent role in burnout.

These are examples of how high job demands and depleted resources are implicated in CAMHS counselling psychologists enduring ongoing exhaustion and, subsequently, distancing themselves psychologically from important aspects of their work lives (Bakker, Schaufeli, Sixma, Bosveld, & van Dierendonc, 2000). Role conflict has been

uncovered as a strong risk factor for emotional exhaustion in burnout and the development of disengagement or cynical attitudes towards clients (Schwab & Iwanicki, 1982).

Depersonalisation is a defence mechanism individuals can use to cope with emotional exhaustion, (Maslach et al., 1996). It takes the form of a self-protective mechanism of withdrawal from relational aspects of the work (Demerouti et al., 2001). Professionals working with children in child protection roles (Anderson, 2000) reported greater levels of depersonalisation in response to emotional exhaustion. This type of problem may be a threat to the success of early intervention mental health work such as CAMHS not least because of the important relational aspects inherent in successful therapeutic work with children and adolescents.

5.5.3.2 Resources and service delivery

Job resources are defined as "*those physical, social, or organisational aspects of the job that may do any of the following: (a) be functional in achieving work goals; (b) reduce job demands and the associated physiological and psychological costs; (c) stimulate personal growth and development*" (Demerouti et al., 2001, p. 501).

Studies have shown that high job demands without reciprocal job resources such as time, feedback, job control, and social support can exhaust employees' energy resources and lead to negative organisational outcomes such as burnout. This, in turn, can foster employee turnover intentions and poor organisational commitment (Chew & Chan, 2008; Hu, Schaufeli, & Taris, 2011).

In American cross-sectional studies, significant correlations have been shown between job satisfaction and patient satisfaction with their care (Haas, Cook, Puopolo, Burstin, Cleary, & Brennan, 2000). Practitioner burnout has been linked to decreased empathy and lower patient satisfaction (Dyrbye & Shanafelt, 2011). Although the counselling psychologists reported being psychologically tired and somewhat withdrawn from clients, they still maintained a very strong empathy and concern for them. The experience of patient relational issues was a factor triggering stress because meaning and professional identity were invested into their patient relations. Berjot, Altintas, Lesage, and Grebot (2013) showed that working conditions can represent a threat to the professional with inadequate resources to practice their profession properly. As counselling psychologist, Michael noted, *"For counselling psychologists, the client relationship is highly prized. Now there are forms to fill in with clients. I check if they've brought a passport and council tax bill. I feel like a bank clerk".* Rather than decrease empathy, the situation only served to make practitioners feel bad for the clients and stressed within themselves about the administrative interference in the therapeutic dyad due to organisational changes.

5.5.3.3 Supervision, reflection time, and service delivery

Counselling psychologists experienced not having time to reflect on cases themselves and also having less opportunity to reflect and consult with other team members. Furthermore, some noted that previously protected clinical supervision time was regularly appropriated and used to discuss line management matters regarding administration, outcomes, and non-clinical issues: *"Even in supervision, the client gets squeezed out..."; "Sometimes my supervisor talked about her own stress... it added to*

mine". These were notable disclosures since a loss of reflective and consultation space were implicated as a stressor in the workplace, a contributor to job satisfaction problems, and was considered important to the psychologists in their provision of good patient care. Overwhelming administration demands placed upon the counselling psychologists in this complex mental health setting seemed to "*catch the mind directly, giving no time for calm, dialectical conversation with their own minds*" (Meerloo, 1956/2009, p. 210). As Laura said, *"I'd like more time to reflect on client work, but sometimes it feels like fire-fighting... back-to-back sessions and running from thing to thing*".

Martin et al. (2005) identified good quality patient care and effective supervisor support as two resources which help employees cope with organisational change. In one US study, when organisational changes were introduced into an early intervention children's service, the new service delivery model affected professionals' work setting dynamics, reduced opportunities for peer consultations, impacted the therapist-client relationships, and caused increased levels of stress. The changes affected job satisfaction and role clarity, and were the precursor to the community service's highest ever rate of staff turnover. This signified a huge loss of specialism for the community's vulnerable children and families (Gill, Greenberg, & Vazquez, 2002).

Supportive supervision and effective communication are important for staff morale and even organisational change acceptance (Leiter & Harvie, 1998). Mental health nurses who had supportive clinical supervisors reported lower levels of burnout and depersonalisation (less negative attitudes towards patients) than those without it. (Edwards et al., 2006).

In a study of over 3,000 staff members of a hospital that underwent significant change and restructuring, Leiter and Harvie (1998) found that supportive supervision, a focus on the meaningfulness of work, confidence in management, and effective communication were associated with positive responses to organisational change. Cognitive processes can be hindered when an individual is continually highly stressed and the lessening of appropriate consultation, reflection time, and team case reflection can leave the psychologist extremely vulnerable to viewing the client's problem too simplistically (Gottlieb, Handelsman, & Knapp, 2013). According to counselling psychologist, Emma, *"It sort of felt frowned upon… seeking a case reflection meeting. There was a comment that the money is being spent on me seeing clients".* The importance of reflection was a priority for Diane, who expressed her awareness of the need for such time in dealing with complex Tier 3 cases: *"With this type of work, you need thinking space... time to reflect. Line management issues... they're talked about in supervision now"*.

Low supervisor support was reported to increase mental health workers' stress levels whilst high supervision support has been associated with higher morale, better quality of patient care, and job security (Smollan, 2015). When change-related stressors were high, healthcare employees who reported high levels of supervisor support reported less burnout (specifically, lower levels of emotional exhaustion and lower levels of cynicism) than employees who had less supervisor support (Day et al., 2017). Supervision is also important for patient safety and service delivery, especially during organisational change, as professionals can be vulnerable to 'ordinary ethical lapses', often without their full awareness during periods of stress (Bazerman & Banaji, 2004, p. 111).

Consultation was the most helpful and frequently endorsed method involved in appropriate client decision making by mental health workers, and is recommended as an important step in ethical decision making (Gottlieb, 2013; Gottlieb et al., 2013; Younggren & Gottlieb, 2004). Supportive supervision and reflection time improves psychological well-being (Martin et al., 2005) and is seen to be a mitigating factor against burnout. Thus, effective supervision acts as a preventive measure in ensuring a positive work environment that contributes to quality of service delivery; worker effectiveness and task assistance; social and emotional support; and interpersonal interaction. Supportive and quality supervisory relationships have also been associated with reduced burnout, reduced turnover and turnover intentions, and improved job satisfaction (Mor Barak, Travis, Pyun, & Xie, 2009).

An important source of coping with work-related stress is support from co-workers (Haslam, O'Brien, Jetten, Vormedal, & Penna, 2005). In contrast, the loss of adequate case reflection time and sub-optimal supervision have been implicated in service delivery issues. Multi-disciplinary teams in complex mental health settings are widely considered fundamental to effective service delivery (Leipzig et al., 2002; Schofield & Amodeo, 1999). Consultations and case discussions amongst professionals with different educational and professional experiences support effective service delivery because they draw together diverse perspectives, expertise, and skills (Kozlowski & IIgen, 2006), which disseminates information and feeds critical thinking. Tapping into this resource is important for complex multi-disciplinary child mental healthcare work that requires different levels of expertise (Roberge & van Dick, 2010). Apart from clinical case discussions and co-working on cases, participative case meetings and reflection

time foster increased communication. These activities also encourage participative decision making and help prevent workers feeling isolated from their colleagues (Maslach & Jackson, 1984, p. 151).

5.5.4 Loss of well-being and early intervention service delivery

Acker (2010) found that high levels of burnout, particularly emotional exhaustion and depersonalisation (dimensions of the burnout construct), were related to increased reports of flu-like symptoms and symptoms of gastroenteritis. Most of the counselling psychologists in the current study experienced higher levels of ill health and absenteeism, which they believed were caused by increased stress and additional pressures they had been experiencing in their teams. They directly attributed their illnesses to work-related stress. Some examples include: *"I think it's probably the most stressed I've ever been at work. The GP offered to sign me off with stress. I was very close but I didn't in the end";* "*My stress has more to do with the changes in management*. *I was off for a couple of weeks because it made me ill"; "I've become more disgruntled. Angry. There has been some change (in me)".*

Some participants witnessed an upsurge of absenteeism as their colleagues became ill, and one psychologist admitted returning to CAMHS whilst still unwell because of her workload pressure. As participants stated: *"There was pressure and morale was low. Quite a few people got sick and needed time off... I've gone back into work when I haven't felt okay"*; "*(I've) been very close to feeling burnt out. I went into therapy... just to help me function in the job".*

These stress responses were similar to consequences of burnout, specifically stress-related illness, absenteeism, turnover, and less psychological availability and engagement in the therapeutic space (Schwab & Iwanicki, 1982). Of the three burnout dimensions, exhaustion is a higher risk factor for stress-related health problems than the other two dimensions of depersonalisation and accomplishment. Exhaustion has been implicated in physiological symptoms such as headaches, chronic fatigue, gastrointestinal disorders, muscle tension, hypertension, colds, flu, and sleep disturbances (Ahola & Hakanen, 2014). In health professionals, sickness absence has been shown to increase two-fold during organisational change (Kivimäki, Vahtera, Pentti, & Ferrie, 2000). The resulting effect is that stress-related illness risks disrupting the continuity of service delivery in early intervention mental health work, and weakening team resources.

Organisational changes are associated with significant risks of employee health and well-being problems, and have been implicated (unrelated to individual differences) in the increased use of stress-related medications (Dahl, 2011). Mental health workers with burnout can experience physical and mental health problems (Acker, 2010; Dahl, 2011; Peterson, Demerouti, Bergström, Samuelsson, Asberg, & Nygren, 2008). Workplace burnout causing a deterioration of health can bring on subsequent sick leave absence (Bakker, Demerouti, de Boer, & Schaufeli, 2003; Dreison, Luther, Bonfils, Sliter, McGrew, & Salyers, 2016; Hasson et al., 2006). When organisational change triggers burnout in professionals, absenteeism tends to follow (Hasson et al., 2006). Organisational change which causes high psychological distress in healthcare

professionals can, in turn, negatively affect cognition and decision-making processes (Lavoie-Tremblay et al., 2010).

5.5.4.1 Well-being and morale: Job insecurity and service delivery

In the public sector, organisational change and restructuring have been shown to cause worries about job security, especially if cost-cutting strategies or downsizing are introduced or colleagues are seen to lose their jobs or status (Armstrong-Stassen, 2005). Job insecurity is a risk factor for burnout and psychological withdrawal (or disengagement) from organisations in the public sector (Dekker & Schaufeli, 1995). Job insecurity increases levels of stress for employees during organisational change (Noblet, 2006). It is defined as a psychological stressor related to the perceived threat of job loss (Schaufeli, 2016). The European Union (2013) identifies job insecurity as a "*main psychosocial hazard*" in life (p. 13). WHO reported that psychosocial hazards are linked to the experience of work-related stress and affect 22% of workers in the European Union (Leka & Jain, 2010).

Counselling psychologists experienced their jobs being threatened and, in some cases, the threats seemed to be applied as leverage to pressure them into complying with the new system of working. The following are three of the participants' quotes: *"Some very experienced psychologists lost their jobs or had to re-apply for them"; "We're told that this is what the Trust wants and if we don't do it, we could lose our jobs"; "There's an implied threat that if we don't reach our monthly targets, we could be out of a job".*

Therefore, job insecurity could affect early intervention mental health service delivery, not least because it can produce elevated anxiety and stress levels, loss of motivation,

lack of trust towards the organisation, and job dissatisfaction (Schaufeli & Taris, 2014). The latter, job dissatisfaction, is a high-risk factor for burnout and is associated with high turnover, poor job performance, lowered organisational commitment (Cheng & Chan, 2008) and lower patient satisfaction (Haas et al., 2000). As job satisfaction decreases, turnover increases (Gill et al., 2002). The impact of job insecurity is multi-faceted and negative. When the professional's job becomes insecure due to redundancy, fear of redundancy, or threats, the negative impact on identity and self-esteem can also trigger burnout (Dekker & Schaufeli, 1995), PTSD (Grebot & Berjot, 2010), and even suicide (Kleespies et al., 2011). To a population of workers already dealing with stressful work content who dedicate their working lives to relieving the mental distress of children, the additional stressor of job insecurity could be harmful.

5.5.4.2 Turnover and service delivery

"...The restructuring left the team with very low morale... I've found another job and I'm leaving."

Burnout can result in the loss of professionals from a team when they terminate their employment (turnover) and choose to work elsewhere. The intention to remain employed, as opposed to turnover intentions, is related to positive treatment outcomes for children and families, while turnover is related to poor service quality (Collins-Camargo, Ellett, & Lester, 2012). Organisational change is a high-risk factor for turnover, which can have a financial, resource, and morale impact on teams (Collins-Camargo et al., 2012). When staff leave, it increases the workload of remaining employees as they try to compensate temporarily or permanently for the loss. Alternatively, when the burnt-out professional remains in the service and continues

working without addressing the burnout, the quality of work they produce can diminish (Maslach & Goldberg, 1998). If performing at diminished capacity, the psychologist's clients are likely to receive an inadequate service (Gilliland, Sinclair, Cupples, McSweeney, Mac Auley, & O'Dowd, 1998). The effect of turnover can also be highly disruptive to client-therapist relationships (Albizu-García & Juarbe, 2004).

Turnover can represent the loss of a highly specialist skill base, with unique experience and abilities (Shaw, Gupta, & Delery, 2005), and this can only be the case if CAMHS counselling psychologists working in early intervention and prevention mental health decide to leave because of possible burnout. This loss of experienced professionals has significantly impacted the quality of support and consultation provided to children and families in communities (Gill et al., 2002) and their teams, and gaps in service delivery have suffered (Cascio, 2006; Summers, Humphrey, & Ferris, 2012). Recruitment and training costs are expensive, and the flow and quality of service delivery is interrupted (Glisson, Dukes, & Green, 2006). Furthermore, in rural areas, when psychologists decide to leave community mental health teams, patients can go without services indefinitely, and sometimes altogether. This can be devastating for some populations, as people with long-term conditions and comorbid mental health problems disproportionately live in deprived areas and have access to fewer resources in general. The interaction between comorbidities and deprivation makes a significant contribution to generating and maintaining inequalities amongst children in our society (Naylor, Parsonage, McDaid, Knapp, Fossey, & Galea, 2012).

Turnover and turnover intentions resonated throughout the majority of the interviews with the counselling psychologists. As Laura stated, *"I am actively looking for a different*

job. I miss how things used to be. I think it's felt across the team". Tash: *"I'd like to leave the NHS completely. I'm giving myself six months to a year".* Diane: *"I think about leaving several times a week".* Emma: *"I've just left CAMHS".* Michael: *"There's a lot of dissatisfaction and I think people work here out of necessity. But I think it's the same issue across the NHS".* Christina: *"I think about leaving all the time".*

5.5.5 Time-limited therapy

5.5.5.1 Less autonomy, involvement in critical decision-making and service delivery

Counselling psychologists stated that treatment decisions in the form of the number of therapeutic sessions allocated to children on their caseloads were often decided by non-clinical management, sometimes without their input. In some cases, counselling psychologists were instructed to throughput clients in and out of the clinic within 6-8 therapeutic sessions. It was stressful for them that some CAMHS management teams regularly bypassed psychology critical opinion input and, in some instances, the psychologist's opinion was actively discouraged. Participants reported an air of intimidation surrounding this: "*It feels difficult to raise any concerns… it isn't safe at all"*; *"There's pressure to comply"*; *"There's a lack of really listening to clinicians"*; *"Psychologists are disempowered".*

Despite individual counselling psychologists and psychology teams protesting that such time limits were not always workable to address the complexity of the child's chronic presentations, *"more and more, we're expected to offer a quick CBT approach that we*

don't feel will work. It's not congruent... not helpful to the client". There was pressure to discharge cases which were not fully resolved because resolution could not be achieved within an allocated 6- to 8-week timeframe: "*Management quote numbers at us... 'We need you to do this many sessions per week, and we need this many people in and out by this time'".* Such client cases, counselling psychologists stated, were likely to require re-referral to a new future waiting list. Therefore, completion of the mental health work depended upon the client's willingness to go through the referral process again and sit on a new waiting list. If they decided to return, their symptoms may have worsened over time. Counselling psychologists were concerned that such a management strategy would eventually cause the more disadvantaged children to suffer. In Laura's words: *"The more vulnerable kids will be marginalised".*

The likelihood of burnout is higher for individuals who do not have an active role in decision making (Maslach et al., 2001). Counselling psychologists' experiences of stress revealed not only less involvement in decision making but also less autonomy in their professional work. Both of these elements are considered to be high risk factors for burnout. High levels of job stress occur when the demands of the job are not matched by adequate levels of decision-making authority and/or support from supervisors and colleagues (Karasek & Theorell, 1990).

Apart from the discouraging outcome for the patient, it is a major source of stress for the psychologists when their therapeutic work is unsuccessful or proves to be ineffective (Thériault & Gazzola, 2006). Pick, Teo, and Yeung (2012) found that exclusion from decision making caused stress to employees. Low input into decision making has been linked to burnout and a loss of health and well-being such as cardiovascular disease,

immune deficiency disorders, depression, anxiety, and emotional exhaustion (Michie & Williams, 2003).

Their experiences of being sidelined in decision making about cases also seemed to demonstrate a lack of congruence with stated NHS values. According to the *Employee Engagement and NHS Performance* paper (West & Dawson, 2012, p. 7), the NHS want "*to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements"*.

It has been evidenced that the burnout experience can be reduced and mitigated against through support of the professional's autonomy as well as prevention of autonomy loss. For example, when physicians were supported to exercise their own discretion in their work, their sense of job autonomy increased and their experience of burnout decreased substantially (Adebayo & Ezeanya, 2010; Bremner & Carriθre, 2011).

5.5.5.2 The Duty of Care in decisions

CAMHS counselling psychologists do more than provide evidence-based therapy. They network with community agencies (schools, social care, voluntary organisations, GPs, midwives, etc.), translating Evidence-Based Practices into early childhood settings and the community. This dissemination is designed to prevent and ameliorate chronic problem behaviours (Domitrovich, Gest, Jones, Gill, & DeRousie, 2010; Durlak, 2010). Therefore, much of the onus falls on them to communicate, psycho-educate, and co-ordinate mental healthcare in the community.

Part of being a counselling psychologist scientist-practitioner psychologist involves a commitment to lifelong learning (Wise, Sturm, Nutt, Rodolfa, Schaffer, & Webb, 2010). Reflecting on their professional conduct, counselling psychologists normally integrate their behaviour to align with the rules governing the profession (such as the Health and Care Professions Council, BPS Code of Ethics, NHS ethical guidelines, legal Duty of Care, etc.) and personal ethical values, specifically to protect and promote client welfare and reduce risk of harm to people in their care. NHS managerial decisions made about individual child mental health treatment without consultation with, or inclusion of, the mental health therapy professional or counselling psychologist in CAMHS may be a critical ethical concern. This type of work practice may pressure the counselling psychologists into a position whereby they risk potentially breaching the local authority's and their own professional Duty of Care to the child. In following this practice, its plausible they could risk Clinical Negligence, by not providing the patients with the treatment they believe is needed and in failing to warn about the risks involved in hurried treatments. There may also be risk involved in management pressuring counselling psychologists to offer time-limited therapy they consider to be insufficient for a positive outcome, and which they believe has the potential to marginalise vulnerable children.

5.5.6 Professional identity issues: Effect on early intervention service delivery

Undermining of professional identity is a risk factor for triggering feelings of low personal accomplishment and burnout (Lesage, Berjot, Altintas, & Paty, 2013). Counselling psychologists have been the new scientist-practitioners entering CAMHS. Their training

should equip them to bridge the gap between the disciplines of psychology and psychotherapy interventions with evidence-based practices. As a relatively new professional addition to CAMHS, the participants experienced other NHS professionals having little or no understanding of their discipline. Initially, this seemed at times to elicit ambivalence and occasional hostility from those more accustomed to the longer-established clinical psychology discipline. This occurred with other psychologist colleagues in their teams but also when some were being interviewed by psychologists on NHS interview panels. Examples of this include: *"The interviewer said, 'The problem with counselling psychologists is that they speak many languages but are fluent in none'. Clinical psychologists are preferred by the NHS"*; *"I used to overhear clinical psychologists say to assistant psychologists, 'Oh, don't apply for counselling psychology, they're not true psychologists'"*; *"Sometimes they refer to me as 'the counsellor'".*

When professional competence is questioned through actual or implied devaluation or humiliation in the workplace, heightened and chronic stress can occur leading to burnout (Berjot et al., 2013; Deery, Walsh, & Guest, 2011). The findings in this study add new information about how professional identity issues for counselling psychologists in CAMHS Tier 3 have been a source of challenge and stress. Professional identity refers to the way in which psychologists experience their work (Berjot et al., 2013) and is an important element of an individual's sense of self and purpose (Lloyd, Roodt, & Odendaal, 2011). The development of professional identity involves an internalisation of values, expectations, and commitment to a professional role and set of standards (Stets & Burke, 2012). High stress levels associated to identity

threat in the workplace have been correlated to all three burnout dimensions (emotional exhaustion, depersonalisation, and personal accomplishment) (Berjot et al., 2013; Maslach, 1982).

Professional identity can be significantly undermined by stressful working conditions and relationships with managers or colleagues, a risk factor that can lead to job dissatisfaction and burnout. As previously pointed out, this can lead to turnover and affect patient care and service delivery.

The retention of professional identity had high importance to counselling psychologists in this study. However, it raises the question of whether such challenges naturally result when there is a departure from working in more traditional counselling psychology settings than the specialist CAMHS work environments. The profession appears still to be under-represented in this setting and historically, child psychology modules were minimal in comparison to the more adult based training modules. One stressful challenge counselling psychologists experienced in CAMHS was the lack of knowledge about their profession amongst clinical psychologist colleagues and other disciplines in their team. At times this manifested/culminated in the experience of professional discrimination with some denigrating comments about the profession, little understanding of it, and lack of acknowledgement from human resources (for example, being referred to on their NHS payslip as a clinical psychologist). Integration of counselling psychology principles and values can be an asset to a team with the potential to make contributions unique amongst other professions (Counselling for Health, 2002, P. 1). In the US when working outside of the more traditional non-medical model-based settings, counselling psychologists have been shown to have endured

stress and a sense of alienation because of a lack of familiarity of the profession and little understanding about the training, principles and values of counselling psychology in those settings (Bernard, 1992). As there seems to be little research on this in the U.K., perhaps the evolution of professional identity in previously non-traditional settings, such as CAMHS, and its impact on stress and working life in counselling psychologists is an area warranting further investigative research. (put at the end)

5.5.7 Experiencing devaluation of psychology

Counselling psychologists referred to the devaluation of psychology when, during the cost cutting service changes, cheaper mental health workers were being suggested as being more cost effective than psychologists: "*We had to justify why people should spend money on psychologists rather than nurses and counsellors who could be trained in CBT and be employed cheaply"*; *"There's an anti-psychology feel from management"*; "*I think psychologists are seen as expensive. They think you can get other people to do it just as well. I don't think it's true but it's happening".* The evidence that such devaluation of the profession has occurred across CAMHS teams would question how the organisational changes were managed, as they were seen to accompany a negative narrative about psychologists and their worth and value. The HSE has stated in its national guidelines that how change is managed is vital in order to avoid it becoming a workplace hazard (HSE, 2004). Devaluation of psychology not only denigrates the professional and individual but also creates a negative climate in which to work. Work setting climate is defined as the psychological impact of the work environment on the individual worker (e.g., emotional exhaustion, role overload), and culture is described as

the organisation's behavioural expectations of its employees and norms in the organisation (e.g., support, conformity) (Glisson et al., 2006, p. 858). Organisational climates and cultures with better work attitudes are less likely to report turnover; they also deliver better services and produce more effective outcomes for children (Glisson et al., 2006).

A negative correlation has been found between burnout and a sense of significance at work (Pines, 2002, 2005). Highly motivated psychologists tend to draw meaning from their work, which in turn adds meaning to their lives. When their work is not deemed important, they derive less significance in their career (Pines, 2005). Triggered by a failure of efforts to redress this, gradual exhaustion and disillusionment follow, leading to burnout. Conversely, positive identification with work often helps people to cope with job stress (Haslam, Jetten, O'Brien, & Jacobs, 2004), and an important source of this coping is social support from co-workers or from the organisation itself (Haslam et al., 2005).

During organisational change, organisational-environmental variables are stronger predictors of burnout than individual differences (Morse et al., 2012). These variables comprise a work setting where there is low involvement in decision making, lack of job resources, lack of supervision (resource) and professional interaction (resource), excessive workload, time pressure, role conflict, unfairness, and low rewards.

These findings support existing stress and burnout literature but also add current information about the pressures on child mental health counselling psychologists in the NHS. The findings offer important insights to CAMHS and counselling psychologist professionals as they show the clinical implications, service delivery implications,

professional and personal implications of working in an arguably underfunded public child mental health service today.

Chapter 6: Intervention

Burnout interventions can be categorised into organisation-directed, person-directed or a combined approach. Organisation-directed interventions aim to modify aspects of the work environment which had contributed to employee burnout such as work overload and insufficient job resources (Schaufeli & Enzmann, 1998). This can mean improving quality of clinical supervision; offering continuing education opportunities to improve staff competence; trainings and job redesign. There have been mixed results. Most interventions to relieve or prevent burnout have focused on a deficit in the individual. Therefore, the emphasis has been on building up the worker's resilience, internal resources or working behaviours. Strategies have included teaching personal coping skills, social support and relaxation (Cooper, 1998), or workshops teaching cognitive behavioural strategies or mindfulness techniques (Awa et al., 2010).

The most effective person-directed programmes have been characterised by cognitive and behavioural interventions such as coping skills, rational emotive therapy, cognitive restructuring, and stress management (Volpato, Banfi, Valota, & Pagnini, 2018). Although supportive to some degree, they have had limited and mixed results. For example, approaches targeted at the individual may help to reduce the sense of exhaustion in burnout to some level but have not helped the other burnout components: accomplishment and engagement. This has been an ongoing issue in the literature as alleviation has been reported in only some but not all dimensions of the burnout construct at the same time (Dreison et al., 2016). Furthermore, intervention strategies aimed at the individual worker have not been particularly effective as workers have little control over environmental stressors in the work setting, such as inadequate resources

or ineffective clinical supervision. There is a need to pay more attention to organisational strategies that can tackle burnout by modifying environmental characteristics or work setting stressors. Perhaps this has not been given more attention because imputing such strategies would necessitate an investment of funds by the organisations into their services. In public sector mental health, this may pose a difficult issue as this arena is already struggling financially. Targeted forms of intervention in professional burnout within the mental health sector will require economic investment. Given the long-term savings for the economy facilitated by effective early intervention child mental health work, targeted organisation-directed burnout strategies may be a worthwhile investment.

6.1 An intervention

The type of administration work demands that participants make reference to in this study include managing and maintaining electronic records. This involves clinical diagnostic and outcome tools; collating demographics; identity checks; updating client mental health histories, mental health presentations, clinical and interagency follow-up notes; writing psychological reports, letters; and scoring tests. The administration also includes the daily electronic recording of auditing information about outcomes and targets. Studies show that managing electronic medical records increases the cognitive demands on GPs (Holden, Brown, Alper, Scanlon, Patel, & Karsh, 2011) and contributes to frequent problems with quality of care due to lack of time and administrative work overload (Beasley, Wetterneck, Temte, Lapin, Smith, Rivera-Rodriguez, & Karsh, 2011).

Given its prevalence in the mental health sector, and especially during times of organisational change, it is worthwhile giving serious consideration to the phenomenon of burnout in CAMHS. Not only is burnout a potentially costly expense in terms of turnover, absenteeism, job performance, and quality of care issues, but it can also have a significant impact on worker morale and health. During organisational change, strategically pre-empting burnout risk factors and mitigating against them could be useful in terms of cost savings and the way in which services are delivered. This could be achieved, for example, by incorporating into teams practice models that support the clinician's own work control. The NHS has introduced relatively new standardised models of working (e.g., requirements for specific numbers of sessions per week/month/year, patients per session, sessions allocated to each client, etc.) in order to reduce variations in the way the service is delivered, so as to keep tabs on productivity, outcomes, and costs (Kessler et al., 2005). While standardisation may seem to lead to better work role definition, it also reduces flexibility and control. The 'demand-control' model of job stress shows that high work demands are mitigated by work control. The experience of ongoing lack of work control is a predictor of burnout and ill health (Shanafelt et al., 2012). Therefore, it may be helpful if the application of standardisation still allows clinicians to have enough control over their schedules and work practices so they are allowed adequate space for their clinical and non-clinical work activities.

Evidence supports organisational-environmental variables as being stronger predictors of burnout than individual differences (Morse et al., 2012) and this impacts change initiatives. Up to 70% of organisational change initiatives fail (Beer & Nohria, 2000). As

participants experienced organisational change factors as highly stressful and an imposition to effective early intervention practice, it makes sense to consider ameliorating the organisational change system that triggered the problems rather than focus on individual differences. The latter has seen well-meaning interventions such as stress management strategies introduced which locate the problem in the worker.

6.2 An organisation-based resource layer

In considering organisational interventions, a new and extra resource layer could be deployed. This could comprise organisationally led instead of individual or employee-based remedial actions, as the latter place the onus on the individual. These have been proven only partially effective historically. For example, within any given NHS Trust this could include: a) a floating team of administrative staff; b) a floating team of multi-disciplinary mental health workers; and c) a floating virtual Skype/Zoom/live video/webcam consultation group that psychologists could plug into for case reflection and discussion, where cases can be confidentially presented and discussed in a clinical manner in order to facilitate and enhance MDT cross-referencing and thinking.

A floating team of administrative staff could be deployed to take on some of the non-clinical administrative work and execute transfer of specified information onto electronic records. This may free up psychologists' time and, therefore, decrease stress, by allowing the psychologists to focus more on clinical activities. Also, a floating mental health team could be made available to take on casework, score the more basic psychological tests, and offer support to the psychologist as per need and individual

request. The floating mental health team could include qualified psychologists but also assistant psychologists and/or counselling psychologists in training, who can gain experience and shadow the more complex clinical cases. This would serve their professional development by providing a learning curve in a CAMHS work setting which can support the post-graduate programme in child psychology training and child modules and those wishing to launch their future careers as CAMHS counselling psychologists. A lack of training in the area of child mental health was a theme put forward by some of the counselling psychologists in this study, one they felt contributed to experiences of professional discrimination. For example, as Tash said: "*Our skills are very transferable and we can work with many types of people, but I think in terms of helping me to work in CAMHS, I don't think the training was strong enough".* This would also give trainees the chance to build up professional networks or contacts and be clear about the demands expected in this complex area of NHS work. The cost of floating administrative staff, psychology/mental health and virtual consultation/supervision teams could be spread across the organisation, as they would not be dedicated to just one service but would serve all the CAMHS teams across a given NHS Trust, to be available as per need.

6.3 Feedback loop

In such a scenario, feedback on the need and volume of help required could be monitored and surveyed. This may at least be a stepping stone to supporting quality of care, promoting optimal early intervention resources, and mitigating professionals' burnout. This may be an option Trusts could consider for fuller development in the

strategic prevention and proactive reduction of burnout and its impact on early intervention mental health counselling psychologists. However, an experiential feedback loop must be established from the worker to the organisation so that the strategy is humanistically driven and based on professional need, and is a live and evolving entity.

In addressing this and improving the CAMHS early intervention model during these difficult times, a platform could be established to objectively assess and measure the level of need for resources and the severity of the burnout-related issues across CAMHS, which could threaten service delivery and quality of care. The decision body that chooses to deploy this resource layer should recognise that there are problems with managing the high volume of administrative, electronic record input that now accompanies the client work and quality of care.

Work overload and conflicting demands on time and energy can undermine healthcare workers' opportunities to clearly communicate with clients/patients. This can provoke negative patient feedback about care and erroneous decisions due to insufficient time for gathering critical patient information (Mache, Vitzthum, Klapp, & Groneberg, 2012).

6.4 Conclusion

Burnout as a psychological phenomenon will be taken seriously by the management of organisations only to the extent to which it contributes to poor business performance (Schaufeli, 2003). Given the evidence, it would seem appropriate to invest in preventative organisational strategies against burnout. Trials and researchers can assist in finding cost-effective interventions. However, inclusiveness and collaboration with

mental health practitioners, management, qualitative researchers, and Trust economic advisors may be an initial way forward. Caseload and job control, as well as patient satisfaction, can be influenced by more thoughtful and sensitive management processes.

The demand and evidence for early preventive intervention in child mental health is likely to continue to grow in the near future, given the current trends in the field of early preventive interventions (Gill et al., 2002). This calls for joint problem solving between higher management, psychologists, researchers and those who hold the purse strings. It also calls for better quality and stronger collaboration between all parties to address the issues leading to early intervention service delivery obstructions, such as burnout consequences and burnout risk. Counselling psychologists who are highly invested in helping mentally unwell children deserve to be protected from stressors they cannot control in work settings which eventually lower morale and undermine their health and well-being.

6.4.1 Limitations of research

This exploratory study is limited by its sample size. Despite this, the study has important implications for qualitatively identifying, recognising, and managing symptoms of stress and possible burnout risk factors and consequences. Pre-empting these could help to reduce turnover and absence from work due to ill health, which would have an impact on costs to the NHS and the economy.

6.4.2 Recommendations for future research

Further qualitative research could focus on capturing and understanding stress and organisational contexts in other NHS child and adolescent mental health settings such as Tier 2 and inpatient environments. Given that meaning is an important mitigating factor in burnout, this could also be explored in more detail. Perhaps it is an area of child mental health that counselling psychologists could research further and disseminate to services, in support of their profession, in the NHS.

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Appendices

Appendix 1: NHS Site Specific Information (SSI) Form

NHS SSI IRAS Version 3.5

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Counselling Psychologists' stress & resource experiences in NHS CAMHS

1. Is your project research?

(•) Yes ( ) No

2. Select one category from the list below:

( ) Clinical trial of an investigational medicinal product
( ) Clinical investigation or other study of a medical device
( ) Combined trial of an investigational medicinal product and an investigational medical device
( ) Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
( ) Basic science study involving procedures with human participants
( ) Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
(•) Study involving qualitative methods only
( ) Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
( ) Study limited to working with data (specific project only)
( ) Research tissue bank
( ) Research database

If your work does not fit any of these categories, select the option below:

( ) Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	( ) Yes	(•) No
b) Will you be taking new human tissue samples (or other human biological samples)?	( ) Yes	(•) No
c) Will you be using existing human tissue samples (or other human biological samples)?	( ) Yes	(•) No

3. In which countries of the UK will the research sites be located? *(Tick all that apply)*

☑ England
☑ Scotland
☑ Wales
☑ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- (•) England
- ( ) Scotland
- ( ) Wales
- ( ) Northern Ireland
- ( ) This study does not involve the NHS

4. Which review bodies are you applying to?

- [x] NHS/HSC Research and Development offices
- [ ] Social Care Research Ethics Committee
- [x] Research Ethics Committee
- [ ] National Information Governance Board for Health and Social Care (NIGB)
- [ ] National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

(•) Yes ( ) No

5a. Do you want your NHS R&D application(s) to be processed through the NIHR Coordinated System for gaining NHS Permission?

( ) Yes (•) No

If yes, you must complete and submit the NIHR CSP Application Form immediately after completing this project filter, before proceeding with completing and submitting other applications.

6. Do you plan to include any participants who are children?

( ) Yes (•) No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

( ) Yes (•) No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

( ) Yes (•) No

9. Is the study or any part of it being undertaken as an educational project?

(•) Yes ( ) No

Please describe briefly the involvement of the student(s):

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

(•) Yes ( ) No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

( ) Yes (•) No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

( ) Yes (•) No

Is the site hosting this research a NHS site or a non-NHS site? *NHS sites include Health and Social Care organisations in Northern Ireland. The sites hosting the research are the sites in which or through which research procedures are conducted. For NHS sites, this includes sites where NHS staff are participants.*

- (•) NHS site
- ( ) Non-NHS site

This question must be completed before proceeding. The filter will customise the form, disabling questions which are not relevant to this application.

One Site-Specific Information Form should be completed for each research site and submitted to the relevant R&D office with the documents in the checklist. See guidance notes.

The data in this box is populated from Part A:

Title of research:
Identifying the complexity of Counselling Psychologists' working lives in the National Health Service (NHS) Child and Adolescent Mental Health Services, Tier 3 work settings - specifically experiences of conscious and unconscious stressors and resources.

Short title: Counselling Psychologists' stress & resource experiences in NHS CAMHS

Chief Investigator:

Title	Forename/Initials	Surname
Miss	Norah	Breslin

Name of NHS Research Ethics Committee to which application for ethical review is being made:
East Central London REC 1

Project reference number from above REC: 11/LO/0450

1-1. Give the name of the NHS organisation responsible for this research site

East & North Hertfordshire NHS Trust

1-3. In which country is the research site located?

- (•) England
- ( ) Wales
- ( ) Scotland
- ( ) Northern Ireland

1-4. Is the research site a GP practice or other Primary Care Organisation?

( ) Yes (•) No

2. Who is the Principal Investigator or Local Collaborator for this research at this site?

Select the appropriate title: (•) Principal Investigator ( ) Local Collaborator

	Title	Forename/Initials	Surname
	Ms	Norah	Breslin
Post	Child & Adolescent Counselling Psychologist & Highly Specialist Perinatal Psychotherapist		
Qualifications	Chartered Counselling Psychologist, Chartered Scientist, MSc Counselling Psychology, MSc Psychoanalytical Developmental Psychology, BSc(hons) Psychology		
Organisation	North East London Foundation Trust		
Work Address	CAMHS Loxford Loxford		
	Loxford Lane		
	Ilford, Essex		
PostCode	IG1 2PL		
Work E-mail	Norah.breslin@nelft.nhs.uk		
Work Telephone	03005551182		
Mobile	07531971603		
Fax			

a) Approximately how much time will this person allocate to conducting this research? *Please provide your response in terms of Whole Time Equivalents (WTE).*
WTE 60-80 minutes

b) Does this person hold a current substantive employment contract, Honorary Clinical Contract or Honorary Research Contract with the NHS organisation or accepted by the NHS organisation? (•) Yes ( ) No

A copy of a current CV for the Principal Investigator (maximum 2 pages of A4) must be submitted with this form.

3. Please give details of all locations, departments, groups or units at which or through which research procedures will be conducted at this site and describe the activity that will take place.

Please list all locations/departments etc where research procedures will be conducted within the NHS organisation, describing the involvement in a few words. Where access to specific facilities will be required these should also be listed for each location.

Name the main location/department first. Give details of any research procedures to be carried out off site, for example in participants' homes.

	Location	Activity/facilities
1	North East London Foundation Trust Goodmayes Hospital, Barley Lane, Essex	60 minute audio recorded interview

5. Please give details of all other members of the research team at this site.

6. Does the Principal Investigator or any other member of the site research team have any direct personal involvement (e.g. financial, share-holding, personal relationship etc) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

( ) Yes (•) No

7. What is the proposed local start and end date for the research at this site?

Start date:	03/03/2014
End date:	30/04/2014
Duration (Months):	1

8-1. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *(These include seeking consent, interviews, non-clinical observations and use of questionnaires.)*

Columns 1-4 have been completed with information from A18 as below:

1. *Total number of interventions/procedures to be received by each participant as part of the research protocol.*
2. *If this intervention would have been routinely given to participants as part of their care, how many of the total would have been routine?*
3. *Average time taken per intervention (minutes, hours or days)*
4. *Details of who will conduct the procedure, and where it will take place*

Please complete Column 5 with details of the names of individuals or names of staff groups who will conduct the procedure at this site.

Intervention or procedure	1	2	3	4	5
Informed consent (written and verbal), Information sheet, audio interviews.	4	4	60 mins	Norah Breslin, BSc(hons), MSc, MSc, Post MSc Dip. Chartered Counselling Psychologist in NHS CAMHS & PIMHS. Research will take place at participating counselling psychologists' homes.	

8-2. Will any aspects of the research at this site be conducted in a different way to that described in Part A or the protocol?

○ Yes ◉ No

If Yes, please note any relevant changes to the information in the above table.

Are there any changes other than those noted in the table?
Yes. Research will only be carried out on an NHS site and NOT in participants' homes.

10. How many research participants/samples is it expected will be recruited/obtained from this site?

One.

11. Give details of how potential participants will be identified locally and who will be making the first approach to them to take part in the study.

Investigator placed a call for research participants through the Division of Counselling Psychology (DCOP) website at the British Psychological Society, and through DCOP Counselling Psychology Forums, the Anna Freud graduate alumni, and by searching for participants at CPD events, and other NHS CAMHS contacts, and calling CAMHS team managers. Through these methods, potential participants were recruited who said they were willing to help, in principle, pending R&D approval.

12. Who will be responsible for obtaining informed consent at this site? What expertise and training do these persons have in obtaining consent for research purposes?

Name	Expertise/training
Norah Breslin, Principal Investigator	Principal Investigator is an experienced researcher and Chartered Scientist with two Master of Science degrees, and a Bachelor of Science degree. Currently working on a Doctoral degree. Investigator has intensive training and experience in Research Ethics and clinical work Ethics, and adheres to NHS ethics & good practice guidelines, British Psychological Society ethics guidelines,

and HCPC ethics guidelines.

15-1. Is there an independent contact point where potential participants can seek general advice about taking part in research?

The British Psychological Society. St Andrews House. 48 Princess Road East. Leicester. LE1 7DR. Tel: +44 (0)116 254 9568. Fax: +44 (0)116 227 1314.

15-2. Is there a contact point where potential participants can seek further details about this specific research project?

Dr Patricia Moran, Course Director,DCPsych, Metanoia Institute, 13 North Common Road, Ealing, London W5 2QB

Tel (direct): 020 8208 1235. email: Patriciamoran@aol.com

16. Are there any changes that should be made to the generic content of the information sheet to reflect site-specific issues in the conduct of the study? *A substantial amendment may need to be discussed with the Chief Investigator and submitted to the main REC.*

No.

Please provide a copy on headed paper of the participant information sheet and consent form that will be used locally. Unless indicated above, this must be the same generic version submitted to/approved by the main REC for the study while including relevant local information about the site, investigator and contact points for participants (see guidance notes).

17. What local arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? *(e.g. translation, use of interpreters etc.)*

If an interpreter is required, one will be accessed from an Interpreter/Translation agency currently on contract with the NHS at researcher's own expense. Any other special communications needs of the participating individual will be discussed with them in advanced and provided in respect of NHS Equality & Diversity Guidelines, and NHS Ethical Guidelines.

18. What local arrangements will be made to inform the GP or other health care professionals responsible for the care of the participants?

Not applicable.

19. What arrangements (e.g. facilities, staffing, psychosocial support, emergency procedures) will be in place at the site, where appropriate, to minimise the risks to participants and staff and deal with the consequences of any harm?

Researcher will contact site team manager or deputy team manager should a risk issue arise, or if appropriate, emergency services.

20. What are the arrangements for the supervision of the conduct of the research at this site? *Please give the name and contact details of any supervisor not already listed in the application.*

21. What external funding will be provided for the research at this site?

- ○ Funded by commercial sponsor
- ○ Other funding
- ◉ No external funding

How will the costs of the research be covered?
Principal Investigator is funding the project.

23. Authorisations required prior to R&D approval

The local research team are responsible for contacting the local NHS R&D office about the research project. Where the research project is proposed to be coordinated centrally and therefore there is no local research team, it is the responsibility of the central research team to instigate this contact with local R&D.

NHS R&D offices can offer advice and support on the set-up of a research project at their organisation, including information on local arrangements for support services relevant to the project. These support services may include clinical supervisors, line managers, service managers, support department managers, pharmacy, data protection officers or finance managers depending on the nature of the research.

Obtaining the necessary support service authorisations is not a pre-requisite to submission of an application for NHS research permission, but all appropriate authorisations must be in place before NHS research permission will be granted. Processes for obtaining authorisations will be subject to local arrangements, but the minimum expectation is that the local R&D office has been contacted to notify it of the proposed research project and to discuss the project's needs **prior** to submission of the application for NHS research permission via IRAS.

Failure to engage with local NHS R&D offices **prior** to submission may lead to unnecessary delays in the process of this application for NHS research permissions.

Declaration:

☑ **I confirm that the relevant NHS organisation R&D office has been contacted to discuss the needs of the project and local arrangements for support services. I understand that failure to engage with the local NHS R&D office before submission of this application may result in unnecessary delays in obtaining NHS research permission for this project.**

Please give the name and contact details for the NHS R&D office staff member you have discussed this application with:

Please note that for some sites the NHS R&D office contact may not be physically based at the site. For contact details refer to the guidance for this question.

	Title	Forename/Initials	Surname
	Ms	Deepti	Sebastian
Work E-mail	Deepti.sebastian@nhs.net		
Work Telephone	01438 28 4379		

Declaration by Principal Investigator or Local Collaborator

1. The information in this form is accurate to the best of my knowledge and I take full responsibility for it.
2. I undertake to abide by the ethical principles underpinning the World Medical Association's Declaration of Helsinki and relevant good practice guidelines in the conduct of research.
3. If the research is approved by the main REC and NHS organisation, I undertake to adhere to the study protocol, the terms of the application of which the main REC has given a favourable opinion and the conditions requested by the NHS organisation, and to inform the NHS organisation within local timelines of any subsequent amendments to the protocol.
4. If the research is approved, I undertake to abide by the principles of the Research Governance Framework for Health and Social Care.
5. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to the conduct of research.
6. I undertake to disclose any conflicts of interest that may arise during the course of this research, and take responsibility for ensuring that all staff involved in the research are aware of their responsibilities to disclose conflicts of interest.

7. I understand and agree that study files, documents, research records and data may be subject to inspection by the NHS organisation, the sponsor or an independent body for monitoring, audit and inspection purposes.

8. I take responsibility for ensuring that staff involved in the research at this site hold appropriate contracts for the duration of the research, are familiar with the Research Governance Framework, the NHS organisation's Data Protection Policy and all other relevant policies and guidelines, and are appropriately trained and experienced.

9. I undertake to complete any progress and/or final reports as requested by the NHS organisation and understand that continuation of permission to conduct research within the NHS organisation is dependent on satisfactory completion of such reports.

10. I undertake to maintain a project file for this research in accordance with the NHS organisation's policy.

11. I take responsibility for ensuring that all serious adverse events are handled within the NHS organisation's policy for reporting and handling of adverse events.

12. I understand that information relating to this research, including the contact details on this application, will be held by the R&D office and may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.

13. I understand that the information contained in this application, any supporting documentation and all correspondence with the R&D office and/or the REC system relating to the application will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.

This section was signed electronically by ms norah breslin on 27/03/2014 20:18.

Job Title/Post:	Child & Adolescent Counselling Psychologist & Highly Specialist Perinatal Psychotherapist
Organisation:	North East London Foundation Trust
Email:	norah.breslin1@gmail.com

Appendix 2: Covering Letter to R&D Departments of NHS Trusts

Miss x
Research Governance Officer
NHS Foundation Trust
Research & Development Department
Trust Head quarters

20th January 2012

REC Reference: 11/LO/0450
IRAS REC Submission Reference : 67490/199885/1/452

Dear X

Please find exported IRAS form. Please let me know if this is readable to you.

Also find attached, as requested:

- NHS R&D Form
- SSI form
- CVs for Principal Investigator, Academic Supervisor. *(Collaborative Investigator's CV will be forwarded to you shortly).*
- Research proposal and protocol.
- A copy of the REC approval letter
- The NHS form for proof of employment is being processed by HR and I will forward this to you imminently.

I hope you will find everything in order.

Thank you, in advance, for your most kind attention.

Yours sincerely

Norah Breslin C Psychol
Tel: 075319 716

Appendix 3: NRES (NHS) Approval Letter

NHS
National Research Ethics Service

NRES Committee London - City Road & Hampstead
South West Research Ethics Centre
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1330
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Email: Ubh-tr.CityRoadHampsteadREC@nhs.net

28 April 2011

Miss Norah Breslin
Counselling Psychologist and Highly Specialist Psychotherapist NHS CAMHS
NHS Child and Adolescent Mental Health Services
Loxford Hall
Loxford Lane
Ilford
IG1 2PL

Dear Miss Breslin

Study title: **Identifying the complexity of Counselling Psychologists' working lives in the National Health Service (NHS) Child and Adolescent Mental Health Services, Tier 3 work settings - specifically experiences of conscious and unconscious stressors and resources.**

REC reference: **11/LO/0450**

The Research Ethics Committee reviewed the above application at the meeting held on 13 April 2011. Thank you for attending to discuss the study.

Ethical opinion

1. You agreed to identify a more neutral territory to conduct the interviews such as contacting the site officers to use one of their rooms.
2. The Committee felt that Question 12 on the Topic Guide regarding countertransference was not in lay language and suggested that this question should be rewritten. You agreed to modify the language used on Question 12 of the topic guide.
3. You stated that you were self-funded; however, you believed that offering the use of an interpreter was a requirement in the interest of diversity and that Welsh participants may prefer to be interviewed in Welsh.
4. You confirmed that recruitment did not start in March but you would like the study to commence as soon as possible.
5. You agreed that an independent person should check the themes identified from the transcripts and confirmed that your supervisor would be willing to do this.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Please phrase Question 12 of the topic guide in lay language.
2. Please identify an appropriate person (e.g. supervisor) to cross-validate the results and check the themes identified from the transcripts.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	1	23 March 2011
REC application	1	24 March 2011
Interview Schedules/Topic Guides	1	23 March 2011

Advertisement	1	
Evidence of insurance or indemnity		10 March 2011
Referees or other scientific critique report		21 March 2011
Investigator CV		18 March 2011
Participant Consent Form	1	23 March 2011
Sample letter to universities	1	
Academic supervisor's CV		
Participant Information Sheet	1	23 March 2011
Covering Letter		23 March 2011
Summary/Synopsis	1	
Metanoia conditional REC approval		21 March 2011

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/LO/0450 **Please quote this number on all correspondence**

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

Yours sincerely

pp.

Dr David Slovick
Chair

Enclosures:

List of names and professions of members who were present at the meeting and those who submitted written comments
"After ethical review – guidance for researchers" (via Email)

Copy to: *Professor Vanja Orlans, Metanoia Institute*

NRES Committee London - City Road & Hampstead

Attendance at Committee meeting on 13 April 2011

Committee Members:

Name	Profession	Present	Notes
Ms Jill Bloom	Drug Information Pharmacist	Yes	
Dr Elizabeth Carrey	MSc Programme Director in Clinical Paediatrics	No	
Mrs Stephanie Cooper	Solicitor	Yes	
Mrs Ros Goldfarb	Retired Immigration Judge	Yes	
Mr Robert Goldstein	Economist	Yes	
Mr Hari Jayaram	Clinical Scientist in Ophthalmology	Yes	
Mr Peter Jones	Retired Head teacher	Yes	
Ms Sarah Kaiser	Director, Human Rights NGO	Yes	
Dr Stella Kingett	Consultant Psychiatrist	No	
Professor Diana Kornbrot	Professor of Mathematical Psychology	Yes	
Ms Mary Ryan	Personnel Manager	No	
Dr David Slovick	Consultant Physician	Yes	

Also in attendance:

Name	Position (reason for attending)
Miss Charlotte Allen	Coordinator
Dr Koula Asimakopoulou	Lecturer in Health Psychology

Appendix 4: Sample Letter to Universities

University of
Counselling Psychology Department
Address

Date

Dear

I am a chartered counselling psychologist working in CAMHS Tier 3 in the NHS. As part of my research, I'm trying to recruit participants who are Counselling Psychologists working in the NHS, Child and Adolescent Mental Health Service (CAMHS) tier 3. My research intends to examine personal experiences of stress and resources in this environment for the Counselling Psychologist.

I'm aware that some of your graduates in counselling psychology may have gone on to work in the NHS CAMHS as our numbers there are increasing. The research is for my doctoral project at the Metanoia Institute, London. Research supervisors: Patricia Moran/Professor Vanja Orlans.

I wonder if you would be kind enough to send the attached call for participants (sample advertisement) in a global email to your past pupils and graduates in counselling psychology?

Thank you, in advance, for your most kind assistance.

Yours sincerely
Norah Breslin, BSc (Hons), MSc, MSc, Post MSc Dip.
Chartered Counselling Psychologist**,** BPS registered
Practitioner Psychologist, HPC registered

Email: breslin.norah@talk21.com or mobile: 075319 71603, Work (NHS) 0844 6001182.
This study is part of my own doctoral research project at the Metanoia Institute, 13 North Common Rd, London W5 2QB Tel: 020 859 2505

Appendix 5: Call for Participants

Are you a Counselling Psychologist working in NHS, Child and Adolescent Mental Health Services at Tier 3 level?

Is it stressful? Does it challenge your resourcefulness?

Will you consent to be individually interviewed for a study on your personal experiences of stress and resources working within this setting? Your contribution will be entirely confidential and made anonymous.

Please contact Norah Breslin, Chartered Counselling Psychologist @ breslin.norah@talk21.com or mobile: 075319 71603 or Work (NHS) 0844 6001182. All enquiries treated in complete confidence.

This study is part of my own doctoral research project at the Metanoia Institute, 13 North Common Rd, London W5 2QB Tel: 020 859 2505

Thank you!

Appendix 6: Participant Information Sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

INFORMATION SHEET

1. Study title

Counselling Psychologists' experiences of stress in National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) Tier 3.

2. Invitation paragraph

You are being invited to take part in a research study. The research is self-funded and part of my own Doctoral studies. Before you decide whether to take part, it's 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 me if there is anything that isn't clear or if you'd 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?

Counselling psychologists have the ability to bring their unique skills to varied and diverse work settings. The number of counselling psychologists working in National Health Service (NHS) settings is on the increase. There is little information about counselling

psychologists' experiences of stressors and resources as experienced by the counselling psychologist in NHS Child and Adolescent Mental Health Services at Tier 3 level. The research will inform the profession through your (anonymised) and unique insight into your experiences of stressors and resources in their conscious and unconscious forms within this work setting. Your contribution, it is hoped, will provide a source of information for the profession and those counselling psychologists wishing to work in a similar setting. It is also intended to use this research to contribute to improving working life in NHS CAMHS tier 3.

Your participation in the study will involve one (maximum two) session of a one to one, audio recorded, interview lasting up to 60 minutes (each). The duration of the research study will be approximately seven months.

4. Why have I been chosen?

You are being asked to participate because you are unique as a counselling psychologist working in an NHS CAMHS Tier 3 setting. Your perceptions and experiences of working within this setting will provide valuable and unique information as there is a paucity of research about counselling psychologists in public sector work. There will 6-8 participants in total.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part **you will be given this information sheet to keep and be asked to sign a consent form of which you will also be given a copy to keep**. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?

This is a qualitative study based on one to one interviews with a small number of people. It involves one (up to two interviews), no more than 60 minutes in duration each. I will arrange to meet you at a mutually convenient date, time and location. In the interview, I'll ask for information about your perceptions of your work environment, and yourself within this context. I'll record the interview on audio. Your confidentiality will be maintained and your contribution will be pseudoanonymised. I'll transcribe your data from the audio interview with any identifying data carefully excluded.

The audio interview will be transcribed and analysed using qualitative statistical methods.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the Metanoia Committee (Metanoia Institute, London). 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 at Metanoia Institute. As your interviews will be pseudoanonymised, you cannot be identified through your research interview transcripts.

7. What do I have to do?

I intend to collect information to answer the research question through the use of a semi-structured interview with you. If you agree to take part, I will contact you to arrange a convenient time and place for one and perhaps a confidential interview. The interview will involve a 60 minute audio recorded session. The audio tape interview will be transcribed at a later date. (In the possible but *unlikely* second interview, you'll have a chance to speak in more detail on issues you've mentioned). Once the research is completed, the audio recordings will be deleted. The results of this study will be written up as a doctoral thesis. I am happy to speak with you again by telephone or

email to discuss the findings of the completed study or advise you if/where it will be published.

8. What are the possible disadvantages and risks of taking part?

Because of the nature of the research which will examine conscious and unconscious processes, this may raise your awareness of your own stress during the interviews. I will approach the work sensitively around this to help you leave the interviews without any unnecessary discomfort. I will offer to recommend outside therapeutic intervention post-interview, if you require this. I am hopeful that the research could be a cathartic experience for you. Furthermore, the information gleaned from this study will inform the profession of counselling psychology about experiences of working within NHS settings.

9. What are the possible benefits of taking part?

I hope that participating in the study will help you. However, this cannot be guaranteed. The information I get from this study will provide information about the issues affecting counselling psychologists in this type of setting and perhaps help me provide recommendations for addressing these in the write up.

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

The researcher will adhere to the NHS Confidentiality Code of Practice Guidelines and the Data Protection Act, 2003. All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it. All personal data will be pseudoanonymised to ensure confidentiality. This will be achieved by attaching codes or other unique references to information so that the data will only be identifiable to the researcher who has access to the key or index.

Your confidentiality is protected and can only be overrided if a risk disclosure pertaining to potential harm to yourself or the public is made by you during the interviews. Then help will be sought for you, or the public in question, and this disclosure of risk will be discussed with the researcher's supervisor(s) in the interests of containing the risk.

Whilst the researcher (myself) is on site interviewing you, the researcher's academic supervisor from Metanoia Institute may have access to your name and contact details. This is a normal safety precaution for the researcher. The research supervisor(s) will not be able to identify you through your research interview contribution as that data will be pseudoanonymised. All data will be stored, analysed and reported in compliance with Data Protection legislation.

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

The results will be used and published as my doctoral dissertation within the next 2 years approximately. There is a possibility that the research will be published in a relevant peer journal. However, you will not be identified in any report or publication. If you would like a copy of the published results, please contact me and I will send it to you. I also hope to present the research findings to NHS trusts particularly CAMHS tier 3 services in the interests of raising awareness and improving the working environments of counselling psychologists.

12. Who has reviewed the study?

This study has been reviewed and approved by the Metanoia Research Ethics Committee, the National Health Service (NHS) Research Ethics Committee, and your Trust's Research and Development Department.

13. Contact for further information

Researcher: Norah Breslin, Chartered Counselling Psychologist, Chartered Scientist.
Child and Adolescent Mental Health Service, Loxford Hall, Loxford Lane, Ilford, IG1 2PL
Telephone: 0844 6001182 or 07531 971603
Email address: norah.breslin1@gmail.com

Research supervisors: Dr Patricia Moran/Professor Vanja Orlans
Metanoia Institute, 13 North Common Road, Ealing, London, W5 2QB, Telephone: 02085792505
Email address : Patricia.Moran@metanoia.ac.uk, Vanja.Orlans@metanoia.ac.uk

Local collaborator at NELFT: Dr Ben Smith, Trust Lead for Psychological Therapies, Psychology Dept, Goodmayes Hospital, Barley Lane, Ilford, Essex, IG3 8XJ.

Thank you for agreeing to take part in this study.

Appendix 7: Consent Form

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

CONSENT FORM

Participant ID Number : Date:

Title of Project:
Counselling Psychologists' experiences of stress in National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) Tier 3.

Name of Researcher: Norah Breslin, BSc (hons), MSc, MSc, Post MSc Dip. Chartered Counselling Psychologist. (HPC registered; BPS registered). Chartered Scientist (Science Council, UK).

Please initial box

1. I confirm that I have read and understand the information sheet dated .....……for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.

3. I understand that my interview(s) will be audio taped and subsequently transcribed

4. I agree to take part in the above study.

5. I agree that this form which bears my name and signature may be seen by a designated auditor.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature
Norah Breslin		
_____	_____	_____
Researcher	Date	Signature

Please be assured you will not be identified as having taken part in this study within your workplace. Only in circumstances of risk disclosure where you identify that yourself or someone else is at risk of harm, can your confidentiality be overrided.

1 copy for participant; 1 copy for researcher

Appendix 8: Interview Schedule

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

Counselling Psychologists' Stress & Resource Experiences in the National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) Tier 3.

1. Topic Guide

1. Can you describe your experience of working in a tier 3 multidisciplinary group including your perceptions of the benefits and disadvantages?

2. Do you find your work demanding? If so, how do you feel about the demands upon you? How would you describe them?

3. Do you find your work rewarding? If so, how do you perceive and feel about these rewards?

4. How do you feel about your professional identity as a counselling psychologist in your multidisciplinary team and community outreach work?

5. How do you think the professional identity of the Counselling Psychologist is perceived?

6. Do you find your work stressful? If so what is the most stressful part?

7. What do you think your resources are in dealing with stressful situations?

8. How do you deal with stress?

9. Do you think you have suffered vicarious trauma from any of your cases?

10. What do you consider your resources to be both personally and professionally?

11. Have you ever had strong reactions (such as anger, annoyance, irritation, etc.) towards a particular client when you'd been feeling calm and normal before the session began? If so, how have you processed this?

12. Do you know other counselling psychologists in tier 3 CAMHS? If not, do you feel isolated or unique in your service?

13. Are you supervised by a counselling psychologist or clinical psychologist?

14. Are your supervision needs adequately met?

15. What are the personal resources you use when interacting with the community, schools, social services and other community services?

16. What are the stresses of interacting with the community, schools, social services and other community services?

17. Do you ever feel your work is affecting your personal life? If so, how?

18. Do you ever feel your personal life is reflected in your work? If so, how?

Appendix 9: The Process of Identifying Emerging Themes

After reading the transcripts and making tables and notes in iNumbers tables (MacBook), I aimed to get a spatial representation of the emerging themes from the transcripts. I initially did this by writing sections of the transcripts and emergent themes on post-it notes. I placed these, for each participant, on the walls and floor of my work space. I did this after the initial organisation of the transcript data into tentative emergent themes. Laying out each participant and their emergent themes in this way allowed me to walk around the data over a period of time, consider them and reconsider them, and also get a birds-eye view of the emerging super-ordinate themes. Although very time-consuming, manually recording transcript sections relevant to the emergent themes on post-it notes was a very effective way for me to collate the emergent themes, cross-reference the similarities and dissimilarities between each participant's data, and capture the themes and then super-ordinate themes in the data.

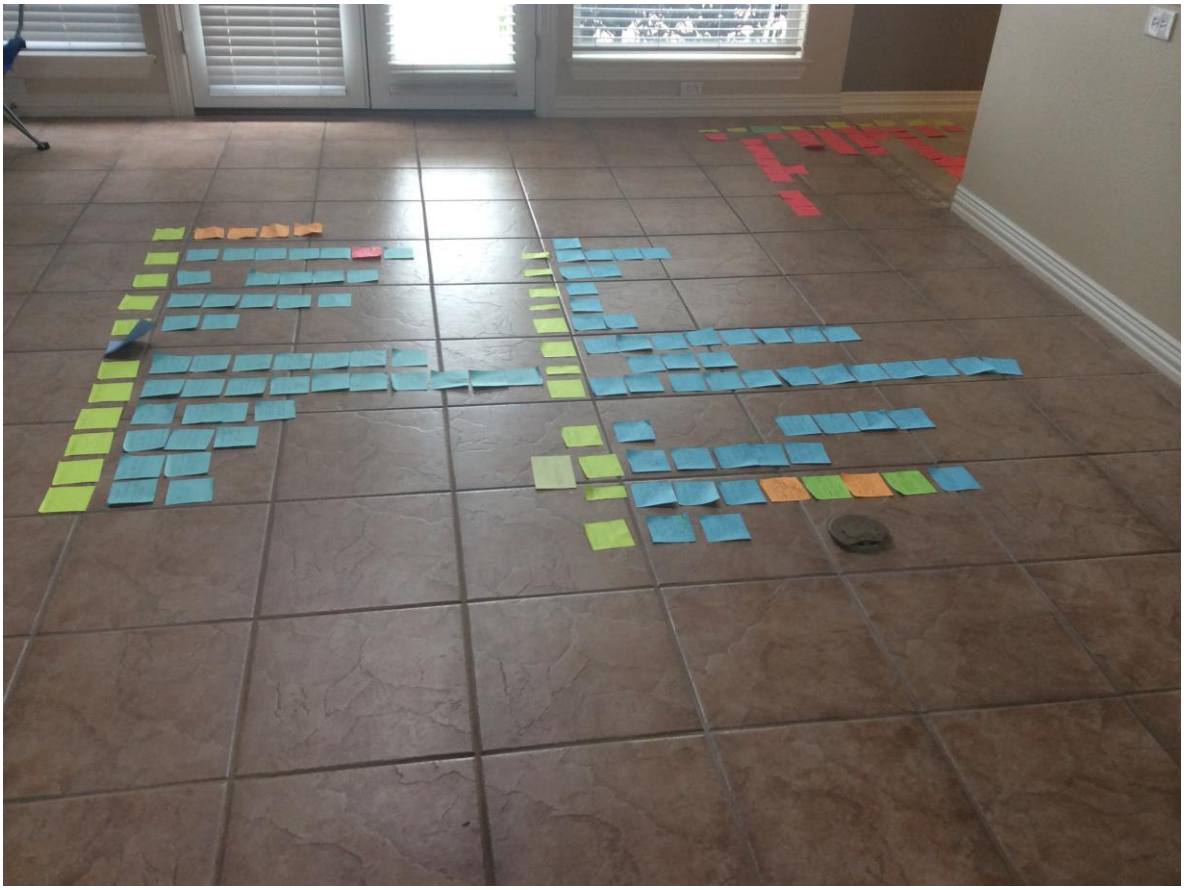
Looking for themes: Each transcript was read several times over until I was completely familiar with the transcript. Notes were constantly made in my notebook and in spreadsheets. All the time, the question in my mind was constantly *"What does this mean to the participant?"*. I then returned to the beginning of the transcript and used the notes to help uncover emerging themes. My initial notes were used to form concise phrases which denoted a higher level of abstraction. The themes hinted at theoretical connections whilst staying grounded in the participant's words.

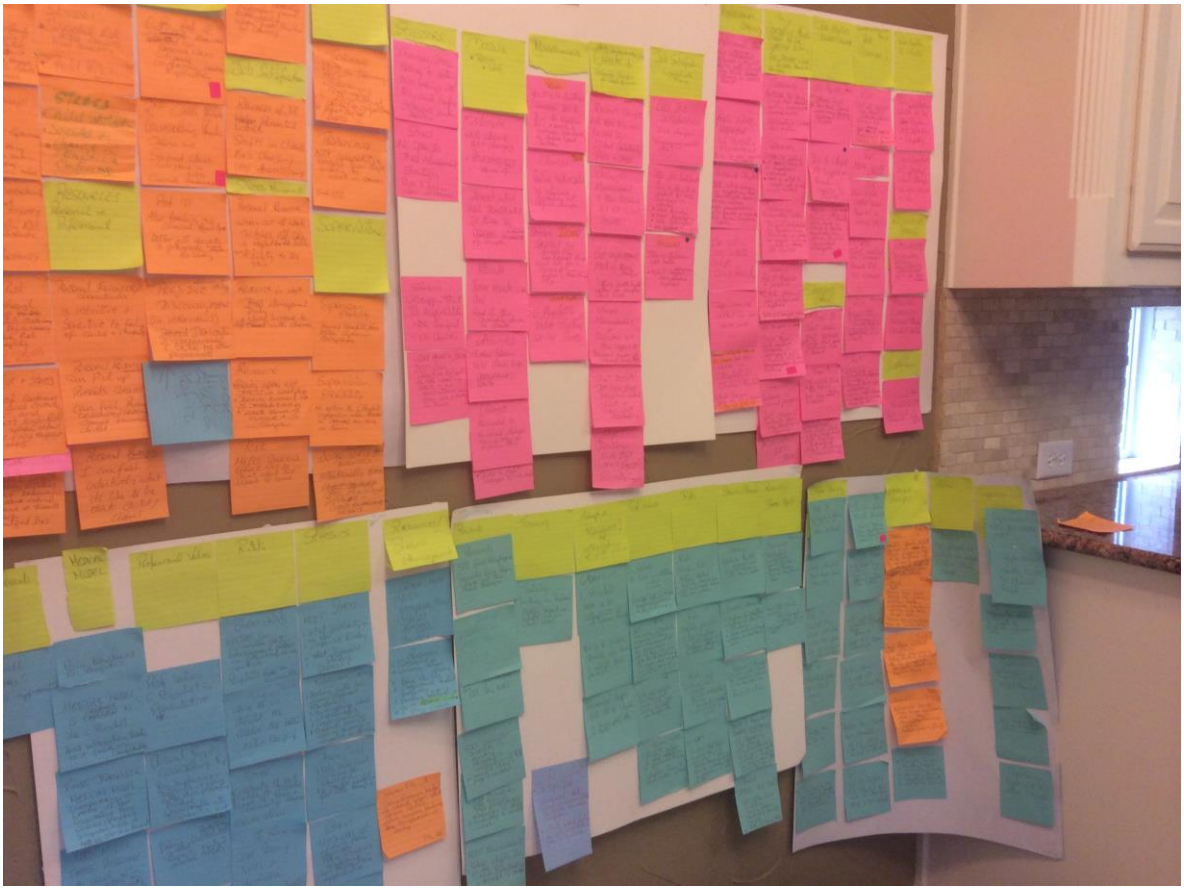
Connecting themes: The emergent themes were listed in the order they arose in the participant's transcript. Each transcript was a case study in itself. I re-read and referenced the participant's exact words used in the transcript many times over. Lists of themes were made in the transcript, and also connections between these themes were being made across all the transcripts as appropriate. Power of expression, rather than frequency of occurrence of themes, was foremost in helping make sense of the themes.

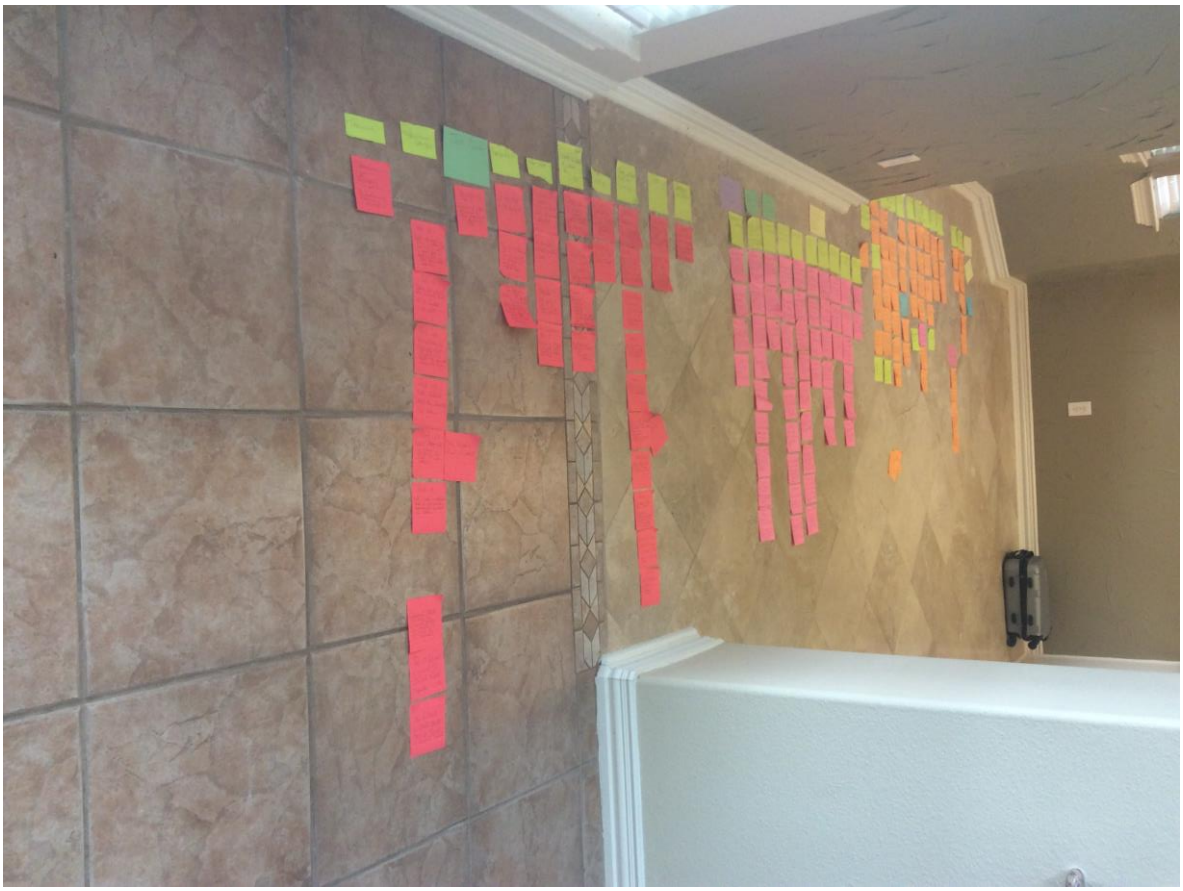
Collaborative analysis: Eventually a final list of themes emerged from my interpretations of the participants' words. This list was clustered into super-ordinate categories following the second interviews. The second interviews

helped to confirm and validate my interpretations or reveal hidden assumptions, and correct any misunderstandings I could have made. I checked with two previously chosen colleagues to help me validate or comment on the trustworthiness of the super-ordinate themes and sub-theme categories.

Conceptual framework: This was the final stage. I constructed a conceptual framework in a table. Then I was able to relate the themes to existing theory in the literature. Themes were explained with verbatim anonymous extracts from the transcripts.







Appendix 10: Samples of Spreadsheets Compiled During Analysis

Example pages for Tash

Line No	Tash 1 - Transcript *doc: transcripts*	Descriptive (non-interpretative)	What is she saying? First impressions	Similarities/ Differences	Descri-ptive Theme 1 (non-inter-pretive)	Emergent Theme 1 INTERPRETIVE - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
244	I: Yeah.							
245	P: There is always a level of- a little bit of - I think you're left with a little bit of traumatised (pause) symptoms.							
246	…actually struggled with my first supervisor that I was allocated when I came into CAMHS. Ehm, so I spoke to the consultant and she just said to sit it out and just- i-it might take time to develop to somebody's personality. Ehm, but I struggled to work with clinical psychologists because I think they're very much (pause) ehm, rigid and very much "Do this", "Do that", or well, if you haven't done this correctly there's a bit of judgement on you about your skills.	Initially struggled with clinical psychologist supervisors because she felt they were too directive and judgemental of her different skills, making her feel uncomfortable and unsafe in the process.	Iniitally she felt clinical psychologists had a linear approach to client work in supervision, which she found incongruent with her professional skills.			Counselling psychologist identity not understood in CAMHS.		Counselling psychology identity in CAMHS
254	Ehm, so then I think after a-a little bit of talk with the consultant, I said I didn't, I didn't feel comfortable or safe being supervised and she offered me the supervision instead.							
280	They feel that we're not as skilled as them, they feel that our therapy is, is, ehm, not as strong as theirs, we've had comments by clinical members of the team saying that we're just *counselling* psychologists, but we're not *clinical*, ehm, and we can't do everything. So, in terms of other members of staff we've had a lot of positiveness, but probably by some clinical staff, it's probably not been, ehm, d- *as* positive.	Has experienced discrimination by clinical psychologists commenting that counselling psychologists aren't as skilled as they are.						Open denigration/ discrimination by clinical psychologists of counselling psychologist skills.
291	And I used to overhear clinicals saying to them (assistant psychologists) "Oh, don't apply for counselling! Only apply for clinical, counselling is a waste of a degree. You're not a true psychologist if you're a counselling psychologist", and I think, at that point, I felt that I, I needed to speak up. So I, I *would* speak up to them, but then I would address some of my concerns to the consultant.							Open denigration/ discrimination by clinical psychologists of counselling psychologist skills.

Example pages for Tash (continued)

Line No	Tash 1 - Transcript *doc: transcripts*	Descriptive (non-interpretative)	What is she saying? First impressions	Similarities/ Difference	Descri-ptive Theme 1 (non-inter-pretive)	Emergent Theme 1 INTERPRETIVE - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
303	No. No. (Training wasn't adequate for CAMHS work.) Ehm, because I would- Ehm, when I decided to do the course at (mentions university) I chose it because it had a whole module on children, and adolescents, but when I actually got to come on the course, we were told that that module had been dropped. Ehm, and I think it's important for the counselling degrees, the counselling psychology degrees to focus on different areas of work within the NHS to better skill equip us to have that kind of background and knowledge to be able to work with the Learning Disabilities team, with the elderly, with adults, ehm, and children. I feel that our skills are very- very transferable and we can work with many types of people, but I think in terms of helping me to work in CAMHS, I don't think the training was strong enough.	Training in counselling psychology wasn't adequate to equip graduates for CAMHS work at all. (RESOURCE: transferable skills.)						Inadequate/ non- competitive training.
325	Ehm, yes (because of NHS restructuring). People feel they're able to do less clinical work, and *efficient* clinical work, and it's more paperwork and, ehm, strategies,						Client work is suffering.	Client care issues.
350	But there are times where I *do feel* that our skills and our, ehm, (speaking faster) status of being a counselling psychologist is being compromised, we're more expected to do (resumes usual pace of speech) short-based therapy, eh, a quick CBT approach, on certain issues that we kind of probably don't feel would work.		Counselling psychologist value system is being compromised by attempted quick throughput of clients.					Counselling psychology value system compromised by changes.
369	I think we try to integrate with the team, but we're st- we've just- but we're still keeping onto our title as being a counselling psychologist		Tries to integrate skills into the clinical team but holds on to counselling psychology identity.			Negotiation of counseling psychology identity whilst integrating to take on clinical psych skill base also.		Integration of skills.
379	We're a Foundation Trust, so we have to generate income, so everything is about income-based, ehm, or we'll have to go out and do trainings, and to, you know, to, to, to gain some sort of financial income. So a lot of it is, and, and they are leaning *more* towards performance-based, (pause) ehm, Trusts, so it would be performance-paid if we meet our targets and contacts, you know, and we'll be rewarded, if we don't in a certain amount of time then we would be penalised. So it's becoming a lot more profitable.	Pressure to show generation of income, and performance-based rewards or risk penalisation and job security.				Job security threat underpinning productivity performance.		Job security threat.

Example pages for Tash (continued)

Line No	Tash 1 - Transcript *doc: transcripts*	Descriptive (non-interpretative)	What is she saying? First impressions	Similarities/ Differences	Descriptive Theme 1 (non-interpre-tive)	Emergent Theme 1 INTERPRETIVE - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
390	Ehm, but unfortunately a lot of the NHS systems are, are working towards (pause) performance-based, so I don't think (pause) our Trust is different to *any* other Trust. Ehm, I-- And a lot, a lot of this whole profit-based organisation is having an impact against- on psychologists the most, because we're perceived as being the most expensive professionals *to have*, so there's a lot of talks about down-banding some of the, ehm, psychologists, and capping it, to save money, not having so many psychologists within, within one team, and so that capacity to work is always being reviewed and audited.		Job security.					
398	Though in terms of that, I think it's- it- there, there is a- probably a strong chance that people will start to look elsewhere.	Pressure on psychologists' productivity in numbers chasing staff out of NHS.						
403	I think in terms of the NHS it's gonna probably die out as a profession, and I think people will probably start to do a lot more in the private sector, because there's more job satisfaction, and there's more *respect* for you as a psychologist, and more, more so than the NHS.	Believes counselling psychology won't last in the NHS because there is more respect, job satisfaction and career progression available in the private sector.	Believes counselling psychology won't last in the NHS because the profession isn't as respected as it is in the private sector.				No future in NHS CAMHS for counselling psychologists.	
412	I think to get a promotion, or to go up in your career as a psychologist, at- eh, in the *current* state of, ehm, things, it, it's very unlikely.							

Example pages for Michael

Line No	Michael 2 - Transcript *doc: 8.14*	Descriptive (non-interpretative)	What is he saying? First impressions	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
12	…a 'sense of self', ehm, (pause, sighs) I think traditionally, I think it's, it's very much, ehm, (long pause) if you like, ehm, constructed from the past, it's like, ehm, my own development, you know, ehm,	A sense of self is constructed from the past, his development, his attachment and how these influenced him to relate to others, and its changes.	Describing his concept of meaning of a sense of self.			Sense of self is a changing entity which was contracted from his developmental and personal history, and his attachment history. It influences how he relates to others.		
380	…the object relations kind of stuff, really, I think. Ehm, so I- you know, like attachment, ehm, model, or what have you, and then, I think, that's how it actually influenced me in terms of how I relate to others, and as to my own sense of self, ehm, (pause) ehm, my own sense of self, mmm, good question. Ehm, a mixed complex bag, really, I think.					Sense of self infused into his work/profession.	Sense of self and choice of profession inseparable.	He is his work. / Location of meaning,
403	…- it took me a long time to *become* a psychologist, and I've tried to protect that as best I can, so that I do, ehm, get meaning from my work. And, and my meaningful work means that I've been able to care for, ehm (pause) *for* my clients as best I can.					Client care part of sense of self.	Caring for clients is integral to his sense of self and locating meaning in his work.	Locating meaning/Psychological well-being.
405	Ehm, I don't think I get as much *meaning from* my work as I *used* to, but it's still there and I fight for it on a daily basis, but it's a battle, and,,,	Not getting as much meaning from work as used to, and has to fight for what meaning he gets.			Fighting to get meaning from his work and sees that ability to find meaning has decreased.	Changes in organisational structure are eroding his ability to locate meaning in his profession, and left him to fight a daily battle and to reflect his sense of self and locate meaning professionally.	Changes in organisational structure now causing him to battle daily to locate meaning, in a profession chosen to reflect his sense of self and locate meaning in his work.	LOCATION OF MEANING,

Example pages for Michael (continued)

Line No	Michael 2 - Transcript *doc: 8.14*	Descriptive (non-interpretative)	What is he saying? First impressions	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
407	I think that sense of, ehm, of self as a psychologist, self as a helping profession, professional and general and job satisfaction, I think is, ehm, (pause) is being eroded away, by, *by* the organisation.	The sense of self led him to a helping profession is being eroded by the organisational structure, as is his professional and job satisfaction.				Feels his sense of self is being eroded by organisational structure which is causing him a daily battle to locate meaning in his work.	Organisational changes negatively impacting his space / the openings to locate (as much) meaning in the work as previously.	Location of meaning/ Dumbing down of psychology: Systemic erosion of meaning and psychology as a profession.
409	I think things changed in the organisation when it became a Trust, I think, and, ehm, yeah, I-I just think it's, it's, it's, it's, it's-- This is not (pause) merely my experience I'm obviously talking about, but hopefully for the counselling psychologists out there because there are lots of other clinicians that feel the same way, and that actually this is systemic.					Loss of meaning in wider context of organisation.		Loss of meaning is systemic.
414	…This is, this is a, a systemic, ehm, (pause) a, a systemic, ehm, (pause)- ehm, almost like an *epidemic* that's happening, not not a - It's a systemic flaw within the organisation.	There is a systemic problem within the organisation of the NHS/CAMHS/Trusts undermining professional values of Counselling Psychologists.					Loss of meaning is systemic.	Location of meaning.
419	Yeah, I *do* think that the way things are going-- I think-- Unfortunately I think, you know, as clinicians we often mention to each other it's gonna take some (pause) – how do I use the word? – some *fatality* of some sort with something *terrible* that would happen to clients, if you like,	He and his colleagues have a sense of foreboding that a fatality or something terrible happening to a client will be the only thing that will make the management stop curtailing the work of the psychologists.		Sara said this, and maybe Natasha?		Client care quality - danger in lower quality.	Sense of foreboding about Client Relationship QUALITY.	Client care / Client relationship quality.

Example pages for Michael (continued)

Line No	Michael 2 - Transcript *doc: 8.14*	Descriptive (non-interpretative)	What is he saying? First impressions	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
423	…risky clients, where clinicians have not been allowed to be able to do the work that they, they, that they *should* be allowed to do and have been overworked and, and not been able to practice as clinicians as much as they *should* be, that will- there will be a knock-on effect on, on a client in a way that could maybe lead to a suicide or something like that. And I think it's only through *that* process that actually- that the organisation maybe will listen and argue, "Now we have to change our track here".	Not feeling allowed to do the work a psychologist should be allowed to do, practice constricted, and fear it has a knock on effect on client welfare with a disaster waiting to happen.			Reorganisation of work practices impacts the client-therapist relationship, and disasters (fatalities) are imminent.	Structural reorganisation and restrictions upon psychologists' practices are affecting the clients, and no one will listen until fatalities occur.	Sense of foreboding about quality of client care.	CLIENT CARE Restricting psychologist work AND DUMBING DOWN OF PSYCHOLOGY.
429	It's about-- You, you know, management don't necessarily listen to the clinicians, I think middle management are (pause) are caught between a rock and a hard place, they're being squashed from above,	Higher management are ignoring team's clinical judgement, and middle management are caught in the middle - seeing both sides but are being suppressed.						CLIENT CARE, QUALITY OF.
432	…and they're being squashed by the commissioners in the- on the field. But at the end of the day I think it, it, it's (pause) it's, ehm (pause)- I just think the- that the- there's a hie- there's a hierarchy and it's just this one direction, and it's going down and just there's no feedback back upwards that, that really makes a change, I don't feel.	Higher management not accepting feedback from the team, directives and feedback going downwards in the hierarchy.						
452	I think because of the changes that have happened, ehm, within the organisation, and because of maltreatment, I've become (pause) more disgruntled, angry, there has been some change,	Combination of changes and perceived maltreatment have changed him into more disgruntled, angry and maverick (challenging).	There has been an impact on his professional demeanour in work and his behaviour is more negative and challenging.			Relating to organisational structure like unhappy, challenging teenager to parent. (unconscious anxiety - paternalising organisation).	Behaviour changes in response to feeling un-cared about (like a teenager acting out? Unconscious reactive behaviours?).	Psychologist well-being (stress).

Example pages for Laura (continued)

Line No	LAURA 2 - Transcript doc: transcripts	Descriptive (non-interpretative)	First thoughts - What is she saying?	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
40	…that I've got quite, ehm, a strong, kind of, political and social conscience, and, and, ehm (pause) and that will- and that comes across in, in who I am in certain ways, you know, empowerment of clients, empowerment of, ehm, you know, myself and colleagues and that kind of thing as well. Not too many managers may like it, but, you know, eh, I think I'm kind of, ehm, (pause)- you know what, I'll speak up, I'll speak up for what I believe in. So quite a strong (pause) ehm- I don't know if I wanna say 'human rights', 'cause that, ehm…	Strong political and social conscience comes across in who she is in terms of empowering clients, herself, and colleagues, doesn't make her popular with managers.	She has a strong social conscience and human rights focus, and seeks to empower clients and will speak up for them and be an advocate.		Advocate for and empowering of the mentally ill, strong sense of human rights.	Holds onto her strong humanistic values and character in the workplace.	She is her work. Inside and outside work environment, she speaks up for client rights and empowerment of the mentally ill.	Client care quality = Location of meaning.
49	*Outside* of work I have, you know, kind of inc- I've, I've been involved in some activism.	Activist - outside of work.					Core self = activist (being activist = locating meaning for her).	Location of meaning/ Sense of self.
96	It's quite interesting (speaking faster) that we're doing this interview, because I've been doing a lot of thinking about my own, kind of, professional practice, and therapeutic practice, ehm, so I've actually been doing a lot of thinking about this anyway, ehm, over the last few months, ehm, year maybe. Ehm, in the— …							
99	*With* all the, ehm, work in the NHS, and *with* all the practices, and changes, and (inhales deeply) the bureaucracy, ehm, commissioner-driven outcomes, etc, etc, etc, it *really* has altered practice and *impedes* your practice, it's quite restricting, and having to *increasingly think* about and be *strategic*, about how you can still- you know, ehm, tick the boxes, and meet the criteria that's expected of you, the e- the *ever-increasing demands*, while *still* actually *trying* to do the job that you're actually trained *for to actually practice as a psychologist.*	Ability to practice as a counselling psychologist is impeded, restricted, and altered because of organisational changes, bureaucracy, commissioner-driven outcomes, which pack ever increasing demands upon her to tick boxes and meet certain bureaucratic criteria.	Changes have really altered, restricted and impeded her specifically in the practice of psychology.			Restrucruing has significantly altered and impeded psychological practice with demands to take on non-clinical related work.	Psychology practice impeded by changes = Location of meaning for her has changed.	

Example pages for Laura (continued)

Line No	LAURA 2 - Transcript doc: transcripts	Descriptive (non-interpretative)	First thoughts - What is she saying?	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
138	…whilst I understand the importance of the paperwork and clinical documentation, and especially in an ever-increasing time of safeguarding etc, *but* having a balance, ehm, would, would help. Would help. Ehm, otherwise you'll just have so much more experienced clinicians just leaving.	Understands that paperwork and clinical documentation is important in increasing safeguarding culture, but feels this is out of balance and that eventually the more experienced clinicians will leave.						
156	With, with *this* type of work, you need *thinking* space, you need time to think about the clients, think about the work, to discuss with colleagues, to have supervision, to have- you know, ehm, *clinical* supervision, *therapy* supervision, where it is a, a *therapeutic* supervision as opposed to around organisational.	Thinking space about the clients and the client work is needed with colleagues and in clinical supervision, as opposed to organisational supervision.				Being more specific about how client therapist dynamics and supervision are changing.		Client care - Change of therapist-client dynamics.
161	…stuff, you know, line-managerial. Often, even though they're supposed to be separate, often the line manager *impedes* and impacts on the *clinical* supervision. (pause) You know, targets and outcomes and stuff, they should be separate conversations, and the fact that- …	Often the line manager impedes and impacts on the clinical supervision to discuss non-clinical organisational issues (targets, outcomes), which is supposed to be a separate conversation.	Boundary-crossing and imposition on clinical supervision hour(s) to check targets are being met.			Boundaries being crossed from management into supervision space. (Supervision is now about supervising admin as well as therapy work.)	Crossing therapeutic boundaries.	
163	,,,and obviously it depends on the supervisor then and how well they are able to maintain these two and, if they're our manager as well. So there may be some people that don't experience that because *their* clinical supervision is provided by somebody else, or that person isn't able to hold that duality. But some people, it, it doesn't- and so, you know, the-the-the-the organisational pressures are coming into, s*eeping* into and contaminating the clinical space.	Organisational pressures are seeping into and contaminating the clinical space, leaving less time to think and talk through clinical issues.				The clinical space is being contaminated by organisational pressures and unboundaried supervision.		Clinical space is being contaminated. - Quality of client relationship being undermined.

Example pages for Laura (continued)

Line No	LAURA 2 - Transcript doc: transcripts	Descriptive (non-interpretative)	First thoughts - What is she saying?	Similarities/ Differences	Descriptive Theme 1	Emergent Theme 1 - concise pithy statement on what was important in the transcript comment	Emergent Theme 2- concise pithy statement on what was important in the transcript comment	Super-ordinate theme - any first thoughts
184	We'd read the article, discuss it, and then someone would bring a case, and you'd do some of the strategies from that article. You know, it was good!							
192	It keeps you on your feet thinking about-- You know. (resumes usual pace of speech) Those kind of things go and it's not necessary that people don't still want them, it's *the time*.	Collective/team reflective spaces based on MDT forums and case discussion meetings aren't available anymore because of time constraints on therapists since the changes.	No time anymore for reflection. No time for clinical case discussions. No time for collective MDT reflective spaces or learning disseminations.					CLIENT CARE - less formal MDT time.
218	…we used to have case presentations (inhales deeply), ehm, where someone would present a case, or if you went on training, you'd come back and discuss about the training to disseminate it.					Team interaction.	CLIENT CARE – Less dissemination of therapy knowledge, less reflective space.	Quality of Client Care - affecting therapeutic relationship on micro/macro level.
250?	I: Ehm, do you ever feel, like, the changes at work or the demands of work, or (pause) things at work *impact* your client relationships? P: Oh, oh, definitely. Definitely.	Client relationship is definitely impacted negatively.					Impact on client care (therapist-client relationship).	
293	2013, was an *extremely* stressful year for me. I think it's probably the most stressed I've been (pause) at work probably.	Experienced the most stressful year ever because of the changes, and experienced ongoing physiological symptoms of stress/burnout.				Extreme stress experienced as direct result of coping with changes, and overall welfare affected.	Psychologist health and welfare.	Psychologist health and welfare and burnout.

Appendix 11: Sample of Emails between Raters and Researcher

From: ANNIE H <anniexxxxxx@xxxxxx.com>
Date: Fri, 19 Dec 2014 at 04:09
Subject: Re: Theme checking
To: Norah Breslin <norah.breslin@xxxxxx.com>

Dear Norah,

Your project is fascinating!

I have had a good read through and agree with all your interpretations.

One point I would make though in reading section 3 when you are talking about stress related illness. Maybe treat the participants' comments with caution here and consider what stress lies outside the workplace (ie. Lucy). Its just a thought!

Do let me know when you want any more help/advice/support.

Wishing you a Happy Christmas and New Year.

Annie x

From: ELEANA S <eleanaxxxxxx@xxxxxx.com>
Date: Sat, 1 Nov 2014 at 17:03
Subject: Re: Theme checking
To: Norah Breslin <norah.breslin@xxxxxx.com>

Hi Norah,

I agreed with your themes and the interpretations. It was really interesting to read the quotes.

I was wondering about the quote in participant 3: “I feel stressed the moment I wake up”. She didn’t specify and it’s not clear to me in that quote if personal stresses are influencing her work experience.
What do you think?

I’m around all weekend and will keep a look out for your emails.

Eleana

Appendix 12: Sample of Themes Examined by Raters

Superordinate theme	Impact on Psychologists' Welfare & Morale		Rater evidence - thesis revisions	
Master themes	Participant 1	Participant 2	**Participant 3**	Participant 4
Stress-related illness	"No". *Participant stated he hadn't had time off because of stress.*	It was an extremely stressful year for me, probably the most stressed I've been at work. (*I knew I was stressed because)* You know you're tired, you don't want to come in, you have to. You know you're kind of forcing yourself in the morning, ehm, you're distracted. (329 T2)	*Q. Did you ever take time off work officially or unofficially because you felt stressed by your work environment?* Mmm, maybe *not officially*. Sometimes I felt the stress was getting too much then I'd take two or three days' annual leave. (289 T2)	My stress is more to do with the changes and the management stuff at the moment… I had to come to terms with the fact that I can't stop the changes.. and that was difficult for me. I was off for a couple of weeks as it kind of made me ill for a while. (T2 143)
Stress-related illness	I think the organisation is completely divided, and I think it adds great resentment, and as a result, y- you know, that just creates discontent, and, you know, it makes one *want* to take a 'screw the organisation, oh, I'll take a sicky *(sick day)* here' and stuff like that, that I *don't* do, *but*, you know, certainly the thought has crossed my mind (373 T2)	I did go to the doctor about going off with stress. I was very, very close but I didn't (take the time off) in the end. I've never felt like that before. I didn't actually want to go off with stress. That was the overriding thing. Even though they're supposed to be confidential, but I didn't want it on my health records. (378 T2)	**I feel stressed the moment I wake up. (T1 102)**	
Stress-related illness		I've never experienced that and I've worked in some very high pressured forensic settings, you know, real full-on highly stressful environments and I've never experienced that before (383 T2)	In Tier 3.. you have to appear to be coping.. I don't think my colleagues were really open about just how stressed they were. ..**The expectation here is that you *have* to cope or you *have* to keep it in**. So if you're obviously stressed, I think **you'll do your best to hide it.** (299 T2)	
Stress-related illness		I was off sick more and I was getting ill more. (361 T2)	The restructuring put so much pressure and stress on people. Well, it just kept stressing everyone badly and that affected the service provision because a lot of people **were stressed and sick** and **had to take time off**. Morale got really low. (476 T2)	
Stress-related illness		In terms of health I definitely had more physical health problems and I was off with physical health problems and they were definitely due to stress. (421 T2)		
Stress-related illness		You know there are symptoms of stress in terms of affecting your sleep, affecting your appetite. For me, I even get irritable bowel syndrome.		