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## PROFESSIONAL DOCTORATES

**Should it come with the territory? Experiences and discourses of two groups of professionals.**

Nickson, Catrin

*Award date:*  
2023

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**Should it come with the territory?**

**Experiences and discourses of two groups of professionals.**

Catrin Gwenllian Nickson

North Wales Clinical Psychology Programme



PRIFYSGOL  
**BANGOR**  
UNIVERSITY

Submitted in partial fulfilment for the degree of

Doctorate in Clinical Psychology

June 2023

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Diolch i Aled. Diolch am gadw trefn ar bob dim tra dwi wedi rhoi pen lawr a ffocysu ar gorffen y thesis yma. Ti wedi coelio yn y fi, neud i mi chwerthin, dangos cariad a wedi bod yn gefn i mi wrth gwlbhau'r cwrs. Dwi'n edrych ymlaen am y pennod nesaf o'n bywydau.

### **Dedication**

Hoffwn gyflwyno'r gwaith ymchwil yma er cof am Dad.

I would like to dedicate this thesis in my dad's memory.

**David Robert Nickson (27/01/17)**

### **Declaration**

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Signed: Catrin Nickson

Dated: 01/06/23



## **Thesis Abstract**

This thesis explores the experiences and discourses of two groups of professionals, firstly police/law enforcement personnel, and secondly, newly qualified clinical psychologists. Chapter one consists of a systematic review which looks at the psychological consequences for police/law enforcement personnel whose role involves exposure to traumatic material, namely, digital child abuse media, as part of their work. This is a systematic review of quantitative studies with a narrative synthesis, and 17 studies were included in the review. Findings suggested that overall, these professionals were experiencing less than anticipated negative psychological consequences resulting from their work. The implications and limitations of this review are discussed in further detail.

Chapter two is a qualitative study, which examines the discourses of eight newly qualified Clinical Psychologists regarding their transition from training and subsequent integration into community mental health teams in the National Health Service. The discourses were analysed using Foucauldian Discourse Analysis. Three main discourses were revealed, which included ‘That was then, this is now’ an overarching discourse with two transition points ‘I can put doctor in front of my name’ and ‘It’s kinda funny looking back’, secondly ‘What we offer isn’t what they want’, and lastly ‘Overhauling the system’. These discourses are discussed in detail in addition to the implications of this study.

Chapter three combines and consolidates findings from the systematic review and the empirical paper to highlight clinical implications, and contributions to theory and practice, including recommendations for future research. This chapter closes with the first authors’ personal reflections on the process of completing the thesis.

## **CHAPTER ONE – SYSTEMATIC REVIEW**

**What are the psychological consequences of police/law enforcement personnel with occupational exposure to digital child abuse media? A systematic review.**

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### **Abstract**

The literature suggests that police and law enforcement personnel are at risk of negative psychological consequences due to the nature of their work. There is an emerging evidence base pertaining to a unique group of police/law enforcement personnel, with occupational exposure to digital child abuse material. This paper systematically reviewed the psychological consequences for these professionals. Seventeen papers met the final inclusion criteria and only quantitative data was extracted. Various measures and outcomes pertaining to different psychological consequences were utilised in the reviewed studies. Results suggested that police/law enforcement personnel with occupational exposure to digital child abuse material experience lower levels of negative psychological consequences, and higher reports of compassion satisfaction. The implications of these studies along with the methodological limitations of the reviewed studies are discussed in the paper.

**Keywords:** Police, Law Enforcement, Internet Child Abuse, Disturbing Media, Digital Media, Occupational Exposure.

## Introduction

There is a large body of evidence highlighting the stress that police and law enforcement personnel experience (Purba & Demou, 2019; Violanti et al., 2017), with their job role being considered one of the most stressful occupations that exist (Toch, 2002; Webster, 2013). Police and law enforcement personnel are used interchangeably in this review and therefore will be referred to as ‘PLE personnel’ henceforth.

Professionals working in these roles are at risk of mental health difficulties such as depression and at increased risk of suicidality, in addition to coping via substance misuse (Houdmont & Elliot-Davies, 2016; Van der Velden et al., 2013; Wang et al., 2010). The focus on PLE personnel wellbeing has been noted as a research priority area given the exposure to difficult experiences as a part of the job role (Craddock & Telesco, 2022). A ‘Freedom of Information’ request regarding the wellbeing of police staff in the UK showed that work absences resulting from psychological ill-health had doubled in the last decade (Cartwright & Roach, 2021).

Traditional policing typically involves difficult roles with ‘day-to-day’ disturbing scenes or involvement with citizens who are in distress or crisis (Abdollahi, 2002). There is an established evidence base regarding the psychological consequences for police staff who are involved in this type of policing, who experience difficulties such as anxiety and depression, secondary traumatic stress ‘STS’, burnout, and post-traumatic stress disorder ‘PTSD’ (Conn & Butterfield, 2013; Foley & Massey, 2021; Foley et al., 2022; Stogner et al., 2020; Syed et al., 2020; Waters & Ussery, 2007).

However, there is a subset of PLE personnel whose role is to monitor, search and review child abuse media, which involves seeing images or videos of various forms of child abuse and exploitation through a digital/online forum. Different terminology is used in the literature to refer to this type of media. For ease, it will collectively be referred to in this

review as ‘digital child abuse material’ (DCAM) to encompass a range of different types of digital child abuse and exploitation exposure. This area of work has received less attention in the literature compared to traditional policing (MacEachern et al., 2019).

The evolution of the internet (Graham & Dutton, 2019) has led to an increased amount of DCAM being available on a hidden part of the internet (Bursztein et al., 2019; Liggett et al., 2020; Seigfried-Spellar & Soldino, 2020) called ‘the dark web’. The dark web not only allows an interface to distribute and circulate DCAM but also to contact children online (Insoll et al., 2022). In Canada, the dark web has been shown to directly contribute to child exploitation such as the production and circulation of child pornography images (Ibrahim, 2022). In 2017, an Independent Inquiry into Child Sexual Abuse in England and Wales found that there was a 700% increase over three years in suspected incidents of DCAM on the internet (Bowcott, 2018). Several recent BBC articles have reported an increase in DCAM being distributed online (Tidy, 2023).

DCAM is not only a pressing matter for the victims but also for PLE personnel who investigate these crimes and therefore are exposed to distressing materials. Several qualitative studies have explored the experience of this unique subset of PLE personnel and the psychological consequences of being exposed to and viewing DCAM (Ballucci & Patel, 2022; Cullen et al., 2020; Denk-Florea et al., 2020) as well as more general exposure to violent media for PLE personnel involved in court preparation (Birze et al., 2023). A survey report found that over half of the respondents working in child sexual exploitation were concerned about the psychological impact exposure to child pornography material might have (Wolak & Mitchell, 2009). Given the high turnover of PLE personnel (Wareham et al., 2015), the subject warrants further investigation.

Despite the advancement of technological systems within policing that automatically trawl the internet for disturbing DCAM (Westlake et al., 2017), there will always be the

requirement for a human to examine and categorise the severity of the DCAM content (Kloess et al., 2019; Krone, 2004). ‘Seeing an abused child’ was reported as one of the most stressful aspects of policing (Violanti et al., 2016). The level of stress generated by exposure to DCAM was highlighted by Krause (2009), who concluded that occupational wellbeing programmes needed to be tailored specifically to these groups of PLE personnel, given that they will see and possibly hear traumatic incidents being played out, as opposed to hearing a narrative during therapy (Burns et al., 2008).

The purpose of this paper is to review the emerging literature regarding the psychological consequences of exposure to DCAM in this subset of PLE personnel. A narrative synthesis of quantitative findings in this area will be provided.

## **Method**

A systematic literature search was conducted in February 2023 using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses, ‘PRISMA 2020 checklist’ by Page et al. (2021). This systematic review was registered with PROSPERO, the National Institute for Health Research prospective register (project registration number: CRD42023395858).

## ***Search Strategy***

The following electronic databases were searched: Web of Science (core collection by ‘topic’), PsycINFO (‘title and abstracts’), and ASSIA ‘Applied Social Sciences Index & Abstracts’ (in ‘abstract and summary’). The limits set on this search included peer-reviewed articles, full-text availability, published in the English language, and reporting on human research. Date restrictions included publication dates between 2010 and February 2023.

Following initial scoping searches, and given the relatively niche area of study, it was decided that the search terms had to be broad. The search terms used were (police OR "law

enforcement" OR investigator\* OR officer\* OR practitioner\* OR personnel OR handler\* OR forensic\* OR "task force\*") AND (computer OR internet OR online OR web OR "dark web" OR media OR cyber OR electronic OR material OR images OR videos) AND (child OR children OR minor OR underage) AND (abuse OR crime OR criminal OR cybercrime OR "cyber crime" OR disturbing OR exploit\* OR sex\* OR pornography OR maltreatment OR paedophilia OR pedophilia OR child sexual abuse OR CSA OR "child sexual abuse material" OR CSAM OR "internet crimes against children" OR ICAC) AND (secondary OR vicarious OR type II OR indirect OR exposure OR "work related" OR trauma\* OR post-trauma\* OR stress OR distress OR "mental health" OR psychological OR impact OR compassion fatigue OR burnout OR PTSD OR PTS).

### ***Study Selection***

The second stage (Stage 2: selection) was completed by the first author and a random subsection of papers (25%) was also reviewed by the second and third authors against the inclusion and exclusion criteria (see below). Any disagreement regarding eligibility was discussed with all three authors and decided via consensus and notes were kept of this process. Articles were included if they met the following inclusion criteria 1) the sample included PLE personnel whose role involved exposure to DCAM and 2) utilised a measure considered a psychological consequence by the research team. Articles were excluded if they either used qualitative methodology only, did not focus on the DCAM element within PLE personnel, or did not utilise a measure of a psychological consequence.

### ***Data Extraction and Analysis***

Data from the studies were extracted and collated in a table (see Table 1 for data extraction). The data extraction comprised of author names, year of publication, country



of publication, study design, sample size, sample setting (i.e., job role) and sample demographics (age/gender/race), measures of psychological consequences and key findings relating to the research question. Priority was given to validated measures of psychological consequences where applicable. With different measures being used to assess various psychological consequences, as well as different definitions for job roles and length of exposure to DCAM, it was not possible to pool data for meta-analyses.

### ***Quality Tool***

The studies included in the final review were assessed for methodological quality, and this was completed during the data extraction phase of the review. The Joanna Briggs Institute (JBI, 2020) Critical appraisal tool ‘Checklist for Analytical Cross-Sectional Studies’ was utilised, and the quality of the papers was used to inform the synthesis of the findings.

### **Results**

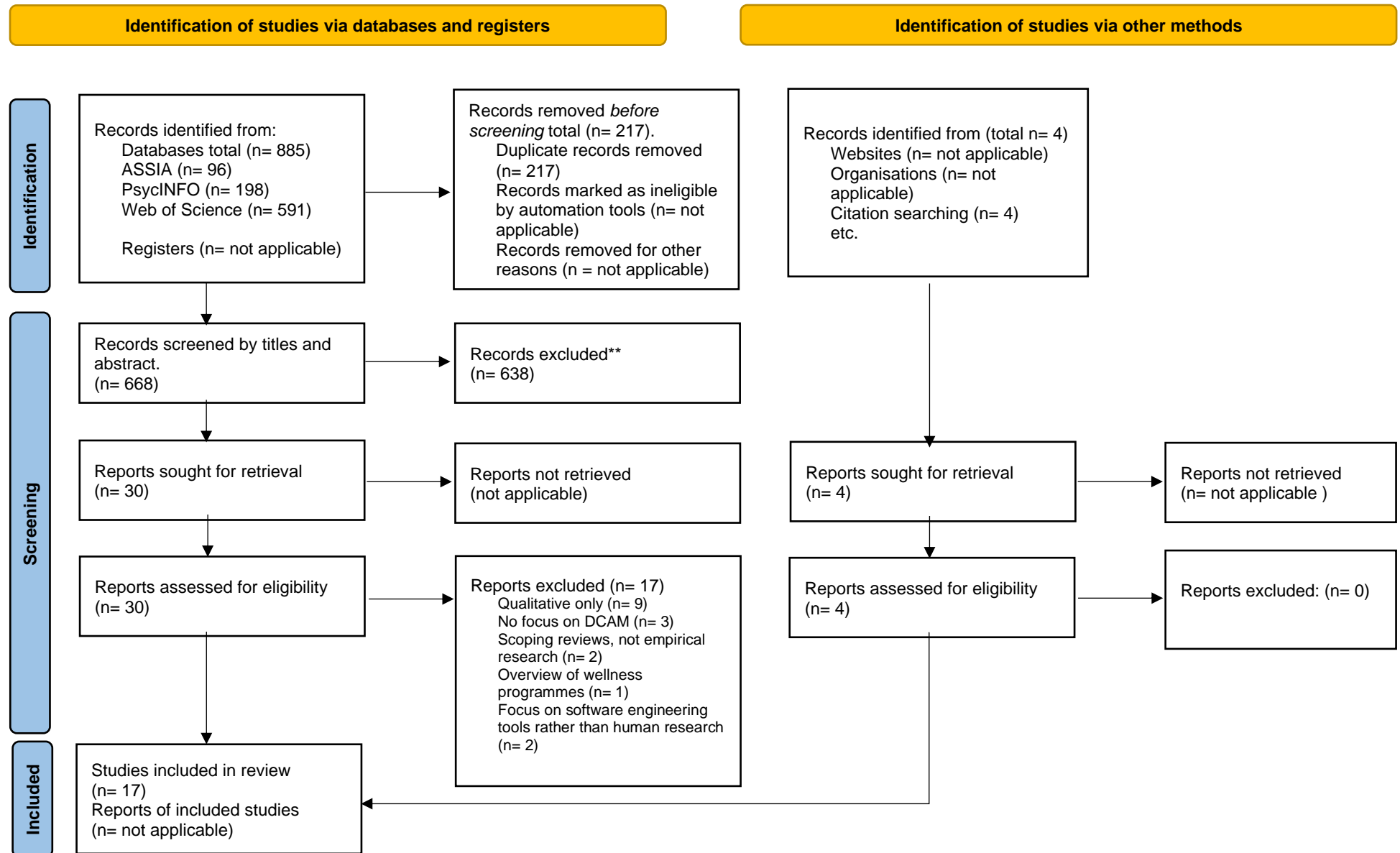
The study selection process is demonstrated in Figure 1, using the PRISMA 2020 updated guidelines (Page et al., 2021). Electronic searches from the databases identified 885 papers, which, once duplicates were removed, left 668 unique papers to be screened for inclusion. Titles and abstracts were screened for their relevance to the review (Stage 1: screening) by the first author, resulting in 30 records being retained. The full texts for these 30 papers were accessed and read in full. After applying the inclusion criteria to the 30 papers (Stage 2: selection), 17 were excluded, leaving 13 papers. Hand searching of the reference lists identified a further four papers to be included which resulted in 17 papers for the final review. Four papers were identified via backward and forward citation searching (Boland et al., 2017).

No papers were removed based on the quality assessment as all were deemed to be of good to high methodological quality (see Appendix 1 for the quality inspection table). The first author rated all 17 studies, and the second and third authors counter-reviewed four studies each. Some disagreement was found between authors, 18% ( $n=3$  studies), and a consensus was reached for the final table included in this study. There was agreement on the remaining 82% ( $n=14$  studies). Discrepancies were mainly related to whether studies had specified inclusion and exclusion criteria (questions one and two on the checklist), as some papers did not explicitly report this, resulting in initial scoring discrepancies between one to two points. Due to the sampling technique used in some studies (sending out surveys), some were unable to provide explicit sample information.

### ***Study characteristics***

There were 17 papers included in the final review which fulfilled the inclusion and exclusion criteria. Details of these papers are presented in Table 1 which provides key summaries of each paper including sample characteristics and setting, measures, and key findings relating to the research question. Most of the studies were published in the USA ( $n=12$ ), followed by the UK ( $n=3$ ), USA and UK ( $n=1$ ), and Australia ( $n=1$ ). All papers employed a cross-sectional research design with most using online surveys. As per the inclusion criteria, all papers utilised quantitative research methodology, with three using a mixed methods approach whereby only quantitative data were extracted for this review.

**Figure 1.** PRISMA Flow Diagram (Page et al., 2021).



### ***Sample Population***

Although the studies examined the same study population of interest, there were considerable differences in how the studies described the job title and roles of PLE personnel with DCAM exposure. Seven studies included PLE personnel working in Internet Crimes Against Children (ICAC) task forces whose job role involved working with DCAM. Other descriptors included Digital Evidence Investigators ( $n= 1$ ), Forensic Interviewers from ICAC ( $n= 1$ ), Specialist sexual and offending police teams ( $n= 1$ ), Digital Forensic Analysts ( $n=1$ ), Law Enforcement Officers who engage in Computer Crime investigations ( $n= 1$ ), Federal Law Enforcement personnel who investigate internet child pornography ( $n= 1$ ), Investigator / Digital Forensic Examiner, in addition to the personnel who perform both roles ( $n= 1$ ), Internet Child Abuse Investigators ( $n= 1$ ), Child Abuse Investigators ( $n= 1$ ) and Internet Child Exploitation Investigators ( $n= 1$ ). Although these occupations were not identical, they all involved exposure to DCAM, with some undertaking this work as a more substantial part of their role.

### ***Sample Sizes and Characteristics***

The sample sizes for each study are reported in Table 1, and these ranged from 28 to 2289. Only three studies reported a response rate, which ranged from 21.79% to 84.8%. Most of the studies were unable to calculate a response rate due to the sampling procedures utilised (snowballing sampling and online survey invitations to heads of departments to circulate surveys). Not all studies reported specific age characteristics. The mean age ranged from 30-50 years in the thirteen studies that reported this characteristic. There were fourteen studies with a majority male sample (over 50%) and three studies with a majority female sample. Most of the studies reported the majority gender sample and did not report other information. Eleven studies reported the participants' race which was predominately White.

**Table 1.** *Data Extraction*

Author Year Country	Design	N	Sample and setting	Measures	Key Findings	QS
Bourke and Craun (2014a)	Cross- sectional	965 USA 677 UK 288	Setting: US and UK ICAC personnel (various roles)	STSS ( $\alpha = .93$ )	<ol style="list-style-type: none"> <li>1. UK sample had more respondents in the ‘low/no STS’ category (36.9%) compared to the US sample (26.4%)</li> <li>2. US sample had more participants in ‘severe STS’ category (15.3%) compared to UK sample (10.4%)</li> <li>3. Higher self-reported difficulty and frequency of interaction with disturbing media were positively related to higher STS in both samples.</li> <li>4. The overall STSS mean score on the Likert scale: UK (<math>M = 1.99</math>) and USA (<math>M = 2.16</math>)</li> </ol>	8/8
USA & UK			UK: Female, (44.4%). USA: Female, (27.1%)			
Bourke and Craun (2014b)	Cross- sectional	600	ICAC personnel (various roles)	STSS ( $\alpha = .94$ )	<ol style="list-style-type: none"> <li>1. Results were as follows: severe STS (15.3%), High STS (9.8%), Moderate STS (18.6%), Mild STS (29.9%), Low/no STS (26.4%).</li> <li>2. Self-reported frequency and difficulty were associated with higher STS scores.</li> </ol>	8/8
USA			Gender: Male (66%) Female, (24.5%), Did not report (9.5%). Race: White (80.1%)			

Brady (2017)  USA	Cross- sectional	443	ICAC personnel across United States (various roles)  Gender: Male, (72.0%,) Race: White (92.4%) Average age between 40-49 (40.6%)	ProQOL-V (STS subscale, $\alpha = 0.853$ ) (Burnout subscale $\alpha = 0.695$ ). (Compassion satisfaction subscale $\alpha = 0.894$ )	<ol style="list-style-type: none"> <li>1. On average, findings indicated that the majority of the sample were low to moderate risk for STS (75%), burnout (75%), and moderate to high levels of compassion satisfaction reported (76%).</li> <li>2. Respondents risk for STS, low risk (23.7%), moderate risk (51.5%), high risk (24.2%).</li> <li>3. Respondents risk for burnout: low risk (24.0%), moderate risk (52.6%), high risk (23.4%)</li> <li>4. Respondents' levels of compassion satisfaction, low (24.0%), moderate (52.6%) and high (23.4%).</li> <li>5. Frequent exposure to Crimes Against Children 'CAC' were associated with scores on the ProQOL-V.</li> </ol>	8/8
Burrus et al (2018)  USA	Cross- sectional	360	National White Collar Crime Center across 23 US States with cybercrime responsibilities (digital evidence investigators).  'Typical respondent' male (no figures provided).	STSS ( $\alpha = 0.938$ )	<ol style="list-style-type: none"> <li>1. Average scores for secondary trauma ranged from 17-85 and overall STSS scores were as follows (<math>M = 23.833</math>, <math>SD = 9.013</math>), corresponding to 'little to no STS' (&lt;28).</li> <li>2. For STS, exposure to CAC evidence was significant and positive (<math>p &lt; 0.000</math>), therefore more exposure increased levels of reported secondary trauma.</li> </ol>	6/8
Craun and Bourke (2014)  USA	Cross- sectional	508	ICAC task force personnel (various roles)  Gender: Male (74.0%) Race: White (92.5%),	STSS ( $\alpha = 0.93$ )	<ol style="list-style-type: none"> <li>1. Average response on the Likert scale for STSS (<math>M = 2.15</math>, <math>SD = .68</math>). Clinical interpretation was not provided however given 5-point Likert scale; the mean is under the midpoint therefore findings suggest relatively low levels of STSS.</li> </ol>	8/8

					2. Greater self-reported frequency and difficulty of viewing child pornography was related to higher STS scores.	
Craun and Bourke (2015)	Cross-sectional	350	ICAC taskforce personnel (various roles)	STSS ( $\alpha = 0.93$ )	1. Average scores for STSS across sample were ( $M= 2.21$ , $SD= .78$ ). Clinical interpretation was not provided however given 5-point Likert scale; the mean is under the midpoint therefore suggesting relatively low levels of STSS. 2. Greater self-reported frequency and difficulty with disturbing media had the strongest positive relationship with STSS scores.	8/8
USA			Gender: Male (73.6%) Race: White (87.7%).			
Craun et al (2015)	Cross-sectional Mixed Methods	600	ICAC taskforce personnel	STSS ( $\alpha = 0.94$ )	1. Average scores for on the STSS ( $M= 2.16$ , $SD= 0.74$ ). Clinical interpretation was not provided however given 5-point Likert scale; the mean is under the midpoint therefore suggesting relatively low levels of STSS.	8/8
USA			Gender: Male (66%) Female (24.5%), Did not report (9.5%) Race: White (80.1%).			
Fansher et al (2020)	Cross-sectional Mixed methods	250	Forensic Interviewers from ICAC personnel.	ProQOL-V (burnout scale $\alpha = 0.85$ , compassion satisfaction $\alpha = .89$ ).	1. Burnout was driven by factors including frequently feeling overwhelmed with work, lower levels of compassion satisfaction, limited organisational support, and exposure to disturbing material involving children were all statistically significant predictors of frequency of experiencing burnout. 2. No clinical interpretation of burnout was provided, other than the model being statistically significant ( $p=$	8/8
USA			Gender: Female (83.5%) Race: White (86.7%)			

			Average age ranges 30-39 (37.6%)		.000), and that factors listed above accounted for 62% of the variance in the dependent variable (burnout).	
Gray and Rydon- Grange (2020)  UK	Cross- sectional	78	North Wales Police Staff from specialist sexual and offending teams (some of sample having roles of online CSA investigation)  Gender: Male (47%), Female (53%). Race: White British (86%). Age ranges 35-54 (67%)	STSS, ProQOL-V	<ol style="list-style-type: none"> <li>Regarding levels of symptomology, overall sample were as follows: Using the STSS, scores were predominately in the 'mild' STS (<math>M= 35.29</math>, <math>SD= 13.34</math>) range.</li> <li>Using the ProQOL-V; group scores of STS on the ProQOL-V fell within the 'low' range (<math>M= 20.08</math>, <math>SD= 6.51</math>)</li> <li>Group scores for were 'average' for burnout (<math>M= 25.77</math>, <math>SD= 6.07</math>) and high average for compassion satisfaction (<math>M= 36.09</math> <math>SD= 6.78</math>).</li> </ol>	7/8
Holt and Blevins (2011)  USA	Cross- sectional	56	Digital forensic analysts  Gender: Male (80.4%), Female (19.6%) Race: White (71.4%). Age ranges 22-55 ( $M=39.23$ )	Job Satisfaction Measure ( $\alpha = .862$ ) from the Quality of Employment Survey (Quinn & Shepard, 1974).  Work Stress Scale ( $\alpha = .896$ )	<ol style="list-style-type: none"> <li>Respondents reported 'high' degree of job satisfaction scale range (1-5) (<math>M= 3.94</math>).</li> <li>Respondents reported a 'moderate' amount of work stress range 4-24 (<math>M= 13.29</math>). Levels of work stress were as follows, nearly 68% participants indicated being under a lot of pressure, with 51.8% indicating that their work could make them upset.</li> <li>60.7% of respondents said they disagreed with feeling tense/uptight at work, with nearly 80% reporting to feel calm at work.</li> </ol>	7/8
Holt et al (2012)	Cross- sectional	224	Law enforcement officers who engage	Job Satisfaction Measure ( $\alpha = 0.807$ ) Quality of employment	<ol style="list-style-type: none"> <li>Respondents in the study reported moderate to high level of work stress (<math>M= 14.38</math>) with midpoint of 12.</li> </ol>	7/8



USA			in computer crime investigations	survey (Quinn & Sheppard, 1974).  Gender: Male (86%) Race: White (85%) Age: ( $M=42$ ) Range 24-62.	Work Stress Scale ( $\alpha = 0.892$ )	2. Respondents reported relatively high level of job satisfaction ( $M=13.29$ ) which was over the midpoint of 10.5.	
Perez et al (2010)	Cross-sectional Mixed methods	28	FLE personnel who investigate Internet child pornography.  Male (75.0%).	STSS ( $\alpha = .97$ ),  MBI-GS (exhaustion: $\alpha = .90$ , cynicism: $\alpha = .85$ , professional efficacy $\alpha = .69$ )		1. Overall STSS score ( $M=36.11$ , $SD=18.06$ ) with scores ( $>38$ indicating 'moderate STS'). Overall scores were in the 'mild' STS range. 2. 18% of respondents ( $n=5$ ) were in the 'high' STS categorisation, 18% ( $n=5$ ) were in the 'moderate' STS categorisation. 3. Using the MBI-GS, 54% ( $n=15$ ) of the sample were in high exhaustion category, 43% ( $n=12$ ) in high cynicism, and 18% ( $n=5$ ) in low professional efficacy (lower scores in this subtest is indicative of high burnout). 4. Time spent with disturbing media correlated significantly with higher STS scores ( $p < .05$ ) but not on burnout scales.	6/8
Seigfried-Spellar (2018)	Cross-sectional	129	Law Enforcement Officers: Investigator only ( $n=71$ ), Digital Forensic Examiner 'DFE' only ( $n=20$ ), Dual roles ( $n=38$ ).	PCL-C ( $\alpha = 0.93$ )		1. Participants who performed both investigator and DFE duties ( $n=38$ ) were more likely to be positive for PTSD (authors regard PTSD as mirroring STS) compared to investigator or DFE only. Scores $>30$ were classified as a 'clinical cut off' indicating 'moderate-moderately high PTSD levels'. 2. Out of the respondents performing both duties ( $n=38$ ), 42% ( $n=16$ ) scored at or above $>30$ which was higher than those who scored $>30$ in the other roles;	6/8

			Gender: Male (80.6%) Female (19.4%). Race: White non-Hispanic and Latino (89%). Age ( $M=41.6$ , $SD=7.91$ ).		investigator only 22% ( $n=16$ ), and 30% ( $n=6$ ) for DFE only.	
Stewart and Witte (2020)	Cross-sectional	212	ICAC task force workers	STSS ( $\alpha = 0.93$ )	1. Respondents' average STS scores was ( $M=35$ , $SD=12.4$ ) (ranging from 17-85) indicating 'mild STS'. 2. Six respondents reported no STS symptoms, and remaining respondents ( $n=206$ ) scored between the ranges of 18-80.	8/8
USA			Gender: Male (65.1%) Female (34.9%). Race: Caucasian (88.7%).			
Tehrani (2016)	Cross-sectional	126	Internet Child Abuse Investigators (ICAI) across two police forces.	ProQOL-V, IES-E, Goldberg Anxiety and Depression Scale.	1. Scores were statistically higher for females than males for PTSD ( $p < 0.01$ ), and STS ( $p < 0.01$ ). 2. The study measured clinical significance with early signs of distress ('level 1') and high levels of distress ('level 2' – as per measures). 3. Females were more than twice as likely to experience anxiety and depression compared to male participants (10% above level 2 cut off). 4. 16% of males were at risk of developing PTSD and 22% at risk of burnout (level 1), none experiencing clinical levels (level 2). 5. 4% of the male subsample ( $n=68$ ) and 7% of female subsample ( $n=44$ ) were reporting clinical levels of STS (level 2).	6/8
UK			Gender: Male ( $n=76$ ), Female ( $n=50$ ). Average Age females ( $M=41$ , $SD=8.9$ ) Average age males ( $M=44$ , $SD=9.4$ )			

Tehrani (2018)  UK	Cross-sectional	2289	Child Abuse Investigators within psychological surveillance screening programmes.  Gender: Female (56%). Average age ( $M=39$ )	ProQOL-V, IES-E, Goldberg Anxiety and Depression Scale.	<ol style="list-style-type: none"> <li>Results are split by gender. Anxiety and depression range scales 0-9 – results were statistically significantly higher for anxiety in women (<math>M= 2.92</math>, <math>SD = 2.63</math>) than males (<math>M= 2.57</math>, <math>SD= 2.53</math>) at <math>p&lt; 0.001</math>., and depression in women (<math>M= 1.86</math>, <math>SD= 2.13</math>) then males (<math>M= 1.65</math>, <math>SD= 2.00</math>) at <math>p&gt; 0.01</math>.</li> <li>There were statistically significant differences between gender for secondary trauma; females (<math>M= 9.94</math>, <math>SD= 6.72</math>), males (<math>M= 9.13</math>; <math>SD= 6.56</math>).</li> <li>PTSD ‘Primary’ trauma; females (<math>M= 31.5</math>, <math>SD= 18.0</math>), males (<math>M= 24.6</math>, <math>SD= 16.8</math>)</li> <li>Although statistically significant differences were between genders, the effect size (Cohen <math>d</math>) was reported as ‘small’. Magnitude of clinical significance was negligible for all measures expect the primary trauma ‘PTSD’ scores.</li> </ol>	6/8
Tomyn et al (2015)  Australia	Cross-sectional	139	Australian Law Enforcement organisation – Internet Child Exploitation investigators (ICE sample)  ICE sample demographics: Male (62%), Female (37%). Age ranges 24-58 ( $M= 38$ , $SD = 7.49$ years).	SWB measured by PWI (ICE group $\alpha = .86$ , non-ICE group $\alpha = .79$ and mainstream sample $\alpha = .78$ ).	<ol style="list-style-type: none"> <li>Mean SWB (represented by ‘PWI’) for the ICE sample (<math>M= 79.97</math>) was 2.39 points above upper end of Australian normative range (<math>M= 76.68</math>).</li> <li>Only (<math>n= 3</math>) investigators (2.2%) scored very low on PWI (&lt;50 points).</li> <li>SWB was comparable between ICE sample (<math>M= 79.97</math>, <math>SD= 12.88</math>) versus non-ICE sample (<math>M= 81.64</math>, <math>SD= 10.26</math>).</li> </ol>	7/8

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Comparative  
samples of non-ICE  
police officers  
( $n=102$ ) and  
Australian Unity  
Wellbeing Index  
( $N = 55,697$ )

**Abbreviations (Terminology):**  $\alpha$  = Cronbach's Alpha - internal reliability/consistencies reported in studies. CAC = Crimes Against Children. DFE = Digital Forensic Examiners. FLE = Federal Law Enforcement. ICAC = Internet Crimes Against Children. M = Mean. QS = Quality Score, SD = Standard Deviation. SWB = Subjective Wellbeing. UK and USA = United Kingdom and United States of America.

**Abbreviations (Measures):** Goldberg Anxiety and Depression Scale = (Goldberg et al., 1988). IES-E = Impact of Events Scale-Extended (Tehrani et al., 2002). MBI-GS = Maslach Burnout Inventory (Maslach et al., 1997). ProQOL-V = The Professional Quality of Life Scale (Stamm, 2020). PCL-C = PTSD Checklist-Civilian Version (Weathers et al., 1999). PWI = Personal Wellbeing Index. STSS = Secondary Traumatic Stress Scale (Bride et al., 2004).

### ***Measures assessing Psychological Consequences***

Different measures were employed to look at the psychological consequences of DCAM exposure within this subgroup of PLE personnel. The measures used to assess the different psychological consequences are reviewed in turn. Where reported in the reviewed studies, reliability properties (Cronbach's alpha) are presented in the data extraction table under the 'measures' subheading.

#### ***Secondary Traumatic Stress / Post Traumatic Stress Disorder / Burnout***

Nine studies utilised the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004). The STSS is a self-reported measure, which asks about 17 secondary stress symptoms experienced within the last seven days using a 5-point Likert scale; 1 (never) to 5 (very often) and assesses three main domains: intrusion, avoidance, and arousal symptoms, resulting from indirect exposure to traumatic events (Bride et al., 2004). Eight studies used the STSS in its entirety, and one study (Stewart & Witte, 2020) implemented minor word changes. Bride (2007) categorised the total summed scores as: 'little to no STS' (<28), 'mild STS' (28-37), 'moderate STS' (38-43), 'high STS' (44-48) and 'severe STS' (>49). The STSS is congruent with the <sup>1</sup>DSM criteria for Post-Traumatic Stress Disorder (PTSD) (Lee et al., 2018). Evidence for the STSS claimed reliability, convergent, discriminant, and factorial validity (Bride et al., 2004).

One study (Seigfried-Spellar, 2018) measured STS using the Post-Traumatic Checklist-Civilian Version (PCL-C; Weathers et al., 1999). This is a 17-item self-reported rating scale whereby participants are asked about different symptoms within the past month and respond using a 5-point Likert scale; 1 (not at all) to 5 (extremely). Responses range from 17-85, with scores >30 being a 'positive' indicator for PTSD (National Center for PTSD, 2014).

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<sup>1</sup> Diagnostic and Statistical Manual of Mental Disorders (DSM)

The Professional Quality of Life Scale-fifth and most recent edition (ProQOL-V; Stamm, 2010) was utilised in five studies: Brady (2017), Fansher et al. (2020), Gray and Rydon-Grange (2020) and two separate studies by Tehrani (2016; 2018). The ProQOL-V is a 30-item self-report professional quality of life measure assessing three domains (burnout, secondary traumatic stress, and compassion satisfaction). Compassion satisfaction refers to pleasure gained from one's work (Stamm, 2010). Participants respond using a 1-5 Likert scale; 1 (never) to 5 (very often).

Different measurement interpretations are provided for the ProQOL-V in the reviewed studies. Grey and Rydon-Grange (2020) used the total 'sum' for each subscale as calculated by Stamm (2010), which equates to severity categories as follows; low (22 or less), average/moderate (between 23 and 41) or high (42 or more), whereas Brady (2017) followed cut-offs on the 25<sup>th</sup> and 75<sup>th</sup> percentile (Stamm, 2010) to categorise low, moderate, and high-risk levels for STS and burnout, and levels of compassion satisfaction. Two studies (Fansher et al., 2020; Tehrani, 2018) did not categorise their findings in this way. Fansher et al. (2020) focused on two out of three subscales (burnout and compassion satisfaction) from the ProQOL-V. Tehrani (2016) focused on burnout and STS (labelled 'compassion fatigue' in the paper) from the ProQOL-V. Across all clinical measures (including the ProQOL-V), Tehrani (2016) stated that 'level 1' cut-off data were established based on a sample of the ICE population deemed 'at risk', and that the 'level 2' clinical cut-off corresponded to clinical cut-off scores of the measures provided by the authors. Despite reporting the cut-offs for level 1 and level 2, the cited paper referring to the evidence and context of the 'level 1' cut-off is an inaccessible internal report. Tehrani (2018) used the ProQOL-V to measure STS only, and they report that scores ranged from 0-50.

In Tehrani's two studies (2016; 2018) the Impact of Events Scale-Extended (IES-E) was used to assess PTSD, called 'primary trauma' in the 2018 paper. This was based on the

15-item self-report measure developed by Horowitz et al. (1979) with three subscales (avoidance, intrusion, hyperarousal) and was extended by Tehrani et al. (2002) to include eight additional items related to stressful incidents within organisations. The measurement properties of the extended version were not reported; however, Tehrani's (2018) paper reported that IES-E scores ranged between 0-92, with no clinical interpretation of scores provided. The original IES scale-revised reports a range of 0-88 possible scores, with scores >24 considered clinically meaningful, and scores >33 indicating the diagnostic presence of PTSD (Horowitz et al., 1979; Weiss, 2007). Tehrani et al. (2002) described that respondents report on the IES-E using a Likert scale; 0 (never) to 4 (most of the time) similar to the original IES scale.

The Maslach Burnout Inventory – General Survey (MBI-GS; Maslach et al., 1996) was used in one study (Perez et al., 2010). The general survey is an adaptation of the original MBI to account for burnout in occupational groups, whereas the original MBI was devised for human services (Schaufeli et al., 1996). This measure consists of 16 items rated on a 7-point Likert scale and assesses exhaustion, cynicism, and professional efficacy. Measurement properties for the MBI-GS were not reported in the Perez et al. (2010) study.

### ***General Mental Health Screening: Anxiety and Depression***

Tehrani (2016; 2018) used the Goldberg Anxiety and Depression Scale (Goldberg et al., 1988) in both studies. The original paper (Goldberg et al., 1988) outlines nine questions each for both the anxiety and depression scale, and the interpretation provided is that anxiety scores of >5 and depression scores of >2 have a '50% chance' to result in 'clinical disturbance' (Goldberg et al., 1988).

### ***Wellbeing***

One study (Tomyn et al., 2015) studied psychological wellbeing more generally, by measuring subjective wellbeing (SWB) using the Personal Wellbeing Index (PWI;

International Wellbeing Group, 2013). The PWI measures life satisfaction across eight domains and produces a total mean satisfaction value. This measure is part of the Australian Unity Wellbeing Index, used in Australian population surveys since 2001 (Lau et al., 2005). Psychometric analyses have found PWI to be a valid and reliable instrument within the Australian population (Cummins et al., 2003). Individual total mean scores correspond to ‘normal/average’ subjective wellbeing (>70), ‘compromised’ (50-69) and ‘challenged’ (<49) (Tomyn, Weinberg, & Cummins, 2015).

### ***Occupational Stress***

Measures were used to assess job stress and satisfaction which could be interpreted as a psychological consequence. Two studies by similar authors (Holt & Blevins, 2011; Holt et al., 2012) utilised a ‘job satisfaction measure’ which consisted of five items derived from the Quality of Employment Survey (Quinn & Sheppard, 1974). It is reported in Holt et al.’s (2012) study that scores range between 5-16 and that higher scores represent higher job satisfaction.

Both studies (Holt & Blevins, 2011; Holt et al., 2012) also utilised a ‘Work Stress Scale’ (Cullen et al., 1985), which consisted of a 4-item question, with a 6-item Likert scale response. Scores ranged from 4-25, with higher scores indicative of higher reports of work stress. It is unclear whether the original scale was validated.

### ***Measures in relation to DCAM exposure***

Several authors of the reviewed studies created their own questionnaire to assess the frequency and self-reported difficulty in viewing DCAM. Bourke and Craun developed a 5-point Likert scale to assess the frequency of viewing child pornography images (1 = zero times in the past six months to 5 = every day), and the difficulty in viewing these images (1 = not at all difficult to 5 = extremely difficult). Five studies involving these authors (Bourke &



Craun, 2014a; Bourke & Craun, 2014b, Craun & Bourke, 2014; Craun & Bourke, 2015; Craun et al., 2015) used this measure.

Perez et al. (2010) developed a 28-item scale called ‘Reactions to Disturbing Media Scale’, with subscales assessing supportive relationships, protectiveness, co-worker relationships, and distrust of the public. Bourke and Craun’s (2014b) study also utilised Perez et al.’s (2010) scale. One study (Burrus et al., 2018) created their own 4-item survey to assess the number of hours per week spent examining DCAM (ranging from 1-3 hours to > 21 hours). They looked at variations in exposure (videos, images, email, chat logs, searching browser histories). Brady (2017) measured exposure to DCAM including weekly hours spent viewing DCAM, and the average age of children in the material viewed. Fansher et al. (2020) examined the frequency of direct exposure using a 5-point Likert Scale. Stewart and Witte (2020) created their own questions to measure the type of exposure and frequency of exposure.

### **Psychological consequences**

The findings pertaining to different psychological consequences studied in the papers are synthesised below.

#### ***Secondary Traumatic Stress***

Craun and Bourke (2014a) compared prevalence data between UK and USA samples, using the STSS. The UK sample was more likely to be in the low/no STS category (36.9%) than the USA sample (26.4%) and was less likely to be in the severe STS category (10.4%) compared to the USA sample (15.3% ). They also reported an overall average for the Likert-scale response for the UK ( $M= 1.99$ ) and USA ( $M= 2.16$ ). Additionally, the data from Craun and Bourke (2014b) appeared to use the same USA pool as used in the (2014a) paper, although this was not explicitly stated. Therefore, the STSS findings for the USA sample

(Craun & Bourke, 2014b) which were used as comparisons in the Craun and Bourke (2014a) study were as follows: a third of the sample reported mild STS (29.9%), followed by low/no STS (26.4%), severe STS (15.3%) and high STS (9.8%).

Similarly, using the ProQOL-V, Brady (2017) found that 75% of the sample were overall at a 'low to moderate' risk for STS. This was further broken down to each level on the ProQOL-V; low risk (23.7%), moderate risk (51.5%), and high risk (24.2%). Gray and Rydon-Grange (2020) found their overall sample was in the 'mild STS' category on the STSS ( $M= 35.29$ ,  $SD= 13.34$ ), and in the 'low' STS range on the ProQOL-V ( $M= 20.08$ ,  $SD= 6.51$ ). Burrus et al.'s (2018) scores corresponded to 'little to no STS' on the STSS ( $M= 23.833$ ,  $SD= 9.013$ ). Stewart and Witte (2020) found that on average, scores were in the 'mild STS' range on the STSS ( $M= 25$ ,  $SD= 12.4$ ).

In Tehrani's study (2016), scores were statistically higher for females than males for STS ( $p < 0.01$ ). Exact clinical interpretations of these scores were not reported however average STS scores (using the ProQOL-V) for males were ( $M= 6.1$ ,  $SD= 5.2$ ) and females ( $M= 9.7$ ,  $SD= 6.0$ ). Furthermore, 4% of the male subsample ( $n= 68$ ) and 7% of the female subsample ( $n= 44$ ) were reporting clinical levels of STS ('level 2'; cut-off reported as '15') and it was concluded that their study found lower STS scores than expected in comparison to other studies. Tehrani (2018) found statistically significant ( $p < 0.01$ ) differences between gender for secondary trauma; females ( $M= 9.94$ ,  $SD= 6.72$ ), males ( $M= 9.13$ ;  $SD= 6.56$ ) using the ProQOL-V. Exact clinical interpretations of these scores were not reported (other than scores ranging from 0-50), however, when comparing with Tehrani's (2016) study, these would similarly indicate 'lower' levels of STS according to Stamm's (2010) clinical interpretation.

Perez et al.'s (2010) study found 'mild' STS scores on the STSS ( $M= 36.11$ ,  $SD= 18.06$ ). However, 18% ( $n= 5$ ) of Perez et al.'s (2010) sample reported 'moderate' levels of STS, and a further 18% ( $n= 5$ ) reported 'high' levels of STS. Some studies reported the average

response on the STSS Likert scale, instead of reporting an overall STSS score; Craun and Bourke (2014) ( $M= 2.15$ ,  $SD= .68$ ), Craun and Bourke (2015) ( $M= 2.21$ ,  $SD= .78$ ) and Craun et al. (2015), ( $M= 2.16$ ,  $SD= 0.74$ ). Clinical interpretation was not provided however given a 5-point Likert scale; the mean is under the midpoint therefore findings suggest relatively lower levels of STS.

### ***PTSD***

Tehrani (2016) found that results on the IES-E were statistically significantly higher in females than males for PTSD ( $p < 0.01$ ), however, no clear clinical interpretation was provided. They did report that 16% of the male sample were ‘at risk’ of developing PTSD, but none were experiencing ‘clinical’ levels (level 2; with a cut-off score reported as ‘50’). The average scores for PTSD (using the IES-E) were reported as follows; males ( $M= 12.8$ ,  $SD= 14.3$ ), females ( $M= 21.6$   $SD= 16.1$ ). No clinical interpretation was provided however given the explanation provided for the original scale (Horowitz et al., 1979) the findings would suggest relatively low levels of PTSD.

Similarly, using the IES-E, Tehrani (2018) found statistically significant ( $p < 0.001$ ) differences for primary trauma ‘PTSD’; females ( $M= 31.5$ ,  $SD 18.0$ ), males ( $M= 24.6$ ,  $SD= 16.8$ ). Given the use of the extended version of the IES used, exact clinical interpretation cannot be drawn, however, from the original IES scale (Horowitz et al., 1979), they would suggest clinically meaningful results, which are under the ‘cut-off’ (33) for PTSD.

Seigfried-Spellar (2018) used the PCL-C to report symptoms of PTSD. Respondents performing dual roles (investigator and digital forensic examiners) were more likely to score ‘positive’ for PTSD (scores  $>30$  as per clinical cut-off). Out of the respondents performing dual roles ( $n= 38$ ), 42% ( $n= 16$ ) scored above 30, compared to 22% ( $n= 16$ ) of those in investigator roles only and 30% ( $n= 6$ ) in digital forensic examiner roles only.

### ***Burnout***

Using the ProQOL-V, Brady (2017) found that 75% of their sample was in the low to moderate risk for burnout, and 76% of the sample reported 'high' levels of compassion satisfaction (higher scores are indicative of lower levels of burnout). This information was further broken down; respondents' risk for burnout: low risk (24.0%), moderate risk (52.6%), and high risk (23.4%). Respondents' levels of compassion satisfaction were as follows; low (24.0%), moderate (52.6%) and high (23.4%) which collectively was referred to as 76% of the sample reporting moderate to high levels of compassion satisfaction, indicating lower levels of burnout across the sample. Similarly, using the ProQOL-V, Gray and Rydon-Grange (2020) found 'average' rates of burnout in their sample ( $M = 25.77$ ,  $SD = 6.07$ ), with high average rates for compassion satisfaction ( $M = 36.09$ ,  $SD = 6.78$ ).

Perez et al. (2010) reported burnout outcomes for each subscale of the measure; 54% were in the 'high exhaustion' category, 43% had high cynicism and 18% in low professional efficacy. Using the ProQOL-V, Tehrani (2016) found 22% of the male sample to be 'at risk' for burnout at level 1 (i.e., authors denote level 1; score of '15' as an early indicator for distress but not reaching clinical cut-off; score of '30'). The average burnout scores for males were ( $M = 15.3$ ,  $SD = 5.8$ ) and females ( $M = 17.5$ ,  $SD = 5.6$ ), and although clinical interpretation was not provided, these scores corresponded to 'low' on the ProQOL-V burnout subscale (Stamm, 2010). Fansher et al. (2020)'s model estimating personal/work factors contributing to burnout was statistically significant ( $p = .001$ ). Low compassion satisfaction was statistically significantly associated with a greater frequency of experiencing burnout ( $p < .01$ ).

### ***Anxiety and depression***

Tehrani (2016) reported that females were more than twice as likely to experience anxiety and depression compared to male participants at both levels 1 and 2 (females were 10%

above level 2 cut-off ‘high distress’, whereas males were 3% and 5% over the cut-off for anxiety and depression respectively). They reported average scores for anxiety in males ( $M=1.2$ ,  $SD=1.7$ ), females ( $M=2.0$ ,  $SD=2.1$ ) and depression in males ( $M=0.51$ ,  $SD=1.1$ ), females ( $M=1.1$ ,  $SD=1.5$ ) suggesting scores in the ‘lower’ range. The cut-off scores for ‘level 1’ were reported as 3 and 2 for anxiety and depression respectively, and 5 and 3 for ‘level 2’.

A later study (Tehrani, 2018) found statistically significantly higher anxiety between genders ( $p < 0.001$ ); which was higher in females ( $M=2.92$ ,  $SD=2.63$ ) than males ( $M=2.57$ ,  $SD=2.53$ ), and depression ( $p < 0.01$ ) which was higher in females ( $M=1.86$ ,  $SD=2.13$ ) than males ( $M=1.65$ ,  $SD=2.00$ ). Score ranges were between 0-9, and although clinical interpretation was not provided, these were suggestive of lower ranges of depression and anxiety. The results were statistically significant between genders, but the magnitude of clinically significant levels was described as ‘negligible’ across all clinical measures, except for PTSD (Tehrani, 2018).

### **Wellbeing**

Some studies focused on wellbeing more broadly. Tomin et al. (2015) found that overall, their sample of Internet Child Exploitation ‘ICE’ investigators ( $n=139$ ) reported average wellbeing, with the mean subjective wellbeing ‘SWB’ for the ICE sample ( $M=79.97$ ) being 2.39 points above the upper end of the Australian normative range index ( $n=55,697$ ,  $M=76.68$ ). Only 2.2% of the ICE sample ( $n=3$ ) scored very low ( $<50$  points). They found no statistical differences in SWB between the ICE sample ( $n=139$ ,  $M=79.97$ ,  $SD=12.88$ ) and the non-ICE police sample ( $n=102$ ,  $M=81.64$ ,  $SD=10.26$ ) which was also higher than the Australian normative range. The differences between the ICE and non-ICE SWB were non-significant ( $p > .05$ ).

### ***Occupational stress***

Respondents in Holt and Blevins' study (2011) reported a 'moderate' amount of work stress ( $M = 13.29$ ) which was described as below the midpoint of 14 on the stress index (range 4-24) using the work stress measure (Cullen et al., 1985). Similarly, job satisfaction, which appeared to be reported as the average response on the scale (range 1-5) was reported as 'high' ( $M = 3.94$ ). Holt et al.'s (2012) study reported moderate to high work stress levels ( $M = 14.38$ ) which they described as slightly over the midpoint scale of 12 (range 4-25), and a 'high' level of job satisfaction ( $M = 13.29$ ) which was higher than the midpoint of 10.5 (range 5-16). Both studies reports using the same two measures (job stress and job satisfaction) however report different scale ranges. Furthermore, Holt and Blevins's (2011) sample indicated that 68% were under a lot of pressure at work, with 51.8% reporting that their work could make them 'upset'. At the same time, 60.7% of respondents reported that they disagreed with feeling tense/uptight at work, and nearly 80% reported feeling calm at work.

All studies which assessed DCAM exposure in varying formats ( $n = 10$ ) found that greater exposure and/or difficulty with viewing DCAM was associated with higher self-reported 'negative' scores on measures of psychological consequences.

### **Discussion**

This review explored the psychological consequences of PLE personnel who experience DCAM exposure. Quantitative results from 17 papers indicated that most of the studies that provided clinical interpretations reported psychological consequences in the low to moderate ranges across different scales that measured different aspects of the psychological consequences of their work. These findings were unexpected, given the concerns expressed in the literature (Burns et al., 2008; Krause, 2009; Wolak and Mitchell, 2009) and the respondents' regular exposure to traumatic material.

Results indicated that overall, respondents were in the low to moderate ranges of STS-related difficulties. Although some studies reported an average score on a Likert scale, which could not be interpreted clinically, the results were consistent with scores at the lower end of the scales, indicating fewer ‘negative’ psychological consequences. Studies that examined burnout found moderate levels and high scores for compassion satisfaction. Studies that focused on PTSD reported findings in the lower to moderate ranges. Findings relating to anxiety and depression found differences between genders (with females tending to self-report more difficulties than males), however, clinical interpretation would indicate relatively lower levels of anxiety and depression across the samples, with some respondents scoring at the cut-off for clinical significance. In one paper where wellbeing was assessed generally, PLE personnel with DCAM exposure reported better wellbeing than a national sample. Despite the overall findings suggesting lower ranges of ‘negative’ psychological consequences, studies that specifically measured DCAM exposure (i.e., the amount of time spent and difficulty with viewing this material) were associated with higher self-reported levels of psychological difficulties.

Findings pertaining to job stress and satisfaction which were interpreted as a psychological consequence indicated moderate-high work stress, and high job satisfaction. This raises the question of needing to understand this mechanism regarding the relative impact of DCAM exposure on PLE personnel, and whether individuals cope differently, given the differences between PLE personnel with DCAM exposure across studies and the psychological consequences experienced. Some of the studies reviewed included aspects of coping and found that the use of humour, supervision and interpersonal support was important. Mitigating factors against the development of psychological consequences such as STS have been identified in other studies with positive coping strategies, such as deriving a sense of meaning and compassion satisfaction (Salston & Figley, 2003) which had a

moderating influence on STS. Identifying the nuances of DCAM exposure and coping strategies would enable a better understanding of the results, in particular, the moderate to high job stress yet high job satisfaction reports.

These relatively low to moderate levels of negative psychological consequences can be explained by the phenomenon of post-traumatic growth, which is how individuals can transform and grow following traumatic experiences (Henson et al., 2021). PLE personnel with DCAM exposure may have found meaning in their work which enables them to manage the need to view and process disturbing material. PLE personnel with DCAM exposure may possibly derive a sense of satisfaction from this work due to their contribution towards identifying crimes against children. This sense of meaning and satisfaction may override the difficulties associated with viewing DCAM, and as a result, serve as a protective psychological mechanism.

The phenomenon of post-traumatic growth may explain the high compassion satisfaction that PLE personnel with DCAM exposure are reporting. High levels of compassion satisfaction were suggested to serve as a ‘buffer’ for traumatic experiences at work (Gomes et al., 2022; Samios et al., 2013). Therapists who work with adult trauma clients reported that positive outcomes derived from their work (compassion satisfaction) outweighed the difficulties associated with exposure to trauma narratives (Sodeke-Gregson et al., 2013). A systematic review (Henson et al., 2021) found that positive coping strategies were one of the factors that promoted post-traumatic growth in professionals with exposure to trauma. PLE personnel who utilise positive coping strategies, such as seeking social or interpersonal support were found to report less psychological distress (Davidson & Moss, 2008). PLE personnel with DCAM exposure report the usefulness of having frequent breaks amidst viewing DCAM and some cope by ‘detaching’ psychologically and remaining analytical to fulfil the duties of the role (Powell et al., 2015).



It is of note that the findings should not disregard some of the samples in the reviewed studies who reported high and severe levels of psychological consequences. This suggests the need to identify PLE personnel who report more negative psychological consequences as a result of DCAM exposure, in order to offer appropriate support and provide debriefing opportunities (Powell et al., 2014).

#### *Quality consideration and limitations*

As all papers were considered to be of high quality, they were given equal weight in the review. There were, however, were methodological limitations in several studies. Some provided outcome data for the measures employed as either an average Likert-scale score or an overall score, rather than discrete subscale results. This limited the interpretation of some of the findings.

All papers were cross-sectional in nature, which provided a ‘snapshot’ of experience of PLE personnel’s experience and could have been impacted by specific events close to the time of the study. Furthermore, cross-sectional research designs do not allow for causal relationships to be drawn, therefore it is not clear whether the psychological consequences experienced were because of DCAM exposure. Different measures were utilised, and there was variation in the interpretations of results, and not all outcomes were reported in replicable formats. Some studies did not explicitly state their clinical ‘cut-off’ interpretations within the body of the papers to allow comparisons across the studies. Most of the research was conducted in the USA and Western countries, therefore, studies will have an American-Westernised bias. Only one study (Bourke & Craun, 2014a) provided a cross-country comparison. The differences in terminology to describe the job roles made it difficult to draw exact comparisons given frequency of exposure to DCAM was not measured in a standardised way, or not measured at all.

A proportion of the studies ( $n=5$ ) included were completed by the same authors, and it is not clear whether the same dataset was used between papers. There was a wide variation in sample sizes varying from 28 to 2289. Two studies (Perez et al. 2010; Gray & Rydon-Grange, 2020) had relatively small sample sizes, 28 and 78 respectively, which limits their generalisability. What seems apparent from the reviewed studies is that identifying this specific PLE personnel population with DCAM exposure was difficult, which has repercussions for research in this area. For example, the total number of USA ICAC personnel is unknown, as roles, demand, and resources continually fluctuate (Wilson, 2010).

Excluding papers that were not published in the English language heightened the risk and likelihood of a language bias by not considering studies published in other languages (Morrison et al., 2012). Publication bias (Sutton, 2009) may have been perpetuated by the exclusion of ‘grey’ literature, e.g., book chapters and/or theses. The benefit however of only including published literature is that the evidence was peer-reviewed, which strengthens the evidence base from which to conclude.

This systematic review identifies a gap in the literature around a niche and under-represented group of PLE personnel with DCAM exposure and the psychological consequences experienced. Continuing to research this area, specifically by examining the coping strategies for individuals with exposure to DCAM, would enable earlier intervention for those showing signs of negative psychological consequences. Despite these limitations, the findings indicate that some PLE personnel experience mild to moderate negative psychological consequences. This review contributes to the scant evidence base of this subgroup of PLE personnel whose role involves DCAM exposure. Given that the circulation of DCAM is rising, and becoming more sophisticated and concealed, even from artificial intelligence (Tabi et al., 2023), continuing to monitor the psychological consequences for this subgroup of PLE personnel with DCAM exposure is important, relevant, and necessary.

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Gray and Rydon-Grange (2020).	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	7/8
Holt and Blevins (2011)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	7/8
Holt et al (2012)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	7/8
Perez et al (2010)	Yes	Yes	Yes	Yes	No	No	Yes	Yes	6/8
Seigfried-Spellar (2018)	Yes	Yes	Yes	Yes	Unclear	Unclear	Yes	Yes	6/8
Stewart and Witte (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	8/8
Tehrani (2016)	Unclear	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	6/8
Tehrani (2018)	Unclear	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	6/8
Tomyn et al (2015)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	7/8

## **CHAPTER TWO – EMPIRICAL PAPER**

**Newly qualified Clinical Psychologists working in community mental health teams, and the impact on professional and personal wellbeing: A Foucauldian Discourse Analysis.**

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### **Abstract**

This study employed Foucauldian Discourse Analysis (FDA) to understand how newly qualified clinical psychologists (NQCPs) constructed their experiences of transitioning from training to becoming qualified, and how they integrated into community mental health teams within the Welsh NHS. Semi-structured interviews were conducted with eight Clinical Psychologists who had qualified within the last four years. FDA was utilised to analyse emerging discourses regarding knowledge and power relationships. Three dominant discourses were constructed by participants: firstly, ‘That was then, this is now’ an overarching discourse containing two transition timeframes, ‘I can put doctor in front of my name’ and ‘It’s kinda funny looking back’. Secondly, ‘What we offer isn’t what they want’ and thirdly, ‘Overhauling the system’. These three dominant discourses highlighted shifts in knowledge and their sense of having influence (power), in their team and at a wider system level, with participants’ positions fluctuating between discourses. All three discourses revealed implications for participants’ personal and professional wellbeing whilst working in the NHS. The limitations of this study are considered within the paper.

**Keywords:** Newly Qualified Clinical Psychologists, Community Mental Health Teams, Foucauldian Discourse Analysis, Knowledge, Power.

## Introduction

In the United Kingdom (UK), Clinical Psychologists (CPs) undertake a three-year doctoral-level training programme, with the aim of joining the National Health Service's (NHS) psychological workforce (Laidlaw & Gillanders, 2011). Across the NHS, there is an increasing demand for psychologists, and recruitment and retention of CPs has been reported as challenging (Saddington, 2021). 'Best Practice for Psychology recruitment' (2021) reported that one in seven CP posts were vacant (BPS; British Psychological Society, 2021). Recently, increased NHS CP training numbers have been commissioned by Health Education England (2020) and Health Education Improvement Wales (2023). Additionally, clinical associates in applied psychology posts have been established across the UK, reflecting initiatives to increase the NHS psychology workforce at a national level (Slender & Taylor, 2022).

CPs are trained in a range of competencies that enable them to work directly with clients across the lifespan, and with the systems around clients using a range of therapeutic modalities (Thomas, 2010). Another aspect of their work is to facilitate psychological thinking and ways of working in teams and services that are historically more aligned with a medical model (Carr et al., 2023; Christofides et al., 2012). This requires leadership skills and competencies in organisational working (Casares & Lake, 2020; Channer et al., 2018). The Division of Clinical Psychology (DCP, 2007; 2010) defined the range of leadership roles and competencies required for CPs of different grades, highlighting the role that CPs should have to transform services to become more psychologically informed.

CPs often work as part of multi-disciplinary teams (MDTs), where they aim to influence their colleagues in conceptualising clients' difficulties using psychological theories and models. Onyett's (2007) BPS report described that for effective teamworking, clear and defined CP roles needed to be established, echoing Blumenthal and Lavender's (1997)

recommendation that greater clarity around the CP role within teams was needed. Boakes (1998) found that CPs who reported clarity of personal role/contribution within MDTs reported higher job satisfaction, which was negatively associated with symptoms of burnout.

For CPs to have an impact on the way colleagues work, this requires knowledge and an understanding of alternative perspectives, including their position in the team to bring about change. To understand CP's ability to implement change within teams, analysing the way CPs speak about their role and position in teams can shed light on these power dynamics. By using Foucauldian Discourse Analysis (FDA), insights can be gained on what and whose knowledge is valued in certain circumstances, and what power positions are enabled by this. This use of knowledge and power leads to a process of objectification and subjectification, which will impact MDT working and service delivery.

There is limited understanding of how NHS newly qualified clinical psychologists' (NQCPs) talk about their work, knowledge, and competencies as they transition from training to post-qualification. This 'newly qualified' period is important as it shapes professional identity and future discourses (Gilligan & Herron, 2019). The challenges of transitioning for NQCPs highlighted increased responsibility and less 'thinking space' (Levinson et al., 2021).

Understanding this transition and possible stresses when integrating into NHS teams is important for the retention of NQCPs. Given their varied role which includes facilitating a psychological perspective within teams, power dynamics in the work environment could be a source of difficulty for NQCPs, impeding the introduction and integration of psychological knowledge. This rationale is in keeping with research which highlighted that CPs' leadership and systemic skills lend themselves well to the NHS, however the 'system' needs to allow applications of these skills (Colley et al., 2015).

This study explores the discourses of NQCPs regarding how they are able to carry out psychological work in community mental health teams, and how this impacts their wellbeing.

Using FDA will allow an exploration of how knowledge and power operate for NQCPs within their work environment through their discourses and related practices. This might elucidate underlying issues that can impact professional and personal wellbeing.

FDA will be used to address these research questions:

- 1) What discourses are drawn on when NQCPs talk about their experiences of transitioning and integrating within community mental health teams?
- 2) What subject positions do these discourses open-up (or disallow)?
- 3) What are the implications of these subject positions on the way NQCPs experience their role and on their general wellbeing?

## **Method**

FDA is based on the work of Foucault, who was a 20th-century French philosopher. FDA is a branch of critical discourse analysis, and studies how language and the discourses created provide insight into social and power practices, particularly what knowledge is legitimised as being ‘true’ (Olsson, 2010), and the power derived from this knowledge.

Foucault saw knowledge and power as being inextricably linked (Forrester, 2017). Knowledge, according to Foucault, is constructed through power relationships and resulting discourses which shape what knowledge is dominant or perceived as meaningful. According to Foucault, knowledge places individuals into different positions, e.g., the ‘expert’ position, who holds knowledge about others, and thus creates ‘objects’. The objects of their discourses become the ‘subjects’ of the discourse who will occupy an internalised position in the discourse (Willig, 2008). This internalised position (subjectification), leads to self-surveillance to ensure that there is adherence to the imposed discourse. Shaping individuals to engage in self-surveillance, according to Foucault (1980), was the ultimate method of controlling people. Dominant discourses provide insight into current legitimised social and

institutional practices. Foucault also attended to alternative and deviating discourses as they open the possibility for new practices.

These five FDA concepts (power, knowledge, objectification, subjectification, and surveillance) will be utilised to understand NQCP's discourses around transitioning and integrating into community mental health teams, the implications on their positioning within the discourses, and the impact on their professional and personal wellbeing.

### *Ethics*

Bangor University's School of Human and Behavioural Sciences ethics committee approved this research study (appendix A).

### *Sampling*

Using purposive sampling, recruitment took place between November and December 2022, via social media, and professional networks and contacts.

Participants were considered for this study if they met the following inclusion criteria:

- 1) <sup>2</sup>HCPC registered Clinical Psychologist.
- 2) Currently working in any six out of seven <sup>3</sup>NHS Health Boards in Wales.
- 3) Were between two to four years post qualification from a UK-based Clinical Doctorate and able to reflect on their newly qualified period.
- 4) Worked in a community mental health team (irrespective of client group) at one point during the first four years of their career.

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<sup>2</sup> The Health and Care Professions Council (HCPC); regulating body for Clinical Psychologists.

<sup>3</sup> To avoid conflict of interest, participants working in the University Health Board where the first author was employed, were excluded.

### ***Participants***

Eight participants were recruited, six females, and two males (Table 1). The demographic questionnaire (appendix B) also enquired whether they wanted their interview to be conducted through the medium of Welsh or English. Participants were given a £35 online voucher for participating in the interview. Participants identified as being of a White background. All interviews were conducted in English. Demographic information is presented in the findings section (Table 1).

### ***Data Collection***

Interviews were conducted remotely, via video conferencing (Microsoft TEAMS), and audio recorded on a university-approved Dictaphone. After potential participants made contact, they received the participant information sheet (appendix C), the demographic questionnaire and a consent form (appendix D). Upon receipt of the completed forms confirming eligibility, an interview was arranged.

Interviews were semi-structured exploring the experience of transitioning as a NQCP working in community mental health teams, and the impact on personal and professional wellbeing (Appendix E). Questions were open-ended, creating space for spontaneous occurring conversation, which is pertinent to FDA (Arribas-Ayllon & Walkerdine, 2017).

Interviews lasted between 45 minutes and an hour, were carried out in December 2022, and were transcribed by the first author (appendix F). Following each interview, the participants were sent the voucher and the debrief information sheet (appendix G), which outlined staff support offered by each health board.

### ***Analysis***

It is imperative to note that there is no agreed methodology or process which outlines how FDA should be conducted. Providing an agreed methodology would contradict

Foucault's philosophy, as there is no single 'truth' (Dore, 2009). Discourses are more than a set of 'true' statements and speech, they are social practices that provide insight into how power relationships are maintained (Alcoff, 2013). Truth is conditional and based upon knowledge provided in the societal culture and time, 'episteme', that people were born into (Megill, 1979). Foucault viewed truth as being contingent, something that we 'construct around ourselves', making the concept of truth less 'final' (Foucault, 1980).

The analysis process followed the guidance described by Georgace and Avdi (2011):

1. The interview data was transcribed by the first author and checked for accuracy.
2. Vocal tones, pauses, hesitations, and laughter were included (bold = said with emphasis/louder voice, underlined = said softly/under breath, (.) = noticeable breathing space, (..) = 3-5 second pause, (...) = more than 5 second pause, - = cut off mid-word/sentence, \* = laughter, [.....] = text removed for anonymity, (... ..) = text removed for readability.
3. The transcripts were re-read to identify emerging discourses and underlying discourses related to the research questions, whilst also attending to emerging and alternative discourses.
4. Instances where participants expressed their views on transitioning and integrating into teams and the impact on their wellbeing were noted, with attention paid to any variability and interaction with the interviewer (e.g., shared laughter, seeking agreement, uncertainty, lacking fluency).
5. Participants' positioning within the discourse was reviewed (expert, object, subject).
6. The role of each discourse in challenging or maintaining current practices, institutions or other power structures were highlighted.

### ***First author's Declaration***

FDA's epistemological position is social constructionism, and this positioning posits the importance of context and culture in understanding what occurs in society, and that knowledge is constructed based on that understanding (Willig, 2008). Therefore, understanding the positioning of the authors will enable the reader to place the findings in their context (Lazard & McAvoy, 2020). The first author was a trainee clinical psychologist, soon transitioning into a team as a NQCP. The first author had a notable experience during one placement whereby difficult team dynamics sparked curiosity and influenced the decision to pursue this research topic: the impact of transition and integration of NQCPs into teams in the NHS, both professionally and personally. The second author had expertise in FDA and worked in Older Adult CMHT for twenty-five years, and the third author worked for over twenty years in an AMH CMHT.

### **Findings**

**Table 1.** *Participants' demographic details*

Participant	Gender	Age Range	Area of work	Qualified - Years
Annie	Female	35 - 44	AMH/CMHT	2019 (3 years)
Ellen	Female	25 - 34	Adult CLDT	2020 (2 years)
Evie	Female	25 - 34	AMH/CMHT	2019 (3 years)
Kate	Female	25 - 34	CS/CMHT (P)	2019 (3 years)
Megan	Female	25 - 34	AMH/CMHT	2019 (3 years)
Owen	Male	25 - 34	CAMHS	2019 (3 years)
Rachel	Female	35 - 44	AMH/CMHT	2020 (2 years)
William	Male	35 - 44	CS/CAMHS	2018 (4 years)



*Note.* Participant names are pseudonyms to ensure anonymity.

Abbreviations: AMH= Adult Mental Health, CS = Children's Services, CLDT= Community Learning Disability Team, CMHT= Community Mental Health Team, CMHT (P)= Community Mental Health Team, Perinatal, CAMHS = Children and Adolescent Mental Health Service.

Dominant discourses emerging from the data are presented below, with quotes from participants' interviews illustrating the Foucauldian concepts of power, knowledge, objectification, subjectification, and surveillance, where appropriate. Details included are anonymised and quotes are illustrated using pseudonyms. The analyses below are only one interpretation of the data and will be impacted and influenced by the authors' and the readers' discourses.

Three dominant discourses emerged relating to the research questions:

1. 'That was then, this is now',
  - a. 'I can put doctor in front of my name',
  - b. 'it's kinda funny looking back'.
2. 'What we offer isn't what they want',
3. 'Overhauling the system'.

### **1. That was then, this is now.**

Participants spoke about two 'transition' discourses in their careers as NQCPs. Firstly, the transition from training to qualifying, and secondly, their current position, whereby participants occupied more senior roles affording them a level of 'hindsight'. These transitions are presented within one overarching discourse to highlight the non-linear process of how knowledge and power shifted for the participants as they progressed in their post-qualification journey.

**‘I can put doctor in front of my name’.**

Central to the ‘first transition’ discourse was participants’ awareness of power awarded with their qualified status, without necessarily the associated confidence and trust in their knowledge. Participants initially compared their new position with being a trainee, using words such as ‘*autonomy*’ and ‘*free*’ (Annie, Megan, Kate, Ellen, Owen) for their qualified status. Participants grappled with the realisation of the assumed expert knowledge and power by virtue of having a clinical psychology doctor title. For Rachel, being called a doctor meant being seen by team members like one of the psychiatrists, whom Rachel initially had positioned in a higher position of power, implying a hierarchy of knowledge:

Rachel: *‘then I clicked that I was the psychologist, you know, I’ve got a doctor title as well, and I think that made the difference in **their** opinion, why they trusted my opinion, on, whether somebody needed a review or not.’*

And similarly,

Rachel: *‘I will literally contradict the psychiatrist now, you know\*. Which is just so far removed from – what, you know, I’d see myself do’.*

Other participants realised that the power afforded by the doctor title influenced their ability to share psychological knowledge for the benefit of team members and clients:

Kate: *‘Even my title is **enough** in convincing people that I’ve got something interesting to say’, and similarly ‘and you’ve suddenly qualified and expected to know what to do, but there is a real privilege in that as well. You suddenly have power. Because you have this super fancy title and you’ve - you can do something amazing with it’.*

Rachel spoke about the power of the doctor title in writing supportive letters for clients, thus positioning herself as an expert within the discourse, and highlighting the implications of hierarchy on team dynamics:

Rachel: *'(... ..) did it from a psychological perspective with the doctor title, you know, the the CPN [community psychiatric nurse] that was the care manager had been fighting for months and wasn't getting anywhere. I sent that letter and things moved, which is sad\*. But there is that hierarchy that that is **more** prevalent than I probably was aware of, which would then impact on the dynamics in the team'.*

However, in contrast with the sense of power experienced post-qualification, their use of language also indicated that participants lacked confidence and trust in their own knowledge in a range of areas. The discourse of lacking confidence and trust in their own knowledge emerged with the realisation of being given power, which felt a mismatch with their internal experiences:

Ellen: *'I can register for the HCPC, I can put doctor in front of my name, but actually I literally went to sleep, and I woke up and that's what changed for me'.*

This conflict between the level of power and knowledge afforded and participants' internal states, had implications for their behaviour and related wellbeing:

Owen: *'I don't think my line manager and stuff was (.) was very good at picking up on it again, but it's - 'cause I was hiding it quite well, but I don't think they ever asked if - never sat me down and said, you know, 'you've been qualified six months, how are you getting on with it? are you finding the transition OK? are you adjusting OK?''*

Owen's fluency changed from previous sections of the interview, suggesting an imbalance in the power relationships with his line manager, possibly fearing retribution if he had voiced his concerns. Someone in a more powerful position (his line manager) did not check in with him, which in turn, might have led to Owen's subjectification, behaving in ways that conformed to the discourse of how NQCPs should conduct themselves and 'hiding' what was going on for him; an apparent mismatch with the level of power given by his doctor title.

Despite their lack of trust and confidence in their knowledge, participants reported taking on additional responsibility within respective teams, associated with the objectification of the NQCP role. Some hesitance might be noted in Kate's subjectification of acting in line with the discourse of the role of NQCPs:

Kate: *'People really know the difference between me as a trainee, and me as a qualified now because I've I've taken on much more responsibility'*

Furthermore, the objectification of the NQCP role by the team, and the participants' subjectification combined with lacking trust and confidence in their knowledge, resulted in participants engaging in self-surveillance and inviting surveillance from those in more powerful positions (supervisors):

Ellen: *'for the first - I don't know how long - just posting my own letters without having to get them countersigned, just felt **really** uncomfortable and I was like 'no one's looking over this' like 'what if I've written this wrong'? You know 'what if this report is wrong?'*

Kate: *'I was, you know - I **was** seeking reassurance. I **was** seeking validation. I **was** asking if people wanted to read my letters and things like that. So, it did. Yeah, it does affect your well-being in some way'.*

The language used also indicated a possible legacy of subjectification experienced by participants as trainees. Furthermore, clinical psychology training and supervisors may have objectified trainees by protecting them from certain experiences, which later directly impacted them as NQCPs, by not having the knowledge to manage these types of experiences:

Ellen: *'all that sort of stuff which I would have been very much sheltered from during training and actually was - **that** was the stuff that caused the anxiety. You know, I wasn't sleeping some nights and it was just like, this is ridiculous'.*

**‘It’s kinda funny looking back’.**

The ‘second transition’ discourse found participants speaking from their current positions, recognising that their power was now supplemented with a confidence in their knowledge, not present in the ‘first transition’ discourse. Here, participants were positioned in more powerful roles with increased control, less self-surveillance, and in turn, becoming the surveillant (supervisor). Participants conveyed a clarity of consolidated knowledge about their role and skillset, were confidently and powerfully positioned within this discourse, and their conversational style appeared more fluent:

Ellen: *‘I definitely feel a lot more established and a lot more confident’.*

As participants spoke from a more senior position, it allowed them to use their knowledge to exercise their power to resist and defend against objectification (‘pressure’) from the system and allowed Annie to evade subsequent subjectification:

Annie: *‘but I do feel in a much different place **now** than I was then, and I think kind of just - I’m not putting that kind of pressure on myself and just very clear about what I can do and what I can’t do’.*

Participants spoke with agency and from a position of power in their psychological knowledge, and confidently adhered to their position within this discourse:

Evie: *‘**Now**, I have no problem, giving an opinion you know, or even just saying ‘I don’t know’, you know? ‘I need to think about that’, or actually ‘you need to come along to formulation so we can think about that together’ (... ..) back then, there probably was a pressure to perform or to to give it to give a good answer to be seen as knowledgeable’.*

Attempting to appear ‘knowledgeable’ (i.e., by having a definitive or conclusive answer) was considered necessary during the first transition, to demonstrate higher levels of knowledge that warranted the related power position. Through seniority of role, (several participants had

moved into higher banded posts), it allowed participants to state ‘not knowing’. Hierarchical knowledge seemed assumed by a higher banding rather than from their ‘expert’ knowledge per se.

Owen used his power within a senior position to impart knowledge to benefit future colleagues in less powerful positions than him, recognising the changes in power relationships across different points of the clinical psychology doctorate trajectory:

Owen: *‘I think my expectations would be **far** lower I guess, just by trying not to put too much pressure on a band seven newly qualified, you know. (... ..) so that people can kind of find their feet a bit more and not have the expectations to just suddenly perform at a level which may not come for a little bit of time, you know’.*

Interestingly, by referring to staff members by their banding (‘a band seven’), they were being objectified. Owen’s use of the words ‘perform’ and ‘expectations’ indicated an objectification of the role of a NQCP, in which the system defined how it wanted the ‘objects’ to behave. Owen conceptualised that there should be different expectations (objectification) regarding this developmental stage for NCQPs:

Owen: *‘Your first two years or whatever, is needed for it to be – for there to be different expectations to somebody else who’s on the same banding but has worked there for longer. I think that would be really nice if that could be kind of written into the culture’.*

Participants responded to discourses with related objectification by either resisting the associated subjectification by taking a stance of not adhering to pressure and expectations or moving to a different role. All participants now occupied senior positions, and the majority were working in different teams. With hindsight and increased confidence and knowledge, participants described an internal pressure (subjectification) that previously influenced their NQCP position and engaged in self-surveillance:

Evie: *'it's it's kind of funny looking back, [.....], actually, it was- because it was internal pressure, you know. (... ..) Maybe I was treating myself with more of a seriousness about being a clinical psychologist, whatever that was.'*

Within this second transition discourse, an alternative, strategic discourse emerged whereby participants acknowledged how colleagues perceived to be positioned as more powerful and the 'leaders' ('psychiatrists'), legitimised the participants' psychological knowledge and status:

Owen: *'I think that was really quite nice because it meant that they [psychiatrists] were kind of leading the way sometimes with being quite formulation and psychologically driven, (... ..). It didn't take a lot of persuasion. You know doctors were already doing these things and already using the same language and the same frames of reference'.*

Kate: *'(... ..) but we're we are lucky in that we have - our psychiatrist is very trauma informed. She's very psychological in her thinking she and she's - that filters down, so it doesn't just come from me you know people get it from multiple angles'.*

Participants' positions were facilitated and supported by the psychiatrists easing and legitimising the sharing of psychological knowledge given their position in the hierarchy of knowledge. This, in turn, provided the participants with a sense of confidence and a more powerful position within teams. This objectification was to the NQCPs' advantage.

## **2. 'What we offer isn't what they want'.**

The second dominant discourse that emerged highlighted how clinical psychology as a profession experienced objectification and subsequently subjectification for the NQCPs in teams. Central to this discourse was the impact of team dynamics, and how individuals within

teams understood each other's roles, positions, and subsequent expectations. Participants' lack of knowledge around on how to offer a psychological service seemed to be at the root of this discourse, implying that what clinical psychology offered to systems and teams, might not be what they wanted or expected. Participants also indicated a lack of knowledge by the team about the way of working of a clinical psychologist, which left Ellen uncertain about her role and engaging in self-surveillance:

Ellen: (... ..) *expected probably more from me than I felt confident in giving in terms of, you know, just like 'do an on-the-spot formulation' with no background or any knowledge about this person and I was like 'is this what psychologists do? '\* Like, am I just supposed to know all of this? '*

Most participants spoke about how team members objectified the clinical psychology profession as 'separate', 'not mucking in', 'unhelpful' or perceived as 'blocking'. Participants attempted to conceptualise this as a difference in how knowledge and power were exercised between professions:

Evie: *'it's just because we help in a **different** way'.*

William: *'CAMHS workers were feeling sort of stressed and overwhelmed, when psychology would want to slow down a conversation about young person or family and try and formulate it a bit more, they would feel frustration just because they wanted to crack on and allocate it (... ..) or they'd want a solution, you know, 'what do I do, what do I do?' and and maybe what we would be offering you know wouldn't be a quick fix 'do it in four session' type type answers'.*

Participants spoke about the role of clinical psychologists being 'hotly debated' within teams (Annie), with psychology being further objectified when teams were under pressure 'so when things were quite stressed, it's nearly like professions were being pitted against each other'



(Evie). Participants conceptualised this subjectification as: *'I think sometimes what we offer isn't what they want'* (Annie). This left participants unsure about how to exert their power and knowledge appropriately. Without clarity of knowledge around how to work psychologically within teams, difficult team dynamics and power relationships seemed to emerge in the discourse. A different objectification occurred from the participants towards their team members as well as from within the clinical psychology team itself:

Annie: *'I don't think they [colleagues/team] would say they want us to help with the team dynamics or to help with staff wellbeing. I don't think they would expect that, or kind of want that, but I guess from the psychology team, erm, I think there is that expectation that we will sort of support the rest of the staff team, that we'll offer teaching, training, and team formulation'.*

Annie used her language tentatively here and implied that non-psychology members of the MDT might have misunderstandings in their knowledge about the CP role. Additionally, Annie had been given a direction from the psychology team to offer a certain type of work to the team (objectification) and was trying to adhere to this (subjectification). Megan spoke with more agency regarding this discourse:

Megan: *'but almost from a sociology point of view, it was like two camps then, it was the CMHT and then psychology'.*

There seemed to be an unclear objectification emerging that was difficult for participants to internalise, and they experienced conflicting subjectification. Annie described the difficulty in exerting her power and sharing psychological knowledge, and in turn, appeared to objectify her colleagues and clients as a defence mechanism against the objectification of the psychology profession:

Annie: *'and it's quite hard to try and share some of that knowledge because, I think it's because they're stressed and burnt out. They wanna pass them over to psychology,*

*so it's like 'I'm not a psychologist', 'I can't do this psychological work' and I just find that a bizarre kind of concept of what are you doing in mental health? If you're not doing any psychological work?'*

The 'what we offer isn't what they want' discourse created discomfort, frustration and confusion regarding which profession was best placed and held the 'best' knowledge to respond to clients' needs. The CPs' role was unclear, and tension occurred not only from non-psychology team members but from participants themselves. Annie attempted to resist the objectification that was created following trauma informed care training delivered to the team:

*Annie: 'when we kind of say, what do you want psychology to do?, there's often not an answer and it's 'well this person's complex'. And recently there's been kind of lots of talk and lots of training around trauma informed care, which has been great, but again, I think people have then interpreted that as if they've had trauma, they need to go to psychology (... ..), so I think there is some kind of misperception as well as misunderstanding about what psychology can do and can offer.'*

The above quote demonstrates a conflicted subjectification from Annie in trying to adhere and respond to team expectations in dealing with the caseload. It also implied a conflict in knowledge, Annie used her clinical knowledge to understand the underpinnings of trauma-informed care, however the team's application of this knowledge from the training may have been misunderstood. Attempts to become involved in service-development initiatives found participants experiencing a hierarchy of knowledge, power expressions and subjectification, reflected in more hesitant speech:

*Megan: 'she she shut it down because she was saying that we – our waiting list was so big we needed to focus on the waiting list rather than the the fancy stuff'*

Owen described the response to his expression of interest to undertake service development work as ‘*tokenistic*’.

This discourse caused participants to turn to internal self-surveillance, questioning the knowledge, power, and related status of clinical psychology as a profession, in which they experienced subjectification:

Annie: ‘*what is the identity of clinical psychology? (... ..) I got asked as an interview question for this job, ‘how would the team know that you were a psychologist?’ (... ..) how **would** the team know that I was a psychologist? and what does it **mean** to be a psychologist? (... ..) and what we should be doing? and what is kind of just that - other people's perceptions of us?’.*

Some participants attempted to understand this position, by re-appraising their knowledge:

Evie: ‘*I came out [of training] learning how to do lots of different things, but not feeling particularly like one hundred percent competent in any’.*

Kate explained what made her feel knowledgeable and powerful, thus legitimising her position and status within the team:

Kate: ‘*what makes you feel safe and contained is knowing how to do <sup>4</sup>VIG, knowing how to do <sup>5</sup>EMDR, knowing how to do a **thing** that you can follow, that has a start, a middle and an end point. **That** has helped early on in my career because I've been like, OK, I am helping someone. (... ..). That's good. I feel skilled in that **thing**, that intervention’.*

Attempts to solidify knowledge were seen as confirming and establishing positions of power and expertise. This might have been in response to how psychology was objectified and perceived within teams, along with pre-conceived knowledge held by teams from psychology

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<sup>4</sup> VIG; Video Interactive Guidance, Psychological intervention.

<sup>5</sup> EMDR; Eye Movement Desensitisation and Reprocessing, Psychological Intervention.

predecessors. An objectification of the role emerged whereby MDT colleagues perceived the participants' role to be predominately that of a therapist, with '*a bit less of a role MDT wise*' (Ellen).

Rachel: *'I kept having to tell them, I was like, I can do training, I can do team formulations – I - it's not only therapy that I'm here for, you know, I'm not just a glorified therapist or whatever you wanna - you know, a **really** highly paid therapist. You know, I I I think they didn't quite get the distinction between therapist and psychologist'.*

Annie spoke about her first NQCP role which was advertised as a practitioner psychologist:

Annie: *'so not a Clinical Psychologist, and that's very common now in Wales to offer those (... ..) so the main duties were kind of for a therapist'.*

The 'what we offer isn't what they want' discourse seemed to undermine the clinical psychology profession at a system level. Participants attempted to conceptualise the differences in knowledge and skillset and to resist the objectification of being perceived primarily as a therapist:

Evie: *'it's learning about the systems, the processes, the responsibilities that come with it, the, erm, systemic impacts of working within a team, teams that are under pressure'.*

When attempting to resist the power of others' objectification, some participants were subject to external surveillance:

Megan: *'the psychiatrist then emailed my manager to complain about me and my conduct in the meeting\* so I I **really** tried, (... ..) 'cause I was so worried about the patient. So it was - it was a team that just didn't **really** want to hear it, and I think they saw psychology as a way to – somewhere to have patients go if nothing that they had done was working'.*

This ‘what we offer isn’t what they want’ discourse, had implications for the participants’ wellbeing, exercising of knowledge and power, and positioned them on an uncertain footing in this discourse.

### 3. Overhauling the system

The previous discourses were the basis for the third discourse which centred around NQCPs’ powerlessness and helplessness within teams that were struggling within the constraints of a wider, powerful system, such as the NHS. Participants described this discourse as a sense of powerlessness beyond an individual level:

Rachel: *‘it is not to do with the team or the the work that I’m doing with the clients. It is the systemic challenges’,*

Kate: *‘the relentlessness of working in the NHS’,*

Ellen: *‘it wasn’t necessarily the service user, it was nothing to do with that’*

Participants described a powerlessness discourse around integrating into teams that were pressurised by the wider system:

Annie: *‘Even the last few months we’ve had a massive increase in referrals up here and that’s caused a load of tension with the team, because we just can’t fit them in - and kind of within the Welsh Government targets, you have to see them in a certain amount of time and no one feels they can take extra work. No one feels they’ve got the space mentally or physically to kind of be able to offer these’*

Here an external powerful organisation (Welsh Government) set targets that staff had to achieve, leading to subjectification, with implications for the team members’ wellbeing. Participants spoke with hesitancy, lacking fluency, and were positioned as powerless with a lack of knowledge within this discourse:

Annie: *‘I think, to be honest, the problem with mental health services, I think you would almost wanna like **completely** overhaul them and kind of change them, because*

*we can see that things aren't working and that this isn't the best way to go about running a mental health service, but how? How do we shift from that? **How** do we change that?'*

The powerlessness discourse emerged when participants were faced with the reality of attempting radical change within an organisation as powerful as the NHS. Owen felt pressure to conform to the system's constraints of the 'CAPA model within CAMHS services and experienced subjectification. However, his knowledge created a dissonance with the powers of the system, recognising that obliging the system impacted the quality of care he could provide:

Owen: *'I think having that pressure really limits and effects the quality of care that you're trying to give, you know (... ..) and it would be so easy to be like, 'OK then, bye', you know, 'not suitable for therapy' (... ..) and that would be really tempting to to do that, and just rather - because of numbers'.*

Owen's ability to act in line with his clinical knowledge was constrained by a system that exercised power by the objectification of clients through *'the DNA [did not attend] policy says kind of two strikes and you're out'* and expecting staff to adhere to these rules. This subjectified position left Owen considering discharging clients. Rachel's fluency changed, as she discussed feelings of powerlessness to the system's constraints:

Rachel: *'and nothing's going to change, if nothing's going to change, if nobody, you know'*

She engaged in pretend subjectification to the service's attempts at power, objectification, and surveillance:

Rachel: *'...because breaching [targets] is a way of showing that there's not enough resources on the ground and what we're doing is we're fudging it, you know?'*

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<sup>6</sup> 'CAPA' Choice and Partnership Approach' which is the model underpinning CAMHS services.

An alternative discourse strand was presented by William's experience of being '*very much just just surrounded by psychology*'. It seemed that shared knowledge provided a sense of shared power, which might be a direct antidote to the powerlessness experienced by others in this discourse. William described imparting knowledge comfortably within the setting he worked in, providing him with a sense of power, backed by his heads of department who had '*really kind of curated and created, and erm, formed the department, so it was a big sort of sense of belonging to a community*'. A benign surveillance and strength in numbers within the psychology profession afforded William more power and security within this discourse. William benefitted from the established positioning by his predecessors of the psychology service within the organisation and subjectified to this discourse with a sense of influence in his team. Although presented as an alternative discourse strand, William still expressed challenges to his power and experienced subjectification related to the constraints of the system:

William: '*So I guess it may just be frustrations with the systems of CAMHS. You are sort of **one** person within a system which, erm can often feel, erm gets in the way of you perhaps working in a way you'd like to, or maybe, erm just with the way it is organised perhaps isn't always doing the best thing for a young person or a family*'

Megan described how systemic and wider issues led to the objectification of clients possibly due to the pressures on the team: '*or if they were transgender. For example, they were deliberately misgendered sometimes*'. Owen described his decision to leave his post, given the objectification of both him and the clients '*and it felt like as a band seven I was kind of expected to kind of be like a conveyor belt, all I would do is just see children for therapy kind of over and over and over again, every day*'. Later, Owen described his struggles with families '*sat on a waiting list*', highlighting how the system objectified clients, and how participants felt that they complied with this discourse. Others attempted to handle the

objectification of the profession by surrendering to the powerlessness discourse during their time as an NQCP, *'I gave up trying to teach, particularly the MDT'* (Megan).

Attempts to manage the powerlessness discourse, led some participants to question their knowledge regarding whether it was the CPs' duty to manage team cohesion and increase wellbeing within the workplace. Here, Annie attempted to conceptualise this in relation to positions of power, however in doing so, objectified her colleagues:

Annie: *'So I think, kind of managing the team and managing their emotions can be quite a big part of our role, (... ..), erm but that takes up quite a lot of our time and again, it's like what actually, how much of that is my role? and how much should I be seeing patients off the waiting list? (... ..), it really adds a lot of extra pressure on to the job I think and I guess feeling some of that responsibility to help sort out some of these dynamics that are really, really tricky to sort out. [... ..] But it feels, though, that there is no solution to this problem'.*

The powerlessness to the system discourse had implications for participants' wellbeing, confidence and capability to carry out their role. Megan spoke about objectification from those in senior positions *'and it felt like it was in quite a demeaning way and often referred to me as my banding instead of my name'*. Participants spoke about how the objectification and surveillance from the system negatively affected their wellbeing, with participants needing to take a considerable amount of time off work for stress-related reasons:

Megan: *'Erm, but as time wore on it, yeah, the impact of the team and my manager really damaged my confidence and my wellbeing. (... ..) I ended up having to take sick leave for a week, which I've never done. (... ..) and I just was so overwhelmed I was having nightmares and I felt completely alone, even though I had my really supportive supervisor. It just - it wasn't enough. (... ..) but yeah, globally it really **really** impacted my confidence and my hopes. I was very passionate about working in*



*adult mental health and it it dampened that quite a lot. Which was really disappointing.'*

Owen: *'After a year of being newly qualified, I was already taking time off work due to work stress. (... ..) it was just purely due to having high numbers of of children on my caseload and just not having time to see them all, you know, just more names being added on and added on. (... ..) I was contemplating just after a year of being qualified\* - I was contemplating just kind of trying to figure out different career paths. (... ..), have I spent the last 10 years making a massive mistake and trying to get to this position in my life, you know?'*

These quotes highlighted the subjectification that participants experienced in this overhauling of the system discourse, which had significant implications on an individual wellbeing level.

## **Discussion**

This study explored dominant NQCP discourses, and how an FDA perspective contributed to an understanding of this NQCP period. Power and knowledge, or the lack thereof, were prominent in each discourse. Participants referred to multiple discourses when describing these transitions, from trainee to qualified and more senior positions. Three dominant discourses suggested that the current system hampers CPs from working in accordance with the strategic direction of the BPS in terms of CPs' skills and expertise (BPS, 2021, Welsh Government, 2021).

Participants' discourses support existing literature regarding the diminished wellbeing of CPs, impacted by their team and work environment (Hannigan et al., 2004; McCormack et al., 2018; Rupert & Morgan, 2005; Saddington, 2021). Findings reflected the difficulties in participants' implementing their psychological knowledge (Colley et al., 2015). The

powerlessness highlighted by some participants in the ‘overhauling the system’ discourse, resulted in sickness absence.

In the ‘first transition’ discourse, ‘I can put doctor in front of my name’, participants lacked confidence and trust in their knowledge whilst adjusting to the power afforded by the doctor title. This finding at the beginning of their career mirrored the ‘imposter phenomenon’ and stress commonly expressed by trainee CPs (Jones & Thompson, 2017). It is plausible that self-surveillance and inviting surveillance from powerful others might have been amplified by this phenomenon, compounded by their new title, and associated power status. There was a mismatch with a legacy of subjectification experienced by trainees during clinical training, whereby the absence of scrutiny as an NQCP was disconcerting to participants. The findings regarding increased responsibilities and adherence to the organisational system supported findings from Levinson et al. (2021). Notions of feeling out of depth and overwhelmed corroborated similar findings from other early career professionals (Cull et al., 2020).

During the ‘second transition’ discourse ‘It’s kinda funny looking back’, participants spoke from a new position of greater power with increased confidence and trust in their clinical knowledge, not present in the first discourse. Participants gained legitimacy about their psychological knowledge from colleagues deemed to be in more powerful positions (psychiatrists). This suggested a hierarchy of knowledge, sanctioned by those in more powerful positions, with the knowledge of psychiatrists being appraised and positioned at a higher level within participants’ discourses. These findings mirror research into power struggles being inherent between MDT professionals, with psychiatrists gaining ‘privileged’ power due to traditional hierarchies which have placed their profession at the pinnacle of the hierarchy (Smart et al., 2018). Despite CPs also having a doctor title, there are differences between psychology and medical training, and the professions’ history, with the suggestion

that CPs have benefitted from positioning adjacent to the medical profession (Pilgrim, 2010; Pilgrim & Patel, 2015).

Additionally, participants' ability to confidently state 'I don't know' when in a 'senior' position was interesting. Power, by virtue of occupying senior positions, gave participants permission to respond, appraise, and process in a way that aligned with their psychological knowledge, training, and profession. This could add to FDA's understanding of knowledge being related to power: as participants journeyed post-qualification, their status (derived from their acquired power and position) allowed the 'not knowing'. It was not pure knowledge per se that offered power, it was a more senior position.

The second discourse featured 'what we offer isn't what they want'. This discourse suggested an objectification of the CP profession which made it difficult for the participants to exert their knowledge and power. There was a misunderstanding of the CP role developed in strategic initiatives (Longwill, 2015), with teams' expecting a 'therapist', and other unique CP skills such as formulation work or service development, perceived as frivolous. Origins of this wide skillset and role description for clinical psychology were based on the recommendations from the 'New Ways of Working' (2007), and further developed in Wales in the 'Together for Mental Health' (2012) strategy, where the role of CPs goes well beyond that of a 'therapist'. In attempting to manage this objectification, participants either engaged in self-surveillance, or even formal surveillance when powerful others were not supportive of the NQCPs' knowledge base. This second discourse links to 'Social Identity Theory' (Tajfel & Turner, 2004) whereby MDTs can divide individuals and professions in the form of 'us and them' through social categorisation.

In the third discourse 'overhauling the system', the language used expressed powerlessness and helplessness regarding the system. Despite their clinical knowledge base and doctor title, participants highlighted limited knowledge and power again. Participants

spoke about power systems within the NHS such as waiting lists, targets, and surveillance, which had implications for their clients and their own wellbeing. This discourse provided an insight into power relationships, resulting in objectification and subjectification, and how these were exercised and maintained through organisations such as the Welsh Government and the wider NHS, and the systems used such as the CAPA Model. Foucauldian concepts have been used to understand the use of power and knowledge at a national level within the NHS, with the use of targets, requiring staff to confirm and use self-surveillance, the ultimate form of power (Lynch, 2004).

Findings from this systems discourse support the importance of maintaining a healthy work environment and culture to prevent burnout (Rupert & Morgan, 2005). The findings are consistent with studies which have looked at how the NHS facilitates a 'learned helplessness' position (Rydon-Grange, 2015), that requires a shift of culture for staff's knowledge to be valued, to be awarded power to implement this knowledge and be supported by compassionate leadership (Dixon-Woods et al., 2014).

It was suggested in an alternative discourse strand that strength in numbers, such as being one of many CPs in a team who shared the same ethos, could operate as an antidote to the powerlessness 'overhauling the system' discourse. Conversely, any larger group of professionals within a team, could further project power and risk reinforcing the 'us and them' dynamic (Tajfel & Turner, 2004) and serve as potential barriers to better interprofessional working.

The discourses emerging in this study may have been influenced by several factors. All participants identified as white, and the majority identified as British nationality. Dominant discourses in this study mirrored Western culture, with Western biases being a notable criticism of human research (Henrich et al., 2010). Most of the sample was female.

This sample demographic, however, was proportionate to the make-up of the CP profession, with a current underrepresentation of males (Reynolds et al., 2022).

For this study, NQCPs were defined by the authors as having 2-4 years of experience and this definition had its strengths and limitations. The strengths included sufficient time for participants to have settled into their NHS role, and perhaps allowing a shift in terms of development, learning and growth. The limitations of defining the newly qualified period in this way included missing out potential participants who were under two years post-qualification, and how they made sense of their experiences without the potential higher banding or different role. In addition, participants who were less than two years post-qualification might have been able to speak about their current role, and not reflect on a previously held role, reflecting a more current account of their newly qualified period.

This study, although pertaining to a particular time and place, has highlighted discourse and associated practices that would benefit from being considered not just for NQCP's experience of transition and integration into teams, but for more NHS staff. Through the unique lens of FDA, discourses have been illuminated that add a different perspective to the accounts of NQCPs and might contribute to improving the retention of the CP workforce in the NHS.

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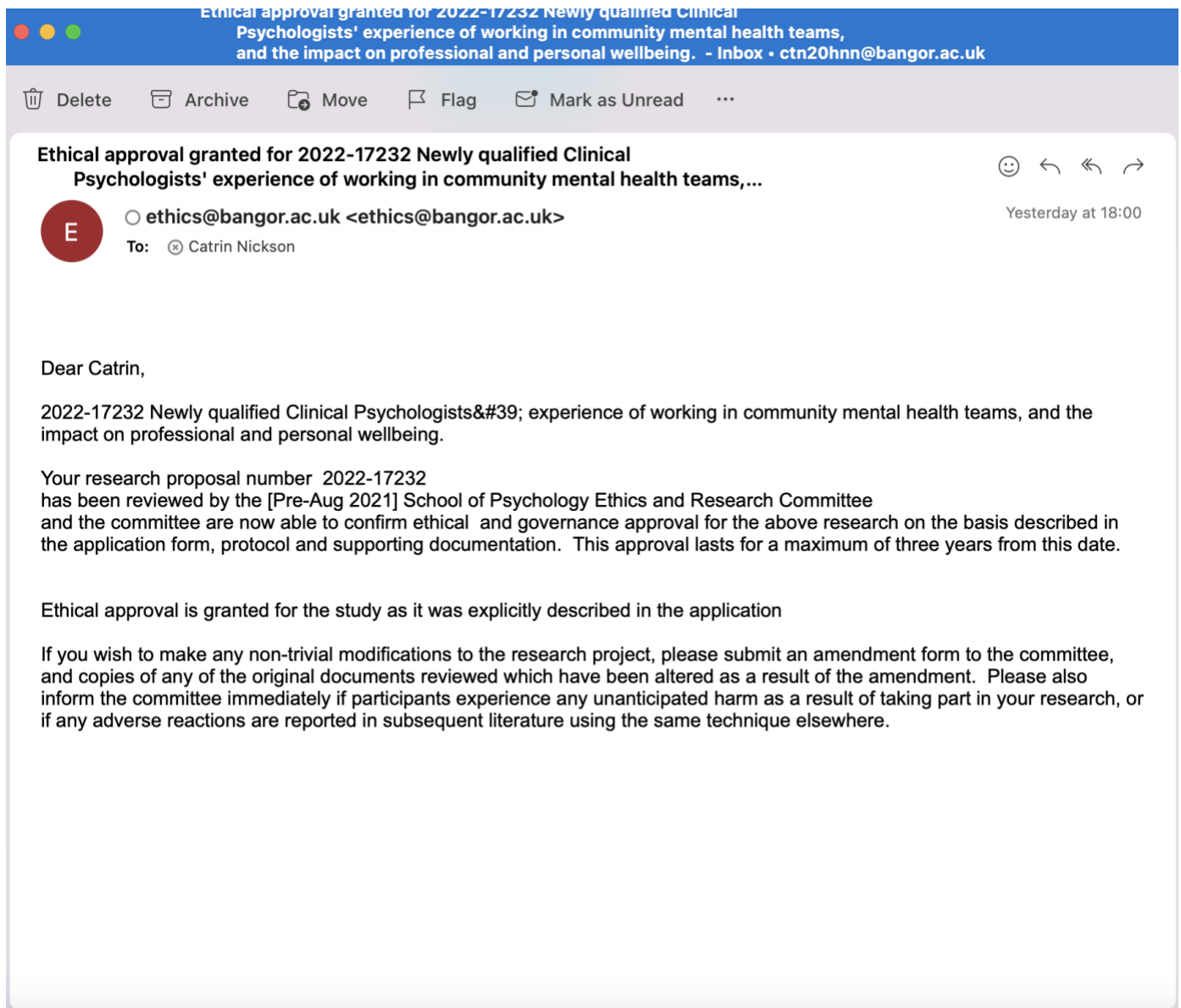
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## Appendix A

### University Ethical Approval



## Appendix B

### Demographic questionnaire (3 pages)

 <p><b>PRIFYSGOL BANGOR UNIVERSITY</b></p>	 <p><b>NWCPP-RSCGC</b></p>
<h3>Demographic Questionnaire</h3>	
<p><i>Newly qualified Clinical Psychologists' experience of working in community mental health teams, and the impact on professional and personal wellbeing.</i></p>	
<p><b>Instructions:</b> Please answer each question as accurately as possible by filling the space provided or ticking the appropriate box (please tick one box only).</p>	
<p><b>1. What is your age?</b></p> <p><input type="checkbox"/> 25-34</p> <p><input type="checkbox"/> 35-44</p> <p><input type="checkbox"/> 45-54</p> <p><input type="checkbox"/> 55-64</p> <p><input type="checkbox"/> 65 and over</p> <p><input type="checkbox"/> Do not wish to disclose</p>	
<p><b>2. What is your gender?</b></p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Prefer to self-describe: _____</p> <p><input type="checkbox"/> Do not wish to disclose</p>	
<p><b>3. What is your ethnicity?</b></p> <p><input type="checkbox"/> Do not wish to disclose</p>	
V 3.0	Project Number (2022-17232)
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☐ **White**

Welsh/English/Scottish/Northern Irish/British

Irish

Gypsy or Irish Traveller

Any other White background, please describe

---

☐ **Mixed/Multiple ethnic groups**

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed/Multiple ethnic background, please describe

---

☐ **Asian/ Asian British**

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, please describe

---

☐ **Black/African/Caribbean/Black British**

African

Caribbean



Any other Black/African/Caribbean background please describe

---

**4. When did you become HCPC registered Clinical Psychologist? (Please specify month and year)**

---

**5. In the first 2-3 years of your newly qualified period of your career, did you work in any community mental health teams?**

☐ Yes

☐ No

**6. Please specify which community mental health client group**

---

**7. Do you wish for your interview to be conducted through the medium of Welsh?**



☐ Yes

☐ No

---

## Appendix C

Participant information sheet (5 pages)

 PRIFYSGOL <b>BANGOR</b> UNIVERSITY	RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME	 NWCPP-RSCGC
<p><i><b>Newly qualified Clinical Psychologists' experience of working in community mental health teams, and the impact on professional and personal wellbeing.</b></i></p>		
<p><b>Participant Information Sheet</b></p>		
<p>You are invited to take part in this research study, which is part of a doctoral qualification.</p> <p>The aim of this information sheet is to help you to understand why the research is being undertaken, and what it will involve, before you decide whether you would like to take part.  </p> <p>Please take time to read the following information carefully. You are welcome to share this information with anyone else who might help you to decide. However, it is up to you to decide whether you would like to take part. You are encouraged to contact the research team if there is anything that is not clear, or if you would like further information.</p>		
<p><b>What is the purpose of this study?</b></p>		
<p>This study aims to explore your experiences of being a clinical psychologist reflecting on your 'newly qualified period', particularly the transition from your doctoral training programme into your first newly qualified post in Welsh NHS settings.</p>		
<p>Recruitment and retention of Clinical Psychologists is a UK wide issue, and the situation is also challenging in Wales. Services are finding it harder to fill their Clinical Psychology vacancies. Research is suggesting that newly qualified clinical psychologists may be struggling within their NHS posts, and this might affect their wellbeing.</p>		
<p>Clinical Psychologists have a wide range of competencies and often have a unique position within the teams that they work in. Several studies have demonstrated that bringing clinical leadership, service transformation, development, and delivery into teams where a medical model can be dominant, to be challenging. The competencies obtained during training and specified by the BPS and the HCPC might not always match the roles that you as a newly qualified CPs found yourself in needing to undertake and may have been shielded from during your training period. There is currently a lack of research exploring</p>		
V. 3.0 (19.9.22)	Project Number (2022-17232)	





clinical psychologists' experience of transitioning to the newly qualified period, and how that transition has impacted them professionally and personally.

Understanding more about clinical psychologists' experiences of transitioning into the newly qualified period may support training courses, employers, and managers to assist in this transition, which might address the difficulties of recruitment and retention. It may give insight into how you, as a newly qualified clinical psychologist, integrated in your community mental health teams.

**Why have you been invited to take part?**

You have been invited to take part because you are a qualified clinical psychologist, who is able to reflect on your 'newly qualified period' which is defined as having qualified in the last 2-3 years, working in a community mental health team (regardless of the nature of the client group). If in your newly qualified period, you only worked in a community mental team for a short period of time, we would still be interested in hearing about your experiences.

**What would taking part involve?**

If you agree to take part, you will be asked to complete an interview with the principal researcher Catrin Nickson (Trainee Clinical Psychologist). In this interview, you will be asked about your experiences of transitioning into the newly qualified period as a clinical psychologist, and how this has affected you professionally and personally. You will also be asked to provide some basic information about yourself (e.g., your age) and your professional role (e.g., how long you have been a clinical psychologist and/or working in a community mental health team setting).

The interview will take place at a time and date which is mutually convenient. Interviews will be carried out remotely, either over the telephone, or via online video conferencing, depending on your preference.

All interviews will be audio or video recorded and transcribed by the researcher.



### **Do you have to take part?**

No, your participation is entirely voluntary. Whether you choose to participate or not, your employment will not be affected. If you decide to take part, you should keep a copy of this information sheet and you will be asked to sign the attached consent form.

In interviews, you do not have to answer any question you do not wish to answer. You can also end the interview at any time without providing a reason. At your request, the recording can be wiped at this point.

### **What are the possible benefits and risks of taking part?**

In contributing to our shared knowledge of what is it like to enter a complex system as a newly qualified clinical psychologist, there is potential to benefit current and future clinical psychologists at the start of their career, as well as clinical psychology managers/recruitment stakeholders. This information may also benefit service and team configurations within the NHS.

Participation may also be of personal benefit to you by providing you with an opportunity to reflect on your experiences of this period in your career.

It is not anticipated that taking part in this study will cause any risks or discomfort to you, however, it is possible that discussing your experiences may cause some distress. If appropriate, you can be signposted to additional support services.

All participants will be compensated for their time with a £35 online retail voucher.

### **How will confidentiality be maintained?**

All the information you share as part of the study will be kept confidential. When the interview is transcribed, you will be identified by a fictitious name, which will be known only to the research team. You will not be identified by your own name in any report, thesis, or publication that arises from this study. We will anonymise transcripts to remove any information that might make it possible to identify you (e.g., the names of the team, or your employing Health Board).



To help convey your experiences accurately, we would like to use anonymous quotes from your interview responses. All efforts will be made to ensure that no information will be contained in quotes that would enable anyone else to identify you or your workplace.

Any personal information collected (e.g., signed consent forms and demographic information) will be stored securely at Bangor University, where it will only be accessible to the research team. This information will be stored for 10 years and then destroyed in line with Bangor University guidelines.

**What are the limits of confidentiality?**

If you disclose information during an interview that indicates a risk of significant harm, either to yourself or another person, this information will be shared with yourself to ensure your safety. It will also be discussed with the research team, but I will always discuss this with you before doing so.

**How do you withdraw?**

You may withdraw from this study by contacting Catrin, prior to the interview using the details below, with your name and contact details. You can also choose to stop the interview and withdraw at any time. Please note that once the interview data has been collected, it will not be possible to withdraw your data. However, you are welcome to contact Catrin or another member of the research team if you wish to discuss any concerns.

**What will happen to the results of the study?**

The results of the study will be published as part of a doctoral thesis and may be published in a journal article. The results will also be disseminated through oral presentations at conferences and seminars. The results may also be used for teaching purposes or to inform future research. Only anonymised data will be shared.

If you would like to receive a brief written summary of the main findings of the study, please indicate this on the attached consent form.



**Will it be possible to complete interviews in Welsh?**

If you wish to be interviewed in Welsh, this could be facilitated as the researcher is a fluent Welsh-speaker. If this is your preference, the information will be translated to English by the lead researcher and then a sample of the translation will be reviewed by professional services. All written materials for this study will be available in Welsh upon request.

**Who has ethically reviewed the study?**

The study has been reviewed and approved by the School of Psychology Research Ethics Committee at Bangor University.

**Who can you contact if you have any concerns about the study?**

If you have concerns about the study, please contact a member of the research team in the first instance (contact details below).

If you still have concerns or wish to raise a complaint about this study or the conduct of its researchers, please contact Huw Roberts, College Manager, College of Human Sciences, Bangor University on +441248383136 or [huw.roberts@bangor.ac.uk](mailto:huw.roberts@bangor.ac.uk)

**Who can you contact for further information?**

If you have any further questions about the study, please contact:



**Principal Researcher:** Catrin Nickson, Trainee Clinical Psychologist, North Wales Clinical Psychology Programme, Bangor University, LL57 2DG. [ctn20hnn@bangor.ac.uk](mailto:ctn20hnn@bangor.ac.uk)

**Academic Supervisor:** Dr Carolien Lamers, Clinical Psychologist and Recruitment and Selection Director, North Wales Clinical Psychology Programme, Bangor University LL57 2DG. [c.lamers@bangor.ac.uk](mailto:c.lamers@bangor.ac.uk)

**Clinical Supervisor:** Dr David Oakley, Clinical Psychologist, Betsi Cadwaladr University Health Board. [Dav.Oa@outlook.com](mailto:Dav.Oa@outlook.com)

## Appendix D

### Consent Form (2 pages)

		
<b>Consent Form</b>		
<p><b><i>Newly qualified Clinical Psychologists' experience of working in community mental health teams, and the impact on professional and personal wellbeing.</i></b></p>		
<p>Please initial in the box as relevant</p>		
<input type="checkbox"/>	<p>I confirm that I have read the information sheet dated (19.9.22 Version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.</p>	
<input type="checkbox"/>	<p>I understand that my participation is voluntary and that I am free to withdraw without giving any reason.</p>	
<input type="checkbox"/>	<p>I understand that participating in this research will involve a one-to-one interview and providing some clinical and demographic information.</p>	
<input type="checkbox"/>	<p>I agree to the interview being audio and/or video recorded.</p>	
<input type="checkbox"/>	<p>I understand that my data will be anonymised (e.g., I will be assigned a code and a pseudonym).</p>	
<input type="checkbox"/>	<p>I understand that direct quotes will be anonymised and may feature in the write-up and any potential publications that may follow from this research.</p>	
<input type="checkbox"/>	<p>I understand that data collected about me as part of this project may be looked at by the research team, which involves members of Betsi Cadwaladr University Health Board and Bangor University. I give permission for these individuals to look at my data.</p>	
<input type="checkbox"/>	<p>I understand that I am free to ask questions or to discuss any concerns with the researcher at any time.</p>	
<input type="checkbox"/>	<p>I understand that the data I provide may be used for research dissemination, teaching and to support other research in the future.</p>	
V 1.0	Project Number 2022-17232	19.9.22



☐ I agree to take part in the above study.

☐ I would like to receive brief written feedback about the findings of this study.

If you would like to be informed about the findings of the study, please indicate how you would like to be informed (e.g., by letter, email, or online meeting) and provide contact details below:

.....

.....

.....

.....

\_\_\_\_\_  
Name of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Principal Researcher:** Catrin Nickson, Trainee Clinical Psychologist, North Wales Clinical Psychology Programme, Bangor University, LL57 2DG. [Ctn20hnn@bangor.ac.uk](mailto:Ctn20hnn@bangor.ac.uk)

**Academic Supervisor:** Dr Carolien Lamers, Clinical Psychologist and Recruitment and Selection Director, North Wales Clinical Psychology Programme, Bangor University LL57 2DG. [c.lamers@bangor.ac.uk](mailto:c.lamers@bangor.ac.uk)

**Clinical Supervisor:** Dr David Oakley, Senior Clinical Psychologist, Betsi Cadwaladr University Health Board. [Dav.Oa@outlook.com](mailto:Dav.Oa@outlook.com)

## Appendix E

### Interview Schedule

Topic	Questions	Follow up	Probes (if required)
<b>Warm up</b>	<p>Can you tell me about your first role as a newly qualified clinical psychologist? (<i>e.g., team set up, client group</i>).</p> <p>What did you enjoy about your work as a newly qualified Clinical Psychologist?</p> <p>What didn't you enjoy about your work as a newly qualified Clinical Psychologist?</p> <p>Has anything changed looking back from the position you are in now?</p>	<p>What was the team set-up?</p> <p>Were there any factors which made your experience easier?</p> <p>Were there any factors which made your experience more difficult?</p>	<p>Can you give me any examples?</p> <p>Can you tell me a bit more?</p>
<b>Transition</b>	<p>How did you find the transition from being a trainee to a newly qualified psychologist?</p> <p>How did your doctoral training prepare you with the knowledge required for your role as a NQCP?</p> <p>Was there anything you would have liked to have been taught or known about before starting as a NQCP in the community mental health team that you worked?</p>		<p>Can you give me any examples?</p>

<b>Team working as NQCP (integration)</b>	<p>Thinking back to when you had to join a new team as a NQ, what was the model of working your team?</p> <p>What were the team dynamics like?</p>	<p>Can you tell me a bit more?</p> <p>Can you tell me a bit more? How did that impact your experience?</p>	
<b>Newly qualified period (NQP)</b>	<p>Were you able to share psychological knowledge and perspectives with the team?</p> <p>How was Psychology (as a discipline) perceived within the team?</p> <p>What were the expectations from the team members from you when you were a NQCP?</p> <p>Was there a time in your NQ period where you tried to suggest or implement a service change / development?</p>	<p>How did that impact your experience?</p> <p>How did you experience being a representative of Psychology within your team?</p> <p>How was that received? What happened?</p>	Can you give me any examples?
<b>Impact on NQ period on personal wellbeing</b>	What impact did the newly qualified period have on you as a person?		Can you tell me a bit more?
<b>Impact on the NQP on professional role / wellbeing</b>	How did the newly qualified period impact on your professional role, if any? ( <i>e.g. impacting ability to carry out role</i> ).	In what ways were you supported during this period?	Can you tell me a bit more?
<b>Closing question(s)</b>	<p>Is there anything you feel that we haven't discussed that's relevant?</p> <p>Are there any areas that feel too difficult to talk about?</p>		



## Appendix F

Example transcript and evidence of analysis (5 pages including 2 pages of transcript excerpt)

6. Annie: Erm, what did I enjoy. I mean, I enjoyed all of it really, so I really I really enjoy individual therapy and I know you kind of that's not really a cool thing to say now as clinical psychologists\*. You kind of have to love research and audits and team formulation, all that kind of stuff, erm but I guess kind of wanting to come into this role and wanted to be a clinical psychologist, therapy is the one thing I guess that - the main attraction for me, I really did want to do the therapy and I really do enjoy the individual therapy [REDACTED]
- [REDACTED] **Redacted – therapeutic modality**, really. Erm and yeah and I worked with a really, really lovely team which definitely helped and they were a really, really kind, supportive team and I guess I was sort of allowed to just, erm, do my own thing really, so be a lot more autonomous than I think from a trainee, you're sort of, you know, rightly so, kind of monitored very closely with everything that you kind of do when you're sort of - everything feels like an assessment and you're, kind of, everything that you do obviously is going into that kind of qualification so, erm, you know you're kind of trying to fit things into the different models and the different things, so it's kind of quite freeing I think as a newly qualified then just be okay, actually, I can just focus on what the client wants now and kind of, to sort of do whatever would be helpful and would be useful. Whereas I think sometimes with the training I kind of felt all 'I need to do this for this assignment' or 'I need to do this to tick off these competencies' and there was sometimes that kind of conflict between what the course needed and kind of what the placement needed. Yeah, so I. I really just enjoyed that. I was kind of feeling like ohh, just kind of being given the opportunity to try out new things and yeah, kind of really developed those therapy skills, I think.
7. INTERVIEWER: Yeah, thank you, and what didn't you enjoy about your newly qualified period?
8. Annie: I think definitely it was for me it was the increase in my workload was just **massive** and in terms of the amount of therapy cases I was having in that first post I found really, really overwhelming and I think it wasn't really until I was moving erm up to this post that I kind of started to wind down a few of my cases so you know the kind that period of 'oh I've finished with this person, but can you pick up a new one'. I kind of noticed the massive difference in my wellbeing from just dropping like about two of my cases and how actually then I felt, I'm more able to think about my clients and think in between the sessions and kind of plan more and feeling much more kind of present and with my clients, whereas there was a real focus on waiting lists, and just working through that waiting list and that you know, like 'how many clients can you see?', and kind of, not really knowing the answer to that. It's like, OK. I've got a spare hour, does that mean I can see another client? But like mentally didn't really have the head space for that I think, [REDACTED]
- [REDACTED] **Reacted – discusses elective placement and therapeutic modality** an elective trainee and like was given lots and lots of space

CN Catrin Nickson  
Self-surveillance -  
normalising what a CP should  
like/dislike

Reply

CN Catrin Nickson  
Knowledge/power

Reply

CN Catrin Nickson  
Surveillance - out of sight -  
autonomy

Reply

CN Catrin Nickson  
Surveillance as a trainee -  
constricted, assessed -  
power/knowledge...  
objectification 'everything you  
do goes into the qualification'

Reply

CN Catrin Nickson  
Surveillance - out of sight -  
autonomy, freedom

Reply

CN Catrin Nickson  
Knowledge

Reply

to think about those cases and to kind of really erm plan what I was doing. Lots of CPD and kind of reading and then kind of when I was newly qualified, most of that just disappeared and it was just that focus on all of these cases and I think I wasn't, I guess, quite prepared for the emotional impact of that, 'cause yeah, I was absolutely like 'ohh you know, I've got this many hours in a day. I can see this many people.' Erm, when actually kind of realistically, I don't think I could! So, kind of when I moved as an 8A, I think it kind of does transition with that of like there is a different focus on the role that you're kind of not just that therapist. So I guess my band 7 job, I should say it was advertised as a practitioner psychologist, so not a clinical psychologist, and that's very common now in Wales to offer those, so anyone could apply, counselling, so could just - so the main duties were kind of for a therapist. So I do think this shift in the 8A is as much more about kind of team formulation, team dynamics, supervising other people, teaching and that kind of stuff which I think has different pressures. And I think for me, I preferred that balance, and kind of preferred that variety, whereas I think even though therapy was **absolutely** what I wanted to do, and I specifically chose a post that would have a lot of therapy, I think I didn't realise how emotionally draining that was and the impact that was kind of having, and how much hard work that was to do that much individual therapy.

9. INTERVIEWER: Thank you, and reflecting on that period in your career, were there any factors that made your experience in the role easier?

10. Annie: So for me, [REDACTED] **Redacted – discusses supervisor**, really supportive and really understanding and I kind of know that the pressures that I was putting on myself about my caseload were absolutely from me and not from [REDACTED]. Erm, I had some personal stuff going on at the time as well, actually had a really difficult time and she was just so lovely and so supportive and so kind, erm and we just had a really really close relationship and erm – not close – I don't know if close is the right word, I guess she was just - I guess we kind of got on and we would get on as **people** too, I guess, and for me that that does make a difference and I think kind of now in this role like I get on well with my supervisor, but it's a very different relationship. I kind of think probably more boundaried, more professional relationship, but I find that just personally a bit more difficult to kind of deal with and I think for me, having someone that I can talk to erm, that I kind of that I trust and that I get on with on that personal level really, really helps and I think to kind of navigate some of those challenges and some of those difficulties. And being able to kind of have those conversations if I was feeling tired or kind of if things were too much. [REDACTED] would absolutely be supportive in that, and kind of helped me think about how to kind of manage that and and yeah, and also [REDACTED] **Redacted – discusses supervisor and therapeutic modality/training** and you know, again, it's almost that kind of thing 'Oh I'm qualified now, I should know everything' but then they don't teach you something that brand new that you've never done before, and it can be like, 'ohh, I still don't know what I'm doing' but then she was so great, offering kind of advice and support and guidance kind of through that time and I think that makes a massive massive difference. Definitely when I've spoken to some of my friends who perhaps didn't get that from their supervisor, I think they definitely found it a lot more



**Catrin Nickson**
...

Power/ personal

**Catrin Nickson**
...

Uncertainty - does CP still retain a unique position? Subjectification?

**Catrin Nickson**
...

Objectification (8A) - different knowledge/power - hierarchy of knowledge differs across seniority

**Catrin Nickson**
...

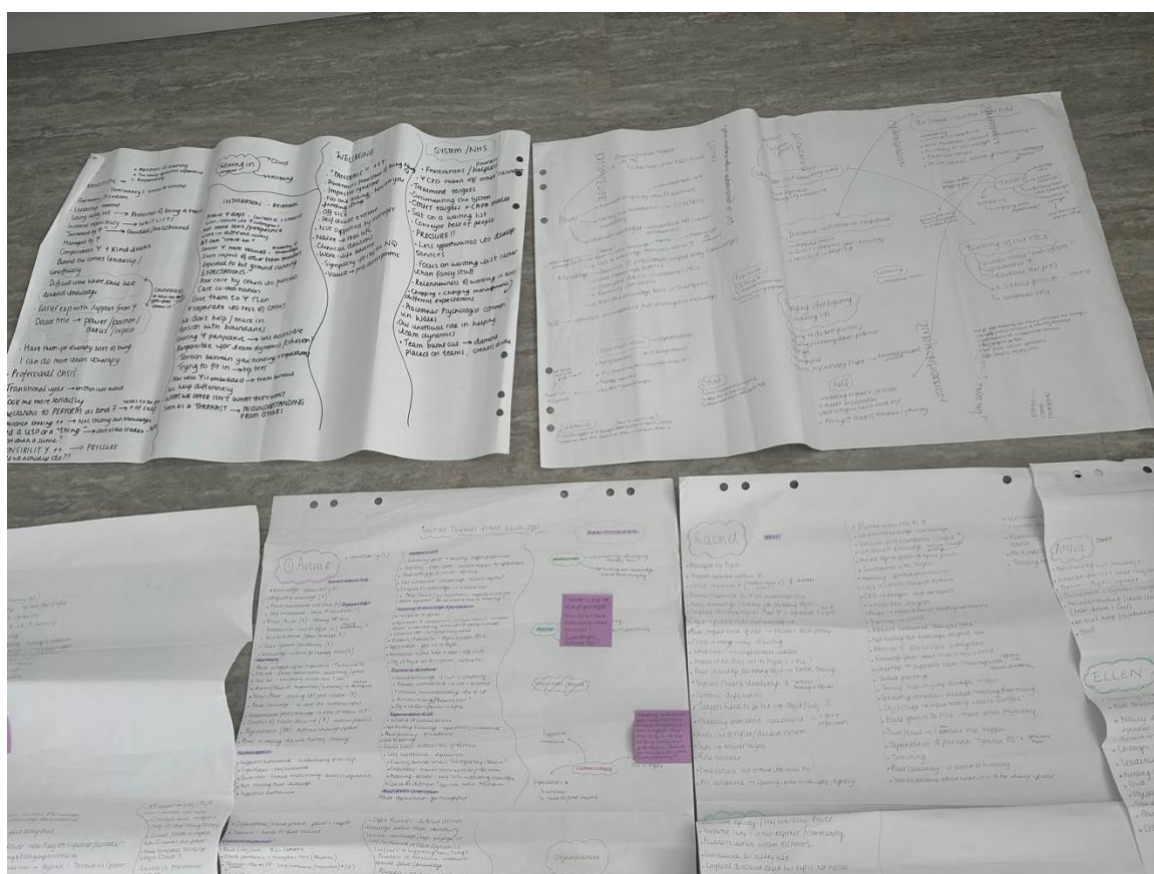
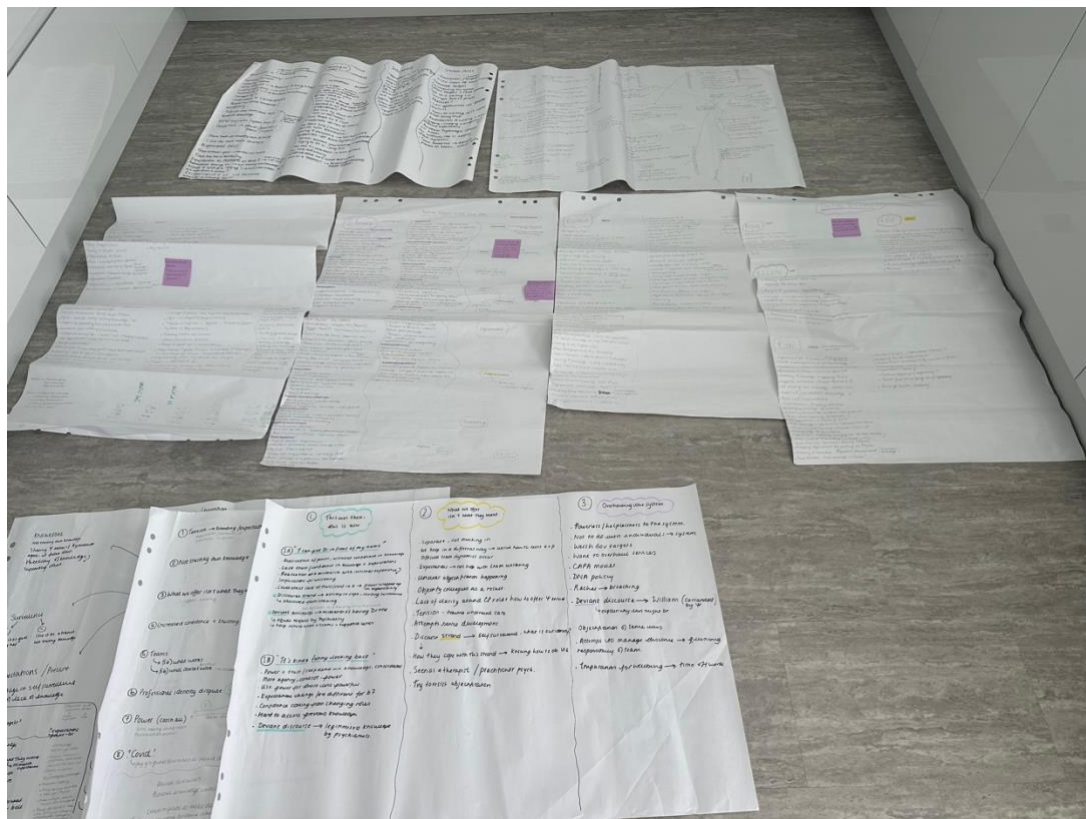
Power / Control / personal

**Catrin Nickson**
...

Supported surveillance from supervisor, but also self surveillance, meeting expectations

**Catrin Nickson**
...

Knowledge - subjectification regarding expectations





### 1. This was then, this is now.

#### 1A "I can put Dr in front of my name"

- Realisation of power, without confidence in knowledge
- Lack trust / confidence in knowledge = experiences
- Realisation of a mismatch with internal experiences
- Implications for wellbeing
- Count on lack of trust / conf in k → power wrapped up in responsibility
- Discourse strand → attempt to cope, involving surveillance
- ↳ sheltered from training
- Deviant discourse → mismatch of having Dr title
- ↳ equal respect by psychiatry
- ↳ help service users + teams + supportive letters

Not deviant → in keeping with discourse

#### 1B "It's kinda funny looking back"

- Power + trust / confidence in knowledge, consolidated
- More agency, control, power
- Use power for those less powerful
- Expectations change (are different for b7)
- Confidence coming from changing roles
- Hard to access previous knowledge
- Deviant discourse → legitimised knowledge by psychiatrists

### 2. What we offer isn't what they want.

- Separate, not mucking in
- We help in a different way → unsure how to exert k + p
- Difficult team dynamics occur
- Expectations → not help with team wellbeing
- Unclear object / plan happening
- Objectivity colleagues as a result
- Lack of clarity around CP role / how to offer ψ sense
- Tension - trauma informed care
- Attempts to develop development
- Discourse strand → self surveillance, what is our identity?
- ↓
- How they cope with this strand → knowing how to do V6
- Seen as a therapist / practitioner psych.
- Try to resist objectification



### 3. Overhauling the system.

- Powerless / helplessness to the system.
- Not to do with individuals → system
- Welsh Gov targets
- Want to overhaul services
- CAPA model
- DNA policy
- Rachel → breaching
- Deviant discourse → William (surrounded by ψ)
- ↳ explain why this might be
- Objectification of some users
- Attempts to manage discourse → questioning responsibility of team
- Implications for wellbeing → time of work

Participant endorsement to dominant discourses.	1. That was then, this is now.		2. What we offer isn't what they want.	3. Overhauling the system.
	I can put doctor in front of my name	It's kinda funny looking back		
<b>Annie</b>	✓	✓	✓	✓
<b>Ellen</b>	✓	✓	✓	✓
<b>Evie</b>	✓	✓	✓	
<b>Kate</b>	✓	✓	✓	✓
<b>Megan</b>	✓	✓	✓	✓
<b>Owen</b>	✓	✓	✓	✓
<b>Rachel</b>	✓	✓	✓	✓
<b>William</b>	✓		✓	✓

## Appendix G

Debrief information sheet (2 pages)

 PRIFYSGOL <b>BANGOR</b> UNIVERSITY	RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME	 NWCPP-RSCGC
<p><b><i>Newly qualified Clinical Psychologists' experience of working in community mental health teams, and the impact on professional and personal wellbeing.</i></b></p>		
<p><b>Debrief Information</b></p>		
<p>Thank you for participating in our research. We really appreciate you sharing and discussing your experiences with us.</p>		
<p>The aim of our research is to explore and learn more about the experiences of newly qualified clinical psychologists in Wales. We hope that by learning more about these experiences, we may be able to suggest ways that the wellbeing of clinical psychologists particularly in the newly qualified period can be supported.</p>		
<p>We appreciate you discussing your experiences with us, and hope that this was not a distressing experience for you. If, however, you have felt distressed discussing these experiences and wish to seek further support surrounding this, please be aware of local services you can contact for support with your wellbeing, such as:</p>		
<ul style="list-style-type: none"> <li>• The Occupational Health Department in your Health Board. As a staff member, you should be able to self-refer yourself to Occupational Health for support, in addition to links to staff wellbeing support services. Each health board is listed individually.</li> </ul>		
<ul style="list-style-type: none"> <li>○ <b><u>Aneurin Bevan University Health Board.</u></b>              Occupational Health Department: 01633 238349  <a href="mailto:occhealth.admin.ABB@wales.nhs.uk">occhealth.admin.ABB@wales.nhs.uk</a> </li> </ul>		
<p>Their employee wellbeing Service is contactable by telephone on 01633 234888 or via links on the ABUHB intranet <a href="https://aneurinbevanwellbeing.co.uk">https://aneurinbevanwellbeing.co.uk</a>  <a href="https://abuhb.nhs.wales/about-us/information-for-staff/">https://abuhb.nhs.wales/about-us/information-for-staff/</a></p>		
<ul style="list-style-type: none"> <li>○ <b><u>Cardiff &amp; Vale University Health Board.</u></b>              Occupational Health Department: Tel: 029 2074 3264 (43264 from an internal phone). Opening Times: Monday - Friday 09.00 - 17.00              Email <a href="mailto:Occupational.health3@wales.nhs.uk">Occupational.health3@wales.nhs.uk</a>  <a href="https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/people-health-and-wellbeing-service/occupational-health-service/">https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/people-health-and-wellbeing-service/occupational-health-service/</a> </li> </ul>		
<p>Their employee wellbeing service is contactable via 02921 844 465, <a href="mailto:employee.wellbeing@wales.nhs.uk">employee.wellbeing@wales.nhs.uk</a> or via links on the CVUHB intranet.  <a href="https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/people-health-and-wellbeing-service/employee-wellbeing-service/">https://cavuhb.nhs.wales/staff-information/your-health-and-wellbeing/people-health-and-wellbeing-service/employee-wellbeing-service/</a></p>		
V 1.0 (19.9.22)	Project number 2022-17232	



RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU  
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME



○ **Cwm Taf Morgannwg University Health Board.**

Their employee wellbeing service is contactable via email

[CTM.Wellbeing@wales.nhs.uk](mailto:CTM.Wellbeing@wales.nhs.uk) or via links on the CTMUHB intranet.

[Cwmtafmorgannwg.wales/staffwellbeing](https://cwmtafmorgannwg.wales/staffwellbeing)

○ **Hywel Dda University Health Board.**

Occupational Health Department: 0300 3039674 or via email

[occupational.health.hdd@wales.nhs.uk](mailto:occupational.health.hdd@wales.nhs.uk)

Their staff psychological well-being service is contactable via email

[wellbeing.hdd@wales.nhs.uk](mailto:wellbeing.hdd@wales.nhs.uk) or telephone 01437 772577, or via links on the

Staff Intranet SharePoint Page:

[https://nhs.wales365.sharepoint.com/sites/HDD\\_Staff\\_Psychological\\_Wellbeing\\_](https://nhs.wales365.sharepoint.com/sites/HDD_Staff_Psychological_Wellbeing_Service)

[Service](https://nhs.wales365.sharepoint.com/sites/HDD_Staff_Psychological_Wellbeing_Service) or the external page <https://hduhb.nhs.wales/healthcare/services-and-teams/staff-psychological-well-being/>

○ **Powys Teaching Health Board.**

Occupational Health Department:

[Powys.occupationalhealthadmin@wales.nhs.uk](mailto:Powys.occupationalhealthadmin@wales.nhs.uk)

Further information is on the PTHB intranet. <https://pthb.nhs.wales/working-for-us/work/staff-benefits-wellbeing/>

- **Swansea Bay University Health Board.** They are contactable via the Staff Advice & Support line (extension 44568, or 01639 684568, or through email [SBU.StaffWellbeing@wales.nhs.uk](mailto:SBU.StaffWellbeing@wales.nhs.uk)). Further information is on the SBUHB intranet site <https://sbuhb.nhs.wales/about-us/staff-info/staff-health-and-wellbeing-service/staff-wellbeing-resources/sbuhb-g-tep-support-for-staff-trauma-and-stress/>.

- Your GP or local support services.

If you have any further questions or concerns about the study, please contact:

Catrin Nickson, Trainee Clinical Psychologist, North Wales Clinical Psychology Programme, Bangor University, LL57 2DG. [ctn20hnn@bangor.ac.uk](mailto:ctn20hnn@bangor.ac.uk)

If you have additional concerns or wish to raise a complaint about this study or the conduct of its researchers, please contact Huw Roberts, College Manager, College of Human Sciences, Bangor University on +441248383136 or [huw.roberts@bangor.ac.uk](mailto:huw.roberts@bangor.ac.uk)

*Thank you for your time and participation*

**CHAPTER THREE –  
CONTRIBUTIONS TO THEORY AND CLINICAL PRACTICE**



## Introduction

This thesis considered two different groups of professionals and how their work influenced their wellbeing. The systematic review examined the psychological consequences of police/law enforcement (PLE) personnel whose role involved occupational exposure to digital child abuse material (DCAM). This review focused on synthesising findings from quantitative published studies. The empirical paper studied newly qualified clinical psychologists (NQCPs) transitioning and integrating into community mental health teams using Foucauldian Discourse Analysis (FDA), describing the findings through the lens of power and knowledge.

The psychological consequences experienced by PLE personnel who had exposure to DCAM as part of their role had unexpected outcomes. While higher levels of distress were assumed, the findings suggested that PLE personnel with DCAM exposure were reporting low to moderate levels of distress, with higher levels of compassion satisfaction and job satisfaction. The psychological consequences of PLE personnel with DCAM exposure are emerging but need further research with clearer definitions of the nature and frequency of the work and consistency in measures.

The empirical paper provided insight into the discourses of NQCPs as they navigated from training to community mental health teams. There was a shift in the participants' power, knowledge, and positions within the discourses during their NQCP period, across three dominant discourses 'that was then, this is now', 'what we offer isn't what they want' and 'overhauling the system'.

The third chapter of the thesis discusses both papers in the context of the wider implications for clinical practice, future research, and theory development. The chapter closes with the first author's personal reflections.

## **Systematic Review - Implications for clinical practice**

The findings have important implications for the managers and organisations that employ PLE personnel with and without DCAM exposure, as well as occupational health departments and clinical psychology practices of any organisation that employs staff exposed to DCAM. More recently, studies are emerging about an increase of child pornography material on social media platforms such as TikTok (Salter & Hanson, 2021; Teunissen & Napier, 2022). This means that not only PLE personnel will be exposed to DCAM, but also other employees such as social media moderators. These moderators whose role also involves protecting the public, may not have the same training, aptitude, or value-based reasoning as PLE personnel.

### ***Individual PLE personnel***

The majority of respondents in the systematic review reported high job satisfaction, high compassion satisfaction and low to moderate ranges of distress. Within these studies, although most respondents were reporting low to moderate ranges of distress, there was a group of PLE personnel scoring in the higher ranges. These findings can be conceptualised in different ways. One explanation is that the majority of the PLE personnel respondents do indeed experience lower levels of distress from their work, possibly by attaching meaning to the need to view DCAM, which in turn might protect them from adverse psychological experiences. The concept of post-traumatic growth (Henson et al., 2021) and the perceived importance of their vital role in helping identify crimes against children could be an explanation in making sense of these findings.

Another explanation for the unexpected results is the notion of under-reporting of mental health difficulties within policing. A stereotype exists in the literature which is that of ‘police culture’ (Porter & Lee, 2023). This refers to a potential stigma regarding the reporting of mental health difficulties in PLE organisations (Velazquez & Hernandez, 2019) which

might impede individuals from seeking psychological support (Cohen, 2019). This could lead to the under-reporting of difficulties, and maladaptive coping styles (Syed et al., 2020). There is a need to consider those PLE personnel who were reporting high levels of negative psychological consequences, in addition to those who might have been under-reporting.

Implications also include the need for PLE personnel or their families to be aware of any individualised indicators that may suggest changes to PLE personnel's level of psychological distress resulting from DCAM exposure.

### ***Managers and organisations***

For workplaces where PLE personnel are regularly exposed to DCAM, it is recommended that staff routinely record the length of exposure to DCAM. Studies from the review that specifically measured DCAM exposure (i.e., the amount of time spent and/or difficulty with viewing this material) were associated with higher self-reported levels of psychological difficulties. If staff highlight difficulty with DCAM exposure, appropriate debriefing sessions or other psychological support should be offered (Horn et al., 2016; Mitchell et al., 2003). Support should be available for those who either self-identify or are perceived by others to be at risk of struggling with DCAM exposure. Identifying coping strategies would be helpful, and further work might be required to establish appropriate and effective interventions and support.

There are resources available in the UK, created by charities such as 'Mind' to support PLE personnel (Blue Light, Mind). In the USA, wellbeing programmes and initiatives available to PLE personnel with DCAM exposure continue to be developed (Krause, 2009), identifying the PLE personnel roles that can lead to negative consequences such as STS. Defining and agreeing on a 'one-size fits all' approach to support PLE personnel is complex (Krause, 2009) due to the different organisational structures in different countries.

### ***Occupational Health***

All PLE personnel should have regular safeguarding training and the implications for workers' risk in viewing DCAM could be raised there. Acknowledging the potential risks associated with DCAM exposure for some employees should be included as part of regular performance reviews and occupational health screening. Mental health or occupational support staff who might encounter PLE personnel would need to consider the unique experience of their PLE role regarding DCAM exposure.

### ***Clinical Psychology practice***

Studies have focused on the profound impact of those in helping professions on the impact of hearing narratives of child sexual abuse (Canfield, 2005; Cohen & Collens, 2013). Clinical Psychology practice can utilise this knowledge when working with PLE personnel or others who, as part of their work, are exposed to DCAM. Findings from this review will be relevant for any employee who is exposed to traumatic material as part of their role or for clinical psychologists that may be working therapeutically or providing consultation regarding employees who are exposed to DCAM. Although this group of PLE personnel might present as resilient, Burns et al. (2008) found in their study that ICE populations felt that society had a lack of understanding about the work. The qualitative study quoted several participants' views regarding professional input: *'Unless the professional is aware of what we see and how it impacts us, it is virtually impossible for them to understand how we feel.'* (Burns et al., 2008). Gaining further knowledge regarding PLE personnel with DCAM exposure is essential for clinical psychology practice in this field.

### **Implications for future research and theory development**

The quality of future research would benefit from important considerations. The variation in terminology used to describe psychological consequences experienced in the realm of indirect trauma has many different labels which often overlap including secondary

traumatic stress, burnout, vicarious trauma, compassion fatigue or post-traumatic stress disorder. These terms are often used interchangeably (Osofsky et al., 2008), whilst other researchers have specified and operationalised what they mean by each descriptor and how it has been measured (Fernando & Cosedine, 2014; Newell & MacNeil, 2010). A review of the trauma literature found that numerous terms were used to describe the same or similar phenomena, suggesting a lack of operationalised terms used and highlighting the implications for collective knowledge (Branson, 2019).

This systematic review raised issues regarding the comparability of the measures used and how the findings were reported. Even when using validated measures, not all outcomes were reported and interpreted using the same categorisation system, making comparisons more difficult. Defining and measuring the length and nature of exposure to DCAM would be helpful to understand dose impact. This applies not only to PLE personnel but also to social media ‘moderators’. DCAM length of exposure might be important for reviewing and comparing samples across the literature. The operationalising of distinct PLE personnel roles might help with this as it was complicated by various job roles and titles used in the reviewed studies. This made it difficult to establish how much of PLE personnel’s role involved DCAM exposure, and the interval between last exposure and the time of the study.

One should also consider the research process in terms of sampling, timing of the studies, and respondents’ willingness to participate and provide truthful answers (Pole et al., 2006). The reviewed studies would not have captured PLE personnel who were having difficulties to the extent of being absent from work, had moved to another division of policing that did not involve DCAM exposure, or had left the profession altogether due to DCAM exposure.

With indicators that some PLE personnel were at risk of developing trauma responses, it will be useful to review what areas of coping were deemed helpful to some. A

recommendation for future research is to understand coping strategies used by PLE personnel with DCAM exposure. Understanding the experiences and coping mechanisms of PLE personnel with DCAM exposure through a qualitative exploration might add further insights into possible coping strategies, and individual or organisational interventions required.

Given the scientist-practitioner model of clinical psychology, there is a role for clinical psychologists to actively continue with research activities and be critical of the evidence base which informs practice. A valuable role of clinical psychologists is to be able to employ both evidence-based and practice-based evidence to further our understanding of research phenomena and critically evaluate the literature in which conclusions are drawn (Petersen, 2007). Critically evaluating and contributing to the research then informs and directs clinical practice, enabling high-quality evidence-based psychology provision.

### **Empirical Paper - Implications for clinical practice**

The clinical implications from the empirical paper will be presented below and will be pertinent for the following: clients, newly qualified clinical psychologists (NQCPs), clinical psychology training programmes, CP managers, CMHT teams and the wider organisation (NHS).

#### ***Clients***

All of the clinical implications presented below will ultimately impact on clients. Diminished wellbeing and burnout of health professionals (Salyers et al., 2015) and ineffective teamworking (Ogrodniczuk & Piper, 2003) have been shown to have a negative impact on clients. If NQCPs are dissatisfied with their roles and ultimately change teams, or work in private practice, this will impact staff turnover in the NHS and pose difficulties to clients' access to clinical psychology provision.

### ***Newly Qualified Clinical Psychologist (NQCP)***

Findings from this study have implications for NQCPs transitioning from training and integrating into their first CMHT post and subsequent posts. It is suggested that NQCPs require ongoing mentoring and support as they continue post-qualification, particularly working within an MDT, recognising the power and knowledge differentials. NQCPs may want to connect with other NQCPs in similar stages of their careers. CPs are uniquely positioned in that clinical supervision is a regulated requirement of their role (DCP, 2014, *Matrics Cymru*, 2017); this will hopefully be a forum to discuss professional development and raise any issues relating to being newly qualified and their adjustment to the role.

Pay and working conditions of NHS CPs were set out in the 2004 Agenda for Change (NHS Health Careers), and CPs were provided with higher bandings compared to other professions, which can in turn add pressure for the profession to demonstrate its value and worth (Hall et al., 2015). Findings from this study, specifically the FDA concepts (power, knowledge, objectification, subjectification, surveillance) and their respective impact on positioning will be useful for NQCPs to consider and reflect upon during this transition. Having an awareness of FDA concepts can help understand the underpinnings of these transition points and their likelihood of fluctuating as NQCPs progress from training to their first post and subsequent posts.

### ***Clinical psychology training courses***

There are implications as to how clinical psychology doctorate courses help support and prepare future clinical psychologists. Towards the end of the training, academic teaching sessions could incorporate sessions about the knowledge and power structures when working in NHS teams, in particular the importance of functional team working, which is essential for clients' benefit and outcomes. Raising awareness of changes in power and how to navigate the objectification that an organisation like the NHS might impose will be essential. Given

the discourse of ‘what we offer isn’t what they want’ and ‘overhauling the system’, the findings reflect the general state of the NHS and the realities of day-to-day service provision. Clinical psychology course organisers could address this apparent disconnect by having real-time information and feedback about changes in the working practices of teams, and CPs’ contribution to those services.

### ***Managers, teams, and the organisation***

Managers who employ NQCPs need to be aware of the differences in professional developmental stages and the NQCPs need to be clear about their specific roles within teams, allowing a timeframe to develop competency and skill in the post. This could be managed with a gradual increase in caseload and regularly reviewing job plans to ascertain that their broader skillset is being utilised appropriately. Supervisors can watch out for signs of subjectification that are impacting on the NQCP's wellbeing and explore alternative options.

CPs require clarity in terms of their role (Onyett, 2007), therefore all job descriptions for NQCPs should explicitly detail the expected service input into the MDT. Line managers could regularly discuss and review with NQCPs, enquiring about their adjustment to the role, especially during induction periods. An important element of effective team working is understanding the different roles, functions, and expectations of the team members. A lack of understanding and ambiguity regarding the CP role by other MDT colleagues has been discussed in other studies (Walker et al., 2022; Wood, 2018; Wood et al., 2019; Mohtashemi et al., 2016).

These studies and the findings from the empirical paper highlight the knowledge differences between CPs and their respective teams. CPs working in CMHTs explained that their professional wellbeing was influenced by organisational pressures, which had implications at a team level including their connectedness and relatedness to other MDT members (Nutt & Keville, 2016). CPs have the knowledge and understanding of what they



can offer to teams (beyond direct clinical work), and this may be at odds with the wishes and expectations of the teams which is to primarily offer psychological therapy. It highlights the differences in knowledge and how this is played out between professionals in MDT teams. Teams of various compositions can support NQCPs by providing aspects such as peer support, mentoring and opportunities for development to facilitate team integration. Findings from the study suggest that NQCPs feel they have limited power in relation to the system and processes within some teams. Given some teams' powerful positions and the constraints and pressure of the system, the potential for NQCPs to acquiesce to the current system and culture could be heightened.

Besides the rationale of career progression, it was not envisaged that all participants would be in different roles. This speaks to the likelihood that NQCPs might regularly change roles, gaining confidence and agency to find the most rewarding environment to practice. The discourses highlighted that the workforce in the NHS was under considerable pressure, with participants reporting that some teams were struggling to meet organisational targets. Organisational cultures that are supportive and inclusive of different disciplines, acknowledging the value that different skills and expertise bring, will support the overarching goal of the provision of quality care to clients (West, 2020).

### **Implications for future research and theory development**

The interest to pursue this topic came from the first author's personal interest, but also an awareness of the pressures within the NHS (Buchan et al., 2017; Mahase, 2021; Sattar et al., 2023; Sizmur & Raleigh, 2018). Implications for theory from this study highlights the need for an active review of best practice by organisations in terms of integrated teamworking and how power operates within teams, at times, leading to poorer outcomes. All MDT members, including NQCPs, need to experience psychological safety within teams (Edmonson, 1999) as working within teams where individualised roles and disciplines are not

valued, can impede team learning and cohesion (Edmondson et al., 2004). Authoritarian leadership styles are shown to be unhelpful (Pizzolitto et al., 2022) and leaders should be encouraged to adopt a compassionate leadership style (Poorkavoos, 2016), as this will likely have a positive impact on wellbeing and performance (West & Chowla, 2017; West & Sinsky, 2022).

There is a need to retain CPs in the NHS by focusing on their personal and professional wellbeing. A study that reviewed the current working circumstances of a clinical training cohort from 1994, found an increase from 8.2% to 13.8% of CPs working in private practice since 2012 (Lavender & Chatfield, 2016). The authors raised an important point that the continuation of funding for CP training is dependent upon retention within the NHS. Continuing to increase the training numbers without a focus on retention might not address the underlying problems.

The sample included in this study had more females than males. Addressing the role of power in organisations and how this may differ between genders is an interesting topic. Dominant discourses suggest that males are more comfortable with expressing power compared to females (Ahl, 2004). Research has also considered the role of the female gender and barriers to positions of power (Schwanke, 2013), and although they may be overly represented in the clinical psychology profession, they might experience differences with positions of power compared to their male CP colleagues.

The participants included in this study were NQCPs working in community mental health teams in the NHS, across different client groups. Recommendations for future research include continuing to build the evidence base not only for those transiting into NQCPs roles but also those in job roles for longer, and the reasons and rationale for CPs leaving the NHS. The socio-political landscape continually changes, and further research will provide insight into whether power relationships will have changed or been maintained. Researching team

cohesion, psychological safety, compassionate leadership, and its impact on clients' outcomes would be an interesting topic to address, as a way of adding to the evidence base.

This section discusses the recruitment strategy adopted in the empirical study. The recruitment strategy consisted of social media, professional contacts, and networks, and not through clinical services. Ethical approval therefore was granted by the University rather than the NHS. The main researcher posted adverts on Facebook and contacted professional contacts to disseminate the study advert. The professional contacts that were asked to disseminate the study were not eligible to participate to prevent sampling bias. In keeping with Foucault's philosophy regarding power relationships and surveillance, recruitment was undertaken through the University rather than the NHS. This was due to the nature and sensitivity of the study regarding the experience of power (or the lack thereof) in the NHS. Additional strengths included being able to access a wide group of potential participants through various methods (social media, namely Facebook) and professional contacts.

Limitations to the recruitment strategy include a potential biased response of participants who use social media, excluding potential participants who do not use social media or were not part of similar professional networks. Such participants would not have seen the advert and thus not have an equal opportunity to participate. One of the professional networks used was 'Psychologists for Social Change', therefore some participants that may have been recruited from that network may have shared similar world views and values with the main researcher.

The recruitment strategy aimed to reflect NQCPs' experiences of working in the NHS in Wales, where the responsibility for the NHS health provision is devolved. Given that the recruitment was for NQCPs working in Wales, there is potential that the main researcher may encounter participants in the future given their shared profession. As the recruitment strategy

was focused on Wales, this excluded NQCPs working in England, Scotland, and Northern Ireland, where different models of psychological services might be delivered.

Using this recruitment strategy might have influenced the findings in the study. The research question itself may have invited clinical psychologists who have had negative experiences in their NHS roles, and this could increase the risk of bias. Every effort was undertaken to try to minimise bias as much as possible e.g., by not interviewing participants known to the main researcher, and confidential handling of participant data. In addition, no participants from the same health board as the main researcher were eligible to participate to safeguard against a possible conflict of interest.

The interviews were carried out by the main researcher who was a trainee clinical psychologist, soon transitioning into a NQCP. This may have influenced the interviews in several ways. Data collection could have been impacted, as participants might have felt indebted to contribute to a fellow peer's research. They may have gravitated towards the research topic, with various aspects that they wanted to discuss in their interviews with a researcher of the same profession. Sharing the same profession and career trajectory may have impacted the interviews and data collection in several ways. Regarding the interviews, participants could have been censoring their views, as not to evoke fear in the researcher, knowing that they, too, were soon going to be experiencing a newly qualified role. There may have been a protective function evolving where participants minimised their experience for the benefit of the interviewer. Additionally, participants were able to speak freely given a common understanding of concepts and the clinical psychology role. Triangulation of the data with the second and third authors aimed to ensure that the analysis was in keeping with FDA concepts, and to be alert for the main researcher's potential bias and pursuing areas of personal interest in the data. The main researcher recognises, however, there is also value in cross-professionals research.

### ***A note on FDA***

The conception of FDA was based on the thinking of Michel Foucault who was a French philosopher and social theorist. The development of his philosophy was marked by post-structuralist and post-modernists movements (Olssen, 2003) where he engaged in challenging traditional forms of power and knowledge. Foucault wrote about disciplines such as psychiatry, medicine and criminology, and the ways institutions such as hospitals, asylums and prisons exercised power over others. For example, Foucault critiqued medical establishments, with medical doctors using their power, exercised through ‘expert’ knowledge to categorise others as ‘normal’ or ‘abnormal’ (Stone, 2004).

It is important to consider the socio-political changes that have occurred since the initial developments of Foucault's thinking, influenced by society and the context in which he lived (Portschy, 2020). There is a recognition that his original theories may have overlooked broader systemic factors such as economic inequalities (Haugaard, 2022), however Foucault’s ideas on discursive power still lend themselves to understanding contemporary power structures, such as reported in the thesis.

### **Personal Reflections**

From an FDA perspective, I can see that in this section, with my use of ‘I’, I can write freely and draw on my personal knowledge. It feels surreal to be writing this, acknowledging that I am nearing the end of my clinical psychology training. Although I knew at an intellectual level that completing a doctorate would not be easy, the journey to get to this point has not felt like plain sailing for me. Despite finding areas of this thesis stimulating and interesting, I encountered many challenges along the way. I, like many others, started the doctorate in September 2020 and most of those formative, early experiences of clinical training were online. This then progressed eventually to academic teaching being delivered in person, but whilst wearing a mask and a visor worn over it. I find it hard to think of the words

to describe that time, and I feel quite sad looking back. It was far from what I had imagined training to be like. Coupled with that, the programme was being restructured, which we as trainees, along with the programme staff, were trying to navigate. This meant new assignments, new placements, and new competencies, which felt overwhelming at times. I learnt that life does not stop on the doctorate, although I wished many a time that I could press 'pause' as I wanted to savour moments of learning, and professional development, but my head felt stuck in 'doing' mode.

That life outside training did not stop became into focus when a close family member experienced health issues, that caused me significant concern. Also, I had considered myself to be a healthy person, never having had any major health difficulties, but I ended up being unwell after contracting covid-19 for two weeks, with post-covid residual symptoms. I then spontaneously experienced acute vestibular neuritis which was awful. I remember worrying excessively about the impact it might have on the progress of my thesis, which ironically, interfered with my recovery. I somehow managed in the middle of that illness to coordinate and schedule participant interview dates, hoping that I would be better by then, which I was, thankfully. I still experienced difficulties in the months and weeks leading up to the submission deadline which forced me to slow down and prioritise myself and my health, even though in reality, this proved quite difficult.

When 'life' happens, it requires an extra push of determination and motivation to keep going. Now, looking back, having reached this point, I am incredibly proud of myself for all the hard work and sacrifices that I have made in the process of completing this thesis, whilst also trying to show compassion to myself throughout this process. Utilising compassion-focused therapy techniques learnt through training has supported my wellbeing, although I wish I would have prioritised my mental and physical health more. This will be an important reminder for me as I embark on my journey as a newly qualified clinical psychologist.

I found my empirical paper to be interesting and stimulating, I found it difficult to ‘sit’ with the uncertainty around choosing my systematic review topic and the problems and changes that arose around that. From an FDA perspective, during the write-up of this thesis, I could see that I was inviting surveillance in the analysis stage, constantly doubting my knowledge, and seeking someone more knowledgeable to offer surveillance of my work.

I secured my first clinical psychology post whilst writing this thesis, which provided me with a sense of permanence and stability. Ironically, when I accepted the post, this was around the same time that the NHS nursing profession was striking for increased pay. It made me reflect on the privileged positions we do occupy as clinical psychologists, especially in comparison to other professions. I enjoyed discussions with my placement supervisor (soon to be a colleague) who was incredibly understanding of the pressures of being a trainee. I was also fortunate whilst discussing my future post within the service, that there was an explicit understanding that it will take time for me to ‘find my feet’. It appeared that participants in my empirical study were not afforded the same sensitivity and understanding perhaps. Writing the empirical paper was an unusual experience. It was interesting (and at times, scary!) to get an unfiltered and candid insight into how people experienced their newly qualified roles. Their experiences, anecdotes, and advice will stay with me as I embark on this next chapter of my career as a clinical psychologist.

In all honesty, I am apprehensive about embarking on the next step in my career. I have always believed in the NHS, matching my values of providing equity of care to clients. With the current socio-political state and the circumstances of the NHS, I do hope that the issues raised in this thesis will contribute towards small but important changes for the psychological workforce in the NHS. I am looking forward to my journey as a clinical psychologist and will take the reflections from my participants along with me whilst I tread a similar path. Completing this thesis has been incredibly demanding, however, I am proud of

what I have achieved and looking forward to spending more time doing things that bring me joy.



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### **Chapter One – Systematic Review**

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Appendix: 287

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### **Chapter Three – Contributions to Theory and Clinical Practice**

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