THE EXPERIENCE OF SUCCESSFUL LEADERS: AN IPA STUDY ON SENIOR FEMALE CLINICAL PSYCHOLOGISTS

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Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds
School of Medicine
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October 2015

This candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

Acknowledgements

To begin with, I would like to thank my supervisors, Jan Hughes and Carol Martin for their patience and support throughout the project. I have found it a steep learning curve getting to grips with qualitative research. I hope I have finally got it!

Thanks to my Mum, my Aunt Lin, Liz, Nicky, Laura, Annie, Gemma and Ruth M. for all their support, particularly, in the final months to handing in the thesis.

Ruth H., your support, empathy and humour have been incredibly containing, particularly in the last few months. Thanks.

Thanks to Pat and Rog for the use of their 'library' and the numerous cups of tea during study sessions.

Finally, thanks to the participants who took the time to participate in my study and for providing me with an insight into their experiences of successful leadership.

Abstract

Introduction: Although women are accessing senior leadership positions, female senior leaders still remain a minority in the public and private sectors. This has meant that much of the leadership literature has been developed from research using predominantly male samples, limiting the generalisability of the findings to female senior leaders. Therefore, the focus of this study was to offer an alternative narrative to the current leadership literature by exploring the successful leadership experiences of senior female leaders in the context of the NHS.

Method: A sample of seven female senior clinical psychologists (NHS agenda for change pay band 8C+) were interviewed using a semi structured interview. The data from the interview was transcribed and the transcripts were then analysed using interpretative phenomenological analysis. Initially, individual analyses were conducted for each participant and then a group analysis was conducted.

Results: Five superordinate themes and fifteen subordinate themes were developed to describe the participants' successful leadership strategies. Participants described relationships as being central to their success as leaders. The superordinate themes 'The Nurturer' and 'The Diplomat' described how they went about forming relationships. If this relationship began to rupture, participants described implementing strategies from the 'The Repairer'. However, if participants perceived an unjust decision or act to have occurred they then described utilising the strategies of 'The Activist' and 'The Warrior'. Participants also described combining and integrating these different leadership strategies which highlighted the complexity of successful leadership.

Discussion: The findings are discussed in relation to psychological theory. The method of the study was evaluated and areas for future research are recommended. Finally, the clinical implications for a range of stakeholders are discussed.

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CHAPTER ONE: INTRODUCTION

Background

Preamble

My interest in understanding female leaders' successful leadership experiences has developed from my awareness of gender roles and from observing gender inequalities in modern day society. Growing up in a male dominated household, where I was the youngest of four children and the only girl I noticed that people expected me to behave differently compared to my three older brothers. This experience led to me questioning the validity of gender roles from a young age. As I grew up, I also became interested in equality and feminism and still have a strong passion for both of these topics today. Having had lived experiences as a female leader in the NHS both in the Improving Access to Psychological Therapies team and in my role as a psychologist in clinical training (PICT) I am aware that these experiences have also shaped my views and interest in exploring this current research topic.

Research indicates that women have experienced barriers in accessing senior leadership roles. This has become known as "the glass ceiling" (Hymowitz & Schellhardt, 1986). Recent research has identified that this glass ceiling is beginning to crack (Hansen, 2009; Goodman, Fields & Blum, 2003). Women are now securing senior leadership roles in the private (Equality and Human Rights Commission (EHRC), 2011; Sealy & Vinnicombe, 2012; Sealy & Vinnicombe, 2013) and the public sector (EHRC, 2011). Therefore, research can now focus on understanding womens' successful leadership experiences rather than emphasising the barriers they face when accessing senior leadership roles, as previous research has done.

Women are still underrepresented in senior leadership roles (Carli, 2001). The percentage of women employed in the UK has risen over the last 30 years (TUC, 2012) with women occupying 46% of the UK workforce (Online National Statistics (ONS), 2013) but with only a third of all leadership roles being occupied by women (ONS, 2013) of which, the majority are middle management roles (Oakley, 2000). Hoyt (2010) proposes that men have easier access to senior leadership positions compared to women and therefore, progress into senior leadership roles at a faster rate than women across a range of contexts (Davies, 2012; TUC, 2012).

Women's underrepresentation in senior leadership roles appears most evident in the private sector. Men dominate the FTSE top 100 companies, particularly CEO positions (EHRC, 2011). There are few female directors in the top 100 FTSE companies, but the number doubled (8.6% in 2003 and 17.3% in 2013) between 2003 and 2013 (EHRC, 2011; Sealy & Vinnicombe, 2012; Sealy & Vinnicombe, 2013). Nevertheless, research suggests that it will take 70 years before the top 100 FTSE companies have equal representation of men and women at director level (EHRC, 2008). Evidence suggests that women in the public sector are also under-represented in senior leadership positions, just not to the same extent as women in the private sector (EHRC, 2011).

The impact of the recession has meant that the NHS has been expected to save £20 billion between 2011/12-2014/15 (Department of Health, 2010). Consequently, NHS departments are being expected to operate at the same level of efficiency with less staff and less money (Hurst & Williams, 2012). One solution to this problem has been to focus on leadership, management and staff engagement (Hurst & Williams, 2012) in an attempt to increase output whilst increasing efficiency savings.

Given that the NHS is one of the largest employers in the world with an estimated workforce of 1.6 million (NHS choices), 80% of which are female (NHS Information Centre, 2012) it seems likely that females within the NHS will be required to lead more. Therefore, there is a need to understand the leadership experiences of successful female leaders in the NHS.

Understanding the role of gender in leadership is complex. The majority of research exploring gender and leadership has been quantitative and conducted in the private sector (Karelaia & Guillen, 2011) and consequently, has not focused on experience (Ford, 2006). There has been a lack of research exploring how female leaders perceive themselves (Ely, Ibarra & Kolb, 2011; Karelaia & Guillen, 2011) in the public sector. Therefore, it is important that researchers begin to understand the experience of leadership among female leaders (Davies, 2011; Ryan & Haslam, 2007) as the majority of research into leadership has been done by men, on men, for men. Understanding the leadership experiences of women may help to alter this dominant narrative and may provide new insights into how leadership is done and defined.

Leadership

In the following section leadership will be defined and a range of leadership models and theories will be discussed, including clinical leadership. Differences between male and

female leaders will also be explored and relevant psychological theory will be discussed. Finally, a review of the qualitative research will be presented which explores the experiences of leadership among females in senior leadership positions.

What is leadership?

Leadership is complex to define given that there is no scientific or standardised definition (Vroom & Jago, 2007). Often the terms "management" and "leadership" are used interchangeably. However, there are distinct differences between the two. "Management processes are considered to be position-and organisation specific" (Day, 2000, p. 582) involving planning, organising, problem solving, budgeting, staffing and controlling (Kotter, 1990). In contrast, "leadership roles refer to those that come with and without formal authority. Leadership processes are those that generally enable groups of people to work together in meaningful ways" (Day, 2000, p. 582). However, it is not clear in Day's (2000) definition how leadership is done. Tourish (2013) attempts to do this with what he calls "positive leadership" which he defines as "when we attempt to influence others, ideally for a common purpose. It is not about imposing one's will on recalcitrant others […]. It is about debate, persuasion and a willingness on the leader's part to change their own actions, minds or plans when it is the logical thing to do" (Tourish, 2013, p. 15).

Theories of leadership

A large majority of the leadership research has been developed within the leadership and management literature rather than by psychologists (Hogg, van Knippenberg & Rast, 2012). Originally, leadership theories perceived the traits of the individual leader to have enabled the team to succeed. These theories have become known as the "great man" theories as they tended to emphasise the charisma and heroism of the individual (Haslam, Reicher & Platow, 2011). The theory of transactional leadership was developed by Burns (1978), a political scientist who proposed that leadership was a transaction between leader and follower. He based his theory on the principles of behavioural reinforcement whereby leaders would dictate goals and the consequences to their followers. If followers achieved a goal they would be rewarded and if they did not they would be punished. However, "if you limit yourself to transactional leadership of a follower with rewards of carrots for compliance, or punishments with a stick for failure to comply with agreed-on work to be done by the

follower, the follower will continue to feel like a jackass" (Bass, 1997, p. 133). It was ideas like this that led Burns to develop transforming leadership, which Bass (1985) built on to form transformational leadership. This theory proposes that leaders inspire their followers to create goals which are in line with their values and the organisation's. Bass argued that if followers were engaged and interested in their work that they would take greater ownership over their work. More recently, there has been more of a focus on transformational styles of leadership in the NHS, for example the emphasis of Engaging Leadership.

Engaging leadership

Alimo-Metcalfe and Alban-Metcalfe (2005) developed a transformational model of leadership that was inclusive of gender and race. They interviewed public sector workers from the NHS and the local government using a repertory grid method, from which 2000 constructs were gathered. This data was then analysed using grounded theory. These themes were then used to inform and develop a questionnaire. This questionnaire was later administered to a similar demographic sample to the one interviewed using the repertory grid method. A total of 2013 questionnaires were returned completed and these responses were utilised to develop the Transformational Leadership Questionnaire. This research proposed that effective transformational leadership involves the execution of six components including; "valuing individuals", "enabling", "being accessible", "being decisive", "networking and achieving" and "acting with integrity" (Alimo-Metcalfe & Alban-Metcalfe, 2005). Furthermore, it was proposed that this style of leadership resulted in staff being more engaged in their work. It is important to note that the sample used in this study was not exclusively female. Therefore, although this theory is inclusive of gender it does not provide a model of leadership specific to women. Nevertheless, it is likely that this theory of leadership will be applicable to a sample of public sector females.

Transactional and transformational leadership theories fail to identify the importance of the context in which leadership occurs. Research suggests that an appropriate culture is necessary for effective leadership to take place (Bass & Avolio, 1993). This is relevant for the proposed study because "leaders do not just shape events, they are shaped by external forces on them and in the NHS these are extensive" (Rowling, 2011, p. 26). The NHS is political by nature; therefore, top-down decisions made in Government will influence NHS leaders. For example, research suggests that senior managers working for a UK local authority found themselves favouring transformational styles of leadership yet leading in a transactional leadership style (Ford, 2006) in an attempt to meet targets.

Secure base leadership

Secure base leadership (Kohlrieser, Goldsworthy & Coombe, 2012) is an example of a transformational style of leadership, which is based on attachment theory (Bowlby, 1988). Attachment theory proposes that the relationships infants form with their primary caregivers affects the development of the infant's future relationships. In essence, the primary caregiver becomes a secure base for the infant to take risks to explore the world from within the safety of their secure base.

Secure base leadership is based on empirical research. A qualitative study was conducted on a mixed gender (70% male) and culture (Europe, USA and Asia) sample within the business sector. Sixty successful leaders (as selected by the research team) were interviewed and their data was analysed using grounded theory (Glaser & Strauss, 1967). Nine key characteristics of secure base leaders were identified: stays calm, accepts the individual, sees the potential, uses listening and enquiry, delivers a powerful message, focuses on the positive, encourages risk taking, inspired through intrinsic motivation and signals accessibility. These findings were then utilised to inform a larger scale quantitative study (n = 1000) which explored the leadership effectiveness of individuals adopting a secure base leadership style. A combination of correlation, regression and structural equation modelling identified a significantly positive relationship between secure base leadership; leadership effectiveness, psychological safety and job satisfaction, which suggests that secure base leadership is an effective style of leadership.

A secure based leadership suggests that successful leadership requires one to be both caring and daring. Being caring involves leaders offering followers security, protection and comfort, which then provides followers with a safe base to be able to become daring. This requires leaders to encourage and motivate their followers to take on challenges, to take risks and to explore. The theory suggests that when followers are provided with both a caring and daring leader they are then able to feel enthusiastic and motivated to access their unleashed potential to then be a success themselves. It is important to emphasise that this research was conducted on samples in the private sector and therefore, may not be as applicable to a UK public sector sample.

The context of leadership

More recent psychological theories about leadership have begun to acknowledge the importance of context (Haslam, Reicher & Platow, 2011). Haslam et al (2011) use Tajfel

and Turner's (1979) social identity theory which suggests that individuals want to become a member of a group to "create and define… [their] place in society" (Tajfel & Turner, 1979, p. 40-41). Haslam et al argue that if a member from a minority in-group (the group in the minority to which one belongs) wants to enter a majority out-group (the group in the majority to which one does not belong) they have two options. First, if they believe that it is possible to make this transition the individual will downplay their membership to their minority group and focus on displaying their characteristics which fit with the values and norms of the majority out-group. In contrast, if the individual felt that their ability to infiltrate the majority out-group was impermeable they would emphasise the skills their subordinate group have over the dominant group.

Haslam et al (2011) argue that "the old psychology of leadership" overemphasised the unique characteristics of leaders, neglecting their followers and the social context in which they and their followers were embedded. They propose that a "new psychology of leadership" involves the interaction between the leader, the followers and the social context. They suggest that leaders need to identify the social norms and values of the group and to show that they possess these norms and values too. It is important to stress that much of the research this theory is based on was conducted on men. Therefore, this theory is limited in its ability to be generalised to females. Additionally, it will be interesting to understand how successful female leaders lead in the current context of the NHS with a heavy emphasis on efficiency savings.

Clinical leadership in the NHS

There is a difference between clinical leadership and managerial leadership in the NHS. Although I am aware of the more recent Healthcare Leadership Model (NHS Leadership Academy, 2013) this model is not specific to clinical leadership and therefore, the 2011 model has been chosen to be discussed given that the proposed sample in the current study are clinicians in senior leadership roles. The Clinical Leadership Competency Framework (NHS Leadership Academy, 2011) says that clinical leadership involves "working in collaboration with patients and carers across health systems in developing new models of care for improved patient outcomes and further developing the skills of the workforce" (p. 4). The NHS Leadership Academy developed a clinical leadership competency framework by interviewing 97 professionals about their clinical leadership experiences, reviewing documentation and gaining advice and feedback from a range of professionals within the field of clinical leadership. The framework suggests that there are five domains of clinical

leadership; (1) ‘demonstrating personal qualities’ (2) ‘working with others’ (3) ‘managing services’, (4) ‘improving services’ and (5) ‘setting direction’. It has been argued that this clinical leadership competency framework is applicable to “every clinician at all stages of their professional journey” (p.4).

There may be some similarities in how different professions approach clinical leadership. However, different professions endorse different philosophical approaches to care. Therefore, it seems likely that these differences will emerge across professions in how they implement clinical leadership. For example, medical practitioners and nurses endorse the medical model, whereas, within clinical psychology a psychological model is endorsed. The BPS (2010) clinical psychology leadership framework describes the clinical, professional and strategic leadership skills that clinical psychologists should be implementing at different levels throughout their careers from a PICT to a clinical director. Table 1 presents the clinical psychology leadership framework skills for a consultant clinical psychologist (as all of the sample will be consultant clinical psychologists).

Table 1: Consultant clinical psychologists’ leadership skills as defined by the clinical psychology leadership framework (BPS, 2010)

Consultant Clinical Psychologist
Clinical
• Ensure psychological formulation work is appropriately shared. • Embed an educated and systematic approach to clinical risk and quality. • Collate outcomes for clinical psychology and benchmark. • Set quality targets aligned to legislation/national frameworks. • Inspire, support /manage others to develop a culture of innovative clinical practice/creative solutions.
Professional
• Inform and join in trust-wide clinical governance groups. • Develop leadership throughout the profession, mentoring those at lower bands/supporting networks. • Ensure the quality and value for money of psychology is enhanced and communicated to heads of service/ directors/ commissioners.
Strategic
• Feedback trends in clinical outcomes to service directors/promote sharing of information. • Lead on sharing cost-effective service development projects across services and profession. • Market and promote a service/ department/professional approach. • Ensure organisational awareness informs decisions/ dynamism/ educated risk-taking/options.

Both these clinical leadership frameworks provide a list of actions that individuals are expected to do or achieve within their clinical leadership roles. However, the above definition of clinical leadership suggests that individuals work in "collaboration". Therefore, it seems likely that clinical leadership involves more complexity than executing a list of actions given the apparent relational nature of leadership.

Clinical leadership versus management

Edmonstone (2009) suggests that NHS management is a position of power where one "commands and controls", whereas, clinical leadership is about gaining credibility and being patient centred. However, Edmonstone (2009) argues that within the NHS clinical leadership is often "ignored" and "unaddressed". Furthermore, Fitzgerald, Liley, Addicott, McGivern and Buchanan (2006) suggest that clinical leaders can experience an incompatibility between clinical leadership and management. Qualitative research conducted in Norway, suggests clinical leaders describe feeling "thrown into" their leadership roles and feel as though they have to "learn on the fly" (Spehar, Frich & Kjekshus, 2012).

Forbes, Hallier and Kelly (2004) have produced similar qualitative findings using a UK sample of NHS medical practitioners entering clinical leadership roles. These medical practitioners perceived management to ignore the clinical implications of the decisions that were being made by management. They also described feeling pressured to adopt a management perspective in their clinical leadership role. However, they said that they remained vocal, providing their clinical opinions on decisions that the management team were making. Forbes et al (2004) described these clinical leaders as perceiving leadership to be "something bolted onto their clinical work" (p. 174), suggesting that they perceived their role as a clinician to be first and foremost and that their role as a leader was secondary. However, research has not identified how clinicians use their leadership skill to manage this potential conflict.

Females as clinical leaders

Women represent 80% of the NHS workforce (NHS Information Centre, 2012) yet men occupy the majority of NHS senior leadership roles (Read, 2013). Additionally, research indicates that female medical practitioners are underrepresented in senior leadership roles (Buckley, Sanders, Shih, Kallar & Hampton, 2000; Deech, 2009; Lane, 2008). Similarly,

male nurses are more likely to occupy higher grade posts (Crampton & Mishra 1999) compared to female nurses and have a tendency to be over-represented in senior leadership positions (Mani 1997; O'Connor, 1996).

Research also suggests that female clinical psychologists are also under-represented in senior leadership roles (Ussher & Nicholson, 1992). Murray & McKenzie's (1998) survey on Scottish NHS clinical psychologists identified a sex ratio of one male to every 4.3 females. However, Murray & McKenzie (1998) noted that once individuals were at NHS pay band 8b or above, this sex ratio changed to one male to every 1.3 females. Lavender's (2005) survey replicated these findings identifying that male clinical psychologists were overrepresented in the higher NHS pay bands (8b or above). More recently, data from the HCPC (July, 2013) has identified that 80% of registered clinical psychologists are female, however, data from The Clearing House website (The Clearing House, 2013) indicates that 70% of Clinical Psychology course directors are male. I intend to use a sample of senior female NHS clinical psychologists because clinical psychologists are trained and qualified to deliver leadership (BPS, 2007). CPs have always had a leadership role, however, the BPS (2007) have recently formalised this in New Ways of Working for Applied Psychologists. Therefore, using a sample of NHS senior female clinical psychologist leaders will be useful as they will have had a range of leadership experiences to draw from.

Differences in male and females' leadership style

Males and females are potentially different and therefore, these differences may affect their leadership styles. Research suggests that differences exist between males and females decision making processes (van den Bos, Homberg & de Visser, 2013). In addition, Tannen (1996) argues that there are differences between males' and females' communication styles, whereby males are more likely to report "factual" information about themselves, whereas females are more likely to build "rapport" and acknowledge the contributions of others in their success (Tannen, 1996). Research has also suggested that there are differences between the sexes in how they go about processing emotions (Kret & De Gelder, 2012) with females being better than males at recognising their emotions and with males responding better to threats compared to females. These three variables (decision making, communication and emotional processing) are likely to be linked to leadership, given the interactional nature of leadership. Furthermore, studies suggest that men and women describe their leadership styles differently (Metcalfe, 1995) and use different leadership styles (Eagly, Johannesen-Schmidt & van Engen, 2003).

This was further explored by Eagly et al's (2003) meta-analysis. They aimed to identify whether male and female leaders use different leadership styles. The databases; PsycINFO, Educational Resources Information Centre and ABI/ Inform Global were used to identify the relevant studies to include in the meta-analysis. Forty five studies were included in the analysis, all of which assessed the transactional and/ or transformational leadership styles of male leaders and/ or female leaders. In total the data was drawn from 20,508 male leaders and 9366 female leaders. The results suggest that female leaders are more likely, compared to male leaders, to use leadership styles which are associated with leadership effectiveness. These effective leadership styles included transformational leadership (Bass, 1985) and 'contingent reward', a transactional leadership strategy which relies on the principles of positive reinforcement (Skinner, 1938). This meta-analysis suggests that although female leaders are in a minority, their most commonly reported leadership style is more effective than the leadership strategies men most commonly report using. Therefore, applying masculine models of leadership to female leaders does not make sense. In addition, given that the majority of the sample were from the USA and worked in the business sector, this makes it difficult to generalise these findings to a UK public sector sample. Consequently, there is a need to understand the leadership experiences of successful female leaders who work in the public sector in the UK, which the current study attempts to address.

Perceptions of women in leadership

Individuals perceive differences in the leadership effectiveness between males and females. Studies indicate that Curriculum Vitaes (CVs) with male names are more likely to be short-listed for leadership roles compared to identical CVs with female names (Davidson & Burke, 2000). Research suggests that individuals perceive women to be less qualified (Eagly & Karau, 2002) and competent in leadership roles compared to men across a range of contexts (Carli, 2001; Heilman, 2001; Ridgeway, 2001; Schein, 2001).

Additionally, research suggests that individuals in mixed sex groups were more likely to perceive and rate (on a 9 point Likert scale) male participants as "competent", "influential" and "playing a leadership role" compared to female participants (Heilman & Haynes, 2005). Similarly, Walker, Ilardi, McMahon and Fennell (1996) suggest that participants in mixed sex groups are five times more likely to identify male participants as leaders compared to female participants. This was based on questionnaires completed by the group which identified how much each individual perceived the other group members based

on how they; spoke, influenced, created solutions, delivered guidance and had knowledge (Walker et al., 1996).

Moreover, women who assert themselves are perceived to be less effective leaders compared to men who assert themselves, (Eagly & Karau, 2002), particularly if the female is leading on a stereotypically masculine task (Garcia-Retamero & Lopez-Zafra, 2006). Therefore, it appears that not only are women perceived to be less effective leaders compared to men, but the leadership styles that they engage in are positively associated with effective leadership outcomes compared to male leaders (Eagly & Karau, 2002).

Gender roles

Gender roles are "consensual beliefs about the attributes of women and men" (Eagly & Karau, 2002, p. 572). Research suggests that women are expected to behave in a 'communal' manner demonstrating kindness, concern for others, warmth and gentleness (Eagly, Wood & Diekman, 2000) whereas, males are expected to be 'agentic' by being confident, assertive and aggressive (Newport, 2001). Gender roles inform individuals' construction of gender stereotypes. These gender roles have been found to be "easily" and "automatically" triggered in response to an individual categorising another's sex (Banaji & Hardin, 1996; Banaji, Hardin & Rothman, 1993; Blair & Banaji, 1996). Therefore, it is likely that individuals will expect female leaders to behave communally yet expect male leaders to be agentic. These gender stereotypes appear to favour male leaders given that people strongly associate agentic qualities with effective leadership (Schein, 2001).

Role congruity theory

Role congruity theory (Eagly & Karau, 2002) which is grounded in social role theory suggests that when individuals behave in ways that are incongruous with their gender role, that this is met with disapproval. As "women who are effective leaders tend to violate standards for their gender when they manifest male-stereotypical, agentic attributes and fail to manifest female stereotypical, communal attributes, they may be unfavourably evaluated for their gender role violation, at least by those who endorse traditional gender roles" (Eagly & Karau, 2002, p. 575). This leaves female leaders in a 'double bind' where if they behave in an agentic manner they are at risk of being perceived to be "too masculine". However, if they behave communally and thus in a manner consistent with their gender role they are at risk of being perceived as being "too nice" (Eagly & Karau, 2002). Eagly and Karau (2002) argue that perceived incongruity between the female gender role and leadership roles

unfairly disadvantages female leaders. This is because a female's leadership potential and leadership ability are less favourably evaluated (compared to males) because male gender roles are perceived to be more congruent with the role of a leader than female gender roles. Research suggests that female leaders who behaved assertively and confidently in their role as a leader were described as "controlling" and "domineering" (Eagly et al., 1992). In addition, Carli and Eagly (1999) suggested that females displaying agentic behaviours experience a backlash when attempting to secure a promotion. Research suggests that these gender biases are internalised (Hogue & Lord, 2007) suggesting that female leaders may also perceive themselves to be less capable in leadership roles compared to their male colleagues. Therefore, female leaders may need to have high levels of self-efficacy and resiliency to cope with this potential prejudice they may experience in their role as a leader.

Self-efficacy and female leaders

Self-efficacy has been defined as "how well one can execute courses of action required to deal with prospective situations" (Bandura, 1982, p. 122). Bandura (1986; 1997) also proposed that self-efficacy is related to an individual's coping style and their resilience.

Empirical research indicates that leadership outcomes are positively associated with high self-efficacy (Chemers, Watson & May, 2000; Hoyt, Murphy, Halverson & Watson, 2003). Additionally, Hackett's (1997) review argues that self-efficacy plays an important role in one's career choice. Stajkovic and Luthans' (1998) meta-analysis also identified that self-efficacy is associated with work related performance, where individuals with a high self-efficacy also do well in their job role. Research indicates that female business managers self-report having a lower self-confidence compared to male business managers (Morris, 1998; Morrison, 1992; Tharenou, Latimer & Conroy, 1994; Tsui, 1998). This suggests that these men have a greater self-efficacy compared to women when completing leadership tasks, which may potentially advantage men in the workplace. However, since this research was conducted over 15 years ago it is possible that women's leadership self-efficacy may have changed with the number of women in executive leadership roles having doubled in the last ten years (EHRC, 2011; Sealy & Vinnicombe, 2012; Sealy & Vinnicombe, 2013).

Females and high leadership self-efficacy

Hoyt and Blascovich (2007) conducted two experimental studies on female undergraduates (study 1: n = 53, study 2: n = 75) selected for having a low or high leadership self-efficacy as they were screened using the self-efficacy for leadership measure

(Murphy, 1992). All participants were told that they had been randomly selected as a leader and needed to prepare for a three minute virtual meeting to influence two assistants to hire a new employee. Participants were then exposed to one of two conditions; the stereotype activating condition or the neutral condition. The activating condition involved participants being left with a folder with images of male leaders and information on the gender gap that women experience with regards to leadership. They were told that the research was about exploring sex differences in leadership ability. In contrast, participants in the neutral condition were exposed to images and information about the virtual reality laboratory and were told that the research was about understanding leadership abilities.

Hoyt and Blascovich (2007) identified that highly self-efficacious women who encountered stereotype threats were reported, (both by themselves on a 7 point scale and by objective observers on a 9 point scale), to perform better on leadership tasks compared to women with low leadership self-efficacy and compared to women with high leadership self-efficacy who were not exposed to the stereotype threat. Additionally, highly self-efficacious women exposed to the stereotype threat reported having a higher self-esteem and lower depressed affect compared to women with a high leadership self-efficacy in the neutral condition. Interestingly, women with a low leadership self-efficacy, who were exposed to the stereotype threat reported having the lowest self-esteem and the highest depressed affect among all the conditions.

Hoyt and Blascovich's (2007) findings indicate that self-efficacy plays a mediating role in women's leadership performance and wellbeing. This suggests that high leadership self-efficacy protects female leaders facing stereotype threats, whereas, women with low leadership self-efficacy become vulnerable when facing stereotype threats. However, it is equally plausible that these women were depressed before the study as no measure was used to screen the participants' mood prior to their participation in the study.

Hoyt and Blascovich (2010) have replicated these findings using a similar population and methodology. However it is likely that these findings are limited in their ability to generalise to populations other than female undergraduate students. Additionally, although the use of virtual reality would control for potential extraneous variables, this benefit does not appear to outweigh the cost of lacking ecological validity. Therefore, further studies are required to establish whether these findings can be replicated with successful senior female leaders. Furthermore, given the methodological design of this study it cannot explain how the women experienced the stereotype threats, nor can it tell us how

these women managed to make use of their high leadership self-efficacy to overcome the stereotype threats.

Summary

The leadership literature is dominated by quantitative research conducted on men in the private sector. Therefore, much of the leadership literature is not applicable to female leaders in the public sector. Given that the NHS, a predominantly female organisation, has emphasised the need for staff to adopt leadership roles at all levels, there is a need to understand how female leaders in the NHS lead successfully. The limited quantitative research suggests that female leaders are undervalued as leaders because individuals perceive the identity of a leader to be in conflict with the gender roles of a female. Therefore, female leaders experience a double bind where they are prejudiced against for demonstrating characteristics that are either too masculine or too feminine. In addition, it has been suggested that females can internalise this bias against themselves. However, research suggests that self-efficacy can help to buffer this as well as enhance general wellbeing. It is important to stress that the above literature on female leaders (although limited) had been quantitative and therefore, little is known about the successful leadership experiences of female leaders. Therefore, there is a need to look at qualitative research to gain an insight into female leaders' experiences of leadership.

The experience of leadership

Qualitative literature search

A literature search was conducted to identity the research most relevant to the current research. Two databases were used PSYCINFO and Scopus. The following search terms were entered into the electronic databases; female, women, woman, leader, manager, experience and phenomenology. It is important to note that some of these terms were truncated (e.g. lead*) and many were combined with one another (e.g. female OR women OR woman) to ensure that the qualitative literature search was comprehensive. An overview of these seven studies is presented in table 2.

The literature search identified seven qualitative studies which explored female leaders' experiences of leadership. The following section will examine how leadership has been defined across these studies. I will then review these seven studies providing an outline of their aims, research design, findings and methodological criticisms. These methodological criticisms will help to identify the current gap in the leadership literature

Table 2: An overview of the seven studies

Author	Country / Sector	Participants	Method	Results
Black & Magnuson (2005)	USA Public	8 female academic counsellors, 2 protégés	Interviews Phenomenological guidelines	Ps described being "authentic" and "passionate" in their personal lives, "compassionate" and "empowering" in their interpersonal lives and in their professional lives described being "visionary" and "intentional".
Bowles (2012)	USA Private	50 female executives	SSIs Grounded theory	Ps described securing their executive positions by navigating a traditional career path or by developing a pioneering path. The pioneering path involved Ps develop a vision which was supported by others. Ps described reflecting on themselves when they encountered barriers to securing their position.
Christman & McClellan, (2008)	USA Public	8 female university leaders	Electronic Delphi technique	Ps rank ordered components of their own resiliency; "somewhat driven", "persevere", "appreciating relationships", "role model for others" "sense of having to succeed", "support from families, partners, husband, colleagues", "optimism", "voice for minority women", "excited about responsibility", "feelings of success and satisfaction" and "tenure". Mobilising social support was the most common component identified.
Hertneky, (2012)	USA Public	12 female college presidents	SSIs Narrative inquiry	Ps described having taken a traditional route to access their role as president. Ps described having an awareness of their strengths and weaknesses. They also stressed the importance of building relationships with others in their success.
Salas-Lopez et al., (2011)	USA Public	8 female medics in senior leadership roles	SSIs "interpretive, iterative, inductive process"	Ps perceived their gender and race (BME) to have a negative impact on their progression into senior leadership roles. Ps described struggling to maintain a good work-life balance. Ps described having a mentor as having been beneficial to their success.
Stead, (2013)	UK Public	6 female university senior leaders	SSIs Grounded theory	Ps described experiencing "right" (e.g. "blending in" as a female in their organisation) and "wrong" (e.g. invited to be on the panel for an interview because they needed a woman on the panel) (in)visibility in their role as leaders. Ps described either revealing or concealing their experiences of being invisible as a female.
Weidenfeller (2012)	USA Private	12 female enterprise leaders	Conversational interviewing. Phenomenological guidelines	Ps described successfully securing their leadership positions by (1) having a desire to control their destiny, (2) aspiring to have an impact in their role as a leader, (3) achieving influence by having a 'connect and collaborate' style, (4) when initiating change focussing on the process as well as the results, (5) in the face of challenges utilise self-knowledge and resiliency.

which my proposed study intends to fill.

It is important to identify how these seven studies defined the term "leader" given that "management" and "leadership" have been used interchangeably, yet are distinct terms. This will be done by examining each study's sample of female "leaders". Those studies conducted in the private sector appear to have defined the term "leader" by one's position. For example, Bowles (2012) used a sample of "50 female executives from major corporations and high growth entrepreneurial ventures" (Bowles, 2012, p 189) and Weidenfeller (2012) used a sample of female enterprise executives.

Additionally, studies in the Medical Leadership literature and the Educational Leadership literature have also defined "leader" by one having a formal leadership position. This is evident as Salas-Lopez, Deitrick, Mahady, Gertner, and Sabino (2011) utilised a sample of female medical practitioners and academics, all of whom were in formal leadership roles. Additionally, Christman and McClellan (2007) used a sample of women "who possessed titles such as department head or chair; assistant department head or chair; dean, associate dean, or assistant dean; or any similar acting or interim position and who worked or identified with as a home department any educational administrator preparation program" (Christman & McClellan, 2008, p. 11). Likewise, Hertneky's (2012) sample of female college presidents and Stead's (2013) sample of women from UK universities in formal leadership roles, indicates that they defined the term "leader" according to one's position and not based on one's ability to influence others. However, Black and Magnuson's (2005) sample included female counsellors who "have contributed to the counselling profession through leadership in counselling organizations, publications in counselling journals, and authorship of books" (Black and Magnuson, 2005, p. 338) suggesting that their use of the term "leader" was not just about a position but also a marker of academic success.

As these studies have utilised samples of women in formal leadership roles, this literature review will provide an outline of the experiences of women in leadership roles and not on the leadership experiences of successful female leaders. This is because a formal leader does not equate to being a successful leader (Tourish, 2013).

Women's experiences of accessing formal leadership roles

Only one USA study was identified from the Medical and Leadership literature (Salas-Lopez et al, 2011) which aimed to understand females' retrospective experiences of accessing formal leadership roles. This study interviewed 8 female medical practitioners and academics who were currently in formal leadership roles.

Participants described being motivated to succeed in their careers from an early age and believed that as women they needed to work harder than men to secure leadership roles. This suggests that participants experienced high levels of self-efficacy in their pursuit of a leadership role. Participants also described prejudice when they became mothers. For example, a participant was told that becoming a mother was a "career liability" and experienced challenges in managing a work-life balance. However, participants described feeling supported by their families who provided social support and help with childcare. They also described feeling supported by mentors who helped them access development opportunities and learn about leadership.

These findings suggest that accessing leadership roles as a woman is a challenging experience requiring individuals to have high levels of self-efficacy, resiliency and support. It is important to note that these participants may have experienced these difficulties while progressing to a senior role but the problem may not be so prominent once they have achieved their senior role. Additionally, these experiences occurred in a corporate American culture which is likely to differ to the culture of the NHS.

Making sense of having accessed a leadership role as a woman

Two USA studies explored the career stories and narratives of women in formal leadership positions. These studies provide an insight into how these females in leadership roles make sense of their career experiences retrospectively. Bowles' (2012) study from the women and leadership literature aimed to "explore women's career stories that …illustrate how women may establish the legitimacy to claim authority in the highest reaches of the business hierarchy" (Bowles, 2012, p 192). Fifty corporate/ entrepreneurial female executives who worked in stereotypically male jobs were interviewed. Grounded theory was used to analyse the data.

These career stories suggest that participants made sense of having accessed formal leadership roles by having taken a "navigating" or "pioneering" account (Bowles, 2012). "Navigators" aspired to specific job roles by climbing up the job hierarchy and by self-advocating with gatekeepers. In contrast, "pioneers" created a strategic vision and developed a following which enabled them to identify themselves as the natural leader. In the face of failure, "navigators" and "pioneers" would gain self-insight into themselves or their vision, alter their strategies and then follow their altered navigating or pioneering strategy.

Similarly, another study identified that female college presidents provided career stories which fitted with a navigating account (Hertneky, 2012). This study aimed to

understand participants' leadership self-identities based on their career stories. Twelve female college presidents were interviewed and the data was analysed using a narrative inquiry approach. Additionally, their career stories suggest that their leadership identity developed as they gained experience in influencing others and not just by being in a leadership role (Hertneky, 2012).

These findings suggest that participants made sense of securing their leadership positions by having had high levels of self-efficacy to pursue either a navigating or pioneering trajectory as well as having a high level of self-awareness and resiliency to overcome failed attempts. Additionally, it could be argued that Bowles' (2012) pioneering account provides an insight into successful female leadership as these participants managed to emerge as a natural leader by having a strategic vision and by developing a following prior to securing a formal leadership role. Therefore, it will be interesting to see how these accounts resonate with the accounts of my proposed sample. It is important to note that Bowles' (2012) sample worked in the private sector, which is male dominated, particularly among those in senior leadership roles (Davies, 2011). In contrast, my proposed sample work in the NHS, which is a public sector organisation whereas these studies used a sample from a USA private sector organisation and therefore, differences may emerge between these samples.

The experiences of women in leadership roles

Two studies explored the experiences of women in leadership roles in educational settings. Christman and McClellan's (2008) USA study aimed to explore female administrator's experiences of resiliency in their leadership roles. Seven female administrators in leadership roles working in leadership programs participated in an electronic Delphi study.

Christman and McClellan (2008) identified a number of components that participants attributed to their resiliency these were (in rank order); "somewhat driven", "persevere", "appreciating relationships", "role model for others" "sense of having to succeed", "support from families, partners, husband, colleagues", "optimism", "voice for minority women", "excited about responsibility", "feelings of success and satisfaction" and "tenure". Interestingly, once participants illustrated these components with examples mobilising social support was the most common component identified as a marker of resiliency.

In contrast, Stead's (2013) UK study aimed to identify "women's learning from their lived experiences of leadership" (p. 63). Six university females in leadership roles were

interviewed about times they had felt visible and invisible as women in leadership roles. The data was analysed using grounded theory. They identified that the participants had "experiences of right and wrong forms of (in)visibility". Right forms of visibility were described as women being seen in leadership roles and being acknowledged as leaders. In contrast, wrong forms of invisibility were identified when women felt excluded from male networks. This was described when "there are kind of in-group things going on…in terms of international boards, journals and that type of thing… friends will recommend friends and because men are probably the ones who have been more dominant in that arena and women tend to be friends with women, you might not be included" (p. 70).

Another theme identified was "experiences of (in)visibility due to stereotype expectations". Participants identified feeling as though they were forced to choose between being visible or invisible as women leaders. One participant described telling someone to "shut up" in a meeting and then being teased by her male colleagues as they had expected her to be "demure", which she felt made her feel "exposed". "Experiences of revealing and concealing their learning about (in)visibility" described how participants either chose to reveal or conceal the discrimination they felt they had experienced. For example, one participant identified "I was asked to take some notes and I thought is that because I am the only woman here. It was awkward but I did speak up" (p. 70)

Research suggests that the experience of being a female in a leadership role is challenging (Christman & McClellan, 2008; Stead, 2013). Some participants in leadership roles experienced feeling isolated and mistreated (Christman & McClellan, 2008). Participants identified feeling resilient when they believed in themselves, persevered (i.e. they had high levels of self-efficacy) and mobilised social support (Christman & McClellan, 2008). Participants also identified how they, as females in leadership positions, felt either visible or invisible (Stead, 2013). However, research suggests that women in leadership roles experienced gender stereotype threats from male colleagues (Stead, 2013) and responded to these threats either by revealing or concealing the stereotype threats (Stead, 2013).

Both of these studies were set in academic institutions which limits the generalisability to other settings, particularly to health settings. However, since Stead's (2013) sample worked for the public sector in UK universities it may be possible to make some generalisations about these women's experiences of leadership roles in the public sector in the UK.

It is important to note that neither of these studies identified the cognitions, feelings and embodiment of their participants' experiences. This is because they did not use a phenomenological approach which may have enabled researchers to achieve this. Research suggests that using a phenomenological approach to explore the embodied experiences of leadership could help provide new knowledge on forming and maintaining leadership relationships (Ladkin, 2013).

The phenomenological experience of being a female in a leadership role

Two USA studies were identified that used a phenomenological approach to explore the experiences of women in formal leadership roles. Black and Magnuson's (2005) study from the psychology literature aimed to understand "the experiences of female leaders within the [academic] counselling profession" (p. 338). Data was collected using telephone semi-structured interviews (SSIs) and contributions from participants' CVs. They suggest that the attributes and behaviours of female leaders arise from a "complex interaction" between one's personal, interpersonal and professional lives. Black and Magnuson (2005) identified that in participants' personal lives they were "authentic" and "passionate", whereas, in their interpersonal lives they were "compassionate" and "empowering" where they provided their followers with advocacy and mentoring opportunities. Finally, in their professional lives they were identified as being "visionary" and "intentional" individuals who exerted power "with" people rather than "over" people.

In contrast, Weidenfeller's (2012) USA study aimed "to understand the meaning of the experience of being a woman enterprise leader" (p. 365). This involved interviewing 12 female senior enterprise leaders. Weidenfeller (2012) identified that participants were "driven by a desire to control their destiny". This described participants as having high levels of self-belief to create opportunities that would demonstrate their leadership skill e.g. putting oneself in a precarious leadership role. "Aspir[ing] to leadership positions with impact" identified that participants described themselves as "change agents" who attempted to use their power and influence to create change. Weidenfeller (2012) identified that participants had done this through a "connect and collaborate style" which participants described experiencing as "collaborative" and "authentic". A difficulty that participants described experiencing was "initiat[ing] culture change whilst staying focused on results", which they attempted to manage by finding a resolution as a team. Finally, Weidenfeller (2012) identified that participants applied a "self-knowledge and resiliency to address challenges". Participants described reflecting on previous experiences and managing a

work-life balance to remain resilient when having to take on multiple roles and adapt to a male dominated culture.

Findings suggest that participants experienced a strong sense of self-efficacy that they would succeed in their job role (Weidenfeller, 2012). They also experienced a desire to use their power and influence to create positive change (Weidenfeller, 2012). An example of this was participants providing advocacy and mentoring to minority groups (Black & Magnuson, 2005) and described achieving this in a style synonymous with transformational leadership. However, participants experienced difficulties in creating change and remaining focused on results, suggesting that they experienced a conflict between managing and leading. Overall they found the experience of working in a leadership role "challenging and demanding". They also experienced gender stereotype threats being directed at them within the workplace. However, participants experienced a strong sense of resiliency by engaging in self-reflection and by managing their work-life balance.

It is important to note that Weidenfeller's (2012) study can only tell us about the experiences of being a female in a leadership position within the business sector, which is likely to differ to the experiences of my proposed sample. Unfortunately, Black and Magnuson's (2005) study did not report specific experiences that their participants had had. Instead they identified a list of attributes and provided some brief information on the behaviours that they engaged in (as identified above). Therefore, limited findings can be drawn from this study to inform our understanding of the phenomenological experiences of women in leadership roles. Additionally, Weidenfeller's findings did not report on experience in a phenomenological sense. Therefore, there is a need for further phenomenological research to be conducted on women in leadership.

Summary

There are currently no qualitative studies exploring the leadership experiences of successful females in senior leadership roles. Therefore, I have had to draw from a literature which has used samples of females in leadership roles. This was because females who have secured leadership positions will have had to successfully influence others to secure this specific role. Among this research, there is a dearth of psychological literature. The majority of this literature has been conducted in the USA either in the private sector or within academia. Only one UK study was identified which was conducted within academia. No research currently exists on the experience of leadership of women in healthcare settings. Furthermore, the literature that exists on the phenomenological experiences of women in

leadership is flawed as cognitions, emotions and embodiment are not identified in either of the two phenomenological studies. Therefore, there is a need to provide a phenomenological account of the leadership experiences of successful senior females in the NHS. This will provide an alternative narrative and will enable us to understand and learn from the detailed and varied accounts of female leaders' successful experiences of leadership.

Research questions

1. How do senior female clinical psychologists describe their experiences of successful leadership?
2. How do they make sense of these successful experiences of leadership?
3. How do I make sense of their data in relation to psychological theory?

CHAPTER TWO: METHOD

In the following section I will describe and justify the methodological stance and data collection method used for this study. A description of the sampling and recruitment method will also be provided. In addition, there will be an outline of the study design and procedure with justifications as to why these choices were made. Finally, there will be an explanation of the data analysis, the quality checks utilised within the data analysis procedure and a reflexive statement.

Methodological Approach

I used a qualitative research method for this study. Mason (2002) argues that qualitative research is a series of research methodologies that are "broadly interpretivist" and based on methods of data generation and methods of analysis. She argues that the aim of qualitative research is to "produce rounded and contextual understandings on the basis of rich, nuanced and detailed data" (p. 3). Given the current research aimed to understand the experiences of successful leadership, a qualitative research methodology seemed most appropriate to "get at the inner experience of participants" (Strauss & Corbin, 2008, p. 12).

Methodologies

The following section will discuss three different qualitative methodologies and provide a justification for the use of IPA.

Foucauldian Discourse analysis (FDA)

FDA focuses on how language creates discourses which offer a "subjective position" from which one can interpret and make sense of the world (Willig, 2008). Therefore, FDA relies solely on discourse to gain an insight into one's subjective experience (Willig, 2008). In contrast, IPA focuses on the content of one's thoughts, feelings and the sense that one makes of their experience, whereas FDA focuses on the meaning that is constructed through one's use of language. Therefore, IPA is a more appropriate method to use to answer my research questions because it identifies phenomenological experiences.

Grounded theory (GT)

GT (Glasser & Strauss, 1967) is a common qualitative method. GT aims to generate new theories by identifying codes, concepts and categories which emerge from the data until no new categories can be created. Links are then made between these categories (Willig, 2008) to generate a theory. GT does not focus primarily on individuals' subjective experiences, its main focus is on social processes as it was created by sociologists (Smith et al., 2009; Willig, 2008). If one wants to identify one's lived experiences, one needs to utilise phenomenological methods (Willig, 2008). Therefore, IPA is better placed to provide a phenomenological account of my participants' lived experiences compared to GT.

Interpretative Phenomenological Analysis (IPA)

IPA attempts to understand an individual's experience and how they make sense of their experiences (Smith, 2004). IPA also assumes that what an individual says parallels their thoughts and feelings (Smith & Osborn, 2003). IPA proposes that individuals have their own unique perspective and understanding of the world. This notion fits with the ontological approach of a social constructionist (Burr, 1995). Burr proposed that individuals interpret the same situation in different ways and that therefore, there is no universal truth. She proposed that this is because each individual constructs their own social reality, which is influenced by their history, culture and language.

IPA has three components on which it is based; phenomenology, hermeneutics and idiography. Phenomenology is a philosophical approach to understanding experiences whereas hermeneutics is the "theory of interpretation" (Smith et al., 2012, p. 21). Individuals interpret their experiences to make sense of the world within which they are embedded. Humans also attempt to interpret and make sense of other people's experiences. This second level of interpretation, where the researcher attempts to interpret and make sense of someone who is interpreting and making sense of their own experience, is known as the 'double hermeneutic'. In IPA the double hermeneutic plays an important role in the analysis as the researcher is transparent about their experience of making sense of the participants' data. Idiography focuses on understanding one's subjective experience in a particular context. This is evident in IPA as each case is examined individually, drawing conclusions about the individual cases. However, if similarities are apparent between cases conclusions will also be drawn across cases.

Why use IPA?

It was decided to use IPA as a research methodology for this study because IPA is concerned with understanding experiences and the sense that individuals make of their experiences (Smith et al., 2009), which fits with the research questions of the current study. Furthermore, Smith and Osborn (2008) suggest that IPA is best utilised when working with "complexity, processes or novelty" (p. 55). This fits with the current study, as exploring senior female clinical psychologist's experiences of leadership involves a complex dynamic and is novel because research has not been done in this area before. This suggests that IPA is an appropriate methodology to investigate the current research questions.

Data collection

The following section will discuss three data collection methods and will identify and justify the chosen method for this study.

Diaries provide a rich personal account of individuals' experiences, thoughts and feelings. Researchers provide guidelines to participants on the frequency they are required to make a record in their diaries, the method of recording (e.g. written, audio recorded, photographic or videoed) and what to focus on when recording. Diaries can enable researchers to access sensitive personal information which may be difficult to obtain face to face (Willig, 2008). Additionally, this information is recorded in real time and therefore, is likely to be ordered temporally (Willig, 2008). However, the act of keeping a diary may alter one's routines and thus one's experiences (Willig, 2008), which may confound the results of the study. Studies that have used diaries have reported experiencing poor recruitment and high attrition rates (Willig, 2008). Therefore, diaries are not a suitable method for my specific research questions.

Focus groups involve a group of participants discussing their responses to specific research questions (Rice & Ezzy, 1999). The group dynamics affect the content that the group discusses. Therefore, it is important to interpret the results within the context of the group dynamics (Millward, 2012) and this can make it more difficult to capture the "phenomenological aspects of IPA" (Smith et al, 2009, p. 71). Therefore, focus groups do not appear a suitable method to collect data for my proposed study.

SSIs are facilitated by an interviewer with an interview guide to enable a flexible and conversational approach to focusing on a specific topic (Smith et al., 2009). SSIs require researchers to be sensitive to the participant's use of language and to gain clarity on issues

that may emerge within the data (Fossey et al., 2002), which is important in understanding one's lived experiences. Therefore, it was decided that SSIs would be an appropriate method of data collection.

Method

Design

This study utilised a qualitative research methodology to explore the experiences of successful leadership among senior female clinical psychologists. I used SSIs to collect the data and Interpretative Phenomenological Analysis to analyse the data.

Sampling

Participants were recruited using purposeful sampling. Pietkiewicz and Smith (2014) identified that the sample size in IPA research varies dramatically ranging from 1 participant to 15 participants. However, Smith et al (2009) suggested that a sample of 3 - 6 participants is sufficient to conduct an effective IPA study. Nevertheless, Turpin, Barley, Beail, Scaife, Slade, Smith, and Walsh (1997) have identified that UK clinical psychology doctoral programs recommend a sample size of between six to eight participants. Therefore, an initial sample size of eight was proposed to ensure that a large enough sample would be collected if any errors incurred. However, only seven participants were recruited. Given that the sample size was small, I created a strict inclusion criteria in an attempt to ensure that the sample that was recruited was homogenous (Kisfalvi, 2002). If the sample were too small, there might be difficulties in identifying similarities within the sample. Additionally, if the sample were too large, this could result in there not being time to analyse the data fully to conduct the IPA appropriately (Smith & Osborn, 2008).

Inclusion criteria

My research supervisors identified ten female clinical psychologists whom they perceived to be "successful leaders" working for the NHS. All participants were selected from a register of clinical psychology supervisors. My research supervisors examined this register and excluded the male supervisors and the psychologists banded at the NHS agenda for change pay scale of 8b and lower. They also ensured that all of the supervisors at 8c+ had been in that role for a minimum of 12 months. The psychologists remaining on the list were then

examined to identify whether they had made a particular contribution to the field of clinical psychology including; developing new services, publishing research and/ or audit and taking a regional and/ or national leadership role. My supervisors then selected ten participants from this short list, being mindful of selecting a sample that represented a number of NHS Trusts and services working with different clinical populations. If any of the participants had dropped out, the above process would have been repeated until a sufficient number of participants had been recruited.

Recruitment

The recruitment procedure began in January 2015. Two senior female clinical psychologists (my research supervisors) utilised a clinical psychology supervisor register to identity potential participants. This register covered supervisors working in 7 different NHS Trusts across the North of England. Initially, my supervisors excluded male supervisors and supervisors banded at 8b or lower on the NHS agenda for change pay scale. From the remaining pool of participants they began to identity those supervisors from the register who they perceived had a reputation for being influential and successful as a leader. The first ten supervisors that they identified as influential and successful leaders were sent an email (see appendix A for email correspondence) inviting them to participate in the study. Attached to this email was a participant information sheet (appendix B). All ten supervisors responded to my research supervisors' emails and consented to their details being passed onto me. I then emailed all ten supervisors. However, only seven responded to confirm that they were interested in participating in the research. Email correspondence continued between myself and the seven participants to arrange a suitable date and time for them to be interviewed. I then emailed the three supervisors who had not responded to the original email. This email invited them to participate in the research a final time. It was specified in the email that if they did not respond to this email within a week that this would be interpreted as them not wishing to participate in the research and that further communication would cease and their contact details would be deleted. None of these three supervisors responded to this final email and therefore, a total of seven participants were interviewed.

Ethical issues

Full ethical approval (SomREC/13/105 appendix C) was obtained from the University of Leeds on the 12th August 2014 on the condition that R&D approval was also obtained prior

to the commencement of the research. R&D approval was gained from four NHS Trusts in the North of England on the following dates; 28/10/14 (IRAS 161/27), 03/11/14 (PY14/11352), 21/11/14 (NP/0163) and 04/02/15 (no identification number stated). R&D approval was sought by completing the CSP Application Form on the Integrated Research Application System because some participants were recruited and/ or interviewed during their working hours. An amendment form was submitted to the University of Leeds Ethics committee to clear some minor amendments that some of the Trusts had requested be made to the information and consent forms.

Anonymity and confidentiality

The information sheet that participants received during the recruitment phase informed all the supervisors that the interviews would be audio recorded, transcribed and that some extracts would be published in the final thesis. Participants were informed that all potentially identifiable information would be anonymised and that a conscious effort would be made by myself and my supervisors to ensure that no identifiable extracts would be published in the final version of the thesis. Of the seven participants who agreed to participate in the interview all of them provided consent to participate in the research. Consent (appendix D) was sought both at the beginning and at the end of the interview. This strategy was put in place to enable participants to consider what information they had disclosed within the interview in case they had disclosed more than they had initially intended. None of the participants withdrew their consent. However, some participants requested that specific extracts were not published. Notes were made on the transcripts to indicate which specific verbatim extracts were not to be published in the final thesis. I edited all the transcripts by removing all identifiable information (e.g. name, family details, name of the service, name of the department, names of colleagues, references to the specific service users (SU) population) to protect the participants' anonymity. In addition, I created pseudonyms for all of the participants.

Participant distress and fitness to practice

It was thought although unlikely, that the current research topic may cause psychological distress to some of the participants (e.g. discussing discrimination and/ or personal issues that may have affected one's leadership experiences). Therefore, I asked all participants at the end of the interview how they had experienced the interview and whether they wanted to

discuss any particular part of the interview. Some of the participants had concerns regarding their anonymity in the write up. I reassured them that I would be anonymising all potentially identifiable information and that only non-identifiable extracts would be utilised in the final thesis. It was also emphasised that if participants disclosed any potential malpractice that this would be discussed with my supervisors and possibly the HCPC. However, this was not necessary as no example of malpractice were raised within the study.

Data protection

The information sheet informed participants that the audio recordings from the interview would be stored on an encrypted device and deleted from this device once they had been saved to the university server M drive. Participants were also informed that once the study ended the data would be deleted from the M drive and after three years of storage the transcripts would then be destroyed. The information sheet also identified that participants' data would be anonymised when transcribed and that only the transcribers and I would have access to the raw data. Transcribers from The University of Leeds read, agreed and signed a confidentiality agreement (appendix E) which bound them to delete the audio and word files that they had used and created once they had completed the transcription. Participants were also made aware that some of their verbatim responses would appear anonymously in the final report.

Measures and procedures

Interview schedule

An interview schedule was created with a total of seven questions (appendix F). This schedule was designed with the intention of identifying participants' personal narratives (Crossley, 2000). Therefore, careful consideration was given to the construction of each question in an attempt to elicit data which provided a rich description of each participant's experience. Consequently, open and expansive questions (as recommended by Smith et al., 2009) were utilised, as were prompts, in an attempt to gain a more coherent description of each participant's experience and to gain clarification on what the participant was describing.

A funneling technique (Smith et al., 2009) was used to develop a logical and rational order in which the questions were presented. This involved beginning the interview with broader and more general questions and becoming more specific nearing the end of the

interview. The rationale for utilising this technique was to enable participants to build trust and become comfortable with me (the interviewer) prior to responding to (potentially) more sensitive questions. Prompts were also used in an attempt to encourage participants to provide a richer account of their experience.

The interview schedule was shown to a female senior clinical psychologist who met all of the inclusion criteria but who was not a participant within the study. This individual made recommendations on the phrasing of certain questions, which were incorporated into the interview schedule. Additionally, a practice interview was conducted and audio recorded with one of my research supervisors who met most of the inclusion criteria but who mainly worked in academia. After the practice interview was conducted, my research supervisor offered some reflections on re-ordering and re-phrasing the initial few questions, which again were incorporated into the final interview schedule.

Engaging in this practice interview was also helpful for me as an interviewer. On reflection I recognised the importance of attempting to make use of my research participant's language where possible and to use the SSI flexibly in an attempt to create more of a conversation (Smith et al., 2009) and thus build rapport. I also recognised that my proposed sample were an 'elite' sample who would have more knowledge about leadership than I and would be "alert to the implications of questions, and of their answers" (Gillham, 2000, p. 54).

Interview procedure

When the participants emailed me agreeing to participate in the interview (as indicated in the recruitment section) they were offered to be interviewed at their NHS base (n = 3) or at The University of Leeds (n = 4). The interviews lasted between 52 minutes and 1 hour and 19 minutes. At the beginning of the interview, I reminded participants of the nature of the research and the rationale for conducting the study. They were provided with an information sheet and a consent form and I was available to answer questions they had about the research. Some participants asked further questions at this stage with regard to their anonymity. I provided reassurance to the participants that caution would be used when selecting verbatim extracts to ensure that individuals were not identifiable. In addition, I reiterated that consent would also be asked at the end of the interview to put the participants at ease during the interview process.

During the interview process I attempted to use the participants' own language where possible. I also used the interview schedule flexibly, with the aim of creating 'a

conversation with purpose' (Smith et al., 2009, p. 57). For example, some participants pre-empted a few of the questions on the interview schedule. Therefore, in order to follow the natural flow of the interview, I responded by altering the order in which the questions were presented to best suit the participant and maintain a 'conversation with purpose'.

I was conscious of the need to provide space for participants to contemplate and reflect, this was especially true of the penultimate question, which required participants to conjure up a phrase, image or metaphor that described leadership. Some participants appeared concerned about the time they were taking to formulate their answer. At this point I reassured them to take their time to think.

All of the interviews were audio-recorded and then transcribed including all of the non-semantic content (e.g. laugh, sigh, hesitate). I transcribed two of the interviews. Due to time constraints the remaining five interviews were transcribed by professional transcribers who were paid for doing this by The University of Leeds. I also did quality checks by assessing the accuracy of the transcription of each transcript. This was done by listening to the audio whilst reading the transcript. If any inaccuracies were noted I then made the necessary amendments.

Table 3: Transcription conventions

Writing convention	**Meaning**
…	Pause
[ ]	Material removed from transcript including verbal utterances e.g, 'er…' and 'um..'
[and then]	Text added to extract to make the extract more understandable
(laughs)	Description of the participant's behaviour

Data analysis

Data from the SSIs was analysed using IPA. This involved analysing each participant's transcript individually to identify superordinate themes and subthemes. Once this process was complete the group analysis was conducted. Below I will describe the data analysis process for the individual analysis and then for the group analysis.

Individual analysis

The individual analysis involved reading and re-reading the transcript to immerse myself in the data and the participant's experience. During this phase segments of the transcript were identified using different coloured highlighters as 'business' (introducing the rationale of the study, agreeing on consent, ending the study), 'opinion' (participants stating their view on a topic rather than stating their own personal experience) or 'experience' (where participants talked about an event and described a self-contained story identifying thoughts, feelings and/ or actions).

The business segments of the transcript were put to one side whereas the opinion and experience segments were utilised to identify descriptive, linguistic and conceptual comments (as recommended by Smith et al., 2009). The descriptive comments were identified as being descriptions, assumptions and figures of speech utilised by the participant whereas the linguistic comments involved commenting on the participant's use of language (their use of metaphor, pauses, tone, laughter or fluency of speech). Finally, the conceptual commenting involved making interpretations about the participant's text which involved me using my life experience and psychological knowledge to question the text in an attempt to open up new meaning of the participant's text. These three types of comments were made in the right hand margin of the transcript. I made descriptive comments in regular font, linguistic comments in italics and I underlined the conceptual comments (as recommended by Smith et al., 2009). I then listened to the audio recording again to see whether my comments fitted with the participant's description of their experience. If I noticed a potential mismatch I made note of this and re-visited this part of the transcript to ensure that the comments and experience matched.

The descriptive, linguistic, conceptual comments and notes were used to construct emergent themes (appendix G). These emergent themes and their associated verbatim extracts were then placed into three different word documents dependent on whether they described the participant's 'successful' leadership experiences, less successful leadership experiences or those leadership experiences they described when they perceived gender to have affected their ability to lead. I re-listened to the participant's audio recording to assess the fit with the emergent themes.

Table 4: Guidelines of IPA data analysis (adapted from Smith et al., 2009)

Strategy
• Familiarise self with text by reading and re-reading the transcript. Segment the transcript into business, opinion and experience.
• Read the transcript again making note of any significant text which provides an insight into the participant's experience. These notes are made in the right hand margin of the transcript.
• Read through the transcript again making note (again in the right hand margin) of descriptive, linguistic and conceptual comments. Listen to the audio recording and make any necessary amendments.
• Read the transcript and the comments in the right hand margin. Incorporate these comments into the development of an emergent theme. Make note of the emergent theme in the left hand side of the transcript.
• Read the transcript again to check whether the emergent themes have captured the essence of the participant's experience.
• Re-read the transcript and re-listen to the audio recording in an attempt to assess whether the emergent themes fit with the experiences the participants describe. Make any necessary amendments.
• Copy and paste the emergent themes with their corresponding quotes into a new document.
• Cluster the emergent themes according to whether they are similar, different or in conflict with one another. Identify appropriate superordinate theme names for each cluster and their associated subordinate themes.
• Develop a draft pen portrait for the participant whose superordinate and subordinate themes have been identified.
• Follow the same procedure for the remaining 6 participants.
• Refine the superordinate and subordinate theme names for each participant.
• Print out all of the seven participants' subthemes and their associated verbatim extracts. Cluster and re-cluster these themes with other participants' subthemes and associated verbatim extracts.
• Compare the subthemes across all seven participants by identifying similarities, differences and contradictions. Develop superordinate and subordinate group theme names for the group.

These emergent themes and their associated quotes were clustered into a list. By holding the specific research questions in mind, I attempted to cluster and re-cluster these emergent themes together by identifying those emergent themes that were similar, different, or in conflict with one another. During this process I developed theme names for each cluster. After much refinement a final subordinate theme (appendix H) name was decided upon. Additional subordinate theme names were added to describe the categories of

experience within each superordinate theme. I then developed a pen portrait (please see the results section for the pen portraits) to describe the narrative of each participant.

I used the above approach to analyse each participant. Each participant's analysis was completed before I moved on to analyse the next participant. It is important to note that once I had completed all of the individual analyses I revisited and refined some of the earlier analyses. This was because I realised that the process of analysing seven participants' data had improved my IPA skills.

IPA group analysis

All seven participants' subordinate themes and their associated verbatim extracts were printed out. I then attempted to cluster and re-cluster these themes together. This was done by attempting to identify similarities, differences and inconsistencies between the participants' subordinate themes and the associated verbatim extracts. Once this was complete, I then categorised and labelled the samples' different clusters of subordinate themes, which resulted in five superordinate group themes being developed. Numerous attempts were made to re-label these clusters. Developing a superordinate theme name which encapsulated the participants' experiences as well as marrying up with the subordinate themes, proved challenging. Therefore, after my supervisors provided numerous quality checks, the superordinate themes were refined. After experimenting with developing a range of superordinate theme names, it was decided that metaphors might be the most appropriate way of describing the participants' experiences. Therefore, all of the superordinate themes were based on roles that participants appeared to be describing in their accounts.

Additional analysis

An additional analysis was conducted to establish whether the five different superordinate group themes were connected. This was implemented because when I analysed the transcripts, the participants' leadership experiences mapped onto more than one superordinate theme at a time. Therefore, I became interested in understanding whether there were connections between the superordinate themes. In addition, IPA has been "positioned as an integrative approach" (Smith et al., 2009, p. 186) and so long as an IPA analysis has adhered to the principles of phenomenology, hermeneutics and idiography "then researchers may draw upon a considerable interpretative range and make connections with an array of other theoretical positions as part of the process" (Smith et al., 2009, p.

186). Smith et al (2009) identified grounded theory as an appropriate method to use in conjunction with IPA because of the considerable overlap between the two methods. IPA and grounded theory complement one another. An IPA analysis provides a nuanced unique analysis of each participant's experiences whereas grounded theory provides a more conceptually based explanation of the participants' experience. The following section will provide a description of the grounded theory approach that was used to explore the connections between the five superordinate themes.

A grounded theory analysis was implemented to examine whether connections existed between the five superordinate themes. This was done by examining each participant's original transcript and identifying the extracts which mapped onto the different superordinate themes. Attempts were then made to identify the sequence of events, (as described by the participant) and their associated superordinate theme names. Once this was complete for six of the participants, efforts were then made to identify whether a pattern emerged from the sequence of superordinate themes and whether these were consistent across the sample. In addition, attempts were made to identify whether these patterns suggested any overlap between the superordinate themes across the sample of six participants. Finally, theoretical sampling was employed. This involved using the seventh participant's transcript to assess whether the patterns and connections identified were also apparent in participant 7's account, which they were.

Quality checks

The quality of qualitative research can be checked by assessing the credibility of the research. Elliott, Fischer and Rennie (1999) have identified seven quality criteria for qualitative research. These are: 'owning one's perspective', 'situating the sample', 'grounding in examples', 'providing quality checks', 'coherence', 'accomplishing general vs. specific research tasks' and 'resonating with the reader'. Additionally, Yardley (2000) also developed a number of quality criteria which are: 'sensitivity to context', 'commitment and rigour', 'transparency and coherence' and 'impact and importance'. In an attempt to increase the credibility of the current research the following strategies were implemented:

- I read and re-read the data a number of times in an attempt to position myself from different perspectives.

- Both of my research supervisors were females who had had leadership experience as consultant clinical psychologists, which provided further insight into my participants' lived experiences.
- My research supervisors viewed anonymous, verbatim extracts from all seven participants to enhance transparency.
- Tables of emergent themes with anonymised verbatim extracts were presented to my research supervisors. They provided credibility checks and constructive feedback which I made use of when analysing subsequent transcripts.
- I met with another IPA researcher and we discussed anonymised, verbatim extracts with one another. Discussions were had about the interpretation of the data and the development of codes and emergent themes. This process enabled me to approach the data from different perspectives.
- Anonymised verbatim extracts were shared with the qualitative research support group. Discussions were had about how individuals had interpreted the extract differently, which enabled me to interpret the data from different positions.
- After each participant's interview I completed a reflective questionnaire. Pre- and post-data collection I participated in a reflective interview and throughout the research process I kept a reflective diary.

Reflexivity

Analysing data utilising IPA involves the researcher engaging in a reflective process because of the double hermeneutic (Smith & Osborn, 2003) which is made transparent and incorporated into the analysis in IPA to assess the quality and validity of the analysis. In the following section I will describe my own perception and experiences of successful leadership. In addition, I will describe the biases and assumptions that engaging in a reflective interview, keeping a reflective journal and completing a post interview questionnaire highlighted to me.

Reflective interview

I participated in a reflective interview in an attempt to uncover my own beliefs, assumptions and biases. This was done so that I could remain conscious of any potential biases operating when I was interpreting the participants' data. The pre- and post-data collection reflective interviews were conducted by another PICT. She interviewed me using my interview

schedule and I responded to the questions as if I were a research participant. Both the interviews were recorded and later listened to. The aim of this was to gain an insight into my own assumptions and biases and to capture any potential change in my thinking. This process enabled me to recognise that the process of interviewing the participants had changed my expectations and definition of what "successful" clinical leadership is. I recognised that prior to the interviews I had naively assumed that participants would be describing leadership experiences where they had successfully managed to influence change among senior executives of the trust. However, after having completed the interviews, I realised that the cost saving measures of the NHS meant that clinical leaders had little power over senior executives and therefore, had to be thoughtful and strategic in how they went about influencing others. I also realised that in order to remain resilient that they needed to be able to accept that they would not always be successful but be able to keep trying.

CHAPTER THREE: RESULTS

Overview of results

This chapter will present the results. Participants' demographic data, leadership activities and leadership experiences will be presented in tables 5 and 8. Participants' leadership experiences will also be presented in tables mapped against (i) the clinical psychology leadership framework (table 9) and (ii) the clinical leadership competency framework (table 10). In the following section pen portraits will be offered for each of the seven participants. The group analysis will then be presented. Initially the findings for the group analysis will be presented in a table outlining the superordinate and subordinate themes. A detailed description of each superordinate theme and its associated subordinate themes will then follow with relevant supporting verbatim extracts from the seven participants.

Participant anonymity

As participants have been selected from a small pool of individuals, I have attempted to protect the participants' anonymity and therefore, decided not to map demographic details, leadership descriptions and leadership experiences against specific participants. Additionally, all participants have been assigned a pseudonym to protect their anonymity.

Table 5: Participants' demographic data

Demographic	**Participant response**
NHS Agenda for change banding	8c (x4) 8d (x3)
Carer status	Not a carer (x4), Yes a carer (x3) caring for 1-2 children (x3) & 1 parent (x1)
Partner status	No partner (x1), Yes partner (x6).
Work part-time or full-time	PT (x5), FT (x2)
Number of hours contracted to work	< 25 hrs a wk (x1) 26-30 hrs a wk (x4*) 37.5 hours a wk (x2)

* 2 stated that they worked longer hours than they were contracted to work.

Table 6: Participants' description of their job role

Participants' description of their job role
Ensuring safe and effective practice
Managing waiting lists
Managing people
Managing the psychology team
Marketing psychology to others
Developing training packages
Ensuring there is a provision for training and supervision
Delivering consultation
Developing service delivery models
Facilitating service transition
Influencing other MDT services
Influencing policy

Table 7: Key to identify participants in tables 9, 10 and 11

Participant pseudonym and corresponding number
1. Astrid
2. Caroline
3. Tara
4. Elaine
5. Melanie
6. Anna
7. Mary

Table 8: Participants' descriptions of their leadership experiences

Participants' description of their perceived successful leadership experiences	**Participants' description of their perceived less successful leadership experiences**
• Influencing a trust wide training strategy • Influencing clinical staff to become engaged in the service re-design. • Influencing the service manager to secure additional funding for psychology staffing. • Influencing the trust to adopt a specific psychological intervention trust wide. • Influencing a disbanded regional psychology group to come together to share best practice ideas. • Designing a care pathway that was formulation based rather than diagnosis based and influencing staff, commissioners and managers to adopt this approach. • Influencing managerial staff to be more empathic towards SUs needs.	• Utilised *"authoritarian"* leadership style when communicating that having a poor staff to SU ratio was a risk to the trust. She perceived a relationship rupture to have occurred, which she repaired. • Experienced a *"turf war"* with a local authority manager over whose training was most suitable and appropriate. She perceived a relationship rupture to have occurred which she repaired. • Speaking without thinking in team meetings, which she perceived to affect other team members. She perceived that others felt *"uncomfortable"* when this happened. • Experienced a dilemma in decision making about a service re-structure. Either the outcome of her decision would affect SUs or staff. She decided to *"mitigate"* making staff redundant but then the waiting list increased. She reflected that she had been *"too"* compliant with the senior executives. • Being informed that a psychology post had been de-banded. She described feeling *"dysregulated"* and described experiencing a relationship rupture with her manager. However, managed to repair this rupture. • Attending a meeting where an anonymous complaint was made by a staff member. She perceived the senior team to be targeting this staff member. She described standing up for the staff member but perceived a relationship rupture to have occurred with the team, which she repaired.

Table 9: Participants' description of their successful leadership experiences mapped against the clinical psychology leadership framework (BPS, 2010)

DCP Leadership Framework Skills	**1**	**2**	**3**	**4**	**5**	**6**	**7**
CLINICAL							
Ensure psychological formulation work is appropriately shared	+			+			
Embed an educated approach and systematic approach to …						+	+
Collate outcomes for clinical psychology and benchmark						+	
Set quality targets aligned to legislation/ national frameworks							
Inspire support manage others to develop a culture of …	+	+	+	+	+	+	
Monitor quality assurance of psychological practice across …				+		+	+
Support the national assessor system for consultant psychologists							
Engage/ motivate and support other clinicians and …	+	+	+	+	+	+	+
Remain fully aware of the political, social, technical …	+		+		+	+	
PROFESSIONAL							
Inform and join in trust wide clinical governance groups						+	+
Develop leadership throughout the profession, mentoring those …	+			+	+	+	+
Ensure the quality and value for money of psychology is …	+	+		+	+	+	
Board level marketing of effective psychological services				+	+		
Strengthen the identity of the profession and support the …							
Inform board commissioners, SHAs, National task groups/ DOH …	+		+	+	+		+
Advocate a psychological stance in conjunction with or …				+			+
STRATEGIC							
Feedback trends in clinical outcomes to service directors …			+	+	+		
Lead on sharing cost effective service development projects …	+	+		+	+	+	
Market and promote a service/ department/ professional approach		+			+		+
Ensure organisational awareness informs decisions …		+			+	+	+
Market effective psychological service developments internally …		+	+	+	+	+	+
Influence organisational/ health/ economy/ strategy	+		+	+		+	+
Set corporate direction	+		+	+		+	+
Set and evaluate service options			+				+

* Regular font indicates the skills for a consultant clinical psychologist, italic font indicates the skills for a clinical director.

Table 10: Participants' description of their successful leadership experiences mapped against the clinical leadership competency framework (NHS Leadership Academy, 2011)*

Leadership skill	1	2	3	4	5	6	7
Demonstrating personal awareness qualities							
Developing self-awareness	+		+	+	+	+	+
Managing yourself.	+	+	+	+	+	+	+
Continuing PPD	+		+	+	+	+	+
Acting with integrity	+	+	+	+	+	+	+
Working with others							
Developing networks	+		+	+	+	+	+
Building and maintaining relationships	+	+	+	+	+	+	+
Encouraging contribution	+	+	+	+	+	+	
Working within teams	+	+	+	+	+	+	+
Managing services							
Planning	+	+	+	+	+	+	+
Managing resources	+	+	+	+	+	+	+
Managing people	+	+	+	+	+	+	+
Managing performance	+		+	+	+	+	+
Improving services							
Ensuring patient safety	+	+		+	+	+	
Critically evaluating	+	+	+	+	+	+	+
Encouraging improvement & innovation	+	+	+	+	+	+	+
Facilitating transformation	+		+	+	+	+	+
Setting direction							

Identifying contexts for change	+	+	+		+		+
Applying knowledge & evidence	+	+			+	+	+
Making decisions	+	+	+	+	+	+	+
Evaluating impact						+	

Leadership experiences

Participants described leadership experiences which mapped onto the clinical psychology leadership framework (table 9) and onto the clinical leadership framework (table 10). These two frameworks were chosen because they provide a framework for clinical leadership, rather than leadership per se, as the more recent Healthcare Leadership Model (NHS Leadership Academy, 2013) describes. With regard to those leadership experiences which mapped onto the clinical psychology leadership framework, participants described experiences which most commonly mapped onto the clinical skills, specifically the ability to "engage/ motivate and support other clinicians and managers both organisationally and through networks" and their ability to "inspire, support /manage others to develop a culture of innovative clinical practice/creative solutions". In addition, participants' descriptions of their leadership experiences frequently mapped onto the strategic skill of "lead[ing] on sharing cost-effective service development projects across services and profession". Each participant's description of their "successful" leadership experiences mapped onto an average of 7.3 different clinical psychology leadership framework skills. According to participants' descriptions of their leadership skills it appears that they were using multiple leadership skills per leadership experience.

Participants' descriptions of their leadership experiences were also mapped against the clinical leadership framework skill. Based on participants' accounts it appears that they were utilising the majority of the skills from the clinical leadership competence framework. The clinical leadership skills that mapped onto all participants' accounts were as follows; 'managing yourself', 'acting with integrity', 'building and maintaining relationships', 'working within teams', 'planning', 'managing resources', 'managing people', 'critically evaluating, 'encouraging improvement and innovation' and 'making decisions'. The majority of these skills appear to parallel the core competencies of a clinical psychologist. In addition, the remaining skills appear to be related to cost-effectiveness, which is not

surprising given the current economic climate and the pressure on services within the NHS currently.

Pen portraits

In this section I will present the pen portraits. These will provide contextual information about each participant. A description of participants' understanding of 'leadership' and the different leadership strategies will also be included. Quotations from participants will be presented in *italics*.

1. Astrid

Astrid's interest in this research was about wanting to contribute to the leadership development of junior NHS clinical staff. She also said that she was *"interested in thinking about clinical leadership and management"* (line 29) as she perceived them to be in conflict with one another. Interestingly, she did not mention having any interest in the research related to female leaders. However, she did share later in the interview that she had experienced sexism which she had perceived to have been directed at her. She described two leadership experiences which were both about leading a service re-structure.

Astrid saw herself as a *"clinician"* who was *"representing the clinical need of the [SUs]"* (line 63). She understood leadership to be about "*swim[ming] alongside others and kind of push[ing] people in the right direction"* (line 504). Astrid described doing this by leading in accordance with her values, which involved her giving others a *"voice"*.

She made a point of noticing when individuals had a *"difference"* of opinion from her and then *"aligned"* herself with these individuals, by taking them for a coffee and a chat. She described feeling influential using her clinical skills by "*ask[ing] them questions that they [were] interested in answering […] to engage them"* (line 314). She accepted her own and others' limits as she realised that not everyone was *"going to buy"* (line 334) what she had on offer. Therefore, she described learning to *"take people's flak"* when individuals did not accept or agree with what she had on offer. However, when no one accepted a decision that had to happen she said *"we have to do this, this has to happen, and that's the end of the line"* (line 217). She perceived that sometimes you have to take an authoritarian stance in a leadership role.

Although Astrid accepted that sometimes "*I have to make decisions that I don't like"* (line 417). She described feeling conflicted when the decision she had to make was incongruent with her values. She then described feeling guilty and regretful of having made

the decision. However, by being a reflective practitioner she concluded that *"I can only do what I can do, and as long as I do it to the best of my ability, I can't ask anymore of myself" (line 408)*, which again suggests that she accepted her own and others' limits.

2. Caroline

Caroline said that the she had become interested in the research as she had wondered whether her "*experience of leadership was different to a man's*" (line 9). During the interview she appeared to answer this by stating she had experienced *"benign*" sexism in her role. She described feeling excluded from *"the old boy's network"* (line 256) and talked about feeling vengeful in response to this exclusion.

Caroline also stated that she was "*not as successful [as she] would like to be" (line 63),* however, she accepted that it was "*a difficult environment [to lead effectively] within the NHS" (line 65)* and also perceived her trust to be "*anti-psychology".* She described coping with this by *"feeling nostalgic"* and by perceiving leadership to be about doing *"the best you can but [not] always win[ing]".* The two leadership experiences that she described were; influencing the trust to implement a trust-wide psychological intervention and protecting the psychology budget.

Being a critic, Caroline developed arguments for a solution she had identified. These arguments were then presented to the individuals she was attempting to influence. In the face of *"huge resistance"* she described feeling resilient and arranged further meetings with the individuals she was attempting to influence, which she said took *"an awful amount of explanation"* (line 241). However, by presenting further recent research that supported her argument, the individuals she was attempting to influence *"loosened up"* and negotiated meeting her half way. She described feeling disappointed that she had not managed to fully negotiate her needs. However, she reflected that sometimes all you can do is "*damage limitation",* which suggests that she began to feel accepting of her limits and the limits of others.

3. Tara

Tara felt *"good"* for taking part in a study about female leaders in healthcare *"because it's a different area of focus".* She also felt *"shock[ed]"* that no previous research had been conducted on this topic. When talking about her leadership, she struggled to feel successful as a leader, stating that *"being a successful leader in the NHS … is a moot point politically*

(laughs)" (line 54). She also described leadership as having crept up on her and that she had *"been lucky"* not to have been the target of sexism in the NHS. However, she did say that she had not *"come across a lot of overt discrimination"* (line 397) but she did not say whether she had come across covert discrimination.

Tara believed that clinical leaders have *"got to be different things in different places"* (line 62) and described herself as being adaptable. She perceived leadership to be about "*being integral and genuine",* which fitted with her need to lead in accordance with [her] values. Tara described these values as being *"fair", "open" and "equal"*. When she experienced inequality, she described feeling justified to *"challenge"* decisions that were "*not in the best interests of the staff or patients that [she] was working for"* (line 383). She said that leaders needed to be aware of "what lines [they] will and won't cross" because standing up and disagreeing *"sometimes put[s] you in an uncomfortable position or a … vulnerable position"* (line 367). However, by bringing people together she described feeling stronger together by*"shar[ing] what's happening" to have "more influence and power"* (line 156).

4. Elaine

Elaine was interested in participating in the research because she was *"keen to support trainees"* (line 8). She also described feeling "*surprised"* and *"flattered*" at having been asked to participate. By reflecting on her transition into her current post, she described having felt "*frustrated"* in a previous role. She then said she had begun to feel passionate and *"excited"* about transitioning into a different service, which was how she secured her consultant post. Elaine perceived others to view her as a 'successful leader' but felt that she was "*playing catch up"* (line 48) with herself. This was because she found the transition into her current post a *"steep learning curve"* (line 55) as she had experienced that *"some of [leadership is] just learning by experience"*.

She also perceived leadership to be about *"scaffolding, enabling and facilitating"* (line 626) others to *"hold [SUs] in mind"* (line 314). Elaine noticed that management spoke about SUs in a *"distanced and removed way"* (line 288). Feeling different as a clinical psychologist she designed interventions to increase managements' capacity to feel empathic towards SUs. She then described feeling able to connect managers with SUs experiences.

When decisions affected SUs care, Elaine *"felt strongly***"** about speaking up to *"get […] the best"* she could for SUs. She even described becoming involved in a *"turf war"*.

When reflecting on this, she recognised when there had been a *"rupture and need for repair" (line 450).* By using her *"therapeutic skills"* was able to create a "*shift"* in the relationship with the individual(s) she had had a rupture with. She reflected that she found the work *"challenging"* but felt that she had *"earnt [her] money today".*

5. Melanie

Melanie said she had participated in the interview because she did not "*turn down trainees' requests"* (line 9) and that the topic had *"personal relevance"*. When reflecting on her success as a leader, she said she had *"done well"* to secure a consultant post but sometimes felt *"slightly fraudulent".* She said that she could not *"bear the bloody term"* 'leadership' and that it was *"just [about] making things happen".* However, she did also say that she perceived herself to be a *"clinician"* whose role it was to ensure that staff deliver *"safe clinical practice",* which fitted with her perception that leadership was about feeling motivated to overcome injustice.

Melanie described feeling constrained by her gender as a leader; where she would feel guilty and embarrassed if she behaved *"authoritatively*" and therefore, would "*try and moderate"* her behaviour to be more *"diplomatic and tactful".* She described developing a solution that individuals would *"own and see the clinical sense"* as well as meet the demand *"for information".* She also described feeling persuasive as a psychologist*"selling"* her solution to clinical staff (with whom she emphasised the clinical sense of her solution) and management or commissioners (with whom she emphasised the demand for information).

Earlier on in her career she described feeling free to create *"innovative"* solutions because she felt she was *"doing something that was important and worthwhile".* However, she recently had begun to feel disappointed with the Trust's decision making as she felt less able to *"do"* the things that she wanted to achieve. She also described feeling sceptical of the decision making of the Trust, asking herself *"what is the point?"* if you cannot do things differently.

6. Anna

Anna identified that the research topic "*felt salient"* as she had experienced *"men taking credit"* for her successes. She also described wanting to use the interview to *"reflect"* on how she perceived her own success. Interestingly, she described feeling uncomfortable being called a "successful leader" as she perceived leadership to be *"a team endeavour"* and

understood it to be about *"empowering others"* (line 400). This approach was used to influence her manager to gain the funding for a member of staff and influencing a decision regarding the pay band of a psychologist.

By developing *"good working relationships"* and an *"understanding"* of others, Anna was able to empathise with the individuals she was trying to influence. By doing this, she felt able to effectively pitch her *"solution"* to an individual's needs. She said *"these are my concerns. This is what I think will happen if we are unable to deliver and this is what I think needs to happen"* (line 337). Anna also described feeling open to accepting compromises if she *"needed"* to.

Anna's *"team endeavour"* leadership approach led her to *"feel excluded"* when others *"did not credit"* or include her. She also described feeling *"dysregulated"* when she felt excluded and said that this led her to behave in ways she later regretted. However, by having *"time to think"* and reflect she was able to make sense of the dynamics that had emerged. For example she formulated that her colleague *"often doesn't contain himself. So in an attempt to be efficient, he sends things out too quickly to manage his anxiety" (line 380).* This enabled her to recognise that she needed to position herself differently in an attempt to repair their relationship because they *"had a big falling out […] but its ok now"* (line 399).

7. Mary

Mary was interested in participating in the research because she wanted to understand *"what women bring"* to leadership that is different from men. She hoped that the interview would enable her to reflect on her experiences as a female from a black minority ethnic (BME) background because of the "*the way that people respond to us and the comments that we might … get from people*". She talked about two leadership experiences; influencing a trust wide training strategy and advocating on behalf of a staff member she perceived to have been mistreated.

Leading by her values was important for Mary as she wanted to be *"equal"* and *"fair*" towards SUs and staff. She perceived leadership to be relational where leaders supported and developed others. However, she also perceived leadership to be about having access to people with "*power and influence*" and "*knowing their motivations".* Once she perceived herself to have gained *"professional respect"* from the individuals she wanted to influence, she described taking the *"opportunity"* to push

where it moves. Mary did this by developing arguments and producing written documents to provide evidence for her proposed solutions which were presented to the individuals she was attempting to influence.

Mary described herself as "ambitious" rather than "*successful"* and said that she feels *"like a work in progress"* where her leadership success *"fluctuates".* She described an example of leadership where she wished she had responded differently. Here she talked about feeling angry when she witnessed *"injustice[s]"* and described feeling "*railroaded"* into playing *"devil's advocate"* where she would then stand up and say *"that's not right, that's not fair".* Although she perceived this to have shifted the team's perspective, she also thought that others could perceive her as a *"trouble maker".* Therefore, her ability to reflect and adapt enabled her to conclude that she could be more influential if she were calmer and *"smarter about alliances*".

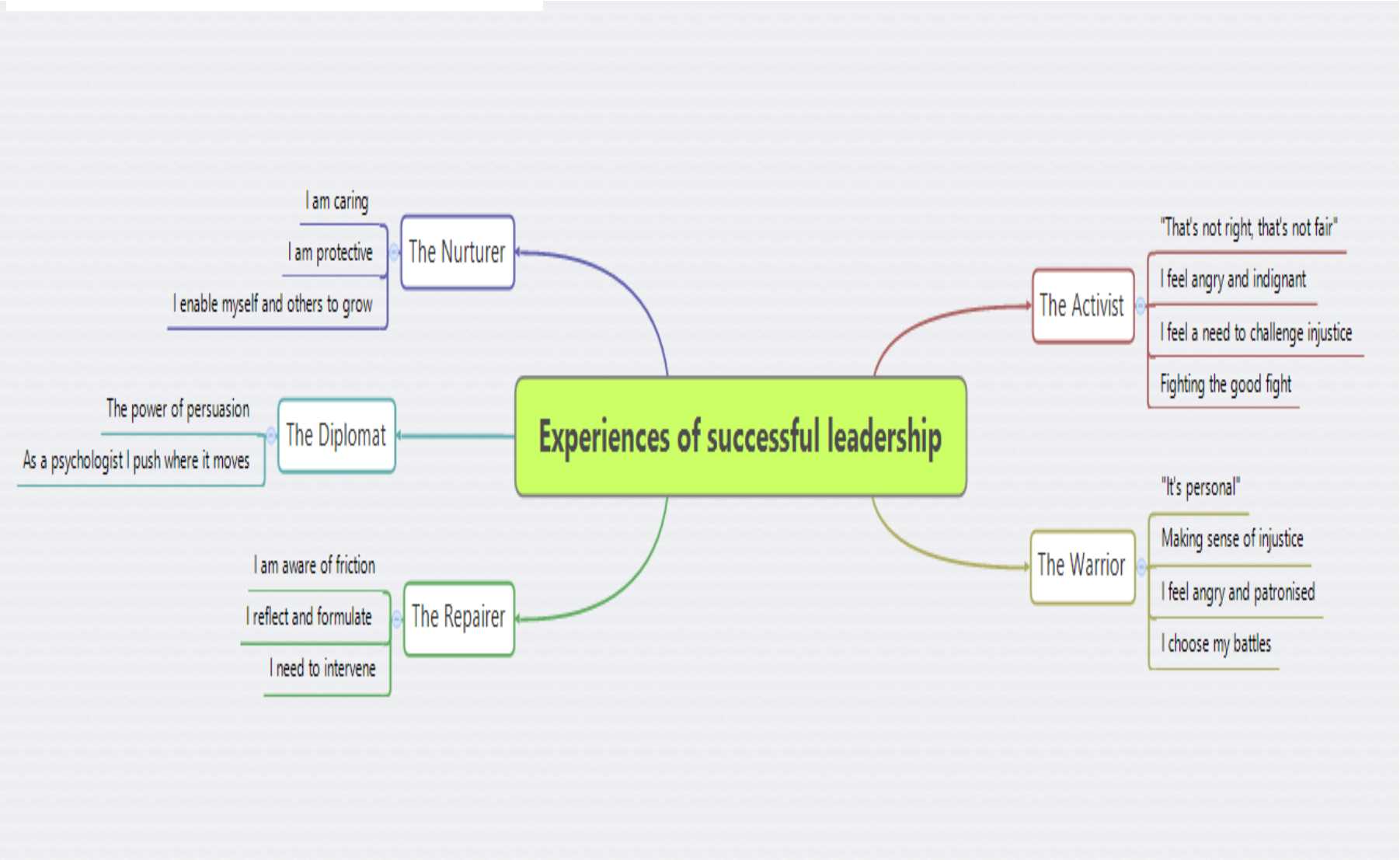
Group analysis

An overview of the group analysis will be provided in the following section. Each **superordinate** theme will be presented in bold with a brief description of the overarching theme. Associated *subordinate* themes will then follow and be presented in *italics. A* description of each of the *subordinate* themes will be offered and supported with the use of participants' extracts. In total there are five **superordinate** themes and fifteen *subordinate* themes (see table 11). An additional analysis was conducted to explore whether these five superordinate themes were connected or inter-linked. A description will be offered of how these five superordinate themes are related to one another.

Table 11: List of the group of superordinate themes and associated subthemes

Superordinate theme Subordinate theme name	1	2	3	4	5	6	7
The Nurturer							
• *I am caring*		x	x	x	x	x	x
• *I am protective*	x	x	x	x	x	x	
• *I enable myself and others to grow*	x			x		x	x
The Diplomat							
• *The power of persuasion*	x	x		x	x	x	x
• *As a psychologist I push where it moves*	x	x		x	x	x	x
The Activist							
• *"That's not right, that's not fair"*	x		x	x	x		x
• *I feel angry and indignant*	x			x	x		x
• *I feel a need to challenge injustice*	x		x	x	x		x
• *Fighting the good fight*	x		x	x			x
The Warrior							
• *"It's personal"*	x	x			x	x	x
• *Making sense of injustice*	x	x		x	x	x	x
• *I feel angry and patronised*	x	x			x	x	x
• *I choose my battles*	x	x			x	x	x
The Repairer							
• *I am aware of friction*	x			x	x	x	
• *I reflect and formulate*	x	x		x	x	x	x
• *I need to intervene*				x	x	x	

Figure 1: Thematic map of the group themes



Superordinate theme: The Nurturer

Superordinate theme	**The Nurturer**
Subordinate theme	*I am caring*
	I am protective
	I enable myself and others to grow

Participants described being protective and caring of their services, staff and SUs. They described needing to balance their care towards staff with getting the job done, to ensure that SUs were cared for by staff. They also talked about recognising the need to develop themselves and their staff so that their service could deliver effective care. This involved participants recognising and accepting that they wanted to remain in control and keep hold of their responsibilities as well as needing to delegate and let go of control. Participants talked about recognising when they were either too caring or too controlling. They reflected on their need to develop themselves and their staff to ensure that their service would deliver the care that they had been commissioned to deliver.

Subordinate theme: I am caring

Six participants described wanting to look after their SUs either directly (e.g. that trust decision making should hold SUs at the fore) or indirectly (e.g. by ensuring that their staff were cared for so that they would then be available to care for SUs). Participants talked about feeling passionate about the services that they delivered. Melanie shared that she *"felt very strongly about the lack of services on the ground for [specific SUs]"* (Melanie, line 117) and said that this was what had attracted her to the post. Participants also described running their services in a caring way. For example Tara talked about managing the waiting list by ensuring there were "*certain criteria for urgent referrals but that [these were] equally and fairly applied"* (Tara, line 377) to ensure that all SUs were treated fairly. Putting SUs at the heart of all decision making was a value that participants described holding. Elaine said she often asked herself "*how will this benefit that [SU] or that [SU}? And if it's not going to then why are we doing it?"* (Elaine, line 675). She described her work to be about influencing *"the movers and the shakers*" so that they would start *"holding [Sus] in mind, holding their needs in mind and thinking about […] … their emotional needs"* (Elaine, 314).

Participants spoke about being caring towards their staff as well as their SUs. They perceived that caring for their staff would enable their staff to be able to care for the SUs. Anna described attempting to "*contain staff"* (Anna, line 205) during a service re-structure to keep them *"functioning"*. In addition, participants' accounts suggested that they perceived their immediate psychology team to be like a *"family"* (Caroline, line 335) that their role was to try and *"maintain some harmony"* so that the team could function. This description draws parallels between the role of a leader and the role of a parent, where parents accept that there will be difficulties within the family but that the family will work together to resolve these difficulties.

Subordinate theme: I am protective

Five participants described feeling protective of their service, SUs and staff. Melanie's account provides an example of this, as she talked about preparing her service for the future. She asked herself "*what's coming down in the future? What do we have to do to prepare ourselves for the things that we can anticipate coming down the line?"* (Melanie, line 215). This need to plan ahead to safeguard one's service from potential threats was important for the survival of participants' services. Participants also described wanting to *"know that [their] service will survive"* (Elaine, 393). One participant described her service as her *"baby"* (Elaine, line 391), which suggests she felt protective of her service, in a similar way to a parent feeling protective of their child.

Participants also described attempting to protect staff by trying to "*mitigate making people redundant by giving up the vacancies into the financial savings part*" (Astrid, line 353) during service restructures. However, Astrid described having reflected on the decision she had made and said she had got *"really caught up with actually not wanting to be responsible for people not being in a job*" (line 370) to the detriment of running an inefficient service that did not meet SU demands.

Subordinate theme: I enable myself and others to grow

Four participants described recognising their desire to remain in control and keep hold of their responsibilities. However, they also described recognising their need to delegate and let go of control to effectively run a service.

Participants talked about recognising the need to strike a balance between supporting staff and getting the job done. Anna described recognising the need to be "*supportive to the staff, to do what they need to do, to look at other jobs [during a*

restructure] but letting them know that there is still a job to do" (line 240). Participants also talked about recognising that when they did delegate tasks it was important to strike a balance between supporting staff and getting the job done. For example, when Astrid was attempting to engage staff in a service restructure she described recognising the importance of "*giving people time to think of solutions for themselves but at the back of your mind, always having a potential solution that you can put on the table"* (line 512). It appeared that participants perceived that it was important to support and contain staff, before delegating staff tasks, to ensure that the tasks were achievable.

Elaine described *"struggling"* to let go of this need to be *"monitoring"* things. She described being aware of needing to *"delegate"* and to *"not be too retentive about everything"* (Elaine, line 350). She said that this then enabled her to arrange a meeting with the staff in her team *"to identify how much should I do and how much should I not do?"* (Elaine, line 382). Mary's account also provides an example of recognising the need to let go of feeling responsible. She described "*not trusting that the preparation or the supervision or the support [she delivered, would have] a lasting … permanent kind of … effect"* (Mary, line 815). However, she described realising that staff *"can still use the line management and the encouragement and support that I have given them before, to be able to […] …think things through and then, when I am available, to then be able to reflect on it"* (Mary, 825). She also recognised that by doing this, she was also able to give herself *"a break"* (Mary, 830).

Superordinate theme: The Diplomat

Superordinate theme	**The Diplomat**
Subordinate theme	*The power of persuasion*
	As a Psychologist I push where it moves

Participants talked about using a range of skills, which paralleled the skill set of a Diplomat e.g. building relationships with a range of individuals, (including staff, managers, commissioners, senior executives) negotiating and influencing. Participants said that securing a consultant post had given them access to individuals with *"influence and power"*. Once participants had described accessing these *"powerful"* individuals, they talked about building rapport and understanding these individual's motives. By holding their motives in mind when negotiating, participants described finding a solution that benefited all parties (SUs, staff, management, commissioners), which sometimes involved them having to

compromise. They then described using their psychological skills, in particular their formulation skills, to 'push where it moves'. This involved them formulating and recognising where a system was most susceptible to being influenced and exploiting this, using their psychological skill.

Subordinate theme: The power of persuasion

Six participants talked about using their rapport building skills to understand the motives of the individuals they were attempting to influence. They talked about attempting to get *"people who are at that higher level, whose work is […] very corporate, to bring them to that experience of what it's like to be a front line care coordinator"* (Mary, line 488) as well as "*holding SUs in mind"* (Elaine, line 314). Participants described needing to engage individuals before attempting to influence them. *"If you can't get their interest or they don't think you're worth engaging with, or you're not going to hear or be interested in their point of view, then they're not going to engage in the process"* (Astrid, line 318). Participants also talked about building trust with the individuals they were attempting to influence. For example, Mary perceived she had gained *"the professional respect"* (line 512) of management because they had "*some experience of me and of what I'm talking about"* (Mary, line 517). The majority of participants described situations where they had gained *"credibility"* and perceived that this had enabled them to access other opportunities e.g. be invited to contribute to policy or be invited to influence trust strategies.

Three participants also described engaging people by developing solutions that created *"the best possible outcome for everybody"* (Elaine, line 649). They described doing this by understanding how their solution was relevant and useful to the individuals they were attempting to influence. Participants attributed their success to having held the motives of each individual in mind when selling their solution to each professional group. For example, Melanie described needing to find a solution for her service, given the need to document outcomes with the introduction of Government schemes such as payment by results. However, she also described being aware that clinical staff would need to routinely collect outcomes measures to meet this demand. Therefore, she decided to *"have measures that [were] absolutely relevant to the clinical work, so I have the clinical staff who do it and then let's sell it [staff's adherence to completing the clinical measure] to the commissioners"* (Melanie, line 78), which enabled her to develop a solution that benefited both the clinical staff and the commissioners.

Subordinate theme: As a psychologist I push where it moves

Six participants described using their skills as a clinical psychologist to formulate where an individual or system was most susceptible to being influenced and exploiting this. For example, Astrid talked about applying her therapy skills to understand how best to influence an individual to enable things to move forwards. She described modelling empathy to the individual that she was attempting to influence by using her

"systemic training [which …] helped me to understand that if I'm the one [trying] to influence somebody's decision making, if I'm having a conversation with somebody who has a very different view than me within leadership or management, rather than a clinical area. I need to ask the things in a way that is going to hook them into the conversation, that's going to make them think, I'm someone who is worth having a conversation with" (Astrid, line 236).

Participants also described using their empathy and clinical skills to influence larger systems. Anna's account provides a description of how she influenced a decision during a service restructure. During this time the ratio of staff to SUs dropped and she said this had resulted in staff and SUs feeling *"anxious".* She described using her psychological skills to complete a *"risk assessment",* which she felt enabled her to say

"*these are my concerns, this is what I think will happen if we are unable to deliver and this is what I think needs to happen […]. And if my recommendations weren't er…. picked up […] it wouldn't be good for the trust, it wouldn't be good for the SUs and staff"* (Anna, line 331).

She concluded by saying "*I think my intervention at that point was quite instrumental to getting things moving"* (Anna, line 321) as she described having secured additional funding for a 0.5 whole time equivalent post. However, she did say that she had been willing to compromise because she *"needed"* to. Caroline also was able to compromise when she perceived herself to be doing *"damage limitation".*

Participants also talked about using their psychological knowledge to influence trust wide decisions. An example of this is provided by Mary's account. She described being invited to advise her trust on a trust wide training strategy. She said that she recognised that

"it's not just about sending people on […] training and expecting them to offer family therapies and CBT for [specific psychological difficulty]. It's about the trust board saying 'we're going to invest in the workforce, we're going to invest in supervision, we're going to change care coordinators jobs and their job descriptions', so they that they have an

afternoon a week for example, to do one and a half hours [of specific psychological intervention] plus time to do a debriefing and have supervision" (Mary, line 422).

She understood that it was the culture of the team that had enabled her strategy to be accepted and thus implemented. She described recognising that there was "*a new group of managers, who really do believe… authentically believe and I think will put their … will act on what they say, rather than saying something but not changing*" (Mary, line 525). She described formulating that the new management team were open and susceptible to being influenced by a psychologist. Therefore, she described having taken this opportunity to pitch her solution to the trust board.

Superordinate theme: The Activist

Superordinate theme	**The Activist**
Subordinate theme	*"That's not right, that's not fair"*
	Feeling angry and indignant
	I feel a need to challenge injustice
	Fighting the good fight

Five participants described witnessing decisions being made that they perceived to be *"unfair"* for staff and/ or SUs. They then described *'feeling angry and indignant'* in response to this injustice. It appeared that this anger then enabled them to begin thinking about *'needing to do something to challenge this injustice'*. Participants described *'choosing to fight the good fight'*, where they described explicitly challenging the injustice they had observed.

Subordinate theme: "That's not right, that's not fair"

Participants described observing injustice happen in meetings. Mary's account provides an example of this, she described senior clinicians saying that it was *"inappropriate"* for a staff member to have raised an anonymous complaint. In response to this, Mary said she thought *"that's not right, that's not equal, that's not fair"* (Mary, line 717). Tara also described witnessing injustice, she perceived there to be *"issues around ... promotional opportunities and how that happens [in her department and thought that] things should be fair, and open and um equal and I'm not sure that that's always the case [laughs]"* (Tara, line 323).

Participants described noticing staff being treated unjustly with regard to their work conditions. Melanie talked about justice for staff and SUs. She described investigating an

incident by conducting a risk assessment and concluded that "*staff were under so much pressure, they were going from one thing, to one thing, to one thing with really complex and stressful and often high risk cases. So I didn't think it was safe clinical practice and I thought it was no good for the staff"* (Melanie, line 440). These extracts suggest that participants had a moral compass regarding the fair and just treatment of their staff and SUs.

Subordinate theme: Feeling angry and indignant

Participants described feeling angry and indignant in response to observing injustice. Mary said that she had felt "*very frustrated and very irritated and very angry"* (line 666) and that she had *"erupted"* (line 696) in response to the perceived injustice. She also reflected that if *"I feel that there is some kind of injustice going on then I find it more difficult to be very calm or say things in a containing calm manner*" (Mary, line 676). This was similar to Elaine's account where she said that the injustice she observed her SUs face got her *"all fired up"* (Elaine, line 328). Melanie talked about the injustice that her staff face and said that in response to this injustice she "*wade[d] in with [her] size nines"* (Melanie, line 446) to discuss this incident with the team managers. Astrid also talked about the injustice affecting her staff where senior executives imposed cuts to the service. However, when the waiting list began to increase, the senior executives then said "*look at our waiting list!".* Astrid described reacting to this by thinking *"no shit Sherlock!"* (Astrid line 380). Tara described her anger less explicitly. Her tone of voice suggested that she felt indignant, when she said that it would be *"unacceptable"* for her not to *"stand up"* for the rights of staff and SUs.

Subordinate theme: I feel a need to challenge injustice

Participants described feeling the need to challenge injustice explicitly. Mary described "trying *to put something completely different in [to the conversation that the team were having] and changing it around. So this person wasn't the problem, this person has actually given us an opportunity"* (Mary, line 680) to think about how to enable staff to raise complaints in a safe way. There was a sense of Mary wanting to offer an alternative narrative that the group had not considered to get them thinking, whereas, Melanie described feeling a more impulsive need to challenge the injustice. She *"decided that the best policy was for me to wade in with my size nines [to] the team around whom this investigation had been based"* (Melanie, line 446). Melanie's perception that she had *"the best policy"* to challenge this injustice suggests that she also felt responsible for doing something about the

injustice. This sense of responsibility was also identified by Tara. She said "*if there's a situation where I think, 'actually maybe this isn't quite fair', I will say it because I feel that is my responsibility to say it"* (Tara, line 334). Astrid also described feeling responsible for challenging decision making that was incongruent with her personal integrity. She said *"I'm going to have to make decisions that I don't like, but then I'm going to say […] 'this is a decision where I feel I'm being pushed too far against my own sort of internal integrity'. I'm going to say 'no, I'm not prepared to do it'"* (Astrid, line 413). This sense of responsibility for standing up and challenging injustice was also apparent within Elaine's account. She talked about the injustices that her SUs experienced and management were emotionally *"removed"* from her SUs experiences and how she felt that it was

"important that that information gets relayed to those people in those settings. And I'm somebody more than a lot of other people, who I'm in the position to do that, I can do that with the work and I'm talking to the movers and shakers and that feels a really important role and a responsible position to be in" (Elaine, line 330).

These extracts suggest that participants felt a sense of responsibility to challenge the unjust decision making they had witnessed.

Subordinate theme: Fighting the good fight

Participants described fighting the good fight to overcome the injustice they felt had affected their staff and SUs. They also described challenging the injustice explicitly. For example, Mary described being *"able to disagree"* (Mary, line 704) and position herself as *"devil's advocate"* (Mary, line 716) when she challenged the injustice. She also said to her team "'*no, I think we're missing the point here. I think this person has been really courageous' […]. I think we also need to think about whether this is a view that other people share and the more we talk about this person and the 'inappropriateness'. The more we are letting ourselves off the hook'"* (Mary, line 691).

Tara also identified having been *"vocal".* However, she perceived that

"*it did make some people uncomfortable around the table. I didn't actually feel bad about that because I felt that those were the principles we'd all said we were working to […]. I would have felt more uncomfortable if I hadn't said something*" (Tara, line 348).

This fits with Mary's reflections. She said *"I'm glad that I said it because I think if I didn't say it. I would go away and think I have condoned that discourse"* (line 725). Interestingly, both Mary and Melanie identified that taking risks and being vocal "*will probably have its own consequences" (Tara, line 357)* as Mary said that she perceived her

team to see her as a *"trouble maker"* who is not always *"toeing the line, making some decisions difficult [and ...] making people feel uncomfortable"* (line 721). However, they both perceived that the fight had been worth this cost as they did not *"regret pushing it" (Tara, line 357).*

Although Melanie explicitly challenged the injustice, she did not describe feeling content with her decision, as Mary and Tara had. She described having *"a meeting with the team managers [where she] talked about how things could be structured differently"* (Melanie, line 447) in an attempt to reduce the likelihood of this incident potentially re-occurring. However, in response to this she said

"how I got received was a criticism of the existing practice, which is always something you have to be mindful of when you're looking at improvements, is that people's default position is 'well don't you think what we're doing is good enough?'" (Melanie, line 449).

It seems that Mary and Tara felt more content than Melanie about the team feeling uncomfortable when they challenged the injustice. Interestingly, it appeared that Melanie had identified the solution to the difficulty whereas Mary had introduced an alternative narrative to encourage thinking within the team. On reflection Melanie said that *"I'd have done much more of not going in with my model and much more what are the issues for you? And try and get them to generate the solutions really, rather than me coming in a more authoritative way"* (Melanie, line 462), which fits with the approach that Mary described having implemented.

Superordinate theme: The Warrior

Superordinate theme	**The Warrior**
Sub-ordinate theme	I*t's personal*
	Making sense of the injustice
	I feel angry and patronised
	I choose my battles

Five participants perceived themselves to be the target of injustice either during or just before the start of a meeting. They talked about experiencing professional discrimination, sexism, racism and ageism. Participants described experiences where they had been discriminated against by other members of staff and how they made sense of this injustice. Discrimination was assumed if they perceived the perpetrator to have a different group

identity (e.g. different profession, gender, race or age) to themselves. For example, a female from a BME background would assume that injustice directed at her by a white female would be because the white female was racist rather than sexist. Participants then described feeling patronised in response to this perceived injustice. They then talked about choosing whether to stand up and say something or whether it was best to ignore what had happened.

Subordinate theme: It's personal

Five participants perceived themselves to have been the target of discrimination. They described locating the difficulty within the perpetrator, rather than within themselves. For example, Caroline described the trust she was working for as *"anti-psychology".* She perceived the trust to have unfairly *"scrutinised"* psychology services compared to other professions. Locating the difficulty in the perpetrator was also described by participants who experienced sexism. Astrid talked about being promoted over a male colleague whom she described as a *"misogynist".* She said that during a recruitment drive this male colleague had commented "'*how long until she goes off and has a baby?' and 'oh what's the point if she's got a baby [she'll be] going on mat leave but we'll still have to pay her'" (Astrid, line 250).* It appeared that Astrid perceived this to be a personal attack because she said she had just returned from maternity leave before being promoted. Participants also described experiencing more informal discrimination, for example Caroline described a male colleague commenting that he could not swear because *"there's ladies in the room"* (Caroline, line 264). Caroline commented that *"it's kind of benign really isn't it but […] it's sexism"* (Caroline, line 265). Participants made assumptions that it was a personal attack. For example, when Melanie spoke about a male senior executive *"quizzing"* her, she said *"I don't think it was personal but I doubt it"* (Melanie, line 389).

Only one participant talked about women being sexist towards other women. Astrid said *"interestingly, […] the biggest … impact of gender, has actually been with other female leaders […] not with male leaders. […] I have encountered more difficulties, in sort of relationships … with female leaders in the senior management team than male leaders in the senior management team"* (Astrid, line 429). Astrid was talking about an argument that she had had with a senior female executive who she said had been *"aggressive"* towards her.

Two participants talked about their experiences of racism. Again, these experiences involved participants locating the difficulty within the perpetrator. For example, Mary said "*I am not listened to or not respected [because of the] BME stuff*" (Mary, line 887). Anna's

account also suggests that she perceived herself to be the subject of racism and sexism. She said *"often I cannot […] be held in mind about things […] and I don't think that that's because I'm rubbish. I think that a gender and race thing kind of operates and I think it's at an unconscious level"* (Anna, line 389).

Subordinate theme: Making sense of personal injustice

Participants perceived themselves to be the target of discrimination. They described making sense of this by assuming that individuals discriminate against individuals who have a different group identity to themselves. Only Elaine explicitly talked about these assumptions saying "*I'm meeting people […] and they're women, my default assumption is that I will be able to connect with them around this agenda [and] that they will understand where I'm coming from"* (Elaine, line 523). She also said *"I don't know whether I have as strong as an assumption when I go to a meeting and meet somebody new who's a man and I think maybe not"* (Elaine, line 557). When participants were asked the question, "*have you ever experienced gender playing a significant role in your ability to lead?"* participants responded either by saying *"I don't think so, [it's difficult to tell as] it's such a female, you know in the health service provision we've got so many female managers, we've got so many female clinicians"* (Melanie, line 347) or they described experiences where men had been discriminatory towards them. Only one participant talked about women being discriminatory towards other women. Astrid described an incident where a senior female executive had been *"aggressive"* towards her and reflected on this saying

"I don't know if she felt she could be like that because we were the same gender. […]. So she was more able to do that, because I think that, I think a male, […] would have thought twice about doing that [being aggressive] to somebody from a different gender" (Astrid, 459).

Participants from BME backgrounds also described assuming that individuals only discriminate against others from different identity groups to their own. For example, Mary described experiencing a situation where you "*get two [clinical psychologists who are] women and one and er … I see it all the time one person will be listened to and one won't be and the common denominator of the person that isn't listened to is somebody… somebody from a BME background*" (Mary, line 870).

This assumption that individuals only discriminate against individuals from different identity groups was also described by Astrid. She talked about having become a senior leader at a young age and perceived that "*people older than [her]"* had treated her

differently because of her age rather than her sex and that this was the case *"regardless of gender"*.

Subordinate theme: I feel angry and patronised

Participants described feeling angry in response to experiencing personal injustice. When they talked about their experiences of sexism and racism they said that they also felt patronised. Participants' anger was expressed through their voice and their choice of words. Whereas, when participants described feeling patronised they stated this explicitly.

When Caroline was talking about her *"anti-psychology"* trust and the *"scrutiny"* they were under she said

"what I do object to is that they don't scrutinise any other professions to the same level as they do ours. And then that they came to the conclusion, I suppose 2 years ago, that actually the root of the problem was the psychologists!" (Caroline, line 94).

The volume, pace and emphasis that Caroline stressed on the words *"object", "any"* and *"psychologists!"* suggested that she was feeling angry. Astrid's account also suggested that she was feeling angry. When she was talking about gaining a promotion over her male colleague, who was "*pissed off that I got it and he didn't"* (Astrid, 148), she emphasised the words *"piss"* and *"off"* suggesting that she was annoyed he had become *"pissed off"* when she had secured the post over him.

Participants who said they had experienced sexism and racism described feeling *"patronised"* and angry in response to this discrimination. Mary described feeling like this in response to white female clinical psychologists saying "*it's really good that you're here and you're at this level*" (Mary, line 933). She later reflected that experiencing this could be *"completely ridiculous"* (Mary, line 938), her emphasis on the word *"ridiculous"* suggested that she also felt angry.

*Subordinate theme: I choose my battle*s

This theme describes how participants made a decision about whether they should address the injustice they experienced or not. As the participants' injustice became more personal participants described challenging the injustice implicitly or not challenging the justice at all. For example, when Caroline described having to fight to keep the psychology budget she said that it was *"inevitable"* and that "*there [was] no point going, 'I don't want you to do it because I don't think it's a good idea,' because you've got to do it (whispers and laughs)"* (Caroline, line 398). She described doing *"damage limitation"* where she put together an

argument against the proposal and eventually just said *"no".* She then reflected on having adopted this strategy saying that she *"could have lain down and accepted it"* (Caroline, line 454).

In addition, Astrid described explicitly addressing her male colleague for making inappropriate comments about recruiting women because of their ability to access maternity leave. She said you "*could not ask a female candidate if she had children, if she was planning to have children or when she was likely to have them [and that…] it was inappropriate to ask it to either gender"* (Astrid, line 152). However, it is important to recognise that Astrid did not explicitly challenge him about the sexism she perceived to be directed at her, instead she was challenging him about sexism which was directed at women in general. This was interesting because she said that she had wanted to be in a leadership role because "*I would much rather be around a table, having difficult discussions and feeling at least my voice was at the table, that it was heard, than actually not being at the table and not being heard"* (Astrid, line, 123).

Mary stated that if "*I feel that there is some kind of injustice going on then I find it more difficult to be very calm or say things in a containing calm manner*" (Mary, line 679). However, she did not describe responding to the racism she perceived to have experienced in this manner. However, she described coping with this injustice by being "*able to laugh*" (line 937) it off and by thinking that it was *"ridiculous" (line 937)*. However, she did not describe having taken any explicit action to challenge this injustice. Interestingly, when Anna described having taken explicit action to challenge discrimination she said that it then became her *"problem […] as opposed to just not recognising that it was really inappropriate not to …validate or …acknowledge my contribution to this [project she had described], which infuriated me even more"* (Anna, line 288).

Superordinate theme: The Repairer

Superordinate theme	**The Repairer**
Subordinate theme	*I am aware of friction*
	I reflect and make sense
	I need to intervene

This theme encapsulated a process that participants described when they experienced a *"rupture and need for repair"* (Elaine, line 450) within their relationship. Participants described noticing friction within their relationship. In their accounts, they described

reflecting and understanding why and how the rupture had happened. They then described feeling a *"need"* to repair the rupture, which involved them using their psychology skills to intervene.

Subordinate theme: I am aware of friction

Four participants described an event where they noticed friction emerge in their relationship with an individual whom they were attempting to influence. They talked about noticing that they *"rubbed up against each other [and] didn't flow"* (Elaine, line 570). They also talked about experiencing *"conflict"* (Elaine, line 434) within their relationship.

Participants described noticing this friction by attending to the individual they were attempting to influence. For example, Anna said her manager *"was cross and he'd come in thinking he would have a bug bear with me"* (Anna, line 396). Melanie, however, described noticing that the managers she had attempted to influence "*didn't look happy"* (Melanie, line 454).

Subordinate theme: I reflect and make sense

Participants reflected on the rupture that had emerged and described how and why they thought this had occurred using their psychological knowledge. Participants described asking themselves "*what do I need to do? What do I actually need to do to improve things, so that I can have a dialogue with this women and it's constructive because at the moment it isn't"* (Elaine, line 513). It appeared that asking questions enabled participants to reflect and make sense of what had happened. For example, Anna described having received news from her manager that the decision to de-band a psychology post had been made without her, which she perceived led to a rupture within their relationship. By taking the "*time to reflect*" she described noticing that *"he often doesn't contain himself. So in attempt to be efficient he sends things out too quickly and to manage his anxiety – he tried to be very efficient and effective and he should sit on things perhaps sometimes rather than just react"* (Anna, line 369).

Participants also reflected on how their relationship could be improved. For example, Mary said *"I could have used different words or there could have been a way to calm myself down […] I could have been a bit smarter about alliances"* (Mary, line 737).

Subordinate theme: I need to intervene

Participants described feeling a *"need to do something about [the rupture]" (Melanie, line 454).* There was a sense that participants perceived this to be their responsibility to repair the rupture within the relationship. Anna described realising that she *"needed to hold the position which is "I didn't understand the meeting" I didn't appreciate what that meeting was about"* (line 378). Participants need to intervene involved them re-visiting their understanding of what had happened and using this to guide their intervention. Elaine said *"I needed to […] rewind several steps and think about how I was going to engage with her and plan it and think about strategy and approach and proceed on that basis"* (line 571).

Participants described adopting interventions which required them to alter their behaviour. For example, Anna said that after reflecting and making sense of the rupture she realised that

"rather than me going in there and going " I can't believe" {shouting}… After those few days I'd got into a position where I realised that that was probably what he was doing. He was in that that position and needed help […]. So I realised I needed to take the stance of rather than coming in and being cross saying 'why did you do this that and the other' I realised that I needed to hold the position which is "I didn't understand the meeting" (Anna, line 374).

Other participants chose to apologise to the individuals that they were attempting to influence. For example, Melanie said

"I thought 'oh I will catch both of them' and I just said' look, I just feel that that was meant to be helpful and supportive but that wasn't how you experienced it. The last thing I wanted to do was to undermine the good stuff'. They were both like 'thank you' […] and they were able to say how they'd experienced it and they were pleased that I had picked it up" (Melanie, line 456).

Reflections

On reflection, it appears that the superordinate theme names represent five different archetypes. According to Faber & Mayer (2009) Jung defined archetype as an "internal mental model of a typical, generic story character to which an observer might resonate emotionally" (Jung, 1968, p. 307). Therefore, it seems useful to refer to these superordinate

themes as 'archetypes' as they provide a symbolic representation of one's cognitions, emotions and behaviour, which helps to make sense of the participants' experiences.

An additional analysis was conducted to explore whether these five archetypes: The Nurturer, The Diplomat, The Activist, The Warrior and The Repairer were inter-related forming categories and whether these categories connected together to form a process. Below I will present an account of participants' successful leadership experiences and how they mapped onto multiple archetypes. In addition, the participants' successful leadership process will be presented, highlighting the connections between the different categories.

Category 1: Combining The Nurturer and The Diplomat

Participants described their relationships being core to their successful leadership experiences. The archetypes The Nurturer and The Diplomat mapped onto participants' descriptions of successful leadership as outlined below.

For example, Elaine talked about being invited to deliver a presentation about the *"importance"* of her service, *"why does it matter"* and *"what's the evidence?"*. She then said

"I just thought we sit in these rooms talking about [SUs] in a very distanced and removed way and I want a [SU]. I want them to think about a [SU], one particular [SU] and I had a particular case, a really tricky case that I was working with at the time and so I presented that case. It was amazingly powerful, I knew it would be but I wasn't expecting it to have quite an impact as it had and I mean there were tears, people were tearful in the room. It was quite a disturbing case, but the power of that I think […] helped my credibility enormously" (Elaine, line 287).

The archetypes The Nurturer and The Diplomat appear to map onto Elaine's account. She described indirectly caring for SUs by influencing the *"movers and the shakers",* which parallels the superordinate themes The Nurturer. In addition, The Diplomat maps onto her decision to share a case with the team to encourage senior executives to become emotionally connected to SUs experiences.

Mary also described having an aim to influence the senior executives to become more caring towards staff (the superordinate theme The Nurturer). She said

"I've been in meetings with those high level people they say well people should be able to do that that's what their job descriptions are. And it's kind of like… 'well do you do you actually know what it's like for the team managers?' You know you're saying that to your team managers but actually do you know what it's like on a shift […] in the {specific}

service [whereas] if you're sat there as I do […] you know what's happening, so it's trying to translate that" (Mary, line 491).

Participants described having the intention of increasing the caring capacity of individuals with power and influence. However, it was the process that they engaged in that enabled them to integrate the archetypes The Diplomat. Elaine reflected on the decision to present a case, saying

"if I had actually put loads of graphs up […] that's fine, that's really important evidence and information but we've all got access to the graphs you know why it makes sense […] but I just felt that I had something that was different and additional and powerful" (Elaine, line 309).

Mary also described using psychological formulation to recognise when it was best for her to intervene (*'As a psychologist I push where it moves'*). She said that she felt as though she had the *"professional respect"* from the associate director of the Trust and said

"I think that we now have a group of people in the care group who are at that level who seem to have cottoned on that psychological work… is the future. So I think in the past we have had lots of retirements of people… […who] would still be of a different culture of yes you're right psychology is important … but …in reality don't really do anything about it" (Mary, line 520).

The Archetypes The Nurturer and The Diplomat were employed when participants were invited to present a staff or SU perspective on a specific issue. For example, Elaine was asked to provide a presentation about the evidence base behind her service, whereas Mary described having to *"translate"* the reality of working on the front line to management. Therefore, it appeared that participants were able to provide a bottom-up form of leadership whereby the views of the staff and SUs were embraced.

This is in marked contrast to categories 2 and 3 where participants described powerful others imposing unjust decisions and opinions upon them. Below is a description of the archetypes that were integrated in an attempt to address this injustice.

Category 2: Combining The Nurturer, The Diplomat and The Activist

Participants described senior staff making decisions which threatened their staff team, which they felt a need to defend. Those who described experiences which mapped onto the archetypes; The Nurturer, The Diplomat and The Activist appeared to be more successful at

influencing others compared to those participants whose accounts did not include all three archetypes.

The superordinate theme The Nurturer was apparent in Melanie's account. She talked about having to complete a risk assessment to identify why an incident had occurred in her service. She said the reason the incident had occurred was because

"*staff were under so much pressure, they were going from one thing, to one thing, to one thing with really complex and stressful and often high risk cases. So I didn't think it was safe clinical practice and I thought it was no good for the staff"* (Melanie, line 440).

However, it appeared that the superordinate theme The Diplomat was lacking from Melanie's account. She described deciding "*that the best policy was for me to wade in with my size nines [to] the team around whom this investigation had been based"* (Melanie, line 446). This extract suggests that Melanie's experience paralleled the superordinate theme The Activist. However, she described engaging in a process which did not parallel The Diplomat superordinate theme, as she said *"how I got received was a criticism of the existing practice"* (Melanie, line 449). On reflection she said she would have *"done much more of not going in with my model and much more, 'what are the issues for you?' And try and get them to generate the solutions really, rather than me coming in a more authoritative way (*Melanie, line 463). This suggests that Melanie regretted having not been more consultative, which appears to map onto the superordinate theme of The Diplomat.

Other participants described successful leadership experiences which paralleled the integration of The Nurturer, The Diplomat and The Activist. For example, Mary talked about a staff member raising an anonymous complaint. She said that she felt as though she needed to stand up to protect this staff member as the team were becoming critical of them. Mary said

"'*no, I think we're missing the point here. I think this person has been really courageous' […]. I think we also need to think about whether this is a view that other people share and the more we talk about this person and their 'inappropriateness', the more we are letting ourselves off the hook'"* (Mary, line 691).

It appears that the superordinate theme The Diplomat maps onto Mary's account as she used a strategy which parallels the subordinate theme *'As a psychologist I push where it moves'* from the superordinate theme The Diplomat. She also chose "to *put something completely different in [to the conversation that the team were having] and changing it around. So this person wasn't the problem, this person has actually given us an opportunity" (Mary, line 680).* Mary said that by offering this alternative narrative that

"*people agreed and we went down the line of well … how do we canvas everybody's opinion and make it safe to say I agree with this person?"* (Mary, line 731).

It appears that participants' accounts which paralleled an integration of the following superordinate themes; The Nurturer, The Diplomat and The Activist had more success in their leadership compared to those participants who described accounts which did not map onto the core relationship strategies The Nurturer and The Diplomat.

Category 3: Combining The Nurturer, The Diplomat and The Warrior

Participants described senior staff making unjust statements which the participants found personally threatening. Participants whose accounts suggested that their leadership experiences paralleled the integration of the archetypes; The Nurturer, The Diplomat and The Warrior described more successful leadership outcomes compared to those participants whose accounts did not parallel all three archetypes.

For example, Caroline perceived her Trust to be *"anti-psychology"* and said *"what I do object to is that they [the Trust] don't scrutinise any other professions to the same level as they do ours. And then that they came to the conclusion, I suppose 2 years ago, that actually the root of the problem was the psychologists!" (Caroline, line 94).*

The anger in this extract suggests that Caroline felt it was unjust that the psychology staff were being targeted. This appears to parallel the superordinate theme The Nurturer.

Caroline also described being told that the psychology budget would be removed and moved over into a general team budget. She said that she could have fought to keep the Psychology budget as it was *"inevitable"* but that "*there [was] no point going, 'I don't want you to do it because I don't think it's a good idea,' because you've got to do it (whispers and laughs)*" (Caroline, line 398). She described having been strategic and done *"damage limitation […] in a way that protects the profession as much as you can"* (Caroline, line 390). This involved her putting together an argument against the proposal which she described blocked her manager from removing the budget. Her leadership account parallels the superordinate theme The Diplomat as she decided not to fight but to do *"damage limitation"*. It also appears to parallel the superordinate theme The Warrior because she was standing up against personal injustice and injustice to the profession.

Interestingly, some participants described not standing up to personal injustice. For example, Mary perceived herself to be the victim of racism. However, she did not describe challenging this perceived racism. This was interesting given that she had previously stated that if "*I feel that there is some kind of injustice going on then I find it more difficult to be*

very calm or say things in a containing calm manner" (Mary, line 679). Instead, she described coping with this injustice by being "*able to laugh*" (line 937) it off and by thinking it was *"ridiculous" (line 937)*.

Anna's account may provide some insight into why Mary's strategy involved her integrating the strategies of The Nurturer, The Diplomat and The Warrior. Anna, unlike Mary decided to challenge the prejudice she perceived herself to have experienced when she felt she had not been credited for a project she had developed and completed. She said that she had shared her concerns about having felt *"excluded"* but that the male manager said it was her *"problem […] as opposed to just not recognising that it was really inappropriate not to …validate or …acknowledge my contribution to this [project"* (Anna, line 288). Therefore, it appeared that by not challenging personal prejudice participants may have perceived themselves to have avoided potential criticism and a potential relationship rupture (like Anna experienced).

Participants who did not appear to have combined The Activist or The Warrior with The Nurturer and The Diplomat archetypes described experiencing a rupture in their relationship. In an attempt to salvage this relationship, participants described repairing the relationship. Below is a description of participants' successful leadership experiences which mapped onto the integration of the following archetypes: The Nurturer, The Diplomat and The Repairer.

Category 4: Integrating The Nurturer, The Diplomat and The Repairer

Participants whose leadership experiences paralleled an integration of the superordinate themes; The Nurturer, The Diplomat and The Repairer described more successful leadership experiences compared to those participants whose accounts did not include all three superordinate themes.

For example, Anna described receiving news that the decision to de-band a psychology post had been made without her. In response to this she described feeling *"furious"*. This suggests that the superordinate theme The Nurturer was utilised at this point as she was feeling caring and protective of the profession. However, Anna then perceived a rupture to have occurred between her and her manager. This was how she described the strategy she implemented in an attempt to repair their relationship.

"rather than me going in there and going " I can't believe" {shouting}… After those few days I'd got into a position where I realised that that was probably what he was doing. He was in that that position and needed help […]. So I realised I needed to take the stance

of rather than coming in and being cross saying "why did you do this that and the other?" I realised that I needed to hold the position which is "I didn't understand the meeting" (Anna, line 374).

This extract suggests that Anna's leadership paralleled the superordinate themes of The Diplomat and The Repairer. She described choosing to use her psychological skills to influence the repair of their relationship which appear to parallel the subordinate theme '*As a psychologist I push where it moves'* from The Diplomat and '*I need to intervene'* from The Repairer.

Participants whose accounts did not parallel the integration of the three superordinate themes appeared to be less successful. For example, Elaine talked about feeling *"pressured"* to agree to deliver training to the local authority without having negotiated a minimum number of staff required to run the training, to make it financially viable. She said that she *"wasn't as clear" (line 419)* as she should have been and described changing tact by saying "*this is the contract and if you fail in your bit of the deal to sign enough people on then actually we will cancel the training" (line 421)*. On reflection she perceived herself to have experienced a *"rupture and need for repair"* (Elaine, line 450). Elaine's leadership experience did not parallel the superordinate theme The Diplomat. However, Elaine perceived that if she carefully negotiated with the team that she might have avoided a relationship rupture. She described a leadership experience, which paralleled the integration of the superordinate themes The Diplomat and The Repairer as she attempted to repair the relationship.

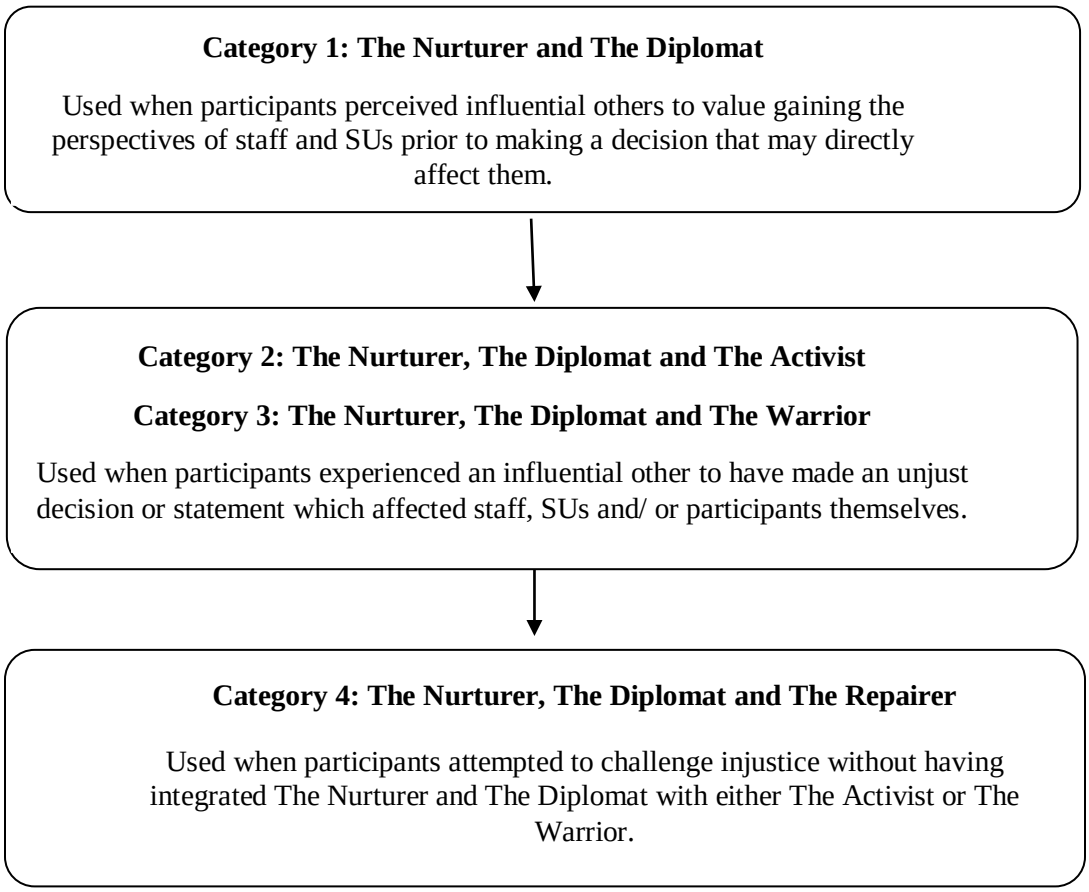
She said *"I've found myself thinking of strategies to engage her, work with her, manage her better with my therapeutic skills and I think it has helped. So actually very satisfying to feel that things have shifted in her relationship, her and me and she's a lot more, we have a much more cooperative relationship" (line 491).*

Summary of the secondary analysis

Participants described successful leadership experiences where they integrated the archetypes The Nurturer and The Diplomat. This strategy was employed when participants had gauged that powerful individuals were motivated to hear the perspectives of staff and SUs. Therefore, combining The Nurturer and The Diplomat appeared successful when participants were able to provide a bottom-up form of leadership.

In contrast, participants described powerful and influential individuals imposing an unjust decision or opinion on staff and participants. Therefore, it appears that the individuals with power and influence were adopting a top-down form of management. However, by integrating the core relationship archetypes (The Nurturer and The Diplomat) with The Activist or The Warrior, participants were able to get their and their staffs' voices heard. Interestingly, if the core relationship archetypes were not integrated with The Activist or The Warrior, participants appeared to experience a relationship rupture. Therefore, in an attempt to repair this rupture participants integrated the relationship archetypes with the Repairer as without the relationship participants were unable to influence powerful others.

Therefore, it appears that the combination of the archetypes: The Nurturer and The Diplomat remained core to participants' successful leadership experiences. The following section will describe the combining of The Nurturer and The Diplomat with each of the following archetypes: The Activist, The Warrior and The Repairer.



Summary of the results

It appears that the archetypes of The Nurturer and The Diplomat were core to the participants' perceived success as leaders. Participants also described having executed successful leadership when they combined the core relational archetypes: The Nurturer and The Diplomat with additional and more dominant archetypes; The Activist: The Warrior or The Repairer. Participants described the circumstances in which one of the archetypes; The Activist, The Warrior, The Repairer dominated when combined with the core relational archetypes; The Nurturer and The Diplomat. For example, The Activist archetype dominated when combined with The Nurturer and The Diplomat when participants described having witnessed unjust decision making that would adversely affect staff or SUs. However, when participants perceived themselves to be the target of prejudice they described The Warrior archetype dominating when combined with the core relational archetypes. Participants also described prioritising the relationship if they perceived a rupture to have emerged within their relationship. In response to this, participants described having combined the core relational archetypes: The Nurturer and The Diplomat with the more dominating Repairer archetype. Therefore, it appears that the core relational archetypes (The Nurturer and The Diplomat) are required to execute successful leadership. The remaining archetypes (The Activist, The Warrior and The Repairer) appear to come to the fore when combined with the core relational archetypes (The Nurturer and The Diplomat) to assert oneself as a leader and to ensure that the core foundation (the relationship) remains intact.

CHAPTER FOUR: DISCUSSION

The current study explored the experiences of successful leadership among senior female clinical psychologists. The three research questions for the study were as follows:

1. How do senior female clinical psychologists describe their experiences of successful leadership?
2. How do they make sense of these successful experiences of leadership?
3. How do I make sense of their data in relation to psychological theory?

This chapter will present an overview of the main findings in relation to the above research questions. The findings will also be discussed with reference to the relevant psychological literature. Then a detailed discussion of the strengths and limitations will follow with recommendations made about future research. The clinical implications will then be presented and finally, a conclusion will be offered alongside some closing reflections.

Main findings

How do senior female clinical psychologists describe their experiences of successful leadership?

Participants' successful leadership experiences were portrayed as five superordinate themes. These superordinate themes encapsulated the essence of the participants' experiences as well as the leadership actions participants described having taken. Below I will present an overview of these five different superordinate themes.

The Nurturer

This superordinate theme encapsulated participants' descriptions of leading in accordance with their values. Participants talked about wanting to ensure that their staff and SUs were cared for and protected. They also reflected on being able to best support and care for SUs,

staff and services by enabling themselves and others to grow. For example, Mary talked about recognising that she was *"not trusting that the preparation or the supervision or support [she delivered] would have a lasting … permanent kind of … effect"* (Mary, line 815) which she described reflecting upon and realising that *"staff can still use […. her] support"* (line 825). By recognising this she then allowed herself to take *"a break" (*line 830).

The Diplomat

This superordinate theme encapsulated participants using their clinical skills to build an alliance with individuals with *"power and influence".* For example, Astrid said *"if you can't get their interest or they don't think you're worth engaging with, or you're not going to hear or be interested in their point of view, then they're not going to engage in the process"* (Astrid, line 318). Participants also talked about using their clinical skills to formulate when it was best to intervene and how best to intervene. For example, Astrid said that

"*systemic training helped me to understand that if I'm the one [trying] to influence somebody's decision making, if I'm having a conversation with somebody who has a very different view than me within leadership or management, rather than a clinical area. I need to ask the things in a way that is going to hook them into the conversation, that's going to make them think, I'm someone who is worth having a conversation with"* (Astrid, line 236).

The Activist

The Activist encapsulated participants perceiving decision making to have been unjust for staff or SUs. This led participants to feel angry and indignant. They then described feeling a *"need"* to challenge this injustice. Participants who described challenging injustices using a more *"consultative"* approach perceived their leadership to have been more successful compared to those who utilised an *"authoritarian"* style. This was because participants who described using an *"authoritarian"* style perceived this to have resulted in relationship ruptures.

The Warrior

This superordinate theme described participants' perception of themselves as having been the victim of injustice or prejudice. Participants who described having experienced profession specific discrimination and sexism described challenging these injustices on behalf of others (e.g. for the psychology profession and for women in general) rather than

for themselves. However, for participants who experienced unique and personal discrimination, none of them described challenging this perceived injustice. Anna described explicitly challenging not being *"credited"* for work she had completed when she had returned from maternity leave. However, she described having been *"invalidated"* for raising this concern as she was told that she was *"the problem".*

The Repairer

This superordinate theme was described by participants when they perceived a rupture to have occurred within their relationship. Participants described experiencing a rupture when they thought they had not been as diplomatic as they could have been. For example, Elaine said *"I don't think I was as clear about it [the minimum number of staff required for a training to go ahead] as I should have been and could have been when we were negotiating the deal"* (Elaine, line 415). Elaine then said that because of this she *"had to cancel a few days"* and that this had been *"slightly trickier […] than it would have been, had I been clearer from the outset"* (Elaine, line 422). When participants described attempting to repair the rupture they described taking responsibility for repairing the rupture. Anna talked about how she attempted to repair the relationship with her manager. She said that she *"realised"* that she *"needed to hold the position which is 'I didn't understand the meeting'"* (Anna, line 374).

Integrating different the superordinate themes

The most successful leaders amongst the sample described leadership experiences which mapped onto more than one superordinate theme. It appeared that the superordinate themes The Nurturer and The Diplomat were core to all leadership success. Participants described having had successful outcomes when their experiences mapped onto the integration of core leadership strategies with another superordinate theme (e.g. The Activist or The Warrior or The Repairer). When participants described leadership experiences where the core strategies had not been integrated with one of these additional strategies, they described less successful leadership outcomes compared to those participants whose accounts suggested that they had incorporated all three (two core strategies and one of the additional other strategies).

How do they make sense of these successful experiences of leadership?

This study suggests that participants made sense of their leadership experiences using their psychological knowledge and skill, indicating that the knowledge base and clinical skills of

psychologists and psychotherapists may be useful in leadership. However, it is important to stress that having this knowledge and skill does not necessarily equate to being an effective leader. This offers a new insight for the leadership literature as previous studies have not suggested that leaders make sense of their leadership experiences using psychology. However, Onyett (2012) has argued that clinical psychologists are well positioned to be leaders because they have the relevant knowledge and skills. Therefore, the current study not only supports Onyett's argument, it also suggests that female clinical psychologists who are "successful" leaders perceive leadership to be an extension of their clinical skills. This was clearly summarised by Elaine when she said

"my core identity is a clinician but I absolutely feel like, as a psychologist, as a psychologist we're equipped to function to make a difference and function quite well […] in leadership. I think it's something that we absolutely should be doing. I think the thing about using the therapeutic skills and the people skills that we've got is a really key part of it" (Elaine, line 674).

Participants described their leadership experiences in terms of their core clinical competencies. These included: assessment and engagement, formulation, intervention, personal and professional skills and service delivery competencies. A discussion of how participants made sense of their leadership experiences using these core competencies will be offered below.

Assessment and engagement

Participants described making sense of their leadership experiences by building rapport with the individuals they were attempting to influence. This supports the leadership literature discussed in the introduction. For example, the Transformational leadership model (Bass, 1985), The Engaging Leadership model (Alimo-Metcalfe and Alban-Metcalfe, 2005) and the Secure Base Leadership model (Kohlrieser et al., 2012) proposed that building relationships with the individual was necessary to influence others. In addition, qualitative research into USA female enterprise leaders suggests that they perceived themselves to utilise a "connect and collaborate style" of leadership (Weidenfeller, 2012). However, the current study also offers a process that participants described when attempting to build and repair their relationships which previous leadership research has not proposed. The current study also offered a process that participants described engaging in to build rapport and repair relationship ruptures, which previous studies have not described.

A key assessment method within clinical psychology involves "securing an effective working alliance" (BPS, 2010, p. 4), which participants described doing in the current study. The theme *'the power of persuasion'* captured participants' experiences of developing these working alliances with powerful and influential individuals. It is not surprising that participants perceived building an alliance to be an important part of leadership, given that within clinical psychology it is widely recognised that the therapeutic relationship is the biggest predictor of outcome in psychotherapy (Norcross & Wampold, 2011). For example, Elaine said that she thought her *"therapeutic skills, the rapport building, the alliance building, the skill in terms of how you interact with people and how you manage them"* (Elaine, line 479) were essential to her success as a leader. Participants also described spending time developing their relationships with the individuals they were attempting to influence. Astrid described thinking:

"If you can't get their interest or they don't think you're worth engaging with, or you're not going to hear or be interested in their point of view, then they're not going to engage in the process" (Astrid, line 318).

Participants also attempted to prioritise repairing the relationship if they perceived a rupture to have occurred (The Repairer). Research within the field of clinical psychology suggests that therapists who address ruptures to the therapeutic relationship have better clinical outcomes compared to those who do not (Safran, Muran, Samstag & Stevens, 2001) and that it is the therapist's responsibility to attend to any potential rupture within the therapeutic relationship (May & Ranks, 1985) which the subordinate theme '*I need to intervene'* described participants doing.

Formulation and intervention

Participants described making sense of their leadership experiences using their psychological formulation and intervention skills, which is a new development within the leadership literature. Previous studies (Salas-Lopez et al., 2011; Weidenfeller, 2012) suggested that self-awareness was important for participants to identify their leadership goals and to execute successful leadership, which may be a similar process to formulating and intervening. However, it is difficult to ascertain whether these concepts overlap because these studies lack experiential data. Psychological formulation involves "draw[ing] on psychological theory and research to provide a framework for describing a client's problem, or needs, or how it developed and is being maintained" (BPS, 2010, p. 5). The themes '*as a psychologist I push where it moves', 'I reflect and formulate*', *'I need to intervene'*, '*I*

choose my battles' and *'I enable myself and others to grow',* and *'fighting the good fight'* all provide examples of how participants were drawing on their formulation and intervention skills to make sense of their leadership experiences. This is clear in Anna's account when she described attempting to make sense of a relationship rupture between her and her manager.

"*He often doesn't contain himself. So in an attempt to be efficient he sends things out too quickly to manage his anxiety.* (Anna, line 380)

It is not surprising that participants attempted to make sense of their experiences using psychological formulation as it has been considered a defining feature of clinical psychologists (Kinderman, 2001). Additionally, it has been recommended as a useful tool used to influence multi-disciplinary teams (DCP, 2010; Onyett, 2007) and therefore, it makes sense for psychologists to be making use of psychological formulation in leadership.

Participants were not only making sense of their experiences using psychological formulation, they also described using formulation to develop interventions. These are "based upon the formulation […and] may involve the use of psychological models to facilitate the solution of a problem or to improve the quality of relationships (BPS, 2010, p. 5). Astrid's account provides an example of this. She talked about recognising that some:

"systemic training […] helped me to understand that if I'm the one [attempting…] to influence somebody's decision making, if I'm having a conversation with somebody who has a very different view than me […]. I need to ask the things in a way that is going to hook them into the conversation, that's going to make them think I'm someone who is worth having a conversation with" (Astrid, line 236).

In the above extract, Astrid describes using her psychological formulation skills to develop an intervention to engage an individual that she is attempting to influence. Participants also described how they intervened. For example, Mary talked about playing 'devil's advocate' when she noticed that the team were critical about a staff member anonymously raising a complaint. She described intervening by saying

"'no, *I think we're missing the point here. I think this person has been really courageous' […]. I think we also need to think about whether this is a view that other people share and the more we talk about this person and the 'inappropriateness'. The more we are letting ourselves off the hook'"* (Mary, line 691).

She later reflected saying that she was *"glad that I said it because I think if I didn't say it. I would go away and think I have condoned that discourse"* (line 725). This suggests that she was drawing from narrative therapy to inform her intervention.

Personal and professional skills

Participants described making sense of their leadership experiences by using psychology to develop themselves. They perceived that through self -development they were more influential in their role as leaders. This was also suggested by Salas-Lopez et al (2011), Weidenfeller (2012), Hertneky (2012) and Bowles (2012). Their studies posited that female leaders perceived that their ability to self-reflect and alter their leadership archetypes had enabled them to secure senior leadership position. Salas –Lopez et al (2011) and Weidenfeller (2012) also posited that participants described leading in accordance with their values. However, they did not specify what the participants' values were, which the current study did. Valuing *"equality"* and *"fairness"* for SUs and staff was perceived to be important for the participants of the current study.

Personal and professional skills are core competencies of a clinical psychologist, which involve them behaving "consistently in a manner that is compatible with ethical principles, codes of conduct and professional standards" (BPS, 2007, p. 7). Descriptions of participants' successful leadership experiences also suggested that their values were consistent with the ethical principles and code of conduct as a clinical psychologist. All the participants' descriptions of their successful leadership experiences mapped onto the clinical leadership competency framework skill "acting with integrity". Participants perceived it to be important to be "*clear about your value system and* your integrity *and about what lines you will and won't cross and how you will stand up for those things, rather than just going along… with things"* (Tara, line 364).

There is no standardised definition of 'personal development' within the psychological literature. Therefore, I have decided to make use of The Leeds Clinical Training programme's definition as they heavily emphasise the role of self-development in their training course. Their definition is influenced by Mearns (1997).

1. "A preparedness and willingness to become more and more aware of self.
2. A preparedness and willingness to try to understand one's self
3. A preparedness and willingness to explore and experiment with one's self i.e. to risk doing things differently, face fears, invite challenge, examine one's character and personality, learn to confront" (Hughes, 2009, p. 30).

Participants' descriptions of their leadership experiences appeared to map onto these three components of self-development. The subordinate themes *'I feel angry and indignant'*, *'I feel angry and patronised'*, *'I am aware of friction'*, *'that's not right, that's not fair'*, *'I am caring'* and *'I am protective'* described participants' willingness and preparedness to notice their emotions, cognitions and values and thus willingness to become more self-aware. Participants also demonstrated their willingness and preparedness to understand themselves which the subordinate theme *'I reflect and formulate'* describes. For example, Anna *"realised"* that to repair a rupture she had had with her manager, that she *"needed to hold the position which is 'I didn't understand the meeting'"* (Anna, line 374). Finally, participants described being prepared and willing to explore and experiment with themselves. The themes; *'fighting the good fight'*, *'I choose my battles'*, *'I need to intervene'* and *'enabling myself and others to grow'* all captured participants' willingness to push themselves to develop and change their behaviour to enable them to successfully influence others.

Participants perceived themselves to be the victim of injustice (profession, sex, race, age). This was also reported in other studies (Salas-Lopez et al., 2011; Stead, 2013; Weidenfeller, 2012) where participants perceived themselves to have been the victim of sexism and in some cases the victim of racism too. These incidents included female leaders perceiving their male colleagues to view them as "potential liabilities" who prioritised their family over their career (Salas-Lopez et al., 2011). They also perceived their male colleagues to impose gender roles on them such as asking them to be the minute taker in meetings (Stead, 2013). Stead reported that participants revealed or concealed their experiences of injustice. Concealing the injustice was described as an attempt to avoid a potential "battle". In the current study participants also described revealing or concealing the injustice they had experienced *('I choose my battles'*). It appeared that as the injustice became more personal, that participants were less likely to challenge the injustice. However, if the injustice applied to others as well as to themselves, for example as psychologists and other females, participants described challenging this injustice.

Service delivery competencies

Participants also made sense of their leadership experiences in terms of the service delivery competencies. These have been defined as a "mixture and synthesis of these [core clinical psychology] competencies, built on the body of psychological theory and data, which are

applied to helping individuals, groups and systems solve personal, family, group, strategic or organisational problems that makes clinical psychology unique in health and social care" (BPS, 2010, p 8). Participants described making sense of their leadership in terms of their core competencies as a clinical psychologist. They also described leadership experiences which mapped onto more than one superordinate theme at a time, suggesting that participants were integrating different competencies. It could be argued that participants were synthesising a range of core competencies to influence service delivery. For example, Mary perceived the trust training strategy to have been unsuccessful for a number of years but recognised it was not the training that needed to change. She said:

"it's not just about sending people on […] training and expecting them to offer family therapies and CBT for [specific psychological difficulty]. It's about the trust board saying 'we're going to invest in the workforce, we're going to invest in supervision, we're going to change care coordinators jobs and their job descriptions', so they that they have an afternoon a week for example, to do one and a half hours [of specific psychological intervention] plus time to do a debriefing and have supervision" (Mary, line 422).

The above quote suggests that Mary was influencing a range of systems within the Trust, the executives, the training strategy, the attitude towards regular supervision and staff's job descriptions, to ensure that the Trust had the appropriate psychological provision to effectively treat the SUs.

Participants described their job roles and their leadership experiences as including them working with groups, systems and organisations (see table 6 and table 8 in the results section). These leadership experiences were described as re-structuring services, implementing psychological training strategies throughout the trust and influencing team decision making. Therefore, it appears that participants did make sense of their leadership experiences in terms of their service delivery competencies.

Summary

Participants described making sense of their leadership experiences using psychology. They described implementing a range of relational strategies (the superordinate group themes) to gain influence. These strategies mapped onto the core clinical competencies of a clinical psychologist including; engagement and assessment, formulation, intervention, personal and professional skills and service delivery competencies. Therefore, participants perceived their role to be a psychologist first and foremost to act as an advocate to their service, staff and SUs.

Making sense of participants experiences in relation to psychological theory

Participants' accounts suggested that they felt congruent in their identity as a leader, psychologist and female. They also made sense of their leadership experiences using the core clinical competencies of a clinical psychologist. This involved participants describing their leadership experiences as being; relational, solution focused, values orientated and requiring resiliency. Therefore, the following section will discuss feeling congruent as a leader and the core competencies identified above in relation to psychological theory.

Feeling congruent as a leader

In the current study, participants experiencing a compatibility between their identity as a leader and as a psychologist. They described being a *"clinician"* or *"psychologist"* first and foremost. This finding supports previous research which suggests that clinical leaders perceived their leadership role to be "bolted on" to their clinical role (Forbes et al., 2004). Tables 9 and 10 provide further support for this as they suggest that participants' descriptions of their leadership experiences were congruent with their identity as a clinician and as a psychologist.

Participants also described holding congruent values in their role as a leader of being *"fair", "equal"* and *"open"*. These values fit with the identity of a clinical psychologist. The BPS (2009) code of ethics and conduct states that clinical psychologists "value honesty, accuracy, clarity, and fairness in their interactions with all persons, and seek to promote integrity in all facets of their scientific and professional endeavours" (BPS, 2009, p. 21). These values also appear to be synonymous with a transformational leadership style, which research suggests is most common among female leaders (Eagly, Johannesen-Schmidt & van Engen, 2003). Furthermore, literature exploring the experiences of females in senior leadership roles also suggests that female leaders lead in a transformational leadership style (Bowles, 2012; Hertneky, 2012; Weidenfeller, 2012; Salas-Lopez et al., 2011; Christman & McClellan, 2008; Black & Magnuson, 2005). In the current study participants also perceived their identity as a leader to be congruent with their identity as a female. For example, Elaine described using her whole identity in her role as a leader saying leadership is *"about professional knowledge and expertise, it's about my experience; it's about my personal attributes if you like. It's about me as a psychologist, as a mother, as a partner, as a daughter, I bring a lot of myself and my own experiences" (line 632).*

Participants described feeling content when they had led in accordance with their values. For example, Tara descried having been *"vocal"*. However, she perceived that although

"*it did make some people uncomfortable around the table. I didn't actually feel bad about that because I felt that those were the principles we'd all said we were working to [...]. I would have felt more uncomfortable if I hadn't said something*" (Tara, line 348).

This finding supports previous research which suggests that female leaders who experience congruence between their leadership and gender identity have an enhanced level of psychological well-being and an increased desire to adopt a leadership role (Karelaia & Guillen, 2011). Karelaia and Guillen (2012) also suggest that having a positive gender identity buffers the likelihood of female leaders experiencing incongruity between their leadership and gender identity, which may explain why participants in the current study experienced congruence between their three identities; as a leader, a psychologist and as a female.

This contrasts with Role Congruity Theory (Eagly & Karau, 2002) which posits that individuals experience an incongruity between stereotypically female gender roles and leadership roles, which results in female leaders experiencing biases against them (Eagly & Karau, 2002). Furthermore, research suggests that women internalise these biases about female leaders, which affects their beliefs about how they act in leadership roles (Hogue & Lord, 2007). However, research also suggests that female leaders with a positive gender identity are less likely to experience incongruity (Karelaia & Guillen, 2011) which appears to fit with the experiences of the participants from the current study.

It is important to note that one participant did experience incongruity between her leadership identity and gender identity. She described feeling guilty when she did not lead in a style that was congruent with her gender identity. For example, Melanie said "*I'm much more authoritatively inclined which is hence why I also have the guilt and embarrassment when I'm not as facilitative and consultative as I should be"* (line 468). In addition, Melanie was the only participant who talked about her leadership style resulting in negative outcomes which she perceived to be stressful as she commented that *"you don't sleep well and drink more (laughs)"* (line 477).

Melanie's experiences support previous research which suggests that females who experience an internal conflict between their leadership identity and their gender identity experience an increase in stress and a decrease in their life satisfaction (Karelaia & Guillen, 2012). It is important to emphasise that the rest of the sample described experiences of

congruence between their different leadership identities. Therefore, it may be that the current study's findings differ to previous literature because they have been in embedded in the context of the NHS which is a predominantly female organisation which is more accepting and tolerant of "democratic and participatory" leadership styles (e.g. Alimo-Metcalfe's Engaging Leadership), which research suggests reduces prejudice against female leaders and increases their representation in leadership roles (Eagly and Karau, 2002).

The Third Wave cognitive behavioural therapies, although used clinically rather than theoretically, are useful as they provide insight into how participants accepted these changes and remained compassionate to themselves. Acceptance and Commitment Therapy (ACT) (Hayes, Kelly & Stroshal, 1999) suggests that once individuals understand what their values are, they can develop an "acceptance of unwanted private experiences which are out of personal control [through taking a] commitment and action towards living a valued life" (Harris, 2006, p. 5). In the current study participants who were committed to leading by their values appeared to not experience an internal conflict. In addition, Compassion Focussed Therapy (Gilbert, 2014), proposes that individuals regulate their emotions by: reducing threats (the threat system), doing and achieving (the drive system) or by feeling safe and content (the compassionate system). Gilbert proposes that humans function at their optimum when individuals draw upon these three systems equally, (as in the current study). However, when these systems are in disequilibrium, well-being may be affected. Therefore, it appears that acceptance, self-compassion and values were important for the wellbeing and success of these participants leadership, in the current context of the NHS where it was a difficult environment to always be influential.

Leadership is about relationships

Participants' data suggests that developing relationships was important in their leadership experiences. This supports previous research, which explored the experiences of females in senior leadership roles (Back & Magnuson, 2005, Christman & McClellan, 2007, Weidenfeller, 2012). Many leadership theories (e.g. transformational leadership, Engaging leadership, the new psychology of leadership and secure base leadership) have proposed that leadership success is related to one's ability to build relationships with others. However, these theories were developed from research which used either an all-male or mixed (male and female) sample. Therefore, this study is the first of its kind to suggest that the relationship is fundamental to female clinical psychologists' successful leadership. In

addition, this research suggested that participants described a process involved in building and repairing relationships, which is a new development within the leadership literature.

Attachment theory (Bowlby, 1988) may provide further insight as to why participants perceived relationships to be important in their leadership. Attachment theory (Bowlby, 1988) proposes that the interactions infants have with their primary caregivers affects their later development and way of relating to others. Given participants' described ability to form relationships with a range of individuals (e.g. The Diplomat), it seems likely that they were using their psychological knowledge to form a secure attachment with their colleagues. It seems likely that by doing this participants were able to contain their own emotions and be available and accessible to contain the emotions of their followers, enabling their followers to safely explore the environment around them (as suggested by secure base leadership (Kohlrieser et al., 2012), which is also based on Attachment theory). For example, Anna described containing her own emotions by accessing supervision and then managing to contain her colleagues' emotions. She said:

"rather than me going in there and going "I can't believe" {shouting}… After those few days I'd got into a position where I realised that that was probably what he was doing he was in that position, he needed help from me and that he didn't understand really" (line 450).

Research suggests that individuals' quality of attachment relates to their ability to mentalize (Fonagy, Gergely, Jurist & Target, 2002). Mentalization describes a process where individuals understand their own mental states and the mental states of others. This involves individuals being able to take the perspectives of others and to empathise with others (as indicated in the above quote). Therefore, having an awareness of attachment theory and attempting to become one's secure base are important for successful leadership. In addition, the ability to mentalize and take others perspectives also appears to be an important component of successful leadership.

Leadership is about developing strategies

Participants described a range of leadership experiences which I interpreted as the following leadership superordinate themes; The Diplomat, The Nurturer, The Activist, The Warrior, The Repairer. More specifically, the themes; '*As a psychologist I push where it moves'*, '*fighting the good fight'*, '*I reflect and formulate*', '*I need to intervene'*, '*I choose my battles'* and '*enabling myself and others to grow*' captured participants' use of formulation and intervention, which appeared to enable participants to remain solution focused. These

also appear to map onto Lazarus and Folkman's (1984) transactional model of stress and coping. This theory posits that individuals experience a stressor (e.g. that's not right that's not fair', or 'It's personal' or 'I am aware of friction'). In response to this stressor individuals appraise the stressor (primary appraisal) by considering what the stressor means for them. In the case of The Warrior and The Activist participants interpreted the perceived injustices as a threat as they become angry. In The Repairer participants also appeared to perceive the rupture as a threat as they described feeling *"friction"* and noticing that others *"didn't look happy"*. Individuals then have a secondary appraisal where they consider what it is that they can do to overcome the stressor. Participants then decided how to respond to these potential threats either deciding to *'fight the good fight'*, to choose their battles or to reflect and formulate and then intervene. Therefore, it appears that being solution focused is an important component of leadership success.

In addition, the Good Practice Guidelines on the use of psychological formulation (BPS, 2011) state that psychological formulation can enable both SU and therapist to "feel contained" (BPS, 2011, p. 8). Containment is a concept originally created by Bion (1962, cited in Ogden, 2004) which describes how caregivers regulate their infant's emotions and anticipate the baby's thoughts in a way which would be containing for the infant. Participants' accounts suggest that their use of psychological formulation and intervention contained their emotions and the emotions of others. The superordinate themes The Activist, The Warrior and The Repairer describe processes where participants experienced an emotion, either *'angry and indignant'*, *'angry and patronised'* or *'friction'*. These emotional reactions are then dealt with in a manner which results in participants feeling contained. They describe engaging in a solution-focused approach of formulating and intervening, which enabled them and others to then feel contained. For example, Anna noticed friction in the relationship when her manager told her that a psychology post had been re-banded. She then described feeling *"furious"* but by taking time out to reflect and make sense of the rupture she realised that "*he often doesn't contain himself. So in an attempt to be efficient he sends things out too quickly to manage his anxiety"* (Anna, line 380). Once she had understood this, she said

"*I realised I needed to take the stance of, rather than coming in and being cross, saying "why didn't you do this?" I realised that I needed to take the position which is "I didn't understand the meeting, I didn't appreciate what that meeting was about" (line 378).*

Anna acknowledged that they had *"had a big falling out […] but its ok now"* (line

399). This extract suggests that by repairing the rupture, Anna no longer felt *"furious"* and that consequently she had managed to contain her emotions and her manager's.

Therefore, it appears that using psychological formulation and intervention can help individuals plan and make sense of the complex dynamic in leadership as well as enable others to feel contained. Sharing this knowledge or using this knowledge also appeared to enable participants' followers to feel contained too.

Leadership is about being resilient

Participants described experiencing a number of stressors that they had to contend with. They described these as experiencing injustice such as sexism, racism and ageism (please see section related to Q2 for further details). Research suggests that female medics progressing into senior leadership roles also experienced gender stereotype threats (Salas-Lopez, 2011), as did female senior leaders in business (Weidenfeller, 2012) and female academics in senior leadership roles (Stead, 2013). This fits with the Role Congruity Theory (Eagly & Karau, 2002) as it suggests that unconscious biases, operate when leaders are not white males, which lead to unfavourable evaluations of these leaders. In addition, the minority stress theory (Meyer, 2003) proposes that individuals from minority groups (e.g. sex, socioeconomic status, race or ethnicity, sexuality) are at an increased risk of becoming a victim of stigma and that these stressful experiences can have a negative impact on one's mental health. Research also suggests that in response to such "challenges" females in senior leadership roles apply "self-knowledge and resiliency" (Weidenfeller, 2012) to overcome this injustice. This study contributed to the existing literature by describing the process that participants engaged in to address discrimination. It also presents the process that participants described undertaking when developing their resiliency (e.g. '*enabling myself and others to grow', 'I need to position myself differently, 'I choose my battles'*).

Resiliency has been defined by Leipold and Greve (2009) as an "individual's stability of quick recovery (or even growth) under significant adverse conditions" (p. 41). Leipold and Greve's (2009) model provides some insight into how participants developed their resiliency. They propose that in response to a stressor individuals either acknowledge the stressor and experience it as "stressful" or they ignore the stressor. If a stressor is experienced as stressful, individuals then appraise the stressor using assimilation (where they develop a solution in line with their values to challenge the stressor e.g. '*fighting the good fight'* or *'I choose my battles'*) or accommodation (where they decide to position themselves differently by using reflection and formulation where they then intervene). If

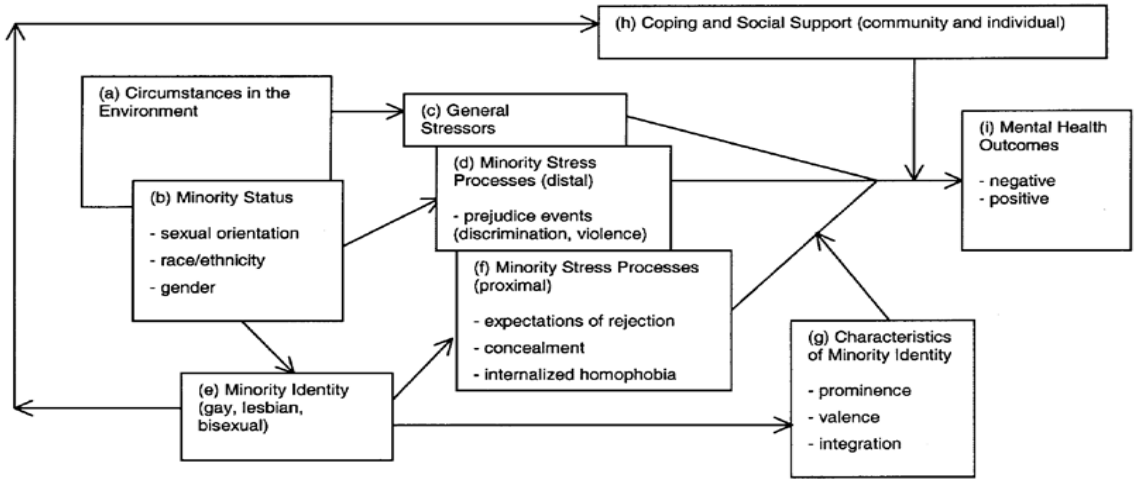
individuals respond to the stressor defensively (by ignoring it), they are unlikely to develop because they have ignored the stressor. Therefore, they cannot create and implement strategies to resolve the impact of the stressor. Leipold and Greve (2009) argue that the process of accommodation or assimilation results in individuals developing their problem solving skills and their personal development skills, which in turn develop an individuals' resiliency. All the participants in the current study described acknowledging the stressor and none described ignoring the stressor. Therefore, this suggests that the participants were emotionally aware and able to engage in assimilation or accommodation and were able to develop their resiliency (Leipold and Greve, 2009).

The Stress Minority Theory (Meyer, 2003) may provide further insight into the participants' experiences. This posits that one's minority status, social norms and values are likely to differ to those of the dominant culture which can create conflict for individuals from a minority culture. Research suggests that being a member of a stigmatised group can result in individuals experiencing a conflict between themselves and their dominant culture, which can result in significant stress for the individual (Alison, 1998; Clark et al., 1999). The theory proposes that there are three underlying assumptions, that the stress is (1) unique, (2) chronic and (3) socially based. This unique stress is additional to the regular day to day stresses of the general population. Therefore, these individuals require strong adaptive coping strategies and social support to compensate for this additional unique stress. Otherwise, as the theory proposes, individuals from minority groups are at a greater risk of experiencing mental health difficulties.

The participants from the current study, in particular the two from a BME background described managing to cope with discrimination, which differs to the proposed rationale of the minority stress theory (Meyer, 2003). Based on the minority stress model (figure 2) it seems plausible that the current study's participants did identify with their apparent minority status (psychologist, female, race/ ethnicity, age). However, participants appeared to appraise their experience of prejudice in a manner which was protective for them. For example, when Mary described experiencing racism she said that she thought how she had been treated was *"ridiculous"*, however, she coped by laughing about this and talking this through with other females from a BME background within the profession. In addition, Anna who perceived herself to have been the target of racism and sexism said that she shared her experiences with her manager. She said that he suggested that she was the one with *"the problem*". In response to this she said that she perceived him to have been *"inappropriate"* and that she had been left feeling *"invalidated"*. In addition, participants

talked about accessing social support, in particular, Mary spoke about sharing experiences of discrimination with other females from BME backgrounds. Therefore, the current study's findings suggest that the values participants held enabled them to appraise prejudice as unfair and unjust, which appeared important for them to remain resilient as a female leader. Additionally, their ability to remain solution focussed and to access social support also appeared important.

Figure 2: The Stress Minority Model (Meyer, 2003)



Strengths and limitations of the study

This study was an original exploratory piece of research as previous research utilised one's leadership position, rather than one's reputation as a successful leader. It was also the first (as far as the author is aware) of its kind to explore the phenomenological experiences of female senior leaders in the NHS. Contributions were made to the leadership literature by suggesting that participants experienced congruence across their identities as a psychologist, as a leader and as a female. A further contribution was offered by participants making sense of their leadership experiences using their psychological knowledge and skill. They also perceived the relationship to be core to all their successful leadership experiences. Participants' descriptions of their leadership experiences were interpreted as superordinate themes which described five different processes, which was a further development within the leadership literature. Below I will discuss both the strengths and limitations of this research.

Smith et al (2009) argued that it is important for an IPA sample to be homogenous so that their experiences are representative of a sample who share similar experiences. This was a strength of the current sample as all the participants met the inclusion criteria. In addition, all of the sample were recruited from four NHS trusts in the north of England, which given the close proximity of these four sites it could be argued had their unique culture.

Recruiting clinical psychologists was a strength of the study because they have been trained to deliver leadership (BPS, 2007) and had a number of leadership experiences to describe. They were articulate and able to reflect and talk about their experiences of leadership, which is important for an IPA study. However, clinical psychologists are a small profession within the NHS. Therefore, these experiences may not generalise to other senior female clinicians within the NHS (e.g. Doctors, Nurses, Occupational Therapists, etc.).

It is also difficult to identify whether these experiences are unique to female senior clinical psychologists or whether there may be some overlap with senior male clinical psychologists' experiences. Given the samples reported sexism (in the majority of cases in relation to men) it is unlikely that these particular experiences would re-emerge in a male sample. However, they may experience prejudice as clinical psychologists or as a minority group within a female dominated profession.

Moreover, my supervisors' definition of "successful leadership" may have led to a sampling bias, affecting what participants disclosed in the interviews, the results and the implications of the research. Interestingly, of the 10 supervisors emailed about the research only 7 responded to the email and decided to participate in the research. Therefore, it is worthwhile considering the possible factors that may have influenced my supervisor's definition of leadership. My supervisors are female clinical psychologists who have secured senior leadership roles. Both of my supervisors have worked in clinical and academic settings, training individuals to become clinical psychologists. In addition, they both appear to have a strong interest in leadership, supervision and personal and professional development. Therefore, it seems likely that their definition of successful leadership would include having the capacity to reflect, learn and develop. Selecting participants based on this definition may have affected how participants presented at interview and thus the findings which suggested that participants did have a reflective capacity.

Furthermore, it is possible that this sample experienced a self-serving bias. This is because when participants were asked to describe a leadership experience they wish they had done differently, the majority of participants described experiencing a success. Instead of talking

about what they wish they had done differently, they described experiencing a relationship rupture which they successfully repaired. They may have described their leadership experiences in this way to gain a sense of self-assurance and self-worth (Snyder, Stephen & Rosenfield, 1976) that they were capable as leaders. However, it is equally plausible that "successful leaders" recognise difficulties, reflect on these difficulties and respond to these difficulties in a considered way, as suggested by Hughes and Youngson's (2009) model of personal development. If this is the case, these participants may not have had any examples of experiencing a difficulty which they did not attempt to resolve. Therefore, this is a limitation of the current study as it remains unclear whether participants described their success due to a potential self-serving bias or because they are competent individuals who attempt to resolve and address ruptures.

Recruitment

My two research supervisors who are senior female clinical psychologists identified potential participants from a supervisor register within the North of England. They selected participants who they noted as reputable leaders. This recruitment procedure enabled me to explore the leadership of "successful" leaders rather than just assume that individuals in a position of leadership would be "successful".

The sample appeared to incur a self-selecting bias where those participants who chose to participate in the study (7/10) identified themselves as being "successful leaders". In addition, participants described deciding to participate because they wanted to make sense of their leadership experiences. This was a strength of the study, as one of the study's aims was to understand how participants made sense of their leadership experiences.

Interview

Participants were asked to bring their work diaries as a prompt to remind them of their previous two weeks of leadership experiences. However, only four participants remembered to bring their diaries with them to the interview. In addition, because one participant had recently left a job she was referring to leadership experiences which had occurred more than two weeks ago. Therefore, her account of her leadership experiences may have been less reliable compared to those participants who utilised memories within the last fortnight.

The other methodological concern regarding this study is that participants may have felt inhibited about describing some of their experiences because of my status as a PICT and the potential of me becoming their future employee. In addition, some of the participants had a relationship with the course and/ or my research supervisors and therefore, may have felt obliged to participate and to have performed well in their leadership role.

Terminology

The term 'archetype' was used as a construct to make sense of participants' leadership experiences. Shadraconis' (2013) theoretical paper argues that the construct 'archetypes' allows us to make sense of one's identity and experience, which fits with the aims of IPA. However, Shadraconis (2013) argues that individuals can become susceptible to idealising leaders and using idealised archetypes. The current study involved using my participants' data to interpret and generate leadership archetypes. Therefore, these archetypes are grounded in my interpretation of my participants' leadership accounts. Therefore, the archetypes from the current study may be less prone to idealisation. In addition, I thought the use of archetypes would be a clear way of portraying my participants' accounts as they would resonate with the reader.

Shadraconis argued that archetypes allow us to make sense of one's identity. The current study manages to convey that successful female leaders adopt a range of identities, which fit across the spectrum of stereotypically male and female gender roles. For example, the archetypes; The Activist, The Diplomat and The Warrior are likely to be perceived as stereotypically male, whereas the archetypes The Nurturer and The Repairer are likely to be perceived as stereotypically female. Therefore, there is a potential danger that individuals will not assimilate all of these archetypes into a successful female leader. However, if individuals manage to assimilate these archetypes they may struggle to accept these females are successful leaders. This is because role congruity theory proposes that female leaders are perceived to be less capable than male leaders because individuals associate stereotypically male gender roles with successful leadership. In contrast, it could be argued that a female leadership model which encompasses stereotypically male and female gender roles may be helpful in challenging the dominant narrative of female leaders. This is because society may then begin to perceive these archetypes as being exclusive to leadership rather than related exclusively to gender roles

Therefore, it appears that the 'archetypes' used in the current study provided a nuanced understanding of the experience of successful leadership. Nevertheless, if these archetypes are misinterpreted as 'heroic archetypes,' this could prove useful. This is because it could potentially lead to the development of an alternative narrative of how female leaders are perceived and portrayed in modern day society.

Quality control

As discussed in the method section a number of quality checks were employed to enhance the credibility of the results. These were based on guidelines outlined by Elliott et al. (1999) and Yardley (2000). Their quality criteria will be explored with reference to the current study in terms of its strengths and limitations.

I have described my preconceptions and expectations of the data throughout the thesis. I also kept a reflective diary, had a pre- and post-data collection interview and kept notes of my initial reactions to each participant after the interview. This enabled me to access my assumptions and biases in how they were interpreting the data (Elliott et al., 1999). This was discussed within supervision which enabled me to notice that I was interpreting the data in a negative light, which I reflected on and made sense of as a PICT about to access a profession under threat with redundancies being made and service restructures happening. Being mindful of this enabled me to notice and process this which enabled me to attempt to access the participants' internal experiences more easily.

I have situated the sample (Elliott et al., 1999) by providing an outline of the key features of the sample and the demographic details of the sample. In the results section I have provided a demographics table (see table 5) which provides an outline of the sample. I have also provided individual pen portraits for each participant which provided an insight into participants' definition of successful leadership and the strategies that they employed as leaders. This provided some useful contextual information to support the readers understanding of the perspectives of the sample.

This was the first time that I had analysed data using IPA, making me a novice IPA analyst. Therefore, numerous attempts were made to analyse and re-analyse the data until consistent themes were emerging from the data. Credibility checks and quality checks were done by my research supervisors and another PICT, who was familiar with the IPA method. I also provided verbatim extracts to support the different superordinate and subordinate themes to increase transparency.

Implications

In this section I will discuss the implications of this research and how they may impact on different stakeholders and organisations. This will include the NHS, the profession of clinical psychology and the associated training courses as well as other NHS leadership courses.

Remaining congruent to one's values as a leader appeared to be important for one's leadership style and wellbeing. Therefore, it may be helpful to consider assessing the values of potential leaders when employers are recruiting for healthcare leaders. It may also be useful for organisations employing large numbers of females in leadership roles to emphasise the importance of having congruent values as a leader and a female as a part of their induction process. Line managers and supervisors may benefit from being made aware of the negative impact incongruent values can have on female leaders overall wellbeing, so that they can support, coach and advise them. These findings also have implications for leadership training both within clinical psychology and NHS leadership programmes. It seems likely that discussing relevant literature such as the role congruity theory may highlight the prejudice that female leaders experience as well as the detrimental effects that incongruent values may have on one's wellbeing. It may also be useful to provide a space for individuals to consider their own values and to assess the congruence or incongruence of their values across their identity as a female and as a leader. In particular, for clinical psychology training it may be useful to emphasise the role that one's identity as a clinical psychologist plays in the congruence of their values across their identity as a female and as a leader.

Building and repairing relationships was also an important skill for participant's leadership "success". It may be useful for recruitment officers to assess leadership style, ability to build rapport and repair relationships when recruiting leaders in healthcare. Providing training on some of the leadership models which emphasise the relationship, for example engaging leadership (Alimo-Metcalfe & Alban-Metcalfe 2005) or secure based leadership (Kohlriesser et al., 2012) may also be important to develop leader's leadership capacity. In addition, providing an overview of the psychological literature on rapport building and repairing relationship ruptures may also enhance the leadership effectiveness of organisations. It is important to note that clinical psychology training courses already cover this topic and therefore, it may be useful for courses to emphasise the importance of this in leadership as well as within therapeutic relationships.

Being solution-focused was highlighted across participants' accounts. There was also an emphasis on participants using their psychological formulation skills and intervention skills to resolve difficulties. Therefore, when recruiting for leadership roles it may be important to assess candidate's capacity to be solution-focused and to draw from psychology to inform their leadership approach. In addition, pragmatism also appeared important for successful leadership. This was because participants described experiencing better overall well-being compared to those who were less accepting of their personal limits. Therefore, training in solution-focused strategies may be useful for leadership training courses. It may also be useful to teach some basic formulation and intervention skills to enable potential leaders to overcome difficulties. Given that the acceptance of one's limits played a role in one's wellbeing it may be useful to teach the principles of ACT (Hayes, Kelly & Stroshal, 1999) to leaders. Again, most clinical psychology training programmes provide teaching on ACT. Therefore, during this teaching it would be sensible to emphasise the usefulness of drawing from this model in leadership as well as within therapy.

Resilience appeared to contribute to participants' leadership "success". Participants also described how being self-aware and able to develop themselves was important in their leadership "success". Therefore, employers may want to assess the resiliency of potential employees before assigning them leadership roles. They may also want to assess an individuals' capacity to self-reflect and develop themselves when recruiting leaders in healthcare. If employers are planning on developing their own workforce it may be useful to consider resiliency training as well as personal and professional development groups. This is so that individuals can reflect on themselves as well as providing support to others.

Future research

The current study highlighted the need for future research in a number of areas. The focus of the current research was to explore the successful leadership experiences among senior female clinical psychologists. This was a small scale study, therefore, it may be valuable for further studies to identify whether other senior female clinical psychologists experience congruent values and identities or whether these experiences are specific to the current sample.

Participants described using psychology in their role as a leader and experienced congruent values across their identity as a female, leader and psychologist. Therefore, it would be interesting to explore whether these findings are replicated among senior male clinical psychologists or whether they experience incongruence because of their male gender

identity. Therefore, future research could explore using a sample of senior male clinical psychologists or attempts could be made to conduct a comparison study to assess whether the current findings are limited to a female sample.

The use of psychology appeared to play an important role across participants' accounts. Therefore, it would be useful to explore this using a sample of senior female health professionals who are not psychologists. This may provide insight as to whether these findings are specific to the profession of clinical psychology or whether they can be transferable to other health professions.

Participants described *'fighting the good fight'* when they perceived unjust decisions being made that would have a negative impact on their SUs and/ or staff. However, they described choosing their battles when they perceived the injustice to target them personally. Therefore, it would be interesting to conduct a further qualitative study to explore the experiences of personal injustice among senior female clinical psychologists. This is because this would identify the barriers female leaders experience that lead to them deciding not to fight, which would be useful in designing potential interventions to enable female leaders to express the prejudice that they perceive themselves to experience.

Conclusion

This study examined the successful leadership experiences of senior female clinical psychologists in the NHS. Participants described their leadership in relational terms. They emphasised the importance of establishing a relationship to influence others. Participants' successful leadership experiences were interpreted in terms of five superordinate themes. These were The Nurturer, The Diplomat, The Activist, The Warrior and The Repairer. Participants described building a nurturing relationship with their staff and SUs (The Nurturer). They also described carefully negotiating a relationship with individuals holding power and authority (The Diplomat). Participants perceived that once the relationship was in place and they had demonstrated their abilities that they were then perceived by others to be "credible". If participants recognised friction developing within their relationship they described a leadership experience which paralleled The Repairer, which repaired the relationship. If participants perceived an injustice to have occurred, they described feeling responsible for challenging this, which was interpreted either as the Activist when they intervened on the behalf of staff and SUs or as The Warrior when they were intervening for themselves. Interestingly, participants described challenging injustices which affected their staff and SUs. However, few described challenging injustices which they perceived to have

been personal, this leadership experience was interpreted as The Warrior. When participants described their leadership style they integrated these different leadership strategies, which highlights the complexity of their leadership.

In terms of making sense of their leadership experiences, participants talked about being a psychologist first and foremost. Their accounts suggested that they perceived leadership to be an extension of their clinical skills as they made sense of their leadership by drawing from their core clinical competencies. These included; assessment, formulation, intervention, personal and professional development and service delivery. Central to participants' accounts was an experience of congruence across their identities as a leader, a psychologist and as a female. These findings highlight the complexity of leadership and the need to utilise more qualitative methods to further our understanding of leadership. Further research is required across different samples to establish whether these leadership strategies are unique to female leaders within clinical psychology.

Closing reflections

My initial interest in conducting this research stemmed from having perceived myself to have struggled to successfully influence in a leadership role prior to commencing my clinical training. Therefore, I had anticipated that the "successful" leadership experiences of female senior clinical psychologists would always manage to influence change within the NHS. However, having conducted this research I now recognise that successful leadership is not necessarily about the outcomes one achieves but perhaps is more about a way of being as a leader. Consequently, I perceive that this shift in my attitude and approach to leadership has enabled me to become more compassionate towards myself and others as a leader.

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APPENDIX

Appendix A: Email Correspondence

Dear XXXX
One of our trainees, Frances Corrigall, is conducting her thesis research into the experience successful leaders. She hopes to interview a small sample of clinical psychologists who are experienced and successful in clinical leadership roles. As her research supervisors, we are starting off the process of recruitment and we considered you to be an ideal participant; we wondered whether you would be interested in participating in the study.
There is an information sheet attached to this email. We would very much appreciate it if you would have a look at this. If you would be prepared to take part, please just let us know this and we will pass on your contact details to Fran.

Appendix B: Participant Information Sheet

The Experience of Successful Leaders: An IPA Study on Senior Female Clinical Psychologists

You are invited to participate in a research project

We are interested in exploring the experience of being a successful leader working as a senior female clinical psychologist in the NHS. It is important that researchers begin to understand the experience of leadership among female leaders as the majority of research into leadership has been done by men, on men, for men. Understanding the leadership experiences of women may help to alter this dominant narrative and may provide new insights into how leadership is done and defined. By understanding and making sense of these leadership experiences we aim to provide data that other female leaders can utilise in their own leadership practice.

Do I have to participate?

No, you do not have to participate in the research. Your participation is entirely voluntary. If you choose to take part you will need to complete a brief consent form. Additionally, you will be able to withdraw from the project at any point up to a week after being interviewed.

How have I been chosen?

Female clinical psychologists have recommended you to me as a potential participant. This is because female clinical psychologist colleagues of yours have identified you as a senior female clinical psychologist who is also a "successful leader".

What does the research involve me doing?

A 60-90 minute face-to-face or telephone interview with yourself and the interviewer will take place either at The University of Leeds or at a place you specify. The interview will involve you reflecting and talking about your experiences of leadership in the workplace over the last week or fortnight.

Pros and cons of participating

One of the disadvantages of taking part in the interview is your loss of 60-90 minutes. Additionally, during the interview it is possible that you may talk about difficult experiences you might have had whilst leading. Therefore, the interview may cause you some discomfort. A potential positive outcome of taking part in this research is that other women may be able to learn from your experiences of leadership and put these into practice.

Will I remain anonymous?

Yes the data will remain anonymous but not confidential as verbatim extracts will be transcribed by Frances Corrigall and professional transcribers working for The University of Leeds. Therefore, some verbatim (but anonymous)

extracts will appear in the final text. You are able to withdraw data from the interview up to a week after taking part. The interviews will be recorded onto an encrypted audio recording device which will be password protected.

What happens to the data?

Once the data has been uploaded to the M drive, which is a secure password-protected university server, it will be deleted from the encrypted Dictaphone. In addition, once the study has ended the data will then be deleted from the M drive and after 3 years of storage the transcripts will then be destroyed. It is hoped that the results of this project will be written up and published, possibly in a peer reviewed journal. Additionally, the findings will be presented at the trainee research conference and possibly at other conferences. Please note that all verbatim extracts will be anonymous.

Who is involved in this project?

Frances Corrigall, Psychologist in Clinical Training, University of Leeds (umfac@leeds.ac.uk).

Dr Jan Hughes, University of Leeds. (J.Hughes@leeds.ac.uk)

Dr Carol Martin, University of Leeds (C.Martin@leeds.ac.uk)

If you are interested in understanding any more about this research or the recruitment process please contact Frances Corrigall on {insert -mobile phone number to be identified by research team}

If you have any queries regarding this research for either Dr Hughes or Dr Martin please contact them on the following number 0113 343 2732 .

If you have any complaints that you would like to make regarding this research please contact the Department of Clinical Psychology Administration team based at The University of Leeds who will be able to arrange this for you.

Lydia Stead l.stead@leeds.ac.uk

Debby Williams d.williams@leeds.ac.uk

Leeds Institute of Health Sciences, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ.

Telephone: 0113 343 0829

Appendix C: Ethical Approval from The University of Leeds

UNIVERSITY OF LEEDS

Faculty of Medicine and Health Research Office
School of Medicine Research Ethics Committee (SoMREC)

Room 10.110, level 10
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Clarendon Way
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03 December 2014

Miss Frances Corrigall
Psychologist in Clinical Training
The School of Medicine, LIHS
Clinical Psychology, Medicine and Health
Charles Thackrah Building
University of Leeds
101 Clarendon Road
Leeds, LS2 9LJ

Dear Ms Corrigall

Ref no: SoMREC/13/105 _ Amendment 1

Title: The Experience of Successful Leaders: An IPA Study on Senior Female Clinical Psychologists

We are pleased to inform you that your amendment to your research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documents received from you:

Document	*Version*	*Date submitted*
Amendment_form_FC_14_11_14[1][1]	1	25/11/14
Follow-up email 11_11_14_V1	1	20/11/14
Research protocol 10_10_14_V3	3	20/11/14
Recruitment email 12_09_14_V1	1	25/11/14
CONSENT+FORM_08_10_14_V2[1]	2	25/11/14
Information sheet_08_10_14_V2	2	20/11/14

Please notify the committee if you intend to make any further amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhsunilethics@leeds.ac.uk)

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

CONSENT FORM: The Experience of Successful Leadership among Senior Female Clinical Psychologists

I confirm that I have read and understand the information sheet which explains the research project. I also confirm that I have had the opportunity to ask questions about the project. ☐

I understand that my participation in this research project is voluntary and that I am free to withdraw up to a week after completing the interview. I know that I can do this without giving any reason and without there being any negative consequences. Additionally, if I do not wish to answer a particular question or questions, I know that I am free to decline to do so. ☐

I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from this research. ☐

I give permission for the interview to be audio recorded. ☐

Name of participant	Date	Signature
Researcher name	Date	Signature

Confidentiality Statement for Transcribers

The British Psychological Society has published a set of guidelines on ethical principles for conducting research. One of these principles concerns maintaining the confidentiality of information obtained from participants during an investigation.
As a transcriber you have access to material obtained from research participants. In concordance with the BPS ethical guidelines, the D.Clin.Psychol programme requires that you sign this Confidentiality Statement for every project in which you act as transcriber.

General

1) I understand that the material I am transcribing is confidential.

2) The material transcribed will be discussed with no-one.

3) The identity of research participants will not be divulged.

Transcription procedure

4) Transcription will be conducted in such a way that the confidentiality of the material is maintained.

5) I will be supplied with the audio-recordings on an encoded USB and will work directly from this USB, not downloading the audio-recordings onto my computer.

6) I will ensure that audio-recordings cannot be overheard and that transcripts, or parts of transcripts, are not read by people without official right of access.

7) All materials relating to transcription will be returned to the researcher, and no copies will be made.

Signed……...Date……

Print name……

Researcher……

Project title……

Appendix F: Questionnaire

Draft Interview Schedule

Introductions, discuss the information sheet and consent.

I am interested in understanding about your experiences of leadership as a female senior CP.

1. What was it that motivated you to become involved in this research?

2. What are the overarching roles of your current post?

3i. {insert name} described you as a successful leader, is that how other people in your system see you?
3ii. I'm wondering whether you see yourself the same way?
3iii. How comfortable are you with being described as a successful leader?

4a. Describe your last working week to me – get the participant to briefly describe all the activities they have engaged in over the last working week.

- *Negotiate with the participant and identify a maximum of 3 acts of "successful" leadership over the last week. Do not utilise line management examples, attempt to focus on MDT meetings, projects, service delivery and Psychology team meetings. If they want to use an example not covered in the last week, use their most recent example.* Then follow up using these questions…
    - What happened?
    - What did you think?
    - How did you feel?
    - Was anyone else involved?
    - What did you think they thought/ felt?
    - How did they respond?

4b. Can you tell me about a time when you think gender played a significant role in your ability to lead?
Or if they have already begun to tell you this in response to the previous question say
"you have already given me an example of when gender played a significant role in your decision to lead, I wonder if you have another example or whether you can elaborate on this?"

- What happened?
- What did you think?
- How did you feel?

5. *Negotiate with the participant and identify a maximum of 3 acts of leadership where they wish they had done something differently.*

Further prompts to follow up questions…

- Do you mean that…?
- Can you tell me more about that?
- What do you mean by …?
- What was that like for you?

6. Having reflected on all these experiences what sense do you make of leadership now?
   Follow up prompts…
   Do you have a metaphor or image to describe this?
   Explain how this makes sense to you.

7. Is there anything else that you would like to tell me?

Have you got any questions for me?

Check in with participant and how they are feeling

Ask participant whether they are still happy to consent.

Thank participant for participating.

Appendix G: Initial coding of the data and the development of themes

The initial coding of the data and development of themes using Anna's transcript as an example

Extract	Initial noting	Pen portrait theme	Superordinate theme (subordinate theme)
Um and I think communicating […] to her [the manager]… […] that this position couldn't continue because it was a risk. The Trust had to deliver on this and if my recommendations weren't …. picked up […] it wouldn't be good for the trust, it wouldn't be good for the SUs and staff.	Negotiate Assertive communication	I feel persuasive (I feel comfortable negotiating).	The Diplomat (the power of persuasion)
"What I've done successfully is manage… tried to manage that which is contain staff, to reduce the level of sickness which which has gone up in some areas service trying to keep staff at work, to keep staff contained and functioning during this process.	Containing Caring Maternal	"I feel part of a team endeavour" (I empathise with staff)	The Nurturer (I am caring)
"He often doesn't contain himself. So in an attempt to be efficient he sends things out too quickly to manage his anxiety and he should sit on things perhaps sometimes rather than just react"	Reflection Applying psychology	I am mindful (I reflect and adapt)	The Repairer (I reflect and make sense)
He [her manager who she had had a falling out with] needed help from me and he didn't understand really. […]. So I realised I needed to take the stance of rather than coming in and being cross saying "why did you not do this?" I realised that I needed to hold the position which is "I didn't understand the meeting", I didn't appreciate what that meeting was about".	Negotiate/ Repair	I am mindful (I need to position myself differently)	The Repairer (I need to intervene)

Appendix H: An overview of themes for each individual participant

Participant	**Superordinate themes** and *subordinate themes*
Astrid	**I am a clinician** - *I feel responsible for SUs* - *I tolerate difference* - *I feel influential using my clinical skills* **I lead in accordance with my values** - *I value giving others a voice* - *I value fairness and honesty* - *I feel guilty and conflicted if I cannot lead by my values* **I am resilient** - *I accept my own and others' limits* - *"I take people's flak"*
Caroline	**"You do the best you can but you don't always win"** - *I advocate for SU's and staff* - *I struggle to influence with limited resources* - *I accept my limits and the limits of others* **I feel disappointed by decision making in the NHS** - *I feel nostalgic* - *I feel protective of psychology* **I feel discriminated against** - *I feel excluded from "the old boy's network"* - *I feel targeted as a psychologist* - *I feel vengeful*
Tara	**"There are lines that I will and I won't cross"** - *I value fairness and equality* - *I feel angry in response to injustice* - *I feel justified to challenge injustice* **I am different in different places** - *I feel a need to adapt* **I feel dependent on others to be influential** - *"There's strength in numbers"*
Elaine	**I feel different as a psychologist** - *I feel empathy for staff and SUs* - *I connect managers with staff and SU's experiences* **"Fighting the good fight"** - *I feel passionate about SUs* - *I fight for SUs* - *I feel pressure to make amends* **"Some of it's learning by experience"** - *"I'm playing catch up"* - *"I feel anxious but do it anyway"*

Melanie	**I feel persuasive as a psychologist** - *I figure out psychological solutions* - *I "sell" solutions to others* **I feel different as a female leader** - *I feel constrained by my gender* - *I feel embarrassed and guilty* - *I feel a need to adapt my behaviour* **I feel motivated to overcome injustice** - *I feel responsible for staff and SUs* - *I fight for justice* - *I feel angry about unjust decision making injustice*
Anna	**I feel persuasive** - *I understand others motives* - *I feel comfortable negotiating* - *I feel able to compromise* **I feel part of a team endeavor** - *I feel empathic towards staff* - *I value empowering others* - *I value crediting the team members* **I am mindful** - *I feel excluded* - *I feel dysregulated* - *I reflect and adapt* - *I position myself differently*
Mary	**I feel influential** - *I understand the motives of others* - *I push where it moves* **I lead by my values** - *"That's not right, that's not fair"* - *I feel angry* - *I play Devil's advocate* **I feel like a work in progress** - *"I'm still learning"* - *I reflect and adapt*