

Exploring Clinical Psychologists' experiences of leading within clinical teams in
relation to their values

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The 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.

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Abstract

Introduction: Leadership in clinical teams is a significant part of a Clinical Psychologist's job role (Leadership Development Framework; DCP, 2010) but little is known about their lived experience as leaders, especially when facing dilemmas. Decision-making and influencing care is a key aspect of leadership and is known to involve individuals' values. Values impact a person's wellbeing whether they are aligned or misaligned, which in turn hold importance for the health of the individual leader and those they are leading.

Aims: To understand participants' experiences of leading in clinical teams and their sense making process. This was with a focus on when they faced dilemmas, and how they made sense of this in terms of their values.

Method: Eight Clinical Psychologists working in NHS Trusts participated in the study and were practicing in Band 8a-8c roles. Interpretative Phenomenological Analysis was used to analyse the semi-structured interviews following Smith, Flowers, and Larkin's (2009) guidelines.

Results: Participants reflected upon 25 examples of experiences that were mostly focused on dilemmas. Three superordinate themes and twelve subordinate themes emerged. The first theme of *'losing control and perspective'* encompasses participants' experience of *'distressing'*, *'helplessness'* and *'frustration with self and others'*. The second superordinate theme, *'regaining control and perspective'*, encompasses their experiences of *'feeling one thing, doing another'*, *'feeling more empowered'*, *'congruence with what is important'*, and *'seeking security'*. The final theme, *'reflections on facing dilemmas'*, encompasses the subordinate themes of; *'what's right versus what's most comfortable'*, *'making sense of retreating from action'*, *'wounds into wisdom'*, and *'personal growth'*.

Discussion: These findings have been discussed in the context of the literature on leadership, values and wellbeing in the context of the NHS and clinical psychology. Recommendations for the implementation of findings have been provided for the individual leader, and stakeholders such as those providing teaching, training and the NHS as an organisation. Suggestions for future research have also been provided.

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Introduction

Brief overview

This thesis explores Clinical Psychologists' everyday experiences of leading in clinical teams and their sense making process. This study particularly focuses on their experience of dilemmas, and making sense of them through the lens of values. Interpretative Phenomenological Analysis was used to explore their experiences and sense making. The study was designed with relevance to clinical practice, but also holds personal and professional importance for me.

The introductory chapter provides a review of the literature that informed the rationale for the study. The first section focuses on leadership in healthcare which is divided into four sub-sections: defining the context of leadership within the NHS, models of leadership relevant to the NHS, leadership in relation to Clinical Psychologists and the experience of dilemmas in healthcare. The second section introduces values as a way to make sense of leadership experiences which has four sub-sections: the definitions and theory surrounding values, specific values in relation to the NHS and then in relation to Clinical Psychology, and the impact of value congruency. The third section focuses on the wellbeing of staff and is divided into four sub-sections: an explanation of the link between values and wellbeing, the experience of burnout in healthcare, the current wellbeing of staff in the NHS and the relationship between wellbeing and leadership. After the literature review the theoretical model, Cognitive Dissonance Theory (CDT; Festinger, 1957), has been outlined to help make sense of differences between values. The introduction concludes with a summary of the rationale for the study along with the research aims and questions.

Leadership in healthcare

The context of leadership within the NHS

Leadership is a topic of great interest and is well established in the published literature. This emphasises its importance across professional sectors including healthcare and the National Health Service (NHS). Understanding leadership has been a key concern of stakeholders, policy makers and academics for a long time. This is driven by the concern

to improve organisational and clinical effectiveness, such as the improvement of service-users' mental and physical health (Martin, Beech, MacIntosh, & Bushfield, 2015). This is especially relevant to the NHS today as a result of the widening disparity between increasing mental healthcare provision and reducing expenditure, along with the significant psychological distress of the British public (Kings Fund, 2015b). With these factors in mind, the way the NHS is led is crucial.

An endorsed definition of leadership has been adopted in the NHS commission and distinguishes leadership from processes associated with management (Kotter, 1996, as cited in Kings Fund, 2011; p. 12). This describes management as being concerned with practices such as 'planning, budgeting, organising, staffing, controlling and problem-solving'. Whereas leadership has been described as 'establishing direction, aligning people, motivating and inspiring'. A psychologist wrote in the British Psychology Forum magazine that "management is doing things right, leadership is doing things the right way" (Skinner, 2011, p. 13). This reflects the wider definition held within healthcare literature that separates leadership from management.

A recent reason for the increased interest in leadership within the NHS follows a series of high-profile failings within the NHS, such as the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013). The reports from these investigations highlighted how the lack of leadership and low staff morale (related to job satisfaction and wellbeing) contributed to these issues (Rydon-Grange, 2015). This was partly attributed to the lack of clinicians' engagement in leadership and management. Reflecting the quality of leadership more recently was a comparison of the 2013 and 2014 staff surveys which specifically assessed their views on the quality of leadership, culture and compassionate care in the NHS (Kings Fund, 2014). Although staff's experiences of leadership had improved, 28% still reported that they perceived the quality of leadership to be poor or very poor across all levels of clinical staff. In 2013 this score was 40%, which was significantly higher than 2014 suggesting there had been an improvement in leadership. The most recent staff survey (2017) suggests there has been a small improvement in leadership, with 68% reporting their immediate managers are interested in their health and wellbeing compared to 67% in 2016 (NHS, 2017). Although these results are encouraging, there are still warning signs about the state of leadership within the NHS, such as staff feeling an increased

pressure from management to attend work when unwell, and work-related stress increasing from 36.7% in 2016 to 38.4% in 2017 (NHS, 2017). Therefore, there is still a demand on academics to improve our understanding of leadership within the context of these large-scale failings with the NHS.

Frontline clinical teams have been identified by the Kings Fund (2013) as one of ‘three lines of defence’ in preventing failures in healthcare services (Dixon, Foot, & Harrison, 2012). Working within teams has dominated services within the NHS, with most staff reporting working in this way (Kings Fund, 2015a). This includes those holding leadership positions. Evidence for this emphasis comes from the finding that the leadership of wards was more influential than the organisational culture on staff wellbeing (Maben et al., 2012a). Well-functioning teams were associated with fewer errors at work and higher staff retention rates (Lyubovnikova, West, Dawson, Carter, & Matthew, 2015). This was evidenced by lower rates of staff sickness, which reduced organisational expenditure. Hospital teams that were considered to have better team working also showed improved patient satisfaction (O’Leary, Sehgal, Terrall, & Williams, 2012). In addition, staff wellbeing was associated with patient satisfaction, again emphasising the requirement for effective clinical teams (Maben et al., 2012b). A review of the literature on developing clinical teams within healthcare described how they are effective when they are working ‘collectively and in collaboration’ (Ezziane et al., 2012). In addition, the British Journal of Medicine has created the ‘clinical leadership team award’ to notice the importance of this type of work (O’Dowd, 2014) and it is advocated that all staff members should be supported to work well within teams (West & Lyubovnikova, 2012). It is therefore important to understand and improve the leadership of clinical teams to support those working in this way, which is the contextual focus of this current study.

NHS models of leadership

Specific leadership models are not of central focus to this study, however a brief summary of the main models promoted by the NHS helps to set the context. Internationally, there has been a rise in clinicians taking on leadership roles and responsibilities within healthcare, following structures seen in Europe (Kuhlmann et al., 2013). Specifically in the UK, the NHS asserts that leadership is also the responsibility of all staff members in line

with the Collective Leadership principles that it advocates, which are described further below (West, Eckert, Steward, & Pasmore, 2014). Current models, that are adopted from the broader literature and advocated within healthcare, are relationally based (Copeland, 2014). Copeland's review of these leadership models also highlights how they draw upon the values, ethics and morals of the leader. Many of these terms overlap or are interchangeable, such as transformational leadership (Bass, 1990), distributed leadership (Spillane, 2006), shared leadership (Pearce & Conger, 2003) and engaging leadership (Alimo-Metcalf & Alban-Metcalf, 2012). These models move away from an autocratic understanding that hold the leader as a hero with all of the power (Fletcher, 2004). Instead, they promote leadership to involve an influence that is shared with other individuals in the organisation (Gronn, 2002). This means that staff on the frontline such as nursing staff and occupational therapists, are able to activate plans to develop services from the bottom-up. In summary, these models of leadership endorsed by the NHS emphasise their relational and values focus, promoting the importance of leadership across all professions. The effectiveness of these models in relation to improving staff wellbeing is discussed in a later section.

Leadership in Clinical Psychology

The role of the Clinical Psychologist has evolved from traditional therapy into a position of greater organisational and systemic influence. This is displayed through leadership roles and responsibilities. The emphasis on leadership is reflected in the New Ways of Working for Applied Psychologists framework (Lavender & Hope, 2007) and more recently the Leadership Development Framework (LDF; Division of Clinical Psychology; DCP, 2010). The latter highlights the development of leadership skills throughout the trajectory of a Clinical Psychologist's career from trainee to consultant. The LDF highlights five domains of leadership that Clinical Psychologists are expected to be involved in: 1. Demonstrating personal qualities 2. Working with others 3. Managing services 4. Improving services and 5. Setting direction. These domains are relevant across Clinical Psychologists' competencies, and each domain contains various sub-categories detailing how they are applied in practice. In relation to leading clinically, examples of their application are included. The domain 'working with others' (p. 8) refers

to working within teams to deliver and improve services which includes influencing the development of other professionals, problem-solving, leading on team dynamic discussions and offering psychological approaches to care in conjunction with medical models of treatment. Whereas ‘Setting direction’ (p. 11) refers to the role of decision-making within clinical teams, and developing services that will improve quality of care and disseminate outcomes within clinical networks. Across these domains, the role of working in teams is emphasised and is based on evidence that shows clear and effective leadership improves the effectiveness of the team (Onyett, 2007).

Ethical Dilemmas

The leadership of clinical teams draws on the day-to-day experiences that are more likely to have an influence on the direct care of service-users. However, within the literature, little is known about the types of everyday leadership situations that clinicians face and their associated experiences. One key element of this role is the involvement in decision-making, which is understood to at times produce dilemmas and challenges for those in managerial positions (Lee, 2015). The literature on ethical and moral dilemmas defines these as decisions between what is “right versus right” and “right versus wrong” (Kidder, 1995, as cited in Bhola, Sinha, Sonkar, & Raguram, 2015, p. 206). Dilemmas are therefore underpinned by an individual’s sense of what is ‘right, good or desirable’, or in other words, their values (Rokeach, 1973, as cited in Moyo et al., 2015, p. 257). Within the context of individual therapy, the experience of facing dilemmas has received significant attention in the literature. The evidence here also shows an effect of career span, with those earlier on in their careers such as those in training, reporting more frequent dilemmas (Bhola et al., 2015). The first systematic review of this literature aimed to conceptualise the types of dilemmas experienced when professionals were making decisions in the context of healthcare (Zydzūnaite, Suominen, Åstedt-Kurki, & Lepaitė, 2010). These happened at a political and local interface level, national level, and institutional level (p. 598). The latter two levels contain dilemmas that may be relevant to those leading within a clinical team. At the institutional level this includes experiences such as ‘balancing between several decisions, as the ethical dilemma emerges in the context of organisational climate and loyalty organisational values’ (p. 599). At a national level this includes experiences such as

'a concern about specific interactions among specialists' (p.599). Although this helps to conceptualise the type of dilemmas experienced by those leading within healthcare, it also highlights that little is understood about the leaders' experience of managing these dilemmas.

Values: a lens to understanding leadership

Definitions and theory of values

The concept of 'values' is complex, raising many questions regarding its definition. Often terms such as goals, motives, attitudes and beliefs, are used interchangeably with values and being able to distinguish between these concepts can be difficult (Oyserman, 2002). This is partly complicated because definitions are rooted within a range of philosophical, social and psychological traditions (Cieciuch, Schwartz, & Davidov, 2015). One commonly used definition is that values are "enduring beliefs that a specific mode of conduct or end state of existence, and is personally or socially preferable to an alternative mode of conduct or end state of existence" (Rokeach, 1973, p. 5). Further, values are thought to be "beliefs and preferences that guide the process of human decisions" (Thomas, 1994, p. 164). These two definitions clearly state the influence of values on individuals' actions as values serve as motivation that is consistent across situations. However, a more commonly accepted and individualised way of viewing values comes from this widely used definition by Wilson and Dufrene (2009) in the psychology literature. They describe them as "freely chosen, verbally constructed consequences of on-going, dynamic, evolving patterns of activity, which establish predominant reinforcers for that activity that are intrinsic in engagement in the valued behavioral pattern itself" (p. 46). This highlights the role of the environment in shaping and influencing the formation and expression of values, which may include personal and professional experiences.

Some researchers and writers have attempted to conceptualise values into themes. For instance, Vernon and Allport (1931) defined the six major themes of: aesthetic, theoretical, social, economic, political and religious values. Schwartz (1992) conceptualised the ten major values of; power, achievement, hedonism, stimulation, self-direction, universalism, benevolence, tradition, conformity, and security. He also investigated the

eleventh value of spirituality, although this was not included in his most recent version of the model. He highlighted that some values held by an individual may complement each other whereas others may compete. In terms of competing values, he offers the example of self-direction, or in other words ‘the drive to be independent’, versus conformity, the ‘need to fit into the norm’. These may be triggered during a situation that may cause an individual to experience an internal conflict between values that they may hold and suggests this may cause internal dilemmas for an individual making decisions. This suggests that it is important to consider the interaction between values on an individual’s experience. This has since been adapted by a review of the literature on the personal and professional values of healthcare professionals (Moyo et al., 2015). The authors mapped onto Schwartz’s model the following more commonly used terms and included the value of spirituality. These were authority, capability, pleasure, intellectual stimulation, critical-thinking, equality, altruism, morality, professionalism, safety, and spirituality.

Schwartz later published a document summarising his and others’ work on basic values (2012, p. 4). This outlines the six major points describing the nature of values. These are that 1) values are beliefs 2) values refer to desirable goals 3) values transcend specific actions and situations 4) values serve as standards or criteria 5) values are ordered by importance 6) the relative importance of multiple values guide action (as there is a compromise between competing values). This theory has a strong cross-cultural evidence-base for its relevance (e.g. Bilsky, Janik, & Schwartz, 2011). This includes studies across a spread of individual characteristics deemed highly diverse, such as age, language and gender (Schwartz, 2012). Although it is noteworthy that the value of ‘spirituality’ was not consistent across all cultures reviewed so far. This model also suggests values are on a continuum and therefore overlap to a degree with each other. This may produce difficulty when trying to distinguish between two values, which is a limitation of this model. Despite this, the theory of basic values framework will be used for defining values within this study due to the strength of its evidence-base and its use already within healthcare based research.

Overall the definitions of values that have progressed over the years share the understanding that they direct behaviour and emphasise their complexity, such as the experience that values can conflict. Therefore, values are a helpful lens to understand experiences that involve an element of decision-making and dilemma.

Values in the NHS

The NHS Constitution is defined by five core values that underpin the purpose of the service and its workforce (NHS, 2015). These are compassion, respect and dignity, working together for patients, commitment to quality of care, improving lives and everyone counts. These values are reflected in the patient-centered leadership document released by the Kings Fund (2013) that emphasises the importance that leadership reflect these core cultural values of the NHS. All healthcare professions practicing within the UK also adhere to their own sets of ethical codes that inform the professional values that influence their clinical practice. For instance, doctors subscribe to the General Medical Councils (GMC) documentation on Standards and ethics guidance (GMC, 2014). It is assumed that these different professional guidelines advocate similar value-based practices but the degree of this similarity is unknown.

The NHS annual staff survey evaluates staff experiences across the year, such as their opinions on the practice of the NHS core values. A comparison of the results from 2013 and 2014 stated that a culture of openness, honesty and challenge is needed to create a compassionate workforce (Kings Fund, 2014). The findings showed that there was a discrepancy in ratings of openness, honesty and challenge across all professional groups, with doctors and nurses rating this as 37% and 31%, respectively. Further, 17% rated leaders in organisations as rarely or never showing compassion to patients and only 25% of leaders showing compassion to employees. Values are important to the NHS but these surveys alert us to the fact that there is a discrepancy between the values advocated and the extent they are practiced in leadership as perceived by staff. The values stated and promoted by organisations have been found to be different from their members' perceptions of the organisations' values in practice (Shapiro & Naughton, 2015). This has been described as a discrepancy in "espoused values" (Schein, 2010). This is important as it highlights the possibility that there may be an increase in the likelihood that staff may experience a conflict in values if there are discrepancies between what is advocated compared to what is practiced within the organisation.

Values in Clinical Psychology

The literature below focuses on Clinical Psychologists' professional and personal values. The Leadership Development Framework (DCP, 2010) distinguishes between organisational, professional and personal values. As discussed further below, it places emphasis on the clinician, in this case the Clinical Psychologist, and reflects on their professional and personal values in relation to their involvement in leadership roles and responsibilities.

Professional values.

Professional values are understood to influence the group's 'identity, principles, and beliefs' (Frankel, 1989). The British Psychological Society's code of ethics and conduct (BPS, 2009) informs Clinical Psychologists' professional activities. The Health and Care Professions Council's Standards of Proficiency (HCPC, 2015) also provides recommendations on the safe and effective practice of psychologists. This emphasises the importance of Clinical Psychologists abiding by the ethical frameworks of the profession. In terms of professional guidelines, the BPS code of ethics and conduct is based on values. Each pillar of responsibility (respect, competence, responsibility and integrity) is introduced by a *statement of value* describing its relationship to 'ethical reasoning, decision making, and behaviour'. Within the ethic of 'competence', it states that in order to make ethical decisions, one should 'reflect upon established principles, values, and standards'. In addition, Moyo et al. (2015) found that values advocated in professional codes of ethics were reflected in the most commonly shared values reported across healthcare professionals (altruism, equality and capability). However, despite the variety of guidelines helping inform clinical practice, the application of values comes with challenges. An evaluation of the limitations of the codes of ethics showed that they do not always correspond to real-world ethical challenges (Routledge, 2015) and therefore do not offer a helpful approach to managing and resolving issues (Van Liew, 2012). In order to supplement these limitations, the clinician's professional judgment is emphasised as important when applying these principles (Barnett, Behnke, Rosenthal, & Koocher, 2007). This suggests it is important to understand that the professional values of the Clinical Psychologist may influence their interpretation and application of these guidelines when making decisions in clinical

practice. Therefore, this emphasises the importance of reflecting on values in relation to practice.

Personal values.

The use of personal values and ethics within clinical leadership is also highlighted within the Leadership Development Framework (DCP, 2010). For example, under the domain of 'setting direction' of the clinical team they encourage the reflection upon personal values in relation to decision-making and responding when ethics and values are compromised (p. 8). Pilleltensky (1997) proposed a framework of five core values for psychologists, with the hope of opening up a dialogue about their impact. This included care and compassion, self-determination, human diversity, collaboration and democratic participation and distributive justice. He suggests that they are not activated alone but in 'concert' with others, echoing Schwartz's theoretical understanding of values (2012). Within the context of therapy, therapists' values are found to effect the goals and interventions they utilise and the importance of being aware of these (Carlson & Erikson, 1999). For example values informed by therapists' religious beliefs (Bilgrave & Deluty, 1998) and their ethnicity (Consoli, Kim, & Meyer, 2008). Values have also been found to influence decisions about their therapeutic orientation (Tartakovsky, 2016), emphasised within particular psychological approaches. Examples include community psychology and the therapeutic tasks involved with particular models of therapy such as 'Acceptance and Commitment Therapy' (Hayes, Strosahl, & Wilson, 2003). Preliminary findings from a study interested in the role of successful senior female Clinical Psychologists identified the effect of values on their experience of leadership identity (Corrigall, 2015). This highlighted service-user and relationship-related values as being significant. In the context of leadership, Clinical Psychologists' lived experience of using their values has yet to be intentionally explored within the literature.

Congruence with values

The importance of values is evident in the business and leadership literature. Yukl (2013) referred to personal integrity as a quality pertaining to effective leadership. Greater

personal integrity is when there is a small difference between altruistic values and relevant behaviours. Kings Fund (2015) summarised personal integrity as when individuals are aware of their values and explicitly express these through their actions. For example, leaders who are able to verbalise and act in line with their values, as reflected by an authentic leadership style, have been found to improve nurses' perceived job satisfaction through feeling empowered (Wong & Laschinger, 2013). However, this research only focuses broadly on values, documenting some ways in which values are important rather than understanding the experience of using values when leading. Further, Copeland (2014) carried out a review on the increasing significance of values within effective leadership. Three characteristics that have gained the most momentum are authentic, ethical and transformational styles, which are all in line with personal integrity. One noteworthy influence of these methods of leading is that they are found to empower and motivate others (George, 2003, p. 108) and thus increase their performance (Bass, 1985).

The importance of congruence between different sets of values has been established within the literature. This includes the individual's values and the organisation's, or the individual's personal values and workplace values. The term "value congruence" (Kristof, 1996) refers to the similarity between the values held by the employee and the organisation's promoted values. A higher correlation between personal values and organisational values has predicted a range of employee factors including their commitment to stay (Sheridan, 1992) and has been linked to employees fulfilling and going beyond their professional roles (Ricketta, 2005). It has also predicted improved wellbeing of staff members (Kristof-Brown, Zimmerman, & Johnson, 2005). As stated, there may also be a difference between an individual's own personal and workplace values. It has been found that an individual's value may reflect the profession's values before they are socialised into their occupation (Rabow, Remen, Parmelee, & Inui, 2010). However Rabow found that at times these two sets of values might not be aligned causing "personal-professional conflicts". An empirical study evaluated the relationship between personal and professional values, and the wellbeing of a range of Australian mental healthcare professionals including psychologists (Veage et al., 2014). They found that a greater congruence between these sets of values was associated with healthier wellbeing and lower levels of burnout. However this study used a card-sorting method, which although it allowed participants to define their own values, it did not explore the participants' understanding and relationship to the value.

Therefore, one way to approach understanding professionals' experiences of leadership may be to understand situations when the relationship between an individual's personal and workplace values are congruent and incongruent with each other.

A more recently explored experience is when individuals face an internal conflict because of differences between their own personal values. Sverdlik (2012) is one of only a small selection of studies that have empirically examined the occurrence of internal value conflicts intentionally. In this study they found evidence to support the idea that an individual's value hierarchy defines what they find conflicting in certain situations. In other words, the situation itself does not define the values triggered but the person's values define what they find conflicting about the situation. In the context of leadership, Corrigan's (2015) study provided preliminary evidence contributing to the importance of the individual's values to their experiences of leading. However this study was not concerned with the experience of values specifically and therefore did not explore them across participants. It is reasonable to assume that internal conflicts between values may be significant when leaders are required to make difficult decisions that affect teams of professionals and service-users, and therefore the lived experience of this needs to be understood directly.

Wellbeing

Wellbeing and values: moral distress

As already suggested, values are important to psychological health (Plumb, Stewart, Dahl, & Lundgren, 2009). The term 'moral distress' originates from the nursing literature (Jameton, 1984). This refers to the emotional and psychological impact when "one knows the right thing to do for a patient but institutional constraints make it impossible to pursue that course of action" (Jameton, 1993). In other words, they are unable to take value driven actions. However, Morley et al. (2017) summarised the extensive range of definitions in the literature regarding moral distress. This review highlighted the related internal experiences evidenced by self-blame, anxiety and powerlessness as a result of not feeling able to take moral action (McCarthy & Deady, 2008). This extended the original definition to include the impact of factors outside of organisational constraints. Browning (2013) found a significant negative association between nursing staff's levels of empowerment and how

many times they experience moral distress. This suggests the importance of empowerment to healthcare staff's workplace experiences and wellbeing.

A review of the nursing literature also highlighted the occurrence of moral distress in other professional groups (Lamiani, Borghi, & Argentero, 2016). This literature has recently been applied to the medical profession with a recent article reflecting on UK doctors' experiences of moral distress (Oliver, 2018). Only one study is known to have looked at the occurrence of moral distress with psychology professionals, which was extrapolated from findings from a larger study with other healthcare professions (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005). This highlighted the importance of personal morals and ethics in relationship to their professional integrity. Participants' experiences came under the themes of 'keeping silent, acting stealth, seeking compromise, speaking out, and leaving' (p. 210). This study did not offer an extensive account of the professional contexts spoken about which limits its applicability (Austin et al., 2005). Also the psychologists' experiences were influenced by the findings of the other professional groups that the study was analysed in combination with. Nevertheless, moral distress has also been recognised in middle and senior management in two American health care authorities in non-clinical staff (Mitton, Peacock, Storch, Smith, & Cornelissen, 2010). However the sample used in this study may have been biased towards those participating that do experience moral distress rather than those who do not. Nonetheless, this highlighted moral distress as an important experience across different professionals and beyond the acute care environment. This also reflects the negative impact of not being able to take the desired value-driven action on healthcare professionals' experiences at work.

Moral distress and burnout

Moral distress has been associated with burnout (Rushton, Batcheller, Schroeder & Donohue, 2015). Burnout, originally described by Freudenberger (1974), in its simplest terms is "to fail, wear out, or become exhausted by making excessive demands on energy, strength or resources". In the recent literature, burnout has been conceptualised as reduced personal accomplishment, depersonalisation/cynicism and emotional exhaustion (Maslach, 1993; Maslach, Jackson, & Leiter, 1996). Bianchi, Schonfield and Laurent (2015) provided definitions of these attributes of burnout that have been summarised here (p. 29). 'Personal accomplishment' refers to a lowered sense of satisfaction with their work that can result in

a lack of self-confidence. 'Depersonalisation' is feeling detached and holding a negative attitude to work resulting in a person withdrawing, and 'emotional exhaustion' is feeling emotionally tired and overstretched physically. Maslach and Leiter (1997) further describe burnout as a process as well as an end state, beginning with reduction in engagement. This is when "energy turns into exhaustion, involvement turns into cynicism, and efficacy turns into ineffectiveness" (p. 24). The occurrence of depressive symptoms has been found to overlap within the presentation of burnout, emphasising the impact of stress and workplace factors on employees' wellbeing (Bianchi, Schonfeld, & Laurent, 2014). These definitions highlight that burnout is a process that is associated with a continuum of experiences in relation to the wellbeing and morale of the staff member. Burnout is also thought to occur when there is a consistent imbalance between demands and resources (Bakker & Demerouti, 2007). The prevalence of this imbalance and the demands from organisations on their staff has resulted in employees today viewing their organisational missions, visions, and values with scepticism (Hemingway & Maclagan, 2004). The public sector is often described as being idealistic in their goals as they often surpass the professional resources of the company (Potter, Gebbier, & Tilson, 2007). This may represent the term described earlier, whereby there is a discrepancy between "espoused values" (what is promoted) and what is practiced by an organisation (Schein, 2010).

Wellbeing in the context of the NHS

One of the recent annual NHS staff surveys (NHS, 2015) compared the findings of the 2014 and the 2015 results, highlighting a significant increase in reported stress. For example, 70% of employees reported this as an experience they have 'all of the time' along with an increase in the occurrence of depression (Rao et al., 2016b). In contrast to previous NHS staff surveys fewer people (25%) reported experiencing musculoskeletal problems, which was overtaken by reports of staff stress related to work (37%). In addition, only 39% felt they were able to deliver the quality of care they wished they could to patients which suggests a conflict between employees' values, beliefs and goals and what is possible through the resources of the organisation (NHS, 2015). Further, the NHS culture and leadership survey (Kings Fund, 2014) found that 18% of staff believed the lack of compassion in the NHS was due to burnout and low morale of employees. Between 2013-

2016 the overall trend showed promising results that there was a decrease in staff sickness due to stress. However the most recent NHS staff survey (2017) showed that more employees reported feeling unwell due to work related stress from 2016 to 2017, with those working in mental health trusts scoring among some of the stressed. More specifically, a survey carried out by the British Psychological Society and New Savoy across 2014-2015 highlighted the alarming extent stress is experienced by psychological therapy professionals and its impact (Rao et al., 2016b). For example, 46% of staff reported experiencing depression, 49.5% reported feeling they are a failure and 70% reported finding their jobs stressful. In summary, these findings show that although there is some evidence over time that wellbeing in the NHS is improving, it is fluctuating and still paints a concerning picture.

The findings of the NHS survey reflect the evidence-base showing a range of professionals are experiencing increasing levels of burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). There are significant consequences of burnout that include its impact on staff (e.g. low morale) and patient outcomes that affect organisational outcomes, such as high economic loss (BPS, 2010, p. 3). Low staff morale is associated with high absenteeism and turnover of staff (Stalker & Harvey, 2002) and reduced productivity (Kahn, Schneider, Jenkins-Henkelman, & Moyle 2006). A person's productivity has been linked to *presenteeism*, a relatively new term defined as being cognitively present at one's workplace (Hemp, 2004). Reduced presenteeism refers to when employees attend work when they are unwell which then impacts on their ability to work productively and may contribute to financial loss (Hemp, 2004). These findings are shared across the wider leadership literature; for example, there were a higher proportion of those in leadership roles in the public sector experiencing burnout compared to those working in the private sector (Subramanian & Kruthika, 2012).

Burnout has also affected staff interactions with colleagues and clients, and outcomes in mental health services (Salyers, Flanagan, Firmin, & Rollins, 2015). For example, from a staff perspective they attributed their own sense of burnout to service-users not experiencing as much benefit from therapy, negatively affecting the therapeutic relationship and service-users terminating therapy early. This is supported by earlier research that showed service-users reported lower satisfaction with therapy when the therapist was burnt out (Paris & Hoge, 2010). Taken in conjunction with the findings from

the recent NHS staff surveys, this illuminates some of the challenges faced by staff and the impact this may have on the quality of care.

Relationship between wellbeing and leadership

In response to these concerning findings, the Charter for Psychological Wellbeing and Resilience in the NHS (Rao et al., 2016a) was initiated which advocates leadership as a method to improve staff resilience. This highlighted the standards set out by the Care Quality Commission (CQC; 2013 cited in Rao, 2016a) that states services must have good leadership that focuses on the wellbeing of staff. Therefore, by its very nature taking care of staff wellbeing is part of good quality leadership. Evidence supporting this comes from the business literature. For example, transformational styles of leadership were effective at increasing a sense of achievement in the individual, and decreased emotional exhaustion and depersonalisation (Zopiatis & Constanti, 2010). Similarly, other leadership styles, such as authentic leadership have been found to be associated with lower levels of nurses' self-reports of emotional exhaustion and cynicism (Laschinger, Wong, & Grau, 2012). From the business literature, engaging leadership has improved general wellbeing, staff commitment and customer service (Alimo-Metcalf & Alban-Metcalf, 2012). A meta-analysis of shared leadership models used within healthcare has also been shown to predict improved team effectiveness (Wang, Waldman, & Zhang, 2014). Therefore leadership, and particular models that are relationally focused and draw upon the values of the leader, are protective of burnout in other staff (Hildenbrand, Sacramento, & Binnewies, 2016).

However, it is important to consider that healthcare based leadership research can be descriptive and lack robust evidence underpinned by theory (Kings Fund, 2015a). Although it is acknowledged that research into models that are understood as being value-based, such as Transformational Leadership, are more commonly underpinned by good quality theoretical research (e.g. Wong, Cummings, & Ducharme, 2013). Further, the applicability of the business and management research to healthcare may be limited due to its basis within the private sector and the types of values that may be more dominant. Firstly, this is because clinicians are unique in that they are face-to-face with patients making decisions that encompass physical, psychological, social and environmental factors. As outlined by Kings Fund (2011) NHS stakeholders also include everyone from regulators, patients, public, and Department of Health, health and wellbeing boards to local and national

politicians (p. 12). This may increase the likelihood that leaders have to make more complex and unique challenges for those leading, as it may affect the health and safety of clients, and the workforce. This is within the current context of austerity in the UK, as there is an increase in the discrepancy between demands and resources in the NHS (Kings Fund, 2015b). This may produce different and more challenging dilemmas for those leading.

This promotes the requirement to understand leadership, as good quality leadership can have a positive impact on staff wellbeing, at a time when the NHS workforce is struggling more than ever. It is arguable that one important place to start would be to understand the experiences of those in defined leadership roles, particularly when they may face dilemmas, and the role of their values during this experience. This may then help understand their needs in order to support them to meet the needs of those they are leading.

Making sense of conflicts in values

As stated, the literature presented here has pointed to the relevance of values to leadership, and the relationship between values and the wellbeing of healthcare professionals. Festinger's (1957) has recently made a helpful contribution to understanding conflicts in values in management-orientated leadership (Lee, 2015). This theory describes the difficult emotions experienced when there is a difference between the cognitions someone holds, or between their cognition and related actions. These cognitions are formed by our beliefs, values, attitudes and experiences. It can be assumed that the larger or the more important the contradiction between the cognition and the action, or two opposing cognitions (Griffin, 2009) the greater the dissonance that is experienced. Festinger describes how dissonance is identified as an internal conflict transpiring in feelings of discomfort or disharmony. The theory explains how we strive for consistency in order to ease this negative emotional state, which is known as the cognitive consistency principle (Festinger, 1957). There are three ways to achieve this: 1) changing dissonant cognitions 2) adding new constant cognitions or 3) reducing the significance of dissonant cognitions.

This theory has been applied to the recent, large-scale failings within the NHS, as described earlier, to understand how unethical behaviour can develop (Rydon-Grange, 2015). A core priority for the NHS is patient care however these authors suggest that in these circumstances this has no longer been the priority advocated by those in leadership

positions. One way this theory was applied to explain this was to highlight the discrepancy between how staff may believe they ought to be behaving and how the system is advocating that they do. This difference may produce a conflict for staff members, causing them to experience cognitive dissonance. In order to ease this dissonance during these failings, they suggested that staff reduced their belief about the importance of patient care, which contributed to them behaving unethically (Rydon-Grange, 2015). Although there is no evidence to support the application of this model from the staff members' perspective, this model still provides a useful way of making sense of these experiences. This may be helpful for the findings of this study to help understand how staff may manage and make sense of experiences that might cause a conflict between values.

Overall rationale

Reduced wellbeing is commonly seen amongst healthcare staff, including those within leadership roles (Morse et al., 2012; NHS Staff Survey, 2017). This can negatively impact on clinical effectiveness and contributes to organisational factors, such as absenteeism (e.g. Stalker & Harvey, 2002). Therefore, one way stakeholders can address these negative effects is by gaining a better understanding of leadership, which would benefit both the individual leader, and their team. This is reflected within NHS guidance and the initiation of The Charter for Psychological Wellbeing that promotes leadership as a method of improving staff wellbeing (Rao et al., 2016a). Leadership within clinical teams is an area that has been well studied as most frontline staff work within this context (Kings Fund, 2013). The impact of leadership on the wellbeing of wider teams is well documented (e.g. Hildenbrand, Sacramento, & Binnewies, 2016). Addressing this area of leadership can have a significant impact on service outcomes, evidenced by lower levels of nurses' self-reports of emotional exhaustion and cynicism (Laschinger, Wong, & Grau, 2012).

Current advocated models and approaches to effective leadership are relationally focused, drawing from the values of the leader (Copeland, 2014). Personal and professional values influence decision-making (Schwartz, 2012) and therefore responses to situations such as dilemmas and challenges. However, values can be in conflict, which can be a source of reduced wellbeing (e.g. Rushton, Batcheller, Schroeder, & Donohue, 2015). Therefore, exploring participants' experiences of dilemmas and how their values influence

how they make sense of these experiences may help to understand the wellbeing and resilience of leaders.

Clinical Psychologists were used as the sample for this study as they are increasingly involved in leadership and decision-making within teams in the NHS (DCP, 2010). They also have professional guidelines that promote reflection on values in clinical practice (BPS, 2009). However, there is no known research exploring their lived experiences of leading clinical teams and how they make sense of these experiences using their values when responding to dilemmas.

Research aims and questions

For these reasons outlined, this study aimed to explore the experiences of Clinical Psychologists working within the NHS to understand their experiences of everyday leadership within clinical teams. There was a particular focus on times when participants faced dilemmas and how they made sense of their experiences in terms of their values.

The research questions for this study are:

- 1) What are Clinical Psychologists' experiences of situations of leading within clinical teams?
- 2) How do they make sense of these situations, particularly in relation to their values?

Method

The method chapter contains three main sections; firstly, the alternative methodologies considered and an outline of the rationale for the methodological approach chosen. The second part is a description of the design of the study and a summary of the analysis undertaken. The third part includes the steps taken to ensure the quality of this research study, including a summary of my reflexive statement and reflective interview pre-data collection.

Methodological Approach

Alternative approaches of methodology

Once the research questions were developed, the appropriate methodologies were considered. Firstly, this involved establishing that qualitative research methods would be best to answer these exploratory questions. This was decided because the central focus was to provide a new understanding of an experience occurring in the natural world (Mason, 2002; Willig, 2008). Secondly, to advance on previous research, Interpretative Phenomenological Analysis (IPA) was deemed advantageous over other methods of qualitative analysis (Smith, Flowers, & Larkin, 2009). In this process of choosing IPA, two main alternative approaches were considered: Discourse Analysis (Edwards & Potter, 1992) and Grounded Theory (Glaser & Strauss, 1967). A brief discussion about each methodology compared to IPA has been provided, followed by a summary of the central tenets of IPA.

Discourse Analysis (DA) is used to understand the personal, social and political aspects of an individual's experience (Edwards & Potter, 1992). In order to achieve this, DA focuses on the development of this through the participants' language and their related actions (Starks & Trinidad, 2007). Although it is acknowledged that both IPA and DA view language as a lens to an individual's understanding of their experience, DA is used by researchers interested in the meaning that is generated from the shared language within a system (Starks & Trinidad, 2007). This is different to IPA that uses the individual's accounts of their subjective, internal experience and sense making, which is of importance

for this study. DA was also considered as this study is focused on leadership within clinical teams, which involves an element of social processes with others. However DA is best used when applied with naturally occurring data rather than for individual interviews, although it is acknowledged that DA can be used in this way. Discourse Analysts would assert that the findings would have been a possible artifact of the interview, rather than of the context of interest (Edwards & Potter, 1992). Therefore, this suggests limitations for the use of DA in a study like this and therefore IPA was believed to be more appropriate.

Researchers using Grounded Theory (GT), similarly to those using IPA, aim to develop a new understanding that may be developed into a theoretical model (McLeod, 2001; Smith et al., 2009). However, GT is more concerned with formalising an explanatory model at a conceptual and theoretical level as its primary purpose (Starks & Trinidad, 2007). This does not fit well with the primary purpose of this study that aims to understand individuals' lived experience rather than being focused on theoretical development. This is understood as the domains of participants' thoughts, emotions and behaviours, which is the central focus of IPA (Smith et al., 2009). In addition a secondary rationale for choosing IPA is that GT analysts hold the position that there is an objective reality that the researcher is trying to understand without the involvement of the analysts own assumptions (Willig, 2001). This is opposed to an IPA analyst's position who hold that their assumptions are important to consider as they affect the interpretation of the subjective world of the participant making sense of a shared real world experience (Willig, 2001). Therefore due to the relevance of this study in relation to the author, it is deemed more appropriate to utilise the reflexive stance of IPA that is discussed further in the reflexivity section of this chapter.

Interpretative Phenomenological Analysis

IPA involves several core concepts that are important to understand. The two main theoretical foundations of IPA are that of hermeneutics and phenomenology (Smith et al., 2009). Hermeneutics refers to the interpretation of a lived experience, or in others words, the sense made of a lived experience. The purpose of this is "to make meaning intelligible" (Grondin, 1994, p. 20). Phenomenology refers to the research of experience; as Smith et al. (2009) describe, it is a commitment "to thinking about how we might come to understand

what our experiences of the world are *like*” (p. 11). IPA also has an idiographic emphasis; this means it is focused on a specific or unique event occurring in the external world (Shinebourne, 2011). In summary, these terms refer to the participants’ internal, private experiences and how they interpret or make sense of these (Smith et al., 2009).

Another term that is important to understand is the ‘double hermeneutic’ position. This refers to the role of the researcher who interprets the participant’s interpretation of his or her own experiences (Smith et al., 2009). This emphasises the importance of the researcher to be reflexive and understand their own sense making, which is discussed at the end of this chapter. The epistemology stance of IPA is the same as other qualitative research (Willig, 2008), which takes a social constructionist position (Burr, 2003). In its simplest form, this stance is defined as believing there is no singular accepted truth, therefore all participants’ accounts are initially analysed separately to acknowledge this position. In keeping with this epistemological stance of IPA, this means that all participants’ experiences and sense making are accepted as being equally valid compared to each other.

In relation to this study, using IPA methodology was believed to be the most appropriate methodology as it enables an analysis of the “complexity, processes and novelty” which is relevant to the three core areas of: leadership, dilemmas and values (Smith & Osborn, 2008, p. 55). As little is understood about the subjective experience of this area, it was more appropriate to focus on the individuals’ lived experience on a micro level, paying attention to details of “texture and nuance” (Smith et al., 2009). Therefore, having a richer exploration of these experiences may help to generate more robust theoretical explanations in the future for further investigation using different methodologies. A detailed analysis of the individuals’ experiences was undertaken. The protocol for IPA methodology was followed and a summary of the analytic process can be found in *table 1* in the analysis section (Smith et al., 2009).

Study design

As traditionally used for qualitative research, semi-structured interviews were employed here to explore Clinical Psychologists’ experiences (Willig, 2008). The use of naturally occurring data was considered, such as observing participants during recordings of team meetings, or the interpersonal processes recalled by the participant while watching

recordings of team meetings. However, it was assumed that it was unlikely that this type of data was already available, that it may be difficult to obtain consent from the whole team to allow their clinical practice to be filmed, and that there can be an impact of known recordings on team interactions. In addition a range of data collection methods have been employed by IPA analysts, from email communication (Turner, Barlow, & Ilbery, 2002) to other interview-informed techniques such as focus groups (Roose & John, 2003). These different methods vary in how problematic they can be, which does not exclude interviews that may still be affected by contextual factors (Smith et al., 2009). Yet interviews are believed by the IPA community to reflect a “commitment” to explore participants’ perspective in a way that is in-depth and flexible to their emerging accounts (Smith et al., 2009).

Sample size

For qualitative research it is suggested that smaller samples are required compared to quantitative research, although there are still differences in the sample sizes deemed acceptable. For example, for qualitative research generally a minimum of seven participants and a maximum of ten participants are recommended (Willig, 2008). In relation to IPA methodology, Smith et al. (2009) emphasised the need to complete a detailed analysis of individual interviews and that this can be prevented when using larger samples. Therefore they recommend between three and six participants. On the other hand, Turpin et al. (1997) found that six to eight participants was average for doctoral research. Therefore, it was decided that on balance from these recommendations in the literature, eight participants would be a sufficient sample size for this IPA study. This was to allow for a breadth of experience to be explored while also still enabling the opportunity for in-depth analysis.

Sample characteristics

To maintain the homogeneity of the sample and to therefore provide results that have value for others (Smith et al., 2009), the following characteristics related to participants’ professional position were considered.

As outlined in the literature review, leading in clinical teams is relevant to many healthcare professionals who are part of those teams. This includes professions such as medical staff, occupational therapists, and social workers. Further the role of values in influencing human behaviour is also relevant to all professionals. Clinical Psychologists were chosen as appropriate participants as this type of leadership in clinical teams is stated in their job description and other professional guidelines (e.g. DCP, 2010). In order to control for factors related to the wider context of participants' services, all participants were employed from the NHS.

As this study is focused on the everyday leadership experiences when leading in a clinical team and influencing patient care, it was believed that recruiting participants across Band 8a-c would be the most appropriate decision. This was based on the assumption that these Clinical Psychologists are more likely to have had more experience of working within clinical teams. In addition, participants in band 8a roles had to have been employed in this position for at least 12 months. Although leadership is advocated in training and newly qualified positions (DCP, 2010), this criterion was applied in order to ensure participants had plenty of examples to draw upon and also that they may have more comparable experiences to those in more experienced 8c positions.

Inclusion and exclusion criteria

Based on this rationale the following inclusion and exclusion criteria were used:

Inclusion criteria:

- Obtained their doctorate or masters in Clinical Psychology and authorised to work in the UK under the HCPC
- Practicing in 8a-c Clinical Psychologist positions
- Currently employed by one of the six participating NHS Trusts
- Practicing in either mental or clinical health settings
- Working within a clinical team

Exclusion criteria:

- Have been in their 8(a) position for less than 12 months
- Have evaluated or supervised the researcher during the doctoral training programme

Method

Recruitment & Procedure

Purposive sampling was used to recruit the eight participants who satisfied the inclusion and exclusion criteria. Participants were identified via the research leads within each of the six participating NHS Trusts who consented to support the study. Research leads forwarded a pre-written and approved email inviting potential participants to take part by emailing me (Appendix A). The email contained a copy of the poster advertisement (Appendix B) and the information sheet (Appendix C), which included information such as the purpose of the study, what the study would involve and information regarding ethics, confidentiality and anonymity. Once a potential participant made contact, either a follow-up email or phone call was used to answer any questions and conduct the screening questions from the demographic pro-forma (Appendix D). If they decided to participate, a date and a place to conduct the interview were arranged with them. The interviews were conducted by the principal researcher at the participant's place of work on NHS property. If it was more preferable or feasible for the participant, the interview was conducted at the Department of Clinical Psychology at the University of Leeds and their travel expenses reimbursed. Only one participant requested to be interviewed at the University.

Figure 1 below displays the recruitment process. As highlighted in the diagram, there were potential participants who expressed an interest in the study but who could not or did not take part. Reasons for this include the person's limited time available to participate and one person had concerns that the interview would be too challenging for them at this current time. Other potential participants did not fit the inclusion criteria, such as one person who did not have current contact with a clinical team and worked independently. Near the end of recruitment, more participants expressed an interest than was required to fulfill the sample size. This resulted in a decision regarding whom to invite to take part first. At this point it was recognised that all participants who had already participated were working within adult or older adult services, therefore a decision was made to prefer potential participants who were working in these services over those within child and adolescent services in the first instance. This was to maintain a homogenous sample (Smith et al., 2009). The sample size was achieved and the participants on hold

were notified of this. One participant was removed at the end of data collection as they had transitioned at the point of interview into a band 8d role. This decision was also made to ensure the homogeneity of the sample in order to understand comparable experiences, which in this case was related to experiences of leading within clinical teams versus managerial experiences.

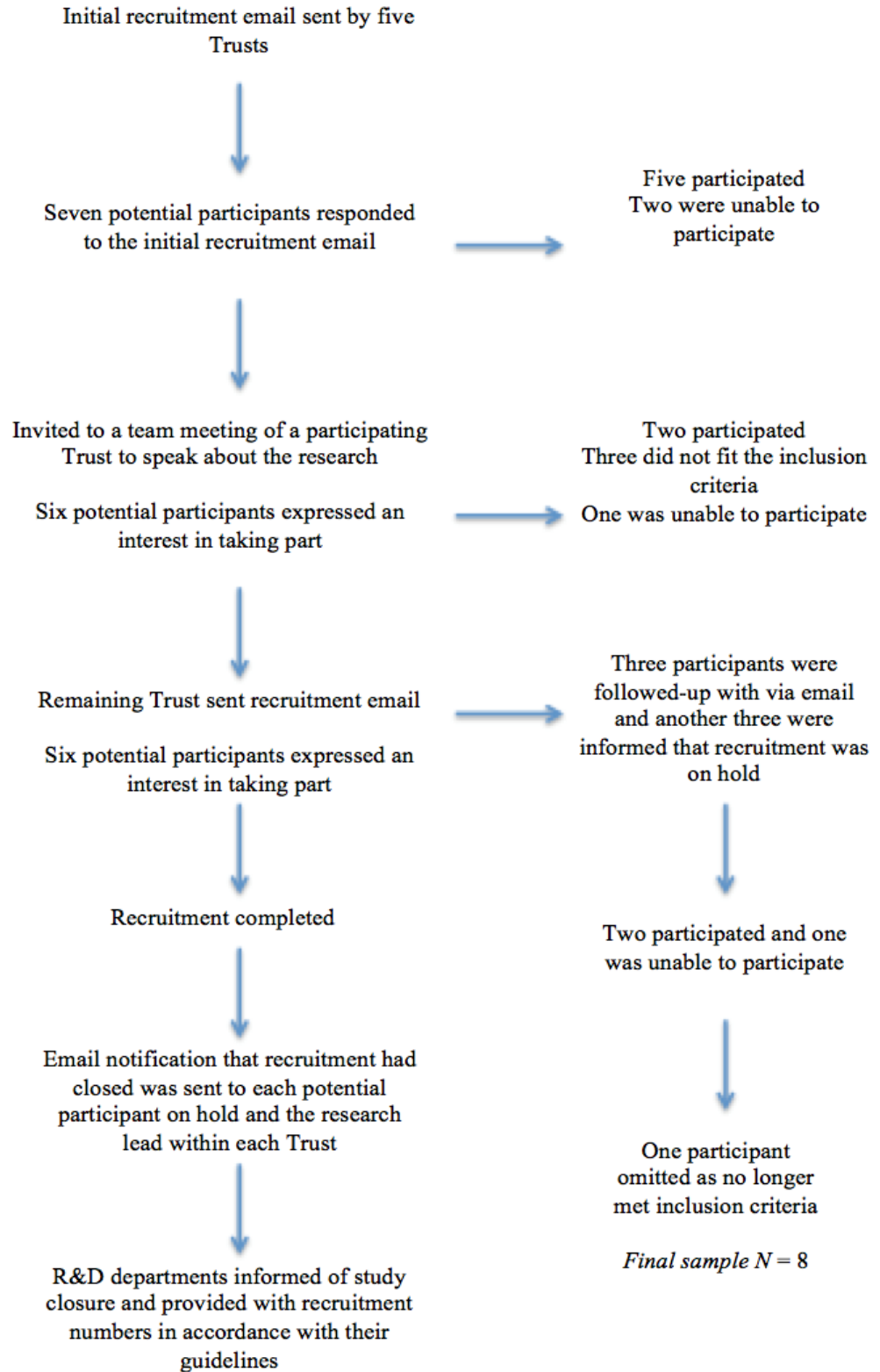


Figure 1. Recruitment flow chart

Ethics

Ethical Approval

Conditional ethical approval was obtained from the University Of Leeds School Of Medicine Ethics Committee (SoMREC16-157, Appendix E). Subsequently, sponsorship from the University of Leeds and HRA approval was gained (IRAS 219925, Appendix F). This was followed by confirmation of capacity and capability from each of the six participating NHS Trust's Research and Development departments. Full ethical approval was granted on 09/10/17.

Ethical Issues

As agreed in the ethics document, the following issues were identified before the study began; the relevant procedures were developed using University of Leeds guidelines, and these approved procedures were followed accordingly.

Informed consent

All participants provided written informed consent prior to data collection (Appendix G). Participants retained their own copy of the completed consent form. This was taken after they had had the opportunity to read the participant information sheet and have all of their questions sufficiently answered. Participants had two opportunities to ask questions, once during the initial email/telephone screening and secondly, before the interview began.

Potential impact on participants

Firstly, it was anticipated that the study was unlikely to cause harm to participants however it was acknowledged that they might find it upsetting to reflect upon difficult professional experiences. To address this, during the debriefing all participants were asked

how they had experienced the interview and if they needed additional support. Secondly, it was acknowledged that there was an unlikely but potential risk of experiences of malpractice being raised when asking participants to talk about their dilemmas at work. This was explained in the participant information sheet and discussed prior to the interview. If this were to have occurred, it was agreed that I would have sought supervision and considered with my supervisors whether the HCPC needed to be notified. This also included the malpractice of others in the team the participant was reflecting on working with. If the malpractice were by another professional who was not regulated by the HCPC then the details for their correct regulatory board would have been obtained and contacted accordingly. I would have also tried to discuss this with the participant before following this action. At completion of data collection, there was no need for follow-up support for any of the participants that took part and no causes for concern regarding malpractice during the interviews conducted.

Data management, anonymity and confidentiality

All information provided by the participant (consent form, demographic information and interview transcripts) was anonymised using a pseudonym. A list of participants' details and their pseudonyms were stored securely and separately to their data. The interviews were recorded on an encrypted dictaphone and then the audio recordings were stored on an encrypted/password file saved on the University of Leeds secure drive as soon as practicable. The original files were then deleted from the recording device. Anonymised transcripts were also stored in electronic form on an encrypted memory stick. Electronic data will be stored for three years after which it will be destroyed confidentially, which participants were informed of.

I transcribed the first interview in order to familiarise and immerse myself in the data, and to develop the following interviews. An approved transcriber from the University of Leeds transcribed the remaining seven interviews. They signed the university confidentiality agreement before beginning this process. I checked the quality of the transcriptions by listening to the audio recordings while reading through the transcripts, correcting any errors identified. Participants' anonymity and confidentiality was maintained

by the use of pseudonyms and all other identifiable information removed from the transcripts, such as names of people, services or some individual characteristics.

Interview Schedule

Development of the interview schedule

In order to develop the interview schedule two important distinctions were made. Firstly, it was recognised that there is a difference in the literature between leadership and management (Kotter, 1996, cited in Kings Fund, 2011), as outlined in the literature review. In order to focus on leadership roles and responsibilities rather than managerial tasks the interview emphasised the clinical context. Secondly, it was also acknowledged that there is a wealth of literature on clinical leadership. However, it was not my intention to focus on this approach to leadership but rather the experience of leading within clinical teams. The Leadership Development Framework (DCP, 2010) was used to inform this definition of leading within clinical teams. Therefore, efforts were made to ensure participants' understanding of this before the interview began and during the interview. Initially, ahead of the interview they were informed that they would be asked to recall examples from their experiences and encouraged to think about these ahead of the interview. They were also given examples of possible types of scenarios in accordance with those already outlined in the participant information sheet. At the beginning of the interview, they were also reminded of the differentiation between a clinical team and a managerial team, and the types of experiences the study was focused on to help provide participants with the context. At times participants required more time to think through and choose an example to reflect upon. This required some discussion between myself as the principal researcher and participant until the participant felt confident with the example they had chosen.

The initial draft of the interview schedule involved asking participants to directly reflect upon their experiences of times when their values had and had not been in conflict. Trial interviews were firstly conducted with another trainee Clinical Psychologist and then with two qualified Clinical Psychologists known the researcher but who did not fully fit the inclusion criteria. Through consultation with my research supervisors and feedback from the trial interviews, it was found that it might have been too difficult for participants to draw upon value-based experiences without having a contextual reference point already

established. This was because the term of values can for some seem tangential and required grounding in experience. Also, it was found during the pilot stage that asking directly about times when participants have faced dilemmas might tell us something about when participants' values were in conflict. Therefore the interview schedule was adapted accordingly to ask participants to identify examples of experiences of leading including experiences of dilemmas, before facilitating reflection on values. This was also to adapt the questions in an open and expansive way to allow for participants to draw upon their own language to provide an as rich as possible description of their experiences, in line with IPA methodology (Smith et al., 2009). Through further practice interviews this adaptation was proven to be an effective way of eliciting these types of experiences and sense making to help answer the research questions.

Final interview schedule

The final interview schedule (Appendix H) began by building the context of leadership in clinical teams, for example by asking what leadership activities participants have been involved in and from their experience what sense they make of what leadership means to them. The main part of the interview then required participants to talk through approximately three examples from their experiences in depth. This included one example of a leadership experience that stood out to them and two examples of times when they explicitly faced a dilemma when leading. The two questions focused on dilemmas aimed to also prompt participants to reflect on different types of dilemmas in order to attain a breadth of experience as well as depth. After a description of each example was provided, follow-up questions were asked to elicit participants' thoughts, feelings and behaviours during their experience. They were then asked about how they coped with these experiences, how they made sense of it in terms of their values, and their sense of resolution from the dilemma. During the interview attention was paid to evidence of conflicts in values and prompts were used where possible to elicit additional information.

Conducting the interviews

The interviews took between 50 minutes to 81 minutes to complete and were recorded on a dictaphone. Initially, participants were given the opportunity to reread the participant information sheet and to ask any questions until they felt satisfied. They then provided written consent. A demographic pro-forma was then administered which recorded information about their personal characteristics (e.g. age, years since qualifying and professional area of work) and leadership focused information regarding their leadership training they have undertaken. In order to situate the participants within the context of leadership before the interview, they were also asked to identify leadership activities they have been involved in from a checklist. This checklist was developed through a previous thesis with the supervisors of the current study (Hunter, 2015, p. 41). This had been compiled through interviews regarding leadership with female Clinical Psychologists. After this pro-forma was completed, the interview was conducted using the schedule.

After the interview had finished a measure of burnout was used to gain an empirical understanding of participants' wellbeing. Different types of measures were considered, however more recent research has promoted the validity of using a single construct to measure burnout compared to comprehensive measures (Hansen & Pit, 2016). As the primary purpose of this study was not to understand burnout, using a single measure was deemed appropriate. At the end of each interview participants were asked to identify which example had the most significant impact on their experience of burnout. This was to gain a simple numerical understanding of how challenging these dilemmas they described were in terms of their wellbeing. They were then asked to rate how burnt out they felt retrospectively at the time of the example on a Likert scale of 'not at all burnt out' ('0') to 'extremely burnout' ('10').

Analysis

The table below provides a brief summary of each step of the analysis taken following the protocol described by Smith et al (2009, pp. 82-107). *Table 1* includes information about what the purpose of the step was and how this was achieved.

Table 1. Step-by-step summary of the analysis procedure (Smith et al., 2009)

Analytic Steps	Aim and process of each analytic step
Step 1. Reading and Re-reading (p. 82)	<p><i>Aims:</i> familiarising and engaging with the data by slowing down the process of analysis to enable attending to the intricacies of the transcript.</p> <p><i>Process:</i> listening to the audio recordings, reading over the transcripts multiple times and begun making annotations to the transcript itself.</p>
Step 2. Initial Noting (pp. 83-90).	<p><i>Aims:</i> develop a phenomenological and interpretative understanding that stays as close as possible to the participants account.</p> <p><i>Process:</i> annotating the transcript with linguistic, descriptive and exploratory comments.</p>
Step 3. Developing Emergent Themes (pp. 91-92)	<p><i>Aims:</i> Simplifying the exploratory commentary into emergent themes while retaining the complexity of the data.</p> <p><i>Process:</i> developing concise phrases to capture the ‘psychological essence’ that encompasses both a sense of the ‘whole’ and the ‘parts’ of the data.</p>
Step 4. Searching for connections across emergent themes (pp. 92-100)	<p><i>Aims:</i> Clustering emergent themes to create a graphical representation of sub-ordinate themes.</p> <p><i>Process:</i> Rewriting themes in chronological order and separate to the transcript, printing these out and cutting them up, and moving the grouping of themes around until satisfied. This process drew upon approaches described to enable grouping e.g. abstraction and contextualization.</p>
Step 5. Moving to the next case (pp. 100)	<p><i>Aims:</i> Developing sub-ordinate themes for each case while trying to achieve the idiographic commitment of IPA by treating each transcript as standalone from the others.</p> <p><i>Process:</i> Completing Step 4 for each participant.</p>

Analytic Steps	Aim and process of each analytic step
Step 6. Looking for patterns across cases (p. 101)	<p><i>Aims:</i> Creating a representation of the final themes for the whole group. Themes retaining the individuals' uniqueness and shared qualities of the whole sample.</p> <p><i>Process:</i> Making connections between participants through links between how the themes relate to each other and reconfiguring/rewording themes where necessary.</p>

Group analysis

The process of conducting the group analysis (step 6, Table 1) involved using thematic maps to develop the relationships between the themes. However during this process this appeared to mask some of the complexities of participants' experiences. In order to maintain these nuances within the data it was decided that presenting the themes in list-form would be the most appropriate method.

Additional analytic steps

The values participants explicitly identified were categorised into Table 3 in chapter three (results) using Schwartz's model of basic values (Schwartz, 1992). Participants identified their own values explicitly and voluntarily when they were asked how they made sense of their experiences in terms of their values. When participants consciously named a value, they either described what was of value to them or another concept, such as their behaviours or beliefs related to the value. This was instead of naming a traditional value in keeping with the model. How participants made sense of their experiences using their values is encompassed within the group analysis.

This categorisation was based on the information provided in a review of Schwartz's work (Schwartz, 2012). Firstly, I familiarised myself with the definitions of each value. Secondly, using the defining goals of each value, I categorised the participants' values according to the model of basic values. This was also guided by the definitions, which compared values that were similar to each other in order to differentiate them. Thirdly, another trainee Clinical Psychologist categorised these values for a second time. We then discussed where we had placed each value and identified three main initial

differences in opinion (e.g. some of the values were placed under power versus benevolence). I went back to the context of the transcript and the definitions provided until consensus was reached. A second trainee then reviewed this and suggested one change, which was then agreed with the first trainee.

Assuring Quality

As recommended by the IPA community (Smith et al., 2009), two established frameworks were employed to enhance the methodological rigour of this qualitative study (Elliott, Fischer, & Rennie, 1999; Yardley, 2000). In accordance with these guidelines, the actions below outline some of the ways in which I have tried to maximise the validity and reliability of this study throughout its completion. The first guideline describes characteristics of good quality qualitative research as ‘sensitivity to context’, ‘commitment and rigour’, ‘transparency and coherence’, and ‘impact of importance’ (Yardley, 2000, p. 219). The second states the necessity of: ‘owning one’s perspective’, ‘situating the sample’, ‘grounding in examples’, ‘providing credibility checks’, ‘coherence’ and ‘accomplishing general vs. specific tasks’ (Elliott et al., 1999). Both guidelines highlight the importance of understanding the context of the sample and providing transparency where possible to create a coherent narrative.

Firstly, I thought about my own competence in IPA methodology to conduct this study. For my undergraduate dissertation I used Grounded Theory, which equipped me with some qualitative research skills such as exploring sensitive topics with interviews. However, this prior experience also highlighted my limited understanding of IPA and the importance of techniques such as reflexivity, which could introduce bias. To respond to this I sought to further develop my skills in IPA. This included teaching, supervision and my own reading, as well as using some of my research budget to attend a one-day workshop on ‘getting great data using IPA’. Each of these contributed to my theoretical knowledge, and interview and analysis skills.

Examples of the other steps I took involved: 1. Immersing myself in the data by listening to the audio recordings and reading the transcripts multiple times. 2. Transcripts were taken to supervision where discussion and feedback on the data took place. This informed the analytic process by developing my skills and knowledge. My supervisors also read several versions of my results chapter including the final version to help the refining

process. 3. During the process of analysis the development of themes were also discussed with my research supervisors as part of the iterative refining process. For example, this involved thinking about the use of language for the themes to remain close to the intricacies of the data. 4. Supervision also helped me to understand what was informing my interpretation of the data to help reduce bias, such as understanding my own emotional reactions to transcripts and to notice when I was drawing upon my experience versus the literature. 5. I shared a few sections of anonymised transcripts with another trainee Clinical Psychologist who has experience of using IPA methodology. This was to gain further feedback on the development of my analysis, such as discussing the grouping of emergent themes into subordinate themes. This trainee also helped to provide a validity check of the grouping of values as already described in the additional analytic steps. 6. My reflective journal and reflexive interview helped across these steps by facilitating the development of my understanding. I have reflected on this in the following section.

Owning My Position

This study originated from my personal and professional interests that have developed over time from my experiences, meaning this research is of personal significance to me. As described, the double hermeneutic position within IPA methodology refers to the role of the participants in making sense of their own experiences in the world, which the researcher then tries to interpret (Smith et al., 2009). Therefore, due to my personal involvement as the researcher and my personal interest in this area, it is recognised that I must be particularly attuned to how I may be influenced to interpret the data (Smith, 2015, p. 268). This also acts as another quality check (Elliott et al., 1999). In response to this requirement to be reflexive I have utilised several methods of improving my conscious understanding of my position as it evolves, such as keeping a reflective log and taking part in a reflexive interview.

Reflexive statement

This research is conceptualised into two main areas – values and leadership. In terms of values, from a young age my Christian faith has nurtured my thinking about what my values are and the importance of living with integrity to them. Examples of these values

that influence me include honesty, justice and forgiveness. I have come to notice the influence they have had on professional decisions I have made. For example when considering my therapeutic orientation and the ways in which I interact with others and respond to situations. In terms of leadership, I have observed and admired my parents and others close to me as they have taken on positions of influence to help others in their local communities and workplaces. This has informed my desire to take on similar positions, whether as a youth leader of my Brownies club to increasingly more responsible and influential roles that I hold now, such as working as a trainee Clinical Psychologist. As I have experienced more responsibility working in healthcare and observed my supervisors' experiences I have noticed how this can at times not be as glamorous a position to hold as I once naively thought and can result in having to lead and cope with situations that can be challenging and be in conflict with their values. Since working clinically I have also become aware of the different ways my supervisors have led in similar situations that have arisen and how they have appeared to hold different values as priorities. An example of a dilemma I have faced was when I noticed feeling pulled into a discussion that was happening between staff that I interpreted as gossip. The challenge for me was to maintain my values around professionalism and not judging others, while also maintaining an approachable reputation and building effective working relationships with my colleagues. The situation made me feel uncomfortable, and my lack of engagement during this interaction further contributed to the internal dissonance that I experienced. These reflections informed my interest to understand the lived experiences of those leading, particularly in the context of how leaders use their values to make sense of, and cope with challenges.

Reflexive interview and log

As described, I kept a reflective log throughout the process of completing this research and participated in a reflexive interview prior to data collection. The interview was conducted with another trainee Clinical Psychologist and involved answering questions from the draft interview schedule. This was to elicit my assumptions about what I might find that may influence my interpretation of the data. I listened back to the audio recording I made of this and made notes on the main points and any subsequent reflections I had. Through the reflexive interview process I became aware of a variety of factors that could

introduce bias to the study. As this was prior to beginning data collection, which then informed the way in which I conducted my interviews and analysed the data. For example, this highlighted the strength of my own beliefs around the importance of using values to understand experiences. I recognised that I needed to step back from my own beliefs when completing the interviews and analysis as I may overlook other factors important to the participant. This realisation enabled me to be more sensitive to the occurrence of values or other factors that participants used to make sense of their experiences than I may have originally. Having completed the interviewing process and reflecting on this, I was able to pay more attention to values that were also implicit and were beyond the participants' conscious awareness during the active process of the interview, as well as the other ways they made sense of their experiences, such as the impact of wider systems and culture.

Results Chapter

The results chapter includes four parts; firstly, descriptive information for the sample which includes a summary of the demographic information and pen portraits for each participant. Secondly, a table of the values identified by participants during the interview has been provided. Thirdly, the group analysis that includes a table of which participants experienced each theme and descriptions of these themes. Fourthly, a concluding brief comment on the group analysis has been provided.

Descriptive Information

Overall participant demographic information

To ensure participant's anonymity their demographic information has been summarised and provided separately to their pseudonyms. In terms of individual characteristics, the sample consisted of three males and five females who were all White British. One participant was between 25-34 years old, three participants were aged between 35-44 years old, three were between 45-55 years old and one was between 55-65 years old. Participants had been qualified Clinical Psychologists for between 5 and 27 years.

In terms of information about participants' employment, participants had worked for 2 and 12.5 years in their current position within a range of adult services including: community and inpatient mental health services, acute health services, occupational health department and older people's service. Two participants were employed at band 8a, two were employed at band 8b and four were employed at 8c in consultant Clinical Psychologist positions. Five participants had taken part in additional training that had informed their leadership skills. This included: the NHS leadership academy; a post-qualification training leadership course; a post-graduate diploma that included a leadership module; group analytic training; values-based leadership training and a psychologist-led leadership course.

Participants were asked to report how burnt out they felt retrospectively, during the examples they reflected upon in detail. One participant scored the lowest at 3 out of 10 suggesting they only felt mildly burnt out. Six participants scored in the middle range

between 4-7 out of 10, suggesting they felt moderately burnt out, and one participant scored 10 out of 10 suggesting they felt extremely burnt out.

Pen Portraits

This section contains a pen portrait for each participant. This includes information such as their reason for taking part, a summary of their journey into taking on leadership roles and responsibilities, their understanding of what ‘leading within clinical teams’ means to them from their experience and what informs their approach to leadership. I have also included some of my own reflections on the interview process and a summary of each participant’s examples of leading in a clinical team that they chose to reflect upon. It is important to note their experiences often contained multiple dilemmas or the main dilemma for the participant was not solely related to the immediate situation itself. Quotations from transcripts have been used to illustrate these portraits so that it remains close to their meaning, and are written in italics and quotation marks.

Janet

Janet participated in this study because it looked “*interesting*” to her as she was taking part in leadership training at the time of the interview. She believed “*value based leadership is very important and [we] don’t think about it enough*”. She also described her drawing from a collective leadership model that reflected her “*bottom-up*” approach. She became involved in leadership responsibilities “*organically or intuitively*” as she described taking initiative to develop projects. Janet’s values were informed by her personal experiences and religious beliefs. These values influenced the type of day-to-day challenges she chose to reflect upon and the other broader service development initiatives she was leading on. Janet spoke passionately about these experiences, and at one point in the interview she became tearful as she was moved by her frustration for the culture of services to change. Before the interview began she had expressed her anxiety as she felt she was not prepared enough for it. This interview was also the first I had conducted and so I was feeling apprehensive. For both of these reasons I think this affected my confidence to ask prompts to refocus the interview or elicit richer detail at certain points.

Janet reflected upon four examples, these were:

- Example 1: Janet described leading the clinical team through difficulties with practical service provisions when they were made to move locations. For example they did not have the right facilities and administrative support to practice safely. This caused her significant distress and frustration at management, and impacted on staff morale and wellbeing, and service-user care. She tried to promote action, hope and motivation by taking practical steps such as contacting the union, and preparing a letter to send to management regarding a group grievance, which she gained consultation on from the team. In response, management made changes and an effective team meeting had been established. However, she felt there were ongoing issues within the wider system, which were causing further emotional challenges for her and the team.
- Example 2: An occasion where she expressed in a written report to the psychiatrist her trauma-informed perspective on a service-user's psychosis-related difficulties. She believed this to be a very different understanding to the team's understanding. She had expected this would be ignored and felt demoralised and worried for the patient. However the psychiatrist came to speak to her, seemed understanding and begun to reduce the service-user's medication. She felt this was an unusually positive experience.
- Example 3: During an MDT meeting where the service-user was present, she felt the team was trying to restrict the service-user's freedom e.g. stopping them driving. Janet expressed her trauma-informed perspective on the service-user's experiences of hearing voices because of her concerns about the direction of care. This was informed by her own lived experience of mental health problems that had not stopped her from working and driving. She described being given a "*dressing down*" for disagreeing with the psychiatrist in her office after the meeting. She felt she had done her best at the time by continuing to speak up in the way she could but believed the problem lay in the culture of mental health services.
- Example 4: During an MDT meeting where the service-user was present, she offered an alternative view on her understanding of their mental health in light of their religious beliefs. After the meeting a formal complaint was made about her from a clinician present at the meeting. This was investigated and no further action was taken. She felt she withdrew despite it feeling unfair, as she wanted the

situation to be over. However in hindsight she felt she should have taken a more proactive approach such as having a discussion with the team and psychiatrist.

Abby

Abby chose to take part as she felt leadership was “*one of the biggest challenges facing the profession*” and therefore wanted to contribute to research in this area. She felt that Clinical Psychologists’ ability to lead is important because of the pressure from others “*looking at psychology going: what do you do? what do you bring? what do you bring that’s different?*”. For these reasons Abby held the view that clinical training courses need to “*build their (trainees’) confidence*” through organisational-based placements focused on leadership. She described taking a social constructionist position that informs how she leads. A main part of Abby’s role is to provide consultation for a variety of different teams in the service she works within. Throughout the interview, Abby reflected on how her social constructionist position contributed to the dilemmas she faced as she was concerned the teams she provided consultation for would become dependent on her. However she did not believe there was one answer or that she could provide it. This position ultimately helped her to support the team to “*comfortably move forward*” instead of providing an absolute answer. Abby provided a personal account of this position when leading in relation to her values. Her energy provided momentum for the interview and she required little prompting to open up about her experiences.

Abby reflected upon three examples, these were:

- Example 1: Abby was asked to help with the transition of a service-user with complex risk-orientated needs from child to adult services. She felt unprepared walking into a meeting regarding this, and felt pressure from the service and family. She took a variety of actions over the period of time such as liaising with the medical director to make a plan and supporting the family to engage. She believed this was ultimately successful, as they had been able to coordinate the care well.
- Example 2: During an MDT meeting, a new psychologist in the team who she was supervising was using an assessment measure in a way she felt was directing the care of a service-user in an inappropriate way. She reflected on how she met with the psychologist afterwards to try and understand her position, and the challenges of

not saying how she felt. She felt she had been able to develop a working relationship with the psychologist in the end.

- Example 3: During an MDT meeting, another clinician was “*begging*” the service-user not to end their life, which she did not agree with. The wider context was that she felt the clinician had a problem with assertive women. She described her reflections on not taking action during the meeting and how she made sense of this afterwards. She reflected on it taking several years to develop a way of working well together. She also believed the overarching issue that it was connected to would remain.

Philip

Philip thought this research was an “*interesting opportunity*”, as he often did not have the chance to step back and think about “*big picture stuff like values*”. When thinking about his journey into leadership, Philip recognised that he could have “*coasted along*” but that if something needed improving or changing he “*just [did] it*”. He described this as being “*impulsive*” and his involvement in leadership happening organically because of this, not waiting to be asked or told to lead. Although this may have been “*naïve*” at the beginning of his career, it contributed to him feeling comfortable to take on responsibility. Philip described leadership in a clinical team as “*having a vision...and nurturing the growth of the service and the individual within the service*” which was evident through his process of thinking about the dilemmas. He described finding it “*difficult to find time to be a great leader when one’s dealing with the fire-fighting of your own clinical work*”. He thought it was important to be “*working towards these sorts of ambitions that [he] set [himself], and as long as [he’s] doing that then it feels okay*”. Philip held a multifaceted role with more managerial responsibilities, which may have contributed to it at times being difficult to tease out his leadership responsibilities directly within clinical teams. However, Philip felt that this variety and autonomy within his job role, and the distance from working directly with service-users enabled him to balance any stress he experienced with finding this type of work rewarding.

Philip reflected upon three examples, these were:

- Example 1: Philip was responsible for making the decision about whether the team should remain involved in a service-user’s care. He did not believe the service-

user's needs came under the remit of the team anymore, but different professionals in the team had different opinions about this. He spoke to different members of the team to get a sense of the direction and to develop a consistent message to the service-user and their family. He then was able to bring this to a team meeting to encourage a similar message was taken. This enabled him to make a decision although he recognised not everyone would agree with him.

- Example 2: Philip was providing consultation to the team regarding whether funding to continue care should be arranged for a service-user. This was difficult due to the risk of homelessness if they were discharged. There was a tension between this risk and the service-user being in an inappropriate service. He tried to find a balance between these two causes for concern, which he felt he was able to achieve.
- Example 3: Philip reflected broadly on his experience of trying to gain resources to develop the service. This was when others had different opinions on how to use the resources available. He reflected on his approach to this, such as seeking advice from others and how he can be privy to knowledge about the system. This helps him to work out what is achievable, although this can feel overwhelming, as he believes the system is complex. He reflected on his approach resulting in him not jumping in feet first and assessing the scene before taking action.

Rose

Rose participated because she wanted to be helpful and spoke about leadership being inherent to the role of a Clinical Psychologist. She described her ability to lead *“evolving through [her] career as [she] became more clinically confident”* and had a better sense of the Clinical Psychologist she wishes to be. She also spoke about the process of being given tasks to lead on and how they became personally meaningful to her, which developed her interest. This was also illustrated when Rose described how leadership *“generates its own momentum”* as the more she sees the benefits of that type of work the more she wants to continue to do it. Rose described her leadership style being based on *“evidence and values”* and that *“when those coalesce... you’re doing the right thing”*. She also spoke about the balance between having an *“open view [that] anything could emerge”* and also providing *“the walls of what’s going to guide what you deliver”*. These ideas that

she initially reflected on ran through her interview, as she grappled with her sense of what is right. The process of interviewing Rose was fluid, as she was able to speak succinctly about her experiences. This enabled me to use thoughtful prompts in order to get more detailed reflections. Rose reported the interview helping her to achieve personal reflections that were both new and helpful to her.

Rose reflected upon three examples, these were:

- Example 1: Rose received feedback from a service evaluation project that the co-led formulation meetings were not effective. She reflected on her difficulties receiving this feedback and took action to keep trying to improve these. This resulted in staff providing more kind and caring support towards service-users. This gave her a sense of satisfaction in her leadership work.
- Example 2: During a ward round, another clinician expressed a different view about the treatment of a service-user, advocating the use of electro-convulsive therapy (ECT). She continued to express her clinical opinion during the meeting despite immediate feedback that this was not well received. She was concerned she had caused a rupture and after the meeting she attempted to repair this with the psychiatrist however she felt she was unsuccessful at this.
- Example 3: During a ward round, she did not express her view of the service-user's mental health that was different to that of the team's despite her internal monologue driving her to share her opinion. She went away and read around the topic, which helped her to feel confident but she did not take this to supervision as she felt ashamed and did not address the issue further with the team.

Daniel

Daniel works into two different types of services and described how he faces a number of dilemmas when leading in both elements. He found his interest was also "*sparked*" by the focus on values because of his therapeutic orientation (Acceptance & Commitment Therapy; ACT). He spoke about how leadership activities were an expected part of his job in terms of his pay scale and the job itself. For Daniel, leadership in clinical teams meant using the knowledge and skills that he gained from clinical psychology training and his experience since then. This was also reflected through his development as a

leader, from his “*experience within services rather than sitting down with a book learning about leadership models*”. He described his broader experience of leading as “*finding [his] own way in the dark kind of a deal*”. This is with the aim of trying to “*communicate psychological understandings but in a way that people can use*”. Daniel’s main therapeutic model of choice explicitly emphasises the need for commitment to values as a way of reducing distress. Some of the techniques from this therapy enabled him to cope with the dilemmas he faced as it enabled him to work in line with them. Along with his interest in values, this may have explained his ability to name and reflect upon how he made sense of these experiences readily. Daniel also reflected on the direct nature of his clinical work contributing to his emotional investment in the dilemmas he faced and thus the extent these experiences affected him.

Daniel reflected upon three experiences, these were:

- Example 1: During an MDT meeting, a new clinician questioned aspects of a project the team had co-developed when the service-user was present. He did not believe this type of discussion was appropriate for service-users to be included in and that the service-user would not have felt able to say if he did feel this way. This was challenging for Daniel and other members of the team as they were personally invested in this project. He did not take action in the meeting but afterwards he tried to consult with the team and then understand the new clinician’s point of view while trying to be open to other perspectives.
- Example 2: He was asked as the senior clinician to assess a service-user who had not been properly consented by another clinician to undergo treatment. He felt strongly that the staff member’s practice was inappropriate and he reflected on grappling with the decision to make a formal complaint, as he was concerned about the impact this would have on the working relationship. After seeking support from the team manager, he was then able to feel empowered to make the complaint with the view that he was protecting service-users. This felt resolved at the time of the interview as it was being addressed formally but Daniel recognised this was on going and could have consequences still.
- Example 3: A clinician in another managerial service changed Daniel’s decision not to offer therapy to a service-user after he had completed an assessment and decided therapy was not appropriate. He learnt of this change when the service-user had

been put back in his diary without his consent and felt pressure to provide therapy. He adapted the therapy he offered, formulated the relationship between psychology and the other service, and had begun to take steps to address the difficulties by spending time with the team. This was an on-going situation.

Miriam

Miriam chose to participate as she values research however other demands normally prevent her from taking part. She also spoke about feeling like she had “*something to offer*”, as leadership is a substantial part of her role. In terms of her journey into taking on leadership roles, Miriam spoke about her own “*ambition*” influencing her to ability to make the most of opportunities that are inherent in her job, and that it depends “*how far you want to take it really and what opportunities you get*”. When leading she described drawing upon many different models, mostly from therapy e.g. mindfulness and psychodynamic theory, stating that you “*you become a product of all you’ve absorbed*”. The influences of these models were also evident as she explored different examples. She described her leadership role as being the “*chief problem-solver*”, which was about creating the “*right environment*” to help others “*thrive*”. She also spoke about the importance of leading by expressing a “*voice for us (psychology profession)*”, to help others pay attention to the profession so that psychologists are more likely to be included in new projects/developments. Miriam was in the latter part of her career and the effect of this was evident throughout the interview. For example, at times she considered retirement, which emphasised the impact of these dilemmas on her but was also a strategy to help her continue working, as she knew she could leave if she needed to. Miriam was the only participant to provide a neutral experience for the first example, although this reflected a situation that others may find challenging. This reflected her competence and confidence that had developed over the course of her career.

Miriam reflected upon three experiences, these were:

- Example 1: During a team meeting she was chairing, another team member made a complaint about a staff member in another team. She felt she was able to handle this well such as by accepting what she could do in that moment, offering a safe space as a minimum and providing solutions if possible. This was a neutral experience for Miriam as she had learnt to manage situations like this.

- Example 2: Miriam felt pressure from the team to support a service-user who had been challenging for the team to contain. She did not believe she could assert her clinical opinion and felt the situation was “*impossible*”. The service user often complained about the service and was a revolving patient. She was caught between management wanting the service-user to be seen for therapy and the clinical team who were resisting offering care. She had tried to speak to the team about this and had felt she had no choice but to provide care to the service-user.
- Example 3: Miriam felt pressure to offer therapy to a challenging service-user for whom the team had refused to provide care. She also felt pressure from management who were not being helpful in securing her some alternative supervision as her supervisor was leaving. Through the process of the interview she decided to only provide care if she was able to secure her own supervision and was planning to raise her concerns over her own needs in an up-and-coming meeting. She was also able to find understanding towards the team’s resistance by recognising their shared humanity.

Emily

Emily participated because she wanted to help me as a trainee. She reported that there had “*not been any other choice*” but to take part in leadership responsibilities, however she also spoke about her own initiative to try and “*take more leadership and push things forward*”. There seemed to be a tension for her between “*being thrust*” into leadership responsibilities and “*wanting to take the lead on something and being in a privileged position to be able to do so*”. Emily spoke about leadership in part meaning to “*tell people what to do*” but that she finds this to be a “*difficult position*” that “*pushes [her] outside of [her] zone of comfort*”. She spoke about having to “*overcome*” this difficulty by being “*more decisive, be kind of more forceful on certain things*”. This tension was reflected throughout her interview as she navigated developing her approach to leadership. Her leadership style was informed by taking a “*dialectical stance*”, drawing on her DBT skills to enable her to “*search for synthesis*” and “*finding a way towards agreement*”. This approach was also evident throughout her different ways of responding to her experiences and modeling her leadership style to others. At the end of the interview when the dictaphone was turned off Emily described not seeing herself as a natural leader, which she

attributed to being earlier on in her career. This may have contributed to my reluctance to ask more probing questions at times. This was also influenced by the shorter limit on our time together.

Emily reflected upon three experiences, these were:

- Example 1: Emily reflected on facilitating a formulation meeting that she led on. She described often experiencing practical issues around staff engagement in the meeting, finding an appropriate space to meet in and feeling pressure to make it useful and interesting. On one occasion she had also taken a service-user issue to the case formulation meeting. During the meeting she felt concerned she had not prepared enough, and talked about the contrast between leadership skills (e.g. “be in charge”) and losing staff members engagement. She discussed trying to get feedback from the team on the meetings to help her develop and also feel valued, as she reflected on the possibility of feeling undervalued. She connected this to psychology as a profession having to work harder to put a psychological model across in the context of the medical model, and the pressure this can cause.
- Example 2: Emily was providing separate supervision to two individuals who were in conflict with each other. She had to hold knowledge that she thought would be helpful but could not share with those who were in conflict with each other. Through seeking her own supervision and reading around the topic she was then able to understand and think of what action she could take in the future. This included modeling how to speak to others about conflicts in a way she felt was dialectical. She also felt she was able to remain professional by not getting involved in the conflict.
- Example 3: Emily was requested by the clinical team to provide a formulation for a service-user however they did not include her in the decision-making process about the service-user’s discharge. She chose not to take action to address this and tried to make sense of the team’s actions and her own. She believed this might be a consequence of her not working directly onto the ward and was therefore not present for the team, and because of the powerful medical model that she felt she had given in to. She also reflected on her overarching dilemma between developing the leadership skills she felt she needed, which was to be more “*demanding to be heard*”, compared to what felt comfortable.

James

James described taking part because of his interest in reflecting on leadership in clinical teams, as it is a large part of his role. When asked about how he came into leadership, James stated how “*post-qualification there’s always some sort of leadership role*”. His approach to this type of work was informed by different theories, although he did not specify these, and his psychoanalytic understanding. James stressed the importance of learning to “*lead in [his] own way*” that “*fits with [him]*” which is influenced by his “*personality*” and “*values*”, describing leadership as “*a values thing actually- what [he] believe[s] in or what [he] think[s] works best, what’s most effective or humane*”. This suggested the importance of congruency between his style of leadership and personal factors such as his values. He also spoke about his willingness to “*stick [his] neck out*” and take a position if he needs to take a more directive role. For James, this was balanced with “*being prepared to back down*” and “*change [his] mind*”. This was evident through James’ certainty about the positions he took when facing some of the dilemmas he faced but also when he decided to stop taking action. This may also have been influenced by James’ level of experience as he was also nearing the end of his career. Also, I felt that James’ confidence in his approach influenced his confidence during the interview as he spoke openly about his experiences, which required me to prompt him less. After reflecting on his first example James described his experience of this as “*quite therapeutic*”, which might have suggested that reflecting on his experiences’ in light of his values might have brought added meaning. James reflected upon three experiences, these were:

- Example 1: James experienced difficulties adjusting to service transformation changes, which led to a personal dilemma about whether to continue working as this had a significant impact on his wellbeing. He initially resigned which allowed his pace of work to slow down. This improved his capacity to continue working and he reflected on his commitment to the NHS through this experience.
- Example 2: A decision was made by the team for ECT to be delivered to a service-user however James did not believe this was appropriate as other methods of treatment still had not been tried first. In various forums he tried to address this and grappled with when to stop trying to change the team’s opinion. He did stop trying, as he believed that ultimately ECT was an evidenced-based treatment and because

he felt it was not worth persisting with fighting for which was guided by his values. ECT was delivered and was ineffective. The team then tried his suggestion, which was helpful in improving the service-user's mental health however he received no credit for this. He described ultimately feeling "*bemused*" at the situation.

- Example 3: James had made a decision that he believed to be right, which was to accept a referral, however another less senior clinician in the team did not agree due to risks. The dilemma for James was to check he was confident in his decision and how to respond. He initially tried to be sympathetic and apologetic. However he strongly believed in his opinion and had support from a senior team member, which resulted in him not changing his decision but focused on trying to support the staff member with this. After he thought this was resolved, they made a formal complaint regarding him. He described how the investigation was resolved but how this did not resolve the difficulty between them.

Types of values

Table 2 below provides each participant's corresponding participant number. This is to interpret Table 3, which provides the values participants identified, categorised using Schwartz's model of basic values (Schwartz, 1992). The process of this categorisation is outlined in chapter two (Method) and reflected upon in chapter four (Discussion). Next to each of Schwartz's values is a summary of its defining goal (Schwartz, 2012). The participant number corresponding to the value named is identified within parentheses in the table.

Table 2. Participant name and corresponding number

Participant Name	Participant Number
Janet	1
Abby	2
Philip	3
Rose	4
Daniel	5
Miriam	6
Emily	7
James	8

Table 3. Values explicitly identified by participants

Schwartz Basic Values (1992)	Defining goal	Participants' values
Power	Social status and prestige, control or dominance over people and resources.	<p>Self:</p> <p>Wanted to be able to stand up and share lived experience (1)</p> <p>Values of kind of pushing myself forward really and making a louder noise (7)</p> <p>Control (3)</p> <p>Autonomy (3)</p> <p>Others:</p> <p>Personal agency for others (2)</p> <p>Freedom of staff (3)</p> <p>Increasing others autonomy (5)</p> <p>Empowering, promoting independence (5)</p> <p>People are able to have the autonomy to make decisions/to empower him (5)</p>
Achievement	Personal success through demonstrating competence according to social standards.	<p>Effective (4)</p> <p>Try (6)</p> <p>Striving (7)</p> <p>Work harder or put more pressure on myself to feel more valuable (7)</p> <p>Pragmatism (3, 6)</p> <p>Cost-effectiveness and cost-effectiveness (5)</p>
Hedonism	Pleasure or sensuous gratification for oneself.	Happiness (3)
Stimulation	Excitement, novelty, and challenge in life.	Movement, growth, change (3)
Self-direction	Independent thought and action-choosing, creating, exploring	

Schwartz Basic Values (1992)	Defining goal	Participants' values
Universalism	Understanding, appreciation, tolerance, and protection for the welfare of all people and for nature.	Service/serving others (1) Fairness (3, 6) Balanced and fair (6) Equality (3) NHS (8) Democracy and people working together (8) Want a patient or any individual to umm, be happy, safe and comfortable (3) Justice (1)
Benevolence	Preserving and enhancing the welfare of those with whom one is in frequent personal contact (the 'in-group').	Improving care for service-users (4) Protective (7) Useful and valuable (7) Helpful (5) Caring (5) Compassion (2, 5) Empathy (5, 6), Understanding towards colleagues (6) Dignity (1) Service-user first (1, 4, 6) Relationships (2) Good working relationships (4) Protecting relationships (5) Relationships with the team (5) Patient-centered (5) Not cause her any harm from a relationship (5) Wanting to make things right (7) Honest (5, 6) Integrity (2) Transparent (6)
Tradition	Respect, commitment, and acceptance of the customs and ideas that one's culture or religion provides	Having the sense of what's the right thing to do (8) Hard to walk away as well, and to, to give up (8, re NHS) Commitment to the service (5)
Conformity	Restraint of	Confidentiality (7)

Schwartz Basic Values (1992)	Defining goal	Participants' values
Security	actions, inclinations, and impulses likely to upset or harm others and violate social expectations or norms. Safety, harmony, and stability of society, of relationships, and of self.	No disputes (1) Respect (1) Respecting other professionals (6) Self-protection (8) Self-defence (8) Valuing self (7) Diplomat/smooth things over (7)
Spirituality	Spiritual life, meaning in life, inner harmony, detachment, unity with nature, accepting my portion in life, devout	Crisis and victory/religion (1)

Group Analysis

Table 4 below shows which participants experienced each of the twelve subordinate themes.

Summary of group analysis

The group analysis describes three superordinate themes and twelve subordinate themes. When facing dilemmas participants went through a process of losing and regaining a sense of control and perspective, and reflecting on facing dilemmas. From the 25 examples that participants reflected on, 14 had been resolved in some way for the participant, 6 felt unresolved and 5 were unclear or were not experienced as dilemmas. The first superordinate theme describes participants' initial experience of *'losing control and perspective'*. Participants experienced dilemmas as *distressing*, had a sense of *helplessness* to take action and felt *frustration with self and others*. The second superordinate theme describes participants' process of navigating dilemmas by having *'regained control and perspective'* as they were able to build their resilience and feel more equipped to take action. Participants' experiences of this happened in five ways: *feeling one thing and doing another, feeling more empowered, congruence with what is important, keeping things in perspective, and seeking security*. The third superordinate theme describes participants' *'reflections on facing dilemmas'* over the dilemmas they faced. This happened in four main ways: noticing the cost of doing *"what's right versus what's most comfortable"*, how they *made sense of retreating from action*, their positive sense-making of *"wounds into wisdom"* and their experience of *personal growth*.

Losing control and perspective

Participants experienced situations in their external world that were characterised by conflicts. These were conflicts between themselves and others' values (and beliefs/attitudes) or between their own actions and their values (and beliefs/attitudes). These produced an internal tension for the participant, as they felt torn between how to respond to these events, which marked the dilemma they faced.

This superordinate theme describes the three main ways participants were affected internally when faced with dilemmas, which caused them to lose a sense of control and perspective. This includes participants' experiences of feeling *'distressed'*, a sense of *'helplessness'* when trying to take action and *'frustration at self and others'*.

Dilemmas did not always occur at one discrete moment in time but were ongoing or unfolding, presenting different dilemmas for the participants over time. These experiences initially occurred in the first moments participants recognised they faced a dilemma.

Distressing

This subordinate theme refers to participants' different experiences of distress, which impacted on their emotional and physical wellbeing. This appeared to be the first step of participants losing a sense of control over the impact the dilemma had on them. These experiences were on a continuum, with some participants on some occasions experiencing milder discomfort. For example, Philip found it "*sometimes uncomfortable*" when having to support the team to decide whether to maintain offering care when it seemed inappropriate or to discharge the patient, which would risk them becoming homeless (Example 2). However most found that the dilemmas they reflected on had a significant impact on their internal world. Janet experienced significant emotional pain during an MDT meeting when she felt unable to share her lived experience of mental health problems when contributing to the team's unhelpful understanding of a service-user's voice hearing (Example 3). She described this experience as "*heart-breaking*" and "*distressing*" to the point she had gone home and "*cried a lot about it actually*".

A slightly different account of this experience came from James's dilemma that was ongoing and led to an enduring impact on his emotional distress until he had been able to find a way forward (Example 1). This was when he faced a service transformation that caused the clinical team he was leading to suffer a significant loss of resources both practically and in terms of colleagues. He described feeling "*quite overwhelmed*" as:

I was under so much stress and, and actually not, not believing in some of the stuff, you know. So it's really hard to, to umm, to lead and well part-part of leadership is containment isn't it and it's helping other people contain their distress sometimes or their stress even. And if you're really struggling to contain your own stress it's even harder to do that. So I guess my leadership function was undermined, as was my clinical function. (Example 1)

When asked how he made sense of his distress and reduced capacity to lead in terms of his values, James described how he “*really believes in and values*” the NHS (Example 1). However he felt the NHS was being “*decimated*”, which was “*hard to see*” and was at conflict with him also finding it “*hard to walk away as well*”. This displayed how he struggled to gain control over his internal experiences in response to the context of the NHS service. This also evidenced participant’s personal investment in their work, as they sometimes reflected on their dilemmas being underpinned by restrictions on their ability to lead with their values.

Helplessness

This subordinate theme refers to participants’ sense of helplessness when trying to take action in response to their values. The lack of power they faced when struggling to gain control over the situation seemed to be saturated in a sense of anger. Participants often made sense of this experience being due to the impact of a more powerful individual or due to the culture of the immediate clinical team or the wider system (another team, higher management or the NHS). This experience often occurred in the moment but sometimes persisted over the time course of participants taking steps to regain control, as explored within the following superordinate theme.

Several participants used visual language to describe their experience of helplessness; for Example, Janet described how her values were informed by her lived experience that was similar to that of the service-users. Her experience of not feeling able to use these values in her clinical practice was like being “*bound and gagged*”, which emphasised the importance of these values to her and the way in which she leads the team. She felt “*[she] couldn’t use [her] own lived experience to inform better practice, that would have been out of the question*” (Example 3). Similarly, Daniel found that a manager without his involvement had overturned his clinical decision when a service-user he had discharged had been put back in his diary to be seen again by him (Example 3). He described it as “*being used as a pawn really in the whole process*” as he felt unable to express his autonomy to decide who might benefit from what.

Miriam also made sense of her feelings of powerlessness being due to management who left her feeling “*a bit controlled*”. This led her to “*think what’s the point of all this training...and you know being able to make a decision if it’s always gonna be overruled*”.

This seemed to result in a sense of ambivalence or resignation for Miriam towards responding to this challenge, which may have affected her ability to lead. She described the impact of management on her sense of control and helplessness as:

And you're always watching your back; you know you're covering your back all the time. And everything is hard and I feel a bit like a mercenary sometimes cause I'm always thinking, 'Well what will the lead investigator say in this situation; and what would they get us on?' and that feels, it feels wrong, you know. It feels um, it is wrong um, cause we've got to be free to act as clinicians um, you know we've got to have that level of autonomy; but, you know how could an ombudsman be more than a senior clinician? (Example 2)

There was a sense that she felt anxious or fearful due to the wider context of the service that she works within that she may be reprimanded. The immediate context did not appear to be the main dilemma for Miriam but rather her experience of navigating the impact of the wider culture on her ability to make decisions.

On the other hand, Abby described a different account of her relationship to control and power, which she struggles with to a lesser extent. Throughout her interview she reflected on her sense that there was a risk the clinical teams that she provided consultation for might rely on her too much (Example 2). Her reflections were triggered when a clinician was acting inappropriately during a meeting with a service-user present, which she did not do anything about in the moment. She reflected on her efforts to reduce this dynamic, which is centered on her value of “*personal agency*”. However, she at times recognised the need to have some more control. Abby explained her sense-making that accepting a less powerful position can still be difficult at times when she would like to take more control:

I think it, some things are just, will remain a struggle at times; you can't have it all the ways. If I want people to feel able to talk to me, not feel that I'm over-influencing people, I can't have that and all of a sudden be able to stop something happening because I think it's...you know because I'm worried about this situation. (Example 2)

Frustration with self and others

This subordinate theme refers to how participants' experience of internal distress and helplessness affected their psychological wellbeing. This resulted in them feeling annoyance and frustration at themselves or others. This affected their life outside of work, such as their familial relationships and interrupted everyday activities at home. Participants appeared to have little control over this impact initially, which influenced their perception of others (e.g. feeling negatively towards others or the complexity of the system and lack of resources) or themselves (e.g. doubting their ability to lead).

Several participants noticed they had ruminated or obsessively thought about the dilemma and their associated frustration. For example, Daniel described his internal response towards a new colleague who had questioned the care pathway he had co-developed with the team. This was during an MDT meeting with a service-user present, and this particular conversation had dominated the meeting. He felt this was not an appropriate use of the meeting as it was not relevant to his care and that the service-user was likely to not have been able to comment on this. He also did not feel the clinician was listening to their rationale, which caused him to feel “*incredibly frustrated*” and described this as “*toe-curling*”. He had tried to take control by highlighting what was happening to the OT leading the meeting but felt this “*wasn't [his] best*”. Daniel described his response after the meeting as affecting him:

For the rest of that day and probably into the evening and even into the next day I was finding myself like completely hooked with my annoyance of this individual. And I guess, yeah, losing touch with, I suppose, other values that I might have around being able to I suppose, empathise with, be empowered with his situation being a new [staff member] and being able to take his view point. (Example 1)

Daniel describes how this had an unhelpful impact on his “*psychological space*” (Example 1), as his frustration at the clinician reduced his ability to hold on to his other value of empathising with others. This represented a conflict between his values focused on the service-user and his values focused on the staff.

For some participants, becoming frustrated by their experience was marked by self-criticism and self-blame which reduced their confidence. For example, Rose received feedback from a service-evaluation project of the ward formulation meetings she had co-facilitated (Example 1). The feedback showed that it had not produced positive change in the care provided by the team. This feedback conflicted with her core value of being an “effective” psychologist which explained her initial experience of finding this feedback “*really disappointing like a bit of a head slap kind of, ‘Argh, no, the idiot!’*”. This resulted in her internal dialogue of self-blame as she described how she believed “[she] *should’ve just described it better. [She] should’ve ensured this from the beginning*”. Her use of the pronoun “*I should’ve*” also gave the sense that she felt a greater sense of responsibility for the effectiveness of this co-led project she was involved in. Participants directly reflected on this self-blame and its impact on their leadership and their ability to cope. For example, Emily had been trying to establish and facilitate MDT formulation meetings. However she found it was challenging to build the team’s engagement in attending these sessions. This impacted on her sense of confidence as “*you start to question the value of what you’re doing*” (Example 1). She experienced this same response in another situation when she was left feeling “*undervalued*” by the clinical team. This was when she had not been included in the decision-making around the discharge of a service-user who she had been developing a formulation with (Example 3), which affected her perception of her job role and herself.

Regaining control and perspective

This superordinate theme refers to participant’s experience of regaining a sense of control and perspective when navigating the dilemma they faced. These experiences enabled them to both maintain resilience and take action. This includes: ‘*feeling one thing, doing another*’, ‘*feeling more empowered*’, ‘*congruence with what is important*’, ‘*keeping things in perspective*’ and ‘*seeking security*’.

Feeling one thing, doing another

This subordinate theme refers to participants’ experience of inhibiting their initial impulse to react to the dilemma they faced and taking limited or no action. For many, this happened in the moment the dilemma initially occurred or came to their attention. This

appeared to be a method of creating time so that they could better prepare themselves to lead.

Some described their experience of this in relation to choosing not to express their immediate internal dialogue. For example, Daniel described how: “*Really I just wanted to scream and just shout, ‘can everybody just shut up! This is ridiculous’. I mean I didn’t [chuckles]*” (Example 1). This was when another clinician was affecting the service-users care during an MDT meeting by questioning the project they had developed (Example 1). All of these participants did not take this action that they had felt compelled to do or had experienced an internal dialogue about in the moment. There was a sense across these experiences that this was protective, to maintain their own professionalism.

Participants had different ways of understanding this process of inhibiting some part of them. For example, Abby described her sense that there was not anything to achieve from responding to the tension straight away (Example 3). This was when she had to watch another clinician “*begging*” a service-user not to end their life during a meeting which she believed was inappropriate. She described how “*you’re not going to be able to change all that just happened then*” and having “*to steel [her]self for another moment*” which resulted in a “*challenge to [her] values and what [she] believe[s]*”. Therefore Abby had to initially not respond in the way her impulses were influencing her to in that moment.

Several participants explained their process of inhibiting themselves being due to their fear of worsening the situation or not being able to trust in their opinion to take action in the moment. For example, Emily described “[*her*] *initial strategy*” as “*don’t do anything*” and “*don’t wade into anything, don’t make anything worse*”. She was reflecting on a time when she was supervising two team members separately who found themselves in conflict with each other (Example 2). Emily described her experience of her strategy as creating time for her to find “*the appropriate way to manage it*”. This is connected to the following subordinate themes whereby participants were proactive in preparing themselves to take action.

Feeling more empowered

This subordinate theme refers to participants’ experience of becoming equipped with resources so that they could take more active control. This enabled them to feel empowered through building trust and confidence in their ability. At times this also served

to temper the initial emotional impact of participants' experience by providing validation or normalising their experience. Participants drew upon different strategies to achieve this, such as reading the literature (e.g. national guidelines), using personal and professional support networks, or through encouraging themselves. For some, this also involved being able to recognise their own needs and taking initiative to have these met, such as when Miriam decided that she was going to stand her ground that supervision should be organised for her if she has to take on further responsibility.

So I guess it's good to talk about here actually cause I think I will say this at the meeting, you know, 'you want me to see this person? I haven't even got a supervisor!' (Example 3)

Rose described a time when she had been able to continue to stand up for her clinical opinion during a team meeting and had felt confident to do so by drawing upon feedback from other professionals that she had received previous to this:

You're the only profession that will stand up to us. And one of them said, 'You stop me behaving like this-this is a saus-sausage factory with the people who come in and we, you know just process them and out they go.' And so I took, you know I took that on board quite a lot and I, and I, i think that gave me confidence to occupy umm, my professional territory a bit more. (Example 2)

This appeared to improve her confidence in her ability to take action that produced a valuable improvement in care so that she was able to have more influence and control when leading the clinical team.

Several participants found their support networks to be effective, such as by keeping them accountable to the appropriate way to lead, and helping them to feel more empowered and confident in their opinions and action. Participants found this particularly helpful when the supervision was external or others aligned to their point of view. For example, Daniel recognised that *"the values of the department kind of m...mirror you know a lot of [his] own values really umm, and [he] knew [he would] be supported by the people who were more senior"* (Example 2). This resulted in him taking assertive action to make a formal

complaint about another clinician. For Abby, she “*need[ed] to know that somebody’s got [her] back*”. Such as others who are “*there in the background that know, agree and believe in the way [she is] working*” but they “*they won’t let [her] go rogue either [chuckles]*” (Example 1). Her clinical director provided this for her, which enabled her to feel “*comfortable going into a situation or ending up that might be really scary*”. Whereas Emily’s experience of supervision enabled her initial emotional reaction to be “*tempered*” as she learnt that “*this is actually quite normal*” which also resulted in her feeling more equipped as she had “*got some more ideas about how [she] might go about working with this*” (Example 2). This seemed to build her confidence that she could take action to regain control over the situation.

Congruence with what is important

This subordinate theme refers to participant’s experience of regaining control by achieving congruence with what is important to them, such as their values. This involved adjusting their perspective in some way on the internal tension that they experienced, reducing the dissonance. For many participants these internal tensions were between their own values, or between their values and the perception of others’. However some participants did not directly name this experience as being about values, although there was evidence of different values influencing their experience.

This experience of trying to take action in congruence with what is important involved participants balancing different values or others factors. For example, Janet described balancing her internal tension between her values centred on providing effective care and protecting the professional alliance as involving “*walk[ing] a tightrope*” (Example 4). This appeared to help Janet to find compromise between her two values. This manifested in her balancing “*between not challenging too much but not completely accepting that way of thinking either*”. For Emily, this balance between tensions was important for her to have integrity to her values and practice within what felt comfortable so that she could “*go home and feel okay about [her]self, because it [did] feel a bit too far outside of [her] own kind of base*” (Example 3). This was when Emily was trying to balance the demands of the ward culture that required her to be more assertive, versus her natural approach to leadership to be “*diplomatic*”. This was a dilemma she experienced beyond this specific example, connected to developing her style of leadership. She believed

that she could try and “*build on [her] own values by kind of pushing [her]self forward really and making a, a louder noise*”.

In order to balance the tension between participants’ service-user focused and staff focused values, several participants bridged this dissonance by noticing the similarities rather than differences between themselves and others. Philip described his perspective helping him to manage the differences in opinion he experienced on how resources should be used to develop care (Example 3). He made sense of this as someone else “*probably has the same values but perhaps with some at a different priority level than others just by the nature of the roles that those individuals have, by virtue of their jobs*”. He described responding to this sense making as “*a negotiation, [he thought], between [him] making sense of what’s important to [him] and [his] values*” as well as “*understanding and appreciating why others peoples’ values are different umm, levels of importance relative to [his] own*”. He found this understanding of others value systems made it “*easier to have productive conversations*”.

Other participants’ values centered on preserving or protecting themselves, which influenced their action within the team. James faced a difference of opinion within the team about the treatment of a service-user (Example 2). He had made various attempts to take action, such as having discussions with different members of the team and reading around the topic, however he felt this had been ineffective. He described balancing continuing to take action and stopping taking value-driven action through how he made sense of his values:

Yeah, so there are certain values, which are non-negotiable, you know umm...you know murder or abuse and stuff like that; stuff that you just don’t do and they-they’re unacceptable. And-and and then there are other values, you know like this one. Umm, it’s really important issue, I think and you know I do, I have strong view about it. But at the end of the day er, it’s not quite the same! Umm, so it’s a bit more negotiable and it’s easier to if, if you’re out argued or outnumbered then it’s easier to accept and not feel like you have to resign or keep fighting. (Example 2)

This suggests that James, like others, have a hierarchy of values and that participants had to negotiate to find what was most important in that any given situation. Here, this enabled James to establish a limit on how far he had tried to lead in line with his

values in this example. For some participants this was a cognitive process of choosing between values to decide what action to take.

Keeping things in perspective

This subordinate theme refers to participant's use of various strategies that enabled them to develop and hold on to a more positive or realistic perspective of what they could change. Participants used different strategies to achieve this, such as being able to laugh at themselves or the situation, using supervision, and the role of their friends and family. This appeared to help participants gain separation from factors that contributed to the emotional impact of the dilemma, such as the responsibility to resolve the difficulty, taking things personally or their personal investment in their role. This then enabled participants to build their resilience so that they could continue taking action or feel confident in the action they had been able to take.

Several participants described how they had been able to keep the role of psychology in perspective. For example, James felt that his efforts were ineffective when trying to address the issue he had with the team decision regarding delivering ECT when other methods had not been tried yet (Example 2). Reflecting on this, having "*share[d] it with close friends and colleagues as a joke from time-to-time*", this changed his perspective of the dilemma to one where he was able to "*[see] it as a job*" and "*[keep] it in context*". Others experienced this process as keeping what they could achieve in perspective. Miriam reflected on her process of having to take action by taking on the responsibility for providing care to service-users because she felt caught between management and the clinical team (Example 3). A senior clinician, who had been involved in supporting the care for this service-user, was leaving the service. This, along with a threat to her receiving ongoing personal supervision was affecting how supported Miriam felt. She described coping by holding in mind that "*good things end and bad things end*" and "*[she'll] do the best I can do*" by being able to "*work where [she] can with the resources [she's] got*". This improved her perspective on what she was able to achieve. Miriam also described the "*main thing*" as "*[she] didn't take it personally*" which enabled her to gain separation from her frustration regarding the team not taking on responsibility with the service-user or supporting her. This also seemed to help participants find acceptance for themselves and manage some of the challenges that come with working within the context of the NHS.

For one participant (Abby), this process of keeping things in perspective involved finding a way of reminding herself of this when she feels she is acting like a “*princess*”. This was when she reflected on her emotional response towards another clinician who she perceived as acting inappropriately during an MDT meeting towards the service-user (Example 3). She described an image she keeps on her wall in her office, which influences her perspective of herself and alleviates her negative internal experience of the situation so that she can feel calmer. She described how staff members were asking her:

What have you got a picture of a nebula on the wall for? And I go, ‘to remind myself how significant I am’. It really helps. Cause when you [chuckles] when you get really quite... Okay it’s like the most, it’s like the only thing going on in the world, in the universe, anything and it so isn’t. We’re nothing. We’re insignificant. We are, we’re just a blink in time. Like all this will mean nothing huh [chuckles][sighs] there you go, let it go. I’ve calmed down now. (Example 3)

Seeking security

This subordinate theme refers to participants’ experience of finding emotional containment and resilience through having sought security. This enabled them to be more in control of their experiences captured within the primary superordinate of them *losing a sense of control and perspective*. Specifically, as described in the subordinate themes of *helplessness* and *‘feeling one thing, doing another’*, participants felt powerless to take action or inhibited their initial emotional reaction when first faced with dilemmas. Here, participants learnt to manage these experiences and find sustenance through these challenges by using different personal strategies alongside professional structures such as supervision. These different sources of support included religious, spiritual, and ethical/moral strategies.

For Miriam, this involved finding control over her how she coped personally in situations that made her feel powerless. Although she did not describe the details of what this involved she expressed the importance of being able to “*try to keep healthy and happy and sustained in every part of your life that you can control and work’ll be work*” (Example 2). This was when she had little to no influence to affect the decision-making around a service-users care. Other participants achieved this through drawing strength from

something or someone else that was stronger. For Janet, this involved drawing upon her religion in order to feel strengthened and therefore resilient across most of her examples of dilemmas. In example one, when leading the team through service difficulties that were causing the team to feel demoralised she reflected on how *“prayer can sustain you, it’s almost like you’re a television and you’re plugging into a source of electricity which isn’t part of the television but it comes from somewhere else, it’s sustaining you, nurturing you and it’s strengthening you”* (Example 1).

Several participants explicitly applied their psychological thinking and skills to help themselves to cope. For example, Daniel was able to apply his ACT skills to *“take the stance of a curious scientist”* which enabled him to *“re-focus on something else”* which was *“one of the most helpful times that [he’d] been able to actually utilise this thing on [himself]”* Before explaining the helpfulness of this method Daniel had described wanting to *“[use] the opportunity to unwind a little”* at home which gave the sense that this coping strategy had allowed him to de-stress to some degree. This was when he had felt negatively towards management for forcing him into the position of having to provide care (Example 3). This enabled him to regain control over his internal experiences.

One participant (Rose) reflected on her sense that her values that enabled her to continue working despite the challenges. This was when managing a situation where she had originally felt ineffective at producing positive change in care. She initially experienced self-criticism regarding this but also became motivated to try again with phase two of the formulation meetings. She described her *“personal values”* being *“overlaid with [her] professional ethics and [her] professional values”* which were sustaining her. She described how these *“run as the core of [sighs] what matters and what gets you up in a morning and how you, how [she], derive[s] a sense of satisfaction and pride in [her] work”* (Example 1).

Reflections on facing dilemmas

This superordinate theme refers to participants’ reflections on their broader learning from losing and regaining control and perspective, when navigating their way through dilemmas. The first two subordinate themes, *“what’s right versus what’s most comfortable”* and *‘making sense of retreating from action’*, were spoken about both in the moment of navigating the dilemma when the participants’ were reflecting on their

experience and more clearly as a hindsight reflection. This led on to participants transition into their final stages of reflection encompassed in the two subordinate themes of “*wounds into wisdom*” and ‘*personal growth*’.

“*What’s right versus what’s most comfortable*”

This subordinate theme captures seven participant’s awareness of there being a cost involved when taking value-driven action. Participants’ experience of holding this perspective enabled them to take action in line with their values. This cost to themselves or others was identified as a participant’s belief that they had done the *right thing*. This is reflected by Daniel’s sense that there is “*often the dilemma in this role about doing what’s right versus what’s most comfortable*” in order to have integrity. He described a cost to himself in that “*ultimately it’s nice to be liked by your colleagues and there’s a real threat to that*” after coming to a decision that he had to submit a formal complaint about a member of the team (Example 2).

Similarly, Janet also experienced an awareness, on reflection, of there being a cost involved to her before taking action; “[*she knew she*] was going to get [*her*]self into trouble” in the sense that she “*wasn’t going to be agreed with*” when standing up for her clinical opinion. Although she was still able to “*speak up and giv[e] an alternative formulation*” (Example 3), this left her feeling “*humiliat[ed]*”. This displayed how participants made sense of feeling this fear but took value-driven action anyway. Sometimes the cost was not experienced directly by the participant but was the participant’s acknowledgement that making a value-driven decision can affect others within the team. For example, Philip described how taking action for the “*greater good and the bigger picture can feel uncomfortable*” and can mean “*caus[ing] stress in another part of the healthcare system*”. This was the case for Philip when he had decided that the team should eventually stop providing care for a service-user despite this not being to the other team members’ approval (Example 2).

These examples display times when participants took action to lead with their values. In some circumstances participants experienced leading with their values to involve *not* taking action. This seemed to be when they perceived an immediate harm to another professional or service-user. For example, Daniel’s clinical decision not to provide therapy to a service-user had been overturned without consent by management. He considered

speaking to the administration assistant who was involved in putting the service-user back in his diary afterwards but decided against this. Daniel questioned himself during the interview as to why he “*chose not to say there’s no way in hell, holy hell that I’m seeing this person because I’ve said I’m not*” (Example 3). He made sense of this as “[*not wanting*] the person (staff member) to feel in the middle of this”. There was a sense that this lack of action to lead with his values involved taking a less powerful position at certain points to protect others.

A different narrative of this experience displayed how in some circumstances there was a limit to participants’ sense that they should continue to withstand this cost. James came to believe his persistence with trying to influence the team’s decision regarding exploring other treatment options before using ECT was jeopardising his morale as he described how he was “*not going to argue until [he was] blue in the face*” which left him asking “*how far do I go with this*” (Example 2). This suggested that he felt it was not worth the cost to himself as ultimately he believed this was an evidence-based decision to use ECT. He believed that although he had to accept his decision, his passion for this issue still remains.

Made sense of retreating from action

On some occasions participants did not take action or stopped taking action in response to the dilemma. They had different ways of making sense of this that involved adjusting their internal views, which enabled them to gain a different perspective of their difficulties when changing their external world. This enabled them to regain control and may reflect their strategies to help them continue in their roles, although this did not always seem comfortable. Some participants had not recognised that they had not taken action until they reflected on this during the interview, which may reflect how they detached from these challenging experiences to cope.

Janet reflected upon a time when she had not taken further action when a team member had made a complaint about her expressing a different clinical opinion in a meeting. She was feeling “*overwhelmed with things*” in her role and “*just sort of wanted to get it out of the way*”. This involved “*deciding which battles to fight and which battle don’t you fight*” (Example 4). However she seemed to doubt this method of responding as “[*she was*] not sure it was the right thing to do”. Although she described choosing her battles,

during the process of the interview she believed she “*could have taken a more proactive approach*” and that she “*might do that now if something like that happened again*”. There was a sense that Janet may no longer feel overwhelmed by the situation and therefore had been able to gain a different perspective on it now, which allowed her to think about resources she could draw upon to take more control in the future. This also suggests that this external experience makes a difference to how she thought she could act and how well she could carry her action through.

Several participants found the wider context of the NHS, the service they worked within or the medical-model approach continued to affect their actions. Emily’s experience of this seemed conflicted between an empowered position, as she initially described making sense of this as being able to “*let it go*”, to a more disempowered position when moments later she described “*giv[ing] in to the medical model*”. This was when she decided not to try and address being excluded from the team’s decision-making (Example 3). She made sense of her decision to “*give in because it feels like such a culture shift for people to, to actually take on board what you’re doing*”. This influenced her approach to the type of leadership role she carries out within the context of a ward describing it as a “*drip-drip approach*”. This suggests that she had to accept the real-world constraints she faced and the training of other staff.

It is noteworthy that two participants near the end of their career (Miriam and James) found these challenging emotions resulted in them questioning their own resilience in the broader sense of their work. This resulted in them not taking action in particular examples or taking steps to completely stop working. For example, Miriam imagined breaks from her work and thought about how long she has until retirement, as she was not sure “*how much longer can [she] stand it*”. This was during a situation when she had felt powerless to influence the clinical team and felt stuck between them and management (Example 2). She had to take on the task of seeing a service-user with complex needs without support. Miriam reflected on her perception of holding in mind that she can leave the service as “*very bad*” but that it helps her to “*detach from it*” by thinking “*oh, I’ll be gone before too long - what will be will be*”. Holding this position appeared difficult for Miriam, as there were still “*bits of the job*” she “*enjoys*” and so viewed this as “*a shame*”.

“Wounds into wisdom”

This subordinate theme refers to participants’ positive sense making of their challenging emotions, that they were a precursor to action and facilitated change. This reflects an adjustment in participants’ perspective on their challenging emotions. Janet described drawing from her faith-based values and prominent cultural figures, which informed her positive perspective that challenges enable growth. This was how she made sense of the challenges and enabled her to make a continued stand against management:

In the [name of religion] faith we talk about crisis and victory, when negative things happen they can be turned into something positive, transformed into something positive for the benefit of others. I think is it Oprah Winfrey said ‘turn your wounds into wisdom’, that’s another belief, there’s a quote from [name of religion] writing as well, it says something like ‘our difficulties should be stepping-stones to progress’. (Example 1)

Other participant’s use of language reflects this shared experience that challenging emotions are useful. Philip described his experience as being *“like comfortable-uncomfortableness”* when making sense of a difficult decision about a service-user’s care as it would enable progress in the long run (Example 2). When Abby was reflecting on a time when she had to make difficult decisions about a service-user transitioning into the service she was working within (Example 1), she reflected more broadly on her sense of anxiety. She made sense of these challenging emotions that she experiences as *“healthy fear!”*. In relation to a time when she had felt challenged by another team member’s response to a service-user, Abby believed that *“the upset, any stress or distress”* is acceptable as *“it’s right”* that she should feel it. Her sense of this was that *“if [she] should stop feeling that, that’s a good sign maybe [she] need[s] to think about change”* from her current position (Example 3).

Several participants described how their difficult emotions caught their attention, which acted as a precursor to them taking action. For example, Rose felt that this *“initial disappointment”* was *“really useful”* and *“temporary”* as it *“motivates you to progress”* when trying to maintain hers and the team’s enthusiasm with reflective practice meetings (Example 1). Rose reflected on her psychological understanding as it’s *“what we tell our service-users [chuckles] if it feels uncomfortable don’t avoid it!”*. She described this

“repeated exposure” having improved her “anxiety” and “competence” by keeping on trying to improve the reflective practice meeting she was co-running and later she generally describes this process over time making it “easier to ride some of the waves ... the ups and downs”.

Personal growth

This final subordinate theme encompasses participants’ experience of personal growth, which emphasised the importance of learning from dilemmas. Some attributed this growth to their experience of the dilemma being resolved or not, and noticed the positive impact of this on their emotional wellbeing, such as feeling relieved. For example, in some situations participants did find resolution and displayed learning from this. When reflecting on mending the professional rupture, Rose learnt about the influence of time in healing the relationship rather than her own attempts to achieve this immediately after (Example 1).

Well it’s interesting umm [sighs] I, longer term, I don’t think it’s had an impact on the working relationship I have with that particularly member of staff. But my attempt to repair it was not the point at which repair...I think repair just happened over the time we’ve just continued to work together. (Example 1)

In other situations participants did not experience a practical resolution of their dilemma but reflected on how they found resolution for themselves by developing from their experiences. This experience led to the personal growth of participants, as they had been able to adjust in some way to improve their perspective and sense of control. Emily believed the dilemma was “more resolved” because she “felt more comfortable with tolerating the dilemma” and “the on-going conflict”. This was in relation to supervising two clinicians through an issue that she could not directly resolve for them (Example 2). Similarly James had “started to feel [he had] adjusted and adapted and found a way of even offering some effective leadership in that team” (Example 1). He described:

It certainly resolved enough; it’s not uncomfortable anymore. It’s not a dilemma anymore...aspects of it are not completely resolved...we’re struggling on and dealing it with it the best we can...I guess I’ve adjusted a bit and being part of the

team. There's a bit of a Dunkirk spirit for want of a better word, you know everybody, we're in this boat together sort of thing that helps. (Example 1)

From this, James had been able to gain a greater control over his own ability to maintain resilience and therefore improved his ability to lead while the service transformation was still causing a strain on the team. James' reflection on his unity with the team helping him to cope also reflects other's learning about what they could achieve with others.

Some participants also described or displayed this growth over the course of their career, which resulted in them feeling better equipped in the long run. Abby reflected on a time when she felt frustrated at how another clinician had acted inappropriately and had felt consumed by her own sense of right and wrong about the situation. She had been able to shift from being internally self-judging, *"How can I be like this in one situation and, yet I'm supposed to be a psychologist?"* to self-accepting, *"yeah, cause I'm only human!"* (Example 3).

On other occasions participants did not experience a sense of resolution of the dilemma. At times they recognised that they still had to undergo continued learning to develop themselves. For example, Emily acknowledged she needed to adapt her leadership style further and Miriam decided she was going to take further initiative to have her own supervision needs met. These reflections on participants' own personal growth or their need to grow further shows the importance of reflecting on their experiences, which may contribute to their ability to manage future dilemmas. However, on a couple of occasions two participants (Janet and Miriam) attributed the lack of resolution to the need for growth to occur within the culture of the clinical team or wider system for their experience of the situation to improve. This was the case for Janet who had been able to bring the team together to take unified action to help improve the practical service issues they were faced with, however she still felt that it had not resolved (Example 1). She exclaimed *"No! Because I feel like there's been no lessons learnt so we're really carrying on with a simmering lack of trust, simmering anger and resentment"*. This resulted in continued emotional difficulties, and an ongoing sense of a lack of control for the participant. She attributed this lack of learning and therefore growth of the team to be due to *"no accountability in the system"*.

Closing comment

Throughout participants' experiences of facing dilemmas, they had to undergo a process of learning in order to transition into a position where they could gain more control over these challenges. This involved both personal and professional learning in order to become equipped to take action and cope with these experiences. Sometimes this learning was directly connected to the specific situation whereas other times this was clearly connected to an ongoing and broader process of learning connected to their leadership or wider job role. Therefore on some occasions for some participants they had yet to undergo the broader learning required for them to feel the dilemma was resolved in some way. The learning that participants underwent contributed to their wider sense making of the dilemmas they faced that may have enabled participants to continue in their roles by gaining a sense of resolution. This learning seemed to become integrated into their personal and professional development. It was also recognised by some participants that systemic factors were outside of their control and a connected lack of learning in the system perpetuated difficulties for them.

Discussion

Overall summary

This study aimed to understand eight Clinical Psychologists' experiences of leading within clinical teams and how they made sense of this. This was particularly focused on when they faced dilemmas and how they made sense of this in terms of their values. Interpretative Phenomenological Analysis (IPA) was used to explore their experiences. The resulting analysis comprised of three superordinate themes and twelve subordinate themes that described participants' processes of navigating their experiences. This section includes a discussion of these findings in relation to the research questions, and is placed in the context of the literature. The limitations and strengths of the study are outlined along with recommendations for clinical practice, and suggestions for future research. In keeping with IPA, I have also shared a final reflection.

Question one: what are Clinical Psychologists' experiences of leading within a clinical team?

Types of leadership experiences

Participants mostly reflected upon types of experiences that were considered dilemmas or were challenging in some way to them. They were firstly asked to provide one example of leading that stood out to them and then two examples of times when they specifically faced dilemmas. In the first example participants more often also reported dilemmas or challenging experiences as well as during the questions specifically targeted to this type of experience. This occurrence in the type of examples participants spoke about in the first example question may reflect the frequency of dilemmas participants faced when leading or suggests the greater significance of these types of experiences to them. This has been discussed further in the strengths and limitations section.

Participants' experiences were clustered into ten different types of central contexts. The numbers of participants who reported examples from each of the ten contexts are provided in parentheses. These were as follows; a difference of opinion (e.g. associated with treatment decisions) within team which often occurred during team meetings (8); pressure from others to take on clinical responsibility (e.g. clinical team, management or another service) (3); the impact of service issues and changes (2); difficulties when supervising others (2); concerns about the practice of another clinician (2); challenges of providing an effective formulation/reflective practice meetings (2); challenges of obtaining and sharing resources (2); exclusion from service-user decision-making by others (1); managing complex service-user transitions and discharges (2); and managing complaints in a team meeting (1). Some participants were able to respond immediately to the central context of the dilemma they faced which contributed to secondary dilemmas about how to continue to take action.

The overarching superordinate themes across these experiences show participants first losing and then regaining control and perspective, and their reflections after facing dilemmas. This process shows their ability to recognise the need to develop as leaders and take action in order to equip them with what they needed to sustain them in their role. This enabled them to continue in their leadership roles despite the difficulties this presented for them.

The dilemmas participants faced were underpinned by tensions between different factors that were important to the participant. Most participants found that external events contributed to internal tensions related to how they should respond. Participants on most occasions experienced a resolution of the dilemmas they faced. However a few participants on some occasions had not found any sense of resolution, which contributed to them facing on-going challenges.

Losing control and perspective

This superordinate theme concerns participants' descriptions of their experiences of dilemmas in the initial stages of leading in clinical teams. They described the different ways this affected their internal world and their emotional wellbeing. Some found these experiences of emotional distress as "*completely overwhelming*", as James described (Example 1). Participants described how this impacted on their leadership such as their confidence, self-esteem, and significantly, their struggle to keep hold of a sense of control. Participants used metaphoric language to communicate their sense of helplessness and disempowerment. For example, Janet described this as feeling like she was "*bound and gagged*" when she could not use her own lived experience to improve the team's approach to a service user's care (Example 3). This led some to experience questioning whether they could continue to do their job if they could not take professional autonomy or control. Participants found this emotional impact to affect their psychological wellbeing, as they became frustrated at themselves and others. These experiences became all-consuming as the impact at times lasted beyond the moment in time a dilemma was recognised and affected their personal life outside of work.

Regaining control and perspective

This superordinate theme encompasses participants' experience of navigating dilemmas by both building their resilience and equipping them to take action. Throughout these experiences were strands of participants having regained a sense of control and developing a more useful perspective. For participants in some situations, one of their first steps involved inhibiting any action, such as not sharing their immediate internal dialogue. This was despite the distress they felt in the immediate moment a dilemma had come to

their attention. Abby described having “*to steel [her]self for another moment*” (Example 2).

Participants experienced feeling more empowered to take action by acquiring the skills and knowledge they needed, which enabled them to feel validated, and normalised the challenges they faced. For example, Rose describes this had “*[given her] confidence to occupy [her] professional territory* (Example 2). Through different strategies participants also tried to achieve internal congruence with what was important to them to enable them to take action with integrity, such as for Emily to be enabled to “*go home and feel okay about [her]self*” (Example 3).

Participants also described finding security and containment for their emotional distress to help them to continue persevering through the dilemmas. They described using different strategies such as moral, spiritual and religious methods. For example, Janet described how prayer “*strengthened [her], sustained [her] and nurtured her*”. Participants also were able to develop a more helpful perspective that was an optimistic or realistic view on what they could achieve, their sense of responsibility or the job role itself.

Reflections on facing dilemmas

This superordinate theme describes participants’ experiences of reflecting from a broader perspective on their experience of facing dilemmas. Participants noticed a personal cost or risk involved when taking action in line with what was important to them. For example, Janet described being “*reprimanded*” during the team meeting which left her feeling “*humiliated*” (Example 2). Importantly, some participants found that leading with their values involved not taking action at times, which they often experienced when protecting others from harm during these events.

On some occasions participants completely retreated from taking any action and had different ways of making sense of this. This did not always feel comfortable for them. Participants found that their challenging emotions were useful at times, as they experienced their emotions as a precursor to them taking necessary action or helped them to find some satisfaction. Finally, participants reflected on their experience of personal growth when exploring their sense of resolution from the dilemmas they faced. Participants either found resolution by learning to adapt themselves or had not found resolution practically but recognised the need for them to adapt in some way. Some recognised the lack of learning in

the system being problematic for them and causing them to experience on-going challenges.

Question two: how do participants make sense of their experiences of leading in clinical teams, particularly in terms of their values?

Participants made sense of their experiences in different ways throughout their process of losing, regaining and reflecting on their struggle with control and perspective. The third superordinate theme, *reflections on facing dilemmas*, is particularly focused on how participants made sense of this process after the event. To answer the second research question the following topics have been discussed, which highlight the challenges, needs and processes experienced by those leading. These are: making sense of dilemmas, the personal impact of dilemmas, making sense of taking action, coping with the challenges, and personal learning. As integral to the IPA position, I have included my own sense making of participants' experience in light of the literature as well in order to further expand on participants' understanding.

It is noteworthy that this study was not concerned with participants following a particular model of leadership, but rather their individual experience of leading and their reflections on utilising their values. As detailed in participants' pen portraits, several reported that they were not familiar with formal leadership models but rather had learnt from experience and used their psychological training.

Making sense of dilemmas

Types of values

When participants were asked about how they made sense of their experiences in terms of their values, they explicitly named or described the values informing their understanding of their experiences. The values that had been identified by participants were organised into the value categories in Schwartz's established model (1992). Although this study was not aimed at providing a comprehensive review of participants' values, the values that were identified are in keeping with this framework. Eight out of the eleven types of values that were identified here were: power, achievement, hedonism,

benevolence, universalism, conformity, safety and spirituality. The only two categories not identified by participants were stimulation and self-direction. The most common values in this study were similar to the pattern of values found in a review of healthcare values that had been mapped onto Schwartz's model (Moyo et al., 2015). These were achievement, benevolence and universalism (altruism, equality and capability), with values such as self-direction being identified less. This reflects what is expected from healthcare professionals as stipulated by the nature of the profession and professional guidelines (BPS, 2009). It is noteworthy that only one participant described the value of spirituality, which is likely to be influenced by the small sample size. This is similar to the review of values, which the authors believed might have been due to evidence that clinicians wished to keep their faith separate to their work (Cadge, Ecklund, & Short, 2009). However, Janet's religion was her most significant way of feeling sustained through the professional difficulties she faced as this enabled her to find "*victory*" in "*crisis*". In addition it is noteworthy that some values were spoken about in relation to the service-user, to members of the clinical team, or themselves.

As the interviewer, it was notable that participants may have limited language to identify their values as at times they described, "*values related to...*" rather than named them (Philip). This is at odds with the popularity of writing promoting the importance of values, for example in professional documentation (e.g. BPS, 2009; GMC, 2014), the NHS constitution (2018), and leadership models (e.g. Transformational Leadership, Bass, 1990). Moyo et al.'s (2015) framework was developed to help facilitate reflection on an individual's values among all healthcare professions. This study suggests that developing a clearer language around values may allow for a deeper level of personal reflection that may promote improved decision-making. However, this finding has not been evaluated. Nevertheless, research shows that applying value-based guidelines to real-world events can be complex (Routledge, 2015; Van Liew, 2012) and therefore using value-based reflective tools may help guide this process.

Participants did not clearly discriminate between personal and professional values. Rose commented on her personal values being "*overlaid with [her] professional ethics and [her] professional values*", suggesting that the personal and professional intertwine with each other. Some participants named values that can be found in the BPS code of ethics (e.g. confidentiality; BPS, 2009) and values from the NHS constitution (e.g. respect,

compassion, and everyone counts; NHS, 2018). However, other values identified were not clearly personal or professional nor did this study aim to separate or explore this. There is mixed evidence regarding this in the literature, with some stating that these sets of values are distinct (Leuty & Hansen, 2012). Nevertheless, this suggests that reflecting on values should include both the personal and professional value systems of the clinician. This is in keeping with the wider literature on the personal and professional realms of the clinician, which asserts that they are intertwined (Barnett, Behnke, Rosenthal, & Koocher, 2007; Hughes & Youngson, 2009).

Internal tensions

A key finding was that participants made sense of their external differences with others as resulting in internal tensions. This represented a tension between their own sets of values or other internal factors; between their own actions and their values; or between others' perceived values and actions, and their own. This was typically when the dilemma was at the individual and immediate clinical team level. This is supported by the literature on ethical and moral dilemmas, which defines these as decisions between what is "right versus right" and "right versus wrong" (Kidder, 1995, as cited in Bhola, Sinha, Sonkar, & Raguram, 2015, p. 206). This can be understood as being underpinned by a person's sense of what is 'right, good or desirable' (Moyo et al., 2015, p. 257) or in other words, their values. This also suggests that values may be operating even when participants did not recognise these themselves within the context of the interview.

When participants felt a conflict between themselves and others, some recognised this as being underpinned by differences in values or other beliefs. This supports previous research that highlights the importance of value congruence between the professionals and others such as the organisation (Kristof, 1996). Similarly, participants made sense of their ability to take difficult action in line with their values at times when their values were aligned with others in the team. Daniel found that he was able to make an official complaint about a clinician's practice when "*the values of the department kind of m...mirror you know a lot of [his] own values really umm, and [he] knew [he would] be supported by the people who were more senior*". Participants also described the need for allies. This suggests the need for alignment of values between members of the clinical team, those providing higher supervision to the leader, and ideally the wider NHS culture and system.

This experience of an internal conflict can be explained by Schwartz's theory of basic values (1992, 2012) that states how some values may be 'complimentary' to each other whereas others may 'compete'. An example of when these internal values were in conflict was given by Philip, who described his value of "*compassion*" versus "*values related to effectiveness and cost-efficient*" (Example 1). He made sense of the conflict by attributing each value to different parts of his job role. Another example was given by Emily, who described her value of "confidentiality" and her desire to fix the dilemma; this can be made sense of as her professional value versus her personal value (Example 2). This theory also describes how participants have a set of values that are ranked in terms of their importance compared to each other, and therefore are in a hierarchy. James described having "*negotiable*" and "*non-negotiable*" values. Sverdlik (2012) is one of a small selection of studies that has examined the occurrence of personal conflicts. In this study they found evidence to support the idea that an individual's value hierarchy defines what they find conflicting in certain situations. Therefore, as highlighted in the introduction, the situation itself does not trigger the values that are in conflict, but the person's individual values define what they find conflicting about the situation. This relates to the findings as participants who had similar experiences of leading had at times different internal experiences of these in relation to their values, such as what they decided was most important to them when responding.

The literature helps to make sense of the impact of internal tensions. For example, staff members with a greater congruence between an individual's personal and workplace values were associated with healthier wellbeing and lower levels of burnout (Veage et al., 2014). Although this was a quantitative study, which did not explore these experiences with participants, it suggests the importance of internal conflicts on the individual. The current study does not try to separate the personal and professional values like Veage et al, and accepts these may overlap. Specifically within the context of leadership, a study that used different methods such as case studies taken from private business management, highlighted the relevance of internal conflicts when managing dilemmas (Lee, 2015). The findings showed that managers experienced negative psychological consequences of dilemmas when their own values were conflicted and that this had the potential to become a positive psychological experience. The key implications to practice to note from this study are that value conflicts are inherent in managerial roles and therefore managers need to be

equipped with strategies to deal with those conflicts. There was preliminary evidence that female Clinical Psychologists in senior 8c and 8d roles need to experience congruence between their values in order to successfully lead (Corrigall, 2015). However there has been no intentional research into the lived experience of dilemmas and value conflicts of healthcare professionals. This study extends and explores this experience further suggesting its relevance for male and female Clinical Psychologists in less senior positions (8a-8c). The findings from this study also highlight the significance of facing dilemmas and value conflicts for those in a position of leadership including: 1) the impact that this could have on their emotional and psychological wellbeing at work and 2) their capacity to lead and adjust accordingly. Therefore, increasing an individual's understanding of their own core set of values may improve their understanding of the challenges a professional is likely to face as well as facilitating value congruent decision-making.

The personal impact of dilemmas

Distressed and helpless

During the initial stages of facing dilemmas, participants lost a sense of control and perspective. This contributed to their experience of distress, which impacted on their emotional wellbeing. This became all-consuming, affecting their psychological wellbeing as participants became frustrated at themselves and others. This in turn impacted on their perception of their leadership abilities and affected their personal lives. This ultimately contributed to participants feeling disempowered and helpless to take action in line with what they perceived to be the right thing to do. Some made sense of this as the effect of individuals in the team or the wider system, whereas other participants felt helpless because of their belief that they were not equipped enough.

These experiences of distress and disempowerment are reflected, to a degree, within the term 'moral distress' (Jameton, 1984). As described further in chapter one (introduction), the original term was defined as when "one knows the right thing to do for a patient but institutional constraints make it impossible to pursue that course of action" (Jameton, 1993). For example, here participants reflected on the effect of a service transformation and pressure from management when trying to make clinical decisions. This was then expanded to account for the emotional and psychological impact of this

experience, which has been characterised as internal experiences such as self-blame, anxiety and powerlessness as a result of not being able to take moral action (McCarthy & Deady, 2008).

Most of the literature in relation to moral distress has focused on the nursing profession, and particularly those within acute care medicine, as reviewed by Lamiani, Borghi, and Argentero (2016). There is only one known study that included psychologists (Austin et al., 2005), despite the alarming findings. These findings are discussed further below in the sub-section, *finding a congruent way through dilemmas*. Briefly, they summarise the importance of personal morals and ethics in relation to their professional integrity; differences in this relationship may cause significant issues such as professionals considering or actually leaving their jobs. This study was not aimed at exploring moral distress in itself, however, participants made sense of their experiences in ways consistent with this literature. It extends these findings by providing context for such an experience to occur within everyday leadership experiences within clinical teams. The findings from this study show that participants may internalise these experiences by blaming themselves, resulting in them feeling undervalued and disempowered, and affecting them beyond their workplace. This points to the significant impact of these experiences. This may also be a way of understanding an experience that may have detrimental effects on other healthcare professionals' wellbeing, including those in leadership positions.

A simple screening measure of participants' retrospective burnout was included (Hansen & Pit, 2016) and has been discussed in the method chapter, and strengths and limitations section of this current chapter. From this, most participants only retrospectively rated a moderate impact on their sense of burnout, and only one participant felt completely burnt out. However, when participants reflected on their process of completing this measure, some spoke about rating how stressed they felt compared to how burnt out they felt. This still represents a degree of the impact on participants' wellbeing. An association between moral distress and burnout has been found in samples of nurses (e.g. Rushton, Batcheller, Schroeder & Donohue, 2015). However, not all participants always made sense of their experiences through conflicts in values. Reduced wellbeing and burnout is also understood to be when the demands on an individual are significantly greater than their resources (e.g. Bakker & Demerouti, 2007). For example, participants did not always feeling equipped to deal with the dilemma they faced straight away. Rose described how

she did not do anything initially until she could leave the situation and find “*the appropriate way to manage it*” (Example 2). Therefore, it may be important for Clinical Psychologists to be supported to build their resources. However, two participants also made sense of their distress through their level of contact with the service-user involved in the dilemma. Philip described not knowing the service-user, which was rewarding overall, whereas Daniel found his relationship with the service-user meant he was more emotionally invested which made the situation more challenging.

In summary, these findings help to explain a contributing cause of reduced wellbeing as highlighted in the BPS’s survey on wellbeing. Identifying a contributing cause is important for developing tools to address increasing levels of depression, low morale and high levels of stress amongst psychology professionals in the UK (BPS, 2010). These observations are corroborated across the multi-disciplinary team in research with IAPT therapists (Westwood, Morison, Allt, & Holmes, 2017), medical doctors in the UK (Imo, 2017), and NHS surveys across professions (NHS, 2015; 2017). A review of mental health professionals highlighted the impact of wellbeing and burnout on the costs of services and quality of care (Johnson et al., 2017). Each of these healthcare specialties includes professionals also taking on leadership roles within clinical teams. Therefore, the findings from this study suggest that if challenges are not dealt with appropriately participants may experience increased stress and distress. Furthermore, it could be implicated that there is a risk of burnout for those carrying out this type of work, however the findings here are limited and therefore are not sufficient to support this.

Disempowering culture

One way participants made sense of feeling disempowered and undervalued was by recognising issues related to other team members’ perspective of psychology, or from the culture of the wider service. For example, James described the “*powerful medical model*” (Example 2), whereas others, such as Miriam, attributed her sense of threat and fear from the wider system in the NHS; ‘*It feels um, it is wrong um, cause we’ve got to be free to act as clinicians um, you know we’ve got to have that level of autonomy; but, you know how could an ombudsman be more than a senior clinician?*’. For some this left them with a continued sense of being disempowered at times to take action, as they did not feel equipped to manage the issues related to the wider system. This sometimes resulted in a

sense of resignation and hopelessness for participants when they faced dilemmas affected by issues outside of their control. This resulted in some participants contemplating resignation, as they could not take control by using their autonomy and asserting their clinical opinion. A broader example is the debate between Psychologists and the medical profession over how to make sense of, and treat mental health problems (Kinderman, 2014). This has resulted in the profession feeling disempowered as NHS services are established on this biological understanding of distress. The culture of the NHS has been on the agenda of commissioners for many years with a recent Kings Fund (2014) publication emphasising the need to empower the workforce. Empowerment, therefore, is an important element in order to prevent healthcare failings (Francis, 2013) and includes that of those in leadership or middle-management positions, which Clinical Psychologists often find themselves in.

Within Schwartz's values framework (2012) and its recent application within healthcare (Moyo et al., 2015), the values of 'power' and 'authority' (respectively) were identified as being one of the least popular held values. They believed this was due to its conflict with other professional values that are typically promoted and therefore more socially acceptable to identify with, such as altruism. Therefore, identifying the value of 'power' may produce discomfort for clinicians to recognise. However, in this study some participants made sense of their helplessness as explicitly concerning their values of needing to be able to take control and express their beliefs to have an influence. This was reflected in their implicit understanding that they at times moved from a disempowered to an empowered position.

The findings from this study suggests that power is important for participants when facing dilemmas, as they typically represented a challenge to their sense of control to occupy their professional territory. Therefore, it is important to have some degree of power in order to have confidence and to be able to use their professional skills. Decision-making responsibility of all staff may involve increased adoption of leadership models that promote sharing influence and therefore promote empowerment (e.g. Transformational Leadership; Bass, 1990). Community psychology ideas promote the role of benign power, when power is used for the good of the group (Orford, 2008). From this body of psychological thinking, Smail described power as 'the means of obtaining security and advantage' (2005, p. 28, as cited in Johnstone & Boyle, 2018).

The Power-Threat-Meaning framework could be applied here to help progress how participants make sense of their helplessness and disempowerment (PTM; Johnstone & Boyle, 2018). This framework was designed to offer an alternative explanation for understanding service-user's distress. However, it also reflects some of the essence of participants' experiences of distress and disempowerment in a professional leadership capacity. Simply, this is that they experience threats to their *power* (their ability to take action that is accepted or useful), which poses a *threat* to factors such as their emotions, relationships and values, which then impacts on their *meaning* of themselves and their leadership ability. This model highlights the necessity for a degree of, or type of, power that is useful so that oppression does not occur, a term used by one participant in this study.

A method that could also be applied to help think about leaders' experience of power and control within their role is the use of 'power-mapping' (Hagan & Smail, 1997). This is a method of breaking down aspects of a person's life and reflecting on the degree of power they perceive themselves to have in each area as a way of targeting interventions. In an article written reflecting on the work of Smail, the authors advocated that 'power-mapping' is revisited within clinical practice (Newnes, 2015). This may also be an applicable method of self-reflection for professionals to think about their use of helpful power and control in the context of leadership. However, the application of PTM framework and power-mapping intervention here is limited and is only tentatively suggested, as there is no evidence of its usefulness in making sense of professional leadership experiences.

Making sense of taking action

Finding a congruent way through dilemmas

As already described participants experienced dilemmas that contributed to an internal tension between different responses. This contributed to a sense of dissonance, or in other words a lack of internal harmony, as participants found ways to find congruence with what was important to them. One way they achieved this was by altering their perspective, which included their sense of values. One framework that informed the development of this study and that might be used to make sense of this is Cognitive Dissonance Theory (Festinger, 1957). This states that humans strive to seek harmony and

that this may be disrupted when there is a difference between attitudes, beliefs and behaviours. As stated in chapter one, this describes three mechanisms that can be used to regain congruence: 1. Changing dissonant cognitions, 2. Adding new constant cognitions, or 3. Reducing the significance of dissonant cognitions. In this study, external conflict was seen when there was dissonance between participants' values and their perceptions of others. Participants reduced this dissonance by noticing that others may have the same value but that they may be expressed differently because of the nature of their professions. For example, Daniel and Philip noticed that the other professionals' same or similar values centered on improving the care for the service user but the values manifest differently because of the nature of their jobs. This may represent the participants' perspective shifting by adding a new constant cognition (mechanism two) or reducing the significance of the dissonant belief (mechanism three). For others such as Emily and Rose, taking action with their values that were in tension with each other involved choosing the most important value in that moment, which may represent mechanism three. This strengthening of a particular value, such as by doing the right thing by the service-user, involved reducing the immediate significance of the dissonant cognitions centred on protecting the professional relationship.

However the application of CDT (Festinger, 1957) to these findings does not explain all the ways participants made sense of this experience. Firstly, this model explains an individual's process and does not account for the impact of others on taking action that is congruent with participants' values. In this study, managing tensions were not only an individual experience but also one when participants made sense of drawing upon the clinical team, particularly when the tension was an experience shared amongst the participants' colleagues. At different points during their process of navigating these dilemmas they sought others within the clinical team, such as rallying the team together to resolve conflicts within or between teams. It may be understood that values advocated socially may serve to resolve internal conflicts by emphasising the more important values within the context (Tetlock, Kristel, Elson, Green, & Lerner, 2000). This is supported by the current study, as when participants drew upon others they felt more empowered and confident to take their desired action when leading.

Secondly, the CDT only explains part of a participant's experience. The model suggests the need to avoid negative internal experiences (Festinger, 1957). However some

participants still took committed action in line with what they thought was the right thing to do. Examples of these actions include: standing up for their beliefs and persisting with this despite facing resistance and hostility, facilitating discussion to seek to understand, drawing allegiance from the team or members in the team, or making formal complaints when necessary. Sometimes this was at a direct cost to them or an indirect cost as they felt discomfort from the cost that others might experience, such as other members of the team that did not agree with their decision. This included withstanding anxiety and concern for the possible repercussions, humiliation within team meetings, or reprimands from others. This mirrors the findings from Austin et al. (2005) who found psychologists recognised there was a cost involved in moral action. Austin et al. also found that at times this cost stopped participants taking action. This was evident from the findings reported here, with some participants occasionally regretting their lack of positive action. For example, some experienced not taking action as shameful or described themselves giving in to the medical model. Austin et al. also found participants questioned whether to continue working, which was also a consideration of those later on in their career in this sample. James made sense of this experience as an opportunity he could think about now, that had not been an option earlier on his career (Example 1) and Miriam described being “*detached from it*” helped her to cope.

Coping with the challenges

Retreating from action

Participants at times did not take action in a way that reflected what they thought would have been the right thing to do. Rose, for example, was ashamed because of her decision not to stand up during the team meeting (Example 3). As a result, she did not take it to supervision. Similar experiences are found within the literature that shows that individuals may try to avoid challenging internal experiences (Ciarrochi & Bailey, 2008), which can limit them from behaving in line with their values (Soriano, Valverde, & Martinez, 2004). It suggests that there needs to be space for leaders to reflect on times when they have not taken value driven action as this may produce subsequent emotional challenges and may cause professionals to leave the profession. This was evidenced by James handing in his resignation and Miriam holding in mind that she could resign if she needed to. This may also cost services valuable senior clinicians.

Practicing what they preach

Participants took various steps to build their resilience while experiencing losing and regaining control and perspective. Participants made sense of their ability to cope by using different psychological models and theories. This helped them to understand the dilemma, inform their leadership response and reflections, and particularly aided their coping to maintain their resilience. As Rose described, “*it’s what we tell our service-users [chuckles] if it feels uncomfortable, don’t avoid it!*”. The models explicitly named by participants were: ACT, psychodynamic ideas, exposure and habituation, modeling, and DBT skills.

Third-wave mindfulness based therapies have been shown to be particularly effective in self-care skills (Wise, Hersh, & Gibson, 2012) and are incorporated into an established self-care guide developed for psychotherapists (Norcross & Guy, 2007). Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) is one relevant behavioural model for understanding how participants experienced becoming resilient and finding congruency with their values while leading. Although only one participant explicitly mentioned ACT, there was evidence that other participants’ experiences mirrored the central tenets of ACT. This model aims to develop the psychological flexibility of recipients through the main processes of acceptance, cognitive defusion, present moment awareness, self-as-context, values, and commitment to action. Participants made sense of having to accept what they were able to achieve with the resources they had available to them at the time by finding an optimistic or realistic perspective. They were then able to commit to, and bear with, continuing to take action in line with what was important to them despite the risks and costs associated.

Evidence shows a positive association between the use of ACT and the reduction of workplace stress. This is from studies with healthcare workers (Waters, Frude, Flaxman, & Boyd, 2018), social workers (Brinkborg, Michanek, Hesser, & Berglund, 2011), and promising preliminary outcomes from an ACT-based self-care skills teaching provided to trainee Clinical Psychologists (Pakenham, 2015). The latter study defined the main benefit as ‘self-care self-efficacy’, a term taken from Bandura’s theoretical work, on the improvement of an individual’s perception that they can attain the skills they need (Bandura, 1977). Participants were also able to learn at least one behavioural skill that they

were able to utilise (Pakenham, 2015). ACT has also been applied to those acting within more explicit leadership roles, highlighting the relevance of this model in developing ‘crisis-resilient’ managers (Moran, 2011). An ACT-based smartphone application was provided to those in middle-management positions in the private sector (Ly, Asplund, & Andersson, 2014). They found a significant improvement in participants’ self-reports of general health and stress. However, there was no association between this outcome and their leadership skills based on the transformational leadership model. The study explained some of the reasons for this finding, such as how participants may already be practicing leadership skills at a high level or that ACT skills may take some time to be internalised in a way that affects their leadership skills. The application of these findings may be limited as it involved private sector employees. They may be less likely to have the same level of psychological coping skills that might be expected from Clinical Psychologists due to the nature of their training and work. Nevertheless, these findings suggest that ACT may help improve professionals’ significant emotional distress and psychological difficulties in order to improve the resilience of leaders facing dilemmas.

However, ACT provides evidence for intra-personal coping and does not help to explain participants’ sense making of the role of others in their ability to feel empowered and contained. This may be an experience emphasised when working in teams. James described how “*leadership is containment*” (Example 1) and recognised he was no longer able to contain himself. To manage these types of experiences and find sustenance through these challenges participants used personal (e.g. family and friends, and religion) and professional structures such as supervision, with several commenting on the use of external supervision being particularly helpful and hearing from those who would validate and agree with their experience.

Bowlby’s attachment theory may help with understanding this (Bowlby, 1988). For example, Abby described needing someone “*there in the background that know, agree and believe in the way [she’s] working*” (Example 1). Her clinical director provided this for her, which enabled her to feel “*comfortable going into a situation or ending up in one that might be really scary*”. Those who had secure attachments available to them were able to feel supported, process their emotions and therefore feel empowered to lead. Through returning to this safe base participants became further confident and empowered to take independent action. This may also be supported by the importance of supervision to one

participant whose certainty about receiving future supervision was unknown and contributed to her ongoing distress. In addition, the role of attachment is also relevant to models of effective leadership advocated by the NHS. For example, a secure attachment type of the leader has been found to correlate with their transformational leadership style (Popper, 2000).

Participants also made sense of coping by practical methods of gaining skills and knowledge. This included reading the relevant literature and guidelines, which helped to normalise and empower participants, which suggests that continued education is important, as recommended in the Core Competencies and Continued Personal Development (CPD) that are required by the BPS (2014). Drawing upon the nursing literature, individualistic and collaborative approaches have been recommended to target moral distress (Burston & Tuckett, 2012, p. 320). Individualistic approaches primarily include: ethics education; seeking morally sensitive support, and self-reflection to enable personal growth and consideration of the role of emotions in decision-making. Collaborative approaches include interdisciplinary education, and dialogue to improve decision-making processes. These approaches may be useful if applied with Clinical Psychologists or those in leadership positions within teams, particularly the education around moral distress. It may be that Clinical Psychologists themselves may benefit from psycho-education around these types of leadership experiences. Browning (2013) found that nurses with improved psychological empowerment experienced less distress and this has been suggested as a possible intervention. Therefore, the findings from this study in light of the literature are important as they highlight the need to empower and support the emotional needs of those doing this type of work. This is relevant to those supervising and managing leaders.

Personal learning

Throughout participant's experience of regaining and reflecting on their process of control and perspective, facing dilemmas was not an inherently negative experience but often represented an opportunity for personal growth. Personal growth and the terms synonymous with this have been incorporated into the understanding of the personal and professional development of Clinical Psychologists (Hughes & Youngson, 2009). The learning process started with participants recognising their needs and taking action by

acquiring time so that they could have these needs met. They then navigated these dilemmas by equipping themselves with resources in a variety of ways: Practically (e.g. reading literature to increase knowledge and confidence), relationally (e.g. seeking validation from senior professionals or the clinical team through their style of leadership), emotionally (e.g. expressing and processing emotions in a safe place) and cognitively (e.g. shifts in perspective, establishing what was feasible for them to attain, and keeping the job in perspective).

Participants also reflected on their broader learning after the event. One key aspect of development was participants' positive sense making of their difficult emotions. For example, these difficult emotions could be constructive in producing change, as they were sometimes a precursor to action. Another important lesson in their development was their sense that the dilemmas they faced did not always resolve practically but that they were able to adjust and adapt personally. This was so that they could withstand the on-going dilemma. For some, they reflected on dilemmas that were ongoing but recognised that they needed to undergo further learning. Some participants were able to recognise their own learning over the course of their career. Rose attributed her learning to her ability to keep on exposing herself to challenges. The literature suggests the importance of developing the skills of a leader and the additional importance of a leader's "personal growth and perspective" (Allen & Wergin, 2009, p. 14). This is with the aim of improving self-awareness, as Avolio and Gibbons (1989) describe how transformational leaders need to get "their own personal shops in order" by understanding themselves, to then enable them to be "free to look outward" and forward "to solve significant problems" (p. 285). To make sense of participants' experience of learning, developmental theories and models of personal and professional development will now be discussed.

Adult developmental theories

Developmental theories have been applied to understand the growth of the individual leader and their interpersonal leadership skills (Allen & Wegin, 2009). The Lifespan Model of Developmental Challenge (Hendry & Kloep, 2002) is an ecological model that focuses on the effects of 'resources, challenges and risks' to make sense of human development irrespective of age. This may be useful here as it explains the relationship between the resources the Clinical Psychologist has access to and the dilemmas

they face. One of the central tenets of the model suggests that without any challenges, the person is at risk of ‘stagnation’. ‘Stagnation’ refers to when little or no development can occur, which may have a negative consequence on the individual, such as a lack of professional development. Philip’s value set of “*movement, growth and change*” may have prevented stagnation.

Most participants had experiences of being able to successfully use their resources, or were able to acquire the resources they needed to manage the dilemmas they faced. Kloep, Hendry, and Saunders (2009; as cited in Dodge, Daly, Huyton, & Sanders, 2012) describes how ‘each time an individual meets a challenge, the system of challenges and resources comes into a state of imbalance, as the individual is forced to adapt his or her resources to meet this particular challenge’ (p. 337). A new definition proposed by Dodge, Daly, Huyton, & Sanders (2012) connected this theory to that of Cummins’ Changing levels of subjective wellbeing (2010). It states that for wellbeing to be maintained then there needs to be a balance for the individual between the *degree* of the challenges and their resources. These developmental models help to understand some aspects of participants’ experience when facing dilemmas and how challenges may lead to growth. For example, this explains participants’ experiences of feeling equipped enough to deal with the challenges they faced that resulted in them having a sense of resolution. This also helps to understand that when participants did not take action it may have been because they did not feel equipped to face their dilemmas and helps to explain the longer lasting impact on their wellbeing. However, these theories only offer a simplified understanding of how one may manage dilemmas on a practical level and do not unpick the processes involved in the deeper personal learning and development of an individual.

Personal and professional development models

Models of change and learning theories can be applied to better understand some of the intricacies of this process. Personal and professional development is advocated within doctoral training and throughout Clinical Psychologists’ careers (e.g. Gillmer & Marckus, 2003; Hughes & Youngson 2009). Models of change explain the intra-psychic processes involved when an individual recognises there is a problem, improves their understanding and finds resolution. Such a process is described in the assimilation model, which results in an individual’s sense of ‘mastery’ that they can then apply to face future problems

(Barkham, Stiles, Hardy, & Field, 1996). However these models only explain individual processes and therefore are limited in their account of the group processes that occurred when leading in clinical teams.

A different model that has been applied to learning across a variety of contexts (including within groups) is Johari's window model (Luft & Ingham, 1955). This model explains how the individual and others have access to information about themselves and others, but highlights that there is information that is not known to the self or others. In order for development to occur, the process of uncovering what is 'blind' to the individual or group is an important part of the process. This can include the individual understanding their own values and other factors that may underpin the dilemmas they face to improve their decision-making/leadership. However, the application of these models may be limited here because participants' processes of learning were not explicitly explored in the interview schedule. Also it is noteworthy that one participant (James) explained that some of the examples he chose to reflect upon were not his most challenging dilemmas and therefore might not capture the full process of learning from navigating dilemmas. Nonetheless, the role of reflective practice in training (Lavender, 2003) is advocated within a range of established structures such as therapy, supervision, doctoral and post-qualification training, and leadership courses, group work, mentoring and coaching (cited in Hughes & Youngson, 2009).

Strengths and limitations

To the author's knowledge, this is the first study exploring the lived experience of Clinical Psychologists when leading specifically within clinical teams. This was with a particular focus on when they faced dilemmas and how they made sense of these using their values. The use of IPA methodology has enabled novel findings into participants' process of losing and regaining control and perspective when leading. This offers a significant contribution to the literature on leadership, values and wellbeing. Specifically, this extends research that has begun to focus on the lived experience of leaders (e.g. Corrigan, 2015) and their experience of internal conflicts including for those in managerial positions (e.g. Lee, 2015; Sverdlik, 2012); the role of values in healthcare (e.g. Moyo et al., 2015); and factors affecting the wellbeing of Clinical Psychologists (e.g. Rao et al., 2016).

In terms of the sample used, a key feature of conducting valid IPA research is ensuring this is with a homogenous group of individuals (Smith et al., 2009). This sample shared the characteristics of those practicing in 8a-8c Clinical Psychologist roles within NHS trusts, all working into teams, which were mostly multidisciplinary. Decisions were also made to ensure this through the recruitment process, such as the exclusion of a participant in an 8d position and those working within CAMHS services. It is noteworthy that one participant in the final sample drew upon an example from a time in private practice. The use of this example was considered and was initially not included in the group analysis. However, the dilemma the participant faced was related to a difference of opinion that was experienced by other participants' within the NHS and was not explicitly related to private practice. It also presented themes reflected across the participants' other examples and were shared across transcripts. For this reason it was included in the final group analysis.

In addition, Clinical Psychologists were chosen because of their increasing capacity and requirement to lead clinical teams, and their familiarity with reflecting on their internal experiences and access to dialogue to explain their experiences. These characteristics minimised some of the weaknesses introduced from being a new IPA researcher. Despite choosing Clinical Psychologists, some participants' reflections on their values seemed limited which may have reflected their access to this specific type of language. In addition, only including 8a-c Clinical Psychologists may limit the value of these results to other non-psychological professionals.

The design of the study involved the use of a demographic pro-forma, which incorporated questions to begin to situate the participants into the context of leadership in clinical teams. One method for this was by providing a list of examples of leadership activities. This was completed before delivering the semi-structured interviews to improve how clearly they could recall their experiences. This did appear to help facilitate these types of reflections, however some participants still could not remember the specifics of their experience and reflected upon some of their examples more broadly. Although during the screening process participants were prompted to reflect on these types of experiences, it may have been helpful to use a formal tool prior to the interview to facilitate eliciting these, such as asking participants to complete a journal or bring their diary (Pietkiewicz & Smith, 2012). Similar methods could have also been used to facilitate the participant to think about

the role of values before the interview, for example by using the healthcare values questionnaire (Moyo et al., 2015).

In terms of the interview schedule, another key strength of this study was that it explored different dilemmas by the same participant. This accounted for a limitation of another study that only explored the experience of one dilemma (Bhola et al., 2015). This improved the value these results have for others. Another of the main findings was participants' need to process and learn from these types of experiences, such as finding realistic resolution through their personal growth. However, several participants' reflections on their learning could have been explored further. This reflects the fact that in any single moment in time a single researcher cannot guarantee that they will think of the question they need to ask. This may have been affected by the limited experience of the interviewer as a qualitative researcher.

At the end of the interview participants were asked to recall which example had the most significant impact on their wellbeing and rate how burnt out they felt on a simple Likert scale (e.g. Hansen & Pit, 2016). However, rather than providing a robust measure of burnout, it only provided a rough sense of the impact of participants' most challenging example on their wellbeing. One participant remarked that he had not spoken about his most challenging dilemmas and another reflected on rating how 'stressed' they felt rather than how burnt out they were at the time. This may have been the same for others and suggests that participants may have been rating different concepts. This reduces the validity of comparing the results from the Likert scale due to the differences in interpretation of burnout as this may have measured different concepts across participants. On reflection, it may have been helpful to ask participants to complete a comprehensive screening measure of their current burnout, moral distress or general wellbeing. This would have strengthened the association possible between experiences reported and may have explained how their current level of burnout may have influenced the way in which they reflected on their experiences. Further information on participants' wellbeing could have been explored during the interview schedule to keep in line with the primary qualitative method of analysis, as this study was not intended to have a mixed method design. This has been explored further in the future research sub-section of this chapter.

During the process of analysis steps were taken following published guidelines from Elliot et al. (1999) and Yardley (2000) in order to enhance the credibility of this study. A

reflexivity issue that arose was that participants had different therapeutic orientations to a variety of models that they used to reflect upon their experiences. This at times began to influence the interpretation of the results, although steps were taken to manage this. Through the use of supervision, following the IPA protocol and using quality measures, awareness to this possible influence was considered and a theme name was reworked to encompass the wider experience of all participants. Various steps were taken to improve the validity of this additional step to the analysis as explained in chapter two (method). In summary this included using descriptions of each value taken from an updated document summarising Schwartz's work (2012) and validity checks using two other trainee clinical psychologists. Although there was an agreement about the final values table, it was believed that a significant proportion of values could have still fitted into multiple values categories. This is a pattern acknowledged in the literature as this model categorises values on a continuum, as it asserts that some values share features with each other and therefore are positioned next to each other on the models' circular diagram. For this reason this theory of values has been criticised as having a "lack of parsimony and theoretical focus" (Gouveia, Milfont, & Guerra, 2014, p. 41). Therefore, although steps were taken to increase the validity of the values table it is recognised that it may still be limited by subjectivity, which may be a weakness inherent within this model. In this study the value of 'spirituality' was also included, similarly to another study (Moyo et al., 2015). However Schwartz's final model removed this value as it had not been validated or proven valid within the same extensive range of cultures as the other values. Therefore the inclusion of 'spirituality' may have also negatively impacted on the validity of this model.

The focus of this research was on dilemmas, however, there was also interest in understanding other experiences participants may have when leading in clinical teams. As already highlighted, participants spoke about dilemmas that they faced when asked for any type of example from their experience of leadership. This was despite efforts made to control for this, such as asking this question first and making it clear this could be any experience that stands out to them. This may represent something important about the nature of leadership roles, however it may also be a consequence of the research materials that focused on dilemmas and may have served to prime participants.

Lastly, this study was focused on experiences of leadership within clinical teams, which particularly involved an element of decision-making. As stated in the introduction,

leadership and management tasks have been described as being different to each other (Kotter, 1996, as cited in Kings Fund, 2011). However, the examples participants reflected on within the current study showed that it was sometimes difficult to delineate activities related specifically to leadership from that of management. This suggests that perhaps there is some overlap between the types of tasks associated with both responsibilities, and that there may not be a clear dichotomy between the two. Similarly, at times, some participants also found it difficult to separate leadership activities from tasks associated more closely with their direct therapeutic work. Therefore this suggests that these findings may be applicable beyond the described context of leadership in a clinical team and to the more general day-to-day clinical or managerial activities of Clinical Psychologists. In addition, key elements of participants' experiences in this current study were around decision-making in relation to the dilemmas they faced. However this is only one aspect of leadership, for example, leadership within teams may also involve the development of projects within services. Therefore this may limit the applicability of the findings from this current study to other elements of leadership within clinical teams.

Recommendations from the main findings

This section provides recommendations from the findings of this study regarding how they might be applied in a variety of settings for different purposes. This may be of interest to different layers of a Clinical Psychologist's system, ranging from the individual leader, their supervisors and managers, doctoral training programmes and NHS stakeholders.

Wellbeing of leaders

A key finding was that Clinical Psychologists' wellbeing was significantly affected when they experienced high levels of distress, psychological difficulties and a lack of empowerment. This impacted on some participants' perception of their ability to contain themselves so that they can then provide containment to others while leading. For some, this had a longer-lasting impact on their wellbeing and experiences at work. It is reasonable to assume that if a leader's wellbeing is suffering there is potential for this to impact on the clinical team's wellbeing, which may then impact on the service-user's care. Therefore,

attention must be paid to the wellbeing of those in leadership roles in order to provide support and resources to help them persist through this difficult work.

Individual strategies

It is recommended that individuals develop personal coping strategies to manage these experiences to build their longer-term resilience. Participants' personal methods of seeking security were important here and should be nurtured, such as the religious, spiritual and ethical ways of coping. In line with the growing evidence-base, the findings suggest that using third-wave therapies may help to better equip Clinical Psychologists with coping strategies, such as the application of ACT (Ly, Asplund, & Andersson, 2014). Participants also made use of others who they described as allies; these ranged from other members of the team, for example, senior members of the service, to those outside of the team. Clinical Psychologists need to consider ensuring they have access to a professional who can act as this secure base for them in order to empower them in their role.

Supervision, teaching and training

The wellbeing of the Clinical Psychologist can be addressed through supervision and training (Hughes & Youngson, 2009). Drawing from the nursing literature, effective methods of coping with moral distress included using individualistic and collaborative approaches such as education around 'moral stress' (Burston & Tuckett, 2012). It could be helpful to familiarise professionals with this concept and to increase their ability to reflect on their experiences that may be related to this. This may be adapted into doctoral training courses and post-qualification training in the UK, as it is relevant to the Personal and Professional Development competencies of their Continued Professional Development (BPS, 2014). For example, supervisory workshops for qualified clinical psychologists may include this to improve supervisors' awareness of these issues. As this finding has relevance and value for those outside of the profession of Clinical Psychology, this may also be considered useful for supervising other members of the MDT.

Dilemmas & Values

Personal and professional development

It was evident that participants needed to process and learn from their experiences. The personal and professional development of Clinical Psychologists is advocated through reflective practice (Lavender, 2003) and models of personal development (Hughes & Youngson, 2009). The findings showed participants reflections on their values offered a helpful insight into their decision-making when facing dilemmas. Therefore using values as a method of reflection may be helpful for those leading to improve their decision-making and learning from these formative experiences. Following on from previous research in the area, tools such as the healthcare professionals' personal and professional values framework (Moyo et al., 2015) may help facilitate this type of reflective discussion. Reflection on dilemmas and the use of values to facilitate this may similarly be incorporated into training, especially the PPD elements of training programmes, and clinical supervision.

Team working

In terms of the context of the clinical team, it may be useful for reflective conversations to be focused towards experiences of dilemmas and values. Again, Moyo et al.'s (2015) values tool may be used within teams to think about the values that may be operating in order to promote discussion about the processes underlying decision-making. Furthermore, this may aid the development of value congruence for the individual and the team. This is supported by research that recommends all clinicians need to reflect on their values and times when these may be in conflict in order to make patient-centered decisions (Rabow et al., 2010). This may lend itself to reflective practice forums that are already established such as Schwartz Center Rounds (Lown & Manning, 2010). In UK hospitals, preliminary evidence showed these to improve empathy and collaborative staff relationships (Goodrich, 2012).

Organisational impact

These findings may be particularly useful for value-based organisations, such as the NHS (NHS, 2018), at an organisational level. It may be useful for those in management to consider the congruency between the NHS and the local Trust's espoused values and how much senior members practice these. They should also consider whether their staff members are provided with the resources needed to practice in a way that enables them to reflect these values. This is based on the understanding that value-based leadership impacts on staff wellbeing and satisfaction at work (Laschinger, Wong, & Grau, 2012). As well as considering resources, reflection around the culture of the workforce could be considered as to whether this promotes the necessary autonomy and freedom at all levels of the system. This would be to empower frontline staff members in clinical teams to work to the organisation's values and the individual's personal and workplace values. Lastly, it may be useful for organisations to use value-based screening measures as part of the recruitment process of employees, which may increase the likelihood of congruency between values for both the individual's wellbeing and the service.

Future research

This study provided evidence for the significance of the impact of dilemmas faced by Clinical Psychologists and the role of values in making sense of these experiences. However, further research may help to clarify and extend these findings.

The inclusion criteria for this study involved participants who were NHS agenda for change band 8a to 8c. However, during recruitment I received feedback that those in band 7 positions wanted to participate and felt strongly about their leadership role. This is reflected within the LDF that outlines the leadership competencies of those in training and those newly qualified in band 7 positions (DCP, 2010). Furthermore, there were also differences between participants who were earlier on in their career compared to participants nearer the end of their career. Therefore, replicating this study with trainees and newly qualified Clinical Psychologists may provide a useful comparison with these findings.

One of the key findings from this study showed Clinical Psychologists' process of losing and regaining control and perspective when facing dilemmas. Further qualitative research exploring this process may help to further understand this finding. This may draw upon other qualitative methods, such as Grounded Theory (Glaser & Strauss, 1967), to

assess whether there is a conceptual model that is occurring. As discussed earlier, this process mirrors that of the assimilation model (Barkham et al., 1996) where participants noticed their dilemma, tried to find an understanding of this, and found resolution. These themes may also benefit from being explored with other healthcare professions. This may enable a comparison of their experiences of leading clinical teams when faced with dilemmas compared to the Clinical Psychologists in this sample. This would enable the more reliable application of these results to other clinical leaders from different professions.

One of the limitations of this study was a lack of robust assessment of participants' wellbeing, which may have helped to strengthen the links made between the findings and the literature. It is recommended that future research could implement a comprehensive measure of burnout or wellbeing as a screening measure. This might shape the type of experiences spoken about as this could increase the likelihood that participants reflect on experiences that may be more challenging. This could also help to explain the link between wellbeing and leadership experiences more clearly. It might also be that employing quantitative methodology to understand the role of values, the occurrence of internal tensions and moral distress within this context may also be a useful contribution. This may provide a sense of the prevalence and extent of these types of difficulties. This could draw upon the framework for healthcare professionals' values used in this study (Moyo et al., 2015).

Concluding summary

This study explored Clinical Psychologists' everyday experiences of leading in clinical teams in the NHS. It particularly focused on when they faced dilemmas and how they made sense of these in terms of their values. This is important because Clinical Psychologists are taking on more leadership roles and responsibilities in the context of the NHS facing new and increasing pressures. This is a shared experience across other clinicians in the NHS, such as nursing staff, and therefore the findings are also relevant to other professions. These specific lived experiences have not been explored in the existing literature to the author's knowledge. Therefore, Interpretative Phenomenological Analysis was useful to explore participants' experiences within this context. The final analysis resulted in three superordinate themes highlighting participants' experiences of: *'losing a*

sense of control and perspective, *'regaining control and perspective'* by equipping themselves and building their resilience, and *'reflecting on facing dilemmas'*.

These themes highlighted the significant emotional and psychological impact Clinical Psychologists experienced when facing dilemmas, that at times left them feeling disempowered to lead. In response to external dilemmas, participants experienced an internal tension between their values and actions, with these different values and actions all being seen as the potentially correct or right way to lead. By managing dilemmas participants sometimes experienced empowerment, security and development of their perspective. Through this process they experienced an improved sense of control and ability to navigate these dilemmas.

Resolution of dilemmas was marked by participants' sense of personal growth, which sustained them through these and other situations. Some participants experienced unresolved and persistent emotional challenges when factors such as culture or the wider system prevented them from gaining control. For some, the effect of this was contemplating or acting on a resignation. Participants used values to give meaning to the decisions they made as leaders. They recognised that their moral actions often carried risk, or a cost to themselves. For some, this was too great.

Protective factors included the positive ways participants made sense of experiences. For example, the revelation that those difficult emotions enabled them to take necessary action and finding a congruent perspective on differences between values. Ultimately, participants were able to learn and develop by recognising the dilemma and identifying their associated needs. This improved their understanding of the experience, which enabled resolution. Furthermore, this contributed to their personal and professional development, as some reflected on their growth over the course of their career.

In summary these results suggest that leaders would benefit from specific support and resources to help them navigate and cope with dilemmas. This also suggests that the incorporation of values into reflective practice may offer a meaningful tool to clinical practice. Implications from these findings have been outlined with relevance to the individual leader and different layers of their system, including professional training programmes and the NHS. These findings are also useful for other healthcare professions, and particularly those working within the NHS. This is because most staff members are known to work within clinical teams where they are responsible for making decisions

affecting the care of others. Future research in this area would be beneficial to progress these findings, and enable more reliable application of these findings to other types of clinicians.

Closing reflections

When thinking about value driven leadership I initially perceived this to be a positive experience, whereby having congruence with the personal self would enable internal satisfaction. However, this research has highlighted to me the complexities around this type of work and the naivety of these beliefs. Interestingly, participants grappled with and found doing the right thing also the costly and risky thing. This involved a commitment from the leader to continue to develop and pursue moral action for the good of those they are working with and for.

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Appendix A - Recruitment email

Dear whom it may concern,

My name is Leanne Messham and I'm a Psychologist in Clinical Training. I'm conducting my thesis research into the experiences of those leading and the dilemmas they may face. This will involve me interviewing a small sample of clinical psychologists who identify as leading within clinical teams.

You have been considered to be an appropriate participant and I wondered whether you would be interested in participating in the study. There is a poster and information sheet attached to this email that I would really appreciate if you would take the time to read.

If you would consider participating or have further questions, please contact myself directly on the email address provided below.

Principal researcher email: umlsm@leeds.ac.uk

Yours sincerely,
Leanne

Appendix B - Poster Advertisement

Version 2 10.06.2017



UNIVERSITY OF LEEDS

Ethical Approval Reference: MREC16-157

Experiences of leadership in clinical teams

The aim of this study is to understand how clinicians experience the challenges and dilemmas of leading in clinical teams.

We're looking for Clinical Psychologists at bands 8a-c who are engaging in leadership responsibilities within a clinical team.

If you are interested in discussing your experiences we would love to hear from you.

If you would like to know more please get in touch by email: umlsm@leeds.ac.uk

Leanne Messham
Psychologist in Clinical Training
Supervised by
Dr Jan Hughes & Dr Carol Martin

Appendix C - Participant Information Sheet



Participant Information Sheet

Exploring Clinical Psychologists' experiences of leading within clinical teams in relation to their values

You are being invited to take part in a research study. Before you decide whether you would like to take part, you are required to understand why the study is being conducted and what it would involve. Please contact the principal researcher whose details are below if you have further questions or would like to take part in the study.

Why have I been invited?

This research is interested in the experiences of Clinical Psychologists in Band 8a-8c positions within the NHS in relation to their leadership roles and responsibilities. It is particularly interested in how they draw upon their values when navigating the dilemmas they face when fulfilling these types of responsibilities in the context of leading clinically within teams. This includes experiences such as making decisions about patient care and contributing to the formulation of a problem with the team.

What is the purpose of the study?

The research shows that within the NHS there are concerning levels of reduced resilience and burnout of staff, including those fulfilling leadership roles. This has been shown to impact on clinical effectiveness and organisational outcomes. Effective leadership has been shown to improve the wellbeing of staff and therefore improve service outcomes. Current models of effective leadership promote a relational focus drawing upon the leaders' values. However there is no literature on the experience of drawing upon values to lead clinically within teams. The aim of this research is to improve our understanding of leadership in relation to the dilemmas leaders face and their values in order to improve the wellbeing of staff.

Do I have to take part and what if I decide to withdraw my participation during the study?

It is up to you to decide whether or not you would like to take part. Firstly you'll be provided with this information sheet and the opportunity to ask any questions and have them answered. You will be given a minimum of 48 hours to decide if you'd like to take part. Before the interview begins you will be asked to sign a written consent form. You are free to withdraw up until one week after you've completed the interview, without giving a reason. If you decide not to carry on with the study, any information you have provided will be removed from the study. You will not be able to withdraw after this one-week period as the analysis of your interview will have begun.

What would taking part involve?

After providing your consent, you will be expected to take part in an interview that will be conducted by the principal researcher face-to-face and will last approximately 60-90 minutes. The principal researcher will also ask you demographic questions. This will be conducted at your place of work. If you prefer this can be carried out on the University of Leeds site and you will be able to reclaim your travel expenses for this.

What are the possible benefits of taking part?

There are thought to be no immediate benefits of taking part. You may find it rewarding to reflect upon your experiences, which are hoped to contribute to the development of the profession.

What are the possible disadvantages and risks of taking part?

It is acknowledged that this study may involve talking about potentially difficult professional situations. Should you find this upsetting, appropriate support would be provided. It is your choice whether you talk about something unprofessional that you have done. In this instance, I would have to discuss this with the supervisors of the study and potentially report this to the HCPC. Should this happen I would aim to speak to you about this beforehand.

What will happen to the results of the research study?

The results of this study will be analysed and written up into a thesis submitted to the University of Leeds for the completion of the academic qualification (Doctorate in Clinical Psychology) in the summer 2018. The findings from this study may be presented at academic conferences and published in peer-reviewed journals. Within these documents the inclusion of direct quotations will be used to evidence the interpretations of results made. Any personal and identifiable information will be removed and a pseudonym will be used. You will also be able to obtain a summary of the

findings that you may request on the consent form. Once the study has finished the University of Leeds will store your data securely before being destroyed.

Will my taking part in the study be kept confidential?

Yes. Ethical and legal practice will be followed. Any information that you provide will be kept strictly confidential, anonymised using your individual pseudonym, and stored securely for three years. An independent individual bound by the Universities' confidentiality agreement will transcribe the interviews.

Why are you conducting the research?

The study is being conducted as part of the Doctorate in Clinical Psychology at the University of Leeds. This study has been approved by the University of Leeds School of Medicine Research Ethics Committee (SoMREC16-157) and has been approved by the Research and Development Department within the NHS.

Further information and contact details

If you would like any further information about the research please contact the principal researcher:

Leanne Messham, Psychologist in Clinical Training, University of Leeds,

E-mail address: umism@leeds.ac.uk

You may also contact the supervisors:

Dr Carol Martin (c.martin@leeds.ac.uk; 0113 343 0812) and Dr Jan Hughes

(j.hughes@leeds.ac.uk; 0113 343 2738), Programme in Clinical Psychology, Leeds Institute of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, Leeds, LS2 9NL.

If you have any concerns about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. You can also approach:

Claire Skinner, The Faculty Head of Research Support, University of Leeds,

E-mail: C.E.Skinner@leeds.ac.uk, Telephone: 0113 343 4897

Appendix D – Demographic Pro-forma

Demographic Questionnaire

Screening information:

- 1) NHS banding?
- 2) Length of your current position?Years (approximately)
- 3) Hours of clinical contact per week?
.....
- 4) Do you currently work within a multi-disciplinary team? Y/N

Demographic information:

1) Age:

- 25-34 35-44 45-54 55-64

2) Ethnicity:

- White British (English/Welsh/Scottish/Northern Irish/British)
- White (Irish, European, traveller, Gypsy, other)
- Black (Black British, , African, Caribbean)
- Asian (Asian British, Indian, Pakistani, Bangladeshi, Chinese, Japanese)
- Middle Eastern/Arab
- Mixed/Multiple heritage

3) Speciality?

4) Years as a qualified Clinical Psychologist?.....

5) What type of leadership activities have you been involved in?

- Supervision of other psychologists, supervision of other professions, consultation with other staff
- Supporting and nurturing staff (other psychologists and other professions)
- Leading psychological input into other teams, leading on increasing psychological input into non-psychology services
- Supporting cultural change on wards
- Service evaluation projects, developing services
- Leading staff well-being projects, leading trust-wide psychology projects
- Leading on demand and capacity for services, leading on referrals systems

6) Are there any other leadership activities that you are involved in?

.....

7) Have you had any additional training in leadership? If so, what was this?

.....

Please draw a line on the likert scale below to rate your level of burnout during the example/situation that you've described which you found most challenging (name situation/example number.....):

0 10
Not at all Extremely

Appendix E - University of Leeds Ethical Approval



UNIVERSITY OF LEEDS

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

Room 9.29, level 9
Worsley Building
Clarendon Way
Leeds, LS2 9NL
United Kingdom

☎ +44 (0) 113 343 1642

18 July 2017

Leanne Messham
Psychology in Clinical Training
Leeds Institute of Health Sciences,
University of Leeds,
Level 10 Worsley Building,
Clarendon Way,
Leeds LS2 9NL

Dear Leanne

Ref no: **MREC16-157**

Title: **Clinical psychologists' experiences of leading and their values**

Your research application has been reviewed by the School of Medicine Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the following documentation received from you and subject to the following conditions *which must be confirmed as being fulfilled prior to the study commencing*:

- Evidence of HRA permission must be submitted

Document	Version	Date Submitted
Leanne Messham Dclin Ethics Form for SoMREC & NHS R&D	1.0	17/07/2017
Thesis PIS Version 3 13072017	3.0	12/06/2017
Recruitment Poster Version 2 10.06.2017	2.0	12/06/2017
Consent Form Version 2 19.05.17	2.0	12/06/2017
Draft Interview Schedule Version 2 10.06.2017	2.0	12/06/2017
Thesis Demographic pro forma Version 2 08.06.2017	2.0	12/06/2017
Thesis Initial Recruitment Email 19.05.2017	1.0	12/06/2017

Please notify the committee if you intend to make any amendments to the original research ethics application or documentation. All changes must receive ethics approval prior to implementation. Please contact the Faculty Research Ethics Administrator for further information (fmhuniethics@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, and all other documents relating to the study, including any risk assessments. These should be kept in your study file, which should be readily available for audit inspection purposes. You will be given a two week notice period if your project is to be audited.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

Appendix F - NHS Research and Development Approval



Health Research Authority

Miss Leanne Messham
Psychologist in Clinical Training
Leeds Teaching Hospital Trust
Leeds

Email: hra.approval@nhs.net

23 August 2017

Dear Miss Messham

Letter of HRA Approval

Study title:	Making sense of clinical psychologists' experiences of leading clinically within teams in relation to their values
IRAS project ID:	219925
Sponsor	University of Leeds

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

Participation of NHS Organisations in England

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

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

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

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

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

Appendix G - Consent Form



Consent Form

Exploring Clinical Psychologists' experiences of leading clinically within teams in relation to their values

Name of Researchers: Leanne Messham

Please initial box

I confirm that I have read and understand the information sheet dated 13/07/17 (version 3) for the above study (SomREC code 16-157). I have had the opportunity to consider the information, ask the principal researcher questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw up to one week after completing the interview without giving a reason.

I agree to the audio recording of the interview.

I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses and for those typing up the interviews to have access to the original, non-anonymised data.

I understand that anonymised quotes from the interview will be used in the write-up and dissemination of the results, but that I will not be identified or identifiable.

I agree to take part in the above study.

I would like to receive information about the findings from this study.

If so, please provide us with your email address here:

.....

Name of participant	Date	Signature

Name of person taking consent	Date	Signature

If you have any queries please contact the principal researcher:

Leanne Messham, Psychologist in Clinical Training & Principal Researcher
 E-mail address: umlsm@leeds.ac.uk

You may also contact one of the supervisors of this study regarding any queries:

Dr Carol Martin (c.martin@leeds.ac.uk; 0113 343 0812) and Dr Jan Hughes
 (j.hughes@leeds.ac.uk; 0113 343 2738), Programme in Clinical Psychology, Leeds Institute
 of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, Leeds, LS2 9NL.

If you wish to make a complaint about the study you can also approach:

Claire Skinner, The Faculty Head of Research Support, University of Leeds,
 E-mail: C.E.Skinner@leeds.ac.uk, Telephone: 0113 343 4897

Appendix H - Semi-structured Interview

Draft interview Schedule

Introduction question

1. What attracted you to take part in this research?

General leadership questions

2. How did you come to take part in leadership roles and responsibilities?
3. What types of leadership activities are you involved in?

Prompts/follow-up questions

- What is the most important/frequent activities that you take part in?
 - Examples when you have engaged in leadership in a clinical team
 - Could you tell me a bit more about that?
4. From your experience, what is your understanding of what leadership means in the context of a clinical team?
 5. What informs the way in which you lead?

Specific leadership questions

6. **Example 1:** Can you describe a time when you've been leading within a clinical team? [Aim to get a specific example of an experience that stands out to them]
7. **Example 2:** Can you describe a time when you faced a *dilemma* when leading within a clinical team? [Aim to get a specific example]
8. **Example 3:** Can you describe a time when you faced a *dilemma* when leading within a clinical team that you think is *different in some way from the example you've just given*? [Aim to get a specific example]

9. **Example 4:** Can you describe a time when leading within a clinical team that you *think is different in some way from the examples you have given me already?* [Aim to get a specific example]

Prompt questions for each example:

Contextual prompts:

- Do you have a specific example that stands out to you?
- What did you think when that happened?
- How did you feel when that happened?
- What did you do when that happened?
- You've already described some ways that you've XXX, is there anything else you'd like to add?
- Could you tell me a bit more about XXX?

[Ensure to get a full sense of their experience]

When asking each example...

5b/6b/7b/8b. How do you make sense of your experience in terms of your values?

Prompt questions for targeting values if they struggle to name them:

- What was important to you about this situation?
- What sense do you make of why this is important to you?

5c/6c/7c/8c. How did you cope with that experience?

5d/6d/7d/8d. Did that feel resolved for you?

Closing questions

10. Having spent time thinking about your experience of leadership, would you like to add anything to your original explanation of what leadership means to you?
11. Does this cover everything for you?

Appendix I - Examples of IPA coding

Quotation	Initial coding	Superordinate <i>subordinate theme</i>
<p>“You know I wanted to do something helpful in a leadership way. Umm, and I guess I was feeling quite overwhelmed and umm...hopeless. And umm, and umm, I was also aware, you know, I’d have been [age] at that time and approaching retirement age actually and, you know that was something that’d been on my mind”</p>	<p>Impacting on his ability to lead and work, contemplating retirement – dilemmas became too challenging, distressed/hopeless</p>	<p>Losing control and perspective <i>Distressing</i></p>
<p>“The way I cope with it is by not jumping in feet first, just sussing the scene and taking time. There’s a balance between that and taking action”</p>	<p>Stepping back from emotions, way of managing dilemma – getting distance, gaining understanding before taking action, balancing act – managing possible tension</p>	<p>Regaining control and perspective <i>Feeling one thing, doing another</i></p>
<p>“I accept it cause it’s not, it’s not that I’m absolutely convinced that psychology is always going to be better or more effective”</p>	<p>Holding psychology/job lightly, perspective on psychology helps find acceptance</p>	<p>Regaining control and perspective <i>Keeping things in perspective</i></p>
<p>“...Interestingly, I don’t remember taking that one to supervision [<i>pauses</i>] I don’t think I did. I think I probably... I’m not sure I connected to it at the time but I probably felt ashamed that I’d just not done what I thought was the right thing.”</p>	<p>Shame stopped her taking action and seeking support, dismissed it at the time, distance from dissonance</p>	<p>Reflections of facing dilemmas <i>Made sense of retreating from action</i></p>