Exploring the Relationship between Authentic Leadership, Workplace Wellbeing and Attachment Insecurity amongst Clinical Psychologists working in the NHS

Hannah Mary Olivia Cartmell

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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

This research explores the association between authentic leadership and workplace wellbeing and how the variable of attachment insecurity mediates this relationship amongst Clinical Psychologists working in the NHS.

A total of 207 participants, who were employed as Clinical Psychologists working in the NHS, completed an online survey. The online survey collected demographic information and data through self-reported outcome measures. The demographic information included: age, gender, ethnicity, length of time qualified, relationship to their leader, the job role of their leader and NHS employment. The self-reported measures quantified authentic leadership, workplace attachment style and workplace wellbeing. A correlational and regression analysis was used to assess the relationship between authentic leadership and workplace wellbeing and whether this relationship was mediated by the variable of attachment style (avoidance and anxiety).

The results showed that the majority of participants identified their leader as fellow Clinical Psychologists and that those leaders often had multiple roles and responsibilities. The findings illustrated that there was a significant positive correlation between authentic leadership and workplace wellbeing. Attachment anxiety was shown to negatively correlate with both authentic leadership and workplace wellbeing. Similarly, attachment anxiety was also seen to indirectly influence the relationship between authentic leadership and wellbeing at work. However, attachment avoidance was found to not be associated with wellbeing and leadership to the same degree as attachment anxiety.

This research highlights that it is important for an individual who experiences attachment anxiety at work to have an authentic leader as this can improve their workplace wellbeing. The strengths and limitations of this research are presented. Implications for clinical practice are discussed alongside suggested directions for future research.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

NHS: National Health Service

UK: United Kingdom

FYFV: Five Year Forward View

CQUIN: Commissioning for Quality and Innovative

CPD: Continuing Professional Development

IAPT: Improving Access to Psychological Therapies

NICE: National Institute for Health and Care Excellence

BPS: British Psychological Society

NSP: New Savoy Partnership

MLQ: Multifactor Leadership Questionnaire

TLQ: Transformational Leadership Questionnaire

LGM: Conditional Latent Growth Model

NWWAP: New Ways of Working for Applied Psychologists

DCP: Division of Clinical Psychology

ANOVA: Analysis of Variance

ASSET: A Shortened Stress Evaluation Tool

SBL: Secure base leadership

USA: United States of America

SMBQ: Shirom-Melamed Burnout Questionnaire

LMX: Leadership Member Exchange

SPSS: Statistical Package for Social Sciences

HCPC: Health Care Professions Council

DClinPsych: Doctor of Clinical Psychology

ALI: Authentic Leadership inventory

SWAM: Short Workplace Attachment Measure

PPWWM: Psychological Practitioner Workplace Wellbeing Measure

M: Mean

SD: Standard deviation

AMH: Adult Mental Health

CAMHS: Child and Adolescent Mental Health Service

CS: Clinical Supervisor

LM: Line Management

TL: Team Leader

CL: Clinical Lead

BAME: Black, Asian and Ethnic Minority

Introduction

The NHS and its current context

The National Health Service (NHS) is one of Britain's most prized possessions and has been delivering publicly funded healthcare to the United Kingdom (UK) since 1948 (NHS England, 2019). Even through global recession and austerity, the NHS has continued to take care of society's health. However, service pressures are building as a result of changes in finances, the health of society and technology (NHS England, 2014). Along with these advances, funding is also strained by a growing, ageing and sicker population (NHS England, 2014).

In 2014, The Five Year Forward View (FYFV) advocated for a focus on wellbeing and the prevention of ill health to ease the growing strain on the NHS (NHS England, 2014). Currently, the NHS depends on its leaders and a strong workforce. With such mounting pressure, the NHS needs to become a better employer by supporting the health and wellbeing of their staff (NHS Staff Survey, 2019).

Therefore, it is likely that the NHS workforce is feeling this pressure. The NHS is one of the largest employers in Europe which accounts for a significant proportion of the UK working population (NHS England, October 2014). The NHS Health and Well-Being Review: The Final Report (NHS, November 2009) acknowledged the need to put staff wellbeing at the heart of its work for employees themselves and for the quality of patient care and to be able to deliver sustainable and high-quality services.

In order to strive through this growing pressure service targets have been established in order to save on costs. However, such targets are thought to increase pressure on staff by taking away resources (NHS England, 2014). Nevertheless, action on staff health and wellbeing is at the forefront as Commissioning for Quality and Innovative (CQUIN) incentive payments have been promised to NHS trusts who improve their staff's wellbeing by 5%. Leaders in the NHS are being looked to in order to implement the next steps of such initiatives.

The recent NHS Long Term Plan (2019) was written in response to the growing health needs of Britain to ensure that the NHS is prepared for the future. The plan is comprised of accounts from staff groups, patients groups and national experts in order to inform the shaping of the NHS (NHS England, 2019). The Long Term Plan (2019) suggests that staff pressures and workforce issues should be tackled whilst optimising the good the NHS does in order to build a sustainable service. The plan recognises that impact that poor staff wellbeing is having on recruitment, retention and sickness rates and discusses these ongoing workforce concerns. As a result, the Long Term Plan recommends a number of actions in order to improve support for staff. The Long Term Plan also acknowledged the role that the NHS as an employer play to ensuring staff can deliver high quality care to patients. The plan recognises that the way in which staff work needs to change and proposes a workforce strategy to improve the way staff work. Within this strategy, an investment in the workforce is highlight through increase training and CPD opportunities to allow staff to develop their skills. The culture of the NHS is also discussed and the need to tacking workplace bullying and harassment is stressed alongside the importance of wellbeing, flexible working and career development.

The NHS and Workplace Wellbeing

NICE (2009) proposed that workplace wellbeing is influenced by the workplace environment, the nature of the work and the individual themselves. O'Donnell, Deaton, Durand, Halpern and Layard (2014) also suggested four factors that affect workplace wellbeing:

- clear expectations and how these relate to the team and wider organisation
- reasonable freedom and autonomy over workload
- support recognition and rewards for efforts
- and a work-life balance.

The NHS Health and Wellbeing Review (Boorman, 2009) highlighted significant links between staff wellbeing and patient safety and experience and overall quality of care. Organisations which prioritised staff wellbeing have shown to produce

better outcomes, including: patient satisfaction, staff retention, low sickness rates, burnout and patient outcomes (Boorman, 2009).

In 2015 the Guardian Society Professionals Network conducted a project called 'Clock Off' which investigated the physical and mental wellbeing of public and voluntary sector employees (Meade, 2015). The project surveyed 3,700 employees and results highlighted that 61% of NHS employees reported feeling stressed at work all or most the time. Also 96% NHS workers work beyond their contracted hours due to lack of resources long hours and increasing workload (Dudman, Isaac, & Johnson, 2015). This may illustrate that the increasing pressure experienced by those working in the NHS as mentioned earlier and may be having an impact on its employees' wellbeing.

As increasing attention is being drawn to workforce wellbeing, the dependence of the NHS on its staff to provide quality care has become more apparent. However, as identified and discussed, growing pressures and targets and a decrease in resources has meant that staff wellbeing has become a priority on the NHS's agenda. The NHS Long Term Plan (2019) has argued the need for the action and stipulated a number of recommendations. These workable actions strive to tackle culture and staffing numbers through the creation of new roles and retaining the staff the NHS has. The plan recognised that one of the main contributing factors to poor staff retention is lack of career development and progression. The Long Term Plan recommends multi-professional credentialing to enable clinicians to develop new skills recognised across professions. In order to ensure that the NHS is a better place to work flexible working, wellbeing and career development should be promoted.

All members of NHS are invited to take part in a survey annually to collect views on staff experience surrounding: appraisal and development, health and wellbeing, staff engagement and involvement and raising concerns. The Staff Survey has been completed for the past 19 years. In 2019, over one million members of staff were asked to participate and in total 569,440 completed the survey from 229 NHS Trusts (NHS England, 2020). The results of the NHS Staff Survey for 2019 highlighted that over half of the staff are working extra hours which are unpaid (56%). However, 54% were satisfied regarding opportunities from flexible working

which has steadily improved in 2015 (51%). Only 29% felt that their Trust takes action to improve staff wellbeing and 40% reported feeling unwell due to work-related stress in the last 12 months. The percentage of those experiencing work-related stress has steadily increased since 2016 when 37% reported workplace stress. Over half of the respondents (57%) reported going to work when unwell in order to perform duties due to the stress and strain of the NHS. This has been consistent over the years (2018, 57%; 2017, 57%). These results continue to highlight the consistent and increasing stress NHS staff are experiencing and the impact this has on their wellbeing.

Due to the pronounced emphasis on staff wellbeing, the NHS Staff and Learners' Mental Wellbeing Commission published a report in 2019 exploring staff and learner happiness and fulfilment at work as evidence shows a correlation between staff satisfaction and compassionate care provision (NHS England, 2019). The report compromises of literature and research findings and is informed by staff accounts of working in the NHS to explore how the NHS is valuing, supporting and caring for staff and learners nationwide. The report contributed to the growing evidence illustrating that the relentless pressures on the NHS and as a result basic employment practices, such as time to go to the toilet, have not been prioritised. The day to day emotional and physical labour of working in the NHS was described as exhausting as staff are experiencing the extreme highs and lows of life on a daily basis which has a significant impact on their wellbeing (NHS England, 2019). The report discusses factors that contribute to poor workplace wellbeing, those who are at risk of poor wellbeing and how is best to support staff through life and career transitions.

As discussed in this chapter, the quality of relationships at work is one of the main contributing factors to workplace support and wellbeing. NHS England (2019) reported that staff can feel isolated at work as they are regularly moved to different departments and wards to meet demands. Consequently, this has an impact on the relationships between staff and management. Regular movement of staff overlooks the importance of social relationships for good mental health and wellbeing. The report acknowledged that peer support appears effective in addressing issues as they improve team cohesion and provide and supportive

space. Overall, the NHS Staff and Learners' Mental Wellbeing Commission made 33 recommendations which aim to improve the wellbeing and learning of those who work in the NHS. These recommendations included:

- Timely provision of post-incident support and post-trauma counselling
- Space for reflection and opportunity to talk
- Provision of a reflective learning space
- Access to a proactive Occupational Health service and psychological therapies
- An NHS Samaritans style service to provide emotional support
- Implementation of Workplace Wellbeing Guardians and Leaders.

Many interventions put in place to support staff are considered secondary as they aim to enable the staff to cope and do not seek to remove the source of stress (NHS England, 2019). Such secondary interventions do not emphases the prevention of poor staff wellbeing and therefore could be considered as reactive as opposed to proactive.

Psychological Professionals and Workplace Wellbeing

Management and leadership style have a major influence on workplace wellbeing. The White Paper (2011) published by the BPS Division of Occupational Psychology argues that the psychological wellbeing of employees benefits both employees and organisations. It is thought that wellbeing in the workplace is impacted by job insecurity, budgets and financial constraints, and resource availability. The paper suggests interventions at a managerial level can foster wellbeing at work as well as workplace support.

Farber (1983) was amongst the first to highlight the personal and professional demands of the psychological profession. It is not uncommon that those who work within the psychological profession are frequently exposed to organisational pressures, high caseloads and low resources, and therefore experience stress at work (Rupert & Morgan, 2005). It has been well documented that psychological professionals are at risk of experiencing anxiety, depression, stress, trauma, burnout and compassion fatigue (Cushway & Tyler, 1994; Di

Benedetto, 2015; Dattilio, 2015; Smith & Burton Moss, 2009). A study exploring workplace burnout amongst psychological professionals was conducted in 2015 (Steel, MacDonald, Schroder & Mellor-Clarke, 2015). An online survey was administered in order to measure burnout and predictors of burnout using self-reported questionnaires which included the Maslach Burnout Inventory. A total of 116 IAPT therapists, including both low and high intensity practitioners, completed the survey. Results showed that 46% of the profession reported experiencing emotional exhaustion. Such findings highlight that IAPT workers are vulnerable to emotional exhaustion. In addition, the results also highlighted that high workload, lack of autonomy and psychological job demand were significant predictors of emotional exhaustion.

The Wellbeing Charter for Psychological Professions was founded by the British Psychological Society and New Savoy Partnership (NSP) in 2015 after conducting a staff wellbeing survey. A total of 1,227 psychological professionals, which included IAPT therapists, counsellors and Clinical Psychologists, in the NHS completed the survey and results highlighted that 48% of psychological professionals reported feeling depressed, 46% felt they were a failure and that 92% find their job stressful (Dosanjh & Bhutani, 2017). This sparked significant concern compared to the previous year's survey (2014) which captured that lower levels of staff (12%) reported feeling stressed at work. Common themes from the survey showed that focus on target performance contributed to 41% of reported stress and that 38% of stress and burnout was related to environmental factors.

Attachment

Attachment theory suggests that the relationship which an infant has with their primary caregiver acts as a blueprint for how the infant relates to themselves and others across the lifespan (Hazan & Shaver, 1987). Bowlby (1958) referred to this blueprint as an internal working model. Ideally, the primary caregiver acts as a secure base for an infant so they experience security and safety which enables them to go out in the world exploring and taking risks with the reassurance of having a safe base to fall back on (Bowlby). Bowlby suggested that attachment

styles are dynamic and adapt and motivate to enable the individual to seek safety, especially in response to threat.

Ainsworth (1969) developed the work of Bowlby and identified different representations of attachment. Ainsworth proposed 3 different attachment variations: secure, insecure-avoidant and insecure-anxious. This thesis focuses on avoidant and anxious attachment styles. An anxious attachment style is characterised by a fear of rejection and/or abandonment and often interlinked with an individual's self-esteem and worth (Main & Solomon, 1990). Whereas, an avoidant attachment style is characterised as uneasiness in close relationships and individuals will avoid becoming reliant on and unwilling to share feelings within these relationships (Main & Solomon).

Both styles are associated with negative feelings and experiences as the primary caregiver has lack consistency in the provision of care. Therefore the infant was unable to rely on them as a source of emotional regulation (Main & Solomon). Those with insecure attachment styles are more likely to experience mental health difficulties (Selcuk & Gillach, 2009). Individuals with attachment avoidance are unlikely to experience satisfaction with and trust in their relationships and are unlikely to seek help if needed (Mikulincer & Shaver, 2007). Mikulincer & Shaver argued that those with an anxious attachment style are likely to evaluate worrying situations more intensely and be less resilient when managing stress. Rasmussen, Storebo, Lokkeholt et al (2018) conducted a systematic review and meta-analysis exploring the role of attachment in resilience. The review and analysis consisted of 33 studies. The results highlighted a significant moderate correlation between attachment and resilience. Therefore, Rasmussen et al concluded that secure attachment is associated with resilience. This suggests that insecure attachment styles are linked to low resilience and wellbeing. This is supported by Karreman and Vingerhoest (2012) who argued that resilience indirectly caused the relationship between attachment pattern and degree of wellbeing. Resilience is also associated with reduced likelihood of experiencing depression (Weinman, Buzi, Smith & Mumford, 2003). Therefore, it could be inferred that insecure attachment patterns are associated with a higher risk of mental health difficulties.

Chopik, Grimm and Edelstein (2019) gathered evidence suggesting that attachment styles may be forged in childhood but are susceptible to change over time and across relationship status. Chopik et al hypothesised that:

- Attachment anxiety is heightened in adolescents before decreasing across the lifespan
- Attachment avoidance generally declines with age
- Those in secure relationships will experience more attachment security and therefore lower attachment anxiety and avoidance; becoming more secure over time compared to when single

Chopik et al conducted a longitudinal study and review archived human development data between the ages of 13 to 72 years old. The data comprised of a total of 1,940 observations, from 628 sets of data, over 47 years between 1920 and 1967. A new measure of attachment orientation was utilised to track changes across the lifespan (Chopik & Edelstein 2015). Relationship status was also examined to assess that impact of relationships commitment on attachment. The data were analysed through test-retest, correlational analysis and a growth curve model to track attachment change and identify moderators of change. The results highlighted that attachment anxiety remained stable across adolescence and declined into middle and older age. It was identified that men experienced more dramatic changes in attachment anxiety compared to women. The results also showed that attachment avoidance changes linearly across the lifespan and that age and gender were significant predictors of this attachment style. Similarly, men illustrated higher levels of attachment avoidance compared to women. Relationship status was as a time moderator in attachment change and the results highlighted that those in relationships had significantly lower levels of attachment anxiety and avoidance throughout adulthood. However, it could also be argued that those who had longstanding relationships are more likely to have secure attachments initially. Overall, Chopik et al concluded that the attachment change seen across the data was significant. However, it was wondered whether this pattern represented larger individual differences as attachment change was small and therefore could be considered somewhat stable across the lifespan.

In 1990, Hazan and Shaver conducted a survey exploring the relationship between attachment style and job satisfaction. Results showed that those who are attached securely reported greater work satisfaction in most aspects of work. Similar results were also found by Kraus et al (2001) and Sumer and Knight (2001). However, Sumer and Knight also found that those with anxious attachment styles reported lower rates of satisfaction with their job. Such evidence suggests that there is an association between an individual's attachment styles, how they experience their workplace and the impact this has on their wellbeing.

Leiper and Casares (2000) explored the attachment styles of Clinical Psychologists and the impact this had on their clinical practice. 500 questionnaires were posted to British Clinical Psychologists and 196 were completed and returned. Demographic information was collected regarding the psychologist's clinical area and background, a measure of adult attachment style, an adult attachment pattern questionnaire and a measure capturing information on early life experiences was administrated. ANOVA and correlational methods were used to analyse the data. The findings showed that 70% of the sample identified as having a secure attachment style and 19% as having a avoidant attachment style. No difference was found between individuals with secure and insecure attachment styles and modality of therapy. However, there was a correlation between the frequency of early life experiences and the use of psychodynamic therapy (Chi-square(5)15.6*; p<.01*).

Attachment and Workplace Wellbeing

Research has shown that attachment style influences wellbeing at work (Simmons, Gooty, Nelson & Little, 2009). Simmons et al explored the link between attachment, psychological state (trust, hope, and burnout) and work performance using a correlational design. It was hypothesised that there would be:

- a positive relationship between a secure attachment and hope, hope and task performance, secure attachment and trust in supervisor
- a negative relationship between attachment, burnout and task performance
- no relationship between secure attachment and task performance.

203 questionnaires were completed by participants and 161 questionnaires completed by their supervisors. Measures included: Self-Reliance Inventory (Quick, Joplin, Nelson, Mangelsdorff & Fiedler, 1996), Hope 6 Item Scale (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Ybshinobu, Gibb, Langelle & Harney, 1991), Trust in Supervisor 4 Item Scale (Mayer & Davis, 1999), Shirom-Melamed Burnout Questionnaire (SMBQ) and performance was rated by supervisors. Results showed a positive relationship between secure attachment and hope and trust (r = 0.52; $p<0.01$), a negative relationship between secure attachment and burnout (r = -0.48; $p<0.01$) and no direct relationship between attachment and work performance. Simmons et al concluded that those with a secure attachment style work effectively independently and also amongst others which supports them to achieve their goals. A secure attachment also fosters trust and hope which facilitates relationships with others which prevents burnout at work (Simmons et al).

Towler and Stuhmacher (2013) considered attachment styles and the relationships quality of women at home and how this influences their wellbeing in work. The authors suggested that the factors for a successful relationship at home are the same for those at work therefore Towler and Stuhmacher proposed a model of connecting attachment style, relationship quality, supervisor relationship and wellbeing. In this study, wellbeing was measured as relationship quality, job satisfaction and physical health. In total 209 women with partners completed web-surveys. The surveys included The Close Relationship Inventory, a measurement of satisfaction with the quality of relationship, Leadership Member Exchange (LMX), Job Satisfaction Index, Conflict at Work Scale and a physical symptom inventory. Variables were controlled for which may link to relationship success at work and home, these included: age, number of children and number of years at a job. The results were analysed using a structural equation model to test all the hypotheses. The results show that an avoidant attachment style was negatively related to relationship satisfaction; whereas attachment anxiety was only marginally related. Partial support was found for the relationship between attachment style and superior relationships. Attachment avoidant was found to be negatively related and anxious attachment was not related. Supervisory relationships also positively related to job satisfaction but negatively related to work conflict. Quality

relationships at home also positively correlated with job satisfaction. However, negatively correlated with workplace conflict. Therefore results suggested that the quality of relationships at home impact on relationships at work and workplace wellbeing.

Leadership

Even though leadership is widely written about and referred to in research and academic literature it is difficult to find a consensus regarding its definition (Grint, 2010). It is argued that the definition of leadership will be ever-evolving as practising leaders, researchers and academics gain further insight into the concept (Winston & Patterson, 2006). The notion of leadership has developed over the years. Historically a leader has been viewed as a "great man" with charismatic and heroic traits who can influence and lead political movements and achieve organisational success (e.g. Haslam, Reicher & Platow, 2009). It was not until the 1980s when the research literature started to appreciate leadership as a more complex concept (Eagly & Carli, 2007) which was thought about in relation to group processes (Hartley & Benington, 2010). This triggered a movement away from the classical notions of transactional leadership, which is based on the notion of exchange of rewards for productivity (Burns, 1978), to transformational theories of leadership. Transformational leadership focuses on the relational aspects of leadership and encourages the development of followers (Avolio & Gardener, 2005). Grint (2010) suggested that at a basic level a leader cannot lead without followers. Which also highlights the importance of the relationship between the leader and the follower.

Table 1

Description of leadership approaches discussed in this literature review

Type of Leadership	**Description**
Transactional Leadership	Based on the notion of exchange of rewards for productivity (Burns, 1978)
Transformational Leadership	Focused on the relational aspects of leadership and encourages the development of followers (Avolio & Gardener, 2005) Based on a relational model of leaders empowering their followers
Authentic Leadership	Emphasis on leaders having honest relationships with followers by valuing contribution, ethical behaviour and transparency which leads to engagement and improved performance (West et al)
Compassionate Leadership	Leadership is driven by compassion as a core value of the leader. The leader role models compassion to their followers which aims to increase compassion within teams and throughout organisations to strengthen relationships (West, Eckert, Collins & Chowia, 2017)
Secure Base Leadership	Leaders provide protection, safety and protection to build trust and influence followers whilst inspiring, explorative and encouraging risk-taking and challenge (Kohlrieser, Goldsworthy & Coombe, 2012)

Leadership Theory and Healthcare Settings

There is a range of evidence which illustrates that transformational and authentic leadership aids the production of beneficial outcomes for healthcare systems (West et al, 2015). West et al considered transformational leadership as the most influential theory of leadership in healthcare.

Gilmartin and D'Aunno (2007) conducted a systematic review of healthcare from 1989 to 2005 which consisted of 60 empirical studies. Evidence showed strong links between transformational leadership and staff satisfaction, performance, organisational climate and staff turnover. This paper also highlighted that the research literature surrounding leadership is unlikely to develop until barriers in this area are addressed, including the role of gender and of medical professionals as leaders (Gilmartin & D'Aunno, 2007). Gilmartin and D'Aunno (2007) suggested that the healthcare sector offers advantages compared to other potential research settings.

Transformational leadership is linked to work-life balance and wellbeing. Munir, Nielsen, Garde et al (2012) asked Danish local government staff to complete a range of questionnaires, including measures of Transformational Leadership, work-life conflict, job satisfaction and psychological wellbeing. Staff who completed these measures were from a range of professions: including healthcare assistants, nurses, cleaners and maintenance staff, who all had leaders with managerial responsibilities. In addition, 30 leaders were rated on transformational behaviours. Measures were completed at baseline and then 18 months later at follow up. In total, 118 members of staff completed measures at both baseline and follow up. There was a 53% attrition rate and 93% of the participants were females. The data collected were analysed using a correlational analysis on all variables and a regression analysis to examine the relationship between baseline transformational leadership behaviours and work-life conflict, job satisfaction and psychological wellbeing data collected at follow up. Results indicated that transformational leadership was directly linked to work-life conflict, job satisfaction and psychological wellbeing for those who worked in healthcare settings (Munir et al). Findings suggested that the relationship between transformational leadership and

psychological wellbeing was mediated by work-life conflict. This evidence adds to existing literature which indicates that leadership/managerial style impacts on perceptions of work-life balance and conflict (Munir et al). An advantage of using longitudinal design for this study is that it allows for the relationship between variables to be examined over time. This adds to the robustness of the study's findings and conclusions.

Authentic leadership has been the focus within healthcare leadership studies (West et al, 2015). Authentic leadership places an emphasis on leaders having honest relationships with followers by valuing contribution, ethical behaviour and transparency which leads to engagement and improved performance (West et al).

Research has linked authentic leadership to increased workplace trust, engagement in work, patient outcomes and a work-life balance (Wong, Laschinge & Cummings, 2010; Wong & Giallardo, 2013). Wong et al collected data from 280 nurses in Ontario working in acute care. Originally 600 nurses were approached and therefore the response rate was 48%. A survey using a cross-sectional design collected data on authentic leadership, trust in managers and patient outcomes. The data were analysed using structural equation modelling to examine the link between authentic leadership, trust and patient outcomes. Results illustrated that authentic leadership, which managers facilitated through trust, was significantly associated with a decrease in adverse patient outcomes. Results showed that nurses who saw their leader demonstrating authentic leadership behaviours reported increased trust and fewer frequencies of adverse outcomes for patients. Wong et al concluded that managers who are perceived as more authentic fostered higher levels of trust in employees.

Transformational Leadership

Popper, Mayseless and Castelnovo (2000) were keen to consider the characteristics of leaders and their childhood experiences. Drawing on attachment theory Popper et al viewed transformational leadership as an internalisation of a secure attachment style and argued the need to internalise a positive model of self and

others in order to deliver transformational leadership. This study explored the relationship between attachment and four leadership characteristics (individual consideration, inspirational motivation, intellectual stimulation, and idealised influence) which are measured by the Multifactor Leadership Questionnaire (MLQ). Participants consisted of 86 men aged 25-35 years old employed as officer cadets in the Israeli Police. Structured interviews were conducted to measure leadership and attachment. Pearson correlation was used to explore the relationship between attachment style and leadership. Results highlighted a negative relationship with insecure attachment styles and dimensions of transformational leadership and a positive relationship with secure attachment styles. These results established a link between the security of a leader's attachment and their qualities as a transformational leader.

Following these results, Popper and Mayseless (2003) recognised the importance of developmental processes and applied aspects of parenting for transformational leadership. Popper and Mayseless proposed aspects of developmental processes which link to the leader-follower relationship and used insights from parenthood to highlight aspects of good leadership and future research avenues. Fundamental psychological theory was applied to think about leadership from a developmental stance including attachment theory (Bowlby, 1958), Maslow's (1943) Hierarchy of Needs and Kohlberg's Moral Development (1963). Popper and Mayseless hypothesised the following by linking attachment theory to leadership:

- leaders who provide security for followers will enhance the follower's self-esteem and efficacy;
- provision of protection and guidance facilitates a follower's exploration and positive risk-taking;
- secure leaders can provide insecure followers with corrective experiences to aid the formation of new and more secure relationships with others;
- leaders can act as a source of empowerment and support the development of confidence, autonomy and competence by being a secure base and scaffolding success without being overbearing;

- leaders can promote moral functioning prosocial values by establishing expectations and demands which can foster trusting and communicative relationships.

Alimo-Metcalfe and Lawler (2001) researched leadership in the public sector workforce (NHS and government employees) which lead to the development of the Transformational Leadership Questionnaire (TLQ). This measure has been established as useful in predicting attitudes of staff and wellbeing (Alimo-Metcalfe, Alban-Metcalfe, Bradley, Mariathasan & Samele, 2008) and acts as a 360 feedback tool. Alimo-Metcalfe et al conducted a longitudinal study to examine the effect of leadership quality on performance, which included: staff attitudes, wellbeing at work and attainment of organisational goals. A positive correlation between these variables was hypothesised. A total of 731 staff who worked in Mental Health Crisis and Home Treatment Teams in the UK completed outcome measures which included the TLQ. The data gathered were analysed using a variety of statistical tests: correlation, regression model and factor analysis. Results showed that the quality of leadership is a significant predictor of staff attitudes, wellbeing at work and attainment of organisational goals.

Authentic Leadership

As argued in previous studies attachment and an individual's internal working model can influence a leader's ability to lead followers by acting as a safe haven to support the development of a follower (Popper & Mayseless). In a literature review paper Hinojosa, McCauley, Randolph-Seng, and Gardner (2014) proposed that authentic leadership had four components: self-awareness, balanced processing, relational transparency, internalised moral perspective. Hinojosa et al suggested that these four proposed components of authentic leadership mirror the characteristics of a secure attachment style. Hinojosa et al proposed that the interaction between the leader's and follower's attachment style produces different levels of relationship authenticity. From this Hinojosa et al argued that for an authentic relationship to occur both the leader and the follower need to have a secure attachment style. Therefore, Hinojosa et al suggested that an individual's

attachment style influences their potential for authentic relationships and that leaders with a secure attachment style have the greatest potential to facilitate relational authenticity. Even though this paper provides vital points and insights the study does not provide empirical evidence. The conclusions also imply potential difficulties for both leaders and followers who do not have secure attachment styles. Exploration of these ideas would be beneficial as Hinojosa et al provide no empirical evidence for their theories.

It has been established that positive leadership approaches aim to support employees and have shown to discourage the development of "burnout" (Maslach, 2004). Burnout is described as a psychological response to enduring and persisting workplace stress and is characterised by cynicism and emotional exhaustion (Maslach, 2004). Spence and Fida (2014) investigated the relationship between authentic leadership and psychological capital in newly qualified nurses and its impact on burnout, job satisfaction and mental health in the workplace. Psychological capital is defined as an individual's internal resource which enables that to respond to challenges at work with positivity. Spence and Fida hypothesised that:

- authentic leadership is negatively related to the likelihood of burnout;
- "psychological capital" will decrease the likelihood of burnout;
- higher levels of, and increases in, burnout will relate to poor mental health;
- and finally, that initial and increasing levels of burnout will relate to lower work satisfaction.

Canadian nurses (92% female, mean age 28) with less than 2 years' experience working in acute hospitals where recruited and asked to complete a range of outcomes. These outcomes included: Authentic Leadership Questionnaire, Psychological Capital Questionnaire, Maslach Burnout Inventory-General Survey, a 5 item Mental Health index and a work satisfaction measure adapted from Shaver and Lacey (2003). The results were analysed using a Conditional Latent Growth Model (LGM). The findings showed that burnout was significantly associated with poor mental health and job satisfaction and authentic leadership and psychological capital are associated with less negative work experiences. Therefore, Spence and

Fida concluded that personal and organisational resources play a role in the prevention of workplace burnout.

Compassionate Leadership

Compassionate leadership is a style of transformational leadership. Compassion is the driving value of those who work and deliver the healthcare that the NHS provides (West, Eckert, Collins & Chowia, 2017). Compassionate care is more likely to have a positive impact on patient satisfaction, health and organisational outcomes (West, Eckert, Collins & Chowia, 2017). West et al recognised that the challenge the NHS faces is to nurture a strong culture of compassion whilst under ever-growing pressure and judgement. To create a culture of compassion NHS leaders need to embody compassion within their leadership practice. There is a growing body of evidence illustrating the clear relationship between the quality of leadership and the quality of care in the NHS (Shipton, Armstrong, West & Dawson, 2008). This alone should be enough to motivate leaders to consider adopting more of a relational and compassion approach within their practice. Compassionate leadership is considered as effective as it reinforces altruism, promotes learning and safe risk-taking and realistic expectations of success within an organisation (Shipton et al). Compassion in the workplace is also argued to create psychological safety which allows staff to work, take risks and speak out without fear. This in turn can increase collaboration, cohesion, optimism and team efficacy and therefore produce better outcomes.

Atkins and Parker (2012) described compassion as an act of an individual attending, understanding, empathising and helping another individual. West et al (2017) proposed that for compassionate leadership to be effective it must be embodied at every level of an organisation. Within the context of the NHS, West et al (2017) suggested that the four 4 elements of compassion outlined by Atkins and Parker translates into paying attention to the other and notice their suffering (attending), understand what has caused the distress (understanding), responding empathically to the others' distress (empathising) and taking appropriate, thoughtful, intelligent action to help relieve the others suffering (helping). This

implied that a compassionate leader should embody these traits to express compassion to their followers.

Table 2

An overview of the skills used in Compassionate Leadership, taken from West et al (2017)

Attending	Understanding	Empathising	Helping
Focusing attention on the key challenges in order to gain a good understanding to implement directed improvements	Collaborating with staff to fully understand the challenges in an engaged and supportive manner	Expression of empathy towards staff regarding the challenges they face creates a supportive environment and increase motivation towards a solution	Taking thoughtful and considered action through the generation of ideas and new approaches to tackle the challenge

Compassionate leadership encourages leaders to be brave, resilient and committed so that they are able to be the best they can be (West et al, 2017). It is essential that leaders embody self-compassion so they are able to attend to and understand themselves (West & Bailey, 2019). West and Bailey argued that being connected and driven by core values can give life meaning and fulfilment; this enables leaders to have deeper, authentic and effective interactions with those they lead (West et al). NHS England (2016) also argued that compassion in leadership is facilitated by the leader's beliefs, values and behaviours and is driven by their core purpose. Delivering compassionate leadership develops self-awareness, resilience and emotional intelligence which enables the leader to be emotionally available for their followers (NHS England, 2016). NHS England (2016) conducted a survey to explore the characteristics of a compassionate leader. 140 respondents from the alumni of the NHS Leadership Academy were asked to identify the 10 most

important characteristics of a compassionate leader. The identified top 21 characteristics from the survey are listed below in descending order (Table 3). NHS England concluded that these characteristics would be useful to inform interviews and values-based appraisals. However, more accurate results could have been produced if data had been collected from NHS staff as well as Leadership Alumni. This would have increased the validity of the results as NHS staff are the followers of such compassionate leaders, and may have been able to provide additional insights into the characteristics of effective leaders.

Table 3

The characteristics of a compassionate leader, taken from NHS England (2016)

Characteristics of a compassionate leader	
1. Emotional Intelligence	12. Resilient
2. Integrity	13. Balance
3. Listening	14. Courage
4. Trust	15. Respectful
5. Authentic	16. Kindness
6. Openness	17. Positive
7. Caring	18. Responsiveness
8. Reflective	19. Responsibility
9. Commitment	20. Motivation
10. Genuineness	21. Non-judgmental
11. Empathy	

As discussed, transformational leadership theories have developed to include various sub-types, such as authentic, compassionate and Secure Base Leadership. There has been criticism that these different sub-types are overly similar, thus making these leadership approaches more complex than necessary (Avolio & Walumbwa, 2014). Banks, McCauley, Gardener and Guler (2016) explored the conceptual similarities between transformational and authentic leadership. A literature search of published and unpublished authentic leadership studies was

conducted. In total 100 studies were coded by independent coders. Some of these codes included sample size, effect size and reliabilities. A meta-analysis was then conducted to analyse the coded data. The results showed that transformational and authentic leadership, even though related, are distinct from each other. These differences can be seen in Table 1, which describes the different leadership approaches born from the overarching aims of transformational leadership. These aims include the leader acting as a role model and facilitator of motivation, to enable follows achieve their potential. However, even though these aims are the foundation of the leadership models outlined in Table 1, each approach focuses on a different aspect to facilitate outcomes. Transformational leadership aims to develop a follower's ability to perform through creative vision and genuine interactions. Both authentic and transformational leadership theories emphasise the importance of self-awareness, role modelling, pro-social interactions and a supportive organisational context. The theory of authentic leadership on the other hand, focuses on the importance of a reciprocal relationship between the leader and follower, and the psychological health of the follower. Authentic leadership also prioritises transparency and value-aligned action to facilitate authenticity. Compassionate leadership stresses role-modelling acts of compassion and values-driven behaviour to lead followers. Secure base leadership focuses on the relational element of leading, and specifically draws on attachment theory to inform this.

Leadership and Clinical Psychologists

Clinical Psychologists utilise leadership skills within various aspects of their job roles. The document 'New Ways of Working for Applied Psychologists' (NWWAP) formally outlines how clinical psychologists work in the NHS in order to maximise and effectively use and develop their professional skill set (Lavender & Hope, 2007).

The National Health Service (NHS) identifies the role of a clinical psychologist as reducing distress and enhancing the psychological wellbeing of their clients (NHS Health Education England, 2018). Similarly, Hope and Lavender view the role of clinical psychologists as improving the wellbeing of the population,

through working with individuals, teams, organisations and communities. In addition, Castro, Whiteley and Boyle (2013) highlighted that psychologists also contribute a unique psychological perspective to organisational planning, policy development, teaching, training, research and audit.

A main focus of NWWAP was for clinical psychologists to take on leadership roles throughout different levels of the NHS to enable implementation of the initiative. Onyett (2012) acknowledges the similarities between clinical practice and leadership, and highlights the suitability of clinical psychologists as leaders. Psychologists are trained to have effective interpersonal skills and systematic knowledge which enables them to be strong leaders. NWWAP outlines that effective leadership should create the circumstances to develop, maintain and maximises team performance.

The Division of Clinical Psychology (DCP) published a leadership framework, (Skinner, Toogood, Cate et al, 2010) which outlines leadership as a core competency of psychologists and how leadership can be delivered and developed by psychologists working in the NHS (Table 4). The framework identifies five competencies of psychologists which enables them to offer leadership. These include personal qualities, working with others, setting direction, managing services and improving services.

Table 4

Proposed Leadership Competency Framework for Clinical Professionals, taken from Skinner et al (2010)

Competency	**How is it demonstrated**
Personal Qualities	Developing self-awareness, managing self, continuous personal development, acting with integrity
Working with Others	Developing networks, building & maintaining relationships, encouraging contribution, working with teams
Setting Direction	Identifying context, applying knowledge & evidence, making decisions, evaluating impact
Managing Services	Managing resources, managing people, managing performance
Improving Services	Ensuring patient safety, critically evaluating, encouraging improvement & innovation, facilitating transformation

An advantage of the leadership development framework is that it provides an accessible overview and examples of how a psychologist can offer leadership at different levels of the NHS. Skinner et al also argue that the framework is an effective implementation of NWWAP. However, Bolden (2004) advocates for less of a focus on competencies and urges for the quality of relationships to be at the forefront of leadership, in order to foster flexible ways of working in complex systems. However, Onyett (2012) suggests that the framework is too simplistic as it fails to capture the complexity of leadership in complex systems.

Attachment and Leadership

Rahimnia and Sharifirad (2015) claimed that attachment security is a potential mediating factor between authentic leadership and a follower's wellbeing. The relationship between authentic leadership and wellbeing which comprised of job satisfaction, perceived work stress and physical stress symptoms, was investigated. Rahimnia and Sharifirad (2015) hypothesised that:

- authentic leadership positively correlated with job satisfaction, fewer symptoms of stress and decreased attachment insecurity
- attachment insecurity caused less satisfaction, increased perceived stress, increased stress symptoms at work.

Hospital employees from the North East of Iran completed paper copies of the outcome measures. Initially, 352 were sent out and 212 were returned completed providing a response rate of 55%. The sample consisted of 55% females and 45% males who were a mix of nurses and other medical professionals. These measures included: Authentic leadership inventory, Close relationships inventory, 2 job satisfaction items by Cammann et al (1979), 2 perceived work stress items by Siu et al (2007) and 6 stress symptoms taken from ASSET. A confirmatory factor analysis was completed and provided supporting evidence for the research hypotheses. Results indicated that authentic leadership positively impacted job satisfaction however did not directly influence perceived stress and stress symptoms (Rahimnia and Sharifirad, 2015). The analysis shows that attachment insecurity fully mediated the relationship between authentic leadership and perceived stress and stress symptoms; as well as attachment insecurity being a partial mediator for the relationship between authentic leadership and job satisfaction. The final analysis model showed that authentic leadership can lessen attachment anxiety; illustrating that authentic leadership can positively influence attachment avoidance and attachment avoidance. This complements previous research which argues that authentic leadership can enhance trust in followers and therefore positively influence the followers attachment style (Rahimnia & Sharifirad)

VanSloten and Henderson (2011) explored the relationship between attachment orientations and leadership styles by priming attachment orientations

of 144 graduate students and measuring leadership behaviours. It was hypothesised that those with avoidant attachment styles were less likely to adopt relational strategies than those with anxious, secure or neutral attachment styles. A participant's attachment style was primed by asking them to write about an experience in a close relationship. Following this, participants were asked to complete a leader behaviour questionnaire which captured a descriptive picture of their leadership behaviours. An ANOVA was completed to analyse the data and displayed a significant effect ($p<0.04$) of attachment style on leadership style. This supports the hypothesis that attachment styles of leaders are likely to affect their leadership style. VanSloten and Henderson discovered support for their hypothesis and concluded that an avoidant attachment style is less likely to produce a relational approach to leadership as they are less attuned to relational cues.

As argued in previous studies attachment and an individual's internal working model can influence a leader's ability to lead followers by acting as a safe haven to support the development of a follower. In a literature review paper Hinojosa, McCauley, Randolph-Seng, and Gardner (2014) proposed that authentic leadership had 4 components: self-awareness, balanced processing, relational transparency, internalised moral perspective. Hinojosa et al mapped the varying attachment styles on different characterised relationships between a leader and a follower and suggested that the 4 proposed components of authentic leadership mirror a secure attachment style. These leader-follower attachment style combinations and levels of relationship authenticity propose that for an authentic relationship to occur both the leader and the follower need to have a secure attachment style. The other suggested relationships are illustrated below (Table 5).

Table 5

An overview of authentic relationship styles between a leader and follower, taken from Hinojosa et al (2014)

Relationship type	Description
Pseudo-authentic	The leader and follower view the relationship as authentic but is likely not to be fully authentic due to attachment style of one who is focused on self, less on others which hinders the reciprocal authenticity. However, it is expected that if the leader has a secure style there is a better chance of developing authentic relationship due to interpersonal power of the leader which may influence the follower.
Non authentic	Either the leader or the follower is avoidant the other secure. The individual with the avoidant attachment won't reciprocate the authenticity of secure.
Anti-authentic	Either the leader or the follower is avoidant and the other ambivalent; resulting in the least functional relationship and has the least potential for authenticity.
Authenticity void	Both the leader and the follower have avoidant attachment styles and are transparent in their transactions which is likely to be viewed as distrustful

Table 6

An overview of leader–follower attachment style combinations and associated levels of relationship authenticity, taken from Hinojosa et al (2014)

	Follower attachment style		
Leader attachment style	Secure follower	Insecure-ambivalent follower	Insecure-avoidant follower
Secure Leader	Authentic	Pseudo-Authentic	Non-Authentic
Insecure-ambivalent leader	Pseudo-Authentic	Pseudo-Authentic	Anti-Authentic
Insecure-avoidant leader	Non-Authentic	Anti-Authentic	Authenticity-Void

Therefore Hinojosa et al (2014) suggested that an individual's attachment style influences their potential for authentic relationships and that leaders with a secure attachment style have the greatest potential to facilitate relational authenticity (table 6). Exploration of these ideas would be beneficial as Hinojosa et al provide no empirical evidence for their theories.

Secure Base Leadership

As noted earlier, leaders cannot lead without followers. This highlights the importance of the leader-follower relationship. Leadership theories have developed, and focus has shifted to relational approaches to leadership originating from transformational leadership which includes authentic leadership and secure base leadership. Research has often linked attachment theory and relational

leadership theory however secure base leadership uses attachment theory directly to inform and create its model of leadership. Kohlrieser, Goldsworthy and Coombe's (2012) research overtly merges leadership and Attachment Theory (Bowlby, 1958) from empirical research.

Secure base leadership (SBL) is defined as "the way a leader builds trust and influences others by providing a sense of protection, safety and caring and by providing a source of inspiration that together produces energy for daring, exploration, risk-taking and seeking challenge" (Kohlrieser et al., 2012: p. 18). SBL allows a leader to act as a secure base so followers feel safe to explore and develop their potential. Semi-structured interviews were completed with 60 leaders and followers analysed using Grounded Theory (Glaser & Strauss, 1967). Following this, 1000 individuals completed a survey exploring if SBL could predict work performance. Results showed a positive relationship with nine elements of SBL: staying calm, accepting the individual, seeing the potential, listen and inquiry, delivering a powerful message, focusing on the positive, encouraging risk-taking, inspiring through motivation and signing accessibility. The essential element of SBL is its relational foundation.

An outcome measure of SBL was developed in a thesis by Duncan Coombe (2010). The measure was developed through quantitative and qualitative methods. 50 organisational leaders of the European Business School, from Switzerland and the USA, were identified by members of the research team and were interviewed using a semi-structured interview protocol. Interviews were analysed using a Grounded Theory Approach. Qualitative factor analysis highlighted 8 dimensions of SBL. These were:

- acceptance and acknowledgement of the person as a human being
- seeing the potential in the other
- allow risk and provide opportunities
- supportive and accessible
- style: calm, dependable and predictable
- listening and inquiry
- intrinsic motivation

- and positive mind-set with problem-solving.

In the quantitative section of the study, an online survey was completed by 50 different leaders who were enrolled on a leadership programme at a business school in Europe. The survey included the SBL measure which was created using the 8 dimensions identified in the previous section of the study. These dimensions were rated using a 5-point Likert scale ranging from 'consistently' to 'never'. The SBL was correlated against the Experiences in Close Relationships which was adapted for work context (Brennan, Clark & Shaver, 1998). Other measurements included: leader effectiveness, job satisfaction survey, psychological safety, leader-member exchange, results and relationship orientation and control for resources and protection. Coombes hypothesised that the analysis would find a positive correlation between all variables measured. Four of the eight dimensions of the SBL measure are above this (Acceptance 0.819, Potential 0.869, Accessible 0.771 and Inquiry 0.736) whereas the other four of the eight dimensions were below the satisfactory Cronbach Alpha level (Opportunity 0.697, Intrinsic Motivation 0.614, Calm 0.695 and Positive Mindset 0.676). Therefore, the analysis indicates partial support for the eight dimensions of secure base leadership as separate sub-scales (Coombes, 2010). Results also highlighted that the 8 factors have a positive relationship with leadership effectiveness, job satisfaction and psychological safety.

Problems within these research areas

Even though the research findings discussed within this section have provided useful insights there are multiple limitations of the studies which impacts on both the validity, reliability and generalisability of the findings. These limitations include:

- Confounding variables that were not measured may have also impacted on the data collected. Such variables include: work life balance, recognition and rewards of effort, autonomy over workload (O'Donnell et al, 2014); budgets and financial constraints, and resource availability (British Psychological Society, 2011); organisational pressures, high workload and

environmental factors (Rupert & Morgan, 2005). This impacts the accuracy of the data and therefore the validity of the study.

- The majority of the studies used self-reported outcome measures to collect data which is open to bias and subjectivity (e.g. Shaver & Lacey, 2003; Wong, Laschinge & Cummings, 2010).
- The sample population of research within the literature is also usually restricted. This weakens the ability to apply the findings to other populations, such as other countries dues to cultural differences, or settings, such as healthcare setting. (e.g. Rahimnia & Sharifirad, 2015; Popper, Mayseless & Castelnovo, 2000;
- Clinical psychologists have access to and knowledge of academic literature surrounding healthcare leadership, which allows them to draw upon the evidence base to inform how they act as leaders. However, the academic literature does not often utilise psychologists as researched populations in the leadership literature. This has implications for the generalisability of research findings and impacts on how reliably psychologists can apply this evidence base to their clinical practice.
- Some sampling techniques used also impacts on the integrity of the data. The use of snowballing to recruit participants through professional organisations limits the generalisability of the results to a wider population. (e.g. Coombe, 2010; Towler & Stuhamcher, 2013)
- Some of the studies included in the introduction used a cross-sectional design meaning that data was collected at one point in time. A longitudinal design would have assessed if there would be any changes in variables over time and therefore would have produced more robust findings. (e.g. Alimo-Metcalfe, Alban-Metcalfe et al 2008; Munir, Nielsen, Garde et al, 2012; Wong & Giallardo, 2013; VanSloten & Henderson, 2013).
- The correlational nature of some of the studies also limits the ability to infer cause and effect between variables and other variables which the study did not account for may have caused or impacted the relationship reported. (e.g. Shaver & Lacey, 2003; Rahimnia & Sharifirad, 2015; Chopik & Edelstein 2015; Simmons, Gooty, Nelson & Little, 2009)

Research questions:

Given the outlined background literature the aim of this study is to strengthen the established relationship authentic leadership, workplace wellbeing and attachment theory for Clinical Psychologists working in the NHS. The research questions are:

- Question 1: What is the relationship between authentic leadership and workplace wellbeing for Clinical Psychologists working in the NHS?
- Question 2: Does attachment insecurity mediate the relationship between authentic leadership and workplace wellbeing for Clinical Psychologists working in the NHS?

Method

This chapter includes a description and discussion of the methodology chosen to answer the identified research questions. The design of the study, participant recruitment, a description of the measures used and the analysis undertaken is incorporated.

Design

This study uses a quantitative method to address the two research questions outlined in the introduction. Quantitative research methods are described as the analysis of a set of numerical approaches to aid the explanation of phenomena (Aliaga & Gunderson, 2005). In order to establish the relationship between authentic leadership and workplace wellbeing amongst Clinical Psychologist, a correlational design was used. A regression mediation analysis was used to assess whether a Clinical Psychologist's attachment style influences the relationship between their experience of authentic leadership and workplace wellbeing.

The design of this research is cross-sectional as it collects data at one point in time from the same cohort of participants using standardised measures. The advantage of this design is that it allows for a large amount of data to be gathered efficiently. However, it is important to be aware that this approach limits the ability to infer causality. It also does not account for other variables which may be influencing the results of the data and is open to the possibility of common method bias which could impact the validity of the data.

Other research designs were considered and deemed not suitable to answer the outlined research questions. A longitudinal design would have provided an insight into the effect of time on the variables however it was not feasible due to time and resource constraints of the project. An experimental design would have provided the opportunity to establish a cause and effect relationship between the variables. However, this design is very rarely employed in these areas of research due to ethical and conceptual difficulties in manipulating attachment styles and

relationships. Finally, a qualitative design would have provided interesting insights and richer data about the potential link between leadership, attachment and wellbeing amongst Clinical Psychologists working in the NHS. Qualitative methodology is used to gain insight into subjective experiences (Maxwell, 2013). However, this design did not allow for a large amount of data to be collected. In addition, the research questions aimed to test the concepts within the questions as opposed to generating more insight into them. Therefore, investigating using quantitative methods is more appropriate. A quantitative design also allows for data to be collected from a wider group of participants.

Ethical Clearance

Ethical approval was obtained on 21st February 2019 (MREC 18-043). The approval letter is included in the appendices (Appendix A).

Distress

There was no potential risk of harm to those who participated in the research. However, if the study caused any psychological distress contact details for the charitable organisation 'MIND' within the 'information page' of the survey were provided so participants could access support if needed. The information page outlined the aims of the research, the requirements of participating, information about confidentiality and withdrawal and the contact details of the lead researchers and supervisors. Provision of this information enabled potential participants to provide informed consent if they chose to take part in the research.

Confidentiality

Participants who completed the survey were assured that the information they provided was anonymous as it asked for no identifiable information. This guaranteed confidentiality throughout the whole research process. Collected data was stored on 'Online Surveys', a secure server, and then download onto Statistical Package for Social Sciences (SPSS). This document was saved and stored onto the University drive which only the main researcher had access to.

Participants

In total, data from 210 participants were collected. Field (2009) suggested that between 25 to 30 participants per variable for a regression analysis to have statistical power. Therefore data from a minimum of 120 participants were needed.

Participants were qualified Clinical Psychologists who work within the NHS. No specific information about any NHS Trusts was collected as part of this research. Participants were recruited through social media, as the study was advertised on the Facebook Group 'UK based Clinical Psychologists Facebook Group'. Clinical Psychologists provided their HCPC registered name and number to qualify for group membership. The provided HCPC name and number is checked by the moderators of the group. This allowed for data to be collected from Clinical Psychologists employed in the NHS throughout the UK.

Participant inclusion criteria asked that potential participants:

- had completed the DClinPsych professional qualification;
- were employed as a Clinical Psychologist working in the NHS;
- were able to identify an individual at work who they described as a leader about whom they can answer relevant questions

In total, 210 participants completed the online survey. Data from three participants were removed due to the provision of unclear and incomplete information. The demographic information collected about the participants is presented in the results section.

Measures

An online survey (Appendix B) was created through 'Online Surveys'. The first page of the survey asked participants to provide demographic information. This included:

- ethnicity
- information regarding years employed as a Clinical Psychologist post-qualification
- area of clinical work

- what profession their identified leader held
- their relationship to their leader

These questions were asked in order to gain an insight into how long and where these Psychologists worked and who is leading the Clinical Psychologists in the NHS.

The psychometric measures discussed below were collected to assess perceived authentic leadership, attachment style at work and workplace wellbeing. Consent was sought and gained through email contact with the authors of all the measures. All authors provided consent for their measure to be used in this research.

Authentic Leadership Inventory (Neider & Schriesheim, 2011)

This questionnaire measures the frequency of authentic leadership behaviours which are exhibited by the respondent's leaders. The questionnaire consists of 14 items which consist of the following subscales: self-awareness, relational transparency, internalised moral perspective and balanced processing. Responses are rated on a Likert scale of: (1) Disagree strongly; (2) Disagree; (3) Neither Agree nor Disagree; (4) Agree; and (5) Agree strongly. The higher the total score, the more authentic leadership behaviours are exhibited and experienced by the respondent. The ALI was established as a valid and reliable measure with all 4 subscales having Cronbach Alpha scores ranging from 0.74-0.85 (Neider & Schriesheim).

Psychological Practitioner Workplace Wellbeing Measure (Summer, Morris & Bhutani, 2020)

This questionnaire measures psychological practitioner's wellbeing at work. The measure consists of 26 statements related to workplace wellbeing and the respondent is asked to what extent they agree or disagree with each statement using a Likert scale: (1) strongly agree, (2) agreed, (3) neither agree or disagree, (4) disagreed and (5) strongly disagree. The higher the total score, the better the respondent's wellbeing is at work. Cronbach's alpha scores indicated high internal consistency of the measure, 0.92, establishing the questionnaire as a reliable

measure of workplace wellbeing for psychological practitioners (Summer, Morris & Bhutani).

Short Workplace Attachment Measure (Leiter, Price, & Day, 2013)

This questionnaire measures a respondent's attachment style at work as a continuous dimension. It comprises of 10 statements and the respondent is asked to rate each statement on a Likert scale of how much it represents them: (1) Not at all like me, (2) Not like me, (3) Unsure, (4) Like me and (5) Very much like me. The questionnaire measures two subscales of attachment style: attachment anxiety and attachment avoidance. Both subscales have reported Cronbach Alpha scores of above 0.7 (attachment anxiety: 0.775 and attachment avoidance: 0.783).

Table 7

An overview of measures used

Variable	*Measure*	*Function*	*Description*
Authentic Leadership	Authentic Leadership Inventory (ALI)	A measure of follower perceived authentic leadership	Followers were asked to rate the frequency of authentic leadership behaviours exhibited by the leader on a 5-point Likert-type scale, using anchors ranging from never to almost always.
Attachment Style at work	Short Workplace Attachment Measure (SWAM)	A measure attachment style in workplace relationships	10-item scale measuring attachment as a continuous dimension. Respondents rate 10 statements on a scale of 1 to 5 which represents who much the statement is like them

Workplace Wellbeing	Psychological Practitioner Workplace Wellbeing Measure (PPWWM)	A measure of workplace wellbeing	26 statements about workplace wellbeing. Scored on a scale of strongly agree to strongly disagree

Procedure

The lead researcher was responsible for advertising the study on social media. The advertisement contained a link to the study where information about the research was provided (*Appendix B*). The study was advertised from April 2019 to September 2019. This allowed for a substantial period of time for the appropriate number of participants to be recruited. In this time the study was repeatedly advertised within the Facebook Group in order to encourage completion.

The first page of the survey asked that participants provided demographic information. This included: age, gender, ethnicity, length of time qualified, relationship to their leader, the job role of their leader, NHS employment. This allowed for the collection of descriptive statistics about the population. Following this, participants were asked to complete the outlined questionnaires measuring leadership, attachment and workplace wellbeing. When participants completed the series of questionnaires and submitted their responses, the final page of the online survey thanked them for their participation, provided them with contact details of the lead researcher and research supervisors if they had any questions and contact information for the mental health charity MIND in case the study had caused them any unintended distress (*Appendix B*). Data collection took place was completed prior to the COVID-19 pandemic and therefore did not influence the results and participants responses.

Participant feedback

Overall, the response to the research project on social media was positive. A total of 15 people got in touch with the lead researcher through social media and email in order to request a summary of the research findings when the research was complete. The leader researcher retained a list of these individuals and their contact details to disseminate a summary of the findings. This list was stored on the University M Drive to maintain confidentiality.

Analysis

Statistical analysis was conducted using SPSS 23.0 IBM software program. In order to address the research question regarding the relationship between authentic leadership and workplace wellbeing amongst Clinical Psychologists working in the NHS, inferential statistics were produced from the data using standardised measures and analysed using a correlational analysis. In order to address the second research question regarding the mediation of attachment style on the relationship of authentic leadership and workplace wellbeing, a regression mediation analysis was conducted to assess the mediating strength of attachment.

Results

The analysis assessed whether there was a relationship between authentic leadership and workplace wellbeing for clinical psychologists working in the NHS and whether this relationship was mediated by the variable of attachment style (avoidance and anxiety).

Assumptions

Prior to the analysis, the data were checked to ensure they met assumptions for normality, linearity, representation and quality of variance. Distribution for kurtosis and skewness were also checked and the results are presented within this section.

Participant characteristics

In total, 207 participants fully completed the survey. Three data points were removed from the data set as unclear answers were provided. Table 8 shows that 73% of participants completed the survey in full. Participant withdrawal occurred at various stages throughout the survey, consequently, the attrition rate was 27%.

Table 8

An overview of participant response rate throughout completion of the survey

Page	P1 Information	P2 Demographic Info	P3 ALI	P4 PPWWM	P5 SWAM	P6 Final page
Frequency	288	19	40	12	7	210

Gender

The majority of participants were female (93.2%). Only 6.3% were male and 1 (0.5%) participant stated they would prefer not to disclose their gender (Table 9).

Table 9

An overview of participant's gender

Gender	Frequency	Percentage
Males	13	6.3
Females	193	93.2
Prefer not to say	1	0.5
Total	207	100

Age

Table 9 indicates that the participant's age ranged between 24-64 years old (mean 39 years 4months, SD 7.1 years). The graph below illustrates that the participants' age was normally distributed (Figure 1).

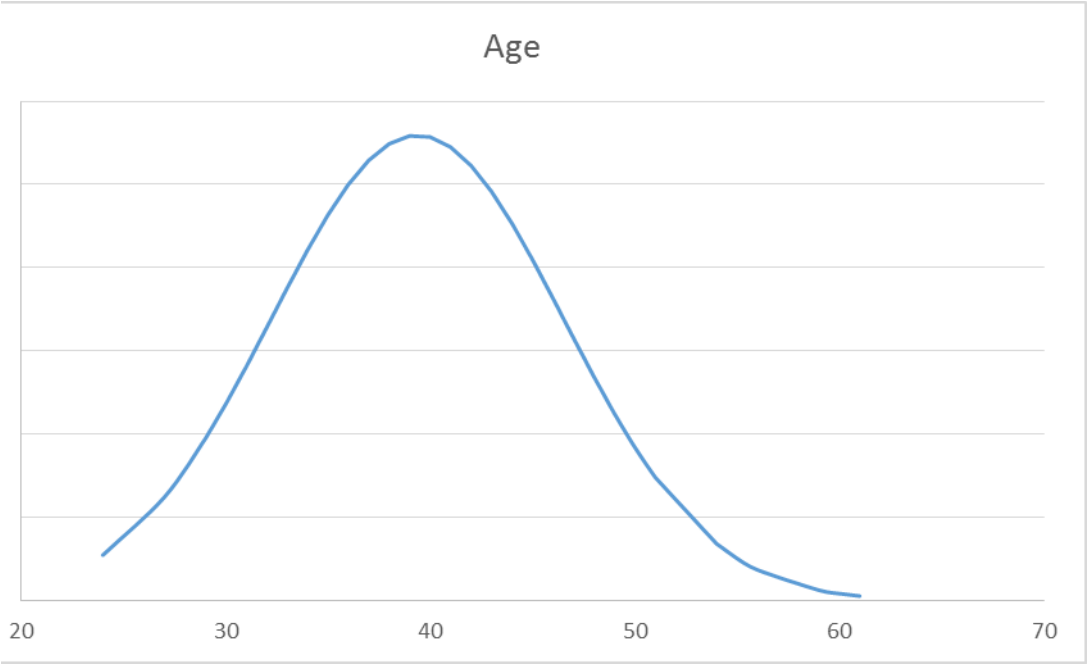

Figure 1. Distribution of participants' age

Ethnicity

Table 10 and figure 2 illustrates that the majority of participants identified as white British/ Welsh/ Irish/ Scottish (92.7%). Followed by 3.4% of participants identifying as 'White Other' which comprised mostly of European countries.

Table 10

An overview of participants' identified ethnicity

Ethnicity	Frequency	Percentage
White British / White Welsh / White Irish / White Scottish	192	92.7
(Other) White Other (European, African)	7	3.4
Black / African / Caribbean / Black British / Black mixed	1	0.5
Asian / Asian British / Asian Indian / Asian Pakistani / Asian Bangladeshi / Asian	5	2.4
Prefer not to say	2	1
Total	207	100

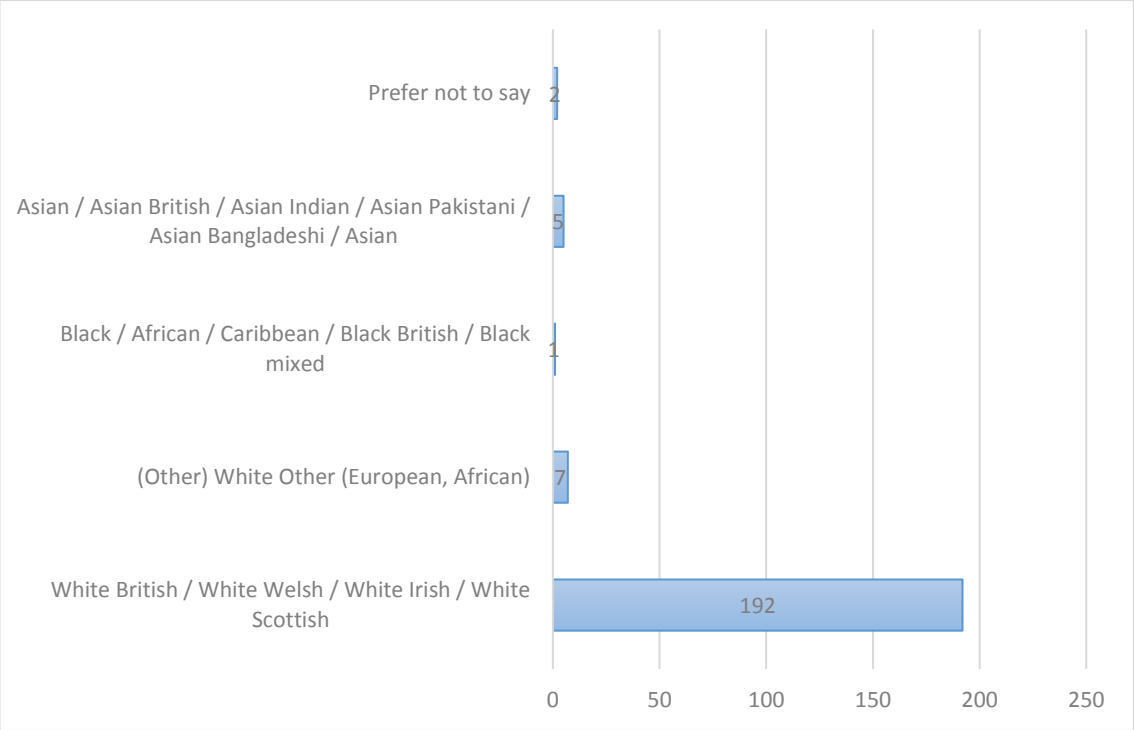

Figure 2. An overview of participants' identified ethnicity

Length of qualification

The analysis showed that on average participants had been qualified as a clinical psychologist for 9.3 years. Qualification length ranged from 0.5-33 years (Figure 3).

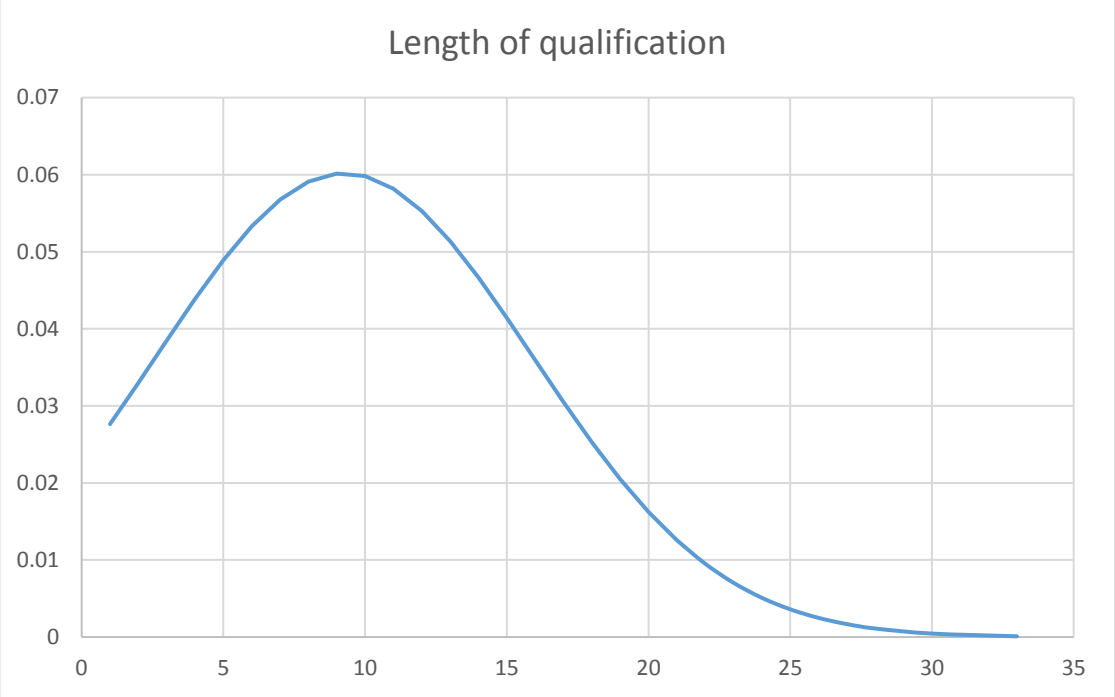

Figure 3. Distribution of the length of time that participants have been qualified as Clinical Psychologist

Clinical Area

Table 11 illustrates the participants who completed the survey worked within a variety of clinical areas. The most common clinical areas were Adult Mental Health (AMH) - Secondary Care (25.6%), CAMHS (20.3%) and Older Adults (9.7%). The least common clinical areas which participants work in were head of service role (1.5%, n=3), Occupational Health (1.5%, n=3) and Adult Mental Health (AMH) - Primary Care (2%, n=4).

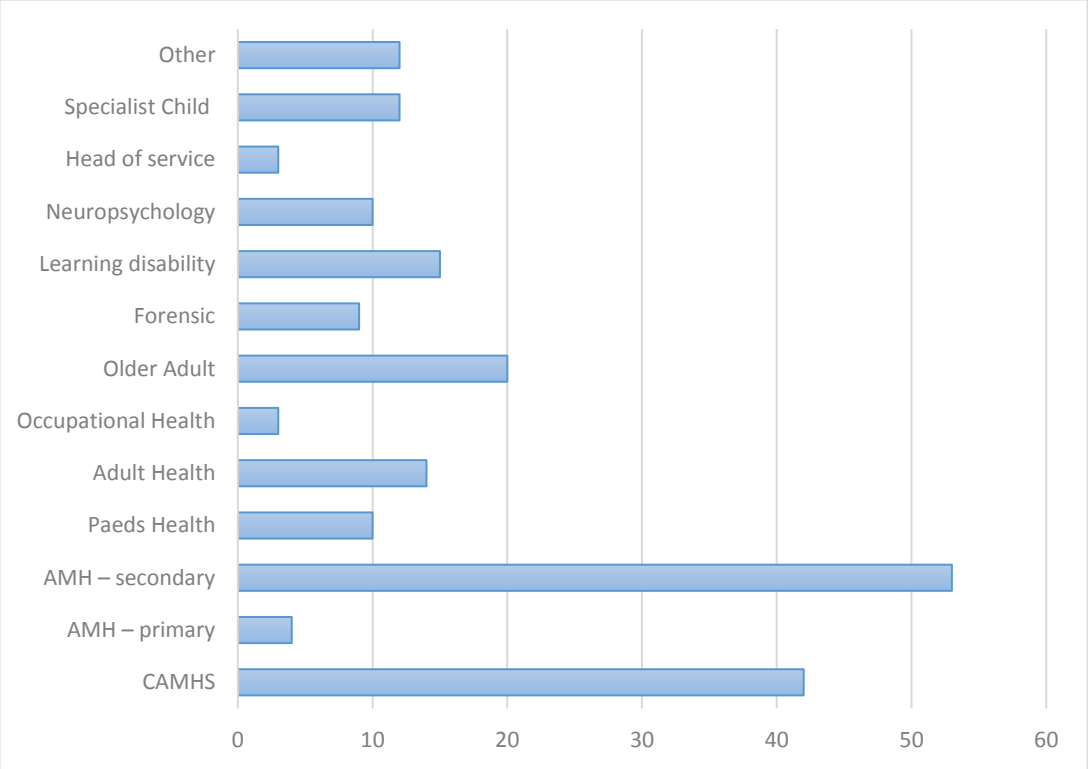

Figure 4. Frequency of Clinical Psychologists working in various clinical areas

Table 11

Frequency of Clinical Psychologists working in the listed clinical areas

Clinical Area	Frequency	Percentage
AMH – secondary	53	25.6
CAMHS	42	20.3
Older Adult	20	9.7
Learning disability	15	7.2
Adult Health	14	6.8
Specialist Child	12	5.8
Other	12	5.8
Paediatric Health	10	4.8
Neuropsychology	10	4.8
Forensic	9	4.3
AMH – primary	4	2
Occupational Health	3	1.5
Head of service	3	1.4
Total	207	100

Profession of Leader

Table 12 and figure 5 shows that the most common profession of participants' identified leaders was Clinical Psychologist (70%). The second most common role was Nurse (16.3%).

Table 12

Professions of participants identified leaders

Profession of Leader	Frequency	Percentage
Clinical Psychologist	144	70
Nurse	34	16.3
Management	9	4.3
Social Worker	6	2.7
Medic	5	2.3
Other	4	2
Family Therapist	3	1.4
Speech and Language Therapist	2	1
Occupational Therapist	0	0
Total	207	100

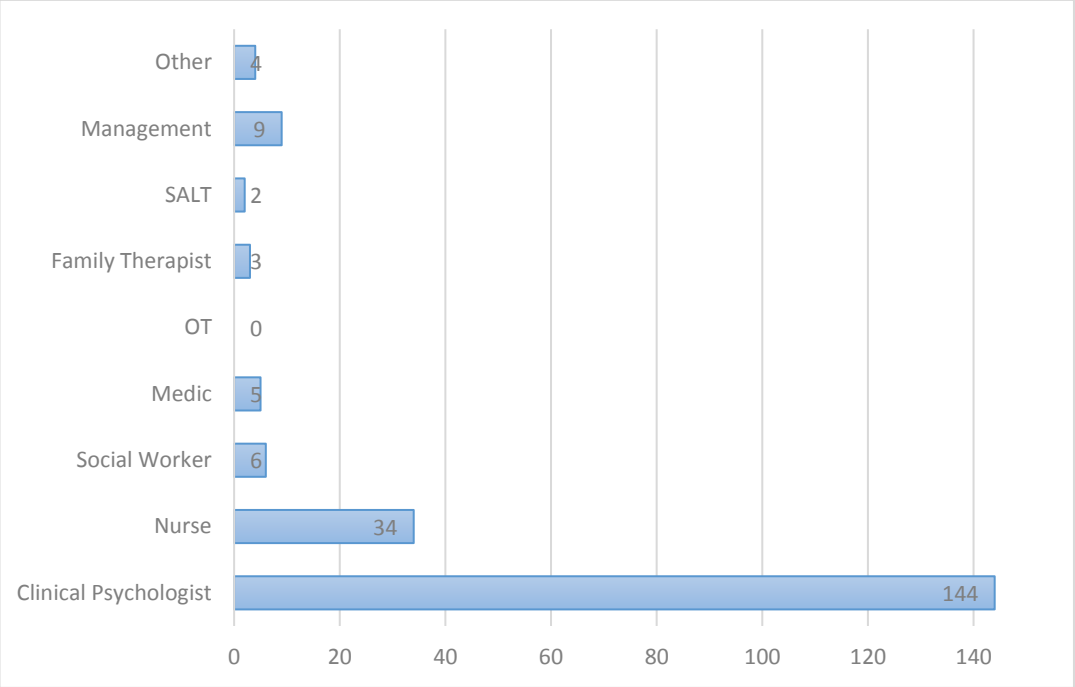

Figure 5. Frequencies of professions of identified leaders

The data illustrated that the leaders identified held various and multiple roles whilst acting as a leader. These roles include: clinical supervisor, line management, clinical lead and team leader. Leaders were identified as having either one of these roles or as having a combination of them.

Over half of participants (54%) identified that their leader had one role in relationship to themselves at work. Whereas, 46% of participants saw their leader as having multiple roles; 28% of identified leaders had two roles, 12% had three roles and 6% had four roles. This illustrates that those acting as a leader in the NHS take on multiple roles.

Table 13

Numbers of roles undertaken by identified leaders

Number of roles	Frequency	Percentage
One	111	53.62
Two	59	28.51
Three	24	11.58
Four	13	6.29

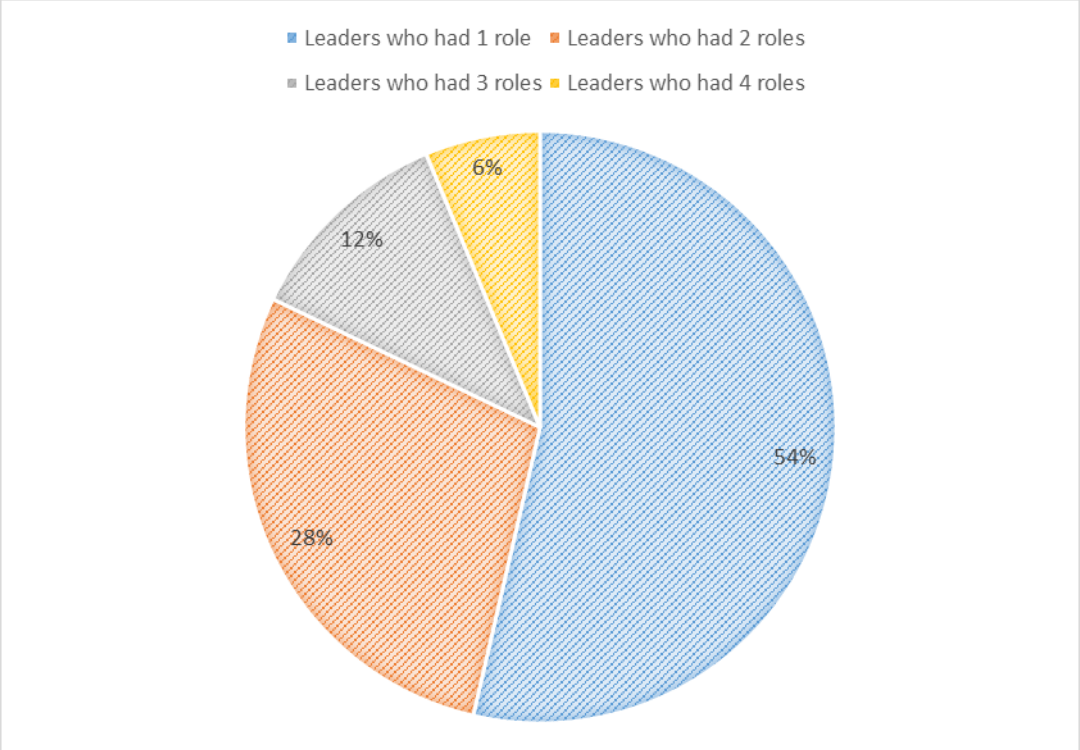

Figure 6. Numbers of roles undertaken by identified leaders

The most common role of the leaders identified by participants was Line Manager (22.22%), followed by Clinical Supervisor (10.15%) and 9.27% of leaders had joint line management and supervisory roles.

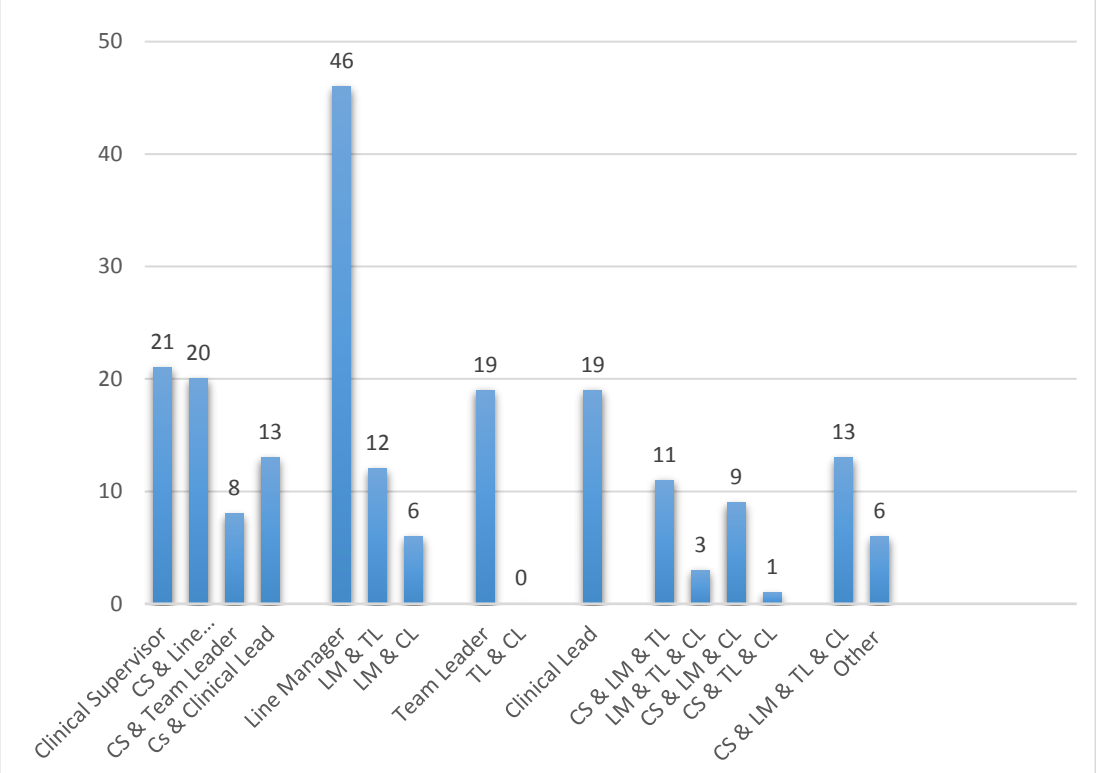

Figure 7. Combinations of roles undertaken by identified leaders

Over half of those identified as leaders in this study held line management responsibility (58%, n=120). Therefore, 42% (n=87) did not have line management responsibilities and were in supervisory, team leader, and clinical leader roles.

Line management and clinical supervisor were the most prominent roles identified. 21% of leaders had supervisory responsibilities (21%, n=43), 32% held line management responsibilities and in total 26% (n=53) filled roles which held both supervisory and line management responsibilities. This may have implications as participants are being led by those who support them.

Clinical Psychologists as leaders

As discussed earlier, the majority of participants identified their leader's job role as a Clinical Psychologist (70%) (Table 14; Figure 8). Whereas 30% of participants classified their identified leader within a non-psychological job role. This illustrates that the majority of clinical psychologists (70%), who participated in this research, identified as being led by other clinical psychologists. Therefore, this data set has been analysed separately to explore the roles and responsibilities of Clinical Psychologists acting as leaders in the NHS.

Table 14

Psychological and Non-psychological professions of leaders

Profession of leader	Frequency	Percentage
Clinical Psychologist	144	70
Non psychologist	63	30
Total	207	100

The most common role of Clinical Psychologists acting as leaders was Line Manager (15.3%, n=22), followed by Clinical supervisor (14.6%, n=21) and 13.9% (n=20) of leaders had dual line management and supervisory roles. 43.75% of participants identified that their leader had one role in relationship to themselves at work. Over half of the Clinical Psychologists filling leadership roles, who were identified in this study, held line management responsibility (59.7%, n=86). Therefore, 40.3% (n=58) did not have line management responsibilities and were in supervisory, team leader, and clinical leader roles. Over half (56.25%) of participants viewed their leader, who was a clinical psychologist, as having multiple roles. This illustrates that Clinical Psychologists in the NHS who are fulfilling leadership role have multiple responsibilities. Overall 26.4% of Clinical Psychologists acting as leaders had

supervisory responsibilities (n=38), 25% had line management responsibilities and 34.7 % (n=50) had both supervisory and line management responsibilities. Similar to the whole sample, line management and clinical supervisor were the most prominent roles identified.

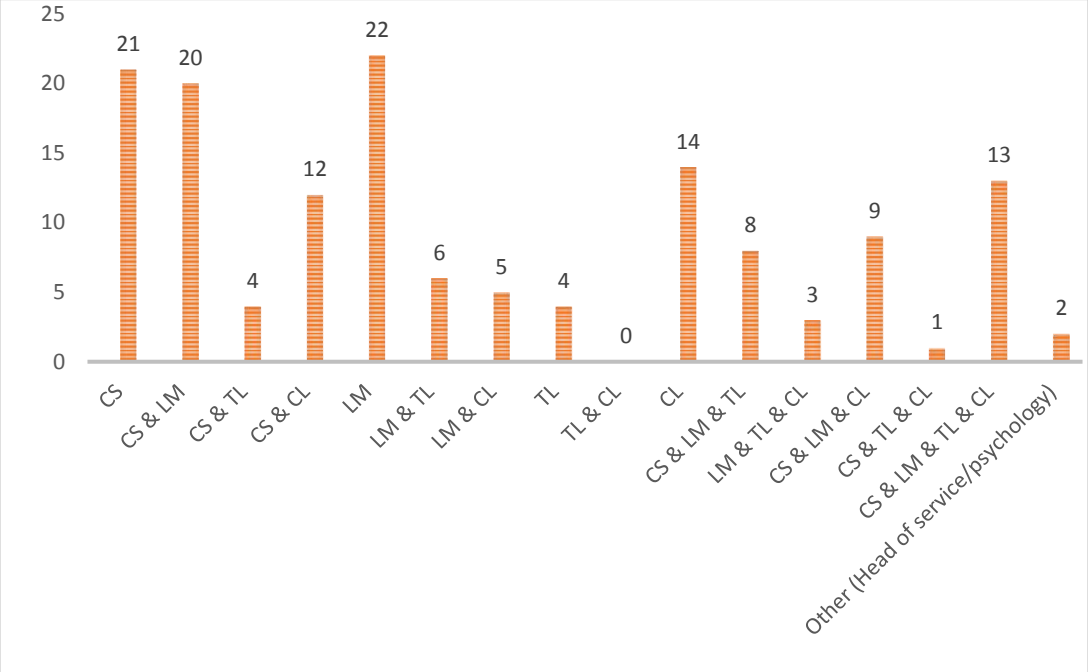

Figure 8. Combinations of roles undertaken by Clinical Psychologist in leadership positions

Table 15

Number of roles undertaken by Clinical Psychologist in leadership positions

Number of roles	Frequency	Percentage
One	63	43.75
Two	47	32.64
Three	21	14.58
Four	13	9.03

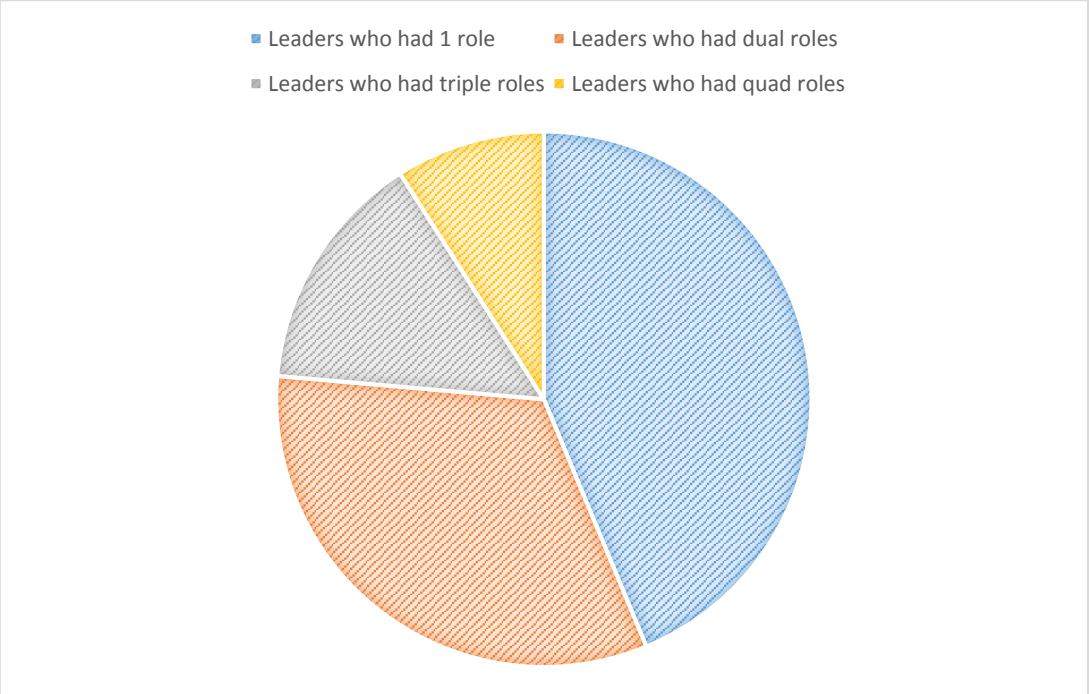

Figure 9. Roles undertaken by Clinical Psychologist in leadership positions

Authentic Leadership Inventory (ALI)

The mean score produced from the ALI data was 3.89 (*SD* = 0.75). This was similar to the findings in the measures original paper (*M* = 3.11, *SD* = 0.57). The main sample ALI scores were normally distributed, with skewness of -0.44 (*SE* = 0.17) and kurtosis of -0.18 (*SE* = 0.34). The histogram (Figure 10) below visually demonstrates that the data set is normally distributed.

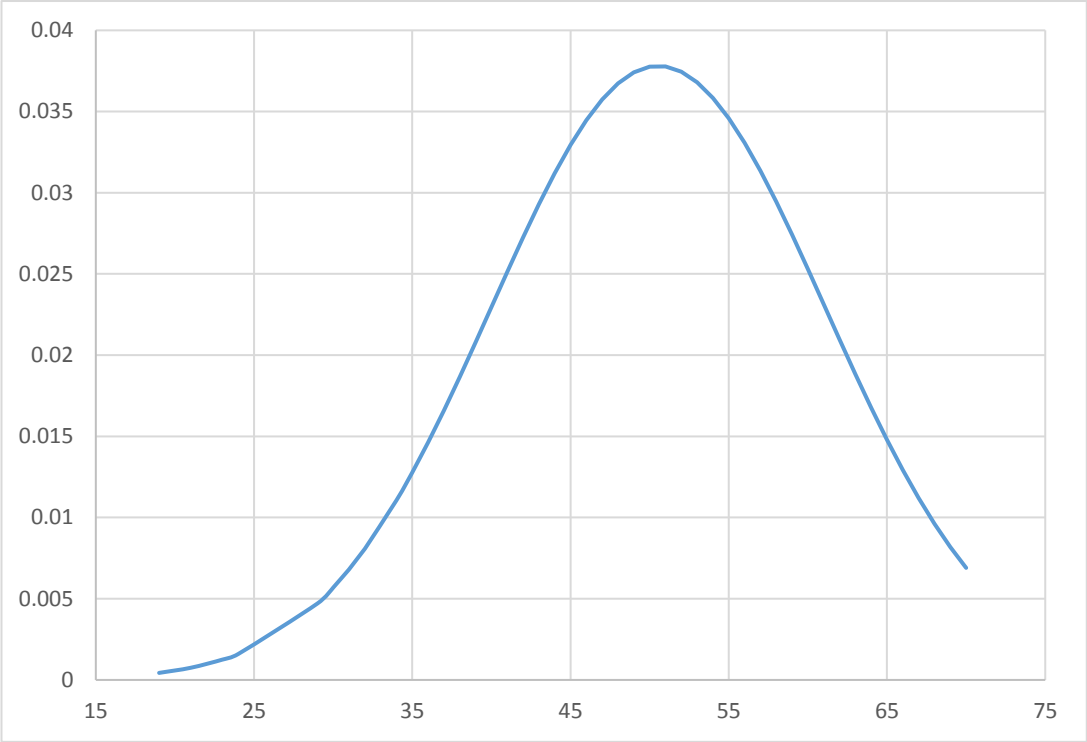

Figure 10. Distribution of ALI data

Psychological Professions Workplace Wellbeing Measure (PPWWM)

The mean score produced from the PPWWM data was 91 (*SD* = 9.46). This was similar to the findings in the measures original paper (*M* = 94.56, *SD* = 18.43). The PPWWM data collected from the sample was normally distributed, with skewness of -0.24 (*SE* = 0.17) and kurtosis of 0.47 (*SE* = 0.34). The histogram (Figure 10) below visually demonstrates that the data set is normally distributed.

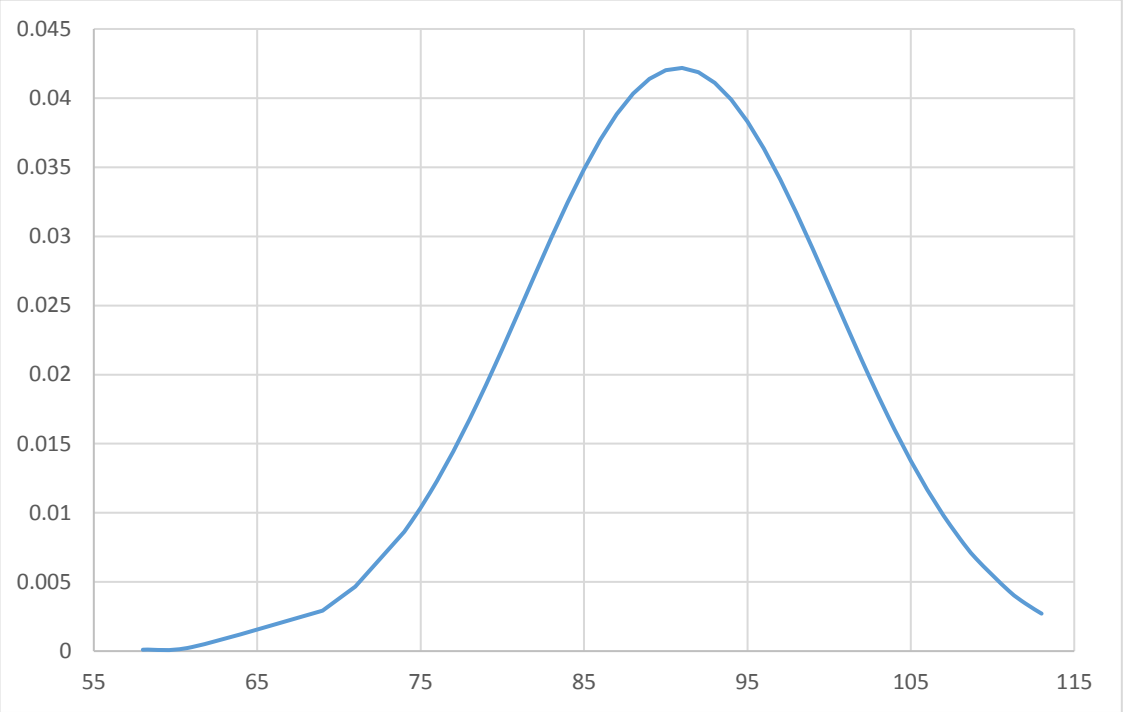

Figure 11. Distribution of PPWWM data

Short Workplace Attachment Measure (SWAM)

The mean score produced from the SWAM anxiety subscale data was 2.28 (*SD* = 0.63). The mean score produced from the SWAM avoidance subscale data was 3.2 (*SD* = 0.44). This was similar to the findings in the measures original paper (anxiety subscale *M* = 1.98, *SD* = 0.75; avoidance subscale *M* = 2.94, *SD* = 0.85). The SWAM anxiety subscale data were normally distributed, with skewness of 0.18 (*SE* = 0.17) and kurtosis of 0.09 (*SE* = 0.34). The histogram (Figure 11) below visually demonstrates that the data set is normally distributed. The SWAM avoidance subscale data were normally distributed, the skewness of -0.15 (*SE* = 0.17) and kurtosis of -0.33 (*SE* = 0.34). The histogram (Figure 12) below visually demonstrates that the data set is normally distributed.

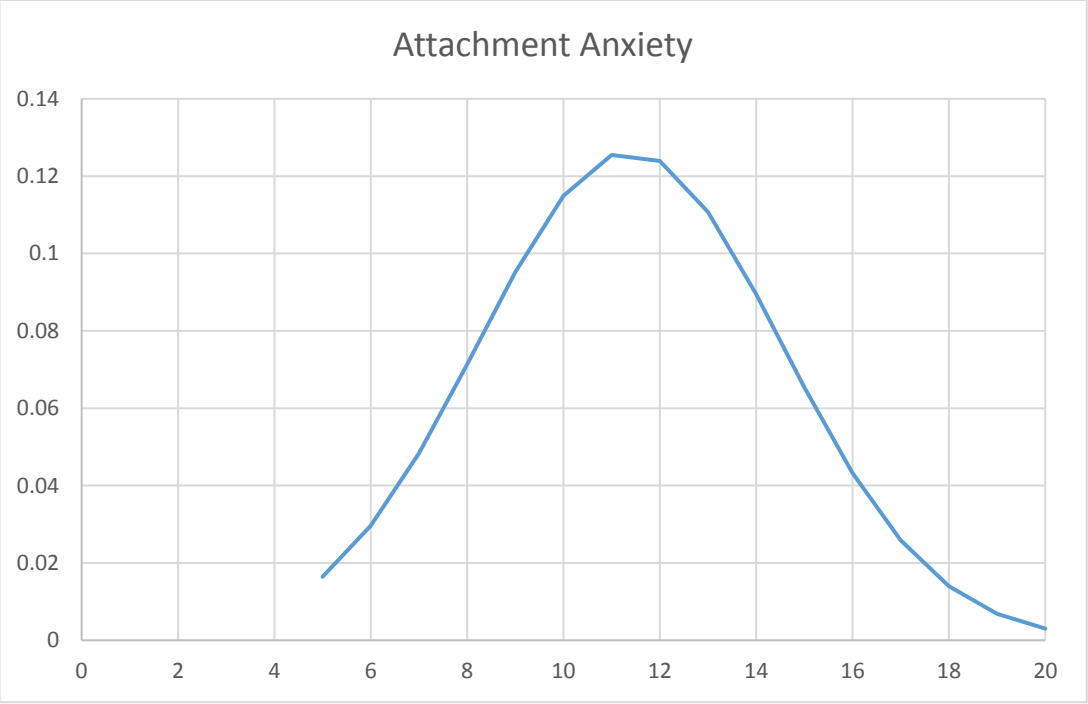

Figure 12. Distribution of data from the attachment anxiety sub scale

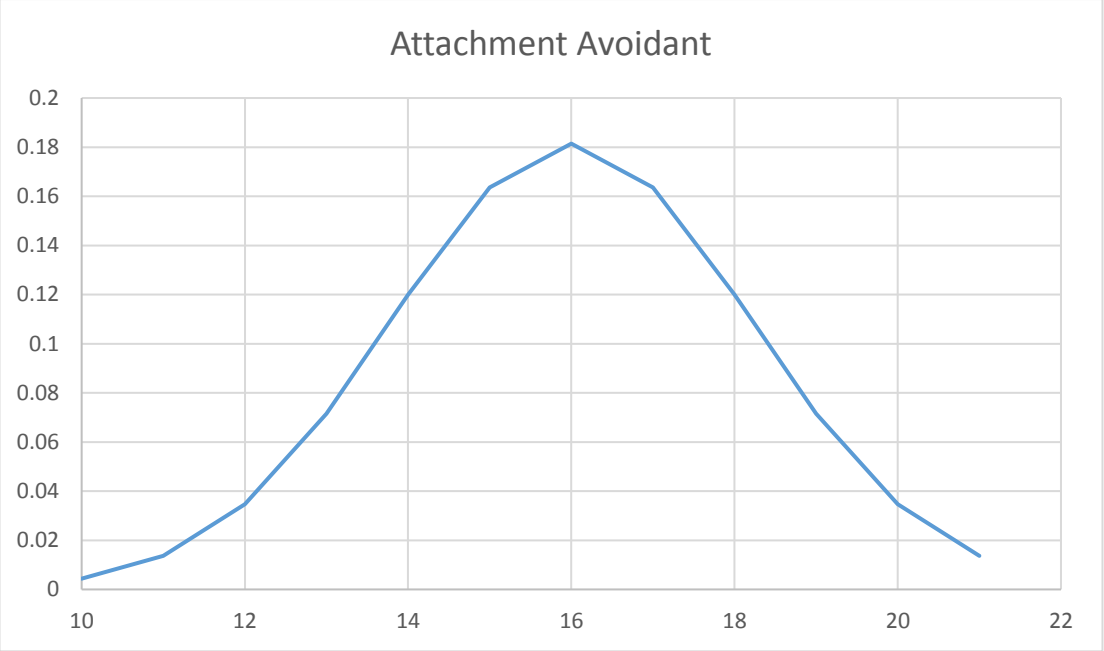

Figure 13. Distribution of data from the attachment avoidance sub scale

Correlational Analysis

In order to address the first research question; to explore the relationship between authentic leadership and workplace wellbeing for clinical psychologists working in the NHS, a correlational analysis was conducted. Spearman's Rho correlation test was used as the ALI, PPWWM and SWAM produced a mix of parametric and non-parametric data.

Table 22 outlines the correlational relationships between AL, WW and attachment style. Table 22 shows a significant positive correlation between AL and WW ($r = 0.53$, $p < 0.001$). This implies that authentic leadership is significantly associated with a follower's wellbeing at work. In addition, the analysis illustrates a significant but small negative correlation between anxious attachment style ($r = -0.176$, $p < 0.011$) and workplace wellbeing ($r = -0.283$, $p < 0.001$). This suggests that authentic leadership correlates with reduced attachment anxiety in the workplace. The analysis also shows a significant but weak positive correlation between avoidance attachment style ($r = 0.193$ $p < 0.005$) and workplace wellbeing ($r = 0.204$, $p < 0.003$). Whereas, the analyses illustrates that attachment avoidance positively correlates with workplace wellbeing ($r = 0.204$, $p < 0.003$). This suggests

that those with attachment avoidant traits have a slight tendency towards better workplace wellbeing.

Table 17

Correlational matrix for all variables

	Authentic Leadership	Psychological Practitioner Workshop Wellbeing	SWAM attachment anxiety	SWAM attachment avoidance
Authentic Leadership	1	0.53*	-0.176*	0.193**
Psychological Practitioner Workplace Wellbeing	0.53**	1	-0.283**	0.204**

*Note. * values significant with respect to a p-value of 0.05. ** values significant with respect to p-value of 0.01*

Attachment style as a mediator

In order to address the second research question; to explore whether attachment style mediates the relationship between authentic leadership and workplace wellbeing for clinical psychologists working in the NHS, a mediation analysis was conducted. Two separate analyses were conducted to assess the mediation effect of the two different attachment styles (anxious and avoidant). A series of regressions were conducted to assess the extent of the mediation. Hayes' (2013) PROCESS macro was installed in SPSS. This allowed for calculations of indirect effects based on bootstrapped samples. 10,000 bootstrapped samples were used to assess any indirect effects.

Attachment Anxiety

The regression of authentic leadership on workplace wellbeing, ignoring the mediator, was significant, b = 0.48, $t(204)$ = 9.5, $p<0.01$. The regression of authentic leadership on the mediator attachment anxiety was also significant, b = -0.044, $t(205)$ = -2.12, $p = 0.03$. The regression of the mediator attachment anxiety on the outcome of workplace wellbeing was significant, b = -0.63, $t(204)$ = -3.74, $p<0.01$. The results also showed attachment anxiety has a significant indirect effect on the predictor of authentic leadership on the outcome of workplace wellbeing, indirect = 0.0277, SE = 0.14 , 95% CI[0.003, 0.05] (Figure 14).

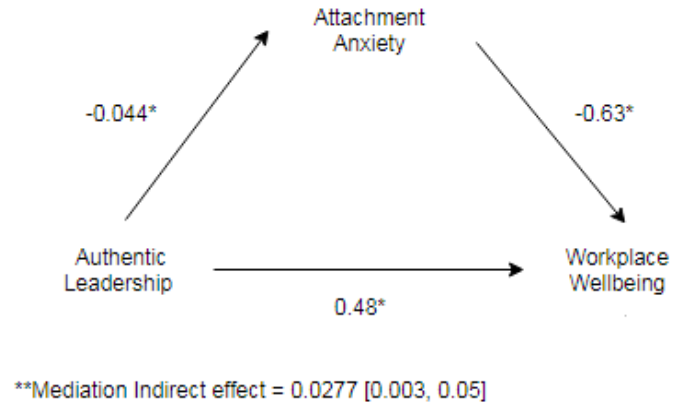

Figure 14. Mediation diagram for the mediating effect of attachment anxiety

Attachment Avoidance

The regression of authentic leadership on workplace wellbeing, ignoring the mediator, was significant, *b* = 0.495, *t*(204) = 9.43, *p<0.01.* The regression of authentic leadership on the mediator attachment avoidance was not significant, *b* = 0.04, *t*(205) = 2.84, *p = 0.12*. The regression of the mediator attachment avoidance on the outcome of workplace wellbeing was also not significant, *b* = 0.33, *t*(204) = 1.3, *p = 1.19.* The results showed attachment avoidance does not have a significant indirect effect on the predictor of authentic leadership and the outcome of workplace wellbeing, indirect = 0.0133, *SE* = 0.014 , 95% CI[-0.0115, 0.0428] (Figure 15).

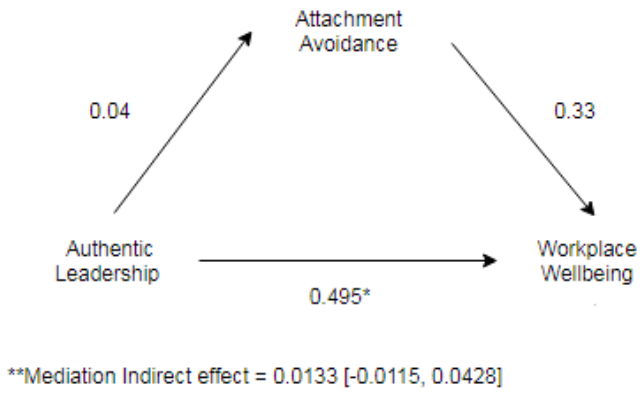

Figure 15. Mediation diagram for the mediating effect of attachment avoidance

Discussion

Within this section, the aims of the research will be outlined and followed by a summary of the results. The majority of this discussion will address the research findings in relation to the wider literature. A description of the strengths and limitations will also be outlined followed by considerations of clinical implications and potential directions for future research.

Research questions addressed

The following questions were proposed:

- Question 1: What is the relationship between authentic leadership and workplace wellbeing for Clinical Psychologists working in the NHS?

The first research question was designed to establish if having an authentic leader at work is associated with the workplace wellbeing amongst Clinical Psychologists working in the NHS. This was answered through the collection of standardised measures to quantify whether NHS Clinical Psychologists experienced their leaders as authentic and if this influenced their workplace wellbeing. The measures used were the Authentic Leadership Inventory (ALI) and Psychological Practitioner Workplace Wellbeing Measure (PPWWM). The data collected by both the ALI and PPWWM were analysed together to explore the relationship between authentic leadership and workplace wellbeing. Correlational analysis showed a significant moderate positive correlation between authentic leadership and workplace wellbeing. This suggests that there is an association between experiencing an identified leader as authentic and reported better workplace wellbeing.

- Question 2: Does attachment insecurity mediate the relationship between authentic leadership and workplace wellbeing for Clinical Psychologists working in the NHS?

The second research question was designed to establish whether either an anxious or avoidant attachment style mediated the relationship between authentic

leadership and workplace wellbeing. Participants' attachment style at work was measured using the Short Workplace Attachment Measure (SWAM). The relationships between the three variables of authentic leadership, workplace wellbeing and attachment style were explored using mediation analysis. Results showed a significant indirect effect of attachment anxiety on the relationship between authentic leadership on workplace wellbeing for Clinical Psychologists working in the NHS. The results also highlighted that attachment avoidance did not have a significant indirect effect on the relationship between authentic leadership and workplace wellbeing for Clinical Psychologists working in the NHS.

Main research findings

Representativeness of sample

The following section will discuss the main findings in relation to the wider literature and answer the research questions accordingly.

Below is a summary of the main characteristics of the sample:

- The majority of participants were female (93.2%). Only 6.3% of the sample were male.
- The participants' age ranged from 24 to 64 years old.
- The majority of participants identified as white British/ Welsh/ Irish/ Scottish (92.7%).
- On average participants had been qualified as a clinical psychologist for 9.3 years. Qualification length ranged from 0.5-33 years.
- Participants identified working in a range of clinical areas. The most common clinical areas were Adult Mental Health (AMH) - Secondary Care (25.6%), CAMHS (20.3%) and Older Adults (9.7%).

As discussed previously, data regarding the demographics of Clinical Psychologists working in the UK were obtained from the Health Care Professions Council (HCPC) at the beginning of data analysis. This data was originally sourced through the BPS who collects demographic data on Clinical Psychologists registered with the HCPC for an annual report. This included data on the age range and identified gender of

Psychologists registered with the HCPC. Further information, including ethnicity, length of qualification and more detail information regarding age was requested to compare the sample to the wider population of Clinical Psychologists. However, the HCPC was unable to provide any further information as the organisation only records ethnicity voluntarily which is not linked to regulation types so is unable to report on the data; length of qualification and context of practice is also not recorded and therefore could not be accessed. The information that was obtained showed that there are a total of 13,460 Clinical Psychologists registered with the HCPC and that 80% of Clinical Psychologists were female and 20% were male (BPS, 2019). Data also showed that age ranged from 20 to 69 years old; with most psychologists falling into the age brackets of 35-39 and 40-44 and the frequency of psychologists registered with HCPC declined after 50 years of age (BPS, 2019). Similar age and gender patterns are also shown in our sample. This indicates, that with regards to the information available, our sample is fairly representative of Clinical Psychologists as a whole. However, it is important to acknowledge that the demographics of Clinical Psychologists are not representative of the general population due to the over-representation of British females. This means that the generabilisability of these findings are limited outside of the Clinical Psychology profession. Nevertheless, the findings may have implications for professions with similar demographics, for example, Nursing and Midwifery. In addition, this research measured traits of insecure anxious and insecure avoidant attachment styles as opposed to diagnosing categorical attachment states. Therefore, it is difficult to comment on the how representative the sample is in relation to attachment as categorical attachment states were not measured.

Main research findings

Profession and roles of leader

Below is a summary of the main findings regarding who participants identified as their leader at work, what profession these leaders held and what roles and responsibilities they had.

- The most common profession of participants' identified leader was a Clinical Psychologist (70%). The second most common role was 'Nurse' (16.3%).
- Over half of participants (54%) identified that their leader had one role in relation to them. However, 46% of participants saw their leader as having multiple roles
- The most common role of the leaders identified by participants was 'line manager' (22.22%), followed by 'Clinical supervisor' (10.15%) and 9.27% of leaders had joint line management and supervisory roles.
- The most common role of a Clinical Psychologists acting as leaders was 'Line Manager' (15.3%), followed by 'Clinical supervisor' (14.6%) and 13.9% of leaders had dual line management and supervisory roles

The results suggest that those acting as leaders within the NHS are taking on multiple roles and responsibilities. This could be argued as inevitable due to the demanding and under-resourced nature of working in the NHS. However, it could be argued that there is a potential for conflicting power dynamics for leaders who hold management responsibilities. Similarly for leaders who hold both supervisory and line management responsibilities as individuals are being led by those who support them.

The role of a clinical supervisor is to provide a safe and confidential space so a supervisee can have reflective and open discussions about their clinical work to develop personally and professionally (CQC, 2013). The BPS clinical supervision guidelines (2014) discusses the inherent power imbalance that exists between a supervisor and supervisee. The supervisor typically has specialised knowledge and is usually senior in some way to the supervisee thus creating the power imbalance (BPS, 2014). Line management and leadership roles are also distinctive and separate from each other. Vecchio (2007) argued that line management is the management of complexity and requires order and consistency to manage the day to day functioning of an organisation/service. Vecchio also proposed that leaders cope with change and transformation of organisations/services which is necessary to survive and evolve in the current climate. NHS Leadership Academy (2016) also outlined the responsibilities of line managers as managing the day to day

operations and quality of service provision whilst also performance managing employees. Line management holds an employee accountable for their workplace performance and competence which naturally creates a power imbalance. Whereas, Vecchio also proposed that leaders cope with change and transformation of organisations/services which is necessary to survive and evolve. The role of a leader also causes an imbalance of power as the follower is expected to follow the leader in the evolution and change of the organisation/service.

As evident from the descriptions, there are natural power imbalances between the relationships of leader and follower, supervisor and supervisee and line manager and employee. As discussed, the results indicate that NHS clinical psychologists view their leaders as having multiple roles which include a combination of these three relationships. This has the potential to heighten these power imbalances as leaders are also providing clinical supervision for their followers or are holding their followers accountable for their workplace performance. The Supervision Alliance Model (Proctor, 2010) is based on the assumption that a supervisee requires a safe and trusting environment to discuss their clinical work openly and transparently. Proctor argued that effective supervision is based on the formation of a co-operative relationship between two colleagues who are unevenly matched in experience and age but who hold the same work-related interests and values. This describes the paradox between the imbalance of power from uneven knowledge and expertise and the need for a mutual working relationship to provide emotional safety for the supervisee. Kennedy, Keaney, Shaldon and Canagaratnam (2018) stressed the significance of the supervisor-supervisee relationship and argued that the effectiveness of supervision is related to the quality of the supervisory relationship. Kennedy et al proposed that the basis of supervision is to engage in a relational process which creates containment and security to enable the supervisee to be vulnerable to share and learn. Again, the need for a safe supervisory relationship creates tension with the inherent power imbalance. Proctor advocated that the safety in the relationship is created by contracting and establishing clear boundaries and parameters in how the supervisee and supervisor will work together. These clear expectations and boundaries aim to reduce the impact of the power imbalance

(Proctor, 2010). Similarly, it could be suggested that as the supervisory relationship develops over time, and a sense of safety and security will foster and develop, this itself has the potential to reduce the negative impact of the power balance.

The findings also demonstrate that the majority of NHS Clinical Psychologists identify being led by other Clinical Psychologists. This provides evidence that Clinical Psychologists are acting as leaders in the NHS. This supports the NWWAP initiative which prompted Clinical Psychologists to embody leadership roles and compliments the argument regarding the suitability of Clinical Psychologists as leaders due to the similar skills required for both clinical practice and leadership (Onyett, 2012). Similar to the whole sample, the most prominent responsibilities that Clinical Psychologists who were identified as leaders held were line management and supervisory. Again, this may have implications as participants are being led by those who support them. The Division of Clinical Psychology policy on supervision (2014) acknowledged that there may be instances when a supervisor may have multiple roles, for example, also be the line manager of the supervisee. The policy identified that dual roles and relationship have the potential to causes issues. The DCP recommended that in such cases all aspects of the different roles and responsibilities within the relationship should be addressed separately to avoid the blurring of lines and to minimise confusion.

Main research findings

Interrelationships between leadership, workplace wellbeing and attachment insecurity

The overall findings from the correlational analysis illustrate:

- A significant positive correlation between authentic leadership and workplace wellbeing *(r = 0.58).*
- A significant but small negative correlation between anxious attachment style and workplace wellbeing *(r = -0.283)*.
- A significant but small positive correlation between avoidance attachment style and workplace wellbeing *(r = 0.204).*

- A small negative correlation between authentic leadership and attachment anxiety *(r = -0.176)*
- Attachment avoidance positively correlated with authentic leadership *(r = 0.193)*.

Leadership and workplace wellbeing

These results indicate that authentic leadership was significantly associated with a follower's wellbeing at work. This may support evidence, discussed in the introduction section, that leadership style can positively influence workplace wellbeing. Munir, Nielsen, Garde et al (2012) found through the collection of quantitative data, which included the measurement of transformational leadership and psychological wellbeing, that there was a positive correlation between leadership and wellbeing which was mediated by work-life conflicts. In addition, Wong et al (2013) also discovered links between authentic leadership, trust and patient outcomes. This evidence supporting the link between relational leadership styles and workplace wellbeing suggests that authentic and relational approaches to leading are beneficial on a follower's wellbeing at work. Spence and Fida (2014) also investigated the relationship between authentic leadership and psychological capital and found that authentic leadership was negatively related to burnout. This supports the argument that relational approaches to leadership, such as authentic leadership, has the capacity to support a follower's psychological capital and wellbeing at work. Relational approaches to leadership have been shown to reduce the potential for burnout as followers feel supported as they promote autonomy, realistic expectations and safe risk taking (Shipton, Armstrong, West & Dawson, 2008). This enables a follower to be the best they can be which in turn has a positive impact on their wellbeing as they feel valued, safe and can reach their potential (West et al, 2017). Relational models, such as authentic leadership, emphases the importance of an honest relationship between leader and follower as it fosters trust and transparency (West et al, 2015). This enables the follower to feel valued and engaged which positively influences their wellbeing (West et al). Relational leadership also allows the leader to be emotionally available. This

promotes good wellbeing as relational leaders are able to meet the emotional needs of and promote wellbeing amongst their followers (NHS England, 2016).

Leadership and attachment insecurity

The correlational results also show that authentic leadership is associated with reduced levels of attachment anxiety in the workplace. These findings are supported by Popper and Mayeless (2003) who hypothesised that leaders who provide security for their followers can provide corrective experiences to aid the formation of more secure relationships and thus reduce attachment anxiety. Hinojosa et al (2014) also argued that leaders who are experienced as authentic and secure can facilitate authentic relationships with followers who have insecure attachment styles. This authentic relationship has the potential to be healing for followers with anxious attachment styles, as the authentic nature of the relationship fosters trust and transparency, which can assist the follower in feeling relationally safe and therefore reduce their anxiety (Hinojosa et al). Rahimnia and Sharifirad (2015) explored the relationship between authentic leadership and attachment insecurity and discovered a negative correlation between the two, suggesting that authentic leadership can reduce a follower's attachment insecurity. The combinations of these findings suggest that if a leader cultivates a secure authentic relationship between themselves and the follower, who is anxiously attached, then this can reduce their attachment anxiety at work. This argument could imply that poor leadership styles can impact follower wellbeing negatively. Davidovitz, Mikulincer, Shaver et al (2007) argued that poor leadership possibly fails to provide a secure environment for a follower which has the potential to impact on their mental health in the long term.

Attachment insecurity and workplace wellbeing

In addition, these correlational findings suggest that attachment anxiety is associated with lower levels of workplace wellbeing. Whereas, those who have avoidant attachment style traits will have better workplace wellbeing. This

indicates that attachment anxiety could potentially exacerbate perceived stress in the workplace and consequently impact on wellbeing.

While attachment avoidance could potentially be protective for some individuals as they may have a tendency to experience less stress at work and therefore greater workplace wellbeing. There is potential that those with an avoidant attachment style are less inclined to be aware of and acknowledge their emotions. Therefore, these individuals may be less likely to report being distressed and therefore appear to have better wellbeing at work.

Rahimnia and Sharifirad (2015) findings also showed a positive relationship between perceived stress and attachment insecurity. This indicates that those with an insecure attachment are more likely to perceive and experience workplace stress which impacts on their wellbeing at work. However, Rahimnia and Sharifirad's study did not explore the difference between the insecure attachment styles of anxious and avoidant as this thesis did. This is supported by the conclusions made by Selcuk and Gillach (2009) who argued that those with insecure attachment styles are more vulnerable to experiencing mental health difficulties. In addition, Mikulincer & Shaver (2007) argued that those with anxious attachment styles are more likely to evaluate worrying situations more intensely and be less resilience when managing stress. Similarly, those with avoidant attachment styles tend to view situations as stressful, however, are more likely to cope independently and not seek help from others. Sumer and Knight (2001) also found that attachment style can influence how an individual experiences their workplace as their results showed that those with anxious attachment styles reported lower rates of satisfaction with their job in some circumstances. This argument is supported by the theory of attachment. An individual with an anxious attachment style is often focused on and fears rejection. This fear causes them to be more cautious and worry about making mistakes and will, therefore, seek reassurance to feel safe. This behaviour pattern is often associated with poor self-esteem and worth and is likely to impact on their satisfaction in life and at work if an individual is anxiously attached in the workplace. If an individual is hyper-aware and sensitive to making mistakes and being rejected they will consequently

experience higher levels of stress and therefore poorer mental health (Selcuk & Gillach, 2009; Mikulincer & Shaver, 2007).

Leadership, attachment insecurity and workplace wellbeing

The findings from the mediation analysis demonstrate that:

- Attachment anxiety significantly indirectly effected the relationship between authentic leadership and workplace wellbeing
- Attachment avoidance did not significantly indirectly effect the relationship between authentic leadership and workplace wellbeing

These findings propose that attachment anxiety indirectly explains the relationship between authentic leadership and workplace wellbeing. This suggests that an authentic leader can positively impact a follower's wellbeing at work if the follower has an anxious attachment style. These results build on from earlier findings of this research which showed that authentic leadership improves attachment anxiety.

However, the results also show that attachment avoidance does not explain the relationship between authentic leadership and workplace wellbeing. Therefore, authentic leadership does not influence a follower's wellbeing if they have an avoidant attachment style. These results build on from earlier findings of this research which showed that authentic leadership does not influence attachment avoidance. In addition, the results also support the relationship found between attachment anxiety and poorer workplace wellbeing and attachment avoidance and better wellbeing. Similar results were found by Rahimnia and Sharifirad (2015). Rahimnia and Sharifirad produced results which showed that attachment insecurity fully mediated the relationship between authentic leadership, perceived stress and stress symptoms; as well as being a partial mediator for the relationship between authentic leadership and job satisfaction. This thesis found similar results, and also explored the impact of the two insecure attachment styles, avoidant and anxious. The results highlighted the different influence of insecure-anxious and insecure-avoidant attachment on workplace wellbeing. This difference was identified by measuring the two styles of attachment insecurity separately. Rahimnia and

Sharifirad did not identify this difference, as the two styles of insecure attachment were measured as a whole concept.

This research provides further insight into the role of attachment insecurity. The findings indicate that having an authentic leader can the improve workplace for those with an anxious attachment style. The results also show that having an authentic leader is more important for the wellbeing of those with an anxious attachment style than those with an avoidant attachment style. This may be because those with attachment anxiety seek security in their leader in order to reduce their anxiety. Those with an avoidant attachment style may be less motivated to seek such relational security and therefore be less responsive to a reliable leadership figure as they tend to avoid relationships in order to cope with their relational insecurity.

A separate mediation analysis was completed to explore the influence of attachment anxiety and avoidance on authentic leadership and workplace wellbeing for participants who identified having clinical psychologists and non-psychologists as leaders. The results showed:

- For participants who identified having a Clinical Psychologist as a leader, attachment anxiety and attachment avoidance did not significantly indirectly effect the relationship between authentic leadership and workplace wellbeing.
- For participants who identified their leader has having a non-psychological profession, attachment anxiety and attachment avoidance also did not significantly indirectly effect the relationship between authentic leadership and the outcome of workplace wellbeing.

These findings illustrate that the profession of the leader, comparing psychological or non-psychological professions, did not influence the relationship between authentic leadership and workplace wellbeing for followers who had either attachment anxiety or avoidance traits.

Strengths and limitations

A strength of this research is its originality. Despite the concern regarding the psychological wellbeing of psychological professions and the highlighted suitability of clinical psychologists as leaders, there is a lack of research published which explores the impact of relational leadership models and workplace wellbeing within the psychological profession. There is also little research into the impact of leadership on attachment style and workplace wellbeing amongst Clinical Psychologists. Therefore, this research fills in gaps within the literature and provides some useful insights. The quantitative methodology allowed for the collection of a large amount of data which provided the opportunity to gain crucial insights into this under-researched area. This allows for meaningful implications to be made to improve clinical practice and suggest directions for future research. The research also highlights novel findings that the use of relational and authentic leadership can improve workplace wellbeing and attachment anxiety within the NHS. This indicates that a leader can provide relational safety for NHS Clinical Psychologists who experience attachment anxiety and as a result enhance their wellbeing at work.

Another strength of the research is that a large amount of data was collected from recruited participants in a short space of time, 210 participants in approximately 3 months. This indicates the interest in the research due to its novelty. As also mentioned, over 20 participants contacted the main researcher through email and social media to request a summary of the findings. This also highlights the interest in this topic and the recognised importance of leadership and workplace wellbeing in the NHS. The recruitment of participants through social media also enabled data to be collected from Clinical Psychologists working throughout the UK within a variety of clinical areas and who had been qualified for varying lengths of time. This also improves the generalisability of the findings to the general population of Clinical Psychologists working in the NHS as a whole. The relatively large sample size also allowed for a large variety of data to be collected. The online survey contained multiple measures which measured a range of different variables (leadership, workplace wellbeing and attachment) and also

provided the opportunity to collect demographic information which provided detailed insight into the sample population.

However, even though this research has a range of strengths it is also important to acknowledge its limitations. The recruitment of participants through social media and the researched topics may have created a sample bias as recruitment was voluntary. This may indicate an invested interest in the topics and consequently skewed their responses and thus imposes on reliability and accuracy of the findings. It is also important to note the lack of diversity in the data. Even though the sample is fairly representative of Clinical Psychologists there is an inherent lack of diversity within the profession, especially a lack of representation of men and people from BAME backgrounds. This limits the generalisability of the results (outside of the profession to other NHS professions).

Another limitation of this research is the use of self-reported outcome measures. Self-reported measures hold the opportunity for participants' responses to change or be influenced. Consequently, this impacts on the validity of the study. In addition, the measures used were not standardised diagnostic measures of attachment style. Therefore, only traits of attachment styles and signs of wellbeing were measured which in turn impacts on the validity of the findings. The correlational and regression methods used to analyse the data also means that causation cannot be inferred from the measured variables therefore the findings and implications of this research should be tentative.

In addition, the research is also reductionist as it does not account for other variables outside of authentic leadership and attachment insecurity which may impact and influence workplace wellbeing. Such variables include: work life balance, recognition and rewards of effort, autonomy over workload (O'Donnell et al, 2014); budgets and financial constraints, and resource availability (British Psychological Society, 2011); organisational pressures, high workload and environmental factors (Rupert & Morgan, 2005). Lack of consideration of other influencing variables limits the validity of the findings and therefore highlights that these research findings should be interpreted cautiously.

Clinical Implications

This section will discuss the implications of the research and suggest how the findings could be used to benefit stakeholders and organisations. This includes the NHS, clinical psychology as a profession and NHS leadership courses.

These results can be used to aid the improvement of staff wellbeing in the NHS which has been highlighted as of national importance. The results indicate that authentic leadership is associated with greater levels of wellbeing for followers. Application of this leadership model within the NHS has the potential to improve wellbeing for staff. As discussed in the introduction section, it is plausible that due to the high pressured nature of working in the NHS, with the lack of resource and target pressures, at points of organisational stress NHS leaders may not have to capacity to lead authentically. This, in turn, could have an impact on staff wellbeing and reinforced the stress and strain of working in the NHS. Therefore, there is the opportunity of incorporating teaching about authentic leadership, within NHS leadership training programmes, would be beneficial in an attempt to improve NHS staff wellbeing.

The results highlight the importance of considering attachment and relational needs at work if a follower experiences attachment anxiety. Therefore, it may be valuable for organisations, including the NHS, to take into account relational styles of their employees. This could be utilised by leaders to inform their leadership style to enable the formation of relational authenticity with all followers and potentially reduce anxiety for those who experience attachment anxiety. Awareness of attachment styles could also be increased throughout an organisation by providing teaching about relational needs at work, how these needs impact on wellbeing and alter depending on stress levels. Such teaching could be incorporated into existing wellbeing and mental health training for frontline staff, leaders and managers.

Through the consideration of follower's attachment style, the leader has the potential to create relational safety and improve the follower's wellbeing at work. These findings also have implications for occupational health and leadership

training within the NHS and also clinical psychology training programmes. The education and presentation of the relevant literature can highlight the significance of attachment anxiety and how this can impact workplace wellbeing. Such knowledge can empower these potential leaders to be responsive to the attachment needs of their followers. Awareness of attachment styles could also be increased within Occupational Health and leadership training within the NHS and also in Clinical Psychology training programmes by providing teaching about relational needs at work, how these needs impact on wellbeing, and change depending on stress levels. This teaching could be incorporated into existing wellbeing and mental health training for frontline NHS staff, NHS leaders, Clinical Psychology trainees and Placement Supervisors.

The findings also illustrate that a large percentage of leaders have multiple roles and responsibilities which included various combinations of line management and clinical supervisor responsibilities. When a workplace relationship has multiple roles the power balance that is inherent has the potential to become more pronounced if not considered. The Supervision Alliance Model (Proctor, 2010) outlined the power imbalance that exists between a supervisee and supervisor and the tension that this creates as supervision aims to provide a safe space for the supervisee to discuss their clinical work transparently. This has implications for staff in the NHS whose supervisor has multiple roles within the supervisory relationship. It may be helpful that staff, who this is applicable for, incorporate the recommendations of ensuring a clear contract is established which acknowledges the boundaries of the relationship and addresses the power imbalance and how this may impact the relationship (DCP, 2014; Proctor, 2010). The impact of dual roles in supervisory relationships also has implications for Clinical Psychology Training programmes. There is a dual role within the supervisory relationship between placement supervisors and Trainee Clinical Psychologists as the supervisors have an evaluative aspect to their role as they ‘pass’ or ‘fail’ the trainee’s performance on placement. Consequently, this amplifies the power imbalance within the relationship. Training programmes may benefit from further consideration of this and explore how best they can support the supervisor and trainee to minimise the impact of such power imbalances. Therefore, training

programmes may benefit from incorporating the issue of power imbalance into their supervisor training. Training programmes may also benefit from mandating regular refresher training for supervisors as it is likely due to NHS pressures that issues with power imbalances may less likely be held in mind. This could facilitate a supervisor's knowledge and skills to create such a relationship with a trainee so that when power may be used in some way, for example, evaluation of performance, it can be done well and avoid rupturing the relationship.

Future Research

This study has emphasised the need for future research in a number of related areas. The results imply that the workplace wellbeing of NHS Clinical Psychologists may benefit from having leaders who practise authentic leadership. Further exploration of this with other NHS professionals would be useful and potentially inform the improvement of NHS staff wellbeing more generally, as opposed to focusing on Clinical Psychologists. This could be done by replicating this research study, using the same design, with different populations of NHS healthcare professionals. Groups of participants could include Doctors, Nurses, Midwives and senior managers. Similar measures could be used to collect data; ALI to measure experience of authentic leadership and SWAM to measure workplace attachment. However, it would be important to change to the measure of workplace wellbeing to a more general measure of wellbeing, such as the Warwick-Edinburgh Mental Well-being Scale (Clarke, Friede & Putz, 2011), as the PPWWM is tailored specifically to measure the wellbeing of psychological professionals. Alongside the replication of this study, the analysis of the data could also remain the same to explore the relationships between authentic leadership, workplace attachment and wellbeing. However, to increase the validity and reliability of the results it would be important to control for some of the identified confounding variables. Therefore, data regarding variables such as work-life balance, resource availability and organisational pressures would need to be collected and controlled for within the analysis. This would make for more robust and meaningful results.

This research focused on the impact of insecure anxious and insecure avoidant attachment styles on workplace wellbeing. Further research into the impact of other attachment styles, such as secure attachment, on workplace wellbeing, may also be of use. The findings showed a potential protective aspect of avoidant attachment traits in the management of stress and wellbeing in the workplace. Mikulincer and Shaver (2007) hypothesised that those with an anxious attachment style perceive and experience aspects of work as being more stressful, which is likely to impact their wellbeing. Whereas, those who have avoidant attachment traits are less likely to experience and perceive things as stressful, which in turn protects their wellbeing. Exploration of how these attachment styles play out and function at work would be useful to build on and confirm this hypothesis. This could be researched potentially by using a qualitative approach to explore the experiences of workplace stress amongst individuals with different attachment styles. Semi-structured interviews could be conducted to explore workplace experiences of stress and wellbeing, whilst incorporating a measure of attachment style, such as the Attachment Style Interview (Bifulco, Jacobs, Bunn, Thomas & Irving, 2008). The data for those with different attachment styles could then be analysed separately, using thematic analysis. Themes across the whole data set could then be compared to identify if there are any similarities or differences in workplace stress for those with different attachment styles.

Conclusion

This research provides novel insights into the wellbeing of individuals who experience the different types of attachment insecurity; findings show that attachment avoidance is associated with relatively better workplace wellbeing compared to attachment anxiety. This highlights that there is a potential difference in how individuals with different attachment styles experience workplace wellbeing and stress. Future research is needed to explore and understand this difference finding further. Importantly, this research also highlights the potential benefit of having an authentic leader has on workplace wellbeing, especially for individuals who experience the trait of attachment anxiety. This is a useful insight for NHS stakeholders, due to the increasing national awareness of, and interest in, staff

wellbeing in the NHS. The findings of this research could be incorporated into existing NHS wellbeing training for staff, leaders and managers. Increased awareness of the impact of relational needs on workplace wellbeing would be useful for NHS leaders to apply in their practice. This would enable them to foster better relationships in order to support improved wellbeing at work. Further research is needed to explore how these findings could be utilised to benefit the wellbeing of all NHS professionals and to address the national concerns regarding staff wellbeing.

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Appendices

Appendix A: Ethical Approval Letter

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

21 February 2019

Hannah Cartmell
Psychologist in Clinical Training
Leeds Institute of Health Sciences
Faculty of Medicine and Health
Clinical Psychology, Level 10, Worsley Building
University of Leeds
Clarendon Way
LEEDS, LS2 9NL

Dear Hannah

Ref no: MREC 18-043

Title: Exploring the between leadership, attachment and workplace wellbeing amongst clinical psychologists working in the NHS

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 listed below.

Document	*Version*	*Date Submitted*
Ethics form - final version 2	2.0	18/01/2019
Advert and Information for participants	2.0	18/01/2019
MREC 18-043 Attachment Styles at Work Manual	1.0	10/12/2018
MREC 18-043 Authentic leadership inventory	1.0	10/12/2018
MREC 18-043 Psychological Practitioner Workplace Wellbeing Measure - Summers et al 2018	1.0	10/12/2019
MREC 18-043 Secure Base Leadership measure	1.0	10/12/2019

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 [fmhunethics@leeds.ac.uk]

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

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

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 B: Online Survey

Exploring the relationship between leadership, attachment and workplace wellbeing amongst clinical psychologists working in the NHS.

0% complete

Page 1: Information for participants

My name is Hannah Cartmell and I am carrying out this research as a student on the Leeds University Clinical Psychology Doctorate Programme, as part of my thesis project.

What is the study about?
I am conducting research into the relationship between leadership, workplace wellbeing and relationships at work amongst clinical psychologists working in the NHS. The study will ask you to complete some demographic information and then three questionnaires which will measure your experience of leadership, workplace wellbeing and relationships at work.

Will my data be identifiable?
The online study is anonymous and no one will be made aware that you have chosen to take part. All responses collected from this study will be kept confidential. All data collected in this study are anonymous and therefore unidentifiable. The data collected for this study will be stored securely on a password protected university hard drive and only the researcher conducting this study will have access to this data.

What will happen to the results?
The data will be summarised and reported as part of my thesis project and may be disseminated through various means including conference presentations and publication in an academic or professional journal.

Are there any risks of taking part?
There are no risks anticipated in taking part in this study.

Are there any benefits of taking part?
Although you may find participation interesting, there are no direct benefits in taking part.

Who has reviewed the project?
This study has been reviewed and approved by Leeds University School of Medicine Research Ethics committee (Reference number: 18-043).

Why have I been approached?
You are a qualified clinical psychologist working in the NHS.

What will I be asked to do if I take part?
If you choose to take part, you will participate in an online study. The online study will guide you through a series of questions that will ask you some general information about yourself such as your age, gender, length of time you have been qualified and relationship to your leader. You will then be guided through a series of brief questionnaires about your experience of your leader, workplace wellbeing and relationships at work. The online study should take around 10 minutes to complete and once your responses are submitted you won't need to do anything else.

Do I have to take part?
No. Your participation in this study is voluntary. If you agree to take part you may withdraw from the study at any point before submitting responses on the final screen. By submitting your responses you consent to the information being used in this study. Once you have submitted your responses, it will not be possible to withdraw your data. There are no consequences to you choosing not to take part or withdrawing from the study. This is an anonymous survey and responses cannot be linked back to you.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the project lead:
Hannah Cartmell Email: ps11hc@leeds.ac.uk

Or alternatively you can contact one of the supervisors of the project:
Dr Jan Hughes Email: j.hughes@leeds.ac.uk
Dr Fiona Thorne Email: f.m.thorne@leeds.ac.uk
Both based at: Clinical Psychology Training Programme, Worsley Building – Level 10, Leeds Institute of Health Sciences. University of Leeds, Clarendon Way, Leeds, LS2 9NL

How can you take part in the project?
If you wish to take part in the project, please follow the link to the online study: (link)
Thank you for taking the time to read this information sheet.

Resource in the event of distress
Should you feel distressed either as a result of taking part, or in the future, please contact: *Mind – www.mind.org.uk – 0300 123 3393*

By pressing the button below you agree to participate in this study

Page 2: Demographic Information

Please state your age

Please specify your identified gender

- ○ Female
- ○ Male
- ○ Prefer not to say
- ○ Other

Please select your identified ethnic group

- ○ Asian / Asian British / Asian Indian / Asian Pakistani / Asian Bangladeshi / Asian mixed
- ○ Black / African / Caribbean / Black British / Black mixed
- ○ Mixed
- ○ White British / White Welsh / White Irish / White Scottish
- ○ Middle Eastern
- ○ Arab
- ○ Chinese
- ○ Prefer not to say
- ○ Other

Please specify the length of time that you have been qualified as a Clinical Psychologist

Please identify who you most readily identify as your leader in the NHS - what is their profession?

- ○ Clinical Psychologist
- ○ Nurse
- ○ Social Worker
- ○ Medic
- ○ Occupational Therapist
- ○ Other

What is your relationship with your identified leader? "They are my..." *(please select more than one if appropriate)*

- ☐ Clinical Supervisor
- ☐ Line manager
- ☐ Team Leader
- ☐ Clinical Lead
- ☐ Other

If you selected Other, please specify:

Please confirm that you are employed by the NHS

- ○ Yes
- ○ No

Please specify your area of clinical work

- ○ CAMHS
- ○ Adult Mental Health - Primary Care
- ○ Adult Mental Health - Secondary Care
- ○ Paediatric Health Psychology
- ○ Adult Health Psychology
- ○ Occupational Health
- ○ Older Adults
- ○ Forensic
- ○ Learning Disability
- ○ Neuropsychology
- ○ Other

If you selected Other, please specify:

Page 3: Authentic Leadership Inventory

Please rate the extent to which you think each description corresponds to you. Responses: (1) Disagree strongly, (2) Disagree, (3) Neither Agree nor Disagree, (4) Agree, (5) Agree strongly.

This part of the survey uses a table of questions, view as separate questions instead?

	1 Disagree strongly	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Agree strongly.
My leader clearly states what he/she means.	○	○	○	○	○
My leader shows consistency between his/her beliefs and actions.	○	○	○	○	○
My leader asks for ideas that challenge his/her core beliefs.	○	○	○	○	○

My leader describes accurately the way that others view his/her abilities.	○	○	○	○	○
My leader uses his/her core beliefs to make decisions.	○	○	○	○	○
My leader carefully listens to alternative perspectives before reaching a conclusion.	○	○	○	○	○
My leader shows that he/she understands his/her strengths and weaknesses.	○	○	○	○	○
My leader openly shares information with others.	○	○	○	○	○
My leader resists pressures on him/her to do things contrary to his/her beliefs.	○	○	○	○	○
My leader objectively analyses relevant data before making a decision.	○	○	○	○	○
My leader is clearly aware of the impact he/she has on others.	○	○	○	○	○
My leader expresses his/her ideas and thoughts clearly to others.	○	○	○	○	○
My leader is guided in his/her actions by internal moral standards.	○	○	○	○	○
My leader encourages others to voice opposing points of view.	○	○	○	○	○

Page 4: Psychological Profession Workplace Wellbeing Measure

Answer items based on your current workplace wellbeing, rather than any historical experiences. Responses: (1) Strongly disagree, (2) Disagree, (3) Neither Agree nor Disagree, (4) Agree, (5) Strongly Agree.

This part of the survey uses a table of questions, view as separate questions instead?

	1 Strongly disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree.
I do not feel there is always someone there for me when I need personal support	○	○	○	○	○
I feel I can seek support from my colleagues	○	○	○	○	○
I feel a sense of belonging to the service/organisation in which I work	○	○	○	○	○

Flexible working arrangements are supported in my service/organisation	○	○	○	○	○
I feel supported by my line-manager to take positive risks without fear of reproach	○	○	○	○	○
I work in an environment where my colleagues are caring and supportive towards each other	○	○	○	○	○
I feel I can balance less fulfilling aspects of my job with more enjoyable aspects	○	○	○	○	○
I cannot see how the service/organisation in which I work can ever be delivered effectively	○	○	○	○	○
The clinical supervision I receive is containing and safe	○	○	○	○	○
I am enabled to manage and organise my workload and diary	○	○	○	○	○

I am clear about my role in relation to other professionals with whom I work	○	○	○	○	○
I feel confident the service/organisation in which I work can adapt to meet future service demands	○	○	○	○	○
Clinical supervision meets my support needs	○	○	○	○	○
My colleagues have realistic expectations of my professional role	○	○	○	○	○
The physical environment and facilities in my workplace enable me to work efficiently and effectively	○	○	○	○	○
My colleagues value my professional contribution	○	○	○	○	○
I have a good work/life balance	○	○	○	○	○
I do not feel included in service/organisational decisions that affect me	○	○	○	○	○

The personal support I receive from family and/or friends meets my need	○	○	○	○	○
My line-manager is approachable and responsive	○	○	○	○	○
My continuing professional development needs are supported	○	○	○	○	○
I am encouraged and supported to develop my skill-set and knowledge	○	○	○	○	○

I am expected to reach unrealistic or unattainable targets	○	○	○	○	○
The physical environment and/or facilities in my workplace adversely affect my workplace wellbeing	○	○	○	○	○
I feel service/organisational targets are meaningful	○	○	○	○	○
My specific skills as a psychological practitioner add value to the service/team/organisation	○	○	○	○	○

Page 5: Short Workplace Attachment Measure

Please rate to the extent to which you think each description corresponds to you. Responses: (1) Not at all like me, (2) Not like me, (3) Unsure, (4) Like me, (5) Very much like me.

This part of the survey uses a table of questions, view as separate questions instead?

	1 Not at all like me	2 Not like me	3 Unsure	4 Like me	5 Very much like me
A close friendship is a necessary part of a good working relationship	○	○	○	○	○
I don't need close friendships at work	○	○	○	○	○
I like to have close personal relationships with people at work	○	○	○	○	○
Others are often reluctant to be as close as I would prefer at work	○	○	○	○	○
I make close friendships at work	○	○	○	○	○
I worry that others don't value me as much as I value them	○	○	○	○	○
I work hard at developing close working relationships	○	○	○	○	○
I fear that friends at work will let me down	○	○	○	○	○
I worry that I won't measure up to other people at work	○	○	○	○	○
I'm afraid to reveal too much about myself to people at work	○	○	○	○	○

Final page

Thank you taking the time to complete these questionnaires. Your participation in this study is very much appreciated as it will allow us to better understand the relationship between leadership, attachment and wellbeing at work.

You have reached the end of the questionnaires, your responses have been recorded and you are now free to close down your browser.

If you have any questions regarding this study, or you would like to receive a summary report of the results please feel free to email Hannah Cartmell: ps11hc@leeds.ac.uk

or you can contact one of the projects supervisors:
Dr Jan Hughes Email: j.hughes@leeds.ac.uk
Dr Fiona Thorne Email: f.m.thorne@leeds.ac.uk
Both based at: Clinical Psychology Training Programme, Worsley Building – Level 10, Leeds Institute of Health Sciences. University of Leeds, Clarendon Way, Leeds, LS2 9NL

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Thank you again for your participation.