Exploring Clinical Psychologists' experiences of being leaders in CAMHS

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

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Abstract

Introduction: The NHS is facing ongoing pressures that impact service provision and workforce wellbeing. Children and Adolescent Mental Health Services (CAMHS) in particular has struggled to meet the growth in prevalence and complexity of children and young people's (CYP) mental health needs. Leadership is considered important to protect staff wellbeing and develop organisational resilience during times of challenge. Leadership is becoming an increasing part of Clinical Psychologists' roles, however, little is understood about what effective leadership looks like in practice. The current study aimed to provide an in-depth exploration of Clinical Psychologists experiences of being leaders in CAMHS. This was in consideration of the challenges leaders faced, how they responded, and the effects that being a leader had on them.

Methods: Semi-structured interviews were conducted with seven qualified Clinical Psychologists working within community CAMHS and undertaking leadership responsibilities. Interpretative Phenomenological Analysis (IPA) methodology was used to analyse the transcript data.

Results: Four General Experiential Themes (GETs) with subthemes emerged from the analysis. These themes reflected the challenges leaders faced and highlighted the ways participants were able to navigate and cope with these roles. Strategies included building relationships, being supported and finding balance. Additionally, the results showed how participants identify with leadership and how this impacts their engagement with and development in the role. The findings of the study also reflected the rewards and benefits that participants felt they gained from being a leader.

Discussion: The results were discussed in line with the relevant literature and psychological theory around leadership and the role of relationships in navigating organisational challenges and developing resilience. Finally, the strengths and limitations of the study were considered, as well as the key clinical implications and recommendations for future research.

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Chapter One: Introduction

This research explored Clinical Psychologists' experiences of being leaders within Child and Adolescent Mental Health Services (CAMHS), including the challenges Clinical Psychologists faced, how they navigated their role, and the effects that being a leader had on them. This chapter will present the research literature and psychological theory relevant to the area of study to provide context and rationale for the research question. Firstly, a brief overview of the current pressures on the NHS and CAMHS, and its workforce, will be presented, followed by a summary of the role that leadership can provide in navigating these challenges. A current understanding of leadership within CAMHS will then be discussed, as well as a summary of the broader literature and understanding around leadership, including leadership in healthcare and clinical psychology.

What is leadership?

Leadership is a concept that is hard to define, as many different definitions exist. It is a complex concept and one that is that is culturally, temporally and context dependent (Leudi, 2022; Patterson & Krouse, 2015). What is considered 'effective' or 'successful' leadership differs depending on the situation, organisation or system (Vecchio, 2012). For example, the conceptualisation of leadership within religious contexts may differ vastly from political contexts or in business sectors. As Gardner (1988) first noted, leaders are not necessarily those in positions of power or status, and used the example of the many 'opinion' leaders' in the United States influencing the political landscape. As leadership is dependent on a number of contextual factors, understanding the context of leadership within CAMHS, the NHS and wider healthcare settings is important to the present study and will be discussed.

What are the current pressures on CAMHS?

The NHS provides healthcare to the UK within increasing economic and socio-political challenges. These have resulted in enormous pressures to the NHS and widespread impact across

services and the workforce. This section will briefly summarise the wider pressures and impact on NHS and CAMH services, and highlight the specific challenges that CAMHS are currently facing.

Wider context and pressures

Wider economic pressures on the NHS include the ageing population in the UK. In 2021, over 11 million people (18.6%) of the total population were ages 65 years or older, compared with 16.4% in 2011 (Office for National Statistics, 2021). This included over half a million people who were at least 90 years of age. This is projected to continue to rise, which brings significant challenges to the UK and the NHS, who need to adapt to providing care to increasing health needs of the ageing population. Further financial pressures have amounted from the 2008 financial crash, which resulted in major economic disruptions in the UK. Following this a period of austerity for the UK led to a reduction in public expenditure, which meant the NHS faced considered constrictions on spending. Additional consequences for the NHS occurred after Brexit, where the UK voted by referendum to leave the European Union (EU) in June 2016. From Brexit, health care challenges have arisen, including uncertainty around the impact of the new processes needed for medicines, supplies and staff entering the UK (Holmes, 2021).

Alongside these challenges, the NHS is battling the largest public health crisis in a century, from the coronavirus (Covid-19) outbreak beginning in 2020. This resulted in the NHS workforce facing immense pressures in mobilizing resources to respond to the acute needs of those infected by the virus, whilst at the same time still providing non-covid related care in novel and remote ways (Lewis et al., 2020; Majeed et al., 2020). Mental health services have encountered the sudden change to remote care across secondary mental health. Challenges for mental health staff arose (Johnson et a., 2021), including service users' conditions being exacerbated by the pandemic, due to reduced coping strategies, access to mental health services and rises in domestic abuse and family conflict. Staff provision has also been affected by sickness, self-isolation and workforce redeployment to inpatient settings. The prevalence of mental health difficulties of the general population has also risen compared to pre-covid times (Daly et al., 2020; Hisham et al, 2020; British Medical Association, 2023).

The accumulated economic challenges for the NHS have been exacerbated by the challenges of pandemic (Bailey & West, 2021). As a result, the NHS has been faced with providing services and care with limited funding and resources. Staff and services are forced to make difficult decisions around to whom and when to provide care provisions (Robertson et al, 2017; Cartolovni et al., 2021). Services in the NHS have been struggling to cope with demand, leading to difficulties with staff burnout and fatigue (The King's Fund, 2022). Within mental health care, there has been a growth in demand, with a 21% increase of people in contact with mental health services since 2016, however the workforce within mental health services has not expanded enough to combat the rise in demand (British Medical Association, 2023).

Further socio-political pressures for the NHS have occurred through the Black Lives Matter movement, which was founded in 2013 and gained traction in April 2020 due to the death of George Floyd. This movement has reverberated globally and highlighted the racial inequalities and oppression that still exist within institutions across the world, including within health care in the UK (Ross et al., 2020). The NHS holds the responsibility to ensure racial inequalities are tackled within health care and confront systemic racism and implicit bias that exist across UK institutions (The King's Fund, 2022).

The current context of CAMHS

Child and Adolescent Mental Health Services (CAMHS) are provided by the NHS to support children and young people (CYP) with their mental health (NHS, 2019). This includes providing care to support a young person's emotional, behavioural, and neuropsychological difficulties. The economic and social pressures over the past decade faced by the NHS extend to these services. Historically, CAMHS has struggled with obtaining funding and resources to provide care to those in need (BPS, 2015, 2021; CQC, 2017). In 2015, the BPS raised concerns about previous defunding and service cuts, resulting in staff and service reductions, and CAMHS failing to meet the growing demand for support for CYP (BPS, 2015). The government published a review "Improving mental health services for young people" (Department of Health and Social Care, 2015) which highlighted these concerns and promised an increase in funding of £250 million per year. Responses and action to

improve mental health support for CYP continued, however, difficulties have persisted. In 2018, CAMHS was described as "in crisis" and "not fit for purpose" (BBC, 2018), with a mismatch between increasing demand and reducing resources (Barrat, 2019).

The battle to provide timely and high-quality care is ongoing and has been exacerbated by the COVID-19 pandemic. The psychological impact of the pandemic on CYP is suggested to be disproportionate to children, as they are in crucial phases of development. Therefore, they are more susceptible to the negative mental health impacts of the pandemic (Lopez-Serrano et al., 2021), such as parental stress and loss of family income. This is demonstrated in the increasing mental health needs of CYP since the pandemic. In a systematic review (Samji et al., 2021), symptoms of anxiety and depression were shown to have increased for CYP since pre-pandemic times. In 17–19-year-olds, rates of mental health difficulties have continued to rise significantly from the pandemic to in ten in 2017 to one if four in 2022. In 7–16-year-olds, rates rose from 1 in 9 in 2017 to 1 in 6 in 2020, and has remained stable at this rate since (Newlove-Delgado et al., 2022).

It is therefore perhaps unsurprising that demand for mental health services is increasing. A recent study using online surveys explored waiting list initiatives across NHS CAMH service in the UK (Valentine et al., 2023). Clinicians reported a subsequent influx of referrals post lock-down, particularly with complex crisis cases. Other studies have shown that higher proportion of referrals are deemed as 'urgent' in community teams, and hospital admissions seeing higher acute mental health complexity than usual (Gorny et al., 2021). This increasing complexity and demand have exacerbated waiting lists for CAMHS (Valentine et al., 2023) which services are struggling to cope with. In an independent review of the provision of CAMHS by the Mental Health Commission (MHC, 2023), 4% of children were waiting for over 12 months for an assessment appointment and 28% waiting for more than 3 months. The authors suggest that many young people and their families are frustrated, distressed and trying to cope with deteriorating mental health difficulties while waiting for lengthy periods.

Whilst mental health services are expanding to meet this demand, it is considered not fast enough to meet the rising needs and growing complexity of presentations, leaving many children and young people with limited or no support (Booth, 2021; Grimm et al., 2022). The Children

Commissioner's report "The State of Children's Mental Health Services" (Lennon, 2021) highlighted how many areas of care failed to meet the expectations set out by NHS England. These challenges impose increasing difficulties for the CAMHS workforce, and CYP, whose increasing unmet mental health needs pose a high risk to their healthy development (O'Shea & McHayle, 2021).

What it is like to work in CAMHS?

Staff wellbeing

'Burnout' has been defined as the result of chronic workplace stress that has not been effectively managed and is characterised by exhaustion, mental distance from and negativity towards one's job and reduced professional efficacy (World Health Organisation, 2020). Burnout often occurs when working in emotionally charged environments (McNicholas et al., 2020) and when demands on staff exceed the resources they have, both personal resources such as lack of skills or training, and resources in teams such as staff shortages (Health and Social Care Committee, 2019).

It is well documented and understood that staff burnout is a prevalent problem within the NHS, induced by the challenging contexts and pressures of healthcare systems (Gemine et al., 2021; Lacoboucci, 2021; Wilkinson, 2015). A number of studies have documented how the pandemic has exacerbated existing challenges of staff wellbeing and resulted in increased mental health difficulties among health care workers (Lamb et al., 2020; Kisley et al., 2020; Murphy et al., 2020), which include high rates of depression, distress, anxiety and insomnia (Lai et al., 2020). The most recent NHS staff survey (NHS England, 2022), conducted nationwide, reported that 44.8% of respondents in the survey reported feeling unwell as a result of work-related stress in the last 12 months. This has risen from 36.8% in 2016. 46.3% of respondents also reported that they "often" or "always" feel worn out at the end of their working day/shift. Difficulties with staff sickness and work-related stress are suggested to be associated with excessive workload (Lacoboucci, 2021). Concerns have been raised that chronic stress is becoming 'normal' and not acknowledged by leaders who feel powerless to find lasting solutions (Bailey & West, 2021).

These difficulties are relevant to and persistent for CAMHS staff. A recent study within a community CAMH service showed a significant decline in CAMHS staff wellbeing since the pandemic, with staff wellbeing also being significant lower compared to normative population data (Bentham et al., 2021). Staff also reported feeling a decreased perceived ability to undertake their clinical tasks, including assessments, interventions, ability to assess risk and build rapport, due to the changes in ways of working. However, as this study was conducted in a single service it may not be applicable to wider CAMH services across the UK. However, these results have been corroborated in a review of the literature on staff experiences working within CAMHS (Wintour, 2022). Burnout and emotional exhaustion were experienced by almost all staff, as a result of high workloads, under-resourced services and job dissatisfaction. Additionally, in a qualitative study, eleven inpatient CAMHS staff were interviewed, exploring experiences of subjective wellbeing working within these services (Hunt, 2020). Staff were found to be significantly impacted by working with young people's experiences of trauma, by feeling and behaving in ways consistent with being under threat.

The impacts of service pressures are also evident within Clinical Psychology professionals, who experience stress, frustration and exhaustions in the context of changing initiatives and the relentless drive to do more with fewer resources (Colley et al., 2015; Hannigan et al., 2004). Roncalli & Byrne (2016) also highlighted Psychologists' vulnerability to burnout working within Community Mental Health Teams (CMHTs). Surveys with 77 psychologists who were currently or had previously worked within CMHTs found that one in five respondents stated that it was unlikely they would choose again to become a psychologist working in mental health services due to their experiences of stress. Within CAMHS, Briggs (2018) suggests psychologists and psychotherapy professionals face challenges of feeling powerless and hopeless working within the systems' challenges that were beyond their control. Additionally, Briggs considered how there may have been a loss of a sense of emotional containment within CAMHS organisations, which is crucial for managing the often complex and high risk of service users within CAMHS. A doctoral thesis using Interpretative Phenomenological Analysis (IPA), explored Clinical Psychologists' experiences of leaving CAMHS (Wintour, 2022). This found that participants shared similar difficulties of not being able to 'do the job' they had hoped and were trained to do. They felt they were unable to help children and families

due to caseloads being too large, and time and resource pressures. A further theme from the study highlighted how participants felt that due to the high level of risk involved in CAMHS, they were constantly responding to crises, and found it difficult to create change. Additionally, participants felt working within CAMHS negatively impacted their emotional and physical well-being and described feeling traumatised by working within CAMH services. These difficulties resulted in frustration, sadness, hopelessness, and ultimately participants leaving CAMHS to work in private practice.

Traumatised systems and organisations

The impact of the burden of financial pressures, social political issues and consequential staff burnout affects not only the individual, but also the deeper systems. Organisations are suggested to be 'alive' just like people, and vulnerable to stress and trauma (Bloom, 2010). NHS systems are under chronic stress and face the difficulty of being able to respond to and care for clients with trauma experiences and highly complex needs in an adequate way. This is especially relevant for CAMHS, due to the often high levels of trauma and adversity experiences of the children young people attending these services (Reay et al., 2015).

The nature of an organisations work is suggested to directly impact the culture of the organisation, which means that services supporting traumatised individuals, families and communities are susceptible to becoming traumatised systems (Hormann & Vivien, 2005). As organisations are made up of people and their relationships, it is suggested the systems as a whole respond to this trauma in the same way as people (Treisman, 2021). To protect itself from painful feelings it may work in 'survival mode', and respond in chaotic, emotionally distant and defensive ways, often named 'organisational defenses'. These processes and responses may 'parallel' the experiences and responses of clients, inadvertently repeating experiences of trauma, creating a vicious cycle between professionals, clients and organisations.

As a result, professionals often feel powerless, helpless and experience vicarious trauma, adding to existing issues of workload and burnout. When this stress and anxiety is not contained by higher levels in the system, staff and services may respond with and engage in reactive care (McElvaney & Tatlow-Golden, 2016), and may struggle to provide the caring and supportive

relationships that are needed within services. The resulting distress can be passed down deeper into the working of the systems and induce trauma on an organisational level.

Leaders working in these trauma-organised systems are at risk of becoming overwhelmed, yet they are required to be sensitive to the way clients, teams and systems are impacted by individual and collective exposure to overwhelming stress and adversity (Bloom, 2010). A recent drive within health care has aimed to address the challenges of traumatised systems, through the development of trauma-informed approaches and care (NHS England, 2021; Triesman, 2021). These promote "awareness of the prevalence of trauma, understanding of the impact of trauma, and a commitment to incorporating those understandings in policy, procedure, and practice" (Yatchmenoff et al., 2017, p. 167). The goals of such approaches aim to create cultures of safety, empowerment, understanding around the impact of trauma and healing for trauma survivors.

How could leadership help to navigate these pressures?

Leadership in times of crisis

Leadership is considered of paramount importance during times of crisis; the 'success' of organisations is suggested to depend on how leadership is able to manage and navigate such turbulence and pressures (Cain, 2022). In response to the pandemic and resulting challenges, including those for healthcare, a wave of literature has emerged around how to 'best' lead and support followers during crises (Petriglieri, 2020; Wilson & Waddell, 2020). During such times, leaders are required to respond in more rapid and adaptive ways than perhaps previously experienced (Ahern & Loh, 2020; Geerts et al., 2021). Currently, health care services continue to be considered in 'crisis', as they endure the impact of Covid-19, workforce shortages and high pressures and demands on services. Therefore, the literature on leadership in crisis is relevant to the present study to understand what is known about how leadership can help navigate these pressures.

The literature on leadership in crisis spreads across a variety of systems and institutions, including political contexts and healthcare organisations, and considers ways to lead effectively within uncertain and unprecedented times. Leadership frameworks during crisis exist from military

and management sectors, however leaders with expertise in various aspects of health leadership, health care and public health domains globally, developed a consensus statement and leadership framework (Geerts et al., 2021). This involved a large systematic review of research on leadership in crisis, conducted by 32 expert co-authors across 17 countries. The authors called for the importance of global leadership and solidarity, and suggested that the pandemic has highlighted and exacerbated health inequalities, which calls for systemic and social change. This creates pressures on leaders, and therefore the authors urge the need for clear guidance to support leaders. The consensus statement asserts that leaders have been dealing with the 'threat' and the emergency stage of the virus, however as the situation has become less acute, it is imperative that leaders extend their focus towards the recovery stage, which is characterised by widespread staff and community fatigue, burnout and lingering fear. The framework highlights the importance of building psychologically safe spaces that engender trust, compassion, and communication and endeavor to communicate constants, such shared values and purpose. Leaders are encouraged to model self-care and transparency, acknowledging mistakes and making decisions based on both evidence and values of putting wellbeing first to develop these psychological safe spaces.

This is echoed within literature across other domains. Ahern & Loh (2020) highlight the importance of leadership actions across all levels and sectors to develop relationships and human connectedness in order to engender and sustain trust. The authors suggest that trust in leadership is vital for collective action during times of uncertainty. Through the lens of situational leadership theory, as first introduced by Hersey & Blanchard (1969), they advise that leaders develop relationships and connectedness through being transparent, authentic, and staying connected to communities. Being adaptive, and providing a sense of control is also needed, and achieved through preparation and planning. The importance of relational leadership is also emphasised in political contexts. Wilson (2020) analysed the leadership approach and practices of the New Zealand government in response to the pandemic and offered a framework of good 'pandemic leadership' practice. Here the author highlights the importance of fostering shared purpose and engaging a community to act collectively in their response to a complex problem. The focus on unity, as well as taking direction from experts and soliciting collective feedback, and being transparent and honest,

enables trust in leadership which is key to leading in crisis. The literature base around leadership in crisis is beginning to grow. A large scale systematic review (Geerts et al., 2021) has begun to offer robust and reliable understandings about what we currently know about this area, particularly in relation to the impact of COVID. However, a large proportion of the literature is formed by scoping reviews or discussions. Whilst this offers preliminary understandings of the area, such literature may be more likely to report bias and may miss relevant studies (Pham et al., 2014). Therefore higher quality studies are needed to improve our understanding about effective leadership during challenging times.

Leadership and building organisational resilience

In addition to the recent research on leadership in crisis, the Covid-19 pandemic and subsequent sources of distress and pressures in health care systems have considered the importance of leadership building organisational resilience. This has been recognised as a key priority for leaders in the NHS (Barton et al., 2020; Igoe et al., 2020). Being a resilient leader is considered important and influential in the context of dealing with unforeseen challenges, in order to help organisations, thrive in the face of adversity and provide safe and effect care to patients (Sia & Jose, 2021; Rangachari & Woods, 2020).

Resilience has often been conceptualised in individual terms (Connor & Davidson, 2003) and has been defined as a person's capacity to successfully adapt and cope in the face of stress and adversity (Windle, 2011). It has been considered a characteristic that is likened to 'grit' or 'hardiness', and within leadership related to being perseverant, committed to the cause and having willpower or self-control (Sia & Jose, 2021). However, more recently within health care leadership literature, the importance of collective and organisational resilience has been recognised, in the face of evolving pressures and challenges of the pandemic within the NHS, and in wider societal and global systems.

Gittel (2008) refers to collective resilience as the role that relationships play in resilient responses to external pressures. Through building cohesion and collective efficacy, a relational work system can develop, which allows a coordinated and collective response to external pressures and organisational changes. When stressors originate from organisations and external environments,

individual coping mechanisms may not be sufficient and such collective processes may be required. Organisational resilience highlights the importance of these relationships across the three different levels, at the individual level, team level, and organisational level, and the role of leadership here is key. Resilience within and across these three levels is considered vital for an organisation to respond and adapt to and thrive in the face of threat (Rangachari & Woods, 2020).

In order to develop such resilience, leaders have been encouraged to develop team relationships by building psychological safety within teams (Barton et al., 2020) and shared mental models about priorities and roles (Tannenbaum et al., 2021). A shift in priorities is suggested, towards self-care and sharing experiences and responsibilities within teams in order to foster psychological safety, which is important for resilience at a collective level (Igoe et al., 2020). Rangachari & Woods (2020) also highlight the need to build psychological safety within teams and services as a key part of organisational resilience. Here they referred to psychological safety as the perceived ability to take interpersonal risks, i.e., trusting in co-workers and leaders to work towards a shared goal, and feeling a sense of safety. The authors highlight the need for leaders need to recognise the emotional distress and burnout that that is continuing to amount from the effects of the Covid-19 pandemic, and how this impacts workers sense of psychological safety. Barton et al. (2020) also emphasised the importance of leaders to also be able to share their experiences and feel psychologically safe, and to build resilience through learning and adapting together.

What do we know about leadership in CAMHS?

Leadership within CYP services is suggested to encompass different roles and responsibilities compared to non-CAMHS services, such as adult services. As ecological systems theory (Bronfenbrenner, 1977) posits, child development occurs within a complex system of relationships, affected by multiple levels or systems of their surrounding environment, from immediate family settings to school, to broad cultural values, customs, and organisational factors. These systems may also include health care services and organisations.

Working with CYP to support their wellbeing and mental health therefore is often complex and requires systemic ways of working, developing relationships and communication across these

different systems and support services (Hunt 2020). This affords Clinical Psychologists additional and distinctive leadership experiences as clinicians work in a number of contexts, and the relationships involved are complex and varied. The reach of CAMHS can extend far into the community and across the spectrum of children and young people's services. Therefore, a key challenge for leaders is to build a range and quality of relationships in their own organisation as well as with its wider partners.

This is demonstrated in guidance for CAMHS leaders (National CAMHS Support Service; NCSS; 2011), which highlights the importance of thoroughly understanding the strategic context of CAMHS and its complexities, and myriad of relationships for successful service development. It suggests that leadership is best viewed within CAMHS as a "social phenomenon shaped by relationships within groups and networks" (p. 11), and proposes the use of distributed leadership (Bolden, 2011), similarly to the wider NHS, as a helpful way to address the systemic nature of services. Further recommendations for successful leadership in CAMHS include clinicians being guided by their values and principles, taking suggestions from Allen et al., (2009) to 'pause, reconnect with that you care about, and be guided by that' (p.26). These suggestions are not without challenges however in the context of limited funding, resources, and exacerbated pressures from the Covid-19 pandemic, as previously described. NCSS's (2011) guidance emphasises the need for stronger leadership in children's services, as leadership is most needed when services face challenges and compelling issues, particularly when funding and resource is scarce. It is suggested that leadership is critical to enhance a system's capacity for change, therefore developing leadership capacity and understanding of leadership in CAMHS is key, particularly considering the challenges leaders may face.

As suggested, relational ways of working are at the core of CYP services, and leaders need to attend to and develop relationships within and across systems. In response to the Covid-19 pandemic, the importance of collective resilience, and building psychologically safe and trusting relationships has been a key focus for leadership in responding to and recovering from immense pressures and changes, and threats to staff and patient wellbeing. Therefore, it may be important to consider the key psychological relational theories to understand leadership within CAMHS. These include psychoanalytic theories of holding and containment (Winnicott, 1960; Bion, 1959). Such theories

refer to the importance of the relationship between child and caregiver, in providing a safe and containing environment for the child to express their emotions. These processes incur the caregiver 'holding' a child's emotional distress and attending to the child's needs, to support their self-regulation. Such relationships are considered key for developing a capacity for managing life and life's difficulties (Casement, 1985), and the importance of these processes extend into adult relationships. Such concepts have also been considered in organisational contexts. Gilmore (2021) proposes the importance of leaders creating 'holding environments' in the workplace in response to times of organisational change, development and transition, and anxieties that may arise from these changes. Additionally, Petriglieri (2020) also extended the ideas of holding and containing to broader institutional and organisational holding. The author suggested that leaders can provide institutional holding by creating an environment of transparency and safety, where members of an organisation feel assured, have a sense of belonging and active participation in change. This is suggested to be important in response to crises, such as the Covid-19 pandemic and organisational pressures.

A further key relational theory is attachment theory (Bowlby, 1969; Ainsworth, 1978). This suggests that humans are biologically predisposed to direct behaviours towards an attachment figure, who serves as the primary giver and develops a bond. A 'secure' attachment relationship provides a safe base for the child, through which their emotional and physical needs are attended to, and they are able to explore and learn to aid their 'healthy' development (Bowlby, 1973). Styles of attachment can vary depending on the quality of the relationship, and influence interpersonal relationships later in life, as well as confidence, sense of self, and self-regulation (Main et al, 1985; Brennan et al., 1988). Theories of attachment have extended its understanding to wider systems and organisations too. Braun (2011) suggests that similarly as a child needs to feel secure enough in the family to carry out developmental tasks, people also need to feel secure enough in organisations to work productively and effectively. Additionally, attachment principles may be extended to clinical settings, as requirements for a secure attachment, such as feeling seen, soothed and safe, mirror those of a happy and productive workplace (Delaney et al., 2021; Uyeda & Miller, 2021). Difficulties in developing attachments within organisations may arise when insecurity and threats are present (Braun, 2011). This may be important to considering the current challenging context of CAMHS.

The literature to date highlights the complexity of leadership within CAMHS, and the importance of relational approaches, however, little is known about CAMHS leadership in practice, and the experiences of those leading within the multifaceted systems/roles that are seemingly required for leaders in these services.

What do we know about leadership more generally?

This section will consider what is known within the literature about leadership in wider organisational contexts. Leadership and management are similar concepts, and there is often overlap between these roles. However, differences are often distinguished, in that management is considered to be a role related to strategic and organisational tasks, and concerned with practices such as planning, budgeting, organizing, staffing and problem solving (King's Fund, 2011). Leadership, however, is considered to be concerned with motivating others in a group, such as fostering commitment and enthusiasm towards a shared goal, and building a guiding coalition (Beech, 2002; Kotter, 1996). As described by the British Psychology Forum magazine, "management is doing things right, leadership is doing things the right way" (Skinner, 2011, p.13). Further distinctions are suggested, such that leadership is largely characterised by relationships, existing in the relationships between leaders and followers (Erdogan & Bauer, 2015, Wood & Dibben, 2015).

Traditional and earlier models of leadership have been concerned with individual leaders, and the traits and characteristics that make them 'successful' in leadership (Kirkpatrick & Locke, 1991). Contemporary models of leadership however have moved towards considering the interactions between leaders and followers (Nawaz & Khan, 2016). Transactional leadership is one such model that considers leadership to be an 'exchange' or transaction between leader and followers (Burns, 1978). It is a rewards-based model, underpinned by behavioural reinforcement theory. Theories of transactional leadership consider followers to be motivated for rewards in exchange for effort and services and considers their personal interests as the principle motivating factor, such as performance goals, and providing a reward upon completion (Aarons, 2006). It has been considered a useful approach for achieving short-term objectives. Transformational leadership, however, takes a different focus and reflects a move towards relational-orientated approaches of leadership. This model is

concerned with transforming followers and organisations and involves a process of motivating and empowering people to work in line with certain values and principles. Transformational models emphasise a collaborative approach aimed at inspiring followers to do things for intrinsic value, enabling collaboration to move towards a shared goal (Mayer, 2018). Transformational models of leadership, and a focus on leadership 'success' being gained through the relationships between leaders and followers has gained increasing interest over the past few decades.

Leadership and wellbeing

Leadership is widely recognised as being important for staff wellbeing withing organisations and has been particularly considered within literature in healthcare settings. Patient care is dependent on the health, wellbeing and effectiveness of the NHS workforce. That, in turn, is determined by the extent to which leaders ensure work environments are conducive to protecting staff (West et al., 2022). Thus, the role of leaders is considered key in supporting, protecting and promoting the health and wellbeing of staff, and can facilitate conditions relating to job satisfaction and a safe working environment (Hu et al., 2022; Jankelova & Joniakova, 2021). This is considered to be increasingly necessary and urgent due to the pressures on the healthcare workforce (Newitt, 2022). A number of studies have explored the beneficial leadership behaviours and styles that may improve and negate staff experiences of burnout and improve wellbeing. Skakon et al. (2020) conducted a systematic review on leadership and the affective wellbeing of employee wellbeing. This found that leaders' stress and wellbeing are associated with that of the staffs. They found that positive leader behaviours included support, empowerment and consideration of others, and these were associated with a low degree of employee stress, and high affective wellbeing. West et al. (2022) also found that leader support positively influenced patient satisfaction through shaping staff experience, particularly by involving and empowering staff in decision making. This supports staff to be able to respond to the demands of their work pressure by taking action to shape and manage their working environment. Similarly, Scanlan et al. (2018) and Morse et al. (2012) found that leadership qualities of investing in the team, communicating and being respectful, and having support from leaders during environmental changes were important for job satisfaction and addressing experiences of burnout.

What do we know about leadership in the NHS?

The topic of leadership is of great interest within healthcare and is considered vital for developing high quality patient care outcomes. Understanding leadership has long been a key concern of stakeholders, policy makers and academics, in order to improve organisational and clinical effectiveness (West et al., 2015). This is particularly relevant to the NHS today, which is a complex system, facing challenging economic context and austerity measures, pressures of the pandemic and an increase in psychological distress and need for mental health provision. Therefore, how the NHS is led is of growing importance, and considered vital to "not only cope with change but also to be proactive in shaping the future" (Skinner, 2011, p.13).

In order to develop the leadership capabilities of the NHS, effective leadership models have long been considered. Transformational models of leadership are often seen as important approaches to delivering effective care (Bass & Riggio, 2006; West et al., 2015), and have significantly influenced healthcare strategies during the last several decades (Gotsis, 2023). Transformational styles are characterised by leaders offering good role models, consistent with values and vision for health care, consideration of individual staff, and inspiring motivation and innovation among staff (West et al. 2015). Further relational-based leadership models have been endorsed in the NHS, such as distributed leadership which has especially been encouraged over the last decade (Bailey & West, 2021). This encourages leadership responsibilities and accountability to be shared by those with relevant skills and expertise, rather than resting with the individual (Bolden, 2011). This is echoed in the interest and drive for clinical leadership within the NHS, in response to the challenges faced by the workforce. The drive promotes leadership being shared, distributed and adaptive (The King's Fund, 2013), and involves clinicians taking on leadership roles within their everyday clinical work.

The development of leadership competencies across the NHS and its clinicians has been set out in the Clinical Leadership Competency Framework, developed by the NHS Leadership Academy (2011). This is a framework that was developed to encourage widespread leadership skills and capabilities across the different levels and professionals of the NHS, and is underpinned by the basic assumption that the acts of leadership can and should come from anybody, not just those in formal

positions of authority. The move to dispersed leadership responsibilities to frontline healthcare workers is consistent with distributed and shared leadership, and the competencies set out in the framework focus on engaging and transformational styles. Five domains of leadership are encouraged and considered applicable and to be developed within all clinicians. These domains are personal qualities, working with others, managing, improving services and setting direction. The proliferation of such leadership programs within the NHS Leadership Academy is considered key to improving leadership across organisations. However, critiques of the framework suggest that there are limitations to the costly approach, that NHS England has invested tens of millions of pounds within (West et al., 2015). Hoskin (2013) considers the framework 'simplistic' and suggests that effective leaders cannot be produced by a course alone and that the fundamental capabilities of effective leaders relies on certain inherent personality traits and attributes, that cannot be 'taught'. Hoskin suggests that this needs further consideration within these frameworks.

A further approach to leadership endorsed within recent years is compassionate leadership (West, 2021). Recent literature on such an approach considers its utility in tackling the challenges and turbulence currently experienced by the NHS workforce, fostering patient-centered care and promoting the well-being of employees (Bailey & West, 2022; Gotsis, 2023). Compassionate leadership involves a focus on relationships through careful listening, understanding and supporting others. This is considered important to cultivate a culture of empathy, kindness and person-centeredness, which in turn creates staff and patient safety and quality care (West et al., 2015; Baily & West, 2022). Compassionate leadership also creates an inclusive, psychologically safe environment in which diversity is valued. This is important given the struggles of NHS to sustain inclusive cultures across organisations (West, 2021).

Leadership in practice

A number of studies have explored the experiences of leaders working within healthcare organisations, to understand leadership in 'practice'. This has particularly been in relation to how leaders encounter the challenges, changes, and pressures that are present within healthcare settings. Anandaciva et al. (2018) conducted surveys and obtained data from 897 executive directors in the

NHS nationwide. The study also utilised interviews with frontline leaders. This highlighted the challenges that leaders experienced, and included the current climate of extreme pressure and widespread staffing vacancies, which made it difficult to meet financial and performance targets, and demands on the service. Leaders also felt there was a culture of blame for failure that made leadership roles less attractive. The authors noted a high level of leadership 'churn' (vacancies) and considered this to be related to the constant pressures on leaders, and leaders feeling disempowered. Gray & Jones (2018) found similar experiences in a qualitative study with 68 healthcare leaders, exploring experiences of resilience and wellbeing during the turbulent times of change of Brexit. Leaders felt overwhelmed and unable to cope with demands placed on them. They struggled to ask for help, for fear of being perceived by others as a failure and having a high expectation of needing to be able to cope. The study also reported how leaders were able to manage the challenges described. This included using an 'internal resource' of self-awareness of the emotional impact of their role and aligning their experiences with personal values to recapture a sense of purpose. External resources used were coaching and peer groups to support their resilience and wellbeing. A systematic review of qualitative studies by Ahti et al. (2023) focused on how leaders managed during the Covid-19 pandemic. In particular it looked at the competencies leaders considered and experienced as important to navigate their role during these turbulent times. The results suggested leaders were required to balance the needs of various stakeholders, such as ensuring patient orientated care, whilst considering staff needs, upholding guidelines and navigating the political climate. Leaders were focused on managing and taking care of staff, which included being present and available. Leaders were also required to stay resilient and adapt in the face of change to new ways of working, and ensure effect communication took place across the MDT to sustain team collaboration.

Considering the challenges faced by being a leader in healthcare settings, a study by the Faculty of Medical Leadership and Management (FMLM, 2018) looked at the factors that support and hinder engagement in leadership. Interviews and focus groups were conducted with a number of clinical professionals in leadership positions, from a range of practice settings, as well as semi-structured interviews with 11 chief executives with clinical backgrounds. These results highlighted a lack of confidence in clinicians in their competencies as a leader, and suggested the importance of

providing role models, support and skills development for emerging leaders. Additionally, clinicians also feared a change in their role, and a potential threat to their identity and values by their role being occupied by more leadership responsibilities rather than clinical. Furthermore, a lack of time for development in their current role towards leadership was suggested, which the authors stated highlights a need for mentoring schemes and opportunities for work shadowing. The report supported existing literature, such as Elliot et al. (2016), who suggested that organisational level factors such as mentoring, support from senior management and opportunities to develop leadership competencies were enablers for practitioners to engage in leadership roles.

The research on leadership in practice in healthcare largely focuses on medical and Nursing professionals in physical health settings. Therefore it cannot be stated that these results reflect the experience of all healthcare leaders, such as in mental health contexts or Clinical Psychologists' experiences of being leaders. Whilst a number of studies include large sample sizes, increasing the generalisability of the results to medical and hospital settings and populations, more research is needed to understand leadership in different contexts, such as community and mental health settings.

Leadership in Clinical Psychology

The role of Clinical Psychologists has extended from traditional therapy into positions of organisational and systemic influence, through leadership roles and responsibilities (Lavender & Hope, 2007; Division of Clinical Psychology, 2010). As service provision in the NHS is constantly changing and developing in how people with psychological distress are supported, leadership is becoming increasingly important for Clinical Psychologists (Mayer, 2018). The relatively high NHS pay banding of Clinical Psychologists often places them as senior members of teams, providing supervision and having greater involvement in service development and managerial level decision making. Clinical Psychologists also often occupies many roles, across different levels of the systems that surround service users, from individual work, consultancy, to service development, commissioning to wider systems and even wider policy change (Browne et al., 2020). Additionally, the NHS Long Term Plan (NHS England, 2019) posits changes that will require Clinical

Psychologists to take on further leadership responsibilities to support the development of psychologically informed care.

The drive for leadership in the profession was first reflected in the New Ways of Working initiative for applied psychologists (Lavender & Hope, 2007). This recommended that Psychologists should work psychologically in teams by undertaking leadership roles and building relationships between leaders and followers. More recently, the Leadership Development Framework was created by the Division of Clinical Psychology (DCP; 2010), to provide structured guidance to enable Clinical Psychologists to understand how to provide more leadership, and to consider what skills Clinical Psychologists bring to leadership, and how they can develop and apply these skills. The framework highlights the development of leadership skills throughout the trajectory of a Clinical Psychologist's career from trainee to consultant. It emphasises five domains of leadership that Clinical Psychologists are expected to be involved in. These domains are demonstrating personal qualities, working with others, managing services, improving services and setting direction.

Some argue however that this leadership framework for Clinical Psychologists may be reductionist and unhelpful, as the systems that Clinical Psychologists work within in the NHS, are too complex (Onyett, 2012). It is suggested that specific professional frameworks can detract from the understanding of the complexities of leadership, and that perhaps the focus should be on developing and building on systemic understanding of the complexity, and develop a more flexible approach to leadership (Bolden, 2004). Nonetheless, Clinical Psychologists are widely considered to possess qualities and skills, such as interpersonal abilities, knowledge of systemic approaches and person-centered values, that enable them to be effective leaders within the NHS (Mayer, 2018; Skinner, 2011). Clinical Psychologists' skills may be well placed to promote and engage in the more collaborative and shared leadership models that have become the focus for the NHS in recent times (Ambrose, 2019).

However, limited research has explored leadership within Clinical Psychology, in practice. A number of doctoral theses have begun to present preliminary understandings of leadership experiences. A mixed-methods study using surveys explored 202 Clinical Psychologists' leadership experiences across the career trajectory, with Assistant Psychologists, Trainee Psychologists and

qualified Psychologists (Ambrose, 2019). The quantitative results showed a varied picture of leadership skills development throughout the career pathway. Qualitative aspects of the study highlight where in career pathway leadership skills development could be improved and developed upon. For trainees this included better supported during placements to utilise and develop leadership skills, and qualified psychologists having access to funding and good quality, psychologically informed leadership training opportunities to develop the skills and practice. A study using Interpretative Phenomenological Analysis (IPA) (Corrigall, 2015) explored the successful leadership experiences of female senior Clinical Psychologists. Participants considered relationships to be central to their successes as leaders. Here they adopted 'nurturing' or 'diplomatic' roles in order to build relationships, and implemented relational repairing strategies if a relationship began to rupture. Additionally, participants' leadership behaviours were guided and motivated by their morals and values and took action as leaders when they considered unjust decisions or acts to have occurred, by challenging injustices. The author concluded that relational leadership strategies were often combined in response to different situations, which highlights the complexity of the role. Messham (2018) explored more challenging experiences and focused on the dilemmas that Clinical Psychologists faced as leaders. This demonstrated the emotional and psychological impact that participants experienced when facing dilemmas, that at times left them feeling disempowered to lead. Through managing dilemmas, however, some participants experienced empowerment, and a sense of personal growth which supported their resilience to cope. Additionally, participants' values were integral to how they made sense of the dilemmas they faced and the decisions they made as leader.

Furthermore, another study looked at Clinical Psychologists' motivations to engage in leadership (McTiffin, 2023). Using online surveys, this explored newly qualified Clinical Psychologists' motivation to lead, and found that transformational style and leadership self-identity were associated with and predictive of participants motivation to undertake leadership roles. Newly qualified Psychologist's also had a reduced belief in their perceived capabilities within their leadership roles, when compared to normative data, which could create a barrier to engaging in leadership. Whilst these studies offer initial insights into the experiences and motivations of Clinical Psychologists in leadership roles, the qualitative studies (Corrigall, 2015; Messham, 2018) used small

sample sizes and were idiographic in focus, meaning the results may not be generalisable to other context such as CAMHS. Furthermore, whilst McTiffin (2023) and Ambrose (2019) offer larger sample sizes, increasing the reliability of the results, the areas of focus are specific to Clinical Psychologists' motivation to lead and leadership development, respectively. This offers limited insight into Clinical Psychologists' experience leading within the complex and challenging context of CAMHS. As leadership is a phenomena that is context dependent (Leudi, 2022) further research that is CAMHS specific is required to understand and develop leadership in this setting.

Rationale and research questions

Due to the current pressures and demands of working in the NHS, the wellbeing of both healthcare staff and leaders is at risk (NHS England, 2022; Lamb et al., 2020; Kilsey et al., 2020; Murphey et al., 2020). This is known to impact on service provision (Kleinpell & Kane, 2021; Triesman, 2021). In CAMHS, there are particular challenges, due to the vulnerability of the children and young people (Samji et al., 2021) and the dynamic, complex, and inter-relational ways of working that CAMHS requires to meet the needs of its users. Before the pandemic began in 2020, funding for CYP has been a persistent concern, which has had detrimental effects on services and care provision (Department of Health, 2015). CAMHS has long been considered in 'crisis', with significant waiting times for CYP, difficulty in accessing services, and working conditions for staff becoming increasingly difficult due to insufficient resources (Barratt, 2019). Calls for change from the Department of Health (2015) report emphasised concerns around treatment gaps and the need for preventative and early intervention services that have been severely lacking due to limited funding. More recently, the COVID-19 pandemic has disproportionately affected CYP and their services and exacerbated these existing significant challenges. Wilson & Waddell (2020) report that services face pressures to support families to deal with a wider range and increasing complexity of problems since the pandemic, as well as the consequences of fewer people receiving support during the pandemic that would usually have been available at key moments in their lives.

Leadership is critical in difficult times and in enhancing a system's capacity for change (Geerts et al., 2021). Leadership plays an important role in wellbeing and protecting staff burnout (Bloom, 2010; Rao et al., 2016) and research in response to the pandemic reflects that building resilience and psychological safety is paramount. Leadership capacity needs to be developed in order to have the "best chance of riding the storm" (Barratt, 2019, p.4), which involves understanding leadership by those who experience it, due to the many challenges leaders may face.

Additionally, service and team structures across mental health services often differ. Within CAMHS services, a focus is on professional collaboration and building quality relationships to work systemically. This may mean that Clinical Psychologists are integrated within teams, and adopting leadership positions and responsibilities within the context of a myriad of relationships and systems. Clinical Psychologists leading in CAMHS also have a demanding and important role, as they are likely faced with supporting staff wellbeing, whilst also navigating and leading within the different and complex systems. The challenges that leaders may face, and the roles and responsibilities, are likely to be unique to CYP services, compared to non-CAMH services, such as adult services. Therefore a specific focus on CAMHS was considered important for the study.

As discussed, research around leadership in healthcare is limited, with a lack of quality studies that offer generalisable results. Whilst some studies have begun to explore the challenges leaders face in health care, the results may not reflect the experiences of leaders in mental health services, CAMHS, and the profession of Clinical Psychology. Therefore, research within CAMH services is needed to better understand leadership here. Furthermore, as our understanding is limited, exploratory research may offer preliminary and in-depth understandings about leadership and how it is experienced by those who do it. This is particularly important given that leadership is a relational phenomenon.

The ongoing pressures and challenges faced by the NHS and CAMHS are likely to remain for the foreseeable future. Therefore, it is important to better understand leadership in these contexts, through the experiences of those who lead. Exploring participants' experiences of leadership may help to understand the how leaders navigate the challenging and pressures contexts of CAMHS.

For the reasons outlined above, and considering no current research exists on this specific topic area, the research questions for the study are:

- What are Clinical Psychologists' experiences of being leaders in CAMHS?

- What meaning have Clinical Psychologists' made of the challenges they have faced in leadership positions and how have they responded?

- What have the effects of leading been on Clinical Psychologists in leadership positions?

Chapter Two: Research Method

This chapter will first discuss the importance of methodological orientation for qualitative research, and the positioning of the present study. The chosen methodology, Interpretative Phenomenological Analysis (IPA) will then be discussed, along with the alternative methodologies that were considered. Following this, the research design, procedure, and the process of the analysis will be described.

Methodological orientation

Research methodologies offer frameworks to investigate or enquire about phenomena and guide research design (Braun & Clarke, 2013). This research used a qualitative framework. Qualitative research encompasses a number of approaches, which aim to examine the lived world of participants (Mason, 2017). Such research frameworks are focused primarily on seeking an understanding of the meaning and experiences of people within the natural world (Miller, 2016), and allows for the development of in-depth and contextual understandings through exploratory and observation processes (Willig, 2013). This is different to quantitative methods which focus on objectively measuring and testing pre-existing theory, and are often concerned with identifying cause-effect relationships. Qualitative methodology was chosen as the literature base is limited in its understanding of leadership within CAMHS, and how leadership is experienced by those who do it. Therefore exploratory research methods are important, to address the research questions that aim to explore the subjective experiences of Clinical Psychologists and how they make sense of their experiences.

Philosophical positioning

Qualitative research methodologies are informed by and rooted in ontological beliefs and epistemological positions (Giacomini, 2010). These positions provide the framework from which the methodology is developed and is intrinsic to its identity. Therefore, it is important to understand and

acknowledge the underlying assumptions of methodologies and ensure that the approach to research is informed by the researcher's philosophical orientation.

Ontology

Ontology is a set of fundamental beliefs about the basic entities that make up our reality (Giacomini, 2010; Willig, 2013). Such beliefs or ontologies concern how one considers reality to 'exist', as something external to our minds, or created within and relative to our perceptions. These beliefs can be considered to fall along a spectrum, ranging from realism to relativism (Braun & Clarke, 2013). Realism proposes that there is an external reality that exists independent of our minds and is accessible to us, independent of our own knowledge and ideas about it. Relativism is the contrast position and proposes that reality is subjective and dependent on our perspective and experience. Thus, a relativism belief considers reality to exist only through the lens of our own ideas. An additional perspective that falls within this spectrum is critical realism (Mason, 2017; Willig, 2013). This assumes that whilst a reality exists beyond human consciousness, the 'nature' of reality is influenced by interpretation and social context (Danermark et al., 2002).

Epistemology

Epistemology is a branch of philosophy that is concerned with the theory of knowledge and access to knowledge and attempts to answer the question 'how and what can we know' (Willig, 2013). Epistemological positions mostly align along the spectrum of ontological beliefs. Positivism follows from realism (Giacomini, 2010), and assumes that an objective truth can be discovered through studying the world using scientific principles. It assumes that the data we collect directly correspond to the reality of participants. Alternatively, social constructionism, which is often described as relativist (Willig 2013), posits that people construct *versions* of reality through the use of language. It rejects the idea that data gathered from participants corresponds to reality, instead there is a variety of interpretations of experience, influenced by individuals' perspectives and values (Burr, 2003). Thus, reality is socially constructed.

Contextualism is an epistemological position that falls between these two contrasting positions (Larkin et al., 2006) and largely aligns with critical realism. It acknowledges that phenomena do exist and operate independently from our own ideas but that knowledge is 'context dependent'; it is influenced by a number of factors such as participants and researchers interpretations.

Establishing an ontological and epistemological position

I have considered my personal ontological and epistemological positions, to understand my orientation towards the nature of reality and how this guides my approach to generating and acquiring knowledge. I consider myself to adopt a critical realist ontology. Through the earlier years in my education that were dominated by objective scientific evaluation, I have recognised a prior orientation to realism beliefs, and an epistemological position of positivism. However, as I have developed and grown, I have come to appreciate the social nature of reality and the variety of different experiences and perspectives across people. I have shifted in my view to consider reality to exist to some extent outside of ourselves, however the 'nature' of reality being influenced by our experiences and perspectives. Through this, I ascribe to an epistemological stance of contextualism, which orientates my approach to how knowledge can be known and understood only through interpretation.

Methodology

The study chose to use Interpretative Phenomenological Analysis (IPA). This is an approach that is concerned with understanding the *lived experience* of participants (Smith et al., 2021). It focuses on understanding participants' "internal world" and establishing rich and meaningful interpretations of individuals' experience (Smith et al., 2009). This is considered important to understand the how leaders navigate the challenging and pressures contexts of CAMHS. As little is understood about the subjective experience of this area, it was considered more appropriate to focus on the "texture and nuance" of individuals' lived experience, at a micro level rather than a surface level to ascertain the inner workings of individual thought processes (Smith et al., 2021). This was particularly important given that leadership is a complex and context dependent phenomena, and the environment of CAMHS is dynamic and ever-changing. Leadership is also a developing area within

the profession of Clinical Psychology, therefore a richer exploration of the experiences within this are may help generate theoretical ideas for future research with different methodologies.

The following section will discuss IPA and further justification for why it was chosen. It will also discuss the consideration given to alternative qualitative approaches.

Interpretative Phenomenological Analysis (IPA)

IPA is concerned with the detailed examination of human lived experience, and attempts to understand phenomena by gaining access to participants' subjective experiences and seeing the world through their eyes (Smith et al., 2009; 2021). IPA is underpinned by three core concepts, phenomenology, hermeneutics and idiography, which will be discussed.

Phenomenology

Phenomenology in IPA is connected to the core phenomenological ideas from philosopher Edmund Husserl in the early 19th Century, and developed upon by key philosophers Heidegger and Merleau-Ponty (Smith et al., 2021). It is concerned with what individuals' experiences of the world are *like*, and posits that experience can be understood by the meaning which someone has for something. These meanings occur within an individual's embodied and situated relationship to the world, and are therefore unique to a person's context. IPA considers phenomenology to be 'coming back to the lived experience' of a phenomenon through the participant's personal experience and person perceptions (Smith et al., 2021). IPA aims to get as close as possible to the 'lived experience', through interpretative process of systematically attending to and reflecting on the experiences in question.

Hermeneutics

Hermeneutics is the "theory of interpretation" (Smith et al., 2021, p.17), and refers to the meaning making of experiences that individuals engage in to make sense of the world they are imbedded in. IPA is informed by a hermeneutic version of phenomenology (Smith et al., 2021). This considers how all human experience is informed by the individual's *lifeworld;* therefore experiences must be

interpreted through this background (Neubauer et al., 2019). Thus, meaning making involves interpretation, attempts to understand experiences are interpretative, and focus upon participants' efforts to make *meanings.*

IPA considers there to be two levels to interpretation. First order interpretation refers to the meaning a participant ascribes to a particular experience. Second order interpretation occurs when the researcher attempts to make sense of this interpretation. This is considered the "double hermeneutic" position (Smith & Osborn, 2003; Willig, 2017), where the researchers are required to be transparent about their own experiences, beliefs and preconceptions, or "fore-conceptions" (Smith et al., 2021, p.20) that may influence interpretation. Therefore, self-reflexivity practice is a key consideration of IPA research (Moran, 2000) and the reflexive practices involved throughout the study will be discussed later in the chapter.

The process of interpretation within IPA is also considered to be 'iterative', as the researcher moves back and forth through a range of different ways of thinking about the data. Through this, the relationship to the data shift according to the 'hermeneutic circle'. This describes the dynamic relationship between the 'part', the individual *pieces* of the data, and the 'whole', the overarching context that the 'parts' sit within. Thus, "to understand any given part you look to the whole; to understand the whole you look to the parts" (Smith et al., 2021 p.32).

Idiography

IPA is concerned with the *particular*, which is in contrast to nomethetics that makes sense of the *general*. The aims of IPA are to look in depth and in detail at phenomena, through understanding the experience and perspectives of "particular people in a particular context" (Smith et al., 2021, p24). IPA considers that experience is imbedded relationally to things, people and concepts. It is individually embodied, and each person can offer a personally unique perspective to their relationship to or involvement in a phenomenon.

Therefore IPA's 'idiographic commitment' explores participants' particular perspectives, within particular contexts. The process of IPA involves analysing each individual case in detail, before moving on to consider the data as a 'whole' (Smith et al., 2021). Whilst generalisations can be made

across a participant group, these are to be cautiously established, and located within the particular (Harre, 1979).

IPA philosophical orientation

There is an increasing suggestion that IPA takes a critical realist approach in its ontological position. IPA considers the presence of an observable 'phenomena', however access to the essence of this reality is influenced by the biases of participants and researchers (Willg, 2013). The aim of IPA is to get as 'close' to the experience as possible, through the levels of interpretation (Smith et al., 2021). Therefore, IPA may also be aligned with a contextualist epistemological position to deriving knowledge of phenomena as suggested by Larkin et al., (2006), who posit that the focus of IPA is understanding individuals' experience, and how they make sense of these experiences within their unique context.

Alternative methodologies

The first alternative methodology considered for the study was Discourse Analysis (DA). This methodology considers the connection between language, people's feelings, and their reactions (Willig, 2008). It suggests that the particular choice of language, such as the words and sequencing of words often has a purpose. DA adopts a social constructivist approach, which suggests that meaning is produced through interaction with multiple discourses. Leadership is a relational concept which involves elements of social processes with others, therefore this methodology was considered. However, DA researchers focus on the meaning that is developed from the shared language within a system (Starks & Trinidad, 2007). Although it is acknowledged that both IPA and DA use language to understand an individual's experience, IPA is different in that it considers the lived experience and subjective accounts of individuals, and how they make sense of these. As experiences of the phenomenon of leadership are important for the study rather than the specific discourses and their impact of these, IPA was believed to be more appropriate for the study.

The second methodology considered for the study was Grounded Theory (GT; Glaser & Strauss, 1967; Charmaz, 2014). The process of GT identifies categories of themes that emerge from the data and develops links between these in order to generate theory. This methodology adopts a 'bottom up' approach, which lends itself to the explorative research question. However, this form of analysis aims to develop generalizable theoretical frameworks rather than focus on the subjective experiences of participants to understand phenomenology. GT aims to identify contextualised social processes that account for the phenomena, where IPA is concerned with gaining a better understanding of the quality and texture of individual experiences (Willig, 2013). Therefore, IPA was considered a better fit to address the research question of exploring Clinical Psychologists' experiences of leadership. Furthermore, GT is an inductive approach and aims to limit biases to theory development such as through avoiding extensive literature reviews prior to analysis (Glaser & Strauss, 1967). This would not have been feasible for the current researcher, as I as the researcher will already hold inherent biases, and knowledge and experience in Clinical Psychology as I am a trainee Clinical Psychologist.

Design

As discussed, the study adopted a qualitative methodology and used IPA. One-to-one semi-structured interviews were conducted to explore Clinical Psychologists' experiences. This is the often the preferred means for collecting data in IPA (Reid et al., 2005). Qualitative research frequently relies on interviewing as the primary data collection strategy, in order to elicit the participant's story and experiences (Willig, 2008). Within IPA, semi-structured interviews are believed to reflect a "commitment" to explore participants' perspectives and elicit a rich, detailed, first-hand account of their experiences and attend flexibly to their emerging accounts (Smith et al., 2021).

Other methods of data collection were considered. Focus groups involve a group of participants discussing their responses to specific research questions and have been used for IPA work (Flowers et al., 2001). However, this method can contain difficulties in applying experiential analysis to complex social activities. Diaries are another method of data collection which can provide a rich personal account of individuals' experiences, thoughts and feelings, and can enable researchers to

access sensitive personal information which may be more difficult to collect face to face (Willig, 2008). However, diaries are an asynchronous method. Interviews allow the researcher and participant to engage in dialogue and build a relationship. This enables the researcher to attend to participants' responses and support the elicitation of more detailed and experiential ways of talking. Considering this, interviews were considered the best method of data collection.

Sample size

IPA methodology is interested in the common features of lived experiences, and to acquire detailed accounts of these individual experiences (Smith et al., 2009). Therefore, small sample sizes are often used, to collect data from multiple perspectives, but also to allow in-depth detailed analysis of individual accounts. Smith et al., (2021) suggested using six to ten participants for professional doctorate research, whereas Turpin (1997) recommended six to eight. The study planned to recruit a target of eight participants. This was to allow for a breadth of experiences to be investigated and to account for any errors incurred during the research process, whilst still enabling the opportunity for in-depth analysis.

Sample Characteristics

Participants were qualified Clinical Psychologists working within community CAMHS and undertaking leadership roles and responsibilities. An inclusion and exclusion criterion were developed in order to maintain homogeneity in the sample. This was important to ensure the data captured detail on a specific and similar group of participants, which is especially important with IPA's focus on the *particular* (Smith et al., 2021).

1. Service context

As leadership is a complex and dynamic concept, the context in which it sits is important. Therefore, the services where Clinical Psychologists worked were considered to ensure a focus on a particular context. Community services, which were of interest to the study, are likely to be operated and structured differently to physical health and inpatient settings. Thus, the experiences

and leadership roles undertaken may vary. Therefore, Clinical Psychologists working within community CAMHS settings were recruited and those working within inpatient and health settings were considered not suitable.

2. Leadership activities

The focus of the research was on Clinical Psychologists' leadership experiences; therefore, participants were required to be undertaking leadership roles. A definition of leadership was difficult to operationalize as there is limited consensus on what constitutes leadership (Leudi, 2022) and Clinical Psychology leadership roles in CAMHS may be varied. Therefore, for the study, leadership was operationalized as "leading in a clinical team" and undertaking an "NHS leadership role at 8a or above" as these roles typically constitute leadership activities, as guided by the DCP leadership framework (DCP, 2010). Although leadership is included in training and newly qualified positions it is likely to be a more substantive part of 8a roles and above. The definition of leadership is intentionally broad, allowing for participants to self-define leadership. Participants' understanding of leadership and the roles and responsibilities undertook were identified during the interview using questions such as, "*What types of leadership tasks are you involved in?*" and "*what are the most important leadership activities you take part in?*". Each participant's conceptualizations of leadership are described within the *pen portraits*. Further leadership questions can be found in the interview schedule (Appendix A).

Recruitment

Purposive sampling was used to recruit participants who satisfied the inclusion criteria. Participants were recruited through the UK Clinical Psychology Facebook Group, which is a network of qualified Clinical Psychologists within the UK. Membership of the group requires validation of people's status as a Clinical Psychologist, such as requesting photographic evidence of an NHS badge or Health and Care Professions Council (HCPC) registration. This group allowed access to Clinical Psychologists nationally for the study. National recruitment was important as the researcher was a

trainee Clinical Psychologist. This created the possibility of pre-existing or potential future relationships between participants and the researcher, however national recruitment reduced this possibility. As the topic of leadership within CAMHS may be related to feelings of stress, frustration or challenges within their role or service, a higher possibility of a future relationship may have been a barrier to participants discussing these issues.

An advertisement was initially placed in the group in September 2022, and re-submitted a second time in November 2022 to encourage additional participants to take part. The advertisement highlighted the focus on leadership experiences and the inclusion criteria (see Appendix B). Participants expressed their wish to take part in the study by contacting the principal researcher's email. Participants were screened according to the criteria by explicitly stating the inclusion and exclusion criteria and asking potential participants if they fulfilled this. Informed consent was then gained from suitable participants, and an interview date and time was arranged.

A total of 10 participants expressed interest in taking part in the study. Two participants did not meet the inclusion criteria due to working in inpatient settings. Whilst one participant fulfilled the criteria of the study, unfortunately an interview date could not be arranged. Therefore, a total of seven participants were recruited to the study.

Ethics

Full ethical approval was obtained from the University of Leeds School of Medicine Research Ethics Committee (SoMREC) on 22nd September 2022 (approval letter included in Appendix C). The key ethical issues addressed within this are discussed in the following section.

Informed consent

Informed consent was sought from all participants. Participants were provided with an information sheet (Appendix D) upon expressing their interest in taking part which detailed further information about the study. Participants were given the opportunity to discuss any questions with the principal researcher via email and also prior to the start of the interview. They were also asked to read

and sign a consent form prior to the interview (Appendix E). Participants were made aware that their

participation was entirely voluntary.

Right to withdraw

Participants were made aware of their rights to withdraw from the study. If participants

wished to withdraw from the interview at any point, the recording was to be stopped immediately and

any data recorded (audio or typed notes) were to be erased. Participants were made aware that upon

completing the interview, they were able to request to withdraw their data for up to two weeks

following the interview, by contacting the lead researcher via email. They were made aware that after

this point, the analysis may have commenced thus it would no longer be possible to withdraw their

data. No participants that took part in the study expressed a wish to withdraw participation or data at

any point in the study.

Anonymity and confidentiality

Efforts were made to ensure the anonymity and confidentiality of participants were protected.

As the study was conducted in the same field in which participants were working, it was also vital to

provide reassurance of confidentiality procedures to ensure the participants felt safe to talk about their

experiences. These procedures included transcripts being edited to remove identifiable information

(e.g., name, family details, name of service, name of department, name of colleagues, references to

specific service users or third party information). Pseudonyms were also created for all participants.

Participants were also made aware that that should they request specific aspects of the interview not

be published, notes can be made on the transcripts to indicate which verbatim extracts were not to be

published to the final thesis.

Data protection

To ensure data protection, the University of Leeds security protocol for collection, handling

and storage of sensitive research data was followed at all times. As interviews took place remotely via

video-calling, audio recordings of the interview were saved directly to a secure area as permitted by the University Security Policy. Electronic documents (such as word documents or pdfs) relating to the research were also stored within a separate encrypted folder in this secure area. Only the primary researcher had access to this data.

Risks

The potential impacts on participants through taking part in the study were considered. It was acknowledged that there were possible aspects relating to participants' (UK Clinical Psychologists) leadership experiences that may cause distress when discussed during the interview. These were managed through the several processes. Participants were informed of the possibility of distress arising from discussing challenging issues, via the information sheet, and we invited to discuss any concerns with the researcher prior to the interview. Participants were made aware they could choose to not answer any questions or pause/stop the interview at any point. If I became aware of participant's distress during the interview, I was prepared to remind them of these points and signpost to further support if appropriate. A debrief was also conducted post-interview to enquire about participants' wellbeing following the interview. Participants were made aware within the participant information sheet that appropriate safeguarding procedures would be followed should I be concerned about their safety. Supervision arrangements were made so that I was able to discuss any difficulties or concerns post-interview.

Procedure

Developing an interview schedule

Semi-structured interviews were used to explore Clinical Psychologists' experiences. The 'semi-structured' nature of interviews requires a schedule of questions, or 'topic guide' in order to elicit a "conversation with a purpose" (Smith et al., 2021, p.23). This permits an interaction that allows participants to tell their own stories, in their own words in depth and in detail, whilst guiding the content of the conversation.

The interview schedule (Appendix A) was developed with support from the research supervisors. The questions were constructed to be open and expansive in order to elicit data that provides rich descriptions of participants' experiences. The structure of the schedule also used a 'funneling technique' (Smith et al., 2009) where broader, more general and descriptive questions are asked at the beginning of the interview, to support the participant to become comfortable talking and build trust with the interview. Questions following this became more specific to elicit examples of leadership experiences, and encouraged more analytic and reflective thinking, once the participant eased into the interview (Smith et al., 2021). A list of optional prompts was also used flexible when necessary. These were to gain a coherent description and clarification of what the participant had described and ensure a full account of their experience (cognitions, emotions and behaviours) was captured.

Once the final draft of the schedule was developed, expert consultation was also sought from a qualified Clinical Psychologist working with community CAMHS, in a leadership position. This was to acquire feedback on the phrasing and order of the questions and any important considerations that might be missing. Feedback was incorporated around the phrasing of questions and developing a more 'conversational' style of questioning.

When the interview schedule was revised, a pilot interview was conducted with a Clinical Psychologist working with CAMHS. This individual was a colleague within my NHS placement at the time of study. Due to a pre-existing relationship, they were identified as someone who would not take part in the project, and therefore were considered suitable to 'test-drive' the interview schedule. This practice interview allowed both the interviewer and interviewee to reflect on the flow of the questions, and whether they elicited in-depth descriptions of experiences in line with the research questions. The interview schedule was considered suitable at addressing the research question and aims. I was also able to practice my interviewing skills, which was important as I was new to IPA and conducting interviews in the context of research.

Following the pilot interview, I accessed supervision to allow for further reflection of the interview process. My prior experience of facilitating therapy meant that I have often adopted a therapeutic approach to conversations, which involved a level of analysis and interpretation. Therefore, it was important for me to reflect and consider the function of IPA interviews, to gather information

about a person's experience, and develop a new set of skills to approach the conversations through this lens.

The final interview schedule

The final interview schedule began with *general* leadership questions, which aimed to gather each participant's individual conceptualisations of leadership. These encouraged participants to describe the types of leadership activities they were involved in, and elicit what was 'important' to participants, in relation to specific tasks, and the influences on their leadership styles. Following this, *specific* leadership questions focused on eliciting specific examples of leadership. The first questions asked about the challenges that participants had faced as leaders, and aimed to produce two different examples. The following questions focused on eliciting the personal effects of engaging in leadership in CAMHS, and also aimed to produce two different examples.

Whilst participants' experiences of leadership were likely to be during or at least impacted by Covid-19 pandemic, the questions did not aim to specifically enquire about Covid-19. This was because participants' experiences were likely to be during the different stages of the pandemic. Therefore, it felt important not to 'single out' a specific point in time so as to not exclude valuable experiences.

Interview procedure

Interviews were conducted via the video-conferencing platform Zoom. Remote interviews were considered the most appropriate as recruitment was conducted nationally, thus they allowed for participants from different geographical areas to take part. Due to technological developments that arose from the Covid-19 pandemic in 2019, remote platforms such as Zoom were readily accessible and established to accommodate online interviewing. At the time of the study, remote platforms were being regularly utilised to facilitate remote working, and thus both myself and participants working with NHS mental health services were likely well accustomed to their use.

The drawbacks of using remote methods were noted, such as a loss of some non-verbal information, and the potential to impact on rapport building (Weller, 2017). However, video-call

interviews are considered an effective means of engaging with participants (Coulson, 2015), and further research indicates that relationships are able to remain as connected and authentic compared to face-to-face interactions (Archibald et al., 2019; Bekes et al, 2020). Therefore video-call interviews were considered a suitable and useful means of engaging in qualitative interviews.

Other potential difficulties of using an online platform were considered to ensure minimal interruption to the interview process. This included ensuring that interviews took place in a confidential space, free of distraction. I conducted the interviews in a private space, and participants were reassured of this at the beginning of the interview. Participants were also asked if they resided somewhere they felt comfortable discussing their experiences. Furthermore, technical difficulties were possible, therefore a plan was agreed at the start of the interview should either the researcher or participant lose connection or endure interruption.

The interviews lasted between 45 and 65 minutes and were audio recorded. Demographic information was collected at the beginning of the interview before the recording was started. Participants were asked if they had any questions prior to the interview commencing, and afterwards. At the start of the interview, participants were reminded of the research area and aims and purpose of the interview. They were then informed of the flow of questioning, starting from broader questions about leadership, moving to more specific examples of leadership experiences. The interview guide was used flexibly to allow for a conversational, reflective tone of interview that is aspired to in IPA, and to ensure I acted as an 'active listener' (Smith et al., 2021). To ensure that key experiences were elicited, I made notes of important or interesting items to refer back to and follow up. At the end of the interview, once the recording was stopped, participants were asked about their experience of the interview, to both consider any potential distress induced and allow for participants' reflections on taking part.

After each interview had finished, I noted any personal reflections in a reflective log, on my own experiences on conducting the interview, including any non-verbal information, and key thoughts, feelings or ideas. This was referred back to during the analysis stage.

Transcription and data protection

All interviews were transcribed verbatim and anonymised to remove any identifiable information, and each participant was assigned a pseudonym. I transcribed the first interview myself and the remaining interviews were transcribed by a University approved transcriber.

Data analysis

The following section describes the process of IPA analysis used for the study. This was guided by the analytic protocol described by Smith et al. (2021, pp. 75-108). Whilst IPA is considered to not prescribe to a single 'method', it is an iterative and inductive cycle which draws upon a set of common processes, strategies and stages. (Larkin et al., 2006; Smith et al., 2021). The stages of analysis are summarised in Table 1.

Table 1. Stages of IPA analysis

Stage	Activity
1	*Immersing self in the data:* reading and re-reading individual transcript.
2	*Exploratory noting*: making initial descriptive, linguistic and exploratory comments on the transcript to develop a phenomenological and interpretative understanding, that stays as close as possible to the participant's experience.
3	*Constructing experiential statements:* developing concise phrases to simplify the exploratory notes, whilst capturing their complexity.
4	*Searching for connections across experiential statements:* grouping statements that fit together, to produce Personal Experiential Themes (PETs); a structure that represents the important aspects of the participants accounts.
5	*Continuing the individual analysis of other cases:* moving to the next participants transcript, repeating steps one to four for each individual transcript.
6	*Developing Group Experiential Themes (GETS) across cases:* looking for patterns across cases and creating a representation of the final themes for the whole group.

Individual analysis

Step 1. Individual analysis began by initially listening to the audio recording of the interview whilst simultaneously reading the transcript. During and after this, initial thoughts and reflections on what was observed were noted in the reflective log, to begin to notice and address any initial reactions to the data. There was a focus on self-reflexivity here, noticing any preconceptions or biases towards the data and 'separating' these out before the analysis.

Step 2: After a re-reading of the transcript, exploratory noting was conducted on the transcript using Microsoft word. This was done down a column to the left-hand side of the transcript data. This step involved noting anything of interest within the transcript, including things of significance to the participant. The noting included and moved between descriptive, linguistic, interpretative coding and conceptual commenting. These levels of 'analysis' were conducted simultaneously. The exploratory noting process was then completed a second time, adding to or adjusting the comments. During this process, notes were made in the reflective log to capture thoughts and potential ideas that were arising from the analysis at this time. Conceptual comments were also noted here to engage in a dialogue between pre-understandings and new emerging understandings of the participant's world.

Step 3: Once the exploratory noting felt complete, and captured all relevant points of significance, the next step, constructing experiential statements, was carried out. This was conducted down a column to the right-hand side of the transcript. This step involved moving back and forth through the text and the exploratory notes to ensure I had captured the key experiences for the participant. I reflected once again, on the 'whole' data, before moved back to the 'parts' and adding to or adjusting the experiential statements, to refine what I considered to be the key emerging experiences for the participant. Here I considered and noted how my interpretation was influenced by the 'whole' data. Once the statements were complete, supporting quotes from the data were added to each one in a table. See Appendix F for an extract of Step 2 and 3.

Step 4: Personal Experiential Themes (PETs). The final step of individual analysis involved clustering the experiential statements into themes. These themes were developed to have an experiential focus, at the level of each participant. The statements were printed onto paper and cut out into each individual statement, and scattered on a surface in no particular order. This ensured that the

statements were given equal significance, and allowed the opportunity to consider multiple

connections. The statements were moved around and patterned in a way that best captured and made

sense of the participants' main concerns and the meanings they made of them. Some of these clusters

of connected statements contained multiple ideas and patterns. These were formed into sub-clusters

within each theme. During this stage, the reflections noted in the reflective log were referred to, to

inform and support the analysis.

Each cluster of experiential statements was then given a title to describe its characteristics,

which formed each PET, and was then transferred into a table (see Appendix G for all individual PET

tables and Appendix H for an example extract with experiential statements and supporting quotes).

Group analysis

Step 5: The final stage of the analysis moved from the 'particular' to the 'shared'. This

involved looking for patterns of similarity and difference across the PETs, to generate a set of Group

Experiential Themes (GETs). During the stage, the PETs were printed and laid on a surface to allow

for a scanning of the individual data and begin to consider possible convergence and divergence

within the data. This was a dynamic process that involved zooming in and out of the data, and

forming ideas about how the PETs connected together, what PETs were most potent, and how was

commonality across the material appearing. Multiple connections and clustering of the material were

considered and reorganized, before the final GETs were developed. The themes aimed to retain both

the individuals' uniqueness and shared qualities of the whole sample.

Validity and quality checks

Assessing the validity and quality of qualitative research through a single set of criteria can be

difficult as there are many types of qualitative research, each with their own unique assumptions.

However, benchmarks of quality have been developed by Elliott et al., (1999) and Yardley (2000),

which are considered useful guidelines to assess the validity and quality of studies within IPA

research. (Smith et al., 2021). These focus on assessing issues of 'trustworthiness' and 'rigour' and

highlight the importance of understanding the context of the sample, providing transparency where possible to create a clear, coherent narrative, as well as ensuring credibility checks that assess the accuracy and credibility of interpretations, and for methodological competence and skills. These have guided the following steps I have taken to strengthen the validity and quality in the current study.

1. Learning IPA: Firstly, as IPA is a novel methodology to me, I had limited prior theoretical understanding and relevant techniques of IPA. I aimed to develop my skills by immersing myself in IPA literature, and online webinars and video teaching content. I used supervision to discuss IPA concepts to improve my understanding and skills, as well as supervision with fellow peers also conducting IPA studies. This allowed me to reflect on concepts and skills in IPA and discover helpful practices and skills from each other as we progressed in our research methods.

2. Reflexive practices: I also reflected on the use of reflexive practices in IPA, and considered the methods that I utilised in my role as a trainee clinical psychologist. I was able to use and develop these for this research process, such as keeping a reflective log of my thought processes, emotional reactions and learning during the research process (see Appendix I for an example extract). This was important to capture my preconceptions and influence upon the research process, and to develop self-awareness of my own 'lens' of interpretation of the data.

3. Situating the sample: Demographic information was collected and presented in the results to provide individual contexts an overview of the sample. Pen portraits were also used, which provide useful contextual information about participants, and the interview process. Summaries of the pen portraits are outlined in Chapter three, and an example of a full pen portrait can be found in Appendix J.

4. Grounding in examples: I used examples of data to illustrate and evidence the process of analysis and interpretation. Direct quotes were used at each stage of the analysis, alongside experiential statements, and within PETs and GETs for each participant to ensure interpretations were grounded in the data. I continually referred back to the original data during the analysis stages, when developing themes, to reaffirm and check that the developing analysis could be evidenced clearly and coherently.

5. Credibility checks: I engaged in multiple credibility checks to strengthen the accuracy and credibility of interpretations. Firstly, I immersed myself in the data and re-read transcripts multiple times to consider different perspectives. I regularly used supervision during the analysis stage, and shared anonymized transcripts with exploratory noting, experiential statements and corresponding developing PET tables to discuss with my supervisors. This was to ensure transparency during the process and allow for feedback on my interpretations and consider data from different perspectives. I also shared my experience of the process of interviews, and regularly shared my developing reflexive stance to support my understanding of the 'double hermeneutic' involved in my interpretations and allow further transparency of my developing ideas. In addition, I engaged in 'peer validity' checks, by sharing sections of anonymized transcripts and getting feedback on possible different perspectives to support the validity of the developing themes. Finally, during the stage of developing the GETs, I utilised supervision to discuss and reflect on potential themes. This was important as this part of the analysis was a challenging process, due to working at a broader and higher analytic level whilst holding each participant's lens and experiences in mind. Therefore, I received feedback from my supervisors about the ideas within the themes, the wording of the themes, and support in thinking about how to reorganize a sub-theme to better capture the connections.

Reflexive statement

Reflexivity is an important concept within IPA, considering its focus on interpretation of participants experiences and the researcher's role within this. As "one is using oneself to make sense of the data" (Smith et al., 2021, p32), self-reflexivity practices are important for researchers to develop self-awareness of prior knowledge, experiences, background and beliefs that may influence the 'lens' through which the data are interpreted. (Finley & Gough, 2008; Willig, 2013).

Therefore, the development and use of self-reflexive practices were considered throughout the research process. Additionally, a reflexive statement allows for researchers to consider and summarise their own influence on the research process, which I will describe. This summarises how I came to

undertake the area of research, highlights my preconceptions and experiences within the areas of leadership and CAMHS and how this may have impacted the research process and results.

Developing my reflexivity

Self-reflective practices are considered a key skill of Clinical Psychologists, therefore as a trainee Clinical Psychologist, this is a practice I am somewhat accustomed to. It is something that I enjoy, to develop my self-awareness, however it is a process that I also found challenging during the research process, holding a continuous reflective 'way of being' with the data.

Throughout the study, I developed and utilised self-reflexive methods and practices. I kept a reflective log within a Microsoft Word document, continuously and systematically, to capture my preconceptions and influence upon the research process (see Appendix H). This occurred during the development stages of the study, as well as during each step of the analysis, as described, and during and following discussions in the supervision. I also allowed spontaneous reflection to occur, by keeping handwritten notes of reflections that occurred outside of designated practices, and incorporated these in the reflective log. I was able to become more aware of my thoughts, feelings, biases and perspectives, and continuously 'check in' on my own developing stance. I regularly discussed both the content and process of the of my reflections within supervision to gain perspective on how these may impact my interpretations of the data.

Reflexive statement

The following section describes my self-reflexive position, so the reader can be aware of my values, views, beliefs and preconceptions. This offers and describes the 'lens' through which I understand the phenomenon of leadership, within CAMHS.

The first topic of the study was leadership. Prior to commencing training, I considered 'leaders' to be particularly strong, confident, and assertive characters, and a concept that I had not considered for myself nor fitting with my personal values and attributes. As I developed my understanding of Clinical Psychology and the wider context of mental health, I began to value the

importance of promoting and influencing psychologically informed services and care, which was a motivator to pursue my career as a Clinical Psychologist. I had previously not considered these values as pertaining to the concept of leadership, and this was something I was introduced to during training, which sparked my interest in the topic area. Nonetheless, being required to undertake leadership roles during training and beyond felt daunting. I paid careful attention to these preconceptions during the interview process and analysis process, such as noting when I was being 'self-critical' hearing the many leadership roles and responsibilities participants held, and the confidence and in which they appeared to engage in leadership. I used supervision to reflect on this and consider the impact on my interpretations. As I move towards completing training and transitioning to a qualified position, I have begun to gain confidence undertaking leadership tasks, and I have considered leadership styles fitting with my personality and values. The research question developed through recognising a limited understanding of what leadership 'looked like' in practice, and how other Clinical Psychologists were experiencing leadership. This limited understanding was also evident within the research literature.

The second topic area of the study was CAMH services. Whilst developing the area of focus for the study, I had an affinity to services for children and young people, and an interest in developing research base for clinical psychologists' experiences, of leading, within these services. During the study, I undertook my final year placement in CAMHS. This was at times a challenging experience, as I understood first-hand the pressures on children and young people's services and the impact on the workforce. I also experienced limited support at times, which often felt stressful and uncontaining.

An example of my developing reflexivity was when I noticed myself being surprised at the often positive experiences of leadership described by participants, and feeling validated in my own experiences of stress working in CAMHS when participants talked about the challenges. An opportunity to explore and develop my reflexivity occurred when asked by my supervisor what it was like working as a final year trainee during the study, in CAMHS, working towards developing leadership competencies, and how this might impact my interpretations of the data. From this I engaged in peer supervision with fellow trainee Clinical Psychologists in CAMHS to reflect on our experiences in CAMHS, and to better understood the challenges and stressors within CAMHS that were impacting on my own experience of stress. I was able to consider how I may have a potential

bias towards participants' challenging experiences, such as loss or a lack of connection and support in services which was relevant to my experiences. I was then able to scrutinize my interpretations and ensure they were grounded in the data.

Chapter Three: Results

This chapter will first set out participants' descriptive information, which includes a summary of the demographic information, and individual pen portraits for each participant. Following this, the results of the group analysis will be presented. It is important to note that the results from the analysis represent an *interpretation* of participants' experiences, as described in chapter two. The aim of the analysis is to "get as close to as possible to participants experiences" (Smith et al., 2021, p.14), whilst understanding that this is influenced by the double hermeneutic of IPA.

Descriptive Information

Demographic information

Seven participants took part in the study, all of whom were qualified Clinical Psychologists working within either generic or specialist community CAMH services, in different NHS trusts across the UK. Participants' demographic information is summarised in Table 2. This information has been kept separate from the pen portraits in further steps to protect the confidentiality of participants. This is of particular importance as the readership of the study is likely include other Clinical Psychologists working within CAMHS.

Table 2. Summary of participant demographic information.

Demographic area	Participant data
Age	Between 30 – 51 years (M= 39.6)
Gender	All Female
Ethnicity	6x White British 1x White Other
Years since qualification	Between 2 – 19 years (M= 11.1)
Service working in at time of study	6x Generic CAMHS 1x CAMHS neurodevelopmental team
Geographical location of service	Somerset Cheshire 2x Yorkshire London Lincolnshire Scotland
Title of current role (defined by participant)	Senior Clinical Psychologist Highly Specialist Clinical Psychologist Clinical Psychologist (Specialist Trauma Lead) 2x Consultant Clinical Psychologist Clinical Psychologist/Clinical Lead Strategic Clinical Director
Current NHS banding (time in current banding)	1x 8a (1 year) 3x 8b (5 months; 2 years; 3 years) 2x 8c (1.5 years; 3 years) 1x 8d (5 years)

Pen portraits

Pen portraits have been created to offer individual contexts for each participant. First, I created a full pen portrait, which included information such as participants' motivation for taking part in the study, participants' conceptualisation of leadership, what they consider to be the most important part of this role, and what guides their way of leading. It also included examples of the challenges participants chose to discuss, as well as examples of the personal effects of being a leader described by participants. These detailed portraits helped me to develop an in-depth understanding of the data for each individual participant which informed the results and discussion of the study. An example of a 'full' pen portrait can be found in Appendix J.

I have presented a summary of these pen portraits, as well as a reflection of my experience of the interview process. Quotations have been used, written in italic and quotation marks to illustrate the portraits. Each participant has been assigned a pseudonym order to protect their anonymity in the study. A name, rather than a number has been used in order to create a more personal connection with the participants as people, rather than 'data'.

Abigail

The leadership responsibilities that Abigail described taking part in were leading multiple service development projects and case formulation meetings and providing supervision to multiple professionals within MDT. Abigail also led a Continued Professional Development (CPD) afternoon, which involved teaching and training, often from psychology, to develop inter-professional skills. Abigail described an important part of her leadership role as developing psychological thinking and skills in formulation across multi-disciplinary teams, which she felt *"psychologists are really good at"*. Abigail was motivated to engage in leadership activities through her own interest in service development as "*they make a bigger impact on a service"*. She had many ideas about how to improve services, and was motivated to bring these to fruition. Abigail pursued her most recent role for the opportunity to engage in wider service development initiatives, that were in line with her *"passion about working in trauma informed way"*. Abigail described how her leadership style was underpinned by values of *"listening to what people are saying"* and psychological principles of formulation and *"understanding what's going on in a system"*. She felt it was important that "*psychological practice informs what you're doing"*. During the interview with Abigail, I felt an overall sense of how she was keen to portray her positive interpretation and experiences of leadership. Abigail's initial response to naming challenges was focused on what she considered others' difficulties to be, and whilst describing challenges of leadership, she did not always consider these experiences as difficult.

Beth

Beth described being involved largely in strategic and organisational responsibilities, such as "*strategic direction*" and *"setting the vision"* for services. She also engaged in *"technical leadership"* such as being the clinical lead for effectiveness in her organisation. Beth described the most important elements of her role to be *"listening to people that use services*" and combining this information with evidence-based practice to set a direction for services *"and then getting everyone else behind it".* Beth talked about how she valued "*relationship leadership*", and considered this key to her way of leading. Beth moved into senior leadership roles, through opportunity of a vacancy, which afforded these types of leadership responsibilities. Beth felt encouraged and supported form others to undertake the role and was motivated by wanting to "*make [services] better*".

Beth described how her *"values"* and *"moral compass"*, particularly around *"person-centered care"* informed her leadership style. She also spoke about being heavily influenced by various models and approaches for leadership. Beth referred to these models often throughout the interview when reflecting on and understanding her experiences of being a leader. I experienced Beth as very keen to share her knowledge and expertise around leadership, and passionate about the topic. At the end of the interview, she acknowledged sharing her learning around leadership to be *"another reason [she'd] like to talk to me."* During the interview, Beth also described her tendency to sometimes *"intellectualise distress",* and I noticed her tendency to focus on and share what she had learnt from challenges and the implications for future Clinical Psychology leaders.

Clare

Clare described being involved in many leadership tasks. These included *"formal mandated leadership*" such as being the clinical lead for 'therapies' in CAMHS, and for the 'risk management pathway'. She also described engaging in the "*clinical governance of treatment*", such as *"treatment innovation*" and *"service development*". Clare also participated in *"informal ad hoc leadership"*, which involved "*informal supervision, support, scaffolding, containment of colleagues and wider professions in the networks".* Clare felt most passionate about service innovation, underpinned by strong values of person-centered care and fairness. She also felt strongly about supporting the

development of colleagues, and ensuring her leadership practices were underpinned *"theory practice integration" and* "*evidence-based practice"* alongside being proactive to pursue *"practice-based evidence"* and "*treatment innovation".* Clare's initially conceptualised leadership similar to 'management' which she felt did not align with her skills. However, gradually she began to understand leadership as relational, and 'way of being" that felt in line with her values and became motivated to inhabit these roles.

Clare's leadership was strongly informed and motivated by her values of *compassion, equity, justice, kindness,* and *"believing that every child and young person with severe and complex mental health problems and their families and carers, deserve a good service!".* I experienced Clare as enthusiastic and passionate about her role, and full of energy and motivation for the role of Clinical Psychology in leadership. Clare was able to be reflective and readily expressed her thoughts and feelings relating to her experiences. Clare found the interview process to be beneficial, stating "*I think I've had an hour of therapy!".*

Daisy

Daisy was interested in taking part in, as she felt that "*it's an important topic for us to reflect on as psychologists"* due to there being a *"push for psychologists to take a leadership role".* Daisy described finding leadership to be personally challenging and *"uncomfortable"*, with leadership feeling in conflict with her "*personality style".* Daisy wondered about how others in the profession may experience this too. The leadership tasks Daisy described taking part in included clinical supervision of mental health practitioners, as well as operational tasks, such as service development and reviews of professionals' caseloads. Daisy also described *"psychological leadership"* which she conceptualised as supporting informal formulation practices for example in meetings or 'huddles', and ad hoc consultations with other professionals. Daisy felt the most important leadership responsibilities were the *"ad hoc stuff"* and a *"trickle down approach",* offering formulation and psychological informed thinking to staff. This felt important due to being part of a large team with limited psychological input.

Daisy became involved in leadership tasks mostly because "*it's just part of [her] job plan*", as well as feeling a "*general expectation from the clinical lead, who is also a psychologist*" to actively engage in leadership. Some of the service development projects were afforded due to her experience in specific areas. Daisy described her leadership style to be underpinned by experience of both "*positive and negative leadership*". She "*looks up*" to those who have exerted quiet confidence as a leader, which she felt aligns with her personal style and comfort zone, as she has a "*tendency in a group setting to step back*".

I experienced Daisy as honest about her experiences, and open to being vulnerable and sharing what she found difficult about leadership. Daisy seemed to readily 'own' her internal self-criticism and how it impacted on her experience of engaging in leadership. Daisy came across, to me, as afraid and uncertain of leadership, but developing in confidence.

Emily

Emily reflected how she was involved in both management and leadership tasks in her position, which she felt often overlapped. Tasks involved supervision of psychology colleagues, consultation within and across services, managing and being responsible for pathways, service development projects and line management of other colleagues. Emily distinguished leadership as relating to "*how would I then contain [the] stress*" of pressured and busy services and considered the importance of leaders to protect staff wellbeing. Emily considered the most important leadership tasks to be supervision and "*ad hoc*" conversations, to support and model support to staff, and build psychological safety.

Emily described her leadership style as being informed by experience of other leaders both positive and negative. She shared a significant difficult experience of a leader being unsupportive and "*really not nice*" which heavily influenced her values of compassion as a leader. Positive leaders who influenced her way of leading were those that build good and trusting relationships with others.

During the interview process I felt that Emily found it difficult to discuss her own feelings and needs, and her focus often moved towards thinking about staff needs, and how she was able to support them through challenging times. It felt slightly challenging to elicit descriptions of emotions

and I wondered if Emily was holding back from this area at times. I found myself working hard to build a good rapport to support Emily to feel safe talking about difficult experiences.

Faye

The leadership activities Faye engaged in were being the *"clinical lead for the team"*. This meant being "*responsible for the delivery of all interventions across [the] service" and* ensuring *"quality"* and services meeting both NICE guidelines, the evidence bas and *"commissioning requirements"*. Faye was the lead of the *"supervision structure within the team"* and also facilitated "*reflective groups for the team"* and *training and processes to help the team improve"*. Faye considered her leadership responsibilities to be *"a mix of lots of kind of management things alongside lots of clinical stuff"*.

Faye adopted leadership responsibilities when an *"opportunity arose"* to move to a more senior position. She was also motivated by service development and considered herself to have *"quite a good eye on what could be improved"*. Faye's way of leading was informed from *"having experiences of good leadership and very poor leadership"* which helped to understand "*what is helpful and not"*. Through this Faye valued leaders being "*kind and empathetic"* and building relationships with others, and adapting leadership styles depending on the needs of the team, and interpersonal dynamics. I experienced Faye as well-engaged in the interview and open to talking about her experiences. Faye seemed to be ambivalent about how she *found* leadership. At times throughout the interview, I found Faye to be uncertain about what leadership styles she felt were useful, as there were some contradictions between her thoughts and feelings towards using more 'directive' and 'authoritative' leadership.

Gemma

Gemma described her leadership role as *"professional lead for the psychologists in CAMHS"* which involved *"supporting psychologists in their role within a multidisciplinary team"*. A second aspect of her role involved being the lead for the service development of pathways within CAMHS, to
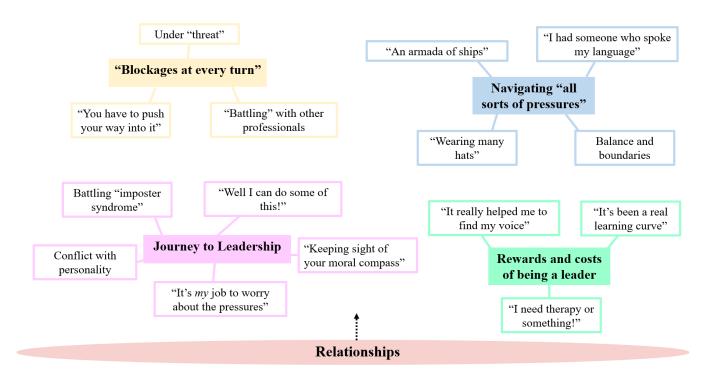
better "*support young people to have a good journey through CAMHS.*" Gemma felt that taking part in such leadership responsibilities are an expected part of the role. Whilst some tasks are *"delegated"* and expected others she has proactively sought, such as certain service development projects. Gemma felt that it was most important, as a leader, to be focused and engaged and collaborative with staff, and inclusive of their views in how services should develop and change. Another important part of being a leader involved sharing psychological expertise and perspectives to influence the direction of change.

Gemma felt that her leadership style was mostly informed by *"past experience of working with other leaders",* and felt she was *"really rubbish at remembering"* models of leadership. Gemma shared how through her experiences she had noted leadership role models that has aligned with her values and adopted these in her own roles. These include building positive relationships, being supportive, and a containing presence for staff. Gemma found leaders *"inspirational"* who had a *"fair, empathic, but boundaried approach".* Negative experiences of leaders included those who had been *"massively uncontained"*, which she noticed led to staff not feeling safe to share their difficulties or seek support. During the interview, I found Gemma to exude confidence, and be assured, clear, and articulate in what she was sharing. It felt easy to build a rapport with Gemma, and she seemed authentic and open to sharing her thoughts and feelings. When talking about difficult and emotive experiences, she did so in a calm and reflective manner.

Results of Group Analysis

The following section will discuss the results of the group analysis. Group Experiential Themes (GETS) were developed, through the exploration of and clustering of the shared experiences and commonality between participants. Four GETs emerged from the analysis, each with between two to five corresponding subthemes. These are illustrated visually in a thematic map, shown in Figure 1. Table 3 presents the how the themes are represented across participants. Each theme and subtheme will be discussed in detail, with supporting quotes from participants to ground the interpretation and analysis in the data. Quotes are written in italics with quotation marks, and page numbers to indicate their location in the transcript.

Figure 1. Map of themes

Table 3. Representation of themes across individual participants

Theme	Subtheme	Participants						
		1	2	3	4	5	6	7
"Blockages at every turn"	Under 'threat'	X	-	X	X	X	X	X
	"Battling" with other professionals	X	X	-	X	-	X	X
	"You have to push your way into it"	X	X	X	X	-	X	X
Navigating "all sorts of pressures"	"Wearing many hats"	-	X	X	X	X	-	-
	Balance and boundaries	-	X	X	-	-	X	X
	"An armada of ships"	X	X	X	X	X	-	X
	"I had someone who spoke my language"	-	X	X	X	X	X	X
Journey to leadership	Conflict with personality	-	X	-	X	X	X	-
	Battling "imposter syndrome"	-	X	X	X	X	X	X
	"Well I can do some of this!"	-	X	X	X	X	X	X
	"Keeping sight of your moral compass"	X	X	X	-	X	X	X
	"It's *my* job to worry about the pressures"	-	X	-	-	X	X	X
Rewards and costs of being a leader	"I need therapy or something!"	-	X	X	-	X	X	X
	"It really helped me find my voice"	X	X	X	X	X	X	X
	"It's been a bit of a learning curve"	-	X	X	-	X	X	X

Relationships

As illustrated in Figure 1, Relationships were a concept that were central to the experiences described by participants and were a common thread that was evident across all the themes and subthemes. The relational element across the themes included either participants' relationships with others, themselves, or with the construct of leadership. These relationships underpinned participants' experiences and were considered to be a key focus for participants in defining and understanding their experiences of leading with CAMHS. Relationships were both a source of challenge, tension and stress, but could also be a key strength for leadership, and something important to be nurtured and

strengthened. The concept of relationships has not been defined as a stand-alone theme, due to their presence across the entirety of participants' data. Rather, the concept of relationships is evident and noted within the description of each theme and subtheme.

Group Experiential Theme One: "Blockages at every turn"

The first theme refers to the many hurdles participants were required to navigate and overcome, to be a leader within their service. This included the difficulties participants faced, such as trying to create change or develop services, or navigate their role within pressured services. Participants shared a sense of feeling '*stuck*' or facing '*battles',* working alongside other professionals in multi-disciplinary teams, within busy, stretched services, and responding to organisational pressures.

Subtheme: Under Threat

This subtheme captures the sense of stress and fear that participants talked about, within themselves, their colleagues and the wider team and service. Participants described services engaging in 'reactive' care, due to the context of high demands and limited resources, which created a sense of overwhelming stress for workers and a resistance to development and change.

Gemma described metaphorically how systemic pressures on the service felt overwhelming, and how without finding ways to relive or hold off pressure, it may continue to create chaos and a sense of overwhelm in the service. "*If we just keep the taps on, we're gonna overflow the sink. And then we're going to be mopping up the mess. You know, taking the plug out or turning taps down a bit, as it were (Gemma, p.23).*

Clare shared a similar analogy, and talked about how leadership priorities can often be turned to managing staff wellbeing, meaning innovative practice can become second order to reactive practice. *"You end up being reactive and containing an awful lot of frustration. I find I'm spending quite a lot of time just trying to mop up frustration and dissatisfaction. And within that it's quite hard them to be positive and innovative and creative, isn't it?" (Clare, p.17).* Clare's use of metaphor also

demonstrated an 'overspilling' of emotions and stress that was present in services. Clare felt this created hardship for her as a leader, and a sense of feeling responsible to manage and contain others' distress, at the expense of developing services and care.

Other participants also talked about reactive practices, and how service process often felt organised around fears and pressures from regulating bodies, which created disagreement amongst professionals. Abigail shared an example of how managerial anxiety around waiting lists resulted in processes that might impede timely care. "*There's something about how waiting lists are perceived, and I think it's just kind of fudging the issue. I understand managerial anxiety about having internal waiting lists. I do respect that, but it has caused some contention cause we need to have a way of you know, not losing track of those people who are waiting for psychological therapies" (Abigail, p.12).*

Feelings of threat were also induced by pressures from senior leaders and management. For example, Faye described feeling overwhelmed by pressures from senior management and talked about having frequent meetings, and receiving emails, *"which happens on a weekly if not daily basis" (p.17),* leaving her feeling criticised and demanded of. "*And probably my thoughts are along the lines of feeling almost like, you know this doesn't feel necessary! Why have you worded it in this certain way?.I guess a feeling of, I've already got so much to do!" (p.19)* and *"then [in meetings] you'll have your directors come and sit in there. And the agenda is very much, you know, we haven't met this criteria! You need to go back to your teams and do X, Y and Z... And we're not meeting our…standards… and so it's very like, you know, you need to do this! And that expectation. Which can just, it can just feel hard" (p.18).* Faye exuded a sense of feeling overwhelmed and threatened when talking about the pressures that senior leaders and management were placing on her. Faye and many of the other participants made sense of the 'stress' and 'threat' experienced, through the context of wider systemic pressures on CAMHS and the NHS. Whist participants held this understanding, it felt evident that these difficulties were ongoing and needing to be consistently dealt with. Clare shared how trying to create change amongst the pressures were "*the beast we grapple with daily" (p.10),* which depicted the enormity of the impact, as something overpowering and hard to overcome.

Subtheme: "Battling" with other professionals

The second subtheme refers to the interpersonal challenges that participants described, that created experiences of tension and conflict in their role. Participants shared a sense of being in 'battle' with other professionals, to create change and get things done. Clare talked about being met with resistance from other professionals when wanting to pilot a new pathway. Clare stated that through facilitating these developments "*we didn't become complete rogue operators…we didn't go off-piste*" *(p.11)* and *"people were thinking… this is a bit woo!" (p.11).* This demonstrated Clare's felt sense of being considered an 'dangerous' or 'crazy' for wanting to try something new, which she had to battle with externally and internally.

Participants made sense of inter-professional conflict through the cultural differences between psychology and other professionals. In particular, this occurred with medical and management members of the service, which created contention and difficulty creating change. This included different members of the team "*coming at things from a different lens… people kind of leading from a psychological perspective. But people leading from an operational perspective" (*Daisy, p.7). Beth spoke about the difficulty trying to implement service development initiatives to improve service quality, due to conflict between and a lack of understanding of different professionals' perspectives and priorities. *"I was trying to think about how we improve the quality of our service? How we became more efficient, more effective and so on? And I think, you know, reflecting back now, the challenges were that I was just speaking a different language"* (Beth, p.9). Therefore, trying to get other professionals on board often felt arduous and slow, as depicted in Beth's use of metaphor "*it felt like it was just wading through treacle some of the time*" (Beth, p.10).

Participants seemed to make sense of these difficulties as due to longstanding hierarchical structures and medical model dominance that were present in services, and difficult to change. *"And that's a part of the NHS that I really struggle with. That very old fashioned … hierarchical … and also, then tied into that you know there's still a very strong medical model dominance. That sits within that."* (Gemma, p. 16). Within this, participants talked about directive leadership styles within these systems that felt uncomfortable, difficult, and in contrast to their values of collaboration. *"What I find*

challenging in that is that again, probably cos it's quite different to my style leadership, it's much more ... let's stick together. You know, I'm not telling! I'm asking! I'm inviting. I want to do it as a team. But I do find the NHS very hierarchical in that you know senior leadership, so directors et cetera, there's a very kind of you must do this!... and there's no discussion." (Faye, p.16)

Participants also talked about how different professionals' perspectives and ways of doing things could create a sense of psychology being misunderstood and underappreciated. Abigail shared how *"in a previous job the manager was a social worker. So, they didn't really understand perhaps how psychology could be used to inform service development and take on leadership roles… because they're just from a different position. And another team I worked in, and it was a nurse manager and they don't put so much value on things like supervision and training"* (Abigail, p.23). In Abigail's experience, other professionals could learn the value of clinical psychology through outcomes, however professionals' resistance impeded this working alliance *"But I think if they see you having a good impact on people and see the impact you're having within the team by allowing you to do what you want, they're more likely to allow you to do it. But sometimes because the barriers are up already, they don't allow you to do it. They can't actually see the good outcome it would have"* (Abigail, p.25).

Subtheme: "You have to push your way into it"

The third subtheme referred to power structures and dynamics within services and between professionals that created challenge for participants. As leaders within these structures and services, participants were required to negotiate and navigate their position of power which they often found difficult. This included the hierarchical structures of leadership, and management structures previously mentioned, that were not accustomed to working with psychologists. Participants often felt that they had to assert their position of power, and were often left feeling "*demoralised"* by professionals' *"push back"* against psychology.

Participants talked about how they often did not feel respected as a leader. *"Other professionals in leadership or higher hierarchical roles have a real disrespect for psychology"* (Faye, p.9). Gemma thought that psychologists and other professionals had limited power compared to other

professionals within similar bandings *"That's a weird set up! I think in the NHS. So, psychologists are very highly banded and yet, yes, they're often, when you're a psychologist not involved in a lot of those [leadership responsibilities]"(Gemma, p.35).* Within these structures, Beth seemed to feel disempowered and dismissed when attempting to create change in services and teams, and 'be a leader'. *"It was difficult… because I was being told it wasn't my job to pilot it and someone else should do it. And I shouldn't have comment on how the mechanics worked downstairs or where the people" (Beth, p.12).* Additionally, Gemma felt challenged and crticised by senior psychiatrist colleagues when trying to assert her psychological perspective. *"And despite my best efforts of having those conversations, there was constantly that, well, my opinion matters more than yours, and what you've got to say doesn't matter, because I'm a consultant psychiatrist. And I think the person actually did say that to me." (Gemma, p.12).* Gemma shared how she made sense of this experience, by considering that the psychiatrist may be anxious about the high risk within the case. However she also indicated the enormity of the stress and disrespect she felt as a result. *"I was absolutely flabbergasted and very anxious. I've never had an experience where somebody has challenged my clinical judgment to that point, and been so disrespectful to my formulation and the extensive work that I've done with a young person, so to be, turn around and say, actually, my judgment was wrong" (p.13).*

Participants also talked about negotiating *"lots of power dynamics going in [in their service]"* between different professionals. Abigail talked about the power of management, often 'gate keeping' opportunities to create change. In her current role, she felt empowered and 'allowed' by management to be autonomous, however in previous roles *"[management] didn't look to psychology as much for kind of service development initiatives and if you suggested them they… you were not met with the same open encouragement [compared to her current service] of trying new things out" (Abigail, p.22).* Abigail however didn't seem to share the same sense of 'struggle' with power as other participants in her current role, and found it difficult to explicitly consider what current 'challenges' she faced, often considering instead what others might find difficult. However she stated that she believed her positive experiences of being able to create change in the service were due to her relationship with her manager, and stated that her manager *"gives me professional autonomy" (p.2)* which suggests the power that management were holding.

Other participants felt that certain individuals *"have a really strong influence on the wider team",* which created complexity in navigating a position of power within teams. Daisy talked about experiencing and navigating dominant voices in the team. *"Having a power within the team does not necessarily, relate to banding or to, you know, who you are. There can be a kind of health care support worker who has been there 20 years who, you know, who is the most powerful individual within the team" (Daisy, p.14).* Gemma also felt that specific personalities within the team had the power to influence the negative perceptions of psychology. *"My experience of challenges of leadership... has been where there's been one or two other people who are very, have very strong opinions, and a very strong characters that that influence the rest of the team, and almost somehow pull against psychology" (Gemma, p.11).*

Group Experiential Theme Two: Navigating "all sorts of pressures"

The second theme refers to how participants navigated the many pressures and challenges of being a leader. These included service pressures, such as managing high demand, and navigating the complexity and different aspects of the role of clinical leader. Participants talked about the methods they utilised and what they considered to be helpful and important to be able to endure and persevere through the challenges.

Subtheme: "Wearing many hats"

This subtheme captures the sense of *"additional"* responsibilities participants talked about through being a leader. These created a sense of participants feeling strained and pulled between the multiple aspects of their roles. Daisy talked about how her role involved navigating and moving between the different levels of the system, such as clinic work, to supporting teams and services, to working at organisational levels. *"You end up wearing many different hats... like now I'm doing individual therapy. Right now, I'm doing clinical supervision. You know, it contributes to just being a bit all over the place around what am I doing now... everything contributes to feeling a bit more frazzled at the end of the day!" (Daisy, p.27).* This depicted how Daisy felt overwhelmed and unable

to give her full self to each part of her role. Additionally, through being responsible for others (staff) and navigating multiple demands, Daisy felt that leadership roles were an extra pressure on her workload. *"It can be stressful…have that demand to know that people are, will be coming to you for things and to have to think about, you know, it's an additional later to your job… I feel like it's another layer of, you know … in terms of thinking about your workload, it's something to … bear in mind" (Daisy, p.27).*

Participants also talked about feeling a strong sense of responsibility within their leadership role, to tackle difficulties within CAMHS. Clare felt that *"a lot of things are given to me to hold" (p.38)* and felt a pressure to take care of and consider the multiple facets of the role. *"I certainly feel that it's my job to be proactive and visionary. And sometimes it's really hard to do that well! And lead others... and keep an eye on many facets of how to be proactive really. Cos it's not just about say service innovation and guidelines. It's also about day to day, checking with colleagues, thinking about staff retentions. Thinking about staff wellbeing" (Clare, p.26).* As a leader, she sometimes found herself battling with 'bearing the weight' of CAMHS, *"I need to just you know pull my socks up and do it! And the context is hard… looking at these waiting lists, that's hard. You really can't take the entire responsibility for the national crisis in CAMHS!" (p.35).* Whilst participants recognised that many of the challenges were out of their control, they often still held a sense of accountability for 'fixing' or 'improving' things, which added tension and strain to their role, particularly in the context of change being hard to create.

Participants also talked the additional pressure of *"the management side of it".* Emily spoke about how being involved in management responsibilities was a new role to inhabit and understand which could feel overwhelming. *"And then I guess coming up to an 8B in the manager's role is also the business… and that's an extra layer of things that take up lots of time and headspace… but I guess the nitty gritty can be quite overwhelming because there's so much to it" (Emily, p.28).* Similarly to Daisy, Emily alluded to feeling depleted, and struggling to give her full capacity to each aspect of the role. The responsibilities as a 'manager' also meant she was now more aware of the pressures. *"The pressures are trickier. And particularly, I guess and the awareness of the detail of the pressure, if that makes sense?" (Emily, p.23).* This seemed to add an extra level of strain to her role.

Subtheme: Boundaries and balance

This subtheme refers to how participants were able to or attempted to hold boundaries to offset the pressures and high levels of responsibility described. Participants talked about how they felt that finding and holding boundaries with the amount of work they take on, and their working hours, was important. However, this could often feel difficult, and there was a sense that participants were at different stages in their learning and confidence with asserting boundaries. Nonetheless, boundaries around workload felt particularly important within what they considered as "*cultures around overwork*" in the NHS. Gemma felt that she was learning to be more boundaried. "*Sometimes I need to be confident and boundaried enough to say I can't do this today. It'll have to come tomorrow! Rather than, you know, moving other things… it's hard! You don't always get it right… and I guess it's knowing what feels okay for you and where your limits and boundaries are*" (Gemma, p.20). Whereas Beth felt more confident in knowing and asserting her boundaries with workload "*I'm like if you, if you're employed to work 9 to 5 … and you can't do your work between 9 and 5, you've either got the wrong job plan or you're doing things wrong! People say to you, oh you must work ex, oh you must be working in the evenings? No! I've got 2 children! I'm not working in the evenings!*" (Beth, p26). Beth talked about boundaries energetically, suggesting that it was really important to her. This makes sense, as Beth had faced a significantly stressful time around two years prior to the interview. This was due to facing challenges in her role as a leader, which coincided with personal life stress, leading her to "*breaking point*" (p.20). Therefore being able to hold boundaries and find ways to cope was crucial, and "*a do or die kind of thing*" (p.22), as described by Beth.

Faye spoke about how holding these boundaries, with psychologists' workload was difficult, in the context of witnessing other staff feeling overwhelmed. However, it felt important in the view of longer term outcomes. "*There was some guilt, a lot of guilt, around because, I'm like well, and we talked about it a lot. Say, well do we ask our staff to see a few more people, a few new extra people a month? But we decided on the whole. No, that wasn't going to be helpful, because when's it going to stop? So yeah, there was a lot of sadness and guilt, and thought about Gosh! What is the actual impact of this gonna be on the wider staff?*" (Faye, p.21).

Participants also talked about the importance of having a *"work-life balance"*, in order to manage the emotional impact of the pressures. *"If there's a particular demand emotionally or there's a workload continually on top of that which often happens in CAMHS. Then… it can feel tiring and energy sapping. But I think on a very personal level I set those boundaries… I do an awful lot of self-care in my personal life" (Clare, p.34).* Gemma shared how having meaning outside of work helped to navigate the impact of work-related stressors. *"I'm lucky in that I've got, you know, things outside are, are really good in my life! It helps put things in perspective really" (Gemma, p.14).*

Subtheme: "An armada of ships"

This subtheme relates to how participants considered the building of relationships, connection and "becoming part of the camaraderie" (Clare, p.43) to be key to navigate leadership in CAMHS, and manage the challenges they faced. This included how participants valued building relationships with others, and the benefits they felt, as a leader, from experiencing positive relationships with others, and feeling part of the team. Participants talked about how they felt that attending to and taking time to build positive relationships with others was key to being a leader, to create a cohesive environment that they felt embedded in, and to navigate pressures and overcome *"hurdles".*

Participants seemed to consider their relational styles and how they engaged with others, in order to build relationships. "*The other thing I think is really important is just generally being friendly and open-minded [with the team] and not too hierarchical as a psychologist. I think it makes you approachable and makes the team warm to you more; and sometimes mucking in with stuff, helping out, offering to do things like duty calls and be helpful" (Abigail, p.26).* Here Abigail talked about "*mucking in"* and wanting people to *warm to her,* which portrayed how Abigail was seeking feeling connected to the team. This had benefits for Abigail, as these relationships, and feeling respected as a team member supported Abigail during times of challenge. *"Well [the pressures and workload] doesn't always feel manageable, but I feel like its manageable enough because of the good team and because you feel valued" (Abigail, p.18).*

Beth shared how she considered CAMHS to be a complex context to work within that required teamwork and coming together to navigate challenges and support children and young

people. *"We're like an armada of ships… we've got to get our kids from A to B and we're carrying them on our ships" (Beth, p.4).* The use of metaphor here also demonstrates the sense of the size of the task of leading in CAMHS to Beth, and implies a sense of 'going into battle' or a 'mission' in relation to supporting children and young people. Through her experiences of leading, she talked about how she learnt the importance of building relationships and gaining support as a leader to create change in service. When reflecting on a previous challenge, she stated *"but I can't help but think… probably build a bigger support base. I'd take more time to speak to others to get buy in for the direction…Build a guiding coalition…I didn't get a base of people around to kind of build on that" (Beth, p.11).* Here Beth seems to highlight how she feels that leadership cannot be done 'alone' and that she requires cohesion and working together with the team to achieve goals.

Participants talked about the importance of having good relationships across the team that supported and valued psychological safety and care, in order to manage the pressures and complexity of CAMHS.*"I think it helps that everyone's just nice people! That helps. We've been there quite a long time… again, that sense of if you went to … kind of anyone in the, in the team, so manager or otherwise and said, "I'm feeling really awful." Or I've made a bit of an error! You'd get … I guess what I describe it, in terms of basic good qualities that you'd get that level response. And we'd do our work as a team. And you know all areas of services are stretched. We help each other out in those different areas" (Emily, p.36).* Here Emily implies that she feels embedded in the team, and this seems to support her relationships with others, and feelings of safety.

Clare shared that she had felt a sense of loss of connection and support between staff due to the COVID-19 pandemic and remote working. Such relationships, she felt were important to navigate the increasing challenges working within CAMHS. *"The challenge was there before [the pandemic], when the support was there. And then the challenges became greater, and the support went oh…And with the pandemic, there was none of this reaching across the desk, going "oh my God, I've just had this disclosure" or "I'm worried about this". Or I can't make sense of this, or you want to take 5 minutes and a cup of tea?"* This highlighted how informal ways of connecting within office spaces, and having close, friendly relationships felt important to Clare. She felt it was important to try and improve team relationships damaged by the pandemic. *"We're trying to rebuild morale. We're trying*

to rebuild belonging and identity and a sense of team cohesion… you know, thrown up in the air and now we're trying to reconfigure something that is quite fragile" (Clare, p.44).

Participants also spoke about the importance of feeling part of a *"leadership team"*. For example, Emily spoke about how a collaborative approach to leadership, with other leaders and team members alongside her, was important to manage the stress of the role. "*I guess my experience is that I've never done it on my own… I guess it's much easier to be a leader when you're not on your own with it... and probably easier to do with a good team around you… I think it would be a lot trickier if you were on your own with it, whereas I don't. I'm not on my own with stress or… business stuff?"* *(Emily, p.34.)* This felt particularly important for some participants, including Emily, who were quite new to leadership, and were feeling uncertain and unconfident in these roles. Therefore, feeling as though they were not alone and well supported by their team seemed important to take on such responsibilities.

Subtheme: "I had someone who spoke my language"

This subtheme captures participants' shared experience of the importance of feeling supported by and connected to other leaders, and being able to access supervisory support for their leadership responsibilities. Participants seemed to want to cultivate an environment and/or relationships where they could feel held and understood. This was vital to navigate work-related pressures and stressors.

Participants talked about how having a space to be able to process the challenges of leadership and gain emotional support was important to develop as a leader. Beth talked about how she used external supervision, outside of the NHS to manage the challenges she was experiencing. *"It's just a space to discharge emotionally… it's processing of what's gone on. And a safe space. Psychologically safe space that I can take my stuff … disassemble myself. Put myself back together and go right I now know where I'm going. And that is really important to me." (Beth, p.13).* Beth's use of 'disassemble' and 'putting back together' implies a sense of her needing to hold herself together in her role, and the importance of her then having a space to be able to be open and vulnerable. Beth felt that this space, where she felt safe to be honest and open was not available in her NHS psychology supervision. *"I have a place that I can go to. Someone not in my organisation. Not a*

psychologist" (Beth, p.14). Gemma also felt that a space to talk about and process the challenges of leadership within supervision wasn't available. "*So, having a place to talk. I, I mean ideally, in an ideal world, that should be your supervision. But unfortunately, in this role, those processes aren't really in place to have … I don't have access to that type of supervision" (Gemma, p.11).* No participants talked about their clinical NHS supervision as a space that they sought support for their leadership roles. Rather, support was sought through external resources and within certain relationships.

Participants talked about the benefits of having an '*ally',* and how this fostered a sense of connection and belonging that was important to support and motivate them within their leadership responsibilities. Gemma shared how she found support within a relationship with a fellow clinical psychologist also within a leadership position. She shared a sense of how this enabled her to feel connected, heard, and supported to navigate the pressures together. *"You know after a really difficult meeting, you know, we can talk on the phone and be like "Gosh! That was so hard!" … Or we can think about before we go in, you know, often before we, if we're delivering quite difficult news to the team, we can think together, you know, how shall we do this? What's the best way? And do that jointly… so having that place where I can talk about what it's like… it's really helpful." (Gemma, p.11)..* Clare felt that having an '*ally'* was important to her in order to feel she had someone 'alongside' her, with similar values that could encourage and motivate her to create change. When talking about her experience of driving forward a project she stated *"I didn't lose morale… And what I had was a… partner in leadership! So a really good sparring partner who is extremely experienced in new development. So I had someone who spoke my language!" (Clare, p.15).*

Participants also talked about how having support in the relationships around them, within the team and with those in their personal life was important, to not feel 'alone' in dealing with stress and pressures. Faye shared how relational support has been the key factor to how she coped with the challenges she faced. *"I think it's massively down to the support that I've had. And also making alliances with some of the managers in CAMHS. I was just thinking that because during the last year and a half of being in my consultant job there's been quite a lot changes…. So I think, having the support of my family too has been massively helpful."* In particular, having support in the team

positively impacted her experience as a leader and her ability to sustain the role. *"I'm so massively grateful for the team that I work in. and yeah, I don't think I'm ever going to leave [laughter]" (Faye, p.30).* Here Faye indicated a sense of belonging to the team, and appreciation for such positive relationships.

Group Experiential Theme Three: Journey to leadership

The third theme relates to participants' relationship with and journey to becoming a leader. This involved how participants constructed and understood their identity as a leader, which was influenced by contextual issues of the services and wider organisations, their values and experiences. It also refers to how confident participants felt in leadership positions, what impacted and influenced this. Participants' relationship to leadership seemed to develop over time, and different participants appeared to be at different points along their journey.

Subtheme: Conflict with personality

This subtheme reflected participants shared experience of how being a leader, sometimes felt in conflict with their personal skills, attributes and values. Participants shared a sense of how being a leader, or considering themselves as a leader felt *"uncomfortable"*. This is shown in Emily's comment *"leader sounds a weird word to use even though we're talking about leadership" (Emily, p.3),* which reflects a disconnect with the idea of being a leader. Daisy found leadership a challenge due to *"the kind of personality style" (p.1)* she felt was required to be a leader. Daisy felt it was different to her personal style *"I don't think I will ever be somebody who is like you know, right.. come to me!... especially in a group, I think temperamentally, I am naturally a quieter person and take a back seat, I think?" (Daisy, p. 22).* This contrast seemed to create internal difficulty for Daisy, who throughout the interview regularly expressed fear at engaging in leadership.

Participants reflected on how they experienced a contrast between psychologists' training and skills in being reflective and non-directive, and the *"leadership styles"* in the NHS, which they considered as more directive and authoritative. Participants seemed to make sense of their difficulties

engaging in leadership in part due to this conflict. *"I think the challenges… I think we're trained very much not to be directive. I mean definitely, obviously, not in therapy! But also our stance often in all the models, you know, systemic, analytic… often quite a neutral stance…. The leadership style in the NHS is very different to that. I mean if you look at a lot of the senior leaders, they're often in quite a directive type, you know, very top down" (Gemma, p.6).*

Daisy felt that the skills of self-reflection she developed as a Clinical Psychologist did not support her to feel congruent with leadership, and resulted in a hyperawareness of her limitations rather than a recognition of her competencies that might make her a good leader. *"And we all think about, you know, the limits to all our competencies and all the rest of it. And I think we're maybe always … we maybe do ourselves a bit of a disservice in kind of … being that way? You know really thinking so hard about that when actually, you know, maybe you take for granted a lot of the stuff that we do know. And it is helpful and it can help us lead?" (Daisy, p.14).*

Additionally, participants felt that being in a position of authority and knowledge was in contrast with their values and approach of person-lead and centred care. *"What I steer away from, is being in that expert position. Because we're trained all the time aren't we, to not take that, you know, we're not that stance. And it's the person. So, I think… that is a challenge being a leader" (Gemma, p.36).* There were some contradictions in participants' accounts however, as many participants also reflected on the important parts of their leadership role to be sharing knowledge and developing teams psychological awareness. This suggested that some uncertainty may be present for participants around how to integrate the conflicting parts of their role as a clinical psychologist versus a leader.

Subtheme: Battling "imposter syndrome"

This subtheme related to participants' doubting their skills and competencies and not feeling confident as a leader. Participants often described experiencing *"imposter syndrome" and* shared a sense of struggling with thoughts around not feeling "*good enough".* Emily shared how she had often felt insecure as a leader, which was in contrast to how she felt others perceived her *"I was maybe one of the people that looks confident when I'm not…I think that a lot of people have seen me as confident. Fake it till you make it!" (Emily, p.25).* During the interview, I sensed that Emily was

holding back from connecting to the difficulties of being a leader, even though there were many challenges she implicitly stated. Instead, it seemed that Emily often shared what she felt she was doing well as a leader. I felt as though that she wanted to portray that she was competent at leadership, which implied there was some worry about not feeling good enough.

Participants talked about how they often held themselves to high expectations. Daisy shared how leadership *"can be stressful sometimes" (p.26)* due to being in a position where she felt she was expected to be knowledgeable, which left her doubting herself. "*I guess it's stressful to be in a position where ... you know there is an expectation that that you're ... you know, that you'll know what to do… so for example when I took this case to the team this morning. Sometimes there's a perception of oh gosh, should I know what to do with this" (Daisy, p.26).* Clare also felt inadequate and doubted if she was 'doing enough', whilst holding multiple responsibilities and feeling unable to meet all of the demands. "*It's feeling responsible [for stressed systems]. And with that responsibility comes a bit of a self-doubt. Or guilt is very strong. But a bit of a sense of shortcoming sometimes…. around having that birds eye view and being proactive…. in the day-to-day life you feel you're not doing that. That could feel like a short coming… I should have done more… could have done better. Could have kept even more of a proactive eye on that" (p.27 & p.32).*

Participants also described feeling inadequate when comparing themselves to other professionals and other leaders. *"I think I often criticise myself if I hear other clinical leads speaking, I think oh wow! Like they are very intelligent. You know they've got all the language! They speak very, and I don't do that! Which sometimes I feel like I wish I could do that more and more like you know professional higher meetings, that type of things." (Gemma, p.29).* This suggested that Gemma held an ideal of leaders needing to be very articulate and smart, and considered herself to fall short at times from this ideal. Daisy too, found it hard to feel confident and assert herself as a leader when comparing herself to colleagues that she perceived as 'more skilled' *"You know thinking about my perception of other people. You know other staff members who, you know, who might, not be as highly banded as me, who I feel have more expertise or more experience." (Daisy, p.12).* Daisy seemed to find it more comfortable to allow others to take the reins. *"Again, feeling I worked with a lot of very,*

very skilled and experienced nurse therapists. And I kind of was just like, I just want to listen to you! You're amazing!" (Daisy, p.21).

Participants reflected on how they recognised their internal dialogue as often self-critical which may have prevented them from asserting themselves as a leader at times. Beth shared how she felt that her experience of *"imposter syndrome"* earlier in her career impeded her engagement in leadership activities. *"I was constricted by my own beliefs… about not putting myself forward too strongly for risk of being considered arrogant or something like that" (Beth, p.14).* Beth made sense of this in relation to societal gender discourses, and wondered how these influenced her difficulties in being confident and assertive, and got in the way of being an effective leader. *"There's stuff around imposter syndrome there… And it's females that have particular family scripts. And stuff like that in terms of who might have imposter syndrome. But I think I had my own set of beliefs based on my experiences… my identity… that weren't serving, not just me but the kids I was trying to help. And everything else" (Beth, p.14).*

Subtheme: "Well I can do some of this!"

This subtheme related to participants' experience of developing their confidence as a leader over time. Participants shared a sense of finding ways of *"leaning into leadership"*. Overtime, participants began to recognise the strengths and qualities that made them a 'good' leader, holding these in mind, and 'leaning into' them, to build their self-confidence. Participants' sense of leadership seemed to grow and develop, and their confidence in it followed.

Participants talked about how they experienced difficulties with confidence, however through gaining experience as a leader they were able to recognise their competence and challenge their inner critic. Daisy talked about how she was previously very resistant to the idea of leadership however had become more active and confident in leadership roles. *"Generally, at the beginning of training, or when we, when I was training and we kind of had these conversations about leadership, I was just like "oh God!" This is painful! Something I really don't want! But I'm definitely more willing to kind of step into that role if and when I need to" (Daisy, p.24).* Beth also shared how she has been able to feel more self-confident through experience and exposure in leadership activities, being true to her

personal style, stating *"I've had enough experiences now to know I can do it! And actually, by going in… being more me!"* (Beth, p.20). Beth seemed to feel empowered by recognising the importance of connecting to her unique skills and characteristics that she brought to leadership, similarly to other participants.

Faye made sense of her experiences of the challenges as a leader, and her proactiveness, as helping her to feel confident in her ability to navigate the role. *"I think in a way it it's helped me be more confident in my job whilst I've encountered lots of challenges with individuals or the systemic things, on the whole, we've come out the other side, it's been fairly successful… And so I think, putting myself out there as a leader kind of in the early days, just by offering to do stuff or lead on projects, chair meetings" (Faye, p.24).* This self-assurance seemed to have developed overtime for Faye, through experience, and reflected a move from initially feeling uncertain in her role, to a place of acceptance and feeling 'good enough'. *"In time, I guess, being a leader, I think, yeah, just confirms actually, I'm all right at it, I think… and I sense of in my job that I am enough, I'm doing enough" (Faye, p.25).*

Participants made sense of their developed confidence as being due to connecting with aspects of leadership they felt they were good at. Emily shared how she felt that the relational aspects of leadership, such as building relationships and supporting others were characteristics she felt she was good at, and these constituted a 'good leader' to her. *"To be able to be a leader, I think that quite often comes down to just … certain characteristics [building relationships and being supportive] that you probably, are a bit more innate in, in you. So, I think being a leader, so long as I guess you like that sort of stuff. And that comes more naturally to you, I don't find as tricky" (Emily, p.22).* This was followed by Emily sharing how her belief in herself was growing *"I probably get more and more confident as you go through your career… that experience of not only learning from your experiences, but also the self-belief that you are pretty well qualified!" (Emily, p.23).*

Gemma also considered how she felt her personality attributes of understanding others and good interpersonal skills, were aligned with being a 'good leader'. "*And my personality outside of being a psychologist actually! Which probably is what I feel makes me good in this role… for example, you know there might be family things that annoy you in your family! Your initial response*

might be to feel angry about that but then when you think about it you can kind of come up with well it might have been because of this, that they said that? Or did that. And ... kind of doing that in work ... you know I can do that in work, which I think makes people, you know the feedback I get is that people feel I'm very approachable. They can come to me for help" (Gemma, p.24). This showed a shift in Gemma's understanding of a 'good leader', from considering herself as less 'articulate' and 'intelligent' than other leaders, to recognising the value of her interpersonal skills.

Participants talked about how overtime, they recognised the importance of connecting to, and trusting their own personal style as a leader. Clare felt her confidence shift as she connected to her own attributes *"And I think I'm leaning into [leadership] thinking, "well I can do some of this!" You know I can do it. And it's about finding your voice and finding your style... we all need to work on our leadership styles. But you should be allowed to be who you are" (Clare, p.28).* Faye reflected how she had become more self-assured in her style and abilities, as she has grown older, and more experienced *"...because I think I was [previously] super excitable, motivated, enthusiastic, I love my job, and I think I've mellowed a little bit. Probably. And I don't know whether that partly is an age thing as well. Just as you grow, you may be a bit more mellowed, you may be a bit more confident in who you are, what you bring" (Faye, p.28).*

Subtheme: "Keeping sight of your moral compass"

This subtheme captured how participants' engagement in leadership activities was often motivated and influenced by the values they held in relation to being a leader, and providing care. Such values, and participants' preferred leadership style were often informed by their experiences of other leaders and their ways of relating.

Participants expressed holding strong values of person-centred care and creating change to develop the quality of care being delivered. Beth shared how she was motivated to lead to improve care. *"I think I, and you know, most people I assume go into leadership cos they think I can make this better" (Beth, p.6).* Clare shared how leadership *"ultimately [was] very, very compatible with my values, which is ultimately about providing the best possible service... equitably of course across our population" (Clare, p.4),* and, *"to see that [service development project] coming to fruition and*

actually to have some meaning to young people and families and colleagues, that's perhaps my biggest passion" (Clare, p.5). Clare also shared how her values often motivated her resilience to push through resistance from other professionals. When talking about her service development project she stated "*I was so confident about it. And I believed passionately with a few, it would improve things" (p.15),* and felt proud at persevering *"I'm very proud of it. I'm really proud that we persisted. And… I'm not saying that the only thing that changed was the pathway altogether… but I think it contributed!" (p.17).* Clare expressed a lot of enthusiasm and passion for leadership, which seemed to stem from being able to create change in services, in line with, and directed by her values. Clare's values for care appeared to be strong motivators to withstand and push through the challenges. Faye also talked about how her strong values of providing 'quality care' and protecting staff wellbeing, supported her decisions to uphold boundaries to service demands. *"We felt [retaining caseload safety] was too closely aligned to our values of how we wanted the service to go. Stick to our guns. And didn't want to cross our boundaries of what kind of we want it to be, because that is the psychology service we work in. We have some very strong values about looking after staff and sticking to boundaries, and so to move away from that, and almost get sucked into this sense of just see more people. It just didn't feel good. It didn't feel at all good, even though the putting in place that boundary also didn't feel good" (Faye, p.21).* Here Faye expressed the emotional impact and difficulty of holding boundaries whilst witnessing suffering in others. However, it seemed that keeping her values in sight enabled and motivated her to withstand this and uphold her decisions.

Participants also talked about how their values around being a leader, and their style were guided by learning from and observing other leaders. Gemma felt she learnt from role models, "*probably my experience of leadership [informed leadership style] … having experiences of good leadership and very poor leadership. So kind of knowing… yes, I guess from those experiences, what works, what I felt helpful and not!" (Gemma, p.5).* Gemma made sense of what she considered 'good' leadership through how she had *felt* in relation to other leaders. Emily also shared this sense, and talked about a personal upsetting experience of another leader and how this had motivated her leadership style to be more compassionate. *"She was just mean, just wasn't, wasn't nice! I think when you have experiences*

of bad leaders that can be really key. Cos you think I remember how that made me feel! I don't want to be that person" (Emily, p.6)

Similar to many other participants, Gemma reflected how *"good leadership has definitely been those leaders who … have, yes, have been kind. Have been … empathic. Are good at what they do but can do it in a way that is supportive" (Gemma, p.7)* and considered *"bad leaders"* as *"quite punitive. Very much you know are telling rather than kind of involving, inviting your kind of views… I think I've observed lots of leaders, you know, telling staff off or, you know, being quite shaming or quite belittling of staff. And you know you really see the impact that that has" (Gemma, p.7)*

Faye's leadership style was also informed by observing and experiencing other leaders. *"I used to make little notes to myself when I was thinking about getting my next job, or moving on, or thinking about… well, what kind of leader do I want to be? What kind of psychologist do I want to be? Because I've encountered some and I've just thought I really don't want to be like that. That didn't work for me…I guess I've soaked in…" (Faye, p.5).* Faye described 'looking up' to leaders who struck a balance between being compassionate and boundaried. *"I think the more inspirational people have nailed it, really, and they've kind of had this really fair empathic, but boundaried approach. Like they don't, take any nonsense, but they put the boundaries in place really nicely… and I think that, yeah, that's super cool" (p.7),* as well as those who offer vulnerability and transparency in a contained manner. *"It's also been really key when I've witnessed other people in leadership positions kind of offer a little bit of vulnerability. Saying, this is really hard just now. But not just splurge uncontained stuff onto you" (p.8).*

Subtheme: "It's <u>my</u> job to worry about the pressures"

This subtheme relates to how participants considered an important aspect of leadership to be supporting and protecting other staff within services, from pressures and stress. This included attending to staff needs and considering their wellbeing. Participants shared a sense of responsibility to ensure that the impact of the service pressures on staff was limited. They seemed to feel that these pressures were something they were required to hold as leaders. This responsibility, was in part, how they related to, and conceptualised leadership.

Participants expressed how they were concerned with containing both their own stress, and the difficult experiences of staff, working within busy, pressured services. Faye felt it was important that her own experiences of stress did not impact others, stating, *"it's important not to kind of put your shit onto other people" (Faye, p,7.).* She was influenced by other leaders who she had witnessed containing stress and protecting staff from being overwhelmed, which she had adopted into her leadership responsibilities. *"They've managed to stay really contained. And they've managed, despite all that stress, to provide a space where other staff, You're not kind of putting that on to other staff. You kind of communicate in a way that, yes, these pressures are here. I'm aware of them. It's my job to worry about them, and it's your job to worry about your job that you're doing and almost like, yeah, contain it… without overwhelming the staff further down" (Faye, p.10).*

Gemma highlighted the importance of leadership supporting staff through change, and how she felt that as a leader she should appear confident and in control, and contain her own feelings of stress, in order to contain the team. *"And it can almost feel very politician like! I think, and I am sure that is a thing now that's part of being a leader. Is the kind of knowing what's going on in the background and the challenges but needing to present yourself to the team as a very contained … coherent … you know, and I guess the main challenge is then, from that, is then managing the whole team's anxiety. And that's really hard to have … the pressures from behind you that are kind of saying this is what you've got to do" (Gemma, p.10).* Within this statement, there appeared to be a difficulty in and a pressure to remain and appear 'resilient' to others, and 'hold off' the *"pressures from behind".* There was a sense of tension within Gemma as she spoke about this, which corroborated this.

Emily felt a significant responsibility to protect staff from feeling overwhelmed by stressed and pressured services, and hold stress at the management level *"It's fine for [the stress] to affect me cos I'm the manager! But I don't think that needs to trickle down to the people that are doing more of the, the clinical work and you know making sure that that pressure isn't really impacting on them. And they're still feeling okay in their job. And that they can still come to me with things they're struggling with. And they're not pressured to take on … you know more work!" (Emily, p.4).* Emily also thought it was important for those senior positions to build trust with staff and create

environments that were psychologically safe. When talking about what she felt constituted a good leader she stated *"if you've got someone that you can go to who is in … you know a higher role than you and if you can go with that stress and say "I'm really stressed. I'm finding this really difficult." Or I've made this mistake or whatever. And you know that they're going to … take that really well and still being really supportive … then I think you've kind of cracked it then!" (Emily, p.5).*

There was a sense from many of the participants that they were at times holding back from sharing the challenges, difficulties and distress related to being a leader. It seemed that participants may have been upholding this conscientious role within the interview in our relationship, and protecting me, as a trainee Clinical Psychologist, from fully understanding the stress that was experienced by participants in qualified, leadership positions.

Group Experiential Theme Four: Rewards and costs of being a leader

The fourth and final theme captures the personal effects that being a leader had on participants and the sense they made of how their experiences as a leader had shaped their current self. This constituted both the benefits, and difficulties that participants had experienced and described.

Subtheme: "I need therapy or something!"

This subtheme reflects the emotional and psychological difficulties participants described from being a leader. This primarily involved experiences of stress, frustration and distress, due to the challenges they faced in their leadership positions and feeling powerless to wider pressures. Participants shared a sense of how the stressors within their role had impacted on their wellbeing. Gemma felt there had been a significant psychological impact from being a leader within CAMHS, stating, as a result of her experiences, *"I need therapy or something! [Laughter]" (Gemma, p.14).* Gemma's laughter whilst talking about the challenges and psychological stress she experienced as a leader, was similar to other participants, who also seemingly used humour as a protective way to talk about their difficulties. This suggested there was a sense of disconnect from or difficulty expressing

their emotions for some participants. Participants often talked about the many ways they had tried to overcome or manage the challenges they faced; there was a sense that compartmentalising their feelings may have been another such strategy. This was seen in Emily's uncertainty about how leadership had impacted her wellbeing, and it seemed as though this was something she had not considered previously. *"I guess key periods of oh God, I'm stressed right now! That affecting me! I think it's probably, that I, probably things that I'm not aware of, that, that are maybe happening." "I don't know how I'd be able to describe how these experiences sort of impact on … on me! Em … other than … when I'm at work, if that makes sense? Although I'm sure they do!" (Emily, p.22).*

Gemma also described feeling under frequent stress working within her service and the wider NHS systems. *"But… he [Paul Gilbert; CFT] talks about the NHS, it's just constantly operating in threat. With a little bit of drive… And I, I feel like that's my constant experience!" (Gemma, p.17).* Beth also experienced significant stress as a result of high pressures and workload, which impacted on her physical health. *"But then also it has been very stressful at time… I did get ill back in 2016 I had pneumonia and that… well it was maybe a CAMHS thing… It was just, the workload was too much!" (Beth, p.21).* This impact was significant for Beth who took a period of absence due to work-related stress. Beth also showed a tendency to intellectualise the challenges she had faced, rather than connecting to associated feelings. There was a sense that this felt easier for Beth, and she was motivated to tell me instead about what she had learnt through her experiences.

Participants also talked about the effects of working within the challenging systems within and surrounding the NHS. Clare spoke about how she found it difficult to witness the lack of retention of staff within CAMHS, *"But retention is another thing. And it saddens me greatly… and we've recently had some quite painful experiences of getting some very good people… attracted them into a job and they leave within…" (Clare, p.40).* Participants expressed feeling frustrated and powerless to wider systemic challenges such as high demand and lack of resource. *"So, it just, it's really frustrating when you know, you come into this job to help kids. To help families. But it's very disheartening to not be able to … do that to the extent you know you could!... Or to have a big pile of kids that are struggling, and we can't do anything about it because we just don't have … the resource!" (Emily, p.14).* Participants also felt that the pressures and challenges felt out of their

control, which could feel de-motivating and hopeless for change. "*Yes, that kind of wider systemic kind of context that you know is what is driving all of this. And not particular people. That can feel quite frustrating, not having that control or that say… the difficulty with that is that it can feel really… you can feel very powerless for things to change and be different. And that's the kind of, that's what can feel hard I think*" (Gemma, p.12 & p.22).

Subtheme: "*It really helped me to find my voice*"

This subtheme refers to the rewards that all participants experienced, from being in leadership positions. Faye shared, *"I really love [being a leader]. I wasn't sure I was going to"* (Faye, p.30). All participants readily and enthusiastically shared the benefits they felt they had experienced through being in leadership roles. Participants talked about feeling empowered in their roles, through having the opportunity and the position of power to have influence and have an impact on services. Clare shared how being in a leadership position enabled her the platform to get her voice heard. *"Sometimes it's invigorating and empowering to have… a chair at the table… You know I have working relationships with, if not commissioners, then certainly sort of very senior leadership and management… so it gives you a formal mandate… it gives you connections… and you have channels. And you have forums"* (Clare, p.26). Gemma also valued the position to express her thoughts and opinions and be heard. *"I do think, being in a clinical lead role has really helped me find my voice. It gives you that platform….So I really value this platform that it's given me to have a voice, being in a leadership role"* (Gemma, p.34). Beth shared the satisfaction she experienced from the opportunities to influence and to learn from being a leader. *"I think huge satisfaction… I think big opportunities by leading in CAMHS. I got this wider role. I've got other roles now. It's been a real springboard to other things. I guess a place to learn I've learnt a lot"* (Beth, p.21).

Participants also talked about how it felt rewarding to be able to support and influence staff and services and feel appreciated and valued by others. For Abigail, she felt that this improved her experience of job satisfaction. *"I think it just makes you feel happier in your job if you feel like you're having a good impact. When we had a team day and people had to write positive things about each other… it was really nice to receive all these kinds of positive comments about how they didn't think*

they could manage in the team without me and things like that" (Abigail, p.16). There was a sense from Abigail how important this felt, to be appreciated, and she talked about this with a sense of pride. Daisy shared a sense that she felt more willing to engage in leadership through the reward of feeling valued and appreciated. *"And I think, you know, a bit of enjoyment as well actually in, you know, leaning into that role a little bit. That actually, it's nice to be able to, you know, if a colleague comes and says you know "oh, I'm wondering about this case." And to think actually no, I do think something! I wonder about this and then for somebody to come back and go" God that really helped. Thank you." And to think well that's something, that's a nice feeling that I can help my colleague in that way" (Daisy, p.22).*

Participants also shared feeling liberated with their new found position of power and authority, as seen in the enthusiasm in which they spoke about this experience. *"When my supervisor isn't here… it's me who people will expect to make decisions. So it was quite daunting. But again it was also quite exhilarating to think yes you know actually I can. I've wanted to do this for a really long time and now here I am doing it!" (Daisy, p.31).* Through feeling liberated in her leadership position, Emily expressed feeling motivated to empower others. *"I think… I know I am completely in charge of this! If I decide to be. So, let's, let's do something… I guess having the sense of well people might have these ideas but not feel they can do anything… in a leadership position like I am now, let's ask people. Let's do these things. Let the people say stuff. Let's see if we can move, let's move on it! Cos I don't need to ask permission anymore because I am a leader. So, I can do these things" (Emily, p.30).* For Emily and Daisy, who were relatively new to leadership roles compared to other participants, they shared a sense that this liberation was a helpful motivator to moving through their difficulties of self-doubt and confidence, and 'lean into' leadership.

Subtheme: "It's been a real learning curve"

This subtheme relates to the learning and growth that participants were afforded and felt they benefited from, through their experience within leadership positions. Although participants shared many challenging and difficult experiences within their leadership roles, they seemed keen to share how they had grown through this, and express the positive learning they had obtained. Participants

shared how their learning had supported their development as a leader, and how the knowledge they acquired about themselves which felt important, to be a 'better' leader. *"So, it's all about self-knowledge. Understanding what pushes your buttons… getting a sense of that and then knowing what you prefer. What you don't like. What you're good at. What you're not good at… If you can be really honest with yourself about that and understand that, you can really motor on and take people with you" (Beth, p.7).* Beth expressed here that being vulnerable, introspective and reflective was important to be a leader that is able to influence and get people on board. This value of vulnerability was something Beth regularly expressed throughout the interview, and this appeared to be a significant learning curve through her experiences as a leader. Gemma also expressed a developed understanding of herself through being a leader. *"It's probably a mixture of things that it's confirmed about me, that I know is me. Versus things where I've developed and grown... I think it's confirmed for me my personality and my style as a psychologist" (Gemma, p.22).*

Participants also talked about the skills they felt they had learnt, in managing their own emotions and stress responses. Gemma developed her utilisation of a compassion-focused psychological model to understand and regulate her stress. *"I'm trying to operate in those 3 equal models (CFT 3 circles). You know… there's you know that I want them all to be equal for me. And … I think they're something I've really been able to develop" (Gemma, p.16).* Emily shared how she had experienced personal growth through being a leader. When discussing the effects of her leadership experiences, Emily seemed to make sense of her growth as being related to, and impacting herself personally, rather than just specifically as a leader. *"It's being a better, just a continual evolution of who we are as … people" (Emily, p.31).* In particular, she felt a change in perspective towards and management of stress, and talked about this within, and how it had benefited her in her everyday life. *"Probably in certain aspects just less stressed because I know what stress is! … because if you have that more conscious sense of, you know, just that tills at Lidl are taking ages or you know whatever like that, and things are really busy. People are getting angry! You just think they're literally trying their best! Just, it's nothing to get stressed about." (Emily, p.32).* This suggested the impacts of being a leader transcended outside of work-related roles.

Participants also talked about being afforded wider learning and perspectives as a leader. This occurred through developing an understanding of organisational contexts of CAMHS and the complexity of the wider systems. Gemma experienced increased compassion for those in leadership roles, *"I guess a lot more understanding and compassion for leaders being in this role! I think, again, I was probably more critical of the senior psychologists or clinical leads, in the past. And now having stepped into that role, I can really understand maybe why they were being quite diplomatic at times. Or there wasn't those clear answers that you wanted. Because I now understand more of the very complex factors that, that go in to that" (Gemma, p.27).* Through her extensive experience working within senior leadership positions and with the wider systems of children and young people's care, Beth seemed to experience a shift in perspective in her approach to mental health care, moving towards more community psychology values. *"I'm much more interested in sort of community kind of approaches… I just think we've, we've got something wrong [in CAMHS], really. And we should be in a middle of a forest with … music and … art… education of a different kind and, and then if somebody needs something, they can access it. It's this individualistic idea of mental health… kind of the whole think isn't quite… right?" (Beth, p.28).*

Chapter Four: Discussion

The current study explored Clinical Psychologists' experiences of leading within CAMHS. The research questions, aimed at understanding such experiences were:

1. What are Clinical Psychologists' experiences of being leaders in CAMHS?

2. What meaning have Clinical Psychologists made of the challenges they have faced in leadership positions and how have they responded?

3. What have the effects of leading been on Clinical Psychologists in leadership positions?

Semi-structured interviews were conducted and analysed using IPA to address these research questions. From the analysis, four General Experiential Themes (GETs) emerged. These were:

- "Blockages at every turn"

- Navigating "all sorts of pressures"

- Journey to leadership

- Rewards and costs of being a leader.

The findings of the study reflected the challenges leaders faced, and offered insight into the ways participants were able to navigate and cope with these roles. Strategies included building relationships, being supported and finding balance. Additionally, the results showed how participants identify with leadership and how this impacts their engagement with and development in the role. The findings of the study also reflected the rewards and benefits that participants felt they gained from being a leader. The following chapter will present a summary of these key findings. These will be discussed in relation to the relevant literature and how it is related to the findings of the study. The findings will also be understood through the appropriate psychological theory. Finally, the strengths and limitations of the study will be presented, as well as the key clinical implications and recommendations for future research.

Key finding one: "blockages at every turn"

This theme encompassed the challenges that participants faced as leaders in CAMHS, which resulted in difficulty engaging in leadership responsibilities and creating change.

The participants' accounts highlighted the significant pressures and stress that the services, other professionals and participants themselves experienced in their workplace. Participants understood this to be largely a result of the current wider systemic pressures of the NHS, which is in line with the literature and understanding of NHS CAMH services. Such services are currently struggling to cope with demands, leading to difficulties of staff fatigue and burnout (The King's Fund, 2022; Gemine et al., 2021; Lacoboucci, 2021; Wilkinson, 2015; HSCC, 2021). This repeated finding across the literature is important considering the seriousness of burnout and its effects on the workforce, staff retention and patient care (Kleinpell & Kane, 2021). This finding also supports Roncalli and Byrne (2016), who showed that Clinical Psychologists are vulnerable to the same risk of burnout, and how one in five participants stated they would consider a different career knowing the reality of the role and pressures. Wintour's (2022) study also highlighted how in fact a number of Clinical Psychologists are leaving NHS CAMH services to work in private practice, due to the difficulties in the workplace.

Participants personally experienced feeling overwhelmed, under threat, criticised, and faced tensions in their inter-professional relationships, particularly with non-psychology professionals. Their accounts also show their perceptions of services and other professionals to be overwhelmed, engaging in reactive care, and being resistant to change. Threats to feelings of safety and security for professionals (Briggs, 2018), as well as experiences of tensions and pressures (Wintour, 2022) within CAMHS have also previously been reported. This was suggested to negatively impact working relationships, which are important to navigate the role of a leader (Wintour, 2022). These experiences may be understood and corroborated by recent literature on traumatised organisations in the NHS. CAMHS services support CYP with increasing complexity and experiences of trauma (Reay et al., 2015; Samji et al., 2021; Gorny et al., 2021; Hunt, 2020), which can induce stress and anxiety within staff. It is suggested that organisations often respond to stress and trauma in similar ways to how individuals respond. When difficulties such as anxiety and stress feel uncontained within services, by

senior leadership and management, systems work in survival mode to protect themselves. This results in staff engaging defensively and reactively, and feeling threatened by and unable to cope with change. Such behaviour and emotional responses may be related to the tension and conflict between psychology and other professionals that participants described.

Further tensions and conflict between professionals in participants' accounts highlighted a possible *"culture clash"* between psychology and medical and management professionals. Many participants felt longstanding hierarchical structures and medical model dominance resulted in other professionals, e.g., psychiatry colleagues and non-psychology senior leaders not respecting or appreciating participants' position as leaders. Participants felt that psychology was often misunderstood, and some professionals were resistant to considering psychological perspectives or ideas for innovation. This made it difficult to create change and develop their role as a leader.

Clinical psychologists as leaders often fall within 'middle management' positions, which may shed light on some of these experiences. A systemic review (Hartviksen et al., 2019) of middle managers' experiences of developing as leaders highlighted how they also often experienced similar disempowerment. The authors highlight how upper management needs to empower middle managers to develop their capacity and capability as a leader, and foster interaction, trust and respect. Additionally, they suggest that a move away from 'command and control' leadership is needed, as such approaches can result in leaders feeling disempowered and frustrated in their roles. The interprofessional struggles that participants in the current study faced as leaders demonstrate how NHS leadership structures are still in development, towards the current promoted approaches of compassionate and shared leadership. These approaches aim to foster inclusive and supportive environments (Bailey & West, 2022; West et al., 2015). Recognising such challenges of interprofessional difficulty are important, as organisational cultures and leaders need to promote psychological safety and collaboration, in order to develop collective resilience in the face of emotional distress and burnout from Covid-19 (Barton et al., 2020; Igoe et al., 2020).

The impact of stressed and traumatised systems within CAMHS on interprofessional differences and non-collaboration may be further understood through the theory of mentalisation. Mentalising is the process by which a person makes sense of themselves and others, through having

an awareness of both one's own mental states, and of those around them (Allen & Fonagy, 2006). It is referred to as the capacity to understand and have insight into one's own thoughts and feelings, and that others also have thoughts, feelings, beliefs, and desires that are different from one's own. Mentalisation capacity has implications for interpersonal relationships, in the development of trust and the ability to seek help and support from others, and also in the management and self-regulation of stress (Fonagy & Allison, 2014; Fonagy et al., 2015). Being able to understand one's own perspectives as well as those of other people leads to more successful interactions and social relationships. However, during times of heightened stress and threat, mentalisation abilities are often reduced (Fonagy et al., 2015). This can result in miscommunication, conflict and heightened interpersonal stress. This may offer insight into the processes of inter-professional conflict in the context of stressed CAMH services.

Key finding two: navigating "all sort of pressures"

This theme refers to how participants navigated and endured the pressures of being a leader in CAMHS, and maintained resilience in the face of this. Participants' accounts highlighted how leadership roles involved trying to hold multiple responsibilities and demands, across different levels of the systems that surround CYP (Bronfenbrenner, 1977). This included individual and family work, staff support and supervision, management responsibilities and service innovation. Participants were often required to move between these different levels on a daily basis.

These experiences reflect the complexity of leadership (Leudi, 2022) and are consistent with leadership in CAMHS entailing a focus on developing a myriad of relationships, across and within the layers of systems (Hunt, 2020). Participants also described how these widespread responsibilities often left them feeling overly responsible for the challenges in CAMHS, and overwhelmed and exhausted holding all levels in mind. This may be understood by previous literature (Anandaciva et al., 2018; Gray & Jones, 2018), that found that healthcare leaders may struggle with a 'culture of blame' within healthcare systems, and that asking for help, or feeling responsible for pressures on services can be difficult for fear of being perceived as a failure, and having a high expectation of needing to cope.

Participants' accounts showed how they were trying to navigate these responsibilities and demands, by finding where they could hold a boundary to pressures, such as caseloads, and working hours, explicitly recognising the toll that these pressures created. Participants also wanted to ensure they held a work-life balance to engage in *"self-care"* and have meaning outside of work to offset work-related stressors. This may reflect participants' attempts to challenge cultures of 'overworking' within NHS which some suggest are becoming normalized (Bailey & West, 2021).

This is a similar finding to Gray & Jones (2018) who found that leaders were able to better manage pressures of the role by having self-awareness of the emotional impact of their role in order. Such strategies speak to individual resilience; this involves willpower and self-control (Sia & Jose, 2021), which is required in setting boundaries. However, the findings also relate to the use of collective resilience. Igoe et al. (2020) emphasised that self-care and the sharing of responsibilities are important aspects of developing organisational resilience to wider pressures and external threats. Similarly, Lovelace et al. (2007) emphasised how leaders should address experiences of work stress by sharing leadership and allowing others to take responsibility and reduce unnecessary demands on leaders. This finding adds to the limited literature on leaders' 'real-life' accounts of navigating work-related stressors and pressures, and how leaders develop and utilise strategies to build and maintain resilience in practice.

Participants also acknowledged the importance of building positive relationships as a leader, within both staff and leadership teams, to create a cohesive and psychologically safe environment. This 'coming together' was considered key to managing the complexity of, and pressures within CAMH services, to support children and young people. Developing relationships, and a collaborative approach, is consistent with key relational leadership models such as transformational leadership, which promotes the importance of motivating and empowering people to work together in line with certain values and principles, moving towards a shared goal (Mayer, 2018). Such a relational focus also reflects the ways of working that are inherent in CAMHS, and leadership in this context being considered a "social phenomenon" (NCSS, 2011). The approaches reflected in participants' accounts also echo the focus of recent literature on leadership in crisis, on building psychologically safe spaces to develop connectedness, trust and compassion amongst staff (Geerts et al., 2020; Wilson &

Waddell, 2020), which is key during times of uncertainty (Ahern & Loh, 200). This finding again reflects the use of collective resilience, highlighting the important role of relationships in resilient responses to external pressures (Gittel, 2008). The benefits of building positive relationships that participants described are in line with research that has suggested that supportive working relationships are important in improving job satisfaction and protecting against work-related stress and burnout (Scarnera et al., 2009; Scanlan et al., 2018).

Participants' accounts further emphasised the importance of relationships. Participants acknowledged the importance of they themselves accessing support as a leader. This was key to manage the pressures and challenges of the role and service. Participants found this valuable to be able to process difficult emotions, and feel heard, connected and supported. However, participants often found this support to be inaccessible within their supervision structures. Some participants described how they had to find and 'outsource' support, such as through supportive relationships or *"allies"* with colleagues, or by seeking external coaching or supervision outside of the NHS.

The finding that leaders need support is consistent with other research. This has shown how leaders use external resources such as coaching and peer groups (Gray & Jones, 2018) and mentoring and support (Elliot, 2016) to sustain their resilience and wellbeing. This finding also adds further support to the importance of collective resilience and suggests how those in leadership roles needed to be considered part of the 'collective' that feels safe and understood. Igoe et al. (2020) suggests that resilience at a collective level often involves sharing mental models about priorities, sharing experiences and sharing responsibilities to foster psychological safety, which participants appeared to be seeking.

Attachment theory may offer further insight into these processes (Bowlby, 1969). This posits that in order to thrive and develop socially, humans require relationships with others that serve as a 'secure base' (Ainsworth, 1979; Bowlby, 1973). This is associated with greater resilience, self-regulation, and sense of self and confidence (Brennan et al., 1998; Main et al., 1985), whereas insecure attachment is associated with the reverse, and difficulty managing stress and interpersonal difficulties (Golding, 2012). Therefore, it is possible participants felt it important to seek security and connection to be able to develop and maintain resilience in the face of challenges. This understanding

is important given research that shows that healthcare workers that do not feel seen, soothed and safe are more likely to make errors and have difficulties forming relationships in teams (Lucian Leap Institute, 2013).

Participants' accounts suggested that they did not always feel psychologically safe within their clinical support processes in the NHS, such as supervision, to seek the support they needed. This is in contrast with the leadership models promoted within the NHS, and wider literature on building resilience and leading through uncertainty. The finding is important, considering the challenges and pressures leaders face, and how imperative it is for them to receive support to navigate their roles.

Key finding three: journey to leadership

This theme refers to how participants identified with leadership, and how this influenced their feelings towards, and engagement in leadership roles and responsibilities. Participants' accounts highlighted how they felt that at times being a leader in the NHS was in conflict with their personality style, and the skills and attributes they developed during training. Participants considered leadership to involve being directive, assertive and holding an expert position, which often felt uncomfortable. These factors felt in contrast to the reflective, non-expert position and values of person-lead and centered care positions that participants expressed as important to them as a Psychologist. Therefore, their identity as a Psychologist could feel misaligned with a 'leadership identity' in the NHS.

The King's Fund position on NHS leadership and culture (2022) shows some support for participants' experiences. It highlighted how some leaders reported receiving poor leadership behaviours from their senior leaders. These were the opposite of the compassionate and inclusive leadership they themselves seek to practice. Therefore, leadership structures and styles in the NHS may continue to adopt practices that are seemingly transactionally based (Aarons, 2006) rather than the transformational and shared approaches that are considered most effective in healthcare settings (Bailey & West, 2021; West et al., 2015).

Battling "imposter syndrome"

Participants also struggled with feeling confident as a leader, experiencing 'imposter syndrome' and doubting their abilities. This was particularly in relation to being in a position of knowledge and expertise as a leader, and having to hold multiple responsibilities. Participants felt that this self-critical narrative had impeded their engagement in leadership activities and responsibilities at times during their career. Previous research has also highlighted difficulties with healthcare professionals' confidence in their ability to undertake leadership roles. Faculty of Medical Leadership and Management's (FMLM; 2018) report showed that healthcare leaders often struggled with feeling competent as a leader, with was suggested to be impacted by a lack of time in the current role for leadership development (FMLM, 2018). McTiffin (2023) highlighted newly qualified Clinical Psychologists self-efficacy as a leader was lower compared to a normative sample of undergraduate psychology students, which impacted their engagement with leadership.

The role of gender

All participants in the study identified as female, and one participant explicitly expressed her understanding of her 'imposter syndrome' to be rooted in societal discourses around gender. Therefore, it may be helpful to consider participants' internal conflict around leadership in part through role congruity theory (Eagly & Karau, 2002). This was developed from social role theory (Eagly, 1987) and applied to a leadership context. It suggests that people are inclined to behave in line with their gender role expectations. For women, gender roles are often in conflict with leadership behaviours. Women may evaluate themselves negatively in comparison to male counterparts, both in relation to their potential for leadership and their actual leadership behaviour. Leadership roles are often seen as requiring more directive and agentic traits, which are more congruent with masculine ideals and in contrast with female stereotypes of caregiving and kindness (Eagly & Karau, 2002). Women are faced with negotiating conflicting role expectations, and as gender biases may often be internalised (Hague & Lord, 2007), women may perceive themselves as less capable in leadership roles compared to males. This also means female leaders may need high levels of self-efficacy and resilience to cope with this conflict and prejudice (Corrigall, 2015).

Developing confidence as a leader

Despite participants' difficulties with self-doubt, all participants described how they were able to develop their confidence as a leader. This was supported by recognising the part of leadership they felt they were good at, often the relational aspects of leadership. Participants' accounts also demonstrated how they were motivated to lead when leadership aligned with their values, which often included person-centered care, creating change, improving quality, and protecting staff wellbeing. When their role as a leader felt congruent with these factors, they felt more aligned with leadership, which supported their resilience to engage in leadership responsibilities, and push through the challenges they faced. These findings reflect the affiliation of Clinical Psychologists within the study towards relationally-orientated leadership styles including transformational and compassionate approaches. These are focused on motivating and empowering people to work in line with certain values and principles (West et al., 2015), working collaboratively towards a shared goal (Mayer, 2018) and fostering cultures of support and inclusivity (Bailey & West, 2022). Shared and distributed leadership approaches, that embody a set of values and foster collective processes and relational abilities are considered an effective mechanism to overcome healthcare hierarchy-based communication structures, and improve performance outcomes (Leach et al., 2021; Mitchell & Boyle, 2021). Therefore, participants' preferred leadership styles may be valuable in fostering collaborative approaches that are required within the context of CAMHS. However, as participants' accounts have established, it is challenging for leaders when these recommended approaches are in contrast to the hierarchical and medical model cultures that persist.

The role of values in leadership identity and engagement

The integral role of values in leadership that was suggested by participants, is supported by previous literature. The use of personal values within clinical leadership is highlighted within the Leadership Development Framework (DCP, 2010). For example, reflection upon personal values is encouraged in relation to decision making, under the domain 'setting direction'. Values are a known

driver and motivator of behaviour (Schwartz, 1992), and in leadership contexts, a number of studies echo the role of values in leadership engagement. Corrigall (2015) highlighted how Clinical Psychologists in a qualitative study on women's leadership experiences, were guided and motivated by their morals and values. Participants took action as a leader when they considered unjust decisions or acts to have occurred, by challenging injustice in line with their values. Messham (2018) in a similar study found that Clinical Psychologists' values were integral to how they made sense of the dilemmas they faced, and the decisions that they made as a leader. Similarly, in the face of challenges, Gray and Jones' (2018) qualitative study on health care leaders found that leaders aligned their experiences with their personal values, to recapture a sense of purpose. This was an important "internal resource" to manage the challenges. Furthermore, healthcare leaders' sense of professional identity and values are highlighted as important by FMLM's (2018) report, as a barrier to undertaking leadership roles was professionals' perceived potential threat to their professional identity and values by their role being more occupied by leadership responsibilities over clinical tasks.

Moyo et al., (2015) explored healthcare professionals' values and found that values of 'power' and 'authority' were identified as being some of the least popular held values amongst professionals. The authors suggested that this was due to the conflict of these values with other professional values that are typically promoted and therefore more socially acceptable to identify with, such as altruism and fairness. Therefore, identifying with the position of 'power' as a leader may produce discomfort for clinicians. This may in part explain participants' accounts of feeling uncomfortable with being in positions of authority and expertise, due to values of compassion and person-led care described by the Clinical Psychologists in the study.

Social Identity Theory (Tajfel, 1982) may be a further way of understanding participants' engagement and identification with leadership. The basic idea of this theory is that a person forms a unique personal identity as an individual and develops a social identity based on the groups to which they belong. This social identity, a person's affiliation to and perceived membership of a group defines a core part of 'who' that person is. The characteristic of those affiliations determines how the individual thinks, feels and behaves (Hogg, 2001). Values are important shared characteristics of a group, and thus a person's values are formed in part by their affiliation to a group. For Clinical

Psychologists in the study, this may explain their difficulty connecting with a leadership identity, as the perceived values of 'leaders' described in their accounts were directiveness, being an expert and authoritativeness. This may not be congruent with the values that participants held, as Clinical Psychologists.

A value of supporting and *protecting* others was considered an important part of being a leader, which perhaps reflects the challenging context of CAMHS and the workforce feeling 'under threat'. This is mirrored in Ahti et al.'s (2023) study which showed that leaders were focused on managing and taking care of staff during the Covid-19 pandemic, a time of crisis. These findings also highlight the affiliation of Clinical Psychologists within the study towards relational-orientated leadership styles including transformational and compassionate approaches, and building organisational resilience rather than a focus on staffs' individual coping strategies. Clinical Psychologists in the study developed their confidence through connecting to their abilities in providing supportive relationships. This reflects how Clinical Psychologists may be effectively placed to promote relational approaches to leadership and resilience; the importance of which is suggested in leadership literature and frameworks.

Key finding four: rewards and costs of being a leader

This theme captured the personal effects of being a leader. Through participants' accounts it was evident that working within challenging systems impacted on participants emotionally and psychologically. Participants felt stressed, frustrated by wider systemic challenges that felt out of their control, and saddened by the difficulties in retaining and losing staff. This adds to 'key finding one' which highlighted the stressors that participants, staff and services faced, that induced feelings of personal and organisational threat.

This finding adds to literature on health care professionals' experience of work-related stress that is evident in CAMHS and the wider NHS (Bentham et al., 2021; NHS England, 2022). Participants' sense of disempowerment mirrors findings from other studies, such as Briggs (2018) who found psychologists and psychotherapists experienced a sense of powerlessness and hopelessness working within systemic challenges that they perceived as beyond their control. Additionally,

Anandavica et al. (2018) suggested that frontline leaders, as the result of widespread pressures felt disempowered, which lead to high leadership 'churn'. These results therefore suggest that feeling powerless against pressures is an important factor that may result in difficulties retaining leaders in their role.

However, there were a number of rewards evident in participants' accounts, that functioned as further protective and motivating factors for engaging in leadership (in addition to those described in 'key finding two'). In fact, all participants were readily explicit about the rewards and benefits of being a leader. Such rewards included feeling empowered as a leader. Whilst participants experienced disempowerment in relation to wider systemic challenges as described, they were able to find a sense of empowerment in relation to creating some change and having influence in their services, as well as being able to support services and staff through challenges. These rewards were important for participants' sense of job satisfaction. This finding supports Scanlan et al.'s (2018) research on job satisfaction in mental health care workers. This suggested that important factors for enhancing satisfaction included workers being able to make a difference and engage in meaningful work. Similar findings were seen in Fleury et al.'s study (2017), which suggested that staff empowerment is important across and for all the different professionals in mental health care. Leadership in Clinical Psychology may further opportunities for influence and feeling liberated. This is reflected in participants' accounts that they felt less empowered in lower banded roles as Clinical Psychologists, and that greater leadership responsibilities and status afforded heightened opportunities for influence and power.

Participants also felt that they benefited from personal learning and growth as a result of their experiences of leadership. This included deepened self-knowledge and awareness, and skills development that impacted not only their professional development, but wider personal development such as stress management. Fletcher and French (2021) investigated the effects of transitioning into leadership roles and found how this was initially met with increased tension. However, over time this transitioned into increased self-esteem and a sense of internal locus of control for leadership. This supports participants' descriptions of how they initially struggled with leadership, yet over time they

were able to develop and grow as a leader and experience a strengthened sense of self and ability to cope.

Post-traumatic growth (PTG) is a concept that refers to the benefits and psychological growth that can occur for individuals, as a result of experiencing a traumatic event (Turner-Sack et al., 2016). This concept has often been researched in relation to healthcare professionals, their challenging experiences working in stressed and traumatised systems, and experience observing other people experiencing trauma (Abel et al., 2014; O'Donovan & Burke, 2022). One salient domain of PTG includes personal strength (Tedeschi & Calhoun, 1996) which refers to individuals recognising and perceiving themselves as being more 'robust' and more equipped to handle challenges compared to before their difficult experiences. Participants' accounts of learning and growth as a leader may align with this notion; through their experiences of challenges, they were able to feel more confidence in their self-efficacy and their abilities as a leader. A systematic review on post-traumatic growth within healthcare workers (Donovan & Burke, 2022) highlighted the factors that supported such growth. These included individual factors such as self-confidence (Cui et al., 2021), finding meaning in work (Martela & Pessi, 2018), self-compassion (Aggar et al., 2022) and resilience, as measured by the Connor-Davidson Resilience Scale (Hyun et al., 2021). An interpersonal factor that enabled PTG was relational support (Hyun et al., 2021; Zhang et al., 2021), which was identified as important for professionals' coping, and was sought from both colleagues and personal relationships outside of work. These factors identified in the review for enabling PTG were also evident within participants' accounts, which suggests that they may be important in supporting and influencing the learning and growth that participants experienced.

The findings related to the 'rewards and costs of being a leader' indicate the benefits of being a leader that may be gained through the role. Such rewards may be important to maintain resilience in the face of challenges and stressors that appear to be inevitable within leadership roles.

Further conceptualisation of the findings

Overall, participants' accounts highlighted the challenges they faced, what motivated them to engage in leadership and persevere through the challenges, and what factors supported them to feel

soothed and connected. These findings seemingly mirror the three emotional systems as associated

states outlined within Compassion Focused Therapy (CFT; Gilbert, 2009a). This evolutionary model

postulates that human behaviour, thought and affect is influenced by and associated with three

emotion regulation systems, which have developed to facilitate survival, and are underpinned by

certain types of feeling and styles of social relating (Gilbert, 2009b). This includes the system of

threat and protection, which is associated with feelings of anxiety, anger or disgust and functions to

notice threats quickly, to act upon them and protect the self. The drive and excitement system directs

humans towards rewards and resources, and is associated with positive feelings of pleasure and

excitement. This system energises and motivates people, and guides them to seek out resources and

achieve goals. The third system, contentment and soothing, is associated with states of safeness,

wellbeing and connection with others, and is activated when threats and dangers are not present, and

resources are sufficient.

As the Compassion-Focused Therapy (CFT) model posits, people often spend a significant

amount of their time in activated threat and drive systems, which can lead to imbalanced emotions and

distress (Gilbert, 2009a). A compassionate mind approach suggests that it is important to notice if the

soothing system is underdeveloped and recognise ways that help to activate this system. A balance of

all three emotional systems is considered conducive to wellbeing (Gilbert, 2009b). Considering the

challenging and threat-inducing contexts of CAMHS and leadership that participants experienced, it

may be helpful to understand and formulate participants' experiences through this lens, in order to

support Clinical Psychologists' wellbeing and resilience as leaders in CAMHS. This model may

demonstrate the factors that pose threats to Clinical Psychologists leading in CAMHS, what drives

them, and what helps to soothe and support them in their role.

Threat-protection system

Participants' accounts highlighted the pressures of CAMHS and the wider NHS, and how

these pressures often induced feelings of threat and stress within themselves and wider staff teams.

This resulted in, and was accompanied by interpersonal threat, between participants and other

professionals. Participants often experienced others to have a limited understanding of, or respect for

psychology within leadership positions. This enhanced the difficulties of participants working and asserting their power within hierarchical structures of leadership, and dominant medical models. Further factors that activated the threat and protection system within participants were their difficulties in identifying as a leader. At times participants felt uncomfortable and not confident as a leader and found themselves engaging in internal self-critical narratives. This induced anxiety around engaging in leadership responsibilities.

Drive and excitement system

Participants' accounts showed how their drive systems were activated by connecting with their values, such as improving quality of care, developing person-centered care and supporting others which motivated their engagement in leadership. Additionally, they were motivated by and rewarded by the benefits of leadership, which included feeling empowered to create change and have influence, and learning and developing skills. Participants were driven to develop as a leader through these factors. Whilst participants found motivation and excitement in leadership, their drive system activation could also pose some difficulty, in feeling overwhelmed and responsible for the array of challenges in the services.

Contentment and soothing system

The activation of the soothing system is considered key to regulate the drive and threat-protection systems. Through participants' accounts, it appeared that receiving support as a leader, through their peers or within their personal life enabled them to feel safe and cared for, which mediated their wellbeing as a leader. This allowed participants to feel connected to others and share the emotional burden of their role. The contentment and soothing system was also seemingly stimulated by having or building positive relationships with the wider team that fostered psychological safety. Furthermore, participants were able to engage in self-compassionate behaviours, such as finding a work-life balance and holding boundaries to workload and service pressures to protect their emotional wellbeing.

Self-compassion for leaders

Self-compassion has been defined as "relating to oneself with care and support when we suffer" (Neff & Knox, 2017, p.1). This is a key component of Gilbert's (2009a) model of CFT, and involves bringing a perspective of acceptance and kindness towards experiences of distress and difficulty. This is in contrast to a 'self-critical' approach of judgement and blame for not feeling good enough or coping well enough with life's challenges. According to the CFT model, self-criticism can often trigger our threat system, bringing about feelings of anxiety and stress. Self-compassion however, is helpful in activating the soothing system, which promotes a sense of belonging and connectedness with others. Self-compassion is associated with a number of benefits for wellbeing, such as greater emotional resilience (Neff & Knox, 2017), less anxiety and depression, and improved relationships and self-esteem (MacBeth & Gumely, 2012).

Considering the difficult self-critical narratives around being a leader that participants experienced, developing leaders' self-compassion may be helpful. In a recent systematic review (Rushforth et al., 2023) that looked at the use of self-compassion in health care professionals, it was found that self-compassion was associated with positive-wellbeing outcomes, in the context of the intense demands of the role and secondary traumatic stress associated with their job. The authors considered self-compassion to be an important skill for health care workers, as it involves responding distress with kindness and understanding. A recent study looked at the use of self-compassion specifically in leaders in health care settings, and how this related to leader self-identity. The authors consider leader role self-compassion "a mindset in which a leader takes a supportive, kind and non-judgement stance" (p.2). It was shown that when leaders engage in leader role self-compassion they identify more strongly with their leadership role. For novice leaders, this effect was stronger. Considering participants struggle with developing their identity as a leader, considering leaders' self-compassion may be important to support Clinical Psychologists' connection with leadership roles. West (2021) also considers self-compassion to be key to leaders' ability to model and embody compassionate leadership. Compassionate leadership involves directing compassion out towards

others, focusing on developing relationships with colleagues, through empathy, carefully listening, understanding and respect (West, 2015). Starting with self-compassion, and modelling self-care and kindness is considered key to creating compassionate teams, organisations and health care systems (West, 2021).

Strengths and limitations of the study

This study explored a novel area of research, as no previous research existed on the experiences of Clinical Psychologists engaging in leadership roles in CAMHS (to the author's knowledge). This is of particular importance given the ever-changing and pressured contexts of the NHS. The study reflects a novel contribution to the literature around the challenges that leaders in CAMHS face, and insight into the ways in which participants were able to navigate and cope with these roles. Strategies included building relationships, being supported and finding balance. A further contribution was offered by how participants identify with leadership and how this impacts their engagement with and development in the role. Furthermore, the study reflects the rewards and benefits that participants felt they gained from being a leader, which are seldom explored. This learning offers important insights to help the profession of Clinical Psychology support and develop their leaders.

The use of IPA, similarly to other qualitative research methods, and the small sample size used means that the results are likely relevant only to the particular participant group of the study. A key component of IPA is idiography, an understanding of the 'particular', therefore any generalisations made must be established cautiously and be located in the particular participant group (Clinical Psychologists), in particular contexts (CAMHS). However, the aim of the research questions was to explore such particular phenomena, and provide in-depth personal accounts of leadership roles, which fitted with the focus of this methodology.

As discussed in Chapter Two, a key feature of valid IPA research is ensuring the sample of individual participants is homogenous. All participants met the inclusion criteria. They were Clinical Psychologists working in NHS band 8a roles within community CAMHS and engaging in leadership activities. The services participants worked in were across the UK, which may have increased the

heterogeneity of the sample, as there may be some differences in the set up and processes of different CAMH services nationally. Nonetheless, it was considered that the inclusion criteria of community services, and exclusion of inpatient or health settings ensured enough similarity. Additionally, a benefit to national recruitment is that it may offer some transferability of the results across UK NHS CAMH services.

In further consideration of the homogeneity of the sample, one participant was in a band 8d position at the time of the interview, and described engaging in largely strategic and organisational responsibilities within this role, which differed slightly to other participants in band 8a-8c positions. However, during the interview and analysis it was considered that this participant shared experiences that were similar to other participants. They also spoke about their experiences in previous 8b and 8c roles in CAMHS which involved more 'clinical leadership' roles.

Further considerations include the characteristics of the sample. Participants were all White British, or White Other, females. Whilst this similarity in gender and ethnicity provides a more homogenous sample, it cannot be determined if the experiences of the participants are shared across the population of male Clinical Psychologists, or Psychologists from different ethnic backgrounds.

A further potential limitation involves the use of semi-structured interviews. Whilst this is the most commonly used, and recommended method data collection in IPA (Smith et al., 2021), the responses gained from participants may have been inevitably influenced by the use of a topic guide and prompts. A further consideration is that the relationship between myself and the interviewees may have also influenced participants' responses. Firstly, I sensed that some participants seemed wary of presenting the challenges and a negative perception of working within CAMHS, and in leadership positions. Participants were aware of my position as a trainee Clinical Psychologist, moving towards qualification and may have wanted to 'shield' me from the potential stressors of qualified life. Secondly, although I did not have any pre-existing relationships with the participants, it is possible that we may have come into future contact professionally, and participants may have considered this during interview. Therefore, participants may have been aware of this, and self-monitored their responses in order to avoid discussing particularly difficult experiences. Those participants in more newly qualified positions may have been concerned about their 'competence', which was evident in

the expression of "imposter syndrome" across participants. Thus, they may have wanted to portray a sense of competence in leadership to me, due to a potential future professional relationship between us. These potential limitations may be reflected in the variability of participants' willingness to be open and reflective.

Finally, due to the 'double hermeneutic' process of IPA, my personal background, perceptions and feelings will have influenced the analysis and results that were produced (Smith et al., 2021). Therefore, maintaining a reflexive stance was crucial to ensure that I continuously reviewed my own role in the research, to promote the validity of the study (Willig, 2013). I engaged in a number of reflexive practices, as detailed in Chapter Two, which included keeping a reflective log and discussing the individual analysis and emerging themes with my supervisors and peers, in attempt to 'bracket' my experiences as best as possible. This helped me to be aware of the meaning I was creating of the data and reduce the imposition of this meaning on the analysis. Furthermore, I ensured that the analytic process was transparent, keeping detailed records of each step of the analysis and sharing with supervisors and peers at each stage of the analysis. This ensured that I gained feedback on my interpretations and considered the data from different perspectives.

Clinical implications

The findings from the study offer a number of implications that may be important to consider. This includes within the profession of Clinical Psychology for developing and supporting their leaders, and more widely within the NHS, including leadership structures and interprofessional working.

Teaching and training

Leadership is a relatively new and increasingly significant part of the role of Clinical Psychologists. Considering the findings that participants struggled with their confidence and identity as a leader, it may be helpful for Clinical Psychology training programs to continue to develop the teaching they provide around leadership, to support emerging leaders. Participants felt motivated to

engage in, and connected to leadership when it aligned with their values. Therefore, promoting values-based leadership and the opportunity to create change in line with what Psychologists consider important, may be helpful. This may encourage emerging Psychologists' affiliation with and drive for leadership roles and responsibilities.

Participants also developed their confidence as a leader when they 'leaned' into their strengths of interpersonal skills and building relationships. This is an important aspect of the promoted leadership styles and approaches in the NHS (The King's Fund, 2013; West et al., 2015). Therefore, within the teaching around leadership it may be helpful to emphasise this, and align it with the skills and competencies that are core to Clinical Psychologists.

It may also be important to consider the role of gender in Clinical Psychologists' relationship to leadership. This may be particularly important in terms of how gender norms and discourses might influence female Clinical Psychologists confidence in and engagement with leadership roles and responsibilities. How female Clinical Psychologists can be supported to be leaders may thus invite further thought and attention.

Working with other professions

Working with other professionals sometimes presented challenges for participants within their leadership roles and responsibilities. This included interprofessional conflict and navigating hierarchical structures of leadership still present in the NHS. Interprofessional relationships are important for providing effective care for CYP (NCSS, 2011), and participants expressed how such relationships were key for navigating the pressures of CAMHS. Clinical Psychologists within CAMHS in leadership positions may want to further consider how to continue developing inter-professional relationships and collaboration. This might include utilising their psychological understanding of relationships, and skills in formulation to understand and navigate team and service dynamics.

Furthermore, considering the difficulties participants faced working with other professionals, a wider implication for the NHS might be how cultures of interprofessional collaboration and understanding can be supported in CAMHS. Effective MDT working is key to the systemic and

relational ways of working within CAMHS (Hunt, 2020), and such cohesion and team relationships are important for organisations to develop collective resilience in the face of challenge (Rangachari & Woods, 2020). Therefore, it may be important to consider ways to increase connection between professionals, and develop trust, safety, and shared responsibility within working environments.

Supporting leaders' wellbeing

The findings of the study highlight that leading with CAMHS can often be a challenging role and can result in difficulty and stress for Clinical Psychologists. Given the ongoing wider pressures and challenges of CAMHS and the NHS, and what is known about the detrimental impact this can have on the workforce, it is important to consider how Clinical Psychologists' wellbeing and resilience can be supported and protected. The participants in the study found that receiving support as a leader was important to manage the stressors of the role. This was found through supportive relationships with colleagues. Clinical Psychologists may want to further consider how they access support to feel connected to others and able to share the emotional burden of their role. It is also important for services and NHS leadership structures to consider how support is scaffolded around Clinical Psychologists relating to their leadership roles and responsibilities, not just their clinical work. This is particularly important as some participants felt that typical supervision structures were not always psychologically safe to discuss leadership responsibilities.

Recommendations for further research

Due to the small sample size of the current study, the findings afford only an insight into Clinical Psychologists' experiences of leadership in CAMHS. As this is a novel area of study, more research is needed, with larger sample sizes, to produce more generalisable and transferable results. This may involve the use of quantitative studies alongside further qualitative research.

As participants were all White and female, it may be helpful to explore Clinical Psychologists' experiences of leadership with males, and people with different ethnicities to compare

experiences to the current study. This may help enhance the understanding of leadership within the profession, and the role that diversity plays in Clinical Psychologists' experiences of leadership.

A focus of Clinical Psychologists in the study was on how they identify with leadership, and connect with and are motivated towards leadership when it aligns with their values. Therefore, it might be interesting to explore this concept further, and how this might help to support the teaching and training of leadership for Clinical Psychologists.

Interprofessional conflict between Clinical Psychologists and other professionals, often medical professionals and management colleagues, was evident in the study. This was particularly evident in relation to a 'clashing' of professional cultures, and Clinical Psychologists attempting to negotiate their position of power within NHS leadership structures. An interesting perspective that may offer more insight into these dynamics may be how other professionals, such as those from a medical background, experience and perceive Clinical Psychologists in leadership roles.

Concluding summary

The study explored Clinical Psychologists' experiences of leading within CAMHS. The findings highlighted the challenges that Clinical Psychologists in the study faced. This included working within pressured and stretched services which induced feelings of threat both within participants and wider staff teams and services. Interprofessional conflict was also experienced by participants which created challenges in making changes in services, towards their values of person-centered and quality care. Participants also experienced difficulty feeling confident as a leader, and identifying with leadership, which impeded their engagement with leadership responsibilities.

Participants were able to align their leadership style and responsibilities with their values, which motivated them to be leaders. Seeking support as a leader, and building positive relationships with staff and teams supported them to feel able to navigate the pressures of the role and wider CAMHS. These findings address the research question *"what meaning have Clinical Psychologists' made of the challenges they have faced in leadership positions and how have they responded?"*

As a result of the challenges Clinical Psychologists in the study faced, emotional difficulties of stress and frustration were experienced by participants at times during their role as a leader. This

included feeling emotionally overwhelmed, and sometimes disempowered by the wider systemic challenges of CAMHS and the NHS. However, a number of positive effects were seen through engaging in leadership. Participants were able to develop their confidence as a leader and were afforded growth and learning both personally and professionally through their experiences. Further benefits within the leadership role included feeling empowered in their position to create meaningful change. These findings address the research question *"what have the effects of leading been on Clinical Psychologists in leadership positions?"*

The current pressures on the NHS are ongoing, and CAMHS continues to experience unprecedented challenges in meeting the mental health needs of Children and Young People. Leadership is vital to provide quality and effective care, and a key aspect of this is through developing relationships and supporting collective resilience. The study highlights how Clinical Psychologists as leaders have been able to overcome the challenges in the role and what is required to continue to support leaders and wider CAMH services during these difficult times.

References

Aggar, C., Samios, C., Penman, O., Whiteing, N., Massey, D., Rafferty, R., Bowen, K. & Stephens, A. (2022). The impact of COVID-19 pandemic-related stress experienced by Australian nurses. International Journal of Mental Health Nursing, 31, 91–103. https://doi.org/10.1111/inm.12938

Aarons, G. A. (2006). Transformational and transactional leadership: Association with attitudes toward evidence-based practice. *Psychiatric services*, *57*(8), 1162-1169. https://doi.org/10.1176/appi.ps.57.8.1162

Abel, L., Walker, C., Samios, C., & Morozow, L. (2014). Vicarious posttraumatic growth: Predictors of growth and relationships with adjustment. *Traumatology: An International Journal*, *20*(1), 9. https://doi.org/10.1037/h0099375

Ahern, S. & Loh, E. (2020). Leadership during the COVID-19 pandemic: building and sustaining trust in times of uncertainty. *British Medical Journal Leader, 5*(4), 266-269. https://doi.org/10.1136/leader-2020-000271

Ahti, M., Taipale-Walsh, L., Kuha, S., & Kanste, O. (2023). Health-care leaders' experiences of the competencies required for crisis management during COVID-19: a systematic review of qualitative studies. *Leadership in Health Services*. 1751-1879. https//:doi.org/10.1108/LHS-10-2022-0104

Ainsworth, M. D. S. (1978). The Bowlby Ainsworth attachment theory. *Behavioural and Brain Sciences*, *1*(3), 436-438. https://doi.org/10.1017/s0140525x00064955

Allen, J. G., & Fonagy, P. (2006). *The handbook of mentalization-based treatment*. John Wiley & Sons.

Allen, R, Gilbert, P. & Onyett, S. (2009). Leadership for personalisation and social including in mental health (Adult services report 27), *Social Care Institute for Excellence. https://www.scie.org.uk/publications/reports/report27.asp*

Ambrose, A. (2019). *Exploring clinical leadership within the Clinical Psychology pathway.* [Doctorate thesis, University of Southampton]. University of Southampton Institutional Repository. http://eprints.soton.ac.uk/id/eprint/434614

Anandavica, S. (2018). Leadership in today's NHS: delivering the impossible. *The King's Fund.* https://www.kingsfund.org.uk/publications/leadership-todays-nhs

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using zoom videoconferencing for qualitative data collection: perceptions and experiences of researchers and participants. *International journal of qualitative methods*, *18*, 1609-1615. https://doi.org/10.1177/1609406919874596

Bailey, M. & West, S. (2022). *Tired of being exhausted: seven key actions for leaders in the NHS workforce crisis.* The King's Fund. https://www.kingsfund.org.uk/blog/2022/02/actions-for-leaders-nhs-workforce-crisis

Bailey, S. & West, M. (2021). Naming the issue: chronic excessive workload in the NHS. *The King's Fund.* www.kingsfund.org.uk/blog/2021/06/naming-issue-chronic-excessive-workload-nhs

Barratt, S. (2019). From adult lunatic asylums to CAMHS community care: the evolution of specialist mental health care for children and adolescents. *French Journal of British Studies*, *3*, 1948-2018, https://doi.org/10.4000/rfcb.4138

Barton, M. A., Christianson, M., Myers, C. G., & Sutcliffe, K. (2020). Resilience in action: leading for resilience in response to COVID-19. *BMJ Leader, 4*(3), https://doi.org/117.10.1136/leader-2020-000260

Bass, B. M., & Riggio, R. E. (2006). *Transformational leadership*. Psychology Press

BBC. (2018). Child mental health: CAMHS 'not fit for purpose'. https://www.bbc.co.uk/news/health-45607313

Beech M (2002). Leaders or managers: The drive for effective leadership. *Nursing Standard*, *16*(30), 35–6. https://doi/org/10.7748/ns.16.30.35.s43

Békés, V., Aafjes–van Doorn, K., Prout, T. A., & Hoffman, L. (2020). Stretching the analytic frame: Analytic therapists' experiences with remote therapy during COVID-19. *Journal of the American Psychoanalytic Association*, *68*(3), 437-446. https://doi.org/10.1177/0003065120939298

Bentham, C., Driver, K., & Stark, D. (2021). Wellbeing of CAMHS staff and changes in working practices during the COVID-19 pandemic. *Journal of Child and Adolescent Psychiatric Nursing*, *34*(3), 225-235. https://doi.org/10.1111/jcap.12311

Bion, W. R. (1959). *Attacks on linking. In Second thoughts*. Karnac.

Bloom, S. L. (2010). Trauma-organised systems and parallel process. In N. Tehrani (Ed.), *Managing Trauma in the Workplace: Supporting Workers and Organisations (pp. 159-173).* Routledge.

Bolden, R. (2004). *What is leadership?*. Centre for Leadership Studies, University of Exeter.

Bolden, R. (2011). Distributed leadership in organisations: a review of theory and research. *International Journal of Management Reviews, 13*(3), 251-269. https://doi.org/10.1111/j.1468-2370.2011.00306.x

Booth, R. (2021). Children's mental health services in England 'unable to meet the demand'. *The Guardian.* https://www.theguardian.com/society/2021/jan/28/childrens-mental-health-services-in-england-unable-to-meet-demand

Bowlby, J. (1969). Attachment and loss: volume I: attachment. In *Attachment and Loss: Volume I: Attachment* (pp. 1-401). The Hogarth Press and the Institute of Psycho-Analysis.

Bowlby, J. (1973). Attachment and loss: Volume II: Separation, anxiety and anger. In *Attachment and loss: Volume II: Separation, anxiety and anger* (pp. 1-429). The Hogarth Press and The Institute of Psycho-analysis

Braun, G. (2011) Organisations today: What happens to attachment? *Psychodynamic Practice*, *17*(2), 123-139. https://doi.org.10.1080/14753634.2011.562692

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). The Guilford Press.

Briggs, A. (2018). Containment lost: the challenge to child psychotherapists posed by modern

    CAMHS. *Journal of child psychotherapy*, *44*(2), 168-180.

    https://doi.org/10.1080/0075417X.2018.1443489

British Medical Association. (2019). Measuring progress: commitments to support and expand the

    mental health workforce. *British Medical Association.*

    https://www.bma.org.uk/media/2405/bma-measuring-progress-of-commitments-for-mental-

    health-workforce-jan-2020.pdf

British Medical Association. (2023). NHS backlog data analysis. *British Medical Association.*

    https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-

    backlog-data-analysis

British Psychological Society (2021). *Building a caring work culture: what good practice looks like.*

    https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/B

    uilding%20a%20Caring%20Work%20Culture.pdf

Browne, N., Zlotowitz, S., Alcock, K., & Barker, C. (2020). Practice to policy: Clinical

    Psychologists' experiences of macrolevel work. *Professional Psychology: Research and*

    Practice, 51(4), 371–382. https://doi.org/10.1037/pro0000301

Burns, J. M. (1978). *Leadership.* Harper Collins.

Burr, V. (2003). *Social constructionism* (2nd Ed.). Routledge

Cain, N. (2022). Why it's important to know how to lead through a crisis. *Charleston Southern*

    University College of Business Blog. https://www.charlestonsouthern.edu/blog/why-is-it-

    important-to-know-how-to-lead-through-a-

    crisis/#:~:text=Success%20during%20a%20crisis%20will,controlling%20what%20is%20see

    mingly%20uncontrollable.

Care Quality Commission. (2017). *Review of children's and young people's mental*

    health services: phase one report.

    https://www.cqc.org.uk/sites/default/files/20171103_cypmhphase1_report.pdf

Čartolovni, A., Stolt, M., Scott, P. A., & Suhonen, R. (2021). Moral injury in healthcare professionals: A scoping review and discussion. *Nursing ethics*, *28*(5), 590-602. https://doi.org/10.1177/0969733020966776

Casement, P. (1985). *On Learning From The Patient.* Tavistock.

Charmaz, K. (2014). *Constructing grounded theory*. Sage.

Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: the Conner-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*(2), 76-82. https://doi.org/10.1002/da.10113**.**

Corrigall, F. A. (2015). *The experiences of successful leaders: an IPA study on senior female Clinical Psychologists.* [Doctorate thesis, University of Leeds]. White Rose eTheses Online. https://etheses.whiterose.ac.uk/12436/

Coulson, N. (2015). *Online Research Methods for Psychologists.* Red Globe Press.

Cui, P., Wang, P., Wang, K., Ping, Z., Wang, P. & Chen, C. (2021). Post-traumatic growth and influencing factors among frontline nurses fighting against COVID-19. Occupational & Environmental Medicine, 78, 129–135. https://doi.org/10.1136/oemed-2020-106540

Daly, M., Sutin, A. R., & Robinson, E. (2020). Longitudinal changes in mental health and the COVID-19 pandemic: evidence from the UK Household Longitudinal Study. *Psychological Medicine,* 1-10. https://doi.org/10.1017/S0033291720004432

Danermark, B., Ekstrom, M., Jakobsen, L., Karlsson, J. C. (2002). *Explaining Society: Critical realism in the social sciences.* Routledge.

Delaney, C., Benhamu, J., McDougall, R., Ko, R., Jones, H., Mileshkin, G. L., Clinch, demand'. *The Guardian.* https://www.theguardian.com/society/2021/jan/28/childrens-mental-health-services-in-england-unable-to-meet-demand

Department of Health and Social Care. (2015). *Future in mind: promoting, protecting and improving our children's and young people's mental wellbeing.* https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

Dingwall. & R. De Vries (Eds.), *The SAGE Handbook of Qualitative Methods in Health Research* (pp. 125-156). Sage Publications Ltd

Division of Clinical Psychology. (2010). Clinical Psychology Leadership Development Framework. *British Psychological Society.* http://www.bps.org.uk/system/files/Public%20files/DCP/cat710.pdf

Eagly, A. H. (1987). *Sex differences in social behaviour: a social-role interpretation.* Lawrence Erlbaum Associates.

Eagly, A. H., & Karau, S. J. (2002). Role congruity theory of prejudice toward female leaders. *Psychological Review, 109*(3), 573–598. https://doi.org/10.1037/0033-295X.109.3.573

Elliott, N., Begley, C., Sheaf, G., & Higgins, A. (2016). Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review. *International Journal of Nursing Studies*, *60*, 24-45. https://doi.org/10.1016/j.ijnurstu.2016.03.001

Elliot, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229. https://doi.org/10.1348/014466599162782

Erdogan, B., & Bauer, T. N. (2015). Leader–member exchange theory. In T.N. Bauer & B. Erdogan (Eds.), *The Oxford Handbook of Leader-Member Exchange* (pp. 76-109). Oxford University Press.

Faculty of Medical Leadership and Management (2018). Barriers and enablers for clinicians moving into senior leadership roles: review report. *Department of Health and Social Care.* https://www.gov.uk/government/publications/clinicians-moving-into-senior-leadership-barriers-and-enablers

Finlay, L., & Gough, B. (Eds.). (2008). *Reflexivity: A practical guide for researchers in health and social sciences*. John Wiley & Sons.

Fletcher, K. A., & French, K. A. (2021). Longitudinal effects of transitioning into a first-time leadership position on wellbeing and self-concept. *Journal of Occupational Health Psychology, 26*(6), 469–490. https://doi.org/10.1037/ocp0000302

Fleury, M. J., Grenier, G., & Bamvita, J. M. (2017). A comparative study of job satisfaction among nurses, psychologists/psychotherapists and social workers working in Quebec mental health teams. *BMC nursing*, *16*, 1-12. https://doi.org/10.1186/s12912-017-02550x

Flowers P., Knussen C., Duncan B. (2001). Re-appraising HIV testing among Scottish gay men: The impact of new HIV treatments. *Journal of Health Psychology*, 6, 665–678. https://doi.org/10.1177/135910530100600605

Fonagy, P. & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy*, *51*(3), 372. https://doi.org/10.1037/a0036505

Fonagy, P., Luyten, P. & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: a new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders*, *29*(5), 575-609. https://doi.org/10.1521/pedi.2015.29.5.575

Geerts, J. M., Kinnair, D., Taheri, P., Abraham, A., Ahn, J., Atun, R. & Bilodeau, M. (2021). Guidance for Health Care Leaders During the Recovery Stage of the COVID-19 Pandemic: A Consensus Statement. *JAMA Network Open*, *4*(7), https://doi.org/10.1001/jamanetworkopen.2021.20295

Gemine, R., Davies, G. R., Tarrant, S., Davies, R. M., James, M. & Lewis, K. (2021). Factors associated with work-related burnour in NHS staff during COVID-19: a cross-sectional mixed methods study. *British Medical Journal, 11(*1), http://doi.org/10.1136/bmjopen-2020-042591

Gilbert, P. (2009a). Introducing compassion-focused therapy. *Advances in Psychiatric Treatment*, *15*(3), 199-208. https://doi.org/10.1192/apt.bp.107.005264.

Gilbert, P. (2009b). *The compassionate mind*. Robinson.

Gilmore, B., Ndejjo, R., Tchetchia, A., De Claro, V., Mago, E., Lopes, C. & Bhattacharyya, S. (2020). Community engagement for COVID-19 prevention and control: a rapid evidence synthesis. *BMJ Global Health*, *5*(10), http://doi.org/10.1136/bmjgh-2020-003188

Gittell, J. H. (2008). Relationships and Resilience: Care Provider Responses to pressures from managed care. *The Journal of Applied Behavioural Science, 44*(1), 25-47. https://doi.org/10.1177/0021886307311469

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of Grounded Theory: Strategies for qualitative research.* Aldine Publishing. Co

Golding, K. S., Fain, J., Mills, C., Worrall, H., & Frost, A. (2012). *Observing children with attachment difficulties in school: A tool for identifying and supporting emotional and social difficulties in children aged 5-11*. Jessica Kingsley Publishers.

Gorny, M., Blackstock, S., Bhaskaran, A., Layther, I., Qoba, M., Vassar, C. & Hudson, L. D. (2021). Working together better for mental health in children and young people during a pandemic: experiences from North Central London during the first wave of COVID-19. *BMJ Paediatrics Open*, *5*(1). http://doi.org/10.1136/bmjpo-2021-001116

Gotsis, G. (2022). Leading with compassion: how compassion can enrich healthcare leadership in a post-COVID-19 world. In T. Newstead & R. Riggio (Eds.), *Virtues and leadership: understanding and practicing good leadership Taylor and Francis* (pp. 144-159). Taylor and Francis.

Gray, D., & Jones, K. (2018). The resilience and wellbeing of public sector leaders. *International Journal of Public Leadership*. *14*(2), https://doi.org/10.1108/IJPL-09-2017-0033

Grimm, F., Alcock, B., Butler, J. E., Crespo, R. F., Davies, A., Peytrignet, S., Piroddi, R., Thorlby, R. & Tallack, C. (2022). Briefing: improving children and young people's mental health services. *The Health Foundation.* https://www.health.org.uk/sites/default/files/upload/publications/2022/CYPMHbriefing_Web_Final.pdf

Harre, R. (1979). *Social Being*. Basil Blackwell.

Hartviksen, T. A., Aspfors, J., & Uhrenfeldt, L. (2019). Healthcare middle managers' experiences of developing capacity and capability: a systematic review and meta-synthesis. *BMC Health Services Research*, *19*(1), 1-19. https://doi.org/10.1186/s12913-019-4345-1

Hersey P, Blanchard K. (1969). Life cycle theory of leadership. *Training and Development Journal,* 2, 634.

Hisham, I. N., Townsend, G., Gillard, S., Debnath, B., & Sin, J. (2020). COVID-19: the perfect vector for a mental health pandemic. *British Journal of Psychiatry Bulletin,* 1-7. https://doi.org/10.1192/bjb.2020.60

Hogg, M. A. (2001). A Social Identity Theory of leadership. *Personality and Social Psychology Review, 5*(3), 184-200.

Holmes, J. (2021). Brexit and the end of the transition period: what does it mean for the health care system? *The King's Fund.* https://www.kingsfund.org.uk/publications/articles/brexit-end-of-transition-period-impact-health-care-system

Hormann, S., & Vivian, P. (2005). Toward an understanding of traumatized organizations and how to intervene in them. *Traumatology*, *11*(3), 159-169. https://doi.org/10.1207/S15327957PSPR0503_1

Hoskin, P. (2023). Nature versus nurture: what underpins great leadership? *Clinical Oncology, 35,* 10-11. https://doi.org/10.1016/j.clon.2022.10.012

Hu, J. S., Phillips, J., Wee, C. P., & Pangaro, L. N. (2022). Physician Burnout—Evidence That Leadership Behaviors Make a Difference: A Cross-Sectional Survey of an Academic Medical Center. *Military Medicine*, 69-81. https://doi.org/10.1093/312.

Hunt, L. S. (2020). *"You absorb trauma, without noticing it": a qualitative exploration of staff experiences and subjective well-being working in CAMHS inpatient services.* [Doctorate thesis, University of Essex]. Research Space Repository. https://repository.essex.ac.uk/29201/1/Leanne%20Hunt%20Thesis%20final%20version.pdf

Hyun, H. S., Kim, M. J. Lee, J. H. (2021). Factors Associated With Post-traumatic Growth Among Healthcare Workers Who Experienced the Outbreak of MERS Virus in South Korea: A Mixed-Method Study. *Frontiers of Psychology*, 12, 1228. https://doi.org/10.3389/fpsyg.2021.541510

Igoe., K. J. (2020). How to build and lead resilient health care teams during COVID-19. *Harvard T.H Chan school of public health.* https://www.hsph.harvard.edu/ecpe/how-to-build-lead-resilient-health-care-teams-covid-19/

Jankelová, N., & Joniaková, Z. (2021). Communication skills and transformational leadership style of first-line nurse managers in relation to job satisfaction of nurses and moderators of this relationship. *Healthcare*, *9*(3), 346. https://doi.org/10.3390/healthcare9030346

Kirkpatick, S. A., & Locke, E. A. (1991). Leadership: do traits matter?. *Academy of management perspectives*, *5*(2), 48-60. https://doi.org/10.5465/ame.1991.4274679

Kotter, J. P. (1966). *Leading Change.* Harvard Business School Press.

Lacobucci, G. (2021). Staff burnout: MPs demand "total overhaul" of NHS workforce planning. *British Medical Journal, 373*. https://doi.org/10.1136/bmj.n1461

Lanaj, K., Jennings, R. E., Ashford, S. J. & Krishnan, S. (2022). When leader self-care begets other care: leader role self-compassoin and helping at work. *Journal of Applied Psychology, 107*(9), 1543-1560. https://doi.org/10.1037/apI0000957

Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. *Qualitative Research in Psychology, 3*(2), 102-120. https://doi.org/10.1191/1478088706qp062oa

Lavender, T., & Hope, R. (2007). *New ways of working for applied psychologists in health and social care: The end of the beginning.* British Psychological Society.

Leach, L., Hastings, B., Schwarz, G., Watson, B., Bouckenooghe, D., Seoane, L., & Hewett, D. (2021). Distributed leadership in healthcare: leadership dyads and the promise of improved hospital outcomes. *Leadership in Health Services*, *34*(4), 353-374. https://doi.org/10.1108/LHS-03-2021-0011

Lennon, M. (2021) The State of Children's Mental Health Services 2020/21. *The Children's Commissioner.* https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf

Leudi, M. (2022). Leadership in 2022: a perspective. *Best Practice in Research Clinical Anaesthesiology, 36,* 229-235. https://doi.org/10/1108/LHS-03-2021-0011

Lewis, R., Pereira, P., Thorlby, R. & Warburton, W. (2020). Understanding and
sustaining the health care service shifts accelerated by COVID-19. *The Health Foundation*.
https://www.health.org.uk/publications/long-reads/understanding-and-sustaining-the-health-care-service-shifts-accelerated-by-COVID-19

Lopez-Serrano, J., Díaz-Bóveda, R., González-Vallespí, L., Santamarina-Pérez, P.,
Bretones-Rodríguez, A., Calvo, R., & Lera-Miguel, S. (2021). Psychological impact during
COVID-19 lockdown in children and adolescents with previous mental health
disorders. *Revista de Psiquiatría y Salud Mental*. https://doi.org/10.1016/j.rpsm.2021.04.002

Lovelace, K., Manz, C. C. & Alves, J. C. (2007). Work stress and leadership
development: the role of self-leadership, shared leadership, physical fitness and flow in
managing demands and increasing job control. *Human Resources Management Review, 17*(4),
374-387. https://doi.org/10.1016/j.hrmr.2007.08.001

Lucian Leape Institute. (2013). Through the Eyes of the Workforce: Creating Joy,
Meaning, and Safer Health Care. *National Patient Safety Foundation.*
http://www.ihi.org/resources/Pages/Publications/Through-the-Eyes-of-the-Workforce-Creating-Joy-Meaning-and-Safer-Health-Care.asp

MacBeth, A. & Gumley, A. (2012). Exploring compassion: a meta-analysis of the association
between self-compassion and psychopathology. *Clinical Psychology Review, 32,* 545-552.
https://doi.org/10.1016/j.cpr.2012.06.003

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to
the level of representation. *Monographs of the society for research in child development*, 66-
104. https://doi.org/10.2307/3333827

Majeed, A., Maile, E. J. & Bindman, A B. (2020). The primary care responses to COVID-19 in
England's National Health Service. *Journal of the Royal Society of Medicine, 113*(6), 208-
210. http://doi.org/10.1177/0141076820931452

Martela, F. & Pessi, A. B. (2018). Significant work is about self-realization and broader purpose:
defining the key dimensions of meaningful work. *Frontiers in Psychology*, 9, 363.
https://doi.org/10.3389/fpsyg.2018.00363

Mason, J. (2017). *Qualitative researching*. Sage.

Mayer (2018). Clinical Psychology and Leadership. *STMayers.*

https://stmayers.com/2018/06/30/clinical-psychology-and-leadership/

McElvaney, R., & Tatlow-Golden, M. (2016). A traumatised and traumatising system: Professionals'

experiences in meeting the mental health needs of young people in the care and youth justice

systems in Ireland. *Children and Youth Services Review, 65,* 62-69.

https://doi.org/10.1016/j.childyouth.2016.03.017

McTiffin, M. H. (2023). *How are leadership self-efficacy, leadership self-identity and leadership style*

related to motivation to lead in newly qualified Clinical Psychologists? [Doctorate thesis,

University of Leeds]. White Rose eTheses Online. https://etheses.whiterose.ac.uk/32048/

Mitchell, R., & Boyle, B. (2021). Too many cooks in the kitchen? The contingent curvilinear effect of

shared leadership on multidisciplinary healthcare team innovation. *Human Resource*

Management Journal, *31*(1), 358-374. https://doi.org/10.1111/1748-8583.12309

Mental Health Commission. (2023). Independent review of the provision of Child and Adolescent

Mental Health Services (CAMHS) in the state by the Inspector of Mental Health Services:

interim report. *Mental Health Commission.* http://hdl.handle.net/10147/635099

Messham, L. S. (2018). *Exploring Clinical Psychologists' experiences of leading within clinical*

teams in relation to their values. [Doctorate thesis, University of Leeds]. White Rose eTheses

Online. https://etheses.whiterose.ac.uk/21692/

Miller. H. I. (2016). *The safe encyclopedia of theory in psychology.* Sage.

https://doi.org/10.4135/9781483346274

Moran, D. (2000). *Introduction to phenomenology*. Routledge.

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in

mental health services: A review of the problem and its remediation. *Administration and*

Policy in Mental Health and Mental Health Services Research, *39*, 341-352.

https://doi.org/10.1007/s10488-011-0352-1

Moyo, M., Goodyear-Smith, F. A., Weller, J., Robb, G., & Shulruf, B. (2016). Healthcare practitioners' personal and professional values. *Advances in Health Sciences Education*, *21*, 257-286. https://doi.org/10.1007/s10459-015-9626-9

National CAMHS Support Service. (2011). Developing leadership in child and adolescent mental health services. *National CAMHS Workforce Programme.* http://www.cmecic.org/resources/Education_Training_and_Development/Developing%20leadership%20in%20child%20and%20adolescent%20mental%20health%20services%20%28CAMHS%29.pdf

Nawaz, Z. A. K. D. A., & Khan, I. (2016). Leadership theories and styles: A literature review. *Leadership*, *16*(1), 1-7.

Neff, K. D. & Knox, M. C. (2017). Self-compassion. In V. Zeighler-Hill & T. K. Shackelford (Eds.), *Encyclopaedia of Personality and Individual Differences* (p.54-63). Springer International Publishing.

Neubauer, B. E., Witkop, C. T. & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on Medical Education, 8*(2), 90-97. https://doi.org/10.1007/s40037-019-0509-2

Newitt, S. (2022). How can managers and leaders support staff wellbeing in the NHS. *The King's Fund.* https://www.kingsfund.org.uk/blog/2022/10/how-can-managers-and-leaders-support-staff-wellbeing-nhs

NHS England. (2019). The NHS long term plan. *NHS England.* https://www.longtermplan.nhs.uk

NHS England. (2021). *A good practice guide to support implementation of trauma-informed care in the perinatal period.* https://www.england.nhs.uk/publication/a-good-practice-guide-to-support-implementation-of-trauma-informed-care-in-the-perinatal-period/

NHS England. (2022). *NHS England staff survey 2022: national results briefing.* https://www.nhsstaffsurveys.com/static/8c6442c8d92624a830e6656baf633c3f/NHS-Staff-Survey-2022-National-briefing.pdf

NHS Leadership Academy (2011). *Clinical leadership competency framework. NHS Leadership Academy.* https://www.leadershipacademy.nhs.uk/wp-

content/uploads/2012/11/NHSLeadership-Leadership-Framework-Clinical-Leadership-Competency-Framework-CLCF.pdf

O'Donovan, R. & Burke, J. (2022). Factors associated with post-traumatic growth in healthcare professionals: a systematic review of the literature. *Healthcare 2022, 10*(12), 2524. https://doi.org/10.3390/healthcare10122524

O'Shea, N. & McHayle, Z. (2021). Time for action: Investing in comprehensive mental health support for children and young people. *Centre for Mental Health.* https://cypmhc.org.uk/wp-content/uploads/2021/12/CentreforMH_TimeForAction.pdf.

Office for National Statistics. (2021). Voices of out ageing population: living longer lives. *Census 2021.* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/voicesofourageingpopulation/livinglongerlives#:~:text=The%20population%20of%20England%20and,the%20previous%20census%20in%202011.

Onyett, S. (2012). Leadership challenges for clinical psychologists: challenge or opportunity? *Clinical Psychology Forum, 1*(238), 10-17. http://doi.org/10.53841/bpscpf.2012.1.238.10

Patterson, B. J. & Krouse, A. M. (2015). Competencies for Leaders in Nursing Education. *Nursing Education Perspectives, 36*(2), 76-82. https://doi.org/10.5480/13-1300

Petriglieri, G. (2020). The psychology behind effective crisis leadership. *Harvard Business Review.* www.nonprofitjourney.org/uploads/8/4/4/9/8449980

Pham, M. T., Rajic, Greig, J. D., Sargeant, J. M., Papadopoulos, A. & McEwen, S. A. (2014). A scoping review of scoping reviews: advancing the approach and enhancing the consistency. *Research Synthesis Methods, 5*(4), 371-385. https://doi.org/10.1002/jrsm.1123

Rangachari P, L. & Woods J. (2020). Preserving organizational resilience, patient safety, and staff retention during COVID-19 requires a holistic consideration of the psychological safety of healthcare workers. *International Journal of Environmental Research and Public Health*, *17*(12), 4267. https://doi.org/10.3390/ijerph17124267

Reay, R. E., Raphael, B., Aplin, V., McAndrew, V., Cubis, J. C., Riordan, D. M. & Preston, W. (2015). Trauma and adversity in the lives of children and adolescents attending a mental health service. *Children Australia*, *40*(3), 167-179. https://doi.org/10.1017/cha.2015.20

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. *Psychologist, 18*(1), 20-23.

Robertson, R., Wenzel, L., Thompson, J., & Charles, A. (2017). Understanding NHS financial pressures: how are they affecting patient care. *The King's Fund.* https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures

Roncalli, S., & Byrne, M. (2016). Relationships at work, burnout and job satisfaction: a study on Irish psychologists. *Mental Health Review Journal*, *21*(1), 23-36. https://doi.org/10.1108/MHRJ-01-2015-0002

Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M., & Dahir, S. (2020). Workforce race inequalities and inclusion in NHS providers. *The King's Fund.* https://www.kingsfund.org.uk/sites/default/files/2020-07/workforce-race-inequalities-inclusion-nhs-providers-summary-jul2020.pdf

Rushforth, A., Durk, M., Rothwell-Blake, G. A. A., Kirkman, A. & Kotera, Y. (2023). Self-compassion interventions to target stress in healthcare workers: a systematic review. *International Journal of Environmental Research and Public Health, 20*(12), 6109. https://doi.org/10.3390/ijerph20126109

Samji, H., Wu, J., Ladak, A., Vossen, C., Stewart, E., Dove, N. & Snell, G. (2021). Mental health impacts of the COVID-19 pandemic on children and youth–a systematic review. *Child and adolescent mental health*. 1888-9891. https://doi.org/10.1111/camh.12501

Scanlan, L. M., Devine, S. G. & Watkins, D. L. (2018). Job satisfaction of mental healthcare workers in multidisciplinary teams. *Journal of Mental Health, 30*(1), 80-87. https://doi.org/10.1080/09638237.2019.1644489

Scarnera, P., Bosco, A., Soleti, E., & Lancioni, G. E. (2009). Preventing burnout in mental health workers at interpersonal level: an Italian pilot study. *Community Mental Health Journal*, *45*, 222-227. https://10.1007/s10597-008-9178-z

Schwartz, S. H. (1992). Universals in the content and structure of values: theoretical advances and empirical tests in 20 countries. *Advances in Experimental Social Psychology, 25*, 1-65. https://doi.org/10.1016/S0065-2601(08)60281-6

Sia, S. K., & Jose, K. A. (2021). Navigating Through the Thunderstorm: at Workplace Understanding and Developing Leadership Resilience at Workplace. In R. K. Pradhan & U. Kumar (Eds.), *Emotion, Well-Being, and Resilience* (pp. 297-308). Apple Academic Press.

Skakon, J., Nielsen, K., Borg, V., & Guzman, J. (2010). Are leaders' well-being, behaviours and style associated with the affective well-being of their employees? A systematic review of three decades of research. *Work & Stress*, *24*(2), 107-139. http://doi.org/10.1080/02678373.2010.495262

Skinner, P. (2011). Leadership is our business. *Clinical Psychology Forum, 225*, 11-14.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). Sage Publications.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41- 42. https://doi.org/10.1177/2049463714541642

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, Method and Research*. Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2021). *Interpretative phenomenological analysis: Theory, Method and Research* (2nd Ed). Sage.

Starks, H. & Trinidad, S. B. (2017). Choose your method: a comparison of phenomenology, discourse analysis and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. https://doi.org/10.1177/1049732307307031

Tajfel, H. (1978). The achievement of inter-group differentiation. In H. Tajfel (Ed.), *Differentiation between social groups* (pp.77-100). Academic Press

Tannenbaum, S. I., Traylor, A. M., Thomas, E. J., & Salas, E. (2021). Managing teamwork in the face of pandemic: evidence based tips. *BMJ Quality & Safety, 30*(1), 59-63. https://doi.org/10.1136/bmjqs-2020-011447

Tedeschi, R.G. & Calhoun, L.G. (1996). The Posttraumatic Growth Inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471. https://doi.org/10.1002/jts.2490090305

The King's Fund. (2011). The future of leadership and management in the NHS. *The King's Fund.* https://www.kingsfund.org.uk/sites/default/files/future-of-leadership-and-management-nhs-may-2011-kings-fund.pdf

The King's Fund. (2013). Patient-centred Leadership: Rediscovering our purpose. *The Kings Fund.* https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/patient-centred-leadership-rediscovering-our-purpose-may13.pdf

The King's Fund (2022). NHS leadership and culture: our position. *The King's Fund.* https://www.kingsfund.org.uk/projects/positions/NHS-leadership-culture

Triesman, K. (2021). Becoming a trauma-informed organisation: practices and principles. *The Churchill Fellowship.* https://www.churchillfellowship.org/ideas-experts/ideas-library/becoming-a-trauma-informed-organisation-practices-and-principles/

Turner-Sack, A. M., Menna, R., Setchell, S. R., Maan, C. & Cataudella, D. (2016). Psychological functioning, post-traumatic growth, and coping in parents and siblings of adolescent cancer survivors. *Oncology Nursing Forum, 43*(1), 48-56. https://doi.org/10.1188/16.ONF.48-56

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J.A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum, 108*, 3-7.

Uyeda, L., & Miller, A. (2021). Curing Through Connection: A 3-part series on attachment, resilience, and health. Article 3: The Importance of Attachment Theory in Healthcare. *The University of British Columbia Faculty of Medicine.* https://thischangedmypractice.com/attachment-resilience-health-attachment-in-healthcare/

Valentine, A. Z., Sayal, K., Brown, B. J., & Hall, C. L. (2023). A national survey of current provision of waiting list initiatives offered by child and adolescent mental health services in England. *British Journal of Child Health*, *4*(2), 78-83. https://doi.org/10.12968/chhe.2023.4.2.78

Weller, S. (2017). Using internet video calls in qualitative (longitudinal) interviews: Some implications for rapport. *International Journal of Social Research Methodology*, *20*(6), 613-625. https://doi.org/10.1080/13645579.2016.1269505

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T., & Lee, A. (2015). Leadership in Health Care: A Summary of The Evidence Base. *The King's Fund*. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_summary/leadership-in-health-care-apr15.pdf

West, M., Bailey, S. & Williams, E. (2020). The courage of compassion: supporting nurses and midwives to deliver high-quality care. *The King's Fund.* https://www.kingsfund.org.uk/sites/default/files/2020-09/The%20courage%20of%20compassion%20full%20report_0.pdf

Wilkinson, E. (2015). UK NHS staff: stressed, exhausted and burnout out. *The Lancet, 385(*9971)*, 841-842.* https://doi.org/10.1016/S0140-6736(15)60470-6

Williams. E. N., & Morrow, S. I. (2009). Achieving trustworthiness in qualitative research: a pan-paradigmatic perspective. *Psychotherapy Research, 19, 576-582.* https://doi.org/10.1080/10503300802703113

Willig, C. (2008). *Introducing qualitative research in psychology*. Maidenhead, England: McGraw Hill Open University Press.

Willig, C. (2012). *Qualitative interpretation and analysis in psychology*. Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd Ed.). Open University Press.

Willig, C. (2019). What can qualitative psychology contribute to psychological knowledge? *Psychological Methods, 25*(6), 796-804. https://doi.org/10.1037/met0000218

Wilson, H., & Waddell, S. (2020). Covid-19 and early intervention: understanding the

impact, preparing for recovery. *Early Intervention Foundation.*

https://www.eif.org.uk/report/covid-19-and-early-intervention-understanding-the-impact-preparing-for-recovery

Windle, G. J. (2011). What is resilience? A review and concept analysis. *21*(2), 152-169.

https://doi.org/10.1017/S0959259810000420

Winnicott, D. (1960). *The theory of the parent-child relationship*, *International Journal of Psychoanalytic,* 41, 585-595

Wintour, L. (2022). *Experiences of working in CAMHS* [Doctorate thesis, Canterbury Christ Church University]. CCCU Research Space Repository.

https://repository.canterbury.ac.uk/item/92w45/experiences-of-working-in-camhs

Wood, M., & Dibben, M. (2015). Leadership as relational process. *Process Studies*, *44*(1), 24-47.

https://doi.org/10.5840/process20154412

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*, 215-228.

https://doi.org/10.1080/08870440008400302

Yatchmenoff, D. K., Sundborg, S. A., & Davis, M. A. (2017). Implementing trauma-informed care: Recommendations on the process. *Advances in Social Work*, *18*(1), 167-185.

https://doi.org/10.18060/21311

Appendices

Appendix A. Interview schedule

Demographic Questions
1) What is your age bracket? (18-24, 25-34, 35-44, 45-54, 55-64, 65 and over).
2) How would you describe your gender?
3) How would you describe your ethnicity?
4) How long have you been qualified as a Clinical Psychologist?
5) What service are you currently working in?
6) What is your current role and length of time in current role (If less than 6 months, ask for previous role and service).
7) What is your current NHS banding, and approximate length of time at this banding?

Introduction

"I'm going to ask you some questions generally about leadership, then I will ask you about specific examples relating to your leadership experiences".

Introduction question

1. What made you decide to take part in this research?

General leadership questions

1. What types of leadership tasks are you involved in?

   1a. What are the most important leadership activities that you take part in?
2. How did you come to take part in leadership roles and responsibilities?

Prompts/follow-up questions

- Examples of when you have engaged in leadership activities in CAMHS?

- Could you tell me a bit more about that?

3. What informs the way in which you lead?

Specific leadership questions

4. Could you tell me about a time where you have found leadership within CAMHS to be challenging? [Aim to get a specific example]

   Prompts/follow-up questions:
- Do you have a specific example that stands out to you?

- How did you respond to this challenge? [aim to get a description for each of the following]:

        What did you think when that happened?
        How did you feel when that happened?
        What did you do when that happened?
- What sense do you make of this experience?

- Could you tell me a bit more about XXX?

   [Ensure to get a full sense of their experience]

5. Do you have any other examples of times where you have found leadership within CAMHS to be challenging, that you think are different in some way from the examples you have given me already?
   - [Aim to get another specific example; use the same prompts from Q.4 as above]

6. What *effects* has leading within CAMHS had *on you*? [Aim to get specific examples]

   Prompts/follow up questions:
- How have things changed for you personally, through you experiences of leadership?

   [prompt: what differences are there in how you think, feel and in what you do, as a result of your experiences?]
- Do you have a specific example that stands out to you?

- What sense do you make of these experiences?

- Could you tell me a bit more about XXX?

   [Ensure to get a full sense of their experience]
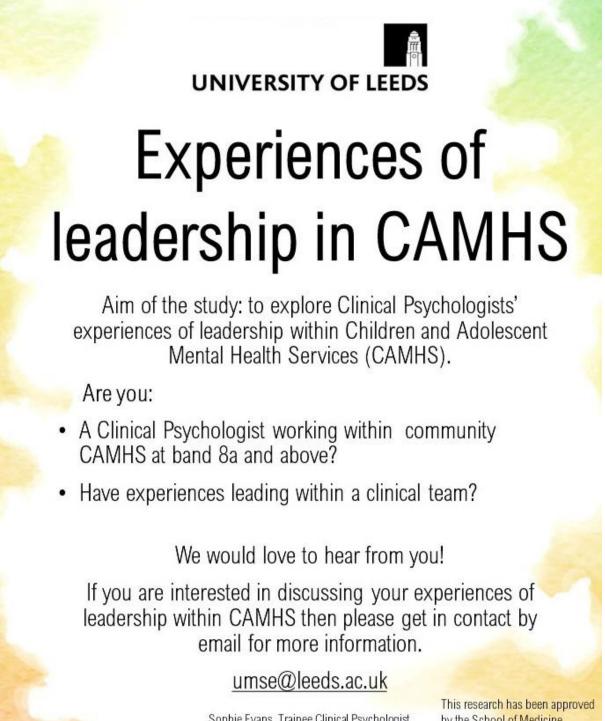
7. Are there any other effects that leading within CAMHS has had on you, that you think are different in some way from what you have shared already?
   - [Aim to get another specific example, use the same prompts from Q.6 as above]

Closing question
8. Do you feel that we have touched upon everything that you would like to share about your experiences of leadership in CAMHS?

Appendix B. Recruitment advertisement

Appendix C. Confirmation of ethical approval

From: Medicine and Health Univ Ethics Review <FMHUniEthics@leeds.ac.uk>
Sent: Thursday, September 22, 2022 11:37 AM
To: Sophie Evans <umse@leeds.ac.uk>
Cc: Fiona Thorne <F.M.Thorne@leeds.ac.uk>; Jan Hughes <J.Hughes@leeds.ac.uk>
Subject: MREC 21-064 - Study Approval Confirmation
Dear Sophie

MREC 21-064 - Exploring Clinical Psychologist's experiences of leading withing CAMHS

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

We are pleased to inform you that your research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and we can confirm that ethics approval is granted based on the documentation received at date of this email.

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see https://ris.leeds.ac.uk/research-ethics-and-integrity/applying-for-an-amendment/ or contact the Research Ethics & Governance Administrator for further information fmhuniethics@leeds.ac.uk if required.

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, 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.

I hope the study goes well.

Best wishes
Sou Chung
On behalf of Dr Naomi Quinton, CHAIR, SoMREC

~~~~~~
Sou Sit Chung, Research Ethics Administrator, The Secretariat, University of Leeds, LS2 9NL,
s.chung@leeds.ac.uk
Please note my working hours are Monday to Friday 9am – 12.30pm

Appendix D. Participant information sheet

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<u>Participant information sheet</u>

Project title: exploring Clinical Psychologists' experiences of leadership in Child and Adolescent Mental Health Services (CAMHS)

You are being invited to take part in a research study. Before you decide whether you would like to take part, please take the time to read this information sheet which outlines why this study is being conducted and what taking part would involve.

What is the purpose of this study?

Leadership is increasingly becoming an integral part of Clinical Psychologists' roles. Research has seldom explored Clinical Psychologists' experiences of leading with Child and Adolescent Mental Health Services (CAMHS). This is important, considering the complex and challenging context of CAMHS. Therefore, this study aims to explore the experiences of those undertaking leadership activities with CAMHS, to better understand this part of the role.

Why have I been invited?

This research is interested in the experiences of Clinical Psychologists in Band 8a positions and above within CAMHS, in relation to their leadership roles and responsibilities. It is particularly interested in how Clinical Psychologists navigate their experiences of these roles, and what effects leading might have on those in leadership roles.

Do I have to take part, and what if I decide to withdraw?

It is entirely up to you to decide whether or not you would like to take part. Firstly, you will be provided with this information sheet and the opportunity to ask any questions you might have about taking part. If you decide to take part, you will then be asked to sign a written consent form before the interview begins.

You are free to withdraw your participation up until two weeks after you have completed the interview, without giving any reason. If you decide not to carry on with the study, any information you have provided will be removed from the study. You will not be able to withdraw after this two-week period as the analysis of your interview will have begun.

What will taking part involve for me?

If you decide to take part, you will be invited to take part in an interview, that will be conducted by the primary researcher. This will take place via the video-calling platform Zoom, and last between 45-90 minutes. You will be required to find a quiet place where you feel comfortable talking about aspects of your work and where you can reflect openly on your experiences.

What are the benefits to taking part?

Your participation in this study and the sharing of your experiences will hopefully help us to better understand the experiences of those leading within CAMHS. It is hoped that this will contribute to the development of the profession. It is possible that you may also find it rewarding and cathartic to reflect upon your experiences.

What are the possible disadvantages and risks of taking part?

The study may involve talking about aspects of your work that you have found challenging or difficult. It is up to you what you share, and you will be under no obligation to discuss anything you do not feel comfortable sharing. However, if you do find yourself becoming distressed the researcher will follow your lead with what you need at this time. You are welcome to take a break or pause the interview, or to continue if you would prefer to at a pace that feels comfortable to you. We appreciate that you may be aware of sources of further support should you want to access this (e.g. your GP, personal therapy, workplace occupational health) but if you would like any further advice or signposting to services the researcher will be happy to support you with this.

How will the information I provide be kept secure and confidential?

With your consent the interview will be recorded, so that nothing important is missed from the conversation. The audio recording of the interview will be saved and stored on a secure network drive that is encrypted. The University will delete the recordings from the study after three years.

What will happen to the results of the research study?

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

Who has reviewed the study?

Ethical approval has been sought from the University of Leeds School of Medicine Research Ethics Committee (MREC 21-064).

Further information and contact details

If you would like any further information about the research study, please contact the principle researcher.

Sophie Evans, Trainee Clinical Psychologist, University of Leeds.

Email: umse@leeds.ac.uk

You may also contact the supervisors of study:

Dr Fiona Thorne (F.Thorne@leeds.ac.uk) and Dr Jan Hughes (j.hughes@leeds.ac.uk)

Programme in Clinical Psychology, Leeds Institute of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, Leeds, LS2 9NL.

Thank you very much for taking the time to read this information sheet.

Appendix E. Consent form

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Project title: exploring Clinical Psychologists' experiences of leading within Child and Adolescent Mental Health Services (CAMHS)

Ethical approval has been sought from the University of Leeds School of Medicine Research Ethics Committee (MREC 21-064).

Please initial box

1. I confirm that I have read and understand the information sheet dated 18.07.2022 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily if required.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. My data will be anonymised with a unique code. These codes will be stored securely and separately from the data you provide. Your unique code can be retrieved from members of the research team should you wish to withdraw from the study.

3. I agree to the audio recording of the interview.

4. I am aware I can withdraw from the study up until two weeks after completing the interview, without giving any reason. Up until this time your data can be withdrawn from the study. After 2 weeks, withdrawal of your data is not possible as analysis of your interview will have begun.

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

6. I understand that anonymised quotes from the interview will be used in the write-up and dissemination of the results, but that I will not be identified or identifiable. The researcher will ensure to remove any personal information (name, people, places, countries, jobs, religion etc.) and any information that might identify others or place of work from quotes, before the data is analysed or presented.

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

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

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

_____   _____   _____
Name of participant   Date   Signature

_____   _____   _____
Name of person taking consent Date   Signature

If you have any queries, please contact the principal researcher: Sophie Evans, Trainee Clinical Psychologist. Email address: umse@leeds.ac.uk

You may also contact one of the supervisors of this study regarding any queries: Dr Fiona Thorne (F.Thorne@leeds.ac.uk) and Dr Jan Hughes (J.Hughes@leeds.ac.uk), Programme in Clinical Psychology, Leeds Institute of Health Sciences, University of Leeds, Worsley Building, Clarendon Way, Leeds, LS2 9NL.

Appendix F. Extract of Analysis (extract of transcript for Faye)

Exploratory noting	Interview transcript	Experiential statements
Meetings with senior leaders – feel very critical! Focus on what they haven't done, what they need to do, putting pressure on Not meeting outcomes ('not good enough') – high expectations placed on her. Lack of compassion and understanding – instead top down authoritative, demanding 'I wish' – desire for more humanity within relationships – sense of working people like a machine, considering people as numbers not as 'people' Feels she doesn't cope with it *well* – impacts her, 'very frustrating' – part of the leadership role that is hard to handle and cope with. Being a 'professional' means tolerating the frustration towards other professionals and the system 'being boundaried' – careful how frustration is expressed? Feels she has to accept the 'culture' of the NHS Feels powerless in being able to make change or make things different - 'no choice in responding to that' – no space or avenue or ability to discuss these systemic/organisational challenges	Interviewer: Yes. Participant: We're not meeting our SEQUIN standards for ROMS. So, that is something that … em … you know, and so it's that very like, you know, you need to do this! And that expectation. Em which can just, it can just feel hard. And I guess sometimes I wish there was more of that leadership style of … kindness, compassion at that higher level? Interviewer: Yes, how do, how do you respond to this? When this occurred? This challenge occurs. Participant: Not very well! I, that's about the job I find very frustrating! Interviewer: [Laughs] Yes. Participant: Em I mean obviously again it's the, you know, we're professional. We have boundaries. And I think, like I said earlier, you just learn. If you always work in NHS, I guess you just accept that that's the way? That's the culture. And it doesn't feel like there's much choice in kind of responding to that. But I might, you know, if there was a scenario where I felt really … kind of … frustrated or … you know, I would speak in supervision about that or em Interviewer: Yes. Participant: Yes, I would think about it with my colleagues. Em … but yes, so, and I guess some of it is also balancing up and then thinking from their position? You know everyone has got a job to do and everyone does have different leadership styles and just because my preference isn't that, doesn't mean to say that other people don't really value that and prefer that very kind of direct … in a way. Interviewer: Yes.	Values compassionate leadership which is lacking in more senior leaders structures Pressures and criticism are difficult to handle and cope with Being a leader in the NHS means tolerating the challenges and frustration, as they are deeply ingrained and difficult to change. Manages the emotional impact of the stressors by connecting with and seeking support from others. Considering her own values as a leader and how these my
'there's no discussion', 'deadlines' – pressure, feeling powerless - considers this 'old fashioned' not developed or progressive (earlier frustration as way of doing things in NHS never changing). 'medical model dominance' – professional conflict in the way of doing things. Using psychological model to understand her experience and the challenges within the NHS. NHS in 'threat mode' – people in organisations feeling threatened by their work and workplace, anxious, unsafe, occupying space of responding to stress and threat. 'drive' – some motivation, achieving striving 'that's my constant experience!' – never changing/ending – experience encompassed in stress and threat. Feeling pressure from more senior leaders happens very regularly! Can be through means of email – asking for things to be done, and quickly. 'what are you doing about this' – pressure and responsibility and being questioned 'by the end of the day' – high expectations on getting things done quickly, responding quickly to their requests	you're familiar with the threats to drive system? But I do, he talks about the NHS, it's just constantly operating in threat. With a little bit of drive. Interviewer: [Laughs] Participant: And I, I feel like that's my constant experience! Interviewer: Yes Participant: Em and so for that reason, yes, that … that is a challenge. Em … Interviewer: Yes, yes. Do you have a specific example of that? It's really interesting. Em about that hierarchy difficulty? And being in a position where, I guess, yes you, you've … moved positions across meetings? That thing? Participant: Em … [Pause] … I mean it happens, it happens weekly if not daily! Interviewer: Yes [laughs] Okay. Participant: I mean a, an example would be just getting an email where we're told, you know, I'll be told … you know what are you doing about this? Can you send me over your data? You know, by the end of the day! Em Interviewer: Yes [laughs] Participant: and so there's that. Em … and … and then there's other examples of yes, these meetings that we have with the senior leadership teams … you know where you've got all your 8As, 8Bs, 8Cs. And then you'll have your directors come and sit in there. And the agenda is very much, you know, we haven't met this criteria! You need to go back to your teams and do X, Y and Z. Then a next agenda item, you know, and it's not all, you know those are the examples that stand out in your head! You know, R, ROMS is a, ROMS is a prime example at the moment.	Feeling under relentless threat and stress in her role as a leader, which feels aligned/as a result of the stressed/unsafe NHS systems. Feeling that the pressures from senior leadership occurs frequently, and through multiple modes (emails, meetings…). Feeling crticised and sense of 'not doing enough' from senior leaders

Appendix G. Personal Experiential Themes (PET) tables

Participant 1: Personal Experiential Themes

    A. BENEFITS OF LEADERHIP – HAVING INFLUENE NAD POWER
    B. VALUING PSYCHOLOGY IN LEADERHIP
    C. TENSIONS AND CONFLICT
        Organisations in 'threat'
        Conflict with values
    D. INTERPROFESSIONAL RELATIONSHIPS
        Importance of understanding and respect between professionals
        Gatekeeping/power of management for creating change
        Relationships important for navigating pressures and challenges
    E. ACCEPTANCE OF CHALLENGES

Participant 2: Personal Experiential Themes

    A. TENSIONS AND CONFLICTS
        Between psychology and other professionals
        Resistance to change
        Clinical psychology integrating into leadership
    B. CONCEPTUALISING LEADERSHIP
    C. RELATIONSHIPS/COMING TOGETHER
        Building others up/mentoring and support
        Feeling supported as a leader
        Leadership creating relationships and connection in CAMHS
    D. PRESSURES OF LEADERSHIP
        Internal pressures – responsibility and feeling 'not good enough'
        Difficult systemic/gender narratives limiting progress and causing internal conflict
        External pressures
    E. LEARNING AND GROWTH
        To navigate challenges of leadership
        Developing awareness and skills
    F. BENEFITS OF BEING A LEADER

Participant 3: Personal Experiential Themes

    A. JOURNEY TO LEADERSHIP
        Developing self-confidence
        Driven by values
        Motivated to improve CAMHS
    B. BARRIES TO CREATING CHANGE
        Systemic pressures
        Change is threatening
    C. IMPACT OF LEADERSHIP
        Feeling responsible
        High expectations/not feeling good enough
        Conflicted relationship with power
    D. IMPORTANCE OF RELATIONSHIPS
        For navigating leadership role
        For navigating stressed systems, impacted by COVID

Participant 4: Personal Experiential Themes

A. UNCOMFORTABLE WITH LEADERSHIP
Conflict with personality
Not feeling good enough
Having power

B. NAVIGATING POWER
Finding ways to comfortably assert power ('quiet leadership')
Managing power dynamics between others
Managing position of power between self and others

C. FEELING OVERWHELMED
Multiple responsibilities
Stressed systems

D. TRANSITIONING INTO LEADERSHIP
Experience develops confidence
Being supported
Developing confidence/challenging inner critic
Building relationships

E. LEADERSHIP IS REWARDING

Participant 5: Personal Experiential Themes

A. SERVICE PRESSURES
Navigating stretched and stressed services pre-pandemic
Impact of pandemic on stretches and stressed services
Feeling powerless

B. CONTAINING AND SUPPORTING STAFF
Limiting the impact of stress
Building trust
Attending to others' needs
Building supportive relationships

C. FEELING SUPPORTED AS A LEADER
Feeling respected
Being part of a team
Difficulty with not feeling appreciated

D. LEADERSHIP VALUES DERIVED FROM EXPERIENCE
Negative experiences of leaders
Positive experiences of leaders

E. IMPACT OF LEADERSHIP
Challenges are in the system
Aspects of leadership can be stressful
Unsure of her own feelings

F. CONFIDENCE AS A LEADER
Not comfortable or confident as a leader
Growing confidence
Relational aspects of leadership feel comfortable

G. NAVIGATING STRESSORS

H. PERSONAL GROWTH FROM LEADERSHIP

Participant 6: Personal Experiential Themes

A. FEELING UNDER THREAT
Leadership is stressful

Pressures from senior leaders
Feeling crticised and being self-critical
Expectation to cope
Containing and supporting staff through change

B. TENSIONS AND CONFLICT
Leadership feels in conflict with values as a psychologist
Conflict with senior leadership
Tensions with systems

C. NAVIGATING POWER
Transitioning to position of power
Navigating position of power within NHS leadership structures
Feeling powerless
Feeling empowered

D. FINDING A BALANCE
Balancing leadership styles and service needs
Maintaining boundaries
Navigating own stress

E. RELATIONSHIPS ARE KEY
Finding support to navigate stressors
Recognising strengths as a leader in building relationships
Supporting others

F. LEADERSHIP VALUES DERIVED FROM EXPEREINCE

G. INCREASING AWARENESS AND UNDERSTANDING
Personal development
Adopting a systemic perspective
Understanding others

H. PERSONALITY ALIGNS WITH BEING LEADER

Participant 7: Personal Experiential Themes

A. TENSIONS AND CONFLICT
Pressures inducing threat
Holding boundaries to pressures
Conflict and contrast between professionals
Staff feeling threatened

B. NAVIGATING POWER
Feeling belittled and challenged
Power of individuals
Asserting and finding power

C. MOTIVATED BY VALUES

D. LEARNING FROM OTHER LEADERS

E. SUPPORTIVE RELATIONSHIPS
Protecting and supporting staff
Feeling supported to navigate challenges
Leadership is a team effort

F. IMPACT OF LEADERSHIP
Leadership is rewarding
Growth and skills in understanding

G. CONFIDENCE AS A LEADER
Taking on responsibility
Feeling self-assured
Developing confidence through experiences

Appendix H. Example extract of Personal Experiential Themes (PET) table (for Emily)

B. CONTAINING AND SUPPORTING STAFF

Limiting the impact of stress

Leadership involves relational tasks such as containment of staff and teams' stress within CAMHS to protect them from service pressures P4

"It's fine for [the stress] to affect me cos I'm the manager! But I don't think that needs to trickle down to the people that are doing more of the, the clinical work and you know making sure that that pressure isn't really impacting on them. And they're still feeling okay in their job. And that they can still come to me with things they're struggling with. And they're not pressured to take on … you know more work!"

"So, I think that's quite a big part of leadership in, particularly CAMHS. So, I guess there's a lot of containment of em … of anxiety and stress."

Important for her to not feel as though she is putting pressure onto or overwhelm staff. P11

"My motto is we can only do what we can do! So, again not trying to put that pressure on … other staff in terms of we've got to ask for a referral so you need to do extra work. Or you need to work harder or faster or whatever! Because actually, everyone's doing what, what they can be."

Feels a personal responsibility for staff wellbeing, within her senior position as a leader, to limit the impact of stressed systems. P11

"And again, just trying to make sure that the people that I'm leading are still … I guess that they're okay and they're not burning out and that they're not feeling too … much of that pressure. And actually just keep trying to do a really good job because I think sometimes if you, when we're under pressure ourselves, our performance can end up going, going down and that's not why we're here! To do our worst!"

Concerned with how staff are feeling during and following conflict, and motivated to contain these feelings rather than exacerbate. P20

"I guess the, the staff member who's done the assessment might be feeling very different things. They might be feeling really frustrated. It might be really angry, there might be lots of other stuff. So, I guess it's again that containment of allowing things without feeding into it."

Building trust

Important for those in senior positions to build trust with staff and create environments that are psychologically safe. P5

"If you've got someone that you can go to who is in … you know a higher role than you and if you can go with that stress and say "I'm really stressed. I'm finding this really difficult." Or I've made this mistake or whatever. And you know that they're going to … take that really well and still being really supportive … then I think you've kind of cracked it then!"

Considers 'confidence in what you're doing' important quality of leaders to build trust with team members. P9

"I guess it's that quietly confidence. And that's something that I've noticed in people, that I've looked up to in the past… and I think that passes down to other people being confident in you…approachable…non-judgemental. Again, mistakes particularly for people that are … in more of a training position or learning, mistakes aren't necessarily a bad thing! Cos usually, when you make them, you then, you don't make them again! 'Cos you learn from them and that, that's fine."

Appendix I. Extracts from reflective log

Reflections following the interview with Beth:
I found the interview to be enjoyable and that she was really interested and enthusiastic about leadership. However I also noticed during the interview that she wanted to tell me about leadership and almost 'teach' me about it because she had a lot of knowledge and experience. whilst this is interesting and helpful it is important to ensure that we focus on her own experiences (thoughts, feelings etc.). I think we did we were able to alongside her sharing of leadership knowledge, but this is something to consider going forward as further interviewees may engage with the interview in a similar.

Reflections following the interview with Clare:
I noticed myself feeling quite inadequate and self-critical hearing all of the many leadership tasks and responsibilities she was involved in. She sounded really passionate, and really competent at her role. I think that as I'm in my third year and being expected to develop my competencies in leadership, and being in CAMHS it has made me feel a bit worried. I think I'm comparing myself to her. I think it will be important to discuss this in both clinical supervision on placement and in my thesis supervision to better understand and unpack my own fears and doubts. This will be important as I continue to do the interviews and to note before I engage in the analysis, to notice my lens on, and preconceptions around leadership in CAMHS.

Reflections following the interview with Emily:
I found myself feeling a little frustrated during the interview. I found that I had to work quite hard at times to elicit her experiences. Often she would tell me about the good things she had done as a leader, and way portraying herself as an effective leader . I felt she was holding back a bit and might have been concerned with how she was 'coming across' to me. I think this is why I felt a bit frustrated, as I was working really hard to try and make her feel safe enough to share. I think she did open up in the end and was able to be vulnerable but this interview felt quite challenging, in ensuring I was getting a real sense of her experiences.

Reflections following a peer supervision session with other trainee Psychologists in CAMHS:
It was helpful to share my experiences of the stressors of working in CAMHS with my peers. I learnt that others are experiencing similar difficulties with busy services and high demands being placed on staff, and as trainees there is a pressure to help out with waiting lists. However it is important that we hold a boundary with our caseloads as we are there to learn. I notice that I am experiencing some similarities with the difficulties described by the participants. This feels validating, but it will be important to separate myself from their experiences as much as possible during the analysis. I will continue to reflect on and notice my experiences and reactions, and discuss them in supervision so that I am not looking at the data through the lens of my own challenges working in CAMHS.

Appendix J. Example of a full pen portrait for Beth

Beth agreed to take part in the study as she felt the topic was *"something [she had] expertise in"* and was *"keen to contribute to the literature and research"* around leadership in Clinical Psychology. Beth felt passionate about, and experienced in leadership, and was keen to share her insight and experiences to develop the area of research. Beth described being involved largely in strategic and organisational responsibilities, such as *"strategic direction"* and *"setting the vision"* for services. She also engaged in *"technical leadership"* such as being the clinical lead for effectiveness in her organisation. Beth described the most important elements of her role to be *"listening to people that use services"* and combining this information with evidence-based practice to set a direction for services *"and then getting everyone else behind it"*. Beth talked how she valued *"relationship leadership"*, and considered this key to her way of leading. Beth moved into senior leadership roles, through opportunity of a vacancy, which afforded these types of leadership responsibilities. Beth felt encouraged and supported form others to undertake the role, and was motivated by wanting to *"make [services] better"*.

Beth described how her *"values"* and *"moral compass"*, particularly around *"person-centered care"* informed her leadership style. She also spoke about being heavily influenced by various models and approaches for leadership. Beth referred to these models often throughout the interview when reflecting on and understanding her experiences of being a leader.

Examples of challenges:

- Beth felt she had faced many challenges as a leader in CAMHS. She first spoke about a specific example of conflict and resistant from other professionals, around improving the quality of services. Beth felt there was a lack of a *"shared understanding about quality improvement"*, which other professionals being reluctant to consider psychologically informed ways of thinking about care. She described professionals as engaging in reactive care, which impeded their capacity to consider creating change in services, therefore creating barriers to moving her ideas forward.

- Beth described a second challenge, similar to the first, around conflicting perspectives between professionals. Beth had wanted to create change in services to be more effective and person-centered, e.g. developing *"more effective care planning"*. She experienced resistance and barriers from her psychiatry colleagues, where they eventually *"reached an impasse"*. Beth was unable to create the changes she felt were important. Beth talked about how she felt this was due to dominating medical model culture that is in conflict with psychology principles, and difficult to change.

- During the interview, Beth described her tendency to sometimes *"intellectualise distress"*, and I noticed her tendency to focus on and share what she had learnt from challenges and the implications for future Clinical Psychology leaders, such as the need for support and mentoring to navigate these roles, and taking time to *"build a support base"*. I found her to be keen to share her knowledge and expertise around leadership with me. At the end of the interview, she acknowledged sharing her learning around leadership to be *"another reason [she'd] like to talk to me."*

Effects of being a leader

- Beth described the impact of being a leader to be significant. She described experiencing *"huge joy"* and *"huge satisfaction"*, and being appreciative of the relationships and connection with other staff, afforded by her role. Alongside this, Beth also talked about the significant stress she experienced as a leader, due to high workloads. Beth experienced *"imposter syndrome"* which often led her to put *pressure on [herself]"*, and feel responsible to hold many demands and tasks. At one point during her career, this significantly impacted her physical health. Beth found solace in support and mentoring from others in leadership roles, and was able to move to a place of *"letting go of responsibility"* and *"patience"* for creating change, valuing her role as building relationships to influence others.