

**Experiences of Newly-Qualified
Clinical Psychologists in CAMHS: An Interpretative
Phenomenological Analysis.**

Submitted to the University of Hertfordshire in
partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology.

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June 2018

Word count: 32,646
(Excluding Tables, Figures, References and Appendices)

Acknowledgements

I am extremely grateful to my participants. Without your candid accounts, this work would not have been possible. I wish you all the best in your careers.

Many thanks also to my supervisors, whose sage advice, time and efforts in the development and construction of this work have been paramount to its completion.

To my family and friends for their love, support (and food) over the course of this research: I am forever indebted.

And finally, to Cohort '15: You have made my clinical training an enlightening and memorable experience, and one that I am most grateful for. Thank you!

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Abstract

Little research has been completed on the experiences of newly-qualified mental health professionals within children's services in the NHS. Consequently, there exists a gap in the literature of how such a population may experience their work environments, how they cope with challenges, and what helps them to thrive or survive in their new roles. This study therefore proposed the research question: *What are the experiences of newly-qualified Clinical Psychologists (NQCPs) in CAMHS?* Specifically, this research aimed to explore three particular aspects of NQCPs' experiences; their transition and development; the MDT and wider organisational contexts; and support and coping in the role. A qualitative design was utilised to explore these topics, with seven participants engaging in one semi-structured interview each. Interpretative Phenomenological Analysis was the chosen method of analysis. This analysis of participants' accounts led to the emergence of three super-ordinate themes; 'A big jump: the transition from TCP to NQCP'; 'The support of home comforts, old and new'; and 'Acknowledging and desiring ongoing development'. These consisted of ten sub-ordinate themes. These themes illustrated the difficulties in NQCPs' initial transitions, their support-seeking strategies, and their growing confidence and desire to develop further as clinicians. There were wide-ranging implications resulting from the outcomes of the analysis, and recommendations made to both Clinical Psychology training programmes and NQCPs' employers. These included: increasing caseloads and the opportunity for further exposure to leadership and management processes throughout training; staggering NQCPs' workloads after joining CAMHS; and improved communication between CAMHS' management and clinical teams. A critique of this research, and suggestions for further investigation, are also outlined.

Chapter 1: Introduction & Literature Review

“An existing individual is constantly in the process of becoming.”

- Søren Kierkegaard (1944).

1.1 Overview

The first aim of this chapter is to introduce the reader to the researcher’s personal interest in the subject matter, and to provide an epistemological basis for the conduct of the research.

The author will define what the term ‘Newly-Qualified Clinical Psychologist’ (NQCP) refers to for the purposes of this project, and the rationale for this, before covering three main subject areas relevant to the project, namely:

- an overview of the macro-context that NQCPs work within, in particular the effects of recent governmental policy for mental health services in the National Health Service (NHS);
- an overview of the micro-contexts NQCPs work within, namely, multi-disciplinary teams (MDTs);
- and an orientation of the reader to transitional models within healthcare.

A systematic review of the literature will also be presented, and the aims and questions of the research proposed.

1.2 Personal and Epistemological Positions¹

1.2.1 Personal interest.

In recent years, I have become interested in the experiences of professionals within mental health services and staff teams in the NHS, and beyond. As a budding NHS professional myself, I have found it to be at times overwhelmingly challenging and frustrating, while at others both incredibly rewarding and inspiring.

As my own journey as a health professional has progressed, with differing roles in various MDTs, I became more interested in how colleagues manage their professional responsibilities and relationships. I found myself considering more and more the dynamics between team members, how people work in the context of exposure to service user distress, and how people act, develop and change given their contexts, training and experiences.

Simultaneously, the context of the current government's 'austerity' measures also piqued my interest in regard to how professionals manage their work in conditions which, for a number of reasons, could be viewed as challenging (Barr, Kinderman & Whitehead, 2015; Iacobucci, 2014), and I will cover this more thoroughly later in this chapter.

As a Trainee Clinical Psychologist entering the final year of training, I had joined a different team approximately every six months for two years. My interests grew, skills developed, and thinking matured; I kept having to adapt to new challenges. I then suddenly became acutely aware that qualification was on the horizon – and realised that any post I might take following completion of this Doctorate in Clinical Psychology (DClinPsy) may place

¹ These positions have been written in the first person due to the more personal nature of the content, whereas the majority of this document is written in the more traditional third person.

substantially more workplace demands upon me than I would have been used to, for example because of the much higher caseload of a Clinical Psychologist working full-time, compared to a part-time trainee. I wondered how people experienced this. Was it exciting? Terrifying? Manageable? Liberating? How did it fit within the context of other changes or adaptations they may have experienced over the last three years or more, in both their personal and professional lives? I wondered where I was going, what I would do, and how I would manage, and conversations on these topics came up often between myself and my cohort colleagues. As a result, I considered that this may be a subject worth pursuing, and a potential basis for a doctoral research project.

With this in mind, I feel it is vital that from the outset of this work, I should state my awareness that my own interests, beliefs and experiences, will in some ways influence the research (Malterud, 2001). As they have influenced the choice of topic, they may also, at times unwittingly, play a part in certain decisions I take when at forks in the road, for example, what to hone in on within the Systematic Review, or the naming and clustering of themes in the analysis of transcripts. I hope that my transparency in this summarising of the context and the inception of this research allows the reader to make their own mind up about the impact of my own beliefs and experiences on the production of, and processes within, this work.

1.2.2 Epistemological position.

It has been asserted that acknowledging one's research position, as well as maintaining a process of self-reflexivity throughout a research project, can enrich the validity of research and its results (Elliott, Fischer & Rennie, 1999). Consequently, this highlights the necessity of the author to illustrate the self-reflection that occurred throughout this research process. I

will demonstrate this through the use of further passages of self-reflection, which will be identifiable by their *italicisation*.

I have considered that meaning is constructed relationally via the medium of language since before I first heard the words ‘social constructionism’ (Burr, 2015). As a Trainee Clinical Psychologist, I have learnt that one’s ontological position may influence their approach to research, and although I accept the material, ‘brute facts’ of our world (Anscombe, 1958), I am also of the opinion that ‘knowledge’ and perception are historically, culturally and socially bound (Gergen, 1985), and therefore that there are not objective observations of the world to view, nor singular truths to uncover (Burr, 2015).

Consequently, this way of viewing the social world led me to choose a research topic which would allow for different people to present their views on a nominally similar experience. This would mean utilising a qualitative methodology, in an attempt to capture something of participants’ “grasp of their world[s]” (Smith, 2007, pg. 4).

However, as I prescribe to the view that the relational nature of reality construction causes me to become a part of the story-telling and meaning-making, I do not believe that I can merely transfer information from participant to reader. In contrast, I am aware that the complex interweaving of the participants’ communications, and my processing, analysis and interpretation of them (both during and following the interviews), means that my own ‘lifeworld’ (Brooks, 2015; Husserl, 1970) inescapably influences the stories of their experiences, and the meaning of them that is created and shared.

1.3 Definition of ‘Newly-Qualified Clinical Psychologist’

The Division of Clinical Psychology (2014) describe a ‘newly-qualified Clinical Psychologist’ (NQCP) as one who receives at least one hour of supervision per week, in contrast to more experienced Clinical Psychologists (CPs) who may receive only one hour per month. The term has also been utilised in literature regarding the importance of ‘Continuing Professional Development’ (CPD; Latham & Toye, 2006), for CPs immediately following the completion of DClinPsy training programmes.

Meanwhile, the BPS (2010) state that Trainee Clinical Psychologists (TCPs) should be supervised only by CPs who have been qualified for at least two years, among other criteria.

Using the above information as guidance, it was decided by the research team that in this particular project, an NQCP would be defined as a CP who has been qualified for less than two years.

1.4 Contexts

As aforementioned, two levels of context are seen as relevant to this research; the governmental policy for mental health services in the National Health Service (NHS), and the multi-disciplinary teams (MDTs) which are commonly employed. These can be seen as the macro- and micro-contexts in which NQCPs are situated.

Situating the research within its broader context is necessary, as particular qualitative methodologies such as IPA have been critiqued for not taking into account historical or contextual factors (Willig, 2013) which contribute to the construction of participants’

experiences (Burr, 2015). Considering these contexts may therefore benefit the presentation of the outcomes of the research, and any conclusions drawn.

1.4.1 The macro-context: the effects of recent governmental policy for mental health in the NHS.

1.4.1.1 'Austerity'.

"The age of irresponsibility is giving way to the age of austerity."

- David Cameron, Leader of the Conservative Party (Brady, 2009).

In 2009, prior to the Hung Parliament of 2010 and his formation of a coalition government, Mr David Cameron gave a keynote address to the Conservative Party Forum, where he discussed the necessity of economic 'austerity' following the policies of the previous Labour government. The effects of austerity are wide-ranging, and for mental health specifically, the reading is stark.

Figures examined by The King's Fund think tank (Gilbert, 2016) show that approximately 40% of the 58 mental health NHS Trusts continued to have their budgets cut in the financial year 2015-16, despite previous assurances from the government that a 'parity of esteem' would see them funded on a par with physical health services.

This followed an analysis by the British Broadcasting Corporation (BBC), which showed that between 2010 and 2015, mental health NHS Trusts suffered cuts of 8.25%, losing the equivalent of £598 million from their budgets each year (Buchanan, 2015). It was noted by Paul Farmer CBE, the CEO of the mental health charity, Mind, that a £1 billion cash injection promised for mental health services would now be insufficient to reduce this gap, and that

75% of people with mental health difficulties were receiving no support at all. Meanwhile, Professor Sir Simon Wessely, chair of the Royal College of Psychiatrists, stated that staff were being ‘asked to do more with less’ (Buchanan, 2015). One could suggest that the experiences of staff working within such contexts may therefore be a valuable area of exploration.

1.4.1.2 Early intervention and investment in children’s services: a rationale.

In the midst of these imposed financial constraints, in 2013 the Guidance for Commissioners of Child and Adolescent Mental Health Services (CAMHS) paper (Joint Commissioning Panel for Mental Health; JCP-MH; 2013) succinctly outlined the argument for investment in children’s services. The reasoning included that mental health difficulties beginning in childhood persist into adulthood unless treated; that they can affect the educational attainment and employment prospects of young people (as well as lead to later physical health problems, resulting in significant economic costs); and that there exists an evidence-base indicating that cost-effective treatments are available to negate these long-term effects (Bailey, 2005).

Despite the clarity of this rationale, austerity has provided hurdles in the way of the implementation of such a strategy, leading to difficulties in areas such as access for potential service users, as well as workforce mobility. The JCP-MH (2013, pg. 3) concisely summed up the situation:

The moral and economic case for interventions to improve children and young people’s mental health and wellbeing has been known for some time. However... shortfalls in service capacity remain and there is evidence of disinvestment.

1.4.1.3 Impact of the financial shortfall.

More recently, the Mental Health Taskforce (MHT) published the Five Year Forward View for Mental Health report (NHS England, 2016), which stated that mental health services have been underfunded for decades, leading to many people receiving no support at all, and “thousands of tragic and unnecessary deaths” (pg. 3). It also claimed that one in four adults experience a diagnosable mental health difficulty every year, calling for a proactive and preventative approach to negate the longer-term impact of mental health difficulties for potential sufferers and their families, and repeating the call of the JCP-MH (2013) for early intervention to be prioritised.

The report offered a set of recommendations to achieve the long-desired ‘parity of esteem’ between mental and physical healthcare, with a particular emphasis on this being necessary across the entire lifespan, from children and young people to older adults. The MHT identified that although there was an annual £280 million investment in place committed to driving improvements in children and young people’s mental health, there remained a need to invest an additional £1 billion a year in mental health services by 2020/21.

The paper recognised the challenges for NHS mental health services as a whole since the 2011 coalition government’s mental health strategy publication, ‘No health without mental health...’ (Department of Health, 2011). These included difficulties with the implementation of system-wide changes and also in the provision of care for a growing number of people attempting to access services. In short, the MHT stated that inadequate provision and worsening outcomes has led to a rise in rates of suicides in those past five years².

² This is also corroborated elsewhere, with the Samaritans’ Suicide Statistics Report (2017) stating that rates have increased overall in the UK by 3.8%, (and by 2% in England, specifically), since 2014.

The MHT claimed that one in ten children aged five to sixteen has a diagnosable mental health difficulty, with those from low income families at the highest risk. It also claimed that half of all mental health difficulties are established by the age of 14, and 75 per cent by 24 years. Importantly, however, the report stated that “most children and young people get no support” (NHS England, 2016, pg. 5), and reiterated that recommendations from the ‘Future in Mind’ (2015) document should be implemented in full. This publication from the Children and Young People’s Mental Health and Wellbeing Taskforce, set out a number of core requirements, including but not limited to: promoting early intervention, improving access to timely support, and developing the workforce.

1.4.1.4 Effects on the workforce.

The above summary of the context of the NHS over the last number of years paints a picture of an environment characterised by financial challenges, leading to difficulties in structural change and a demanding level of clinical practice for a stretched workforce.

Whilst the effect on those who experience mental health difficulties has been noted, what it does not bring into light is the additional impact on front-line staff, and their experiences of a context which is limited in its resources, and thus unable to implement strategies which have been repeatedly advised, most notably the improvement of access and provision in early intervention services, or CAMHS, (JCP-MH, 2013). One wonders about the experiences and coping mechanisms of professionals working within this system, and even more so the newly-qualified practitioners transitioning into such a context from their training posts.

It also stated that in England (and the UK as a whole), female suicide rates are at their highest in a decade; and that male rates remain consistently higher than female suicide rates across the country.

Qualified CPs' experiences of NHS organisational change was recently investigated, and 'stress, frustration, exhaustion and tedium' were cited as consequences of the pressure caused by needing to do more with less resources (Colley et al., 2015). Research has also provided evidence that work-related stress can be harmful to both professionals and service users (West et al., 2011), with the BPS (2016) finding that 70% of psychological professionals find their jobs stressful. In addition, resilience has been discussed by Andrews and Thorne (2015) as an important quality of staff in the context of 'financial, structural and cultural change' within the NHS. The same authors also noted that little work has been done to explore the effectiveness of training programmes to adequately prepare TCPs for life after their training programmes. An exploration of this would therefore be a valuable endeavour.

In light of the continuing change and challenges within the NHS, one could assert that it is imperative to gain further insight from NQCPs, in order to explore their experiences of working in services that have been directly impacted by both an under-developed workforce, and an increasing throughput of individuals and families (NHS England, 2016) emerging from a context of rising distress and limited access to support.

1.4.2 The micro-context: working in MDTs.

"[The Clinical Psychologist's] co-workers have little patience with... long-winded statements of probabilities... They want something done and... done immediately."

- J.B. Rotter (1954).

1.4.2.1 Clinical Psychology in the NHS.

Clinical Psychology has a long and illustrious history in the United Kingdom. Evolving as a profession within the post-war development of the NHS (Hall & Llewelyn, 2006), it was eventually founded as a formal Division of the British Psychology Society in 1966 (Hall, Pilgrim & Turpin, 2015). Now established as a profession requiring a doctoral level academic qualification, the DClinPsy, CPs in the NHS commonly work with professionals from other healthcare disciplines, such as Nursing, Psychiatry and Social Work, as part of multi-disciplinary teams (MDTs), with, for example, CAMHS utilising this structure in their clinical staff teams.

1.4.2.2 MDTs: benefits & drawbacks.

Although the above quote from Rotter (1954) could perhaps be described as an out-dated generalisation, recent research has highlighted the difference between the approaches towards patients from professionals from other disciplines within MDTs, compared to CPs.

Opposing views between TCPs and medics, for example, with regard to the ‘biopsychosocial continuum’, has been discussed (Read et al., 2016), with TCPs favouring psychosocial understandings of mental health difficulties over more biological explanations. Similarly, Long and colleagues (2006), in Australia, claimed that there is a positivist medical dominance that transcends specific disciplinary discourses, leading to an overarching simplification of care which fails to fully address the complexities of clinical cases.

This appears to lead to the question as to whether there are any effects of divergent epistemological standings between professions. For example, the professions of Psychiatry

and Nursing could be seen as originating from a ‘lineal’ epistemology (Bateson, 1971), or the medical psychopathological paradigm (Auerswald, 1985). Clinical Psychology, on the other hand, has in recent times been influenced by the post-modern ideas of social constructionism (Burr, 2015), which has stamped its mark on the field of Family Therapy, and as a result many Clinical Psychologist training programmes now train their students in ideas from systemic theory (Dallos & Stedmon, 2006); a ‘non-lineal’ point of view (Bateson, 1971).³

On the other hand, Cowley and colleagues (2016) identified that MDT members’ detailed knowledge of co-workers’ roles and skills was viewed as useful in streamlining work and facilitating holistic care in a geriatric service, in the context of a new advanced practitioner nursing role being implemented. Furthermore, Young (1994) suggested that when MDTs work they can enhance job satisfaction, but that they can also cause confusion and stress for staff, while Fay and colleagues (2006) noted the indication within the literature that multi-disciplinarity may not always benefit members of a team.

Consequentially, it is logical to suggest that the impact of MDTs could be explored further in the investigation of the experience of NQCPs, and to query whether MDT working can lead to any challenges, for example, in particular discourses of mental health difficulties prevailing over others. Conversely, positive experiences may be uncovered, perhaps a useful flexibility in approaches to clients, shared responsibilities, and efficient teamwork, all of which may enhance clinical care and practice in services.

³ This is not to suggest that all Psychiatrists and Nurses cannot or do not think from a systemic or cybernetic viewpoint, nor that all Clinical Psychologists do, but is an attempt to make the point that there may be varied emphases within the training programmes of the different professions. I also remain aware that the systemic approach has evolved over time from modernist, behaviourist origins (Dallos & Stedmon, 2006).

1.5 Transitions

“The role of the... training of clinical psychologists is... crucial... It should provide a clear example of the role the clinician will eventually be expected to assume... training centers must assume fully their responsibility for training clinical students in the role society demands of them.”

- M. W. Kahn & S. Santostefano, ‘The case of clinical psychology: A search for identity’ (1962).

The final area of relevance to research involving NQCPs will now be discussed: professional transitions within the healthcare system.

‘Transition’ has been described as an internal, psychological re-orientation experienced by people whilst external changes are occurring (Bridges & Mitchell, 2000). This definition comes from one of a number of models of transition, which are situated in organisational contexts, relevant here given the above discussion of the impact of government policy on the workforce’s environment. Nevertheless, it may be more useful for us to focus our attention on a particular model of transition related to personal change, given the idiographic nature of this research and the emphasis on individual, phenomenological experiences (Smith, Flowers & Larkin, 2009).

Following this, it will also be important to explore the issues that have arisen in the literature up to this point, in regard to transitions for staff members within the healthcare professions.

1.5.1 A theoretical perspective: Schlossberg's 'Model for analysing human adaptation to transition' (1981).

Schlossberg's model of transition (1981) provides us with one useful framework for considering adaptation and change in the individual, and has been chosen over other frameworks for discussion here due to its phenomenological focus; the perceptions, experiences and personal changes of the individual undergoing the transition.

Within this framework, transition is conceptualised as occurring when "an event... results in a change in assumption about oneself and the world, and this requires corresponding change to one's behaviour and relationships" (pg. 5). Notably, Schlossberg (1981) identified transitions as times not just of challenges, but also of opportunities.

According to Schlossberg's (1981) model, the factors influencing adaptation to a particular transition can be divided into three broad categories, as follows:

- the perceptions of the particular transition - for example whether the transition is associated with changes in a professional role, or if changes are gradual or expected to come into effect in a short space of time;
- the characteristics of the pre- and post- transition environments - such as levels of support within the organisation or system;
- and the characteristics of the individual experiencing the transition - for instance personal values or coping skills.

This model allows us to consider the factors related to the transition and potential adaptation from a trainee position to that of a NQCP. For this transition specifically, three factors posited as relevant in the process can be mapped as follows; the individuals' perceptions of

their experience, such as the new demands of the change; the individuals' experience of the environment or contexts, such as the potential access to support structures found within this; and the individuals' characteristics and resources, such as their values, internal coping mechanisms or support-seeking behaviour.

This triad can be abbreviated into the following:

- individuals' experiences and perceptions of the transition;
- individuals' experiences and perceptions of the micro- and macro-contexts;
- individuals' experiences and perceptions of coping and resources.

These could be useful foci to help shape the particular research questions for this project.

1.5.2 Transitions of healthcare professionals.

It shall be beneficial at the outset of this section to briefly explain the change in circumstances of the TCP moving into a qualified role. Following this, research exploring this transitional phase will be summarised.

In short, the trainee completes five or six placements over the course of a three-year training programme. Due to the demands placed on a TCP, in the shape of clinical practice, academic endeavours, and doctoral level research, however, each placement requires trainees to work for approximately half of the week for most of the year, with the rest of the working week consisting of lectures and time set aside for research activities (BPS, 2015).

This begs some important questions regarding the impact of the change for those entering full-time NHS employment following the completion of their training, given that they may be

spending significantly more time than they have become used to in a clinical practice setting, in addition to having more responsibilities than they did as a trainee. These could include:

How does one experience the increase in weekly clinical work and responsibility? And how does one experience the loss of regular academic teaching and study time?

Latham and Toye (2006) discussed the challenging nature of this adjustment from trainee to NQCP, the continued development of professional identity that is required, and that a feeling of vulnerability may be unsurprising at this stage of a CP's career. They concluded that this transitional period requires a significant adaptation and adjustment by the practitioner.

Unfortunately, however, there is a dearth of peer-reviewed research on this subject for NQCPs in particular. In the context of these professionals offering therapeutic services to vulnerable young people and families, it should be emphasised that the experiences of NQCPs at this time absolutely requires further and thorough investigation.

Support for this assertion comes from Fouad and Bynner (2008) in the United States of America (USA), who argued that professionals from all disciplines need to be aware of the challenges of work transitions because of the impact it can have on their own mental health, while Corrie and Harmon (2001) have proposed that employers should attend closely to NQCPs in terms of support, supervision and CPD in this transitional period. Additionally, it is well understood that healthcare professionals can experience negative psychological responses in their work, including secondary responses to patients' iatrogenic traumas (Chan et al., 2016).

This highlights the importance of research of this nature, with it potentially affording professionals, supervisors and trainers a greater understanding of what may be both challenging and beneficial at these times for professionals, such as NQCPs, who are, of course, heavily involved in managing, stabilising or improving the mental wellbeing of many distressed individuals.

1.5.3 Transitions of TCPs and others – changes in identities?

A body of work has begun to emerge, investigating the evolving identities of TCPs, but with a focus on their professional development and transition during their training years. This has looked at their management of the challenges they face, and factors contributing to their difficulties. Woodward (2014) posited that the development of self-acceptance and self-awareness within clinical training allowed TCPs to negotiate the dilemmas involved in their evolving professional roles, and appropriately subsume their changing personal identities into their developing professional ones.

Meanwhile, an ‘inextricable link’ between personal and professional identities was recently proposed by Woodward, Keville and Conlan (2015, pg. 777), who highlighted the themes of enhanced self-awareness, managing uncertainty, and developing self-acceptance, as key to the development of trainees’ reflective clinical practice. Additionally, Kaslow and colleagues (1992) confidently stated that following post-doctoral training, a professional’s “identity solidifies... he/she... develops an increasing self-efficacy and self-acceptance as a psychologist” (pg. 369). Nevertheless, in more recent times, McElhinney (2008) discussed that conflict in work, ambiguity around the professional role, and the expectations of others can all impede trainees’ ability to identify with their assumed professional responsibilities. This makes one curious about how NQCPs in full-time NHS posts respond to such potential

developmental challenges, perhaps utilising particular personal strengths or coping skills, or by accessing certain sources of support. An investigation of this could help future professionals in the same and similar roles.

1.5.4 The role of the MDT in the transitional phase.

Fouad and Bynner (2008) proposed that the adjustment to work transitions is connected to the development of one's identity, but that the outcome of such changes is also influenced by institutional contexts. Additionally, the cognitive-relational stress theory (Lazarus, 1991) suggests that adapting to new circumstances can be aided or impeded by both personal and contextual resources, or indeed the lack thereof.

Furthermore, research looking at staff in professional disciplines such as nursing and social work has highlighted the difficulties which may arise for newly-qualified professionals, in regard to their transitions to being qualified (Burns, 2009; Maxwell et al., 2011), and working within MDTs (Fay et al., 2006; Frost et al., 2005). These ideas suggest that the ease or difficulty in which healthcare professionals transition into new roles or teams may to some degree be connected to the environment and culture of their workplace, including the macro- and micro-contexts previously discussed. This appears to be a key area to explore, as supported by Schlossberg's model (1981).

An MDT may be seen as a contextual resource for NQCPs to draw upon in their new roles, however, they have been viewed as an environment in which TCPs required 'survival skills' to manage (Cole & Blake, 2015, pg. 7). One wonders how NQCPs experience the MDT context, and if and how this is related to their experience of their transition, development and any potential changes in their identities.

Keville et al. (2017) stated that Problem-Based Learning, (PBL; a method of learning utilised across some Clinical Psychology and medical training programmes), can help clinical psychology trainees develop skills to manage groups and negotiate diverse views and experiences, but the authors also highlight the differences between PBL and MDTs. One wonders whether Clinical Psychology training courses are succeeding in helping trainees develop the relevant skills to thrive in NHS MDTs. It may also be of value to explore whether the working environments NQCPs may find themselves in can help or hinder their transitions, and how they feel they manage any challenges that arise within these settings.

1.6 Systematic Literature Review

1.6.1 Overview.

In this section, a systematic literature review of research relevant to this doctoral thesis will be presented. The review initially aimed to answer the question of what the literature informs us about CPs' experiences of organisational, team and clinical factors in their roles within NHS MDTs, however this was modified to a broader focus on these experiences for health professionals in general. A rationale for this will be provided.

An outline of the search strategy that was employed will be discussed, followed by an overview and critical evaluation of the methodology and results of the identified papers, to illustrate what can be understood from previous research. A synthesis of the main points of the papers, as well as limitations and implications of the review, will also be provided.

The chapter will then conclude with the rationale for this research, its aims, and specific questions to be explored.

1.6.2 Search strategy.

This review of the literature is the result of a number of searches over a nine-month period, from May 2017 to February 2018, a process which evolved due to the challenging nature of finding research that would usefully illuminate and guide the current project.

Databases such as Scopus and PubMed were utilised, resulting reference lists scoured, and enquiries made to the research supervisors regarding any pertinent papers they were aware of. The researcher also searched the ‘Clinical Psychology Forum’ archive for any relevant papers from the last five years.

At the outset, the aim was to hone in on the subject of CPs’ experiences of organisational, team and clinical factors, in their roles within NHS MDTs. For searches on online databases, combinations of several search terms were utilised, such as: ‘(qualified OR newly-qualified OR newly qualified)’; ‘AND psycho*’; ‘AND (multi-disciplinary OR MDT OR inter-disciplinary)’; and ‘AND (experienc* OR transit*)’. Additionally, terms to be ignored, for example: ‘NOT military’; ‘NOT cardio*’; and ‘NOT business’, were also included, to refine the search and remove any results which were not in the sphere of mental healthcare research.

This provided 252 results, however following each title being screened, and 29 abstracts viewed, it came to light that only one paper was focused on CPs in the NHS, suggesting a dearth of research on this particular profession. Further, refined searches were conducted, with 55 results, only two of which were relevant, and only one peer-reviewed. Please see Appendix A for flow charts of various example stages of the search process.

Therefore, the decision was made to broaden the search and to include, within this systematic review of the literature, papers focused on all health professionals' experiences of organisational, team and clinical factors in their roles within NHS MDTs. These perspectives are valuable to the researcher due to the importance of hearing the stories and experiences of those professionals who work in multi-disciplinary teams within the NHS, prior to settling on the rationale and aims of the current research project.

The full inclusion and exclusion criteria decided upon by the researcher can be found in Appendix B. One aspect to briefly highlight from this is that the researcher decided not to make peer-reviewed papers a necessary criterion, due to finding a previous Clinical Psychology thesis which was extremely salient to the current study, but which was not downscaled in order to be published in a scientific journal. The document was requested from the author and will be summarised as part of the following review.

Further searches of online databases were therefore completed (see Appendix A). The combined searches yielded 375 articles. Excluded were those that did not meet the inclusion criteria, as well as duplicates. This left 31 articles, and the full texts of all of these were screened, leaving six relevant articles. There was also one unique reference found, from searching the 'Clinical Psychology Forum' archive, taking the total number of documents to be reviewed to seven.

1.6.3 Quality of the literature under review.

A useful guide to assessing the quality of qualitative and quantitative literature identified has been set out by Elliott, Fischer and Rennie (1999). The following review of the identified

papers will refer to relevant aspects of their quality, and a comprehensive, tabular summary can be found in Appendix C.

1.6.4 Overview and critical evaluation of papers.

An overview of the literature borne out of the above systematic review process will now be presented. A summary table of the pertinent points of this literature, such as the aims, and strengths and limitations of each paper, can also be found in table format in Appendix D.

1.6.4.1 Identified papers on the experiences of organisational change for health professionals.

The first two papers to be presented are especially salient findings of the literature review and may usefully inform the current research, due to their dual focus on the viewpoints of CPs, and the impact of the structural changes and financial difficulties that are unfortunately ongoing within the NHS.

Nutt and Keville (2016) investigated the impact of organisational change such as budget cuts and reorganisation on CPs' ability to build alliances with colleagues and clients. This paper focused on CPs working in adult, multi-disciplinary, community mental health teams (CMHTs), and specifically reflected upon a theme titled, 'There isn't any time for thinking any more,' which emerged in the lead author's wider doctoral research.

Eight participants were recruited from different services across the country and were employed at different pay grades, which will have negated potential selection bias to a substantial degree; participants would have naturally had a range of experiences given the varied responsibility of their job roles, and the geographical locations of their service.

Qualitative, semi-structured questionnaires were utilised, and data was analysed using Narrative Analysis, drawing upon the ideas of Mishler (1997), on the construction of professional discourse. Unfortunately, however, the researchers did not provide their theoretical orientations or personal anticipations, nor that of the chosen methodology, which would have been useful in order to disclose their approach, values, or any assumptions, to the reader. The researchers did offer a useful summary of the validity criteria of this chosen method of analysis (Yardley, 2008), though, and the credibility checks of the first author's main research were referred to, providing an indication of the quality and reliability of the analysis process.

The theme under consideration was helpfully deconstructed into five distinct categories, which aided the paper in bringing together similar and common participant accounts, while also preserving their nuances. The analysis outlined that change within organisations can result in narratives of struggles for staff, while the impact of organisational pressures was thought to be reflected in participants' relationships with both their colleagues and clients (Nutt & Keville, 2016). Participants also voiced a sense of feeling distant from personal values. The authors considered how shifting from short-term planning and a focus on efficiency, to long-term thinking regarding relational values, may be of benefit to both staff and service users.

In the wider research that this paper stems from, Nutt (2016) suggested that further research of this kind could explore the experiences of other professional groups in other MDT environments, to capture the experiences of those facing similar changes who could not be included in her research. This, of course, informs the current author's view that further

research in this area would be valuable, and the current study could supplement literature of this kind from the perspective of a similar group of professionals working in an alternative setting.

Colley, Eccles, and Hutton (2015) also explored CPs' experience of organisational change within the NHS. This qualitative study utilised a semi-structured interview schedule, which was helpfully designed with the aid of consultation with members of the profession. The authors, however, recruited their eight participants from only one area of the UK, calling into question the generalisability of their results and recommendations. They also did not state their theoretical orientation or assumptions, which would have allowed for a greater understanding of their approach to their research, and perhaps elucidated their analysis further.

The selection process, with a volunteering strategy being employed, may also have engendered a bias whereby the research may have been more attractive to potential participants who would offer negative reports. Nevertheless, one could argue that participants with more difficult experiences of organisational change are valuable in such a study, as their experiences may be vital to voice in the context of the researchers' aim to potentially inform and help facilitate positive adaptation to future change, for CPs and other NHS professionals.

Colley et al. (2015) chose Thematic Analysis as their method of analysis, and acknowledged their attempts to avoid their own expectations unwittingly being imprinted upon their results, for example through the use of systematic coding. Three main themes were identified and particular participant reports brought forth in a data- driven narrative 'Results' section, providing a sense of coherence to this section of the paper. These themes were: the

challenges the CPs experienced, how their knowledge and skills have helped them cope with change, and what they can take forward from their experiences.

Quotes were embedded within the narrative of the results, which kept the reporting of the themes grounded in the participants' accounts. A sense of threat to their jobs and careers was reportedly expressed by participants, while 'stress, frustration, exhaustion and tedium' were cited as consequences of the pressure caused by needing to do more with less resources.

This seems relevant to settings across the country, including CAMHS, in the context of the previously-discussed, wide-ranging impact of austerity. The experiences of staff in such areas of the NHS therefore require exploration, especially given that they are set up to support significantly vulnerable people, young and old, and their families.

1.6.4.2 Identified papers on the experiences of team and personal factors for health professionals.

Chana, Kennedy and Chessell (2015) recently completed research on health professionals which is particularly relevant to the current study in terms of its areas of focus. These were, specifically: 'structural' factors (for example work stressors); 'individual factors' (including social support); and 'transactional factors' (such as staff coping mechanisms).

Indeed, in light of the Schlossberg's model of transition (1981) previously discussed (please see section 1.5.1 'A Theoretical Perspective...'), and the potential foci of the current project which could be borne out of its structure, Chana and colleagues' (2015) research almost mirrors the potential focus of the current research. Therefore, in spite of it being slightly

unclear as to whether the participants in the study are working in mental health or general nursing, this paper is a valuable source of information for the current research project.

Chana et al. (2015) used a number of measures in a correlational analysis, recruiting 102 members of nursing staff. All participants were from the same NHS Trust, as this was a convenience sample, which may limit the generalisability of the study somewhat. The authors utilised a non-parametric correlational analysis following the important completion of assumption testing. The authors employed an appropriate method of data collection for such a large sample, while they also discussed all eight measures in depth, and provided information on the analysis methods employed.

A comprehensive 'Results' section utilised a number of tables and figures, which gave clarity to the presentation of their outcomes. These included the subscales of 'Emotional exhaustion,' 'Depression' and 'Anxiety' being positively correlated with measure items titled 'Inadequate preparation to deal with the emotional needs of patients and their families,' 'Work load' and 'Lack of staff support.' 'Emotional exhaustion' and 'Anxiety' were also positively correlated with 'Conflict with nurses and supervisors.' In addition, 'Emotional exhaustion' was negatively correlated with 'Social support,' as well as with various 'Coping strategies,' indicating that these may be protective in reducing emotional difficulties for staff.

The authors concluded that the emotional well-being of nursing staff needs to be supported, for the benefit of both themselves and their patients. Recommendations to NHS employers were made, including that workloads must be monitored to avoid a reduction in authentic caring behaviours if they rise too high, as well as that employers should help staff foster a positive work-life balance, and access support both in and outside of the workplace. Further

training for staff was also suggested as necessary. This research was a very helpful contribution towards a subject area where very little work has been completed.

Brooker and colleagues' (1999) paper was another piece of research deemed a valuable finding in the literature review, due its focus on clinical staff in contact with service users with significant mental health difficulties, and its aim to utilise this information to guide potential service changes. The researchers were helpfully explicit in stating the context and purpose (Elliot et al., 1999) of this work, considering how it is situated in relation to previous literature, and clarifying their particular research aims.

Despite being written in 1999, and only utilising descriptive statistics for its focus on staff, the researchers used measures which allowed et al. (2015), suggesting a commonality over time, and that these issues can continue if participants to highlight the aspects of their clinical roles which caused them the most difficulties. We will see that these factors overlap in part with the outcomes of the more recent literature by Chana not addressed.

This research utilised a quantitative methodology to gain further understanding of the factors of the roles which contribute to the stress of staff, such as Nurses and Social Workers. The questionnaires used covered a number of different aspects of employment, useful in helping the researchers pinpoint specific difficulties for staff, and making this an appropriate method for the aims of this work.

This was a well-presented paper, for example utilising tables to illustrate data, which provided a clarity of the outcomes to the reader. The majority of identified stress factors were related to aspects of the service and its structure, rather than clinical factors, and included

‘coping with changes’ and ‘insufficient time for personal study’. Additionally, many of the questions receiving the lowest scores (zero, indicating they were not stress factors for staff), were in regard to ‘relatedness’ (Nutt & Keville, 2016), such as ‘Not feeling I can rely on the support of my colleagues’, ‘Insufficient respect from other professionals’, and ‘Receiving unhelpful supervision’.

One wonders whether the researchers could have taken their analysis further and explored whether these factors of relatedness mediated any of the stress factors for staff, in effect acting as protective to their level of morale, especially given that, overall, the participants’ levels of stress were not very high. Nevertheless, it could be suggested that an overlap exists between these outcomes and those of Nutt and Keville (2016), in that ‘change’ within services can affect staff experiences, and that the support of colleagues is paramount to the wellbeing of professionals.

The authors also noted the established concept of stress being connected with sickness (and time off), and therefore the subsequent impact of stress upon the care of service users (Brooker et al., 1999). They stated that insight into stress factors of staff is valuable in informing management decisions to improve morale, as well as in ameliorating levels of staff stress.

This paper made a contribution to the understanding of which areas of services may require improvement, and cause increases in staff stress. Future research on factors which may cause difficulties for staff within challenging clinical settings, such as the current project, could potentially offer these types of recommendations to management teams, as well as to their

trainers, in order to prepare staff members for the realities of the environments they may transition into.

Currid (2008) aimed to ascertain the experiences and meaning of the stressors of work, for nurses in an acute mental health setting. He utilised semi-structured interviews, which were transcribed and analysed with a qualitative methodology, utilising the phenomenological approach of IPA (Interpretative Phenomenological Analysis). The researcher helpfully outlined the principles of hermeneutics and phenomenology, and discussed the appropriateness of this approach to the research. He also recognised prejudices borne out of his own life history, therefore owning his perspective, and how it may impact upon the analysis and presentation of the results. Although the author also discussed the study's limitations, including it being carried out at a time where finances were particularly challenging within the organisation, and that the experiences were looked at over a brief period of time, they hone in on important staff experiences to learn from.

Currid (2008) discussed that the emerging themes were shared and their accuracy checked with the participants, on two occasions before they were finalized. Four overarching themes were presented in the paper, which framed the narrative presentation of the outcomes, and participants' quotes were utilised in order to ground the results in their accounts. Currid (2008) found that competing demands and the pressures of a heavy workload were stressors which could contribute to staff questioning their self-worth, fearing making mistakes and being blamed, and not feeling supported by management. This led to them feeling less valued and struggling to be recognised for their professional values. The author went on to suggest that stress reduction strategies are needed to aid professionals, and that patient wellbeing should be thought of as inter-connected with that of the staff.

Although Currid (2008) saw it as a weakness of his study, one could argue that the completion of this research at a time of financial difficulty now makes this research all the more important. One wonders, ten years on, whether the changes that have occurred across mental health services, including the effects of austerity previously discussed, have made the experiences of these participants more common. It seems important to ask questions related to the organisational factors influencing the experiences of staff, in any potential research in this area.

Higgins, Hurst and Wistow (1999) carried out an extensive study funded by the Department of Health, looking at the nursing care of acute psychiatric patients. This chapter does not have the scope to summarise the entirety of this extensive study, which, across eleven sites, utilised statistical profiles of the services, staff and patient interviews, staff and patient questionnaires, and non-participant observation, to investigate the contexts, processes and effects of psychiatric care, in order to inform policy and practice. The procedures utilised were particularly appropriate to the particular questions of the study, for example, the use of interviews, questionnaires and observations, of staff activities and processes.

A number of pertinent results can be highlighted, although it is important to add that this paper is content-heavy, with little focus on process, such as ethical considerations, or interview procedures. The absence of the latter would therefore make duplication of this work challenging.

Multi-disciplinary processes (both in hospital and community settings) were found to not always be appropriately developed, meaning that timely clinical work and communication

between staff could have been more effective, with some staff even reporting that these factors led to increased stress. The authors also evidenced poor morale for staff, due to factors including work-load pressures on their time, resulting in an inability for senior staff members to provide appropriate supervision to colleagues, and for staff in general to offer holistic care to patients.

Finally, the paper uncovered that newly-qualified staff believed that they were under-prepared for what they faced in their qualified positions, due to lacking sufficient experience. This suggests that it may be particularly important to explore the experiences of this staff group further.

Higgins and colleagues (1999) did not discuss any limitations of the study, nevertheless this paper does helpfully contribute to the knowledge base of policy and practice, and could be drawn upon by managers and clinicians responsible for the running of acute services. The authors also concluded that further examination of the mental health services, and relevant remedial action, must be undertaken in order to develop effective services across the country.

The current research hopes to be able to contribute to that endeavour, in an area which may be effected by various contextual factors, and with a staff group who may have a challenging transition into post-qualification work, but who may also hold the potential to bring energy and change into clinical environments.

The final data source to be discussed in this review is a thesis by Nugent (2007), who used a series of one-to-one semi-structured interviews and a Grounded Theory methodology (Charmaz, 2011), to investigate multi-disciplinary professionals' perspectives on effective

inter-professional collaboration in CAMHS, and identify the main factors contributing to it. To the current author's knowledge, this is the only time this has been explored, however also remains aware that this work was not peer-reviewed as it was not written for submission to a journal following its completion as a doctoral thesis. Nevertheless, this work meets a number of quality criteria to which qualitative research should be reviewed against, which indicates its validity and usefulness. One example of this is that the author presented her theoretical orientations and reflected upon her assumptions and biases, therefore owning her perspective and approach in advance of completing her methodology and analysis.

Nineteen healthcare staff, from a range of professional backgrounds including Clinical Psychology and Psychiatry, working across seven MDTs, were interviewed; a fairly large sample for research of this nature. The material was presented in a way which provided an accurate representation of participants' accounts, for example by using a number of their quotes.

The data indicated that three main domains effect inter-professional collaboration, namely 'interpersonal factors, team culture, and organisational factors' (Nugent, 2007, pg. 70). These three overarching themes were comprised of factors such as: 'understanding of professional roles,' and 'willing participation' (for 'interpersonal factors'); 'informal processes,' and 'trust and mutual respect' (for 'team culture'); and 'professional drivers,' 'workspace' and 'supportive management' (for 'organisational factors'). This displays the 'multi-factorial' and 'complex' (pg. i) interweaving of features within teams that can contribute towards effective inter-professional teamwork. Nugent (2007) concluded that these mediating factors can either facilitate effective teamwork, or inhibit it. Furthermore, she suggested that future research assessing inter-professional working should retain a focus on the three main groups of factors

identified; the interpersonal, team culture, and organisational. This research will therefore endeavour to do so.

1.6.5 Synthesis of the main outcomes of the reviewed literature.

This systematic review of the literature provides an overview relevant to the current project, specifically of papers that investigate the organisational, service-related and personal factors which impact upon experiences of healthcare staff.

A common theme of the identified research is that organisational change and resulting pressures can contribute to experiences of personal and workplace difficulties for staff. These include feeling that their values are not consistent with how they have to work (Currid, 2008; Nutt & Keville, 2016), and with forming positive working relationships with colleagues and clients (Nugent, 2007; Nutt & Keville, 2016).

Pressure and stress in a wide range of staff members' day-to-day roles also emerged from the review, evident in the work of Colley and peers (2015), Currid (2008), and Chana and colleagues (2015). The latter importantly identified the connection of 'Emotional exhaustion' and 'Anxiety' to a number of difficulties, including 'Work load', 'Lack of staff support', and 'Conflict with... supervisors'.

The association of emotional stress with organisational and team difficulties is consistently echoed and evidenced across the reviewed research (Brooker et al. 1999; Currid, 2008; Higgins et al., 1999). In addition, and importantly, the research indicated that this host of difficulties experienced by staff may impact upon patient care (Currid, 2008; Higgins et al., 1999), or "the emotional needs of patients and their families" (Chana et al., 2015, pg. 2838).

The literature reviewed also suggests that newly-qualified professionals may lack sufficient experience to deal with the stress of certain environments early in their careers (Higgins et al., 1999), and that these environments may be effective, or not, due to a complex web of team, interpersonal and organisational factors (Nugent, 2007). Further research on these groups of staff is recommended (Higgins et al., 1999; Nugent, 2007).

The review also informs us that recommendations for more support for the emotional well-being of staff have often been made, (Brooker et al., 1999; Chana et al., 2015, Currid, 2008). One such recommendation was for organisations to endorse particular values that staff held (Nutt & Keville, 2016), including a positive work-life balance, and a commitment to staff development (Chana et al., 2015). In addition, a recommendation across the literature was that the provision of increased or improved supervision may also improve staff morale, and reduce their stress (Brooker et al., 1999; Chana et al., 2015; Higgins et al., Hurst, & Wistow, 1999).

In summary, the literature informs us that:

- a host of difficulties can be experienced by a wide-range of healthcare staff within NHS organisations and MDTs, one prominent contributor of this being stress as a result of changes to the organisation;
- that this may be a difficult environment to enter for newly-qualified professionals and that further research is required on this staff group;
- that these difficulties can impact upon the wellbeing of staff of all professional disciplines;
- that this can filter down to negatively impact the care received by service users;

- and that recommendations have been made as a result of the research, which could be implemented to better support staff, and ameliorate the likelihood of the difficulties within NHS teams impacting upon those who should be receiving care from them.

1.6.6 Implications of the review.

One clear implication of this review is that research on groups of newly-qualified professionals is a necessity for a number of reasons, including that a lack of sufficient experience can make it challenging to cope in stressful environments (Higgins et al. 1999), and that difficulties for staff can in turn affect the care of service users (Chana et al., 2015; Currid, 2008). In addition, only one of the identified studies investigated CAMHS settings (and this was not peer-reviewed), therefore it seems appropriate that the experiences of staff within these services are explored through more research. This is especially important given their common utilisation of MDTs, the aforementioned socio-political context CAMHS are situated within, and the vulnerable nature of the clinical population. Additionally, the literature indicated that client care can be impacted negatively when staff experience difficulties in the context of organisational or team challenges, and this is a particularly disquieting implication of the review.

Further implications could be put forward specifically for the profession of Clinical Psychology, including that TCPs may be exposed to stress and impacted by it during their training, or indeed that, as NQCPs, their experiences of full-time NHS roles may be even more challenging, in comparison to a training experience where they fulfilled only 2.5 days per week of clinical placements. This also raises the question of whether these environments and experiences may adversely affect newly-qualified staff, in terms of their health, their capacity to offer clients appropriate support, or indeed their services' ability to support and

retain them. With the literature suggesting that significant levels of stress are pervasively experienced by different staff groups across various services, it is imperative to investigate newly-qualified staff members' experiences of their roles, and any support structures or coping mechanisms which are available or utilised by them.

A final implication is borne out of the fact that from the information gathered, researchers were able to recommend particular implementations to counter specific challenging experiences, for example increased support or supervision for those under increasing levels of pressure. As a result, the current research will endeavour to provide recommendations that arise directly from what emerges from participants' accounts. As the literature review indicated, these recommendations could, theoretically, be directed to structures surrounding participants, such as their training programmes or employers.

1.6.7 Limitations of the review.

Although the search strategy was rigorous (see Appendix A), a limited amount of literature on CPs was identified, and almost nothing on the transitions of healthcare staff into full-time NHS roles, therefore it is possible that relevant literature may have been missed.

In addition, with regard to the literature that was retrieved and assessed, the quality checks of the literature found that not all of the research met each of the recommended quality criteria (please see Appendix C). This suggested, for example, that some of the papers may have been affected by researcher bias, due to a lack of credibility checking.

Lastly, although it could be said to indicate the longevity of difficulties experienced by NHS teams over time, three of the studies were more than ten years old, and as discussed earlier in this chapter, the socio-political context has changed significantly over that time.

1.6.8 Proposed research project.

1.6.8.1 Rationale.

This chapter has illustrated that little research has been completed on the experiences of newly-qualified mental health professionals in community or children's services within the NHS, whether this be regarding transitions into roles as qualified professionals, or a focus on the contexts of organisational change and multi-disciplinary team working.

Due to the dearth of this literature, there is a gap in our knowledge of how such a population may experience their work environments, how they cope with challenges, and what helps them thrive or survive in their new roles. It is imperative that this be one key focus of the current project, and therefore this project will focus on NQCPs within NHS CAMHS settings.

It seems important to explore the experiences of professionals working within CAMHS services due to the organisational difficulties these services have endured, including the imposition of financial constraints. The researcher also believes there is an ethical consideration to justify this focus of the project, in that there is a duty to investigate the experiences of professionals in such environments, given that they are working with individuals and families in services where high-quality, effective care for both staff and clients is imperative. It seems vital to understand staff experiences and any potential challenges they face, as well as their views on what has helped or could help reduce such challenges.

There is also a clear case for the exploration of NQCPs' experiences of their roles in this transitional period of their careers, as the limited research which has looked at nursing staff has indicated that difficulties may exist more widely for newly-qualified professionals. The researcher would suggest that a consideration of the experiences of this transitional period for NQCPs within CAMHS could potentially benefit various parties, including trainers, employers, the NQCPs themselves, and ultimately their clients. This research could potentially reveal NQCPs' views on what has been more or less helpful about their training programmes, or may highlight the presence or absence of structures of support within their organisations.

The rationale is therefore to gain first-hand accounts to understand the experience of NQCPs, to inform trainers and employees of these experiences, and to ultimately have positive effects on both the future development, support and wellbeing of CPs, in order to assist them in offering valuable and effective client care.

1.6.8.2 Aims & Research Questions.

This research aims to explore three particular aspects of NQCPs' experiences (in line with Schlossberg, 1981), namely:

- transition and development;
- contexts (the MDT and the wider organisational factors)
- and support and coping.

These areas of interest will provide the researcher with a number of questions, such as:

- what are NQCPs' experiences of the transition to their roles?;

- what are NQCPs experiences of their roles in the context of organisational factors?;
- and what are NQCPs experiences of coping and support?

These questions will be utilised in order to answer the overall research question:

What are the experiences of NQCPs in CAMHS?

Chapter 2: Methodology

2.1 Overview

This chapter will provide an overview of the methodology utilised within this research project. It will discuss the design of the research, and why the chosen method of analysis was selected ahead of other potential alternatives.

The theoretical underpinnings of the method of analysis, Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009; Smith & Osborn, 2003), will be reviewed, followed by an outlining of the use of consultation, participant details, and recruitment strategies. Ethical considerations, interview development and procedure, and details of the process of analysis will also be discussed.

Finally, there will be a consideration of the quality, validity and self-reflexivity of the research, focusing specifically on the guidelines proposed by Yardley (2008).

2.2 Design

A qualitative design was utilised in this research, with seven participants each engaging in one semi-structured interview.

A qualitative design and analysis was chosen as it is concerned with providing rich accounts of the phenomena under examination, and essentially is interested in what these accounts mean (Smith, 2015). It is beyond the scope of this chapter to discuss in detail why particular quantitative research methodologies were not utilised for this research, however it is important to note that some qualitative methodologies, depending on their theoretical

grounding, can be seen as post-modern in their approach (Smith, 2015) and bearing in mind the ontological and epistemological position of the researcher, a qualitative methodology felt a necessary choice.

The number of participants interviewed falls within the range stated by Turpin and colleagues (1997) as an appropriate number for doctoral psychology research when employing the particular qualitative method of analysis utilised in this study (IPA).

2.3 Consideration of methodologies

A number of qualitative methodologies could have been employed by the researcher for this project. Here I will briefly outline the options available, and the rationale for the final choice.

2.3.1 ‘Grounded Theory’.

Grounded theory (GT; Charmaz, 2011) is an appealing method of qualitative analysis when the researcher’s principle aim is to generate theory from the data (Strauss & Corbin, 1997). It develops explanations of social processes, giving weight to the contexts they occur within (Starks & Brown, 2007). As this research project was concerned more with the experiences of individuals, rather than attempting to create an overarching theoretical explanation of how NQCPs act or feel in their new roles, GT was not considered the most appropriate option.

2.3.2 ‘Discourse Analysis’.

Discourse Analysis (DA) focuses on linguistic structures, patterns of conversation and social communication through the medium of conversation (Smith, 2015). It focuses on the role of language in describing a person’s experience (Biggerstaff & Thompson, 2008), rather than

how people make sense of their experiences and interactions within their contexts, such as IPA (Smith, Jarman & Osborn, 1999).

2.3.3 ‘Narrative Analysis’.

Researchers who utilise Narrative Analysis (NA) often share the social constructionist position of the rejection of single truths. It is employed to make sense of people’s stories and has been widely used in research on health-professionals and their education (Taylor, Bogdan & DeVault, 2015). This made it a potentially viable methodology for this research. However, NA is concerned more with how incidents are storied, who they are constructed for, and for what purpose (Burck, 20005; Riessman, 2008). This is in contrast to the current project’s interest in allowing for an in-depth exploration of the experiences that would be shared, and its emphasis on participants’ perspectives and meaning-making.

2.3.4 ‘Thematic Analysis’.

Thematic Analysis (TA) was considered as a potential methodology for this research, as it is a method that can help to identify, interpret and report the patterns and themes that may emerge across qualitative datasets (Clarke & Braun, 2014). Nevertheless, it has been discussed as commonly resulting in broad, descriptive analyses of a number of participants (Hefferon & Gil-Rodriguez, 2011), and although it can involve interpretation (Boyatzis, 1998), this seems in contrast to the more penetrative, idiographic and interpretative focus of IPA, where a person’s lived experience is emphasised and studied in detail (Braun & Clarke, 2006).

2.3.5 ‘Interpretative Phenomenological Analysis’ (IPA).

Interpretative Phenomenological Analysis (IPA) was the chosen qualitative methodology for this research. IPA focuses on how individuals create meaning in relation to their life experiences (Pietkiewicz & Smith, 2014), and how they make sense of their personal and social worlds (Smith, 2015). A phenomenological and interpretivist approach of this nature would allow the researcher an insight into people’s lives from “their own frame of reference” (Taylor, Bogdan & Devault, 2015, pg. 7), and as the focus of the research was to explore participants’ experiences of their new roles, it was thought that IPA would lend itself well to this task.

IPA can aid a researcher endeavouring to make interpretations that discuss meaning, thoughts, feelings and behaviour (Reid, Flowers & Larkin, 2005) and is considered a robust methodological approach to analysing and understanding people’s experiences (Biggerstaff & Thompson, 2008), including those of health professionals (Reid, Flowers & Larkin, 2005). Smith, Flowers and Larkin (2009) also specify it as an appropriate method to investigate major transitional experiences. It also allows for an analysis of similarities and differences between individuals (Pietkiewicz & Smith, 2014).

2.3.5.1 *IPA’s theoretical underpinnings.*

Smith, Flowers and Larkin (2005) discussed the theoretical underpinnings of IPA; phenomenology, hermeneutics and idiography. This section of this work will briefly summarise these philosophical approaches, in order to orientate the reader to the foundations of the chosen methodology, and provide an insight into why it has been selected.

2.3.5.1.1 *Phenomenology.*

Phenomenology is a philosophical approach to the study of experience, and has been noted as ‘the science of the essence of experience’ (Husserl, 1982). Husserl (1982) thought it possible to identify the key components of experience through reflection and bracketing, which involves stepping outside the immersion of experience, and becoming conscious of the process of experiencing.

IPA, a little less ambitiously, endeavours to investigate and encapsulate the lived experiences of particular people (Smith, Flowers & Larkin, 2005), in order to gain an ‘insider perspective’ (Smith & Osborn, 2003). This is in line with phenomenology’s attempt to, as far as possible, give a direct description of experience as it is (Merleau-Ponty, 1996). On this note, however, Heidegger (1962) discussed that each of us is inescapably a ‘person-in-context’, for instance we may consider that even being alone requires an understanding of relatedness. Thus our experiences are always connected inter-subjectively; ‘in-relation-to’, in communication with, and to be interpreted by, others. This underscores the interconnection of phenomenology and hermeneutics.

2.3.5.1.2 *Hermeneutics.*

Hermeneutics is the theory of interpretation (Smith, Flowers & Larkin, 2009). This approach suggests that a pure description of an experience from one person to another is not possible, and that every communication involves interpretation; it therefore follows that IPA researchers cannot avoid involvement in the construction of experiences which are relayed to them (Griffin & May, 2012).

Hermeneutics is also concerned with the inevitable interplay between one's own preconceptions, biases and past experiences, and the new information being presented to them. This is important to note when considering that IPA researchers are bound in a 'double hermeneutic' (Smith, 2004; Smith, 2015), meaning that they are involved in a process of interpreting the participant's own interpretations of their experience.

By its very nature, then, this methodology involves a co-construction of participants' experiences, the meanings they are assigned, and the subsequent conclusions drawn. Moreover, the 'experientially-informed' lenses of both the participants and the researcher, are the frames through which the constructions are viewed (Smith, Flowers & Larkin, 2009). It feels necessary to be explicit with the reader about this interpretative element of IPA, whereby the participants' 'first-order' meaning-making is subsequently heard and interpreted in a 'second-order' process by the researcher (Smith, Flowers & Larkin, 2009).

2.3.5.1.3 *Idiography.*

Idiography, or an idiographic approach to psychology, concerns the uniqueness and specificity of each individual (Smith, 2015). This is in contrast to the nomothetic perspective, where overarching laws, applied to all, are sought out to be uncovered (for example, the theory of personality; Eysenck, 1953). Idiography is therefore committed to detailed, in-depth analyses, while it also emphasises the value of the personal accounts and perspectives of particular people in specific contexts (Smith, Flowers & Larkin, 2009).

IPA is idiographic; it seeks to allow a researcher a deep insight into the experiences, perceptions and understandings of a small number of participants (Pietkiewicz & Smith,

2014), rather than attempting to reach more general claims and conclusions for a wider population (Smith & Osborn, 2003).

2.3.5.1.4 *Limitations of IPA.*

It is also important to acknowledge the limitations of the chosen methodology, and Willig (2013) helpfully identified three potential weaknesses of IPA. These limitations are a reliance on language, description over explanation, and IPA not theorising reflexivity.

Willig (2013) discussed the limitations of language with regard to potential participants expressing the complexity of their experience, stating that IPA presupposes that language is an adequate tool to capture participants' experiences. This is relevant to the current project, as one could argue that participants may not be able to adequately express the nuances of their experience, and that the analysis may not be able to capture the phenomenological differences between interviewees through the use of language alone. This is especially valid in the context of the post-modern concept of language constructing rather than describing reality (Burr, 2015; Willig, 2013). In addition, and although not directly relevant to this study, Willig queries IPA's potential exclusion of participants with, for example, cognitive impairment leading to difficulties with speech.

Willig (2013) also critiques IPA for not taking into consideration the historical or contextual factors contributing to the construction of the meaning of participants' realities. She explains that phenomenological approaches are concerned with how the world presents itself, (experiences as described by individuals), but that it does not make claims about the nature of the world, (the explanation of experience). Willig therefore queries what can be uncovered

from participants' experiences given the temporal limitations of their reports, and a lack of focus on the conditions that contribute to them.

Finally, and in connection to the previous point, the language of IPA, such as 'emerging themes' (Smith, Flowers & Larkin, 2009) suggests a form of discovery rather than co-construction. Although IPA acknowledges that the researcher is implicated in the analysis (the interpretative element), Willig (2013) states that it does not inform researchers how to avoid this becoming problematic. Therefore, throughout this work the researcher will endeavour to acknowledge the inevitability of the double hermeneutic of co-construction between participants and researchers (Smith, 2004). Attempts to adhere to the analytical process in ways which seek to avoid any potentially deleterious effects of the current researcher's contribution to it, will also be discussed.

The researcher kept in mind these limitations throughout the entirety of the analytical process, in order to reduce the impact of them on the interpretation of the data, and to also remain aware of the boundaries of interpretation.

2.4 Consultation

From the outset of the project, the researcher consulted with a current NQCP on a number of topics, including her experiences of using IPA in research and her recent experiences of working in a CAMHS service in the South of England. This eventually led to completing a pilot interview with her, as she would have been a viable candidate to participate in the research if she had not been contributing in this consultative role.

Following this pilot interview, the researcher was able to reflect with the consultant about her experience of the wording and delivery style of the questions. She provided feedback which allowed a honing of the interview schedule to increase the likelihood that it would produce responses from participants which were relevant to the research aims and questions.

Experts by clinical experience, or their carers, have not been involved in this study, due to the research not being directly related to any particular clinical treatment or therapy.

2.5 Participants

This section will cover the inclusion and exclusion criteria put in place for recruitment, the sampling and recruitment strategies, as well as demographic information regarding the recruited participants.

2.5.1 Inclusion and exclusion criteria.

For reasons provided in the previous chapter, NQCPs within this research were defined as CPs who had been qualified for less than two years. Additionally, this study only sought NQCPs who were in more than half-time NHS roles, in order to identify the experiences and potential challenges for those who are substantially integrated and involved in the workings of the NHS.

The research also only included NQCPs working within CAMHS services, in order to provide a homogeneity between participants, as advised in IPA studies (Smith et al., 2009). CAMHS was chosen over other clinical settings because of the financial and political context discussed in the 'Introduction' chapter, and its effect on CAMHS, as well as the researcher's supervisors' extensive experience as clinicians within CAMHS.

Participants were likely to be fluent in English due to this being a requirement for CPs working within the NHS, given their clinical responsibilities and the necessity of communication with patients and staff teams. Nevertheless, this was also an inclusion criteria due to the issues around nuance and complexity of the expression of experience, which the researcher felt would not be met if participants were not fluent in English.

2.5.2 Participant sampling.

A fairly homogenous sample is recommended for IPA studies (Smith, Flowers & Larkin, 2009). A purposive sampling approach (Tongco, 2007) was employed to ensure that the participants were homogenous in terms of their working hours and remit (for example, working as part of a multi-disciplinary environment), but similarities were not required in regard to other potential characteristics such as participants' ages or ethnic backgrounds. This allowed a certain level of natural variability between participants that reflected the diversity of NQCPs.

2.5.3 Participant recruitment.

The researcher utilised two recruitment strategies in order to seek out NQCPs working within CAMHS settings.

Following receiving ethical approval for access to NHS staff (please see '2.6 Ethical Considerations') via the Health Research Authority (HRA), the researcher shared a summary of the research via a recruitment advert with collaborators from the named NHS CAMHS services (as outlined on the HRA application), by email, to disseminate to staff they identified as meeting the inclusion criteria. It was important to consider the wording of the

advertisement for recruitment, in order to not unduly influence the expectations or potential responses of potential participants. This recruitment advert can be found in Appendix E.

The researcher also shared this summary advert with current and ex TCPs from various universities, who he knew in a personal capacity. This was in order for them to share this with their own contacts who may be interested in the research. Interested parties were then able to contact the researcher.

2.4.4 Participant information.

This research involved the interviewing of seven NQCPs, in line with the range of 6-8 participants expressed as appropriate when utilising IPA in doctoral psychology research, (Pietkiewicz & Smith, 2014; Turpin et al., 1997). One male and six females were recruited. The age range of participants was from 30 to 33 years old. One of the participants identified as British Bangladeshi, one as British Indian, and five as White British.

Table 1 displays the participants' IDs, demographic information, and pseudonyms, with the latter being used throughout the remainder of this document:

Table 1
Participant Demographic Information and Pseudonyms

Participant ID	Age	Gender	Ethnicity	Pseudonym
#1	33	M	British Bangladeshi	Amit
#2	32	F	White British	Sian
#3	30	F	White British	Helen
#4	32	F	White British	Mary
#5	32	F	White British	Katherine
#6	30	F	White British	Christine
#7	31	F	British Indian	Frida

2.6 Ethical Considerations

This section will cover how ethical approval was obtained and the particular ethical issues of relevance to this study.

2.6.1 Ethical approval.

In order to gain permission to conduct the study, as well as to protect the safety of participants (Madill & Gough, 2008), the researcher applied for ethical approval from both the host University, (protocol number: LMS/PGR/UH/02699), as well as from the Health Research Authority (HRA). The latter ethical approval permitted contact with NHS members of staff, to aid the aforementioned recruitment strategy. The Ethics approval notification from the University can be found in Appendix F, and the letter of HRA Approval can be found in Appendix G.

2.6.2 Informed Consent.

Participants were required to read a Participant Information Sheet (PIS; please see Appendix H) and sign a Consent Form (Appendix I) before agreeing to take part in the study. This allowed them an opportunity to make an informed decision about their participation.

The PIS was shared with potential participants over email, to avoid any information being new for participants prior to interviews commencing, and to allow participants to ask the researcher questions in advance of meeting.

In addition, the PIS and Consent Form informed participants that they would be able to withdraw their interview from the research process any time up to two weeks after their interview was recorded. This was in order to avoid the loss of interviews for the study at a

point in time where it would prove difficult to conduct new ones, given the time constraints of the research.

2.6.3 Confidentiality.

In order to maintain confidentiality, all interview recordings and transcriptions were anonymised, coded, and kept securely, in line with the Data Protection Act (1998). Once uploaded, the audio files were password protected. The transcription documents were also password protected, and only the research team had access to them. All transcripts and recordings will be stored in University archives once the research is complete and they will be destroyed after five years, in accordance with University policy.

The PIS informed participants that their interview would be transcribed by either the researcher or a professional transcription service. Data was transferred to this service via secure means. It was necessary for the transcription service to sign a non-disclosure, confidentiality agreement to protect participants' anonymity and confidential information. This can be found in Appendix J.

Each participant's recording and transcript was given a matching numerical code (for example, #1) and participants were referred to only by their numerical code, for example when discussions took place between the researcher and his supervisors. Participants were informed that direct quotations would be used in the research, and agreed to this as part of the consent process.

Audio recordings were not intended to include any personally identifiable information; participants were not asked their names during interviews and asked not to disclose the

service they worked within, or their employer. Identifiable information that was disclosed by accident, such as the name of a colleague, was removed in the transcription process. Every effort was therefore made to protect the identities of participants.

2.6.4 Risk of distress to participants.

The research team did not foresee any risk of harm to participants, however interview questions may have reminded staff of challenges within their work which could have potentially been emotionally-loaded. Interviews did not include questions around highly sensitive areas or where accidental disclosure would have serious consequences. It was highly unlikely that any criminal or other disclosures could have occurred during the interviews, however in the event of this, the researchers were prepared to follow the guidance stated in the PIS.

At the end of the interview, participants were given the opportunity to feedback to the researcher and discuss any difficult emotions that were brought up during the interview. The researcher used his experience of working therapeutically as a TCP, drawing upon his clinical skills in order to gauge whether a break or a discontinuation of the interview was necessary. No interviews were paused or discontinued due to distress experienced by participants.

2.7 Development of Interview Schedule

Biggerstaff and Thompson (2008) discussed that an interview schedule for an IPA study should be a “basis for a conversation” (pg. 181) and that a prompt sheet should be drawn up. The researcher and principal supervisor therefore drafted a semi-structured interview schedule together, based on the guidelines outlined for IPA interviews by Smith, Flowers and

Larkin (2009). The main topics covered by the interview were transition, contexts, and coping.

It was important to consider the wording of the questions within the interview schedule, for example leaving them open so that experiences of participants emerged, rather than asking leading questions. As discussed, this schedule was used for a pilot interview with a consultant, and subsequently modified, following further discussions with both her and the principal supervisor. Specifically, amendments to the order and wording of questions were made. The final version of the full interview schedule can be found in Appendix K.

2.8 Interview Procedure

On each occasion, the interviews took place in confidential spaces, but where possible, in a location of the participants' choice, for example their work setting or home. Participants completed one interview each, which lasted approximately one hour. Following the interviews, the researcher briefly discussed with interviewees how they had found the experience, and how they were feeling following it. This was in order to gauge any difficult feelings it had provoked in them, in case they required any further support.

Following each interview, I reflected upon my experience of it, which was useful in informing the writing up of the 'Results' chapter, as it allowed me to discuss my experiences with my supervisors, and bracket my own thoughts and feelings about the participants' experiences. This bracketing process is recommended in qualitative research in order to "mitigate the potentially deleterious effects of preconceptions that may taint the research process", (Tufford & Newman, 2012, pg. 80), and helped me maintain a fidelity to the analytical process of IPA.

2.9 Data Analysis

The researcher analysed the interviews using IPA methodology (Smith et al., 2009), and transcripts were analysed one at a time, in line with the idiographic nature of IPA. It was necessary to read the transcripts several times to engage in ‘immersing’ myself in their content (Smith et al., 2009). At first, notes and reflections were made on three levels of analysis; descriptive, linguistic, and conceptual, as recommended (Smith et al., 2009). Key phrases and specific comments which reflected participants’ experiences, as well as possible interpretations, were highlighted.

Following this, for each transcript, a line-by-line analysis was then conducted on the participants accounts, whilst the reflections that had been made were also taken into account. This line-by-line analysis, repeated a number of times for each transcript, brought to light emerging themes.

As one of the participants’ personal experiences and difficulties from both her childhood and clinical training resonated with, and were similar to, my own life experiences, I felt very connected to her during the interview. However, this also made me consider whether this could lead me to projecting my own feelings and thoughts into what she was relaying to me.

Therefore, when analysing her transcript, I attempted techniques which allowed me to process the data as much as possible in isolation from my own ‘lifeworld’ (Brooks, 2015), for example by reading some sentences backwards in order to focus on the words in their own right (Smith et al., 2009). I attempted to maintain an awareness of my own view of how she may have felt at these times, based on my own template of my own experiences, in the

knowledge that this could affect my perception and interpretation of her personal experience. As a result, I endeavoured to remain committed to elucidating her personal, phenomenological experience as far as possible.

Subsequently, these emerging themes were pulled from each document, and the researcher engaged in a process of clustering them into four or five groups, titling each. Methods such as ‘function’, ‘numeration’ and ‘contextualization’ were utilised (Smith et al., 2009), which refers to the varied processes of identifying clusters of themes by their function, frequency, or temporal location, respectively. Pertinent participant quotes were used at times to name themes, in line with the phenomenological aspect of IPA, and this continued throughout the process. Added to these clusters and themes were examples of the quotes from which they had emerged, in order to keep the analysis grounded in the text, and also aid the writing up of the ‘Results’ chapter.

In Appendix L, an excerpt of one of the transcripts can be found. This is annotated with the analysis conducted upon it, with reflections on the left-hand column and emerging themes on the right. Appendix L also includes the list of emerging themes which were identified from this transcript, and the clustering of them, with relevant quotes.

Once this process of clustering themes and adding quotes had occurred for every transcript, a process of cross-referencing ensued. This involved looking across the seven documents of clustered themes, and working towards the identification of super-ordinate themes which reflected numerous clusters or themes across the interviews. Differences, as well as similarities, were highlighted, in order for the super-ordinate themes to be identified. This is

due to the importance of highlighting divergent ideas, as well as the convergence of experiences, between cases within an IPA process (Smith et al., 2009).

Appendix M is a table which was developed in order to aid the process of cross-referencing similar themes that had emerged across transcripts, to work towards the highlighting of super-ordinate themes of the entire data set. Following this process, a list of super-ordinate and sub-ordinate themes for the whole data set was compiled, which can be found in the 'Results' chapter.

During this entire process, the researcher's supervisors were involved in quality checks of the analyses, and the clustering of themes for individual transcripts, for example that which the excerpt in Appendix L is taken from. Additionally, they contributed to the process of cross-referencing sub-themes across transcripts, which led to the emergence of the final super-ordinate themes. This was imperative to ensure that the analytical process remained loyal to each original transcript, without allowing the author's own experiences, biases and beliefs, or ideas from previous transcripts, to permeate a stringent and systematic analysis.

2.10 Quality Assurances

The quality standards employed in quantitative research, such as reliability and validity, do not apply in the same manner in qualitative research, often due to the difference in epistemological standpoint, such as the former's position of neutrality and search for objective truths (Mason, 2002).

Nevertheless, many guidelines for evaluating the quality and validity of qualitative research have been developed (Elliot et al., 1999; Yardley, 2000; 2008), with Yardley's applied to IPA

studies on numerous occasions, (Smith et al., 2009), and recommended as the most appropriate for explicating the validity of an IPA study (Hefferon & Gil-Rodriguez, 2011).

Yardley (2008) highlighted four areas that qualitative research should be measured by; sensitivity to context; commitment and rigour; coherence and transparency; and impact and importance. These will be discussed in turn below. In addition, Appendix N provides a further evaluation of the quality of the present study, based on guidelines by Elliot et al. (1999). This will also be referred to again in the ‘Discussion’ chapter.

2.10.1 Sensitivity to context.

The study has utilised a systematic review of the literature. This allowed for an understanding of what the literature can already tell us, and identified a gap in knowledge which helped inform the research question. This sensitivity to context has contributed to demonstrating the validity of this study (Yardley, 2008). This followed a general exploration within the ‘Introduction’ chapter, of the relevant socio-cultural context relevant to CAMHS services, also recommended by Yardley. Moreover, the researcher had some awareness of the CAMHS context having completed a six-month clinical placement in a service in the South of England.

The current researcher’s statements of his personal and epistemological positions provide transparency and offer the reader an awareness of his perspective and the contexts from within which he is working out of. Therefore, the researcher has maintained a sensitivity and awareness of not only the context of his participants, but also his own. This has also allowed him to consider how this may impact, potentially deleteriously, upon the study. The researcher hopes that this can be avoided by a continuous process of self-reflexivity, which

he will continue to illustrate at various junctures of this document, by reflections printed in italics. These have been taken from the diarised reflections he made throughout the research process. Additionally, the researcher utilised bracketing (Biggerstaff & Thompson, 2008; Tufford & Newman, 2012) with other IPA researchers, and also his supervisors, in order to maintain sensitivity to the analytical process, and avoid his own biases and assumptions being projected into the data.

The use of a consultant in interview development, as well as the completion of a pilot interview with her, allowed the researcher to become aware of the relevance and sensitivity of potential interview questions. Following this pilot interview, participants were given some choice as to the location of their interviews. The researcher was also mindful of the potential sensitivity of the information they divulged, and allowed participants to ask him questions, or stop the interview at any time, in order to put them at ease, thus being sensitive to “the interactional nature of data collection within the interview” (Smith et al, 2009, pg. 180).

Furthermore, within the ‘Results’ chapter, it will become clear that the idiographic nature of IPA has helped uphold a sensitivity to the individual contexts of participants. The divergences between their experiences (Smith et al., 2009) have been highlighted, for example through the use of quotations from the interviews.

2.10.2 Commitment and rigour.

The researcher’s ethical applications, leading to both university and NHS approval, were rigorous in their evidencing of the awareness of ethical issues relevant to this study, as summarised earlier in this chapter.

During data collection, a commitment was made to put participants at ease, as described previously. The researcher was rigorous in his efforts to carry out a stringent analytical process, and attended practical, group analysis sessions, led by his principal supervisor, as well as a specialist IPA lecture at the university. The principal supervisor also carried out quality checks on two of the interviews the researcher had analysed, which was beneficial for a number of reasons, including to help focus the researcher on the specific words and phrases used by participants, which aided the process of identifying emerging themes. The researcher's inclusion of an example of the analytical process (Appendix L) is an attempt to provide the reader with evidence of the rigour of the process.

Rigour has also been evidenced by both the pilot interview process, as well as the process of bracketing. The latter not only included discussions with supervisors and colleagues, but also diarised reflections (Ahern, 1999), with selected excerpts shared in this document. The researcher hopes that his efforts of commitment and rigour will be evidenced by these reflections. The researcher is also optimistic that his efforts will be exhibited by a comprehensive 'Results' chapter, that adds a breadth and depth of new insights to the subject matter under exploration (Yardley, 2008).

2.10.3 Coherence and transparency.

Yardley (2008) discussed transparency as how clearly a reader can see what was done in a study and the rationale for each of the steps. This began with the systematic review, which allowed the researcher to provide a rationale for the current study. The researcher has also been transparent in his consideration of various research methodologies, provided a rationale for the selection of IPA, and discussed its limitations.

With regard to the analysis process, the researcher has evidenced a significant portion of an analysis of a transcript, and the steps involved, in Appendix L. The researcher has also attempted to provide coherent narratives, both in the 'Introduction' chapter, and also in the 'Results,' with the use of quotes in the latter offering transparency to the actual reports of participants.

The transparent accounts of each of these steps will allow the readers to judge for themselves as to the quality and validity of this study.

2.10.4 Impact and importance.

Yardley discussed that the impact of a study, and its potential to make a difference, is intrinsically related to its validity. Little research has been conducted in this subject area, and the researcher hopes that through participant accounts, important information will emerge that may be useful to trainers, employers, and newly-qualified CPs, as well as, potentially, staff from other disciplines. Clinical implications and recommendations will be made in the 'Discussion' chapter.

Chapter 3: Results

3.1 Recognising the ‘Hermeneutic Turn’

This ‘Results’ chapter presents a narrative of the researcher’s IPA analysis of the experiences of NQCP’s in CAMHS MDTs. It is important to recognise the inevitable double hermeneutic (Smith et al., 2009) at play in this process; a researcher attempting to make sense of the participants own sense-making. Nevertheless, the researcher believes that the value of the analytical process he has engaged within is upheld by the measures he has taken to ensure the rigour and legitimisation of this process (Elliot et al., 1999) and that other researchers would have acknowledged the pertinence of the following themes by reaching and producing similar outcomes.

It should also be acknowledged that a third layer of meaning-making and understanding is added to this hermeneutic process, in that the reader of this chapter will unavoidably integrate their own meanings, perceptions and biases into their reading of the presented outcomes, and thus into their understanding of them (Smith et al., 2009). The results are therefore brought into light by the joint efforts of participants, researcher, and reader, influenced in part by a degree of shared social context and understanding of various words, ideas and concepts; they are socially constructed (Nel, 2006).

3.2 Summary of Themes

Table 2 illustrates the three “super-ordinate themes” (Smith et al., 2009, pg. 107), and their sub-themes, which emerged from the analytical process.

Table 2
Super-ordinate and Sub-ordinate Themes

Super-ordinate Themes	Sub-ordinate Themes
A big jump: the transition from TCP to NQCP	<p>The challenge of increased responsibility.</p> <p>Feeling overwhelmed at the outset of the transition.</p> <p>Self-doubt and feeling de-skilled.</p> <p>The loss of the luxuries of training; time and space.</p> <p>Feeling the impact of the pressures of CAMHS.</p>
The support of home comforts, old and new	<p>The benefit of seeking external support.</p> <p>The importance of support from supervisors and the wider MDT.</p> <p>Benefits of training experiences.</p>
Acknowledging and desiring ongoing development	<p>A drive for more.</p> <p>Growing confidence.</p>

3.3 Presentation of Outcomes

This chapter will attempt to illustrate not only the “commonality” between participants’ experiences, but also their “individuality” (Smith et al, 2009, pg. 107). This will involve a narrative presentation of the above themes, dovetailing with relevant quotes⁴ from the interviews, to offer sensitivity to context (Yardley, 2000) and allow the reader to check the interpretations that have been made (Elliott et al., 1999). Participants have been given pseudonyms to preserve their anonymity and maintain confidentiality. The researcher hopes

⁴ Where quotes are provided to support the narrative presentation of themes, all potential participant identifiable information has been removed, such as names of colleagues or places. This will be denoted by parentheses, for example ‘(the young person)’. Any additional words inserted into the text to clarify meaning are indicated by brackets, for example ‘[is]’. Parts of extracts which have been removed for the sake of brevity and to improve readability will be indicated by the following ellipsis: ‘...’.

that this chapter succeeds in bringing the participants' experiences to life, stimulating a "resonance in readers" (Elliot et al., 1999, pg. 224).

3.4 A Big Jump: The Transition from TCP to NQCP

3.4.1 Overview of super-ordinate theme.

This first superordinate theme subsumes the participants' experiences of the transition from TCP to an NQCP working in CAMHS, including illustrations of the stark differences they felt existed between clinical training and their new role, and the emotional experiences that arose for them in response. Although participants shared some common experiences, divergence (Smith et al., 2009) in the impact of the transition and their responses to it will also be presented.

3.4.2 The challenge of increased responsibility.

This sub-ordinate theme articulates the participants' acknowledgment of, and emotional responses to, the increase in responsibility of the role, in comparison to when they were TCPs.

Katherine used the metaphor of various jumps she has made since qualifying throughout her interview, including in relation to the increase in responsibility she experienced. In the very first sentence of her interview, she mentions, almost out of context, 'the level of responsibility', before returning to the topic to explain:

I had a lot of responsibility... Child-In-Need Plans and Child Protection Plans... clinicians like Key Workers... Social Workers [were] expecting me to make... quite serious decisions...

At the end of the interview she comments:

I knew I was going to talk about the jump of responsibility... knew that was gonna come outta my mouth...

This revealed that when thinking in advance about the interview, Katherine had highlighted this increase in clinical responsibility as a significant aspect of her transitional experience to be discussed. Katherine both started and ended her interview talking about this change, and these quite serious decisions she had to make were evidently a testing facet of her professional progression.

A similar metaphor to describe the change from being a TCP to a NWCP is used by Frida three times, including:

...the biggest leap is in terms of accountability and responsibility...

These repeated metaphors of jumps and leaps in responsibility across the interviews indicate that this move forward in participants' careers felt significant in its scale. Additionally, this connection of increased responsibility and feeling accountable for the safety of the young people, by Frida, is evident across participants' interviews:

...the difference between being a trainee and being fully qualified has been quite big for me in terms of managing risk... throughout the Doctorate I didn't really have that many risky cases, I felt... protected from that... coming here and dealing with really risky kids... hospital and... overdoses... that was really eye-opening... (Maggie);

...the transition was quite difficult... a bit of shock and you really don't feel like a trainee anymore... all of a sudden you realise that you're responsible... for all of your clients... when you go through training... if anything goes wrong, it's on your supervisor's head... Whereas now it's definitely on yours... you feel a bit responsible for somebody else's life (laughs nervously)... (Sian).

Sian begins this last sentence tentatively before being able to vocalise the gravity of feeling responsible for the lives of her clients. She minimises the statement slightly, preceding it with ‘kind of... a bit’ and then laughs nervously, indicating that this was a particularly difficult aspect of the transition to manage.

Sian was also able to pinpoint that the change in responsibility was not just about managing a bigger caseload and having more work, but that she felt more responsible for the safety or futures of the young people she saw. She later goes on to reveal something of her fear of accountability, and the perceived dangers involved in this responsibility:

...you really don't want... your head to be on the block... you don't want to have massively fucked up... missed something that means that somebody... has done something really dangerous...

This resonates with Katherine's prior comment on the ‘quite serious’ decisions she was expected to make, and not only alludes to the new level of import the participants felt their decisions had, but also that there could be significant consequences to them, such as serious incidents of self-harm or suicide attempts by young people.

Furthermore, Sian discusses a feeling of isolation within this experience of an increased responsibility:

...all of a sudden you realise... you are on your own, and it is your responsibility...

Interestingly, only two other participants discussed feeling alone or isolated in the transition:

I went in as the only Clinical Psychologist... and having to take on the responsibilities of being the only Clinical Psychologist... was a huge leap for me... (Frida);

...in my first year post-qualification, I did feel really quite isolated... (Katherine).

These three participants connected their new levels of responsibility with accountability, indicating that feeling isolated and unsupported in the role was connected with a heightened awareness of the seriousness or danger inherent within the work, and a fear of getting things wrong leading to serious consequences.

Managing the safety of vulnerable clients, and the associated unease this elicited within participants, was evident across the interviews, but clearly more so for those who felt alone or isolated at the outset of their transition. This is a good example of differing experiences between participants, and also illustrates the importance and impact of context, a subject which will be revisited in due course.

This difference in intensity of experience was also reflected in how I felt in the room when conducting the interviews. Sian's portrayal was particularly vivid, her 'head on the block' quote still fresh in my memory, and I remember leaving the interview wondering if I could work in CAMHS following my own qualification. This was a powerful indicator to me of the degree of the challenge she had faced with this sudden increase in clinical responsibility and new feeling of accountability for the safety of her clients.

This may also be seen as a useful illustration of the importance of recognising the double hermeneutic; this experience stood out to me, where it may not have, as plainly, to another researcher. It was important for me not to be led by my own feelings of what was significant within the interviews, and maintain a fidelity to the analytical process. As is evident,

however, this experience was also pertinent to other participants, leading to its inclusion in this chapter.

3.4.3 Feeling overwhelmed at the outset of the transition.

This sub-ordinate theme is for one participant explicitly connected to the step up in clinical responsibility discussed in the first, but overall it speaks more generally to participants' experiences of the change in working schedule and increase in clinical workload. This emotion, when not explicitly stated, was often illustrated by them expressing their previous feelings with exclamations such as 'oh my God!', and usually in reference to how they felt at the very beginning of their new roles as NQCPs.

Amit discussed feeling overwhelmed in relation to an increase in the amount of clinical days as a NQCP, in comparison to working as a TCP:

...five days and a full caseload... immediately speaking that felt quite overwhelming to... manage, manage working... that's quite a difference and required some thinking about in terms of how to manage...

We can see Amit's repeated use of the word 'manage' indicating that dealing with this feeling was not easy for him, and he later added:

I really, immediately, did genuinely... think oh my God, five days a week does feel like far too heavy work... I want to be back in Uni...

The word 'heavy' speaks to him feeling weighed down and emotionally overloaded or overwhelmed, and he admits to wanting to retreat to his previous stage of employment and training. He presses home his emphasis of the seriousness of this by using words such as 'really' and 'genuinely', to illustrate that this was too much for him to cope with initially.

This language is repeated by Hannah when talking about the early days of her new role:

I couldn't, couldn't manage the sort of amount of emotional and kind of workload that... one case caused.

The repetition of the word 'couldn't' suggests that both the workload and the related emotional response to a particularly difficult case was too much to manage at the outset of her transition. This is reflective of the participants' experiences of their clinical work practically and emotionally weighing heavily on them immediately after qualifying.

Maggie said, in relation to holding risk:

I remember thinking ohhhhh myyyyy Gooooodddd!... yeah out of my depth... is definitely how it sums it up...

Her elongated vocalisation of the words emphasise the strength of feeling that this transitional change elicited for her, and this feeling of being out of her depth was a common occurrence across many of the interviews.

Maggie also shared two further metaphors when discussing the challenges at the beginning of her transition, and reiterated the difficulty Amit expressed of the increase in clinical hours:

...coming into... CAMHS... long days... I remember speaking to one of the psychologists... she... used to talk about being a sponge and [her] sponge would get really full... [the team's] bucket's quite full or I'm feeling like I'm overflowing... that's been a huge transition...

Maggie's language is vivid and evidences that the increase in clinical work, in comparison to the training schedule of 2.5 days per week, is a 'huge', challenging change to manage for NQCPs.

In the above quotes, Amit also uses the word 'immediately' twice, and this immediacy of the emotional response is something that is shared by a number of participants. Katherine admitted:

It was quite stressful... I did feel... I suppose at the beginning, a little bit out of my depth...

Helen repeated that this change happened 'all of a sudden' no less than three times, and this is also reiterated by others:

...all of a sudden you're working full time... (Sian);

...once you get... your badge that says Doctor... the Clinical Psychologist, suddenly you feel... oh shit... (Frida).

Furthermore, Helen was explicit in portraying her experience of feeling overwhelmed:

I remember feeling like really kind of overwhelmed with aaahhh like I've just kind of started and it felt quite overwhelming... [I] felt a bit woah, like woah... that was really sort of overwhelming...

These comments all share the notion that feeling overwhelmed was experienced soon after beginning the role. The phrase 'out of my depth' also brings to mind a further idiom of 'being thrown in the deep end,' and perhaps conspicuous by its absence was no participant discussing any experience of being able to bed in to their new roles. These participants shared an experience of feeling there was much to do from the off, with Helen's repeated use of the

word 'woah' quite tellingly signifying a wish for things to slow down or to stop, in order for her to not feel so overwhelmed.

3.4.4 Self-doubt and feeling de-skilled.

This sub-ordinate theme speaks to the near-universal experience for participants of feeling self-doubt, a lack of competence, or de-skilled, in the early phases of taking on their new roles. These feelings appear to arise in the context of experiencing a perhaps unhelpful level of self-expectation, believing that their service had challenging expectations of them, or indeed both.

One participant to talk to this quite frankly was Maggie:

I guess there was a bit of self-doubt to begin with...

She also suggested that she had expectations of herself to be able to help young people who were at risk of harm to themselves, at the outset of working with them:

...(the young person) who had taken an overdose before our session, when I first started working with them, I was like oh, how am I ever going to help?...

One could also wonder whether this expectation may have partly arisen from the organisational or workplace environment, which will be explored in depth in a later sub-theme.

Sian made similarly open comments about when she started as an NQCP:

...it was like - I know nothing... when you don't have the teaching anymore, you kind of perhaps lose sight of well, what are my skills?

She placed feeling deskilled within the context of no longer receiving lectures, as she did during training, which may indicate her experiencing this teaching as a useful scaffold that has been removed.

Sian's experience of self-doubt also appears to be connected to her perceived expectations of her role. She briefly expressed her wish to help others, but also reported feeling that she needed to know what to do because she was the first CP in her team:

...going into a team where there hadn't been a Clinical Psychologist before... it's like okay well I need to figure out... what are my skills?

This repeated questioning of what her skills are, in the present tense, brings home the strength of feeling and questioning of herself she experienced at the outset of her transition. She felt there was a 'need' to know what she would offer the team, as the only CP. Christine was also the only psychologist in her team:

I initially found myself going in where I was the psychologist of the team... positioned more as an expert.

This expert position seems a difficult one to hold for her, with the word 'more' suggesting a comparison to when she was a TCP and not being positioned in this way. She twice repeats how she remembered feeling that she didn't know what she was doing:

I feel very new and I don't really know what I'm doing...

Christine continued to discuss this and her memory of this period of her transition intensifies:

...oh my God, where do I even begin?... ok I'm qualified... I know the things that I've learnt and... can call myself an expert in some ways, but I don't feel that yet...

Similarly to Sian, Christine speaks in the present tense, and participants often spoke thoughts from the past aloud in this way. This made me wonder if this feeling, and others, were still present in some way, or if the transition was just such a difficult time that the thoughts they experienced were readily accessible to them. It will be evident in a later sub-theme that these participants express feeling more confident and settled in their roles, so perhaps this reverting to the present tense illustrated the level of difficulty they experienced in the recent past and remembered so sharply. Nevertheless, it appears that these feelings may have lingered.

Participants illustrated how these high expectations, or aspirations, led to them experiencing intense self-doubts. Christine thought back to a point in time where she questioned her future in the profession:

Oh my God, what am I doing? Why can't I hack it? Everyone else is hacking it um, what is it about me? Maybe I was never meant to do this job...

This is clearly a powerful communication and gives a flavour of the degree of difficulty some of the participants experienced. After spending a significant amount of time completing a clinical training programme, early in her first role Christine feels that she might in fact be in the wrong career. She compares herself to others, who remain abstract in the interview. This may be her perception of other NQCPs, or her more experienced colleagues. Either way, her experience was one of immense self-doubt, and feeling significantly unsettled.

Other participants had similar experiences, but some nuanced differences were evident. Frida and Amit were not the only CPs in their team in their first roles, but both discussed the expectations for them which came with the title, which may have been detrimental to them:

...starting as a Clinical Psychologist there was a sort of expectation of being just able to crack on with it... myself and... it took some getting used to... (Amit);

I felt... I'm a Clinical Psychologist, I should have this knowledge... (Frida).

Amit goes on to concisely sum up what appears to have occurred for all of the participants mentioned:

In the early days I felt... not very capable, not very competent, there was a sort of feeling you know, 'am I in too deep with this?'... so a little bit of feeling of am I capable?

This is perhaps not as intense an experience as Christine's, but evident once more is a participant's consideration of whether this is actually what they want from their work. Is it too much? Are they in too deep? There was an expectation of expertise and an ability to immediately manage, for example, their new responsibilities, which may not have been realistic, either from themselves or their services.

Amit's quote neatly connects our first three themes; he feels that he's jumped into deep waters, that it may be too much, and that he has ended up not feeling capable. The jump in transition had an intense emotional impact on participants, causing them to question their competence and ability to manage.

3.4.5 The loss of the luxuries of training; time and space.

The penultimate sub-topic of this overarching theme concerns the participants' experiences of what the jump into qualified work has meant in terms of what they have lost since leaving their clinical training programmes. Simultaneously, this brings into light some further challenges of their transitions not yet discussed.

A number of participants compared their experiences of thinking time and space as a NQCP to that as a TCP during their clinical training:

I can't reflect as much as the university taught me... I can't plan as thoroughly for sessions...
(Katherine);

...a huge reduction in thinking space... you're used to having time to be able to give a lot more to your clients... whether that means that training doesn't quite match up to the realities [of CAMHS]... that was quite a challenge... (Christine).

The latter quote throws up the question of whether training in some ways does not match or meet the needs of certain students, for example those who will go on to work full-time in CAMHS. This is commonly expressed across the interviews, with a number of participants questioning whether it is possible to be prepared for work in CAMHS, which again highlights an acknowledgement of how difficult they experienced their new roles to be:

[CAMHS is] quite stressful... I don't think anything prepares you, I don't think... the Doctorate can prepare you for... [CAMHS] life ... (Katherine);

...whether it's that we needed to be doing more towards the end of placement to match that reality of what it's like to be qualified... it's tricky because I think you're never going to map onto everybody's experience (Christine).

These participants acknowledge that the difficulties they are experiencing may not be due to their training programmes, which they recognise are unable to prepare every student for what they will experience in their varied roles as NQCPs. They discuss that training programmes

are in a difficult position because although students are exposed to a breadth of knowledge, more specialist preparation for everyone may not be realistic:

...[her clinical training programme] can't win, it really can't win... (Sian).

Christine developed her ideas further by expressing why her work is difficult, namely because of a reduction in time to think:

...you might have on placement the luxury of lots of time to be thinking... that's taken away, so training might have really prepared you, but the absence of that is what makes it challenging.

In just two brief sentences, Christine says that 'time to be thinking' or 'headspace' has been 'reduced,' 'taken away' and is 'absent', repeating and emphasising her ideas by using various synonyms. She highlights that training did prepare her for clinical work, but that the lack of time to think about it in a full-time CAMHS role is challenging; a pertinent point.

Evident in these last two excerpts is that Christine's experiences may have led her to some level of uncertainty about whether space to think was a 'luxury' of training, or a necessity for her current workplace, expressed in the following questions:

...was that just a luxury of training... this [is] what it was always going to be like and I'm just adjusting to that? Or is it that I'm actually lacking that space that I need to do my [work]?

Sian and Katherine also used the words 'luxury' and 'privilege' to describe what they previously had as trainees, which is now absent, emphasising the fact that this was valued highly in their training years, but also how much it is now missed:

...opportunities for discussion about working with clients... there's not that luxury anymore.

You need to find the time, I think that's the luxury [of training]... (Sian);

...you get amazing lectures and we don't get that here because we don't have time... we had the luxury of, as a trainee... time to kind of plan sessions... I certainly miss what I now see as a privilege of being able to go into Uni... (Katherine).

The loss of time for thinking, planning, and learning were common for these participants. In combination with Christine's earlier comment on the 'realities' of clinical work, these shared experiences bear witness to the challenging nature of CAMHS for NQCPs, in terms of the lack of time and space there is to think about clients, especially in comparison to when they were TCPs.

Importantly, participants also suggested that this lack of time may be directly problematic for the young people and families they see, for example in preparing therapy sessions:

...clinicians... have absurd amounts of admin to do... that will mean that they have less time for clinical thinking and reflection... that's going to have a negative impact on how they treat [clients]... (Amit);

...if I plan [sessions] it's just thinking very quickly about what I'm gonna do, which isn't ideal... it's not good... (Katherine);

...less time to think, to read... to prepare for sessions... those things that I think are really, really important... I do think it's very short-sighted of the systems we work in... you could argue if we had more time to do those things maybe we'd need a shorter amount of time to see our clients... (Christine).

This is a vitally important point to consider; the lack of thinking time is not just causing clinicians to feel challenged, but may also lead to the treatment received by clients not being

as efficient or effective as it could be. Participants worry about the impact of their own transitions, as well as the contextual factors which contribute to this, upon their clients, and wonder if it could be changed or improved for everyone's benefit.

This sub-ordinate theme illustrated the experiences of a loss of time and space for NQCPs in their clinical work, which they now consider to perhaps only be a luxury of clinical training. This section highlighted that there may be a challenge for training programmes to provide TCPs with experiences which accurately mimic a CAMHS environment, in order to prepare students for what they may move on to. On the other hand, this theme brings to light participants' questioning of whether their CAMHS environments are guilty of not providing the appropriate amount of time and space necessary for adequate clinical work to be completed.

3.4.6 Feeling the impact of the pressures of CAMHS.

This final sub-theme of the first super-ordinate topic concerns the impact of organisational pressures of CAMHS environments on participants' experiences.

A quote from Katherine summed up a number of issues within her context; the pressure of waiting lists, the severity of the difficulties experienced by clients, and the lack of resources in terms of staff:

CAMHS is in a bit of trouble... our waiting times are a year, we've got children saying they're gonna kill themselves and... we're understaffed, we can't recruit... because of the pressures people are becoming burnt out.

This reflects a common view of participants regarding the pressures of the role, and the emotional and physical impact it can have upon them. This is reiterated by a number of metaphors to express how participants felt ‘squeezed’ or ‘stretched’ by their organisations:

...the more... pressure you get, you’re going to be more stretched... (Amit);

It’s just relentless... we are getting inundated with referrals, it feels a bit like a conveyor belt... (Katherine);

Frida raises important questions about the emotional impact of these significant and persistent pressures, and later answers them:

...you’re taking it all in, but where is it going?... is it affecting you physically? Is it affecting... your relationship at home? I think that emotional impact is huge...;

I think it definitely is both; my body and relationships... I start to feel unwell, I start to feel quite lethargic, I... know that there’s been too much and... I need a break...

This reference to there being too much to keep up with, leading to her feeling physically unwell, reiterates Katherine’s comment regarding staff burning out. It is not only the NQCPs who are impacted, however, as participants discuss their experiences of how the pressures within CAMHS can affect both staff and clients:

...the pressures... management and commissioners asking you to take on more and more cases, we’ve got big waiting lists which makes all of us unhappy, including clients...

(Katherine);

...there are some things that are difficult with clients... when they see you they’re frustrated that they’ve waited a long time... those things impact the client and is a consequence of the organisational... pressures... (Christine).

Christine elaborated on her experience of these organisational pressures:

...if things need doing and it's gonna impact your client if it's not done... you do end up staying later because you need to get it done, or you need to attend to something, or you're aware... you've got a really busy day on Monday... that had a big impact on me...

The repetition of the word 'need' reveals the pressure she felt under, and her mention of the 'big impact' of this reflects wider participant experiences of their emotional responses to organisational needs; they are being pushed to get things done and this is causing significant levels of stress.

Catherine explained how this may lead to a cycle of continuous difficulties for all concerned:

I wonder whether... the NHS gets itself in a pickle... the people working in the service say... I owe it to my clients to do this, so we go above and beyond and then we're expected to do more because it's seen as though we're coping... I don't know how we can change that. I mean, we shout about it, we feed back, we... try and actively do what we can...

This was an illustration of an underlying dilemma I heard participants were facing. They were clearly conscientious, caring, and motivated to offer effective therapeutic work, but also frustrated by pressures, restrictions, and the limited opportunities they had to raise their concerns, with those they did have making no impact. They felt unable to move away from the 'conveyer belt' of their roles, however, because that would have meant refusing to support vulnerable and distressed individuals. I wondered about the ethics of this, and whether organisations were keeping staff in mind appropriately.

Also discussed by all but one of the participants, was that a restriction in resources narrowed their roles to more focused, pressurised, clinical ones. Christine repeated that she could not engage in other aspects of what a NQCP could offer:

I'm not actively doing research or teaching and I think it's lovely to think of ourselves as a profession able to do lots of things, but when there's pressures on a service you have to prioritise clinical work...;

...we don't have a lot of opportunity for sort of service evaluation and development...

As well as service development, a lack of opportunities for personal development and growth was widely reported by participants, with financial limitations the reason given by their various organisations:

...there is bugger all opportunities for CPD [Continuing Professional Development], because no one wants to pay any money towards it... (Amit);

I'd like to do some more training on systemic and family therapy practices and always being told oh there's no funding for it... (Maggie).

Amit was open in expressing his feelings about the impact of financial restrictions throughout his interview, and a quote of his reiterates Christine's admission of not knowing how anything will change. This reflected a feeling of powerlessness and frustration across the interviews; participants could see what was problematic within their working contexts, but unable to effect change:

I... [was] quite challenging [to management]... up front about how I feel... I was completely fruitless and ignored.... I have felt, I think, powerless...

Amit's experience of the consequences of financial pressures in his organisation was clearly a very difficult one, and he also explained the significant impact that staff cuts had indirectly made on him:

It has been absolutely miserable... team after team being cut, entire sections of the workforce no longer working... a lot of people de-banded, it's just been awful.

One can only imagine the difficulties this caused for those directly affected. Sian also discussed staff members leaving, in this case of their own accord, but again because of financial difficulties within her service, leading to no further training or possibility for promotion:

...development of staff... did not appear to be a high priority for the organisation... some clinical psychologists... left because there was no further development for them...

These comments reflect the unequivocal difficulties experienced by participants in relation to the lack of professional development and impact of losing staff, due to organisational pressures. These pressures contributed to them feeling undervalued and powerless within the system, on top of being stretched and expected to just keep up with organisational needs and demands.

Interestingly, the only participant not to discuss feeling frustrated, or mention the impact of service pressures throughout her interview was Helen, who was the sole participant to express feeling connected to her senior team:

...clinical directors and people quite high up in CAMHS have their offices very close, so it feels like they are more on the ground.

This leads one to wonder about the impact of factors such as communication between, for example, directors, managers and clinical staff, and the understanding of each other's daily work, on how NQCPs (and other staff members) may feel about their roles.

This sub-theme has honed in on NQCPs' experiences of the pressures of CAMHS, and how this impacted them, as well as the young people they work with. It has highlighted numerous difficulties experienced by participants, including feeling under pressure to do more and more, frustrations with the restrictions of their roles, and that nothing will change. Their experiences of their organisations' financial pressures and subsequent difficulties in supporting both staff development and retention have also been discussed and illustrated.

3.5 The Support of Home Comforts, Old and New

3.5.1 Overview of super-ordinate theme.

This super-ordinate theme envelops the factors for participants which acted as support mechanisms to aid them in their new roles, including them drawing support from established networks, such as their training cohort, as well as finding and utilising new ones, for example their MDTs. It also comprises NQCPs looking back on the beneficial aspects of their training programmes.

3.5.2 The benefit of seeking external support.

This sub-ordinate theme brings together the various support networks sought out by participants, including a continuation of contact with previous trainee colleagues, support from within family or personal life, and, for one participant, the use of personal therapy. This is a good illustration of commonality and difference, in that participants shared a need to seek

out support to aid their transition, which was beneficial, but that they found it in different ways.

Maggie spoke of her experiences of personal therapy:

I was doing it more frequently when I first started to manage the transition I guess, but now I have it about once a month...

It is telling that Maggie used this more so when she first became a NQCP to help her manage emotionally, and she goes on to say that she hasn't had felt this way more recently, supporting ideas within the previous sub-theme, 'Feeling overwhelmed at the outset of the transition,' in that this is experienced at the outset of working as a NQCP:

I've not felt oh God I really need to speak to (therapist)... I haven't for a while.

A number of participants talked about how they were affected by the loss of the network of their training programme, which had been a source of support for them:

...one of the things that I think has not necessarily been particularly helpful is... you have... this cushion of Uni, and then it just gets entirely taken away... (Sian).

Particular participants clearly had an affinity and attachment with their programmes, such as Katherine, who repeatedly discussed her pride in being connected to a particular course, for a number of reasons including that it helped her have 'faith' in herself. Katherine wanted to maintain her connection to her training course, and indicated that she had reconnected with it in new ways:

...always having that bond and link with the course is really important to me...

I go to meetings because I'm part of the Clinical Rep[resentative], [and] Supervisor Rep Committee and I always joke... I'm going back home...

This idea of the training programme as a home she can return to is important, and we may conceptualise many of the participants' experiences of support-seeking during their transition as an attempt to return to networks which provide them with similar feelings of comfort, belonging and understanding.

Participants discussed that they sought support elsewhere following the loss of their training networks, especially in difficult times, and Sian was one such participant who found this from other members of her trainee cohort:

...whenever [I] came [across] difficulties it was like I know there would be a group of people that are likely to be feeling the same way... so other members of my cohort, I'd talk to them and we'd share how we were getting on...

Amit shared a similarly beneficial experience of seeking support from a previous trainee while Katherine also discussed the same strategy more than once in her interview:

...the cohort friends... they knew me inside out... they were part of my journey, they connected with me at... difficult times... they knew what I was going through because they were going through the same...

The importance of connecting with people with a shared experience appears to have given these participants a sense of comradeship and comfort; even in their day-to-day absence, the participants felt connected with those who were, or had been, in similar positions.

Other participants utilised strategies of talking to friends or family members who were in a similar line of work:

...thinking about other ways of how can I manage this... having somebody else to talk about it with... it would have to be a friend... in a similar line of work... (Frida);

My mum's... a Social Worker... she works as a Child Protection Conference chair... I can kind of speak to her a little bit about having a tough day... (Helen).

These are further illustrations of participants seeking to connect with people or networks that understand their professional roles, who they could talk to and reflect with in order to help them manage their transitions.

Additionally, every single participant emphasised the importance of a work-life balance, and in particular the balance between discussing work with select people who would understand, and not thinking about work in other contexts. Despite using her mother (who she did not live with) as support, Helen added it was important to keep her home life protected from the stresses of work:

...make sure that you have that break and kind of appreciate that it's a really emotional job so it's good to not take it home.

Amit discussed enjoying his time outside work with his young son and wife, and Maggie discussed that her choice of a therapist to discuss work was partly due to not wanting to speak about work with people who she lived with 'day-to-day'. Although seeking support was vital to participants, they also emphasised the importance of forgetting about work, and instead enjoying their time with loved ones at home, to help them manage the emotional impact of their roles.

The participants perhaps strategically found people to support them who would understand to some degree their positions as NQCPs, but also used their homes and the people within them to take their mind off work. These can be seen as imperative implementations self-care, which they required in the midst of what we have seen was an overwhelming professional transition. The increase in responsibilities and pressures of their new roles meant that they required emotional support and understanding from others who could empathise, and each of them managed this in their own way.

3.5.3 The importance of support from supervisors and the wider MDT.

The support of supervisors and the wider MDT network emerged as a sub-ordinate theme in its own right due to the vast number of overwhelmingly positive reports about their impact on participants throughout the interviews.

Within this theme, there is an underlying sense of the importance of trust within relationships between participants and their colleagues, which has aided them in their transitions. As with ideas in previous sub-ordinate themes, this is both explicitly and more subtly discussed by participants. An example of the former is from Sian:

I'm quite fortunate in that... I'm kind of trusted to do my own thing... I trust them [team members] as well.

Sian suggested that this trust was engendered by excellent support from her supervisor, with whom she had conversations about her development and transition. Her suggestion of the development of a mutually-trusting relationship which was also echoed by other participants:

...everybody is kind of supporting each other... if you've had a tough session you can come out and there will be certainly somebody who you can... share that... with... (Helen);

I know how lucky I am... we support each other... we can say - I don't know what I'm doing...
(Maggie).

Maggie repeated the words 'supportive team' to emphasise what helped her settle into her role, and suggested the idea of mutual trust helping her feel not judged. In addition, she was a participant who indicated a team value of openness as beneficial:

...everybody is open about when they do need that support, we'll support each other in whatever we need to...

Helen also discussed the open and honest nature of the team, where she is able to discuss difficulties and feel that she would not be judged for it, yet another allusion to the trusting nature of a participant's MDT. These values of teams being open, trusting and non-judgemental, emerged from many of the participants' portrayals of their experiences.

Helen described her team as a 'secure base', and the wide-ranging portrayals of participants' attempts to find new support networks indicated that, to some degree, the MDTs had compensated for the support they had lost, or as Katherine expressed, the 'home' from which they had left.

A further experience of the MDT that was commonly discussed was the usefulness of hearing different perspectives on clinical cases, which allowed the participants a very valuable space to learn, feel connected to others, and receive support and help with their clinical thinking and therapeutic work:

MDT thinking... discussing [cases] and getting different perspectives... that invaluable space... (Amit);

The openness, mutual trust and cultivation of a working culture that caused the NQCPs to not feel judged, and able to discuss their difficulties, led to participants finding the MDTs a space for learning and thinking. This, in turn, allowed them to feel supported in both their transition in general, and also specifically in clinical thinking. It may have also alleviated to some extent the aforementioned loss of thinking time and space from being a TCP:

...what made that leap easier was the team I've got who are just absolutely brilliant and I think being in this team made me realise just how important the people you work with are... (Frida).

This was also the case for participants' relationships with their supervisors. Christine and Katherine both described their supervisors as 'protective' for a period after they joined their teams, while Amit suggested similar:

...my supervisor was really keen to allow me to have almost as much supervision as I wanted...

Christine elaborated and said her supervisor wanted her to feel comfortable in the amount of work she was completing, perhaps acting as a buffer to the aforementioned organisational pressures:

...[she wants] to make sure that I actually have the time, have the capacity... that things do feel contained and that I've got a space to feel comfortable to say to her: actually, it's not...

The ideas of time and space emerge here again, and supervisors have provided this for participants, in order to allow them some breathing room in the context of a very challenging move into full-time work. Participants experienced their supervisors as aware of the difficulties they faced, and supportive in helping them to cope.

This theme illustrates the vital importance of support from the MDT, and the supervisor as one leading aspect of it. NQCPs were supported in the management of their transition into their new roles, with supervisors aware that they may need some protection. MDTs offered helpful advice and ideas, and the teams created an open, trusting and non-judgmental environment for new practitioners to feel secure and settled in their new roles.

3.5.4 Benefits of training experiences.

Although previous sections of this chapter have presented difficulties experienced by participants in their transitions, and illustrated the difficulty for clinical training programmes to prepare them for CAMHS environments specifically, it is also important to note that one theme which emerged strongly was of training experiences that participants saw as transferable to new settings, and thus beneficial for their transitions. These benefits included feeling prepared to not always feel competent, enhancements in their interpersonal and group skills, and attaining direct experience within relevant specialist placement settings.

Participants often looked back at what had help them move forward.

The concept of learning, through clinical training, to feel comfortable with not feeling prepared or competent, was an idea echoed by various participants. This was discussed in relation to not needing to have the answers, or feeling confident, within therapy, in the completion of formulations, or in discussions with the MDT:

...a feeling... [of being] comfortable with the uncertainty of not feeling competent...

(Maggie);

...training kind of prepares you for not feeling ready a lot of stuff, and... when things come, you just do it... (Sian);

I felt prepared that I would feel incompetent... prepared that I would feel out my depth and lost... so... [I thought] this is part and parcel of what we do... knuckle down and work out what you're doing, and that's what happened... (Amit).

These latter two quotes also reflect a common experience across the interviews; a sense of being able to keep going and being confident that they would eventually be able to manage. Participants reported that their training experiences had given them a resilience to survive the initial challenges of the transition into these demanding and pressurised services, and that they were able to 'knuckle down', carry on, and come out of the other side.

Participants also discussed other benefits of their clinical training, including for example experiencing challenging clinical situations, which prepared them for clients they would go on to see in their current roles:

...on training you have to deal with a lot of different situations... some less pleasant than others, you get used to just getting on with things... (Sian).

Helen spoke specifically about how training prepared her for the 'peaks and troughs' of CAMHS work, including that the competing demands of both clinical placements and academic work was challenging when it led to particularly busy times, and that this set her up well for similar periods of stress as a NQCP:

...[training] helps in terms of... trying to organise... think about what needs to be done first and then get through that [stressful period] knowing it's gonna pass... [training] does help you to not get too overwhelmed... you [learn].... it's probably not gonna be intense for that long...

Interestingly, Helen's view that 'overall, the course prepares you well' is characteristic of her interview, which was in general a very positive account of her experience as a NQCP in

CAMHS, and of her training. During her interview, I worried that this was not going to result in useful information for this research. I wonder if this was based on my pre-conceived ideas about working in CAMHS, and my previous experiences of working in mental health services for children, CAMHS included. In retrospect, I see that many of Helen's quotes have been valuable in illustrating the themes presented in this chapter, while it is also refreshing and important to see that some participants, not just Helen, are not only feeling comfortable but thriving in their post-training roles.

Another commonly expressed view by participants was that training had been beneficial in enhancing their skills in working in teams. They highlighted that their training programmes used the cohort of students as a resource, for example through Problem-Based Learning (PBL) groups, to develop their communication and team-working skills, as well as helping them to experience and manage different group dynamics which may arise. Participants reflected on how they had been able to transfer what they learnt from training directly to the MDTs they worked in.:

...it was brilliant cos we learnt so much about the MDT working and building relationships and group dynamics with PBL... the team working is so important and feeling a connection with other psychologists as well as other MDT disciplines... (Katherine);

...in training we did some work on group dynamics... that's been really helpful, especially when thinking about the dynamics in the [MDT]... (Frida).

Particular clinical placements that participants had the opportunity to work within were also cited as beneficial in aiding their development in advance of qualifying and taking up a NQCP post:

CAMHS is also a fairly comfortable setting because I've worked in a very similar setting as a trainee... (Sian);

my specialist placement was in Looked After Children's team and that really helped... (Frida).

The participants highlighted that many transferable clinical skills they developed during training occurred within these types of highly specialised placements, which provided them with an insight into environments which were challenging in similar ways to CAMHS, and exposed them to the types of families they would go on to work with clinically as NQCPs.

This sub-ordinate theme has brought to light the views across the interviews of how clinical training was beneficial to participants, and how they drew upon these useful experiences in this challenging, transitional period of their careers. It provided evidence that participants' training experiences helped mediate their transition, as well as giving many participants a feeling of growth in their ability to manage the challenges of their roles. Participants' training placements were relevant to their NQCP posts, and provided them with valuable experience in managing stress, while a pertinent focus on team dynamics was of great benefit in the taxing contexts of CAMHS MDTs.

3.6 Acknowledging and Desiring Ongoing Development

3.6.1 Overview of super-ordinate theme.

The final super-ordinate theme of this chapter moves us away from participants' experiences of their initial difficulties and what helped support them, instead illustrating their clear and extensive expressions of forward-thinking, and their acknowledgment of their progress thus far in their careers. This theme elucidates participants' continued desire, motivation and

ambition to learn and achieve, as well as their recognition of their growing confidence, increasing self-assurance, and ongoing development in relation to their roles.

3.6.2 A drive for more.

This penultimate sub-ordinate theme reflects participants' wishes to progress and advance in their careers. It was discussed in general terms as a desire to succeed, but also often exhibited by a wish to learn new skills from further, specialist training.

A number of participants discussed not only what is needed to succeed in the profession but also specifically as a NQCP following the end of training:

...you need that in [Clinical] Psychology, you need an inner drive... (Katherine);

...you have to be a lot more motivated... (Sian).

Participants highlighted how characteristics of this kind were implicated in their desire to succeed and develop, and they discussed looking forward to how they can better themselves. Many discussed specific future plans, which indicated their forward-thinking and desire for further development:

I want to become a Consultant Clinical Psychologist so I know I want to push myself and show my ambition because this is where I want to stay and progress... (Katherine).

Amit spoke about wanting to continue to work in the same service and achieve a longer, permanent contract, with his language illustrating the vigour with which participants were pushing and driven to succeed in this transitional period of their careers, and their desire to progress as practitioners:

I was... driven to make sure that I was I was you know doing as much as I possibly could... I was conscious of trying to be the best I could be...

A number of participants also expressed their specific wishes for professional development and progression through the completion of further clinical training, in order to enhance their roles, and help them advance in their careers and support clients more effectively:

I didn't necessarily have an awareness when I finished that actually I would now be craving more training... (Sian);

I've been quite vocal in... my supervision and personal development [meetings], saying I'd like to do some more training... I push for it... (Maggie).

Maggie expressed her forthright attempts to receive this, and had already decided which model this would be; 'systemic and family therapy.' This was an example of a broad wish of participants to complete training relevant to children and families, indicating their desire to develop further expertise with this particular clinical population. Maggie's use of the word 'push' mimicked Katherine, above, and she repeated her wish for further training a number of times in her interview, demonstrating just how much she wanted to continue to advance in her practice.

Further illustrations of this desire to achieve and move forward were evident:

I feel like I want to learn more... I guess the value of training is... actively learning all the time... (Christine);

I'm deliberately putting myself outside my comfort zone... getting trainees or assistants or supervising nurses... (Katherine).

This was reflective of the participants as a whole, with the repeated use of words such as ‘driven’, ‘wanting’ and ‘craving’ across the interviews giving a palpable sense of participants’ wishes for more specialist clinical knowledge, a focus on their future development, and their overarching desire to continue to become more rounded and learned professionals.

Katherine’s above quote may also reveal her desire to enhance and develop her leadership skills. As well as a wish to progress in their careers, it is clear that some participants demonstrated a desire to take on further responsibilities and offer a leadership role within their teams:

...although... I said before that we don’t have a lot of opportunity for sort of service evaluation and development... I am a lot more aware and a lot more involved with thinking about ways in which we can make the service better... (Christine);

Although there was a common experience of participants looking forward, due to the fact that they had been NQCPs for slightly different periods of time, and also had varying personal preferences for their futures, this wish to lead for some, but not others, is a good example of differing experiences between participants, within a general theme.

This sub-theme illustrates the inner drive of participants to progress professionally, both for their own development and for the benefit of their clients. Many had particular areas of interest in mind for further training, often directly relevant to the CAMHS settings they worked within. Ultimately, participants wished to become more skilled clinicians, or leaders, within their teams.

3.6.3 The acknowledgement of growing confidence.

The final sub-ordinate theme of this chapter brings together the comprehensive and widespread reports by participants of their experiences of feeling more confident in their roles. Many of these descriptions were connected with receiving positive feedback from, or working with, their team members, which led to them feeling valued, and also the benefits of gathering experience. It was also evidenced by their experiences of becoming increasingly able to voice their thoughts and opinions within team or organisational forums.

A number of participants acknowledged their increase in confidence since they began their NQCP roles, highlighting the benefits of time within their new contexts, and becoming accustomed to the demands:

I am... more proficient in other skills that perhaps I wasn't to begin with... I certainly feel more proficient... (Maggie);

...at first finding it... difficult to manage, to then actually becoming... quite happy to maintain what I was doing... (Amit).

This reiterates the ideas of previous sub-themes; there was a sudden change in role which may have been overwhelming, or made participants question their proficiency or capability. Nevertheless, they have also reported that over the one to two years of working as NQCPs, their clinical and MDT experiences have contributed to them feeling much more confident in their abilities and competencies.

Participants discussed that this awareness of progress had been aided by feedback from management or working alongside clinical colleagues, who had commented on their progression since they first began as NQCPs. This also led to some of the participants feeling

valued by their colleagues too, which only increased their feelings of confidence, and helped them feel that their contributions were respected:

...it wasn't only me that noticed it, it was my clinical lead that noticed it before I did... that increase in confidence was... about how others [MDT members] valued that knowledge [I have] and wanted to know more... (Frida);

...seeing a positive change is really really important... and the fact is that I am valued here... (Katherine).

Participants spoke of their confidence growing through connecting and working with others, for example Frida discussed working with a systemic therapist on a new therapy group as one aspect of her experience which helped build her confidence:

...a huge learning curve and development in terms of my own professional skills... that increase in confidence to be able to implement something...

The acknowledgment of moving up the 'learning curve', and recognising their development over time, was also expressed by others:

I think that's been a big learning curve but I've finally started to get there... (Maggie);

I can have really good, high quality output without... being overwhelmed again... (Amit).

This illustrates participants' acknowledgment that as time within their roles increased, so too did their confidence, and the development of their clinical skills.

Participants also acknowledged their development had benefited from the exposure to new clinical experiences, for example working with clients with diagnoses they had not worked

with before, or learning new information from families which would benefit them in the future, such as about their backgrounds and cultures:

I've had to think a lot about cultural issues and how people view mental health and how that impacts engagement and how to work with families and... not to impose my own ideas on families... that's definitely something I'm learning from clients... (Christine).

An increase in confidence was also widely evident through participants' experiences of voicing their views in their teams, which gave a sense of them growing into their roles and being able to contribute more in both clinical and management discussions:

I think voicing my opinions more in meetings, I'm confident to do that now... in the first year... I just was much more hesitant... (Katherine);

...in those meetings you've got like the clinical lead, the whole team, but that doesn't impact on what I wanna say, which I think... helps me evidence that increase in confidence... (Frida).

I wonder if participants became more vocal within their teams as they settled in to their new roles, exhibiting their ideas and knowledge more explicitly, which led to a virtuous cycle of feeling more confident in both themselves and their colleagues, and importantly their colleagues in them. Participants often seemed to open up and speak more freely about these more positive experiences in the interviews, compared to the difficulties they faced, as if they were reflecting the more relaxed feelings which may have accompanied a momentum and confidence shift following their challenging, first forays into these clearly demanding CAMHS environments.

Many participants also shared an acknowledgement that their development remains ongoing:

I am literally imagining a red thread in my brain and the thread is... just still going...

(Christine);

...there's the realisation that no you're never done with learning... (Sian).

This appeared to offer the participants some comfort, in that although things had been challenging for them, they remained in a process of progression, and that it was okay for them to still be developing.

This final sub-ordinate theme of the chapter has illustrated that despite the challenges faced by participants within this period of their careers, they also experienced and acknowledged an increase in confidence and self-assurance. Participants were able to recognise that their progress had been ongoing, that their roles and competencies, and related feelings about them, had developed or changed, and that increasing feelings of comfort and proficiency in the role may continue as they gain further skills and experience.

Chapter 4: Discussion

4.1 Overview

In this chapter, the results of the analysis will be discussed in relation to the research questions stated at the conclusion of the ‘Introduction’, and the relevance of these outcomes to the wider literature. A visual representation of the results will also be tentatively illustrated.

Clinical implications and recommendations will be proposed, and a consideration of the strengths and limitations of the study presented. Suggestions for further research will follow, before this chapter closes with the researcher’s final conclusions and reflections on this work.

4.2 Summary of Results

The outcome of the analysis of participants’ interviews was the emergence of three super-ordinate themes: ‘A big jump: the transition from TCP to NQCP’; ‘The support of home comforts, old and new’; and ‘Acknowledging and desiring ongoing development’. These consisted of a total of ten sub-ordinate themes. The research question, ‘*What are the experiences of NQCPs in CAMHS MDTs?*’, was separated into three distinct topics and sub-questions in the ‘Introduction’ chapter, which were focused on: NQCPs’ transitions; the contexts they worked within, specifically the MDT and the wider organisation; and support and coping. Therefore, this summary and discussion of the results will utilise this triad in order to synthesise the sub-ordinate themes. Additionally, as this research is a contribution to the sparsity of literature on the transitional, contextual, and coping experiences of NHS professionals as a wider group, it is appropriate to situate this work within its context, and

discuss the relevance of the new knowledge it provides in relation to previously-conducted research.

4.2.1 What are NQCPs' experiences of the transition to their roles?

In the 'Results' chapter a number of difficult transitional experiences reported by NQCPs were presented, both emotional and practical, which affected them in the outset of their transitions. These included increases in both clinical responsibility and thinking space from when they were TCPs, as well as feeling overwhelmed and deskilled. They spoke of this 'jump' being difficult to manage, and feeling out of their depth in the early stages of taking up their new posts. This echoes previous research from the nursing profession, where newly qualified nurses described stressful experiences, particularly in relation to new responsibilities and feeling deficient in the required clinical skills (O'Shea & Kelly, 2007). Furthermore, Lazarus' cognitive-relational stress theory (1991) suggests that adapting to new circumstances can be aided or impeded by both contextual resources, clearly evident within the outcomes of this research's analysis.

These NQCPs' experiences also reflect the BPS' (2016) recent findings that 70% of all psychological staff find their jobs stressful. It is important to acknowledge that if stress is a general experience across the board for Clinical Psychology staff in the NHS, the needs of NQCPs must be given appropriate consideration, given their experiences of, for example, the dramatic increase in workload and clinical responsibilities.

Particularly pertinent also was the connection between feelings of isolation and accountability, indicating that feeling alone and unsupported in the role was connected with a fear of making mistakes in the cases of vulnerable or 'risky' clients. Essentially, the

participants who were isolated as the only CPs of their team experienced significant discomfort, due to feeling that they could be held accountable for any harm which came to their clients. This supports ideas within Schlossberg's transitional model (1981), that levels of support within the system, or indeed the lack thereof, can influence the adaptation to a transition. Clearly, these particular NQCPs felt unsupported and therefore experienced more negative feelings at this time.

The introductory chapter of this work discussed that there has been a dearth of research on the transition for NQCPs, or indeed healthcare professionals moving from training to full-time practice, in the UK. Nevertheless, the accounts of participants within the current research, in particular their elucidations of clinical training being beneficial for their transition, and their growing confidence as qualified professionals, echo Woodward's (2014) assertion that an increasing self-awareness aided TCPs in their development. The current researcher would propose that participants' acknowledgment of the 'learning curve' they have been on, and continue to navigate, evidences their awareness of the progress they have made throughout training and since, and that this ongoing process of self-discovery benefited them in their management of a challenging transition, and the contexts within which it occurred.

Widely discussed by participants were specific training experiences that were transferable to their new settings, such as a focus on team dynamics, and opportunities to work within specialist placements. These were reported to have provided participants insight into the levels of stress that can be experienced in CAMHS. Keville et al. (2017) stated that Problem-Based Learning (PBL), can help trainees develop skills to manage groups and negotiate diverse views and experiences, while Nel, Novelli and Nolte (2017) reported 'Group

dynamics' and 'Developing transferable skills' as two super-ordinate themes in their paper on the impact of PBL in training. These conclusions and experiences, respectively, have clearly been substantiated within the current research.

NQCPs also discussed the difficult experience of feeling deskilled, or not always competent, in various aspects of their roles. This is one example of the current study very closely mirroring two major outcomes of an IPA study on family therapy trainees' experiences of their training, namely of it being 'overwhelming' and 'deskilling' (Nel, 2006). In the current study, however, the challenge of feeling deskilled was tempered by NQCPs' previous experiences of managing similar feelings throughout their training, for example learning that they may not always have 'the right answers'. This sits in line with the work of Woodward, Keville and Conlan (2015), who highlighted the themes of enhanced self-awareness and managing uncertainty, as beneficial to TCP's development. The NQCPs in the current study acknowledged this aspect of their training and development, which aided them in their transitions.

The challenges and prior stress involved in juggling clinical placements and academic requirements within training programmes were also commonly discussed as positive experiences in preparing NQCPs for their new roles in CAMHS. This supports the idea within Schlossberg's (1991) model that personal coping skills - in this case experience in stress management, as well as support seeking behaviours - can help individuals manage significant professional transitions.

A further encouraging experience for participants was of feeling more confident as they came closer to the end of their first two years of being an NQCP. This was connected with a feeling

of being valued by their colleagues, which was also seen as a major positive for newly qualified nurses in the work of O'Shea and Kelly (2007). Contributions of the team were significant not only to NQCPs' clinical thinking, but positive feedback was also noteworthy to their increasing feelings of competence and belonging within the team.

A sense of becoming accustomed to the environment was portrayed, and participants acknowledged their increasing contributions, and voicing of ideas, within their teams. They looked forward to offering the service more than they had been, such as taking the lead on projects or supervising others, as well as expressing a desire to complete further training, in order to progress as practitioners. O'Shea and Kelly (2007) reported that their participants found 'making a difference' an aid to their transition, and this forward-thinking of this research's participants reflected their desire to progress in their ongoing professional development, not only for personal gain, but also to offer better therapeutic work, and contribute to the development of their services.

The participants acknowledged that their professional development had continued since they finished clinical training and began as NQCPs, and recognised that this would remain the case; this was tied to a growing confidence and comfort in their new skins. This forward-thinking by participants could be considered not only a product of coming out of the other side of a difficult transition, but also posited as a thinking style which aided them in coping with such a challenging professional transition in the first place; thus it could be proposed as an additional personal coping strategy which aided them in their transitions (Schlossberg, 1981).

4.2.2 What are NQCPs' experiences of their roles within the MDT and wider organisational contexts?

The participants' experienced their MDTs as a great source of support in their transitions; a secure base where they could continue with their learning and development with the help of their colleagues. The varied perspectives of the MDT staff members were highlighted as being significantly beneficial to participants' clinical thinking, while the theme 'A drive for more' also connected with participants wish to draw upon their MDT colleagues' knowledge in order to help them become more rounded clinicians. This is in line with Cole and Blake's (2015) acknowledgment that MDTs can be a resource for trainees to draw upon, suggesting that this process continues following qualification.

The current research, however, does not substantiate the same researchers' claims that MDTs can be difficult environments to manage (Cole & Blake, 2015), whilst it is also a divergence from the outcomes of other work which concluded that working relationships can be affected by pressure and organisational change (Nugent, 2007; Nutt & Keville, 2016). Within the current research, portrayals of MDT experiences were overwhelmingly positive.

Brooker and associates' (1999) quantitative study noted that scores of zero were received for items such as 'Not feeling I can rely on the support of my colleagues', when attempting to identify factors which contributed to stress. The current research supports this previous literature, and acknowledges that the relationships between staff are neither always affected by stress, nor always a driver of it; indeed, positive relationships can act as a protective mechanism in engendering feelings of safety and support for newly-qualified professionals within teams. In addition, Fouad and Bynner (2008) proposed that the adjustment to professional transitions can be influenced by context, and this resonates in the current

research; the support of the MDT was deemed by participants a significant factor in coping with the challenges of their transitions.

NQCPs' clinical supervisors were also singled out as an especially valuable resource in shielding them, to some degree, from the immediate challenges they faced, and supporting them with their transitions to the increased demands of full-time CAMHS work. Conflict with supervisors was therefore not uncovered as a difficulty for participants in this research, as it was in the paper by Chana and colleagues (2015). One could suggest that this may be because of the difference in the nature of supervision between the fields of Clinical Psychology and Nursing, however this is difficult to expand upon given the lack of information regarding the content of the nurses' supervision in their research.

A difficulty experienced by participants immediately following their appointments as NQCPs, however, was the pressures they felt from the organisation. These pressures included having to see a certain number of clients, and the administrative workload associated with this. These difficulties were discussed as being borne out of financial cuts and structural changes, growing waiting lists, and a lack of resources, including staffing and training opportunities. This study therefore upholds the proposition that newly-qualified professionals may lack sufficient experience to immediately deal with the stress of certain environments early in their careers (Higgins et al., 1999), and also that they may feel vulnerable at this time (Latham & Toye, 2006).

The present study also brings to light concerns from participants that a number of difficulties experienced by staff, in particular workload pressures, can ultimately impact upon patient care, and this supports a number of outcomes presented within other studies (Chana et al., 2015;

Currid, 2008; Higgins' et al., 1999). These organisational challenges were portrayed by participants as leading to high levels of stress or frustration, and importantly also potentially leading to the treatment received by clients being less effective than it could be. Whereas the experience of the MDT was portrayed in a positive light, the wider organisational context and its impact on participants was presented as much more problematic and stress-inducing. This resonates with the work of West et al. (2011), that work-related stress can be harmful to service users as well as clinicians.

Furthermore, this research has reiterated the view that the emotional toll of healthcare roles, in particular anxieties over the safety of clients, is specifically connected with practitioners not feeling supported (Chana et al., 2015), and also the pressures of a heavy workload (Currid, 2008). The current study also reaffirms reports from nursing staff within Chana's work, that not feeling fully prepared for the demands of a new role contributed to feeling stressed or overwhelmed. This provides evidence that this can be a common experience across settings, for staff of different disciplines.

4.2.3 What are NQCPs' experiences of support and coping?

The participants utilised varied support strategies, which they experienced as beneficial in coping with the challenges of their career progression. As well as support being found from supervisors and within MDTs, participants reported experiences of external support-seeking, from various sources such as former trainee colleagues, also now NQCPs, a personal therapist, or others in their lives who understood aspects of their work roles, for instance family members who worked in health or Social Care. Some participants looked to particular individuals, and others to larger networks, however what they all shared was an understanding or experience of working environments facing similar practical and clinical

challenges. This strategic support-seeking by participants was a collective experience, and supports the work of Chana et al. (2016) that social support and effective coping strategies may reduce the likelihood of emotional difficulties.

Colley et al. (2015) uncovered that stress and frustration experienced by qualified CPs was partly caused by organisational changes and the resulting pressures facing staff. This was clearly also experienced and reported by this research's participants. Reassuringly, however, another of the major themes of their work was reiterated in the current project, in that NQCPs' knowledge and skills from previous relevant experiences helped them cope with challenges such as time pressures, organisational demands, and financial cuts which had led to a reduction in resources. In addition, although Colley and colleagues' (2015) paper honed in on their participants' ability to cope specifically with organisational changes, the current research also highlighted the NQCPs' ability to manage the significant changes in professional roles they were transitioning into, as well as the organisational factors that challenged them in their new, and more senior, positions.

Moreover, another of Colley and colleagues' (2015) main themes underscored what it is that CPs take forward from their challenging experiences, whilst the current research has similarly presented the super-ordinate theme of 'Acknowledging and desiring ongoing development'. This theme included the portrayal of NQCPs' ability to look to the future and their experiences of striving for further professional progression, as well as their wishes to become more skilled and rounded clinicians.

4.3 A Visual Representation of Participants' Transitions

The researcher is aware that it is not routine for IPA studies to propose a model, nevertheless has become aware that a tentative, temporal representation of the super-ordinate themes and contexts the participants discussed, may add an additional angle from which they can be viewed. The researcher would only propose this as a provisional conceptual framework which emerged from his data, which requires further investigation.

Previous researchers have conceptualised the development of counsellors from training positions onwards, through the use of models (e.g. Rønnestad & Skovholt, 2003; Stoltenberg, 1981). Stoltenberg (1981) proposed a four-stage developmental model through which trainee counsellors progress in relation to their supervision and practice. These four stages can be succinctly summarised as: 1) the trainee being dependent on the supervisor; 2) becoming more independent but still requiring their needs to be met (“a dependency-autonomy conflict”, pg. 62); 3) increasing identity and self-confidence as a counsellor; and finally, 4) an independent and self-aware practitioner who is aware of their limitations. Importantly, Stoltenberg (1981) acknowledged, albeit briefly, that his model may suggest a rigid and artificial distinction between each stage, and that a counsellor would perhaps straddle two of these stages simultaneously.

Similarly to the ideas of Stoltenberg (1981), the participants in the current research tended to discuss and, by extension, conceptualise their experiences developmentally, from entering their NQCP role onwards. This was implicitly portrayed to some extent in the presentation of the super-ordinate themes of the ‘Results’ chapter (Table 2). This may have occurred in part due to the ordering of questions, for example participants were firstly asked how they experienced their transition, followed by questions on support and context. Nevertheless, the

interviewees tended to discuss their difficult starts much more in the first half of their interviews, and ended with more of a focus on their progress and forward-thinking. It may therefore be useful to offer a more explicit, developmentally-progressive visual representation, in line with the themes which emerged from participants' accounts.

The researcher also remains aware, however, that this way of conceptualising the themes may be influenced by the linear epistemology (Bateson, 1971) of his own 'lifeworld' (Brooks, 2015), and that a more circular element to participants' transitions was also evident in their narratives. This is most clearly evidenced by their common mixture of the past and present tenses, in particular the regular use, across the interviews, of talking their previous thoughts aloud as if it was happening now, perhaps indicating the lingering impact of difficult experiences. This is evident in the following examples taken from the 'Results' chapter:

...oh my God where do I even begin?... ok I'm qualified... I know the things that I've learnt and... can call myself an expert in some ways, but I don't feel that yet... (Christine);

...going into a team where there hadn't been a Clinical Psychologist before... it's like okay well I need to figure out... what are my skills? (Sian).

Therefore, the researcher would like to tentatively propose a developmental, transitional representation of the super-ordinate themes of his 'Results' chapter, which also portrays a crossover of present and past experiences and contexts. Please see *Figure 1* below:

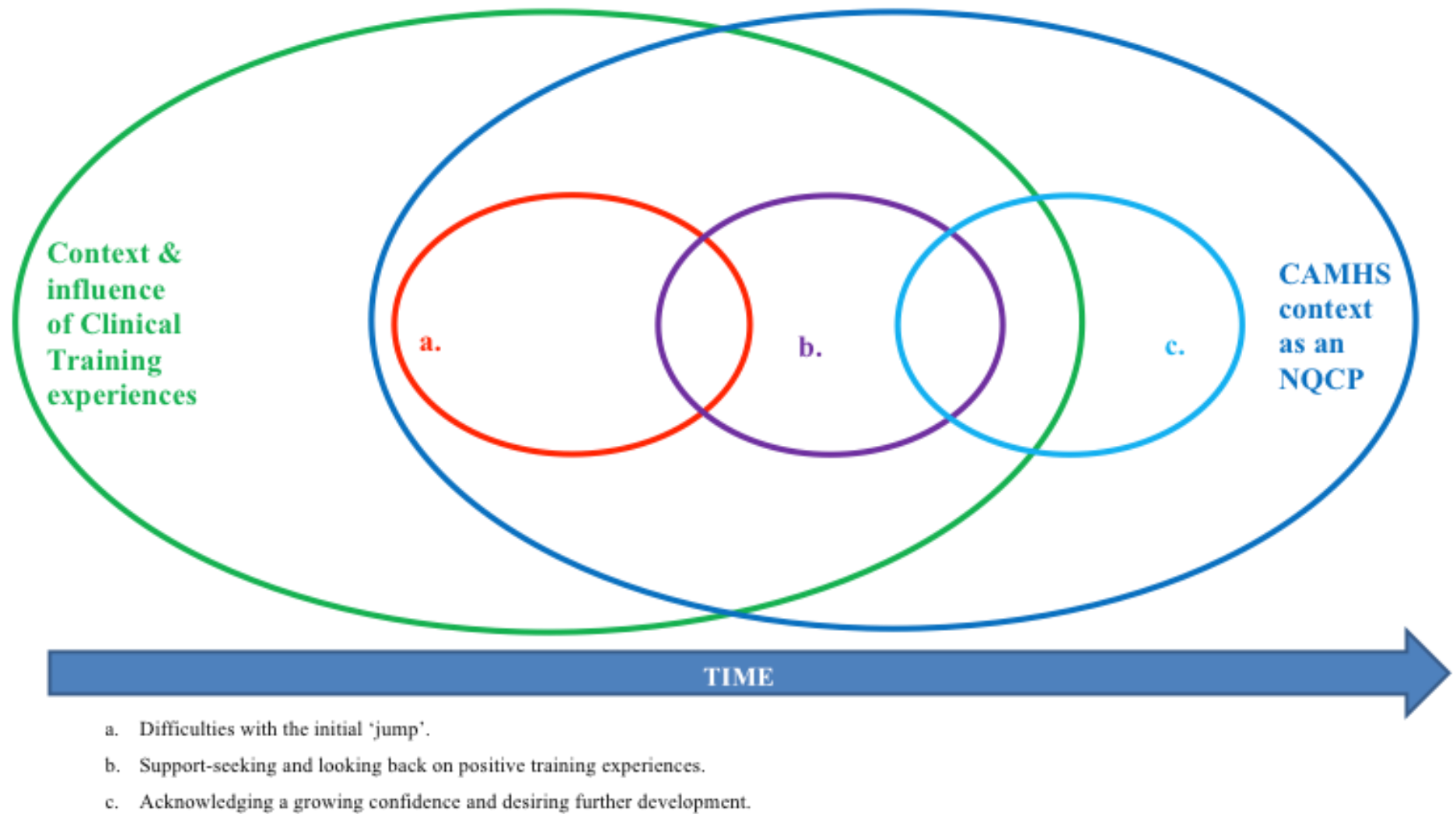


Figure 1. Visual Representation of Transition for NQCPs.

In the figure, contexts are acknowledged, in line with Stoltenberg's (1981) recognition of the prominent influence of practitioner's environments. The first, in green, is the previous context and lasting influence of the experiences of training, as described in a mostly positive light by participants. Then, in dark blue, the new context of CAMHS as an NQCP. These contexts envelop the developmental journey of three distinct yet overlapping stages of participants' transitions:

- a. difficulties with the initial 'jump';
- b. support-seeking and looking back on positive training experiences in their previous context;
- c. acknowledging a growing confidence and desiring further development.

These three stages are abbreviated descriptions of the three main super-ordinate themes presented in the 'Results' chapter.

These stages begin when the practitioners enter the CAMHS context, in line with this research's enquiries of participants' experiences as NQCPs only. Nevertheless, participants' numerous references to the influence of their clinical training programmes meant that it was paramount to also acknowledge this previous context. As with Stoltenberg (1981), the three stages of transition overlap, due to the fact that these are not clearly delineated. They illustrate an apparent developmental process for an NQCP over the course of time: from finding their new context significantly challenging; subsequently seeking support and drawing on previous training experiences; to later feeling more confident and desiring more in the future, in the shape of further training and professional development. This final stage is placed over the edge of the border of the previous training context; as well as helpfully reflecting on past experiences,

participants reached a point where they experienced more forward-thinking, and looked ahead to the future of their careers in CAMHS.

4.4 Clinical Implications

There are a number of clinical implications of this research, relevant to Clinical Psychology doctoral training programmes, as well as those in management and supervisory positions within CAMHS leadership structures. The researcher is aware that a number of the difficulties the participants discussed occur in the context of an economic and political climate which means that services are restricted in their resources, and that significant change is unlikely to occur in the near future, no matter how significant the outcomes of this type of research. Nevertheless, the researcher believes that this work highlights recommendations which can be implemented to improve the experiences of both NQCPs and service users.

4.4.1 Recommendations to ameliorate the impact of the transitional ‘jump’.

As it was clear from participants’ reports that they were overwhelmed at the outset of their transitions, employers should attend closely to NQCPs in terms of support and supervision in this transitional period. Corrie and Harmon (2001) have proposed this in the past, and the researcher of the current work believes that this study offers evidence to support claims that this is still relevant and would be beneficial. As a result, a number of ways this can be achieved will be proposed.

Specifically, this research indicates that one major contributor to NQCPs feeling overwhelmed was the increase in their workloads compared to training contexts where they engaged in

significantly less clinical work. Therefore, one way that employers could offer NQCPs support in the earliest phases of their transitions would be through a staggered workload, for example for the first three to six months of their employment. This would involve management allowing NQCPs a graded introduction to clinical contact, to help avoid them feeling out of their depth immediately after beginning in the role. This would mimic, in a more formal manner, the descriptions provided by particular participants of the protective role their supervisors played, which ensured they had the appropriate time and space to manage their responsibilities. This could also be an appealing feature of the role to prospective employees, if NHS Trusts implemented this idea.

Training programmes may also be able to do more to bridge this gap. For example, they may wish to encourage trainees, or set a requirement for them, to progressively increase the number of clients they see over their three years of clinical placements. It may be the case within some training programmes that students have more prescribed placement days in their final placement, and therefore more opportunities to develop their skills in caseload management. This may be aided by the fact that on many clinical training programmes, trainees' final, specialist placements continue following the completion of academic requirements, such as lectures and the submission of their theses.

Another pertinent outcome of the analytical method was the acknowledgement from NQCPs who were the only CPs in their teams, that they felt isolation and a heightened sense of accountability for their clients' safety. As a result, it may be beneficial for all NQCPs to receive a thorough induction to their clinical team and wider organisation, including meeting staff members both

within and outside their immediate service or work base. This may ward off the feelings of seclusion and individual responsibility which arose for some of this research's participants, enable more robust inter-agency working, and essentially aid NQCPs in feeling more connected to others soon after joining their new teams and organisations.

Furthermore, an additional recommendation from this research would be for recruiters to ensure that where an NQCP joins a team as its only psychologist, supervision is set up and provided by a more senior CP, or a clinician of another relevant professional discipline. This supervisor could be from a neighbouring team within the same NHS Trust, or if necessary, from outside the organisation. The researcher became aware from one of his participants that this has been made possible in their NHS Trust, and that the external provider of supervision was appropriately recompensed. The BPS' DCP (Division of Clinical Psychology) policy on clinical supervision (BPS, 2014) clearly supports these recommendations. They suggest that "a full time newly qualified clinical psychologist" should receive one hour of clinical supervision per week, from an "appropriately trained" individual (pg. 5). In addition, they clearly state that although there may be settings where only one CP is employed, their manager should help ensure that their supervision needs are met. It is vital for the development of NQCPs that the benchmarks of their profession are upheld by their employers; these services should anticipate NQCPs' support needs in advance of their recruitment.

The participants' candour in their portrayals of their experience shed light on the anxiety they experienced because of the lack of supervisory support at this initial stage of their transition. At a time when they felt particularly deskilled, they experienced a pressure to make important

decisions alone, and feared making serious mistakes. Therefore, the rationale for this recommendation is to not only to protect the mental health of NQCPs who are in a vulnerable period of their careers, but also to ultimately help maintain the safety of the young people and families they are working with. This would also help safeguard the organisation as a whole from increased risks of serious incidents occurring.

Additionally, as another theme to emerge was the benefit of previous training experiences which focused on team dynamics, and their transfer to later MDT work, the researcher would also encourage training programmes to engage in exercises and activities which promote team-work and develop students' experiences, thoughts and understandings of team dynamics, in order to aid their transitions into full time-work within MDTs. One example of this cited by participants within the current research was PBL. This has been identified as helping TCPs develop "life-long" transferable skills, such as managing and responding to conflict in groups, or contributing to beneficial group dynamics, partly by resembling real-life scenarios (Nel et al., 2017, pg. 6). Training programmes may wish to offer assessed group tasks such as this as part of their curriculum, as both the current and previous research indicate that this is a hugely important aspect of TCPs' development, and crucial experience for them to draw upon as NQCPs.

4.4.2 Recommendations to increase NQCPs' systemic influence within their organisations.

This research also evidenced that NQCPs and their colleagues can feel powerless in effecting change in their services, and although this may be difficult to remedy because of much wider financial and structural reasons, the researcher feels that there may be actions that organisations

can take in order to avoid the distance NQCPs felt existed between commissioning or management, and themselves and other front-line MDT staff. For example, services could consider setting up forums to foster communication between management and staff, potentially including commissioners. This could allow NQCPs and their colleagues a space to ask questions and express their feelings about, for example, the pressure of taking on more and more clients.

Although change may not come about as a consequence, this contact with senior management was evidenced by one participant, and the divergence of her experience of this from others was coupled with her not feeling frustrated by the decisions of the senior management or commissioners, while overall she portrayed a much more positive experience of being an NQCP. Therefore, the introduction of, or increase in, this type of contact may be beneficial to clinical staff. Essentially, and as was evidenced in both this research and previous work, challenging organisational factors can negatively affect the emotional well-being of staff, and also the service experiences of their clients (Chana et al, 2015).

In addition, Clinical Psychology training programmes may be able to do more to develop NQCPs' skills in advance of their transitions, while they are still TCPs. The most recent BPS accreditation standards (2015) speak closely to this, outlining that there should be teaching on topics such as "the organisation of health and social care services" (pg. 29), as well as on leadership theories and models, and their application to service development and provision. This could act as a scaffolding from which trainees grasp further opportunities to effect change in their placement organisations, with the support of their supervisors. This could be in the shape of attending Senior Management Team meetings, or shadowing senior CPs in business and

governance meetings. It may also be worthwhile for training courses to set up specialist, third-year leadership placements for trainees who are interested in this aspect of their potential future roles. This would afford them the opportunity to work more closely with senior CPs, or indeed other members of staff in senior positions, in order to gain more comprehensive experience of commissioning, governance and management processes.

Furthermore, training programmes may also be able to encourage TCPs to engage in training course committees. This may provide them experience in contributing to discussions, or in the implementation processes, of a large-scale provision, in this case an accredited training course. Alternatively, where PBL is utilised in particular doctoral training programmes, the organisers may wish to use one such exercise to focus on organisational processes and challenges. For example, one such exercise could concern the difficulties that can arise for members of a clinical team in communicating with commissioners and managers, and require trainees to consider how this may be approached. There are a number of ways that Clinical Psychology doctorate courses can more comprehensively prepare their trainees for the organisational context of, not only CAMHS, but the NHS as a whole.

4.4.3 Recommendations to aid NQCPs' support and development needs.

With regard to the importance of external support discussed by participants, recommendations can be made to both their training programmes and their new services to this end. Firstly, if the scope of their previous training programmes' resources allows, they may wish to offer NQCPs transition days as a way to avoid their students feeling such a significant loss immediately after qualifying. The current researcher has become aware that this has been re-introduced by the

University of Hertfordshire, and therefore that other programmes may be able to follow suit. These have involved a reflective space to consider the challenges and experiences of moving from TCP to NQCP, as well as CPD sessions, for example on research skills, or becoming a supervisor. Sessions such as these, which need only occur on a limited amount of occasions following NQCPs' qualification, could be offered in the context of them maintaining contact with their previous programmes. The participants in the current research discussed returning to their training programmes in order to contribute to selection processes, or teaching on the programme, therefore they may already be receiving some support for these roles. These transition sessions could be an extension of this, and a chance for cohorts to remain connected; this was of course one support-seeking strategy which emerged as significantly beneficial to participants in this research.

Additionally, due to MDT support emerging as a theme in the earlier 'Results' chapter, NQCPs' employers could set up regular peer supervision or reflective practice sessions within the team or service. Implementations of protected time such as this could provide NQCPs more appropriate time and space for them to think and reflect with their colleagues, the lack of which was reported by participants as one of the main challenges in their transition. This may also promote the potential benefits of group support to NQCPs, and others.

This also brings up the more general recommendation made previously in the nursing literature that staff should organise their time in line with their preceptor (Lewis & McGowan, 2015), and this could be mirrored by NQCPs and their supervisors. This would allow supervisors to model useful structures of their working weeks, thus that time towards clinical, team and continued

learning or development experiences are balanced as far as possible. This is especially important in the context of this research's theme of the experience of lack of time and space to think and plan work. The researcher is aware from his own experiences and clinical placements that senior clinicians can experience similar difficulties to NQCPs, in terms of time pressures, and that the research indicated that NQCPs become accustomed to the nature of the CAMHS climate over time. Nevertheless, this may still be a useful strategy for an NQCP who may inevitably feel squeezed in the commonly reported context of not experiencing a staggered introduction to the role, and facing a sudden increase in workload and responsibilities.

Finally, one of the latter themes presented in the Results chapter was the NQCPs' desire to learn more, for the benefit of themselves, their teams and their service users, and in particular their frustration with the lack of funding available to pay for training courses. The researcher understands the financial limitations which exist in services, however would recommend that employers are not only sensitive to NQCPs' wishes for CPD, and aware of their frustrations at the absence of it, but would also encourage employers to remain aware of the literature which presents the period immediately following the completion of doctoral training as a crucial one in regard to NQCPs' CPD needs, and that further specialist training may be a necessity (Latham & Toye, 2006). NQCPs may benefit from their supervisors prioritising the discussion of CPD with them, looking for courses which may be financially accessible, and ensuring they have time to complete them. This also echoes Chana and colleagues' (2015) recommendation that organisations be committed to staff development.

The researcher believes that these numerous recommendations can be implemented to help protect the emotional well-being of staff, improve the likelihood of their retention in services, and also contribute to more effective client care.

4.5 Methodological Strengths & Limitations

As outlined in the Introduction chapter, there was a clear rationale for this research topic, which was necessary to explore given the gaps in the literature. The insight this work has provided therefore offers new understandings which are beneficial to a number of stakeholders, including trainers, NQCPs and employers, and enriches the existing knowledge base. In particular, focusing on participants' experiences of the transitional period within CAMHS, as well as their coping mechanisms, were important aspects to capture, as an awareness of these experiences may be useful not only to the profession of Clinical Psychology, but also to the wider professional disciplines within the NHS.

The use of IPA has allowed an idiographic spotlight to be shone on the experiences of a homogenous sample of participants, while the interpretative element of the method has allowed common themes to be drawn together, and nuanced, varying experiences to be portrayed. Nevertheless, due to the epistemological position of both the researcher and, as a consequence, the chosen analytical method, this work has not sought to present 'findings' of 'objective observation' (Burr, 2015). For readers of particular epistemological leanings, this may be viewed as a limitation of the current study, however the researcher would consider that although no conclusive answers are purported to have been found, this research highlights a number of useful

outcomes of participants' narratives which can be utilised in various ways, in order to improve the experiences of both staff and service users.

The recruitment strategies of this research led to the attainment of seven participants, and although this meets the recommendations for a doctoral IPA study (Smith et al., 2009), the nature of this qualitative method naturally leads to a relatively small sample size, in comparison to other research where information is gleaned from many more individuals. Therefore, a downside of this illumination of the experiences of a small number of individuals, could be said to be a restriction in the generalisability of the outcomes.

Importantly, though, the participants were trained on various Clinical Psychology training programmes, worked across different CAMHS services, and one male participant was recruited. This may have helpfully contributed to the emergence of a breadth of experiences and viewpoints which reflect wider experiences. With regard to the geographical location of the participants, however, they were all working within CAMHS teams in the South of England, and as the financial and organisational contexts of these services vary across the country, differing outcomes may have emerged if this research had focused on NQCPs from various areas of the UK.

Of these seven participants, three different ethnicities were represented, a positive outcome of the recruitment strategy, and cultural background is another diversity aspect (Burnham, 2013) of the participants' demographics which the researcher hopes contributed to a breadth of experiences to be explored. Nevertheless, the researcher has considered whether both his

interview questions, and his understanding of the answers, were implicitly influenced by ideas promulgated by the Western, individualistic, lineal view of the world he has been brought up within (despite his own ethnic minority background). This is a further example of the assertion of Ahern (1999) that a researcher cannot entirely bracket the influences of their beliefs and experiences of their 'lifeworld' (Brooks, 2015).

Within the Methodology chapter, however, quality assurances employed by this research are presented, following a set of guidelines often utilised in IPA research, by Yardley (2008). These are, namely: sensitivity to context; commitment and rigour; coherence and transparency; and impact and importance. Additionally, Appendix D outlines further criteria, from Elliott, Fischer and Rennie (1999), which includes information on the endeavours of the researcher to, for example, own his perspective, and provide credibility checks of the transcripts, by member-checking, engaging in bracketing meetings, and keeping a reflective diary.

4.6 Suggestions for Further Research

This study has indicated that further research could be beneficial in expanding the knowledge base of the topics explored within this work.

First, this researcher is curious as to whether themes which emerged in this literature are particular to CAMHS settings, or whether this may be the case in other services, especially in the context of financial difficulties occurring across the spectrum of mental health services at the time of writing (Bulman, 2018). A larger, similar study may be beneficial in leading to emergent ideas which support, or indeed counter, the current work. This could be a geographically wider

study which therefore takes into account experiences of NQCPs working in different parts of the UK. Research of this kind could perhaps access services that face even more significant financial difficulties, and subsequent lack of resources. This would also allow the inclusion of staff who have trained in a wider pool of universities.

Future research could also involve widening the exploration of experiences to the MDT more generally, rather than maintaining a focus on NQCPs. Also, an investigation of how newly-qualified professionals from other professional disciplines experience CAMHS or other environments, such as mental health nurses or social workers, could be beneficial. The systematic review indicated that there is a dearth of this type of research within mental health.

The current researcher has discussed that the sample size of this research may reduce the generalisability of the emergent themes of this study, and is conscious that a quantitative approach may allow for a much wider pool of professionals to share their views. This could be conducted using a survey created for the specific purposes of the research, or existing measures of workplace stress could be utilised, such as the ERI model (Effort-Reward Imbalance; Siegrist et al., 2004) or the COPSOQ (Copenhagen Psychosocial Questionnaire; Nübling et al., 2006).

Further studies could also pose questions regarding the effects of the stresses and strains of CAMHS work, as well as other types of mental health services, on the retention of staff. If difficulties for staff were to be proposed as potentially detrimental to the length of time they remain in particular services, and organisations were made aware of this, this may encourage them to make changes to avoid this.

On the flipside, future research could more explicitly examine the benefits which emerged for participants in this research, such as the support of supervisors and wider MDT relationships. The disparity between the outcomes of this research and those of Chana et al. (2015), with regard to the utility of supervision, was stark, and it may be useful to identify the particular aspects of the kind of supervision received by NQCPs, which leads to this feeling of support for them.

Also possible are additional investigations of potential gender and cultural factors which may play a part in staff members', such as NQCPs, ability to manage these challenging transitions, as well as their professional aspirations. Equally, the socio-economic context which services are based within could be explored, and the potential impact of the economic difficulties of particular NHS trusts, or geographical areas in general, could be studied. For example, questions to be asked could include: Does one's cultural background and view of the world affect or influence their coping style as a healthcare professional? Do male and female mental health professionals have varying experiences of: the frustrations of their roles and services; and their aspirations to lead within them?⁵ Do newly-qualified staff in more deprived or culturally-diverse areas of the country experience more difficulties in their work than those in more affluent or less ethnically-diverse areas?

There are a number of avenues of further investigation which remain open, and that can follow from this research, all of which could not only benefit healthcare professionals' trainers, the

⁵ Although conceptualising gender as binary in this way has its limitations, this is relevant in the context of research investigating men in professions which are seen as 'women's work' (Williams, 1993), as well as the spaces women occupy in organisations (Sandberg, 2013).

management of organisations they join, and the clinicians themselves, but lead to changes which create more supportive, proficient and effective services, for those who need them most.

4.7 Conclusions and Reflections

My own journey of completing this doctoral thesis work in some ways mirrored the participants' experiences of their transition into NQCP roles. At times I felt overwhelmed, deskilled, I sought various support structures within and external to the University, I found new internal coping mechanisms, and I looked forward to completing and gaining further skills and experience to make me a more proficient scientist-practitioner.

The subject matter has made me consider my own next steps in my career, and the stories I heard have been useful in helping me understand the nature of the challenges which lie ahead, both clinically, and in organisations I may work within. I gained a new-found level of admiration for qualified healthcare professionals, and have every respect for all of my participants; for their ambition, resilience, and, of course, their openness, without which this project would not have been possible.

In short, this has been a challenging yet invigorating experience, one which has helped me develop numerous skills; from research areas such as interviewing, my epistemological understanding, and in qualitative analysis; to more personal strategies, such as in organisation, reflexivity and mental resilience. Again, like the participants, I have been able to acknowledge my development, and recognise how this experience can stand me in good stead in the future.

The completion of this research marks a major, and one of the final, milestones of my clinical training, a journey I have found to be exasperating but invigorating, perplexing yet inspiring. This project has brought up all of these emotions and more, and has been an endeavour which has seen me realise that although pressure can feel perilous, it is also a privilege.

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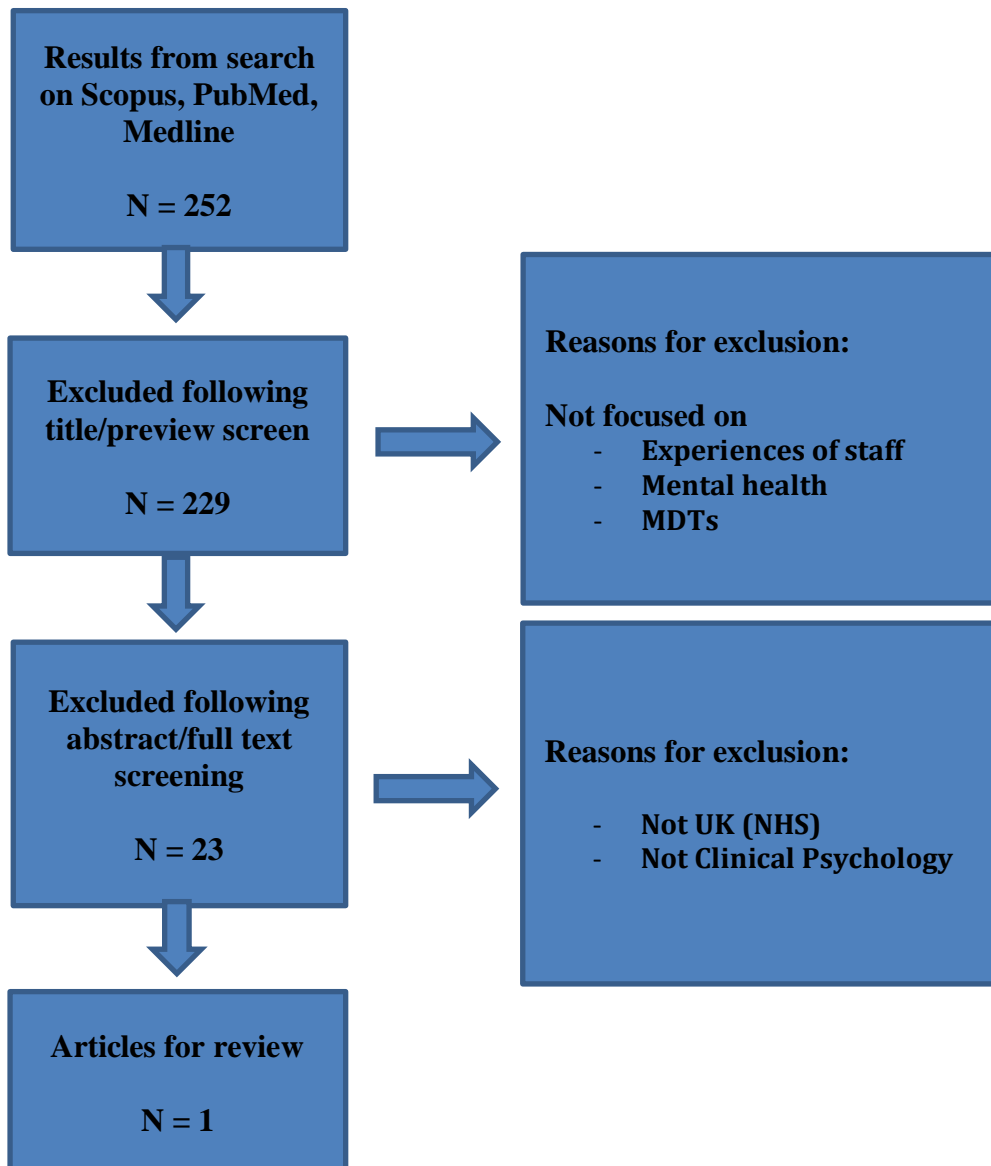
Appendices

Appendix A

Flow charts of stages of process of systematic literature review

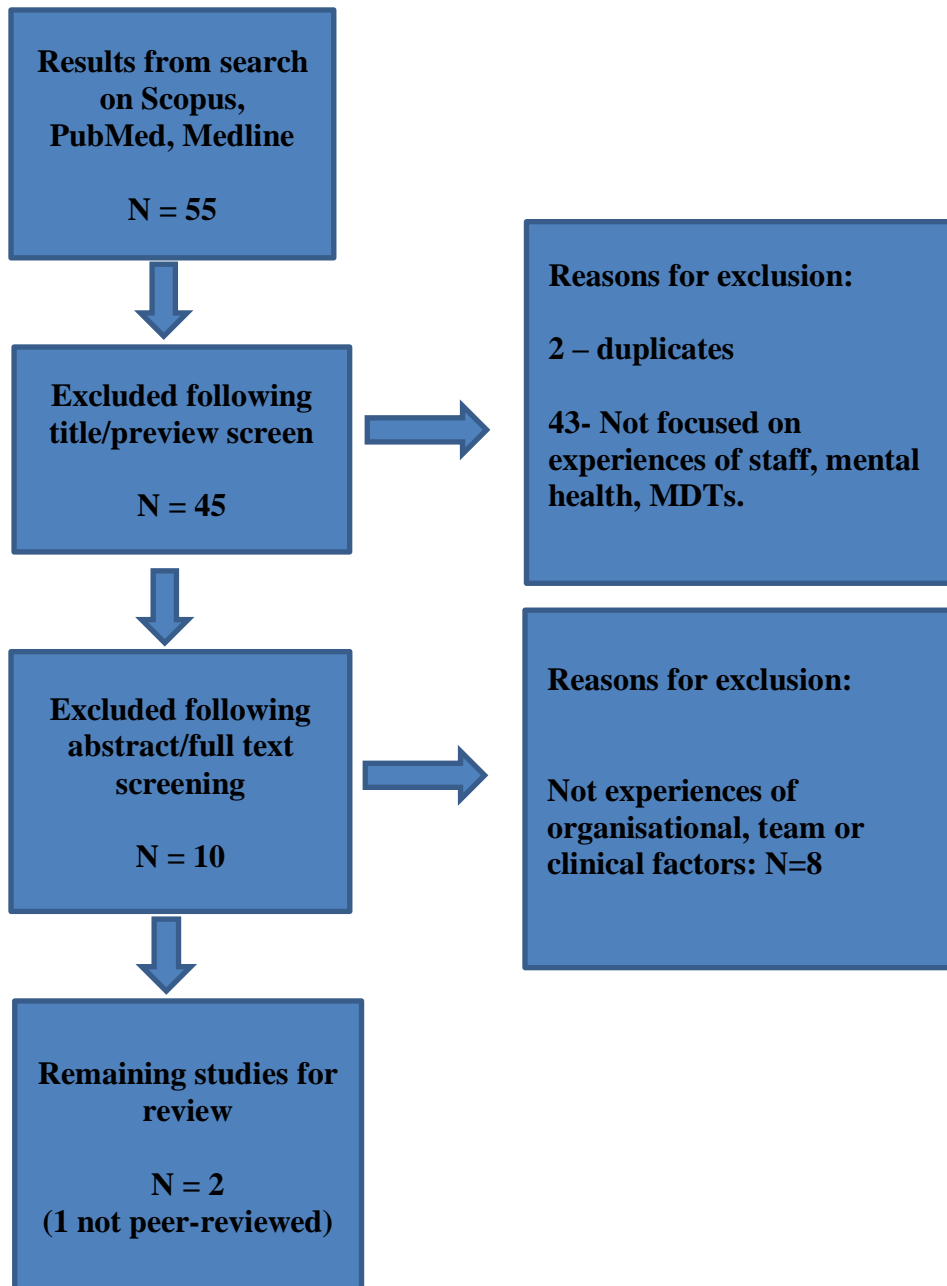
Example of search terms & Results when inclusion criteria only Clinical Psychologists:

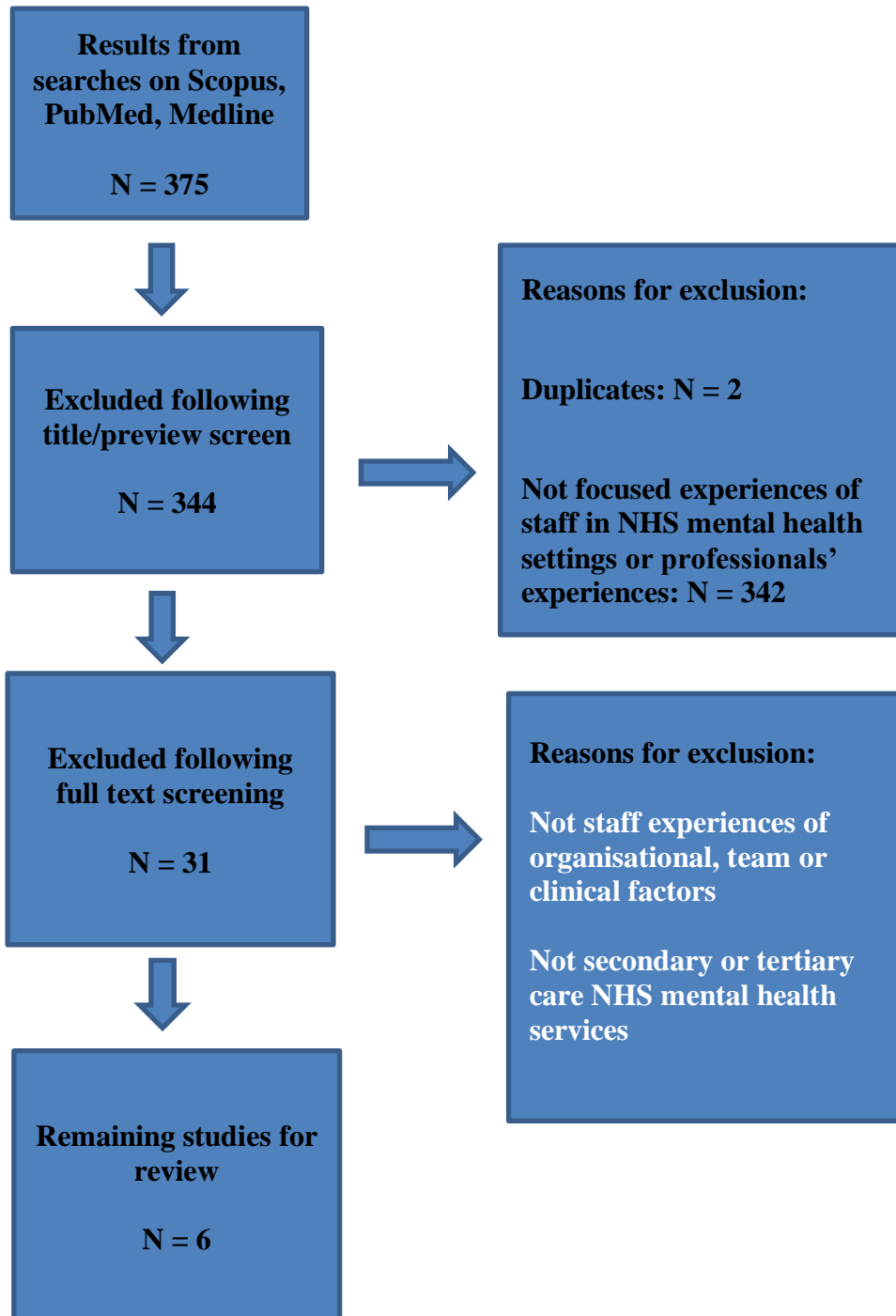
“(Qualified OR newly-qualified OR newly qualified) AND (psycho*) AND (Multi-disciplinary OR mdt OR mdts or OR multi disciplinary) AND (experienc* OR percept* OR interpret* OR transit*) AND (nhs) NOT (heart OR cardio* OR business) NOT (teach* OR radio* OR milit*)”



Example of refined search terms & Results when inclusion criteria only Clinical Psychologists:

“(Clinical) AND (psycholog*) AND (Multi-disciplinary) OR (multi disciplinary) OR (mdt) AND (nhs) NOT (heart) NOT (nursing) NOT (cardio*) NOT (business) NOT (teach*) NOT (radio*) NOT (cancer) NOT (physio*) NOT (milit*) NOT (prison) AND (experienc*) OR (percept*) OR (transit*)”



Results when inclusion criteria broadened to all NHS health professionals:

Appendix B**Inclusion and exclusion criteria for Systematic Literature Review**

Inclusion criteria	Exclusion criteria
Peer reviewed *	Non-peer reviewed
Available in English	Not available in English
UK only	Non-UK studies
Papers which provide an insight into NHS professionals' experiences of organisational, team or clinical issues.	Papers which do not provide an insight into professionals' experiences of organisational, team or clinical issues.
Studies specifically related to inpatient, community or children's mental health services.	Studies specifically related to primary care, forensic or general medical services.

*This criterion dropped during process of review as discussed in 'Introduction' chapter, so to include pertinent research.

Appendix C
Quality of the research utilised in the Systematic Literature Review

Evaluation of Recommended Guidelines for the Qualitative Research Papers of the Review

	Guideline						
	Owning one's perspective	Situating the sample	Grounding in examples	Providing credibility checks	Coherence	Accomplishing general vs specific research tasks	Resonating with reader
Paper							
Colley, R., Eccles, F. & Hutton, C. (2015). <i>Clinical psychologists' experience of NHS organisational change.</i>	The authors did not state their theoretical orientations or assumptions.	The researchers revealed how many years of experience participants had, and whether they had managerial responsibilities. No other information was shared.	Quotes are embedded within the narrative of the 'Results' section, which kept the reporting of the themes ground in the participants' accounts.	Codes were discussed as being based on the text to avoid the researcher's experiences being 'superimposed' onto them, however this was not expanded upon.	Three main themes were illustrated and particular participant reports brought forth in a 'data'-driven narrative results section.	CP's experiences of organizational change were sought for exploration, and this was achieved. Ways in which CPs manage challenges and influence the process was also identified, which met the specific aim of the study potentially aiding CP's adaptation to future change.	The paper created a resonance in the reader, with the material presented in a way which indicated an accurate representation of the experiences of participants.

<p>Currid, T. J. (2008).</p> <p><i>The lived experience and meaning of stress in acute mental health nurses.</i></p>	<p>The researchers utilised an IPA analysis, and therefore outlined the principles of hermeneutics and phenomenology, and the discuss the appropriateness of this approach to their research. They also recognised prejudices borne out of their life histories.</p>	<p>The contexts of where participants worked was discussed, however demographics of the sample were not provided.</p>	<p>A number of participants' quotes were utilised in order to ground the results in their accounts.</p>	<p>The researchers suggest that they shared the themes, and checked their accuracy, with the participants, on two occasions before they were finalised.</p>	<p>Differing themes were presented effectively and coherently. Four overarching themes helped frame the narrative presentation of the results.</p>	<p>The researchers specifically aimed to ascertain the lived experience of stressors of acute qualified mental health staff, and achieved a contribution to the literature to this end.</p>	<p>The material is presented in a way in which it can be judged to accurately represent the portrayals of participants. Implications are offered, therefore themes that were uncovered are attempted to be utilised for practical value in future.</p>
<p>Nugent, E. (2007).</p> <p><i>Effective Inter-Professional Collaboration in Child Mental Health Services.</i></p>	<p>The researcher presents her theoretical orientations and reflects upon her assumptions and biases.</p>	<p>Appropriate demographic information on the participants is provided, however their anonymity maintained.</p>	<p>The author uses a number of participant quotes to allow the reader to contextualise the data.</p>	<p>The author used supervision to check interpretations of the data, while a colleague carried out checks on coding and themes.</p>	<p>This work captures the nuance of individual stories while also presenting an integration of the outcomes of the interviews.</p>	<p>Limitations of generalisation are discussed, however this work focused on a specific task, and offered a model to understand this.</p>	<p>The material is presented in a way which suggests an accurate representation of participants' accounts, and which expands the reader's understanding of this area.</p>

<p>Nutt & Keville (2016).</p> <p><i>'... you kind of frantically go from one thing to the next and there isn't any time for thinking any more': a reflection on the impact of organisational change on relatedness in multidisciplinary teams.</i></p>	<p>The researchers do not present their theoretical orientations or personal anticipations, nor that of the chosen methodology (Narrative Analysis).</p>	<p>The authors give information on the participants, including their gender, workplaces, years of experience, and level of seniority as a Clinical Psychologist in the NHS.</p>	<p>A number of quotes are provided to illustrate the particular theme under consideration in this paper.</p>	<p>Credibility checks are not discussed in this paper, nevertheless the main thesis which this paper is borne out of is referenced, and this discussed in depth the credibility checks which were undertaken.</p>	<p>The theme under consideration was helpfully deconstructed into five distinct categories, which aided the paper in bringing together similar and common participant accounts, while also preserving nuances.</p>	<p>The authors aimed to explore how CPs narrate their experiences of working within community mental health teams. Narratives of 'struggle' were identified, therefore this accomplished the specific research task.</p>	<p>This paper elucidates the challenging experiences of the participants in the results section.</p>
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Evaluation of recommended guidelines for the Quantitative or Mixed Methods Research Papers of the Review

Paper	Guideline						
	Explicit scientific context and purpose	Appropriate methods	Respect for participants	Specification of methods	Appropriate discussion	Clarity of presentation	Contribution to knowledge
Brooker, C., Molyneux, P., Deverill, M., & Repper, J. (1999). <i>Evaluating clinical outcome and staff morale in a rehabilitation team for people with serious mental health problems.</i>	This work considers how it is situated in relation to relevant previous research, and states the intended aims and purposes of the research.	The methods used are appropriate for the aims and research questions of this research (self-reporting, three times over the course of 1 year, for 29 staff members).	The authors did not make mention of ethical considerations including informed consent or confidentiality. They also did not discuss any consideration of potential harm to participants, despite asking about levels of staff stress in an acute setting.	Methods of analysis, as well as the particular questions asked of participants, were specified in the paper.	Discussion section brief, and weaknesses of the measure only alluded to, however the data is tentatively discussed in terms of its potential contribution to practical changes, and future research.	This is a well-presented paper, which utilises tables to illustrate data. Subheadings are used to organise sections, and distinguish the two main research questions and their results.	The paper makes a contribution to aid the understanding of which areas of a particular service may require improvement.
Chana, N., Kennedy, P.,	Aims and objectives of this work	The questionnaire method is	The authors inform the reader that	A brief 'Data Analysis' section	There is a comprehensive discussion, which	This is a very well-presented paper, using a	This research is a very helpful

<p>& Chessell, Z. J. (2015). <i>Nursing staffs' emotional well-being and caring behaviours.</i></p>	<p>are clear. A background section helpfully informs the reader of the context within which this work is based.</p>	<p>appropriate for this large sample of 102 members of staff.</p>	<p>ethical approval was granted, however do not elaborate on aspects of this such as confidentiality and potential harm. The researchers report that a consent was signed by participants.</p>	<p>outlines the methods used. All eight measures used are discussed in some depth, although specific questions of the measures not included.</p>	<p>includes limitations of the study. Contributions of the data to previous knowledge. The results are utilised to make a number of recommendations, to support both staff wellbeing and 'patient' care.</p>	<p>number of tables and figures to elucidate a comprehensive results section. Subheadings are also very helpful in organising the content</p>	<p>contribution to a subject area where little investigation has been carried out.</p>
<p>Higgins, R., Hurst, K., & Wistow, G. (1999). <i>Nursing acute psychiatric patients: A quantitative and qualitative study.</i></p>	<p>The paper specifies where the study fits within relevant literature, while the four principal research questions are outlined.</p>	<p>The procedures utilised are responsive to the particular questions of the study, for example, the use of interviews, questionnaires and observations, of staff activities.</p>	<p>Ethical principles and practices are not discussed in this paper; it is content-heavy with little focus on process.</p>	<p>Procedures for data gathering are not specified, making duplication of the study difficult. The varied methods of analysis are highlighted however.</p>	<p>The rich data and understanding of it is discussed in depth in the context of their contribution to knowledge to aid future policy and practice. Limitations of the study were not discussed.</p>	<p>The manuscript is well organised and well-written, with subheadings signposting the reader to the various outcomes of the research, and their implications.</p>	<p>This work contributes to the knowledge base of policy and practice, and could be drawn upon by managers and clinicians responsible for the running of acute services.</p>

Appendix D
Summary & evaluation of studies in the Systematic Literature Review

Authors, year & Title	Type & Aim	Participants	Methodology	Results and Conclusions	Strengths & Limitations
<p>Nutt & Keville (2016).</p> <p><i>'... you kind of frantically go from one thing to the next and there isn't any time for thinking any more': a reflection on the impact of organisational change on relatedness in multidisciplinary teams.</i></p>	<p>Qualitative.</p> <p>To investigate the impact of organisational change, in the context of cuts and reorganisation, on CPs ability to build alliances with colleagues and clients.</p>	<p>8 participants – qualified Clinical Psychologists between pay bands 7 and 8c.</p>	<p>Qualitative, semi-structured questionnaires utilised.</p> <p>Data was analysed using Narrative Analysis (Mishler, 1997).</p>	<p>This paper focused on one theme (of four from a wider study), titled: 'There isn't any time for thinking any more.'</p> <p>The analysis reveals that change within organisations can result in narratives of struggle for staff.</p> <p>The impact of organisational pressures is reflected in CPs' relationships with their colleagues and clients; while there is also a sense of being pushed away from personal values.</p> <p>Considers how shifting from short-term planning (& financial focus), to long-term thinking re relational values, may be of benefit to the system as a whole (staff & clients).</p>	<p>Adds to the small body of research on professional experiences of NHS organisational change.</p> <p>Discussed validity criteria of the method of analysis.</p> <p>Participants from different services.</p> <p>No information as to the content of the interview.</p>
<p>Colley, R., Eccles, F. & Hutton, C. (2015).</p> <p><i>Clinical psychologists' experience of NHS</i></p>	<p>Qualitative.</p> <p>To capture the organisational change experiences of CPs, to perhaps aid their future adaptation to further changes.</p>	<p>8 Clinical Psychologists working in the NHS – recruited from Lancaster DClinPsy programme stakeholders.</p>	<p>Semi-structured interview schedule.</p> <p>Thematic analysis.</p>	<p>Three themes revealed the challenges they experienced, how their knowledge and skills have helped them cope with change, and what they can take forward from their experiences.</p> <p>The authors suggested that remaining sensitive to the needs of colleagues as well as to the possible effects of</p>	<p>Adding to limited body of research into professional experiences of NHS organisational change.</p> <p>Consultation by members of the profession on the interview outline.</p>

<i>organisational change.</i>				one's own coping styles may enhance the experiences of others in the team. They also encourage CPs to promote their own skills in order to aid future plans and implementations of change within the NHS.	Participants from only one area of the UK. Selection bias – volunteering process and first-come first-served basis – the study may have been more attractive to those who would offer negative reports.
Brooker, C., Molyneux, P., Deverill, M., & Repper, J. (1999). <i>Evaluating clinical outcome and staff morale in a rehabilitation team for people with serious mental health problems.</i>	Quantitative. This study aimed to audit the clinical outcome of the service and in doing so assess staff morale in order to inform future service strategies.	29 members of staff – 14 community mental health nurses, seven support workers, four social workers and four administrative staff.	The Community Psychiatric Nursing Stress Questionnaire.	The majority of stress factors were related to organisational factors, rather than client based. Insight into stress factors can inform management decisions to improve morale and ameliorate staff stress	The questionnaire covered a number of different aspects of employment, useful in helping the researchers pinpoint the specific difficulties for staff. Fair sample size. No inferential statistics used. Could have been useful to investigate the impact of varying types of factors, e.g. organisational versus team issues.
Currid, T. J. (2008). <i>The lived experience and meaning of stress in acute mental health nurses.</i>	Qualitative This study aimed to ascertain the experience and meaning of the stressors for acute qualified mental health staff.	8 qualified MH nurses.	Semi-structured interview format utilised. Interviews transcribed and analysed using IPA.	Heavy workload can contribute to poor support from management and fear of blame. This led to feeling less valued and struggling to be recognised for one's professional values. Stress reduction strategies needed to aid nurses.	Adding to limited body of research on mental health care in an acute setting. Study carried out at a time where finances were particularly challenging within the organisation. (This can be seen as either a strength or weakness of the paper, however

					<p>generalisability of the findings may be compromised by this).</p> <p>Participants from the same NHS Trust.</p> <p>Experiences of staff were looked at over a brief period of time.</p>
<p>Chana, N., Kennedy, P., & Chessell, Z. J. (2015).</p> <p><i>Nursing staffs' emotional well-being and caring behaviours.</i></p>	<p>Quantitative</p> <p>“To examine the relationships between structural factors (work stressors), individual factors (demographics and the personal resources of resilience and social support) and transactional factors (appraisals and coping), and nursing staffs' levels of burnout, psychological distress and caring behaviours. A further aim was to examine the relationships between nursing</p>	<p>102 nursing staff</p>	<p>A cross-sectional correlation-based survey design.</p> <p>Questionnaires: Nursing Stress Scale, Social Support Questionnaire-Short Form, Connor and Davidson Resilience Scale-2, Occupational Coping Self-Efficacy Scale for Nurses, Psych- Nurse Scale, Maslach Burnout Inventory, The Hospital Anxiety and Depression</p>	<p>‘Emotional exhaustion’ ‘depression’ and ‘anxiety’ positively correlated with measure items titled ‘inadequate preparation to deal with the emotional needs of patients and their families,’ ‘work load’ and ‘lack of staff support.’</p> <p>‘Emotional exhaustion’ and ‘anxiety’ were also positively correlated with ‘conflict with nurses / supervisors.’</p> <p>‘Emotional exhaustion’ negatively correlated with ‘social support,’ indicating that this may be a protective factor in reducing emotional difficulties, as well as with various coping strategies.</p> <p>The authors conclude that emotional well-being of nursing staff needs to be supported, both for them and patients.</p> <p>They make recommendations to NHS employers, including that workloads must be monitored to avoid a reduction in authentic caring</p>	<p>All participants from the same NHS Trust – a convenience sample.</p> <p>A number of measures used. The researcher acknowledges the limited validity and reliability of the questionnaire used.</p> <p>Non-parametric analyses following results of assumption testing.</p> <p>Correlational rather than utilising regressions to identify direction of causality.</p>

	staffs' levels of burnout and psychological distress and their caring behaviours. "		Scale and Caring Behaviours Inventory-revised . Non-parametric tests carried out.	behaviour, as well as that employers should help staff foster a positive work life balance and social support both in and outside of the workplace.. Further training is also suggested to be necessary.	
Higgins, R., Hurst, K., & Wistow, G. (1999). <i>Nursing acute psychiatric patients: A quantitative and qualitative study.</i>	Mixed methods To examine care in acute mental health wards, looking at four areas including the activities undertaken, and continuing education, of staff, in order to inform policy and practice.	11 sites – not all information provided, however 118 staff completed questionnaire.	Four methods of data collection: Statistical profiles of the services; Sstaff and patient interviews; Staff and patient questionnaires; Non-participant observation.	Multi-disciplinary processes not always appropriately developed; timely clinical work and communication between staff could be more effective. Poor morale, due to factors including work-load pressures on staff time and a resulting inability to provide appropriate supervision to colleagues, and holistic care to patients. Newly-qualified staff believed that they were under-prepared for what they faced in the wards, due to a lack of sufficient experience. Further examination of the mental health services and relevant remedial action must be undertaken in order to develop effective services across the country.	Adding to limited body of research on mental health care in an acute setting. Large and extensive study funded by DoH. Various methods of data collection – triangulation of findings. Study so broad that it also gained an insight into community processes connected to acute care.
Nugent, E. (2007).	Qualitative	8 male and 11 female healthcare	Semi-structured interviews.	The data indicated three main areas effect inter-professional collaboration,	First ever study to investigate multidisciplinary perspectives of what facilitates effective inter-

<p><i>Effective Inter-Professional Collaboration in Child Mental Health Services.</i></p>	<p>To investigate how professionals within CAMHS settings experience inter-professional collaboration, and identify the main factors associated with effective inter-professional working.</p>	<p>staff, from a range of professional backgrounds, including Clinical Psychology and Psychiatry across seven MDTs.</p>	<p>Grounded Theory.</p>	<p>namely ‘interpersonal factors, team culture, and organisational factors.’</p> <p>These three overarching themes were comprised of factors such as: ‘understanding of professional roles,’ ‘willing participation,’ ‘informal processes,’ ‘trust and mutual respect’ ‘professional drivers,’ ‘workspace’ and ‘supportive management’. This displays the ‘multi-factorial’ and ‘complex’ (pg. i) interweaving of features within teams that can contribute towards effective inter-professional teamwork.</p> <p>Complex and multi-factorial mediating factors can facilitate effective teamwork, or inhibit it. Future research assessing inter-professional working should retain a focus on the three main factors identified; interpersonal, team culture, and organisational.</p>	<p>professional collaboration within CAMHS MDTs.</p> <p>A small sample size which restricts the validity of generalising the findings, however sample size greater than other similar studies.</p> <p>A balance of professions interviewed. Sampling bias also reduced due to participants being recruited from seven different MDTs.</p>
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Appendix E

Recruitment advert

Dear all

I am looking for Clinical Psychologists in their first 2 years of employment following qualification (at any banding), to participate in research exploring:

'Experiences of Newly Qualified Clinical Psychologists working within Multi-Disciplinary teams in CAMHS.'

Participants will be required to attend a single 1 hour interview regarding their experiences.

This is a qualitative research study where content is expected to emerge from participants' accounts, however the aims of the study are to provide insight into the experiences of Clinical Psychologists, in regard to MDT working, the potential effects of current contextual factors, readiness following training (potentially elucidating the strengths and areas for improvement in training programmes), as well as coping management and resources.

Therefore topics of enquiry **may** include CP's roles as part of an MDT, adjustment, relevant contextual factors, and sources of support.

Contact details:

s.levinson@herts.ac.uk

Please feel free to pass on this address to anyone you think may be interested.

Best wishes

Appendix F
Ethics approval notification



HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA
ETHICS APPROVAL NOTIFICATION

TO: Simon Levinson **CC:** Dr Pieter Nel **FROM:** Rev/ Dr Kim Goode, Health, Sciences, Engineering & Technology ECDA Chair **DATE:** 9th June 2017

Protocol number: LMS/PGR/UH/02699 Title of study: *Experiences of Newly Qualified Clinical Psychologists working within Multi-*

Disciplinary teams in CAMHS

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 09/06/17 To: 01/06/18 Additional workers: no additional workers named Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered

misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix G
Letter of HRA Approval**Health Research Authority**Email: hra.approval@nhs.net

Dr Pieter Nel
Programme Director, Doctorate in Clinical Psychology,
University of Hertfordshire
Cambridge and Peterborough Foundation Trust
Health & Human Sciences Research Institute, Room 1F414,
Health Research Building,
College Lane Campus, University of Hertfordshire,
Hatfield
AL10 9AB

05 July 2017

Dear Dr Nel,

Letter of HRA Approval

Study title: Experiences of Newly Qualified Clinical Psychologists working within Multi-Disciplinary teams in CAMHS (Child and Adolescent Mental Health Services).

IRAS project ID: 224452
Protocol number: LMS/PGR/NHS/02699
Sponsor University of Hertfordshire

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

Participation of NHS Organisations in England

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

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

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities

- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.

- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

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

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

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document “After HRA Approval – guidance for sponsors and investigators” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research

- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is 224452. Please quote this on all correspondence.

Yours sincerely

[Thomas Fairman HRA Assessor](#)

Email: hra.approval@nhs.net

Copy to:

Professor John Senior, University of Hertfordshire, (Sponsor Contact) Ms Thanusha Balakumar, HPFT, (Lead NHS R&D Contact)

Appendix H Participant Information Sheet

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
(‘ETHICS COMMITTEE’)

FORM EC6: PARTICIPANT INFORMATION SHEET

1 **Title of study**

Experiences of Newly Qualified Clinical Psychologists working within Multi-Disciplinary Teams in CAMHS (Child and Adolescent Mental Health Services).

2 **Introduction**

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University’s regulations governing the conduct of studies involving human participants can be accessed via this link:

<http://sitem.herts.ac.uk/secreg/upr/RE01.htm>

Thank you for reading this.

3 **What is the purpose of this study?**

The purpose of this study is to explore experiences of Newly Qualified Clinical Psychologists (those within the first two years of work following their qualification), within Multi-Disciplinary teams within CAMHS services in England.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it.

You are free to withdraw from this study at any time up to two weeks after your interview has been completed. This time limit has been set due to the impact a later withdrawal may have on the potential completion of the study, due to only 6-8 participants taking part in the study and being included in the analyses.

5 **Are there any age or other restrictions that may prevent me from participating?**

For the purposes of this research, a Newly Qualified Clinical Psychologist is defined as one who has not been practicing (in the NHS) for two years or more. This is because the British Psychological Society recommends that Clinical Psychologists who are able to provide supervision to others should have at least two years of experience following their qualification. Therefore you will not be able to participate if you are a Clinical Psychologist who has been working in the NHS for more than two years.

6 How long will my part in the study take?

If you decide to take part in this study, you will only be required to take part in a single 1-hour long interview.

7 What will happen to me if I take part?

During this interview, you will be asked about your experiences of your role as Clinical Psychologist in the NHS. This interview will be audio-recorded, and your interview transcribed, in order to be used as part of a wider qualitative data analysis.

8 What are the possible disadvantages, risks or side effects of taking part?

Questions may bring up emotionally charged previous experiences of your work, however you will be free to pause the interview, or discontinue it if you feel this is necessary.

9 What are the possible benefits of taking part?

You may be able to share information which may be of benefit to future trainee and qualified Clinical Psychologists, as well as their trainers and employers, in the future.

10 How will my taking part in this study be kept confidential?

Only the Student and supervisors will have access to participants' personal data, via consent forms which will be stored in a locked box at the Student's home. The audio recording of the interview will not reveal any personally identifiable information; all interviews will be coded against the consent forms.

Your interview will be transcribed by either the student or a transcription service. If a transcription service is used to transcribe your interview, a signed non-disclosure / confidentiality agreement from the service will be gained prior to giving them the recording. Further to this, all names and identifiable information will be removed from the transcripts by the researcher and kept securely and separately from the transcripts.

Results will be reported in a thesis for the purpose of gaining a Doctorate in Clinical Psychology. Due to the qualitative nature of the methodology, direct quotations from transcripts may appear in the final paper, and there may be a small chance that those that know you may identify you; however, all efforts will be made to reduce this possibility. The thesis will be held at the University of Hertfordshire Learning Resource Centre and will be accessible to interested parties.

11 Audio material

Audio material from the interview will be recorded and stored. This coded data will be kept on the student's personal computer.

12 What will happen to the data collected within this study?

12.1 The data collected (audio interview and transcript) will be stored electronically, in a password-protected environment, for a maximum of 5 years, after which time it will be destroyed under secure conditions;

12.2 The data collected (consent form) will be stored in hard copy by the student in a locked cupboard for a maximum of 5 years, after which time it will be destroyed under secure conditions;

12.3 The data will be anonymised prior to storage.

12.4 The data will be transmitted only to the supervisory team.

13 Will the data be required for use in further studies?

You are consenting to the re-use or further analysis of the data collected in a future ethically-approved study;

The data collected (audio interview and transcript) will be stored electronically, in a password-protected environment, for a maximum of 5 years, after which time it will be destroyed under secure conditions;

The data collected (consent forms) will be stored in hard copy by the Student in a locked cupboard for a maximum of 5 years, after which time it will be destroyed under secure conditions.

14 Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority

The UH protocol number is: LMS/PGR/NHS/02699

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities.

16 Opt-in to receive final publication

Participants can opt to be sent a copy of the results, in the form of a final publication, on the Participant Consent Form. Therefore, as in point 12.2 above, your consent forms

(which will include your email address) will be stored as a hard copy by the Student in a locked cupboard for a maximum of 5 years, after which time it will be destroyed under secure conditions. I would expect you to receive the results in the form of the final peer-reviewed article, between January and December 2019.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by phone or by email: s.levinson@herts.ac.uk

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar.

Thank you very much for reading this information and giving consideration to taking part in this study.

**Appendix I
Consent Form**

FORM EC3 - ETHICS COMMITTEE CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

UNIVERSITY OF HERTFORDSHIRE

I, the undersigned [*please give your name here, in BLOCK CAPITALS*]

.....
of [*please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address*]
.....

.....
hereby freely agree to take part in the study entitled
Experiences of Newly-Qualified Clinical Psychologists' working within Multi-Disciplinary Teams in CAMHS (Child & Adolescent Mental Health Services): An IPA Study.
(UH Protocol numberLMS/PGR/NHS/02699.....)

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw my interview from the study ***any time up to two weeks after my interview has been recorded***, without disadvantage or having to give a reason, with this time limit set due to the impact a later withdrawal may have on the potential completion of the study.

3 In giving my consent to participate in this study, I understand that audio recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

4 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

5 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

6 I have been told that I may at some time in the future be contacted again in connection with this or another study.

Please indicate if you would like to be directed to a copy of the final peer-reviewed publication

Yes No

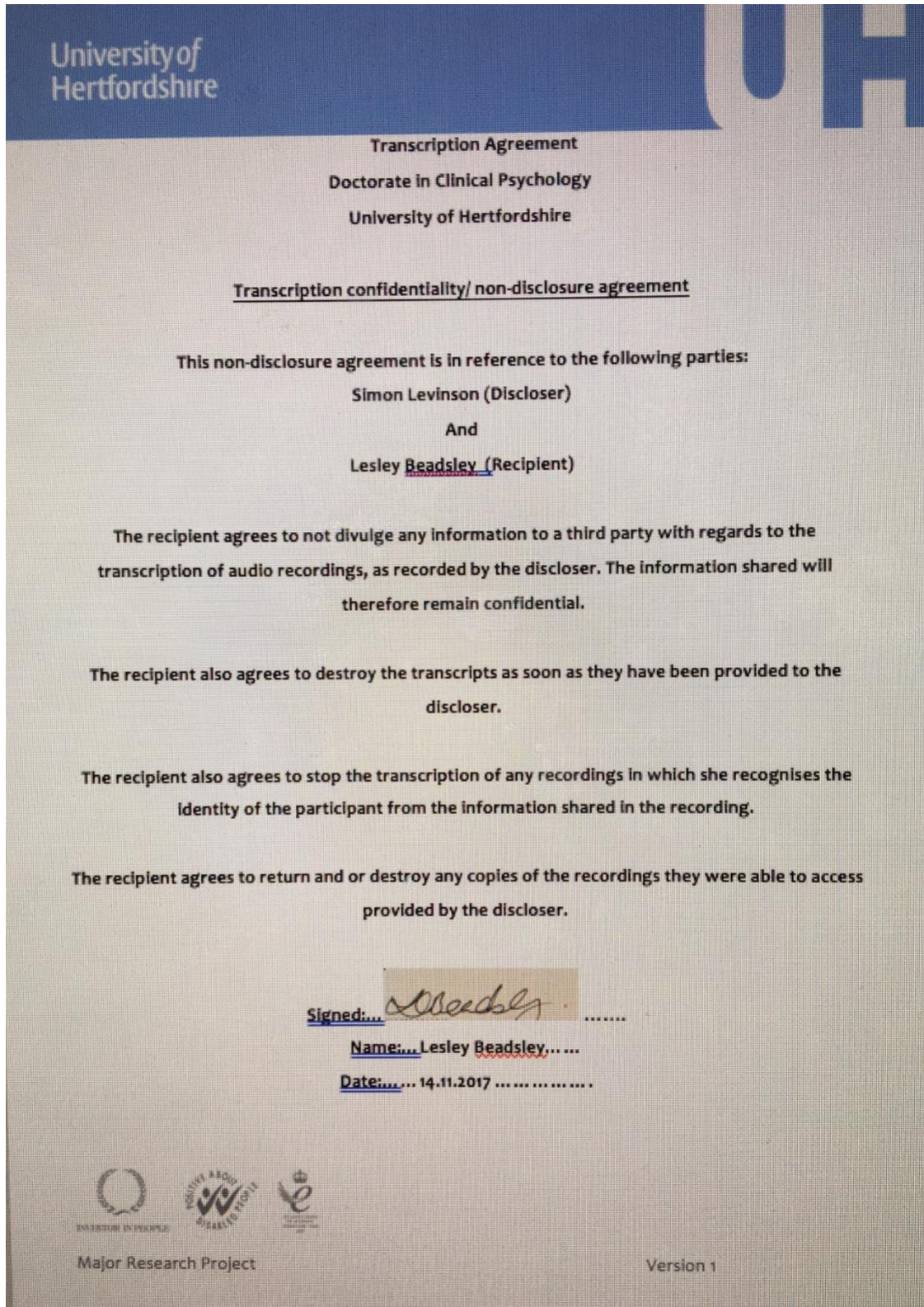
Signature of participant..... Date.....

Signature of (principal) investigator Date.....

Name of (principal) investigator
.....*SIMON LEVINSON*.....

Appendix J

Non-disclosure, confidentiality agreement signed by the transcription service



Appendix K

Final Interview Schedule

PROFESSIONAL AND PERSONAL DEVELOPMENT

What is your experience of the transition/adjustment from trainee to qualified professional?

as a: professional?

person?

psychologist?

(What is your experience of your ongoing development?)

CONTEXTS

What is your experience as a newly qualified CP of (your role in) the context of the NHS as a changing organisation?

(financial, structural, cultural factors)

What are your experiences as a newly qualified CP of multi-disciplinary team work?

(this may be meetings / joint clinical work)

What skills do you have as a newly qualified CP in working with MDTs?

- Where these are from? (doctorate training/ Pre-training/ Ongoing learning?)

In relation to your role, what are your experiences as a newly qualified CP of any (personal or collaborative) difficulties or successes?

(personal/ related to MDT or organisation / cultural factors)?

- Can you tell me about your experience of mental/physical/emotional/relational reactions to any difficulties?

COPING

What helps support you / helps you cope in your role as a newly qualified CP ?

- is this from clinical training?
- from workplace (supervision/further training eg CPD)?
- personal skills/strategies?

How do you feel about how prepared/ready you were for your role as a newly qualified CP?

- knowledge base
- specific skills... eg clinical/team skills
- Where are these from? (clinical training/ Pre-training/ Ongoing training)

Appendix L

Example of analytical process from transcript to final themes and quotes

P2 27.10.2017.MP3

Reflections:

Bold = repeated quotes/comments (descriptive/conceptual/thematic)

Italics – linguistic comments/interpretations

Reflections	Text	Emerging themes
<p>Tricky (question) Difficult - shock – “dont feel like a trainee” - feeling responsible ‘All’ x2 – so much ‘Support’ – metaphor ‘you are on your own’ – isolated realise x2/shock</p> <p>Feeling responsible Missing the teaching – new knowledge & rest days? Previous strategies – consolidation Loss of resources/strategies</p> <p>Support mediating transition/more resp?</p>	<p>SL: [00:00:01] The first question is, um, what is your experience of the transition or adjustment from being a trainee to being a qualified professional?</p> <p>P1: [00:00:13] Well, umm, that's a tricky one. Looking back the transition was quite difficult, erm, I think it comes as a bit of shock and you really don't feel like a trainee anymore, um because all of a sudden you realise that you are responsible I think for all of your work, all of your clients, erm and although I had an amazing supervisor um when I first started er in CAMHS, umm who, and so I had really regular supervision which was really nice and very supportive. And but yeah all of a sudden you realize you on, you are on your own.</p> <p>SL: [00:00:59] Mmm.</p> <p>P1: [00:00:59] And it is your responsibility, erm, and I think I missed the teaching as well, like the, say you're busy working with your clients and then on Thursdays and Fridays you would go into uni and you would be taught kind of new stuff or you would consolidate old stuff and that would help you with then your clinical work and you just don't get that anymore, and you don't have the time to revisit that stuff. Yeah...</p> <p>SL: [00:01:26] Well hopefully we'll come back to some of the main points you've said there, but I just wanted to go back to the feeling responsible...</p>	<p>Transition is difficult Transition is difficult Feeling increased responsibility Importance of supervision Importance of supervision Feeling isolated</p> <p>Increased responsibility Loss of past resources</p> <p>Transition is difficult Loss of thinking time</p>

<p>Less responsibility before, more now. Burden/weight</p> <p><i>'on yours' (head) – jeopardy</i></p> <p>Risk – complex – danger Where is support from? Loss of support cautious not to miss anything – danger of missing? More responsibility than before Danger – responsib. / fear of mistakes.</p> <p>(Fear? Avoidance? Discomfort?)</p> <p>Head on the block Fucked up – fear of missing something</p>	<p>P1: [00:01:33] mmhmm..</p> <p>SL: [00:01:33] And, and ask what that felt like, so that, it sounded like it was a new responsibility.</p> <p>P1: [00:01:39] Ummm...</p> <p>SL: [00:01:39]... level of responsibility.</p> <p>P1: [00:01:41] Yeah I think when you go through training you kind of make yourself feel better by thinking that actually, if anything goes wrong, it's on your supervisor's head, umm.</p> <p>SL: [00:01:52] Mmm.</p> <p>P1: [00:01:52] Whereas now it's definitely on yours. Umm, and I went into working in the adolescent team in CAMHS which is the team that deals with the sort of more high risk, more complex young people, um and so it was kind of figuring out where else you got your support from checking out your decisions, making sure that you'd kind of done everything that you needed to do, um in terms of mostly managing the risk I think, um, yeh was the challenging part, you're kind of, you feel a bit responsible for somebody else's life (laugh), which I think you don't necessarily feel so much when you're on training.</p> <p>SL: [00:02:38] I notice that we're like doing kind of like a rye smile about this.</p> <p>P1: [00:02:40] (laugh)</p> <p>SL: [00:02:40] And I wonder if there's any like feelings to be named around the being responsible for someone's life as you put it.</p> <p>P1 [00:02:51] Yeh...</p> <p>SL: [00:02:52] And what that experience is.</p>	<p>New level of responsibility</p> <p>Increased level of responsibility</p> <p>Wanting more support New level of responsibility</p> <p>New level of responsibility to training</p>
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<p>Fearing feeling of ‘fucked up’ x2</p> <p>‘Yeah’ - a fear of harm not always possible to help ppl Helpless sometimes people cant be helped You may accept – but will your organisation? (You v organization?)</p> <p>Blame x 3 Fault x 3 Shame/judgment from colleagues</p> <p>Fear of judgement 4th fault</p> <p>personal dilemma x2 * Pressure from service?</p> <p>‘need’ x3 to disch. Pressure. ‘you’ (her) Personal dilemma x 2 personal v org’al philosophies? ‘prob come back’ – no control?</p>	<p>P1: [00:02:54] Oh that's a tricky one, I think... [5] essenti- oh... [3] It's hard but there's kind of, you really don't want it to like, mm, your head to be on the block basically, you don't want to have massively fucked up if I'm honest, and have missed something that means that somebody you're working with has done something really dangerous, um, yeah. And essentially you would then hold that feeling that you have massively fucked up, ummm..</p> <p>SL: [00:03:34] So is that a fear?</p> <p>P1: [00:03:36] Yeah I think a fear and also like a wanting to help people. Um and the I think the realisation that that's not always possible. And also I think in some way a bit of a helplessness that actually you kind of recognize, start to recognize that no matter what you do actually sometimes the situation is just.. that you can't help some people at that moment in time you can only do what you can do. And I think it's the acceptance of that. And will your organization also accept that?... Yeah I think there is a massive culture of blame covering backs and things like that. And I think you recognize that very quickly. Um, I don't want to be the person who gets blamed. Whether it's your, fault or not. And I don't think it would be that person's fault or my fault but it would feel that way. And it would feel like your colleagues felt that it was that way.</p> <p>SL: [00:04:36] Which way would your colleagues feel it was, was?</p> <p>P1: [00:04:39] I think some - you would feel that some of your colleagues thought that it was your fault and you could've done something different.</p> <p>SL: [00:04:46] Can you say any more about that kind of dilemma of, umm, realizing that you can't help everyone the way you'd like to, but that it might not be accepted.</p> <p>P1: [00:05:03] Um, I think that's more I think of a personal dilemma that I have rather than an organizational one that I feel within the organization because now within CAMHS there's very much a focus on</p>	<p>New level of responsibility</p> <p>Not wanting to make mistakes/miss something. New level of responsibility</p> <p>Wanting to do more/help Feeling limited Feeling deskilled Accepting limitations Accepting limitations</p> <p>Fear of blame & shame</p> <p>Fear of blame Fear of blame Fear of shame/judgment</p> <p>Fear of being at fault/ shame</p>
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<p>Ignore – coping strategy? – avoid Laugh - Discomfort with the org ’s approach Benefits from team & autonomy <i>Hiding something from service (whispering to me!)</i> - Personal v organizational rules/values/ideas. - Team as support. - Independence as coping mechanism?</p> <p>[team (personal) v organisation beliefs/values? Difference in outlooks? Trust as a useful resource?</p> <p>Phases - confidence building ‘know nothing’ -deskilled? Thoughts that protocols help (reduce anxiety) at first Now thinks they don’t. growing confidence/comfort. Less dependent on structures. become more...assured? still wants training – (as resource). gap in training – too broad?</p>	<p>you do something short term, somebody might not be completely better but you need to discharge them because you need throughput and you need to see more people. Um, wh - and so I think for me it is more of a personal dilemma of wanting to help somebody so they don't have to come back. Whereas I think the CAMHS philosophy is more now that actually we kinda get someone as okay as they can be and they'll probably come back in the future.</p> <p>SL: [00:05:44] How does that sit with you?</p> <p>P1: [00:05:46] Err, I tend to ignore that (laugh), erm.. And I think I'm quite lucky in the team that I am in, in that we do deal with the more complex people and so I don't tend to get questioned very much about how many sessions some people have had, (whisper) some people have had a lot...</p> <p>SL: [00:06:02] Ok, so you kind of... Is it kind of trying to do your own thing?</p> <p>P1: [00:06:08] Yeah. Yeah I think so. Um, and I think I'm quite fortunate in that the team I'm in I'm kind of trusted to do my own thing and to make the appropriate clinical decisions as to when people are ready to move on or not.</p> <p>SL: [00:06:26] Mmm.. We're kind of moving towards um, this idea of you in the context, but I don't want to miss a question about how you f - experienced or how you feel your, your development is, has been continuing since qualifying. So I wanted to ask about that and maybe return to the context. So it's kind of a question around how you see your, at the moment your ongoing development.</p> <p>P1: [00:06:53] Mmm, I think.</p> <p>SL: [00:06:56] I guess it's connected to what you're talking about as well, you know.</p>	<p>Under pressure to do Under pressure to do Under pressure Dilemma/conflict between her and org/service Accepting limitations</p> <p>Feeling supported by team Feeling trusted/autonomous?</p> <p>Feeling supported by team. Feeling supported by team</p>
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<p>Wants more ‘solid’ -ity. But still feeling uncertain (models)</p> <p>Wanting to be grounded in models at advanced level</p> <p><i>(I used the word first) but “Grounding” as anxiety reduction?</i></p> <p>Feeling safe and utilising structure to manage difficult feelings (e.g being overwhelmed?)</p> <p>Strategies to manage anxiety/fear (e.g. feeling grounded)?</p> <p>Gap in /limit of training – not advanced enough?</p> <p><i>She keeps using word – 3rd time.</i></p> <p>Specific models – specific tools. A way to manage (that has developed/changed – is new?)</p> <p>‘Focus’ from NHS -> scrutiny? Pressure?</p>	<p>P1: [00:06:58] Yeh, and it kind of went in phases for me. I think when I started it was like - I know nothing. And I want to go back to my books and I want to remind myself of protocols and all of that kind of stuff. And then I think the more you try and use protocols the less you, the more you realize that actually they don't really help you very much. And so then you kind of feel more comfortable in that you know your stuff and your development... you kind of pick and choose what you look at whenever. But now I think having been there about a year - I'm now kind of starting to think about well if somebody asked me what models do you use actually what do I use and why do I use it? And looking at kind of more training to feel like I'm more solid in particular models whereas I feel ***** gives you a very broad kind of umm experience of a number of different models. Whereas if you said well what one do you use? Well I can't really answer that question.</p> <p>SL: [00:08:05] So there's something about wanting to be grounded in.</p> <p>P1: [00:08:07] Yeah...</p> <p>SL: [00:08:08] In theory or something?</p> <p>P1: [00:08:08] Yeh, having a basic grounding. Well sorry a more advanced grounding in fewer models but actually it's trying decide which models do I like the most.</p> <p>SL: [00:08:20] So it's interesting because I'm hearing you say that you'd like to be grounded now in more specifics, but at the beginning once you qualified and moved into this job you looked at protocols and you, I think you said that it wasn't so helpful to have protocols.</p> <p>P1: [00:08:33] Yeh.</p> <p>SL: [00:08:33] So I'm wondering what that's about, at the beginning wanting protocols, but finding actually, no that wasn't so...</p>	<p>(Phases of transition) Feeling deskilled Wanting knowledge.</p> <p>Feeling more confident</p> <p>Feeling more confident/settled Training was broad in prep.</p> <p>Feeling more settled</p>
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<p>Justify self? To organisation <i>We – Clinical Psychology</i> (them v us) CP less appealing <i>better – more/broader skills/models/’ -ways of thinking?</i> Standing up for the profession to the org Wants to be more confident – keep developing – thinking it is ongoing Explicit x2 Sharing something of CP with org.</p> <p>Promoting the profession Wanted to communicate with CP more</p> <p>Comfort (x2) in camhs – what she did in training.</p> <p>Confident x2 <i>‘become’ then to now – development</i> Gaining confidence/ <i>‘taking on’</i> Team as resource?</p>	<p>P1: [00:08:37] I think now about being more grounded in the techniques of specific models perhaps rather than a protocol of - you do this in each session. I think is the difference now. It's like being more specific in my toolbox. Um yeah.</p> <p>SL: [00:08:57] And I'm just wondering, what would be the reason or reasons now that you'd want to be able to say, 'cause I think you sort of talked about relationally, you want to be able to show or say that you have a model. So what would be underneath that, what would be the reason why?</p> <p>P1: [00:09:16] Um, I think there's something about, within the, certainly within CAMHS, within the NHS there's a real focus on people using CBT which don't get me wrong I think it has its place but I think it's important to be able to say that I used this other thing because - I used this other thing because - And actually provide evidence for th- for why we're useful rather than a CBT therapist being employed, I think there's, professionally I think that clinical psychologists are becoming less appealing within CAMHS because we're expensive, and so we need to start thinking politically about OK well why am I better than these other people and being explicit about that and that's the models that we're trained in and that's the ways of thinking that were trained in which is different. And so I guess I want to be able to be more confident and explicit about that for myself so that then I can share that, with the organization.</p> <p>SL: [00:10:22] So is it kind of about proving to others your value or - I don't want to put words in your mouth...</p> <p>P1: [00:10:29] Yeah. Maybe, uh, proving I think is not quite the right word. But I think erm I guess illustrating umm I think - and kind of promoting the profession. Um, yeah I think the number of clinical psychology certainly when I started wasn't that high in CAMHS and that wasn't really what I signed up for initially.</p>	<p>Feeling more settled/confident? ('grounded')</p> <p>Trying to make sense of new role.</p> <p>Trying to make sense of new role. Growing confidence Desire for development/ increased confidence</p> <p>Difficult initial transition</p>
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<p>Increasing responsibility ‘Avoid/approach’ Try and try – ‘exposure’ Change in (confidence in) professional identity/role. Now more rounded. ‘not to change, but try & implement’ – gauging what’s possible...</p> <p>limits of powers (above was limitations of therapy)</p> <p><i>Change (as has she)</i> Training experience useful <i>Imposed – an imposition</i> <i>‘the teams’ Them v us.</i> Unhappiness of staff – her friends? As a result she’s unhappy. <i>‘the organisation’ – them.</i> Valuing development.</p>	<p>SL: [00:10:58] Mm, okay, we'll come back to that context, that's really important. But I just wanted to ask also about um your experience of your transition in terms of you as a person rather than only as the CAMHS practitioner.</p> <p>P1: [00:11:13] Yeh.</p> <p>SL: [00:11:13] And whether there's been any changes or...</p> <p>P1: [00:11:16] That's a hard one, umm, I guess I feel quite comfortable in CAMHS um and in the CAMHS I'm in it's also a fairly comfortable setting because I've worked in a very similar setting as a trainee. So I think the experience of CAMHS itself um I think hasn't felt particularly different. For me as a person... [4] ohh that's hard (laugh) erm, probably I've become more confident. I think when you first start you still feel a little bit like a trainee and that you're going into your next placement. So I think I've become a little bit more confident within the team um I think in sharing my opinions, voicing my views, taking on more responsibilities that sort of thing. I think it's taken quite a long time but also I think now feeling more able to - not change things but try and implement some changes, try and suggest new ways of doing something. And actually I now see that as my role as well whereas I think before I was like, no I come in I do therapy with clients and that's it (laugh)</p> <p>SL: [00:12:37] So it's changed over the year?</p> <p>P1: [00:12:37] Yeah.</p> <p>SL: [00:12:38] Over this first year.</p> <p>P1: [00:12:39] Yeah.</p> <p>SL: [00:12:39] Okay so moving on to sort of contexts, um wanted to ask what are your experiences of your role in the context of NHS or organisational factors, so I think you've begun to touch on that.</p>	<p>Feel more confident/settled. Feel more comfortable/conf Training preparing for post-qual. Feeling more confident</p> <p>Feeling more confident. sharing opinions. More responsibilities. Trying to expose self – feeling more confident. Making sense of role. Increased responsibility.</p>
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	<p>P1: [00:12:53] Mmhmm, um I think, ohh, the CAMHS I am in erm has undergone some quite significant change. Erm I knew this was kind of coming because, so we were taken over by a different trust, erm, when I was actually a trainee, in a very, in the sort of similar location. Erm and a lot of change was imposed on erm the teams, lots of restructuring, lots of people left lots of people very unhappy. So I went into quite a discontented (laugh) group of people some of whom are still not overly happy. Um, yeah in a place where kind</p>	<p>Changing NHS context</p> <p>Training prep for post-qual Changing NHS context.</p> <p>Difficult context</p>
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Repeated and pertinent emerging themes from transcript (repetitions removed, moving towards clustering):	
Difficult transition	Importance of work-life balance for coping.
Increased responsibility to training	Clinical training experiences preparing for new role.
Feeling isolated	Importance of supportive supervision.
Feeling under pressure	Importance of peer support.
Fear of doing harm	Importance of ‘trust’ in relationships.
Fear of blame & shame	Realisation of ongoing development
Loss of support in transition.	Growing confidence.
Loss of thinking time (theory to practice).	Trying to make sense of role.
Changing NHS context	Importance of work-life balance for coping
Difficult service context.	Wanting more in-depth knowledge.
Seeking support elsewhere following loss of support network (from training).	Inner drive/motivation to learn.

Clustering of themes	
<p><u>‘Shock’ of Initial Transition</u> Difficult transition Increased responsibility to training Feeling isolated - ‘All of a sudden’... ‘you are on your own’ Fears of doing harm, blame & shame Loss of support in transition. Feeling deskilled ‘When I started it was like - I know nothing.’</p>	<p><u>Factors aiding transition</u> Seeking support elsewhere following loss of support network (from training). Importance of supportive supervision. Importance of peer support. Importance of ‘trust’ in relationships. Importance of work-life balance for coping Inner drive/motivation to learn Clinical training preparing for new role.</p>
<p><u>Challenges of Context</u> Feeling under pressure Loss of thinking time Changing NHS context / Difficult service context</p>	<p><u>‘You are not what you will be’</u> Realising development is ongoing. Growing confidence Trying to make sense of role. Wanting more in-depth knowledge.</p>

Table of Clustered Themes	
Superordinate and Subordinate Themes	Quotes
<p><u>'Shock' of Initial Transition</u> Difficult transition Increased responsibility to training</p> <p>Feeling isolated - 'All of a sudden' ... 'you are on your own'</p> <p>Fears of doing harm, blame & shame</p> <p>Loss of support in transition.</p>	<p>Looking back the transition was quite difficult. It comes as a bit of shock... you realise that you are responsible... for all of your clients. Responsible for somebody else's life. Through training you kind of make yourself feel better by thinking ... if anything goes wrong, it's on your supervisor's head... Making sure that you'd kind of done everything that you needed to do, um in terms of mostly managing the risk ... yeh was the challenging part.</p> <p>all of a sudden you realise you on, you are on your own there was no transition support for us.. Which didn't feel very satisfactory and it did feel quite a lot like we were on our own.</p> <p>You are on your own.</p> <p>You do kind of feel a bit on your own.</p> <p>You don't want to have massively fucked up.</p> <p>I don't want to be the person who gets blamed.</p> <p>You would then hold that feeling that you have massively fucked up. I don't think it would be that person's fault or my fault but it would feel that way. You would feel that some of your colleagues thought that it was your fault.</p> <p>You have all of this cushion over Uni, and then it just gets entirely taken away. I feel like we were just left, umm, which didn't feel very thoughtful there is always someone at Uni that keeps you in mind while you're going through training and then it very much felt like well you've gone, you're not in mind anymore felt like you were just forgotten... And it wasn't a mutual forgetting either.</p>

Supportive supervision.	I had supervision quite frequently to begin with, erm, which was one of, kind of, providing that space I had really good support from my supervisor at that time ... and so we had a lot of discussions about sort of transition and kind of development
Peer support.	find the support in other ways, so certainly other members of my cohort I would talk to them
'Trust' in working relationships.	I think I'm quite fortunate in that the team I'm in I'm kind of trusted to do my own thing. I think it's a lot easier to get on well with somebody if you feel like they're good at their job.... And I trust them as well. I think we look out for each other quite well. And I think we're quite honest with each other I don't tend to get questioned very much
Importance of work-life balance for coping	I guess it's, yeh it's making sure that, umm, that I have a good work life balance and I do a lot of the stuff I enjoy. not just there sitting at your desk all the time, actually you have a lunch break with somebody. Um or you have a chat about normal things and not work. I guess I'm quite fortunate that for the most part that I can leave work at work. making sure that, umm, that I have a good work life balance and I do a lot of the stuff I enjoy.
Inner drive/motivation to learn	You have to be a lot more motivated to learn new stuff or consolidate old stuff when you're not being fed it I <u>need to</u> figure out what I think if I've said I'm going to do something I just get on and do it I kind of forced myself to do written formulations and stuff like that to just keep... things ticking over really If I say I'm going to do something I do it. You have to and you can. when things come, you just do it.
Clinical training preparing for new role.	training kind of prepares you for not feeling ready a lot of stuff I think the variety that you get from training is helpful. Um I think on training you have to deal with a lot of different situations, um some less pleasant than others. So you kind of get used to just getting on with things. Um I think that's been helpful

<u>'You are not what you will be'</u>	
Realising development is ongoing.	<p>yeah when you come out, you kind of, after a bit you realize that, yeah I'm not done. when you qualify you are not what you will be always there's the realisation that... you're probably never done</p>
Trying to make sense of role.	<p>something about ironing out what the role actually looked like. So rather than kind of coming in and knowing this is what I'm doing in this team um it wasn't quite that straightforward, um there was needed to be quite a lot more thought about well actually what do you want me to do?</p>
Growing confidence	<p>I've become more confident. I think when you first start you still feel a little bit like a trainee ... So I think I've become a little bit more confident within the team</p> <p>a little bit more confident within the team um I think in sharing my opinions, voicing my views, taking on more responsibilities...</p> <p>it kind of went in phases for me. I think when I started it was like - I know nothing. ... then you kind of feel more comfortable in that you know your stuff and your development</p> <p>I think it's taken quite a long time but also I think now feeling more able to - not change things but try and implement some changes, try and suggest new ways of doing something.</p>
Wanting more in depth knowledge.	<p>craving more training in a specific something What do I want to learn about next? What do I want to be more specific in next?</p>

Appendix M**Cross-referencing of emerging themes across transcripts**

Theme	Amit	Sian	Helen	Maggie	Kath	Christine	Frida	Total
'A big jump' in responsibility		X		X	X	X	X	5
Feeling overwhelmed ('oh my god' / 'out of depth')	X		X	X	X	X	X	6
Less time to think/reflect / loss of 'luxury' of time	X	X	X	X	X	X	X	7
Feeling deskilled	X	X	X	X		X	X	6
Increased expectations	X					X	X	
Increased workload / demands	X			X		X		4
Increase in complexity of clinical cases			X			X		2
Feeling isolated		X			X			2
A 'chaotic' context						X	X	2
Loss of support		X	X		X		X	4
Frustrations' with 'higher powers'	X				X	X	X	4
Service pressures	X	X		X	X	X	X	6
Challenging NHS demands	X	X		X	X	X	X	6
Restrictions in resources	X		X	X	X	X	X	6
Negative impact on clients/ client work	X				X	X		3
Emotional burden / 'anxiety' about clients	X			X		X	X	4
Inner drive / wanting more	X	X	X	X	X	X	X	7
Importance of work-life balance		X	X	X	X	X	X	6
Importance of support of MDT	X	X	X	X	X	X	X	7
Importance of supervisor	X	X	X	X	X	X	X	7
Seeking compensatory support following training	X	X		X	X			4
Importance of different perspectives of MDT	X		X			X		3
Trainee peer support	X	X			X			3
Importance of support at home	X		X		X		X	4
Benefits of training experiences	X	X	X		X	X	X	6
v not prepared in other ways	X	X		X	X	X		5
Clinical highs make job worthwhile	X		X	X	X	X		5
Ongoing learning / development	X	X	X			X	X	5
'Learning curve'				X		X	X	3

Growing confidence	X	X		X	X	X	X	5
Importance of vocalising feelings			X	X	X	X		4

Appendix N**Evaluation of Present Study based on Guidelines for Qualitative Research (Elliot et al., 1999)**

Criteria (Elliot, Fischer & Rennie, 1999)	Evidence for meeting criteria
Owning one's perspective	<p>The researcher provides both personal and epistemological positions, to own his perspectives, from the outset of the main document. This provides the reader with an opportunity to perceive the researcher's values and perspectives, and the role these may play in the inevitable double hermeneutic of understanding the meaning of participants' accounts.</p> <p>A presentation of reflections throughout this document was a further attempt by the researcher to offer his personal perspective upon the research process. They also provide some insight into important processes the researcher carried out, such as bracketing, and his attempts to maintain stringency in the analytical process.</p>
Situating the sample	Demographic information about the sample has been provided; their age, gender and ethnicity.
Grounding in examples	Examples of quotes from the interviews were provided throughout the Results chapter, therefore grounding the sub-themes in the text they emerged from. On occasion, super-ordinate and sub-ordinate themes were titled in part by participants' quotes.
Providing credibility checks	<p>The researcher's principal supervisor conducted credibility checks on two interviews, to ensure that the researcher was grounding his emerging themes in the text, rather than, for example, being led by his own biases and assumptions, or extant theories (Smith et al., 2009).</p> <p>The researcher also discussed with colleagues and his supervisors, his initial reactions to interviews, such as that of Amit's transcript, in order to bracket off his own thoughts and beliefs about the content before beginning the analysis.</p>
Coherence	The researcher has provided an integration of ideas across the interviews in the Results chapter, in order to arrive at super-ordinate themes, however he has endeavoured to retain the nuances of each transcript, being conscious of the importance of presenting both difference and divergence (Smith et al., 2009).

<p>Accomplishing general vs specific research tasks</p>	<p>The researcher utilised an appropriate sample size for a doctoral thesis employing IPA as a methodology, however IPA is idiographic and seeks to allow a researcher a deep insight into the experiences of a small number of participants (Pietkiewicz & Smith, 2014), rather than attempting to reach more general claims and conclusions for a wider population (Smith & Osborn, 2003).</p> <p>As a result, the Discussion chapter discussed the relevance of the Results section to a particular population (NQCPs, in CAMHS settings, in England), but also the limitations of the generalisability of the information gathered. This was held in mind when clinical implications and recommendations were drawn up.</p> <p>The researcher completed specific research tasks, namely the particular research questions which emerged as a result of the Systematic Review; these were the focus of the interview schedule, and these areas of interest were covered in the Results chapter.</p>
<p>Resonating with reader</p>	<p>The researcher has attempted to accurately represent the accounts of the participants in the Results chapter. The researcher endeavoured to embed particularly emotive and resonating quotes in the narrative presentation of the outcomes within this chapter.</p>