UNIVERSITY OF HULL

Exploring experiences of wellbeing amongst psychological professionals in healthcare

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by

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Overview

This thesis portfolio comprises three parts: a systematic literature review, an empirical paper and appendices. This thesis aims to explore experiences of wellbeing amongst psychological professionals working within healthcare, with a particular focus on thriving at work.

Part One: Systematic Literature Review

The systematic literature review explored conceptualisations of wellbeing within the qualitative literature regarding psychological practitioners in healthcare. It also explored psychological practitioners' experiences of wellbeing at work in healthcare. Twelve studies were identified as meeting the inclusion criteria following a systematic search of the literature. A narrative synthesis was undertaken to inform of an overall picture of understandings and experiences of wellbeing amongst psychological practitioners in healthcare. The National Institute for Health and Care Excellence (NICE) Methodological Quality Checklist for Qualitative Studies was used to assess the quality of the included studies. Two main themes emerged: heterogeneity in understanding wellbeing, with different theoretical conceptualisations of wellbeing across studies. Secondly, practitioners experienced a journey of wellbeing over the course of their careers, with feeling a sense of purpose in their roles playing a key part in their wellbeing at work. Clinical implications and further areas for research are discussed.

Part Two: Empirical Paper

The empirical paper explored clinical psychologists' (CPs) experiences of thriving at work within a National Health Service (NHS) context. A qualitative Interpretative Phenomenological Analysis (IPA) methodology was employed. Ten participants completed semi-structured interviews. Four core conditions were identified which needed to be fulfilled for CPs to thrive at work: making a difference as a clinical psychologist, working in line with personal, professional, and organisational values, growing and developing as a professional, and safety: psychologically safe environments

and job security. These conditions were subject to multiple threats in the current NHS context, which CPs attempted to overcome in various ways. The findings suggested that CPs can thrive within their roles, and that they played an active role in shaping their thriving at work. Recommendations for further research are discussed, alongside the implications of this research in clinical practice and training contexts.

Part Three comprises the Appendices

The appendices contain further information to support the systematic literature review and empirical paper. The role of the researcher is also considered further in the epistemological and reflective statements.

Total word count (excluding appendices): 20254

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Part One – Systematic Literature Review

Part One – Conceptualisations and experiences of wellbeing amongst psychological practitioners working in healthcare: An international, qualitative, systematic review and narrative synthesis

This paper is written in the format ready for submission to the International Journal of Wellbeing. Please see Appendix A for the Guideline for Authors.

Word count: 8104 (Excluding figures and tables)

Abstract

Background: Wellbeing amongst psychological practitioners is increasingly recognised as an issue within healthcare, with clinical, financial, and ethical implications. This review aimed to explore how wellbeing at work has been conceptualised amongst psychological practitioners in healthcare, and to explore experiences of wellbeing amongst this population. *Method:* Four electronic databases were searched: Academic Search Premier, MEDLINE, CINAHL Complete and APA PsycInfo. Twelve qualitative and mixed-methods papers met the inclusion criteria for review. The methodological quality was assessed, and narrative synthesis undertaken to inform an overall picture of how wellbeing at work is conceptualised and experienced by psychological practitioners in healthcare. *Results:* Two main themes emerged. The first theme, 'heterogeneity in understanding wellbeing', explored different theoretical understandings of wellbeing. The second theme, 'a journey of wellbeing' explored changes in wellbeing at work over time. A sense of purpose at work played a key part in practitioners' wellbeing. A move towards self-preservation over an individual's career was apparent. Implications for research and clinical practice are discussed.

Keywords: wellbeing, narrative synthesis, systematic review, psychological practitioners, healthcare, qualitative

Introduction

Promoting wellbeing amongst psychological practitioners working in healthcare has been increasingly recognised as a priority in the United Kingdom (UK) in multiple national agendas (Department of Health, 2009; Health Education England [HEE], 2017; NHS England, 2016; Stevenson & Farmer, 2017). This has been reinforced during the Covid-19 pandemic, with calls from professional bodies to ensure the provision of timely support for practitioners (British Psychological Society [BPS], 2022). Summers et al (2020) define psychological practitioners as "any professionally qualified practitioner working in a psychological or psychotherapeutic role" (p.12), including psychologists, therapists, and counsellors. Individuals working in psychological professions can be particularly vulnerable to experiencing poor wellbeing (Hannigan et al, 2004; Longwill, 2015; Rupert et al, 2015; Rupert & Morgan, 2005; Summers et al, 2021); often attributed to the emotional burden of their work (Rupert et al, 2015), which can result in vicarious trauma (McCann & Pearlman, 1990), moral injury (Shay, 2014), burnout (Rupert et al, 2015) and compassion fatigue (Joinson, 1992). Poor wellbeing amongst psychological practitioners can detrimentally impact on the quality of patient care and patient safety (Guy et al, 1989; Hall et al, 2016; Maslach & Jackson, 1981).

The UK is experiencing difficulties with the retention of the psychology workforce (Association of Clinical Psychologists UK [ACP-UK], 2020; Longwill, 2015; Rao, 2019; Summers et al, 2021), with subsequent challenges to the provision of psychological services. Commonly, psychologists in the UK work for the National Health Service (NHS), a government-funded organisation providing healthcare services, free at the point of access. A survey of NHS mental health professionals detailed a loss of experience and expertise amongst staff, limited opportunities for promotion and inflexibility in the delivery of psychological interventions (ACP-UK, 2020). Research highlights a lack of leaders in clinical

services impacting on the provision of supervision, training, and governance (Longwill, 2015; Rao, 2019). These difficulties are not limited to the UK, with pressures in psychological services reported internationally, particularly following the Covid-19 pandemic (Daffern et al, 2022; Kolar et al, 2017; Turnbull & Rhodes, 2021).

To understand how to support and retain psychological practitioners, there is an increasing body of literature seeking to understand positive wellbeing amongst practitioners, including experiences of resilience, personal and professional growth, and compassion satisfaction, defined as pleasure gained from helping others (Billings et al, 2021; Briggs & Munley, 2008; McKin & Smith-Adcock, 2014). The occurrence of positive experiences may appear challenging to reconcile with the current healthcare context. However, others understand wellbeing as the presence of strengths and skills that promote positive states of functioning (Park et al, 2004). This definition can perhaps be more readily related to practitioners' experiences of wellbeing. Further, Keyes (2007) argues that wellbeing exists on a separate continuum to illbeing, stating: "the absence of mental illness is not the presence of mental health (wellbeing)" (p.95). Positive psychology studies the role of positive subjective experiences and traits in cultivating quality of life and wellbeing (Seligman & Csikszentmihalyi, 2000). Seligman (2011) introduced the PERMA model of wellbeing; whereby positive emotion, engagement, relationships, meaning, and achievement are all proposed to contribute towards wellbeing, however none entirely or collectively encapsulate it.

Many researchers utilise measures of burnout, anxiety and depression when attempting to study wellbeing amongst healthcare professionals (Denning et al, 2021; Johnson et al, 2018; Shreffler et al, 2020), thus the understandings may be limited. Whilst a pathogenic approach regards wellbeing as the absence of disability, disease, or distress, a salutogenic understanding focuses on the presence of positive states of human functioning.

Positive psychology is at times criticised for over-emphasising the individual's role in wellbeing, alongside the danger of striving for solely 'positive' emotions (Held, 2002). To address this, second-wave positive psychology (2WPP) recognises the dialectical nature of wellbeing, whereby positive and negative experiences can both contribute to positive states of wellbeing (Lomas & Ivtzan, 2016), including post-traumatic growth (Dekel et al, 2012) and resilience (Schwarz, 2018). This aligns with qualitative literature examining psychological practitioners' experiences (Barrington & Shakespeare-Finch, 2013; Hyatt-Burkhart, 2014; Ling et al, 2014). Emerging qualitative evidence from the Covid-19 pandemic highlights positive aspects of wellbeing occurring during adversity amongst healthcare workers, including personal achievement and professional growth (Billings et al, 2021); alongside challenges to wellbeing, like moral distress, as individuals experience suffering as a result of transgressing their sense of moral expectations (Liberati et al, 2021; Williamson et al, 2018).

Having a clear conceptualisation of wellbeing for practitioners, and understanding their experience of wellbeing, could allow the development of supportive interventions. The Framework for Improving Joy in Work (Perlo et al, 2017), by the Institute for Healthcare Improvement (IHI), based on 2WPP principles, demonstrates a continued shift towards promoting wellbeing by emphasising joy, values and meaning in work, in the context of an organisation's challenges. Accordingly, Dodge et al (2012) propose 'wellbeing' as the balance point between an individual's resources (psychological, social, and physical), and the challenges faced (psychological, social, and physical). Wellbeing is understood as an individual having the resources required to meet challenges. These ideas were developed into the job demands-resources theory (JDRT; Bakker & Demerouti, 2017), considering factors influencing wellbeing at work. Similar to Dodge et al (2012), job and personal demands and resources are considered. The theory elaborates on processes like 'job-crafting' and 'self-undermining' behaviours, which involve the individual modifying their working conditions,

creating gain and loss cycles, to promote or hinder wellbeing at work. A strength of this theory includes its comprehensive account of positive and negative wellbeing states, attending to the individual and context. The JDRT encourages researchers to explore the physical, psychological, social, and organisational elements influencing wellbeing at work.

The purpose of this review was to explore how 'wellbeing' has been conceptualised in the qualitative literature exploring psychological practitioners' wellbeing within healthcare. It also aimed to explore what is known about practitioners' experiences of wellbeing within healthcare. Previous systematic reviews exploring wellbeing amongst those working in healthcare have tended to focus on negative experiences of wellbeing (O'Connor et al, 2018), or evaluated interventions aiming to improve wellbeing (Lomas et al, 2018, Murray et al, 2016). More recently, reviews have explored the impact of the Covid-19 pandemic on healthcare workers' wellbeing (Aymerich et al, 2022; Wong et al, 2021). There has been limited focus on psychological practitioners' wellbeing (see reviews amongst other healthcare professions: Hall et al, 2016; Jarden et al, 2020; Potts et al, 2021). Existing studies that have explored the wellbeing of psychological practitioners have adopted quantitative methodologies to understand factors associated with wellbeing (Summers et al, 2021; Summers et al, 2020).

This review adopted Bakker and Demerouti's (2017) understanding of wellbeing to holistically consider individual and contextual factors, capturing the multi-faceted nature of wellbeing at work. To meaningfully explore wellbeing amongst this population, considering nuances in language and experience, only studies including qualitative data were reviewed. This is a gap in the current literature, as prior reviews have focused on quantitative data. It was hoped focusing on qualitative data would allow experiences of wellbeing to be captured, based on participants' own accounts, enabling further understandings to be drawn (Lachal et al, 2017; Paterson et al, 2001). To achieve this, the review considered both practitioners' and

researchers' understandings of wellbeing, with both influencing one another's understandings. Researchers' and practitioners' views were explored together, due to the co-created nature of qualitative research making it difficult to disentangle their respective understandings. Understanding wellbeing amongst this population could help to inform clinical services and policies, supporting with the retention of psychological practitioners in healthcare.

The following review questions were answered:

1. How is 'wellbeing' conceptualised by researchers and practitioners in the qualitative literature exploring psychological practitioners working in healthcare?
2. What are psychological practitioners' experiences of wellbeing at work in healthcare?

Method

Search Strategy

A systematic literature search was completed from January 2012 to September 2022. The following databases were accessed via EBSCOhost: Academic Search Premier, MEDLINE, CINAHL Complete and APA PsycInfo. These databases were selected to ensure relevant literature from healthcare settings over the preceding 10 years was identified. Focusing on this time period aimed to capture experiences of wellbeing within healthcare for psychological practitioners, at a time of evolving definitions of wellbeing (Seligman, 2011; World Health Organisation [WHO], 2013), with an increasing emphasis on the importance of wellbeing internationally (WHO, 2013). To ensure all relevant articles were included, manual searches of reference lists and citation searches for included articles were completed.

Search Terms

Search terms were developed by reviewing the existing literature and identifying keywords from relevant articles to ensure variations in terminology were included. Based on Summer et al's (2020) definition of 'psychological practitioner', the terms 'psychologist*', 'therapist*', 'counsellor*' and 'psychological practitioner*' were used. The truncation '*' was used to ensure search results pertained to professionals, not 'therapy' or 'psychology' more generally. Due to many studies investigating 'wellbeing' across professions and settings, the title function was applied for the terms to ensure studies identified were specific to this population. Specific descriptors of wellbeing, such as resilience or thriving, were not included in the search terms, instead 'wellbeing' as a term was included more broadly, aiming to capture its multifarious nature. Different spellings of wellbeing were included, alongside variations like 'wellness'. The term 'quality of life' was included within the search, as it was highlighted in early scoping searches of the literature that this is often used synonymously with 'wellbeing'. These terms may be conceptually different, but they are often used interchangeably by participants and researchers (Skevington & Böhnke, 2018).

To yield qualitative studies exploring experiences, search terms like 'experience', 'perception' and 'view' were included. The truncation '*' was employed to capture plurals and spelling variations. The search terms were reviewed by research supervisors and research librarian with experience in undertaking systematic literature reviews. Searches were limited to peer-reviewed, academic journals, and English-language only. The final search terms were:

- wellbeing OR "well-being" OR "well being" OR "quality of life" OR wellness

- AND psychologist* OR therapist* OR counselor* OR counsellor* OR "psychological practitioner*"

- AND experience* OR perception* OR attitude* OR view* OR feeling* OR qualitative OR perspective*

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria, with rationale, are shown in Table 1 and Table 2.

Table 1.

Inclusion criteria and rationale

Inclusion criteria	Rationale
Population: Psychological practitioners as per Summer et al's (2020) definition. **Context:** Working with clinical populations in health and third-sector settings providing health care services.	The review aimed to investigate the experiences of wellbeing amongst psychological practitioners working in health and third-sector settings. Due to limited studies exploring specific professions within this context, Summer et al's (2019) definition was used to include a range of professions, united in their psychology background. Because of the sparsity of literature, international articles were included, meaning private practice and third-sector organisations were common settings. As such, context was not limited to public health care settings.

Language: English	English is the only language the researcher can understand and read. Research budget not sufficient for translation services.
Date range: 2012 - present	As new ideas around wellbeing were emerging around this time (Seligman, 2011; Dodge et al, 2012) and the WHO's (2013) drive to measure and prioritise wellbeing in the European Health Report, it was deemed considering studies following this could be insightful.
Study design: Qualitative or mixed methods studies (using qualitative data only)	The review sought to explore experiences of wellbeing, therefore qualitative data was deemed suitable for answering the research question.
Peer-reviewed journal	To increase the likelihood of high-quality, rigorous studies being included in the review.
Findings: Themes relating to wellbeing at work were included in the results and discussions. Studies did not have to explicitly aim to explore wellbeing.	As 'wellbeing' is a common term used in the literature, this criteria aimed to ensure studies were included which had findings specific to the area of wellbeing at work.

Table 2.

Exclusion criteria and rationale

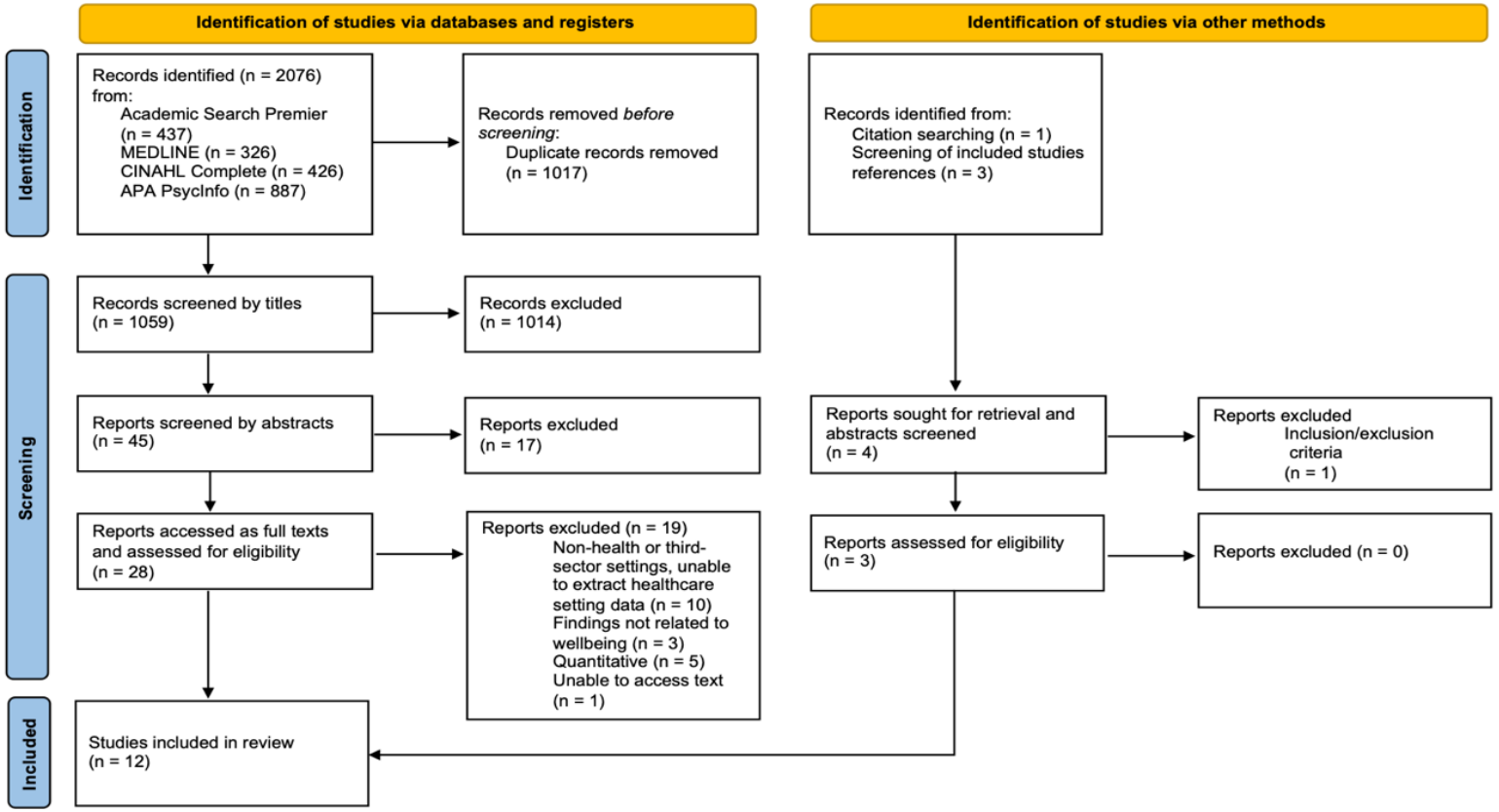
Exclusion criteria	Rationale
Population: Non-psychological practitioners; samples of trainees or students **Context:** Working with clinical populations in non-health or third-sector settings	As the purpose of the review was to understand the experiences of wellbeing amongst psychological practitioners in healthcare settings. Therefore, studies which included other professionals (e.g.., GPs, teachers, service-users) or working contexts (e.g., educational, organisational) were not included. Likewise, the experience of trainees and students may differ from qualified professionals in terms of levels of clinical responsibility and supervision, thus studies including these participants were excluded.
Language: Non-English	English is the only language the researcher can understand and read and no provision for translation.
Study design: Quantitative studies	The review sought to explore experiences of wellbeing, and quantitative would not provide the in-depth, detailed data required to enable this.
Non-peer-reviewed journals and secondary research articles	The review aimed to investigate original, primary research studies, with secondary

	research beyond the parameters of this review. To increase the likelihood of including high-quality articles, only peer-reviewed articles were included.

Article Selection

Figure 1.

Article Selection Summary (The Preferred Reporting Items for Systematic Reviews and Meta-Analyses [PRISMA] Flow Diagram) (Page et al, 2021).



Further information regarding the exclusion of studies is in Appendix B.

Quality assessment

The quality of included studies was assessed using the NICE Quality Appraisal Checklist (NICE, 2012; Appendix C), consisting of 13 questions to assess the quality of qualitative studies. Studies were rated as either '++', '+' or '-", depending on the fulfilment of criteria. This measure was selected as it has been used in other qualitative reviews on wellbeing (Sweeney et al, 2021; Tsirimokou et al, 2022; Turner et al, 2022; Wolverson et al, 2015). It assessed aspects of qualitative research, regarded as important for this topic. Evaluating 'trustworthiness' by examining descriptions provided about the researchers' roles was critical in contextualising the reviewed studies. Where included studies adopted a mixed-methods approach, only qualitative data was used and evaluated.

To ensure rater reliability, six papers were rated by a peer reviewer, unaware of the original ratings. The percentage level of agreement was 83%. Any discrepancies were discussed until an agreement was reached for the final rating. Two ratings were changed as a result.

Data Extraction

Data was extracted using a bespoke data extraction form (Appendix D), developed by considering the information required to answer the review questions, and to contextualise each study in terms of their key features. The information gathered includes the author(s), year of publication, research aims, the aspect of wellbeing explored, population and sampling technique, setting, research design, type of qualitative methodology, and the key findings from each study in relation to the review questions.

Data Synthesis

This included firstly conducting a preliminary synthesis of the data, via tabulation, and producing textual descriptions of each study. Popay et al's (2006) narrative synthesis was employed. This approach uses language to "*tell the story"* of the included studies (p.5; Popay et al, 2006), allowing for a wide exploration of topics. Given the divergence in aims and conceptualisations across studies, and the heterogeneity in the contexts of studies, occurring across international healthcare settings, this was deemed a suitable approach for this review. Narrative synthesis was considered robust in exploring such differences, and drawing together to synthesise into an overall picture of the present knowledge.

Guidance on narrative synthesis by Popay et al (2006) was followed. Utilising the information gathered in the data extraction stage, relationships between studies were considered, exploring emerging patterns and contradictions. An inductive approach was used, whereby initial findings were developed from each study, then compared across studies to identify patterns or contradictions related to the research questions. Finally, the robustness of the synthesis was assessed, through utilising a quality assessment checklist, engaging in critical reflection and considering the synthesis findings in relation to existing literature.

Researcher position

The first author identifies as a white-British female, employed as a trainee clinical psychologist (CP) within the NHS, with two years of working as a psychological practitioner Consequently, the researcher's ideas and narratives will have influenced the data interpretation. To maintain an awareness of their assumptions, the researcher engaged in regular supervision and reflective journaling. This aimed to bolster the level of transparency and rigour in the analysis process. However, it is acknowledged that 'fore-ception'

(Heidegger, 1962, p. 191-192), inescapably influenced the interpretations. Research supervisors also identified as insiders, working as CPs.

Results

Descriptive Overview of the Characteristics of Included Studies

Studies were published between 2013 and 2022 and were representative of multiple countries: four from the UK, three from Australia, and one each from the Republic of Ireland, Sweden, Denmark, United States of America, and Canada (see Table 3).

Across the studies, 134 participants were included, with sample sizes ranging from four to 36 participants. A range of practitioners were represented, including 66 clinical or counselling psychologists, 50 counsellors, 16 psychotherapists, one consultant psychiatrist and one psychological caseworker. Length of years in practice ranged from under 14 months to 27 years, however not all studies reported this. Information regarding gender, age and race were not consistently included across the studies. Predominantly, purposive sampling was used to recruit participants, however convenience sampling (Bjerck-Amundsen et al, 2022) and snowball sampling were utilised too (Clarke et al, 2021; Roberts et al, 2018).

Some studies focused on specific experiences relating to wellbeing, including compassion fatigue and compassion satisfaction (Norrman et al, 2020), burnout, vicarious trauma, resilience (Barton, 2020; Finan et al, 2022; Hammond et al, 2018; Michalchuk & Martin, 2019; Roberts et al, 2018), and post-traumatic growth (Bartoskova, 2017). Others explored wellbeing broadly (Bjerck-Amundsen et al, 2022; Levinson et al, 2021; Neswald-Potter et al, 2013). Some studies did not have an explicit aim to explore wellbeing, however their findings answered the research question (Chemerynska et al, 2022; Clarke et al, 2021). Levinson et al (2021) aimed to explore experiences of newly qualified CPs regarding transitions, contexts, support and coping, yet participants' accounts provided insights into

their experiences of wellbeing at an early-career stage. For example, practitioners initially felt overwhelmed by the increased responsibility upon qualification.

Most studies were qualitative, utilising semi-structured interviews to gather data, however one study adopted a mixed-methods approach, using an online survey featuring open-ended questions (Neswald-Potter et al, 2013). Interpretative Phenomenological Analysis (IPA; Smith et al, 2009) was adopted in seven studies for data analysis (Barton, 2020; Bartoskova, 2017; Bjerck-Amundsen et al, 2022; Chemerynska et al, 2022; Finan et al, 2022; Levinson et al, 2021; Michalchuk & Martin, 2019). Thematic Analysis (Braun & Clarke, 2006) was used in four studies (Clarke et al, 2021; Hammond et al, 2018; Norrman et al, 2020; Roberts et al, 2018). Constant comparative method (Glaser & Strauss, 1967) was employed in one study (Neswald-Potter et al, 2013).

Table 3.

An Overview of the Included Studies

Author (Year)	**Research Aims**	**Aspect of Wellbeing and Definition (if provided)**	**Population and Sampling**	**Setting and Location**	**Design and Method of Analysis**	**Quality Rating**
Barton (2020)	To explore the experiences that counsellors have of taking care of their own mental, emotional and spiritual wellbeing.	Wellbeing defined as attention to self-care, self-knowledge and ability to be resilient (p. 517)	5 counsellors with a minimum of 8 years experience. Purposive sampling.	Private clinical practice. UK.	Qualitative. Semi-structured interviews. IPA	+

Bartoskova (2017)	To gain insights into trauma therapists' experience of trauma work and to understand the factors enabling post-traumatic growth.	Post-traumatic growth – "psychological and cognitive development, emotional adjustment and life awareness" (p. 31)	10 trauma therapists (psychiatrists, counsellors, clinical psychologists, psychotherapists). Purposive sampling.	NHS healthcare settings specialising in sexual health, veterans and women in the criminal justice system. UK.	Qualitative. Semi-structured interviews. IPA	+
Bjerck-Amundsen, Opsahl & Emiliussen (2022)	To explore psychologists' experiences of how their understandings of the good life	The 'good life' – "our beliefs about the good life form the basis of our dreams, ambitions, life,	4 therapists (pluralistic, CFT, psychodynamic and Gestalt backgrounds).	Clinical healthcare settings. Denmark.	Qualitative. Semi-structured interviews. IPA	+

	affect their clinical practice.	values and ideals" (p. 8)	Convenience sampling.			
Chemerynska, Marczak & Kucharska (2021)	To understand psychologists' experiences of working with people with intellectual disabilities during the pandemic.	Wellbeing	11 clinical psychologists (CPs). Purposive sampling.	Intellectual disability services. UK.	Qualitative. Semi-structured interviews via video conferencing platforms. IPA	+
Clarke, Rees, Breen & Heritage (2020)	To explore the perceived effects of emotional labor in psychologists	Wellbeing	24 registered psychologists providing psychotherapy. Early career = <3	Clinical practice in the provision of individual	Qualitative. Semi-structured interviews.	++

	providing individual psychotherapy, and to explore differences in the perceived consequences of emotional labor between psychologists of varying experience levels.		years qualified. Mid-career = 4-9 years qualified. Experienced = 10+ years qualified. Purposive and snowball sampling.	psychotherapy. Australia.	Thematic analysis	
Finan, McMahon &	To gain an understanding of psychotherapists'	Burnout – "psychological syndrome	8 psychotherapists working in	Private clinical practice. Ireland.	Qualitative. Semi-	+

Russell (2022)	lived experience of burnout while working exclusively in private practice in Ireland.	emerging as a response to chronic interpersonal stressors on the job" (p. 2)	private practice. Purposive sampling.		structured interviews. IPA	
Hammond, Crowther & Drummond (2018)	To examine clinical psychologists' different experiences of burnout.	Burnout – "a syndrome that results from overwhelming work-related mental stress, considered to consist of three domains: emotional	6 clinical psychologists (CPs) in private practice. Purposive sampling.	Exact settings not specified; however, names were screened against the National Register of the Australian Health	Qualitative. Semi-structured interviews. Thematic analysis	+

		exhaustion, depersonalisation, and decreased personal accomplishment" (p. 2)		Practitioner Regulation Agency, when endorses health profession. Australia.		
Levinson, Nel & Conlan (2021)	To explore three particular aspects of newly qualified clinical psychologists' (CPs) experiences: transition and development,	Emotional wellbeing and emotional stress.	7 newly qualified clinical psychologists (NQCP; under 2 years qualified). Purposive sampling.	Child and Adolescent Mental Health Services. UK.	Qualitative. Semi-structured interviews. IPA	+

	contexts, support and coping.					
Michalchuk & Martin (2019)	To explore the lived experiences and meaning of vicarious resiliency and growth in psychologist who work with trauma survivors.	Vicarious resiliency – "the positive meaning making, growth and transformation of the therapist that results from exposure to clients' resilience throughout the course of the therapeutic process" (p. 146)	6 registered psychologists. Purposive sampling.	Clinical settings including child and adult services, forensic psychology services, across public healthcare and independent practices. Canada.	Qualitative. Semi-structured interviews. IPA	+

Neswald-Potter, Blackburn & Noel (2013)	To develop a greater understanding of the wellness practices used by postgraduate counselors.	Wellness – "a state of optimal wellbeing that maximises a person's potential" (p. 177).	36 professional mental health counselors (psychologist, family therapists, art therapists and clinical social workers). Purposive sampling.	Providers of professional mental health counselling services. USA.	Mixed methods. Online survey including Likert-Type closed questions and open-ended questions. Constant comparative method (Glaser &	+

					Strauss, 1967).	
Norrman Harling, Hogman & Schad (2020)	To investigate psychologists' experiences with compassion fatigue, to identify contributing and protective factors.	Compassion fatigue – "the negative effects of being exposed to patients' suffering" (p. 1)	8 clinical psychologists with a minimum of 5 years experience. Purposive sampling.	General and specialised healthcare services in publicly funded organisations. Sweden.	Qualitative. Semi-structured interviews via telephone. Thematic analysis	++
Roberts et al (2018)	To identify the factors that counsellors working with refugees and	Wellbeing	9 professionals working with this population in counselling roles (counsellors,	Non-profit and governmental organisations. Australia.	Qualitative. Semi-structured interviews.	++

	asylum seekers consider influence their wellbeing and effectiveness	counsellor advocate case workers, psychologists). Purposive and snowball sampling.	Thematic analysis

Methodological Quality Assessment of Included Studies

Three studies scored '++', indicative of all or most of the criteria being met, and where not fulfilled, conclusions are viewed as highly unlikely to alter. Nine studies scored '+', illustrating some fulfilled criteria, but some not adequately described, with conclusions regarded as unlikely to alter. None were categorised as '-', suggesting few or no criteria being met, with the conclusions likely to alter. For greater detail regarding the extent to which each study fulfilled the checklist criteria, see Appendix E.

A clear rationale underpinned all studies and the use of a qualitative approach. Neswald-Potter et al (2013) utilised a mixed-methods approach, using pre-selected questions. This lacked depth and detail, but as an initial exploration, this was justified to establish a foundation of understanding. All other studies used semi-structured interviews, enabling the researchers to guide discussions, whilst responding flexibly to participants' ideas.

Most commonly, studies scored the mid-level rating, '+', due to lacking detail and reflexivity around the researchers' roles (Barton, 2020; Bartoskova, 2017; Bjerck-Amundsen et al, 2022; Hammond et al, 2018; Levinson et al, 202; Michalchuk & Martin, 2019). Studies scoring '++' thoroughly considered the researchers' position, including potential biases and assumptions, which boosted the overall trustworthiness of their studies (Clarke et al, 2021; Finan et al, 2022; Neswald-Potter et al, 2013; Norrman Harling et al, 2020; Roberts et al, 2018). In others, the researcher's role was superficially addressed (Barton, 2020) or not included (Bartoskova, 2017; Bjerck-Amundsen et al, 2022; Levinson et al, 2021).

Some studies described attempts to enhance quality through using multiple coders during analysis (Levinson et al, 2021; Neswald-Potter et al, 2013), whilst others referred to reflective discussions enhancing reflexivity and interpretative depth (Norrman Harling et al, 2020; Roberts et al, 2018). Many studies are criticised for limited reporting of ethical considerations and processes (Bartoskova 2017; Roberts et al, 2018), especially regarding sensitive issues like vicarious trauma.

However, others scored highly in this domain (Finan et al, 2022; Norrman Harling et al, 2020). It was unclear for some studies *(n=6)* how systematic the data collection and record-keeping were.

Narrative Synthesis of Findings

The first theme captured various understandings of wellbeing amongst psychological practitioners working within healthcare. The second theme explored psychological practitioners' experiences of wellbeing at work in healthcare, with quotes included to illustrate the findings.

How is 'wellbeing' conceptualised in the qualitative literature exploring psychological practitioners' working in healthcare?

1. **Heterogeneity in understanding wellbeing**

It was challenging to extricate researchers' understandings from participants' views about wellbeing. The researchers' lens and methodology, alongside the introduction of specific constructs and the endorsement of particular models, inevitably informed participants' accounts. Likewise, bidirectionally, the data collected from participants may conflict with researchers' understandings, impacting on the conclusions drawn. Many researchers were, or had previously been, practitioners themselves, holding an insider position, which was considered when assessing methodological quality (Barton, 2020; Chemerynska et al, 2022; Clarke et al, 2021; Finan et al, 2022; Michalchuk & Martin, 2019; Neswald-Potter et al, 2013; Norrman Harling et al, 2020; Roberts et al, 2018). In several studies, the researchers regarded this as a strength, enabling insight into the area being investigated. Clarke et al (2021) considered diversity in the research team to enhance the integrity of their findings.

1.1 Theoretical understandings of wellbeing

The reviewed studies are organised according to their alignment and similarities with different theoretical perspectives. The first group focus on negative wellbeing, including experiences of burnout and compassion fatigue. The second group align with a positive psychology understanding, whilst the last group appeared to adopt a 2WPP conceptualisation of wellbeing.

Table 4.

Overview of theoretical perspectives with representative studies

Concept/model/framework	**Studies included:**	**Focus**
Burnout (Maslach & Jackson, 1981, 1982)	Finan et al (2022) Hammond et al (2018)	Negative states and experiences of wellbeing
Compassion stress and fatigue model (Figley, 2002)	Norrman Harling et al (2020)	
Thriving; good life conceptions (Bronk, 2008; Tafordi et al, 2011)	Bjerck-Amundsen et al (2022)	Positive states and experiences of wellbeing
Wellness theory (Roscoe, 2009)	Neswald-Potter et al (2013)	

Compassion stress (Figley, 2015); self-compassion (Neff, 2011)	Barton (2020)	Positive and negative states and experiences of wellbeing
Vicarious trauma (McCann & Pearlman, 1990); post-traumatic growth (Tedeschi & Calhoun, 2004)	Bartoskova (2017)	
Conservation of resources theory (Hobfoll, 1989)	Clarke et al (2021)	
Vicarious trauma (Saakvitne & Pearlman, 1996); compassion satisfaction (Radley & Figley, 2007); vicarious resiliency (Hernandez et al, 2010); vicarious post-traumatic growth	Michalchuk & Martin (2019)	
Vicarious trauma (McCann & Pearlman, 1990); psychological growth (Tedeschi et al, 1998)	Roberts et al (2018)	

Most researchers (*n=5*) adopted a 2WPP conceptualisation, considering the co-existence of positive and negative wellbeing, and the role of adversity in positive experiences of wellbeing. For instance, one psychologist considered their experience of growth in the context of challenging trauma work;

"I do not know if it's a conscious thing as 'Every day I'm going to grow." I think it just kind of happens because every day you're thrown something new' (Michalchuk & Martin, 2019, p. 149)

Other researchers aligned with positive psychology (*n=2*), focused on negative wellbeing (*n=3*), or did not seem to align with a particular theoretical approach (*n=2*), as interpreted by the researcher. Levinson et al (2021) did not highlight specific models of wellbeing in their study with newly qualified CPs', nor did Chemerynska et al (2022) when exploring CPs' experiences within intellectual disability services during the pandemic.

Overall, participants and researchers understood wellbeing similarly, inferred from participants' accounts complementing researchers' claims and choice of models. However, any contrasts are highlighted by the first author in the results. Any differences arising may be the result of different studies' aims and research questions, rather than different understandings of wellbeing. For instance, Bartoskova (2017) and Michalchuk and Martin (2019) note literature exploring trauma therapists' wellbeing typically focuses on adverse effects. This fits with some of their findings regarding negative experiences of work, but does not fit with participants' reports of growth and resilience. Bartoskova (2017) noted participants describing changes in their self-perception and philosophy from engaging in trauma work, however, but they did not directly refer to this as growth;

"…I'm not saying I was completely selfish before I started work but starting work did I think change me and I think it made me try to be more thoughtful and attentive to others" (Bartoskova, 2017, p. 39)

1.2 Wellbeing as a continuum: positive, negative and neutral experiences

There was no unifying definition of wellbeing common across studies. However, there was a consensus between researchers and practitioners that wellbeing was a transient, evolving experience, in which individuals moved between positive, negative and neutral experiences (Bartoskova, 2017; Bjerck-Amundsen et al, 2022; Michalchuk & Martin, 2019; Norrman Harling et al, 2020; Roberts et al, 2018);

Along this continuum, positive and negative experiences could co-exist. Michalchuk and Martin (2019) explored vicarious resilience and growth, alongside difficulties like vicarious stress and trauma, amongst psychologists working with trauma survivors.

"When you hear difficult things and you witness things that people have encountered and have had to endure, it often has me appreciating what a beautiful life I have" (Michalchuk & Martin, 2019, p.149)

This highlights the co-existence of difficulties, alongside gains like gratitude and satisfaction. Bartoskova (2017) explored wellbeing, focusing on post-traumatic growth, thus implicitly introduced a tension between experiences of difficulty (vicarious trauma), alongside benefits and gains (post-traumatic growth). Whilst researchers and practitioners generally agreed that positive and negative wellbeing were not mutually exclusive, some participants' narratives focused on difficulties at work (Finan et al, 2022; Hammond et al, 2018; Norrman Harling et al, 2020). This may represent a recruitment bias, as participants identified as experiencing compassion

fatigue or burnout. This may mean participants were more inclined to discuss negative wellbeing at work, rather than other aspects of their experiences.

1.3 Wellbeing as dichotomous states

In contrast to understanding wellbeing as a continuum, some practitioners and researchers understood positive and negative experiences of wellbeing as dichotomous states (Chemerynska et al, 2022; Finan et al, 2022; Levinson et al, 2021; Norrman Harling et al, 2020). This is exemplified by themes like 'Survive or Thrive' (Chemerynska et al, 2022, p. 589), the framing of compassion fatigue and compassion satisfaction as mutually exclusive (Norrman Harling et al, 2020), and labelling experiences as either indicative of stress or wellbeing (Levinson et al, 2021). It varied across studies whether practitioners, or researchers, separated wellbeing like this. Bjerck-Amundsen et al (2022), Michalchuk and Martin (2019) and Roberts et al (2018) did not present wellbeing as dichotomous states, instead understanding wellbeing as occurring on a continuum, unlike the studies described above. Chemerynska et al (2022) identified their position as a trainee CP, utilising supervision and a reflective journal to explore biases. Their conclusions are further bolstered by the practitioners included in their study sharing similar understandings about the challenges of work leading practitioners to survive or thrive in response.

Some practitioners identified as being in or out of states of burnout or compassion fatigue (Clarke et al, 2021; Finan et al, 2022; Hammond et al, 2018), reinforcing a dichotomous understanding of wellbeing. From this, practitioners may be regarded as either competent, or lacking in the emotional and psychological resources required to fulfil their roles (Clarke et al, 2021). Whilst most researchers provided non-pathologising accounts of negative experiences of wellbeing, some deviated from this, discussing 'symptoms' of burnout (Hammond et al, 2018). This medicalised view can be interpreted as practitioners being positioned as either 'well' or 'ill', echoed by some practitioners (Bartoskova, 2017; Finan et al, 2022);

"I remember at the time going to counselling, sitting there, so the emotional toll it took on me, sitting there, crying, crying, crying, asking the counsellor was I depressed? Was I, you know? What the fuck was wrong with me? And just feeling, like […] not getting any answers, you know? […] but left with this constant questioning, and constant unknowing was I depressed? Was I this? Was I that?" (Finan et al, 2022, p. 6).

This understanding contrasts with other practitioners' ideas, with wellbeing understood in terms of relationships, identities, values, capabilities, and balance between roles and demands (Bjerck-Amundsen et al, 2022; Michalchuk & Martin, 2019; Neswald-Potter et al, 2013; Roberts et al, 2018). This clashes with understanding of wellbeing as part of one's health, instead regarding wellbeing more holistically, considering personal, professional, relational, cultural and moral aspects. Practitioners adopting a positive psychology or 2WPP approach tended to understand wellbeing at work in this way.

What are psychological practitioners' experiences of wellbeing at work in healthcare?

2. Journey of wellbeing

Considering the review's second question, aiming to understand the experience of wellbeing amongst psychological practitioners in healthcare, this theme details participants' accounts of a changing experience of wellbeing over their careers. Practitioners recognised the importance of feeling able to effect positive change in their work, with purpose from their roles essential to their wellbeing throughout their journeys. Noticing changes in one's wellbeing was common, which tended to be followed by developing insight into what helps and hinders their wellbeing at work. There then appeared to be an adjustment of expectations, of oneself and of other practitioners, around what one could realistically provide within their roles. This marked a move towards self-preservation across personal and professional contexts.

2.1 Purpose as a psychological practitioner

Practitioners described the importance of a sense of purpose in their wellbeing at work, and feeling motivated to fulfil one's role, which was seen as helping those in distress. Satisfaction with one's contributions at work was essential for wellbeing (Michalchuk & Martin, 2019), identifying as '*part of the solution making'* and '*contributing to the betterment of others and self*' (Neswald-Potter et al, 2013). A '*calling'* or '*sense of duty'* to help others was integral to some practitioners' experiences of wellbeing (Michalchuk & Martin, 2019, p.151). Participants acknowledged the positive impacts of helping others on their sense of identity and meaning;

"Feeling like I've had the opportunity and privilege of working alongside someone, and hopefully contributing to their lives in a way that has moved them to a better place… that fills me, that feeds me" (Michalchuk & Martin, 2019, p. 148-149).

A strong sense of purpose at work also related to practitioners' negative experiences of wellbeing. Practitioners felt they were expected, by themselves, other professionals, and service-users, to demonstrate infinite compassion and empathy (Norrman Harling et al, 2020), alongside being perceived as bearers of solutions, with power and responsibility to create change (Chemerynska et al, 2022; Michalchuk & Martin, 2019; Roberts et al, 2018). Some noted a desire to '*rescue people'* (Barton, 2020, p. 519), which was challenging to practitioners' views of themselves and their competence. Wider systemic factors, like changing legislation, often impeded practitioners' ability to effectively perform their roles, and to work in line with their values; associated with feelings of uncertainty, injustice, inadequacy, and threats to wellbeing (Chemerynska et al, 2022; Roberts et al, 2018).

Whilst Neswald-Potter et al (2013) attempted to differentiate between professional and personal wellbeing, this finding suggests overlap between the two domains. Practitioners' purpose in work impacted on their identities, extending beyond their work setting. Differences across psychological

professions were indicated, with psychologists tending to feel greater responsibility for contributing to change than other professionals (Chemerynska et al, 2022; Michalchuk & Martin, 2019). However, Neswald-Potter et al (2013) did not capture data about participants' roles, meaning it was not possible to identify different professional groups' experiences across their sample. This may have been insightful in understanding variations in experiences.

2.2 Moving away from an expected standard of wellbeing

With purpose key to practitioners' wellbeing, practitioners assessed this according to an internal sense, known as '*that gut-feeling'* (Bjerck-Amundsen et al, 2022, p.11), an '*inner voice'*, or '*inner compass'* (p.12). Through a connection with one's body, individuals recognised changes in their wellbeing, with the body presenting signs of distress, like physical illness or pain (Finan et al, 2022), or sleep disturbances (Hammond et al, 2018). Some practitioners described an awareness of their own '*warning signs'* (Barton, 2020, p. 519), suggesting an attunement with their bodies. These indicators signified a shift away from an individual's subjective baseline for wellbeing, described by practitioners as feeling balanced and satisfied in the present (Bjerck-Amundsen et al, 2022, p.11). This suggests an internal gauge monitors indicators of change, important in maintaining wellbeing amongst practitioners. Deviation from one's baseline, like during times of burnout, are experienced physiologically and psychologically;

"You know when you see the red on the battery that you have to plug it in, you have to charge it up, and I suppose, for me, it was like constantly running on red" (Finan et al, 2022, p. 6).

2.3 Developing insight

From this internal assessment, participants reflected on their evolving self-awareness, learning about their emotional responses and helpful strategies to respond to the impacts of their work (Barton, 2020; Bjerck-Amundsen et al, 2022; Clarke et al, 2021; Michalchuk & Martin, 2019).

Practitioners explored internally what was affecting them, and what proved effective in managing their wellbeing (Bjerck-Amundsen et al, 2022). For some, professional development, like training, was helpful in this process (Levinson et al, 2021; Norrman Harling et al, 2020), alongside obtaining feedback from peers. Desiring professional development was apparent amongst practitioners across different career stages (Levinson et al, 2021), with participants acknowledging the benefits gleaned personally from their learnings at work (Bartoskova, 2017). This further illustrates the connection between psychological practitioners' professional and personal wellbeing;

"The awareness of my own capacity and my own limitations is easier because I am more in tune with myself and all the multiple dimensions of who I am" (Michalchuk & Martin, 2019, p. 148).

Clarke et al (2021) described their experiences as psychologists, highlighting the insight this enabled into the area of study. There appeared to be an assumption that having experience of working as practitioners within healthcare helped the researchers to identify pertinent issues relating to wellbeing at work amongst this professional group. Whilst this assumption proved helpful in connecting to participants' experiences, many participants diverged from this initial understanding. Practitioners highlighted the benefit of personal growth through their work, which was not initially expected by the researchers and as 'emotional labor' was not defined to participants, this allowed for alternate understandings to emerge. This appears a major strength of this study, revealing participants' perceptions of positive impacts, which may have been missed from the researchers' initial assumptions.

2.4 Changing role expectations

In light of their developing insight, practitioners adjusted their expectations of their professional roles. Many described a lack of adequate preparation from training about the impacts of work on their wellbeing, including feeling overwhelmed upon the transition from trainee to qualified roles

(Barton, 2020; Hammond et al, 2018; Levinson et al, 2021). Others reflected on the development of resilience, viewed as helpful in coping with uncertainty post-qualification (Levinson et al, 2021). A shift from a naïve to an informed position, through acquiring experience, was echoed by many practitioners (Barton, 2020; Levinson et al, 2021; Roberts et al, 2018). Ideas of what they could realistically hope to achieve in their roles were then adjusted;

"When I first started here, I was so enthusiastic. I wanted to solve everything and you recognise you can't" (Roberts et al, 2018, p. 5).

During analysis, Roberts et al (2018) used two researchers to review themes, which arguably enhances the consistency, and in turn, the quality of their findings. They also asked for participants' feedback to inform the analysis, strengthening their findings. However, their sample was exclusive to practitioners working with asylum seekers and refugees, thus the findings' transferability to other professionals needs to be considered, particularly as working with this population might prove challenging to practitioners' values, ethics and sense of competence. However, a similar shift in expectations was reported by practitioners working with other populations too, including counsellors working in private practice and trauma therapists working within the UK (Barton, 2020; Bartoskova, 2017).

Alongside changing expectations about feasibility, practitioners' self-expectations evolved. Practitioners became more accepting of their vulnerability to distress and limits to compassion, acknowledging this as a shared experience, and normalising their needs for support (Finan et al, 2022; Michalchuk & Martin, 2019; Neswald-Potter et al, 2013; Norrman Harling et al, 2020). It is unclear in the current literature what experiences or learnings evoked this changing perspective. However, Norrman Harling et al's (2020) use of pilot interviews may have positively impacted on the interview schedule developed, contributing to the rich accounts garnered from participants, informing of their changing expectations over time;

"It's my experience that people in general think that we're some sort of freaking superhumans. We're not supposed to feel, and we're supposed to hear about all this suffering without being affected by it (…) But we're human! That's it. We're humans too. And we have the same needs as everyone else" (Norrman Harling et al, 2020, p. 8).

2.5 Move towards self-preservation to maintain wellbeing

As practitioners' expectations changed, they reported a greater ability to recognise and compassionately attend to their needs (Barton, 2020; Bartoskova, 2017; Clarke et al, 2021; Finan et al, 2022; Neswald-Potter et al, 2013; Roberts et al, 2018). Self-care was discussed by practitioners as integral for wellbeing, including strategies like physical exercise, a nutritious diet, humour, meditation, connecting with others, and solitary time. Participants described a need for re-energising activities, like pursuing hobbies, balanced with rest and "*psychological space*" (Clarke et al, 2021, p. 421), from work. This required practitioners to respond flexibly to their needs;

"I make sure at the end of the day… I've got space to diffuse. So my family are all at home so I have a cup of tea before I leave the office just spending those few minutes processing and thinking about the day and the not so good days and so that's probably mainly what I do. And then other days I'll come in by myself and watch TV or read a book and just switch off really" (Barton, 2020, p. 521).

Barton (2020) reflected on the 'helper' nature of practitioners, hypothesising this can act as a barrier to them responding to their own needs, with Barton's (2020) interpretations likely influenced by their own experiences as a counsellor. As their data was coded and themed by only one researcher, with an insider perspective, the potential for their assumptions to impact on interpretations ought to be considered when reviewing their findings.

Following experiences of burnout and compassion fatigue (Finan et al, 2022; Norrman Harling et al, 2020), participants described giving themselves greater permission to care for themselves proactively as part of maintaining their wellbeing, as compared to earlier in their careers (Barton, 2020; Finan et al, 2022). This included marking transitions between work and personal life, alongside enforced boundaries around their time outside of work (Barton, 2020; Clarke et al, 2021; Neswald-Potter et al, 2013; Roberts et al, 2018). Participants described moving from a "*sacrificial*" to "*self-preserving*" approach (Barton, 2020, p. 519) either explicitly, or inferred through their discussion of changed priorities and enhanced permission to look after themselves;

"I think I was being a therapist to everybody else except to myself, and I give myself the same level of care now that I give others" (Finan et al, 2022, p. 8).

Discussion

Overview of findings

This review explored conceptualisations of wellbeing amongst psychological practitioners working in healthcare, alongside experiences of wellbeing at work amongst this population.

Heterogeneity in understanding wellbeing

Most researchers adopted a dialectical conceptualisation of wellbeing, whereby wellbeing was understood as more than the absence of illbeing, fitting with Keyes' (2007) stance. In accordance with this, researchers explored a range of concepts related to wellbeing, including post-traumatic growth and compassion. This enabled a nuanced understanding of wellbeing to emerge, exploring the co-existence of positives and negatives, strengths and difficulties, whilst working as practitioners in healthcare. Participants tended to understand wellbeing as a continuum of transient, subjective experiences. Accounts of simultaneous positive and negative wellbeing (Bartoskova, 2017; Clarke et al, 2021; Michalchuk & Martin, 2019; Roberts et al, 2018) reinforced a dialectical

conceptualisation of wellbeing promoted by 2WPP (Lomas & Ivtzan, 2016). The findings fit with the understanding that wellbeing at work occurs when an individual has sufficient resources to manage challenges and demands (Bakker & Demerouti, 2017; Dodge et al, 2012). Wellbeing was not conceptualised as a lack of challenges or demands, but included learnings and gains from such experiences. The JDRT therefore appears to be a useful model in conceptualising wellbeing amongst psychological practitioners in healthcare.

Journey of wellbeing

This review captured the multi-faceted, transient experience of wellbeing amongst this population. Practitioners work in environments with high emotional and practical demands, that can give rise to positive experiences of wellbeing, like joy, satisfaction, fulfilment and growth (Barton, 2020; Bartoskova, 2017; Bjerck-Amundsen et al, 2022; Clarke et al, 2021; Michalchuk & Martin, 2019; Roberts et al, 2018), alongside negative experiences of wellbeing, including burnout and compassion fatigue (Chemerynska et al, 2022; Clarke et al, 2021; Finan et al, 2022; Hammond et al, 2018; Norrman Harling et al, 2020; Roberts et al, 2018). Challenges to practitioners' values within their organisations may have related to experiences of moral injury, reported in other healthcare professions (Liberati et al, 2021). This review suggested congruency between individual and organisational values are imperative to wellbeing at work. In the theme 'Purpose as a psychological practitioner', organisational and legislative changes sometimes clashed with practitioners' values. Whilst these findings have been illustrated previously (Billings et al, 2021; Briggs & Munley, 2008; Hannigan et al, 2004; Longwill, 2015; McKin & Smith-Adcock, 2014; Rupert et al, 2015; Rupert & Morgan, 2005; Summers et al, 2021), this review demonstrates that positive and negative wellbeing can emerge from the same challenging contexts. This may elicit hope, as it suggests practitioners can experience positive wellbeing, even in challenging healthcare contexts (Bartoskova, 2017; Clarke et al, 2020; Michalchuk & Martin, 2019; Neswald-Potter et al, 2013; Roberts et al, 2018).

From experiences of success and challenge, practitioners became more aware of how to respond effectively to their own needs. Practitioners began to proactively take care of their wellbeing, so they could perform and develop at work. This aligns with self-determination theory (Ryan & Deci, 2000), as individuals are motivated to strive for conditions in which their development is promoted. This is echoed in JDRT, as individuals engage in 'job-crafting' behaviours to promote their wellbeing at work. JDRT considers job-specific, plus personal demands and resources, representing the interaction between personal and professional domains described in these studies. This further suggests it provides a useful model for understanding practitioners' experiences of wellbeing working in healthcare.

This review also revealed the importance of purpose in practitioners' experiences of wellbeing at work, fitting with Seligman's (2011) PERMA model. Difficulties arose from the same pressures that evoked positive experiences, like growth, also occurring during adversity. Whilst purpose could be enriching, it sometimes became an avenue for self-criticism amongst practitioners. Many reported providing care beyond their personal and professional capacity (Barton, 2020; Finan et al, 2022), suggesting an imbalance between job demands and personal resources (Bakker & Demerouti, 2017; Dodge et al, 2012). This could explain Clarke et al's (2021) initial assumption that work would be associated with diminishing resources, neglecting the potential for growth acknowledged by practitioners. Spreitzer et al's (2005) Socially Embedded Model of Thriving at Work could explain the gains practitioners reported when fulfilling their purpose at work. This is referred to as the resources produced in the doing of work, including positive meaning, affective resources and relational resources.

Strengths and Limitations

No studies involved practitioners approaching the end of their careers; at least, this was not specified in the data. Participants' experience ranged between under two, to twenty-seven years. It is likely that many practitioners' experiences, namely those working for longer periods of time,

have not been captured in this review. This would inform further on what helps practitioners stay well in work, meaning they continue in their roles over the longer-term.

It may be regarded as a strength that the review's sample included different psychological professions. Recruitment and retention issues are affecting psychological professions widely (ACP-UK, 2020; Longwill, 2015; Rao, 2019; Summers et al, 2021), therefore it is important to document and understand their experiences. This considered, it is necessary to acknowledge the difficulties of exploring various professionals' experiences together. In a UK context, due to banding on the Agenda for Change NHS Pay Scale, psychologists often adopt leadership roles alongside their clinical practice. In New Ways of Working for Applied Psychologists in Health and Social Care (2007), the BPS highlights psychologists' *"wider role in providing consultancy to organisations on organisational and systems improvement"* (p.3). This contrasts with the roles and responsibilities of other practitioners, impacting on the comparisons made when evaluating their experiences jointly. Yet, due to the sparsity of research focusing exclusively on one profession, this was deemed a suitable way of bringing together practitioners' accounts. However, it is acknowledged that the review is limited through using a predominantly UK, Westernised dataset. Subsequently, non-Westernised perspectives from other cultures, who may conceptualise and experience wellbeing differently, are missed.

Yet, an overarching limitation of this review is that all studies were dependent on participants' disclosures about wellbeing at work. Norrman Harling et al (2020) highlighted the taboo nature surrounding wellbeing amongst practitioners, whilst Finan et al (2022) considered the shame felt by practitioners during experiences of burnout. These factors likely impacted on the information shared, but it cannot be ascertained exactly how this affected the data collected. Some studies used purposive sampling to recruit participants, with experiences of burnout or compassion fatigue (Finan et al, 2022; Hammond et al 2018; Norrman Harling et al, 2020). This may have influenced and constrained participants' accounts of their wellbeing, contributing to a focus on negative wellbeing in these studies.

The challenges of establishing researchers' and participants' respective views is another limitation. As there are limited models of wellbeing within the literature, especially focusing on practitioners, this inevitably would have influenced researchers' understandings of wellbeing, and participants' exploration of their experiences. To exacerbate this, there appeared to be a lack of reflexivity around the researchers' positions and assumptions in several papers, especially given the qualitative methodologies used. This may relate to word-counts for peer-reviewed articles; however, given the approaches adopted, particularly IPA considering the double hermeneutic (Barton, 2020; Bartoskova, 2017; Bjerck-Amundsen et al, 2022), exploring the researchers' position is key, thus required greater discussion.

Clinical Implications and Future Research

This review suggests positive wellbeing can be experienced within the current healthcare climate. However, it should not be read that all practitioners should experience positive wellbeing irrespective of the conditions. Whilst practitioners may experience growth and resilience during adversity, wellbeing is understood as a subjective, transient experience. Held (2002) questions whether emphasising positive aspects, whilst aiming to avoid negative experiences, is helpful for promoting wellbeing. This could limit experiences, like challenges, that could be beneficial for wellbeing. Emphasising resilience within healthcare has been criticised for locating responsibility in the individual to remain well, ignoring the politicised, under-resourced and disempowered context in which many healthcare professionals work (Traynor, 2018). Instead, Traynor (2017) advocates for '*critical resilience'*, whereby professionals' experiences are viewed in context. In this review, researchers did not always collect sufficient information to enable this. Future qualitative research exploring wellbeing amongst healthcare professionals ought to capture information enabling experiences to be meaningfully contextualised. Considering Dodge et al (2012) and JDRT (Bakker & Demerouti, 2017), it is necessary to evaluate the balance between personal and job resources and

demands, when understanding wellbeing at work. Greater consideration of organisational context is imperative in further research.

Stage of career has previously been found to influence wellbeing amongst psychological practitioners (Briggs & Munley, 2008; Rupert et al, 2015), aligning with this review's findings. Research with practitioners in mid-to-late stages of career is required to ascertain what promotes wellbeing across the career span. This review portrays practitioners' journey towards self-preservation, but it remains unclear what facilitates this shift, or what may follow in this journey. Research with more experienced practitioners is needed.

Some researchers focussed on negative aspects of wellbeing (Hammond et al, 2018; Finan et al, 2022; Norrman Harling et al, 2020), however more researchers promoted 2WPP conceptualisations of wellbeing. Further research should enhance what is known to facilitate positive wellbeing, including thriving and resilience. Research focusing on the dialectical experience of wellbeing, including growth, joy and meaning, in the context of challenges and adversity, could glean greater insights into practitioners' wellbeing at work. This could inform what practitioners need for their wellbeing at work, and potentially help retain practitioners within healthcare.

Poor wellbeing appears a common experience amongst psychological practitioners in healthcare, at times (Hannigan et al, 2004; Longwill, 2015; Rupert et al, 2015; Rupert & Morgan, 2005; Summers et al, 2021), yet this review suggests difficulties around practitioners acknowledging this, illustrated in the themes: 'changing role expectations' and 'move towards self-preservation to maintain wellbeing'. However, over their careers, practitioners became more accepting of their vulnerability to distress. Trainers in psychological professions, alongside leaders within healthcare, have an important role in facilitating conversations around wellbeing at work. This review highlighted practitioners' experiences of feeling inadequately prepared for the emotional impacts of their roles (Barton, 2020; Hammond et al, 2018; Levinson et al, 2021), revealing another area for training providers and supervisors to support practitioners. Normalising

practitioners' experiences of distress early in their careers could facilitate this, alongside supporting practitioners to develop insight into their subjective indicators and strategies to promote wellbeing.

Healthcare organisations have a role in creating a culture which promotes self-preservation amongst its professionals. Prior literature shows practitioners hold negative connotations about self-care, often regarding this as selfish, even during distress (Baker & Gabriel, 2021). A cultural shift may be needed for practitioners to feel able to proactively look after their wellbeing as an imperative part of their work, and not only as a response to poor wellbeing. For practitioners who value the need for self-preservation, organisations can play an influential role by also advocating for this. Organisations employing psychological practitioners may benefit from attending to Perlo et al's (2017) suggestion that they facilitate conversations around what matters to professionals, to promote wellbeing within their organisation.

Conclusion

This review explored conceptualisations and experiences of wellbeing amongst psychological practitioners in healthcare. Most researchers and practitioners adopted a 2WPP understanding of wellbeing (Lomas & Ivtzan, 2016). Purpose at work emerged as important in practitioners' experiences of wellbeing. Over their careers, practitioners' wellbeing evolved; often beginning in a naïve, optimistic position, then entering a period of gaining insights and adjusting expectations. A shift towards self-preservation occurred over time, as practitioners reflected on their wellbeing, and considered ways of maintaining their wellbeing moving forward.

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Part Two – Experiences of thriving at work amongst clinical psychologists working in an NHS context

This paper is written in the format ready for submission to the British Journal of Clinical Psychology. Please see Appendix F for the Guideline for Authors.

Word count: 5999 (Excluding Abstract and Practitioner Points)

Abstract

The value of clinical psychologists (CPs) within the National Health Service (NHS) has been highlighted in various agendas, particularly relating to the transformation of mental health services. However, increasing numbers of CPs are opting to leave the NHS, or the profession entirely, due to experiencing poor wellbeing at work. Research with CPs has generally focused on individual experiences of burnout and resilience, rather than how CPs manage adversity in the context of organisational challenges. Understanding experiences of thriving at work, defined as the experience of vitality and learning whereby an individual develops and feels energised, could help understand what maintains CPs' wellbeing. This study aimed to explore NHS CPs' experiences of thriving at work. Ten NHS CPs took part in semi-structured interviews. Interpretative Phenomenological Analysis (IPA) was utilised to analyse the qualitative data gathered. Four themes were developed: 'making a difference as a clinical psychologist', 'working in line with personal, professional and organisational values', 'growing and developing as a professional', and 'safety: psychologically safe working environments and job security'. These were regarded as core conditions needed for participants to thrive, experienced on personal, professional and organisational levels. In the current NHS context, various threats impeded these conditions, hindering CPs' thriving at work. The findings highlight CPs' active role in responding to these threats, attempting to cultivate thriving.

Keywords: clinical psychology, thriving, well-being, adversity, NHS, experiences, qualitative, IPA

Practitioner Points

- This study, to our knowledge, is the first qualitative exploration of thriving at work amongst CPs working within an NHS context. It highlights four core conditions required for CPs to thrive at work: making a difference, working in line with personal, professional and organisational values, growing and developing as a professional, and safety: psychologically safe working environments and job security.
- Within the NHS, CPs are subject to increasing threats to their thriving, including values conflicts, challenging organisational culture and limited scope for progression. CPs respond actively to these threats in an attempt to promote their thriving at work.
- Compassionate or transformational leadership styles may promote CPs' thriving at work, with CPs needing to feel autonomous and able to draw upon their range of competencies within their roles.
- Training organisations should introduce the concept of 'thriving at work' within a training context, and create a safe space to discuss the professional, personal and ethical challenges arising in the current healthcare context, and the potential impacts on the wellbeing of NHS CPs.

Introduction

Thriving at work

Spreitzer et al (2005) define thriving at work as "the psychological state in which individuals experience both a sense of vitality and learning" (p. 538), associated with growth, energy, and development, and possible in a range of contexts. Based on research into wellbeing at work (Csikszentmihalyi, 1990; Spreitzer et al, 1995; Spreitzer et al, 1996), Spreitzer et al (2005) propose a socially embedded model of thriving, considering the individuals' role alongside their organisational context.

Spreitzer et al (2012) emphasised organisational enablers of thriving, such as a climate that promotes diversity. Yet, the model fails to consider how individuals may shape their work context. Alternatively, Bakker and Demerouti's Job Demands-Resources Theory (JDRT, 2017), suggests individuals actively create their work environment, via self-undermining or job-crafting behaviours, considering how individuals approach their work context.

Organisational and health outcomes are associated with thriving at work (Kleine et al, 2019; Porath et al, 2012). Porath et al (2012) found thriving was positively related to career development initiative, job performance and organisational commitment. Kleine et al (2019) found thriving was associated with subjective health, job satisfaction, commitment and positive attitudes towards self-development. Conversely, thriving at work negatively correlated with burnout and turnover intentions.

Thriving in healthcare

The NHS context is widely regarded as challenging and as presenting threats to thriving, including inadequate staffing, lack of resources and high staff turnover, contributing to healthcare professionals not being able to provide quality care (The Kings Fund, 2018). This has been exacerbated in the COVID-19 pandemic, with heightened vicarious trauma, moral injury and blurred work-life boundaries reported (Billings et al, 2021; Liberati et al, 2021). Burnout and poor

wellbeing are consistently reported by NHS workers (Ackerley et al, 1988; Rao, 2019; Cushway & Tyler, 1994; Darongkamas et al, 1994; Hannigan et al, 2004; Longwill, 2015; López-López et al, 2019; O'Connor et al, 2018; Rupert et al, 2015; Summers et al, 2021).

Research exploring wellbeing at work (Billings et al, 2021; Jackson et al, 2018; Niessen et al, 2012), focuses on nurses' experiences, one of healthcare's largest professional groups (Nuffield Trust, 2022). Jackson et al (2018) investigated nurses' responses to adversity, proposing a continuum of responses. On one side, individuals can positively manage exposure to adversity, by thriving or demonstrating resilience. On the other, individuals respond by surviving, or more detrimentally, becoming burnt-out. Adopting a grounded theory methodology meant Jackson et al (2018) formed a testable theory, but this requires greater exploration to ascertain its utility. Future research needs to test the transferability of their findings, considering whether other professions experience workplace adversity similarly. Billings et al (2021) explored mental health professionals' experiences of supporting healthcare workers during the COVID-19 pandemic. Some reported purpose and opportunities for growth, which aligns with components of thriving, namely positive meaning from work (Spreitzer et al, 2005; Su et al, 2014).

Thriving in CPs

CPs are an important group within the NHS, working within primary, secondary, and tertiary care across all healthcare settings, supporting service-users and staff (British Psychological Society [BPS], 2023; National Institute for Health and Care Excellence [NICE], 2011). The NHS Five Year Forward for Mental Health (NHS England, 2016) identifies CPs as essential in transforming mental health services, with growth of the CP workforce required to achieve these aims (Health Education England [HEE], 2017). However, CPs were added to the Shortage Occupation List in 2019 (Migration Advisory Committee, 2019). The Psychological Professions Workforce Plan (HEE, 2021) proposes an additional 2,520 practitioner psychologists, including CPs, are required to deliver the NHS Long Term Plan (NHS England, 2019), outlining priorities for

healthcare for the next ten years. HEE (2020) responded to the shortage of CPs by increasing funding for CP training programmes.

Whilst in demand, evidence suggests around 23% of CPs contemplate or choose to leave the NHS, or the profession entirely, citing contributing factors like stress and poor working conditions (Rao, 2019). In a survey conducted by the British Medical Association (BMA), Royal College of Nursing (RCN), and Association of Clinical Psychologists (ACP-UK), of 281 CPs surveyed, 22% reported a shortage of at least one CP within their service (ACP-UK, 2020). Some CPs report feeling able to perform their roles more effectively outside the NHS, experiencing greater flexibility and sense of reward (Longwill, 2015). This is reflected in increasing CPs leaving the NHS for private practice (Chatfield & Lavender, 2016). In the ACP-UK (2020) survey, 41% of respondents reported feeling 'demoralised' on their last day at work. However, in the same survey, nearly half of CPs reported feeling 'fulfilled' in their work (ACP-UK, 2020). Understanding what contributes to CPs' experiences of fulfilment at work is important, otherwise attrition will likely continue to be an issue (HEE, 2020).

Limitations of current research

Research has examined fluctuations in thriving, but not over extended periods. Niessen et al (2012) explored thriving during adversity amongst social workers, using diaries over a day. However, this does not inform about thriving over a career. This is important considering the transition cycle of change: honeymoon period, times of uncertainty, crisis, acceptance, recovery, or transformation (Hopson, 1986; Williams, 1999). Most newly qualified CPs begin working within the NHS, however increasingly, CPs move into private practice later in their careers (Chatfield & Lavender, 2016). The role of time in CPs' thriving could be important.

Many studies focus on increasing resilience to promote wellbeing (Leppin et al, 2014; Maslach & Leiter, 2005; Rupert & Morgan, 2005; Rupert et al, 2015; Tregoning et al, 2014). However, resilience initiatives have varied effectiveness (Leppin et al, 2014; Tregoning et al, 2014),

and an emphasis on resilience has been criticised for implying individual accountability, ignoring organisational challenges like inadequate funding (Longwill, 2015; Traynor, 2018). Second-wave positive psychology (2WPP) offers an alternate understanding, moving from a binary view of wellbeing and ill-being, to viewing wellbeing as the co-existence of positive and negative experiences (Lomas & Ivtzan, 2016; Ryff & Singer, 2003). Positive aspects of human existence, like growth, can be experienced during, despite and because of, adversity (Ivtzan et al, 2015; Wong, 2015). O'Leary and Ickovics (1995) propose four responses to adversity: succumbing, survival with impairment, resilience, and thriving. Resilience refers to individuals returning to pre-adversity levels of functioning, whilst thriving considers how individuals go on to experience greater levels of functioning. Considering a 2WPP approach to wellbeing allows for exploration of what keeps CPs thriving at work.

Research aims and questions

Given the challenges within the NHS, research should address ways of improving wellbeing amongst healthcare professionals, including facilitating thriving. As CPs are increasingly leaving NHS employment, they are an important group to consider. This study aims to explore thriving at work amongst NHS CPs, and to consider these experiences over time. Thriving at work is understood as a multi-faceted, subjective experience, more broadly relating to positive wellbeing, incorporating satisfaction, meaning, and growth, contributing to an individual feeling their best self at work (O'Leary and Ickovics, 1995; Spreitzer et al, 2005; Su et al, 2014).

The research question to be investigated is: 'What are the experiences of thriving at work amongst CPs working in an NHS context?'

Method

Design

An exploratory qualitative design was used, consisting of semi-structured interviews. An Interpretative Phenomenological Analysis (IPA) methodology was followed (Smith et al, 2009).

Participants

Purposive sampling identified suitable participants. Following an IPA approach, inclusion and exclusion criteria ensured a level of homogeneity (Tables 1 and 2). Homogeneity is important as a similar group of individuals can provide insight into a particular perspective on a phenomenon being studied (Smith et al, 2009). Participants were recruited via social media, including LinkedIn and CP-related groups (Appendix G). According to Smith et al (2009), 6-10 is an adequate sample size for an IPA study, allowing for the exploration of similarity and difference, without producing an overwhelming amount of data.

Table 1

Inclusion and exclusion criteria and rationale

Inclusion criteria	Exclusion criteria	Rationale
NHS employed (full- or part-time)		As the research is interested in studying clinical psychologists' experiences within an NHS context.
Health and Care Professions Council (HCPC) registered clinical psychologists	Non-HCPC registered clinical psychologists	All clinical psychologists work with individuals or families experiencing distress. Registration with the HCPC ensures participants are all practicing in accordance with specific standards.
Between 2-5-10 years qualified	Newly qualified clinical psychologists	As it is anticipated staff will be clinically autonomously practicing in their roles, with a similar level of experience and at a similar stage on the career transition cycle (Hopson, 1976; Williams, 1999). Newly qualified psychologists are typically regarded as around 0-2/3 years qualified, however ten years post-qualification inclusion criteria included to

		ensure all participants have a relatively similar amount of experience.
	Clinical psychologists known professionally or personally to the researcher	To remove the possibility of professional, personal or ethical issues arising for participants and the researcher.
	Clinical psychologists who do not speak proficient English	As the researcher will only be able to speak, understand and transcribe in English, and the research budget would not accommodate a translator.

Ethical considerations

Ethical approval was granted from the Faculty of Health Sciences Research Ethics Committee at the University of Hull (Appendix H). Participants received a copy of the information sheet (Appendix I) and could ask questions before and throughout the study. All participants gave informed consent (Appendix J). Confidentiality was ensured by using pseudonyms, presenting demographic information collectively, and anonymising any interview data that may have identified participants. Participants were asked if they would like to choose a pseudonym, however all declined therefore these were assigned by the researcher. Participant information was stored securely in line with ethical guidelines. Following participation, participants received signposting to sources of support. There were no pre-existing relationships between the researcher and participants prior to the study.

Procedure

Participants followed a link to an online questionnaire (Appendix K), where they were provided with the study's information sheet. Participants were asked to complete an online demographic questionnaire, providing non-NHS contact details. Participants were asked to provide their professional registration number, enabling the researcher to highlight any concerns around practice to professional regulatory bodies, if necessary. Participants gave consent to be contacted by the researcher for the study. The researcher contacted participants via email to ascertain if they wished to participate (Appendix L). Participants who agreed were sent via email a consent form. Participants were asked to electronically complete and sign the form before the interview, returning this via email. A mutually convenient time, and format (in-person or remote) was agreed. In-person (n=1) interviews were conducted in a private study room at the University of Hull. Remote (n=9) interviews were conducted via MS Teams. Allowing participants to choose the format aimed to increase participation, and promote their comfort. If participants were unable to return the consent form electronically, verbal consent was audio-recorded pre-interview.

Interview questions were developed by the researcher and supervisors. Established measures of thriving were reviewed (Su et al, 2014), alongside thriving models and literature reviews (Kleine et al, 2017, Porath et al, 2012; Spreitzer et al, 2005). The schedule was used as a guide, containing open questions so participants could direct the discussions. The schedule covered participants' understandings and experiences of thriving at work, alongside generic prompts to elicit more in-depth descriptions of their experiences (Appendix M).

Interviews were audio-recorded, ranging from 54-76 minutes (*mean= 59.7 minutes*), using an encrypted NHS laptop, accessible only to, and transcribed by, the researcher. Verbal informed consent to record was given by the participants at the start of the interviews. Participants were asked how they found the interview, and received information regarding further support via email (Appendix N).

Researcher position

Due to the subjective nature of thriving, an interpretivist stance was adopted to explore this topic (Guba & Lincoln, 1994). The researchers' own interpretations were considered in understanding participants' experiences, alongside how they may understand thriving differently. The researcher, a trainee CP, brought their own understanding to the topic, including assumptions about the participant group, influenced by their experiences of working within NHS clinical psychology. Adopting an IPA methodology (Smith et al, 2009) meant the double hermeneutic was considered, acknowledging that participants' experiences are not captured 'purely', with the participants' and researchers' interpretations playing a role. To enhance quality and maintain an awareness of the researchers' role in the analysis, regular research supervision and a reflective journal were used. The research supervisors (JB, EW and SOC) are CPs, and supported with the development of the procedure, interview schedule and data analysis. See Appendix O for exploration of the researchers' assumptions.

Data analysis

IPA (Smith et al, 2009) provides a specific methodology allowing for an in-depth exploration of participants' experiences. As thriving at work is understood as a highly subjective experience, IPA was considered an appropriate approach to understand the complexities of CPs' experiences of thriving in the current NHS context. Considering the researchers' position as a trainee CP within the NHS, alongside the study aiming to explore NHS CPs' experiences, IPA, with its consideration of the double hermeneutic, was deemed the most suitable methodology to explore the research question. An IPA study exploring this topic also provides greater insight into the experience of thriving during challenging work contexts, which could be valuable in understanding what promotes, or hinders, CPs' thriving in healthcare currently, with implications for the wellbeing and retention of the CP workforce.

Considering Smith et al's (2009) guidance, the data analysis involved the following stages (see Appendix P for an example of data analysis). The researcher immersed themselves in the original data by reading and re-reading the transcripts. Initial noting of thoughts and ideas occurred in the transcripts' margins. Emergent themes were developed by focusing on sections of the transcript, then considering connections across emergent themes. Similarities and differences across emergent themes were noted. The researcher moved onto the next transcript, repeating the above outlined steps. Comparisons amongst emergent themes were made across the transcripts. Through clustering similar themes, final themes were developed. Transcripts were repeatedly re-read whilst exploring themes and relationships between themes to ensure consistency. Once initial themes were developed, transcripts were shared with supervisors.

Results

Table 2 summarises participants' demographics. The level of homogeneity within the sample is considered, with greater variability in the length of time qualified, and number of hours worked.

Table 2

Participants' demographics and other relevant information

Demographic	**Number of participants (*n=10*)**
Age (years)	25-34 *(n=5)*, 35-44 *(n=5)*
Length of time qualified (years and months)	Range: 2y 9m – 9y 9m Mean: 5y 9m SD: 11.18
NHS hours worked weekly	Range: 18.75 – 37.5 Mean: 31.88 SD: 6.55

Hours worked outside of NHS weekly	Range: 0 – 15 Mean: 2.2 hours SD: 14.20
Employment status	Full-time (*n=5)*, Part-time (*n=4)*, Maternity leave (*n=1)*
Pay band	8a (*n=7*), 8b (*n=1*), 8c (*n=2*)
Clinical/Non-clinical role	Clinical (*n=7*), Non-clinical (*n=3*)
Type of service	Adult (*n=4)*, Child (*n=1)*, Neuropsychology *(n=2*), Staff support (*n=1*), Forensic/secure (*n=2*)

Based on participants' experiences, four themes were generated by the researcher. All participants stated they have experienced thriving within the NHS. These themes formed four core conditions that needed to be met for participants to thrive:

- Making a difference as a CP
- Working in line with personal, professional and organisational values
- Growing and developing as a professional
- Safety: psychologically safe working environments and job security

These conditions were experienced on personal, professional and organisational levels, which are explored in turn for each condition. In the current context, participants experienced several threats to these conditions, which impeded their thriving. CPs responded to these threats, attempting to restore the conditions needed to thrive at work.

Making a difference as a CP

The first condition essential to thriving, was that participants had to feel they were making a difference. Participants had a strong sense of purpose within their roles, which centred around aiming to make a difference to others by alleviating distress and promoting wellbeing. Participants reflected on feelings of fulfilment, satisfaction, pride and meaning they garnered from their roles. Megan described this as *"that real feeling you're left with at the end of the day of 'oh, you did a good job today'".* Amy discussed the need to feel "*like I'm getting something out of it other than paying the bills",* highlighting the importance of feeling able to contribute something meaningful and worthwhile, and illustrating the interconnection between CPs' personal and professional lives. Feeling able to make a difference at work could be a source of enrichment in CPs' lives, contributing to positive identity and meaning, personally and professionally.

Being able to make a difference was acknowledged to fluctuate at different times. Claire explained:

"*As long as I feel like I'm effecting change somewhere or helping something somewhere. It can even be a small thing, you know, like you've done a session with a staff member and helped with patient stuff and they're like "that makes sense, yeah let's do that" or you know, you have a bit of a window with someone you're working with and they're like "ah, that's helped'."*

Victoria explained her thriving at work was "*not a linear progression*", instead occurring in moments, or as glimmers during challenges. This was echoed by Lewis, who categorised his work as either "*thriving*", "*surviving*", "*bored*" or "*somewhere in the middle*".

Participants described organisational pressures impacting on their ability to make a difference, with many describing current NHS conditions. As services are under-resourced compared to demand, participants noted an emphasis on efficiency, with services likened to a

"conveyor belt" (Sally). This contributed to CPs not feeling able to effectively make meaningful differences. Claire explained:

"*No one is wanting to do a bad job, but we can find it hard to do a good job because we don't have the time or resource to be able to do a good job."*

The use of "we" in this context is notable, perhaps creating some distance for Claire, who may understandably have experienced a sense of helplessness.

Changes to service provision based on pressures also impeded CPs' ability to make a difference. Max noted feeling "*more disillusioned and sad and disconnected*" when the number of sessions he could offer was capped. Due to pressures, participants discussed limited opportunities for service development and research. This frustrated many CPs, as they valued the varied nature of their roles; "*I think sometimes we are viewed as, I hate to say it, but just a therapist"* (Samantha).

In response to these threats, participants sought out other opportunities whereby they felt able to make a difference, namely working in private practice. This was described as an "*antidote"*, a "*vent"* and an "*escape*" by Michelle, Lucie and Max, with greater creativity and flexibility. Michelle identified making a difference through providing timely interventions within private work, which contrasted with her NHS experience:

"You do feel like you're making a difference [in the NHS], but it also feels like a difference you shouldn't have to be making. Because things shouldn't have got worse, because they shouldn't have been on that waiting list or they shouldn't have experienced feeling neglected by services."

Working in line with personal, professional and organisational values

CPs have personal, professional, and organisational values that influence their practice, and acting in alignment with their values was essential for thriving. Participants shared values of

authenticity, integrity, equality, and helping those in need. The NHS was regarded as more than an employer, rather working for the NHS being representative of one's values. Alongside upholding professional and organisational values, working in line with personal values as a clinician was important.

Participants reflected on a discrepancy between the NHS' aims to provide fair, quality care, versus what is currently possible due to increasing pressures and demands. Amy explained her struggle of "*sticking them [service-users] on a waiting list*", when she values providing good quality care. Similarly, Victoria described a bind for CPs when trying to work by their values, but this not being possible with the resources available.

"*Being able to provide a service, but that meets a client's needs, that you think meets a client's needs, is really difficult in lots of NHS Trusts. I think that doesn't sit very well with a lot of psychologists."*

Despite this values conflict, participants felt tied or indebted to the NHS, with a notion that CPs are trained specifically for the NHS, as their training is funded by the organisation. Max referred to this as a "*duty".* Samantha echoed this in relation to the type of work CPs engage in, noting her experience of "*little pangs of guilt"* upon moving from a clinical to non-clinical role. Therefore, it seemed challenging for participants to contemplate leaving the NHS. Some expressed discomfort around working privately, often experienced as a move away from their values.

Participants' ability to work in line with their values was also threatened by the current culture within the NHS. Participants described a norm of over-working, impacting detrimentally on work-life balance. Michelle wondered: "*I don't know at what point I kind of picked up on or got trained to sacrifice myself".* This placed CPs in another bind, creating a tension between their roles as NHS employees, and as CPs, with professional tenets around the importance of boundaries to promote safety and wellbeing.

In response, CPs described needing to implement values-based actions and decision-making, personally and professionally. Asserting one's boundaries and establishing a balance that worked for them helped participants move towards thriving at work. This involved changing their working hours from full-time to part-time, working condensed hours, or changing work setting. However, participants reflected on feeling guilt, perceiving themselves as leaving their colleagues behind, when they asserted boundaries.

Growing and developing as a professional

To thrive, participants identified needing to feel they are continually developing in their roles. As a profession, CPs aspire for continued improvement and learning. Growth was described by participants in two sometimes competing or conflicting ways. Firstly, as a sense of feeling more competent and developing greater insight, personally and professionally. Secondly as career progression, recognised through markers like pay rises and promotions. Megan contemplated this:

"*There's that balance then isn't there of weighing up I guess doing more training, progressing to the next banding… but also I guess balancing that with that day-to-day job satisfaction, and actually that feeling you're left going home with. Is that actually more important than I guess feeling like there's certain milestones you have to tick off to be a good psychologist?"*

Lewis shared this idea of needing to be a "*proper psychologist"* to identify as thriving. Some participants evaluated their thriving according to norms within the profession. Victoria regarded her progression to a consultant grade in a short time as indicative of her thriving. Others reflected on mistaking striving for thriving throughout their careers. This demonstrated the influence of Western ideals, with success associated with money and status. This conflicts with the professions' values and purpose discussed previously, perhaps explaining participants' struggle to

reconcile inner growth with societal and organisational messages about what development looks like.

Participants identified limited avenues for progression as threatening to their growth in the NHS. Many described having to leave roles they enjoyed, to feel they were developing professionally. Financial constraints impacted on development opportunities; Megan described her frustration that "*I could put the best argument forward ever, but if there's not the training budget, I can't magically make that appear".* Self-comparisons to other CPs also threatened how fulfilled participants felt in terms of their development.

In response, CPs described a shift over time away from external markers of growth and development. Claire, a Band 9 CP, explained:

"*I'm probably settled where I am and the banding, I'm not kind of looking at the next kind of thing. I feel like I have got good experience under my belt, not that I'm not learning but like I've got good experience, like I've got something to offer."*

This could be interpreted as adaptive cognitive reframing, intended to reduce distress associated with fewer opportunities for progression. This career stage may have allowed Claire to stop striving, instead becoming more attuned to her inner sense of thriving. Over time, CPs may reach a 'good enough' position concerning their career progression.

Other participants discussed measuring their growth beyond conventional measures. Michelle discussed pursuing training in areas of interest, not directly relevant to her clinical role. Likewise, Max shared his experience of seeking specialist supervision outside of his NHS role to promote his development.

Safety: psychologically safe working environments and job security

To develop, work in alignment with values, and make a difference, participants emphasised the importance of safety. This referred to feeling safe and secure, having practical needs met, plus feeling relationally and psychologically safe in their teams. Many regarded this as fundamental for thriving.

Organisationally, participants discussed the benefit of "*those things built in"* (Max) to the NHS for creating safety, including pensions, annual leave and sick pay. As individuals, having job security through a permanent contract was important. CPs also needed relational safety to engage in their work and to grow. Participants highlighted the importance of relationships in promoting, or hindering, their thriving. They described a sense of containment through belonging to a team. Michelle explained: "*there is a real, a real safety in not having to hold any of that alone*".

Relational safety could facilitate positive risk-taking, with mutual trust integral. Victoria referred to this as being able to "*go back to your secure base",* whilst Claire referred to her team as "*safety nets*". Samantha elaborated:

"*I feel like I can kind of push those boundaries a little bit, I can stretch myself. I can take … calculated risks… push myself and develop a bit more because I know I've got that support.*"

Participants also described instances of feeling undervalued as a profession within an MDT context, threatening this safety. Claire described how at times she felt her contribution was minimised:

"*The psychologist can 'just', and they love saying that… it makes it sound like it's really easy."*

Whilst on the one hand, CPs' roles could be minimised, there was a conflicting message perceived by participants about them holding a "*magic wand*" (Michelle and Samantha). Participants felt they were expected to provide solutions, which harmed their sense of competence if unable to meet others' expectations. Not feeling valued as a CP threatened participants' sense of safety in their teams.

Some participants initially laughed when asked about thriving in the NHS, whilst others said they had not previously considered this. The researcher wondered whether this may have been a reaction due to implicit, and explicit, messages around survival in the NHS, or being resilient *enough* to overcome challenges, meaning there is not a "*will*" (Sally) for thriving. Perhaps at present, thriving in the NHS is perceived as unrealistic, unacceptable, or selfish to aim for.

CPs described attempting to cultivate a sense of safety at work, recognising the need for connection with colleagues. Max acknowledged the detrimental impact of the pandemic on opportunities for this. Others responded to an absence of safety by changing teams or services, attempting to find greater safety at work.

Discussion

This study aimed to explore the experience of thriving at work amongst NHS CPs. From ten interviews with NHS CPs, this study provides an understanding of how NHS CPs' experience thriving at work currently. Four conditions were needed for these CPs to thrive: making a difference, working in line with values, growth and development, and safety. In the current context, these conditions are impeded by multiple threats, hampering CPs' thriving. CPs responded to these threats by attempting to cultivate thriving in their work, including taking values-based action, connecting with others, and acknowledging development beyond banding and pay. For some, this included seeking opportunities outside of the NHS to feel able to thrive.

Thriving at work as a CP

All participants identified experiences of thriving, however the extent to which they were currently thriving varied. Some were influenced by existing evidence around thriving when discussing their experiences, naming factors from the literature and considering how these fit with their experiences. This did not constrain their understandings, as several reflected on how their experiences differed. Participants referred to attachment (Bowlby, 1979) and Maslow's hierarchy of needs (1943). This tendency to relate to theory may suggest participants' sense-making was informed by their professional background, aligning with a scientist-practitioner model advocated within CP (Shapiro, 2002). It was considered whether the participants' and interviewer's positions, as qualified to unqualified, potentially contributed to a trainee-supervisor dynamic emerging in the interviews, with participants adopting an educative position in relation to the interviewer.

Generally, participants' experiences fit with other professions' experiences of thriving. Positive relationships, empowering leadership, autonomy, and decision-making discretion (Kleine et al, 2019; Spreitzer et al, 2005) are highlighted as important for thriving. Participants' experiences included vitality, learning and development, mirroring Spreitzer et al's (2005, 2012) model of thriving. Purpose at work was highlighted, fitting with wellbeing and thriving models (Pratt et al, 2003; Seligman, 2011; Spreitzer et al, 2005). This perhaps relates to Gilbert's (1992) 'care giving social mentality', reflecting CPs' helping natures, and their core purpose. Models of thriving at work may need to be adapted to reflect the importance of purpose for healthcare professionals.

However, some aspects emerged specifically amongst CPs. An acknowledgement of their competencies was discussed by participants as part of their thriving. This may have implications for their professional identity, and how they feel valued within teams. The importance of values was woven throughout participants' thriving. This is highlighted in the Framework for Improving Joy in Work (Perlo et al, 2017); however, it appears absent in existing models of thriving at work.

CPs' role in cultivating thriving at work

The JDRT (2017) propose individuals actively shape their work context. Participants shared examples of job-crafting, like advocating for in-person meetings to promote relationships in work. Job-crafting behaviours extended beyond CPs' NHS settings, with participants seeking opportunities in private practice to meet their professional needs, including supervision and training. This illustrates creativity and resourcefulness by CPs, reinforcing Bakker and Demerouti's (2017) claim that individuals proactively shape their work context, demonstrating bottom-up processes within thriving. This further informs Spreitzer et al's (2005) model, illustrating individuals affecting change in their working contexts to promote their thriving. Developing the JDRT (Bakker & Demerouti, 2017), this demonstrates a form of 'role-crafting': individuals actively work to develop as CPs, not necessarily confined to their NHS roles.

'Role-crafting' may relate to the importance of identity amongst CPs. The profession is underpinned by ethics (BPS, 2021), which CPs demonstrate through their efforts to ensure working contexts aligning with their values. Currently, this did not feel possible for many participants, as they grappled with what difference they could make. Making a difference was essential in CPs' thriving, therefore adjusting self-expectations and ensuring values-based actions was important to promote their thriving at work.

Implications

Clinical practice

Participants described the harmful impacts from overstretching themselves due to unmanageable workloads, leading to feeling incompetent, moral challenges and values conflicts. Increasing service pressures mean many CPs are faced with acting incongruously to their values. Given the importance of values-based working, this likely contributes to moral distress and injury (McCarthy & Deady, 2008). The working context creates a mismatch between what individuals consider the right thing to do, and what is possible within their services. This conflict may be exacerbated by representing an

organisation that purports to value fairness and quality care, when in reality this often cannot be actualised. CPs may experience submissive compassion (Catarino et al, 2014), prescriptively fulfilling their roles believing this is the professionally and societally appropriate response, without an intrinsic motivation to fulfil their roles. Media narratives around NHS 'heroes' (Cox, 2020), may further complicate CPs' experiences of moral distress and submissive compassion. Being positioned as infinitely compassionate helpers will make it more challenging for professionals to assert their boundaries to stay well.

Organisational culture influences the conditions for thriving. Hughes and Youngson (2009) describe an unspoken culture whereby CPs' progression involves exceeding contractual hours, with aspects like research, occurring in one's personal time. Professional wellness is said to derive from a healthy organisation (Young & Lambie, 2007), with leadership shaping the service context. Transformational leadership is implicated in thriving at work during adversity (Niessen et al, 2017), involving elements of support, challenge and individualised consideration. However, the evidence is mixed, with transformational leadership associated with depleting resources in some instances. Compassionate leadership is associated with thriving at work in non-CP populations (Koon, 2022). West (2020) highlights the value of compassionate, collective leadership within healthcare, considering hierarchical leadership counterproductive to a culture of high-quality, compassionate care.

CPs identified needing opportunities to utilise all of their competencies, with this recognised within job plans. Having protected time for all aspects of their roles could be helpful; however, as autonomy is associated with thriving, CPs may benefit from flexibility in pursuing different elements of their roles. Managers should consider guidance from professional bodies (BPS, 2019) regarding CPs' competencies.

Training

Several participants commented on previously not considering thriving within their roles. Training institutions should create space for reflection about thriving for trainee CPs. Clinical supervisors responsible for supervising trainees on placements could benefit from support regarding this, if thriving at work is a novel concept within their roles.

Training organisations may facilitate greater discussions around 'role-crafting' in CP, supporting trainees to consider different ways of achieving development and satisfaction in their careers. Participants noted making comparisons to other CPs in their judgements about their development. It could be beneficial during training to reflect upon different career trajectories, including portfolio careers, and normalising remaining on lower bands. As training requires regular evaluation of progress, trainers could attend to indicators of development beyond external measures, to promote alternate conceptualisations of development, potentially reducing a sense of feeling stagnant within the NHS.

Most importantly, training organisations have a responsibility to accurately reflect the NHS context within their programmes, for instance by facilitating reflective sessions exploring the challenges of working in the current system. All participants discussed instances of feeling professionally inadequate, morally distressed and conflicted in their values. Given the profession's core purpose of wanting to help others, this can be highly damaging, personally and professionally. Psychological practitioners often report feeling inadequately prepared from training for the emotional impacts of their roles (Barton, 2020; Hammond et al, 2018; Levinson et al, 2021). Naming and normalising experiences like compassion fatigue or vicarious trauma during training could be invaluable for trainees beginning their careers in the current context.

Limitations and Future Research

It is a strength that participants were recruited nationally from England, Scotland, and Wales. As the inclusion criteria permitted any NHS-employed CP, this did not account for variation

in service provision across the UK, namely the impact of the Increasing Access to Psychological Therapies (IAPT) service. This difference may impact on CPs' working contexts, affecting the homogeneity of the sample. However, participants' interpretations of experiences of thriving as NHS CPs was fairly homogenous.

This study included CPs with 2.5-10 years of qualified experience, capturing participants in the early-to-mid career stage. It became apparent during the interviews that for those qualified for around three years, most of their careers had occurred during the Covid-19 pandemic. This hugely impacted on their experience of services. Future IPA research should consider the impact of the pandemic when ensuring homogeneity within inclusion criteria, particularly when seeking to explore temporal aspects of experiences. As this was a small and exploratory study, it did not aim to generalise its findings to all CPs. More research is required to explore the role of time in CPs' experiences of thriving. Narrative analysis (Riessman, 2008) may be an appropriate methodology for exploring temporal changes over CPs' careers.

Exploring CPs' relationship to the NHS is required, to understand the role of duty in CPs' thriving. The NHS was experienced as a source of threat and challenge, alongside as a place of security and connection. It is unclear if these meanings are unique to CPs or are shared with other psychological professionals. This multi-faceted relationship informed CPs' decision-making around staying in NHS employment. This study captured CPs at various points in their journeys, including participants who worked solely in the NHS, others who had partially left, alongside those contemplating work outside the organisation. Further research could explore this decision-making process to better understand why some CPs leave. This is timely given the retention difficulties within the profession.

Future research investigating thriving may benefit from asking participants to identify their state of wellbeing (e.g., thriving, not thriving) at the time of data collection. Some participants shared this, which helped the researcher to contextualise their accounts during analysis. Knowing participants' wellbeing state may have been helpful in understanding their use of theory during

discussions. Intellectualising their experiences may have felt psychologically safer for some participants, as discussions were experienced on a cognitive rather than personal level. Shame around difficulties as a psychological professional ought to be considered (Finan et al, 2021; Norrman Harling et al, 2020).

This study highlights that thriving at work is relational, occurring through connections with others. Organisational culture is imperative in workplace wellbeing (Young & Lambie, 2007). Kleine et al's (2017) review highlighted the role of transformational leadership in thriving, particularly during adversity. Further research exploring leadership styles conducive to thriving at work is vital as the evidence is inconclusive.

Conclusion

This study highlighted that CPs can thrive within the NHS. Four conditions were integral to this: making a difference, working in accordance with values, growth and development, and psychological safety and job security. CPs must work to maintain their sense of thriving in the currently challenging healthcare context. CPs demonstrated 'role-crafting' behaviours, whereby they actively sought development within and beyond, their NHS roles, to thrive as professionals. To support with the retention of the CP workforce, further research is needed to explore CPs' decision-making to leave the NHS, and their experiences of thriving over their careers.

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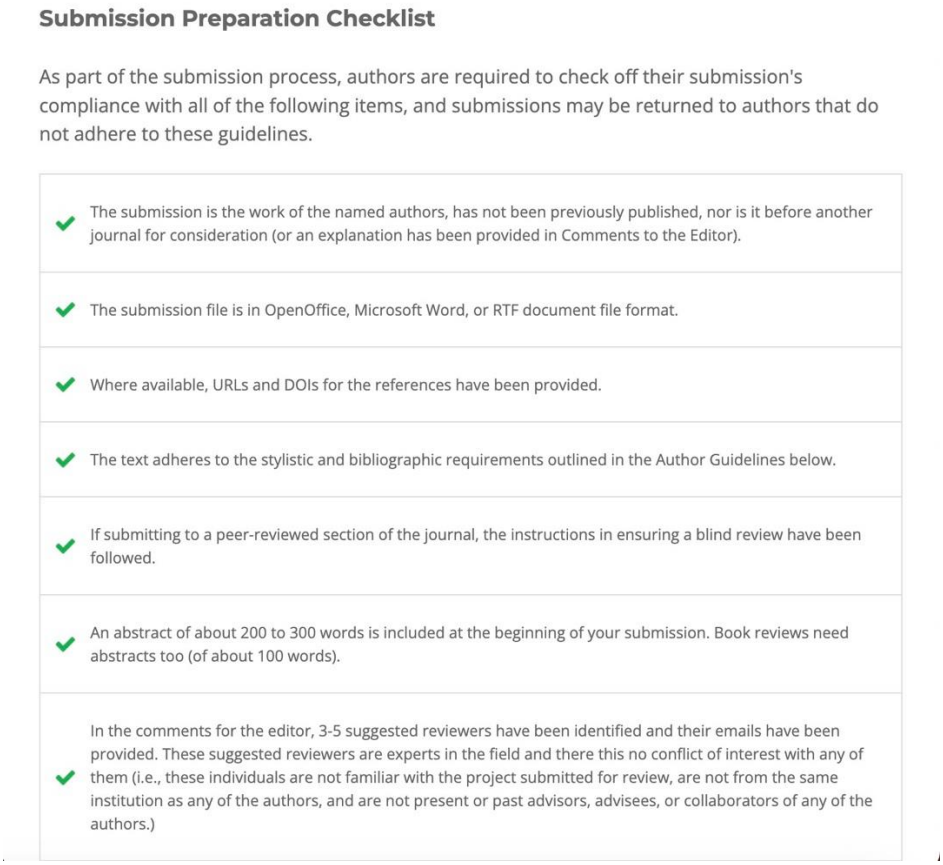
Part Three: Appendices

Appendix A: Submission instructions for the International Journal of Wellbeing (Systematic Literature Review).



Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

- ✔ The submission is the work of the named authors, has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
- ✔ The submission file is in OpenOffice, Microsoft Word, or RTF document file format.
- ✔ Where available, URLs and DOIs for the references have been provided.
- ✔ The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines below.
- ✔ If submitting to a peer-reviewed section of the journal, the instructions in ensuring a blind review have been followed.
- ✔ An abstract of about 200 to 300 words is included at the beginning of your submission. Book reviews need abstracts too (of about 100 words).
- ✔ In the comments for the editor, 3-5 suggested reviewers have been identified and their emails have been provided. These suggested reviewers are experts in the field and there this no conflict of interest with any of them (i.e., these individuals are not familiar with the project submitted for review, are not from the same institution as any of the authors, and are not present or past advisors, advisees, or collaborators of any of the authors.)

Author Guidelines

All articles will preferably be up to 8,000 words, but longer articles will be considered if written concisely. The text should be double-spaced; use an easy-reading 12-point font (such as Times New Roman); sparingly employ *italics*, rather than underlining for emphasis (except with URL addresses); and all illustrations, figures, and tables should be placed within the text at the appropriate points, rather than at the end. If your article is accepted for review, you may be asked to layout the article in the IJW format.

Please note the policy in 'About the Journal' about the types of articles that the IJW is looking to publish.

All articles should use internally consistent spelling, grammar, and language (American and British English will both be accepted). Please also restrict the use of Latin phrases, long sentences, and overly-technical writing as much as possible.

Referencing should follow any one of the major referencing formats (APA, Chicago author-date or footnote, etc.). Please see existing articles for examples. If using APA, please refer to the latest Publication Manual of the American Psychological Association. Basic and comprehensive guides to APA style and referencing are available here.

To ensure a blind review, identifying information such as author names should be removed from the manuscript. Self-citations should be in third person.

Authors of accepted articles are encouraged to create a Video Abstract (see guidelines here) to accompany their article. The video abstract will be posted on the article page as well as on the *International Journal of Wellbeing* YouTube channel.

The journal will consider for peer-review articles previously available as preprints. Authors may deposit any version of the paper in a preprint server, repository, or archive (e.g., PsyArXiv, OSF). A note on the title page must explicitly state the date and version of the draft deposited (e.g., version submitted for peer review, version accepted for publication). Authors may post a link to the published articles on a personal or institutional or scientific network website (e.g., ResearchGate). Once the paper is published, authors are requested to update any pre-publication versions with a link to the final published article.

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Book reviews are by invitation from the editors only. Book reviews should be less than 1,500 words for regular books and less than 2,000 words for reviews of edited collections of papers.

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Appendix B: Further information regarding article selection

From the articles returned in the electronic database search, reasons for exclusion included studies that collected only quantitative data (Cetrano et al, 2017), or investigated concepts that perhaps related to wellbeing, such as adjustment (for instance, Lamiani et al, 2022), but did not produce findings specific to wellbeing. Similarly, some articles returned in the search explored specific impacts of working as a psychological practitioner, for instance the effects of working with children with experiences of sexual abuse (for example, Wheeler & McElvaney, 2017), but were not deemed to inform of the general experiences of wellbeing in relation to the work. Another common reason for excluding studies was that they consisted of samples of mixed professional groups, including psychological practitioners, or occurred outside of a healthcare context, for instance educational settings, but it was not possible to extract the data specific to the population and settings of interest for the purposes of this study (for instance, Hitge & Van Schalkwyk, 2017).

Appendix C: **Methodological Quality Appraisal Checklist for Qualitative Studies (NICE, 2012)**

Checklist

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s?	Clear Unclear Mixed	Comments:

• Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?		
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:

Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		

8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feedback on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:

11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		

14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (See guidance notes)	++ + –	Comments:

***Appendix D*: Data Extraction Form**

Author(s) and Year of Publication	Research Aims	Aspect/ Definition of wellbeing	Population and Sampling	Setting and Location	Design	Qualitative Method of Analysis

Appendix E: Quality assessment summary table for reviewed studies

Article	1. Is a qualitative approach appropriate?	2. Is the study clear in what it seeks to do?	3. How defensible/rigorous is the research design/ methodology?	4. How well was the data collection carried out?	5. Is the role of the researcher clearly described?	6. Is the context clearly described?	7. Were the methods reliable?	8. Is the data analysis sufficiently rigorous?	9. Is the data 'rich'?	10. Is the analysis reliable?	11. Are the findings convincing?	12. Are the findings relevant to the aims of the study?	13. Is there adequate discussion of any limitations encountered?	14. How clear and coherent is the reporting of ethics?	Overall assessment
Barton (2020)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropri-ate	+
Bartos-kova (2017)	Appropriate	Clear	Defensible	Appropri-ately	Not described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropr-iate	+
Bjerck-Amundsen et al (2022)	Appropriate	Clear	Defensible	Appropri-ately	Not described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropri-ate	+
Chemer-ynska et al (2021)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	++
Clarke et al (2021)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	++
Finan et al (2020)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropr-iate	+
Hammond et al (2018)	Appropriate	Clear	Defensible	Appropri-ately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	+
Levinson et al (2021)	Appropriate	Clear	Defensible	Appropri-ately	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	+
Michal-chuk and Martin (2019)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Appropr-iate	+
Neswald-Potter et al (2013)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Poor	Reliable	Convincing	Relevant	Adequate	Appropr-iate	+
Norrman Harling et al (2020)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	++
Roberts et al (2018)	Appropriate	Clear	Defensible	Appropri-ately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropr-iate	++

Appendix F: Submission instructions for the British Journal of Clinical Psychology.

AUTHOR GUIDELINES

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

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- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, read the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

4. PREPARING THE SUBMISSION

Free Format Submission

British Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (If you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-anonymous peer review policy. Anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

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To submit, login at **https://wiley.atyponrex.com/journal/BJC** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

Author Contributions

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

Keywords

Provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading 'Practitioner Points'. These should briefly and clearly outline the relevance of your research to professional practice.

Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation "Main Document – LaTeX .tex File" on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as "Main Document - LaTeX PDF." All supporting files that are referred to in the LaTex Main Document should be uploaded as a "LaTeX Supplementary File."

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- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

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- Up to seven keywords;
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- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

Figures

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

Supporting Information

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

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- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

Wiley Author Resources

Manuscript Preparation Tips: Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, we encourage authors to consult Wiley's best practice tips on Writing for Search Engine Optimization.

Article Preparation Support: Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, read the terms and conditions of submission and the declaration of competing interests.

We aim to provide authors with a first decision within 90 days of submission.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

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Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: https://www.crossref.org/services/funder-registry/

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

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Data Sharing and Data Accessibility Policy

The *British Journal of Clinical Psychology* recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or

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If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

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Open Research initiatives.

Recognizing the importance of research transparency and data sharing to cumulative research, *British Journal of Clinical Psychology* encourages the following Open Research practices.

Sharing of data, materials, research instruments and their accessibility. British Journal of Clinical Psychology encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (http://www.re3data.org). Personal websites and most departmental websites do not qualify as repositories.

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Authors are reminded that the *British Journal of Clinical Psychology* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors. Read Wiley's Publication Ethics

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As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when submitting a manuscript. This takes around 2 minutes to complete. Find more information here.

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When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with Wiley Author Services. The author will be asked to sign a publication license at this point.

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8. POST PUBLICATION

Access and Sharing

When the article is published online:

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- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

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Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

Appendix G: **Research Advertisement**

PARTICIPANTS NEEDED

UNIVERSITY OF HULL

For research exploring experiences of thriving at work amongst clinical psychologists in an NHS context.

Thriving at work can be defined as the joint experience of vitality and learning at work but may also include elements of a sense of growth, mastery, autonomy, improvement, satisfaction, purpose, or worthwhileness. However, there is no singular definition of thriving, it can look and feel differently for everyone.

We want to give staff an opportunity to share their experiences, to try and understand clinical psychologists' experiences wellbeing within the NHS.

Who can take part?

- **HCPC-registered clinical psychologists**
- **Recent NHS experience (within last 2 years)**
- **Qualified for around 3-10 years**
- **Proficient English speakers**

What will it involve?

- *Following the link at the bottom of this page will provide you with more information about the study*
- *After reading this, you will be asked to complete a 5–10-minute questionnaire asking questions about yourself and your job role*
- *If you are still interested, you can leave your contact details and the researcher will be in touch to arrange a date and time for an interview*
- *Interviews will last between 60-90 minutes and will take place either virtually from your home, or in a private study room at the Brynmor Jones Library at the University of Hull – whichever is easiest for you!* Interviews will be held outside of your working hours.*

**Face-to-face interviews dependent on COVID-19 guidance at the time*

If you would like to participate in the study, please follow this link:
https://hull.onlinesurveys.ac.uk/experiences-of-thriving-at-work-for-nhs-clinical-psycholog
If you would like more information, or require any reasonable adjustments in order to participate, you can contact the researcher via email: C.Hussey-2017@hull.ac.uk or telephone: 07929741847.

Version number and date: 4 – 15/06/2022

Appendix H: Documentation of Research Ethics Committee Approval

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w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Chloe Hussey
Faculty of Health Sciences
University of Hull
Via email

11th May 2022

Dear Chloe

REF FHS425 - Experiences of thriving at work amongst clinical psychologists working within an NHS context

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

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w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Chloe Hussey
Faculty of Health Sciences
University of Hull
Via email

20th June 2022

Dear Chloe

REF FHS425 - Experiences of thriving at work amongst clinical psychologists working within an NHS context – Form C

Thank you for submitting your ethics Form C: Notice of Substantial Amendment to Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

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Appendix I: Participant Information Sheet (PIS)

Version number and date: 7 - 15/06/2022

UNIVERSITY OF HULL

Participant Information Sheet (PIS)

You will be given a copy of this information sheet to keep.

Title of the study: Experiences of thriving at work amongst clinical psychologists in an NHS context

I would like to invite you to participate in a research study, which is part of my Clinical Psychology doctorate thesis. The study will explore how clinical psychologists working within the NHS experience thriving at work. Thriving at work is defined by some as the joint experience of learning and vitality at work, but other definitions include elements like a sense of growth, mastery, autonomy or purpose, satisfaction, energy, development or improvement, or a feeling of worthwhileness. Put simply, thriving at work can be viewed as being your best self at work. There is no one definition of thriving at work, as it can look and feel differently for everyone, but these are some similarities in the experience of thriving at work.

Before you decide to participate, it is important that you understand why the research is being completed, and what your participation will involve. Please take the time to read the following information sheet carefully, discussing it with others if that feels helpful to you, before deciding to be involved. If anything is not clear or you would like further information, please ask me.

What is the purpose of the study?

Clinical psychologists have been identified as a key group within the NHS workforce, particularly in relation to the transformation of mental health services. However, for some clinical psychologists, poor wellbeing at work can be an issue, with increasing numbers choosing to leave the NHS, or the profession, entirely. Yet, others report experiencing fulfilment and growth in their roles, despite experiencing

challenges at work. Some research has explored how healthcare professionals can positively manage adversity at work, including thriving as a response. However, research considering wellbeing amongst healthcare professionals has so far largely focused on burnout and resilience, meaning there are limited studies exploring thriving amongst this population. There is also limited research exploring the experience of thriving at work over time. Therefore, this study aims to explore experiences of thriving at work amongst NHS clinical psychologists.

Why have I been invited to take part?

You are being invited to participate in this study as you are a Health and Care Professions Council (HCPC) registered clinical psychologist with recent experience of working within the NHS, meaning you have worked within the NHS in the last two years. Eligible participants have between around 2.5-10 years experience working as qualified clinical psychologists.

What will happen if I take part?

If you choose to take part in this study, you will be asked to read the participant information sheet and complete a demographic questionnaire. This will take roughly 10 minutes, and will ask questions about yourself (e.g., age), and your work (e.g., length of career, current employment status, HCPC registration number). By providing this information, I can check that you meet the criteria to participate in this study. Once you have completed the questionnaire, you will be asked to provide contact details, specifically a non-NHS email address and telephone number, and provide consent for me to contact you to arrange to meet for an interview.

Interviews can be conducted face-to-face at the Brynmor Jones Library at the University of Hull, in a private study room to ensure privacy for the duration of the interview. However, participants may prefer to complete the interview virtually from their home, via Microsoft Teams. Participants are encouraged to choose whichever option is most convenient for them. In total, it is expected the study will require a minimum of 60 minutes and a maximum of 90 minutes of your time, which may be inconvenient for you. To support with this, the interview will be arranged for a time most convenient for you. If expenses are

incurred during your participation, you can claim these back; for instance, the cost of travel to and from the University of Hull campus, including fuel mileage, public transport costs, or tolls.

Due to COVID-19, how the interviews are completed may be governed by restrictions in place at the time, meaning there is the possibility that interviews will need to be conducted remotely. If the interviews are to be completed remotely, it is advised that participants use headphones. Interviews will be arranged for a mutually convenient time for you and the researcher; however, the interview will be conducted outside of your working hours.

Prior to the interview, you will be sent a consent form via email that you will be asked to complete, sign, and return to the researcher. If this is not possible, verbal consent will be recorded at the beginning of the interview instead. The interviews will be audio-recorded and will last for as long as you want them to. There are no correct answers; the research is only interested in your experiences of working as an NHS clinical psychologist.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way.

What if I change my mind about taking part?

You are free to withdraw from the study at any time before the data has been analysed without having to provide a reason - withdrawing from the study will not affect you in any way. Data analysis will occur approximately 1-2 weeks following the interview. After data analysis, the withdrawal of your data will no longer be possible as the demographic questionnaire and interview data will have been anonymised and committed to the final report. If you choose to withdraw from the study before this point, any data collected will be destroyed.

What are the possible risks of taking part?

It is not expected that this study will cause you emotional distress; however, some people find talking about their experiences at work provokes difficult memories and feelings. If this occurs during the interview, support and reassurance will be provided. You will have the opportunity to take a break, and/or end the interview. You can also withdraw from the study up until the point of data analysis. Sources of further support will be provided at the end of the interview, outlining organisations available should they be needed. Further, if the researcher has any concerns relating to safeguarding, such as potential harm to yourself or others, they have a responsibility to pass this information on. However, due to the focus of the interview on the experience of thriving at work, this is thought to be unlikely.

Due to COVID-19, if attending for a face-to-face interview, the researcher will complete a lateral flow test beforehand and will not attend if feeling unwell. You are asked not to attend if you feel unwell. In this case, the interview can be rearranged for another time, or completed remotely if you choose. Further, you will be asked to follow the university campus guidelines for mask-wearing. If completing the interview remotely via video conferencing platforms or telephone, it may be possible for others you live with to overhear parts of the interview. Headphones are therefore recommended to partially mitigate this.

What are the possible benefits of taking part?

We cannot promise any direct benefits from taking part in the study. However, some people find it useful to have the opportunity to discuss their experiences. We hope that the information that you provide us will inform a better understanding of clinical psychologists' experiences of thriving within the NHS. As a result, this could inform what may facilitate experiences of thriving at work amongst this population and could help other professionals in their work. Due to increased demand for clinical psychologists within the NHS, it is vital that their voices are heard when considering wellbeing in the NHS workforce.

Data handling and confidentiality

GDPR stands for the 2016 General Data Protection Regulation. In the UK, we follow GDPR rules and have a law called the Data Protection Act. All research using person identifiable data must follow UK laws and rules. Researchers must show how they protect the privacy of the people who take part in their research by ensuring all identifiable information is kept confidential to the individual and only those in the research team who need to know. There are rules to ensure confidential information is kept safe and secure. A research ethics committee checks this before the research starts. Some of the research team will need to know your name and contact details so they can contact you about your research appointments or to send you information about the study. Researchers must always ensure that as few people as possible can see this information that can show who you are. In this study, your name will be removed from the research data and replaced with a pseudonym. By doing this, the research data can be matched up with the rest of the data relating to you by the pseudonym. Any information that could be used to identify you will be anonymised. Researchers must ensure they write reports about the study in a way that no one can work out that you took part in the study. Information collected from this study will be used for this study only and will not be used for any other purpose.

Throughout the study, all the data collected will be stored on an NHS encrypted laptop which only the researcher has access to. All information will be backed up to the secure network drives at the University of Hull, by uploading the files stored to Microsoft One Drive to share with research supervisors. Participants contact details and pseudonyms will be transferred to a password-protected Microsoft Excel document. This information will be deleted once the study has ended and the researcher has contacted all participants who requested feedback on the findings. Personal information provided on the demographic questionnaire will be anonymised using the pseudonym assigned to you and transferred to a password-protected Microsoft Excel document. Information from the demographic questionnaire will be combined with other anonymised participant responses in a summary table in the final research report to provide context to the sample.

Participant consent obtained via an audio recording will be saved as an audio file in a password protected folder. Participant consent obtained through a written signature on the participant consent form

will be saved as a password protected Microsoft Word document. To protect the security of these files, an encrypted NHS recording device will be used. Interviews will be kept confidential, unless you disclose something that suggests you or someone else is at risk of harm. If this happens during the interview, the researcher is legally obligated to report this to the appropriate authorities to ensure that you and others are safe. It is unlikely that this will occur given the focus on thriving at work, but should it happen, the researcher will discuss this with you. During the study, all interviews will be anonymously transcribed and transferred to a password-protected Microsoft Word document. Anonymised research data transcripts will be under the responsibility of the academic research supervisors and will be stored for a period of ten years on secure drives at the University of Hull. Anonymised research data transcripts will be analysed and reviewed by the primary researcher along with their researcher supervisors.

Data protection statement

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer. If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113). The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. In legal terms, this means that the University process your data for research purposes as part of 'a task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form on the day of the interview. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/unviersity-and-region/key-documents/data-protection.aspx.

How is the project being organised and funded?

The researcher carrying out this research is a student at the University of Hull and this research is being conducted as part of a doctorate level training program in Clinical Psychology.

What will happen to the results of the study?

The results of the study will be summarised in a thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's online repository https://hydra.hull.ac.uk. Once the final report is completed, feedback will be shared with participants who requested it. The research may be published in academic journals or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of research participants. This study has been reviewed and given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull.

What should I do next?

If you are still interested in participating in the research, please let me know by completing the consent to be contacted section at the end of the online survey. You can also contact me if you have any further questions. We can then arrange a mutually convenient time to meet for an interview. We will discuss informed consent and you will have the opportunity to ask any questions before we begin.

Who should I contact for further information?

If you have any questions or require any further information, please contact me using the following details:

Chloe Hussey

Clinical Psychology

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Telephone: 07929741847

Email address: C.Hussey-2017@hull.ac.uk

What if there is a problem?

If you have concerns about this study, you may discuss these with the researcher who will do their best to answer your questions. You can contact them with the details provided above.

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for advice and information:

Dr Jo Beckett

Clinical Psychology

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Telephone: 01482 463 568

Email address: Jo.Beckett@hull.ac.uk

Appendix J: Participant Consent Form

Version number and date: 4 – 15/06/2022

UNIVERSITY OF HULL

Consent Form

Title of study: The experience of thriving at work amongst clinical psychologists in an NHS context.

Name of Researcher: Chloe Hussey

Please initial box

	Please initial box
1.I confirm that I have read the information sheet dated 15.06.2022 (version 7) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that it is up to me to decide whether to take part in this study.	☐
3. I understand that I am free to withdraw at any time before data analysis occurs without giving any reason and without any cost or legal rights being affected. Due to the data analysis method being used, data analysis is anticipated to begin within two weeks following the interview. I understand that if I withdraw from the study before the interview, the demographic information that I have already provided on the online survey will be destroyed. I understand that once the interviews have been linked to the demographic information from the online survey, and both sets of data have been anonymised, I cannot withdraw my data. I understand that the data I have provided up to the point of withdrawal will be retained.	☐
4. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. I understand that the research will be submitted for publication in a research journal.	☐
5. I understand that I will be given a copy of this consent form.	☐
6.I agree to take part in the above study.	☐

Name of Participant	Date	Signature

Do you want to hear about the results of the study? ☐ ☐

Name of person taking consent	Date	Signature

Appendix K: Participant Demographic Questionnaire

Page 1

I would like to invite you to participate in a research study which forms part of my clinical psychology doctorate thesis. The study is exploring how clinical psychologists working within the NHS experience thriving at work within their roles. Thriving at work is defined by some as the joint experience of learning and vitality at work, but other definitions include elements like a sense of growth, mastery, autonomy or purpose, satisfaction, energy, development or improvement, or a feeling of worthwhileness. Put simply, thriving at work can be viewed as being your best self at work. There is no one definition of thriving at work, as it can look and feel differently for everyone, but these are some similarities in the experience of thriving at work.

If you are still interested in taking part in this study, please read the participant information sheet on the next page of the survey. Once you feel that you have understood the participant information sheet, you will be asked to complete a demographic questionnaire. The questionnaire will ask you questions about yourself and your work role. The final part of this survey will involve providing your contact details, to enable myself as. the researcher to contact you to discuss meeting for an interview about the topic of interest.

If you have any questions about the survey before you continue, please contact myself, Chloe Hussey, as the principal invesitgator on: 07929741847 or C.Hussey-2017@hull.ac.uk.

Your interest and involvement in this study is really appreciated.

Next >

Page 2: Participant Information Sheet

Version number and date: 6 - 22/04/2022

Participant Information Sheet (PIS)

You will be given a copy of this information sheet to keep.

Title of the study: Experiences of thriving at work amongst clinical psychologists in an NHS context

I would like to invite you to participate in a research study, which is part of my Clinical Psychology doctorate thesis. The study will explore how clinical psychologists working within the NHS experience thriving at work. Thriving at work is defined by some as the joint experience of learning and vitality at work, but other definitions include elements like a sense of growth, mastery, autonomy or purpose, satisfaction, energy, development or improvement, or a feeling of worthwhileness. Put simply, thriving at work can be viewed as being your best self at work. There is no one definition of thriving at work, as it can look and feel differently for everyone, but these are some similarities in the experience of thriving at work.

Before you decide to participate, it is important that you understand why the research is being completed, and what your participation will involve. Please take the time to read the following information sheet carefully, discussing it with others if that feels helpful to you, before deciding to be involved. If anything is not clear or you would like further information, please ask me.

What is the purpose of the study?

Clinical psychologists have been identified as a key group within the NHS workforce, particularly in relation to the transformation of mental health services. However, for some clinical psychologists, poor wellbeing at work can be an issue, with increasing numbers choosing to leave the NHS, or the profession, entirely. Yet, others report experiencing fulfilment and growth in their roles, despite experiencing challenges at work. Some research has explored how healthcare professionals can positively manage adversity at work, including thriving as a response. However, research considering wellbeing amongst healthcare professionals has so far largely focused on burnout and resilience, meaning there are limited studies exploring thriving amongst this population. There is also limited research exploring the experience of thriving at work overtime. Therefore, this study aims to explore experiences of thriving at work amongst NHS clinical psychologists.

Why have I been invited to take part?

You are being invited to participate in this study as you are a Health and Care Professions Council (HCPC) registered clinical psychologist currently working within the NHS. Eligible participants have between 3-10 years experience working as qualified clinical psychologists.

What will happen if I take part?

If you choose to take part in this study, you will be asked to read the participant information sheet and complete a demographic questionnaire. This will take roughly 10 minutes, and will ask questions about yourself (e.g., age), and your work (e.g., length of career, current employment status, HCPC registration number). By providing this information, I can check that you meet the criteria to participate in this study. Once you have completed the questionnaire, you will be asked to provide

and complete a demographic questionnaire. This will take roughly 10 minutes, and will ask questions about yourself (e.g., age), and your work (e.g., length of career, current employment status, HCPC registration number). By providing this information, I can check that you meet the criteria to participate in this study. Once you have completed the questionnaire, you will be asked to provide contact details, specifically a non-NHS email address and telephone number, and provide consent for me to contact you to arrange to meet for an interview.

Interviews can be conducted face-to-face at the Brynmor Jones Library at the University of Hull, in a private study room to ensure privacy for the duration of the interview. However, participants may prefer to complete the interview virtually from their home, via Microsoft Teams. Participants are encouraged to choose whichever option is most convenient for them. In total, it is expected the study will require a minimum of 60 minutes and a maximum of 90 minutes of your time, which may be inconvenient for you. To support with this, the interview will be arranged for a time most convenient for you. If expenses are incurred during your participation, you can claim these back; for instance, the cost of travel to and from the University of Hull campus, including fuel mileage, public transport costs, or tolls.

Due to COVID-19, how the interviews are completed may be governed by restrictions in place at the time, meaning there is the possibility that interviews will need to be conducted remotely. If the interviews are to be completed remotely, it is advised that participants use headphones. Interviews will be arranged for a mutually convenient time for you and the researcher; however, the interview will be conducted outside of your working hours.

Prior to the interview, you will be sent a consent form via email that you will be asked to complete, sign, and return to the researcher. If this is not possible, verbal consent will be recorded at the beginning of the interview instead. The interviews will be audio-recorded and will last for as long as you want them to. There are no correct answers; the research is only interested in your experiences of working as an NHS clinical psychologist.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way.

What if I change my mind about taking part?

You are free to withdraw from the study at any time before the data has been analysed without having to provide a reason - withdrawing from the study will not affect you in any way. Data analysis will occur approximately 1-2 weeks following the interview. After data analysis, the withdrawal of your data will no longer be possible as the demographic questionnaire and interview data will have been anonymised and committed to the final report. If you choose to withdraw from the study before this point, any data collected will be destroyed.

What are the possible risks of taking part?

It is not expected that this study will cause you emotional distress; however, some people find talking about their experiences at work provokes difficult memories and feelings. If this occurs during the interview, support and reassurance will be provided. You will have the opportunity to take a break, and/or end the interview. You can also withdraw from the study up until the point of data analysis. Sources of further support will be provided at the end of the interview, outlining organisations available should they be needed. Further, if the researcher has any concerns relating to safeguarding, such as potential harm to yourself or others, they have a responsibility to pass this information on. However, due to the focus of the interview on the experience of thriving at work, this is thought to be unlikely.

Due to COVID-19, if attending for a face-to-face interview, the researcher will complete a lateral flow test beforehand and will not attend if feeling unwell. You are asked not to attend if you feel unwell. In this case, the interview can be rearranged for another time, or completed remotely if you choose. Further, you will be asked to follow the university campus guidelines for mask-wearing. If completing the interview remotely via video conferencing platforms or telephone, it may be possible for others you live with to overhear parts of the interview. Headphones are therefore recommended to partially mitigate this.

What are the possible benefits of taking part?

We cannot promise any direct benefits from taking part in the study. However, some people find it useful to have the opportunity to discuss their experiences. We hope that the information that you provide us will inform a better understanding of clinical psychologists' experiences of thriving within the NHS. As a result, this could inform what may facilitate experiences of thriving at work amongst this population and could help other professionals in their work. Due to increased demand for clinical psychologists within the NHS, it is vital that their voices are heard when considering wellbeing in the NHS workforce.

Data handling and confidentiality

GDPR stands for the 2016 General Data Protection Regulation. In the UK, we follow GDPR rules and have a law called the Data Protection Act. All research using person identifiable data must follow UK laws and rules. Researchers must show how they protect the privacy of the people who take part in their research by ensuring all identifiable information is kept confidential to the individual and only those in the research team who need to know. There are rules to ensure confidential information is kept safe and secure. A research ethics committee checks this before the research starts. Some of the research team will need to know your name and contact details so they can contact you about your research appointments or to send you information about the study. Researchers must always

ensure that as few people as possible can see this information that can show who you are. In this study, your name will be removed from the research data and replaced with a pseudonym. By doing this, the research data can be matched up with the rest of the data relating to you by the pseudonym. Any information that could be used to identify you will be anonymised. Researchers must ensure they write reports about the study in a way that no one can work out that you took part in the study. Information collected from this study will be used for this study only and will not be used for any other purpose.

Throughout the study, all the data collected will be stored on an NHS encrypted laptop which only the researcher has access to. All information will be backed up to the secure network drives at the University of Hull, by uploading the files stored to Microsoft One Drive to share with research supervisors. Participants contact details and pseudonyms will be transferred to a password-protected Microsoft Excel document. This information will be deleted once the study has ended and the researcher has contacted all participants who requested feedback on the findings. Personal information provided on the demographic questionnaire will be anonymised using the pseudonym assigned to you and transferred to a password-protected Microsoft Excel document. Information from the demographic questionnaire will be combined with other anonymised participant responses in a summary table in the final research report to provide context to the sample.

Participant consent obtained via an audio recording will be saved as an audio file in a password protected folder. Participant consent obtained through a written signature on the participant consent form will be saved as a password protected Microsoft Word document. To protect the security of these files, an encrypted NHS recording device will be used. Interviews will be kept confidential, unless you disclose something that suggests you or someone else is at risk of harm. If this happens during the interview, the researcher is legally obligated to report this to the appropriate authorities to ensure that you and others are safe. It is unlikely that this will occur given the focus on thriving at work, but should it happen, the researcher will discuss this with you. During the study, all interviews will be anonymously transcribed and transferred to a password-protected Microsoft Word document. Anonymised research data transcripts will be under the responsibility of the academic research supervisors and will be stored for a period of ten years on secure drives at the University of Hull. Anonymised research data transcripts will be analysed and reviewed by the primary researcher along with their researcher supervisors.

Data protection statement

You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer. If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113). The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. In legal terms, this means that the University process your data for research purposes as part of 'a task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form on the day of the interview. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/unviersity-and-region/key-documents/data-protection.aspx.

How is the project being organised and funded?

The researcher carrying out this research is a student at the University of Hull and this research is being conducted as part of a doctorate level training program in Clinical Psychology.

What will happen to the results of the study?

The results of the study will be summarised in a thesis as part of a Doctorate in Clinical Psychology. The thesis will be freely available to access on the University of Hull's online repository https://hydra.hull.ac.uk. Once the final report is completed, feedback will be shared with participants who requested it. The research may be published in academic journals or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, who protect the interests of research participants. This study has been reviewed and given a favourable opinion by the Faculty of Health Sciences Ethics Committee at the University of Hull.

What should I do next?

If you are still interested in participating in the research, please let me know by completing the consent to be contacted section at the end of the online survey. You can also contact me if you have any further questions. We can then arrange a mutually convenient time to meet for an interview. We will discuss informed consent and you will have the opportunity to ask any questions before we begin.

Who should I contact for further information?

If you have any questions or require any further information, please contact me using the following details:

Chloe Hussey

Clinical Psychology

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Telephone: 07929741847

Email address: C.Hussey-2017@hull.ac.uk

What if there is a problem?

If you have concerns about this study, you may discuss these with the researcher who will do their best to answer your questions. You can contact them with the details provided above.

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for advice and information:

Dr Jo Beckett

Clinical Psychology

If you have concerns about this study, you may discuss these with the researcher who will do their best to answer your questions. You can contact them with the details provided above.

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for advice and information:

Dr Jo Beckett

Clinical Psychology

Aire Building

The University of Hull

Cottingham Road

Hull

HU6 7RX

Telephone: 01482 463 568

Email address: Jo.Beckett@hull.ac.uk

Page 3

By continuing with the online survey, you have stated that you have read and understand the participant information sheet. This indicates that you are aware of the purpose of the study, your involvement in the study, and you give your consent for your data to be used in this research.

The next stage of the survey is to complete the demographic questionnaire. This will involve several questions about yourself and your work role. This information is important as it allows me to check that you meet the criteria to take part in this study. Additionally, it also allows for an exploration of the different factors which may influence the experience of thriving at work.

Page 4: Demographic Questionnaire

All questions marked with an asterix (*) require you to provide an answer.

1. Please select the category that includes your age.

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 or over

Page 5: Demographic Questionnaire (continued)

2. Please indicate the length of time (in years and months) since qualification from a Doctorate in Clinical Psychology course. * *Required*

3. Please indicate the length of time (in years and months) since your registration with the Health and Care Professions Council (HCPC) as a qualified clinical psychologist. * *Required*

   a. Please provide your HCPC registration number: * *Required*

4. Please indicate the total length of time (in hours) that you work each work. * *Required*

5. Please indicate the total length of time (in hours) that you work in your role in the NHS each week. * *Required*

6. Please select the category that best describes your current employment status within your NHS role: * *Required*

- [ ] Full time
- [ ] Part time (less than 17.5 hours per week)
- [ ] Part time (more than 17.5 hours per week)
- [ ] Other
- [ ] Other

7. Please indicate the pay banding you are employed at: * *Required*

- [ ] 7
- [ ] 8a
- [ ] 8b
- [ ] 8c
- [ ] 9

Page 6: Consent to Contact

If you are still interested in taking part in this study, please leave your contact details in the spaces provided below. Completing the demographic questionnaire and providing your contact details will provide me with your consent to contact you about the study.

All questions marked with an asterix (*) require you to provide an answer.

8. Please provide your full name: * *Required*

9. Please provide a non-NHS phone number: * *Required*

10. Please provide a non-NHS email address: * *Required*

11. What is your preferred method of contact?

- ☐ Telephone
- ☐ Email

12. Are there any specific times of the day that you would prefer to be contacted?

Page 7: Study results feedback

Some people may wish to be updated on the outcome of the study once it concludes. Consequently, I am able to provide a summary of the study findings once it is completed via email.

13. Do you consent to being sent information regarding the outcome of the study over email (using the email address provided above)? * *Required*

- ☐ Yes
- ☐ No

Page 8

14. It is important that you understand the purpose of the study and your involvement. Do you consent to being sent a copy of the participant information sheet and my contact details (using the email address provided above)? This will allow you to be able to get in contact at any time if you have any questions or queries about the study. * *Required*

- ☐ Yes
- ☐ No

Final page

Thank you for your interest in this study exploring how clinical psychologists experience thriving at work within an NHS context.

Shortly after you submit this survey, if you have consented for me to do so, you will receive an email providing you with a copy of the participant information sheet and my contact details, should you have any questions about the study.

The next step will involve arranging a mutually convenient time, date and location for the venues (face-to-face or virtual via videoconferencing platform).

Thank you again for your interest in this study. If you have any questions or require more information, please contact me using the following contact details:

Chloe Hussey

Clinical Psychology, Aire Building, The University of Hull, Cottingham Road, Hull, HU6 7RX.

Telephone: 07929741847

Email address: C.Hussey-2017@hull.ac.uk

Appendix L: Email communications to participants

Email 1 – After completing online survey

Dear (INSERT NAME)

Thank you for expressing interest in this study, exploring experiences of thriving at work amongst clinical psychologists in an NHS context.

You are receiving this information as you completed an online survey regarding this study. In the survey, you provided consent for me to send you a copy of the participant information sheet (attached to this email) and my contact details using the email address you provided.

What happens next?

The next step will involve waiting for me to get back in touch, using your preferred method of contact, to arrange a mutually convenient time and date for the interview. I am incredibly grateful for everyone who wants to be involved in this research, and I hope that I can capture some of the experiences of clinical psychologists within the NHS.

With warm wishes,

Chloe Hussey (Trainee Clinical Psychologist and Chief Investigator)

Contact: C.Hussey-2017@hull.ac.uk / 07929741847

Supervised by Dr Jo Beckett (Research Supervisor and Clinical Psychologist)

Contact: jo.beckett@hull.ac.uk / 01482 463568

Email 2 – Before the Interview

UNIVERSITY OF HULL

Dear (INSERT NAME)

Thank you for your interest in this study exploring experiences of thriving at work amongst clinical psychologists in an NHS context.

You are receiving this information as you have spoken to myself, and we have agreed a suitable time and date for an interview as part of this study. Before the interview, please take some time to read the following information carefully. If you are completing your interview using a video conferencing platform, please read Appendices 1, 2 and 5. If you are attending a face-to-face interview, please read Appendices 3, 4, and 5.

- Appendix 1 – Information on how to prepare your home environment for a video interview
- Appendix 2 – Information on how to access and use MS Teams for video conferencing
- Appendix 3 – Information on getting to the Brynmor Jones Library at the University of Hull
- Appendix 4 – University of Hull campus map
- Appendix 5 – Participant consent form

What happens next?

Once you have read the attached information and feel happy to proceed, please provide a signature and date on the consent form (either written signature and scanned, or electronic signature) and return to myself. If you do not have the facility to do this, do not worry, we will cover the information again on the day of the interview and verbal consent can be provided as an alternative.

If you have any questions or require any further support, please do not hesitate to contact me using the details below. I look forward to speaking with you further about your experiences, on the day of the interview.

With warm wishes,

Chloe Hussey (Trainee Clinical Psychologist and Chief Investigator)

Contact: C.Hussey-2017@hull.ac.uk / 07929741847

Appendix 1: Preparing your home environment for a video interview

- Make sure that you sit in a space in which you feel comfortable.
- Make sure that you are on your own in the room, so you feel safe to disclose experiences at work. The interviewer will also be doing the same to ensure the confidentiality of the interview.
- It is ideal to have a background free of distractions (a plain wall often works best).
- To improve sound quality, wearing headphones or earphones can be helpful.
- Check your camera and microphone/headset at working ahead of time.

Appendix 2: How to access and use video conferencing tools

How to use Microsoft Teams:

- You do not need to download anything to join Microsoft Teams.
- The interview/meeting setting have been set to maximise the security of the interview. Please do not share access codes or the invite to this meeting, as this will compromise security.

- You will receive the MS Teams invite via the non-NHS email that you provided.
- You may be asked to accept the meeting, but don't do anything with it (if you do accept the meeting, you may find it disappears into the 'trash folder', rather than the 'index folder').
- When it is 5-10 minutes before the meeting, click the link which says 'Join Microsoft Teams Meeting'.
- You will then be asked to enter your name.
- You will then see a message which says you are waiting for the meeting host. The meeting host will let you into the meeting at the right time.

- You can find out more about Microsoft Teams here: https://biz30.timedoctor.com/how-to-use-microsoft-teams/
- If you experience any technical difficulties, you can call myself on: 07929741847

Appendix 3: Getting to the Brynmor Jones Library at the University of Hull

Address:

Cottingham Road, Hull, HU6 7RX

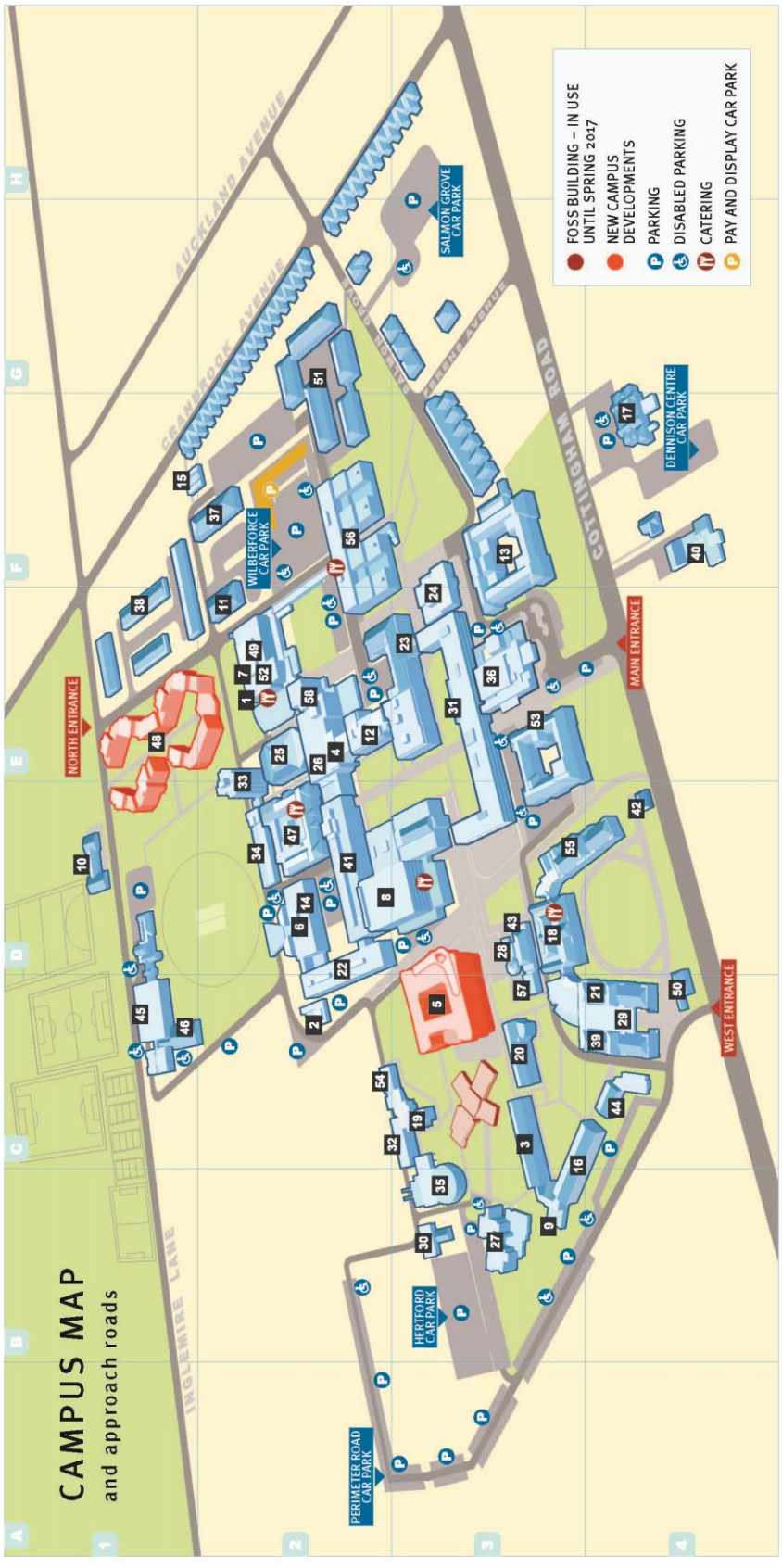
Travelling to the campus via the M62 and A63:

- Take the A15 Humber Bridge exit, just after the fuel station on the left. At the first roundabout, go straight on. At the second roundabout, turn left onto the A164 – there is a sign saying 'Universities'. At the next roundabout, go straight on.
- After 2.3 miles, the next roundabout will appear. Go straight on. There is a fuel station either side and a Mercure Hotel on the right. At the next roundabout, go straight on.
- At the next roundabout, turn right onto Castle Road, following signs for 'Castle Hill Hospital'.
- Drive to the end of Castle Road, passing the hospital on the left. At the bottom, turn left at the mini roundabout.
- Go straight at the next mini roundabout and over the level crossing.
- At the next roundabout, turn right onto Hull Road. Bear left, remaining on Hull Road (B1233). At the next roundabout, go straight on.
- You are now on Cottingham Road. Drive past the University main entrance and turn left at the lights onto Cranbrook Avenue. Turn left at the mini roundabout onto Inglemire Lane and then left into the University North entrance.

Parking at the University of Hull campus:

- Wilberforce Car Park:
  Multi-storey car park. Parking charges apply: £1 for up to 4 hours or £2 for over 4 hours. Open 24/7.

Appendix 4: University of Hull Campus Map



Email 3 - confirmation to participants

UNIVERSITY OF HULL

Dear (INSERT NAME)

Thank you again for your participation in the study exploring experiences of thriving at work amongst clinical psychologists in an NHS context. By sharing your experiences as part of this study, you have contributed to research which hopes to understand wellbeing at work amongst NHS clinical psychologists.

You are receiving this information as you were interviewed for the study. Attached to this email, you will find further information about how to access further support if it is needed.

What happens next?

If you have requested feedback about the findings of the study, I will be in contact shortly after the study has ended.

If you any further questions or queries arise, please do not hesitate to get in contact with me.

With warm wishes,

Chloe Hussey (Trainee Clinical Psychologist and Chief Investigator)

Contact: C.Hussey-2017@hull.ac.uk / 07929741847

Appendix M: Interview Schedule

Version number and date: 5– 09/07/2022

Interview Questions:

Introduction:

- Thank you for agreeing to participate in the research. It is anticipated the interview will last around an hour today. Please let me know if you are uncomfortable at any time and if you would like a break. Do you have any questions before we begin?
- I'd just like to remind you that this research is interested in your views, therefore I will say as little as possible throughout the interview, as I am here to listen to you and am interested in your thoughts, reflections, and ideas about the topics.

Understanding thriving at work

Primary:

- When you saw the study related to thriving at work, what did you understand by the word 'thriving'?
- What does the phrase 'thriving at work' mean for you in your work as a clinical psychologist in the NHS?

Supplemental:

- Can you recall a time when you felt like you were thriving within your role at work?
- How did you know you were thriving at the time?

What shapes thriving at work

Primary:

- Can you tell me about a time when something helped you thrive at work?
- Can you tell me about a time when something got in the way of your thriving at work?
- What do you consider influences your experience of thriving as a clinical psychologist in the NHS?

Supplemental:

- What helps you experience thriving at work?
- What do you think can get in the way of you thriving at work?

Temporal aspect to thriving

Primary:

- Thinking about thriving at work as a clinical psychologist in the NHS, and the passage of time since qualifying, has your understanding of thriving altered at all? If so, how? Can you give examples?
- When you think about thriving as a clinical psychologist working in the NHS, and you think about the future, what thoughts and feelings come to mind?

Supplemental:

- Thinking about thriving over your career, are there any changes or differences in your experience of thriving at work over time?
- Can you think of an example which illustrates changes in your experience of thriving over your career?

Generic prompts:

- Can you tell me more?
- Can you give me an example?
- Can you tell me more about your reasons for this?
- Can you tell me more about how you understand this to be the case?

Conclusion of interview

- We have reached the end of my questions now, is there anything else you would like to share or discuss about your experiences of thriving at work as an NHS clinical psychologist?
- Do you have any questions for me?
- Thank the participant for their time and contributions to the research

***Appendix N*: Further sources of support sheet**

Version number and date: 2 – 01/03/2022

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Sources of Support

At work

Speak with your **Line Manager/Supervisor** as they can listen and help you to access appropriate support from within the service.

Occupational Health Services offer information and support to promote and maintain physical and psychological health and wellbeing of employees in the workplace.

Humber, Coast and Vale Staff Resilience Hub provide support and advice to all health and care workers, and their families, who live or work in the Humber, Coast and Vale Region.

https://www.hcvresiliencehub.nhs.uk

External support

Speak to your **GP** who can advise and help you to manage physical and psychological health concerns. They can also signpost you to other services including community groups and psychological therapy.

Improving Access to Psychological Therapies (IAPT) provide psychological support to individuals with common mental health difficulties. Follow this link to find further information about your local IAPT provision. This requires you to enter your GP's address, before providing the local psychological therapies services

https://www.nhs.uk/service-search/find-a-psychological-therapies-service/

Samaritans offer free, confidential support lines for health and social care workers and volunteers based in England and Wales. The supports lines are run by Samaritans and all calls are answered by trained Samaritans volunteers, who provide confidential, non-judgemental support.

Telephone: 0800 069 6222

Mind Infoline provides an information and signposting service. They are open 9am to 6pm, Monday to Friday (except for bank holidays), and can provide information about mental health problems, where to get help near you, treatment options, and advocacy services.

Email: info@mind.org.uk

Telephone: 0300 123 3393

Additional contacts

If you still have concerns which have been raised by taking part in this study, you may contact the researcher at C.Hussey-2017@hull.ac.uk or by telephone on 07929741847. However, please note that they are unable to provide psychological advice or support and can only have a conversation about the impact of the research and signpost to other services.

Appendix O: Reflective statement

When exploring ideas for my research, I was repeatedly drawn to topics relating to staff wellbeing. To contextualise, this was around the time of the second Covid-19 lockdown, in the winter of late 2020, to early 2021. There seemed to be a growing recognition of the importance of looking after our healthcare professionals, in a time of increasing challenge and adversity. My experiences of volunteering with the Samaritans and working as a support worker with children and young adults with complex needs meant I had experienced first-hand, both a sense of reward, purpose, and fulfilment from supporting individuals in distress, alongside the challenges this posed. With this in mind, alongside beginning my first clinical placement within the NHS, questions around maintaining wellbeing were beginning to bubble under the surface.

Around this time, I was (re)introduced to some positive psychology ideas by my supervisor, Dr Jo Beckett, and I was particularly struck by the notion of 'thriving', from an academic and personal perspective. Had I felt this before? If so, how did I know? Is it possible to thrive in times of challenge? Could thriving be sustained in the current healthcare climate? From here, the research question developed organically. As there was little in the literature about thriving amongst clinical psychologists, I thought adopting a qualitative, exploratory approach would allow me to dive into this area, hopefully capturing the depth and detail needed to understand this experience.

Method and Approach

Quite quickly, I felt compelled to explore this area, but wondered about my position as a trainee clinical psychologist beginning their journey within this system. As I began to consider the methodology for the study, I became aware of IPA, and the key principle of the double hermeneutic within this approach. This felt highly relevant and necessary to consider when embarking on a research topic that I felt so closely connected to. I valued the ideas of fore-understanding (Heidegger, 1927/1962) and fore-projection (Gadamer, 1960/1990) discussed within IPA literature, as I considered the importance of holding in mind my influence on the research as a result of my professional experiences thus far. Furthermore, this study sought to understand the subjective meanings of thriving at work, rather than establishing patterns across participants' experiences, like in Thematic Analysis (Braun & Clarke, 2006). A Grounded Theory methodology (Corbin & Strauss, 2014) was not deemed to be suitable to the research question, as this approach would have focused on developing an explanatory level account, rather than exploring participants' understandings of their experiences.

Ethics Process and Recruitment

The process of applying for and receiving ethical approval was relatively smooth, which I partly attribute to my decision to apply via the Faculty of Health Sciences' Research Ethics Committee, and not to apply for NHS Ethical Approval in addition. I maintain this was a suitable decision for this piece of research, for multiple reasons. Predominantly, I wanted participants to feel safe and able to discuss their experiences of working in the NHS as openly as they wanted to. I was concerned about the potential effects on participants' willingness to participate, and to wholeheartedly share their experiences, if they felt the study was in any way connected to their place of work, or employing NHS Trust; for instance, if they learned about the study through seeing advertisements in their work settings.

Early in the recruitment phase, I began to second-guess this decision, as there was initially limited expressions of interest from participants. Of the interest that was shown, these volunteers did not exactly fit the inclusion/exclusion criteria, with many identifying as CPs who no longer were employed by the NHS but were keen to discuss their previous experiences. As a result, I submitted for an amendment via ethics, around a week or two into recruitment. This was influenced by my concern around initially slow-moving recruitment, alongside a sense of intrigue and desire to explore these potential, willing participants' experiences. In the end, all participants included in the sample were currently employed in the NHS, however some were in non-clinical roles. Reflecting on this decision now, I think I should have spent more time considering the implications of including both participants who had left the NHS, and those currently employed, instead of allowing my anxieties around recruitment to influence this decision-making.

As mentioned, I received a lot of interest from CPs who had seen the advert circulating via social media, who did not meet the inclusion criteria but who expressed their interest regardless. I wonder what this says about the relevance of this topic for CPs currently, and the need for further research to explore the experiences of CPs who have left the NHS.

Interviews

During the interviews, I remember feeling a sense of energy around the process and meeting with participants to explore their ideas and perspectives. I recall feeling satisfaction, enjoyment, and renewed curiosity in the research, following the somewhat arduous process of producing research proposals, making revisions, and then nervously awaiting ethical approval. Looking back, I wonder to what extent the language I am ascribing to this period has been influenced by my discussions with participants around their sense of thriving, alongside my knowledge of the literature. It made me reflect on the positions of my participants, exposed to ideas of thriving through academia and

clinical practice (or not), within their teams and organisations, and wondered how this may impact upon their experiences.

I also recall feeling nervous for the first, and only, face-to-face interview I completed throughout the research, despite this occurring towards the end of the data collection period. Throughout the interviews, I was mindful of my position as a trainee clinical psychologist, particularly being a University of Hull trainee thus completing a 'fast-track' course, and how this may impact on others' assumptions about my competencies. I wonder how this may have contributed to some of my own anxiety around being 'good enough' as a researcher. I find it interesting to reflect on this retrospectively given my discussions with participants around their perceptions of their own thriving at work as shaped by the expectations of other psychologists. Considering clinical psychology as a competitive profession, the role of comparison feels rife at times throughout the application process and training. Some participants reflected on this sense of comparison and competition in their interviews, and it seems I also fell into this pattern at times throughout research process. I recall points when I noticed experiencing a sense of pressure to 'do well' in my research, struggling at times with the iterative nature of the process. However, I can also reflect on this in the context of completing a clinical psychology doctorate, with time constraints and evaluative components at the fore. It makes me wonder about the impact of this on CPs in their careers, following the experience of this in their training years.

Further, as a trainee CP, I straddled both insider/outsider positions at different points. I was mindful of 'assumed knowledge' between myself and participants. However, there were advantages to having a shared language and understanding at times, for instance when participants referenced specific psychological theories or concepts. Additionally, as some participants were curious about the development of the research question, I found reflecting honestly about my position as a trainee, embarking on hopefully a long career within the NHS, to be valuable. I think this consolidated my position as a 'native' in participants' eyes, showing I was someone who 'got it'. I think this was helpful in participants' feeling able to be open with me, instead of feeling the need to be protective of a newcomer to the profession. Likewise, small moments reflecting on elements of shared experience, such as humour around the trials and tribulations of NHS IT systems, all seemed to help to put participants at ease. I am reminded here of advice from supervisor, Dr Emma Wolverson, regarding the importance of establishing a relationship with my participants, creating a space where they can feel safe enough to reflect openly on their experiences. Conversely, my position may have been disadvantageous, hindering participants' sharing of their experiences if censoring the more challenging or distressing parts in an attempt to minimise potential upset or anxiety for me. For example, one participant joked about 'putting you (me) off' after recalling their experience of burnout and some of the challenges of working in the NHS.

The importance of 'drilling down' into participants' lived experiences stuck with me throughout the interviewing process. I was conscious of the possibility of CPs presenting me with an intellectualised account of their experiences, citing what is known about thriving from the literature as opposed to exploring their own meanings and sense-making. As such, as the interviews progressed, the semi-structured schedule was revised, with greater emphasis placed on specific questions. Whilst participants might readily describe in an academic, detached sense, the core components of thriving at work, at times I was still unclear on how that was *their* experience of thriving at work. The question of 'how do we know this is thriving for you/me/us?' seemed to ring in my ears, particularly following the early interviews. Thus, to focus in on the lived, felt sense of thriving, the question: 'How did *you* know you were thriving?', seemed to develop greater weight and importance. For some, it appeared easier to reflect on what was not thriving at work for them. Therefore, often I found myself returning to this question several times, from different angles, to get to the heart of what thriving at work felt like for each participant.

Similarly, as the interviews progressed, I noticed some participants advising me in moving forward in the profession. This seemed to take us from a researcher-participant dynamic, towards a supervisee/supervisor, unqualified/qualified position. This was not unexpected, however, I wondered at times whether participants were reflecting on what they wished they had done differently themselves. Consequently, this developed into a question incorporated in the latter interviews, whereby I asked: 'If you could rewind to the start of your career in clinical psychology, what advice might you give your younger self about this topic?'.

Context around the Study

The period of time in which the interviews and data analysis occurred feels significant for this research. Around the time of the interviews (June – July 2022), Boris Johnson had resigned as Prime Minister, with a Tory leadership race ensuing, in which we saw the NHS being weaponised in a bid for power (again). Alongside this, there were growing discussions in the media and by unions around below-inflation pay rises for public sector workers, with the threat of proposed pay cuts looming. All of this in the aftermath of a gruelling global pandemic, with the '*greatest workforce crisis in NHS history'* (proclaimed by Jeremy Hunt).

By the time of data analysis, many CPs employed at Band 8a were informed by their Trusts (with others not informed at all), that their take home pay would be less than usual, following backdated pay rises and pension contributions. Concurrently, NHS staff were receiving information via Trust Communications regarding advice on accessing foodbanks. Similarly, changes to pension rules were associated with many NHS doctors leaving, which caused delays in NHS pensions being paid out. When I think to my discussions with participants about what keeps many of them working

in the NHS, with the security of the NHS mentioned by many, I wonder what impact hearing news stories like this may have had on morale and motivations to remain within their NHS roles. In future research, I would consider paying greater attention to the political context in my discussions with NHS employees.

Data analysis

At the beginning of the analysis, I felt overwhelmed by the number of interesting and important insights that my participants had shared. I wondered how I could portray these in a way that did the data justice. My supervisors reminded me of the importance of focusing on my research question and highlighting the 'take-home' messages. Due to the exploratory nature of this study, and my own curiosity regarding the topic and wider discussions within clinical psychology, my head was brimming with ideas. However, maintaining fidelity to the IPA approach, and ensuring a focus on the individual experiences of my participants was vital. Immersing myself in IPA literature was essential in finding a way to tell the story of participants' experiences, but through my own lens. The challenge of figuring out what is 'mine' and what is 'theirs', ran through this process. Keeping a reflective diary and examining my own assumptions was crucial. Early on in the process, when putting together my first research proposal, I noted down some of my initial assumptions underpinning this research. A key one stood out:

"I think one piece of research into this cannot reveal any one experience or 'truth', but I hope it may suggest themes or highlight some shared 'truths'".

Therefore, holding this idea in mind throughout the analysis was helpful, particularly at points when the amount of data felt overwhelming, or I was struggling with deepening my interpretations in line with an IPA methodology. Further, when thinking about how best to tell the story of my participants, I found drawing out diagrams and repeatedly 'going back to the drawing board', reorganising my themes and considering new ways of relating themes together, to be both exciting and infuriating. Yet, it also felt absolutely necessary in trying to capture the participants' unique experiences.

The research team held different assumptions about thriving at work amongst NHS CPs, particularly concerning the role of time. I wondered if greater experience, associated with skills and confidence, could facilitate thriving. My supervisors proposed less experienced CPs were perhaps more likely to experience thriving, due to growth associated with the acquisition of skills and knowledge in earlier career stages.

It struck me early in the analysis that I had unknowingly held a significant assumption about thriving at work, which contrasted greatly with some participants' understandings. I understood thriving at work as an internal experience, associated with feeling joyful, enthusiastic, and purposeful, alongside a sense of development. This therefore would not necessarily correspond with banding, pay or recognition from others. From my perspective, how I feel in my work feels much more important than my position. I do not identify with an urgency to move up to the next band, but I do want to feel a growing sense of competence in my skills and what I can offer within my role. Therefore, I was mindful of identifying too closely with participants' whose sense-making around what thriving at work is, aligned with my own. Equally, I did not want to skirt over how thriving at work is understood and experienced very differently by others. I recall noting in my reflective journal that this variation was surprising to me, which reinforced the importance of capturing this within the analysis. Discussing this in supervision was also helpful in encouraging me to widen the lens, exploring the influence of wider, societal, and cultural norms and narratives around success at work within a Western context, and how this may have impacted participants understandings of thriving at work.

Lastly, during the analysis, I noticed that exploring 'thriving at work' felt somewhat threatening at times. In periods of high anxiety and stress related to challenging experiences on placement, I perceived it as my responsibility to ensure my own wellbeing, therefore thinking about how to maintain my own thriving in work, felt really testing. From this, I wonder about how this may have impacted on the recruitment of NHS CPs who may also identify with finding the topic of 'thriving at work', as potentially threatening. Introducing 'thriving at work' in the recruitment poster was reported by some participants as a source of interest and intrigue. Yet for others, it could have acted as a barrier to their involvement due to thriving at work being associated with threat in their current context.

Systematic literature review (SLR)

When deciding on a topic for the review, I knew I wanted to explore wellbeing amongst psychological professionals within the context of healthcare settings. I was intrigued as to how much research captured the positive experiences associated with working as a psychological professional in healthcare, alongside accounts of the challenges. An initial difficulty arose in deciding whether or not the research question should focus exclusively on positive experiences, or whether to approach wellbeing more broadly. However, I think using the latter approach was useful in capturing a range of experiences pertinent to the research question, that may have been missed if only using search terms centred around positive wellbeing, such as thriving, resilience and growth.

Due to the paucity of research regarding specific psychological professions, including clinical psychology, it made sense broaden this out to include psychological practitioners more generally.

As I simultaneously undertook the review alongside completing the data analysis for my empirical research, I was initially concerned by some of the similarities in themes emerging across the two pieces of research. However, upon repeatedly taking a step back from each piece of research respectively, I since interpret this as potentially suggesting the research has tapped into a shared experience and understanding amongst psychological professionals in healthcare. From reflecting with peers, colleagues and supervisors, the findings seem to make sense with some of our own experiences.

From completing this SLR, I have a greater appreciation for the value of adopting a systematic approach to inform clinical rationales and decision-making. The wealth of evidence available can sometimes feel conflicting and overwhelming, however the skills I have begun developing throughout undertaking this SLR will help me to channel future curiosity regarding what is known within the evidence base, in a way that feels containing and focused.

Journal Choice(s)

For my empirical study, the British Journal of Clinical Psychology was selected due to the focus on thriving at work in the context of NHS CPs. Whilst some of the findings may be relevant to healthcare settings outside of the UK, I wanted to focus on distributing the key messages and implications from this empirical study within a UK context. The unique relationship between the NHS and CPs could be critical in considering wellbeing and retention of the CP workforce.

As my SLR explored conceptualisations and experiences of wellbeing amongst psychological practitioners in healthcare settings internationally, the International Journal of Wellbeing was regarded as an appropriate journal choice. From discussions via email with a co-editor for the journal, it appeared this journal would reach a varied audience, including academics, healthcare professionals and lay people internationally, for whom the findings could be useful or interesting.

It has been challenging to meet word counts as required by journals, and as a result, I've needed to leave some ideas out of the empirical paper. Deciding which parts to include, and which to leave behind, has been difficult, as I consider myself to have acted as a voice for my participants and their experiences. I hope to have captured what felt important to my participants.

Final reflections

Over the course of this project, there have been periods of frustration around the iterative nature of research, particularly with completing a qualitative analysis using a methodology I was previously unfamiliar with. Yet now I am here, I am incredibly proud of this research, and the time and effort I have invested into it. This research has felt like somewhat of a 'personal project' for me. I've wondered at points if I've been 'looking for the answers' from other CPs when thinking about how I can sustain my own thriving at work as an NHS clinical psychologist moving forward. Whilst I have felt highly motivated to explore this topic, it has also been a challenge to immerse myself within this area for the past few years. As I embark on a qualified career as an NHS CP myself, I have been required to reconcile this with the current picture of increasing numbers of CPs leaving the NHS. This has not always sat comfortably. The advice and insights generously shared by participants has been invaluable, on a professional and personal level, and in terms of adding to the knowledge base.

References

Gadamer, H. (1960/1990). *Truth and Method* (2nd ed.). Crossroad.

Heidegger, M. (1927/1962). *Being and Time.* Blackwell.

Appendix P: Example of data analysis

Transcript	Comments	Emergent themes
I: Thank you for giving me a bit of a flavour of your experiences and the context around that. I'm just curious, in terms of when you saw the advert for the study and saw it said about thriving at work as a clinical psychologist in the NHS, what did you understand by that term thriving at work?		
P: I thought how nice would that be (laughs). To be perfectly honest. I think thriving at work, to me, would be being challenged enough that I feel like I'm really using my skills. That I'm being encouraged to grow and to learn. That I'm not bored. I think it would also be that I'm enjoying my job. I think it would be having space to	Importance of growth, challenge, development. To be stretched but not stretched too far? Zone of proximal development? Using entire skillset	Growth and development Value of psychology, using all CPs' skills Thriving as relational

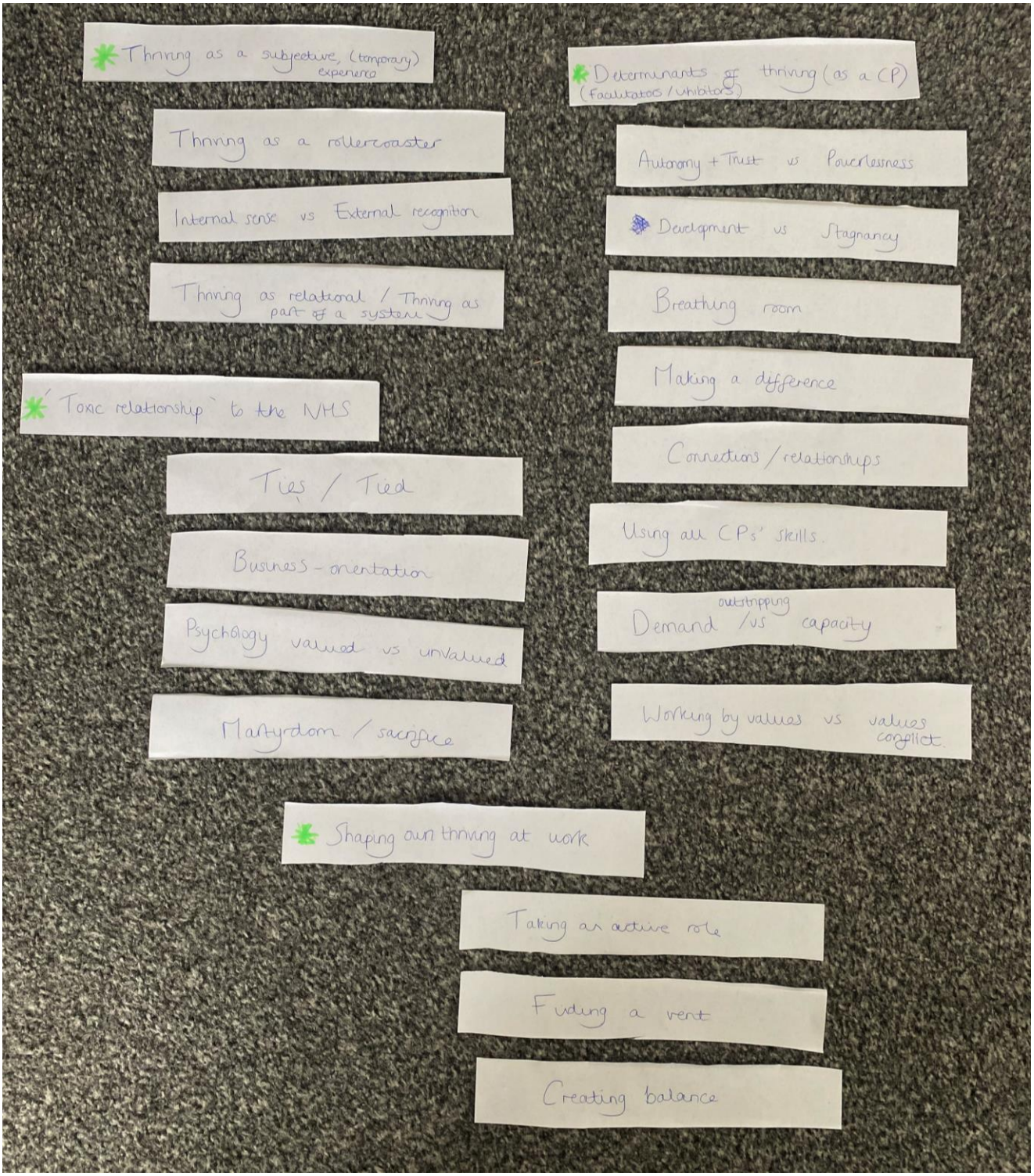
think. I think it would be having space for service development, to feel like you're really improving things. It would be having space to take on projects. It would be enjoying where you work, having good working relationships with colleagues. It would be feeling that you are really, really making a difference. Yeah. I: And I notice you're saying 'it would be…', from your experiences, do you feel like you have experienced thriving in your work in the NHS, or privately? P: I think there are definitely periods of time where I would've said that. I think the year that I worked in paediatrics, I would've said I was thriving quite a lot	Something relational about thriving – promoted, encouraged by others Psychological permission? Space, room to grow and learn Making a meaningful impact through work Affective component Relational element Making a difference, value around contributing to change Fluctuates, temporary nature of thriving Clear example comes to mind	Safety Working by one's values Making a difference

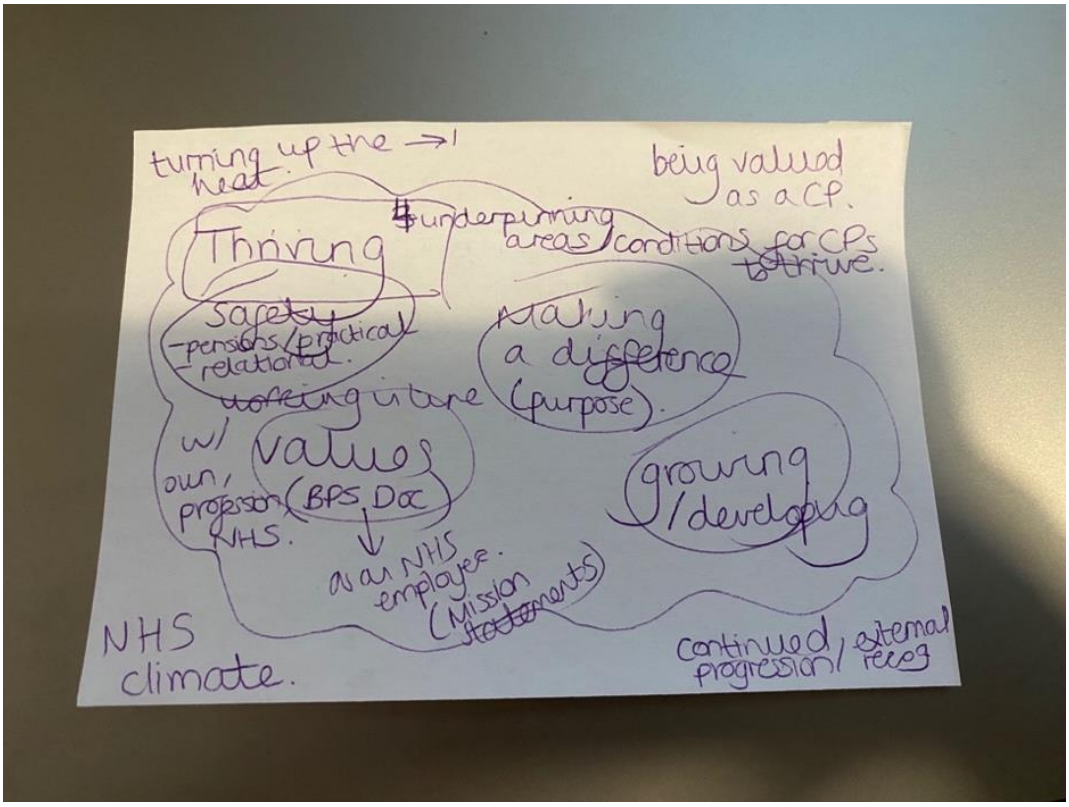
actually. I think that was a particularly good team. It was a nice mixture of having quite a lot of psychologists working in the psychological medicine team, so feeling quite supported and well connected. There was a lot of interesting psychological conversation going on but everybody had their own specific health teams that they would work into, so there was also opportunity to learn from other physical and social health professionals and to feel like you were really being useful and valuable cos you were bringing a psychologists' perspective into a team that otherwise didn't have psychologists in it. I think that balance was quite nice. I think balance of work is quite important. There were lots and lots of opportunities.	Importance of relationships, relational safety Stimulating environment Professional connections Learning, development, growth Clinical psychology valued as a profession Role within wider MDT Organisational values/interests fitting with personal values/interests Variety in work important	Temporal aspect to thriving Thriving as relational Growth/development Value of psychology, using all of CPs' skills

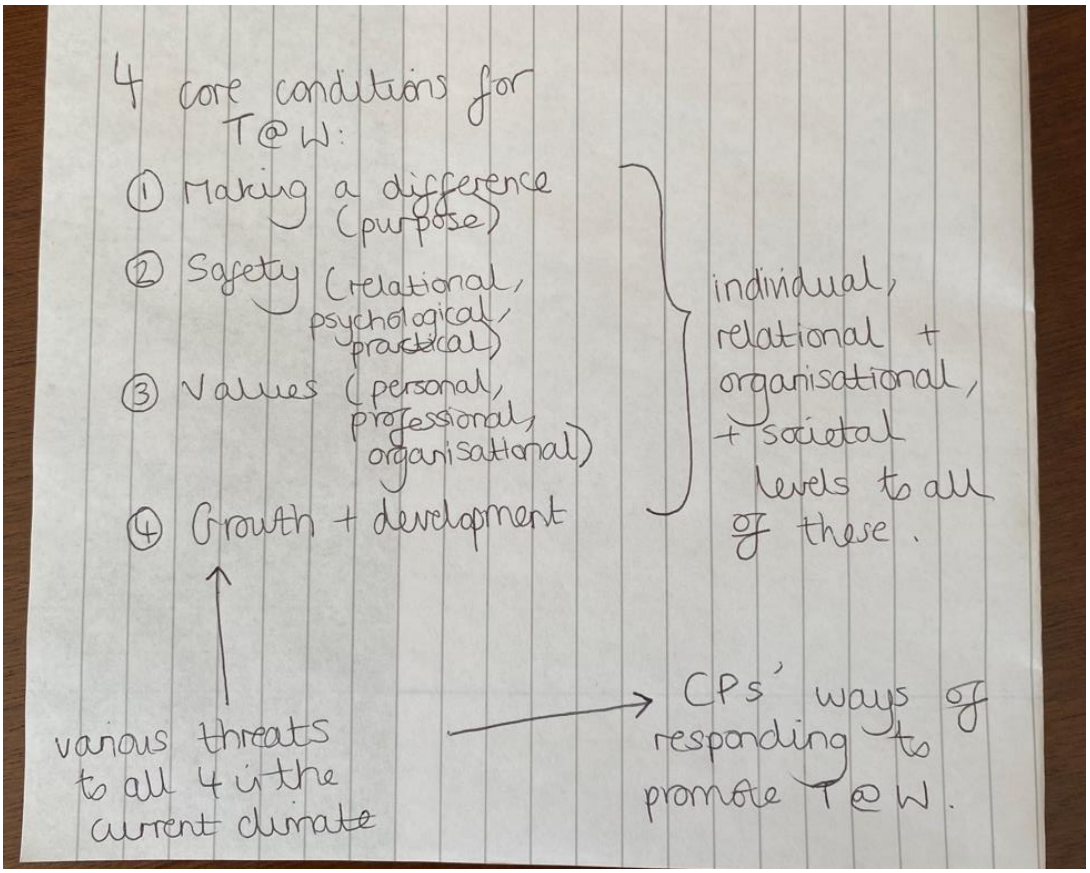
There was a value of research and pushing people to think about research they could do. There was encouragement and support around that. I quite liked the buzz of a hospital environment. I think I felt quite similar first coming to CAMHS. I think again in terms of being challenged, one of the downsides of working in paeds is that I didn't feel I was using more complex psychological skills, because of the kind of mental health, well you're not seeing a lot of mental health difficulties, let's put it that way. It's really valuable work but at times it felt frustrating. I suppose the simplicity of what we were being asked to do. But then CAMHS is the opposite end and you don't get anything that's straight forward (laughs). I think that's why I ended up wanting to get	Using all of clinical psychologists' skills- CP as more than providing therapy Climate around the person Buzz – associated with energy Somewhere along the way, the participant lost this feeling? Feeling less competent or not able to demonstrate competencies? Doing what feels like the right thing but not fully believing in it and enjoying it? Juxtaposition – enjoyment, buzz, positive relationships and affect, alongside a sense of not doing 'proper' psychology work? A sense of going from one extreme to another?	Values, as an individual, as a CP, and as an NHS employee Felt experience of thriving Safety (relational, psychological, organisational) Using all CPs' skills Importance of feeling able to make a difference

a bit more of a balance of with doing the private work perhaps. I think there are definitely periods of time, there are days or there are weeks, or there have been, where I feel like I really love my job, I feel really good at my job, I feel really energised by my job. It all feels manageable enough, but I think those times are getting fewer, were getting in my old job, fewer and farther between, hence why I moved.	Private work as an outlet Creating balance for self – actively making changes to create a working context that works for them Transient nature of thriving Energy component to thriving – participant knows they are thriving when they feel energised by their work Sense of vitality, satisfaction, enjoyment, competence – less frequent	Threat to thriving at work Acting in line with own values, re-establishing balance Temporal aspect to thriving Acting in line with own values, re-establishing balance Threat to thriving

***Appendix Q*: Examples of theme development**




turning up the heat
being valued as a CP.
Thriving
underpinning areas/conditions for CPs to thrive.
safety
- personal/practical
- relational
working in care
making a difference (purpose)
w/ our, profession, NHS.
values (BPS, DoC)
growing/developing
as an NHS employee.
(Mission statements)
NHS climate.
continued progression/ external recog


4 core conditions for T@W:
① Making a difference (purpose)
② Safety (relational, psychological, practical)
③ Values (personal, professional, organisational)
④ Growth + development
individual, relational + organisational, + societal levels to all of these.
various threats to all 4 in the current climate
CPs' ways of responding to promote T@W.

Appendix R: **Epistemological statement**

This statement outlines the epistemological and ontological positions of the researcher in relation to this research and considers assumptions that may have influenced the development of this research.

Ontology refers to the study of being, the nature of reality and existence (Crotty, 1998), and is often regarded in terms of two main positions: realist and relativist (Willig, 2012). Whilst a realist position considers an observable, measurable truth, a relativist stance presumes subjectivism in experiences, with multiple, valid interpretations. Wellbeing at work is understood as a subjective experience, with a lack of consensus regarding an exact definition that encapsulates what wellbeing at work means to different people, in different contexts (Keyes, 2007; Park et al, 2004; Schulte & Vainio, 2010). Some studies have tended to adopt a positivist, ontological position, seeking to quantify and measure wellbeing at work amongst psychological practitioners (Denning et al, 2021; Johnson et al, 2018; Shreffler et al, 2020; Summers et al, 2021). This takes a realist stance, promoting the notion there is an absolute true experience of wellbeing common across all practitioners, which can be captured. This contrasts with my beliefs about research. Whilst several people may experience the same (or similar) event, their experience and sense-making of this will be different depending on their own subjective position. The truth is context-dependent; therefore, research needs to ensure there is understanding of the context in which experiences occur. Having considered the above, the research question evolved to focus on exploring the experiences of thriving at work amongst NHS CPs. A qualitative, exploratory approach was employed, adopting an interpretative paradigm (Fellows & Liu, 2003), in order to explore and answer the research question.

Epistemology refers to the study of knowledge, considering how we acquire knowledge and how we know what is known about reality, as well as considering the relationship between researcher and participants (Willig, 2012; Scotland, 2012). The epistemological stance of this research was a social constructionist position in which knowledge is viewed as co-constructed by individuals from their experience and interactions with the world. This contrasts with a positivist stance in which knowledge is regarded as measurable and discoverable, distinct from the researcher (Taylor et al, 2006). One assumption underpinning this research was therefore that one ‘truth’ about NHS clinical psychologists’ experiences of thriving would not exist. However, the study hoped to shine a light on some CPs’ experiences of the same phenomena of interest, thriving at work. This fits with my own experiences of working as an NHS trainee clinical psychologist, seeing how different CPs understand and experience thriving at work in many different ways.

Several qualitative methodologies were considered for this study: Thematic Analysis (TA; Braun & Clarke, 2006), Interpretative Phenomenological Analysis (IPA; Smith et al, 2009) and Grounded Theory (GT; Corbin & Strauss, 2014). Ultimately, IPA (Smith et al, 2009) was utilised as the methodology, as this enabled the exploration of how individuals make sense of and experience thriving in their roles. No universal definition of thriving exists, with different conceptualisations between 'thriving' and 'thriving at work' (O'Leary & Ickovics, 1995; Porath et al, 2012; Spreitzer et al, 2005; Su et al, 2014;). Because of this, and due to the limited understanding of thriving in the context of adversity or challenge, IPA was regarded as an appropriate methodology, enabling individual's understandings of thriving at work to be explored. IPA was chosen over alternate, qualitative methodologies as it provided a specific methodology allowing for an in-depth exploration of participants' experiences. IPA allowed for multiple valid perspectives, exploring the experience from participants' unique positions. The study sought to understand the subjective perspectives and meanings of thriving at work per each individual, rather than establishing patterns across participants' experiences, which TA aims to do (Braun & Clarke, 2006). Further, a GT approach (Corbin & Strauss, 2014) was deemed unsuitable for answering the research question, as GT focuses on developing an explanatory level account, considering factors and impacts, rather than exploring participants sense-making of experiences within their context. The research did not seek to explain, but to understand participants' experiences in their own right.

IPA was also chosen as the concept of the double hermeneutic (Smith & Osborn, 2003) seemed especially important for this study, given the researchers' position as a trainee clinical psychologist in the NHS, seeking to understand the experiences of NHS clinical psychologists. A bottom-up approach occurred, as the themes were derived from participants' data, whilst a top-down approach occurred simultaneously, as I was repeatedly required to check how my interpretations fit with the original data. Throughout this research, a tension between the idea of 'bracketing' (Husserl, 1927) alongside the concept of 'fore-conception' (Heidegger, 1962, pages 191-192) was noted:

'*Whenever something is interpreted as something, the interpretation will be founded essentially upon the… fore-conception. An interpretation is never a pre-suppositionless apprehending of something presented to us'*

For instance, entering the analysis, I was aware of existing models and literature around of thriving at work, including the importance of relationships and autonomy in this experience. Therefore, I consciously had to somewhat 'bracket' this during the analysis, in order to ensure

faithfulness to participants' understandings. Yet, alongside this, my top-down interpretations meant this prior knowledge inevitably will have impacted on the analysis.

Finlay and Gough (2003) therefore highlight the importance of reflexivity as a process of self-awareness, in which researchers consider how their understandings are formed, and decisions made. As such, it was important to consider the assumptions that may underpin this research. The main assumption held was that clinical psychologists would play an active role in shaping their thriving at work, based on my theoretical understanding from Spreitzer et al's (2005) Socially Embedded Model of Thriving at Work. Likewise, my own perception of clinical psychologists as autonomous, creative, and driven professionals also informed this assumption.

Throughout the analysis, I tried to be mindful of what Smith et al (2009 – pp. 26) refer to as '*the dialogue between what we bring to the text, and what the text brings to us'*. Participants' meaning-making can be viewed as first-order meaning-making, whilst second order meaning-making refers to the researchers' subsequent sense-making. Initially, I assumed an idea of thriving at work based on personal experience, associated with an internal sense of energy, joy and growth. Thus, remaining open to the participants' interpretation and experience, irrespective of whether this fit with my perspective, was vital. Utilising a reflective journal and supervision was critical in considering this dual, insider-outsider perspective. It was also important in considering the impact of my position as a trainee clinical psychologist, beginning a career in this profession, and how this may impact upon data analysis and interpretation. Whilst I had insider knowledge and experience of the profession and NHS, I also felt a sense of being on the periphery, still remaining as an outsider, yet to become a qualified clinical psychologist.

Alongside the empirical paper, the systematic literature review involved a narrative synthesis aiming to develop a meaningful account of the findings of the included studies (Popay et al, 2006). This approach also fits with a social constructivist stance, as it focuses on encapsulating the essence of a range of findings from prior studies, through the construction of a clear story. This was important for this systematic literature review, as there were similarities and differences in terms of focus, conceptualisation of wellbeing, populations, methodologies, and geographical locations across the articles. The methodologies within the synthesis tended to align with a social constructionist stance, primarily involving IPA or TA. One study deviated from this, instead adopting a Constant Comparative Method (Glaser & Strauss, 1967), often used in GT. There is debate in the literature regarding the compatibility of GT, in classical and remodelled forms, with social constructionism (Andrews, 2012). However, it is proposed Narrative Synthesis serves as an appropriate methodology to unite the key ideas shared across the included studies, irrespective of underpinning epistemological and methodological stances (Popay et al, 2006).

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