The System’s Impact on Mental Health Professionals: Clinical Psychologists’ Experiences in Adult Acute Inpatient Services and Clinician Burnout

Athena Despoina Sideri

Registration Number: 100217775

Primary Supervisor: Dr Adrian Leddy

Secondary Supervisor: Dr Corinna Hackmann

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Thesis Abstract

Introduction: System pressures impact both staff wellbeing and care quality. This thesis portfolio explored staff’s experiences of burnout within mental health services in the National Health Service (NHS) and how this impacts care delivery. The systematic review and meta-analysis explored the prevalence and risk factors of burnout among mental health professionals. The empirical study looked into the experiences of Clinical Psychologists, a profession whose role lies within team leadership and staff support, in adult acute inpatient services when working with people with Borderline Personality Disorder (BPD).

Methods: A systematic review and meta-analysis were conducted to explore the prevalence of burnout among mental health professionals in the NHS. Relevant risk factors were explored and narratively synthesised. The empirical study involved semi-structured interviews with Clinical Psychologists working in acute inpatient mental health services. Interviews were analysed using reflexive Thematic Analysis.

Results: The systematic review and meta-analysis highlighted that burnout continues to be prevalent among mental health staff in the NHS. Relevant risk factors were both individual and organisational, with an emphasis on the latter. The empirical study identified three main themes: ‘delivering compartmentalised tasks’, ‘containing a system riddled with complexity and dissonance’, and ‘shifting the culture around the Personality Disorder diagnosis’.

Discussion: The thesis portfolio highlights the different needs across the layers of the system, including service users with BPD, mental health staff, and NHS services. Staff members working in NHS mental health services and with service users with BPD are trying to manage the wider system’s pressures. Clinical

Psychologists experience moral distress and dissonance when supporting staff members, and particularly in their work with people with BPD.

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Chapter 1

Introduction to Thesis Portfolio

***Where appropriate, material from the Thesis Proposal assignment of the UEA DClinPsy has been used throughout this chapter.**

Introduction to Thesis Portfolio

Mental Health Professionals’ Mental Health

Over the years, mental health professionals (MHPs) have been found to experience burnout, compassion fatigue and moral distress, impacting on their personal life, work, and care delivery (Delfrate et al., 2018; Morse et al., 2012; Simionato et al., 2018; Tane et al., 2022; Vivolo et al., 2024). Higher levels of burnout, and particularly emotional exhaustion, have been previously linked with the use of seclusion and restraint in acute inpatient mental health services (Happell & Koehn, 2011), whilst low levels with the use of less coercive measures (Bowers et al., 2011). Equally, compassion fatigue impacts on the relationship with service users (Xie et al., 2020), including on empathy in the work context (Wijdenes et al., 2019). Considering that previous research has suggested a connection between burnout, compassion fatigue, and moral distress (e.g., Maiden et al., 2011; Sorenson et al., 2016), and these terms are sometimes used interchangeably, it is of importance to clarify their use throughout the present portfolio.

Burnout

Freudenberger (1974) described burnout as exhaustion linked to professional life, accompanied by feelings of anger and irritation, that can manifest somatically like “being unable to shake a lingering cold” (p. 160). Burnout has been conceptualised through three dimensions: emotional exhaustion, depersonalisation of clients, and reduced sense of accomplishment (Maslach & Jackson, 1981). Awa et al. (2010) perceived burnout as a work-related mental health difficulty, often experienced in the relationship between “a helper and a help recipient” (p. 184), such as healthcare providers (e.g., Elshaer et al., 2018), MHPs (O’Connor et al., 2018), and teachers (Garcia-Carmona et al., 2019). MHPs, including psychologists and psychotherapists, have been suggested to experience high levels of burnout, and particularly emotional exhaustion (McCormack et al., 2018; O’Connor et al., 2018). Some of the related risk factors include increased workload and caseload, lack of control over work and lack of time (Simionato et al., 2019). Burnout has also been attributed to organisational factors including lack of resources, lack of support, from management and supervision, ambiguity around the role in the service, and following a rigid hierarchical culture (Simionato et al., 2019; Vivolo et al., 2024). Considering this, interventions targeting burnout are suggested at a team and organisation level, such as developing the team structure (Bowers et al., 2011).

Risk factors of burnout at a personal level have also preoccupied researchers for many years. Naisberg-Fennig et al. (1991) found that the higher the anxiety levels and the time spent on considering conflicting problems, the greater the likelihood of burnout. Simultaneously, more access to coping strategies has been linked with lower levels of burnout (Naisberg-Fennig et al., 1991). Zaninotto et al. (2018) explored the link between mental health professionals’ characteristics, burnout, and stigma towards people with mental health difficulties and found that negative appraisals or feelings towards service users are linked with personal accomplishment, whilst emotional stability and openness to experiences with lower levels of burnout. Similarly, Angelini (2023) in his systematic review on the link between personality traits and burnout, found higher levels of neuroticism and lower levels of extraversion, openness, agreeableness, and conscientiousness to predict higher levels of burnout. Regardless of burnout interventions being formulated at a wider team and organisational level (Bowers et al., 2011), emphasis has also been given on understanding the triggers of burnout at an individual level through identifying attributes associated with a greater risk (Angelini, 2023).

Compassion Fatigue

Compassion fatigue was described by Joinson (1992) as the “loss of the ability to nurture” (p.118). Initially, compassion fatigue was perceived in the context of secondary trauma as it was linked with working with people who have experienced traumatic events (Stamm & Figley, 1996). In recent years, the term became broader, and involved difficulties with sleep, emotional exhaustion, and low work effectiveness (Sorenson et al., 2016). Compassion fatigue has often been used inter-changeably with burnout due to an overlap in symptoms (Nolte et al., 2017). However, the two terms are considered distinct due to differences in the onset and severity of symptoms (Norman-Harling et al., 2020). Compassion fatigue has also been conceptualised as an umbrella term that involves burnout and secondary trauma (Rivera-Kloeppel & Mendenhall, 2023). Furthermore, Sorenson et al. (2016) suggested that compassion fatigue and burnout are positively correlated and therefore connected. In the present thesis portfolio, compassion fatigue will be used distinctively from burnout and will refer to the psychological and physical fatigue following prolonged use of empathy in the helper’s role (Turgoose & Maddox, 2017).

Risk factors contribute to experiences of compassion fatigue lie within an individual and organisational level. Turgoose and Maddox (2017) in their narrative review on compassion fatigue predictors suggested MHPs’ personal trauma history combined with high levels of empathy may increase the possibility of experiencing compassion fatigue. Simultaneously, lack of time, increased caseload, lack of management support, and lack of compassion from the wider organisation (Norman-Harling et al., 2020; Sorenson et al., 2016; Tane et al., 2022) have been identified as compassion fatigue risk factors. Compassion fatigue interventions are also perceived at a personal and organisational level. Examples include practicing mindfulness (Turgoose & Maddox, 2017), increasing awareness around compassionate care through training, reflective practice, and formulation (Tane et al., 2022), offering space to MHPs for self-care through supervision, and having strong leadership at an organisational level (Marshman et al., 2021).

Moral Distress

Moral distress derives from the nursing literature and refers to the emotional and psychological impact following failing to take an action that is considered appropriate due to organisational barriers (Jameton, 1984). McCarhy (2013) defined moral distress as the emotional and psychological impact following acting in ways inconsistent with one's own values. Even though moral distress has been seen as a driver towards moral growth (Tigart, 2017), it has also been considered as impacting nurses' wellbeing through feelings of guilt, shame, and failure (Ohnishi et al., 2010), as well as experiences of numbness (Jansen et al., 2022). Unresolved moral distress can leave moral residue, which may build over time leading to a 'crescendo effect' making it more difficult to address ongoing distress (Rathert et al., 2016). Apart from nurses, Clinical Psychologists have also been found to experience moral distress, which may challenge a sense of professional integrity (Austin et al., 2005).

Jansen et al. (2022) suggested that moral distress is "an organisational problem, albeit experienced at a personal level" (p.178). Consistently with this finding, Lamoureux et al. (2024) in their systematic review exploring moral distress among mental health nurses in acute inpatient services argued that risk factors include lack of resources, low staffing levels, relationship difficulties with other professions, as well as contribution to coercive practices. Interventions aimed at addressing moral distress are conceptualised at an individual level through offering information around moral distress and considering helpful coping strategies

(Morley et al., 2021), and at an organisational level through advocating for support from management (Amos & Epstein, 2022).

Personality Disorder

Based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association, 2013), Borderline Personality Disorder (BPD) diagnosis is defined as involving intense feelings in response to rejection, an unstable sense of self, emotional dysregulation, and difficulties with developing and maintaining relationship. BPD is also described as Emotionally Unstable Personality Disorder based on the International Classification of Diseases 10th Edition (ICD-10; World Health Organisation [WHO], 1992). The ICD-11 (WHO, 2018) replaced pre-existing Personality Disorder (PD) Diagnoses with the 'Personality Disorder' term, which is perceived at three different severity levels (mild, moderate, severe). In addition to severity, five trait domains were added: Negative Affectivity, Detachment, Disinhibition, Dissociality, and Anankastia (WHO, 2018). To support with accessing evidence-based interventions, a 'Borderline pattern specifier' was included in the diagnosis, which is equivalent to BPD (Bach et al., 2022). Considering its frequent use within the literature and the NICE Guidelines, the term BPD will be used throughout the thesis portfolio.

Over the years, several theories have focused on making sense of BPD related difficulties. For example, theories on the sense of self have argued that difficulties with mentalising, epistemic trust, and social learning are linked with experiences of Complex Trauma (Fonagy, 2000; Luyten et al., 2020). Ryle (2004) perceived difficulties with self-reflection as an outcome of the absence of an adequate caregiver in the early life. Linehan's (1993) biosocial model saw the BPD diagnosis as the result of the relationship between the person's biological vulnerability to emotional dysregulation and an invalidating environment.

Stigma and Clinician Responses

Erving Goffman (1963) defined stigma as the relationship between a discredited characteristic and a stereotype leading to the belief that “the person with a stigma is not quite human” (p. 4). Goffman (1963) saw those engaging in stigmatising narratives, distancing themselves from the person, whom they blame for their characteristics.

Since its introduction by the American Psychiatric Association (1980), BPD, and PD diagnosis in general, has attracted a lot of debate. Over the years, BPD has been described as one of the most stigmatised types of PD diagnosis, and mental health diagnoses in general (Bonnington & Rose, 2014). Lewis and Appleby (1988) argued for the PD diagnosis to be abandoned, due to its link with rejecting narratives. Narratives include that people with BPD play an active role in their difficulties, are manipulative, and therefore unworthy of NHS services (Koekkoek et al., 2009; Lewis & Appleby, 1988). Such accountability for their responses has often placed them in comparison to people with psychosis or schizophrenia who are seen as ‘unwell’ and thus worthy of support from services (Koekkoek et al., 2009). Even though the use of stigmatising narratives was viewed within the nursing profession (Bodner et al., 2015), clinicians in both mental and physical healthcare, regardless of professional background seem to also engage in those (Baker & Beazley, 2022). Similarly, Klein et al. (2022) suggested that people with BPD diagnosis and their families often experience negative interactions with healthcare professionals.

Attitudes around the BPD diagnosis also refer to unresponsiveness to treatment (Treloar, 2009). Westwood and Baker (2010) suggested that mental health nurses in acute inpatient services struggle with ‘treatment optimism’ particularly when working with people with BPD, whilst community MHPs have been suggested to experience ‘therapeutic nihilism’ (Troup et al., 2022). Such experiences are seen to impact on clinicians’ sense of self due to feelings of ‘failure’ (Rizq, 2012), which are addressed through emotional distance (Troup et al., 2022). Despite its function, emotional distance is seen as a perpetuating factor to diagnostic stigma, and as interfering with the therapeutic relationship (Aviram et al., 2006). Previous associations identified between BPD diagnosis and attachment difficulties (Luyten et al., 2020), may suggest that interpersonal distance may be perceived as threatening, and result in further feelings of rejection among people with a BPD diagnosis (Aviram et al., 2006).

In association with stigmatising narratives, clinicians have expressed ambivalence towards the BPD diagnosis, and PD in general (Donald et al., 2017). For example, some clinicians report reluctance to use the diagnostic language in research interviews (Papadopoullos et al., 2022), others choose not to communicate the diagnosis to people or show a preference in using alternative terminology, such as ‘Complex Emotional Needs’ or ‘Complex Trauma’ (Sulzer et al., 2016; Troup et al., 2022).

Despite such efforts at an individual level, people with BPD have been reported to also experience structural stigma, at an institutional, macro-level (Hatzenbuehler, 2016). Ring and Lawn (2025) proposed that the stigmatising narratives around the BPD diagnosis lie within the wider healthcare system, and result in powerlessness affecting both people with this diagnosis and clinicians. Past research has attributed the difficulties with supporting people with BPD diagnosis to the lack of resources and knowledge within healthcare systems, and the failure of the medical model in meeting their needs (Klein et al., 2022; Treloar, 2009). Regardless of the model used, others have described the healthcare system itself as inaccessible for people with BPD (Troup et al., 2022).

Overview of the Thesis Portfolio

The aim of the thesis portfolio is to explore MHPs’ experiences of burnout in the UK and the role of Clinical Psychologists in supporting them. Considering that staff pressures impact on both staff wellbeing and care quality (Care Quality Commission, 2023), Chapter 2 presents a meta-analysis and systematic review on the prevalence of burnout, and relevant risk factors, among MHPs in the National Health Service. Chapter 3 bridges the key findings of the systematic review with the empirical paper. Chapter 4 explores Clinical Psychologists’ experiences of their role when working with people with BPD and the system involved in their care in adult acute inpatient services. Chapter 5 offers additional information on the methodology of the systematic review and empirical study and discusses the ethical considerations and reflexivity of the empirical study. Finally, Chapter 6 critically appraises both the systematic review and the empirical study and offers reflections on the research process of the portfolio as a whole.

Chapter 2

Systematic Review and Meta-Analysis

Prepared for submission to:

Counselling and Psychotherapy Research*

**Please refer to Appendix A for Authors guidelines.*

Prevalence and Risk Factors of Burnout among Mental Health Professionals in the NHS: A Systematic Review and Meta-analysis

Athena Despoina Sideri[a], Dr Eleftherios Kipoulas[b], Dr Adrian Leddy[c], Dr Corinna Hackmann[d]

[ac] *Department of Clinical Psychology, Norwich Medical School, University of East Anglia, Norwich, United Kingdom, NR4 7TJ*

[bd] *Norfolk and Suffolk NHS Foundation Trust, Hellesdon Hospital, Norwich, United Kingdom, NR6 5BE*

Correspondence to:

Dr Adrian Leddy, Department of Clinical Psychology, Norwich Medical School, University of East Anglia, Norwich, United Kingdom, NR4 7TJ, a.leddy@uea.ac.uk

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Abstract: 210

Abstract

Introduction: Approximately 41% of NHS staff experience work-related stress. Previous reviews on mental health professionals’ (MHPs) burnout have suggested that up to 40% experience emotional exhaustion, 22% depersonalisation, and 19% low personal accomplishment. The present review aimed to explore the prevalence of burnout among MHPs in NHS mental health services, and the associated risk factors.

Methods: A systematic review and meta-analysis on the prevalence and risk factors of burnout was conducted. Synonyms and related terms with ‘mental health professionals’ (population), ‘burnout’ (outcome) and ‘NHS’ (context) were searched on CINAHL, MEDLINE, EMBASE, PsycINFO, and Web of Science in March 2025. The meta-analysis on burnout prevalence was conducted using the ‘metafor’ package on R. Cochran’s Q and I^2 were used to assess heterogeneity. A narrative synthesis was employed to explore risk factors.

Results: A total of 14 studies were included, out of which seven were used for the meta-analysis due to the available data. Pooled prevalence for emotional exhaustion was 42%, for depersonalisation 22%, and for personal accomplishment 19%. Risk factors are conceptualised at an individual and organisational level.

Discussion: Future research is needed to explore NHS MHPs’ experiences of burnout, particularly Clinical Psychologists, who were the least represented group across the included studies. Clinical implications and limitations are also discussed.

Key Words: Mental health professionals, burnout, NHS, prevalence, risk factors

Introduction

Burnout was initially described as the emotional and physical exhaustion associated with professional life (Freudenberger, 1974). Maslach and Jackson (1981) conceptualised burnout at three levels: emotional exhaustion, depersonalisation, and reduced personal accomplishment. Emotional exhaustion is defined as experiences of physical and emotional fatigue whilst depersonalisation as the tendency of employing negative and cynical narratives towards service users, or others in general (Maslach & Jackson, 1981; O’Connor et al., 2018). The reduced sense of personal accomplishment reflects experiences of difficulty, failure, or incompetence, both at a personal and professional level (Maslach & Jackson, 1981).

Since its introduction, burnout has been considered to impact those with a caring role (Awa et al., 2010), including mental and physical healthcare professionals (Elshaer et al., 2018; O’Connor et al., 2018). The term burnout has often been used interchangeably with compassion fatigue (Sorenson et al., 2016) and occupational stress (Simionato & Simpson, 2018). This is partly due to an overlap of symptoms (Nolte et al., 2017). Sorenson et al. (2016) proposed emotional exhaustion as a common symptom between compassion fatigue and burnout. Furthermore, Rivera-Kloeppel and Mendenhall (2023) considered compassion fatigue as a broader term that contains burnout and secondary trauma. Simionato and Simpson (2018) attributed the overlap between occupational stress and burnout to the psychological distress linked with work-related difficulties.

It has been suggested that many Mental health professionals (MHPs) experience high levels of burnout (McCormack et al., 2018; O’Connor et al., 2018), with prevalence ranging from 25% to 40% for emotional exhaustion, 15% to 22% for depersonalisation, and 19% to 22% for personal accomplishment (Lopez-Lopez et al., 2019; O’Connor et al., 2018). Consequences of burnout have been linked with

MHPs' work and personal lives and have been perceived at an emotional and physical level (Vivolo et al., 2024). Previous studies have suggested a connection between burnout and work-related wellbeing, staff turnover and absenteeism (Johnson et al., 2018; von Hippel et al., 2019). MHPs' emotional wellbeing is impacted by burnout, with MHPs experiencing depression and anxiety (Papathanasiou et al., 2017). Additionally, Vivolo et al. (2024) in a systematic review on psychotherapists' experiences of burnout, suggested a decrease in therapists' social engagement and empathy towards others. Burnout also impacts on the delivery of care, with MHPs' burnout being associated with poor treatment outcomes (Hall et al., 2016).

Risk factors of burnout are broad. Being male has been associated with higher levels of emotional exhaustion and depersonalisation (Lopez-Lopez et al., 2019; Schandenhofer et al., 2018). Negative affectivity and difficulties with managing stress have been linked with experiences of burnout, through their relationship with work-related conflict (Duan-Porter et al., 2018). The nature of the mental health service has been commented with community MHPs experiencing higher levels of emotional exhaustion than MHPs in inpatient acute mental health services (Johnson et al., 2012). Simultaneously, experiences in the role have been associated with burnout and particularly having an increased workload and lacking independence in the workplace (Simionato et al., 2019). Lack of resources at a service and wider organisation level, amount of support, clear boundaries within the role, and organisational structure also play a significant role in such experiences (Simionato et al., 2019; Vivolo et al., 2024; Westwood et al., 2017).

Since O'Connor et al. (2018) explored the prevalence and risk factors of burnout, the Covid-19 outbreak contributed to an increase in burnout among MHPs (Pappa et al., 2021). Such an increase was attributed to staff experiencing work-related pressures, with working overtime whilst services lack financial resources (Hiam et al., 2020; Pappa et al., 2021). Therefore, an updated review including studies conducted during and post Covid-19 is warranted. Furthermore, the most recent National Health Service (NHS) Staff Survey (2024) yielded a 41.63% of NHS staff experiencing work-related stress. Simultaneously, a recent report by the British Medical Association (BMA; 2024) highlighted numerous pressures impacting on mental health services within the NHS, including lack of funding and low staff levels. Considering this, the present review focussed on NHS MHPs.

Review Questions

1. What is the prevalence of burnout among MHPs working in NHS mental health services?
2. What are the risk factors of burnout among MHPs in NHS mental health services?

Method

Protocol Registration

The systematic review protocol was pre-registered on PROSPERO (registration number: CRD420251000919), as per Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidance (Moher et al., 2009).

Search Strategy

An initial scoping review was conducted to explore the pre-existing literature and relevant terms used in relation to burnout, MHPs, and NHS. Relevant pre-existing systematic reviews and meta-analyses (McCormack et al., 2018; O’Connor et al., 2018) were used to ensure consistency in the terminology. Medical Subject Headings (MeSH) terms were also used. The search terms included synonyms and alternative terms for “mental health professionals” (population), “NHS” (context) and “burnout” (outcome) (Table 2.1). A systematic search of the literature was conducted on the 6th of March 2025 and included research papers published from 1st of January 1997 until March 2025, as per O'Connor et al. (2018). Databases included PsycINFO, MEDLINE, CINAHL, EMBASE, and Web of Science. Searches were restricted to those published in English. In addition to database searches hand searches were conducted of reference lists of included studies and previous reviews.

Table 2.1

Search Terms

Professionals	**Wellbeing**	**NHS**
'mental health professional' OR 'psychiatric staff' OR 'psychiatric personnel' OR 'mental health personnel' OR 'psychiatric nurs*' OR 'mental health nurs*' OR 'occupational therapist' OR 'social worker' OR psychiatrist OR psychologist OR therapist OR psychotherapist	'professional burnout' OR burnout OR 'burn out' OR 'burn-out' OR 'job stress' OR morale OR 'compassion fatigue' OR fatigue OR 'job satisfaction' OR depersonalisation OR 'workplace wellbeing' OR 'workplace well-being' OR 'occupational stress' OR 'occupational burnout' OR 'emotional exhaustion' OR 'psychological burnout' OR 'burnout syndrome' OR 'career burnout'	NHS OR 'National Health Service' OR UK OR 'United Kingdom' OR Britain

Eligibility Criteria

Inclusion Criteria involved quantitative, peer-reviewed studies that explored burnout among qualified MHPs in NHS mental health services. Qualified

MHPs were defined as Clinical Psychologists, Psychiatrists, Psychotherapists, mental health nurses, and Social Workers. Exclusion criteria involved: non-MHPs (e.g., administrative staff, physical healthcare staff), MHPs in physical health settings (e.g., general hospitals), MHPs in non-NHS services, MHPs in other countries, MHPs in training (e.g., trainee Clinical Psychologists), non-qualified MHPs (e.g., healthcare assistants), and MHPs in Veteran services. Books, book chapters, unpublished and non-peer reviewed studies (e.g., thesis projects), commentaries, editorials, conference proceedings, and purely qualitative studies were excluded. Finally, studies that did not report prevalence data and data on risk factors on burnout were excluded.

Data Extraction

Data extraction was conducted by two reviewers independently and involved information for the authors, year of publication, study aims, service setting, sample characteristics, study design, and results associated to burnout-specific measurements and risk factors.

Data Analysis

A meta-analysis on the prevalence of burnout was calculated using the metafor package on R (R Core Team, 2021). The prevalence (N or percentage) of participants who scored above the measurement's threshold for burnout was extracted from each study. Heterogeneity was assessed by the Cochran' Q (Cochran, 1954) and I^2 statistic (Higgins & Thompson, 2002). An I^2 between 30% and 60% suggests moderate heterogeneity, 50% and 90% substantial heterogeneity, and 75% and over considerable heterogeneity (Higgins & Green, 2011). Due to increased heterogeneity of the population, mental health services, measurements, and reported results, a narrative synthesis approach was employed to explore risk factors of burnout (Popay et al., 2006).

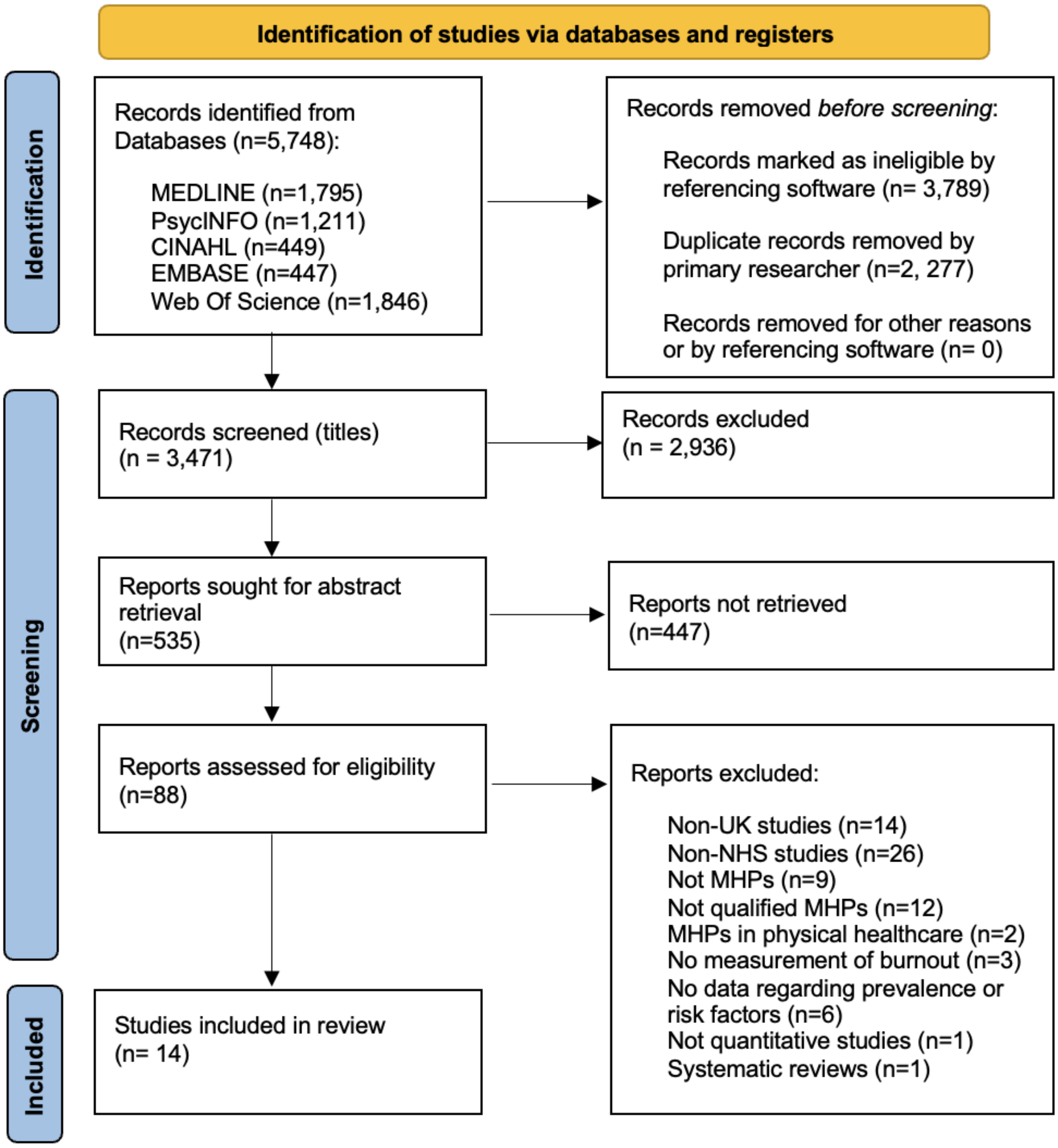
Results

Screening and Study Selection

Database searches were conducted on 6th of March 2025 and returned 5,748 articles, of which 1,795 were identified from MEDLINE, 1,211 from PsycINFO, 449 from CINAHL, 447 from EMBASE, and 1,846 from Web of Science. Following removal of duplicates, a total of 3,471 of titles were initially screened. A total of 88 studies were deemed appropriate for full-text screening. Six studies were excluded due to not reporting prevalence data, or data related to burnout. All identified abstracts and full texts were screened independently. The agreement rates for abstracts were 96% and 92% for full texts. Any disagreements between the reviewers were resolved through discussion, and consensus was reached. The systematic review involved a total of 14 studies, out of which seven included prevalence data. All 14 studies included data on risk factors. Figure 2.1 shows the PRISMA flow diagram of selected studies.

Figure 2.1

PRISMA Flow diagram of selected studies



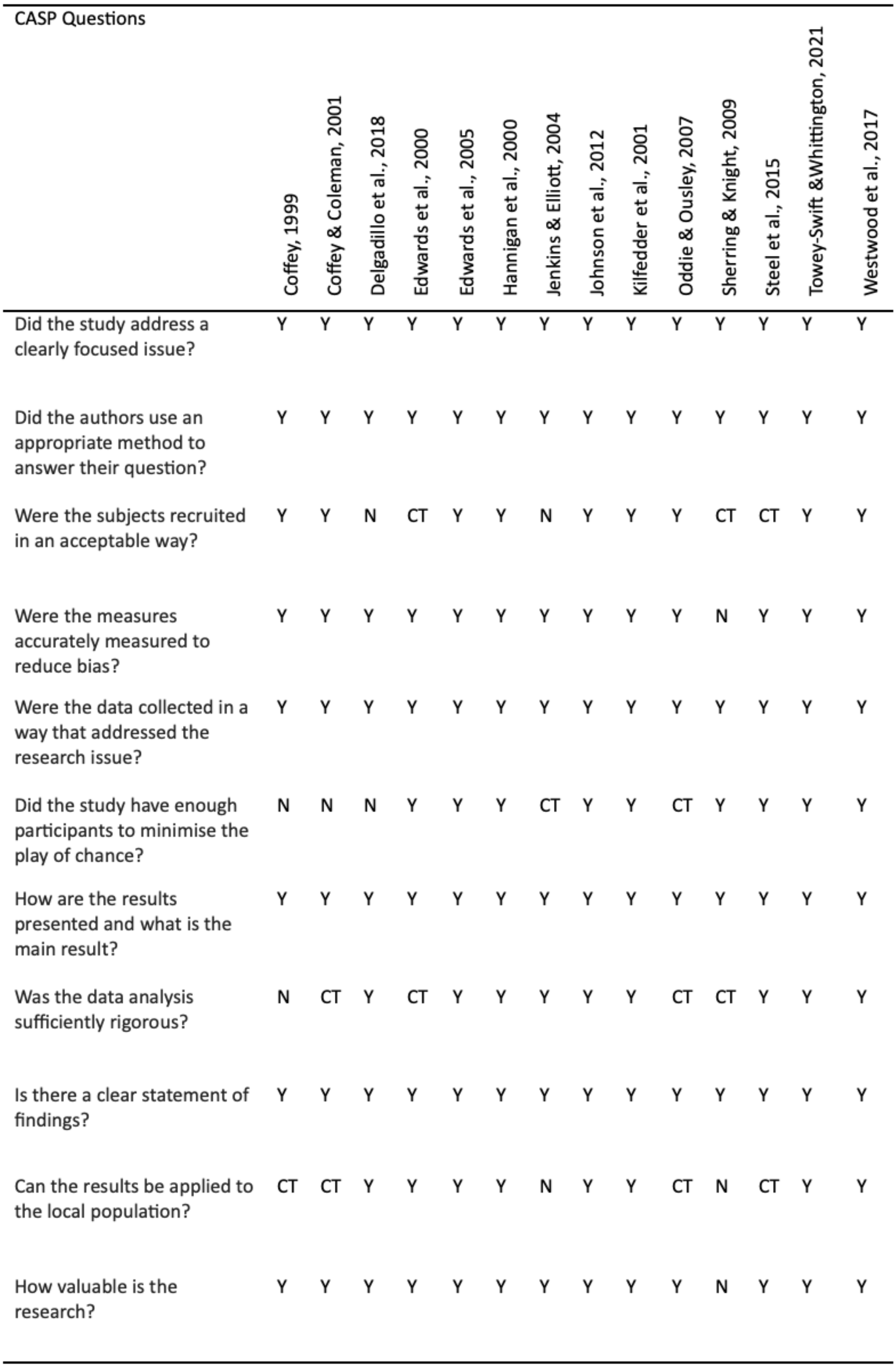
Quality Appraisal

The quality assessment was conducted independently by two reviewers using the Critical Appraisal Skills Programme (CASP) Quality Appraisal tool for Cross-sectional studies (CASP, 2024). The CASP includes 11 questions, answered with 'Yes', 'No', and 'Can't Tell', exploring the validity and reliability of the methodology, results, and the applicability of the study. In case around 2/3 of the questions are not answered with ‘Yes’, then the study quality may be considered poor (CASP, 2024). Each sub-section of the CASP tool was independently rated by both reviewers and inter-rater agreement rates were 91%. Any disagreements were solved through discussion.

Each study’s quality appraisal is presented on Table 2.2. From the 14 studies, one met the fewest criteria (Sherring & Knight, 2009) and six met all the criteria (Edwards et al., 2005; Hannigan et al., 2000; Johnson et al., 2012; Kilfedder et al., 2001; Towey-Swift & Whittington, 2021; Westwood et al., 2017). All studies had specific aims, and cross-sectional study design was considered appropriate in addressing these. Nine studies specified their inclusion and exclusion criteria and justified the reasons behind participants’ exclusion. All but one study used reliable and validated measurements to explore the main variables. Additionally, all studies described the data collection process and presented the methods in detail. Nine studies presented power calculations, and the sample sizes were considered adequate. Five studies lacked information regarding power calculations, and used a small sample size, however the authors highlighted this as a limitation (Coffey, 1999; Coffey & Coleman, 2001; Delgadillo et al., 2018). Nine studies presented a detailed analysis plan, whilst results were presented in a clear and detailed way across all 14 studies. Results from eight studies could be generalised; in the remaining six studies, transferability and generalisation of the findings was impacted by the small sample sizes or use of convenience sampling. All authors, apart from one, were clear about the study’s contribution and stated the limitations.

Table 2.2

Quality Appraisal of included studies



CASP Questions	Coffey, 1999	Coffey & Coleman, 2001	Delgadillo et al., 2018	Edwards et al., 2000	Edwards et al., 2005	Hannigan et al., 2000	Jenkins & Elliott, 2004	Johnson et al., 2012	Kilfedder et al., 2001	Oddie & Ousley, 2007	Sherring & Knight, 2009	Steel et al., 2015	Towey-Swift &Whittington, 2021	Westwood et al., 2017
Did the study address a clearly focused issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Did the authors use an appropriate method to answer their question?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Were the subjects recruited in an acceptable way?	Y	Y	N	CT	Y	Y	N	Y	Y	Y	CT	CT	Y	Y
Were the measures accurately measured to reduce bias?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
Were the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Did the study have enough participants to minimise the play of chance?	N	N	N	Y	Y	Y	CT	Y	Y	CT	Y	Y	Y	Y
How are the results presented and what is the main result?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was the data analysis sufficiently rigorous?	N	CT	Y	CT	Y	Y	Y	Y	Y	CT	CT	Y	Y	Y
Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Can the results be applied to the local population?	CT	CT	Y	Y	Y	Y	N	Y	Y	CT	N	CT	Y	Y
How valuable is the research?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y

Note. Yes (Y), No (N), Can’t Tell (CT)

Study Characteristics

Overall, 14 studies were included in the systematic review, all of which used a cross-sectional study design. Characteristics of each study are presented on the Table 2.3, as suggested by Popay et al. (2006).

Table 2.3

Included studies characteristics

Author (Year)	Setting	Participants	Aim	Method	Burnout Measure	Other Measures	Key Findings	
							Burnout specific	Secondary
Coffey (1999)	Medium secure units in England and Wales	Forensic community psychiatric nurses (N=79) 46.2% females Mean age 37.8	Explored the levels of burnout in MH nurses. Explore the main stressors experienced by MH Nurses.	CS	MBI-HSS	Demographic Questionnaire GHQ-28 CPNSQ-r	MH nurses experience moderate levels of burnout 44.3% of participants scored in the high category for EE.	1/3 of the sample experienced psychological distress.
Coffey& Coleman (2001)	Medium Secure Units in England and Wales	Forensic community psychiatric nurses (N=79) 46.2% females Mean age 37.8	Explored MH nurses' experience of stress and burnout.	CS	MBI-HSS	Demographic Questionnaire GHQ-28 CPNSQ-r	Higher caseloads were linked with higher levels of burnout.	Higher caseloads were linked with higher scores on GHQ-28.
Delgadillo et al. (2018)	IAPT	PWPs, CBT therapists, MH Nurses N= 49 N=43 females Mean age: 37.9 Linked patients N= 2509	Explored the link between therapist burnout and client treatment outcomes.	CS	OLBI	JDSS Patient measures: GAD-7, PHQ-9	Higher burnout linked with patients' low mood and anxiety. Low burnout linked with therapist effectiveness.	Lower job satisfaction was linked with patients' low mood and anxiety levels.
Edwards et al. (2000)	MH Teams in 10 NHS Trusts in Wales	Community MH Nurses (N=283) N= 185 females Mean age: 40	Explored the variety. Frequency, and severity of stressors among Community MH Nurses.	CS	MBI-HSS		51% of MH nurses experience EE, 25% DP, and 14% PA.	MH nurses experience high levels of stress attributed to organisational factors.
Edwards et al. (2005)	11 NHS Trusts in Wales Community	Community MH Nurses N= 166 N=160 females	Explored to what extent clinical supervision influences levels of burnout.	CS	MBI-HSS	MCSS	36% scored high on EE, 12% scored high on DP, 10% scored high on PA.	Significant negative correlation between clinical

Author (Year)	Setting	Participants	Aim	Method	Burnout Measure	Other Measures	Key Findings	
							Burnout specific	Secondary
	Mental Health	Mean age: 42						supervision and EE and DP.
Hannigan et al. (2000)	MH Teams in 10 NHS Trusts Community MH	Community MH Nurses (N=283) N=185 females Mean age: 40	Explored burnout in All-Wales community MH Nurses.	CS	MBI-HSS	Maslach Human Services Demographic Data Sheet; GHQ-12; Demographic Data Sheet; Rosenberg Self-Attitude Questionnaire; CPNSQ; PsychNurse Methods of Coping Questionnaire	Emotional exhaustion higher for MH nurses in urban than those in rural areas.	Lack of management support linked with high EE; being longer in the profession linked with lower DP; higher PA linked with holding managerial positions, a specialist post-qualification, and alcohol.
Jenkins & Elliott (2004)	Adult Acute Mental Health Wards	MH Nursers (N=57) N=62 females Mean age: 37.1 Nursing assistants (N=36)	Explored burnout between professions, the link between stressors and burnout, and the impact of social support on burnout.	CS	MBI-HSS	Demographic information MHPSS Social Support scale	No differences between professions on EE, DP, and PA. Higher scores on the MHPSS associated with higher levels of EE and DP. Higher levels of colleague support were linked with lower levels of EE. Higher levels of support were found	'Lack of resources' as a main stressor for MH Nurses; particularly 'lack of adequate staffing' and 'lack of adequate cover'.

Author (Year)	Setting	Participants	Aim	Method	Burnout Measure	Other Measures	Key Findings	
							Burnout specific	Secondary
							to weaken the relationship between stress and DP.	
Johnson et al. (2012)	Adult Acute Mental Health Wards; CMHTs; CAMHS; Forensic Wards; MHCOP ward; Rehabilitation ward; PICU; CRT	Total N=2258 N=1421 females Mean age: 40.7 MH Nurses (N=1054) Doctors (N=135) Psychologists (N=44) OTs (N=82) Support Workers (N=640) Social Workers (N=86) Ward managers/ team leaders (N=111) Other (N=93)	Explored staff wellbeing, satisfaction, and associated factors in NHS mental health services.	CS	MBI-HSS	Job-related Affective Well-being Scale Combined items from the 2004 Workplace Employment Relations Survey and the NHS Staff Survey	49% of acute inpatient staff and 60% of CMHT staff experienced burnout. Social workers scored the highest on EE; nurses’ and OTs’ mean scores just reached threshold for high EE. No professionals scores within the high DP and PA category.	From 22% of older adult ward staff to 39% of CMHT staff scored above threshold on GHQ. Job involvement varied by profession, but not by service type. CMHT staff scored the highest on demands and control followed by staff in Rehabilitation wards, CAMHS, and CRT.
Kilfedder et al. (2001)	Acute and Community Care Services	MH Nurses N=510 86.9% females Mean age: 40.1	Explored the occupational stress model among MH Nurses, where burnout is perceived as a strain.	CS	MBI-HSS	Understanding Predictability and Control Scale; Role Conflict measure; Role Ambiguity measure; Job Future Ambiguity Questionnaire; Nursing Stress Scale;	Overall, 2% of participants reported high burnout	Higher DP was linked with younger age and less years post-qualification; higher EE and DP were linked with lack of social support; low PA was linked with lack of job independence and limited coping strategies.

Author (Year)	Setting	Participants	Aim	Method	Burnout Measure	Other Measures	Key Findings	
							Burnout specific	Secondary
						Occupational Stress Indicator; Social Support measure; PANAS; Psysom; GHQ-12; Job Satisfaction		
Oddie& Ousley (2007)	Medium Secure Service	MH Nurses OTs N=71 60% males Mean age: 34	Explored work-related stress factors and burnout.	CS	MBI-HSS	PNOSS	Almost half of participants reported high levels of emotional exhaustion.	Stressors mostly linked with the wider organisation as opposed to clinical practice.
Sherring& Knight (2009)	MH Services in a city NHS Trust	MH Nurses N=166 73.1% females Mean age: <25yrs: 1.7% 26-30: 9.3 31-35: 11% 26-40: 12.2% 41-45: 18.6% 16-50:18.6% 51-55: 14.5% 56-60: 9.3% 61-65: 1.7% >66: 0.6%	Explored the levels of burnout among MH Nurses, and the link between burnout, training, and feeling supported in the workplace.	CS	MBI-HSS	Further questions (e.g., demographic information) were added by the authors	41% of MH Nurses experienced high levels of emotional exhaustion, 20.5% high levels of depersonalisation, and 21.7% high levels of personal accomplishment.	MH nurses with higher EE thought of leaving their roles, and the NHS organisation; MH Nurses with higher qualifications and who felt supported had lower levels of burnout.
Steel et al. (2015)	IAPT	15 IAPT Services Therapists working with Trauma N=116	Levels of burnout among IAPT therapists; burnout predictors.	CS	MBI-HSS	JCQ TWIS	High EE and low levels of DP and PA. High job demands, and lack of	

Author (Year)	Setting	Participants	Aim	Method	Burnout Measure	Other Measures	Key Findings	
							Burnout specific	Secondary
		Gender: NR Mean age: 36.9					independent practice predicted EE.	
Towey-Swift& Whittington (2021)	CMHT	Qualified MH staff (MH Nurses, OTs, Psychiatrists, Social Workers, Psychologists) N=132 72% females Age: 31-40yrs: 27% 41-50yrs: 34% 51-60yrs: 23%	Explored the link between congruence and CF; explored the relationship between CF with recovery attitude.	CS	ProQol (Burnout Subscale)	AWS RKI	Psychologists reported significantly lower burnout; years in the service and profession significantly correlated with burnout.	Workload, Reward, and Values were negatively linked with burnout. Workload was negatively linked with secondary traumatic stress, and positively with compassion satisfaction.
Westwood et al (2017)	IAPT	PWPs, HITs N=262 N=37 males Age: 40+ PWP: 19% 40+ HIT: 50%	Explored the prevalence of burnout; explored burnout predictors.	CS	OLBI	Mental Health Professionals Stress Scale	Burnout prevalence between 78.8% and 77.3% for PWPs and 40.2& and 60.8% for HI therapists; predictors involved longer experience in the IAPT service, telephone contact with clients.	

Note. Key terms per column. **Settings**: Improving Access to Psychological Therapies (IAPT), Community Mental Health Teams (CMHTs), Crisis Resolution Team (CRT), Child, Adolescent Mental Health Service (CAMHS), Psychiatric Intensive Care Unit (PICU), Community Mental Health Care of Older People (MHCOP). **Participants**: Mental Health Nurses (MH Nurses), Psychological Wellbeing Practitioner (PWP), High Intensity Therapists (HITs), Cognitive Behavioural Therapy (CBT), Occupational Therapists (OTs). Method: Cross-sectional (CS). **Burnout measure**: Maslach Burnout Inventory (MBI), Oldenburg Burnout Inventory (OLBI), Professional Quality of Life Scale (ProQol). Burnout Prevalence. Emotional Exhaustion (EE), Depersonalisation (DP), Personal Accomplishment (PA). OLDI-Exhaustion (OLDI-E), OLDI- Disengagement (OLDI-D), General Health Questionnaire (GHQ-28), General Health Questionnaire (GHQ-12), Maslach Human Services Community Psychiatric Nurse Stress Questionnaire –revised (CPNSQ-r), Job Discrepancy and Satisfaction Scale (JDSS), Job Content Questionnaire (JCQ), Therapist Work Involvement Scale (TWIS), Areas of Work Life Scale (AWS), Recovery Knowledge Inventory (RKI), Positive and Negative Affect Schedule (PANAS), Psychiatric Nurse Occupational Stress Scale (PNOSS), Manchester Clinical Supervision Scale (MCSS): Mental Health Professionals Stress Scale (MHPSS),

Sample and Settings Characteristics

From the 14 studies, three were conducted in medium secure services, three in Improving Access to Psychological Therapy (IAPT) services (now called NHS talking therapies), two in Community Mental Health Teams (CMHT), and one in acute inpatient wards. Three studies did not specify the nature of the mental health service, one study was conducted across acute inpatient wards and CMHTs (Kilfedder et al., 2001), and one study across acute inpatient wards, CMHTs, Rehabilitation services, Forensic Wards, Child Adolescent and Mental Health Services (CAMHS), Crisis Resolution Teams (CRT), Psychiatric Intensive Care Units (PICU), and inpatient mental health wards for older people (MHCOP) (Johnson et al., 2012).

A total of 4,077 MHPs took part in the 14 studies. From those, 64.5% identified as female and 35.5% as male, and their age ranged from 23 to 66. Four studies reported participants' ethnicity, in which 71% identified as White. Across all 14 studies, mental health nurses were represented in 12 studies (86.7%), occupational therapists (OTs) in three (20%), social workers in two (13.3%), IAPT therapists including Psychological Wellbeing Practitioners (PWPs), Cognitive Behaviour Therapy (CBT) therapists, and high intensity therapists in three (20%), psychiatrists in two studies (13.3%), and clinical psychologists in one (6.7%).

Measurements of Burnout

Burnout was measured by the Maslach Burnout Inventory-Human Services Scale (MBI-HSS) in 11 studies, the Oldenberg Burnout Inventory (OLBI) in two studies (Delgadillo et al., 2018; Westwood et al., 2017), and the Professional Quality of Life questionnaire (ProQol) in one study Towey-Swift & Whittington, 2021). The MBI-HSS includes 22 questions across three subscales: nine items explore emotional exhaustion, five depersonalisation, and eight personal accomplishment.

Scores for each subscale are added separately and are categorised into high, moderate, and low burnout categories. The OLBI is a 16-item questionnaire that explores burnout through exhaustion, emotional and physical, and disengagement (Demerouti et al., 2001). Finally, the ProQol is a 30-item questionnaire measuring professional quality of life, across three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress (Stamm et al., 2010).

Prevalence of Burnout

Due to the MBI-HSS, OLBI, and ProQol differing on how they measure burnout, and the majority of included studies using the MBI-HSS as a measurement of burnout, three studies that used the OLBI, and the ProQol were excluded from the meta-analysis (Delgadillo et al., 2018; Towey-Swift & Whittington, 2021; Westwood et al., 2017). Two studies were excluded from the meta-analysis (Coffey & Coleman, 2001; Hannigan et al., 2000) due to sharing the same data as two of the included studies (Coffey, 1999; Edwards et al., 2000). Two more studies were excluded, due to not reporting prevalence data (Johnson et al., 2012; Steel et al., 2015). Overall, seven studies were included in the meta-analysis (Coffey, 1999; Edwards et al., 2005; Edwards et al., 2000; Jenkins & Elliott, 2004; Kilfedder et al., 2001; Oddie & Ousley, 2007; Sherring & Knight, 2009). Considering that the MBI-HSS categorises the respondents into 'high', 'moderate', and 'low' burnout, the pooled prevalence on the 'high' categories for emotional exhaustion, depersonalisation, and personal accomplishment were calculated separately (O'Connor et al., 2018). Reported prevalence data per study is presented on Table 2.4.

The pooled prevalence showed 42% (CI 33-51%) of participants scoring within the 'high' category for emotional exhaustion (Figure 2.2). The Q test was significant (Q= 98.87, df= 6, p<.0001) suggesting considerable heterogeneity between the included studies (I^2= 90.73%). Pooled prevalence suggested 22% (CI 14-30%) of participants scoring within the ‘high’ burnout category for depersonalisation (Figure 2.3). The Q test was significant (Q= 89.84, df= 6, p<.0001) suggesting considerable heterogeneity (I^2= 92.26%). Finally, pooled prevalence showed 19% (CI 13-26%) of participants scoring within the ‘high’ burnout category for personal accomplishment (Figure 2.4). The Q test was significant (Q=70.91, df= 6, p<.0001) suggesting also considerable heterogeneity (I^2=87.39%).

Table 2.4

Reported prevalence of 'High', 'Moderate', and 'Low' burnout on the MBI-HSS scale

Authors	EE			DP			PA		
	High	Moderate	Low	High	Moderate	Low	High	Moderate	Low
Coffey, 1999	N=35, 44.3%	N=15, 18.9%	N= 29, 36.7%	N= 21, 26.58%	N= 22, 27.5%	N= 41, 51.89%	N=21, 26.58%	N= 17, 21.5%	N= 41, 51.89%
Edwards et al., 2000	N=145, 51%	N=70, 25%	N=68, 24%	N=70, 25%	N=51, 18%	N=162, 57%	N=40, 14%	N=77, 24%	N=166, 59%
Edwards et al., 2005	N=77, 36%	NR	NR	N=27, 12%	NR	NR	N=22, 10%	NR	NR
Jenkins & Elliott, 2004	N= 30	N=11	N=16	N=20	N=12	N=25	N= 8	N= 11	N= 38
Kilfedder et al., 2001	21.6%	NR	NR	7.10%	NR	NR	33.10%	NR	NR
Oddie & Ousley, 2007	N=38 54%	N=22 31%	N=11 15%	N=25 35%	N=15 21%	N=31 44%	N=11 15%	N=17 24%	43 61%
Sherring & Knight, 2009	41%	20.5%	38.5%	20.5%	17.5%	62%	21.7%	28.9%	49.4%

Figure 2.2

Forest Plot for Emotional Exhaustion

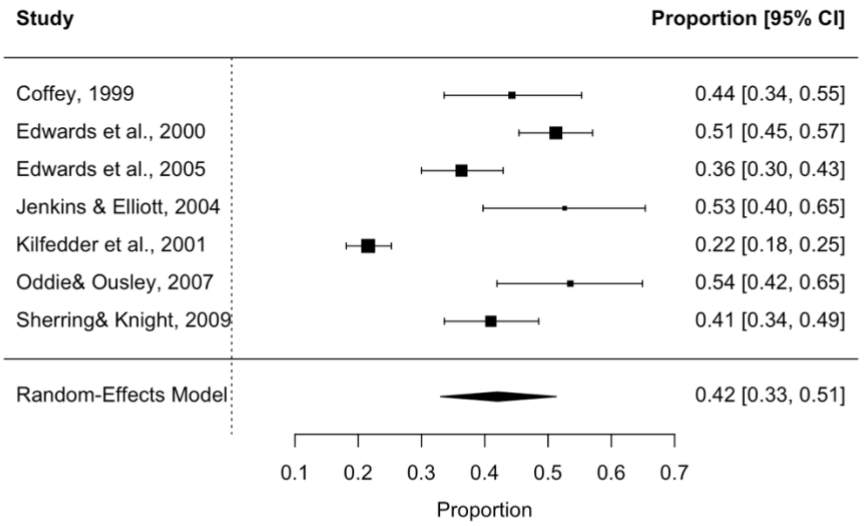


Figure 2.3

Forest Plot for Depersonalisation

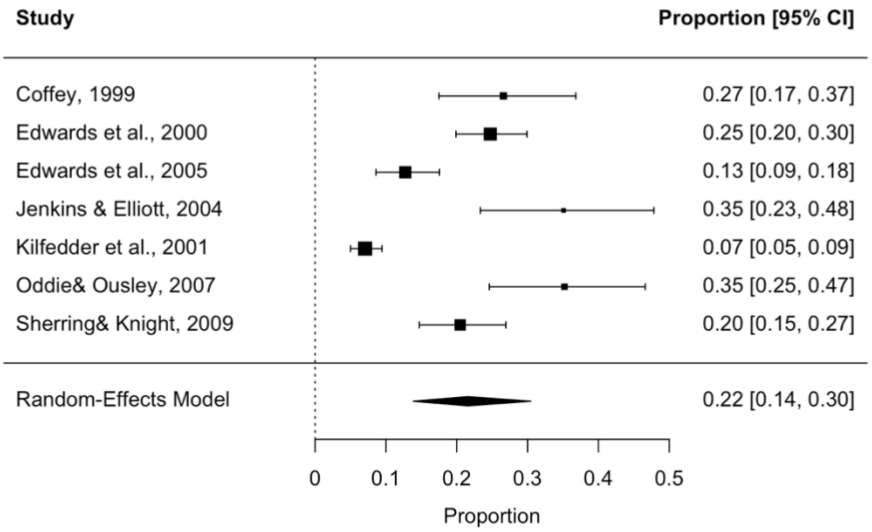
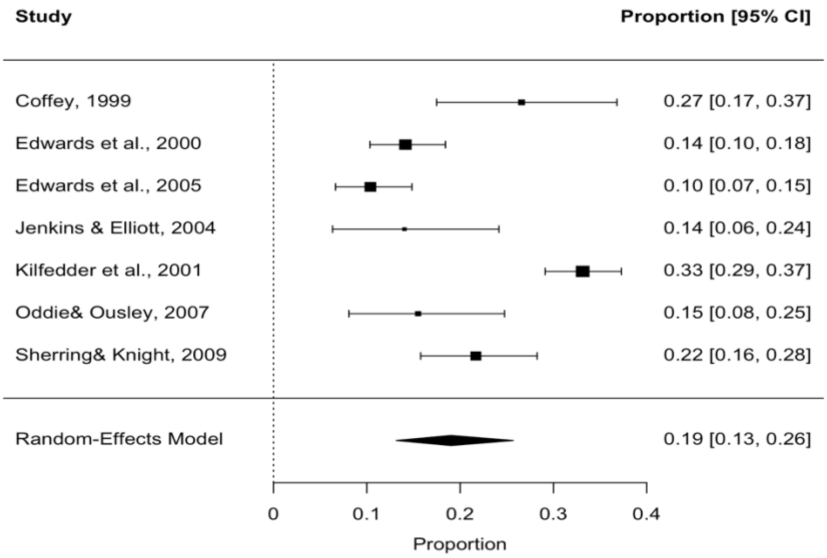


Figure 2.4

Forest Plot for Personal Accomplishment



Burnout Risk Factors

Data from all 14 studies were synthesised into key themes, following the review of the studies. Risk factors for burnout were conceptualised at an individual and organisational level. Information on the reported risk factors per study is shown on Table 2.5.

Table 2.5

Reported risk factors per study

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
Coffey (1999)	MBI-HSS	CPNSQ-r 10 highest reported items:	NA	NA	NA
		Lack of community support to refer clients (M=1.844), interruptions in the office (M=1.688), talks/ lectures to other staff (M=1.526), working with 'unco-operative' clients (M=1.455), lack of sufficient hospital support (M=1.442), long waiting lists before clients can access support (M=1.442), 'Managing my workload efficiently' (M=1.434), visiting 'unsafe areas' (M=1.429), lack of 'co-operation' from other professionals (M=1.408), supporting suicidal clients 'on my own' (M=1.408)			
Coffey& Coleman (2001)	MBI-HSS		**t-test reported values**	**t-test reported values**	**t-test reported values**
		Age	p=.868	p=.681	p=.109
		Gender	p=.194	p=.053	p=.40
		Drinking more than three alcohol units a day	p=.001	p=.458	p=.647
		Smoking	p=.685	p=.237	p=.009
		Unable to discuss problems with colleagues	p=.05	p=.858	p=.648
		Perceived Job security	p=.165	p=.936	p=.576
		Attitude of line manager	p<.001	p=.506	p=.888
		Clinical caseload	p=.005	p=.627	p=.087
		Time in present job	p=.202	p=.173	p=.014
		Years in psychiatric nursing	p=.517	p=.60	p=.829
Delgadillo et al. (2018)	OLBI		**OLBI-E**	**OLBI-D**	NA
		Higher scores on OLBI-D were linked with smaller symptomatic improvement in clients as measured by the GAD-7 and -PHQ-9.	NA	NA	
		Profession	NR	MH nurses had the highest OLBI-D scores (M=2.34,	NR

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
				SD=.52), then PWPs (M=2.29, SD=.47), and CBT therapists (M=1.92, SD=.37)	
		Job Satisfaction	NR	r=-.51***	NR
Edwards et al. (2000)	MBI-HSS	CPNSQ-r 10 highest reported items (mean): Lack of community facilities to refer clients (2.20), keeping up good quality care (2.02), having interruptions at work (2.00), long waiting lists before clients can access services (1.94), keeping detailed notes/ records (1.89), visiting unsafe areas (1.79), feeling that others expect too much from me as a CPN (1.76), not being informed of treatment affecting my client (1.73), supporting suicidal clients alone (1.73), lack of sufficient hospital back-up (1.72)	NA	NA	NA
Edwards et al. (2005)	MBI-HSS	Age	NA	r=-.19, p=.007	NA
		Gender	NA	z=-3.583***	NA
		6 sessions of Clinical Supervision	NA	z=-.2935, p=.003	NA
		MCCS	r=-.148, p=.05	r=-.22, p=.003	NA
		- Finding time	r=-.037, p=.08	r=-.21, p=.006	NA
		- Trust/ rapport	r=-.19, p<.01	r=-.23, p=.002	NA
		- Supervisor advice and support	NA	r=-.17, p=.02	NA
		- Importance value of clinical supervision	NA	r=-.17, p=.02	NA

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
Hannigan et al. (2000)	MBI-HSS	GHQ-12	r=.497**	r=-.369**	r=.253**
		Rosenberg Self-Attitude Questionnaire	r=.413**	r=-.369**	r=.345**
		PsychNurse Methods of Coping Questionnaire	r=-.36**	r=.301**	r=-.271**
		CPN Stress Questionnaire	r=.579	r=-.151*	r=.307**
		Urban service location	t(266)= 2, p=.047	NR	NR
		Unsupportive line manager	t(268)=2.90, p=.004	t(268)= 1.94, p=.054	NR
		Lack of job security	NR	t(277)=2.98, p<.01	NR
		Gender (male)	NR	t(278)= 2.65, p<.01	NR
		Having completed a specialist course	NR	NR	t(278)=2.04, p=.042
		Being in Supervisory/ Management position	NR	NR	t(276)= 1.94, p=.054
		Alcohol consumption	NR	NR	t(279)=3.4, p=.001
		Length of time in the service	NR	r=-.129*	NR
Jenkins & Elliott (2004)	MBI-HSS	MHPSS	r=.6***	r=.43***	r=.03
			β=.574**	β=.511**	NA
		- Workload	r=.51***	r=.31	r=.18
		- Client-related Difficulties	r=.42***	r=.39***	r=-.05
		- Organisational Structure and processes	r=.42***	r=.09	r=.11
		- Relationships with other professionals	r=.46***	r=.39***	r=.07
		- Lack of resources	r=.27	r=.21	r=.09
		- Professional self-doubt	r=.38***	r=.40***	r=-.18
		- Home-work conflict	r=.46***	r=.33***	r=-.05
		Social Support Scale	r=-.28**	r=-.01	r=-.001
		- Support from supervisor	r=-.15	r=.02	r=-.09
		- Support from co-workers	r=-.32**	r=.04	r=-.10

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
		- Support from spouse/ partner	r=-.09	r=-.09	r=.16
		- Support from friends and relatives	r=-.09	r=-.07	r=.18
		No associations between staff group and burnout.			
		Interaction between social support- MHPSS	β=.054	β=.191*	NA
Johnson et al. (2012)	MBI-HSS	Type of service	F= 8.87 p<.0005 49% of Acute inpatient ward and 60% of CMHT staff experience high EE.	NR	F=4.38, p<.0005
		Type of profession	F=6.56, p<.0005 Nurses, social workers, and OTs reported the highest EE.	NR	F=2.87, p=.006
Kilfedder et al. (2001)	MBI-HSS	Predictability	β= -.2***	β= -.2***	β= -.2***
		Role conflict	β= .2**	β=.1	NR
		Role ambiguity	β=--.1	β= -.02	β= .2***
		Job future ambiguity	β= -.1***	β= -.01	β=.1
		Nursing Stress Scale	β= -.2***	β=.01	NR
		Social Support	β=-.1**	β=.01	β= .01
		Positive affectivity	β=-.2***	β- -.1	β= .3***
		Negative affectivity	β=.3***	β=.2**	NR
		GHQ-12	β= .2***	β= -.1	NR
		Job satisfaction	β= -.2***	β= -.1	β= -.02
		Control	NR	NR	β=.02***
		Age	NR	β= -.1	NR

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
		Gender (male)	NR	p<.01	NR
		Length post-qualification	NR	β= -.1	β= -.2***
		Type of service	NR	NR	Community nurses reported higher burnout on PA than those in hospitals.
Oddie& Ousley (2007)	MBI-HSS	Age	NR by authors as p>.05	NR by authors as p>.05	NR by authors as p>.05
		Gender	NR by authors as p>.05	NR by authors as p>.05	NR by authors as p>.05
		Length in the service	NR by authors as p>.05	NR by authors as p>.05	NR by authors as p>.05
		PNOSS			
		- Organisational/ Administrative	r=.439**	r=.419**	r= -.383**
		- Limited resources	r=.313**	r=.325**	NR
		- Staff conflict	r=.287*	r=291*	r= -.337**
		- Patient care	r=.248*	NR	NR
Sherring & Knight (2009)	MBI-HSS	Having Clinical Supervision	t=2.51*	NR	NR
		Being supported at work	F=3.448, p<.009	NR	NR
		Feeling valued at work	F=16.82***	NR	F=2.55, p=.026
		Being involved in decision-making regarding nursing issues	F=9.60***	F=3.83, p= .005	NR
		Being involved in decision-making regarding changes	F=8.06***	NR	NR
Steel et al. (2015)	MBI-HSS	Psychological job demands	β= .491***	β= .13	NR
		Decision latitude	β= -.109	NR	β= .063
		Stressful involvement	β=.290**	β=.45***	NR
		Age	NR	β= -.232*	NR
		Length of training	NR	NR	β= .187*
		Control coping	NR	NR	β= .222*
		Healing involvement	NR	NR	β= .387***

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
Towey-Swift& Whittington (2021)	ProQol (Burnout Subscale)		**Burnout**	NA	NA
		Time in the service	r=.178, p= .041		
		Time in the profession	r=.246, p= .005		
		Workload	r= -.48** β= -.355***		
		Control	r=-.43**		
		Reward	r= -.483** β= -.22, p= .011		
		Community	r= -.32**		
		Fairness	r= -.429**		
		Values	r= -.454** β= -.206, p= .015		
Westwood et al. (2017)	OLBI		**OLBI-E**	**OLBI-D**	NA
		Organisational structure	**PWPs** B= 2.90*** **HIT** B= 2.21***	**PWPs** B= 3.01*** **HIT** B= 2.65***	
		Conflict with other professionals	**PWPs** B=3.53*** **HIT** B= 2.24, p= .002	**PWPs** B= 3.26*** **HIT** B= 2.39***	
		Patient contact	**PWPs** B=.18, p=.001 **HIT** B=.20, p=.005	**PWPs** B=.15, p=.003 **HIT** B=.23, p=.001	
		Patient telephone contact	**PWPs** B=.11, p= .05 **HIT** B=.75, p=.005	**PWPs** B=.06, p=.224 **HIT** B=.19, p=.003	
		Time inputting data	**PWPs** B=.29, p=.003	**PWPs** B=.18, p=.051	

Authors (Year)	Burnout Measure	Risk Factors	Burnout		
			EE	DP	PA
			HIT B=.07, p=.433	**HIT** B=.02, p=.809	
		Doing overtime	**PWPs** B=.92*** **HIT** B=.24, p=.092	**PWPs** B=.71*** **HIT** B=.1, p=.475	
			Total burnout Doing overtime predicted higher odds of burnout (Odds ratio =1.87, 95% CI 1.27–2.77, p=.002)		
		Clinical Supervision	Lower odds of burnout (odds ratio= .41, 95% CI 0.18–0.94, p=.036)		

Note. *p<.05, **p<.01, ***p<.001, NR: Not reported, NA: Not applicable. MBI-HSS: Maslach Burnout Inventory- Human Services Scale, OLBI: Oldenburg Burnout Inventory, ProQol: Professional Quality of Life Scale.

Individual Factors

Individual factors associated with burnout involved participants' demographics, profession, and affectivity.

Demographic and Personal Characteristics

Six studies considered participants' demographics identifying age and gender as factors associated with burnout (Coffey& Coleman, 2001; Edwards et al., 2005; Hannigan et al., 2000; Kilfedder et al., 2001; Oddie & Ousley, 2007; Steel et al., 2015). Age was strongly associated with burnout (Oddie & Ousley, 2007) however, the directions of this relationship were not clear due to lack of reported results. Edwards et al. (2005) found a negative relationship between age and depersonalisation, whilst Steel et al. (2015) suggested age to predict depersonalisation. However, Kilfedder et al. (2001) did not find such relationship, whilst Coffey & Coleman (2001) found no significant differences in burnout between age groups. Gender, and particularly being male, was associated with higher rates of depersonalisation in three studies (Edwards et al., 2005; Hannigan et al., 2000; Kilfedder et al., 2001). Oddie and Ousley (2007) found a strong relationship between gender and all three dimensions of burnout; however, as with age, the authors did not report the relationship's direction. Two studies also explored MHPs' alcohol consumption and smoking in relation to burnout. MHPs who drink alcohol were also found to experience higher levels of emotional exhaustion (Coffey & Coleman, 2001) and lower levels of personal accomplishment (Hannigan et al., 2000), whilst smoking was associated with lower levels of personal accomplishment (Coffey & Coleman, 2001).

Affectivity

Two studies commented on MHPs' affectivity, particularly experiences of stress and coping (Hannigan et al., 2000; Kilfedder et al., 2001). Hannigan et al.

(2000) suggested that higher levels of stress were associated with higher levels of burnout across emotional exhaustion, depersonalisation, and personal accomplishment. Similarly, Kilfedder et al. (2001) found negative affectivity and low levels of positive affectivity to predict higher levels of burnout.

Profession

Two studies reported mental health nurses to score the highest on the OLBI-Disengagement and MBI-Emotional Exhaustion subscales. Johnson et al. (2012) reported that, alongside nurses, social workers and occupational therapists experience higher emotional exhaustion in comparison to psychiatrists and clinical psychologists. Delgadillo et al. (2018) by exploring burnout in IAPT services found that following nurses, PWPs and CBT therapists experienced high disengagement, as measured by the OLBI.

Individual studies explored time in the profession, role, service, as well as experience post-qualification, and their association with burnout. Specifically, Towey-Swift and Whittington (2021) found time in the profession to be a significant factor linked with the burnout subscale, whilst time post-qualification was considered a significant negative predictor of personal accomplishment (Kilfedder et al., 2001). One study also found length of training to predict personal accomplishment (Steel et al., 2015), whilst holding a specialist qualification was associated with higher levels of personal accomplishment (Hannigan et al., 2000). Three studies considered MHPs' time in the service and its link with burnout. Specifically, Towey-Swift and Whittington (2021) found this to be positively linked with the ProQol burnout subscale, whilst Hannigan et al. (2000) suggested that it is negatively associated with depersonalisation. Finally, Coffey and Coleman (2001) suggested time spent in the role to be significantly positively associated with personal accomplishment.

Organisational Factors

Organisational factors associated with burnout included the service nature, workload, support and work relationships, available resources, organisational structure, and experience in the role.

Service

Two studies suggested MHPs in CMHTs experience higher levels of burnout than those in the acute inpatient services. Specifically, Johnson et al. (2012) who reported CMHT MHPs to experience high levels of emotional exhaustion (60%), followed by MHPs in acute inpatient services (49%). Similarly, Kilfedder et al. (2001) reported higher levels of burnout in relation to personal accomplishment among mental health nurses in the community in comparison to those in hospital settings. Service location was considered by one study, with MHPs working in an urban area to experience higher levels of emotional exhaustion (Hannigan et al., 2000).

Workload

The relationship between workload and burnout was explored by four studies. Two studies found workload and caseload to be linked with higher levels of emotional exhaustion (Coffey& Coleman, 2001; Jenkins & Elliott, 2004), and one study to be negatively correlated with burnout (Towey-Swift & Whittington, 2021). Westwood et al. (2017) by exploring burnout in IAPT services, found that working overtime predicted higher odds of experiencing burnout, whilst increased patient contact predicted higher levels of exhaustion and disengagement for both high intensity therapists and PWPs. The same authors suggested time spent inputting service user related data to predict exhaustion among PWPs, but not high intensity therapists.

Service user related difficulties and therapists' involvement were explored in relation to burnout by three studies. MHPs' stressful involvement predicted higher emotional exhaustion and depersonalisation (Steel et al., 2015), whilst limited improvement in service user difficulties was associated with higher levels of disengagement, as measured by the OLBI-Disengagement subscale (Delgadillo et al., 2018), and with higher emotional exhaustion and depersonalisation, as measured by the MBI-HSS (Jenkins & Elliott, 2004).

Support and Work Relationships

Eight studies found support in the workplace to be significantly linked with burnout. Two studies reported perceived lack of support from management to be associated with higher levels of emotional exhaustion (Coffey & Coleman, 2001; Hannigan et al., 2000). Similarly, Sherring and Knight (2009) reported perceived support from supervisor to be negatively linked with emotional exhaustion, and Edwards et al. (2005) with depersonalisation. Westwood et al. (2017) suggested that having supervision predicts lower odds of MHPs experiencing burnout overall. Feeling supported at work and part of a community was associated with lower levels of emotional exhaustion in three studies (Kilfedder et al., 2001; Sherring & Knight, 2009; Towey-Swift & Whittington, 2021), whilst lack of overall support was considered a predictor of emotional exhaustion (Kilfedder et al., 2001).

Four studies explored the link between colleague relationships and burnout. Edwards et al. (2005) found trust and rapport with colleagues to be negatively associated with both emotional exhaustion and depersonalisation. Jenkins and Elliott (2004) found a significant association between relationships with professionals and burnout, whilst interaction between social support and stressors predicted depersonalisation. Staff conflict was reported as a predictor of high exhaustion and disengagement (Westwood et al., 2017), and was negatively correlated with emotional exhaustion, depersonalisation, and personal accomplishment (Oddie & Ousley, 2007).

Available resources

Four studies explored the relationship between service or wider organisation resources. One study reported a significant positive relationship between lack of resources and emotional exhaustion and depersonalisation (Oddie & Ousley, 2007). Edwards at al. (2005) also found a negative relationship between finding time to complete work-related tasks and depersonalisation. Two studies reported lack of available facilities in the community and long waiting list for clients to access support as two of the highest rated items on the Community Psychiatric Nurse Questionnaire-revised (Coffey, 1999; Edwards et al., 2000).

Organisational Structure

Organisational structure was found to be negatively correlated with emotional exhaustion in one study (Jenkins & Elliott, 2004) and as a predictor of exhaustion and disengagement in another (Westwood et al., 2017).

Experiences in the Role

Six studies explored specific MHP experiences in their role and their association with burnout. Such experiences involved work-related stress, job satisfaction and job security, involvement in decision-making, and the sense of values and fairness in the workplace. Specifically, three studies found organisational and work-related stress factors to predict emotional exhaustion (Kilfedder et al., 2001; Steel et al., 2015) and overall burnout. Two studies suggested job satisfaction was a predictor for depersonalisation (Delgadillo et al., 2018) and emotional exhaustion (Kilfedder et al., 2001). Furthermore, Hannigan et al. (2000) found MHPs who experience higher lack of job security to experience higher levels of depersonalisation. One study found being involved in decision-making predicted emotional exhaustion (Sherring & Knight, 2009). Having a higher sense of control of the role predicted lower levels of emotional exhaustion and personal accomplishment in one study (Kilfedder et al., 2001) and was found to be negatively associated with burnout (Towey-Swift & Whittington, 2021). Towey-Swift & Whittington (2021) found values, fairness, and reward to predict experiences of emotional exhaustion. Similarly, Sherring and Knight (2009) found significant differences between those who feel valued in the workplace and those who do not, particularly in relation to emotional exhaustion.

Discussion

The present review explored the prevalence of burnout and relevant risk factors among MHPs working in NHS mental health services. Mental health nurses were the most represented profession among the included studies, and clinical psychologists the least represented. Overall, seven studies were included in the meta-analysis, due to the heterogeneity of the burnout measures, and lack of reported prevalence.

The pooled prevalence for high emotional exhaustion was 42%, for high depersonalisation 22%, and for high personal accomplishment 19%. This finding supports previous reviews suggesting that 40% MHPs experience emotional exhaustion, 22% depersonalisation, and 19% low personal accomplishment (O'Connor et al., 2018). Emotional exhaustion was the aspect of burnout that was experienced by most of the MHPs. McCormack et al. (2018) found applied psychologists to experience higher levels of emotional exhaustion, in comparison to depersonalisation and personal accomplishment. Similarly, Lopez-Lopez et al. (2019) found mental health nurses to experience higher levels of emotional exhaustion in comparison to the other burnout dimensions. Such an observation has been previously associated with the nature of the therapists' or MHPs' work which requires high levels of involvement (Maslach et al., 2001; McCormack et al., 2018). The I^2 and Cochran's Q test highlighted significant heterogeneity in the studies. Differences in participants' demographic characteristics, professional background, services, and associated challenges, may contribute to the high levels of heterogeneity. Thus, prevalence findings should be interpreted with caution.

Risk factors varied across the studies and were conceptualised at an individual and organisational level. Individual factors included participants' age, gender, profession, and affectivity. First, participants' gender, and particularly being male, was associated with higher levels of depersonalisation. This finding is consistent with previous research suggesting that female practitioners are more likely to experience emotional exhaustion, whilst male practitioners experience depersonalisation (Vincent et al., 2019). Age was associated with burnout and its dimensions, which also reflects previous findings that younger applied psychologists (McCormack et al., 2018) and younger psychotherapists (Simionato & Simpson, 2018) are more likely to experience burnout. Mental health nurses appeared to experience the highest levels of burnout in comparison to other MHPs. Mental health nurses and social workers have been previously suggested to experience the highest levels of burnout (O'Connor et al., 2018). However, it should be highlighted that in the current sample, mental health nurses were over-represented, in comparison to other MHPs, and therefore it may be difficult to conclude on the relationship between profession and burnout.

From the available data, the relationship between other personal characteristics, and particularly between alcohol consumption, smoking and burnout were explored. However, as it was not possible to interpret whether this relationship between burnout and alcohol consumption and smoking was predictive or consequential, such information should be considered attentively. Participants' affectivity was also perceived a risk factor for burnout, considering its previous predictive role (Parkes, 1990). However, only a limited number of studies focussed on MHPs' affectivity, whilst great emphasis was placed on organisational factors.

MHPs in community services appeared to experience higher levels of burnout than those in inpatient settings, which is consistent with previous reviews (O'Connor et al., 2018; Richards et al., 2006). Even though lack of resources and increased workload were explored as risk factors, MHPs' experiences in the service, and the support they receive in the workplace were commented in depth. Being involved in decision making, having control in the role, and feeling valued were experiences that negatively predicted burnout and could be explained by a sense of powerlessness in the workplace. Vivolo et al. (2024) in their qualitative synthesis, emphasised therapists' experiences of powerlessness, particularly in relation to influencing organisational challenges.

The review highlighted lack of support as a risk factor for burnout, and particularly for emotional exhaustion. Adding to the existing literature (O'Connor et al., 2018; Simionato et al., 2019; Vivolo et al., 2024), having clinical supervision was emphasised as a way of preventing and managing burnout. However, support was also considered in the context of being part of a community in the workplace. It has been previously suggested that having peer support and support from the leadership team, can improve morale and minimise experiences of burnout (Vivolo et al., 2024; Wood et al., 2011). The current review highlights the importance of such relationships in the workplace, built on trust and open communication, and their role as protective factors against burnout.

Clinical Implications

The current review suggests that high levels of burnout experienced by MHPs in NHS mental health services can be attributed largely to organisational factors. The consistency of this finding in relation to previous reviews, emphasises the importance of considering interventions of burnout at an organisational, as well as individual level. For example, Bowers et al. (2011) suggested interventions to focus on team structure, and particularly on improving teamwork. Offering opportunities for the team to bond, such as ‘away days’ or group reflective practice may be beneficial. Specifically, group reflective practice has been found supportive of MHPs’ wellbeing and development of team relationships in various settings (Fenton & Kidd, 2024; O’Neill et al., 2019). Clinical supervision has also been emphasised not only for its impact on MHPs’ development, but also for the benefit of the relationship between supervisor and supervisee on the latter’s wellbeing (Bradley et al., 2021).

The importance of supporting staff wellbeing through addressing NHS pressures, particularly staff shortages, is not a new concept (The Kings Fund, 2021) and appears in the current review. With just over 34% of NHS staff feeling that staffing levels are adequate and not impacting on their work (NHS Staff Survey, 2024), staff capacity and availability should be considered in delivering and engaging staff in supportive spaces. Team culture may also play a significant role in the implementation and maintenance of such spaces (Yiu et al., 2025). Stigma of NHS staff experiencing mental health difficulties in addition to the lack of resources (particularly time) have been suggested as barriers to staff accessing support (Billings et al., 2021). Clarkson et al. (2023) by exploring NHS staff experiences of accessing mental health support, highlighted leadership as an enabling factor. Thus, increased compassion and empathy from staff in leadership positions may foster an environment where staff feel enabled to seek support and attend supportive spaces.

Limitations

The present review faced several limitations. First, all 14 included studies were cross-sectional, with just half meeting all the quality criteria on the CASP quality appraisal tool. Therefore, the findings should be interpreted with caution. A lot of studies reported correlational relationships between burnout and various factors. Such relationships were difficult to be interpreted in detail, as causation between these factors and burnout should not be assumed. Furthermore, during the full text screening process, it became apparent that some studies did not describe in detail the services that were included in the sample, which made it difficult to understand whether participants were under NHS mental health services. Other studies, even though they were conducted in the NHS did not differentiate their findings between qualified and non-qualified MHPs, as well as between clinical and administrative staff members. Considering this, there is a possibility of several studies which may meet the inclusion criteria to have been excluded due to a lack of information provided. Finally, due to the considerable heterogeneity in the studies and the lack of prevalence data, the meta-analysis included seven studies, all of which were already considered in a previous review (O’Connor et al., 2018). Consequently, no studies conducted during or following Covid-19 were included, and therefore it was not possible to explore to what extent the prevalence of burnout has changed. Despite this, the current review provided further evidence on the prevalence of MHPs’ burnout, and particularly of those working in NHS mental health services.

Conclusion and Future Research

The current review highlighted that 42% of MHPs experience high levels of emotional exhaustion, 22% of depersonalisation, and 19% of personal accomplishment. Even though risk factors are conceptualised in both individual and at organisational level, there is an emphasis on work-related difficulties and experiences in the workplace. Considering the limitations that accompany the cross-sectional nature of the included studies and difficulties with capturing MHPs’ experiences of risk factors, future research could explore these through a qualitative approach.

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Chapter 3

Bridging Chapter

Bridging Chapter

Evidence suggests that there is high prevalence and re-admission rates for people with Borderline Personality Disorder (BPD) in adult acute inpatient services (Gregory et al., 2021; Lewis et al., 2019). The National Institute of Health and Care Excellence guidelines (NICE; 2015) have emphasised the importance of staff support and communication in relation to care linked with BPD diagnosis on acute wards. This is due to the possibility of different services being involved in people's care, and staff needing support to explore the impact of the work on their wellbeing, as well as the impact of their responses on people (NICE, 2015). However, acute wards have been described as a fast-paced environment which faces pressures on bed availability, staff shortages, and lack of resources in general, impacting on both care quality and staff wellbeing (Care Quality Commission, 2023).

The systematic review and meta-analysis found NHS mental health professionals continue to experience burnout. Identified risk factors were both at the level of the individual and the organisation, with a particular emphasis on mental health professionals' increased workload and experiences of support. Mental health professionals in community services were also suggested to experience high levels of burnout, followed by those in acute inpatient services. The systematic review highlighted the importance of fostering a supporting environment for staff members, in which they feel enabled to share their difficulties and needs with those in leadership positions.

The importance of the Clinical Psychologist role in staff support, through offering supportive spaces such as reflective practice and supervision, has been previously documented in mental health services, including acute inpatient services (Association of Clinical Psychologists- UK [ACP-UK], 2021). However, Clinical

Psychologists themselves report burnout as organisational pressures, including a lack of psychology resources and lack of understanding around the nature of the role have significant impact on their role (Ebrahim, 2022). Considering the emphasis on staff support within the NICE guidelines for people with BPD in addition to the supportive role that Clinical Psychologists hold, the empirical paper aimed to explore an identified gap in the literature in relation to Clinical Psychologists’ role in acute inpatient services, particularly when working with people with BPD and the system involved in their care.

Chapter 4

Empirical Paper

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**Please refer to Appendix A for Authors guidelines*.

***Where appropriate, material from the Thesis Proposal assignment of the UEA DClinPsy has been used throughout this chapter.**

"I'm just a cushion used by the system to kind of soften the blow of the system": Clinical Psychologists' experiences of their role when working with people with Personality Disorder in Adult Acute Inpatient Services

Athena Despoina Sideri[a], **Dr Adrian Leddy**[b], **Dr Corinna Hackmann**[c]

[ab] *Department of Clinical Psychology, Norwich Medical School, University of East Anglia, Norwich, United Kingdom, NR4 7TJ*

[c] *Norfolk and Suffolk NHS Foundation Trust, Hellesdon Hospital, Norwich, United Kingdom, NR6 5BE*

Correspondence to:

Dr Adrian Leddy, Department of Clinical Psychology, Norwich Medical School, University of East Anglia, Norwich, United Kingdom, NR4 7TJ, a.leddy@uea.ac.uk

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Abstract

Introduction: NICE guidelines emphasise the importance of staff support and communication between services when a person with Borderline Personality Disorder (BPD) diagnosis is admitted to an Acute Inpatient Mental Health Service (AIMHS). Clinical Psychologists are often considered advocates of staff support and formulation-driven and person-centred care within AIMHS. Considering the lack of psychology resources across AIMHS, it is important to explore Clinical Psychologists' experiences of their role and their needs when working with people with BPD.

Methods: Twelve Clinical Psychologists working in AIMHS in England were interviewed about their experiences of their role in terms of BPD in AIMHS. Interviews were analysed using reflexive Thematic Analysis (rTA), through a critical realist stance.

Results: RTA generated three superordinate themes, through which participants spoke about the visible aspects of their role being driven by feelings of dissonance and moral distress. To manage this position, Clinical Psychologists shared the experience of trying to shift the team's culture around BPD diagnosis through formulation and informative conversations with staff.

Discussion: The current study emphasises the underlying mechanisms driving visible aspects of the Clinical Psychologist role, particularly in the context of the BPD diagnosis, which has been previously highlighted for its stigmatising connotations. Clinical implications and recommendations for future research are discussed.

Key words: Clinical Psychologists, Adult Acute Inpatient Mental Health Services, Personality Disorder, moral distress, cognitive dissonance.

Background

In the period 2023 to 2024, NHS Digital (2024a) estimated approximately 102,738 people were admitted to an Adult Acute Inpatient Mental Health Service (AIMHS). Of these, 52,458 were detained under the Mental Health Act (MHA; NHS Digital, 2024b). It has been suggested that people with a Borderline Personality Disorder (BPD) diagnosis are more likely to be admitted to AIMHS than people with other mental health diagnoses or difficulties (Comptois & Carmel, 2016).

The BPD diagnosis is described in the context of interpersonal difficulties, difficult feelings in response to rejection, and emotional dysregulation (Bach & First, 2018). Over the years, the BPD, and 'Personality Disorder' (PD), diagnosis has been associated with stigmatising narratives used by professionals regardless of their background (Baker & Beazley, 2022), suggesting that people are accountable for their behaviour (Koekkoek et al., 2009), demanding, and unresponsive to treatment (Troup et al., 2022). Even though such perspectives may enable staff to emotionally distance themselves and cope with burnout (Troup et al., 2022), they can perpetuate the stigma of the diagnosis and lead to possible feelings of rejection (Luyten et al., 2020).

Due to perceptions that the diagnosis impacts the person's identity, professionals have been ambivalent towards its use (Donald et al., 2017). Some clinicians choose not to share the BPD diagnosis with people or use alternative terms such as 'Complex Trauma' and 'Complex Emotional Needs' (Sulzer et al., 2016; Troup et al., 2022). Amongst people with lived experience, the diagnosis has been described as having both explanatory power and carrying stigma (Troup et al., 2022). The International Classification of Diseases 11th Revision (ICD-11; World Health Organisation [WHO], 2018) replaced the PD Diagnoses with the 'Personality Disorder' term, and added a 'borderline pattern specifier'. However, this change was suggested as invalidating of people's experiences (Hackmann et al., 2019). Whilst acknowledging the ongoing debate around the terminology, the term BPD is used throughout the study, as it is widely recognised in the literature and in clinical provision and used within the National Institute of Health and Care Excellence guidelines (NICE; 2015).

NICE guidelines (2009) have recommended for people with BPD to be admitted to AIMHS in case of detention under the MHA or in case of crisis where risk towards self and others cannot be managed effectively by community services. Furthermore, there is an emphasis on staff support and communication between services in relation to inpatient treatment for people with BPD, to ensure consistent input (NICE, 2015). However, wider system factors such as lack of resources, pressures on inpatient beds, waiting lists in community services, low staffing levels, and inconsistent communication between management and frontline staff have affected the quality of care and staff wellbeing (Care Quality Commission, 2022; Totman et al., 2011).

The Clinical Psychologist role in AIMHS can lead to positive outcomes for both service users and staff (ACP-UK, 2011). Clinical Psychologists can advocate for formulation-driven inpatient care and treatment (Wood et al., 2019) and support staff needs, through training, supervision, and reflective practice (ACP-UK, 2021; Ebrahim, 2022). To ensure care quality and increase therapeutic interventions, the Royal College of Psychiatrists (2019) suggested that each inpatient ward should have at least one Clinical Psychologist (NHS, 2019). However, AIMHS lack psychology resources, whilst Clinical Psychologists feel that the AIMHS team and the wider organisation misunderstand their role (Ebrahim, 2022).

Considering the significance of supporting the system around the person with BPD in AIMHS (NICE, 2015), and Clinical Psychologists' diverse role in supporting service users and staff, it is important to explore Clinical Psychologists' experiences of their role in AIMHS. Awareness of the ongoing lack of resources, at a psychology and wider AIMHS level, could help understanding the consequences of not meeting the psychology resource standards in AIMHS and conceptualising ideas on the support that Clinical Psychologists and the system around service users with BPD might need to ensure quality of care.

Research questions:

1. What are Clinical Psychologists' experiences of their role in their work with people with BPD in AIMHS?
2. How do Clinical Psychologists work with the multidisciplinary team and the wider organisation that supports people with BPD?
3. What are Clinical Psychologists' needs in terms of delivering this role?

Method

Design

A qualitative approach using reflexive Thematic Analysis (rTA; Braun & Clarke, 2006) was employed.

Ontology and Epistemology

The researcher held a critical realist position, acknowledging that reality exists outside of our observation, knowledge, and understanding (Bhaskar, 2008). This position allowed an understanding of how participants perceive their experience in the context of their work in AIMHS, and how this may have impacted their perceptions (Sayer, 2010). The researcher kept a reflexive journal and held reflective discussions with the research team, to understand how their experiences, role, and position to the research topic may impact the interpretation of participants' experiences. Research supervision was also used to ensure the rTA methodology was followed appropriately.

Quality Assurance

The study's quality was ensured using Braun and Clarke's (2023) recommendations on using and reporting rTA. This guidance was used in addition to Yardley's (2000) qualities for qualitative research which include sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Firstly, sensitivity to context refers to being aware of ethical issues, the relevant and current literature, and participants' context of experiences, and secondly commitment and rigour to the full emersion with the data and the topic (Yardley, 2000). Thirdly, transparency and coherence is related to having transparent methodology where reflexivity is also present (Yardley, 2000). Finally impact and importance to the relevance of the research to the clinical practice and wider socio-cultural context (Yardley, 2000).

Ethical Approval

The University of East Anglia Faculty of Medicine and Health Sciences (FMH) provided ethical approval (ID: ETH2425-0637). Since recruitment involved NHS professionals, approval was also sought and provided by the Health Research Authority in England (IRAS ID: 335255).

Patient and Public Involvement (PPI) and Stakeholders Groups

To ensure relevance to stakeholders and encourage transparency (Greenhalgh et al., 2019), PPI and stakeholder perspectives were sought in the research process. A person with a diagnosis of BPD and experience of admission in AIMHS and a Clinical Psychologist with experience of working in AIMHS were involved in the development and piloting of the interview schedule. The main researcher shared the interview schedule with the lived experience PPI member and the Clinical Psychologist stakeholder separately, to allow space and time for them to familiarise themselves. Following this, the main researcher met online with each member separately and gained their feedback. Overall, the main researcher met once with the PPI member and once with the stakeholder prior to data collection. Following data analysis, the researcher met once with the stakeholder, to share the results and explore whether and how these resonated with the stakeholder's experiences of their role. All meetings took place online.

Participants' Recruitment

Participants were qualified Clinical Psychologists working in AIMHS in England in the past 24 months. The timeframe of 24 months was chosen considering that NHS systems evolve, and to ensure participants had good recall of their experiences. To allow participants with different levels of clinical experience to take part, the project invited Clinical Psychologists with at least six months of experience working in AIMHS. Braun and Clarke (2013) suggested the sample size for a 'medium' interview project, as the present study, to involve 10 to 20 participants. Recruitment was influenced by information power, that is the more relevant the information participants offered, the smaller the sample size (Braun & Clarke, 2021; Malterud et al., 2016).

Measures

Demographic Questions

At the beginning of the interview, participants were asked a series of demographic questions to support data interpretation and contextualisation. This included age, ethnicity, role in the service, number of years working in AIMHS, number of years working as a qualified Clinical Psychologist, and experience in other NHS mental health services.

Interview Schedule

Interviews were semi-structured and based on an interview schedule, used to guide a deep exploration of the topic and capture participants' experiences. The researcher used prompts such as "Can you give me an example of?" to ensure a good understanding of participants' experiences, and encouraged them to consider their role in the different layers of the care system (e.g., with people with BPD, the AIMHS team, other community or specialist teams).

Procedure

Following ethical approval, a mental health NHS Trust in England circulated the study poster to potential participants, through existing email lists asking them to contact the researcher to express their interest if they wished to participate. Potential participants were also asked to circulate the study poster to other professionals who met the study inclusion criteria and may be interested in taking part, leading to a snowball effect. Potential participants who met the study inclusion criteria, were emailed the Participant Information Sheet and, at least 48 hours following this, the Consent Form.

All interviews were conducted online via Microsoft Teams and lasted up to one hour. Interviews were transcribed verbatim. Microsoft teams was used for the initial transcription. The main researcher revisited the transcription to ensure accurate representation of participants' input, and to remove confidential information, such as participants' names.

Analysis

RTA supported the researcher to identify, analyse and report different themes within participants' responses (Braun & Clarke, 2006), and allowed the different aspects of the research questions to be explored in depth (Boyatzis, 1998). As the project focusses on participants' experiences, rTA allowed the researcher to notice their shared experiences in the wider data (Braun & Clarke, 2006). The analysis followed the six phases of rTA (Braun and Clarke, 2022). The researcher familiarised themselves with the data through re-visiting the interview recordings and the transcripts. Transcripts were then coded at a semantic level, capturing the explicit meaning within participants’ responses, and at a latent level, capturing the analytic meaning, whenever possible. Codes were grouped based on meaning, and initial themes were generated. Themes were reviewed, and codes were moved between themes and sub-themes based on their meaning. This process stopped when boundaries between themes were clear. RTA took an inductive ‘bottom-up’ approach, grounding the analysis in the observed data. This allowed the researcher to initially identify patterns in participants’ responses without the influence of pre-existing theories (Braun & Clarke, 2006). NVivo software was used for the coding and generation of initial themes, and pen and paper for the refining of themes and sub-themes.

Results

Twelve Clinical Psychologists working in AIMHS in England participated. Participants’ demographics are presented on Table 4.1.

Table 4.1

Participants' Demographic Characteristics

Key Demographic	Frequency
Gender	
Female	9
Male	3
Age range	
25-30	2
31-35	3
36-40	5
41- 45	1
46-50	1
Ethnicity	
White- British	11
White- European	1
Role in AIMHS	
Qualified CP	5
Senior CP	1
Principal CP	3
Consultant CP	3
Years of experience post-qualification	
0-5	7
6-10	2
11-15	2
16-20	1
Years of experience in AIMHS	
0-5	8
6-10	3
11-15	1
Experience in other MH services (post-qualification)	4
No Experience in other MH services (post-qualification)	8

Note. Key Abbreviations: Acute Inpatient Mental Health Services (AIMHS), Clinical Psychologist (CP), Mental Health (MH).

RTA generated three overarching themes: delivering compartmentalised tasks, which included two subthemes (direct work with service users and staff support), containing a system riddled with complexity and dissonance, which included three subthemes (the need to be held, holding people and the team, and holding the system), and shifting the culture around the Personality Disorder diagnosis. Figure 4.1 presents themes, sub-themes, and the relationship between these. Table 4.2. presents example quotes per theme and sub-theme.

Figure 4.1

Thematic map including the generated themes and sub-themes

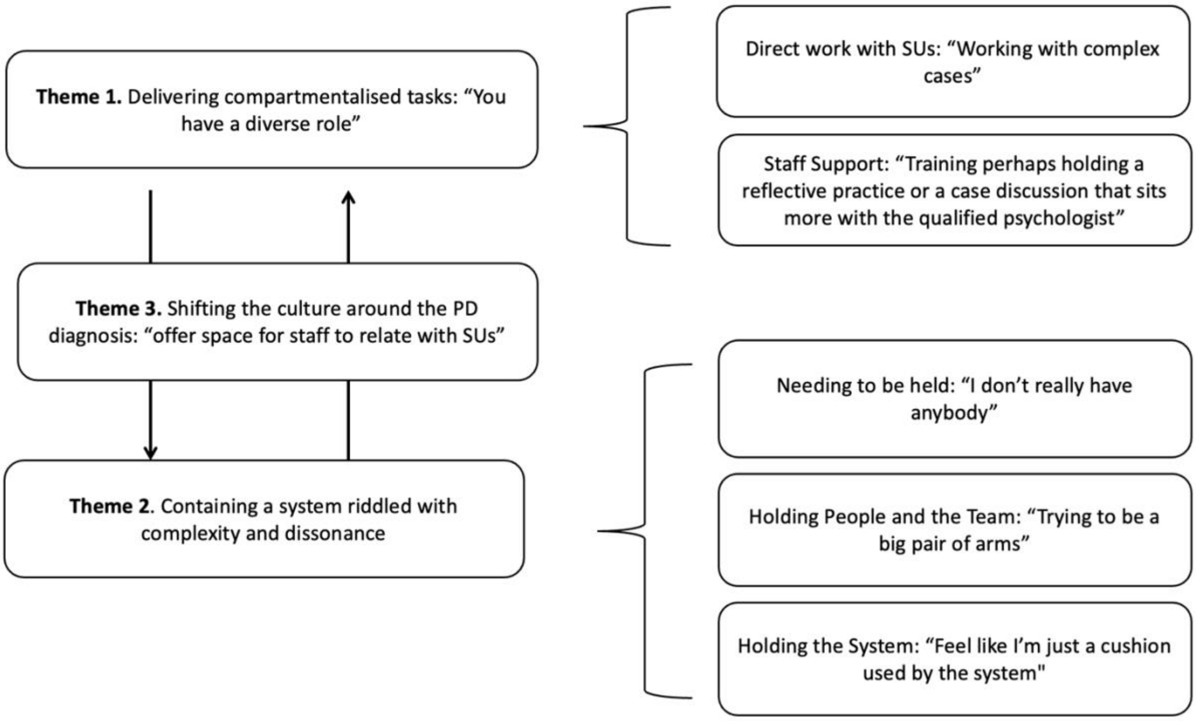

Table 4.2

Example quotes per sub-theme and theme

Theme Sub-theme	Example Quote
Delivering Compartmentalised Tasks	
Direct work with service users	"They would automatically always get DBT positive behaviour support plan so we would do that directly with them"- Participant 6 "Now when I work with somebody particularly with personality disorder but also true with anybody I'd probably try a bit more thinking about how I can help this person in this admission rather than how can I help this person's life overall"- Participant 3
Staff support	"We have that reflective space a chance for them to come and reflect on what's going on the ward at the moment and like their practise what's difficult what's going well"- Participant 9 "Developing training on personality disorder to support kind of nursing colleagues and other non-psychological colleagues to work with this presentation"- Participant 2
Containing a system riddled with complexity and dissonance	
Needing to be held	"There's some difficulties when discussing patients who do have this diagnosis because we do have different opinions, from a psychological perspective we're coming at it with trauma informed and trying to understand that behaviour and think about it from a compassionate lens and then the consultant is more around it's behavioural"- Participant 9 "NHS would probably say it's a lot of staff support including debriefs and whatever and one-to-one work I don't know if they would necessarily identify that I'm there for the most complex situations"- Participant 3 "It's kind of not every day that the team sit down and say, right as the only clinical psychologist in the team, what are your needs and what can we do for you, which is really interesting but yeah I think it is just about being asked that I guess, and having that space"- Participant 12
Holding People and the Team	"There's some unhelpful reciprocal roles playing out in the relationship the boundaries have bled people find it difficult to separate themselves from the people and they can get all overly involved or completely distant"- Participant 7 "Needing to normalise this that they are humans in their own right and if any of us were facing 12 and a half hours potentially like three or four days in a row of being verbally or racially or physically abused by somebody it would be hard for any typical human being to maintain compassion consistently so I think there's a big thing about normalising that"- Participant 11 "I guess it's lot lots and lots of like the work we do with patients with personality disorder is that normalisation and that validation and just having that empathy and I think that's exactly the same with the staff just that understanding"- Participant 12

Holding the System	“I think this this kind of client group I think often gets referred to psychology and then there's a pressure I think the words kind of need intensive psychological support while they're in hospital gets used and that just feels like a lot of pressure”- Participant 10 “The makeup of an acute ward that is by definition you know fast-paced and often pumping people full of meds is the quickest way to get people out but that's not necessarily what's kind of best for that individual”- Participant 5 “Providers are choosing not to offer to people who have risks to self and risks to others”- Participant 11
Shifting the culture around the PD diagnosis	“I don't think that it can be done by psychologists deployed in teams to sort of diffuse the psychological principles”- Participant 3 “I would rather spend an hour with a member of staff who can then go back to work and support 24 people who are on the ward than spend an hour with a patient”- Participant 4 “You try really hard to shift a culture but it's such a slow process say you feel like you have to keep being persisting and present because the moment you go off or you stop selling the formulation you stop being present and then people go back to what they know”- Participant 7

Note. Dialectical Behaviour Therapy (DBT), Personality Disorder (PD).

Delivering Compartmentalised Tasks: “*You have a diverse role*”

Participants described the visible formalised aspects of their role, through listing their tasks and responsibilities when working with people with BPD and the AIMHS team. The role was perceived as diverse and was divided into two aspects, generating two sub-themes: direct work with service users and staff support.

Direct work with service users: “working with complex cases”

Direct work with people with BPD involved psychological assessment, formulation, and individual or group-based interventions. Interventions were mostly driven by the psychological model used within the service care pathway. Some participants used a Cognitive Analytic Therapy (CAT) or Dialectical Behaviour Therapy (DBT) approach, whilst others described interventions focussing on the “here-and-now” (Participant 8), and as being informed by an “assessment-formulation- intervention” (Participant 1) model. Regardless of psychological model, interventions aimed at reducing risk-related behaviour and to “help manage their distress on the ward if they are still presenting with high levels of self-harm” (Participant 2).

Staff support: “training perhaps holding a reflective practice or a case discussion that sits more with the qualified psychologist”

All participants considered offering staff support crucial, particularly when working with people with BPD. Formal ways to support staff included support channels already established by the service or by practice guidelines (e.g., supervision, reflective practice, debriefs). Offering training was perceived almost by all participants as a way of increasing understanding around the BPD presentation. However, such training was experienced as limited and not meeting staff’s needs:

“We'll do a day on personality disorder and hope that you are now all better at doing this stuff and finding that actually that doesn't really work”- Participant 3

Formal spaces as such, were perceived as an invitation for staff to slow down in the fast-paced environment of the acute and attend to their self-care through being aware of their own emotions and responses, which seemed vital in working with people with BPD. Offering supervision to psychology or nursing staff was seen as another way to support staff to “grow” and “develop expertise and experience” (Participant 6). This growth was often seen as two-way, as several participants would use the space to reflect alongside their supervisees. As Participant 4 shared “it is really helpful to also have the kind of back and forth and kind of like reflection on people”.

Containing a system riddled with complexity and dissonance

This theme focussed on the ‘felt’ experience, underlying the more visible or formalised aspect of the role. This was conceptualised through three sub-themes: needing to be held, holding the team and people with BPD, and holding the system.

Needing to be held: “I don’t really have anybody”

Most participants discussed being in a “distant” (Participant 5) and “lonely” (Participant 10) place, away from their non-psychology colleagues, due to holding a different perspective around people’s difficulties. Even though this distance was attributed to a prioritisation of medicalised perspectives, the emphasis on symptoms and responses may suggest that diagnostic overshadowing plays an active role in the sense-making of individual needs. Some participants rationalised this distance, as they saw themselves having the “easy job” (Participant 5) of interacting at a minimum level with people on AIMHS. This, however, felt challenging when trying to influence the culture around people with BPD diagnosis whilst being mindful of the power dynamic between themselves and the MDT.

“I don't respond to incidents I don't remove ligatures I don't need to do CPR if people have significantly harmed themselves so I think that's a big challenge is trying to build rapport with staff to help them understand what might be underlying for that person without that coming across as me coming at it from an expert position which I’m absolutely not”- Participant 8

The MDT’s narratives on participants’ role in relation to people with BPD were discussed with frustration. The MDT was seen as holding unrealistic expectations of Clinical Psychologists, who were considered the “cure” (Participant 7) for people with BPD.

“It would magically change something I could physically sit in a room with somebody do something over two sessions and stop them trying to kill themselves you know like immediately”- Participant 1

Regardless of such narratives, the MDT’s understanding of the role depended on how “psychologically minded” (Participant 7) staff are and were described by a dichotomy between aligning with service users or staff. Again, the concept of “distance” was present. Clinical Psychologists were either “aligned with the service user and not maybe understand what it's like for the rest of the team” (Participant 9) or were team “leaders” (Participant 6) supporting staff in decision-making and offering conversations that other professionals may not. Some participants attributed the misconception of the role to wider NHS Trusts being in their “infancy” (Participant 3) of understanding the Clinical Psychologist role in relation to BPD needs.

Many participants emphasised a need for connection with other professionals, both in psychology provision and the wider MDT, and identified that “you’ve got their backs and they have yours” (Participant 11). For some participants, having good and regular supervision was a space helpful to feel connected and contained, and “talk about being human” (Participant 12). Even though, supervision was considered a protected space to meet their “own emotional needs” (Participant 8), it was also influenced by participants’ level of expertise and seniority. For example, senior Clinical Psychologists (e.g., consultant or lead consultant) become the AIMHS “containing vessel”, but “they don’t have anybody” (Participant 6) to contain them. Equally, being supervised by a senior Clinical Psychologist, was sometimes perceived as a barrier to seeking connection and containment.

“When you're supervised by a kind of less senior psychologist I think they don't have to be the Trust they can just say oh yeah the Trust is shit blah blah blah just as much as you can”- Participant 3

Holding People and the Team: “Trying to be a big pair of arms”

Staff’s unmet needs were highlighted in the context of working with people with BPD. Many participants attributed staff’s difficulties with empathy and negative attitudes towards people with BPD to burnout and compassion fatigue.

Hence, the need to support staff before supporting service users was emphasised and was suggestive of staff needing to feel contained prior to containing others.

"I think the service users may be looking to you to be a secure base as a staff member the staff member they're looking for a secure base and they haven't got one"- Participant 3

Many participants commented on staff responses being split between being dismissive or anxious, particularly following people with BPD engaging in risk related behaviours. Such emotional responses were seen as impacting on people's care as staff would "just get them discharged" (Participant 4), involve as many professionals as possible, or detain them under the MHA.

"There's still a lot of work to do around risk formulation and people that are assessing at the time to be a bit braver probably in not feeling that they have to detain somebody because that person's refusing to safety plan which is what tends to happen"- Participant 6

Participants viewed as part of their role to meet these needs not just through the formal support channels, but also through informal discussions, often described as "difficult to measure" (Participant 6). Many participants saw themselves as "a big pair of arms to hold people" (Participant 3) who validate and normalise staff experiences working with people with BPD, but also give staff permission to feel "human" (Participant 12).

To understand staff needs, many Clinical Psychologists emphasised the importance of being present on the ward to understand the "vibe" (Participant 11) or the "temperature" (Participant 9), and using different psychology-related skills, such as 'noticing'. Many participants shared their 'open door policy' according to which staff can access support whenever they needed ("being like a little island of calm that people can access no matter what is going on the ocean", Participant 3).

Good communication with the ward manager was highlighted, and enabled participants to be aware of the team’s needs, and make these visible across the ward hierarchy.

Holding the System: “feel like I’m just a cushion used by the system”

Participants felt that people with BPD “are failed by the system” (Participant 4) as treatment was impacted by the admission and the AIMHS environment. For many Clinical Psychologists, effective treatment should be in the community “where the person is having to cope” (Participant 11). Length of stay in addition to the unpredictability of discharge were often perceived as a challenge to offering long-term therapy. Simultaneously, there was frustration around the guidelines suggesting short admissions, whilst people waited to be admitted on the ward.

“They might also wait two weeks for a bed (emphasis) and then they come in and we discharge them back out again within 72 hours you know? and so they've waited all that time for a bed and it's just it's not very good for them really”- Participant 6

The admission ‘goal’ was seen as “trying to survive the chaos of the acute” (Participant 7), where alarms go off and people are in distress. Participant 1 felt that “if we could design a service to harm somebody's attachment and sensory needs, we'd build it like an acute ward”. Rooms, whenever available, were not soundproof, making confidential conversations during therapy difficult. To manage this, some participants would attempt to take people off the ward for psychology sessions. However, this was dependent on whether they were detained under the MHA or not.

Some participants mentioned that due to people with BPD being in distress, offering therapy may be difficult as they “just can’t tolerate” (Participant 5) it.

Others spoke about the guidelines and the evidence-based therapies for people with BPD, however, this was accompanied by frustration, as they did not feel able to follow them.

“If you think about more clinically we feel often we don't do enough here isn't it? (laughs) and we only like touch the surface”- Participant 7

Even though most participants conceptualised the BPD diagnosis in the context of trauma, there was no agreement around diagnostic terms or the psychological framework. Participants were divided on language use, as some used the diagnostic language (e.g., ‘EUPD’), whilst others alternative terms (e.g., ‘Complex Emotional Needs’). Despite this, they agreed that they are mostly led by the person’s preferences. Equally, the DBT framework was perceived as useful to understand people’s experiences, whilst others preferred the CAT perspective.

“I don't think we have a shared language for understanding behaviour or understanding what is this thing called personality disorder”- Participant 3

Diagnostic overshadowing was an element of the AIMHS culture as treatment, narratives and ‘right for admission’ were considered in the context of diagnosis. Several participants felt more pulled towards supporting people with BPD than with other mental health diagnoses or difficulties. Yet people’s care was perceived as “more psychologically based than it is kind of psychiatry based” (Participant 11). This increase in psychology referrals for people with BPD added pressure on participants.

“Often it's seen as this person is your responsibility now like this is this person has got a personality disorder diagnosis therefore the psychologist will fix them in that magical way”- Participant 5

Staff narratives were also diagnosis-led, with people with BPD being compared to those with psychosis or schizophrenia. For example, people with BPD were seen as accountable for their behaviour and trying to manipulate their care, whilst people with psychosis were considered unwell, and therefore worthy of acute admission. Alongside this, since hospital admissions are combined with medication, having no medical treatment meant that people with BPD should not be admitted on the ward. Such narratives left Clinical Psychologists feeling demoralised.

“I have always been surprised how unwelcomed this client group is on the wards is like people have very strong reactions and it's like people don't want to help them they want to kick them out of the hospital as soon as possible which is really against our values as people as psychologists”- Participant 7

Many participants spoke about the wider system pressures impacting on their role, staff, and service users. Lack of communication with community teams was a particular challenge to supporting people with BPD post-discharge. Some participants commented on the difference between the two cultures and “how both the inpatient team and the community team might understand and feel about that person's risk” (Participant 8). Others attributed the lack of community support to people’s difficulties, and particularly risk-related behaviours.

This lack of communication, however, challenged the relationship between people with BPD and the AIMHS teams, as collaborative discharge plans are not actioned, and formulation is not considered. This inability to follow the discharge plan was attributed to community teams also lacking the relevant resources and therefore needing containment themselves.

“We've got the inpatient services who promise the world to someone on discharge then we've got police who are doing something different because they don't know any different they're just doing the best that they can with the resources they have

we've got A&E who are frustrated that they're having to stitch up a laceration." – Participant 4

Lack of communication was present within the AIMHS team itself, and particularly lack of consistency in staff responses towards people with BPD. This inconsistency was attributed to the uncertainty around supporting people with BPD and particularly "how much is trauma how much is the personality disorder how much is treatable how much is not treatable" (Participant 7).

Many participants highlighted the lack of funding and described a "real staffing crisis" (Participant 9) in the context of having fewer staff and more people admitted on the ward. As a result, staff have limited physical or mental space for reflections, experience burnout and compassion fatigue, and therefore hold "the right distance" (Participant 9) with people, to manage.

"There is something around the level of activity on the wards and that not being balanced with the resources that we have you know the number of staffing that we have on shift" - Participant 2

NHS policies were commented on as not allowing space for formulation-driven support. Emphasis was given to policies in relation to risk management on the wards, and the impact of not following those.

"So people feel that if they don't follow the policy they're going to be left high and dry and if it goes wrong so that gets in the way of doing usually more therapeutic risk taking"- Participant 3

Many Clinical Psychologists try to help the system cope with its difficulties, through facilitating communication between different parts of the system. Regardless of their efforts, participants described feeling defeated and "demoralised" (Participant 7) as their support to the team would be welcomed but not necessarily implemented. Demoralisation was also present as some Clinical

Psychologists through supporting staff, felt as if they were enabling NHS pressures. As Participant 3 shared “sometimes I feel like I’m just a cushion used by the system to kind of soften the blow of the system”.

Shifting the culture around PD diagnosis

To cope with “demoralisation” (Participant 7), many participants used the visible aspects of their role to influence staff narratives and culture around people with BPD. This was often done through supporting the team by thinking about service users and “trying to change how the team interacts with that person” (Participant 1). Clinical Psychologists saw themselves as advocating for, and contextualising people’s needs, both within the AIMHS team and the wider system, through having a “caring ethos” (Participant 11), ensuring they are involved in their care, and becoming people’s “translators” (Participant 3) in various MDT meetings. Most participants described their work with service users as indirect, where they are “helping the team to help them to cope” (Participant 11). Formulation was seen as a tool to shift staff’s focus from a person’s diagnosis towards their experiences, and a way to encourage holistic reflections about their own practice.

“Teams who are curious reflective pause and think some of the time notice if they're getting stuck and kind of very rigid in different ways”- Participant 1

Offering training was a way to upskill the team, therefore allowing them to feel more confident to respond to people with BPD. This upskilling, in addition to formulation, would often aim at staff “to develop more compassion, understanding around these people” (Participant 7). Some participants felt that their indirect work supported the team on language use through addressing unhelpful narratives around people with BPD.

Increasing psychology resources was considered important for some, whilst others emphasised the need to continuously support the team to internalise psychological thinking or be more ‘psychologically minded’. However, shifting the culture at a ward level was not always seen as enough, as the difficulty around supporting and understanding the needs of people with BPD diagnosis was perceived as being “societal” (Participant 5) and located within the wider system.

Discussion

The study explored Clinical Psychologists’ experiences of their role in AIMHS when working with people with BPD. RTA generated three overarching themes: delivering compartmentalised tasks, containing a system riddled with complexity and dissonance, and shifting the culture around PD diagnosis. These themes could be conceptualised through the iceberg metaphor which presents an ‘observed’ or visible behaviour, driven by non-visible factors or experiences. Clinical Psychologists’ visible aspects of their role were driven by their experiences of containing a complex and dissonant system and the emotional impact of this work. Simultaneously, their ‘formal’ direct work with service users and staff support would make them more aware about the system’s dissonance. Shifting the culture around the BPD diagnosis was seen as participants’ coping strategy against the system’s dissonance and complexity.

Participants’ role was perceived at two levels: direct work with service users with BPD and formal staff support. Direct support was brief, offered either individually or in a group setting, and aimed at providing distress management skills. Assessment and formulation were highlighted and used to inform the nature of individual therapy. Regardless of diagnosis, formulation driven work has been suggested to compliment person-centred care (Ebrahim, 2022). Formal staff support involved supervision, reflective practice groups, debriefs following serious incidents, and re-occurrent case discussions; these support channels were thought to be formal as they are visible, easily documented, and expected from the Clinical Psychologists' role (BPS, 2017).

Being the 'containing vessel' for the different levels of the system underlined Clinical Psychologists' compartmentalised tasks. Containing the team informally, was considered separate from formal staff support, and was described in the context of offering staff a 'secure base'. Regardless of participants' descriptions, in theoretical terms, the data suggests that Clinical Psychologists try to foster psychological safety and act as staff's secure base (Bowlby, 1979). Clinical Psychologists try to be approachable and accessible, whenever staff need support, and enable reflections relevant to clinical practice, and therefore resilience and development. Despite this, participants identified that staff continued to have unmet needs, which were attributed to NHS pressures and lack of resources, and resultingly impacted staff understanding and empathy towards people with BPD. Consistent with previous research (Tane et al., 2022; Troup et al., 2022), BPD specific narratives were described due to burnout and compassion fatigue. Knowing that staff experiences were an outcome of the wider NHS systemic pressures, Clinical Psychologists found themselves in a moral dissonance and conflict around supporting staff to continue coping with such pressures, instead of challenging the wider system.

Despite their role supporting the team, participants felt distant from the MDT. Dandan et al. (2024) in their study exploring the MDT's perceptions of Clinical Psychologists suggested that the MDT considers a referral to psychology based on the person's difficulties, diagnosis, and readiness for therapy. Simultaneously, lack of understanding around the Clinical Psychologist role in AIMHS has been attributed to the prioritisation of medical perspectives, known as the 'medical model' (Ebrahim, 2022). The felt distance that Clinical Psychologists experience can be explained by social identity theory, based on which one's sense of self is influenced by the group that one identifies with (in-group), and the significance attributed to this group in comparison to the out-group (Tajfel et al., 1979). Clinical Psychologists (in-group) described individual needs and treatment being approached predominantly from a medicalised perspective (out-group). Participants highlighted the MDT's expectations of psychology 'fixing' people, and particularly those with BPD. Being pulled into supporting people due to a BPD diagnosis without necessarily considering their formulation resulted in diagnostic overshadowing, common with this diagnosis (Sharda et al., 2021).

The frustration and demoralisation expressed by participants may indicate moral distress (Deschenes et al., 2020). Moral distress refers to the physical and mental healthcare professionals' internal conflict when they are unable to follow what is ethically appropriate due to personal or external factors (Jansen et al., 2022). Participants were aware of the evidence-based support for people with BPD, but did not feel able to implement it due to not having the space, time, or capacity. The nature of the AIMHS environment and admission highlighted this feeling of demoralisation. In the past, AIMHS have been perceived as offering people psychological safety (Adshead, 1998). However, the clinical environment is currently seen as counter-therapeutic considering the lack of social activities for people (Dandan et al., 2024). This is compounded by a lack of confidential spaces appropriate for therapy (Paterson et al., 2019; Wood et al., 2019), and the high levels of noise (Moore et al., 2019). Consistent with previous research, the short and unpredictable nature of the AIMHS admission was seen as a barrier to people's care and offering therapy (Berry et al., 2022).

Participants commented on the lack of a shared language around the BPD diagnosis and the need for a shared and universal understanding. Mental health professionals are considered ambivalent towards the use of the diagnostic terminology of BPD (Donald et al., 2017) and are more inclined to use alternative terms (Sulzer et al., 2016). Clinicians have also been reluctant in using diagnostic language in research interviews when talking about young people (Papadopoullos et al., 2022). The lack of shared language and non-use of diagnostic terms was reflected in participants' responses, as some Clinical Psychologists used the diagnostic language whilst others used alternative terms.

Throughout participants' responses, some antitheses were observed. Clinical Psychologists expressed discomfort following being pulled into supporting people with BPD, yet they emphasised the evidence-base around psychology support. Containing staff was seen as important in the context of working with people with BPD in AIMHS, yet participants felt as if they were enabling system pressures. Similarly, having a shared language around BPD was a highlighted need, yet different terms and theoretical models are used in clinical practice. These inconsistencies may be explained by cognitive dissonance based on which holding two or more conflicting beliefs or perspectives is experienced by discomfort (Festinger, 1962). As with experiences of practicing outside their values and what they considered the evidence base, these antitheses were often shared with a sense of discomfort. Dissonance, however, was not only observed in Clinical Psychologists' experiences as the NHS system and the AIMHS teams, even though they were conceptualised as a people's secure base (Adshead, 1998), their policies were perceived as enabling restrictive practices.

The final theme referred to the importance of shifting the culture around BPD diagnosis through supporting the team in understanding people's difficulties. This may have represented Clinical Psychologists' attempts to re-connect with their values and manage feelings of moral distress and dissonance. Formulation was highlighted as a way of shifting the team's focus from diagnosis towards individual needs and increasing compassion. Indeed, formulation can be used instead of diagnosis (Johnstone, 2018), challenge the stigma around mental health diagnoses (Carey & Pilgrim, 2010) and increase an understanding of people's distress (Carey & Pilgrim, 2010; Short et al., 2019). A lack of knowledge around the BPD diagnosis can lead to more negative narratives than for other mental health diagnoses (McKenzie et al., 2022). By contrast, developing an understanding of people's experiences has been suggested to increase compassion amongst AIMHS staff (Tane et al., 2022). Alongside the use of formulation, participants highlighted the role of offering information around the BPD diagnosis, through training but also through their attendance in MDT meetings, and informal conversations with staff.

Consistent with previous research (Ebrahim, 2022), to achieve such a cultural change, participants advocated for additional psychology resources in AIMHS. The present study suggests such changes may require a policy-level approach. Even though narratives around people with BPD have been perceived as improving (Day et al., 2018), mental health staff, regardless of type of service, tend to hold negative attitudes (McKenzie et al., 2022). Such responses are also expressed by physical health staff in general hospitals (Baker & Beazley, 2022), whilst the public tends to consider people with BPD as having an active role in their difficulties (Ociskova et al., 2023). Regardless of context, both professionals and public tend to distance themselves from people with BPD (Ociskova et al., 2023; Troup et al., 2022) leading to a maintenance of stigma and further feelings of rejection.

Implications

Even though staff burnout and compassion fatigue are not the only factors impacting on people diagnosed with BPD, they can be a barrier to understanding their needs. Wood et al. (2025) introduced a care framework for AIMHS emphasising the importance of compassionate care. For its implementation, organisational pressures and their impact on staff's wellbeing should be explored in depth. This study suggests that apart from their visible and well-documented workload, the Clinical Psychologist role lies within the informal support and containment of the AIMHS team. Additional psychology resources may support with further implementation of the NICE guidelines (2015) around supporting the system, formally and informally and with offering containment to Clinical Psychologists themselves.

A persistent narrative around people with BPD is that of the 'revolving door' patient due to increased re-admission rates into AIMHS (Barbosa & Marques, 2023). This term has been described as stigmatising as it situates the 'problem' within people instead of the system (Beresford & Wallcraft, 1997). An emphasis was placed on inpatient care focussing on admission, and the lack of communication with community teams, crucial to transition of care post-discharge. Even though staff roles specific to discharge have been suggested to improve transition in the community, there has not been an agreement in discharge specific interventions (Tyler et al., 2019). Hence, it would be useful to explore the possibility of developing a discharge intervention, focussing on the complexity of the NHS system.

Limitations

The current study lacked diversity, due to participants identifying, at their majority, as white-British and female. However, this reflects the current workforce, as most Clinical Psychologists identify as white and female (Health & Care Professions Council, 2021). Furthermore, all participants were self-selected. Considering the impact of organisational pressures on participants' experiences, such experiences may not be shared by Clinical Psychologists working in well-resourced NHS Trusts. Some participants raised the difficulty of attributing some of their experiences to the wider NHS system, or to the narratives around people with BPD and their care. However, this may reflect the 'complexity' of understanding people's needs nestled within the complexity and the challenges of the NHS system itself. Finally, even though the researcher followed Yardley's (2000) principles for qualitative research, kept a reflective diary, and stayed grounded in participants' data, the data interpretation may vary depending on the researcher's lens.

Conclusion and Recommendations for Future Research

The debate on diagnosis was evident throughout the study and included a lot of antitheses. Future research should explore the meaning of diagnosis amongst Clinical Psychologists, whilst being aware that they may not be immune to stigmatising narratives. The current study emphasised Clinical Psychologists' frustration as an outcome of moral distress and cognitive dissonance. Such experiences seem to be well-documented amongst physical health professionals but overlooked in mental health. Considering the debate and stigma on the diagnosis, it would be helpful to explore Clinical Psychologists' experiences of moral distress specifically in relation to working with people with BPD.

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Chapter 5

Extended Methodology

***Where appropriate, material from the Thesis Proposal assignment of the UEA DClinPsy has been used throughout this chapter.**

Extended Methodology

The present chapter includes information in relation to the methodology of the systematic review and meta-analysis and methodology and ethical considerations of the empirical study that due to strict word counts were unable to be included in the empirical paper. The lead researcher’s philosophical position and reflexivity in relation to the empirical study are also discussed.

Systematic Review and Meta-analysis

The systematic review and meta-analysis were conducted based on the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidance (Moher et al., 2009). The PRISMA checklist is presented on Appendix B.

Search Strategy

Searches were conducted on five databases: PsycINFO, MEDLINE, CINAHL, EMBASE, and Web of Science. The search terms included synonyms and alternative terms for “mental health professionals” (population), “NHS” (context) and “burnout” (outcome). The full search strategy is presented on Appendix C. Search restrictions in relation to year of publication were added, as per O’Connor et al. (2018). The possibility of having no year restrictions was considered, however as the review questions were in relation to the NHS, which continuously evolves, it was not considered appropriate.

Quality Appraisal

The quality assessment was conducted independently by two reviewers using the Critical Appraisal Skills Programme (CASP) Quality Appraisal tool for Cross-sectional studies (CASP, 2024). The CASP tool consists of 11 questions that explore the validity and reliability of the methodology, results, and the applicability of the study. Each question can be answered as ‘Yes’, ‘No’, or ‘Can’t tell’, depending on the information presented in the study. In case around 2/3 of the questions are not answered with ‘Yes’, then the study quality may be considered poor (CASP, 2024).

Narrative Synthesis

The narrative synthesis was conducted based on Popay et al. (2006). Initially, key information of each study was extracted and summarised on a table. Such information involved the authors and year of publication, sample characteristics, aims of the study, key measures, and key findings. Further data in relation to risk factors of burnout were extracted and summarised on a separate table. This allowed the authors to present the data as reported in the original studies, irrespectively of statistical significance. Risk factors related information, as presented on the summary table and the original papers was reviewed several times, until common themes were identified (Popay et al., 2006).

Empirical Study

Recruitment Process

Participants were recruited through purposive sampling and snowballing. Following internal university (Appendix D) and Health Research Authority ethical approval (Appendix E), a mental health NHS Trust in England circulated the study poster (Appendix F) to potential participants, through existing email lists. Potential participants were encouraged to contact the lead researcher (ADS) to express their interest if they wished to participate. Ethical approval allowed ADS to encourage potential participants to circulate the study poster to other professionals who meet the study inclusion criteria and may be interested in taking part, leading to a snowball effect. All potential participants were asked to email the primary researcher (ADS) to express their interest in taking part in the study, and confirm that they meet the study inclusion criteria. Where participants used a non-NHS email address, ADS asked them to confirm that they met the study inclusion criteria to minimise scenarios where they provided their time but were ultimately ineligible to participate in the study. Overall, one participant used a non-NHS email, however they confirmed they met the study inclusion criteria, and therefore were included in the study.

Ethical Considerations

Informed Consent

After participants confirmed they met the study inclusion criteria, ADS emailed them with the Participant Information Sheet (PIS; Appendix G), which detailed the study aims and the risks and benefits to taking part. At this stage ADS offered to meet with potential participants to answer any outstanding questions about the study and the interview process; no participants asked to meet in advance of their interviews. Forty- eight hours following sharing the PIS, the researcher shared the study Consent Form (Appendix H) and offered possible time slots for the interview. Participants who agreed to take part in the study were asked to sign and return the consent form, at any point prior to their interview. All participants returned the signed consent form prior to the interview. Consent to participate and record the interview for the transcription phase were revisited verbally at the beginning of each interview. No participants who consented to participate changed their mind when this was revisited.

Anonymity and Confidentiality

Data was stored according to the General Protection Regulation Act (2018) and the UEA Research Data Management Policy (2019). ADS transcribed the interviews using Microsoft Teams. During this phase, participants’ identifiable information (e.g., participants’ names, NHS Trust names, etc.) was removed to protect participants’ confidentiality. Participants were aware that confidentiality would only be broken in instances where they implied harm to others or other people’s care; in this case, ADS had the duty of care to inform the participant’s NHS Trust safeguarding team. Each participant was made aware of this through the PIS and was reminded by ADS at the beginning of their interview. No such scenarios arose during the interviews. Participants’ anonymised research data was stored electronically on the UEA OneDrive. Only ADS and the project supervisors (CH, AL) had access to the research data. Participants’ personal information (e.g., consent forms, recruitment log) were also stored electronically on the UEA OneDrive. Files containing participants’ identifiable information were password-protected and stored in separate folders from the research data to prevent the risk of de-anonymisation. Only ADS had access to this password.

Minimisation of Participants’ Risk of Harm

Inpatient mental health services have been previously described as a challenging environment to work in due to the increased level of people’s distress and the staff pressures (Ebrahim, 2022). As the study explored Clinical Psychologists’ experiences of their role, there was a possibility of participants referring to difficult experiences in their workplace. ADS was attentive to participants’ well-being throughout the interviews. All participants were offered the NHS Support Line (111) before their interviews in case they would like to seek further support. As specified in the approved protocol, participants were asked to comment on their role as part of a multidisciplinary team (MDT), thus there was a possibility of them referring to team dynamics. At the beginning of the interview, participants were reminded of the study aims, their confidentiality, as well as of their right to stop, pause, withdraw, or not respond to a question should they wished to. At the end of each interview, ADS explored the impact of the interview questions on participants. No participants expressed experiences of distress associated with their interview and the interview questions. In case participants experienced distress, ADS reminded them that they could contact the NHS Support Line or share work-related difficulties within their supervision.

Researcher's Safety

All interviews were conducted by ADS. In consideration of the researcher's safety, all interviews took place online via Microsoft Teams. The research supervisors were aware of the time of the interviews and were available to check-in with ADS in case this was needed. As participants were qualified Clinical Psychologists and ADS a trainee Clinical Psychologist, there was a possibility of both participants and ADS experiencing a power imbalance during the interviews. ADS used research supervision and reflexive diary to reflect on these issues. Reflections on power dynamics during the interviews are discussed later on the chapter.

Patient and Public Involvement (PPI) and the Stakeholder's Group

The study included PPI and a Stakeholders input. The Guidance for Reporting Involvement of Patients and the Public (GRIPP2; Staniszewska et al., 2017) was used to report the outcome of the PPI and Stakeholder members.

Aim of PPI and stakeholder input

A person with a diagnosis of BPD and previous experience of admission in Adult Acute Inpatient Mental Health Service (AIMHS) and a Clinical Psychologist with previous experience of working in AIMHS were invited to offer their feedback on the interview schedule (Appendix I). It was hoped that by involving both people with lived and clinical experience will encourage transparency and ensure the study outputs are relevant to those who work in and use mental healthcare services (Greenhalgh et al., 2019).

Methods

ADS shared the interview schedule with the PPI member and the stakeholder separately, to allow space and time for them to familiarise themselves. Following this, ADS met with each member separately and gained their feedback.

Study Results

The PPI Member. During the feedback session, the PPI member and ADS revisited the interview schedule. Discussion was held around the language and use of the diagnostic terms (e.g., BPD, 'Emotionally Unstable Personality Disorder') throughout the questions. Further questions were added to capture a lived experience perspective of inpatient admission; such questions included Clinical Psychologists' role in relation to treatment (e.g., 'what is the main focus of your interventions with people with PD on the ward?').

The Stakeholder. During the feedback session, the interview schedule was trialled with the stakeholder, which helped with understanding whether the different aspects of the role were considered. As a result, some follow-up questions were added allowing space for reflections (e.g., 'What are your needs as a Clinical Psychologist to support your work with people with PD in the service? (prompt: cultural, materialistic, emotional factors)').

Discussion and Conclusion

Both stakeholders offered their reflections on the interview questions and explored whether these covered the different aspects of Clinical Psychologists' role, as well as the service users' experience of treatment within the AIMHS environment. At the end of the analysis process, the results were disseminated with the stakeholder to explore whether these resonated with their experiences and to allow space for their reflections of the role. This discussion did not impact on the analysis and interpretation of the results.

Reflections and Critical Perspectives

The fast-paced environment of the AIMHS was evident within both stakeholder discussions. The ongoing debate of the use of 'Personality Disorder' as a diagnostic term was named and allowed space to shape the interview schedule. To remain curious on participants' understanding of the diagnostic terms, and ensure openness, the terms BPD and PD- Borderline pattern were used at the beginning of the interviews, followed by an exploration of participants' preferred terms (e.g., 'How do you understand this term?', 'is there a term you prefer using?'). Involving both stakeholders was particularly helpful in ensuring people's experiences are captured. A limitation of the stakeholders' input was that, due to time constraints, the recruitment of wider input, which would have allowed for more people's experiences to shape the project, was not possible.

Transparency and Quality in Qualitative Research

To ensure the study's quality and rigour, Yardley's (2000) qualities of qualitative research were used throughout the research process.

Sensitivity to Context. All interviews took place online via Microsoft Teams, allowing for Clinical Psychologists in England, regardless of area, to participate. ADS offered flexible interview slots to support participation in interviews. The interview schedule was used as a guide, and questions were asked empathically and in a conversational way; this helped with building rapport with participants and offered space for reflections.

Commitment and Rigour. Participants' demographic characteristics were gained to support with contextualising the data (Braun & Clarke, 2021); however, to ensure their confidentiality, such information was captured at a minimum level. The researcher's commitment with the research topic was demonstrated through their active engagement with the data analysis process (e.g., revisiting the recordings, transcripts).

Transparency and Coherence. Following study completion, all 12 participants were offered a copy of the results, following having consented to be contacted for this purpose. A reflexive diary was kept throughout the data collection and the analysis, for ADS to reflect on her position in relation to participants' role and experiences. This is discussed further in the chapter, and in the critical discussion chapter. Research supervision was used as an additional reflective space during the data collection and analysis process. Finally, the results were discussed with the stakeholders to explore whether they resonated with their experience; however, upon stakeholder's feedback, no changes were made in the analysis.

Impact and Importance. As an outcome, additional knowledge on the Clinical Psychologists' role in AIMHS has been developed, and particularly on the 'felt sense' of the role when working with people with BPD. Findings offer considerations on the support that the Clinical Psychologist role may need, as well as recommendations from the findings to support the care of people with BPD or similar difficulties within the AIMHS environment.

Philosophical Underpinnings

Ontological perspectives support consideration of whether or how reality exists outside a researcher's understanding and practice while epistemology concerns the acquisition or generation of knowledge (Braun & Clarke, 2013). Both ontology and epistemology exist in a continuum. The ontological continuum contemplates the nature of reality and how we can access it. On the one pole there is 'realism' viewing reality as an objective truth accessible through research, whilst on the other is 'relativism' viewing reality as dependent on our understanding

(Braun & Clarke, 2013). Critical realism is a philosophical stance that reality exists outside of our knowledge and understanding of it but can only be understood through our construction of what we observe (Bhaskar, 2008). Epistemology is viewed on the continuum between 'positivism', where knowledge can be accessed through reliable scientific methods, and 'constructionism', where knowledge depends on specific contexts (e.g., cultural, social, etc.) (Braun & Clarke, 2013; Chamberlain, 2015; Madill et al., 2000).

The empirical study was designed and conducted through the lens of critical realism, which considers both epistemology and ontology (Fletcher, 2017). From the critical realist position, research aims at understanding how people make sense of their experience in a certain context, and how this context can impact on their understanding (Sayer, 2010). Being a trainee Clinical Psychologist and having clinical experience in NHS teams where treatment was diagnosis-led, I noticed that I had an active role as a researcher throughout the study. The critical realist position allowed me to consider my own perceptions and how these impacted on the analysis. Hence, Clinical Psychologists' experiences were understood and interpreted through the lens of the researcher's experience as well as the influence that the NHS and the AIMHS context and relevant policies have on their role when interacting with people with BPD, the AIMHS team, and the wider NHS organisation.

Reflexive Thematic Analysis

Thematic Analysis (TA) is a qualitative research method which supports researchers to identify, analyse, and report themes in a dataset (Braun & Clarke, 2006), whilst considering the different aspects of the research question (Boyatzis, 1998). TA has a number of advantages, which include being a 'flexible' method not bound to a specific theoretical framework, and emphasising participants' shared or different experiences (Braun & Clarke, 2006). Within TA, there are different types based on the theoretical framework: 'coding reliability TA', 'codebook TA' and 'reflexive TA' (Braun & Clarke, 2021). Coding reliability TA sits within the neopositivist epistemology and includes multiple coders aiming at ensuring inter-rater reliability. Codebook TA uses various qualitative methods, and themes are developed at early stages in the analysis. Reflexive TA (rTA) considers the researcher's subjective perspective and therefore multiple coders are not needed to ensure quality. Data analysis is grounded in the data (inductive) and in the theory (deductive) and is viewed through the researcher's interpretation (Braun & Clarke, 2021).

The empirical study employed a rTA framework for the analysis acknowledging that the researcher plays an active role in the analysis and interpretation of the data (Braun & Clarke, 2006). The theoretical flexibility of rTA allowed me to hold a critical realist position as the researcher, and consider my interpretation of participants' responses, as viewed through my perceptions, experiences, and interactions with participants. A reflexive journal was kept throughout the study to aid transparency and to offer space to 'press pause' and reflect on my own position and beliefs in relation to the research questions (Nadin & Cassell, 2006). This is discussed and reflected on further in the extended discussion chapter.

Reflexivity

Reflexivity refers to the process of continuous evaluation and questioning of the researcher's own perspectives and values, and the recognition that these may impact on the research process and outcome (Berger, 2013). Whilst engaging with reflexive analysis, the researcher actively considers their personal experiences and characteristics (e.g., age, gender, values, beliefs, etc.) as well as emotional responses to participants (Finlay, 2000). Such experiences and perspectives can impact the relationship between interviewer and interviewee and the level of information that the interviewee choses to share, and act as the researcher’s lenses used to make sense of participants’ responses (Berger, 2013). To ensure transparency, in the section below, I will be discussing my position towards the research topic, the participants, and the research journey, as the lead researcher. Such reflections are made through my lenses as a 32-year-old Greek, female trainee Clinical Psychologist.

Positioning in Relation to the Research Topic

Before starting the doctorate, I worked in various CAMHS and specialist NHS services across the UK. One of my roles was a Research Assistant in an NHS research project aiming at shaping the discharge process from AIMHS into the community. Throughout the review of the literature and conversations within the research team, I noticed that staff pressures, lack of communication and gaps between services were impacting on service users’ experiences of admission and discharge. Simultaneously, the Clinical Psychologist role was questioned, particularly at times when frontline staff were pressured. This led to an internal conflict as, even though my experience to that point had taught me that Clinical Psychologists contain teams, the role was presented as distant. This conflict triggered my curiosity not only on the nature of the role, but also on the experience of the role in a system where both service users and staff may carry distress.

The doctorate gave me the opportunity to expand on this curiosity, through exploring the experience of the role in relation to working with people BPD, as this diagnosis has been debated extensively with some suggesting its abandonment (Lewis & Appleby, 1988), whilst others replace the term or avoid using it (e.g., Papadopoullos et al., 2022; Troup et al., 2022). Through my clinical experience, I noticed diagnosis-led narratives being re-enacted. For example, the term 'EUPD' was sometimes used as the underlying reason of a ruptured therapeutic relationship, whilst there was an avoidance of naming the diagnosis with service users, but also within team meetings. The BPD or 'EUPD' diagnosis often appeared on service users' clinical letters without evidence of an assessment. Furthermore, I was raised in Greece where I was exposed to dominant stigmatising narratives linked with mental health diagnosis (Porfyri et al., 2022; Tzouvara et al., 2016). For example, there were times when the use of the word 'madness' in relation to people with a mental health diagnosis was prevalent among people regardless of age. Simultaneously, a learning difficulty diagnosis would sometimes be sought as a way to access support for a young person in their learning journey, when perhaps this was not needed. Such experiences made me critical towards the use of mental health diagnoses but also increased my curiosity around what may underlie such narratives. Whilst having a critical stance towards diagnosis, I do not hold an anti-diagnosis position due to acknowledging that people may find this helpful in understanding their difficulties. Discussing the use of diagnostic terminology with the PPI group helped in remaining curious about service user perspectives. Such discussions also highlighted that the perspectives and experiences that would be shared in the study were from clinicians, and therefore they may not represent service users.

Positioning in Relation to Participants

An insider researcher tends to share key characteristics with the participants whilst an outsider researcher does not (Braun & Clarke, 2022). My position throughout the study was moving between an insider and an outsider researcher. My demographic characteristics were, at times, the reason for such a movement as almost all participants identified as 'White-British', and most of them as females, leading to reflections on diversity in the Clinical Psychology profession. Participants were qualified Clinical Psychologists, most of whom shared the same professional background prior to the doctorate as me (e.g., Assistant Psychologist). At the end of the interviews, participants would often wish me the best for my research thesis and briefly mention their own experiences of training. Participants were qualified Clinical Psychologists working in adult AIMHS, an environment I have not experienced in my professional role. This moved my position from an insider to an outsider researcher. Considering my position as a trainee and participants’ position as qualified Clinical Psychologists, particular thought was given in relation to the power dynamics during interviews. For example, this sense of power felt more evident when participants queried about my experience in the AIMHS environment and knowledge of the Mental Health Act. Keeping a reflexive diary supported me in thinking about this experience in depth, as well as the impact that participants’ experiences in their roles may have on my future career aspirations.

The Reflexive Analysis Journey

All interviews were recorded and transcribed on Microsoft Teams. Following each interview, participants’ identifiable information was removed to ensure confidentiality. The interview recording and the transcript were revisited to ensure the accurate representation of the interaction with participants (Braun & Clarke, 2006). All interviews were transcribed verbatim, and punctuation was removed whenever necessary to ensure the meaning of participants’ responses was not altered. Participants’ non-verbal cues (e.g., pausing, laughing, signing ‘quotes’ with hands) were also noted to capture the key features of the interaction. To support further with familiarisation, the recording was revisited and initial thoughts and reflections on participants’ experiences and responses were noted down (Table 5.1).

Initial reflections following the interviews were around participants’ responses to questions, as well as the experience of power dynamics during interviews. However, as the interviews progressed, I noticed that my reflections on participants’ qualified and seniority status, started being related to the data itself. For example, I started becoming aware that more senior Clinical Psychologists would often reflect on the impact of the wider system, whilst more newly qualified psychologists would reflect at their team’s level. Simultaneously, more senior psychologists would be more likely to use diagnostic terms, whilst more recently qualified psychologists would tend to use alternative terminology. Such reflections were shared in research supervision and supported in the conceptualisation of the analytical themes.

Table 5.1

Reflective diary extracts from interviews and familiarisation with the data.

Participant	Reflection
Participant 1	It was very interesting but also frustrating to see how even though there are guidelines around supporting people, these are not always implemented; this made me wonder about the development of guidelines themselves, and whether there is thought into the “how to” question when it comes to their implementation. Do the guidelines themselves add on the system pressures? is this an experience of moral injury? A main theme is the expectations for different parts of the system: an expectation for people with ‘EUPD ‘not to self-harm or attempt to end their life, an expectation for the team to feel compassionate at all times regardless of incidents, an expectation for the psychologist to “magically fix” people, an expectation of the ward to keep people safe. However, what is striking is that all these expectations are unrealistic and add pressure. It all feels like a “dance of expectations”, with steps impossible to follow or learn!
Participant 3	The participant reflected in depth about the wider system and the need of parts of the system to be “held” throughout the interview. Their role feels more like being a “cushion” or an “island” for staff in sense that they contain staff. However, this posed an ethical question- is it ok to contain staff in a system that does not work? Are we containing staff for themselves or for the system? If it’s the latter, is this ethical? I found this particularly powerful; within my roles in different services, I have highlighted (through words and actions) the importance of supporting staff. But I noticed that the teams and myself never acknowledged the role of the wider system in this. Is the system the "elephant in the room” when it comes to our motivation in preventing burnout? But what or who is “the system”?
Participant 6	The participant kept referring to younger service users and professionals trying to explore whether they meet the criteria for an EUPD* diagnosis and shared their frustration for services having “failed” young people. I found myself sharing this frustration. I kept thinking of my own experience working in a similar service before the doctorate and how younger people lack support due to the system. A lot of questions popped-up in my head- is being distressed and using risk behaviours to manage described by using the diagnostic label of “EUPD”? Are we pathologising young people’s distress?
Participant 11	The participant felt distant; throughout their interview they named some difficulties but spent more time celebrating the achievements. Words of previous participants around senior psychologists “advocating” for the system kept popping up in my mind. Was the participant “advocating” for the system? Or was there my strong “pull” towards wanting to hear the “problem”?

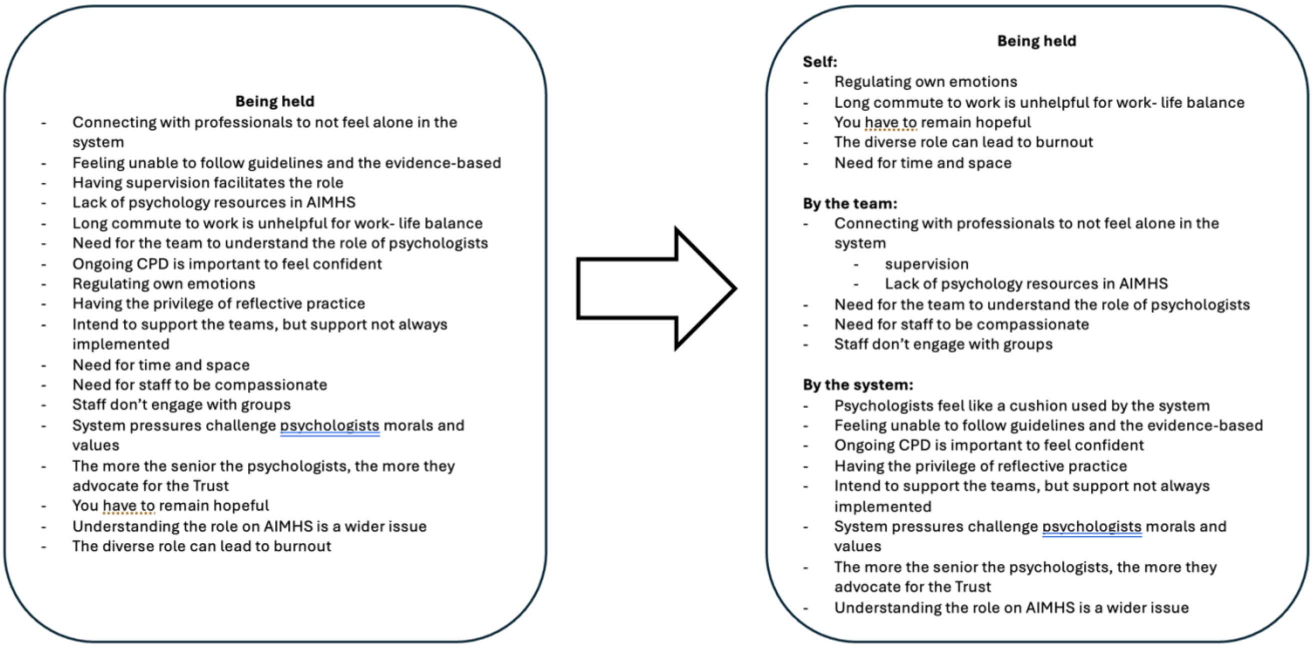
Note. Even though the term ‘BPD’ is used throughout the portfolio, participants’ preferred terminology (e.g., ‘EUPD’) was used in the reflexive diary.

Coding was semantic and took an inductive approach, during which codes were grounded in the data (Braun & Clarke, 2021). To support with this, whenever possible, participants’ exact words were used on the code names, whilst research questions were not considered at this stage. NVivo software was used to support the coding and initial clustering of the codes. Once the initial coding process was complete, the codes were revisited, and information under identical codes were combined. Then, codes were clustered together based on their underlying meaning, taking a latent approach (Braun & Clarke, 2021) and allowing for initial descriptive themes to be generated. At this stage, codes that did not relate to the research questions were discarded. Acknowledging that participants’ experiences were in the context of the different layers of the AIMHS and wider NHS system, the initial descriptive themes were organised at different levels (e.g., personal level, person with BPD, AIMHS team, wider organisation) (Figure 5.1).

Codes were printed to allow for the reviewing and refining of the themes (Figure 5.2). Themes and code groups were continuously revisited and shaped throughout the analysis process, and particularly following the reviewing of the themes (Braun & Clarke, 2006). Reflective conversations during research supervision allowed space for further reviewing of the themes, and the conceptualisation of analytical themes. Questions such as ‘what story does this theme tell?’ (Braun & Clarke, 2021; p.36) and the themes’ link to the research questions were also discussed to ensure each theme is relevant and clearly defined. At this stage I found myself feeling pulled by the meaning of the PD diagnosis and the relevant debate, as well as the link between diagnostic overshadowing and Clinical Psychologists’ experiences. Using research supervision reflectively helped name this pull explicitly and offered space for a deeper exploration and refinement of the themes.

Figure 5.1

Reviewing of the themes to understand participants' experiences at different system's levels



Being held

- Connecting with professionals to not feel alone in the system
- Feeling unable to follow guidelines and the evidence-based
- Having supervision facilitates the role
- Lack of psychology resources in AIMHS
- Long commute to work is unhelpful for work- life balance
- Need for the team to understand the role of psychologists
- Ongoing CPD is important to feel confident
- Regulating own emotions
- Having the privilege of reflective practice
- Intend to support the teams, but support not always implemented
- Need for time and space
- Need for staff to be compassionate
- Staff don't engage with groups
- System pressures challenge psychologists morals and values
- The more the senior the psychologists, the more they advocate for the Trust
- You have to remain hopeful
- Understanding the role on AIMHS is a wider issue
- The diverse role can lead to burnout

Being held

Self:

- Regulating own emotions
- Long commute to work is unhelpful for work- life balance
- You have to remain hopeful
- The diverse role can lead to burnout
- Need for time and space

By the team:

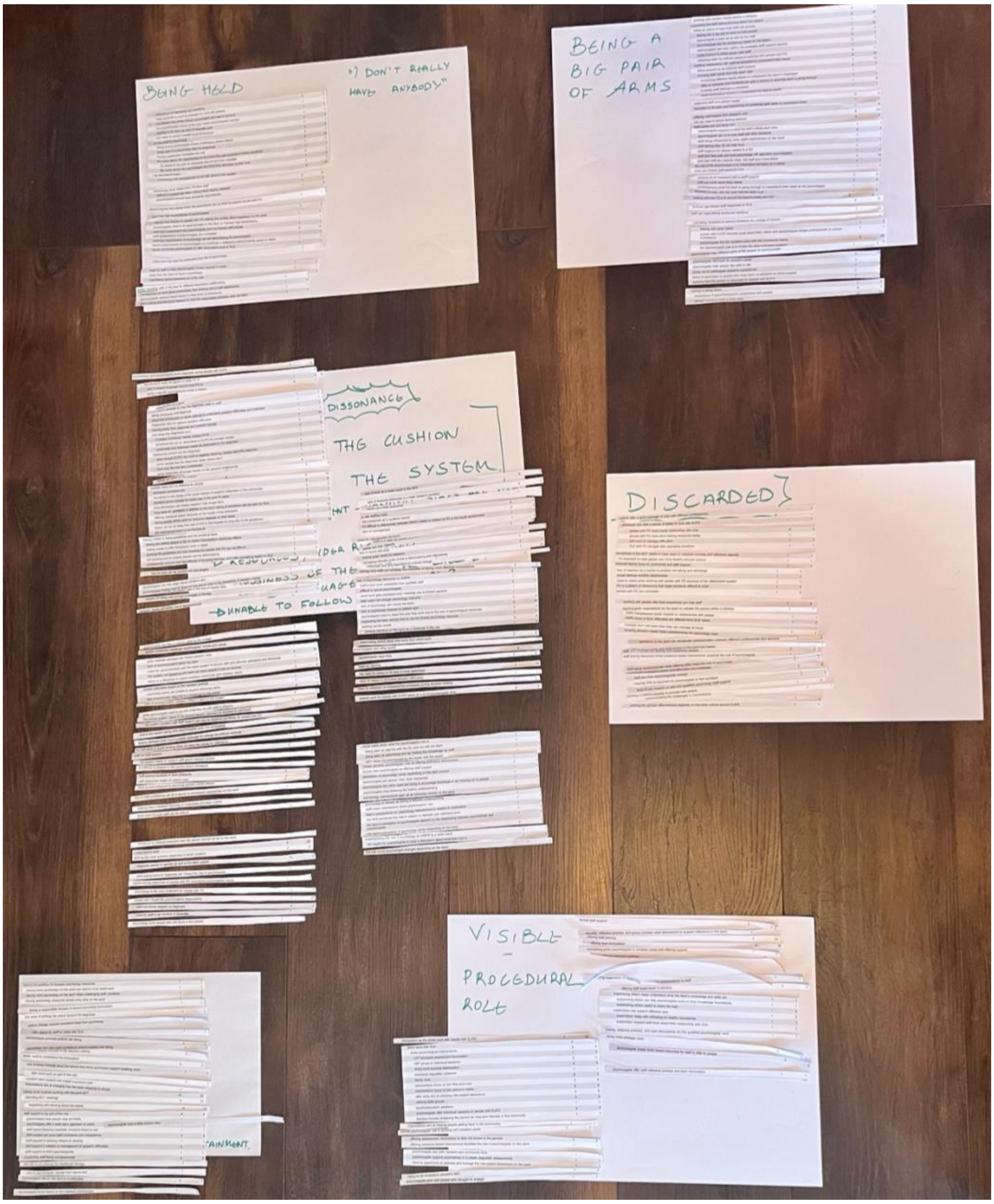
- Connecting with professionals to not feel alone in the system
    - supervision
    - Lack of psychology resources in AIMHS
- Need for the team to understand the role of psychologists
- Need for staff to be compassionate
- Staff don't engage with groups

By the system:

- Psychologists feel like a cushion used by the system
- Feeling unable to follow guidelines and the evidence-based
- Ongoing CPD is important to feel confident
- Having the privilege of reflective practice
- Intend to support the teams, but support not always implemented
- System pressures challenge psychologists morals and values
- The more the senior the psychologists, the more they advocate for the Trust
- Understanding the role on AIMHS is a wider issue

Figure 5.2

Printed codes to allow the generation, reviewing, and refinement of themes



Chapter 6

Discussion and Critical Evaluation

Discussion and Critical Evaluation

This chapter offers an overall discussion and critical evaluation of the thesis portfolio. Findings from the empirical project and the systematic review and meta-analysis are summarised and discussed, alongside strengths and limitations. Suggestions for future research and clinical implications are also presented. Towards the end of the chapter, the author presents their reflections on the research journey.

Summary of the Findings

The Systematic Review and Meta-analysis

The systematic review and meta-analysis highlighted that burnout, and particularly emotional exhaustion, are prevalent for mental health professionals in the NHS. Despite the high heterogeneity, considering the different nature of the services, participants' professional background, and measures used to explore burnout, it provided further evidence of mental health professionals' experiences of burnout. Risk factors were considered at individual and organisational levels. Being younger and male was associated with higher levels of emotional exhaustion and depersonalisation, whilst mental health nurses, followed by social workers, were the professional groups that experienced the highest levels of burnout (Delgadillo et al., 2018; Johnson et al., 2012). However, mental health nurses were represented in 86.7% of the studies, leaving other professions under-represented and therefore conclusions here were tentative. Factors that have been previously commented on, such as NHS pressures, including increased workload and lack of available resources, were associated with higher levels of burnout. Feeling supported, part of a community, and receiving supervision supported staff wellbeing. The importance of fostering a supportive environment and a team culture which allows space for staff to seek support were emphasised. The review also highlighted a possible lack of relevant research into burnout in NHS mental health provision post-Covid.

The Empirical Project

When exploring Clinical Psychologist’s experiences of their role in acute inpatient services, particularly when working with people with BPD, three main themes were identified: (a) delivering compartmentalised tasks, (b) containing a system riddled with complexity and dissonance, and (c) shifting the culture around providing services for people with BPD diagnoses. Clinical Psychologists’ everyday tasks and responsibilities relating to this client group were dominated by feelings of dissonance and moral distress. To cope with this, Clinical Psychologists found it important to shift the culture around BPD and Personality Disorder diagnosis more generally.

Clinical Psychologists acknowledged their awareness of the evidence-base around BPD care, however struggled to put this into clinical practice. At the same time, the acute wards were described as counter-therapeutic and triggering of service users’ difficulties. Apart from containing service users with BPD diagnosis, Clinical Psychologists reported attempting to contain other staff members in terms of managing the emotional impact of this complex work in acute inpatient environments. This was considered an essential, but not a formalised, component of the psychologist’s role. However, the participants described that this did not feel an easy task, as staff difficulties were also attributed to wider NHS pressures, over which Clinical Psychologists had no control. Simultaneously, the medicalised perspectives of the acute environment in addition to the narratives around support offered to people with BPD led to a culture of emotionally distancing, othering, and an ‘us and them’ attitude towards service users with BPD in the wider multi-disciplinary team.

Issues relating to diagnostic BPD labelling were evident across the three themes, and particularly related to expressions of dissonance. Even though Clinical Psychologists agreed that there is a need to define BPD, and use a common language, there was no agreement on the term. Equally, even though Clinical Psychologists identified that the evidence-base for service users with BPD lies mainly within psychology provision, there was frustration around increased psychology referrals and the need to challenge narratives around psychology being the panacea for BPD treatment. Clinical implications are discussed at an individual, interpersonal, and wider organisational level. Future research highlights the importance of further exploring Clinical Psychologists' and mental health professionals' experiences and management of moral distress in their role.

Overall Discussion

Bronfenbrenner (1977) introduced the social ecological theory, according to which the person's development is influenced by the experiences of different systems surrounding the person, and the interaction between them. Systems are portrayed at four levels: (a) the microsystem, consisted of the person's immediate interactions such as family members, peers, and mental health and physical healthcare services, (b) the mesosystem which refers to the impact of the microsystem on the person, (c) the exosystem consisted of factors that indirectly impact the person, such as wider healthcare organisations and broader politics, and (d) the macrosystem which is the wider environmental context where the person and the other systems exist and includes the wider community values, culture, and law. An important element in the social ecological theory is that the different levels of the social ecological system interact with each other, and such interactions have an impact on the person (Eriksson et al., 2018). The overall thesis portfolio suggests that when one component of the social ecological system is not contained, its distress ‘spills over’ the other components. A specific emphasis is given on the mental health professionals’ needs, including Clinical Psychologists, and the importance of “helping the helper” (Moody et al., 2013; p.275), a phrase that has been previously used in the literature when referring to professionals in caring roles. Mental health professionals were described by both the systematic review and the empirical study as experiencing burnout and compassion fatigue due to wider organisational pressures. This became more evident during the empirical study where Clinical Psychologists commented on the pressures of community services impacting on inpatient staff and consequently on people’s care. For example, Clinical Psychologists spoke about community mental health services struggling with long waiting lists and lack of resources, and therefore having no space to liaise with inpatient staff and support with the discharge planning process. As a result, inpatient staff would often develop discharge plans which were not always implemented in the community.

As stated above, the impacts of interaction between different parts of the wider system are highlighted. Bertalanffy (1968) introduced the general system’s theory which explores the interaction and relationship of the different parts of a system in detail. Drawing from Aristotle’s Metaphysics where “the whole is greater than the sum of its parts”, the general system’s theory considers individuals as one component, and the inter-relationships between them as another (Bertalanffy, 1972). Therefore, emphasis is given to the system’s characteristics being attributed to the interaction of its components, as opposed to the individual characteristics of each component separately (Drack, 2015). The wider system can be described as an organism characterised by its parts and the relationship between its parts: people with BPD, mental health professionals including Clinical Psychologists, service-related contextual factors, wider organisational factors, local and national policy, and wider sociopolitical contextual factors. However, this relationships between the system's parts were described by participants as being strained. For example, the relationship between staff and service users with BPD tended to be described as primarily infantilising or punitive. This, however, was attributed to efforts made to manage or respond to staff's internal experiences of burnout and compassion fatigue and the additional impact of systemic pressures relating to limited support and resources. Clinical Psychologists identified efforts to support other staff as well as their clinical role with service users with BPD. This was whilst trying to manage their own experience of moral distress and dissonance arising from a mismatch between what is being offered to people with BPD, NHS policies and their own values and ethics. Thus, rather than situating the 'problem' within one component of the wider system, such as the person with BPD or the staff member, a greater understanding can be achieved when considering the impacts of the relationships between different systemic components.

The systematic review and meta-analysis highlighted that burnout remains prevalent among mental health professionals in the NHS, regardless of professional background. An interesting observation was that in early studies, published mostly in the period 2000-2001, risk factors were explored in depth at an individual level. For example, Coffey and Coleman (2001) and Hannigan et al. (2000) considered alcohol consumption and smoking among clinicians and its association with burnout. Even though the level of data analysis did not allow in-depth exploration of the nature of their relationship (e.g., whether this was a risk factor for, or an outcome of, burnout), such factors were not considered in the studies following 2004, where there was a shift in focus towards organisational level factors.

The important impacts of organisational factors were also evident throughout the empirical study. Clinical Psychologists voiced that acute inpatient staff experience burnout and compassion fatigue due to the intensive environment of the acute wards and the interpersonal nature of supporting people with BPD. Additionally, an imbalance between staff and service user ratio was perceived as impacting on staff's ability to care for both service users and for themselves. Furthermore, the lack of resources in community services and long waiting lists were highlighted as contributing factors negatively impacting on inpatient staff wellbeing. Community mental health staff have been suggested to experience higher levels of burnout than acute inpatient staff (Johnson et al., 2012), and particularly emotional exhaustion (Sorgaard et al., 2007). However, the source of such experiences was suggested in the context of community staff experiencing more lack of support whilst inpatient staff more lack of control in their work (Sorgaard et al., 2007).

Furthermore, the systematic review suggested that service user related difficulties and limited improvement predicted burnout (Delgadillo et al., 2018; Steel et al., 2015; Jenkins & Elliott, 2004). Clinical Psychologists identified that such relationships are more complex and commented that stigmatising narratives around the BPD diagnosis appeared more prevalent when staff were experiencing burnout and compassion fatigue. Consistent with previous research, othering and dehumanising narratives were seen as a way for staff to create distance between themselves and service users, in an attempt to cope with burnout and therapeutic nihilism (Troup et al., 2022). Such distance appears to support staff maintain their identity as a compassionate carer, whilst being distinct form people with BPD, forming an in-group and an out-group respectively (Tajfel & Turner, 1978). However, such social distance is detrimental for people with BPD as it can be experienced as rejecting or threatening (Luyten et al., 2020). Clinical Psychologists in the empirical study commented that both staff and service users appeared to be trying to survive threatening situations in the acute context; staff try to manage the organisational and service pressures and internal dissonance or moral distress, whilst service users try to manage their mental distress alongside possible experiences of rejection, stigma, and/or infantilisation from staff. Such experiences seemed to be more evident when the element of risk to safety appeared and responded either through loss of autonomy, restrictive practices, or unplanned discharge.

Main (1957) in his work ‘Ailment’ discussed the origin of therapists’ feelings when supporting service users who may show limited or no improvement following treatment. Main (1957) argued that when therapists cannot relieve service user distress, they experience guilt and self-blame, which gets projected onto other therapists or professionals and their ability to offer support. To cope with this guilt, professionals find themselves promising an idealised notion of care to people, which is unstainable. However, similar to the impact of social distance (Luyten et al., 2020), this can be a way to cope for professionals but also detrimental to service users, and lead to the “trauma of betrayal” (p. 87; Main, 1957) and to a “splitting of the staff” (p.86; Main, 1957). Such ‘splitting’ was reflected in the empirical study with staff either infantilising or rejecting service users and other clinicians, but also in Clinical Psychologists discussing their views around diagnosis and its usefulness, whilst referring to other Psychologists’ views and preferences. In both examples, service user’s needs and voice were not attended to, whilst patterns around power and control between staff and service users were perpetuated.

Clinical Implications

Clinicians’ experiences of being part of a community and feeling supported in the workplace was a theme highlighted throughout the thesis portfolio. This raised an important question: what happens when both supervisee and supervisor are struggling? Even though Clinical Psychologists have a leadership role in services and often act as clinical supervisors (British Psychological Society [BPS], 2017), participants in the empirical study highlighted their need to be supported themselves, as their clinical supervision does not always meet their emotional needs, whilst they feel distant from the ward multidisciplinary team. Developing a team structure with clear support pathways for staff regardless of where they sit in the NHS 'hierarchy' can foster an environment where staff and service user needs are visible and can be met. An increase in psychology resources could provide Clinical Psychologists with additional support and spaces for peer support and supervision, whilst sharing the increased workload, but also offer staff additional formal and informal support. Such an increase can also be beneficial for service users as Clinical Psychologists can support with fostering therapeutic relationships (ACP-UK, 2021).

Participants highlighted the importance of offering evidence-based interventions for people with BPD. However, this was not always possible due to factors outside their control and limitations of the current evidence base in terms of understanding the needs of people with BPD. Length of admission, detention under the Mental Health Act (MHA), available resources, and the acute inpatient environment itself were repeatedly identified as barriers to implementing evidence-based support, leaving Clinical Psychologists feeling morally distressed. Evlat et al. (2021) in their systematic review highlighted the ward environment and lack of staff support and training as the main barriers to implementing evidence-based therapies, whilst it was highlighted that the NICE guidelines not considering the context of the service. Similarly, Baker et al. (2021) in their COMPARE systematic mapping review exploring interventions reducing restrictive practices in inpatient services highlighted the lack of understanding of mechanisms leading to the reduction of such practices, making these hard to implement at a wider, national level. Thus, the service context, including the available resources, should be contemplated when considering the implementation of NICE guidelines.

Regardless of theoretical model underlying clinical interventions, participants raised the difficulty of clinical recommendations and skills offered during the admission not being thought of in the community, whilst post-discharge plans were not always being implemented. Therefore, consideration should be given to the person’s transition to the community. Similarly to the NICE guidance implementation, discharge planning and interventions aiming at facilitating people’s transition to the community should not be considered independently from the wider organisational and community context (Hackmann et al., 2023). Adopting a wider systems approach may support with development of such interventions to meet the person’s needs, whilst considering the available resources, the staff involved in the person’s care and the wider organisational context (Komashie et al., 2023).

Future Research

Telford and Faulkner (2004) outlined the importance of involving people with lived experience in research and service development. The debate on the diagnosis of BPD, and Personality Disorder more generally, was highlighted in the empirical study and led to a need for using a shared language and understanding. However, considering the aims of the study, this need was expressed by Clinical Psychologists and not people with a BPD diagnosis. Since diagnosis can influence the person’s identity and sense of self (Tekin, 2011), it is important to actively involve people in such discussions and conduct research ‘with’ instead of ‘to’ people (Hanley et al., 2004). Involving people in the debates about diagnosis may support with understanding their meaning making of the diagnosis and its impact more in depth.

Considering changes that have been introduced over the years within the NHS, such as the NHS Long Term Plan (2019), and the impact of organisational pressures on clinician burnout, it is important to continue exploring mental health professionals' experiences of service delivery. Apart from burnout, future research should explore other experiences impacting on staff wellbeing, including compassion fatigue and moral distress. Through the systematic review of the literature, it became evident that the term 'compassion fatigue' was often used as an umbrella term that involved burnout and was not as extensively researched as burnout. However, despite the overlap in symptoms (Nolte et al., 2017) compassion fatigue has been previously differentiated from burnout on the basis of the onset and severity of symptoms (Norman-Harling et al., 2020). Clinical Psychologists experiences of moral distress were also highlighted in the empirical study. Moral distress has been extensively researched within the nursing literature (e.g., Lamoureux et al., 2024), however little is known about such experiences within the clinical psychology profession. Considering the source of moral distress being within the organisation (Jansen et al., 2022), and the responsibility of Clinical Psychologists to practice in a specific ethical framework (BPS, 2021), Clinical Psychologists' experiences of moral distress should be explored in depth. This will allow us to explore further clinical implications within NHS services in order to understand the needs of mental health professionals.

Finally, participants in the empirical study often referred to staff either infantilising and restricting people with BPD or discharging them, particularly following risk-related behaviours. This may raise significant questions around the function of the MHA for people with BPD. Considering that people with BPD are frequently admitted in inpatient wards under the MHA (Baldwin & Beazley, 2023;

Zinchenko & Elhamoui, 2025), it is important to explore not only its function but also its use by staff members and services.

Strengths and Limitations

The thesis portfolio had several strengths and limitations. Both studies highlighted that mental health professionals continue to face significant challenges in the workplace that affect both their wellbeing and the delivery of care and treatment. The systematic review and meta-analysis found that such experiences are still prevalent, particularly in the context of NHS service delivery. The empirical study also highlighted experiences of moral distress among Clinical Psychologists, a concept that has been under researched among mental health professionals, which seems to be particularly present in the context of working with people with BPD diagnosis. Using a qualitative study design offered the space for such experiences to be explored in depth. Reflexive Thematic Analysis (rTA) within the critical realist position, allowed the first author (ADS) to consider their position in relation to the research topic and be aware of her experiences and how these impact on the interpretation of the data. Holding interviews online encouraged participants from different NHS Trusts and different geographical areas to participate, and therefore more experiences to be heard.

There were also several limitations. Even though the meta-analysis replicated previous reviews (O'Connor et al., 2018), by also specifying them to the NHS environment, it did not involve any recent studies, and particularly studies conducted during and following the Covid-19 outbreak. Considering the impact of organisational experiences on professionals' wellbeing, and the changes within the NHS system in the recent years (e.g., NHS Long Term Plan, 2019) it may be difficult to draw conclusions without being aware of the impact of service and organisational changes on staff. All included studies used a cross-sectional design with some having a small sample size or lacking power calculations to determine this, making generalisation of the results difficult. Finally, a limited number of studies reported participants ethnicity which made it difficult to describe the sample size more in depth.

The empirical study also contained weaknesses. Clinical Psychologists named the impact of the NHS Trust resources on themselves, other inpatient staff, community services, and on service user care. Such experiences may differ among Clinical Psychologists who are part of well-resourced NHS Trusts. Some participants raised the difficulty of differentiating between their experiences in the acute inpatient ward in general and more specifically in relation to their work with people with BPD. This also felt evident in relation to staff needs, as participants wondered whether these are due to people with BPD or the organisational pressures. With the study results suggesting a link between organisational pressures impacting on staff and, consequently, on people's care, this difficulty expressed by participants may reflect the complexity of understanding interpersonal and systemic impacts on staff wellbeing. Finally, participants expressed the need to have a shared language around BPD, and Personality Disorder more generally, whilst different views and experiences were shared around the usefulness of the diagnostic label. It is of importance to name that since the study explored Clinical Psychologists' experiences, such views around diagnosis may not reflect those of people with lived experience of the BPD diagnosis.

Reflections on the Doctoral Research Journey

A challenge I faced since the beginning of the empirical study was the use of reflexivity in the context of research. Until the beginning of the doctorate, I had experienced reflexivity mainly within clinical practice. Conducting qualitative research encouraged me to challenge this belief and notice its routes lying mainly within my experiences of conducting research from a positivist perspective. The use of reflective Thematic Analysis (rTA), particularly from a critical realist perspective, emphasised the importance of being aware of my own position, perspective, experiences, and identity particularly in understanding the nature of my interpretations of participants' experiences.

During the interview phase of the empirical study, I found I became preoccupied with participants' qualified status. Even though initially I attributed this to the experience of power, I soon noticed the challenge of exploring Clinical Psychologists' difficulties and needs in their role, whilst being on training and on the journey of forming my professional identity. Despite this, I was taken by participants' passion in ensuring that the voices of service users and staff are met. Even though the lack of diversity in the empirical study was a limitation, it also reflected the psychology workforce and led to further wonderings around gender. Having studied psychology at an undergraduate level in Greece, and postgraduate and doctoral level in the UK, I was often exposed to conversations around the limited number of male peers. Even though the Greek and British societies may be different, such conversations seemed to be shared, and led to questions around how psychology, a profession that thinks about feelings, is perceived considering a person's gender. Interestingly, the concept of gender was also mentioned by some participants in relation to the BPD diagnosis. BPD was described as a 'female diagnosis' and was challenged in the context of how distress and feelings are expressed or allowed to be expressed depending on gender.

The experience of conducting the empirical study challenged my perception of diagnosis further and deepened my understanding on the debate around diagnosis and formulation. Having been exposed to societal beliefs around mental health diagnoses and difficulties translating into 'madness' and a person's ‘problem’, I was cautious around the use of diagnostic language since the beginning of my psychology studies. Such caution became more powerful during my clinical practice in the UK, where a person’s diagnosis was sometimes portrayed as the reason for a difficult interaction. This was particularly evident during the write-up of the thesis portfolio, when I found myself moving between using diagnostic and non-diagnostic language, questioning what term is most appropriate. My discussions with the person with lived experience in the context of developing the interview schedule made me realise that even though non-diagnostic terms may aim at reducing the stigma on BPD, they may also perpetuate it. For example, such terms could be considered the professional’s avoidance, whilst not all people find these helpful in their sense making journey. Clinical Psychologists’ experiences also highlighted that the function of the BPD diagnosis may differ depending on the context and the person’s perspective. Considering that some people with lived experience may prefer using diagnostic language whilst others do not, led to further exploration of this debate and to the question around ‘who is the diagnosis really for?’. This question made me more mindful of the risks of advocating for or against a diagnosis, worrying about the impact that this might have on the person’s identity, but without involving the person themselves in such conversations.

A topic that was often reoccurring in my reflexive diary and was discussed in supervision was the concept of ‘complexity’ particularly in relation to working with people with BPD. However, the more participants were describing their experiences, the more it became evident that this ‘complexity’ was moving away from the person and towards the wider system, which was seen as impacting on the person. Staff were encouraged to engage with positive risk taking whilst NHS Trust policies were described as encouraging of restrictive practices. Simultaneously, NHS pressures appeared in a ripple effect, impacting community mental health services first and inpatient wards after. Considering this, it felt that the complexity of the BPD diagnosis reflects the complexity of inpatient services, and the wider NHS system. To navigate this, staff needs seemed to lie within having clear guidance instead of holding a position of dissonance and uncertainty.

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Appendices

Appendix A- Counselling and Psychotherapy Journal, Author Guidelines

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Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at https://wiley.atyponrex.com/journal/CAPR.
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1. Manuscript preparation

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- The title page of the manuscript, including statements relating to our ethics and integrity policies:
- data availability statement
- funding statement
- conflict of interest disclosure
- patient consent statement
- permission to reproduce material from other sources
- clinical trial registration

Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:

- For single agency grants: "This work was supported by the [Funding Agency] under Grant [number xxxx]."

- For multiple agency grants: "This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx]."

- Abstracts of 250 words are required for all manuscripts submitted.
- Each manuscript should have 4 to 6 keywords .

- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it.
- Each paper should include brief points on the implications of the findings: three Implications for Practice and one Implication for Policy.
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
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- Authors must adhere to SI units . Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

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Submitted manuscripts should conform to the Declaration of Helsinki on the Ethical Principles involving Human Participants (WMA Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks – WMA – The World Medical Association), and follow the recommendations and procedures of national and international ethics jurisdictions bodies. Authors should provide the following information:

In the main text of the manuscript, and within the Methods section, authors should address the following research ethics requirements:

- Confirm that the research was granted approval by an authorised body, with its name stated in the non-anonymised draft of the manuscript.
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In the title page *document, a*uthors should provide details on the authorizing research ethics body, its institution, and the reference number of the approval for their study. If the research fell under any of the above described categories, these should also be explicitly named.

Potential contributors may also wish to consult the following resources:

- Falco, L., & McCarthy, C. (2013). Writing for publication: A guide for counseling practice articles. Journal of Counseling & Development, 91(3), 343-348. doi: 10.1002/j.1556-6676.2013.00103.x
- Wilkinson, L. (1999). Statistical methods in psychology journals - Guidelines and explanations, American Psychologist, 54(8): 594-604.
- Morrow, S. (2005). Quality and trustworthiness in qualitative research in counseling psychology, Journal of Counseling Psychology, 52(2): 259-260.

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Appendix B- PRISMA Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.17
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.18
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.19-20
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.20-21
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.21-22
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.21-22
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.21-22
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.21-23
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.22-23
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.22
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.22
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.24
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	p.22
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.22
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data	p.22

Section and Topic	Item #	Checklist item	Location where item is reported
		conversions.	
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.22
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.22
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.22-23
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	p.27-32
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	p.24-25
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	p.26-49
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.25, 27-32
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	p.26-49
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	p.26-49
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	p.26-49
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.49-52
	23b	Discuss any limitations of the evidence included in the review.	p.49-53

Section and Topic	Item #	Checklist item	Location where item is reported
	23c	Discuss any limitations of the review processes used.	p.52-53
	23d	Discuss implications of the results for practice, policy, and future research.	p.51-52
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.21
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.21
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	p.17
Competing interests	26	Declare any competing interests of review authors.	p.17
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	p.21

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71. This work is licensed under CC BY 4.0. To view a copy of this license, visit https://creativecommons.org/licenses/by/4.0/

Appendix C- Systematic Review, full search strategy

1. Professionals Terms

‘mental health professional’ OR ‘psychiatric staff’ OR ‘psychiatric personnel’ OR ‘mental health personnel’ OR ‘psychiatric nurs*’ OR ‘mental health nurs*’ OR ‘occupational therapist’ OR ‘social worker’ OR psychiatrist OR psychologist OR therapist OR psychotherapist

2. Wellbeing Terms

‘professional burnout’ OR burnout OR ‘burn out’ OR ‘burn-out’ OR ‘job stress’ OR morale OR ‘compassion fatigue’ OR fatigue OR ‘job satisfaction’ OR depersonalisation OR ‘workplace wellbeing’ OR ‘workplace well-being’ OR ‘occupational stress’ OR ‘occupational burnout’ OR ‘emotional exhaustion’ OR ‘psychological burnout’ OR ‘burnout syndrome’ OR ‘career burnout’

3. NHS Terms

NHS OR ‘National Health Service’ OR UK OR ‘United Kingdom’ OR Britain

Final Search: 1 AND 2 AND 3

Appendix D- UEA FMH Ethics approval

University of East Anglia Norwich Research Park Norwich. NR4 7TJ

Email: ethicsmonitor@uea.ac.uk Web: www.uea.ac.uk

Study title: Exploring Clinical Psychologists’ Perspectives and Experiences of Their Role in Acute Inpatient Mental Health Systems when Working with People with Borderline Personality Disorder Diagnosis.

Application ID: ETH2425-0637 (significant amendments)

Dear Athina,

Your amendments to your study were considered on 1st November 2024 by the FMH S-REC (Faculty of Medicine and Health

Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you

can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the

application required, which is submitted through the IRAS system.

This approval will expire on **26th September 2025**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project

must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH

S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one

which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the

unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH

S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the

amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as

evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act

2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer

(dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

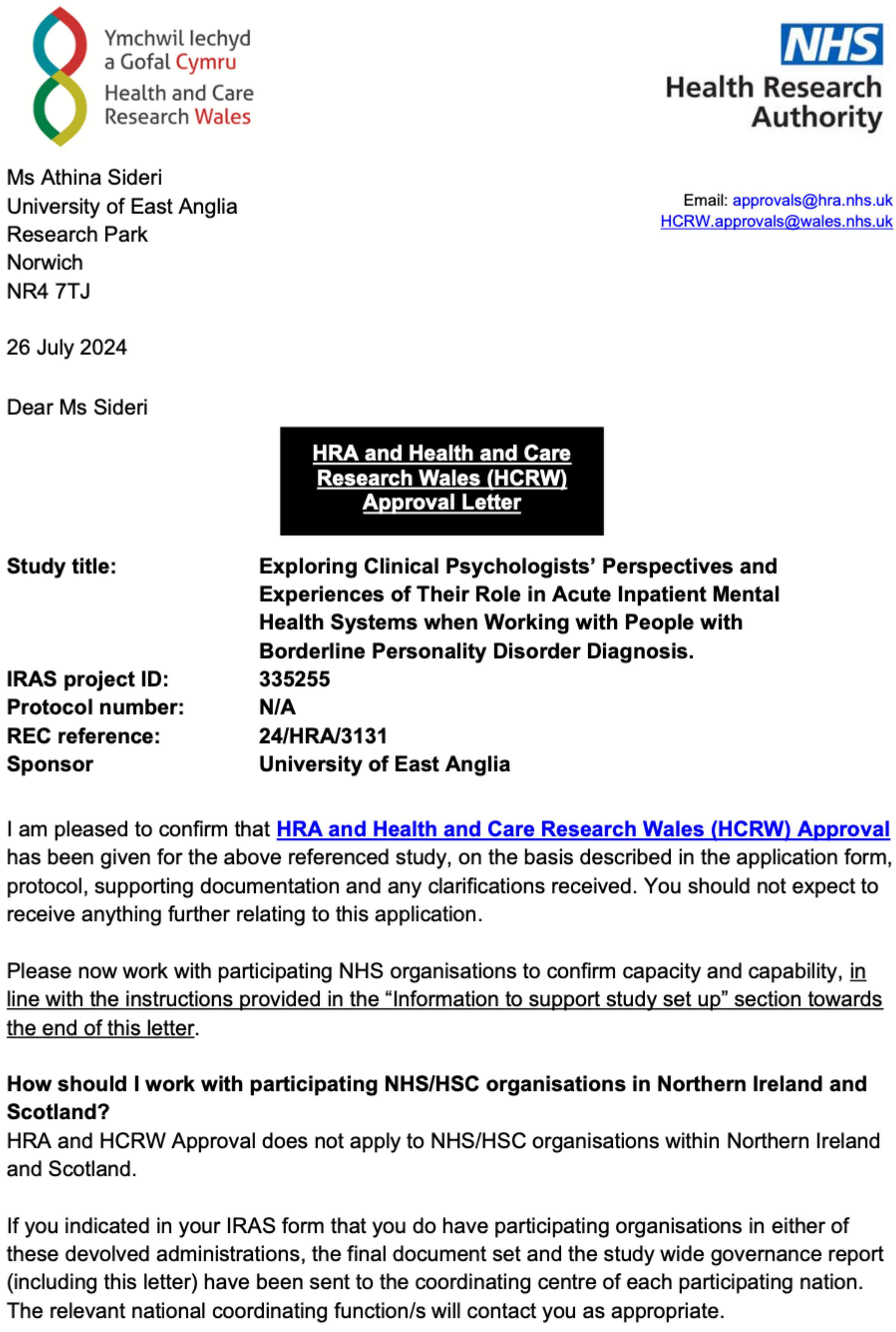
I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Appendix E- Health Research Authority Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Ms Athina Sideri
University of East Anglia
Research Park
Norwich
NR4 7TJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

26 July 2024

Dear Ms Sideri

HRA and Health and Care Research Wales (HCRW) Approval Letter

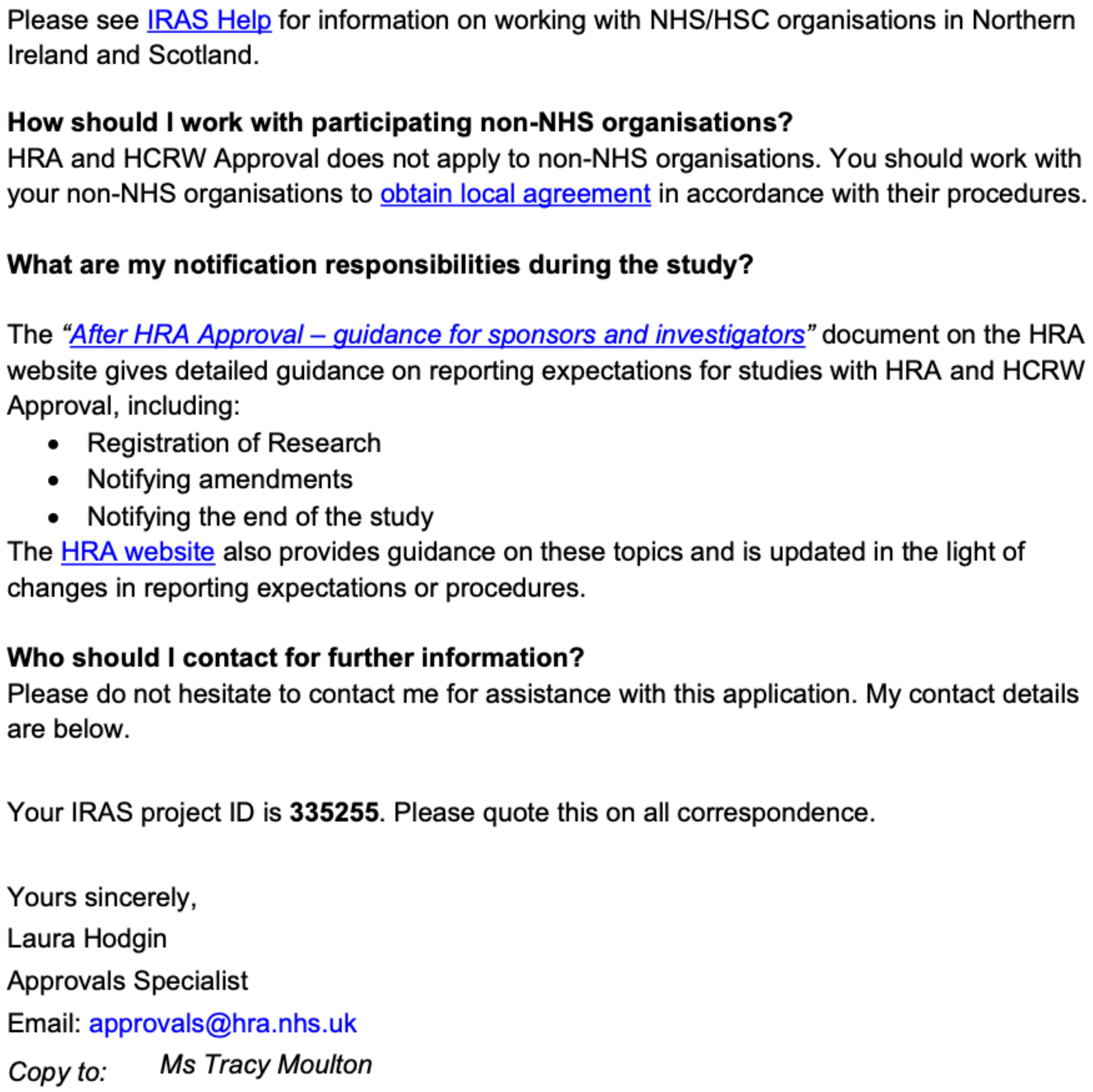
Study title: **Exploring Clinical Psychologists' Perspectives and Experiences of Their Role in Acute Inpatient Mental Health Systems when Working with People with Borderline Personality Disorder Diagnosis.**
IRAS project ID: **335255**
Protocol number: **N/A**
REC reference: **24/HRA/3131**
Sponsor **University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.



Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

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

- Registration of Research
- Notifying amendments
- Notifying the end of the study

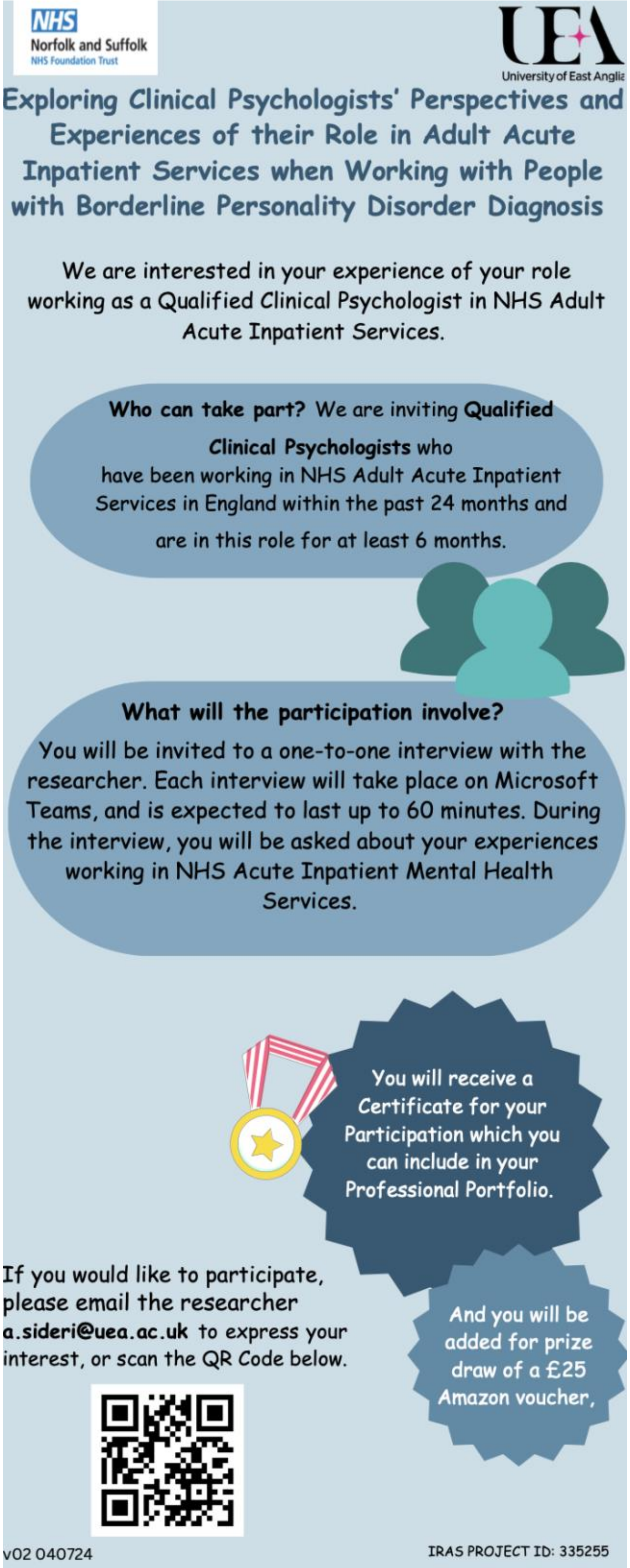
The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **335255**. Please quote this on all correspondence.

Yours sincerely,
Laura Hodgin
Approvals Specialist
Email: approvals@hra.nhs.uk
Copy to: *Ms Tracy Moulton*

Appendix F- Study Poster



NHS Norfolk and Suffolk NHS Foundation Trust

UEA University of East Anglia

Exploring Clinical Psychologists’ Perspectives and Experiences of their Role in Adult Acute Inpatient Services when Working with People with Borderline Personality Disorder Diagnosis

We are interested in your experience of your role working as a Qualified Clinical Psychologist in NHS Adult Acute Inpatient Services.

Who can take part? We are inviting **Qualified Clinical Psychologists** who have been working in NHS Adult Acute Inpatient Services in England within the past 24 months and are in this role for at least 6 months.

What will the participation involve?

You will be invited to a one-to-one interview with the researcher. Each interview will take place on Microsoft Teams, and is expected to last up to 60 minutes. During the interview, you will be asked about your experiences working in NHS Acute Inpatient Mental Health Services.

You will receive a Certificate for your Participation which you can include in your Professional Portfolio.

And you will be added for prize draw of a £25 Amazon voucher,

If you would like to participate, please email the researcher **a.sideri@uea.ac.uk** to express your interest, or scan the QR Code below.

v02 040724

IRAS PROJECT ID: 335255

Appendix- G- Participant Information Sheet

Exploring Clinical Psychologists' Experiences of their Role in Acute Inpatient Systems when Working with People with Borderline Personality Disorder Diagnosis

You are being invited to take part in an interview as part of some research.

This information sheet explains the purpose of the research and what will happen if you decide to take part.

In this research study we will use information from you. We will only use information we need for the research study. We will let very few people know your name and contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data in case we need to check it.

We will make sure no-one can work out who you are from the reports we write.

The information pack tell your more about this.

- Please read this information to help you decide whether to take part in the interview or not.
- Please do discuss it with others if it is helpful.
- You do not have to take part if you don't want to.
- If you do decide to take part, and then change your mind, this will not affect any aspects of your work or your relationships with your colleagues.
- If you wish to withdraw at any point during the study, you can do this without giving a reason.
- Ask us if there is anything that is not clear, or if you have any questions.

What is the research about?

These interviews are being carried out as part of the researcher's thesis for the Doctorate in Clinical Psychology at the University of East Anglia (UEA), which aims at exploring Clinical Psychologists' experiences of their role in Adult Acute Inpatient Wards when they work with people with a Borderline Personality Disorder diagnosis. We want to find out how these experiences can be improved for staff members, including Clinical Psychologists, and for service users.

We are asking qualified Clinical Psychologists who have been working in Adult Acute Inpatient Services for at least 6 months within the past 2 years, to take part in interviews. It is important that the findings of this study make sense in real life, not just on paper. Therefore, we want to capture the views and thoughts of people who have experience working on a mental health ward, to explore what actually happens in these situations.

Why are we finding out about this?

Adult Acute Inpatient Mental Health Wards are complex environments to work in. A big percentage of people who get admitted on these wards have a Borderline Personality Disorder diagnosis. Like in other NHS mental health teams, staff working in acute inpatient wards may struggle due to the lack of resources and other factors. Therefore, we are trying to understand what the role of Clinical Psychologists in acute wards actually looks like in clinical practice. By doing this, we are hoping to understand how we can improve the support offered to service users and staff, including Clinical Psychologists, in Adult Acute Inpatient Services.

We have invited you to take part because:

You are a qualified Clinical Psychologist working in NHS Adult Acute Mental Health Inpatient Wards at some point during the past 24 months, and you are in this role for at least 6 months.

What will Taking Part involve?

- If you are interested in taking part in the study, you can contact the researcher, express your interest, and ask questions about the study and your participation. If you are happy with the information provided and you would like to take part in the study, then you can sign the consent form.

- All interviews will take place online, via Microsoft Teams. The researcher will contact you to schedule a time for the interview based on your availability.

- The researcher will answer any questions you may have beforehand, obtain your consent to participate, then have a conversation with you about your experience of your role.

- The conversation will be recorded on Microsoft Teams and transcribed (written down from the recording). Your name, or any other details that might identify you, will be removed during the transcription phase. Following this, the recording of your interview will be deleted.

- The interview should take up to 60 minutes to complete.

What might be good about taking part?

- You may enjoy taking part and sharing your experiences.

- You may find the questions interesting.

- You will help us to understand how the role of Clinical Psychologists in acute wards can be shaped further to support staff and service users with a BPD diagnosis, and what are the current difficulties in the role that need to be addressed.

What might be difficult about taking part?

- It will take your time, and you may find the conversation tiring.

- It may bring up experiences that are difficult.

- You may find talking about your experiences upsetting. You do not have to continue with the conversation if this is the case.

Will I be reimbursed for taking part?

- You will receive a certificate for your participation in the study, which you can use as part of your Continuous Professional Development (CPD).

- You can be added to a list for a prize draw which will be a £25 Amazon Voucher. You can express your interest in being considered for the prize draw on the consent form, by adding your initials in the relevant box, and by sharing your preferred contact details. Only the research team will have access to these details. Following the end of the study, the researcher will contact you to offer you the prize, in case you have won this. After this, your contact details will be deleted.

How will we use information about you?

We will need to use information from you for this project.

This information will include your name and contact details. People will use this information to do the research or to check to make sure that the research is being done properly.

People who do not need to know who you are, will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- At www.hra.nhs.uk/information-about-patients/
- Our leaflet available from the lead researcher
- By asking one of the research team
- By sending an email to a.sideri@uea.ac.uk

What will happen to the information collected during the interview?

- We will keep information about you safe and confidential.

- The information we collect during the interview will get anonymised. After your interview, we will transcribe the recording and we will anonymise any identifiable information. After the transcription, the recording of your interview will be deleted.

- Only the researcher will have access to your interview recording to allow for the accurate transcription of your conversation with them. The researcher's supervisors will have access to your interview transcript, after this has been anonymised.

- We will publish the study results (in print or online) for others to read. We may also share results with others at conferences and forums.

- You may see some of your words quoted in reports of findings, but no-one would ever be able to identify you personally from this information.

- Only members of the study team will have access to your personal information (name, email address and/or telephone number). Please let the researcher know how to best contact you, if you wish to take part.

- A stakeholders’ group will be involved in parts of the data analysis. However, stakeholders will only be given access to specific quotes from your interview, after these have been anonymised.

- Your personal information and your interview transcription will be saved electronically in two separate folders so that nobody will be able to identify you. Both folders will be held securely on UEA OneDrive and will be protected by a password only known to the research team. Your personal information will only be used to contact you about this project. We will not keep any of your information in a physical form (e.g., hard copies).

- Your details will not be used for anything other than this project.

- We may have to share information about you if we have any serious concerns regarding your health, safety, and wellbeing or safety of others. If this happens, the researcher has a duty to inform an appropriate professional, such as their supervisors who also hold a position of Clinical Psychologists in the NHS. However, prior to doing this, the researcher will have a conversation with you and let you know about the next steps. Should you wish to seek further support for your wellbeing, then you can contact the 111.

- The researcher would make every effort to explain to you why we need to share this information before doing so.

Do I have to take part?

- No, taking part is your choice.

- If you do not take part or choose to withdraw from the study at any point this will not in any way affect any aspects of your work or your relationships with your colleagues.
- If you decide to withdraw your consent, then you can do this without giving a reason.

- If you decide to withdraw during the interview, your interview will be terminated at that point, and your personal information including your research data, will be deleted.

- You can withdraw your consent at any time within 2 weeks after your interview. Following this period, it will not be possible to withdraw your data, as your interview will have been transcribed anonymously and be no longer identifiable.

- If you decide to take part to the study but decline to answer to some questions due to their nature, then you can let the researcher know. The researcher will then move forward to the question.

- Take time to read the information as many times as you would like.

- You can ask as many questions as you like before agreeing to take part.

- If you agree to take part, we will ask you to sign a consent form.

Who is supporting and approving the project?

The project is conducted as part of the Doctorate in Clinical Psychology at the University of East Anglia, and has been given ethical approval by the UEA Faculty of Medicine and Health Sciences (FMH) Ethics Committee.

What if I have any questions or if something goes wrong?

If you have any complaints or concerns about the way you have been approached or treated during the project, and you would like to talk to a person independent from the study, please contact the Clinical Psychology Doctorate Director, Professor Sian Coker (S.Coker@uea.ac.uk), who will contact you in the first instance to resolve this:

If you have any questions about the study, please contact the researcher or her supervisors:

Researcher: Athina Sideri, Trainee Clinical Psychologist (a.sideri@uea.ac.uk)

Research Supervisors: Dr Corinna Hackmann, Research Clinical Psychologist, (corinna.hackmann@nsft.nhs.uk); Dr Adrian Leddy, Clinical Associate Professor in Clinical Psychology (a.leddy@uea.ac.uk).

Thank you for reading this information and for considering taking part in this research. Please let us know if you have any questions.

Appendix H- Consent Form

NHS
Norfolk and Suffolk
NHS Foundation Trust

UEA
University of East Anglia

Exploring Clinical Psychologists' Perspectives and Experiences of their Role in Acute Inpatient Systems when Working with People with Borderline Personality Disorder Diagnosis

Participants' Consent Form- Staff Interviews

Please Initial Each Box

Please read the following statements and if you agree:

1. I confirm that I have read and understood the Participant Information Sheet and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary, and I am free to withdraw at any time, without giving any reason and without my legal rights being affected. ☐
3. I understand that all personal information will remain confidential. ☐
4. I understand that the interview will be audio-recorded during this interview. ☐
5. I give permission for any views I express to be anonymised, and used as quotations in study reports, publicity materials and publications. ☐
6. I understand that my personal details will remain confidential. I understand that if the researcher is worried about my safety or the safety of others, they may share my relevant personal information. ☐

7. I understand that my personal data and my fully anonymised interview data will be stored securely by the University of East Anglia in an electronic form. ☐
8. I understand that any data collected during the study may be looked at by the research team and individuals from regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data. ☐
9. I understand that a stakeholders' group will be given access to my anonymised quotes for the purposes of the data analysis. ☐
10. I would like to hear about the findings of the research (optional). ☐
    If you're interested, please provide your contact details here:
    ____
11. I understand that if I want to hear about the research findings, the research team will keep the contact details I provided above, until they share the findings with me. ☐
12. I would like to be considered for the prize draw (optional). ☐
    If you're interested, please provide your contact details here.
    ____
13. I understand that if I want to be considered for the prize draw, the research team will keep my contact details until the outcome of the draw has been shared with me. ☐
14. I agree to take part in this interview. ☐

Name of Participant (PRINT): ....

Signature

Date: ....

Name of Researcher (PRINT): ....

Signature

Date: ....

Appendix I- Interview Schedule

Suggested Interview Schedule

A. Demographic Questions

1. Gender
2. Age
3. Ethnicity
4. Role in the service
5. How long have you been working as a Clinical Psychologist? Have you worked in other NHS mental health services?
6. How long have you been working in Adult Acute Inpatient Mental Health Services?

B. Interview Schedule

Interview Schedule
1. This project looks into psychologists' experiences when working with people with PD. How do you understand this term?
Role in relation to Working with People with PD 2. What does your role as a Clinical Psychologist involve in the service daily in relation to working with people with PD? (prompt to think about engagement with the team and other teams if needed) 3. What is the psychology provision in your work in relation to supporting people with PD? 4. Who else do you supervise, as part of your role? - Does this effect the way that you work with people with PD? 5. What factors may influence your role when you work with people with PD? - Are there any challenges to your role when working with people with PD? (prompt: cultural or materialistic) - Is there anything that supports you in your role, when working with people with PD? (prompt: cultural or materialistic) - Are there any things (prompt: cultural, materialistic, emotional) that you have or don't have that makes your work with people with PD better on the ward?

6. Based on your experience working in the service, how does the MDT make sense of your role when supporting people with PD?

Role Specific to Treatment

7. What is the main focus of your interventions with people with PD on the ward?

8. How effective do you feel Clinical psychology interventions are in the treatment of people with PD?
- Based on your experience, what are the challenges in these interventions?
- What are the things/ factors that support these?

Clinical Psychologists’ Needs

9. What are your needs (prompt: cultural or materialistic or emotional) as a Clinical Psychologist to support your work with people with PD in the service?

Needs in relation to:
- Working with people with PD and their carers
- The team
- And you personally

The MDT

10. How do you support the MDT to work with people/ to respond to people with PD?

11. Based on your experience, what are the team’s needs when they support people with PD?

12. How do you judge/ know what the team needs in supporting people with PD?
- How do you, as part of the team, respond to these needs?
- How do you support team members to support people with PD or similar traits? (prompt: include emotional support and wellbeing)

13. Is there anything that I haven’t asked/ that you think it’s really important for me to know?