Workforce Sustainability: Class in Clinical Psychology and Moral Injury in the Mental Health Workforce

Thomas George Westwood

Candidate Registration Number: 100458886

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Primary Supervisor: Dr Rachel Russell

Secondary Supervisors: Dr Sheryl Parke and Dr Jinnie Ooi

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Thesis Portfolio Abstract

NHS workforce retention is an issue of continued importance as staff are being asked to support the general public with ever shrinking resources (Harding et al, 2025; Moscellli et al, 2022; Palmer et al, 2021; Stinton , 2025). It is vital to consider all potential factors that may impact staffs' roles and responsibilities and what may be leading people to leave the NHS, with the goal of addressing them to support staff wellbeing and retention. A systematic review exploring the prevalence of moral injury in mental health staff in the NHS identified five studies that met inclusion criteria, yet, was unable to obtain data relating to the prevalence of moral injury amongst NHS mental health staff. However, supplementary analysis revealed that mental health staff appeared to endorse factors such as transgressions of others and betrayal more readily than other factors on the Moral Injury Events Scale (MIES). Social class may be another factor impacting overall staff experience as being working-class has been shown to negatively impact trainees' experiences, leaving them feeling out of place or misunderstood (Place, 2023). An empirical study was then conducted to explore the experiences of working-class clinical psychologists in the NHS, private practice and those splitting their roles between the two. Semi structured interviews of 13 participants were analysed using Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2022). Four interconnected themes were constructed: *Money and class*, *Experiences of Class Migration*, *The Push and Pull of the NHS and the Working-class Clinician* and *Us and Them (Seen/Unseen, Heard/Unheard differences)*. This portfolio highlights the challenges faced by NHS mental health staff and the factors that may be most salient to moral injury. It also highlights the need for more research into the prevalence of moral injury among the mental health workforces to fully understand this issue. Furthermore, it sheds light on the impact of class and class migration on working-class clinical psychologists and what may bring them back to the NHS or cause them to leave, as they navigate their careers. Future research should examine the prevalence of moral injury among mental health staff, as well as explorations of other aspects of identity and their impact on clinical psychologists' experiences in and out of the NHS post-qualification.

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Declaration

Material submitted by the portfolios author for the Thesis Proposal as part of the Doctorate in Clinical Psychology at the University of East Anglia has been updated, adapted and used in the completion of the overall thesis portfolio.

Chapter One:

Introduction to the Thesis Portfolio

Introduction

The National Health Service (NHS) is the largest employer in the United Kingdom, and it has been for decades (Bailey, 2020). It has been recognised as having a diverse and complex workforce consisting of medical doctors, nurses, clerical/administrative staff, cleaning and culinary staff to name a few. However, despite this enormous, diverse workforce, staff retention and wellbeing continues to be an ever-present issue (Ferreira & Collins, 2023; McCaffert & Hill, 2015; Palmer et al, 2021).

The most recent NHS long term plan outlines the proposed use of Artificial Intelligence (AI) to increase productivity, the increase of specialist training and development plans in addition to the alteration of upper management pay scales to reflect performance, however, other issues relating to staff retention remain (NHS, 2025). Stress and burnout, a lack of upward mobility in job roles, moral injury, problems with the Agenda for Change Framework (AfC) are some of the most commonly reported issues surrounding the workforce (Harding; 2025; McCaffert & Hill, 2015; McCormack et al, 2018; Palmer et al, 2021; Stinton, 2025). These challenges must also be considered in the context of the differences in roles and responsibilities of the workforce. One example of the difference between disciplines when it comes to staff retention in mental health services comes in the form of a recent systematic review exploring the reasons behind the near forty-thousand vacancies in mental health nursing (Adams, Ryan & Wood, 2021). This study highlighted that due to the specific issues faced within mental health nursing that retention plans should be specific to each speciality (Adams, Ryan & Wood, 2021). Therefore, it is important to consider the individual needs of different disciplines within the mental health NHS workforce.

Moral injury is of particular interest, starting from its appearance in the world of veterans and seen as a psychological response to the violation of one's moral values. More is now being done to explore the impact of this in the NHS as staff are regularly expected or asked to act in ways that go against their morals due to the needs and limitations of services (Bell et al, 2025; French, Hanna & Huckle, 2022). Moral injury has been investigated in certain staff groups more heavily than others and when considering mental healthcare staff, the evidence base appears to be limited. Moral Injury is defined as "*the distress that can arise from actions, or lack of action, that are seen to violate one's ethical code*" (French, Hanna & Huckle, 2022). It is the psychological, emotional, and existential impact of being involved in, witnessing, or being unable to prevent events that violate one's deeply held moral values (Bell et al, 2025; French, Hanna & Huckle, 2022).

Mental health staff and clinical psychologists are one group that have been shown to be leaving the workforce, potentially for the private sector, due to the opportunity to earn more and have more flexibility in their roles (Palmer et al, 2021). The NHS has shown commitment to increasing the mental health workforce, aiming for mental health services to become more accessible and for waiting lists to shorten (NHS, 2019). This aim is currently under threat due to problems with staff retention, resulting in lengthy vacancies due to multiple recruitment freezes, whilst certain trusts face large financial deficits (Punton, Dodd & McNeil, 2022; Tran, 2024).

Additionally, studies have also focused on the wider staff retention picture within the NHS over recent years. Recent research using YouGov polling has reported detailed information on reasons why people are choosing to stay or leave the NHS in the years after the COVID-19 pandemic (Weyman et al, 2024). The main reasons for staying in the NHS for a

wide range of staff in this report were ‘job security’, ‘to make a difference’ and ‘the job satisfaction from caring for patients’ (Weyman et al, 2024). Conversely, the main reasons for feeling compelled to leave were ‘stress’, ‘shortages in staff and resources’ and a mix between ‘the jobs impact on the person's mental health and the pay’ (Weyman et al, 2024). Whilst there may be some carryover between these roles and the role of a clinical psychologist in the NHS, such as how progression limits time with patients and may feel like it impacts the person’s ability to make a difference, there may be other factors not previously explored within this group of people (Buchanan & Wiklund, 2020; Muthy, 2022; Palmer et al, 2021; Scevoli, 2020; Weyman et al, 2024).

Research into the reasons why psychological professionals may choose to leave the NHS, and the factors impacting this, is still growing. Stress, burnout and restrictions of the role are named as some common reasons for mental health staff retention issues, however, one area relates to the role of social class and the personal experiences of working-class clinical psychologists in the NHS (Harding, 2025; Place, 2023; Stinton, 2025). More recent evidence has emerged, highlighting that these staff members can feel out of place and undervalued due to their background and class history (Muthy, 2022; Palmer et al, 2021; Place, 2023). This is yet to be explored in the wider, qualified clinical workforce and how it may impact their career decisions post qualification.

Given the existing literature, the aim of this thesis portfolio is to explore the experiences of working-class clinical psychologists in the NHS, those split between NHS and private work and those who are solely in private practice. This portfolio also hopes to better understand the impact and levels of moral injury on staff retention within the NHS mental health workforce. This will begin with a systematic review considering the prevalence of moral injury

within mental health staff members working in the NHS. Following this, the researcher aims to consider the links between the systematic review and the empirical paper, reflecting on overlapping concepts that may arise within the interviews carried out in the empirical project. This will lead into a qualitative study exploring the experiences of working-class clinical psychologists in three distinct working categories and how their working-class backgrounds impacted their career positions and journeys.

Chapter Two:

Systematic Review Paper

The Prevalence of Moral Injury Amongst Mental Health Staff Within the National Health Service (NHS): A Systematic Review and Synthesis without Meta-Analysis

Thomas Westwood[1a], Khadija Shah, Dr Rachel Russell[1b], Dr Sheryl Parke[1c] and Dr Jinnie Ooi[1d]

[1]Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, University of East Anglia, Norwich, UK

[a]https://orcid.org/0009-0004-1150-1924

[b]https://orcid.org/0009-0008-8732-2526

[c]https://orcid.org/0009-0007-0546-4620

[d]https://orcid.org/0000-0003-0344-9172

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Abstract

In healthcare, factors such as stress and burnout have been shown to be detrimental to workforce wellbeing and retention (Harding et al, 2025; Stinton , 2025). However, there is a growing evidence base for the impact of moral injury on health care professionals that is appearing to be another factor in this area, impacting overall staff wellbeing and retention across the UK and other countries (Hagarty et al, 2022; Rabin et al, 2023). Moral injury refers to the psychological distress experienced following a situation or event that infringes upon a person's moral beliefs or values (Litz et al, 2009; Williamson et al, 2023). Over time, this is shown to contribute to the development of other mental health issues such as Post-traumatic Stress Disorder (PTSD), depression and anxiety (Williamson et al, 2023; Griffin et al, 2019). Currently, there is a lack of research into the prevalence of moral injury among mental health staff in the NHS. This systematic review (PROSPERO: CRD420261308335) aimed to explore this and report the findings following guidance from A Synthesis without Meta-Analysis (SWiM; Campbell et al., 2020). Systematic searches of five databases (APA PsycINFO, Medline OVID, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed and Embase) were completed in November 2025, identifying five studies that met the inclusion criteria. This review was unable to obtain data relating to the prevalence of moral injury amongst NHS mental health staff due to a lack of specificity relating to groups and a lack of supplementary data relating to prevalence. However, supplementary analysis revealed that mental health staff appeared to endorse factors such as transgressions of others and betrayal more readily than other factors on the Moral Injury Events Scale (MIES). This review suggests that further research is needed to better understand the levels of moral injury among this staff group to support staff wellbeing and workforce retention.

Keywords: Moral Injury, NHS, Mental Health Staff, Prevalence

Introduction

Across several parts of the world, mental health staff continue to be overburdened, overworked and underequipped to meet the needs of an ever-growing population. The lack of resources and staff means that the workforce is experiencing situations which may violate their values (Thibodeau & Cutforth, 2025). For many mental health staff, ethical and moral decisions in complicated situations are becoming ever-present and the need to break one's moral and ethical codes in clinical practice due to system demands can lead to the development of what is termed 'moral injury' (Litz et al, 2009; Williamson et al, 2023). The NHS itself, is an enormous and diverse institution that provides healthcare to the UK population and is free at the point of use. It is the largest employer in the UK and is made up of a wide array of professionals, from clinical staff to administrative and clerical staff. Within this workforce, there is a need to explore issues that are currently impacting workforce retention as people continue to leave the organisation due to things like moral injury, burnout and stress (Broughton, 2023; Moscellli et al, 2022; Palmer et al, 2021).

Moral injury refers to the psychological distress that is experienced following a situation or event that may infringe upon that person's own moral belief or expectations (Litz et al, 2009; Williamson et al, 2023). Moral injury itself is not termed as a mental health difficulty, however, in 2025, 'moral problems' was added to the DSM-5 in a revision (American Psychiatric Association, 2022; Centre for Evidence and Social Innovation, 2025). Moral problems has been added alongside religious or spiritual problems in which one's morals or beliefs are violated in a way that causes psychological harm (American Psychiatric Association, 2022; Centre for Evidence and Social Innovation, 2025). Research indicates that repeated incidents of potentially morally injurious events (PMIE's) may link to mental health disorders such as post-traumatic stress disorder (PTSD), depression, anxiety and increased suicidality in some (Williamson et al, 2023; Griffin et al, 2019). Moral injury is also associated with feelings of

guilt, shame, loss of trust in oneself and others, in addition to the potential feeling of a loss of meaning in one's life (Houle et al, 2021; Litz & Kerig, 2019; Plouffe et al, 2025).

When exploring prevalence rates of moral injury in healthcare workers abroad responding to the pandemic, reported rates were around 32% in the US and between 20-41% in China (Hagarty et al, 2022); similar to those found in UK healthcare workers (Hagarty et al, 2022; Rabin et al, 2023). This research shows that many of those reporting experiences of PMIEs at work would meet the criteria for moral injury and may also have other mental health difficulties such as PTSD and depression because of these incidents (Rabin et al, 2023; Williamson et al, 2023).

This may be particularly pertinent to mental health workers in the United Kingdom (UK) as limited staffing numbers and role changes (i.e. less patient facing work and increased managerial responsibility), amongst other factors, are leading to difficult choices which may infringe on their morals (Williamson et al, 2023). The reoccurrence of such events can in time lead to the formation of maladaptive beliefs about the self and the world, such as the belief that "I am a bad person" or that "I have failed myself or my team" (Williamson et al, 2023).

Within the National Health Service (NHS), research shows the prevalence of moral injury in general hospital staff. In the UK, it is reported that almost a third of healthcare staff have experienced Potentially Morally Injurious Events (PMIE) whilst at work (Rabin et al, 2023). These PMIEs relate to witnessing risky or unethical practices or observing a lack of respect for patients' autonomy, seeing a lack of decision-making at organisational levels and a growing incongruence with the government's goals of optimal care whilst leaving teams chronically understaffed (Rabin et al, 2023). For mental health staff in the NHS, this issue of moral injury is becoming more pressing (Fradley et al, 2025; Williamson et al, 2023). Moral injury appears to be inflicted not only by the individual, but by the systems and organisations they inhabit

such as the NHS itself. The NHS is commonly referred to in the media as 'broken', with some news articles using titles such as; "*The NHS is broken, but not yet critical*" due to growing waiting lists and reported inadequacies in the services received (Broughton, 2023; Cunningham, 2025). This can often be coupled with staff's lack of control or influence over the workplace, leading to decisions about their work being made by others (Broughton, 2023). The impact of moral injury was evident during the COVID-19 pandemic and the ramifications of this are still being felt by many staff today (French, Hanna & Huckle, 2022). During the pandemic response, staff were seen as being at high risk of moral injury as they were often left without the needed resources or staffing to provide the best care (French, Hanna & Huckle, 2022). One study explored the impact of betrayal perpetrated by the organisation against the staff, morally injured at a time of overwhelming stress in the pandemic (French, Hanna & Huckle, 2022). A key example of system/governmental betrayal was reported in recent research into moral injury, staff reflected on a time when the eat out to help out scheme was implemented (A scheme in which restaurant prices were reduced to encourage people to eat out), resulting in a spike in COVID patient numbers. Further exploration coupled this experience with a below inflation, 1% pay rise, which left staff feeling undervalued during a period intense threat (Hegarty et al, 2022).

Interestingly, other researchers have also spoken of the impact of the environment and or organisation on the workforce, highlighting that supportive workplaces in which staff felt able to express concerns and that they were listened to, lead to lower rates of moral injury (Hines et al, 2021). Additional research into levels of moral injury in healthcare workers took place in Sheffield, UK, in 2020, in which 858 healthcare workers completed a survey on moral injury (Fradley et al, 2025). In this study, it was shown that levels of moral injury across the workforce were moderate to high and that betrayal, systemic failures and an inability to provide adequate care were common sources of moral injury for staff (Fradley et al, 2025).

As shown above, exposure to morally injurious events can lead to mental health difficulties in NHS staff and in wider contexts such as veterans and police forces. In nursing, evidence has indicated that there is a need for a focus on moral injury and the wellbeing of nursing staff to help reduce the rates of people leaving the profession (Kim et al, 2024). Reports of being overworked and overly stressed at work whilst also being exposed to morally injurious events leading to staff burning out or leaving are evident in the nursing literature (Kim et al, 2024). However, this trend is not just seen in nursing, it is evident across all healthcare settings (Mewborn et al, 2023). Amongst doctors during the pandemic, moral injury was quoted as having the biggest long-term impact on wellbeing (Roycroft et al, 2020). It is noted that this moral injury was created by the need to make difficult decisions alongside a rising mortality rate and the potential for moral/ethical dilemmas during the pandemic (Roycroft et al, 2020). Overall, moral injury has a huge impact on staff retention as it often goes hand in hand with staff burnout and staff leaving the workforce (Bell et al, 2025; French, Hanna & Huckle, 2022).

It is evident that there is a need for more to be done to quell the impact of this and a few suggestions have been cited in the literature. It has been said that NHS Trusts should proactively prepare their staff to deal with PMIEs which are likely to be unavoidable at work (Hegarty et al, 2022). There is also an emphasis on clear and transparent communication from upper management and beyond, to help avoid situations like the ones seen during the pandemic in which staff on the ground were left feeling betrayed by their organisation and the government (Hegarty et al, 2022). Furthermore, it is explained that trusts must increase their responsiveness to these situations and offer accessible support for those experiencing moral injury at work (Hegarty et al, 2022).

Despite the research in other professions, investigations into the prevalence of moral injury in mental health staff in the NHS is sporadic or limited at best. In a profession that has undergone a lot of pressure and reports of stress and burnout (Harding et al, 2025; Stinton,

2025), and people thinking about leaving the NHS (Harding, 2025; Stinton, 2025), it is important to understand the prevalence of moral injury to see if this contributes to staff wellbeing and retention issues. Understanding the prevalence of moral injury may help inform interventions moving forward to explore if this is an unavoidable part of the work in mental health settings or if there is something that can be done to limit or lessen the occurrences of morally injurious events. Without this, mental health staff may continue to be subject to such events and continue to leave the workforce. This review aims to explore the extent to which moral injury is experienced by mental health professionals within the NHS; this being a positive forward step towards prevention of moral injury, in turn supporting staff retention.

The research question of this review is:

1. What is the prevalence/levels of moral injury in mental health staff in the NHS?

Methods

Study Design

The full protocol for this systematic review was registered on PROSPERO on the 17th of February 2026 (CRD420261308335). This review conforms to the guidance provided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement and Systematic and Synthesis Without Meta-Analyses (SWiM) guidelines (Moher et al, 2009; Campbell et al, 2020).

Search Strategy

A systematic search strategy was developed to identify key research papers that aligned with the research questions of this review. Search terms and strategies were reviewed with support of the academic librarian at the University of East Anglia (UEA) and the final search was completed on the 13th of November 2025. Search string was as follows: NHS OR “national

health service" OR "united kingdom" AND Mental health staff" OR "mental health workforce" OR psycholog* OR "clinical psychologist" OR therapist OR "allied healthcare professional" OR "psychological therapist" AND "moral injury" OR "moral distress" OR moral.

See search string used in Appendix B. Additionally, see Appendix E for the list of NHS staff considered as mental health professionals.

The following databases were searched: APA PsycINFO, Medline OVID, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed and Embase. No restrictions' were placed on publication period. See table 1 for inclusion exclusion criteria.

Eligibility Criteria

Table 1: Inclusion and exclusion criteria.

Inclusion	Exclusion
Studies containing the aforementioned NHS professionals (Allied Healthcare Professionals, Psychological Professionals) (Appendix C)	Studies exploring the psychological concepts on patient groups
Studies including data on levels of moral injury e.g. quantitative, including validate measures such as: The Moral Injury Outcome Scale (Litz et al., 2022), Moral Injury Event Scale (Nash et al, 2013) etc.	Studies including non-NHS mental health staff (i.e. private healthcare)
Studies referring to prevalence statistics of moral injury/distress	Non-English publications
English language publications	Studies using non-UK samples
Studies using UK samples	Studies with poor description of methodology and/or analysis
Quantitative studies	Grey literature (e.g., unpublished articles, conference proceedings, master's dissertations, doctoral theses, book chapters,

	and commissioned reports, literature reviews)
Mixed method studies	Studies where we are unable to obtain the full-text
Peer-reviewed journal articles	
Studies including primary data	

Screening and Study Selection

A total of 6,850 articles were retrieved via the searches which was reduced to 5,685 after the removal of duplicates using Rayyan software (Ouzzani et al, 2016). The lead researcher (TW) screened all (100%) titles and abstracts and full texts articles. The second reviewer (KS) screened 25% of the papers at each stage to ensure inter-rater reliability. After reviewing the titles and abstracts, there was 1 conflict out of the 1423 titles and abstracts which was managed via discussion before reaching a consensus. Inter-rater reliability was considered almost perfect (k=.94).

At total of 27 full texts remained for review, the lead researcher reviewing the full 27 and the second researcher reviewing seven (25%). There were no conflicts at this stage resulting in a perfect inter-rater reliability score (k=1). (see Figure 1 for the full PRISMA flow diagram)

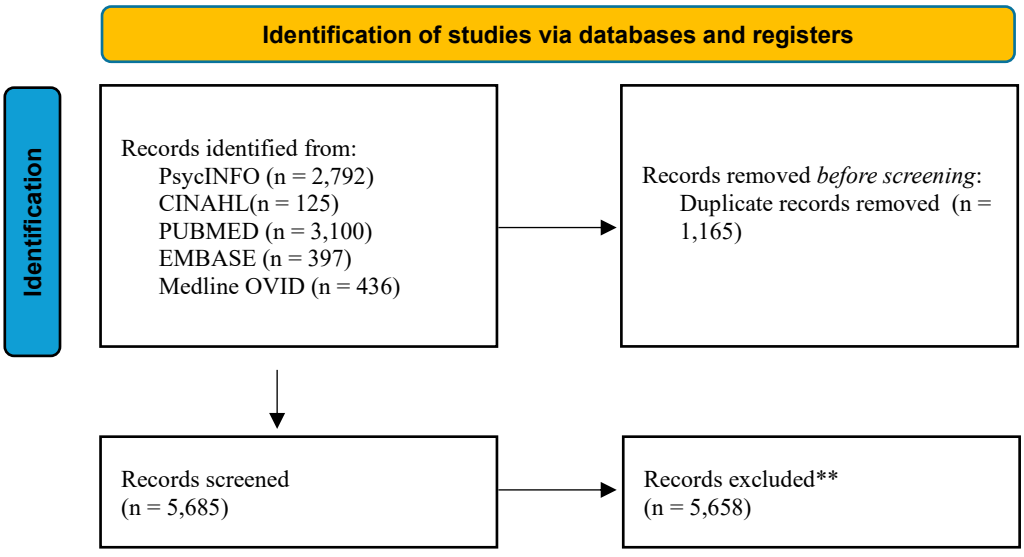
Quality Assessment

The JBI checklist for prevalence studies critical appraisal tool (Munn et al, 2020) was used to assess quality and bias of the five included studies. This tool assessed the methodological quality to examine the extent to which a study had addressed the presence of bias in areas such as design, conduct and analysis (Munn et al, 2020). This tool was used to evaluate nine elements to inform the synthesis and interpretation of results and did not prescribe cut offs, therefore inclusion and exclusion of a study in the review is not specified. These questions

examined the appropriateness of the population and of how they were gathered. Additionally, the adequacy of the sample size and the descriptions of such in addition to the presence of valid measures and the reliability of said measures. Further, it explored the appropriateness of the analysis and the adequacy of the response rates. Both the primary (TW) and secondary researcher (KS) assessed the quality of all (100%) of the included studies with a 100% rate of agreement (Appendix B).

Data Extraction

The primary researcher managed the extraction and summarisation of the data from the studies included. The data extracted was as follows: population, sample size, outcomes measured, measures used, levels/prevalence of outcome measured. See table 2 for summaries for types of professions included, i.e. allied healthcare professionals and mental healthcare professionals, sample sizes, moral injury measure used and means and standard deviations reported. See table 3 for included study characteristic information.



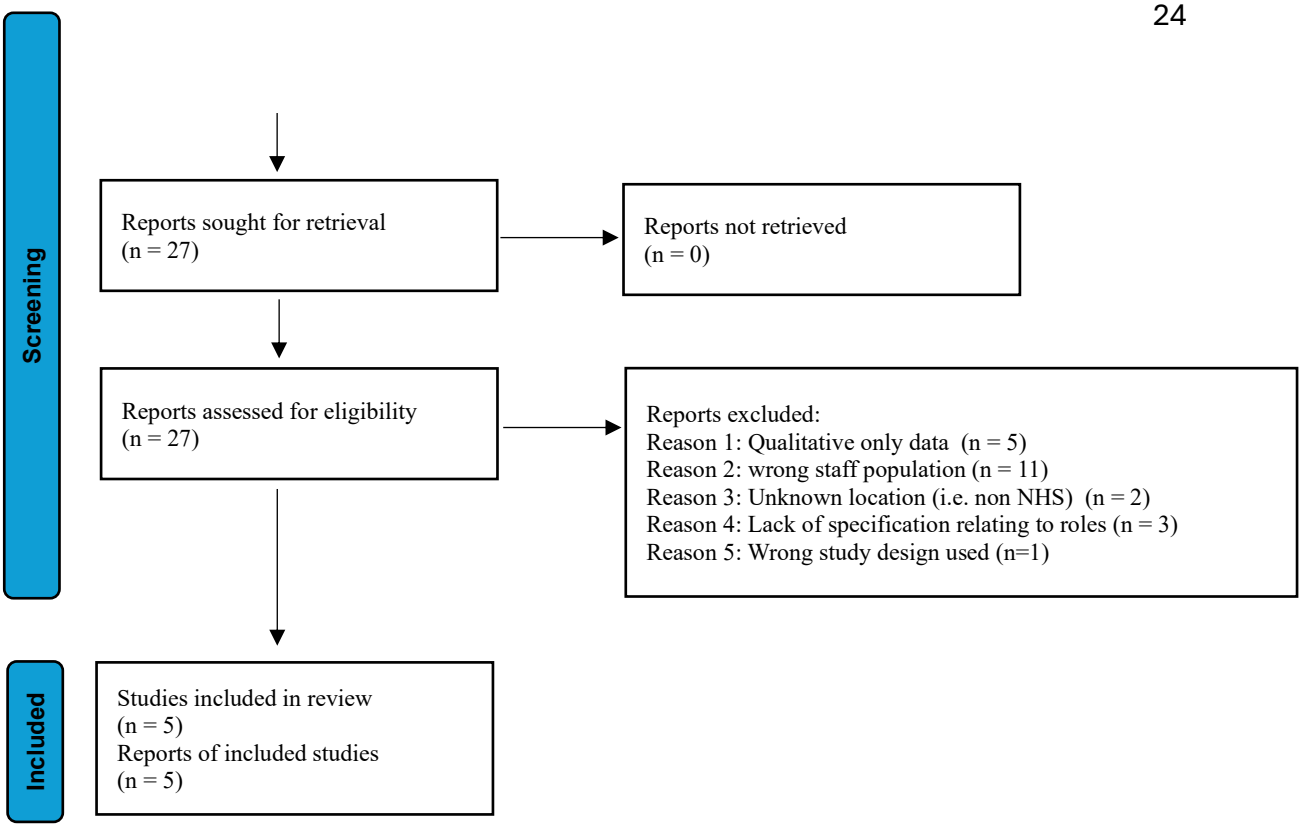


Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram.

Data Synthesis

Initially, a meta-analysis was planned to synthesize the data, however, there were inconsistently reported samples that may have not included the necessary professionals. Furthermore, mental health staff were often not separated them from the larger sample and lacked overall data relating to prevalence of moral injury in the specific staff groups explored, so a meta-analysis was not possible. The primary researcher contacted three of the five authors of the included papers to request missing data. Two of which were uncontactable at the registered email addresses, one of which did not respond. Therefore, a meta-analysis could not be completed. Due to this, a narrative synthesis was conducted using SWiM guidance (Campbell et al., 2020) for the data synthesis.

Further exploratory analyses were completed to explore the studies' findings relating to endorsement of factors on the Moral Injury Events Scale (MIES) and the Moral Distress Scale Revised (MDS-R). This was done to explore the results in relation to previously completed research into other areas of healthcare using these same scales. Further information on this and the measures used is included in the study characteristics section of this review.

Results

Primary Research Question

Unfortunately, the main research question: What is the prevalence/levels of moral injury in mental health staff in the NHS? Could not be answered in this review. This was due to limited/missing data despite efforts to reach out to authors.

Study Characteristics

Table 2 summarises the characteristics of the included studies. Within the five papers, there was a lack of specification about the exact professionals involved in the studies, only that they were either Allied Healthcare professionals (AHP) (n=58) or psychological staff (n=27); this included clinical psychologists, assistant psychologists and other therapeutic staff but the breakdown of numbers was not given. Different professions being grouped together meant that data for mental health staff specifically, could not be extracted for analysis.

All papers were published within the last 5 years of the search being completed, ranging from 2020 to 2025. The majority of the researchers used the Moral Injury Events Scale (MIES; Nash et al, 2013) to measure levels of moral injury (k=4). The MIES consists of nine statements which are rated by the participant based on how much they endorse that statement. There are three subtypes in the MIES, these are 'transgressions of others' (i.e. I saw things that were morally wrong), transgression of self (i.e. I am troubled by having acted in ways that violated my own morals or values) and betrayal (i.e. I feel betrayed by leaders who I once trusted). The

remaining study utilised the Moral Distress Scale – Revised (MDS-R; Hamric, Borchers & Epstein, 2012) (k=1). The MDS-R uses a four-point Likert scale to rate a person's level of agreement with certain statements related to morally distressing events, including; '*I witnessed healthcare staff giving "false hope" to a patient of family'* and '*I have witnessed that the quality of care is reduced due to poor team communication'*.

Table 2: Study Characteristics of Included Papers, Reported Professions, Samples, Measures of Moral Injury and Means/Standard Deviations Reported on Measures.

Author (year)	Profession/s reported	Sample sizes	Moral Injury Measure	M (SD)
Brennan, McKay & Cole (2022)	Allied Healthcare professionals (AHP), Psychological	(n=58) (n=27)	MIES	**AHP** Transgression - others = 2.71 (1.44) Transgression to self = 1.90 (1.05) Betrayal = 2.55 (1.41) **PSY** Transgression - others = 2.83 (1.32) Transgression to self = 1.79 (.98) Betrayal = 2.56 (1.08)
Brennan, McKay & Cole (2025)	Allied Healthcare professionals (AHP), Psychological	(n=58) (n=27)	MIES	**AHP** Transgression - others = 2.81 (1.36) Transgression to self = 1.83 (1.04) Betrayal = 2.57 (1.44) **PSY** Transgression - others = 2.93 (1.45) Transgression to self = 1.84 (1.05) Betrayal = 2.90 (1.25)
Greene et al, (2024)	Health and Social Care Workers (including	(n=1,056)	MIES	Data is for the whole group: **Transgression of others** Q1: 501 (52.7%) Q2: 383 (40.3%)

	psychologists and AHPs but not grouped)			**Betrayal** By managers- 462 (48.6%) By colleagues- 316 (33.2%) By the public- 444 (46.7%)
Hegarty et al, (2022)	Included psychologists and AHP's but not reported separately	(n=30)	MIES	At least one of more scales on the MIES was endorsed by every participant. 80% of which endorsed betrayal.
Jones et al, (2020)	'Other' group Included psychologists, SLTs, play therapists but was not well defined.	(n=192)	MDS-R	36 (33) 10% of 192 scored >90 indicating significant levels of moral distress.

As shown in table 2, two different measures of moral injury were used across the papers reviewed. These were the Moral Injury Events Scale (PMIES; Nash et al, 2013) and the Moral Distress Scale – Revised (MDS-R; Hamric, Borchers & Epstein, 2012).

Quality Ratings

The JBI checklist for prevalence studies critical appraisal tool (Munn et al, 2020) was used to assess the quality and bias of the papers included (Appendix B). While all papers were included in the review, quality varied and the ability to obtain further information and data was limited. Brennan, McKay and Cole (2022; 2025) provided unclear sample frames and remained unclear when exploring the appropriateness of their recruitment methods. Overall sample sizes appeared adequate (n=400) with the total number of mental health staff being an adequate sample of that (n=85). Response rates were reported as adequate and slow responses were clearly managed. The study subjects and settings were described in detail, including health and

social care workers and the areas in which they worked. Valid methods were used to complete the analysis which was also appropriate for the study and validated measures of moral Injury were used (MIES).

Whilst all other studies recruited from the NHS check participant pool which is specifically for NHS staff or from social media, Brennan, McKay & Cole (2022; 2025) recruited through 'Prolific', which is a participant pool that is not open to anyone who is not signed up to the network. However, they did manage to recruit specifically NHS professionals which was important for this review, yet, a different method of recruitment could have created a larger sample. Greene et al (2024) and Jones et al (2020) recruited adequate samples (n=>1000) for their overall group, however, defining specific numbers of mental health staff was not possible within these papers. Recruitment methods for these papers were adequate, utilising NHS check and social media and both used validated measures of moral distress (MDS-R) and moral injury (MIES) to complete their analyses.

It was clear from Hegarty et al (2022) that the sample size was not adequate (n=30) when compared to the others discussed in the review. However, this may have been due to the qualitative nature of the research. Furthermore, due to an inability to obtain further data pertaining to the MIES scores, the appropriateness of the analysis and the adequacy of the response rate remained unclear.

All papers reported using well defined and validated measures of moral injury and moral distress. The two measures reported were the Moral Injury Events Scale (Nash et al, 2013) and the Moral Distress Scale – Revised (Hamric, Borchers & Epstein, 2012). Based on the data available, authors and others involved in Hegarty et al (2022), Greene et al (2024) and Jones et al (2020) were contacted for further information after reviewing full texts and supplementary data. However, no response was gained.

Table 3: Study Characteristics

Characteristic	n
Year of Publication	
2020	1
2022	2
2024	1
2025	1
Mental Healthcare Professional	
Allied Healthcare professional (unspecified)	58
Psychological staff (unspecified)	27
Other total numbers reported but not otherwise specified into groups	1,278
Measure	
Moral Injury Event Scale (MIES)	4
Moral Distress Scale – Revised (MDS-R)	1

Additional Narrative Analyses

Moral Injury Events Scale (MIES) with Defined Groups

Two of the included studies (Brennan, McKay & Cole (2022, 2025) explored responses to the MIES and included psychologists and allied healthcare professionals as separate groups. These research papers were completed over two timepoints, with a 12-month follow up. When considering both time-points for each study, transgression by others and betrayal were more readily endorsed factors on the MIES than transgression by self. Suggesting that the impact of managers, colleagues and the public produced more moral injury than the actions of the individual in this research.

Brennan, McKay & Cole's (2022, 2025) findings highlighted in table 2, show that Allied Healthcare Professionals (AHPs) reported moderate exposure to transgression by others which is shown as similar to the moderate exposure rating for psychologists in the study. At the follow-up point, transgression by others for AHP and psychologists remained at moderate levels.

AHP's reported slightly more distress relating to their own actions/inactions in the 'transgressions by self' factors when compared to psychologists but both would be considered low. In the follow-up, transgression by self levels remained low for both groups, AHPs and psychologists showed limited change over the 12-month period on this factor and remain low in levels of moral distress.

When considering levels of betrayal, both AHPs and psychologists reported similar, moderate levels suggesting moderate feelings of betrayal from management, colleagues and or the public. Levels of betrayal for AHPs remained similar at the 12-month follow-up, and increased slightly for psychologists, both continuing to report moderate levels of betrayal.

Moral Injury Events Scale (MIES) and Moral Distress Scale Revised (MDS-R) without Defined Groups

The next portion of the results must be interpreted mindfully and not be used to speak definitively about prevalence of moral injury in each group.

Greene et al (2024) recruited 1,056 total participants, a number of them being psychologists and AHPs, however, these groups were not analysed separately. Hegarty et al (2022) completed their research using interviews, however, all participants had to complete the MIES as a part of the recruitment process and those who endorsed one or more factors on the

MIES were included in the research. This study included psychologists and AHPs, however, the total number of participants (n=30) was low.

Although Hegarty et al's (2022) participants were not separated into job roles and further descriptives were not available. The main finding that relates to this current systematic review was that betrayal was the most commonly endorsed factor by all participants (~80%). This appears to align with Greene et al's (2024) findings in their 1,056 participants, as it was shown that 462 (48.6%) endorsed feeling betrayed by managers or team leads. A total of 444 (46.7%) endorsed feeling betrayed by the public and others outside of their organisation and 316 (33.2%) respondents felt betrayed by their colleagues in some way. These results appear to align with findings in both Brennan, McKay and Cole papers (2022, 2025) relating to increased levels of endorsement for the betrayal factor.

When considering transgressions of others, the most endorsed by participants and reported by Greene et al (2024) was "*I saw things that were morally wrong*" (n=501, 52%) and "*I am troubled by having witnessed others' immoral acts*" (n=383, 40.3%). These findings align with what was shown in Brennan, McKay & Coles (2022, 2025) research, however, in a larger, less specified group.

Considering Jones et al (2020) research in levels of moral distress amongst Paediatric Intensive Care Units (PICU's) included a large number of participants (n=1,656). The 'other' group (n=192) was comprised of psychologists, speech and language therapists, play therapists, clerical staff, emergency drivers amongst other professionals, yet it did not specify the total number of each profession within each group. The 'other' group was analysed as a whole, and so there may be reasons for the scores differing from colleagues from other groups, such as doctors and nurses which will be discussed later.

This study utilised the Moral Distress Scale – Revised (MDS-R; Hamric, Borchers & Epstein, 2012) and found that the overall mean scores of moral distress for the 'other' group appeared lower (36, SD 33). They reported that only 19 out of the 192 (~10%) scored above the clinical cut off (>90) on the MDS-R which would indicate increased levels of moral distress. Contributing factors are suggested as related to the inconsistencies of roles included in the 'other' group with clinical psychologists and clerical staff having vastly different roles on the PICU and experiencing very different situations. The authors for this study were contacted by the lead researcher to explore the missing data; however, no response was gained.

Discussion

This review was important to explore a profession that has undergone a lot of pressure and reports of stress and burnout (Harding et al, 2025; Stinton, 2025) leading to people thinking about leaving the NHS (Harding, 2025; Stinton, 2025). This review is the first to explore the literature investigating the prevalence of moral injury amongst mental health staff in the NHS specifically. Previous efforts have been made to explore this psychological concept in general medicine, veterans services and other sectors. However, the research on NHS mental health staff as described in the inclusion criteria and the levels of moral injury among them has not been reviewed until now. We attempted to synthesise the current evidence surrounding levels of moral injury amongst the NHS mental health workforce with the key question being: What is the prevalence/levels of moral injury in mental health staff in the NHS? Unfortunately, this question was unable to be answered. The reasons for this are multifaceted and will be explored in more detail in the limitations section of this review. The main reasons the research question was not answered was because there were insufficient reported prevalence rates in the papers themselves for mental health staff in particular. Many researchers included mental health professionals in groups such as 'other', which included professionals that would not meet the inclusion criteria. Others included the chosen staff groups, however, did not examine the

professions separately, rather, it was completed as whole samples meaning that prevalence rates for the included staff groups could not be attained. Furthermore, for some, data was not provided in the initial paper, nor the supplementary data and on attempting to contact the authors and institutions, no response was gained. Despite this, supplementary analysis did provide information pertaining to the factors endorsed by these professionals on the MIES and MDS-R and highlighted key factors from this that are important to consider.

Supplementary Analysis

It was clear that literature regarding the prevalence of moral injury among mental health staff was limited compared to studies on other NHS staff (Fradley et al, 2025; Kim et al, 2024; Roycroft et al, 2020). Despite this difficulty, some evidence has been found relating to moral injury amongst mental health staff in studies exploring larger staff populations.

The main findings of the supplementary analysis were that the two prevalent factors amongst staff groups were transgression by others and betrayal as endorsed on the MIES. Brennan, McKay & Cole (2022, 2025) used the MIES (Nash et al, 2013) to record levels of moral injury, they found that among 85 AHPs/psychological professionals results on the three subscales varied (Brennan, McKay & Cole, 2022). Their findings showed that for these staff members, the transgressions by others (managers, team leads etc) and betrayal factors were moderately endorsed causes of moral injury at the first time point during the pandemic. Participants endorsed these items on the MIES more regularly than the transgressions by the self-factors at both time points (Brennan, McKay & Cole, 2022, 2025). This finding suggests that these factors moderately impact levels of moral injury and are more likely to be endorsed by staff. This finding supports the information discussed in the introduction to this paper, outlining that NHS staff having to work in ways that violate their morals and the betrayal that is felt when staff are not supported or vilified by external sources and sources within the

organisation are the most common causes of moral injury (Broughton, 2023; French, Hanna & Huckle, 2022; Hegarty et al, 2022).

Due to the limited focus of the research on mental health staff specifically in the other papers included (Greene et al, 2024; Hegarty et al, 2022; Jones et al, 2020), interpreting prevalence rates of moral injury among mental health staff was not possible. However, the results do reinforce other findings into the prevalence of moral injury, especially when considering the prevalence of certain factors amongst a wider range of staff. Whilst it was apparent that the other studies included in this review lacked specificity to the chosen demographic, their results remained informative and highlighted key similarities to previous research. It was shown in a group of over one-thousand participants, including mental health staff, that "*seeing things that were morally wrong*" (n=501) or being "*troubled by witnessing others immoral acts*" (n=383) were prevalent issues for staff (Greene et al, 2024). Furthermore, feeling betrayed by managers or team leaders and feeling betrayed by the public and others external to the organisation were commonplace and around half of the staff included in the study reported this (Greene et al, 2024).

Furthermore, when reviewing Hegarty et al (2022), of the group of thirty participants, 80% of them endorsed the betrayal factor, which again links to the earlier research and what is becoming a theme in the current systematic review. However, it must be mentioned that due to the inability to obtain the MIES data from this project, this must be understood in the context of the wider Health and Social Care Workforce (HSCW) staff group due to the lack of separate group statistics (Hegarty et al, 2022).

Jones et al (2020) utilised the Moral Distress Scale – Revised (MDS-R; Hamric, Borchers & Epstein, 2012) and grouped mental healthcare staff into the 'other' section of their findings. This 'other' group made up a small sample of the larger research and included other professions

such as clerical work and emergency drivers, due to this, the results are difficult to compare with others. They showed that only 19 of the group (n=192) scored above the clinical cut off for moral distress in this study, which was different from the doctors and nurses' groups. This difference may be due to the varied sample of the 'other' group and how different the roles are. Psychological professionals being more likely to encounter or be present for challenging and threatening situations on the PICU compared to other staff in this group.

Clinical Implications, Limitations and Future Research

Limitations

One limitation of this systematic review is evident, the lack of research investigating the prevalence of moral injury in mental healthcare staff. Factors such as betrayal and transgression from others appear common throughout the literature, however, when considering just how common amongst this staff group, we remain unsure due to the lack of larger more specific samples of the mental health staff population. This is likely due to this being a fairly new research area as highlighted by only five studies being included in the final analysis and all of them being published within the past five years.

Additionally, there were limitations to report regarding the quality assessment using the JBI checklist. Whilst it appeared that the samples used in each of the research papers were recruited from adequate populations and detailed correctly, there were clear limitations to the specificity of the groups and in some cases the size of the samples within the overall set of participants (Brennan, McKay & Cole, 2022; 2025; Jones et al, 2020). Furthermore, when reviewing Hegarty et al (2022), the sample size used in the final analysis was below the adequate size as a result of it being a qualitative project with no further information on the initial, larger sample used to refine the study.

Most research explored groups of staff from select recruitment pools including mental health staff. However, these pools of participants were then grouped in a way that made it difficult to include in this review. Staff groups such as nurses and doctors were often grouped appropriately, however, when mental health staff were added to sections titled 'other' it became less well defined. It has already been mentioned that the 'other' groups in this review were often made up of varied roles, comparing the moral injury prevalence of a psychologist to admin staff may discount this nuance. Mental health staff such as clinical psychologists may be in positions of decision making, which may lead to the violation of values if they need to make a particular decision about a patients care. Furthermore, they may be present and hear about the transgressions of others perpetrated towards the staff they supervise and those they care for. Whilst administrative staff are exposed to potentially traumatic events over the phone and in person, they may not share the same level of responsibility as certain mental health staff, meaning the grouping of these professions together impacts the data.

Future Research

More research is needed exploring the prevalence rates of moral injury among this staff group. As shown in the data above, mental health professionals are experiencing moral injuries at work and often this is via betrayal or by transgressions of others. This has been shown across wider staff groups and prevalence has been examined. However, for mental health staff, there is currently a lack of data on how prevalent moral injury is. Future research should explore groups more specifically, for example, completing a measure such as the MIES in NHS mental health community teams and defining groups based on profession. This may then allow us to see prevalence rates of moral injury in each profession across mental health services.

Clinical Implications

One key implication is clear from the lack of data regarding prevalence rates of moral injury among mental health staff in the NHS. If we are not able to ascertain prevalence of moral injury, we don't know how common this is. In a profession that reports high levels of stress and burnout (Harding et al, 2025; Stinton , 2025), and people thinking about leaving the NHS (Harding, 2025; Stinton, 2025), it is important to understand the prevalence to see if this contributes to staff wellbeing and retention issues.

Conclusions

The findings of this review revealed that currently, we are unable to determine the prevalence of moral injury among mental health staff in the NHS. Additionally, it was shown that transgressions of others and betrayal are the most commonly endorsed items on the MIES for mental health staff in the NHS. Results indicated that around half of all participants endorsed these items and that this aligns with previous research into other staff groups. The main conclusion of this review is that there is a need for further research into prevalence rates of moral injury amongst mental health professionals in the NHS. Whilst the factors associated with moral injury continue to be explored, further investigation into the specific nature of betrayals and transgressions of others is also needed. These projects could in turn, inform NHS trusts and others of improvements that may need to be made in order to lessen the presence of moral injury and overall improve staff retention and wellbeing.

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Author Contributions

Hannah Baily: conceptualisation

Khadija Shah: Data screening, quality assessment, data extraction

Dr. Rachel Russell, Dr. Sheryl Parke, Dr. Jinnie Ooi: Conceptualisation, supervision, writing, review and editing.

Highlights

- There is a lack of research into the prevalence of moral injury in mental health staff specifically, when compared to other professions.
- Mental health staff experienced moral injuries during the pandemic and a year after its start, mainly via betrayal or through the transgressions of others.
- The main moral injuries endorsed related to ‘transgression by others’ and ‘betrayal’.

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Chapter Three

Bridging Chapter

Bridging Chapter

The systematic review above aimed to explore and discuss the prevalence of moral injury amongst NHS mental healthcare professionals. However, on completion of this review process it was apparent that statistics relating to levels of moral injury among mental healthcare staff in the NHS are not yet available. Nonetheless, out of the five papers included in the review, findings do align with previous evidence exploring causes of moral injury and the levels of endorsement for certain moral injury factors.

Brennan, McKay and Cole (2022; 2025) demonstrated that amongst Allied Healthcare Professionals (AHPs) and psychological staff the factors most readily endorsed were transgressions of others and of betrayal. They found that at both the initial time-point and the 12-month follow-up, staff reported moderate levels of endorsement in these two factors. Greene et al (2024) did not report their findings for each profession, rather, they reported the findings across the whole sample (n=1,056). This sample did include the desired staff groups, however, finer detail on these groups was unobtainable. Despite this, they also found that transgressions of others and betrayal were the most endorsed factors in their sample. Specifically, relating to the witnessing of others immoral acts, or feeling betrayed by team leads and managers (Greene et al, 2024). Hegarty and colleagues (2022) recruited participants using the Moral Injury Events Scale (MIES; Nash et al, 2013) as participants interviewed would have to endorse one or more factor on the MIES. They noted that around 80% of the participants recruited endorsed betrayal, again, linking to others research using this tool. The final paper included utilised the Revised version of the Moral Distress Scale (MDS-R; Hamric, Borchers & Epstein, 2012) to explore moral distress in Paediatric Intensive Care Units (PICU) across the UK. Mental healthcare staff such as clinical psychologists were grouped in the ‘other’ section and out of the total ‘other’ group (n=192), it was unclear how many were of

the chosen professions. Other members of this group included admin staff and emergency drivers which may be reflected in the results found. They reported that 19 of the total 'other' group scored above the clinical cut off on the MDS-R, suggesting lower overall mean scores for this group (Jones et al, 2020).

As the systematic review found and as was outlined in the introduction, research into the experiences of clinical psychologists and mental healthcare workers is growing but still remains small compared to other professions. Also, moral injury is only one factor impacting the experiences of these staff members in the workplace. Clinical psychologists in particular appear to be an interesting and under-reported sample in the literature. The factors that impact their careers and career choices are also multi-faceted, not only related to potentially morally injurious events at work (Palmer et al, 2021).

Ultimately, clinical psychologists are presently facing choices relating to their career in the NHS. The notion of working privately vs in the NHS has always been a much-discussed topic and one facet of that which is growing pertains to the personal life circumstances that may shape a person's experience. Previous research has explored the experience of working-class clinical psychologists as they make their way through clinical training on the doctorate, however, there is yet to be research into this group following qualification (Place, 2023). Researchers found that whilst completing the doctorate, working-class trainees felt out of place, undervalued or misunderstood (Muthy, 2022; Palmer et al, 2021; Place, 2023). Feeling out of place is a common experience for working-class people as they undergo class migration, as shown previously when people move from working-class to university student. They may then experience that when their earning potential increases again, as it does when they qualify from doctoral training (Bourdieu & Passeron, 1990; Ivemark & Ambros, 2021, 2023).

The following empirical paper intends to explore the experiences of working-class clinical psychologists in the NHS workforce, private sector and those split between the two. This paper will aim to explore the ways class migration has been experienced and how this and other factors have impacted their career decisions.

Chapter Four

Empirical Paper

Experiences of Working-Class Clinical Psychologists in the NHS Clinical Workforce and beyond: A Qualitative Study

Thomas Westwood[1], Rachel Russell[1], Sheryl Parke[1] and Jinnie Ooi[1]

[1]*Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, University of East Anglia, Norwich, UK*

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Abstract

Clinical psychology as a profession is seen externally as a middle-class career (Daly, 2025). However, there are many people who decide to access this profession from other areas of life and there are many factors that impact this journey and their career as clinical psychologists. One key consideration is the role of social class and how a lack of social capital and habitus can impact a person's ability to access courses and jobs but also how it impacts their ability to fit into this new social sphere (Bourdieu & Passeron, 1990; Kaiser & Prieto, 2018; Ivemark & Ambros, 2021, 2023). Factors such as these are important to consider amidst an NHS workforce sustainability challenge, in which several factors are being reported as impacting people's careers and choices (Moscellli et al, 2022; Palmer et al, 2021). Previous research into working-class trainee clinical psychologists revealed that they often felt different, or out of place, suggesting that their opinions were less valued than others based on their class history (Muthy, 2022; Palmer et al, 2021; Place, 2023). This empirical project aimed to explore the experiences of a qualified cohort of working-class clinical psychologists in the NHS, private practice and those splitting their work between the two. The researcher aimed to understand how these individuals' experienced movements through social class systems and how this may have influenced their career decisions since qualification. Semi structured interviews of 13 participants were analysed using Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2022). Four interconnected themes were constructed: *Money and class*, *Experiences of Class Migration*, *The Push and Pull of the NHS and the Working-class Clinician* and *Us and Them (Seen/Unseen, Heard/Unheard differences)*. The findings highlighted that for these clinicians, their early life and class journey impacted their careers in many ways, leading to alignments with the NHS and the values it represents and also fractures between the individual and the system. Growing up working-class often impacted people's ability to 'fit in' to this middle-class profession and shaped their journey post qualification in some way. More research is needed to explore other groups of clinical psychologists in and out of the NHS to better understand this staff retention issue and their reasons for staying or leaving.

Keywords: Class, Habitus, Clinical Psychology, NHS, Class Migration, Private Practice, Split

Introduction

Clinical psychology is predominately seen as a middle-class career in terms of earning potential and due to external perceptions of the role (Ahsan, 2020). This is apparent throughout the journey to becoming qualified as there are barriers that many strive to overcome to access clinical training. Aspiring clinical psychologists from working-class or minority ethnic groups face several barriers that their middle-class peers may not. Many are shown to be less able to accept unpaid or low-paid positions to gain experience as they may be more likely to have dependants, restricted household income, travel challenges or other accessibility issues, in addition to systemic barriers and a lack of support or capital (Afrah, 2024; Atayero & Dodzro, 2021; Bawa et al, 2021; Palmer et al, 2021; Ragavan, 2018). Due to this, they are less represented in the clinical psychology workforce. Social class and how this affects a person's journey through the profession, and their experience of this, is a key characteristic that at times is overlooked.

Social Class

Social class can be understood as an economic culture which is defined by higher or lower levels of privilege based on one's access to finances, social capital, wealth and power (Kaiser & Prieto, 2018). Working-class is defined as a person or people from areas of financial deprivation, engaged in semi-skilled manual roles with low pay, lacking security and holding limited entitlements (Kaiser & Prieto, 2018; Taylor-Hill, 2024). However, working-class may be better defined by the values held by an individual and their family of origin as the working class have often been defined by their sense of collective identity in addition to their income levels and skill set. As such, people from other professions may still consider themselves 'working class' despite increased earnings (Kaiser & Prieto, 2018; Taylor-Hill, 2024). Despite a drop in the number of people that would be categorized as working-class due to the increases

in minimum wages, job security and access, many would still self-identify as such due to the constraints on earnings amidst increasing inflation and living costs (Gallo, 2020; Manstead, 2018; Robinson et al, 2021). Research indicated that people who identify as working-class are more likely to have several traits which may be important to consider when thinking about why someone from this background may want to become a clinical psychologist (Manstead, 2018). The main trait being empathy, leading to the suggestion that people from this class group would be more prone to support people in distress (Manstead, 2018).

Another consideration for people from working-class backgrounds choosing a career in clinical psychology is the class transition they may undertake, from working-class to more middle-class settings. The role change post-qualification comes with an increase in wage to band 7 and above in the NHS, which is contextualised as 'middle-class' income in today's economy and creates space for class migration .

Clinical Psychology and Class

Bourdieu's Social Theory (Bourdieu & Passeron, 1990) suggests that people inherit a level of social, cultural and economic capital from their early environment which positions them in a specific social space and forms the basis for where they may 'fit in' to society. When entering a new social field, such as the move to middle-class university structures, they may experience challenges fitting in (Arm, 2022; Bourdieu & Passeron, 1990; Heslop et al, 2023; Ivemark & Ambros, 2021, 2023).

This challenge fitting in may appear once more when moving to the role of a qualified clinical psychologist. This ability to fit in, depends on the persons 'Habitus', that is the individuals socially structured system that organises their perceptions and judgements of the world around them on a more instinctive level (Bourdieu & Passeron, 1990). Previously identified difficulties were reported in the trainee role for those from a working-class

background, some feeling unheard, mislabelled or struggling to fit in amongst their peers (Daly, 2024; Place, Crew & Saville, 2024). This is in keeping with what is already known of the working-class experience, facing potential discrimination and at times vilification from others due to misguided perceptions from people outside of this social sphere (Crew, 2020; Chen et al, 2022; Day et al, 2020; Friedman, 2019; Littler, 2013). These external perceptions in addition to the potential struggle of class change may be factors that impact clinical psychologists' lives post qualification and thus influence their decisions to stay or leave the NHS.

NHS Workforce Sustainability

The NHS itself is a diverse institution with people from all different class positions and cultures. Many researchers and organisations are currently exploring ways to keep the NHS an accessible and diverse place to work. However, in the current social and economic climate, staff recruitment and retention issues in the NHS persist (Moscellli et al, 2022). There are numerous reasons outlined in the literature suggesting why staff leave the NHS. One factor is the challenges with upward mobility in the role of a clinical psychologist (Palmer et al, 2021). As clinical psychologists progress through pay-bands, client focused time reduces and managerial responsibilities take precedence (Palmer et al, 2021). Recent staff surveys highlight that for many clinicians, the best part of their role is seeing patients for treatment and helping them move towards a goal (Palmer et al, 2021).

Others suggest that pay is one of the main reasons for leaving as some critics explain that the Agenda for Change framework has been one of the key factors of negative change within the NHS due to the aforementioned implications of less patient facing work, rigid pay scales and limited flexibility (Bimpong et al, 2020; NHS, 2024; Stockton & Stoye, 2024). Furthermore, researchers found that clinical psychologists were facing organisational difficulties at work, feeling undervalued and underutilised, leading to a sense of disillusionment

in the role (Harding, A, 2025; Stinton N, 2025). Exploring the experiences of NHS staff, those who left for the private sector and those split between the two, may give more concrete answers about not only what leads people away from the NHS, but what may be pulling them back or stopping them leaving. Whilst no concrete numbers have been reported on the total number of clinicians leaving the workforce, this is an important starting point.

Another challenge that has been highlighted in the literature is that some groups within the clinical workforce may experience discrimination which impedes their progression into higher bands (Greaves, 2021; Scevoli, 2020). Evidence shows that individuals from global majority groups occupy fewer managerial positions within the NHS when compared with white British staff (Palmer et al, 2021). Social class is another factor impacting people's experiences within the workforce (Place, 2023). Staff from working-class backgrounds feeling different or out of place and indicating their opinions may not be as valued due to their background or class history (Muthy, 2022; Palmer et al, 2021; Place, 2023).

Gaps and Aims

The points outlined above, such as the difference between working-class clinical psychologists and their middle-class peers, the issues with pay structures and the challenges with fitting into new class systems illustrate the importance of exploring the experiences of those qualified clinical psychologists from working-class backgrounds within the NHS and beyond. This research aims to do this whilst keeping in mind the sociological framework outlined initially by Bourdieu and expanded by others such as Ivemark and Ambros in the early 2020's. This may help us to better understand this lesser explored group's experiences in the clinical workforce and how this impacts their career choices. This research hopes that in turn this can guide future understandings and increase staff retention in the NHS as currently, there is a lack of research into the experiences of those from working-class backgrounds within the clinical

psychology workforce and how this experience influences their working life and their career decisions.

Research Questions

1. What is the experience of a working-class clinical psychologist in the NHS, private sector and those split between the two, post-doctoral training?

2. (a) how do these individuals experience movements through social class systems?

   (b) has this influenced their career decisions since qualification?

Method

Epistemology and Ontology

This research was carried out from the social constructionist epistemological position using reflexive thematic analysis. This position suggests that reality is dependent on the ways we as the individuals come to know it (Clarke & Braun, 2013). This allowed for the unique perspective of each participant to be shared based on their own journey and how they came to make sense of the world. This permitted the lead researcher to be placed as a point of reflection in the interview to garner further insight based on each question and the follow-up. The focus is on the experience of the individual and their working-class roots and how this has shaped their perception of themselves and the systems they inhabit. Within this framework, the research aimed to consider the impact of external and internal perceptions on the individual and the overall impact of this on the working life and environment of the person.

Study Design

This cross-sectional qualitative study utilised semi-structured one-to-one interviews to explore the experiences of working-class clinical psychologists working in the NHS, private sector and split between the two.

Participants

This research initially gathered a total of 29 Participants, due to disengagement or inclusion thresholds for total numbers for each group, the total number of participants used for the analysis was n=13. Five of which were working full-time in the NHS, four, were working part-time between NHS and private settings and the remaining four were working full-time in private clinical settings. Of these 13 participants, the majority were female (n= 10), with the remaining participants being male (n=3). Time since qualification varied, with some interviewees being qualified in the past five years and some being towards the end of their career having spent thirty plus years in the profession.

Participants self-identified as working-class or from working-class backgrounds. The term working-class was defined as; a person or people from areas of financial deprivation, engaged in semi-skilled manual roles with low pay, lacking security and holding limited entitlements (Kaiser & Prieto, 2018; Taylor-Hill, 2024). However, this definition was used as a reference point for people to reflect on and was not used as a point of inclusion/exclusion for taking part.

Materials

Participants received a participant information sheet (Appendix J) which contained information about the research project and what would be asked of them as a participant. Furthermore, they received and completed a consent form (Appendix I) to take part in the interview. The interviewer used a topic guide for the semi-structured interviews (Appendix item G), example questions included, "*In what ways has class, class migration and habitus states been influential in your career decisions?*"; "*What impact do you think your class or habitus state have on your career today?*".

Procedure

The current study was granted ethical approval by the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee (ETH2425-2463) (Appendix L).

To gather participants for this study, several purposive strategies were used. Online forums, posters (Appendix H), word of mouth discussions with other clinical psychologists and distribution networks like the Psychological Professions Network (PPN) within the East of England were used to share the study poster (Appendix H). Research posters were shared via these routes once ethical approval was gained, following participants' response to the poster, participant information sheets were then shared, and dates were set for interviews. The participants completed semi-structured interviews, one-to-one with the primary researcher via Microsoft Teams with the transcription function enabled. These interviews lasted up to 90 minutes, and each interview was completed using an interview schedule (Appendix G). Interviews took place between August 2025 and October 2025.

Participants were verbally debriefed after the interview and received a debrief sheet (Appendix K) via email. All participants were sent a copy of the cleaned transcript and then any comments or changes were completed on their behalf.

Patient and Public Involvement (PPI)

This research utilised three qualified clinical psychologists who identified as coming from working-class backgrounds to help inform the structure of the interview schedule and review the participant information sheet. Those from the PPI group were consulted on the participant information sheet (Appendix J) and the topic guide (Appendix G) and provided feedback. Consultation then took place between the lead researcher and members of the research team, further refining the topic guide. Mock interviews allowed for further refinement of this. This was done to aid the researcher in confirming the presence of themes with people who would

also fit the chosen participants' demographics. This process helped in pointing out what questions needed restructuring to align more closely with the aims of the project.

Analysis

The data for this project was analysed using reflexive thematic analysis as detailed by Braun and Clarke (2006) using the six stages they set out. Firstly, *data familiarisation*, completed by the lead researcher and involving immersion in the dataset, reviewing transcripts and interview recordings. The next step involved inductive *coding*, by further familiarisation with the data and organising data into sematic and latent codes. This process aimed to capture concepts across the dataset and was completed in an inductive way, meaning data-led codes were developed while acknowledging the influence of the researcher in the process (Braun & Clarke, 2022). *Candidate themes* were created from codes that fully captured the data and were then *developed and reviewed* around a core concept of class and class experience. The development of themes and the review of these underwent several iterations, exploring the intersections within themes and across them. Themes were then *refined, defined and named* by a process to arrive at a place of clarity and coherence for each theme (Braun & Clarke, 2022). Creating the thematic map considered each theme as a distinct category and how each theme related to one another and reflected an analytic narrative, it was then *written up*.

Rigor and Reflexivity

As the researcher, reflexivity was a vital part of the qualitative research process as the researcher is the tool in which the data is analysed (Busetto, et al, 2020). This emphasises the importance of the researchers position and experience within the chosen topic. The main researcher of this research project was a white, male, trainee clinical psychologist from working-class routes, having completed an apprenticeship in bench joinery and working in the

trades for several years as members of his family did before him. Furthermore, prior to accessing training, the earnings of the lead researcher were below the median income.

Upon reflection on their own position within Bourdieu's habitus model, they were aware of the position they found themselves in and the reasons behind this. Due to this, a reflective journal was logged monthly from the start of this project, completed using internal and external dialogues. This was to consider the role of the researchers' beliefs and experiences on the data and how the questions asked are framed and ultimately, how they are analysed.

This was also a point of reflection regarding the power dynamics within the interviews. When thinking about the researchers own habitus state when compared to the participants and how changeable this may be along the progression of this career journey. Power was a theme of consideration throughout this project as part of the habitus state of the researcher left them feeling out of place in this environment, yet, still interviewing and discussing challenging topics with seniors in qualified positions they hope to one day inhabit. These factors were considered when exploring and analysing potential themes.

Theme consultation and refinement was conducted between the primary researcher and the lead supervisor for the project (RR). This allowed for discussions and the challenging of assumptions relating to personal reflexivity that influenced the analysis.

Extended Methodology

Reflective Journal – Reflections on Conducting this Research

Coming into this research from a position in which I felt much like an outsider in this new world and far more connected to my roots, there were several challenges I encountered in this process. Firstly, that interviewing qualified clinicians was frightening and felt affronting to my

class position as I worried about how I would be perceived by participants. I have always had a negative feeling about my own ability in this role and this links to my class position and habitus very closely. I still feel as though I do not belong here and then having to ask people who have completed this part of the journey and now work in roles I one day wish to, felt scary. Furthermore, the power imbalance was another interesting hurdle as on one hand, the research holds power, being that they are the one who understands their topic the most and knows the questions they intend to ask. However, asking those questions as a trainee, to qualified clinicians, I felt, placed far more power in the participants' hands.

Thankfully, my actual experience of this process was the opposite of my worries. I was met with reflective and thoughtful clinical psychologists, inside and outside the NHS who were so open and caring with their responses and of my position. Participants made me feel welcome in the space I had created and power seemed to be a nullified factor, as much as it could be. Reflecting further, the process actually helped me on a personal and professional level as these conversations felt like places I belonged in. Thus challenging my initial sense of mismatch and allowing me to feel a part of the profession I had failed to experience before.

Ontology and epistemology

This research was carried out from the social constructionist epistemological position using reflexive thematic analysis. This position suggests that reality is dependent on the ways we as the individuals come to know it (Clarke & Braun, 2013). This allowed for the unique perspective of each participant to be shared based on their own journey and how they came to make sense of the world. This permitted the lead researcher to be placed as a point of reflection in the interview to garner further insight based on each question and the follow-up. The focus

is on the experience of the individual and their working-class roots and how this has shaped their perception of themselves and the systems they inhabit. Within this framework, the research aimed to consider the impact of external and internal perceptions on the individual and the overall impact of this on the working life and environment of the person.

Other positions were considered such as critical realism, however, this stance would have wondered more about the "why" and less about the individual's constructed experience. Emphasis would have been more about the underlying mechanisms rather than the underlying meaning for the individual which is what this research was most interested in. What was the experience of these individuals and the socially constructed narratives of their journeys to this point in their career which felt more aligned to Bourdieu's model and the reflexive thematic analysis of this project.

Further PPI

Further to the PPI discussed in the methodology, there were also conversations with the ClassClinPsy collective, notifying them of the study and opening the door for recruitment. Additionally, an initial discussion was published in the BPS North East online edition and further conversations are being held to publish a piece relating to the findings of the study.

Thematic analysis

Reflexive thematic analysis was used in this project as it is the main qualitative methodology that aligns with the ontological and epistemological position of this project. It also aligned most closely with the aims of this research project as the goal was to explore the experiences of the

working class clinical psychologists rather than interpret them or be objective in the positioning of the researcher.

RTA embraces subjectivity in the researcher, placing them as an active meaning maker in the process. Whereas an approach like Interpretive Phenomenological Analysis (IPA) would then add a layer of interpretation through the lead researcher and the analysis team and perhaps move away from the individual's constructed narrative and towards a more collective understanding. For the purpose of this research project, the aims of the research questions, and the ontological and epistemological position, RTA was the most appropriate form of analysis.

Themes Generation

Table 4: Table to show how themes and subthemes were derived from codes and quotations.

Themes	Subthemes	Codes	Quotes included in final analysis
Money and Class	Money within the profession	Semantic: "Pay scales undervalue psychologists" "Private work offers better financial return"	"icky about the amount of money that companies want to pay me to advertise stuff" "the additional income that I've got now… feels like a really icky thing to talk about, but is a part of it" "excited at the earning potential, but uncomfortable being one of the highest paid members of the team" "you are paid more than your peers and people will hate you for it" "I just think, you know, id be pricing out my cousins and you know, my dad, … these are people that need it… these are people that I love, that I care about and they should have every right to receive care and
		Latent: psychology as a profession that moralises low pay. Economic precarity shaped identity and confidence.	

			support for those things as anyone else”
	Financial security	Semantic: “not broke anymore between 30-35” “financial stability changed my life trajectory”	“that worry that you’re never safe” “I’ve never let myself forget how close people are to being in really dire financial straits like that”. “job done, almost like you’ve done it” “My dad worked down the mine and now I am working down the mines” “im going to be a millionaire if I get onto the doctorate, it just seemed like such a lot of money” “what it meant to be on that kind of salary, it was a really big deal for me and within three months of qualifying… we were moving house”.
		Latent: Financial security as a driver for class migration. Money as a buffer to vulnerability derived from class	
	Financial security and gender	Semantic: “Financial transitions felt more gendered than classed at times” “Income shaped decisions about part-time work”	“make sure that there is a certain standard of income is absolutely the overriding factor” “I think that if you're a middle-class person, the reason you it's like you're, it's like you're, it's like you're on a tightrope Underneath the tightrope, there are mats, you know that you can safely fall off and you can just say, ok, I can't really do this. Jump onto the mat. You know, if you, you know, you failed to get on to the doctorate. So OK, I'll just jump onto the mat. I'll be fine. Everything will be good” “I think particularly I suppose as well, I think the I think I'm probably not acknowledging this here, but I think maybe as a male working-class person, I don't know how you feel about this as well. But I think that you're on a tightrope. And there's not mats underneath, but you know, fire and brimstone.
		Latent: Economic stability intertwined with caregiving roles. Money as a place where gender and class intersect	

			It's not, you know, there isn't really a choice. It's you've got to you've got to do this. You know, there isn't meaning that if I fail, its over and everyone suffers”
The Push and Pull of the NHS and the Working -Class Clinician	The view of the NHS and the role within that	Semantic: “NHS as a community orientated and values driven” “feeling aligned with the NHS values” Latent: NHS as symbol of working class identity. NHS as both a place of safety and a place of constraint.	“I see myself as an NHS professional” and that they “didn’t get into psychology to work in the private sector”. “there's a sense of wanting to support people in an accessible way in the NHS being like free at point of access and probably kept because to be honest, I don't think the game plan was ever to be fully private like independent like the goal was never to be fully independent when I qualified" “I'd always thought the NHS was pretty safe, so when I left that, that's pretty risky. I didn't know. You know, there's things like I know the pensions aren't as good and again, all that money stuff that has been drilled into me, like thinking about your security and redundancy pays and all that sort of stuff". “to leave the NHS fully would be like turning my back on myself, my family, my town, and the organisation itself” “some gratitude. I think gratitude to the NHS as a whole. Being in it together, helping each other of and then then I think it offers types of working that that also fit with that like MDT working"
	Leaving	Semantic: “due to bullying, whistleblowing, or poor treatment” “feeling lonely and ostracised when leaving” “Leaving for childcare flex” Latent: leaving as an act of self-preservation.	“What the NHS maybe once was probably isn't anymore. So I actually think I probably stayed in the NHS longer because of my class and the loyalty and wanting healthcare to be free at the point of access… The thing that kept me the longest was my values”.

	Exit triggered by violations of ones values	“bureaucratic nonsense” "There was a big whistleblowing incident in the service I was in, which I was very much on the periphery of, but sort of got pulled into a bit and suppose it just became a hostile place to work". “we're trained to be to do 5 things. So we start off, we come out of training as like these five pointed stars. And then when as we roll through the NHS, be mindful of who is trying to knock off the edges and wanting you to become this ball that is just rolling and rolling” And that "I feel like it (the NHS) clips your wings a bit, and even when it is flexible and great” and that ultimately the NHS is “not using clinical psychologists to their full potential" - "they're filling their diary with this ball stuff" “within the NHS Bandings now, you know if consultant goes then it goes to 8B and people are just expected to do so much more within that role”. “in a clinical role in the NHS, when there was talk about moving to as a waiting list strategy, there was talk about writing to everyone on the waiting list and saying if you don't reply to this letter within a week, you'll be kicked off the waiting list. And not just me. A bunch of us all raised very valid concerns about how that would hamper certain pockets of, you know, pockets of the community it would. It would disproportionately affect some people more than others. And that just got ignored and overlooked and shut down. It was. No, this is happening. You

		know, that top-down style of management". "As a as a mother, especially big part of my identity and a big part of the reason that I left, I couldn't reconcile how I could feel like I was doing a good job and be a good mother …. And also a bit of doing a good job was feeling like I was colluding with things that that did not align with my values and having to work in ways that that crossed my boundaries a lot and the impact that that was having on it is". "ineffective… as a psychologist and the impact of that over time was that I ended up feeling hugely deskilled... It isn't you with this. This is more systemic than you just being a crap psychologist. So there was that lack of progression opportunities and actually the real sort of kicker at the end was that I realised that I didn't want to be a consultant"
Staying	Semantic: "for pension" "for values" "staying to serve working class communities"	"NHS is the main employer for clinical psychologists, so it doesn't take much to stay there. So NHS or university, I've always wanted job security" "shared risk, shared responsibility. It will be another reason why I like MDT's and why I'm not inclined to go and do it on my own privately". "I can't see myself turning my back on the NHS and I use those words purposefully. It would feel like I'm turning my back on my town and the people that I grew up with and was surrounded by, and that I relate to, I would feel like, I guess I'm turning my back on myself to an extent, and that doesn't sit well with me".
	Latent: staying as a preservation of the working class identity. NHS acting as an anchor amidst class migration.	

		"I think that sense of kind of like duty sounds too strong a word, but there does feel like that sense of kind of. Like the NHS is where we're most needed and it's where people access healthcare free at the point of use. So, it's where, yeah, your average Joe comes to get what they need". "you know, the NHS trained me. So I do feel that there's that kind of loyalty there and I feel that, you know, people should have access to therapy and to psychology under the NHS". "I want the NHS to work. I don't want things to be privatised…I do struggle with that….it would be a travesty, wouldn't it, if all psychologists went into private practice".
Return and barrier to this	Semantic: "return possible with supportive team" "return dependant on values alignment"	"if you could be guaranteed like full autonomy, you know, not so much sort of restrictions on number of sessions and things like that that you provide Been able to have that hybrid working because I think like now I would really struggle to go into the office like every single day and see, you know, sort of see service users like back-to-back. I think having that flex and having flexibility around kind of working hours". "there'll be an advert that comes up and I think maybe that something will put me off. It'll either be because of what I know about that trust or that team. It'll be that, almost that fear of being put back into that position, of feeling really so demoralised that I was. I was thinking of changing careers all together and I think that's not a nice place to be, to be honest with you, because I think. I'd love for an NHS service to ring
	Latent: Return imagined as conditional and value dependant.	

		me up and say you're exactly what we want and we're going to pay you really well to come and do this really interesting role, you know, brilliant, great". "If two particular supervisors that had had job openings that were at least an 8B because you know, like that's and it's not so much the money like obviously the money is great, but it's more about like that's where I see myself like it's less you're less likely to be a ball at an 8B or an 8C".
Us and Them (Seen/Unseen, Heard/Unheard Differences)	Semantic: "not fitting in with psychologists" "Feeling posh to prisoners despite shared roots" Latent: class visibility shaping belonging and exclusion. Professional identity obscuring class identity.	""I think middle class people are kind of driven by their own personal I would like to do this and I would, you know.....For me, you know, for me it's more like put some food on the table and make sure that you know I can stay on top of everything and you know, create some safety for myself" "There was always this sense of difference and there was always this sense of like. A bit of a gradual awakening of like, Oh yeah, my experience is a bit different to some of my colleague's experience" "Same boats, different storms" "for example, if you're a trainee coming from working-class background and you go and work into a team and you kind of speak in your natural way. Use your natural accent, your natural language, and people in that team, you know, like you, I don't like you. Whatever happens with that, your supervisor might take a very critical view of that and say, well, you're coming, you're coming across in the wrong way. You're not. You're not behaving like you should be behaving"

	“I guess, kind of obvious that maybe you were a little bit a little bit different. Yeah. And I think with being qualified and working, I think being over straddled both camps I think has been noticeable sometimes, perhaps with some colleagues who might be more likely to be working class, like nursing colleagues and might be more likely to come from working class backgrounds. I said her, because my mum was a nurse and she came from working. Or then maybe actually other colleagues, such as some of the medical doctors who might be less likely to come from working class background and kind of noticing and straddle the two" “my mum always says, like laughs about, like Downton Abbey. We're the downstairs people. We're not the upstairs people” “job or no job” "I remember pre-training being in a job and my manager asking me if I was going to change my accent. You know, I was working in [place/institution name] at the time. So just a little stuff like that" "I think maybe like two or three years after being qualified, I did a radio interview and then I think a couple of my friends and family like listened to it and there was like, oh, you sound really posh at work" "remember being mocked immediately, you know, just, you know, the my accent, obviously. I've not toned it down or learnt to tone it down at that point”

			"don't get too big for your boots" - "you know, keep it where you are and don't think you, you know, your accents changed a little bit. Don't think that, you know. You're any better than anyone else" "they mask and they mould and they pretend to be a certain way so that they fit in. So we lose out on all of that difference and all of that diversity. And we kind of run the risk of ending up with a profession that is just. Like increasingly in carbon copies, you know each copy gets a little bit worse, and at the end of the day, like I just think that's a real shame" “people will make assumptions based off my looks, how I talk, my education that I am more middle class than I am” "I think I play the game and I get involved with. You know, superficially, I can come across as middle class if I want to and I can sort of. Not fake, but sort of"
The Experience of Class Migration	Positives	Semantic: “financial stability improved life trajectory” “Feeling grateful for indoor work and no physical labour” Latent: Class mobility seen as expanding horizons and what is possible for someone.	“I had a sense of almost excitement. I think when I got onto training that it was going to be a change in class and that I was going to have access to maybe a world that I hadn’t had access to before”. “professionally, it's felt much more like. That there's that space to that the profession itself kind of defines a set of values” “Cultural assimilation”
	Negatives	Semantic: “Feeling embarrassed about working-class routes” “feeling embarrassed about middle-class routes later” Latent: class mobility triggering shame and guilt around the change.	“entering into professions that like we've been talking about class migration, that kind of move you on that actually like in some ways make life more difficult than if you sort of stay”.

		Loss of self, cultural ties and familiarity	“biggest challenge was to maintain contacts with school friends as they find it difficult to accept the me now” “Battle” “my attitude to… money and stuff is always the same”, “I've not suddenly become like… really free about, like money and things like I'll still shop at ALDI. I refuse to shop anywhere more expensive, you know, think just things like that and the things that I'm interested in, like I still, I still go to like… the local pub over the road, which is full of very working-class people… like they'd always not had enough. So we're really cautious about stuff”
	Middle ground	Semantic: “feeling a foot in both camps” “feeling more preadapted over time” Latent: holding dual identities in class is both stable and fragile.	“naïve optimism” “I would do better than they had done … or … change, you know, family narratives around success”- “embodied discomfort” “under the surface, but had never actually spoken about”.
	The dynamic nature of habitus	Semantic: “Habitus shifts with each transition” “Cultural assimilation over time” Latent: identity as responsive, flexible and adaptable.	“a lot of times there are points where I feel like I have a foot in both camps and I do fit-in, in both areas. I guess there are just little trigger points where suddenly I can feel like I don't” “in my doctorate, I didn't really feel like it was much that much of a problem, but when I went to [place name], I was right back to when I did my undergraduate with. Like you guys just do not get. You have no clue what life is like in my world”. “internalised perception of what a psychologist is” “are in this place where we have these secret conversations, and then we swoop in and we

	see words that people don't understand” “careful where you are going and careful how you'll get treated and you might stick out" “just a bit of everything”, “the old world continued into the new, so there was never a huge leap all at once, meaning the transition has never felt like a transition” and “I suppose now I feel much more middle-class. I live a middle-class life. So I guess, but I feel like my working-class background always comes with me”.

Results

From reflexive thematic analysis, four overarching themes were generated as shown below in figure 2, these being, *Money and class*, *Experiences of Class Migration*, *The Push and Pull of the NHS and the Working-class Clinician* and *Us and Them (Seen/Unseen, Heard/Unheard differences).* Subthemes were also added into this diagram. Each theme and the associated subthemes are presented and discussed below,

illustrated by individual verbatim quotes. Codes have been used to protect participant anonymity and categorised together by employment group: Full-time NHS (FT), Splitter (SP) or Full-time private (P).

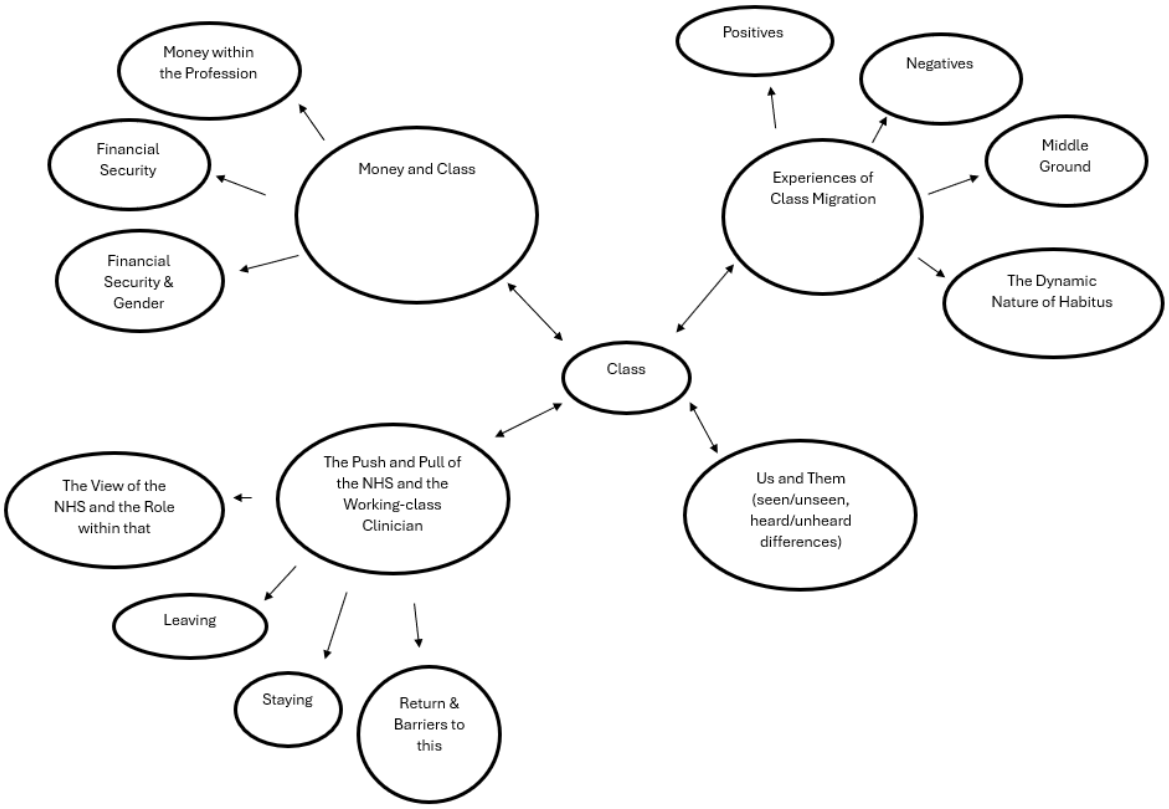


Figure 2:Themes and Subthemes

Money and Class

In many senses, money defines class, it defines what area of the class spectrum people find themselves in and how much access and capital they have. In all the interviews conducted in this project, the changing of financial circumstances for the individual marked a moment of reflection, and recognition for how this impacted their journey as a clinician. This shift was met often by their own class history and understanding of financial security.

"*I can't let go of that low, low income mentality and it and I've I've that's something I've had to try really hard at in my personal relationship because. I guess my wife didn't have to worry*" – FT 4

Financial Security

Figure 2. ***Themes and Subthemes***

FT 4 expressed a class related fear around money, "*that worry that you're never safe*" financially, even with a new, higher income. This narrative echoed the experience for many working-class clinicians, coming from their youth, in which it was understood that; you have it now, doesn't mean it will be there forever. This helped some to keep the appreciation for money and how it can enhance life, such as P2's explanation that; "*I've never let myself forget how close people are to being in really dire financial straits like that*".

Despite the inner challenges that arise for some when considering the role of money in their life, others discussed the positive implications of this increase in wealth and attainment. A sense of pride was expressed from families, as if "*job done, almost like you've done it*" FT 2. Not only that, but a sense that the narrative had shifted from older working-class ideas such as; "*My dad worked down the mine and now I am working down the mines*" – FT 1. A new idea had taken its place, that a child building a different life, through education and change, metaphorically and literally, leaving the mines perhaps, was wanted.

Accessing this level of income was seen as life changing "*im going to be a millionaire if I get onto the doctorate, it just seemed like such a lot of money*" FT 2. Despite the realisation that we adjust to our incomes accordingly, for many, it was life changing. As P1 highlighted "*what it meant to be on that kind of salary, it was a really big deal for me and within three months of qualifying… we were moving house*". The doctorate income and then qualified income gave people access to wealth they had never seen possible, meaning access to homes and other things that provided that sense of financial security.

Financial Security and Gender

When exploring this notion of financial security, gender intersects in an interesting way for working-class clinical psychologists. The role of being a man and needing to provide for a family and themselves filtered its way into the experience. Needing to "*make sure that there is*

a certain standard of income is absolutely the overriding factor" – FT1. In addition to this, FT 4 reflected on the reoccurring thoughts of money and needing enough to survive and sustain himself and his family's new life in the middle-class. FT 1 expressed this working-class idea that for them, there is no safety net financially;

"*I think that if you're a middle-class person, the reason you it's like you're, it's like you're, it's like you're on a tightrope Underneath the tightrope, there are mats, you know that you can safely fall off and you can just say, ok, I can't really do this. Jump onto the mat. You know, if you, you know, you failed to get on to the doctorate. So OK, I'll just jump onto the mat. I'll be fine. Everything will be good"*

They go one step further in this explanation, tying that experience to this experience as a man and the expectations that come with that.

"*I think particularly I suppose as well, I think the I think I'm probably not acknowledging this here, but I think maybe as a male working-class person, I don't know how you feel about this as well. But I think that you're on a tightrope. And there's not mats underneath, but you know, fire and brimstone. It's not, you know, there isn't really a choice. It's you've got to you've got to do this. You know, there isn't meaning that if I fail, its over and everyone suffers*" – FT1

Money within the Profession

Money remains a challenging topic for this group of professionals, not only in the experience of earning more, but also in the discussions of it. Some feeling "*icky about the amount of money that companies want to pay me to advertise stuff*" (P3) and being mindful of even having that discussion about earnings, reflecting that "*the additional income that I've got now… feels like a really icky thing to talk about, but is a part of it*" (P1).

This embodied discomfort seems to leak into the workplace, with feelings of being "*excited at the earning potential, but uncomfortable being one of the highest paid members of the team*" (FT 5) and the idea that "*you are paid more than your peers and people will hate you for it*" (P1), This notion stems from that place of insecurity about what it means to earn a certain amount of money and how others, including those from your working-class background, will see you for it.

However, one key principle remained, for most that related to this notion of access for others regardless of finances and capital, and the impact growing up working-class had on their own levels of access. FT 4 summarised this;

> **"***I just think, you know, id be pricing out my cousins and you know, my dad, … these are people that need it… these are people that I love, that I care about and they should have every right to receive care and support for those things as anyone else*"

This connection to their routes, their understanding of what it means to have very little, influenced their experience as they came to earn more whilst keeping most aligned with that feeling for themselves.

Experiences of Class Migration

Working as a clinical psychologist comes with an earning potential that would be considered middle-class in the UK. This means that for the participants, there would be an experience of class migration. This change comes with a shift in setting and the sense of 'fitting in' being challenged.

For some this was a positive experience and for others it appeared more negatively or almost unnoticed. Whilst SP3 stated "*Some elements have felt quite confronting, but it has been a slow burner*" and FT1 noticed that it hasn't felt like "*there has been no solid line where ive gone from being working class to middle class … I don't feel like ive just entered into a new*

class situation", others have noticed the change. Below, the positive and negative experiences of class migration are outlined in separate sections.

Positives

Class migration provided access for some, whilst remaining complex, P1 noticed

"*I had a sense of almost excitement. I think when I got onto training that it was going to be a change in class and that I was going to have access to maybe a world that I hadn't had access to before*".

This highlighted that positive aspect of class migration, the ability to have access to more social capital.

Further to this, it became clear that for some, class migration was aided by the role, FT2 reflected that clinical psychology defined a set of values; "*professionally, it's felt much more like. That there's that space to that the profession itself kind of defines a set of values*" and that these values aid the experience of "*Cultural assimilation*" as working-class values and clinical psychology values align in some ways.

Negatives

However, class migration also came with negatives for this group, FT2 highlighted on reflection that "*entering into professions that like we've been talking about class migration, that kind of move you on that actually like in some ways make life more difficult than if you sort of stay*". This notion that staying in the known and not going through class migration would have been the easier option. That going through it meant challenges with friends and family, as FT2 explained, that the "*biggest challenge was to maintain contacts with school friends as they find it difficult to accept the me now*"

FT4 spoke of the change as a "*Battle*" between the new, middle-class system and the old, noticing the want to hold onto working-class values, but having them challenged. Some values like those surrounding money were ones that people felt would never change, as SP4 reflected "*my attitude to… money and stuff is always the same*", which is in some ways challenging, but in other ways it keeps them aligned with their routes and understanding of money and what it means to struggle.

"*I've not suddenly become like… really free about, like money and things like I'll still shop at ALDI. I refuse to shop anywhere more expensive, you know, think just things like that and the things that I'm interested in, like I still, I still go to like… the local pub over the road, which is full of very working-class people… like they'd always not had enough. So we're really cautious about stuff*" – SP 4

Middle Ground

Overall, for most, class migration led to a sense of "*naïve optimism*" from one's family, that "*I would do better than they had done … or … change, you know, family narratives around success*"- (P2). This notion, that for the family it meant you had completed something and been successful in moving upwards. But, as shown above, this comes with a sense of "*embodied discomfort*" (FT4) for the individual going through it, something that is also "*under the surface, but had never actually spoken about*". This highlighting the duality of this process, not only in the pros and cons, but in the experience for the person and the external perceptions of others.

The Dynamic Habitus

It became clear that the notion of habitus was dynamic, especially when considering the differences between the professional role as a psychologist and the personal role as a friend or a family member. This was noticed when considering challenges and pinch points that arose in these new spaces. FT4 noticed that "*a lot of times there are points where I feel like I have a*

foot in both camps and I do fit-in, in both areas. I guess there are just little trigger points where suddenly I can feel like I don't" – highlighting that for the majority of the time, people can feel aligned, preadapted, but then something can knock them back to feeling out of place.

Different places and people can cause this feeling of dislocation for some, as FT3 suggested that

"*in my doctorate, I didn't really feel like it was much that much of a problem, but when I went to [place name], I was right back to when I did my undergraduate with. Like you guys just do not get. You have no clue what life is like in my world*".

This sentiment appeared in other workplaces, as some felt closely aligned with different members of the staff team at work. Noticing that their habitus depended on their own views of themselves in their role and this idea of the "*internalised perception of what a psychologist is*" – P1 and who they as the psychologist aligned themselves with.

In relation to the professional world they now inhabit, some discussed a sense of mismatch occurring in the clinical setting. P3 spoke about this in the therapy room and how the clients view of them may impact the therapeutic relationship. The client seeing them as more middle class and believing they would not understand their life story, that psychologists "*are in this place where we have these secret conversations, and then we swoop in and we see words that people don't understand*" (P2). This narrative of not fitting in was also seen in SP4's description of their family narrative relating to their career. They noted that their father may say "*careful where you are going and careful how you'll get treated and you might stick out*" – which speaks to this idea that even if they may feel settled at times in their new environment, it is not only their narrative that they have to be aware of, it is also the familial, the perception of others at work, patients and colleagues, and how this then informs their habitus.

Preadapted state

As SP3 highlighted, this experience can feel like it is "*just a bit of everything*", like it is always changing. However, some discussed the ways in which they may keep themselves in that preadapted state, feeling safe and in place in both the new and the old. Having a sense of continuation or continuity was a clear way to do this, P4 noticed that

"the old world continued into the new, so there was never a huge leap all at once, meaning the transition has never felt like a transition" and *"I suppose now I feel much more middle-class. I live a middle-class life. So I guess, but I feel like my working-class background always comes with me".*

This sentiment was echoed by others, that if they remain in the areas they grew up in, in those social circles and don't shift to far from them, preadaptation can be easier as they never truly leave that old world behind. As P2 highlighted how her partners working-classness kept her connected or how FT5 also discussed that living and working in that same area eased the transition and brought the old world into the new, aiding preadaptation.

The Push and Pull of the NHS and the Working-class Clinician

This theme describes the factors related to clinicians wants to stay, leave or return to the NHS. As will be shown, many come from deep seated class related beliefs about need and access as well as relating to finances and flexibility. What is clear for these participants is there has been a class view of the NHS itself and over time for them, this view has either remained solid or has been changing based on their experiences of their role as a qualified clinical psychologist. As FT2 summarised, working in the NHS was seen in their community as "*contributing to the collective good*" and being a part of that larger organisation that supports people.

ST: The view of the NHS and the Role within that

As was clear for many participants, people viewed themselves as NHS professionals, even if they no longer worked in the NHS. SP1 explained that "*I see myself as an NHS professional*" and that they "*didn't get into psychology to work in the private sector*". However, for them and others, it was clear they felt their face did not fit in certain areas of the NHS and that in the private sector, their voice and expertise was more heard. P1 discussed the impact of their client group on their want to work in learning disabilities settings, and that the shift to private work had them questioning the move as it meant that their core client group may struggle to access support. This was compounded by the feeling that the NHS was the only place for these patients, meaning leaving was a further violation of their own class values.

P3 reflected on this too, noting that;

"*there's a sense of wanting to support people in an accessible way in the NHS being like free at point of access and probably kept because to be honest, I don't think the game plan was ever to be fully private like independent like the goal was never to be fully independent when I qualified*"

Others discussed the safety and security the NHS appeared to offer, SP 4 explained that;

"*I'd always thought the NHS was pretty safe, so when I left that, that's pretty risky. I didn't know. You know, there's things like I know the pensions aren't as good and again, all that money stuff that has been drilled into me, like thinking about your security and redundancy pays and all that sort of stuff*".

The goal, like many of the others, was to work in the NHS to support people from backgrounds like theirs, for people who could not access private healthcare.

This sentiment is summed up by (FT 4) "*to leave the NHS fully would be like turning my back on myself, my family, my town, and the organisation itself*" and that their view towards the NHS was

"*some gratitude. I think gratitude to the NHS as a whole. Being in it together, helping each other of and then then I think it offers types of working that that also fit with that like MDT working*"

So, the view of the NHS and the role for most was that they would be within the NHS, increasing access for people. However, as shown, many found that they were pulled towards private practice despite their class beliefs about the NHS.

ST: Staying

For most participants, the NHS was seen as a place of financial safety due to the secure and reliable pay structures and the apparent job security. This sense of safety in a role was important for many working-class clinicians as it intersected with that working-class belief in needing job security to avoid falling back into financial hardship. FT3 noted that the "*NHS is the main employer for clinical psychologists, so it doesn't take much to stay there. So NHS or university, I've always wanted job security*" and this sentiment was echoed across all the groups in relation to job security.

It was also noticed that the NHS encompassed this idea of shared decision making and a communal approach to care in a way. FT4 explained that this was one of the main reasons for them staying, that feeling of "*shared risk, shared responsibility. It will be another reason why I like MDT's and why I'm not inclined to go and do it on my own privately*". Moreover, there was a sense of duty, to one's community and to those who do not have the means to access private support, this being a reflection of where they found themselves growing up. FT4 explained what leaving the NHS would mean to them, a sense of turning away from who they were;

"*I can't see myself turning my back on the NHS and I use those words purposefully. It would feel like I'm turning my back on my town and the people that I grew up with and was*

surrounded by, and that I relate to, I would feel like, I guess I'm turning my back on myself to an extent, and that doesn't sit well with me".

This idea was echoed by people's sense of duty, to the systems that trained them, in addition to their communities. FT2 suggested that

"*I think that sense of kind of like duty sounds too strong a word, but there does feel like that sense of kind of. Like the NHS is where we're most needed and it's where people access healthcare free at the point of use. So, it's where, yeah, your average Joe comes to get what they need*".

It was re-iterated, that people should have access to this support and that leaving would directly limit that access. So, the sense of loyalty to the NHS, and this idea of improved access to care for people who came from similar backgrounds were strong reasons for people staying. SP2 shared their thoughts on this, "*you know, the NHS trained me. So I do feel that there's that kind of loyalty there and I feel that, you know, people should have access to therapy and to psychology under the NHS*". Overall, for those in the NHS full time or splitting their role, there was a want for the NHS to work and for it to be the institution they believed it could be. One built on working-class values and community and free at the point of use, accessible for all. SP3 outlined this clearly, noting that "*I want the NHS to work. I don't want things to be privatised…I do struggle with that….it would be a travesty, wouldn't it, if all psychologists went into private practice*".

ST: Leaving

Despite those expressing a want to stay and the various reasons for this, there were several discussions about the reasons people had to leave, potentially against their core working-class

beliefs. This decision appeared challenging for many, P1 for example, explained that their class routes actually kept them in the NHS longer than they should have,

"*What the NHS maybe once was probably isn't anymore. So I actually think I probably stayed in the NHS longer because of my class and the loyalty and wanting healthcare to be free at the point of access… The thing that kept me the longest was my values*".

The things that made them and others leave, included poor leadership, bullying, systemic issues and overall "*bureaucratic nonsense*" which caused harm to patients and clinicians. P3 highlighted this issue in the workplace, sharing their experience of a whistleblowing incident that left those blowing the whistle in a dangerous situation; *"There was a big whistleblowing incident in the service I was in, which I was very much on the periphery of, but sort of got pulled into a bit and suppose it just became a hostile place to work".* They explained that they were bullied and ostracised for speaking out, which goes against what is shared widely, that speaking out is a positive and helpful thing.

Others explored what the NHS was turning them into, how the systems were limiting them in what they were trained to do. P1 described this;

"*we're trained to be to do 5 things. So we start off, we come out of training as like these five pointed stars. And then when as we roll through the NHS, be mindful of who is trying to knock off the edges and wanting you to become this ball that is just rolling and rolling*"

And that "*I feel like it (the NHS) clips your wings a bit, and even when it is flexible and great*" and that ultimately the NHS is "*not using clinical psychologists to their full potential*" - "*they're filling their diary with this ball stuff*"

This feeling of not being used to their full potential was a big reason for many to leave, which was paired with expectations that actually exceeded what people were able to do with their time, whilst being paid less than they should be. SP3 noted "*within the NHS Bandings*

now, you know if consultant goes then it goes to 8B and people are just expected to do so much more within that role". This suggests that whilst services are restricting what a clinical psychologist can do based on their training, they may also be filling their days with work above their station, that they are not compensated or acknowledged for doing.

However, it was also clear that at times, people's voices were not listened to in the NHS settings. SP1 explained that

"*in a clinical role in the NHS, when there was talk about moving to as a waiting list strategy, there was talk about writing to everyone on the waiting list and saying if you don't reply to this letter within a week, you'll be kicked off the waiting list. And not just me. A bunch of us all raised very valid concerns about how that would hamper certain pockets of, you know, pockets of the community it would. It would disproportionately affect some people more than others. And that just got ignored and overlooked and shut down. It was. No, this is happening. You know, that top-down style of management"*.

Suggesting again, that speaking up against these issues or other systemic problems was not heard.

It was also mentioned that the way people experienced the NHS, actually shattered that illusion of the 'working-class institution' they believed it to be. P2 explained that

"*As a as a mother, especially big part of my identity and a big part of the reason that I left, I couldn't reconcile how I could feel like I was doing a good job and be a good mother …. And also a bit of doing a good job was feeling like I was colluding with things that that did not align with my values and having to work in ways that that crossed my boundaries a lot and the impact that that was having on it is*".

The role and the expectations of it directly impacted their ability to be the mother they wanted to be. This was something that was discussed among many of the female participants

and how what appeared to be a flexible institution, actually limited their time with family. Ultimately, people were led to feel;

"*ineffective… as a psychologist and the impact of that over time was that I ended up feeling hugely deskilled... It isn't you with this. This is more systemic than you just being a crap psychologist. So there was that lack of progression opportunities and actually the real sort of kicker at the end was that I realised that I didn't want to be a consultant*" – P2

Despite the want for many, to stay in the NHS for what it represented for them and their working-class values, their hands were almost forced into action when the ways of working no longer aligned with their own values or when they were directly at threat. For these working-class clinicians, return to the workforce appeared difficult to consider. However, as was discussed, there were things that would bring most people back to the NHS.

ST: Returning and the potential barriers to this

One barrier for returning to the NHS, which was highlighted in the above section when considering how the role in the NHS was challenging their values as a mother, was the need for flexibility. It appears that despite its attempts to do so, the NHS cannot offer the same level of flexible, autonomous working than the private sector. If this could change, perhaps people would be more open to a return, as SP2 summarised;

"*if you could be guaranteed like full autonomy, you know, not so much sort of restrictions on number of sessions and things like that that you provide Been able to have that hybrid working because I think like now I would really struggle to go into the office like every single day and see, you know, sort of see service users like back-to-back. I think having that flex and having flexibility around kind of working hours*".

Others noticed a want to belong somewhere in the NHS and to feel like their voice would be heard. That would be the grounds for many to return, however, as SP1 highlighted, returning full-time would always remind them of the challenges they faced last time,

"*there'll be an advert that comes up and I think maybe that something will put me off. It'll either be because of what I know about that trust or that team. It'll be that, almost that fear of being put back into that position, of feeling really so demoralised that I was. I was thinking of changing careers all together and I think that's not a nice place to be, to be honest with you, because I think. I'd love for an NHS service to ring me up and say you're exactly what we want and we're going to pay you really well to come and do this really interesting role, you know, brilliant, great*".

This notion of being wanted or fitting somewhere was important for working-class clinicians. It was also important that they respected and valued those they worked with, which would help them feel more fulfilled in the role if they returned. P1 summarised many of the views on this, saying;

"*If two particular supervisors that had had job openings that were at least an 8B because you know, like that's and it's not so much the money like obviously the money is great, but it's more about like that's where I see myself like it's less you're less likely to be a ball at an 8B or an 8C*".

Pay and flexibility, were factors that continued to come up when thinking about barriers to return. It appeared that despite the potential risk of moving to private work that has been outlined by some of the Full-Time participants, the pay and flexibility of private work, for the most part, cannot be matched in the NHS currently. When considering this from the class lens it may be clear that the need to earn more and be financially secure can be satiated by the

private sector once the move has been made, excluding the pension as this is one thing that people have suggested frequently as a pull factor to stay and to return.

Us and Them (Seen/Un-seen, Heard/Un-heard Differences)

The experiences of working-class clinical psychologists appear to be filled with seen/unseen and heard/unheard differences. Class at first appearing to be a notable characteristic with which to identify with, becomes very much a hidden characteristic based on how much or how little the individual themselves choses to share. This theme appeared to overarch the experiences of all the working-class clinicians that were spoken to in this process and directly impacts their experiences of working in the NHS, working privately or working between the two roles.

Initial conversations revealed a hidden difference when considering the motivations of middle-class persons in this profession. FT 1 suggested that:

“"*I think middle class people are kind of driven by their own personal I would like to do this and I would, you know.....For me, you know, for me it's more like put some food on the table and make sure that you know I can stay on top of everything and you know, create some safety for myself*"

Implying that as had been mentioned before, there is no safety net for those in the working class, they may have to think about the personal risk and safety of the profession whereas, those who are more well off, may not even have to worry. People in the middle class can be driven by a want or desire to engage in something they are interested in, but the working-class cannot. This was then presented as an interesting conundrum when considering personal motivations for progression in a field in which this conversation is less well received.

In general, lots of people spoke about class being this unspoken social grace, something that the individual was aware of, but others might not have been. In this quiet, personal experience, SP 1 spoke about this gradual sense of change:

"There was always this sense of difference and there was always this sense of like. A bit of a gradual awakening of like, Oh yeah, my experience is a bit different to some of my colleague's experience"

This feeling for many becoming noticed for them in moments when they felt inadvertently alienated or misunderstood. When someone may ask what's for dinner and disagreeing on the time (geographical difference) or not knowing what earl grey tea is or who Laura Ashley is (SP 2 & 3). What people often discussed was the notion of masking, or hiding a part of themselves, whether it be an accent or an interest as to not expose themselves as being from a different class background.

When considering these differences, SP 1 reflected on a part of the journey that they believed was meant to be the level playing field due to the financial remit of DCLIN courses. However, when discussing the plight of others and what challenges they may have faced on the course outside of finances, they posited *"Same boats, different storms"* which highlighted further, the difference between challenges and how even with the financial level playing field, the mentality, the upheaval, is fundamentally different.

Discussions highlighted the need for differences and what it can bring to the profession. SP1 emphasized that personal journeys, through class and class migration, leads people to this point and all of that builds one's values and ultimately, how they come to see themselves'. They explained that these differences can clash with what is seen to be the norm:

"for example, if you're a trainee coming from working-class background and you go and work into a team and you kind of speak in your natural way. Use your natural accent, your natural

language, and people in that team, you know, like you, I don't like you. Whatever happens with that, your supervisor might take a very critical view of that and say, well, you're coming, you're coming across in the wrong way. You're not. You're not behaving like you should be behaving" – SP 1

Perhaps this clash was why people reported not often having these conversations about their class, and why their own differences meant many aligned themselves more with nursing and other staff groups typically seen as more working class. P 3 suggested that

"I guess, kind of obvious that maybe you were a little bit a little bit different. Yeah. And I think with being qualified and working, I think being over straddled both camps I think has been noticeable sometimes, perhaps with some colleagues who might be more likely to be working class, like nursing colleagues and might be more likely to come from working class backgrounds. I said her, because my mum was a nurse and she came from working. Or then maybe actually other colleagues, such as some of the medical doctors who might be less likely to come from working class background and kind of noticing and straddle the two"

As FT 2 summarised these differences with a quote from their mother

"my mum always says, like laughs about, like Downton Abbey. We're the downstairs people. We're not the upstairs people"

These unseen differences, or perhaps, unseen by those outside of the working-class clinical psychologists appear present throughout the journey. Whether it be from the early school years as FT 2 suggests the difference for them being "*job or no job*" as the defining characteristic of someone's career.For several participants it became clear that on their journey in this career, their accents became either a source of strength or something that needed adapting to avoid exposing their working classness.

When discussing this, FT 4 explained that when moving to a more affluent area and experiencing new class spaces, they had not previously inhabited:

"I remember pre-training being in a job and my manager asking me if I was going to change my accent. You know, I was working in [place/institution name] at the time. So just a little stuff like that"

Whilst some experienced this explicitly, this prejudice towards their accent and what that meant about them. Others adapted their accents more subconsciously, SP 2 explained:

"I think maybe like two or three years after being qualified, I did a radio interview and then I think a couple of my friends and family like listened to it and there was like, oh, you sound really posh at work"

Others consciously masked this aspect of themselves in their professional roles after previously hurtful experiences. SP 4 noted that during their undergraduate degree they: *"remember being mocked immediately, you know, just, you know, the my accent, obviously. I've not toned it down or learnt to tone it down at that point"* which meant that when they were qualified, they would mask their accent, soften it and make it so the difference was less recognisable.

This difference and the masking of one's accent was noted several times in the interviews and highlights how people still connect class to accent and geography, despite this being less relevant nowadays. However, it was clear that this experience had an impact on people working as a clinical psychologist in the NHS and outside of it. SP 3 summarised this experience, noting that despite changing and masking their accent to fit in at work, this came at a cost when returning to family and being reminded –

"don't get too big for your boots" - "you know, keep it where you are and don't think you, you know, your accents changed a little bit. Don't think that, you know. You're any better than anyone else"

For the professional world they came to inhabit, this aided them, however, it created its own alienation from the old working-class part of them. Overall, this masking in the profession limits representation of the patients that are being supported, as SP 1 explains:

"they mask and they mould and they pretend to be a certain way so that they fit in. So we lose out on all of that difference and all of that diversity. And we kind of run the risk of ending up with a profession that is just. Like increasingly in carbon copies, you know each copy gets a little bit worse, and at the end of the day, like I just think that's a real shame"

It appears then, that masking and becoming a chameleon to 'fit in' to the profession risks the world of clinical psychology being characterised by homogeneity.Much like the way one's accent impacts external perceptions of them, how they look also has the same effect. However, as the participants in this project explained, it would often leave them feeling like others didn't fully understand where they came from or what their life had been like as they were seen as more well off than they were. For example, FT 5 explained – "*people will make assumptions based off my looks, how I talk, my education that I am more middle class than I am"* – which was seen as a source of frustration as it felt invalidating and meant they appeared to be another psychologist in the *"ivory tower"*.

Others spoke of the need to fit in and in turn did things, or acted in ways that avoided suspicion. As FT 1 noted *"I think I play the game and I get involved with. You know, superficially, I can come across as middle class if I want to and I can sort of. Not fake, but sort of"*

The seen differences appeared far less apparent and easier to hide, changing how someone looks to others was described as easier and aided the fitting in. Conversely, masking an accent was far harder, and often came at the price of compromising one's personal values.

Discussion

This qualitative project aimed to explore the experiences of working-class clinical psychologists in the NHS, the private sector and those splitting their role between the two. Alongside this, we hoped to develop a better understanding of these individuals' experiences of movements through social class systems and how these factors influenced their career decisions since qualifying as a clinical psychologist. Reflexive thematic analysis of 13 interviews led to the development of four overarching themes: "*Money and class"*, "*Experiences of Class Migration"*, "*The Push and Pull of the NHS and the Working-class Clinician"* and "*Us and Them (Seen/Unseen, Heard/Unheard differences)"*. There were various factors impacting a working-class clinical psychologist's experience of working in the NHS and elsewhere and how their class background informed their career experience and choices. Many navigated working-class morals and values being challenged in their career such as the impact of finances, relationships at work and external perceptions.

Clinical psychology is typically a white, middle-class profession and for people outside of this, fitting in can be challenging (Ahsan, 2020; Place, 2023). This difficulty has been explored for working-class clinical psychologists in the trainee stage which has shown people can feel unheard, be mislabelled and struggle to fit in with their peers on training (Daly, 2024; Place, Crew & Saville, 2024). This experience appears to extend into qualified life for some, with people feeling out of place or like their face did not fit in the profession. Some clinicians reported that it was only once they had left the NHS, that they felt their voice and opinion was heard. This point was furthered in reflections of their role, suggesting that in the NHS they

were underutilised, or as one person put it, the five-pointed star they were trained to be was being ground into a ball doing only one thing. This aligns with previous findings relating to clinical psychologists at times feeling undervalued or underutilised in the NHS (Harding, A, 2025; Stinton N, 2025).

Furthermore, it was noticeable that there was an impact of people's class and class journey on their experience in work. Some explained that this was due to the role of money and how growing up working class impacted their view of money. One key point to recall when considering this is that 'working-class' was termed as low paid, lacking security and holding limited entitlements (Kaiser & Prieto, 2018; Taylor-Hill, 2024). With this in mind, it was seen that this sense of insecurity and limited entitlements impacted clinicians spoken to in this project, even though they now inhabited the middle-classes. Discussions of the security of employment the NHS offers, the reliability of the pensions and what this may mean for them and their families' lives occurred on several occasions. This was best summarised when speaking with a full-time NHS staff member who spoke of the differences between working and middle class when it comes to this. They summarised; "*there is not safety net*", reflecting that for people from a working-class background, there is nothing under the tightrope and a wrong career decision leads to something worse than it would for someone with the financial safety net.

Additionally, the impact of the NHS being free at the point of use, which meant that everyone could access it, irrespective of finances. One participant spoke of this in connection to their class values, noting that leaving the NHS would be like turning their back on themselves, on their family and the people who may need this support most. It was felt that there was a sense of 'duty' for some, to remain in the NHS partially or fully or for those who left, to return despite the organisational and other systemic issues discussed. Which suggests that in spite of the previously discussed reasons for leaving, such as feeling undervalued, or

mislabelled/mis-classed and overworked, their class values did in some way impact their career decisions, potentially making it harder to leave (Harding, A, 2025; Muthy, 2022; Palmer et al, 2021; Place, 2023; Stinton N, 2025).

The overall experience of the working-class clinical psychologist in the NHS and outside is varied and complicated. There exists a sense of duty even in a space they may not fully 'fit in' and a want to create systemic change and improve access. However, many are faced with being judged, undervalued and misunderstood in a profession and workplace that may have once been more representative of them as a working-class person. These experiences appear to turn the heads of working-class clinicians and lead to them explore other career choices. The main reasons discussed that were leading to people leaving or thinking of leaving the NHS were, the need for flexibility, increased wages, safety following organisational failures and a want to engage with more aspects of their training, i.e. research. The need for increased earning and the impact of organisational failings appear to link closely to the working-class values, that need for financial safety and a working-class organisation acting in ways that do not align with that value. Conversely, the main reasons for staying were to remain in an organisation that on the surface, fits with their own working-class values or to work with like-minded people who share those values. Additionally, being part of a team and taking on a shared responsibility were also named, which is a commonly reported ideal of the working-class throughout history, being a cog in a larger machine rather than on your own (Kaiser & Prieto, 2018; Taylor-Hill, 2024).

The experience of class migration was described in several ways, some feeling it as a slow-moving process that was not entirely noticeable, others feeling that it was accompanied by the notion of cultural disconnect. As was discussed in the onset regarding the move to university settings, class migration can create a sense of innate challenge and impact a person's habitus, others may experience adaptation to the new environment (Bourdieu & Passeron, 1990; Ivemark & Ambros, 2021, 2023). For many in this project, it was reflected that this

process of class-migration led to a dynamic habitus, meaning that it was changing all the time based on how long someone works somewhere, where they are living now in conjunction to where they grew up and based on their relationships in their personal lives. Connection to the old, working-class world outside of work led to a sense of comfort and familiarity when approaching new worlds for most people. Whereas, for others, assimilating into the new middle-class world created a disconnect with the old, almost like a personal betrayal of sorts.

Ultimately, class and class-migration does appear to impact peoples career decisions in some ways. The experiences of fitting in, of finances, of class migration all lead to a developing value in their role as a clinician that can often align with the working-class values they grow up with, such as supporting others and working in a community. However, when this is injured or they are made to feel like they are deskilled or undervalued or no longer fit in, they may look elsewhere. It would then take a lot for those working-class clinicians to be brought back in, mainly, a trusted and respected figure or figures that represents the same values as they did, which would then protect them from the wider structures that made them leave.

For this group of people, leaving the NHS was challenging, and brought with it a rift from their original view of their role which was initially created by their working-class identity. Increased financial security and improving role flexibility meant that leaving the NHS was possible and even fruitful. However, for all of those spoken to, there was and still is a cultural, class connection to the NHS and what it represents at its most basic form. A place that is free at the point of access, for everyone, for their families, their friends and for anyone living with less social and financial capital or access to support in this world. When thinking about how the NHS can retain this group of staff or help bring them back from private work, these class factors must be considered alongside the monetary incentives that are often discussed. For a working-class clinical psychologist, feeling like they are part of something that helps those in

need, and that they can be supported and ‘fit in’ while doing so, must be remembered as a key factor.

Practical Implications

One important point that was highlighted from the perspective of working-class clinical psychologists was the notion of flexibility. For many, it was clear that the NHS way of working cannot currently offer the same level of flexibility that comes with private work, particularly for new parents and families. More space to plan your own calendar, less emphasis on mandatory meetings and more focus on work life balance could aid in retaining more staff if their life is allowed to feel more balanced and aligned with their values.

Fitting in or feeling as if you belong in a workplace clearly has a big impact on people’s ability to speak out and to feel happy at work. This empirical project has highlighted that when working-class clinicians do not feel comfortable somewhere, they are more likely to leave and seek other opportunities where they fit in and that align with their values. Further to this, the apparent lack of safety in some workplaces was stark, people feeling unable to speak out against injustice in work leaving them feeling alienated and fearful. This needs to be approached at all levels in the NHS as it is often referenced as ‘everyone’s responsibility’. However, people may be made to feel vulnerable or othered when speaking out, which may encourage them to avoid doing so due to a perceived lack of safety and support.

Class and discussions around class differences are becoming more widely reviewed. Teams in the UK such as the ClassClinPsy collective and others similar to them are creating spaces for people to think about this. However, it still remains the case that people are cautious when raising these conversations as it can feel affronting to them in a workplace. People worried they would be perceived by others in a certain way or thought lesser of because of where they come from was a real thing of note in these discussions. Encouraging people to feel

safe enough to have these discussions could be helpful in creating safer spaces at work, thus increasing their want to remain in the workforce, rather than feeling compelled to leave due to feeling ‘different’ or ‘othered’.

Limitations and Future Directions

As discussed in the introduction, the experience of working-class clinical psychologists makes up just one group of clinicians that are often not researched enough. Future research should be interested in exploring other, less represented groups of clinical psychologists. Understanding their experiences of working in the NHS and elsewhere may increase awareness of how these differences may intersect and where they are separate.

Furthermore, research should continue to explore the role of the un/heard and un/seen differences between clinicians and how this impacts their career. Many discussed the impact of their accent and how this was responded to by other clinicians and by patients when moving around the UK. Accents appear to trigger some to mock or undervalue based on their own prejudices of where that person may be from. Investigating this form of implicit racism further amongst clinicians would be important when considering their career decisions based on where may feel safe to work for them.

The above leads into one of the key limitations of this empirical project, a lack of emphasis on demographic information. When thinking about the way people are treated at work, research suggests that differences in demographics can often impact how people are received or how they are treated, even if this should not be the case (Crew, 2020; Day et al, 2020; Friedman, 2019; Littler, 2013). The researcher did not obtain detailed demographic information outside of class and gender. Other demographic information was missed, not limited to but including age, disability and ethnicity.

Furthermore, it would have been useful to explore how services and trusts potentially discussed or avoided discussions of class in the workplace. Doing this may have given more information about how their experience at work was impacted and how people were or were not made to feel safe to share such information. This may have also opened more discussions about local changes that could be made relating to job satisfaction as each trust will be constrained in some way by budgets and staff etc.

Conclusions

Growing up working-class and with limited social capital appears to create several challenges in the early stages of one's life which then carry forward into their career. These challenges and the values created, such as a shared experience or a need for universal healthcare and support appear to align with the values of the NHS structure at its core. This in turn, creates an opportunity for a workplace to reflect the values of the working-class and could mean that for a working-class clinical psychologist, they 'fit in' to that space. However, despite the strength of these values and the connection to what the NHS may represent, the financial security and flexibility of private practice may still provide a safer and more secure place to work for some.

Yet, as was discussed, with the right input and support, people would for the most part, want to return to the NHS. Whilst increasing earnings in the NHS and offering more flexibility may never be enough, having safe places to work, with people who are supportive and have shared values may be a bigger part of improving workforce retention in the NHS. Positively, NHS trusts and services are equipped to begin creating these kinds of spaces for work, but it will take systemic changes to do so. These findings, alongside the work of Harding (2025), Stinton (2025) and Baily (2026) can hopefully inform these systemic changes and strategies to enhance the experiences of clinical psychologists and working-class clinical psychologists and support retention in the NHS.

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ORCID

Dr Rachel Russell https://orcid.org/0009-0008-8732-2526

Dr Sheryl Parke https://orcid.org/0009-0007-0546-4620

Dr Jinnie Ooi https://orcid.org/0000-0003-0344-9172

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Chapter Five

General Discussion and Critical Evaluation

General Discussion and Critical Evaluation

Workforce Sustainability: Class in Clinical Psychology and Moral Injury in the Mental Health Workforce

This chapter summarises the findings of both the systematic review and the empirical paper. Findings will be considered within the context of the wider literature in order to understand how both projects relate and add to the evidence base. The strengths and limitations of the whole thesis portfolio are explored and the clinical implications and areas for future research are discussed. This chapter closes with the main conclusions for the overall portfolio.

Overview of the results

This thesis aimed to explore areas of workforce sustainability within the NHS by considering the prevalence of moral injury among mental healthcare professionals in the NHS as this factor among others such as stress and burnout have been shown to impact staff retention (Harding et al, 2025; Stinton, 2025). Furthermore, it aimed to explore the experiences of working-class clinical psychologists by reviewing their career journeys in the NHS and outside of it and how the experience of class migration impacted their career.

A systematic review synthesised relevant literature to explore the prevalence of moral injury among mental health staff in the NHS. This review was important to explore a profession that has undergone a lot of pressure and reports of stress and burnout (Harding et al, 2025; Stinton, 2025) leading to people thinking about leaving the NHS (Harding, 2025; Stinton, 2025). Overall, data on levels of moral injury among this staff group is not currently available. However, it became clear that when reviewing answers from mental health professionals on the MIES, factors such as betrayal and transgressions of others are more commonly endorsed as contributing to moral injuries in mental health staff (Brennan, McKay & Cole, 2022, 2025).

The empirical paper attempted to understand the experiences of working-class clinical psychologists in the NHS, private practice and those split between the two. The researcher aimed to explore how factors such as class migration and working-class identity impacted career choices and staff retention in the NHS. Interviews from 13 working-class clinical psychologists were analysed using Braun and Clarke's Reflexive Thematic Analysis (RTA; Braun & Clarke, 2022). The findings created four key themes: '*Money and class'*, '*Experiences of Class Migration'*, '*The Push and Pull of the NHS and the Working-class Clinician'* and '*Us and Them (Seen/Unseen, Heard/Unheard differences)'.*

Summary of Main Findings

It was clear that there are several factors that impact a working-class clinical psychologists' experience of working in the NHS and elsewhere and how their class background informed their career and career choices. Many spoke of the impact that growing up working-class had on their perceptions of money and finances, even when they had risen to earnings considered to be middle-class today. Working-class clinicians spoke of the perceived financial safety the NHS offered as an employer and how this need for financial security was born from their social class growing up. The notion that there is no "*safety net*" for the working-class clinical psychologist was a poignant summation of this point and referred to the tightrope people in this position found themselves on, that if something went wrong, there was no financial safety net to catch them if they fell.

Another key point was the link between the working-class and the ideals and values of the NHS. The NHS for many participants, represented something that was free at the point of use, available to everyone and supporting everyone in need of help. People spoke of a duty to be a part of this structure and the potential moral injury endured when the organisation

began to represent something less aligned with that. This point links clearly with the findings of the systematic review when considering the responses to the MIES in particular (Nash et al, 2013). All papers reviewed highlighted participants' endorsement of betrayal and the transgressions of others as key factors related to moral injury (Brennan, McKay & Cole 2025; Greene et al, 2024; Hegarty et al, 2022; Jones et al, 2020). These may have been the betrayals and transgressions of team leaders, managers and others in the organisation as well as those outside of it. These factors have also been shown in the wider moral injury literature amongst other staff groups (Kim et al, 2024; Mewborn et al, 2023; Roycroft et al, 2020). Recent changes in government may appear to show similar transgressions towards staff in the NHS. This comes as the new long-term plan aims to reduce waiting list times for patients which in turn adds further stress onto the clinical workforce and may create more moral injuries, increase burnout and stress at work (Clark, 2025; Cudmore & McGrath, 2022). Without systemic change, moral injury may continue to be common place in the clinical psychology workforce and in the future this may contribute to deepening feelings for individuals to feel anxious at work, lack confidence and become increasingly low before exiting the workplace (Clark, 2025).

For many participants in the empirical project, their morals and working-class values appeared to keep them in the organisation for longer than they felt they should have. People spoke of a want to help people who struggled to access private care, a want to support people who they represented (i.e. other working-class people), but knowing that for their own wellbeing and financial security, they may have to leave. There existed a sense of “duty” for these individuals, in a space where they may not have felt like they fully “fit in”. Similar to findings at the trainee stage for working-class clinical psychologists, this left people potentially feeling judged, undervalued and misunderstood in a profession and workplace that may have

once been more representative of them as a working-class person (Place, Crew & Saville, 2024; Place, 2023).

Both papers raise important points about the staff retention dilemma. Firstly, when considering the empirical paper, it is seen that working-class clinical psychologists appear to have a view of the NHS itself which is built from their background. That the NHS is a financially secure place to work, that it represents the same values and ideals of them as a working-class person and that leaving that, would be turning their backs on people like them who need help. However, when this perception is fractured by incidents that create moral injuries or challenges to one's safety, people leave. The organisation may no longer represent them as a working-class person and may also not provide the financial security it once did. The working-class clinicians discussed a want to feel valued and understood in the NHS and at times this was the case. Yet, at other times, people were made to feel undervalued or like they didn't fit in, because of their class background and for other reasons. The systematic review highlights that there is a need for more research into the prevalence rates of moral injury among mental health staff. However, by showing the endorsement of betrayal and transgressions of others on the MIES, it links to previous research in this area and further supports the claim that the working conditions of the NHS are leading to these injuries at times (Broughton, 2023; French, Hanna & Huckle, 2022). Thus, suggesting ideas to support the lessening of these morally injurious acts.

Strengths and limitations and Clinical implications for practice and NHS trusts

One potential strength of the systematic review conducted may be that it appears to be the first attempt to explore the overall prevalence of moral injury among mental health staff in the NHS. However, this also poses a potential limitation, that although factors such as

betrayal and transgression from others appear common throughout the literature, when considering just how common amongst this staff group, we remain unsure due to the lack of larger more specific samples of the mental health staff population.

Furthermore, when considering the JBI and the quality assessment completed, further limitations appear. Mainly, when considering the samples that were used in the papers reviewed. Whilst many appeared to recruit large samples of participants, the grouping of these participants appeared to lack specificity. When considering the samples using the JBI checklist, it was shown that most had adequate samples, however, when exploring further in the review, mental health staff were often grouped in 'other' categories, which included staff from admin and cleaning staff (Brennan, McKay & Cole, 2022; 2025; Jones et al, 2020). Mental health staff, including clinical psychologists, may be in positions of decision making, which may lead to the violation of values if they need to make a particular decision about a patients care. Furthermore, they may be present and hear about the transgressions of others perpetrated towards the staff they supervise and those they care for. Whilst administrative staff are exposed to potentially traumatic events over the phone and in person, they may not share the same level of responsibility as certain mental health staff, meaning the grouping of these professions together impacts the data. Furthermore, due to the inability to obtain full data sets, larger samples could not be explored fully in the review (Hegarty et al, 2022).

The challenges with population samples carries over to the empirical project in some distinct ways. Whilst the empirical paper was concerned with the experiences of working-class clinical psychologists, this represents just one sample of under explored clinicians in the workforce. It also lacked exploration into the demographic information of the participants and thus limited the understanding of potential intersectionality in the workforce. Furthermore,

while there was some discussion about potential seen and unseen or heard and unheard differences in the participants and how this impacted their careers, more is needed to explore this further among larger populations and how those explicit and implicit differences impact their careers.

However, this project did highlight that for this group of staff, flexibility in the workplace is a huge driver for their retention. It was clear that while the NHS attempts to make the workplace a flexible one, it cannot compete with the offer of the private sector. Whilst this does appear to be an unavoidable problem, this does not mean that the NHS cannot create a more flexible working culture to fit the needs of the staff, especially when it relates to families and new parents. More space to plan your own calendar, less emphasis on mandatory meetings and more focus on work life balance could aid in retaining more staff if their life is allowed to feel more balanced and aligned with their values.

Furthermore, this empirical project showed how important the notion of 'fitting in' at work is, not only in creating a safe place to share and reflect, but also a space in which people can feel happy and safe to speak out. Participants highlighted that when working-class clinical psychologists do not feel comfortable somewhere, they may be more likely to leave for a workplace that better aligns with their values. A lack of safety and security to speak up was apparent in some cases and this furthered people's feelings of alienation in the workplace. When considering the practical implications of this research, we must understand this problem and encourage change so that the suggested idea of whistleblowing and safeguarding being 'everyone's responsibility' is a reality.

The main clinical implication to consider regarding the systematic review is that if we are unable to ascertain the prevalence of moral injury among mental health staff, then we are

unable to see how common it is in the NHS for this staff group. This may mean that interventions focusing on tackling moral injury are not implemented for mental health staff. When there is increased research highlighting the pressures and reports of stress and burnout in this staff group (Harding et al, 2025; Stinton, 2025), and more and more clinicians thinking of leaving the NHS (Harding, 2025; Stinton, 2025), it is crucial to understand the prevalence of moral injury to see if and how it contributes to staff wellbeing and retention.

Further to this, the empirical project highlighted that whilst conversations relating to class are becoming more common, more is needed to create these safe spaces for discussion. People still appear cautious at work and some worry of how others may perceive them if they reveal their class background. Whilst this challenge leads to conflict in the individual as they assimilate into the middle-class world of clinical psychology, it also has been highlighted that differences allow people to be a better representation of the population rather than a homogenous group of professionals. Encouraging these conversations in the workplace and stopping the 'othering' that may happen could be one step in creating these safe spaces people are more readily able to work in and remain in for many years.

Directions for Future research

More research is needed exploring the prevalence rates of moral injury among this staff group. As shown in the data above, mental health professionals are experiencing moral injuries at work and often this is via betrayal or by transgressions of others. This has been shown across wider staff groups and prevalence has been examined (Kim et al, 2024; Mewborn et al, 2023; Roycroft et al, 2020). However, for mental health staff, there is currently a lack of data on how prevalent moral injury is. Furthermore, explorations in this area appear to be heavily linked to the COVID-19 pandemic and the moral injury inflicted at this time. More

research is needed exploring moral injury in relation to more 'business as usual' time periods as that was one particularly rare incidence and may not be widely generalised to daily practice.

This empirical project highlighted the experiences of working-class clinicians in the NHS and private sector and those working between the two. It also uncovered several areas for future research. One being the need to explore how services and NHS trusts are engaging in or avoid engaging in discussions relating to class in the workplace. Many expressed not wanting to talk about their class background at work or waiting until a trusted ally appeared and opened that conversation. While it may be fairly common for conversations about class when reflecting on patients, why is it less discussed among staff in relation to themselves? And does this have any role on people's ability to fit in at work and more widely, on staff retention?

One important consideration regarding class which has been discussed briefly in this paper is the changing nature of class and class structures in the UK. Whilst on the surface, it appears that there are growing opportunities to experience class mobility, deeper, it appears that in the UK, social mobility is in decline (Folkes, 2025). There appears to be a growing gap between classes as the upper class move into a new area and the space between working class and middle class shrinks with a cost of living crisis going on (Folkes, 2025). While many of the ideas and values discussed in this research paper may still be relevant as they are firmly held beliefs, it may be interesting to see how well the current findings fit in years to come with this changing landscape.

Furthermore, explorations into other demographic information should be conducted if studies like this are completed again. There appeared to be an intersection between being working-class and gender in this project and it highlighted the differences between the

potential thinking styles around earnings. Whilst money was important to both, the reasons why were different, men often feeling the need to earn more and be financially safe in order to provide for the family, and women appearing to worry more about lifetime earning and financial security in general. Other intersections are likely to exist as differences in experiences are not merely down to one factor, more likely several overarching and individualised factors that need further discussion.

Conclusions

The studies contained within this portfolio provide valuable insights into the world of staff wellbeing and retention in the NHS. Evidence first highlighted the lack of research exploring the prevalence of moral injury in mental health staff in the NHS. However, further exploration highlighted the impact of factors such as betrayal and transgressions of others on the development of moral injury in mental health staff in the NHS. This was then shown to be a present factor in the more focused population of working-class clinical psychologists. As a lack of flexibility, a lack of safe spaces, challenges fitting in and an apparent sense of embodied discomfort appear alongside consistent challenges to the morals and values of this group. All of these factors must be considered as we reflect on the current staffing crisis in the NHS and begin to develop new approaches to supporting staff and aiding retention.

It was clear that growing up working-class meant growing up with limited social capital which can create several challenges in early life which carry forward into people's careers. At its core, it appears to instil values associated with the idea of community, relating to this ideal of universal healthcare and what the NHS can and always has represented. Whilst the NHS may be unable to match the perceived flexibility of private work, it is not without options to support and retain this staff group. The presence of respected and valued colleagues who aid

the process of fitting in and provide a safe place to work may be a starting point to encourage discussions that allow people to feel safe to share at work. Hopefully, this can aid in increasing openness and safety in the workplace and ultimately lead to better staff retention and wellbeing. The findings from this portfolio, alongside the work of Harding (2025), Stinton (2025) and Baily (2026) can hopefully inform these systemic changes and strategies to enhance the experiences of clinical psychologists and working-class clinical psychologists and support retention in the NHS.

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Appendices

Appendix A

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Appendix B

Search String for Systematic Review

Service and country		Psychological profession		Synonym/term defined
NHS OR "national health service" OR "united kingdom"	AND	Mental health staff" OR "mental health workforce" OR psycholog* OR "clinical psychologist" OR therapist OR "allied healthcare professional" OR "psychological therapist"	AND	"moral injury" OR "moral distress" OR moral

Appendix C

Methodological quality using the JBI Critical Appraisal Checklist for studies reporting prevalence data *(Munn et al., 2015)*

Summary of methodological quality	Study 1 Brennan et al 2022		Study 2 Brennan et al 2025		Study 3 Greene et al 2024		Study 4 Hegarty et al 2022		Study 5 Jones et al 2020	
Rater TW/KS	TW	KS	TW	KS	TW	KS	TW	KS	TW	KS
Was the sample frame appropriate to address the target population?	0	0	0	0	1	1	1	1	1	1
Were study participants sampled in an appropriate way?	0	0	0	0	1	1	1	1	1	1
Was the sample size adequate?	0	0	0	0	1	1	0	0	1	1
Were the study subjects and the setting described in detail?	1	1	1	1	1	1	1	1	1	1
Was the data analysis conducted with sufficient coverage of the identified sample?	0	0	0	0	0	0	0	0	0	0
Were valid methods used for the identification of the condition?	1	1	1	1	1	1	1	1	1	1
Was the condition measured in a standard, reliable way for all participants?	1	1	1	1	1	1	1	1	1	1
Was there appropriate statistical analysis?	1	1	1	1	1	1	0	0	1	1
Was the response rate adequate, and if not, was the low response rate managed appropriately?	1	1	1	1	1	1	0	0	0	0

Note: TW refers to the primary researcher, KS refers to the secondary researcher. 1: Yes, 0: No/Unclear.

Appendix D

PRISMA 2020 item checklist and Abstracts checklist (Page et al., 2021)

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Title
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Appendix C
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Introduction
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Introduction
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Method, eligibility criteria, Table 1
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.	Method, search strategy
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Method, appendix A,
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.	Method, screening and study selection
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.	Method, screening and study selection, data extraction
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.	Method, data extraction
	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.	Method, data extraction
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.	Method, quality assessment
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.	Method,
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)).	Method, data synthesis

Section and Topic	Item #	Checklist item	Location where item is reported
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	Method, data synthesis
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	Method, data synthesis, table 2
	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.	Method, data synthesis
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	Method, data synthesis
	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.	Method
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.	Results, figure 1,
	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.	Results, table 2, study characteristics
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Results, quality assessment appendix B
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.	Results table 2
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	N/A
	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.	Results
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A
	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.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			

Section and Topic	Item #	Checklist item	Location where item is reported
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Discussion
	23b	Discuss any limitations of the evidence included in the review.	Discussion, clinical implications, limitations and future research
	23c	Discuss any limitations of the review processes used.	Discussion, clinical implications, limitations and future research
	23d	Discuss implications of the results for practice, policy, and future research.	Discussion, clinical implications, limitations and future research
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.	Method
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Method
	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.	Funding sources
Competing interests	26	Declare any competing interests of review authors.	
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.	Table 2, Appendix A

Section and Topic	Item #	Checklist item	Reported (Yes/No)
TITLE			
Title	1	Identify the report as a systematic review.	Yes
BACKGROUND			
Objectives	2	Provide an explicit statement of the main objective(s) or question(s) the review addresses.	Yes
METHODS			
Eligibility criteria	3	Specify the inclusion and exclusion criteria for the review.	No

Section and Topic	Item #	Checklist item	Reported (Yes/No)
Information sources	4	Specify the information sources (e.g. databases, registers) used to identify studies and the date when each was last searched.	Yes
Risk of bias	5	Specify the methods used to assess risk of bias in the included studies.	No
Synthesis of results	6	Specify the methods used to present and synthesise results.	Yes
RESULTS			
Included studies	7	Give the total number of included studies and participants and summarise relevant characteristics of studies.	No
Synthesis of results	8	Present results for main outcomes, preferably indicating the number of included studies and participants for each. If meta-analysis was done, report the summary estimate and confidence/credible interval. If comparing groups, indicate the direction of the effect (i.e. which group is favoured).	Yes
DISCUSSION			
Limitations of evidence	9	Provide a brief summary of the limitations of the evidence included in the review (e.g. study risk of bias, inconsistency and imprecision).	Yes
Interpretation	10	Provide a general interpretation of the results and important implications.	Yes
OTHER			
Funding	11	Specify the primary source of funding for the review.	No
Registration	12	Provide the register name and registration number.	Yes

Appendix E

Job Roles Included under the terms Allied Healthcare and mental health professionals

As defined by NHS England, allied healthcare professionals are listed below:

- Art, drama, or music therapists
- Dietitians
- Occupational therapists
- Physiotherapists
- Speech and language therapists

Psychological professionals are broken into 18 different professions in the NHS, listed below:

- Psychologist: Clinical, Counselling, Forensic, Health Associate and
- Clinical associate
- Assistant psychologist
- Psychological therapists
- Cognitive Behavioural Therapists
- Counsellors
- Child and Adolescent Psychotherapists
- Adult Psychotherapists
- Family and Systemic Therapists
- Psychological Wellbeing Practitioners (PWP)
- Children and Wellbeing Practitioners (CWP)
- Education Mental Health Practitioners (EMHP)
- Mental Health and Wellbeing Practitioners.
- Youth Intensive Psychological Practitioner (YIPP).

Mental health staff are considered to be those who typically comprise the Multi-Disciplinary Teams (MDT)of mental health teams in the community and in inpatient services. This includes mental health nurses, psychiatrists, and healthcare assistants.

Appendix F

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Where one or multiple data sets are associated with a manuscript, these are not formally peer-reviewed as a part of the journal submission process. It is the author's responsibility to ensure the soundness of data. Any errors in the data rest solely with the producers of the data set(s).

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Queries

If you have any queries, please visit our Author Services website or contact us here.

Updated 11th February 2026

Appendix G

Topic Guide

V3.0 Date:07/02/2025

Topic Guide/Semi-Structured Interviews

*Variation from interview to interview in how the questions are asked (order) and depending if **full NHS**, **split NHS**, **no NHS**. Additional prompting Qs are included but may or may not be required, depending on the interviewee.*

Research questions to keep in mind

1- *What is the experience of a working-class clinical psychologist in the NHS, private sector and those split between the two, post-doctoral training?*

2- *How do these individuals experience movements through social class systems?*

3- *Has this influenced their career decisions since qualification?*

Beginnings

Introduce myself again and confirm verbal consent to participate.

Our interview today should take between one hour to one and a half hours to complete and you have the right to decline any questions in the interview that may adversely impact you or the interview. **What would be the best way for you to indicate this for you?**

You have the right to end this interview at any time with no adverse consequences to yourself, please do let me know now how you would like to communicate this to me that you would like to end the interview.

There will be an audio and video recording of this interview with the transcription function enable on MS Teams.

There are no right or wrong answers to any questions as this is about your own experience.

If at any point you would like to have a break, please let me know, what would be the best way for you to indicate the need for a break?

Would you like a copy of the questions added to the chat as we go through the interview? This may help to avoid any technical issues or communication difficulties. For longer questions I will pop them into the chat.

Before we start, can I please confirm that you are an HCPC registered Clinical Psychologist who only works in the NHS?

Before we start, I want to note that I will be using the term splitting/split to refer to psychologists like yourself who have split employment between the NHS and the private sector. Please can I clarify what your areas of employment are at this time and how your hours are split between the two (Note, not about where specifically they work but the hours split between NHS and private). Please can I clarify how your split employment came about, if this was from full-time NHS to split or from full time private to split etc.

Please can I also confirm that you are an HCPC registered Clinical Psychologist.

Before we start, can I please confirm that you are an HCPC registered Clinical Psychologist who has previously worked within the NHS. Can I please also confirm that you are now no longer working within the NHS but are instead working privately as a Clinical Psychologist.

1) What has your journey been up to this point in your career post-doctoral training?

2) There is a model that discusses the experiences of people from working-class roots and their movement through class systems **that you would have seen in the participant information sheet (add Bourdiue's model in chat).** Do you feel any of these Habitus states resonate with your experience?

3) How has this experience of class migration been for you personally?

4) In what ways has class, class migration and habitus states been influential in your career decisions?

    a. Do you feel this experience influenced your career decisions to stay working in the NHS?
    b. Do you feel this experience influenced your career decisions to remain working partially in the NHS?
    c. Do you feel this experience influenced your career decisions to leave working in the NHS?

5) What was your experience of the transition from working-class roots to university?

a. Did this change overtime?
b. How did you find the experience of fitting in, in these new surroundings?
c. How do you align now in your career with that state?

6) How did you find the transition from training on the clinical doctorate to working in the NHS as a qualified clinical psychologist and being paid what would equate to an upper middle-class income in the UK?
    a. Do you feel that your class and class migration may have impacted this?

7) What is your **personal experience** in your role now?

8) What impact do you think your **class or habitus** state have on your career today?

9) Do you feel that your current social class impacts your next career move?

10) With a large number of colleagues leaving the NHS workforce within the first 5 years of qualifying, what do you feel are the biggest factors influencing your decisions to leave/stay?
    a. What factors are there that may keep you in the NHS?
    b. Is there a reason you remained partially within the NHS?
    c. Are there factors that would make you want to return?

11) Is there anything in your current experience of the NHS as a clinical psychologist that would influence/influenced your decision to stay or leave the NHS?
    a. Does your class journey or habitus state have any influence on this?
    b. What would have to change for you to return to the NHS full time from your split role?
    c. What would have to change for you to return to the NHS full time from your private role?

12) How have discussions around class shown up for you at work in the NHS and outside of it?
    a. Is this a conversation you have had in the workplace, or university before today?

b. Why? (To yes or no)

13) How might your habitus state as detailed earlier influence your decision making around your career?
    a. Looking forwards in your career, what are your thoughts on your next career move?
    b. How would you manage such feelings/thoughts moving forward?

Endings

Thank you so much for taking part in this interview and for your time today.

I want to remind you that the time period to withdraw from this study is 4 weeks, that means it would need to be before **DATE**. After this date, the data will be anonymised and it will not be possible to for the research team to identify your personal responses so it will not be possible to withdraw after this date.

Your love2shop voucher/ £10 payment will be emailed to you following the ending of the withdrawal period, I must stipulate that even if you withdraw in that time, you will still receive the voucher for taking part. Can I please confirm the best email address to send this to.

Please consider how you will look after yourself following this interview, if this experience has been particularly emotive or distressing, please refer to the support services in the PIS and the debrief sheet will also be sent over in due course.

Thank you again so much for taking part in this research project!

Appendix H

Empirical Project Advert

University of East Anglia

V5.0, Date:03/07/2025,

Are you a clinical psychologist working in the NHS, private sector, or split between the two?

Do you also come from a working-class background?

We are conducting research to explore people's experiences from working-class backgrounds and how it has shaped their personal journey in this profession. We are hoping to hear from people working in the NHS, those working full time privately and those working a split role between the NHS and private sector.

We will be looking to recruit people to take part in interviews via MS Teams and these will take from 60-90 minutes.

In this profession, there is a spread of people from different backgrounds. Our journeys may have shaped the way we are as professionals but also had an impact on our choices and experiences in the field.

If you would like to take part,

please email me to hear more about it.

Lead Researcher: Tom Westwood

Email: T.westwood@uea.ac.uk

This study has been granted ethical approval

by UEA FMH ethics (ETH2425-2463)



Appendix I

Participant Consent Form

Consent form V.5, Date:03/07/2025

Title of the study: Experiences of Working-Class Clinical Psychologists in the NHS Clinical Workforce

Name of the researcher (Chief investigator): Tom Westwood, Trainee Clinical Psychologist

Please add your initials in each box if you agree to each statement

1. I confirm that I have read and understand the participant information Sheet for the above study. I have had the opportunity to consider the information and ask questions. I have had these answered to my satisfaction.	
2. I understand that my participation in the study is entirely voluntary and that I am able to withdraw from the study before or during the interview and up to two weeks after my chance to review the interview transcript and ask that my data be destroyed without giving any reason.	
3. I understand that my interview will be either audio-recorded using a digital recorder or video and audio-recorded using the recording function in Microsoft TEAMS (through the researcher's university account), and I consent to these recordings.	
4. I have been informed and I understand how my personal information and information related to my involvement in the study will be handled. I understand how this will be stored securely, who will have access to this and how this will be used.	
5. I understand that should I disclose any information that raises concerns about my safety or the safety of others, appropriate third parties and services may be contacted without my formal consent, to ensure the safety of myself and others. Staff will endeavour to discuss this with the participant where appropriate, unless it is not possible to do so. This would normally be discussed with the project	

supervisors first, unless immediate support was required due to an imminent risk to life or health.

6. I understand and agree that quotes from my interview may be included in research reports and publications, all data used will be treated anonymously and with confidentiality. ☐

7. I understand that if I am not able to be contacted following the two-week period I have to review my transcript, then I will still receive payment for participation and my transcript will be used in the final analysis. ☐

8. I agree to take part in the above study. ☐

Optional Questions: ***Please add your initials in the box if you agree to the statement***

I agree to be contacted via email to receive a short summary of the findings of this research project. ☐

Name of Participant Date Signature

_____ _____ _____

Name of Person taking consent Date Signature

_____ _____ _____

Appendix J

Participant Information Sheet

Participant Information Sheet V8.0, Date:03/07/2025

Experiences of Working-Class Clinical Psychologists in the NHS Clinical Workforce and Beyond

My name is Thomas Westwood, and I am a trainee Clinical Psychologist at the university of East Anglia. As part of my professional doctorate, I am conducting a research study into the experiences of qualified Clinical Psychologists from working-class backgrounds within the NHS and private sector and their journey from undergraduate to qualification and life beyond that.

I would like to invite you to take part in this study. However, before you decide to take part, it is important that you understand why this research is being conducted in the first place and what it will involve. I am happy to go through this information sheet if you have any questions regarding the study and I want to remind you that **taking part is completely your choice.**

What is the aim of this study?

There is a sociological model developed by Bourdieu which details what he calls 'states of Habitus' which refers to a person from working-class backgrounds transition to university. He and other researchers outline several felt states relating to this transition and how they may impact the persons journey from there. I hope to explore this further by looking at the journey of a qualified clinical psychologist and how they experienced potential class migration. Furthermore, I want to explore what habitus state they may align with now they are qualified and how that may influence their career decisions moving forward. This research hopes gather experiences from a group within psychology that is not overly researched and hopefully inform NHS boards on the personal experience of working-class people's time in the NHS.

Do I have to take part?

No! you do not have to take part unless you want to. This is entirely up to you and please do take your time to think about it. If you do decide to take part, you will be asked to sign a consent form to document your agreement but, even after signing this **you are still free to withdraw within two weeks of the chance to review your interview transcript, and you do not need to give me a reason.**

Am I able to take part?

The proposed research project hopes to engage in meaningful and representative research. Therefore, barriers to participation and engagement must be identified and mitigated for. Due to this, the research aims to feature fewer restrictive exclusion criteria while still aligning with the overall goals of the research.

Inclusion Criteria:

- Qualified clinical psychologists working full-time within the NHS, Full-time in private practice or working a split role between the two.
- Self-identifies as from working class roots or backgrounds.
- A definition of working-class is outlined below for reference and reflection.

o From the bottom of the economic hierarchy, engaged in semi-manual and non-cognitive roles marked by low pay, insecurity and limited entitlements (Taylor-Hill, 2024).

Participants self-identified working-class status will not be formally assessed and will rely on the self-reports to remove potential barriers to engagement. The definition above is for reference if people are unsure.

Exclusion Criteria:

- Those working in the NHS in any other role outside of that of a Clinical Psychologist
- Those who are working full-time in the NHS and working additional hours in the private sector. These people are considered NHS plusers and will not be included in the project.
- Those not from working-class roots or backgrounds. While people may still have valuable experiences and contributions from this population, this research is currently interested in working-class people's experiences in the field based on its relation to a certain sociological model specifically related to people from working-class backgrounds.

What will taking part involve?

If you choose to take part, you will be invited to complete an online interview which will be recorded using Microsoft teams. This will last a maximum of 90 minutes, during which time I will ask about your journey to this point in your carer and your experiences of this. I am interested in hearing real experiences and reflections, so honesty and bluntness is always welcome. All questions are optional and if you do not want to answer a question **you do not have to answer it.** You can also stop the interview at any time and specify if you would like anything said to be deleted or replaced.



Confidentiality

All the information I collect about you throughout your involvement in this research will be kept completely confidential. Confidentiality will only be broken if myself or the research team have any immediate concerns about your wellbeing or the wellbeing of someone else. We add this as we want to ensure the safety of both yourself and others. In the case that you disclose information that raises any concerns about your safety or the safety of others, I may have a legal responsibility to share this information with a third party, however, I would always try to discuss this with you unless I was unable or it was inappropriate to do so. I will ask for your agreement to record the interview so it can be transcribed (meaning it will be typed up word by word) and analysed. I will use a recording device for this and any identifiable information will be stored securely and separately from your consent form and audio-recorded interview so they are all never in the same place at once.

As the interview takes place over MS Teams I will ask to video record this. Your data, interview and transcript will be stored securely using encrypted password-protected professional UEA one drive. Once the period for review has passed and you have received your payment for taking part, the data will then be anonymised and you will not be able to withdraw. Any verbatim quotes in the interview will also be anonymised. However, due to the personal nature of quotes and what we are discussing I cannot guarantee that your quotes will not be recognised by others.

Your interview data will only be reviewed by the members of the research team at the university. Academic and professional staff may also be able to access your anonymised data in order to evaluate the quality of this doctoral research. However, they will also have a duty to maintain confidentiality. Any data related to your involvement will be transferred to a master file which will be kept with the research supervisor Dr Rachel Russell at the university of East Anglia. Data will be stored securely for ten years following the final submission of the thesis project, after this time the data will be destroyed.

What are the risks of taking part?

The interview questions will ask you to reflect on your own experience of class migration which may elicit some challenging memories to reflect on. All of our journeys are different

and some may contain difficult memories or distressing emotions. If there is anything that is asked that leads to you feeling upset or distressed please remember that **all questions are optional** and you do not have to answer anything you do not feel comfortable answering.

What are the good things about taking part?

By taking part in this research you will help to inform the wider workforce and structures of the NHS about the experience of those coming into it from working-class roots, into qualified life in the NHS and in the private sector. The hope is that this will help others in similar situations to explore their own experience. In addition, we hope this may also inform staff retention planning if there is anything identifiable that the NHS clinical workforce can change to retain staff in these roles. Another aspect of participating is that you will receive a £10 love2shop voucher for your time!

What will happen to the results of this research study?

If you agree, a summary of the findings will be made available to you after the study is completed. The findings will be written up and included in my doctoral thesis and journals that it may be submitted for publication and conferences thereafter. The master file of the research study will be held at the University of East Anglia for ten years post-completion.

What if I do not want to carry on with the study?

Taking part at any stage is your decision and you can change your mind at any time before the interview takes place, during the interview itself and up to two weeks after you have had the chance to review the interview transcript.

Who has reviewed the study?

The research being undertaken as part of the completion of the doctorate in clinical psychology at the university of East Anglia and is funded and organised by the university of East Anglia and has received ethical approval by the UEA FMH ethics committees.

This research is being undertaken in the completion of a professional doctorate in clinical psychology.

Information and Contact Details  

Please do not hesitate to contact me with any questions you may have. If you have read this information sheet and are certain you wish to take part then please contact me so we can schedule an interview.

Contact me:

Principal Investigator: **Tom Westwood**

Email: **.T.Westwood@UEA.ac.uk**

Address:	Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, Norwich Research Park, University of East Anglia, Norwich, Norfolk, NR4 7TJ.
Primary Supervisor:	Dr Rachel Russell
Email:	R.Russell@UEA.ac.uk
Address:	Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, Norwich Research Park, University of East Anglia, Norwich, Norfolk, NR4 7TJ.

What if I have a complaint?

If you have any concerns or complaints about anything related to this study, please don't hesitate to contact the research supervisor or director of the Doctorate in clinical psychology.

Research supervisor

Dr Rachel Russell

Email: R.Russell@UEA.ac.uk

Tel: 01603 593061

Address: Norwich medical school, Norwich, NR4 7TJ

Independent contact

Dr Sian Coker

Email: S.Coker@UEA.ac.uk

Tel: 01603 593061

Address: Norwich medical school, Norwich, NR4 7TJ

Thank you for taking the time to read through this information sheet. Please keep a copy for your records.

Appendix K

Participant Debrief Sheet

V6.0, Date:03/07/2025
Participant Debrief Sheet

Participating in research can be challenging and some questions from this project may have led to some challenging thoughts or memories. If for any reason you would like further support, below is a list of services that are available:

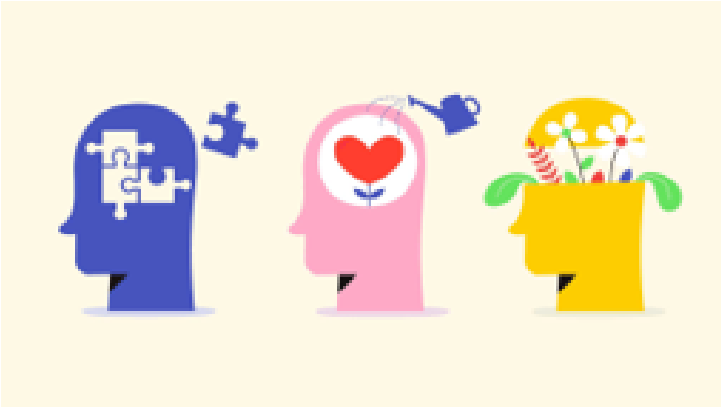
Samaratans: If you need to talk to someone at any time please call 116 123

ClassClinPsyh: to discuss with others from similar backgrounds in a safe space and share experiences in the workforce and beyond.
Follow on twitter @ClassClin and videos of recent talks are available on their YouTube channel at #ClassClinPsych

Wellbeing support in Norfolk and Suffolk: non-emergency number,
0300 123 1503

NHS talking therapies Cambridgeshire and Peterborough: 0300 300 0055

If you have any questions for the researcher or want to get in touch following the interview please contact me via email.



If you do wish to speak to any of the research team, please find the contact details below.

Lead researcher: Tom Westwood
Telephone: 07581344109
Email: t.westwood@uea.ac.uk

Project Supervisor: Dr Rachel Russell
Telephone: 01603 593061
Email:R.russell@uea.ac.uk

Appendix L

University of East Anglia Ethical Approval

Decision - Ethics ETH2425-2463 (Significant amendments): Mr Thomas Westwood

From Ethics Monitor <no-reply@ethicsreview.uea.ac.uk>
Date Mon 14/07/2025 10:05
To Thomas Westwood (MED - Postgraduate Researcher) <T.Westwood@uea.ac.uk>

University of East Anglia

Study title: Experiences of Working-Class Clinical Psychologists in the NHS Clinical Workforce and beyond

Application ID: ETH2425-2463 (significant amendments)

Dear Thomas,

Your amendments to your study were considered on 14th July 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved.**

This approval will expire on **1st October 2026**.

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

Ethics ETH2425-2463 (Significant amendments): Mr Thomas Westwood

Appendix M

COREQ Checklist - COREQ (COnsolidated criteria for Reporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	50
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	X
Occupation	3	What was their occupation at the time of the study?	51
Gender	4	Was the researcher male or female?	51
Experience and training	5	What experience or training did the researcher have?	51
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	X
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	51
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	51-52
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	50-51
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	49
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	49
Sample size	12	How many participants were in the study?	48
Non-participation	13	How many people refused to participate or dropped out? Reasons?	48
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	50
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	50
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	48-49
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	49, 50
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	N/A
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	50
Field notes	20	Were field notes made during and/or after the inter view or focus group?	50
Duration	21	What was the duration of the inter views or focus group?	50
Data saturation	22	Was data saturation discussed?	X
Transcripts returned	23	Were transcripts returned to participants for comment and/or	50

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	52
Description of the coding tree	25	Did authors provide a description of the coding tree?	53
Derivation of themes	26	Were themes identified in advance or derived from the data?	51-52
Software	27	What software, if applicable, was used to manage the data?	X
Participant checking	28	Did participants provide feedback on the findings?	X
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	53-73
Data and findings consistent	30	Was there consistency between the data presented and the findings?	53-80
Clarity of major themes	31	Were major themes clearly presented in the findings?	53
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	53

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.