# At the Coalface of Mental Health: Exploring the Experiences of Psychologists in the Aotearoa New Zealand Health Care Service.

A Grounded Theory Study

Glenn James Lucini

A thesis submitted to Auckland University of Technology in fulfilment of the requirements for the degree of Doctorate of Health Sciences (DHSc)

2022

Faculty of Health and Environmental Sciences

Primary Supervisor: Dr Elizabeth Day

Secondary Supervisors: Dr Brian Rogers and Dr Kim Ward

"Anger and hate in this situation is a normal reaction and important to validate. But it is important to channel it into something useful, she said, such as making incendiary bombs out of empty bottles".

Olha Koba, a psychologist in Kyiv.

**New York Times, 7 March, 2022**

## Abstract

The District Health Boards (DHBs) of the Aotearoa New Zealand (ANZ) healthcare service is the single largest employer of psychologists in the country; and psychologists operate across many diverse sections of the healthcare service. Unfortunately, in keeping with international trends, psychologists in the public healthcare system also experience high levels of stress and burnout. Consequently, recruiting and retaining clinical psychologists in a public healthcare service is challenging. It is therefore important to understand clinical psychologists' experiences of working within the ANZ healthcare service.

The aim of this research was to explore the experiences of clinical psychologists working in the New Zealand healthcare service, and especially their experiences of providing psychological therapies within a large organisational structure. 17 psychologists working in various ANZ District Health Boards agreed to participate in open-ended interviews for this study. Using constructionist grounded theory, data were gathered and analysed until theoretical saturation was reached.

The central finding and overarching theory of this study is that clinical psychologists use alliance-building as a gambit, or strategy. They do this to manage the vulnerability they feel from working within an overburdened, and politically complex public healthcare system. The research study explored three primary institutional processes that provide context and impetus for this gambit. These categories were *being productive, navigating power, a*nd *revisiting protocols.* The theory is predicated on two conditions: that psychologists experience *feeling vulnerable* in their roles, and that they use a process of *allying* to address the expectations of their service.

A clearer picture emerged of how the institutional culture of the DHBs impact the delivery of therapeutic care. Additionally, the tenacity and flexibility of clinical psychologists in preserving and upholding their agenda was demonstrated. This study highlights the importance of a seeing professional activity, like therapy, as a form of dialogue with the environment. While therapy is first and foremost a clinical activity intended to facilitate healing, it also serves to communicate and co-construct a social narrative within the ANZ public healthcare service.

The research has the potential to illuminate the experiences of an important profession operating within the ANZ public healthcare service. The results may stimulate critical reflection and ongoing dialogue between the leadership and policy makers within the ANZ health care system and the psychologists they employ.

## Acknowledgements

First and foremost, I want to acknowledge my family for all their love and support. When I began this project, my family consisted of Debbie and our dog, Dylan. As I finalise the thesis, we now have an inquisitive little scientist called Max, and a hurricane called Layla. I don’t think I have never made peace with the parenting time sacrificed. However, I hope that the intellectual energy that emanated from this project will inspire you both to seek your own higher learning, in whatever form that may take.

Debbie - thank you, thank you, thank you. Thank you for your patience, your perseverance, and for covering for me at birthday parties and shopping trips. Most of all, thank you for the hours you sacrificed to help me get through this. I know you did more than your fair share of the cleaning, baby care, and enduring solo nights while I typed away. In fact, you are making school lunches at 10pm as I write this. When you are ready to do what you need to do; just say the word.

Thank you to Yvonne, Allen, Adeline, Eric, and my closest friends for always wishing me well, and quietly letting me get on with it. Thank you to my late father, Vic, and my grandmother Lorraine, for setting this all in motion.

I think I have been blessed with the best supervision team imaginable, a true dream team. Thank you to Elizabeth, Brian, and Kim. I have thoroughly enjoyed watching you demonstrate your skills and elegant thinking. Each of

you has played an essential role in this project. Elizabeth, thank you for your wonderful balancing act of clear unequivocal feedback and comforting reassurance. Kim, thank you for your razor-sharp insight and infectious passion for grounded theory. Brian, thank you for sticking with me all the way through; and for always saying the one thing that filled the gap and advanced the conversation.

I also acknowledge the Counties Manuaku District Health Board community for the direct and indirect support for my studies. I want to especially acknowledge the various managers I worked with throughout the project, and my colleagues in the various teams. Each of you put up with my foggy brain, unprompted monologues, and unexplained absences from meetings. I also want to acknowledge *Ko Awatea* for providing funding through a TUPU emerging researchers grant. I would also like to thank Becky for tutoring me on formatting issues, and Shoba for the excellent transcription support. I am certain that we will work together again.

Lastly, I would like to thank the participants for agreeing to assist me; and for opening their hearts to my curiosity. I had expected to learn a great deal from such knowledgeable professionals, and I was not disappointed. But I was truly touched by your tenacity, compassion, and resilience. Large organisations can often render the personal experiences of an individual invisible. But I was privileged to hear the heartbeat of public healthcare, and I experienced the soul of a therapist in your words. That is a massive privilege.

## Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Name **Glenn J Lucini** Date **8 June 2022**

## Contents

## List of Tables

## List of Figures

# Chapter 1 Introduction

Aotearoa New Zealand (ANZ) has one of the most well-regarded universal healthcare systems in the world and boasts several unique features (Goodyear-Smith & Ashton, 2019). Specifically, the ANZ healthcare system is characterised by innovative cultural services, a no-fault accident compensation scheme, and nationwide pharmaceutical management system. According to Goodyear (2019), this has contributed to favourable health outcomes for the population. In the last decades the healthcare system has progressed through various reviews and re-orientations to ensure adaptable, equitable, and efficient care for all. At present, the Ministry of Health is navigating a significant health care system restructure aimed at centralising the health care system under one organisation (Ministry of health, 2021d).

One of the core priorities in this new restructure of the healthcare system will include efforts to improve the skills and work experiences of the practitioners employed by the Ministry. This is certainly an important priority in community mental health, as mental healthcare workers based in community healthcare settings experience significant stress and burnout (Colley et al., 2015; Dorociak et al., 2017). In particular, psychologists in community mental health report high levels of work dissatisfaction and describe struggling with the organisational processes that impact their professional function (Colley et al., 2015).

The difficulties psychologists face are a combination of the challenges typical of any healthcare service; for example high workloads (Levinson et al., 2021) disruptive organisational restructuring (Colley et al., 2015), and the lack of resources (Thompson et al., 2014). But there are also stressors that are more subtle. Psychologists often feel compelled to defend and advocate for their psychological interventions within the dominant medical model paradigm (Richardson & Hobson, 2006). They also have to navigate power dynamics, especially with management and psychiatrists, that they find impeding (Leventhal et al., 2021). These challenges can breed a disconnect between psychologists and the public healthcare system and can foster an inherent sense of vulnerability among psychologists (Hannigan et al., 2009).

The significant organisational changes that are afoot in the healthcare system, coupled with the historical challenges for psychology in a public healthcare system, present a daunting challenge. According to Stewart et al. (2014) psychologists will need to ready themselves for more adjustment and adaptability if they are to contribute to the future of the ANZ healthcare system. This study explores how psychologists may be addressing that challenge, and how they preserve and promote their profession in the midst of organisational systems.

## Background and rationale for the study

This study aims to understand the experiences of psychologists working in the District Health Boards (DHBs) of the ANZ healthcare service. Specifically, this study explores how psychologists use their clinical expertise to navigate and manage the organisational processes within the mental healthcare infrastructure. The study also addresses what motivates them to do so. Psychologists typically conceptualise therapy as a clinical service for those with mental health problems; so the thought of using a clinical resources like therapy to manage organisational pressures is a contentious issue. Furthermore, psychologists are compelled to adhere to ethical and professional obligations of the carer to the vulnerable (Barnett, 2008). To suggest that therapeutic relationships between psychologists and their clients serve an additional contextual or systemic function is both a novel and a relatively untested idea.

Using constructionist grounded theory, this study will explore psychologists' experience of providing therapy in the public healthcare system. Constructionist grounded theory methodology is an interpretive research approach that explores and describes previously poorly understood areas of social life (Charmaz, 2006). The goal is to give a voice to a social process that may once have remained hidden or unacknowledged (Charmaz, 2021b). Given the research question, constructionist grounded theory is an appropriate and effective methodology for this research project. This study will explore how psychologists manage pressures and expectations by utilising their connection with their clients; and how they use their therapeutic relationships to serve as a resource in co-constructing a new social relationship with the ANZ healthcare service. The study hopes to promote understanding of a specific professional group and to deconstruct the institutional processes in health care services. In doing so, my study aims to contribute to a better service for the community.

## Personal journey

I initially began my doctoral study while I was the clinical leader of the children's teams at the Counties Manukau District Health Board. I coordinated and organised clinical activity for approximately 18 professionals including a sub-team of psychologists. The practitioners all provided therapy in some form, and would often describe the challenges of providing therapy within the organisational structure of public healthcare. Consequently, I grew increasingly interested in promoting more effective therapeutic relationships between clinicians and clients. I found myself constantly balancing the needs of the healthcare service with the needs of my clients; and I was finding that clinical work seemed easily compromised. I could see my colleagues trying to do the same and experiencing the same challenges. These experiences led to an interest in developing relationship-focused therapy processes for the team in a way that still met the expectations of my DHB.

My initial research interest focused on the implementation and management of a version of *feedback informed treatment* (FIT) that organises and monitors therapy using session-based psychometric tools to aid the therapist. However, in our preliminary discussions for a pilot project, it became clear that introducing therapy protocols into the service was fraught with complexities. These challenges immediately struck me as curious. I wondered why organising therapy in a public healthcare service was proving to be so challenging and confronting. Afterall, a mental health team is precisely the place where therapy belongs; and this team was especially collegial and adaptive. Nevertheless, there seemed to be emotional and practical barriers to introducing such a project. Early feedback from practitioners suggested that therapy and organisational structures do not mix and that they needed to "protect" their clinical role from outside intrusion.

I began to consider how I may have contributed to their discontent. Had I perhaps communicated my ideas in an unhelpful or disempowering way? Was it possible that I was asking too much of stressed colleagues? Or was I experiencing the often-encountered resistance to imposed organisational pressures? I began to wonder if the ideas were simply too novel and provocative. Despite some reflection, I still felt that there was something fundamental about their concerns beyond my initial reservations. Their concerns left me wondering about the experience of providing therapy in the ANZ healthcare service, and why my colleagues had reacted with such resistance in the face of change. There seemed to be a tension inherent in attempting something as aspirational and profoundly human as therapy while navigating impersonal organisational and bureaucratic processes.

I have always been fascinated by the experience of working in large structures and the ways that social pressures can shape and distort human experiences. I grew up in a small coal mining community in rural South Africa, where the company held sway over most aspects of the community. So much so, that the mining company actually owned the community resources, roads, and shops. The community was navigating their everyday lives within an imposed and coordinated corporate infrastructure. People raised families, socialised, and went to church; while all around them, social life was essentially contained and framed by a commercial structure that determined their status and options.

My childhood experiences and work experiences have left a deep impression on me. I feel that one of the central challenges of the modern age concerns how we retain our humanity and purpose, while maintaining, and being maintained by, large impersonal social structures. Participating in therapy is a profoundly human and immediate endeavour. It asks so much of both parties and strips away much of the artifice of our institutionally driven lives. In my view, ppsychologists are like those mining families: they live out their narrative in the shadow of something bigger than themselves. Preserving and making space for therapy in an organisation as complex as ANZ’s healthcare service is ultimately a complex but essential process. In my efforts to introduce an organisational change, I had stumbled straight into that complexity. The psychologists had intuitively retreated to a protective stance, and I wanted to understand why. This curiosity is the seed of my study and the reason behind my grounded theory study.

## Setting the scene globally

This study concerns the complex relationship between psychologists and healthcare infrastructures in ANZ. Perhaps this complexity emerges because psychology and public healthcare have very different histories. Each evolved in a different way and under different assumptions and conditions.  In the contemporary context, collaboration between the field of psychology and a healthcare system is undertaken in an increasingly complex world. This chapter begins with an overview of public health infrastructure, especially mental health, and its contribution to society. The present state of psychology in ANZ is then discussed, and the profession's capacity to contribute to public healthcare is critiqued. These observations and perspectives establish the context for my grounded theory study.

The modern healthcare infrastructure is characterised by an interplay between progress in healthcare initiatives and increasing structural strain on these systems. This is perhaps best encapsulated in the world's response to the COVID-19 pandemic. The capacities of well-equipped and under-resourced healthcare infrastructures have been severely tested (Boserup et al., 2021). In addition, health authorities express concern about the unequal distribution of vaccines and treatments between wealthier nations and developing countries (Tatar et al., 2021). There are also indications that vaccine uptake is negatively impacted by the public's eroding confidence in healthcare systems (Verger & Dube, 2020). In this way, the pandemic has illuminated structural fragilities in public healthcare and highlighted the problems in the relationship between the public and their healthcare systems.

The challenges confronting clinical psychologists working in the DHBs of an ANZ healthcare service are experienced worldwide, and in some cases, the roots of the challenges are located in global affairs. Global population health has seen many positive developments over the last three decades. These developments are a consequence of scientific advances and trans-national collaboration in health care (Shiffman et al., 2016). As a result, women, children, and babies are better protected; and the profile of infectious diseases  being managed more effectively (World Health Organization, 2020). These developments are especially true for low-income countries, where health has improved due to literacy and knowledge about essential health, improved family and nutrition management, and more effective treatment and vaccination protocols (Shiffman et al., 2016).

However, despite these advancements, there is a notable discrepancy in healthcare delivery between and within countries (Naal et al., 2020). Middle to low-income countries are increasingly struggling to progress from the gains of the last century as their infrastructure struggles to keep up with population growth and urbanisation (Naal et al., 2020). According to Labonte and Stuckler (2016), a recent exacerbating factor of this discrepancy is the 2008 economic crisis. They note that the worldwide recession precipitated further cuts in health and social support structures in many countries, and a decline in public expenditure on health initiatives, the dismantling of social health care infrastructure, and increased profiteering from healthcare services.

## The emergence of public health

The above changes are part of the growing pains of a developing global public healthcare infrastructure. According to Koplan et al. (2009), the concept of public health evolved from a combination of clinical and sociological conditions. Doctors in the late 1800s started making significant progress in understanding general hygiene and tropical medicine along with the causation and management of infectious diseases. Public health initiatives also emerged, along with the broader mid-19th century social reforms in Europe (Koplan et al., 2009). Societies started developing practices and techniques to emphasise collective accountability for creating a healthy environment and prioritising the control and management of infection and disease. Antoniou et al. (2010) add that these developments were influenced by the foundational principles of the Hippocratic oath which served to instil an ethical and humanistic ethos into medical treatment. For Antoniou et al. (2010), the Hippocratic oath helped curtail the technological and sociological developments from dehumanising or depersonalising medicine. The age of the modern public healthcare infrastructure, based on principles of care for the vulnerable, had arrived.

Koplan et al. (2009) describe the modern concept of public health as both a *notion* (the current state of world/community health), an *objective* (a group of healthy people), and an *ideology* (a collection of research, practice, and policy processes). Koplan et al., saw public health as consisting of four key characteristics: public health care decisions are made based on data and evidence, there is a focus on populations rather than individuals, social justice and equality are prioritised, and prevention, rather than curative care, is emphasised. Accordingly, public health care aims to protect, promote, and restore the health of communities. Public health care operates by applying scientific knowledge to maintain and improve people's health through collective action to achieve these goals.

However, public healthcare has other conceptual dimensions. Roy et al. (2017), draw attention to the socially constructed nature of the public health system. They see it as a "social enterprise" (p. 144); an activity involving actors who influence the process, negotiate power dynamics, and acquire social returns. For Roy et al. (2017), the public healthcare system is a space for negotiating power and influence, an opportunity for individuals to influence their environment, and a context to gain and lose that influence. McMichael and Beaglehole (2000) adopt a more overtly strategic stance. They note that in practice, public health care has become more than just a specialist branch of medicine: it is a politically motivated, socially maintained, and leadership-driven process. For these writers, the public healthcare system and the broader political discourse of society are interdependent, and healthcare is a form of political action.

Other writers such as Sell and Williams (2020) and Venugopal (2015) adopt a more critical view about the direction of public health in the second half of the 20th century. Specifically, they critique the emergence of a neoliberalist agenda that has come to dominate western societies. Schrecker (2016) describes neoliberalism as the belief that minimal government oversight will encourage efficiency and practicality. Neoliberalism assumes that governments are responsible for coordinating broader health care systems and that individuals are left to self-determination and self-sufficiency (Venugopal, 2015). In the context of health, Sell and Williams (2020) argue that this has meant mass privatisation of services and a shift to seeing patients as consumers of products such as medication, health insurance, and clinical interventions. The capitalist infrastructure protects the profitability of healthcare delivery by regulating the sale of medicines, healthcare resources, intellectual property rights, and the use of austerity policies at a political level. Healthcare services become a business, and health becomes a product.

According to McGregor (2001), the impact of neoliberalism has resulted in significant institutional change and a devaluation of individual rights and values. On international and national levels, this has also meant that healthcare initiatives have moved away from a Hippocratic-informed healthcare strategy of previous decades and replaced by an overriding strategy of pursuing profit by selling medicines and medical technology, and maintaining corresponding commercial structures. In summary, public healthcare is a socially constructed enterprise, but one where power and influence are contexts, and differing ideologies compete for dominance (Venugopal, 2015). Consequently, working in the ANZ healthcare service is not solely about providing clinical care; it is a social structure shaped by multiple cultural, political, and historical forces. Working in public healthcare involves participating in a broader political process with deep historical roots that represent and maintain a complex and often contradictory set of values and aspirations.

## The prevalence and impact of mental health disorders

It is helpful to describe an overview of the state and scale of mental health needs globally and within ANZ. Public health comprises different components of health, including physical and mental health. The focus for this thesis is specifically the implications and treatment of mental health disorders in the community. Alonso et al. (2018) gathered data from 23 surveys across 21 countries. From a total sample of 51,000 respondents, 9.8% of the adult population reported clinically significant anxiety. In their meta-analysis, Hoppen and Morina (2019) estimated that approximately 350 million people would be diagnosed with post-traumatic stress disorder. The prevalence of mental health disorders has also increased since the COVID-19 pandemic, especially among frontline healthcare workers (Wu et al., 2021). The high prevalence of mental health problems also has significant economic consequences. The World Health Organization (2020) reports that the global cumulative impact of mental health disorders will exceed US$16 trillion between 2011 and 2030. Mental health conditions are also the leading cause of health-related disabilities. According to the Oxygen Youth Health Research Centre in Melbourne, mental health problems, along with heart disease and cancer, represent the most significant health threat to the gross domestic product of most nations (McGorry, 2013).

As a health condition, poor mental health also has the most significant impact on overall wellbeing across a lifetime (McGorry, 2013). Unlike other notable health problems that disproportionately affect adults and the elderly, mental health concerns often emerge in childhood and adolescence (Malla et al., 2020). Birchwood and Singh (2013) identified a steep rise in mental health problems throughout childhood, concluding that more than 50% of people experience a diagnosable mental health disorder before the age of 21. There is also a significant longitudinal implication. Birchwood and Singh (2013) found that most adult patients report that their first symptoms presented in youth, suggesting that they experienced mental health problems throughout their lives. Jones (2013) study was more specific, noting that more than half of people with a mental health condition report their first symptoms during or before early adolescence. This suggests that mental health problems can be a lifelong stressor for both individuals and healthcare services.

The early onset of mental health problems has significant sociological and economic implications. Gibb et al. (2010) examined correlations between mental health problems in young adults and their work productivity and living standards. They found a significant relationship between having a psychiatric diagnosis between 18 and 25 and standard of living, income, and work productivity at age 30. There is also a corresponding impact on state support structures. Mills et al. (2012), for example, report that mental health problems cost ANZ between NZ$62-200 million a year.

## Mental health in Aotearoa New Zealand in 2022

By international standards, ANZ is primarily a safe and healthy society, with one of the highest living standards in the developed world. Approximately 80% of New Zealanders report positive life satisfaction (Ministry of Health, 2021b). However, every society has its challenges, and New Zealand is no different. In many ways, ANZ is a microcosm of the issues described above, with many of the international concerns relevant to ANZ. This section will explore the circumstances of ANZ's mental health needs and highlight the unique and contextually specific nature of the national public mental health service along with the changes to prevalence of mental illness over recent years.

The last decades have seen significant changes in the delivery of healthcare in ANZ. Neoliberal political changes during the mid-1980s in New Zealand have resulted in a systematic dismantling of the welfare state and the introduction of one of the least regulated economies in the world (Goodyear-Smith & Ashton, 2019). These political changes led to higher unemployment, increased crime rates, and increased social stressors. This social upheaval led to a society with increased poverty and socio-economic inequality (Stanley & Manthei, 2004). Socially disadvantaged groups, such as Māori, experienced the brunt of this upheaval (Ministry of Health, 2021). The unequal distribution in health outcomes became a grave economic concern for New Zealand. Examining health inequalities in New Zealand society, Mills et al. (2012)  found that the cost of managing and responding to disparities amounted to NZ$25 million per year.

Aotearoa New Zealand also has a diverse population, with a variety of different cultural groups. The largest of these are Māori, the indigenous people of the land (*Tangata Whenua*). Māori comprise approximately 16% of the ANZ population, and experience a disproportionate level of mental health problems (Kopua & Bracken, 2020). Pasifika peoples comprise 8% of the total ANZ population, and this figure is expected to increase to 10% by 2038 (Kapeli et al., 2020). The Samoan community makes up the largest portion (47%) in ANZ, followed by Cook Island (21%), Tongan (21%), and then Niuean, Fijian, Tokelauan, and Tuvaluan communities (Kapeli et al., 2020). In addition, Fa’alogo-Lilo and Cartwright (2021) stress that most Pasifika are urban and New Zealand-born, with two-thirds living in the Auckland region and two-thirds of Pasifika people born in Aotearoa New Zealand. Polynesian ethnicities will also grow faster than the national average; Māori comprising 16.6% by 2026, and Pasifika comprising 9.8% by 2026 (Fa’alogo-Lilo & Cartwright, 2021). In addition to this, the South-East Asian population is the fastest growing ethic community in ANZ, with over 70% of people of South East Asian descent being immigrants (Montayre et al., 2019)

The prevalence of mental health disorders has also changed in recent years. This is partly due to significant population growth which has resulted in socio-economic stressors, institutional strain, and familial adjustment challenges (Poulton et al., 2015). In addition, the impact of the Christchurch earthquake (Beaglehole et al., 2019), and the Christchurch terrorist attack (Sulaiman-Hill et al., 2021), and the rapid increase in the cost of living and housing (Teariki, 2017) have generated increased stress and trauma for New Zealanders.

More recently, the global COVID-19 pandemic negatively impacted the mental health of New Zealanders (Nicolson & Flett, 2020). Nicolson and Flett (2020) surveyed adolescents and young adults about their mental health during the 2019 lockdowns. They noted that mental health problems were common for young people during and post-lockdown: almost 60% of young people had some experience of depression or anxiety post-lockdown, with 10% experiencing a severe form. Additionally, people with a previous diagnosis of a mental health difficulty are at greater risk of detrimental psychological outcomes from the pandemic. Bell et al. (2021) surveyed New Zealanders reporting that people with pre-existing mental health problems are twice as likely to report high levels of stress. They are also more likely to abuse substances and report more difficulties sustaining relationships during local and national lockdown periods.

Perhaps unsurprisingly, an estimated 50-80% of New Zealanders will experience difficulties related to mental distress and addiction during their lifetime (Classen et al., 2021). For a portion of this population, their mental health needs will be severe enough to warrant treatment. Of the general population, approximately 3.5% engage with specialist services in a typical year, representing a steady and gradual increase from 143,208 in 2011 to 176,310 in 2017 (Ministry of Health, 2017). The increase in people accessing mental health services indicates the need for a robust specialist mental healthcare service. The broader picture suggests that far more people would benefit from some mental health support. In this context, Aotearoa New Zealand requires an expansive and well-resourced mental health service infrastructure to ensure a healthy and productive society.

The prevalence of mental health conditions is particularly high among Māori (Rangihuna et al., 2018), who are twice as likely to experience mental health problems compared to the general population (McClintock et al., 2013). More specifically, Tapsell et al. (2018) found that schizophrenia rates among Māori were more than double the national average, and mood disorders were substantially higher than the national average. A recent survey of Māori adults conducted by Graham and Masters-Awatere (2020) found that living with intergenerational distress and trauma is significantly more common for Māori than for the general population, and that this has a significantly negative impact on willingness to engage in public health care services.

These vulnerabilities are compounded by Māori experiences and perceptions of the healthcare system. Graham and Masters-Awatere (2020) note that some Māori experienced the ANZ public health system as hostile and alienating. Participants in their study described both barriers and facilitators to health. The primary obstacles were organisational structures, staff interactions, and physical access considerations. Facilitators of better care were the provision of whānau (family) support in the form of practical assistance, emotional care during interaction with healthcare providers, and resources to navigate the health system.

Pasifika and immigrant communities also experience higher depression and adjustment difficulties than the general population. They are also less likely to access mental health services (Ataera-Minster & Trowland, 2018). Barriers include stigma surrounding mental health, a tendency to turn inwards to find solutions within the family, and a combination of mistrust and lack of knowledge about services. From a service perspective, non-Pasifika providers often lack understanding of the collectivist cultural values and practices of Pasifika, including spiritual beliefs. Pasifika are more likely to use services if the providers demonstrate respect for Pasifika practices and are attentive to developing relationships in a culturally appropriate way (Fa’alogo-Lilo & Cartwright, 2021). Hudson et al. (2017) argue that the higher rate of mental health concerns among indigenous populations may reflect a combination of socioeconomic disparities, an embedded disconnect between indigenous people and colonial authority figures, and practical access issues.

In keeping with international trends, ANZ is experiencing a  two primary challenges: greater expectations of a health service in a changing society, coupled with historical inequalities and longstanding community vulnerabilities. Since 2020, significant stresses related to the COVID-19 pandemic have had additional social and economic implications. Norcross and Phillips (2020) suggest that mental health professions have been increasingly strained and burnt out, functioning on minimal or dwindling resources. Additionally, clinical psychologists are increasingly expected to account for their contribution and evidence their economic value (Stewart et al., 2014). They are also expected to work more collaboratively and efficiently with other services (Schoen et al., 2011).

## The Aotearoa New Zealand healthcare service

Aotearoa New Zealand has a progressive and well-regarded healthcare system that has provided universal health coverage since the 1930s (Gauld, 2020). This system shares ideological and organisational commonalities with other universal public healthcare systems such as the British, German, and Scandinavian models (Gauld, 2020). These modern healthcare systems trace their roots to the 19th century asylum system, with an emphasis on a bed-based, pathology-focused model of care (McGorry et al., 2013).

According to Bennett and Liu (2018), ANZ has inherited these models from its colonial past, resulting in a system that is mainly Eurocentric in nature and anchored in a biomedical model. However, the post-war years of the 20th century ushered in significant ideological and structural changes in how mental health care services were organised and provided in ANZ.

From the 1950s onwards, ANZ began moving away from large, centralised psychiatric hospitals to community-based clinics and outpatient services. Unfortunately, there was comparatively less money spent on community-level services to absorb the clinical activity of these large hospitals (Ministry of Health, 2021b). Limited expenditure on community supports led to increasing disparity and fragmentation in the delivery of services. This was further exacerbated by significant population growth and social disruptions of the 1970s and 1980s, such as an increase in juvenile delinquency, and rapid urbanisation (Rodgers, 2012).

Since the mid-1980s, several government-initiated reports and initiatives have attempted to address the growing concerns with mental health services. The first of these was the Mason report published in 1988 (Ministry of Health, 2021b). This report outlined significant gaps in mental health services and criticised the lack of a national strategy to integrate and coordinate mental health services (Ministry of Health, 2021b). Various policy and consultation documents followed the first Mason report, each outlining strategies to modernise the healthcare system; these include *Blueprint II* (2012) and *Rising to the Challenge* (2012b).

These various reports described significant concerns in the infrastructure and accessibility of New Zealand's mental health services and focused on two main areas of difficulty. First, the government was increasingly facing budget and resource constraints, and all the documents described mechanisms to bring spending under control. Second, there had been a shift in how the ANZ healthcare systems conceptualised the notion of wellness. In the 1990s and 2000s, healthcare moved away from the pathologising and insular approach of the turn of the 19th century healthcare paradigm, to something more integrative and strengths focused. *Blueprint II* (2012), for example, identified four guiding principles, suggesting that healthcare should be people-centered, people-directed, and recovery and resiliency focused.

In 2018, the ANZ Government reviewed the progress of *Blueprint II* and canvassed the perspectives of the public, mental health workers, and community services. The resulting document outlined recommendations and guidelines for the government and led to the publication of *He Ara Oranga* (Pathways to Wellness) in 2018. This document outlined the strengths of the ANZ healthcare service and made recommendations for future development (New Zealand Government, 2018). Specifically, *He Ara Oranga* emphasises community-driven and empowerment-based approaches to addressing mental health needs in the community. He Ara Oranga emphasises marrying the existing infrastructure with the resources embedded within the community (New Zealand Government, 2018).

This most recent iteration of the national mental health strategy aims to further integrate tertiary and primary care services and encourage collaboration between  the ANZ healthcare service and the community (Ministry of Health, 2021b). The government's 2019 budget earmarked NZ$1.9billion to develop and modernise the mental health sector and drew heavily on the recommendations of *He Ara Oranga* (Ministry of Health, 2021c). To date, this funding has driven numerous initiatives. These include changes to mental health legislation, the establishment of controlling bodies, increased resourcing to primary care and community services, and efforts to modernise the workforce and ensure better representation of minorities and vulnerable populations (Ministry of Health, 2021c).

This paradigm shift has had significant implications for mental health services delivery. A central premise of this new model of care is that people, and their experience of care, are at the heart of ANZ's healthcare delivery (Government inquiry into mental health and addiction, 2018). Kopua and Bracken (2020) suggest that western healthcare keeps patients in a passive role within the health process; and treats people as objects to be corrected and managed (Kopua & Bracken, 2020). The New Zealand Ministry of Health aims to include the public at all health system levels and ensure their voice is heard (New Zealand Government, 2018). The goal is to empower and give voice to all, ensure that health interventions accurately reflect the needs of the public, and encourage the public to contribute their wisdom and life experience to promote social health (New Zealand Government, 2018).

Aotearoa New Zealand’s healthcare system is presently consists of twenty District Health Boards (DHBs), with each DHB servicing between 33,000 and 600,000 people (Goodyear-Smith & Ashton, 2019). The distribution of the DHBs is illustrated in figure 1. Presently, each DHB operates within its budget and is largely independently of other DHBs. While the Ministry of Health is tasked with outlining the central agenda and setting the budget, goals are interpreted and implemented locally by individual DHBs (Gauld, 2020). The DHBs are also responsible for overseeing various tertiary services such as inpatient, crisis intervention, early intervention, and psychiatric liaison services. At present, DHBs also fund the primary healthcare infrastructure that is located outside of the DHBs. Primary care consists of general practitioners, primary health care organisations, and various non-governmental organisations (Gauld, 2020). In this way, ANZ’s health service is tasked with collaborating with the community and embedding the Ministry of Health's present values and goals.

Currently, a DHB typically has a parallel leadership structure with management collaborating with senior clinical staff. This structure means that services may have a service manager with a corresponding clinical leader (usually a senior consultant psychiatrist), various professional leadership roles, and team coordinator roles that nurses usually fill. Clinical teams within a mental health service commonly consist of professionals with psychiatrists, clinical and sometimes health psychologists, nurses, social workers, and occupational therapists. Typically, the psychiatrist acts as the de facto team leader and the responsible clinician concerning clinical matters. The team leadership structure mirrors the broader organisational structure. In this way psychologists operating in a community clinic are guided and influenced by policy ideals and goals that have been set at the highest level in government. In this context, the psychologists in this study are embroiled in a complex political process, whether they are aware of this or not. This study explores the impact of these political agendas on everyday practice and considers the implications for clinical psychologists in the ANZ healthcare service.

The following figure illustrates a map of the DHBs across ANZ:

Figure 1

“My DHB”: Distribution of NZ DHBs

*Figure 1 - Map of the District Health Boards 2022*

Note. From Ministry of Health NZ, 29 September 2016.

The internal team structures of DHBs are likely to continue for the foreseeable future, but the broader organisational structure of the ANZ health service is experiencing significant restructuring. In April 2021, the Ministry of health (2021d) announced plans to integrate the twenty DHBs under one centralised organisation. This new structure will be drafted into legislation with the introduction of the Pae Ora Healthy Futures Bill, which is expected to pass by late 2022 (Ministry of health, 2021d).

The main aims of the integration of the DHBs are threefold. First, the government intends to create a centralised governing body for delivering healthcare in Aotearoa New Zealand and ensure that New Zealanders receive an integrated and seamless healthcare service. Second, the government wants to ensure better use of resources and seeks to deploy resources more strategically. Third, there will be an increased focus on the health needs of Māori and Pacific communities and their experience of care. Accordingly, the government also established the Māori Health Authority to ensure the needs of Māori are adequately addressed (Ministry of health, 2021d).

Along with the strategic and ideological changes inherent in Ha Ara Oranga, structural changes represent attempts to reshape the ANZ healthcare system for the 21st century. The present generation of practitioners are living through some fundamental changes to their work environment and way of working. The following section explores several pertinent concepts that frame the experience of being a psychologist within the new ANZ healthcare infrastructure. The principles described in He Ara Oranga suggest a health service that is accessible, people-focused, culturally responsive, and committed to offering choices and inclusion (New Zealand Government, 2018). Clinical psychologists will need to be able to meet this brief and adjust their practice models in line with He Ara Oranga ideals. The following are the more pertinent issues in addressing this challenge.

### *New Zealand psychologists in public mental health*

The new healthcare model has several important implications for clinical psychologists and the way they practice within the ANZ health service. First, practitioners will be expected to focus on transferring care to the community and keep people in their homes and connected to their primary care supports. The goal is to ensure that people with episodic needs can quickly access local support, and those with chronic conditions can be supported within their communities (New Zealand Government, 2018).

However, many psychologists have expressed concerns that brief episodes of care with a high reliance on community support will compromise the most vulnerable, and that marginalised clients will fail to access or connect to specialist services such as psychologists (Richardson & Hobson, 2006). This is a justifiable concern as, according to the Ministry of Health (2016), 14% of the population and over 20% of Māori report that consultation costs inhibit access to a general practitioner (GP). Bushnell et al. (2003) surveyed New Zealand GPs, revealing that more than half of patients reported some mental health concern, with 10% describing a significant problem. This finding indicates that mental health concerns may become one of the more pressing concerns that GPs encounter. Despite this, a sizable portion of the population cannot access this channel effectively due to the consultation costs.

The MOH plans to counter the concerns about health care access by expanding the range of available therapies. On 31 July 2020, for example, the government announced funds of NZ$75 million for schools to employ additional mental health counsellors. This government initiative, called *Mana Ake* (Stronger for Tomorrow), includes a pilot project that aims to ensure that approximately 210 schools are resourced to support children’s mental health and absorb some of the pressure on secondary services (Martin, 2020). This initiative is similar to the Australian government's *Better Access* program, which aims to place frontline mental health workers in GPs’ offices (Bastiampillai et al., 2019). Other initiatives include parenting programmes to foster psychological resilience in children and empower parents: the internationally renowned “The Incredible Years” programme is an example (Zhou et al., 2021) that  has already been utilised by mental health workers collaborating with community partners across Aotearoa New Zealand.

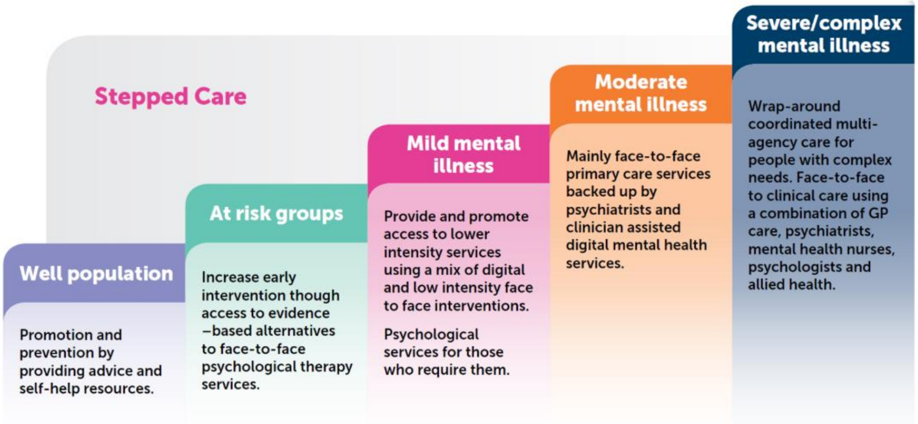
Psychologists have generally welcomed these initiatives. Williams et al. (2017) are among psychologists and academics who recommend that the range of psychological therapy be expanded in primary care, especially low-intensity therapies and brief interventions. However, the wholesale introduction of large-scale mental health programs does have its critics. Bae (2019) questions the implications of introducing a largely westernised version of psychological resilience and parenting into indigenous communities, for example. Bae comments on how the use of broader community based mental health programs can perpetuate a colonial imposition and maintain the dominance of western models of mental health.

One of the proposed mechanisms for expanding the reach of therapy into the community is the Stepped Care Model (New Zealand Government, 2018). The model was created in the United Kingdom to determine the level of care appropriate for treating mental health problems and expanding the reach of services. The goals of stepped care are to ensure that all professionals are adequately trained for their level of care and that the treatment delivered is at the step that has the best chance of providing a positive outcome (Cross & Hickie, 2017). The New Zealand government (2018) has championed this concept and calls for an integrative model of care that includes collaboration between tertiary and primary services. *He Ara Oranga* proposes that a stepped care model can be useful in closing the loop" (p.133) and ensuring that services are structured to represent the spectrum of the population's needs.

The following diagram illustrates the range of treatment possible under a stepped care model:

**Figure 2**

*The different stages of the Stepped Care approach to mental health*



Promotion and prevention by providing advice and self-help resources.

Increase early intervention though access to evidence –based alternatives to face-to-face psychological therapy services.

Provide and promote access to lower intensity services using a mix of digital and low intensity face to face interventions.

Psychological services for those who require them.

Mainly face-to-face primary care services backed up by psychiatrists and clinician assisted digital mental health services.

Wrap-around coordinated multi-agency care for people with complex needs. Face-to-face to clinical care using a combination of GP care, psychiatrists, mental health nurses, psychologists and allied health.

*Figure 2 - Stepped Care Model*

Note. From Murray PHN. (2020). A stepped care approach to mental health. Retrieved 27 April 2022. (https://www.murrayphn.org.au/information-and-resources-for-healthprofessionals/mentalhealth/steppedcare/)

A combination of stepped care structures and primary care resources is sensible from an access and social-change perspective. The potential result could be more people accessing psychological services sooner. However, some concerns have been raised. Bellamy (2014) highlights that stepped care can create the potential for less qualified people providing therapy, and raises concerns about a stepped care model's adaptability to complex cultural-clinical formulations and specialist areas such as in the case of a child, minority, or disability populations. Bellamy (2014) is concerned, for example, that the move towards prioritising treating people in primary care might lead to a therapy aimed at achieving just enough change to function, as opposed to a more comprehensive and sustained change. Additionally, as Cole et al. (2020) argue, a stepped care model also requires a high level of supervision and coordination by skilled leaders and consultants, and this means psychologists’ roles may change from client-facing to more clinician consultation.

It is debatable whether the ANZ health service can resource the skills needed for a stepped care intervention and specialist support. Bastiampillai et al. (2019) also note that large scale stepped care projects like *Better Access* have struggled to gain traction due to poor planning and few control studies. They also note that this model requires a high level of financial investment for a notoriously complex initiative. Nonetheless, we can see that the future of healthcare delivery will look different to the past. Psychologists working within the current DHBs may be watching these developments with concern. According to Bellamy (2014), they may wonder how their unique skill set fits within the proposed plans. However, others like Stewart et al. (2014) and Cole et al. (2020) are suggesting that psychologists adapt to this new model, and advocate for a more consultative role and a more systemic involvement for psychologists.

Despite these reservations, the Ministry of Health is still moving towards a prevention-focused, self-management-driven, home-based service (New Zealand Government, 2018). This means building a workforce that can deliver care in multiple contexts, provide advice, and facilitate the introduction of preventative care programs. This means building a clinical workforce that can work across sectors, be more consultative and collaborative, work with technology and communication tools, and that can remain flexible, team-orientated, and solution-focused in their actions (Ministry of Health, 2021c). Additionally, the government has emphasised the use of service-user technologies and 'smarter' health care tools such as e-therapies, integrated information networks, and patient-focused resources such as telehealth and accessible portals (New Zealand Government, 2018).

E-therapy refers to online platforms such as phones and laptops that can provide therapeutic guidance. These resources are aimed at low to medium range mental health problems. Simmonds-Buckley et al. (2020) reviewed the primary initiatives in use by the NHS in the UK. Their research concluded that e-therapies could have significant and sustained positive impacts. Telehealth, in particular, is considered a viable resource to extend access and ensure more cost-effective mental health support (Campbell & Simmonds, 2011; Perle, 2021). However, Simmonds-Buckley et al. (2020) caution that the UK government's rush to exploit these resources, in a context where many versions are not adequately reviewed and few randomised controlled studies exist, could be risky.

The government will need to convince the practitioners of their value and efficacy, which may be challenging. Hale and Brennan (2020) describe a distinct reluctance among psychologists to embrace telehealth. Many psychologists still have reservations about the ethical and risk management issues associated with a non-face-to-face consultation. Other psychologists have expressed concerns that telehealth impacts the alliance and connection with clients (Hale & Brennan, 2020). From Hale and Brennan’s perspective, the introduction of telehealth and e-health are examples of a growing fear among psychologists that the relationship aspects of therapy are being undervalued and are under threat. Notably, the impact of work-from-home restrictions during the COVID-19 pandemic has increased psychologists' familiarity with telehealth, and early indications are that psychologists may be becoming more accepting of the technology (Jurcik et al., 2020).

Along with new technologies to increase access, the government also encourages the development of collaborative and adaptive skills among the workforce (Ministry of Health, 2021c). However, there is a clear subtext to these developments. On an explicit level, the Ministry of Health is calling for new infrastructure and a new set of professional roles and behaviour to support this infrastructure. On an implicit level the Ministry is also saying that people have to change; it is not enough for us to have a new model of healthcare delivery, we will also require a new type of patient and a new type of practitioner. Psychologists are seen as a vital component of this new model of care, especially concerning their consultative and interpersonal skills (Stewart et al., 2014). However, scholars such as Colley (2015), Nutt (2016), and Tweed (2000) argue that this new collaborative, integrated healthcare model sits uneasily with the traditional role of a clinical psychologist. Pursuing a politically, organisationally, and socioeconomically driven agenda may risk diluting the contribution of psychologists.

## Psychology in Aotearoa New Zealand

This section briefly describes the state of psychology in Aotearoa New Zealand. The intention is to illustrate the ways in which the present model of practice may influence psychologists' ability to adapt to the expectations of the ANZ health service. New Zealand has a rich psychological and psychotherapeutic tradition, with the first significant psychological clinic established in 1926 in Wellington (Kazantzis & Deane, 1998). Since then, the profession has grown in scale and stature. There are now approximately 4,000 psychologists in Aotearoa New Zealand that are registered in four distinct professional categories: clinical, counselling, educational, and neuropsychology (New Zealand Psychologists Board, 2020).

The Aotearoa New Zealand health service primarily employs clinical psychologists but does also employ counselling psychologists and psychotherapists. This preference for clinical psychologists may be attributed to the skill set associated with the role, with an emphasis on psychopathology, biopsychosocial clinical assessments, and internships in hospital settings (Mihura et al., 2017). The New Zealand Psychologists Board (2020) defines clinical psychologists as practitioners that possess extensive diagnostic, clinical mental health knowledge, and provide evidence-based psychological therapies and formulations grounded in the scientist-practitioner paradigm.

By comparison, counselling psychologists would differentiate themselves as being less wedded to the medical model in terms of assessment and treatment; and with a greater focus on ecological and strength-based thinking (Rodgers, 2012). In Aotearoa New Zealand, psychotherapy is also a discrete and separate profession. Consequently, psychotherapists in Aotearoa New Zealand are differentiated by a different registration process. Psychotherapists are also typically committed to a relational and often transpersonal understanding of therapeutic interventions (Thorpe, 2016).

A continuum of therapeutic models is represented through various professional bodies with clinical psychology emphasising the scientist/practitioner ethos. By contrast, counselling psychology is aligned with systemic practices, and psychotherapists draw on intersubjective models. Psychology in Aotearoa New Zealand, is hampered by very poor cultural representation within the profession:  only five per cent of the mental health workforce in New Zealand identifies as Polynesian, for example (Fa’alogo-Lilo & Cartwright, 2021). A further implication is that the professional dialogue is one-sided: there is an absence of localised expertise and narrative within indigenous cultures. According to Groot et al. (2018), this represents an unbalanced view of psychological therapies anchored in western private practice ideas and assumptions.

This study faced the challenge of integrating an array of perspectives on psychological therapies. In ANZ, psychologists are seen as practicing a therapy that focuses on evidence-based treatments and the reduction of clinically significant symptoms. Other prominent therapeutic professions like counselling psychologists and psychotherapists approach therapy from a relational, process-orientated, and intrapsychic perspective. However, across the literature, the term psychotherapy is frequently used interchangeably to describe various psychological or mental health therapies without referencing a specific profession.  This study acknowledged the complexity of the term; and will use the concept of psychotherapy in a broader more pragmatic sense, without aligning to any specific profession.

The practice and place of psychotherapy in Aotearoa New Zealand has been subject to significant ideological and socio-political changes that have shaped the profession. This is echoed in global differences in training models and theoretical orientations (Norcross et al., 2018b) describes a gradual shift at the beginning of the 21st century toward cognitive-behavioural approaches, away from psychodynamic/psychoanalytic models. Recent empirical findings support this view. Jaimes et al. (2015), for example, surveyed psychologists' preferences and found that, while most practitioners drew from various models, the core skill set is the strongly empirical evidence-based models such as cognitive-behavioural therapy (CBT). This finding implies a move away from the relational, interpersonal aspects of treatment to the implementable, instrumental aspects of treatment.

Aotearoa New Zealand clinical guidelines do not specifically recommend a particular model of talking therapy (The National Centre of Mental Health Research, 2012b). However, a survey conducted by Earl et al. (2014) found that evidence-based models such as CBT, dialectic behaviour therapy, and solution-focused therapy were most prevalent. Williams et al. (2017) conducted a survey that found that CBT, in particular, tends to dominate the preferences among psychologists in Aotearoa New Zealand. According to Hazlett-Stevens (2002), CBT is characterised by a focus on maladaptive thought processes and corresponding problematic behaviour. Treatments such as CBT are predicated on the scientist-practitioner model, also known as the Boulder model, which argues that psychologists should balance the empirical, evidence-based interpretation of mental health with applied knowledge grounded in philosophical and humanistic values (Navab et al., 2015).

However, Jordan et al. (2021) argues that labelling clinical psychologists as scientist-practitioners highlights the dominance of western knowledge systems. This approach encourages easily replicable, time-bound, and proscriptive psychological interventions. According to Bennett and Liu (2018), the scientist-practitioner model risks ignoring the relational, holistic, nonlinear, or spiritual pathways of healing. Furthermore, the label ‘scientist-practitioner’ is questionable, as the practice moves beyond the white, middle-class, Anglo-Saxon contexts. Consequently, the label of scientist-practitioner can obscure how influential psychologists can be in adapting to a community context for which they were not designed (Hamley & Grice, 2021).

Aotearoa New Zealand’s psychologists are trained and socialised to work in an individualised, pathology-focused, and almost isolationist manner typified by individualistic approaches such as CBT. However, as noted above, the ANZ healthcare service hopes to instill a new type of practitioner dedicated to collaboration and well-versed in political and systemic manoeuvring. Psychologists may find that they are required to adapt and develop their skills considerably. This is significant, because a high portion of psychologists in Aotearoa New Zealand are employed within the government infrastructure. Waitoki and Levy (2015) reviewed workforce data and reported that approximately 35% of all psychologists in ANZ work in one of the large government organisations (namely, the ministries of health, education, corrections, and social development); and of these, approximately 20% of registered psychologists work in a DHB. According to Waitoki and Levy (2015), DHBs are also the most significant single employer of psychologists in Aotearoa New Zealand.

Compared to the UK and the United States (US), Aotearoa New Zealand also has a far higher portion of psychologists working in government organisations. By comparison, Carr and Miller (2017) note that one in three psychologists in the UK are self-employed; and as of 2014, just 6% of psychologists work in Britain’s National Health Service. The American Psychological Association's 2015 survey results indicate an estimated 9% of psychologists work in the public sector compared to 36% working in independent practice (Carr & Miller, 2017). This has two significant implications: first, a sizable majority of psychologists in Aotearoa New Zealand, work in community settings; second, they are trained in a manner that equips them for client-focused, evidence-based, pathology-orientated interventions. As a result, they may struggle to adapt to a community service's political focus. This limitation is further amplified by a DHBs tendency to employ predominantly clinical psychologists because of their medical model orientation. The ANZ healthcare service has preselected the psychologist population and reinforced the medical model paradigm dominance.

In summary, psychology in Aotearoa New Zealand is now practiced within a context of increased social inequality and diversity, structurally induced poverty, and governmental policies that exacerbate the situation. One of the significant developments has been a conceptual shift in the thinking of healthcare delivery, one that is responsive, integrated, and non-pathologising (New Zealand Government, 2018). Within this context, practitioners have been charged with providing therapy that uses resources effectively, is in more significant partnership with other service providers, and focuses on recovery promotion, wellness, and resilience (Earl et al., 2014).

Psychologists will inevitably have to adjust their practice to meet the environment's needs. According to Gibson et al. (2001), psychologists that are new to community mental health struggle to adapt to the complexities of community mental health care: they struggle especially with the political and sociological impactors that influence their clinical activity. Gibson et al. (2001)

argues that the need to adapt causes a sense of uncertainty and distress in psychologists. An examination of how psychologists can adapt their practice to meet the needs of a community, and specifically the needs of the ANZ healthcare service, is needed. This examination relates to how psychologists can expand their skill set beyond the confines of evidence-based treatments such as CBT, to incorporate the subtleties of client and organisational relationships that they encounter. This study addresses these issues.

## Thesis overview

This study examines the experiences of working in the Aotearoa New Zealand public healthcare system. It explores what it means to marry the clinical agenda, with the sociological and political complexities of a community health care setting. This chapter has contextualised the work of this study, describing the evolution and present context of ANZ public healthcare infrastructure. It pays particular attention to the philosophical underpinnings of public health as a concept, and how societal forces have shaped its present structure.

The chapter also provides an overview of healthcare delivery, the state of healthcare (and especially mental healthcare), in Aotearoa New Zealand. It also explores the ANZ healthcare structure, with a focus on the present DHB structure and its historical development. Of particular importance are the ideals and goals that will drive the growth of a new national healthcare system, and how this will impact psychologists working in public healthcare in the future. The final section of the chapter outlines the current role and structure of psychology in Aotearoa New Zealand, especially the role of psychologists in community health care.

The next chapter of this thesis consists of two parts. The first explores the world of psychology and the role of therapy as a mental health intervention. This section begins by contrasting two different theories on why therapy is effective. The first theory suggests therapy is effective because of the specific factors of that particular therapy models. The second theory suggests that therapy is effective because of a set of common factors inherent in all the different models. The role of the therapeutic relationship as a common factor in therapy is then addressed. The first section concludes with an exploration of the importance of therapeutic relationships to psychologists and how they are utilised in therapy.

The second section of chapter two explores the experiences of working in large public healthcare organisations and community hospitals. The tension between organisational and clinical priorities is discussed. The emotional toll of working in community mental health is then explored, especially the role of burnout and compassion fatigue. A review of how practitioners adapt and cope, and especially the ways in which therapy can serve as a resource in managing this tension, is provided.

The second part of the thesis introduces my research design. Chapter three consists of an exploration of the philosophical assumptions that inform my research design. It introduces grounded theory and specifically constructionist grounded theory, which involves an integrated process of gathering and analysing data to arrive at a conceptual theory of a social process (Birks, 2019). This section also describes how the philosophy of constructionism guides and shapes the application of grounded theory in this study. Chapter four describes how I used the various research methods of constructionist grounded theory to collect, code, and analyse the data. In particular, the foundational methods of grounded theory, theoretical sampling, conceptual coding, memoing, theoretical sensitivity, and constant compassion of data are introduced and described.

The theory, the main categories, and conditions are presented in chapter five, and then discussed in chapter six. The implications for the conditions and categories are explicated and the findings are compared and contrasted with existing ideas in literature. The final chapter reflects on my study and considers the strengths and weaknesses of my research design, and also considers possible implications and contributions of my findings for both the public healthcare system and psychologists as a profession.

# Chapter 2 Literature Review

A review of the extant literature was conducted to establish a context for my theory. Typically, a literature review is conducted to describe the context of the study, the prominent findings within the research area, and to identify gaps in literature (Hallberg, 2010). However, in grounded theory, the issue of *when* to conduct a literature review has been debated. Initially Glaser and Strauss (1967) argued against consulting literature before the research process, as this risks contaminating the analysis. However, this study shares Charmaz (2006) view that previous literature is a voice that helps shape the development of the research project.

In this study the literature review is seen as an opportunity for various narratives to be included in the construction of the theory. This stands in contrast with traditional perspectives of a literature review which see the literature review as serving a more static, almost contextualising function (Charmaz, 2006). However, within this socially constructed grounded theory literature review, the intention is also create space for the voice of ANZ public health care, and the profession of psychology in ANZ. In this way these narratives can contribute and enrich the socially constructed word of this study.

A dialogue is encouraged between the descriptions of the participants, and the perspectives of the profession, and broader health care context. Within this dialogue the research can give voice to previously marginalised experiences of working in public health care; problematise ideas and concepts that have become dominant and assumed; and offer a reframe of the socially constructed process of public health care delivery in ANZ

This literature review consists of two parts that explore both the central clinical and organisational implications of working in the ANZ healthcare service. In the first section a brief history of psychological treatments is described, and the essential facts of therapy's efficacy and validity are outlined. The section then contrasts evidence-based treatment with the common factors model. This highlights two variations on the mechanics of therapy and exposes the current epistemological debate that underpins the profession. Special attention is paid to the role of the therapeutic alliance, the importance of therapists as part of the therapeutic process, and the variability of psychologists' involvement in sociocultural processes. The goal is to illuminate the experience of providing therapy and the central debates that inform the practice.

The second section describes the present DHB structure of the ANZ healthcare service and differentiates between clinical and organisational components. The prominent forms of stress for practitioners are introduced. The chapter concludes by exploring the role of therapy as a resource to cope with these stressors. The ways that therapy can be implemented in an organisational way, and terms of clinical activity, are also outlined.

## The history of psychotherapy

According to Goldfried (2013) research into psychological therapy evolved through a series of historical stages. Inspired by the early work of Freud and other psychoanalysts, the first generation of researchers focused on psychodynamic therapies and adopted a more experiential approach to understanding therapy. However, their methodologies lacked rigour and were often anecdotal and speculative. The second wave of therapy research emerged in the 1960s and 1970s. This phase saw the emergence of behavioural and cognitive-behavioural therapies. During this time, the focus shifted to presentation-specific approaches and more targeted interventions focused on behavioural or cognitive change.

In keeping with an increasingly empirical approach to understanding therapy, Goldfried (2013) states that this era also saw the introduction of more systematic and empirical methodologies. During the late 1970s, the increased credibility and reliability of research findings also resulted in increased funding and greater acceptance of therapy in the healthcare community in both America and Europe. This stage also saw the arrival of the first therapeutic manuals, treatment guidelines, and specific therapy techniques. Therapy began to settle into a systematic and structured practice with a clear underlying rationale and guidelines.

Cook et al. (2017) note that, by the 1980s, the biomedical model of healthcare dominated healthcare delivery. This period saw the introduction of innovative and influential new medications and the increasing influence of medical and clinical diagnostic terminology. Psychological therapy was conveniently placed to adopt many of these assumptions and practices and was quickly inserted into the medical model paradigm. As a result, psychological problems became clinical presentations, client challenges became symptoms, and therapy started to target diagnostic presentations rather than psychological presentations. Consequently, over the past 50 years of psychotherapy research can boast significant credibility and acceptance as a clinical intervention in the health community. Therapy is now practised in most hospital and clinical settings and is an integral part of treatment protocols in the public healthcare system (Stewart et al., 2014).

However, these developments have come with unintended consequences. Mulder et al. (2017) argues that psychological therapies now pay disproportionate attention to treatment outcomes, with relatively little attention to the processes of psychotherapies. As a result, therapy has taken on the epistemological properties of medication: it is prescribed, quantified, and implemented. Much like medical interventions, the last decades have seen an explosion of studies that examine the outcomes of specific treatments under controlled conditions. Laska et al. (2013) refer to this broadly as evidence-based treatments (EBT). Evidence-based treatments are treatment protocols comprised of a discrete set of specific psychological techniques designed to reduce a specific clinical symptom and are delivered in a prescribed, manualised way.

The 2000s have seen a further shift in thinking within the world of psychological therapies. Approximately ten years ago, Norcross and Wampold (2011) edited a special edition of the *Psychotherapy* journal and speculated on the development of therapy research. They predicted that a future research agenda would focus on understanding the mediators and moderators between relationship elements in therapy and outcomes. Since then, Norcross et al. (2018) note that therapy relationship processes have become increasingly crucial in psychological therapy research and implementation. The interpersonal dimension and culturally sensitive treatments have become the new frontier of therapy's ongoing development. There is a subtle shift back to the interpersonal focus of earlier generations of therapists.

## The value of therapy as a treatment

However, psychological therapies have not always been as well regarded within the psychiatric community. In a seminal paper published just after the second world war, Eysenck (1952) presented findings based on 19 studies on the outcomes of psychological therapies. He famously concluded that therapy was not a significant agent of change and that psychologists should exercise caution in their assumptions. Perhaps Eysenck had not anticipated the furore he was to cause, but his paper was certainly galvanising. Since that initial controversy, multiple studies and countless hours of research have attempted to establish the efficacy and value of therapy as a healing mechanism.

Fortunately, the outcome of these efforts has been encouraging. Psychological therapies, for example, are routinely found to be more effective than unstructured helping interactions, and certainly better than no actions at all (Miller et al., 2013; Mulder et al., 2017). The first and most significant meta-study on therapy efficacy was conducted by Smith and Glass (1977). They concluded that therapy is, overall, highly effective, with the average treated person being better off than 80% of those who do not have the benefit of treatment. Since then, various meta-studies have asserted this finding. Tolin (2014), for example, conducted a meta-analysis on 13 studies that compared CBT to various treatment-as-usual therapies. He concluded that CBT was consistently effective in reducing depression and anxiety, even when the research team controlled for various confounding factors, including included differing measures of efficacy, differing control groups and treatments, or differing mood diagnoses. Multiple studies have been more specific, and focused studies have also demonstrated the efficacy of therapy across a range of mental health problems. These include anxiety disorders (Pompoli et al., 2018), post-traumatic stress disorder (Gerger et al., 2014), psychosis (Velthorst et al., 2015), and personality disorders (Cristea et al., 2017).

The diversity of therapy is illustrated in Figure 2.

**Figure 3**

*Examples of the conditions therapy can treat*

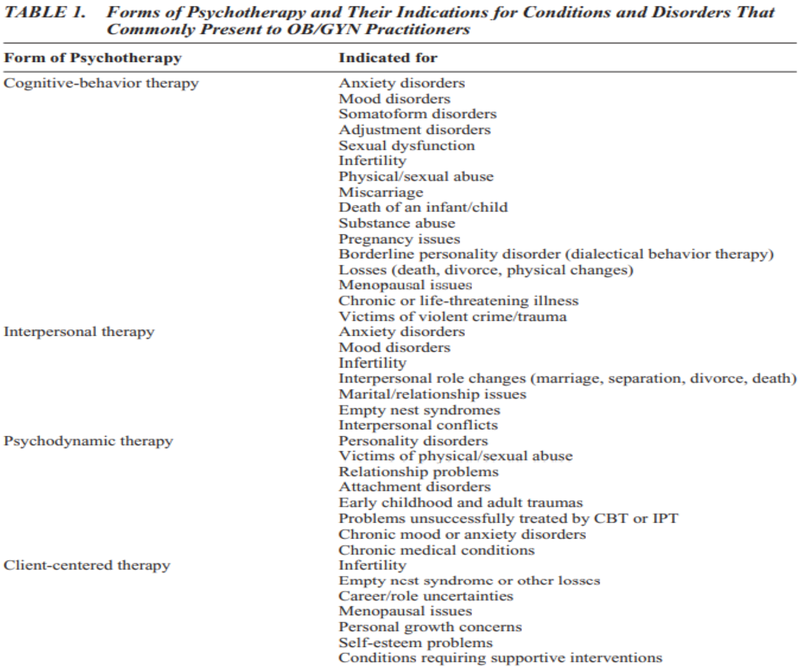


***TABLE 1.*** ***Forms of Psychotherapy and Their Indications for Conditions and Disorders That Commonly Present to OB/GYN Practitioners***

| Form of Psychotherapy | Indicated for |
|---|---|
| Cognitive-behavior therapy | Anxiety disorders<br>Mood disorders<br>Somatoform disorders<br>Adjustment disorders<br>Sexual dysfunction<br>Infertility<br>Physical/sexual abuse<br>Miscarriage<br>Death of an infant/child<br>Substance abuse<br>Pregnancy issues<br>Borderline personality disorder (dialectical behavior therapy)<br>Losses (death, divorce, physical changes)<br>Menopausal issues<br>Chronic or life-threatening illness<br>Victims of violent crime/trauma |
| Interpersonal therapy | Anxiety disorders<br>Mood disorders<br>Infertility<br>Interpersonal role changes (marriage, separation, divorce, death)<br>Marital/relationship issues<br>Empty nest syndromes<br>Interpersonal conflicts |
| Psychodynamic therapy | Personality disorders<br>Victims of physical/sexual abuse<br>Relationship problems<br>Attachment disorders<br>Early childhood and adult traumas<br>Problems unsuccessfully treated by CBT or IPT<br>Chronic mood or anxiety disorders<br>Chronic medical conditions |
| Client-centered therapy | Infertility<br>Empty nest syndrome or other losses<br>Career/role uncertainties<br>Menopausal issues<br>Personal growth concerns<br>Self-esteem problems<br>Conditions requiring supportive interventions |

*Figure 3 - Examples of Different Psychological Therapies*

Note. From Bea, S. M., & Deleon, M. (2004). ‘All stressed up with no place to go: A brief guide to psychotherapy referrals for primary care providers, including obstetricians and gynecologists. *Clinical Obstetrics and Gynecology, 47*(3), 597-607.

According to Wampold and Imel (2015b), therapy has an equivalent, if not better success rate than many standard medical interventions and treatments. The authors note that several naturalistic studies support the findings of randomised controlled studies. Mahon (2020) reviewed decades of publications and concluded that therapy outcomes in everyday practice and across multiple settings match or maintain the high efficacy rates associated with controlled randomised control trials. Frost et al. (2020) argue that we have reached a point where replications of efficacy studies are now redundant. However, therapy is still a focus of extensive research, especially the mechanics and efficacy of different therapy models. For example, Wampold et al. (2017) conducted a trans-model analysis, and their findings suggest that, while therapy is effective, no one model is more effective than another. Wampold et al. (2017) argue that differences tend to be minor, clinically insignificant, and often only relevant to aspects of the treatment. The relative equivalency of all therapies has been a central finding of the 2000s and has significantly changed how therapy is researched and conceptualised (Duncan et al., 2010).

In a later study, Wampold et al. (2002) reviewed 22 different studies that compared CBT to other therapy models. They found discrepancies in many of the research designs that paint an inaccurate picture. Specifically, while cognitive therapy was undoubtedly more effective than the non-bona fide control interventions (i.e., treatments that were not intended to be therapeutic), it produced the same outcomes as bona fide interventions (i.e., treatments intended to be therapeutic). Interestingly, this finding is in direct contradiction with Tolin’s (2014) conclusions. The above examples draw attention to central methodological aspects of therapy research, explaining the divergent findings. However, the central commonality in all of these studies is that therapy, however, conceptualised for research analysis, is ultimately effective.

Additionally, a more fundamental debate in understanding psychotherapy has emerged in the last few decades. Many researchers (Castonguay et al., 2015; Norcross & Wampold, 2011; Wampold, 2015) recommend prioritising clinician-driven judgement and placing the client's characteristics as the central focus in treatment planning. Laska et al. (2013) argue that the narrow focus on random-controlled studies (RCT) has limited the scope of psychotherapeutic development. More specifically, the focus on RCTs has also compromised creativity and adaptability in therapy, especially the role of relationship process factors in psychotherapy.

Consequently, a fundamental debate has emerged in the field of psychological therapy; namely, whether therapy works because of the specific factors outlined in the treatment model, or whether therapy is effective because of a collection of common factors evident across all therapies. Proponents of the common factors model emphasise relationship processes, the dynamic variability of client and clinician characteristics, and the context in therapy. By comparison, proponents of the specific factors model focus on the role of the instrumental and procedural techniques in therapy, and the specific treatments that match a specific presentation (Mulder et al., 2017). Norcross and Wampold (2011) refer to this debate as a ‘culture war’ (p.101) within the psychotherapy community. This dialogue illuminates two distinct ways of being a therapist and how therapy should be organised and provided within a public healthcare service.

The debate between specific treatments and processes in therapy has produced a sizable body of research (Cuijpers et al., 2019). Increasingly the common factors model has become the paradigm of choice for many professional groups ranging from family therapists (Davis & Hsieh, 2019) to psychotherapists (Watkins, 2017). Nonetheless, treatment-specific interventions have dominated clinical psychology practice and organisational policies for decades and are still the primary way that therapy is delivered in public healthcare services (Norcross & Wampold, 2018). However, clinicians and patients express increasing discomfort with conceptualised therapy as a medical intervention. As Guy et al. (2012) rather succinctly suggests, many patients prefer dialogue over drugs.

## Problems with evidence-based Treatments

Central to the debate over process and specificity is the role of the relationship in therapy (Wampold & Imel, 2015b). Research suggests that the relational dynamics of therapy have several benefits. Attention to relationship processes encourages cultural and contextual sensitivity in therapeutic care (Rangihuna et al., 2018). Additionally, clinicians who focus on developing their relationship skills also produce better outcomes (Chow et al., 2015). Most importantly, therapy approaches that focus on the relationship, result in better client outcomes (Duncan & Sparks, 2015). There appears to be a sea-change in how therapy is conceptualised; as relationships, adaptability, and responsiveness emerge as the critical values in therapeutic engagement.

Alongside the value of relationship processes in therapy, is growing criticism of the ways evidence-based therapies are developed. Increasingly researchers and thinkers are challenging the outcomes of the typically heavily structured, restrictive, and context-specific research process used in therapy research trials (Norcross & Lambert, 2018). Specifically, randomised controlled trials and the resulting treatment guidelines do not adequately represent the true nature, mechanisms, and effects of therapy.

A central critic of the validity of RCTs in driving practice habits is Bruce Wampold (2015b): much of his writing draws attention to the flaws in RCTs methodology. Wampold and Imel (2015b) highlight several of these crucial flaws. First, they challenge the use of placebos as a controllable variable. Second, they argue that researchers attempt to control for hope or expectation, which is a central component of psychotherapy. And thirdly, they disagree with using non-therapeutic control groups, which often hold little or no clinical merit and thus create an artificial difference between the control group and the experimental group.

Evidence-based treatments can provide much-needed structure, credibility, and consistency in therapy in routine practice. Evidence-based treatments also ensure that therapists are closely connected to the body of data being accumulated (Rousseau & Gunia, 2016). However, Wampold and Imel (2015b), and Norcross and Lambert (2018) argue that RTCs have essentially endeavoured to remove the therapist as a variable in the outcome of therapy. This is done to ensure that the active ingredient in change is the intervention, not the clinician's characteristics. In this respect, the hope is to develop treatment protocols as independent of clinician interpersonal characteristics as possible. This is a problematic assumption as the therapist, as a person, is always a significant factor in therapy outcome (Barkham et al., 2017).

In the same way, clinician variables are seen as something to be controlled for, and so too are client factors. Unless it is the focus of the study, RCT will frequently control for the factors clients bring to therapy. In a way, the client's contributions to therapy are neutralised to understand the intervention better. Significantly, these approaches deny the innate responsiveness of clients in any care arrangement (Stiles et al., 1986). Stiles et al. (1986) argue that people will respond in unpredictable and variable ways, which makes the predictive nature of evidence-based practices unreliable.

In essence, while pure random controlled trials attempt to establish stable and dependable clinician and client behaviour, this is not a realistic expectation as they operate in a complex and ever-changing environment. There has been a concern that psychotherapy research and practice occupy two different worlds: there seem to be difficulties in translating the processes of evidence-based practices into real-world settings (Cook et al., 2017; Weisz et al., 2015). An example of this is the ANZ public healthcare service, where practitioners are continually adapting to the clients' needs, and the community manages complex stressors and pressures.

Aotearoa New Zealand public healthcare services still explicitly ascribe to evidence-based treatments (New Zealand Government, 2018). Similarly, many organisational and professional guidelines like the *National Institute for Clinical Excellence* (NICE) guidelines in the British health care system, or the *American Psychological Association* (APA) privilege evidence-based treatments such as CBT over other therapeutic approaches (Guy et al., 2012). Psychologists confront a dilemma – the research data suggests that evidence based treatments largely work in real world settings, but yet in daily interactions psychologists are still adapting their practice. Consequently, the discrepancy between what is expected of evidence-based treatment and what happens in practice, is a significant consideration for psychologists working in the ANZ public healthcare service. Court et al. (2017) notes that psychologists are compelled to adapt their therapeutic approaches to be effective with their clients in community settings.

The necessity of adapting evidence-based treatments may well be inevitable and necessary. Addis and Krasnow (2000) suggest that strict adherence to evidence-based treatment protocols can lead therapists to oversimplify their clients' presentations. There is also the risk of de-emphasising or underestimating the therapist's contribution. Cook et al. (2017) suggest that rigid adherence can also impact therapy outcomes. These authors' findings suggest that this may be due to rigid adherence interfering in the fundamental therapeutic processes required for effective therapy (e.g., interpersonal flexibility or alliance-building). This is especially significant in a community healthcare setting of the ANZ public healthcare service. Rangihuna et al. (2018) argue that public health care in Aotearoa New Zealand frequently serves the most complex, disempowered, and vulnerable populations, and sensitive attunement to clients is even more essential.

In summary, psychologists working in a community health setting like the ANZ public healthcare service find that therapy is not predictable or stable (Colley et al., 2015; Court et al., 2017). They are tasked with incorporating the environmental needs, assumptions, and expectations in their therapeutic activity. Many may concur with Wampold and Imel (2015b) who express concerns that EBT encourages seeing clients and therapists as passively receptive, uniform in their presentation, and predictable in their behaviour. Evidence-based treatments risk underestimating the challenge of adapting to the environment. In addition, there is the risk of not adapting to the social and political undercurrents that inform therapy in the ANZ public healthcare service. The following section introduces a more responsive, contextually sensitive paradigm of therapy; a perspective on therapy that, according to Duncan et al. (2010), and Wampold (2021) addresses these limitations and provides a much-needed correction.

## Introducing the common factors model

An alternate perspective to specific treatments focuses on interpersonal and systemic processes. The common factors approach proposes that therapy's efficacy derives from certain universal or shared aspects of a therapeutic encounter (Mulder et al., 2017). Therapeutic activity has been part of the human experience for millennia, and historical records contain detailed descriptions and artefacts of the efforts to provide psychological healing. According to Wampold (2021), these interventions were often cloaked in cultural or spiritual rituals, but they still served the same intention; to provide relief from suffering and seek restoration. An exploration of the common factors of therapy is an exploration of the universality of therapy, and it is an attempt to locate therapy in the story of humankind and healing. Writers such as Wampold draw inspiration and guidance from these early processes.

Rosenzweig (1936) was the first to propose that common factors across diverse psychotherapy methods are the reason therapy is effective. In his brief but influential paper, he hypothesises that four factors are present in any effective therapeutic encounter. These elements complement and underpin the intentionality utilised methods of the clinician's particular intervention model. Rosenzweig (1936) challenges clinicians to look beyond their "consciously held theoretical orientations" (p. 412) and recognise crucial underpinnings in the therapy process.

In the years following Rosenzweig, significant figures such as Frank and Frank (1993) emphasised the relationship aspects of therapy. They argued that therapy's role is to instil hope and expectancy in the client through rituals and interpersonal processes. In recent decades Wampold (2015) and Norcross and Wampold (2011) have proposed adjustments to the model that factor in the role of treatment protocols and client and clinician responsiveness. There is, at present, a wealth of perspectives on what constitutes the common factors, and over 80 common factors have been proposed, all within different organisational structures (Finsrud et al., 2022). While this is a bewildering range of considerations, the one central theme is always the role of an interpersonal process embedded in a therapeutic relationship.

Originally, Rosenzweig (1936) defined the four common factors as the therapeutic relationship, the ability of psychotherapy to provide a consistent and congruent ritual or protocol for a healing experience, the clinician’s interpersonal skills, and the client’s capacity to embrace change. Since the publication of Rosenzweig’s paper, the common factors have been refined and reconceptualised by different authors. According to Davis and Hsieh (2019), the most routinely cited common factors model consists of the client factor, including incidental events in their life that impact therapy; and the alliance factor which refers to the emotional and collaborative bond between client and therapist. In addition, Davis describes the hope factor, which refers to the aspirations and expectations generated in therapy, and the intervention factor, which refers to the theoretical model and specific techniques of that model.

Wampold (2015) proposed a variation of the common factors that have become increasingly influential. He argued that therapy works through the activation of three pathways. The first pathway to healing is the affective bond between the therapist and the client; a  relationship based on mutual regard, trust, and a close emotional connection. Wampold argued that this bond is itself a healing experience and serves to activate the second pathway, namely a sense of hope. Clients who feel connected and supported in therapy develop a sense of hope and capacity in themselves and the therapy. This hope can include a viable understanding of their problems, a sense of growing efficacy in their ability to address them, and ultimately an emerging belief that things can be different. The third pathway is the specific interventions of the therapy model, which are dependent on the model used and the presenting problem, but they all serve to stimulate healthy and adaptive behaviours.

Recent research findings support the concept of the common factors in therapy. Finsrud et al. (2022) measured clients' experiences of therapy across a collection of validated relationship factors. An analysis of their data suggested that the common factors rest on two fundamental factors that anchor the process: these are 'confidence in the therapist' and 'confidence in treatment'. From a client's perspective, these two factors were the essential relationship factors that predicted positive outcomes. Finsrud's (2022) research supports the notion that the relational dynamic (the sense of confidence clients have in the process and the therapist) is an essential component of effective therapy.

The common factors model has, however, been critiqued. Some researchers view the common factors as too vague for use in credible research. Critics argue that there is not enough clarity and consistency concerning common factors' properties, and the existing guidelines are too vague and broad (Davis & Hsieh, 2019). Laska et al. (2014) offer a compromise In that they highlight the point that, while adherence to a particular treatment approach is essential as this brings structure and professionalism to therapy, utilising the dynamic and adaptive nature of common factors is "crucial" (p.476) if therapy is to be effective. They call for an integration of the specific ingredients' paradigm and the common factors paradigm in psychotherapy.

Psychologists who incorporate a common factors paradigm make a particular statement about their work: they are communicating with their environment through their actions and values. Wampold (2015) argues that these factors are more than a set of therapeutic elements common to all or most psychotherapies. They collectively shape a theoretical model of the mechanisms of change in psychotherapy. They essentially describe a way of being a therapist and functioning within the environment. The common factors approach, especially its emphasis on the power of the relationships, can be very liberating for the therapist. Psychologists who adopt this approach have more freedom to adapt their approach to suit their client's circumstances and accommodate the therapy's broader systemic and contextual context (Davis & Hsieh, 2019).

This study explores the adaptability and flexibility of psychologists working in public healthcare. It proposes that common factors can provide a way of addressing the systemic and organisational needs of the ANZ public healthcare service. There is some research on how common factors can be helpful in systemic therapies such as family therapy (Davis & Hsieh, 2019). In this instance, the common factors model intends to provoke change at a family or even community level. However, the organisational implications of working from a common factors approach are mainly unexamined, especially considering the dominance of evidence-based treatments in healthcare settings.

## The role of the therapeutic relationship

According to Norcross and Lambert (2018), the therapeutic relationship is the most potent of the common factors and the most predictive of a better outcome. Norcross and Lambert (2018) recommend that developing the therapeutic relationship should be the primary aim in the treatment of patients. Wampold (2021) adds that therapeutic relationships improve adherence to treatment plans; they combat the loneliness and alienation in clients; they encourage expectations and generate hope within the client, and help clients regulate their emotions. Therapeutic relationships are relationships of action. They are collaborative and interdependent, but there is an intent and goal to the process. When a therapist forms a therapeutic relationship with a client, the intention is humanistic and empathic and purposeful, but also outcome focused. Commonly this type of relationship is referred to as building a therapeutic alliance (Nienhuis et al., 2018).

Bordin (1979) was the first to operationalise the concept of a therapeutic alliance. He described the alliance as consisting of an agreement of *goals,* and assignment of *tasks,* and developing the affective *bond* between clinician and client. Building on these ideas, Del Re et al. (2021) suggested that the therapeutic alliance may be better understood as two distinct components; the personal relationship-focused aspect and the collaborative task-related aspect. These two concepts could be seen as complementary, while also having quite different properties. The relationship component, for example, speaks to an interdependent interactional process between client and clinician, while the collaborative component speaks to the role expectations of each party within therapy. Campbell and Simmonds (2011) attempt to avoid a dichotomy, adopting a more integrative approach: they see the therapeutic alliance as the ability to create a respectful and accepting environment and instil a sense of safety and containment in therapy.

The therapeutic alliance is the most extensively studied relationship variable in psychotherapy, with over 300 studies that have examined the relationship between the therapeutic alliance and therapy outcomes (Wampold, 2021). A consistent finding is that a favourable alliance is a predictor of therapy outcome and that it is not easily confounded by diagnostic, presentation, or circumstantial changes (Fluckiger et al., 2018). In a meta-analysis of over 300 studies, Fluckiger et al., (2018) found that the influence of alliance in positive outcomes remained significant regardless of the assessment measures used, treatment approaches, therapist, or client's characteristics, context such as face-to-face or internet-mediated therapies, and cultural norms. Furthermore, studies demonstrate that the therapeutic alliance is relevant in all age groups (Halfon, 2021) and intervention models (Fluckiger et al., 2018).

Therapists who successfully form alliances with various clients and across various settings tend to have better outcomes with their clients (Wampold, 2021). There is also a consensus that building, maintaining, and especially restoring the alliance is an essential therapeutic function that merits prioritisation. Various studies have repeatedly illustrated the importance of the therapist in maintaining the alliance (Duncan & Reese, 2015; Eubanks et al., 2018). This aspect of therapy is highly relevant to psychologists working in public healthcare settings, as one of the critical concerns with working in strained and oppressive healthcare systems is the effect on therapeutic relationships (Andrews & Thorne, 2015). Essentially, psychologists in ANZ public healthcare services regularly raise concerns about the capacity of mental health workers to engage meaningfully with their clients, while trying to function in DHBs (Graham & Masters-Awatere, 2020).

## Psychologists and the therapeutic relationship

Wampold (2015) notes an increased focus on clinician characteristics in fostering an effective therapeutic alliance. For Norcross and Wampold (2011), the future of psychotherapy research will be on the *responsiveness* of clinicians to treatment. Clinician factors have become increasingly important in understanding effective therapy. Initially, Rosenzweig (1936) argued, rather vaguely, that we know a good therapist when we see one. However, certain clinician factors have been highlighted and often operationalised more specifically over time. At a most basic level, research confirms that therapist effects are a significant predictor of better outcomes; and potentially more than the intervention model itself (Laska et al., 2013). Additionally, some therapists perform better than others (Johns et al., 2019); the question is in what way, and why.

Various researchers have conceptualised therapist effects in different ways. Ackerman and Hilsenroth (2003) highlight two broad categories of clinician skills: *personal attributes* (i.e., empathy, flexibility, honesty, and respectfulness) and *interpersonal techniques* (i.e., exploration, reflection, and accurate interpretation). They describe a type of persona or an archetype. Wampold and Imel (2015b) take a more interpersonal stance and highlight that therapists that are adaptable and thoughtful, and take time to analyse their effectiveness, achieve better results. Similarly, both Schottke et al. (2017) and Anderson et al. (2016) found that therapists' interpersonal sensitivity and facilitative skills predicated better outcomes in their clients as much as a year later. Duncan and Reese (2015) found that clinicians who had more success in repairing therapeutic ruptures had better outcomes in therapy.

Clinician demographic characteristics such as experience, age, or gender have also been considered; but there is little evidence that therapist characteristics are significant (Goldberg et al., 2016). Researchers found a small but significant impact of experience, especially in retaining clients in therapy, however variables such as gender and age were not influential. It is notable that most demographic characteristics do not predict better outcomes and the therapist effect has more to do with the behaviours that therapists exhibit in therapy (Chow et al., 2015). Psychologists can adapt and develop their clinical skills through *practice-based evidence;* this involves a continuous and systematic review of data and real-world feedback on performance to ensure the best outcome (Rousseau & Gunia, 2016).

Some scholars (Duncan & Reese, 2015; Miller, 2012) suggest that the crucial ingredient in practice-based evidence is feedback and input from clients. In this way, the client becomes part of generating evidence for the therapy's efficacy. Miller et al. (2016) found that clinicians that can access and assimilate client feedback tend to develop expertise and produce better results. This is a significant development as psychologists do not automatically improve by simply practising. They also need to embrace their evolution and skills development as a conscious and even strategic purposeful process (Duncan & Reese, 2015). In terms of professional work habits, Chow et al. (2015) report that the more effective therapists in their study spent more time developing specific therapeutic behaviours than the average clinician.

These studies suggest that psychologists who have space and time to nurture their therapeutic relationships will be more effective, and thus more productive, as employees of the ANZ public healthcare service. A symbiotic relationship is happening at the heart of the ANZ public healthcare service model. A psychologist's relationship efforts improve treatment outcomes, and a client's relationship efforts improve the psychologists. In the context of ideological and structural shifts in the ANZ healthcare system, this is an illuminating proposition: fostering therapeutic relationships fosters a better service.

## Psychologists and society

The debate concerning specific and common factors, and the role of deliberate feedback, is not simply a critique regarding techniques and methods. It also represents a shift in perspective of the therapist's role. Evidence-based treatments view therapists as relatively passive conduits for the clinical intervention; however, the common factors approach conceptualises therapists as active creators and authors of therapy. In a common factors paradigm, therapists are a central part of the therapy: they have agency, they can exercise choices, and initiate processes to further the therapeutic goal. In this regard, therapists are active participants in shaping the world around them; they are agents of change as they respond to their social environment.

Psychologists are increasingly expected to participate in the broader social discourse of society: as the pandemic has illustrated, therapy cannot operate in a social vacuum. However, the pandemic is only one example of social upheaval. In the past decades, civil and cultural change has impacted every domain of life, including mental health and its treatment. According to Kozan and Blustein (2018), there are two primary ways that psychologists can participate in addressing civil concerns and collective wellbeing. First, they may be involved in advocacy in society, by participating in public discourse and involving themselves in social concerns. Second, psychologists can focus on empowerment within their therapeutic activities, directly with clients or in their immediate ecosystem. Psychologists can use the therapeutic space to empower and address social processes occurring outside the therapy room. In a sense, therapy becomes a point of departure or a place of sustenance and affirmation before a change in the environment can be attempted.

Some psychologists have used therapy to champion civil and human rights issues in a collection of areas. Feminist therapists, for example, use the therapeutic process to challenge gender dynamics and foster resistance to power imbalances and oppression. In the 1980s and 1990s, feminist therapists began to extend their focus to include diversity and egalitarianism and the diverse sociocultural experiences of women (Conlin, 2017). The purpose of feminist therapy is certainly for psychological healing and restoration, but there is also a social and cultural function. Feminist therapy aims to address gender imbalances and prejudice from within the therapy room outwards. It is a form of purposeful and strategic social activism.

Some psychologists have also been part of the struggles for racial inequality worldwide. Hayes (2000) describes the formation of a social services organisation called OASSSA, based in Durban South Africa, in the 1980s. The service was staffed by a collection of psychologists and mental health workers committed to addressing the psychological and sociological effects of living under apartheid. OASSSA provided conventional trauma and stress counselling, but Hayes argues that “OASSSA's greatest claim was insisting on a link between apartheid and mental health” (p. 336). For Hayes, the act of therapy served as a form of communication with South African society. In this way, OASSSA and the practitioners who worked there served two functions: they provided clinical care, but they also impacted, critiqued, and challenged society through providing therapy.

Another example of therapy as an act of empowerment and social change is a cultural model for engaging Māori, entitled Mahi a Atua (Rangihuna et al., 2018). This model incorporates a cultural process including karakia (engagement rituals), a recitation of creation stories, and a collection of shared rituals designed to incorporate cultural identity and belonging into the clinical work. The teams involved in Mahi a Atua consist of mental health workers from various disciplines working alongside whanau (family) and the whaiora (the unwell person). The goal is to extend therapy into a cultural space and to ensure that therapy acts as a conduit to cultural belonging. In this way, therapy is provided in service of cultural healing.

As the above examples illustrate, psychologists can use their role to contribute and influence broader mental health needs in their communities. They influence the environment by empowering patients to act, and they often do so in explicitly political ways. However, there is a third level of social involvement for psychologists: they are also tasked with adapting their therapeutic activity to meet the needs of broader organisations and healthcare structural needs. They are required to participate in the political agenda of the political healthcare system.

A recent example of organisational needs impacting therapy delivery is the response to the COVID-19 pandemic. Since 2020 many societies have enforced restrictions on face-to-face contact and have implemented work-from-home mandates. Jurcik et al. (2020) describe how psychologists have been compelled to adjust their practice to accommodate organisational and government policies. Psychologists have been obligated to change both the way they provide care (i.e., telehealth and the use of masks); and also, treatment planning considerations such as treatment length and frequency, including focusing on COVID-19 management content in their sessions.

In real world settings, psychologists are compelled to move beyond evidence-based treatment protocols. In doing so they become free to recognise and embrace the socio-cultural and organisational aspects of providing therapy. They are venturing into a relational and contextually sensitive therapy domain, whether that be issues of civil rights and injustice, the empowerment of cultural and gender identities, or the needs of a public healthcare infrastructure. The ANZ public healthcare service is one of these political and social environments. Much like in feminist therapy, the cultural process of *Mahi a Atua*, or the social activism of OASSA, practising therapy will also take on a socio-political intention, whether that is overtly expressed and explicitly acknowledged. This study adopts this perspective when exploring the experience of providing therapy in the ANZ public healthcare service, unpacking the political and organisational intentions and impactors of providing therapy.

## Working in an Aotearoa New Zealand healthcare service

The second section of the literature review explores the ANZ public healthcare service, and how clinical psychologists experience this environment. Particular attention will be paid to the two central pillars of any public healthcare structure: namely, the underlying clinical structure and the underlying operational structure. The clinical structure of the ANZ public healthcare service is organised around the biomedical paradigm for healthcare and concerns the nature of treatment and the epistemological underpinnings. The organisational paradigm comprises the values and aspirations of a healthcare system, and the processes implemented to organise the system. Typically, these values include quality of service and uplifting of the community, coupled with efficiency and productivity. This section will also look at how clinical psychologists struggle with the organisational structures and then adapt to these clinical and organisational structures in the public healthcare service. Lastly, the section discusses the use of therapy as a resource to manage this tension.

### The clinical domain

According to Wahass (2005), the western healthcare system has been predicated on the biomedical model of healthcare delivery. This is the central organising paradigm that defines, classifies, and organises health problems and treatment plans. This is also true for mental health care services in

Aotearoa New Zealand (Bennett & Liu, 2018; Fa’alogo-Lilo & Cartwright, 2021). The key features of the medical model are the diagnosis of pathological states and illnesses, the reliance on scientific data to make decisions and develop treatments, and the privileging of specific experts to provide this care (Bracken et al., 2012). Epistemologically the medical model paradigm is premised on two central philosophical perspectives: *materialism,* or the belief that physical matter is the sole basis of reality; and *specificity*, the belief that a dependable, explanatory cause can be determined (Wampold & Imel, 2015b). These two epistemological premises lay the foundation for modern medicine and the treatment of illness.

Societies worldwide enjoy the benefits of generations of scientists and practitioners who operate from the biomedical paradigm, and we live in a healthier society because of it (Shiffman et al., 2016). However, critics of the biomedical model express concerns about the psychosocial implications of biomedical thinking. Wahass (2005) argues that this approach overemphasises labelling/diagnosis and risks patients assuming a medicalised social identity that is to their disadvantage. Byrne et al. (2016) suggests that the biomedical model encourages an authoritarian or paternalistic culture in medicine and risks placing vulnerable patients in a disempowered role. McCann (2016) argues that we may risk negating a more comprehensive understanding of a health problem by adopting a potentially restrictive and narrow diagnostic perspective. There is a risk that we may fail to recognise how medical discourses can restrict and negate how people’s illnesses are experienced, depicted, and viewed within society. This concern is echoed by Aotearoa New Zealand based psychologists who also question the applicability of a western model of healthcare delivery (Fa’alogo-Lilo & Cartwright, 2021).

Consequently, the biomedical model that dominated the previous century has shifted to a more inclusive model called the biopsychosocial approach to healthcare (Wahass, 2005). Aotearoa New Zealand has embraced this change and is moving towards a model that emphasises wellbeing and coping, and de-emphasises a focus on symptom management and pathology (Ministry of Health, 2021b). According to Wahass (2005), the biopsychosocial model extends the biomedical model to include contextual factors such as environmental and cultural elements, and psychological factors such as patient behaviour, emotional responses, and meaning-making.

Furthermore, the biopsychosocial model calls for various clinical perspectives from various professions, including social and cultural welfare, psychology, and occupational health (Lee et al., 2012). Consequently, in a hospital setting, doctors rely on the biomedical approach to identify disease and illness and to address symptom reduction. Simultaneously, allied professions such as psychologists, social workers, and occupational therapists tend to focus more on recovery and maintenance of the wellbeing of patients. Wahass (2005) argues that healthcare now has two divergent narratives contributing to the treatment process.

The increasing influence of the biopsychosocial model has the potential to encourage dialogue and a re-evaluation of health problems. This may contribute to a richer interpretation of healthcare. However, Byrne et al. (2016) argues that the biomedical model remains the prevailing paradigm for organising treatment and, indeed, the organisational infrastructure in many healthcare environments. Byrne's research suggests that non-medical staff find this troubling. They see the dominance of the biomedical model as impeding a recovery-orientated model of practice in the hospital. The debate between the biomedical and biopsychosocial models has implications for psychologists working in hospital settings. The following section highlights two of these concerns. First, there is a corresponding imbalance, inequity, and tension between medical and psychological treatments. Second, the tensions between the biomedical and biosocial models impact team dynamics and power distribution within teams. Both concerns are central to the outcome of this study.

In public healthcare settings, patients are more likely to receive psychopharmacological interventions and case management than psychological interventions (Carr & Miller, 2017). According to Carr and Miller (2017), this may be due to a relative scarcity of psychologists in community health, but it also reflects the prioritisation of medication in mental health treatment. Dereboy et al. (2017) adds that in many community health settings, clinical assessments and treatments are frequently conducted under the oversight of psychiatrists, because they serve as the responsible clinician and are also tasked with overseeing the treatment plan. However, Dereboy adds that psychologists often make only a limited contribution; and frequently this contribution occurs *after* the assessment has been completed.

One of the significant consequences Dereboy notes is that the choice of treatment tends to be medication, and psychotherapy as a treatment modality is frequently neither offered nor demanded in routine practice. This has implications for patients (in that they miss out on treatment options) and the practitioner (as this impacts on a psychologist's capacity to contribute their skills). According to Bond and Drake (2015), there are also implications for the healthcare service. As many healthcare systems embrace a recovery-focused and wellness model, therapy's role in sustaining and imbedding clinical change is even more critical.

The second implication of working with the medical model concerns the relationships within teams and especially the relationships between psychologists and doctors. Leventhal et al. (2021) examined psychologists' experience working with general practitioners in community health teams. They found that fostering relationships and working together improved psychologists' sense of confidence and collaboration. However, this was not as evident when psychologists were collaborating with psychiatrists. Leventhal et al. (2021) hypothesised that this pattern reflects psychologists' complex relationship with psychiatrists, as the psychiatrist also serves as a manager or clinical leader in many instances.

Relationship difficulties may also reflect concerns from psychologists about the professional territories of the two disciplines, as well as power distribution, and hierarchy. Multi-disciplinary teams that rely exclusively on psychiatric formulations and biomedical assumptions can disadvantage their clients (Dovey-Pearce et al., 2020). Psychologists serve an essential function in ensuring a non-binary, strength-based formulation is developed (Dovey-Pearce et al., 2020). In essence, the service, the profession and, most importantly, the public, benefit from a harmonious and egalitarian relationship between professionals.

### The organisational domain

In Aotearoa New Zealand, the public healthcare system is presently structured around a collection of twenty DHBs and their related services. Other countries such as Britain and Denmark have equivalent universal health care systems (Gauld, 2020). This section draws from experiences of many kinds of community based public health services, as many of the challenges are universal. One consistent finding is that psychologists describe working in a public healthcare system as an emotionally challenging and occasionally daunting experience. This is a significant consideration given that one in five psychologists in Aotearoa New Zealand work in a community mental health facility or hospital (Waitoki & Levy, 2015).

In the last decades, hospitals and staff have contended with budget reductions, changes in organisational processes, and a shift in the paradigm of care (Durdy & Bradshaw, 2014). The COVID-19 pandemic has also increased the role of public healthcare and thus placed an additional and considerable strain on existing resources (Boserup et al., 2021). It is reasonable to assume that healthcare workers are regularly and continually processing some degree of organisational change (Colley et al., 2015). This is true for Aotearoa New Zealand too, as multiple policy documents can attest (New Zealand Government, 2018). How effectively staff manage these changes is determined in part by the organisational climate.

Berberoglu (2018) defines organisational climate as employees' collective perception of their organisation and its purposes: it is the staff's consensus, or average impression of how things are done and why. The organisational climate influences staff perception of change, their role and purpose, and their meaning to their professional role. According to Berberoglu (2018), if staff perceive their organisational climate positively, then efficiency and commitment improve. Other studies support this relationship between a positive organisational climate and staff participation and commitment. Yanchus et al. (2015) found that psychological safety, civility, procedural justice, and autonomy predicted job satisfaction for hospital staff. Interestingly, they found similar findings for a wide range of healthcare professionals, suggesting that the relationship between organisational climate and wellbeing is a universal experience for all staff.

Both organisational and clinical priorities are considered essential for an effective healthcare service. The organisational climate often involves balancing organisational, economic, and political goals with clinical goals. Many hospitals have replaced or reconfigured traditional profession-based management to include organisational management structures to balance these differing priorities. Martinussen and Davidsen (2021) describe two potential leadership approaches representing these differing priorities. These are the *professional-supportive* and *economic-operational* models of management: professional-supportive management focuses on clinical standards and patient care, while economic-operational management approaches emphasise budget control and resource management.

Martinussen and Davidsen (2021) examined staff perceptions of working under these two models. They found that organisations characterised by a professional-supportive approach encouraged a positive organisational climate, more innovation, and increased engagement by staff. Contrastingly, Le Boutillier et al. (2015) note that economic-operational models characterised by differing priorities are often met with suspicion and resistance from staff. Colley et al. (2015) interviewed a collection of psychologists about their experiences of organisational change in the NHS and found that psychologists attribute much of the organisational change to political interference and the public sector's privileging of the business model.

There is also a common perception that the NHS is reorganising for no apparent reason; a culture of “change for change’s sake”.

Research consistently suggests that regular changes to policy and structure can be stressful for staff. This is especially evident if staff do not identify with these changes or if the change is predicated on values they do not share (Holm & Severinsson, 2010). Andrews and Thorne (2015) point out that healthcare workers value compassion, care, and service to others in their working life. They express concern that the organisational plan of healthcare services can erode their capacity to attend to their patients. Andrews and Thorne (2015) note that staff interpret funding cuts and increased targets as compromising their values, which can then impact the quality of care provided. There is very little data concerning psychologists' experiences of organisational climate in the ANZ public healthcare service. However, what has been published typically critiques the cultural adaptability of the present DHBs (Jordan et al., 2021). This study is one of few that explore ANZ psychologists' experience of organisational climate and its impact on clinical activity.

An environment in constant change, coupled with an unsupportive organisational climate, can provoke obstructive and disruptive attitudes in staff. Uncertainty and fear about role changes, reassignment, or even retrenchment can lead to anxiety and, eventually, the development of defensive behaviours (Hyde & Thomas, 2002). This is especially evident when practitioners are concerned with the loss of agency and autonomy over their professional lives (Callaly & Arya, 2005). Durdy and Bradshaw (2014) study found that one of the consequences of coping with change and diverse management styles was that staff can become resistant and obstructive. McDonald (2005) describes different types of resistance, including “quiet resistance”, such as applying for jobs outside the organisation or choosing to ignore new ways of working; and “open resistance” (p. 201), which includes opting out of new initiatives and openly challenging senior management.

The significant consequence of this tension and resistance to the organisational process is an erosion of *organisational commitment*. According to Cohen (2007), organisational commitment involves three distinct properties. First, it involves employees embracing the values of an organisation, working for its interests, and identifying with the institution's purpose. Cohen (2007) also stresses that organisational commitment typically involves employees experiencing a beneficial association and affinity with an organisation. Both are essential aspects of a healthy and efficient organisation. Gokce et al. (2014), for example, found that doctors’ perceptions of leadership behaviour positively affected their level of organisational commitment. This is especially evident if the organisation adopted a transformative, rather than transactional, leadership approach. One of the critical challenges that the ANZ public healthcare services face as they progress with the ideals of *He Ara Oranga* is fostering organisational commitment while balancing divergent organisational and clinical agendas.

## Stressors in a public healthcare service

Encouragingly many clinicians describe positive aspects of working in a public healthcare service (Fleury et al., 2017). A healthy working environment can promote collegiality and a sense of community that comes with being part of a team. Many practitioners report that providing healthcare to the vulnerable can also instil a sense of purpose and personal satisfaction (Fleury et al., 2017). However, health workers also tend to report high levels of stress, frustration, and exhaustion due to working in a stressed environment (Colley et al., 2015; Dorociak et al., 2017). These clinicians describe stressors that emerge from coping with organisational life, and stressors from the emotional burden of providing clinical care. This combination of two sources of work stress is especially evident in public healthcare services. QualityWatch (2014) reports that British healthcare workers report higher than average rates of organisational stress compared to other industries.

Psychologists are not immune to work-related stress. In 2016, the UK British Psychological Society reported that 70% of NHS psychologists find their jobs stressful, and 52% reported working overtime in a typical week (Levinson et al., 2021). Long working hours, organisational expectations, and high clinical and administrative workloads are significant factors in stress levels. Luther et al. (2017) found that psychologists working overtime reported significantly increased burnout and work-life conflict and significantly lower job satisfaction and quality of care than those not working overtime. McCormack et al. (2018) conducted a meta-analysis on the reasons for work-related stress, and their findings echo the above concerns. The most cited stressor was emotional exhaustion and high workloads, and stressful work settings were reported as the most consistent contributors.

One of the consequences of organisational stress is the risk of burnout, a psychological syndrome following a prolonged response to ongoing interpersonal stressors at work (Maslach, 2003). Typically, burnout is characterised by emotional exhaustion, depersonalisation and cynicism, and a low sense of accomplishment in one’s work (Dyrbye et al., 2017). Multiple studies have demonstrated burnout's high prevalence and impact within healthcare settings. McCade et al. (2021), for example, surveyed 248 psychologists in hospitals and found that nearly a third met the criteria for burnout, while nearly one in five reported at least mild depressive symptoms.

According to Thompson et al. (2014), practitioners in community health settings are also at higher risk of burnout than their colleagues in private practice. Thompson hypothesises that this may be due to more demanding work environments, less remuneration and resourcing, and a lack of congruence between the values of the practitioners and that of the organisation. Ray et al. (2013) adds that a lack of agency and self-determination are significant predictive factors.

Along with organisational stress, healthcare workers also experience the stressors related to providing healthcare to the unwell and vulnerable. For psychologists in community hospital settings, this is often represented in the size and complexity of caseloads and the demand for therapy among psychologists. Like many other studies, Yang and Hayes (2020) found that high caseloads are associated with burnout. However, Yang notes that high caseloads alone are not a predictor and that burnout correlates with frequency and intensity of contact with clients and the complexity of their presentations. Kim et al. (2018) found similar outcomes in their research. While high caseloads were associated with increased emotional exhaustion, practitioners who felt confident and competent in their therapeutic work were somewhat protected from emotional exhaustion.

Similarly, research by Rupert et al. (2009) and Rupert et al. (2015) also suggests that a sense of accomplishment and meaning somewhat protect psychologists from the stress associated with high caseloads, and challenging clinical work. The above research suggests that the defining factor for whether caseloads and therapy result in stress may be categorised as 1) the complexity of cases; 2) the sense of clinician agency; and 3) most importantly, the perception of competence and efficacy of the psychologist. In a sense, a psychologist’s perception and experience of therapeutic competence serve as a form of professional self-care and a protective factor against burnout.

One clinical consequence of struggling with the triad of stressors is the risk of developing *compassion fatigue*. Figley and Figley (2017) define compassion fatigue as a reduced capacity to show empathy or compassion involving struggling to tolerate and carry the burden of another's suffering. Compassion fatigue occurs when a practitioner "succumbs to the demands of client care over self-care" (p. 2), after repeated exposure to distress and trauma. Clinicians tend to withdraw, avoid work, and find it increasingly difficult to perform their duties. Ray et al. (2013) adopts a more psychological perspective and describes compassion fatigue as a state of tension or preoccupation with the difficulties and suffering of patients. This state of tension can leave practitioners numb, irritable, incapacitated, or emotionally drained. Figley and Figley (2017) emphasise the behavioural aspects of compassion fatigue, while Ray et al. (2013) emphasise the psychological or emotional state.

Compassion fatigue is typically evident when healthcare workers experience prolonged and sustained exposure to the suffering of others (Pehlivan, 2017). Yoder (2010) explored factors that could trigger compassion fatigue and grouped them into three categories: caring for patients, system problems, and personal issues. Her study concluded that the factor most predictive of compassion fatigue was the practitioner's perception of their incapacity and helplessness in the face of patient suffering. The clinicians with higher levels of compassion fatigue reported feeling that they had not been effective or competent. Killian (2008) interviewed a different cohort of healthcare workers, and his findings offered some essential differences. This study focused more on the daily, long term risk factors that increased the likelihood of compassion fatigue, and described more chronic and cumulative stressors such as high caseloads, poor support structures, regular traumatic work incidents, and a lack of efficacy and agency.

One of the central protective factors against compassion fatigue is the internal resources of the practitioner. Figley and Figley (2017) offer some insight into how clinicians can manage compassion fatigue. They describe how some practitioners foster high levels of *compassion fatigue resilience*, or the ability to retain a compassionate stance to their patients, despite the stress they are experiencing. Various mechanisms promote resilience; these include distancing oneself, practicing self-care, accessing personal supports, and experiencing a sense of satisfaction in their work. Practitioners who can manage these self-care factors have high levels of *compassion satisfaction*.

According to Phelps et al. (2009), compassion satisfaction refers to the positive aspects of care. High levels of compassionate satisfaction suggest that practitioners find their clinical work gratifying, rewarding, and meaningful, despite the compounded stressors. Working in a meaningful and clinically effective way has significant implications for clinical psychologists in the ANZ public healthcare service; as in the case of managing burnout, it is a psychologically protective factor. Questions worthy of further examination are how clinical psychologists can engender a sense of capacity and competence in their clinical work, and how they can maintain a sense of compassion satisfaction. The following section addresses these questions.

## Therapy as a resource

As illustrated by Pehlivan (2017), and Ray et al. (2013), providing intensive therapy can exacerbate feelings of burnout and compassion fatigue. However, the inverse is also possible; there is some evidence that the act of providing therapy is protective and restorative (Dlugos & Friedlander, 2001). Therapeutic activity can be a powerful source of self-efficacy and professional confidence. According to Dlugos and Friedlander (2001), and Ronnestad and Skovholt (2001) many psychologists describe providing therapy as an affirming and rewarding activity. Most research focuses on the emotional and professional satisfaction from participating in compelling and meaningful interactions.

However, there is also some evidence that fostering solid therapeutic alliances with clients can help psychologists cope with organisational stressors in other ways. Butler (2014) argues that therapists navigate an almost universal tension between feeling some responsibility for their patient’s well-being, while doubting their capacity to make a difference. The stressors inherent in public healthcare only intensify those feelings of responsibility and capacity. Providing therapy in any public healthcare service involves managing the tension between trusting in the therapeutic process and wrestling with professional competence. However, Butler (2014) argues that, by occupying this place of tension, a therapist can foster a sense of resilience and humility and the ability to tolerate ambiguity and uncertainty.

In this way, a strong working relationship with clients can assist the therapist in coping with the intrusive stressors and disruptions of a strained environment. Hayes (2014) describes how this can occur. As psychologists navigate stressful and emotionally challenging working environments, they are more at risk of projecting their emotional difficulties into the therapy. Hayes notes that over identification with clients and poor attunement to the therapist's emotional state can distort the therapeutic relationship. Gelso and Hayes (2007) adopt a psychoanalytic interpretation of this dilemma and suggest that distress and being unsettled can present as countertransference, which risks interrupting and even fracturing the therapeutic process. This is especially evident if the countertransference is not acknowledged openly and explored appropriately. However, a solid therapeutic alliance can help a therapist navigate the impact of countertransference. A strong working relationship founded on trust, congruency, and a willingness to be open, can ensure that a therapist addresses the emotional distress they may inadvertently bring into the room, in a safe and containing way (Yeh & Hayes, 2011).

Gelso and Hayes (2007), and Yeh and Hayes (2011) describe the risk of blurred emotional boundaries in therapy, fueled by the pressure of environmental stressors of an overwhelmed public healthcare service. One of the most significant protective factors in aiding a therapist in managing these difficulties is an appropriate and effective therapeutic alliance. In this way, the therapeutic alliance is an opportunity to ensure that organisational stress does not intrude into clinical processes, thus compromising effective healthcare delivery. The therapeutic alliance services both a direct clinical function, and an indirect organisational function. Maintaining solid alliances with clients protects the therapy space and, to an extent, the therapist too.

Duncan and Reese (2015) and Brattland et al. (2019) have explored more systematic and deliberate ways of using the alliance as a resource to enhance both the efficacy of therapy and a means to promote organisational efficiency. They champion the use of routine outcome measurements (ROM) such as the *Partners for Change Outcome Management System* (PCOMS). Tools such as PCOMS serve dual functions in that they improve service outcomes and the therapist's skills through constructive feedback from clients (Duncan & Reese, 2015). Brattland et al. (2019) compared therapists who used the PCOMS system to those providing treatment as usual in an outpatient community hospital setting, concluding that the group using feedback informed treatment protocols presented with improved outcomes.

Shimokawa et al. (2010) completed a meta-analysis of a large healthcare service and found that clinical routine outcome measurement protocols were effective in improving organisational outcomes. Using ROM was especially effective in preventing treatment failure. In contrast, Chow et al. (2015) found that individual practitioners experienced significant benefits in using tools such as PCOMS. Specifically, his research found that regular client feedback improved practitioner confidence, efficacy, and connection to clients.

Using ROM is mandatory in New Zealand healthcare services and typically involves various online psychometrics utilised as a part of routine care (Stasiak et al., 2012). The intention is to ensure better monitoring of progress to inform clinical decisions and improve the patient experience by eliciting and including patient input and feedback. However, psychologists can also harness the PCOMS organisational tool to improve their practice and sense of confidence and efficacy in their therapy. The use of PCOMS can be an opportunity to consolidate therapeutic skills and evidence and reinforce therapy power as an organisational resource. This is an example of using therapeutic activity as both a clinical and organisational tool, and a means for psychologists to protect and maintain therapy within a stressed service.

Introducing psychometric tools such as the PCOMS and harnessing interpersonal processes like countertransference represent two distinct ways that psychologists can use their therapeutic relationships to cope with organisational pressure and enhance their clinical care. Gelso and Hayes (2007) describe a psychoanalytic process, while Brattland et al. (2019) describe an empirical, practice-based psychometric process. Adopting a common factors paradigm gives psychologists the space to utilise therapy in more relational terms within a public healthcare service context, and to access both these resources. In this way, therapy becomes a resource or an interpersonal strategy in coping with a strained and convoluted public healthcare structure. Accordingly, a focus of this study was to describe how psychologists routinely use a different therapeutic strategy to cope with organisational stressors.

My research concerns a fundamental social process deeply impacted by organisational and social processes. However, the role of therapy in the ANZ public healthcare service as an organisational activity has not been the focus of significant research. Instead, the focus has been on service-user experience, or therapy's efficacy and merit in an organisation. However, conceptualising therapy as resource for an organisational and political process has been underrepresented in literature.

## Summary

The first section of this chapter explores the complex experience of providing therapy in a public health setting. The section illustrates the historical context of psychological therapy and the evolution and changes in the psychological therapy paradigm. The impact of developments within the broader public health care arena are also noted. The uneasy alliance between the scientific, symptom-based interpretation of therapy and a relational, dynamic interpretation are also discussed.

Special attention is paid to the role of the therapeutic alliance in therapy; and the ways that evidence-based treatments can potentially side-line the therapist and even the client in favour of a symptom-focused approach. The scope and influence of therapy as a resource for sociocultural change is also described. The literature describes tension at the heart of providing therapy. This tension is between a symptom-driven interpretation of therapy (i.e., evidence-based treatments); and a relational/contextual interpretation of therapy (i.e., the common factors). This section also demonstrates the inherent flexibility in the relational common factors approach, which may be a powerful resource for both the therapist and the organisation.

The second part of this literature review explores the experience of working in a ANZ public healthcare service, particularly the experience of working with the public healthcare's organisational and clinical agenda. In both cases, psychologists responded with a constellation of emotions ranging from dismay to distress, but also a certain resilience and fortitude. This section describes the implications of burnout, compassion fatigue, and organisational commitment for psychologists and explores how therapy plays a role in responding to organisational and clinical pressures and ameliorating those stressors. Sometimes the response is in the very act of therapy. And in these moments, therapy becomes something restorative and affirming. At other times, the reaction is more organisational and strategic; therapy becomes a tool to be resourced and utilised within public healthcare.

The following two chapters describe my method and the underlying methodology that forms my research design for my study. Following that, the findings of my study and a discussion of these findings are presented.

# Chapter 3 Methodology

This chapter describes the research design of this project, including my epistemological beliefs, methodological position, and the corresponding methods accompanying my chosen methodology. I begin by introducing my methodology, which is constructionist grounded theory, outlining its relevance to the type of inquiry and the research question.

## The rationale for grounded theory in this study

Grounded theory is especially useful when exploring the motives and patterns of people involved in complex social interactions (Bryant, 2017). This methodology provides the tools and processes to explicate social phenomena and social processes and is especially useful for areas where there are few or no existing explanatory models (Kenny & Fourie, 2015). Grounded theory is considered a flexible, adaptable, and robust research methodology, and it has been used in healthcare research (Adams et al., 2017), education (Thornberg et al., 2013), and business information systems (Carmichael & Cunningham, 2017). Since its inception, grounded theory has become the most widely used qualitative research method in academic literature due, in part, to its applicability to diverse disciplines, professions and topics of interest (Belgrave & Seide, 2019a).

Grounded theory has also been used to explore the interpersonal dynamics and decision-making processes in healthcare organisations. Breckenridge et al. (2019), for example, used grounded theory to describe the daily interactions, social negotiations, and shared lived experiences of staff nurses and their line managers. Their data became the material to build a theory of a new organisational model. This example illustrates the power of grounded theory to integrate the grass-roots experiences of people with their overarching organisational experience and to explore the human experiences that underpin organisational processes in healthcare.

Other grounded theory studies have focused more specifically on mental health care. Gallagher et al. (2015), for example, used grounded theory to explore the decision-making processes of palliative-care nurses for end-of-life care. In contrast, McPherson et al. (2016) focused on the experience of managing patient distress and agitation in dementia wards and the impacts on the culture of care. In these instances, the research area was on organisational practices, but from the perspective of the intimate and routine interpersonal, clinical processes within an organisation. Grounded theory studies have also been used in psychology and mental health research (Charmaz, 2021b).

As with my study, there are some grounded theory studies that focus on how clinical psychologists use these clinical skills to cope with organisational pressures. Nutt and Keville (2016), for example, used grounded theory to explore how clinical psychologists navigate workload stress in the NHS using their reflective and conceptual skills. Colley et al. (2015) described how psychologists use their facilitative skills to manage organisational change in hospitals.

Other researchers have adopted a constructionist grounded theory perspective to illuminate the socially constructed narratives and processes that impact psychologists working in hospitals. One example is Arczynski and Morrow (2017), who used constructivist grounded theory to explore how feminism and multicultural narratives were preserved and upheld in clinical supervision. In their study, the use of a constructivist epistemology allowed for a deconstruction of the cultural, societal, and clinical discourses that permeate the experiences of participants. Likewise, Tickle et al. (2014) used a constructionist grounded theory study to understand the challenges of implementing a recovery-focused protocol. In both of these studies, the constructionist paradigm allowed for an analysis of the social narratives of the hospital system and how they impede or liberate participants in the organisation.

The above examples describe the significant contribution grounded theory has made to our understanding of social processes, the experiences of psychologists in hospitals, the role of our socially constructed realities, and the way that shapes the world of psychologists. These studies also explore the complex relationship between practitioners and organisational structures.

Each examines the dynamics between the interpersonal and the organisational components of a healthcare service. My study follows a similar path; and therefore grounded theory methodology is suitable for exploring the experiences of psychologists in the ANZ public healthcare service.

## Epistemological considerations

The following section explores the underlying philosophical assumptions of my research design. Glaser (1992), one of the original developers of grounded theory, was famously indifferent to addressing epistemological positions in research. However, other researchers consider epistemology a fundamental aspect of pursuing knowledge. Indeed, Birks and Mills (2015) assert that explicitly stating one's epistemological position helps locate the researcher in the study and clarifies how and why ideas are constructed and described. This section begins by describing the ontological and epistemological position of this study, and then describes how that position informs the choice of research design.

Hathcoat et al. (2019) claim that any systematic inquiry is grounded in a belief about the nature of reality: this is called an ontological position. Guba and Lincoln (1994) postulate that only two ontological positions are possible in the social sciences. The first is naïve realism, which describes the view that an objective reality can be named, systematically explored, and then predicted. Naïve realism typically underpins the *positivist* stance of enquiry.

The alternate position is relativism, which asserts that reality is multiple and transactional, and the truth is a fluid concept and depends on the perspective of the observer (Guba & Lincoln, 1994).

Clarifying one’s ontological and epistemological position is complex. Psychological therapy, for example, would be conceptualised differently depending on personal ontological positions. From a position of realism, therapy may be seen as a sequence of identifiable and implementable behaviours. From this perspective, therapy is real because it is a set of discrete actions that exist independently of the therapist or therapy relationship. Alternatively, therapy might be conceptualised as a socially constructed phenomenon where therapy is shaped by language and social processes. Therapy is thus conceptualised as real only so far as it is constructed out of the perspectives, positions, and assumptions of participants.

The application of a particular set of beliefs and assumptions based on an ontological position demonstrates an epistemological perspective. An epistemological perspective describes one’s understanding and assumptions about how reality is manifested (Hathcoat et al., 2019). From a research perspective, epistemology is the belief system or worldview that guides the researcher and informs which methodology and research design they would be most comfortable with (Guba & Lincoln, 1994). In this way, a researcher’s epistemology shapes their assumptions, perspective, choices, and actions as a researcher. According to Birks and Mills (2015), this forms the methodology of the research project, and involves describing the philosophical principles and ideas that underpin and inform the research design and assure methodological congruence.

According to Denzin and Lincoln (2011), outlining and clarifying the researcher's paradigm guides the research process and gives the inquiry structure, purpose, and conceptual consistency. There are many ways of conceptualising the range of paradigms. In their critical review of the history of research methodology, Denzin and Lincoln (2011) acknowledge various research paradigms that are located in three broad groups. These are the relativist stances like constructionism; the critical stances such as feminism; and the more positivist and post-positivist stances common in quantitative research. Each has an underpinning set of assumptions about the nature of reality and social order and assumptions that maintain, or challenge established narratives. Each paradigm informs a research design and structure and frames the research process. I locate myself in the relativist paradigm as this aligns most closely with my epistemological position.

## Constructivism and constructionism

The roots of my personal paradigm are located in the shared territory between constructivism and social constructionism. Constructivism is concerned with how the individual constructs an understanding of the world.

It is an internal and cognitive process and originates in the developmental theories of Piaget and Vygotsky (Rob & Rob, 2018). A constructivist perspective describes the view that social reality can only be apprehended in the form of intangible mental constructions. The world we access is a cognitively constructed social reality defined by language and experiences (Losantos et al., 2016).

Conversely, a more systemic or contextual perspective on constructivism can be adopted with emphasis on the construction of reality as a collective experience (Andrews, 2012). Guba and Lincoln (1994) add that this relationship with a constructed reality is transactional in that all participants in social life (including the researcher) are part of creating that reality. This perspective is called *social constructionism,* which postulates that social processes, shared ideas, and culture shape the individual and the community's understanding of the world (Kelly et al., 2018).

Andrews (2012) argues that our collective ideas become our actions, and if enacted often enough, they become patterns. These patterns then represent a form of social reality that individuals respond to, influence, and are influenced by. As people experience and describe the world, they develop a collective shared meaning which is maintained together (Gergen, 2001). An example of this is the notion of wellness. This is a social construct that we all live with and enact, through our behaviour. Without people agreeing to maintain a concept of wellness, it would not exist as a social construct.

Constructionism recognises that one interpretation of the social world sometimes dominates the social narrative. Grounded theory constructionists are particularly drawn to these moments, either when individuals or groups are compromised or oppressed by a dominant reality or when people become entrapped in a narrative that impedes new possibilities from emerging (Grant & Giddings, 2002). From this frame of reference, objective social phenomena, for example, collaborations on treatment plans or maintaining leadership structures in the ANZ healthcare service, become re-negotiated conceptual worlds full of assumptions and possibilities, ripe for deconstruction.

One of the central concerns for research within a constructionist or constructivist paradigm is the relationship between the individual and their environment. Constructivists believe that cognitive mental models are the primary vehicle for defining reality; they emphasise an individual psychological model of meaning-making and the role of personal cognitive processes in constructing reality (Appleton & King, 2002). In contrast, prominent constructionists such as Papert (1991) propose a different position. Papert (1991) argues that the construction of reality develops in the engagement with the environment and others within that environment.

Papert (1991) uses the metaphor of a builder, and specifically that all builders need material to build their buildings. We draw material from our co-created social interactions and artefacts and rituals in the environment. From a social constructionist perspective, a concept such as therapy is built out of the social processes and rituals that make up the world of mental healthcare (Kim Ward et al., 2015). Constructionism is primarily concerned with the social world that people operate in, as this facilitates the co-construction of reality. In this sense, constructionism is an epistemology of context and its capacity to construct reality.

Social constructionism has evolved into a significant epistemological paradigm evident in various intellectual areas. Constructionism has become increasingly influential in pedagogy and learning theory, especially related to culture and context in learning (Noss & Clayson, 2015). However, constructionist researchers have turned their attention to even more diverse fields of interest.  In a sociological vein, for example, Zhao et al. (2017) used a social constructionist perspective to critique governmental use of mass communication tools to manage the population’s perception of national crises. In addition, Druzhinin (2020) applied a constructionist lens to the discourse of the physical sciences. These scholars use constructionist concepts to illuminate the debate concerning multiple universes and multiple realities.

Constructionism has encouraged a generation of social science researchers to rethink their relationship to the research process or participants. Alongside other related relativist paradigms, constructionism has encouraged humility in researchers and cultural open-mindedness in contemporary research processes (Losantos et al., 2016). Losantos et al., (2016) elegantly describes his research experience and how, through a constructionist lens, he came to understand that “the answer to the research question was not mine to construct, but theirs to give” (p. 33). I am especially drawn to how constructionism challenges dominant ideas or social processes. From a constructionist perspective, ideas that could be entrapping and unjust can be challenged and re-examined. I share Charmaz (2016b) view that constructionism can reposition the act of research to be more than the pursuit of knowledge; a worthy goal, to be sure. Constructionism can locate research processes within a moral frame and introduce justice, dignity, and respect questions.

### My epistemological position

While epistemologically, I acknowledge the fundamental premises that underpin the relativists’ paradigm, social constructionism’s contextual focus has greater resonance. The origins of this perspective originate back to my training as a psychologist. While I was strongly influenced by constructivism, especially the developmental theorists such as Piaget and Vygotsky, my training also emphasised community psychology and the role of social processes in mental health. In addition, I was exposed to narrative and systemic thinkers such as Michael White (2006), and the various family therapy schools from the 1970s (Lebow & Sexton, 2015). In this sense, my training and eventual worldview were in constructivism, but with a growing emphasis on systemic and relational ideals. A consequence is that I am drawn to a perspective on mental health that emphasises the dynamic *between* people.

Constructionism resonates deeply with me as a therapist. My first experiences as a psychologist were with community-based mental health services. Frequently these communities lived in extreme poverty and social deprivation. I was exposed to how entrapping assumptions of health, empowerment, and collaboration, and social reality, were imposed on disempowered communities by the broader healthcare system. Consequently, I was trained to see therapy as a vehicle for challenging dominant discourses and a means to reframe the social experiences that entrap people, families, and communities. My life’s work has become an exercise in exploring shared meanings and the processes and strategies we use to construct the reality of our emotional lives. I struggle to imagine being a psychologist without acknowledging this underlying assumption.

These experiences have also shaped my research processes for this study, which concerns the act of psychological therapy. This is an area that has been the focus of extensive research. However, the majority of previous studies have been conducted from a positivist or post-positivist perspective (Wampold & Imel, 2015b). Positivists believe that behaviour can be predicted probabilistically, and causality can be at least partially understood (Lincoln & Guba, 2013). However, constructionists view this notion with scepticism. For

Charmaz (2008) and the constructionists, the assumptions of neutrality and objectivity in the positivist paradigm make data unproblematic and present results as *givens* rather than *constructions*.

I conceptualise therapy in these constructionist terms and intend to ask a different set of questions. I aimed to explore how therapy is co-constructed in social processes, specifically, the relationship between clinical psychologists and the DHBs in the ANZ healthcare services. This study is also interested in the ways power and meaning are negotiated in routine clinical care and the implications. The study explores how therapy, and even the notion of a psychologist, can be perceived differently by different parties within the ANZ healthcare service. As in my professional word, I am interested in the social narratives we construct and how these narratives liberate or entrap. Therefore, the constructionist concepts that have permeated my experience of mental health are also evident in this study.

One of the most significant characteristics of social constructionism is the view that people construct knowledge through their interactions with their environment and each other. People continually absorb, incorporate, and reframe the information we collectively share and maintain. We learn about and co-construct reality as we live and socialise (Alanazi, 2016). How people construct realities and then challenge and develop those realities is a profoundly social process. The individual and the environment are bound together in their efforts to shape reality. In this study, I pay close attention to the socio-political processes, rituals and rules, and culture of institutional life.

According to Andrews (2012), constructivism and constructionism are often used interchangeably, despite their subtle but significant differences. Charmaz (2006) readily acknowledged that she might adopt a constructionist or constructivist perspective, depending on the context. This poses a challenge for me as I engage with the literature for this study, as the literature may reference either position. When referencing literature and authors, I have used the term the authors use; but interpret their ideas through a constructionist frame. This is possible, as constructivism and constructionism share the same underlying relativist ontological and epistemological premise (Charmaz, 2006). In addition, the term constructionism will be used throughout this thesis, with the concept of *social* being implicit.

Section two of this chapter describes my rationale for adopting a constructionist perspective in my research and how this is congruent with my broader worldview and professional practice. The following two sections introduce grounded theory and how and why constructionist grounded theory applies to my research area. I then address the methodological implications for adopting a constructionist grounded theory method.

## A brief history of grounded theory

Regardless of the grounded theory variant, the research processes inherent in the methodology are the same. Grounded theory involves gathering qualitative information from specifically selected sources and then identifying a conceptually rich theory through stages of increasing abstraction to explain a particular social phenomenon (Glaser & Strauss, 1967). From a constructionist grounded theory perspective, a theory is then constructed and is grounded in the original data (Charmaz, 2014). Grounded theory requires constant interaction with the data, and the researcher remains constantly involved in the developing analysis. Data collection and analysis co-occur, each informing the process of the other (Charmaz, 2014).

This is illustrated in Figure 4.

**Figure 4**

*The Stages of a Grounded Theory Analysis*

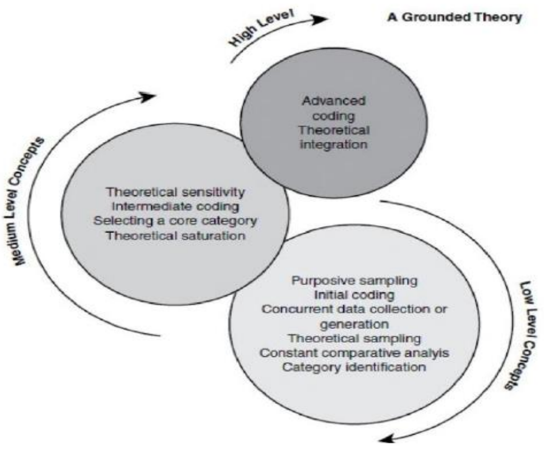


*Figure 4 - The Stages of a Grounded Theory Analysis*

*Note.* From *Grounded theory: A practical guide,* by M. Birks and J. Mills,(p. 110),2015,Sage. https://doi.org/https://doi.org/10.1177%2F0894318417724473

In grounded theory, a series of empirical checks, or methods, are built into the analysis that allow the researcher to locate and refine the theoretical extrapolations from the data (Bryant, 2017). The various schools of grounded theory all draw on these empirical checks. However, they may interpret them differently, depending on the epistemological premises of the researcher. Charmaz (2014) adds that while qualitative research methods are typically effective for uncovering the *what* and *how* of social processes, grounded theory can also address the *why* of social processes. Grounded theory does this by developing a theory that integrates, elevates, and encapsulates the analysis of the data.

## Introducing constructionist grounded theory

In the late 1990s and 2000s, several researchers such as Charmaz (2006), Clarke (2003), Bryant (2017), and Thornberg (2012) were drawn to the relativist threads running through Strauss and Corbin's ( )work, and in particular, the space they created for alternate epistemologies within grounded theory (Mills et al., 2006). According to (Mills et a.., 2006), Corbin and Strauss never explicitly describe their ontological perspective. However, Mills et al., (2006) suggest that Corbin and Strauss gradually adopted several key post-positivists and even postmodern perspectives in their writing. Mills et al. (2006) note how Corbin and Strauss reference multiple realities, the difficulties in confidently identifying an absolute truth, and acknowledge that social reality is embedded in a historical and social context. Each of these ideas can be viewed as enabling the constructivist perspectives that would follow. Consequently, in the early 2000s, Charmaz, a student of Strauss, introduced an explicitly constructivist interpretation of grounded theory, which was initially described in *Constructing grounded Theory: A Practical Guide through Qualitative Analysis* (2006).

According to Charmaz (2020), constructivist grounded theory continues with the iterative, comparative, emergent stance of Glaser and Strauss' original ideas, but challenges the underlying positivist epistemological premises. However, constructivists would argue that a researcher is never free from an epistemological position. Birks et al. (2019) suggest that Glaser is ultimately grounded in positivist assumptions of reality, despite his desire to extricate himself from such debates. Charmaz (2014) argues that constructivist grounded theory takes the methodological strategies of grounded theory and places them explicitly within the relativist epistemological frame. In this way, constructionist grounded theory incorporates many of the epistemological developments in social science research.

The various schools of grounded theory differ in how knowledge is gained in a grounded theory study. In classic grounded theory, knowledge *emerges* through systematic and objective enquiry. In a positivist sense, it was always there, independent of the observer, waiting to be located (Charmaz, 2006). However, in constructionist grounded theory, knowledge is *constructed. T*he meaning does not lie dormant within phenomena waiting to be discovered, but rather it is created as individuals interact with and interpret the phenomena (Breckenridge et al., 2019). Mills et al. (2006) remind the reader that a constructionist perspective requires that the researcher actively co-construct the data as they analyse. The goal is to go beyond the surface to seek meaning, search for, and even question tacit meanings about values, beliefs, and ideologies. The debate between the discovery of reality and the construction of reality is a fundamental difference between classic and constructionist grounded theory.

Charmaz (2008) champions an open-endedness to our inquiry, calling for a willingness to build an understanding of the social world without the comfort of finding certainty. In essence, constructionists aim for insight and illumination rather than certainty and finality in their analysis. Constructionism understands social processes as constantly being reframed and re-constructed as new information enters the system. Seeing an individual or group as the cause of change to another, is epistemologically inconsistent with constructionism, as all participants perpetuate and contribute to an evolving reality (Charmaz, 2021b). This stance has implications for the researcher, participants, and the relationship between them. The following section discusses some of the central methodological implications for a constructionist grounded theory.

## The origins of grounded theory

Grounded theory was developed in the 1960s by two sociologists, Anselm Strauss and Barney Glaser. Their ideas emerged from their studies of hospitals and the social processes surrounding death. During this period, they developed the essential components of the grounded theory research method, which they described in their seminal work, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (1967). By the 1960s, the traditional methods of ethnography, interview, and case studies had fallen out of favour, and broader quantitative studies dominated social research. Qualitative research was often perceived to be impressionistic and vague, with less validity and reliability than quantitative research (Oktay, 2012). Glaser and Strauss critiqued this view, especially the prevailing notion that qualitative research best served as a precursor to the more rigorous forms of quantitative research. They argued that a well-constructed qualitative inquiry could provide a persuasive and substantial study of social phenomena (Thornberg & Dunne, 2019).

Over the ensuing years, Glaser and Strauss developed a method to build an understanding of local social phenomena and explore the meanings and mechanics of social processes (Kim Ward et al., 2015). Glaser and Strauss were interested in documenting the perspectives of those intimately involved in their research area. In addition, they were interested in working with data and developing ideas immediately and directly. To achieve this, Strauss and Corbin would often focus on uncovering the social rituals and processes for organising and collaborating (Corbin, 2013). Strauss and Corbin (1990) argued that, in developing their method of researching social phenomena, they could potentially forge new territory or even challenge the prevailing wisdom of academia.

In addition to this bold approach to inquiry, Glaser and Strauss (1967) also developed a set of qualitative research methods that were systematic and structured, empirical, credible and, perhaps most importantly, adaptable to different research questions and paradigms**.** Consequently, their methods quickly found an enthusiastic audience (Birks et al., 2019). This is because they offered a chance for researchers to use carefully constructed principles and methods in an accountable and confident manner, and to do so with creativity (Charmaz, 2020). According to Corbin and Strauss (1990), a new generation of researchers also had the means and methodological validation to work more closely with the lived experience of their participants and had the methods to immerse themselves into the development of social processes as they occurred. They could also explore areas that were previously not of interest to the established academic community. Grounded Theory revolutionalised qualitative methods and principles (Charmaz, 2020).

Corbin (2013) traces the roots of grounded theory to the philosophies of *symbolic interactionism*, especially the founding philosophers Charles

Cooley and Herbert Blumer, and its underlying philosophical tradition of *pragmatism*. Symbolic Interactionists argue that humans perpetually interpret social interactions dynamically and creatively. They then act based on these interpretations and assign symbolic meanings to objects and social processes (Aldiabat & Le Navenec, 2018). According to Corbin and Strauss (2008), symbolic interactionism informed the development of grounded theory in two crucial ways. First, symbolic interactionism highlights that phenomena are constantly changing. As actors assign meaning to the things they experience, their behaviour changes through reflective thought and environmental feedback. Second, symbolic interactionism has a non-deterministic view of people and social events, in that actors are seen as having (if not necessarily using) the ability to change and respond differently.

Glaser and Strauss also brought different skill sets to their collaboration, and the combination of their worldviews created an innovative and unique research method. Glaser was trained as a quantitative researcher, and he incorporated positivist epistemological assumptions and a systematic approach into grounded theory. In contrast, Strauss was initially trained in ethnography and drew on symbolic interactionism and other sociologically orientated paradigms (Chun Tie et al., 2019). Charmaz (2020) would argue that the fundamentals of grounded theory contain both positivistic and interpretivist undercurrents. The commitment to a systematic technique reflects Glaser's positivist roots, while the Straussian emphasis on social processes and the relationship between individuals and the environment reflects Strauss' interpretivism.

Over time, Strauss and Glaser began to differ in their approach to grounded theory. Strauss began to align more closely with his symbolic interactionist ideas and thus moved to a more interpretivist stance on analysis (Corbin, 2013). Glaser primarily stayed close to their original method, but Strauss partnered with his ex-student, Juliet Corbin, to advance a differing perspective on grounded theory: their work culminated in the publication of the influential text, *Basics of Qualitative Research* (1990). While both schools retain many of the central methods that define grounded theory, such as theoretical sampling, constant comparison, theory development, and memo writing, there are notable differences between the two schools of grounded theory (Charmaz, 2021b).

The primary differences concern the analytic process, the corresponding coding approaches involved, and the nature of the theory that develops from these processes. Strauss and Corbin called for a more structured analysis. They introduced, for example, a third coding category called axial coding; a type of code that explores and defines the connections and conditions between the open codes (Scott & Medaugh, 2017). Corbin and Strauss re-emphasised the *creation* of data gathering and thus moved away from the *emergence* of a theory that Glaser still championed (Kenny & Fourie, 2015).

According to Charmaz (2020), Glaser retained a firmer focus on emergent concepts and theory construction compared to Corbin and Strauss. Instead, Corbin and Strauss focused more on verification and adding preconceived techniques to the data to develop a theory. Glaser remained critical of Corbin and Strauss' ideas, and argued that the techniques they were proposing were overly complicated and inhibiting and risked forcing data into preconceived categories (Glaser, 1992). Glaser believed in an approach that stripped away anything that could convolute the emerging concepts, such as a researcher's assumptions and past knowledge or research techniques like coding structures.

Regardless of the school, I am drawn to the challenging, almost anti-establishment ethos that underpins grounded theory. The foundation of grounded theory is a desire to uncover and illuminate social life through active inquiry and the development of a theory to encourage change and understanding. According to Charmaz (2008b), grounded theory is now very much a part of the established world of academia and is the most cited and used qualitative method in the social sciences. But beneath its considerable credibility and standing in the world of research lies a method that is comfortable asking the uncomfortable questions and seeking out ideas and insights that might otherwise be quickly side-lined or ignored.

## Methodological considerations

The following section introduces and explores the central methodological implications for a constructionist grounded theory study and how these implications have impacted on the data analysis. The central methodological implications are the presence of multiple voices within the data, and the significance of the position the researcher holds in the process. The importance of maintaining methodological self-consciousness, and the role of theoretical sensitivity in an analysis are also considered.

Each of these methodological perspectives encourages a sharper, more focused deconstruction of the research question. They also encourage rigour, accountable practice and, perhaps most crucially, they encourage an ethical and self-aware stance of the researcher and analysis.

## Multiple dialogues

The grounded theory method is typically interested in understanding the inherent complexities in different perspectives of a social experience (Birks and Mills, 2015). However, Appleton and King (2002) state that constructionist researchers are especially drawn to the multiple voices and the contradictions in those voices. Constructionist research allows the participants space to describe their reality and express their unvoiced experiences of their lives. In my research project, the participants describe the world of a public healthcare system, and the act of therapy. From a constructionist perspective there is no single ANZ healthcare service or even a ‘true’ form of therapy: each participant constructs a new experience of life in the ANZ healthcare service, and each participant views the notion of therapy from their unique vantage point.

The grounded theory method recognises the multitude of perspectives and points of view and opens the possibility of exploring the contradictions embedded in people's experiences. As Charmaz (2020b) notes, in constructionist grounded theory, the differences in language between those in power and those that are not, is especially significant. Charmaz (2020b) suggests that a constructionist inquiry can also hold a critical stance on how the social world is structured and maintained. Constructionists are free, if not *obligated*, to pursue an analysis that illuminates injustices and irregularities. Once unshackled from the obligation to reduce ideas to an inherent (and often singular) truth, the researcher can consciously, and as part of their method, give voice to those who would otherwise be silenced or marginalised.

This study involves a population of professionals who seem empowered and aligned with the dominant narrative. They have status, resources, and opportunity to shape or influence their environment. Essentially, the clinical psychologists seem to enjoy a stable and productive relationship with the ANZ healthcare service, and a clear understanding of their role and skills. However, data analysis reveals an unacknowledged participant narrative, and a set of institutional processes that disempower, marginalise, and negate the social experience of psychologists working in public healthcare. This undercurrent in the analysis was revealed as a result of the use of constructionist methodology.

## The positionality of the researcher

In Glaser and Strauss' original grounded theory, the observer can and should maintain a position alongside the findings: the researcher is conceptualised as a neutral and detached presence in the research process (Birks et al., 2019). However, Charmaz (2008) argues that objectivity is a questionable goal in constructionism and that what researchers perceive as objective, still contains "partial knowledge and particular positions" (p. 402).

Consequently, constructionist researchers must acknowledge that they take material into their research process. This view differs from the classic grounded theory stance. Glaser (2007) argues that the material a researcher brings to the research process is an inevitable and valuable part of the process. However, Glaser treats these assumptions as "just another variable" (p. 95) that must be factored into the analysis and addressed through constant comparison and data review. Essentially, Glaser sees bias as something that needs to be controlled.

Charmaz (2008) and Clarke (2005) challenge the classic position in this regard. Both argue that researchers and their positions, privileges, perspectives, and interactions affect the research outcome. Clarke (2005) draws attention to *positionality*, or paying attention to where the researcher and participant are located in social space and time. This perspective has significant implications. First, the treatment and analysis of data and participants are never clean or pure in an objectivist sense. Second, the implication is that the researcher needs to be sensitive and alert to their position and assumptions.

## Methodological self-consciousness

Constructionism asks for an in-depth exploration of the *why* and not only the *how* of a social process (Holstein et al., 2013). The question of *why* often drifts into moral and ethical territory. In this regard, Charmaz (2016b) challenges grounded theory researchers to examine our own ethical and moral positioning and to account for the impact that this has on the experiences of participants. Charmaz (2016b) calls this process “methodological self-consciousness” (p. 3), which involves a deeply reflexive examination of the researcher’s values, standpoints, and actions.

According to Charmaz and Belgrave (2019), methodological self-consciousness involves two reflexive processes. First, the process involves a “searching self-scrutiny” (p. 750) beyond what qualitative researchers typically engage in. Second, researchers embrace a process of profound and ongoing self-reflection that involves learning to recognise how our worldviews, language, and meanings enter the research process, and affect participants in tacit ways (Charmaz & Belgrave, 2019).

Alongside this interpersonal reflection, methodological self-consciousness involves being cognisant and alert to the taken-for-granted privileges that researchers gain from their roles and positions (Charmaz, 2017b). Constructionist grounded theory means being aware that researchers, often by consequence of their education, role, or position, can maintain an influence that shapes what participants can express and reveal. Therefore, Charmaz (2017b) calls on researchers to be carefully attuned to the interpersonal and situational factors that inform what we, as researchers, present to participants and research processes.

Similar to Clarke (2005), methodological self-consciousness also requires awareness of the researcher's location in the inquiry. Harding (1991), for example, encourages researchers to stand behind participants and view the cultural and social landscape from their perspective. This view is especially pertinent considering that qualitative research frequently involves populations experiencing prejudice or disempowerment. Regardless of how much agency and influence one has, most people are subject to unwanted or prejudicial influence by those with more power.

Therefore, constructionist thinking raises a dilemma: how do researchers occupy the role of research, with all its inherent power dynamics and privileges, while empowering participants to be part of creating the social narrative of the research? Charmaz (2020b) champions a simple but powerful suggestion: do the research *with* people and not *on* people. This stance is ultimately what Charmaz, Clarke, and Harding are suggesting: the position that we take, and that which we empower others to take, matters.

## Theoretical sensitivity

The positionality and methodological self-consciousness of a researcher are influenced by the researcher’s theoretical sensitivity or prior knowledge. This is a much-debated issue, and each school holds a differing perspective on accessing literature before analysis and preconceived assumptions. According to Thornberg and Dunne (2019), in classic grounded theory, prior knowledge should be set aside and even ignored in the foundational stages of the analysis: bringing prior knowledge and assumptions into the research confounds the outcome, and dilutes the theory.

According to Charmaz (2008b), Corbin and Strauss adopt a more inclusive stance compared to classic grounded theory: they recognise that prior knowledge brings depth and clarity to the analysis. Corbin (2013) would add that theoretical sensitivity opens the researcher to theoretical possibilities and insights, but that the resonance of the data is ultimately still located through the analysis. Therefore, properly integrated prior knowledge should not impede the discovery of the theory. Generally, constructivist grounded theory offers a significantly divergent perspective. Charmaz (2020b) suggests that our exposure to literature and prior knowledge can and should be acknowledged in the analysis. I am, for example, very familiar with the theory that there is a collection of common factors embedded in all forms of psychological therapy (Cuijpers et al., 2019). I was mindful of this theoretical perspective as I conducted interviews, both as a resource in understanding the nature of therapy, and as a potential personal bias.

Theoretical sensitivity involves more than the application of our prior academic knowledge. Theoretical sensitivity refers to the level of insight of a researcher, and their sensitivity to the nuances and complexity of the world under investigation (Hallberg, 2010). According to Corbin and Strauss (1990), theoretical sensitivity allows the researcher to discern and separate the pertinent information from what is not. It is the sum of all that researcher has learned, experienced, and been exposed to, and what they assume about the world; and it is the process of using this knowledge to sharpen their analysis. In this way, the researcher also accounts for their voice in the analysis and uses their theoretical sensitivity as a sensitising concept to explore the data (Birks et al., 2019).

For Charmaz (2014), prior knowledge consists of the researcher's unacknowledged assumptions, privileges, and positions in social life, as well as their professional and academic insights and biases. It is challenging for a researcher to extricate themselves from their worldview, and from their own history. Charmaz (2016b) advocates that researchers acknowledge their prior assumptions, precisely because they engage actively with the social world and learnt knowledge, constantly participating in, and constructing their social reality of the world. In this regard, researchers cannot ignore or set aside their own assumptions until a convenient time.

I occupy a unique position in this study in that I also work in an ANZ healthcare service as a psychologist. Consequently, I have had experiences and hold perspectives similar to those of participants. I have also held various formal leadership roles in the ANZ healthcare service and therefore, I am sensitive to the organisational perspective. In this context, I acknowledge that I am not a completely neutral social scientist. However, working in a constructionist-informed way allowed me the space and tools (such as positionality, methodological self-consciousness, and theoretical sensitivity), to contextualise the inevitability of my position in the research area. This contextualisation informed my discussions with supervisors and my memo writing: constructionism provided me with the concepts and vocabulary to express this tension.

## Conclusion to methodology:

This chapter describes the methodology of my study. It presents a rationale for using grounded theory as a research methodology. It specifically, emphasises the grounded theory model’s applicability to researching social processes in complex organisations, by drawing a thread through grounded theory studies in health service contexts, then mental health, and finally in mental health organisations. My epistemological position is introduced and the relationship between constructivism and constructionism is addressed. I also describe how and why I bring my epistemological views into my research choices and interests.

I introduce grounded theory as a method and trace its history and evolution. Importantly, the history of grounded theory and the ways it has evolved illuminate many of the tensions and difficulties inherent in using this method. I focus on the relativist side of the grounded theory continuum, and I describe how constructionist grounded theory distinguishes itself within the broader grounded theory family. The next section describes how these methods were used in my research project.

# Chapter 4 Method

Chapter 5 outlines some of the key grounded theory methods and describes how these methods were implemented in my study. Corbin and Strauss (1990) and Charmaz (2006) caution that grounded theory techniques and methods are not prescriptive and should be seen as guiding ideas. According to Charmaz (2006), the intention of the grounded theory method is to provide a way of thinking about data analysis, rather than a set of procedures to be implemented. Nonetheless, several specific methods define the grounded theory research process.

Sections two and three describe the various processes completed to ensure an ethical and sound study. The fourth section presents the central components of a grounded theory research design. The fifth and sixth sections describe the steps taken to engage with participants, the preparation and processes for the interviews, and the considerations I needed to focus on while conducting interviews. I also describe the sampling process and the rationale for the approach from a grounded theory methodology. I discuss the data gathering process, and comment on the co-construction of the research and the interdependence of the researcher and participants. Section seven uses Charmaz' constructionist-informed grounded theory coding perspective to describe the analysis. Again, I explore the central components of the grounded theory method and review the quality of the study's design using Charmaz' (2006) and Corbin, and Strauss' (2008) ideas concerning the characteristics of quality or trustworthiness in a grounded theory study.

## The approval process

An AE1 Ethics Approval form was submitted on 8 March 2018, to the Auckland University of Technology (AUT) research board and was approved on 24 April 2018 (see appendix B). The AE1 submission indicated that none of the participants were likely to be vulnerable persons, and the implications of the sample containing *Tangata Whenua* was considered. There were no significant ethical concerns during the research raised by participants, the researcher, or supervisors.

The following sections describe the various ethical considerations relevant to this study. In particular, I examine the ethics of engaging with participants and the means to collect and store information.

## Ethical considerations

Birks and Mills (2015) describe three central principles of an ethical study. First, in their view, a researcher is obligated to ensure participants can exercise autonomy and capacity for self-determination during the research. Second, the researcher must ensure that the project’s outcome has tangible benefits for the population in question and that these benefits are presented in an accountable and applicable manner. Third, the researcher needs to ensure that the participants experience no harm or discomfort during their involvement. The three principles of autonomy, empowerment, and safety, form the bedrock for this project's guiding ethical principles.

This study was conducted in Aotearoa New Zealand, where we acknowledge the significance of Māori as *Tangata Whenua* (people of the land, or people who identify as Māori). In the event of the study including any potential Māori participants, I had planned to seek the consultation of a kaumātua within our ANZ healthcare service. This would ensure that my interactions with potential participants and subsequent analysis of their transcripts were conducted in a culturally safe and respectful manner. I do acknowledge that I live, work, and conduct research within a multicultural society, and that all social aspects, and especially the delivery of healthcare is experienced through a multicultural lens. For this reason, I took care to ensure representation of Māori and indigenous academics in my literature review and data analysis. This step was in place to ensure contextual information for any potential participants who identify as Māori.

A central aspect of an ethical study is how participants are treated and engaged in the research process (Charmaz, 2020b). I took care to approach and select potential participants respectfully and safely. I elected to use email to introduce myself and the study. This was done to minimise any risk of coercion and ensure that the participants had the time and privacy to contemplate their involvement. I also sent them a brief email summary of the study as an introduction, to give them a manageable amount of information to consider. If a potential participant expressed interest, I sent a more comprehensive description of the study (see appendix C). In this way, ambivalent or disinterested candidates did not need to read through too much information unnecessarily. The participants were also emailed a copy of the consent form to review, which they were invited to sign and return to me. However, in practice, most participants acknowledged reading the consent form, but elected to sign a printed copy that I brought with me to the interview: this task was addressed at the beginning of the interview. See appendix D for the consent form.

The research design and ethical management outlined in my EA1 application form were informed by my obligations under the HPCA Act of 2003 to protect and uphold the health of New Zealanders. The audio files and transcriptions were stored on a password-protected computer, and any reference to participants was initially in a two-letter code, and later a pseudonym, to ensure the participant's privacy. The data protection protocol is outlined in Appendix E. The only third party who knew the identity of participants was the transcriber, who signed a confidentiality agreement (Appendix F). I also ensured that any identifying details were excluded or concealed while writing the results. In the case of one participant, I took extra steps to remove gender identity as the participant has a high-profile role and was expressly concerned with privacy breaches.

I also thought carefully about the venue and circumstances of the interviews. I ensured that the participant selected a venue of their choosing, and I reminded them of how important comfort and privacy would be to the process. All participants suggested an appropriate venue (either their private office or mine). In the case of this research, all participants had experience in conducting sensitive conversations and had past research experience, ensuring a prudent choice of venue. During the interview, I orientated participants to the process, introduced myself, and briefly outlined my hopes and expectations for the interview; namely that they would feel free to be candid and comfortable expressing their perspective.

With the exception of the first three interviews, all the transcripts were emailed to a transcriber via a password-protected dropbox. As per my sensitive data safety protocol, the designated transcriber transcribed, emailed, and then deleted the files. I selected a well-regarded transcriber in the academic community to ensure that the confidentiality of participants would be maintained and that their data would be treated with respect. I offered to send participants their transcript following the interview and indicated that changes or clarifications would be welcome.

I also offered participants opportunity to select a pseudonym. This can serve to include participants in co-constructing the research design and also affords them a chance to personalise their contribution without breaching confidentiality. The majority of participants were did not take the opportunity to read the transcript, and most were happy for me to select a pseudonym. At the end of interviews, I spent a few minutes debriefing about the process and engaging in some light conversation to help ease the participants out of the interview context.

## The grounded theory methods used in this study

The following sections describe grounded theory methods used in this study. As has been discussed, grounded theory provides a collection of well-established research methods and analytic devices that aid in gathering data and analysing and conceptualising that data. These include concurrent data collection and analysis, purposive and then theoretical sampling, an inductive coding paradigm, and memoing (Belgrave & Seide, 2019a).

The following sections explore each of these stages of the research in more detail. The first section details how the data in my study was collected, and describes the participants involved in the data collection.

## Data collection

The following section describes the processes involved in data collection. Sampling is a common process in research that involves identifying and engaging with potential participants for the purposes of data gathering. From a constructionist perspective, sampling involves selecting and inviting participants to be part of a co-constructed description of a social phenomenon based on their knowledge of the area (Tracy, 2019). Charmaz (2014) adds that the goal is to enrich and develop a description of the social world through interaction with, and contributions from, the participants, existing literature, and the researcher.

### Inclusion criteria and rationale

To ensure that knowledgeable and informed potential participants were invited into the study, a number of inclusion and exclusion criteria were applied, as illustrated in Table 1.

**Table 1**

*Inclusion and Exclusion Criteria.*

| **Inclusion Criteria** | |
|---|---|
| A | Registered with the New Zealand Psychologist Board and presently practising psychological interventions. |
| B | At least three years of experience. |
| C | An expressed interest and confidence in working with the interpersonal aspects of psychological therapies. |
| D | Experience in working in a ANZ healthcare service. |
| **Exclusion Criteria** | |
| E | New graduates or professionals still in their early years of working life. |
| F | Psychologists working within one of my own clinical teams. |

*Table 1 - Inclusion and Exclusion Criteria*

The selection criteria solely focused on psychologists, despite many other competent and skilled professionals participating in psychological therapies. This decision is justified for two specific reasons. First, psychologists in healthcare organisations are a vulnerable population, with increased risk of burnout, staff attrition, and mental health problems directly resulting from organisational stressors (Levinson et al., 2021). Understanding the experiences of psychologists dealing with stress and attrition and how they manage this stress, is essential to maintaining a functional public healthcare system. Second, almost one-fifth of psychologists work in a ANZ healthcare service (Waitoki & Levy, 2015). Understanding the experience of working in this public healthcare service is therefore especially significant to the development of the profession in Aotearoa New Zealand.

I also wanted a broad range of perspectives within the profession, and to hear from psychologists who hold distinct perspectives on the ANZ healthcare service. For this reason, mixed roles (such as those in policy and clinical work, or those in part-time or leadership roles) were not excluded as possibilities. This looser approach to the inclusion criterion is in keeping with the ethos of grounded theory, that the data should lead the inquiry and that participants should be selected because they may provide insights into the data.

## Sampling and recruitment

Psychologists were recruited in accordance with the protocol outlined in the ethics approval process. Initially, I emailed two highly regarded senior psychologists, who agreed to meet with me and participate in the study. This was useful because they had worked in several different roles across the healthcare service. These initial participants also provided me with a shortlist of possible candidates and a better understanding of the social structure of the psychology cohort of the ANZ healthcare service, enabling a more systematic sampling in the later stages of theoretical sampling.

In some cases, initial participants approached potential candidates on my behalf. Other possible participants were contacted via a brief email, according to my ethics approval plan. If they agreed to participate, I sent additional information, and negotiated a time for the interview. I had anticipated that participants would reply via email, but they instead frequently approached me in passing, or called me on the phone. I would still email the appropriate documents to ensure that they had a complete understanding of the process and access to relevant information.

Any qualitative study intends to gather information from informed and knowledgeable participants who can illuminate and broaden the understanding of an issue. Sampling in grounded theory involves pursuing ever-enriched theoretical concepts (Charmaz, 2014). In grounded theory, there are two sampling processes to achieve this goal. Initially, the researcher approaches participants who may hold valuable information about the research topic. This is a form of *purposeful* sampling that typically involves a small and diverse sample to keep the enquiry as open-ended as possible (Birks et al., 2019). During this stage of my project, I also utilised aspects of *snowball* sampling, which involves asking the initial participants to recruit or suggest participants based on their insights into the population. (Patten & Newhart, 2017).

The mixture of different sampling techniques also illustrates that grounded theory is an approach to the analysis of data and can incorporate other research methods (Charmaz, 2008). Once a provisional body of data was gathered, I began developing preliminary theoretical concepts through my initial coding phase. These theoretical concepts guided the data gathering, the unfolding sampling process, and analysis. Of course, researchers cannot be sure where – or to whom – their preliminary theoretical concepts may take them. But in this way, the second phase, *theoretical* sampling, was introduced. Theoretical sampling shifts the focus and explores developing concepts, and not participants (Charmaz, 2008b).

New concepts were developed through subsequent data collection, and findings were empirically scrutinised against new data from interviews. Successive potential participants were then selected because they may shed light on inconsistencies or abnormalities in the theoretical concepts or provide information that further developed existing concepts (Charmaz, 2016a). Grounded theory researchers consider their data gathering and analysis complete once they reach *theoretical saturation*. This is when the new data no longer elicit any new insights into the theoretical categories that have been developed, and the category is fully explained (Charmaz, 2014).

### Participant characteristics

In total, 17 clinical psychologists were interviewed for this study, all of whom were clinical psychologists registered with the New Zealand Psychology Board (NZPB). All participants had completed masters or doctoral-level training in psychology. Participants all receive supervision from an experienced psychologist and use this time to sharpen and refine their perspectives on their working environments. They are also expected to maintain their clinical skills through a self-directed continuing competency plan for each year and embark on a sustained and continued reflection and professional development process.

Participants were all employed at an ANZ healthcare service. Some were part-time, and some were in leadership roles. The participants held, or *had* held, a caseload of clients with clinically significant mental health concerns and were responsible for providing psychological therapies in keeping with their training and the needs of clients. Participants were also involved in other clinical activities such as assessment, addressing urgent cases, or group activities. In addition, participants would routinely attend multi-disciplinary team meetings (MDTs) to review cases and receive and provide feedback to colleagues.

**Table 2**

*Participant Demographics*

| **Participants’ Training Background** | |
|---|---|
| Trained in NZ | 10 |
| Trained in South Africa | 5 |
| Trained in the United Kingdom | 1 |
| Trained in Hong Kong | 1 |
| **Working background** | |
| Adult mental health | 3 |
| Child and adolescent mental health | 5 |
| Perinatal services | 4 |
| Management role | 5 |
| **Ethnicity** | |
| NZ European or European | 11 |
| South African | 5 |
| Chinese | 1 |
| **Gender** | |
| Male | 5 |
| Female | 12 |
| Other | 0 |

*Table 2 - Participant Demographics*

### Participant setting

Participants worked in four different DHBs within the ANZ healthcare service. These were the three Auckland DHBs (Counties Manukau, Waitemata, and Auckland Central), and one in the Great Lakes district which is in the north-east of the North Island (Te Ika-a-Maui). Auckland hosts most New Zealand-based psychologists, and the highest portion of New Zealanders live there. The sample offers a window into urban and rural psychologists' experiences in ANZ healthcare services.

The nature of an ANZ healthcare service and its relationship to psychology are crucial aspects of this study. Working in a challenging and fluid community setting asks more of psychologists. A psychologist operating in a public healthcare service setting needs to accommodate far more socio-political and cultural considerations than what is typically associated with clinical psychology (Gibson et al., 2001). They also must work with a diverse range of professionals in an organisational structure dominated by the medical model (Wahass, 2005). In this way, the ANZ healthcare service proves an illuminating environment to explore the experience of a psychologist.

## Data generation

Data were generated using individual, semi-structured face-to-face interviews. Structured interviews, focus groups and online surveys, which are common data gathering approaches in qualitative research (Tracy, 2019) could have been used. However, I selected semi-structured interviews conducted in a conversational tone as, according to Charmaz (2006), semi-structured interviews allow participants the opportunity to explore ideas and perspectives and leave space for unexpected narratives and avenues of discussion.

## Conducting interviews

Charmaz (2006) differentiates between “informational interviewing” (p. 25) and conversational interviewing. The latter provides possibilities for a greater depth and range of information, encouraging dialogue and a reciprocal feedback loop between the researcher and participant. (Charmaz, 2021b) also notes that a thoughtful and empathetic interview allows the researcher and participant to share a safe experience. Interviews allow participants to share their emotional experiences of what they have experienced, and the privacy allows for gentle and empathetic probing.

The majority of the interviews were an hour, with some of the final ones being briefer and more focused. Toward the end of data gathering, some interviews were conducted via telephone, including follow-up interviews. This was due to both the limitations of face-to-face contact due to the COVID-19 pandemic, and the location of some of the participants. Notably, telephone interviews are not considered detrimental to establishing rapport or data gathering: K. Ward et al. (2015) found that telephone interviewing did not compromise the interview process, and that many participants described telephone conversations as convenient and more engaging.

I began the interviews by explicitly mapping out the territory of the inquiry, namely that the focus was on the experience of working within the ANZ healthcare service, as opposed to experiences in private practice or academic institutions, and on the process of therapy, as opposed to a psychologist's other clinical tasks. The first interviews were grounded in six to eight broad questions (see Appendix G) to approach the research question with an open mind and encourage description of the lived everyday experience of psychologists.

I often began with broad opening questions. These included examples such as, "Can you describe your journey to your present role?"; "Can you describe your present role?"; "What is it like working in the New Zealand healthcare service?"; "What does therapy mean to you?" and "In what way does working in a public healthcare service impact providing therapy?" Additionally, many of the first interviews began with a run-through of the typical role of a psychologist, including the everyday pressures and challenges of the role, and how participants experienced these. Often, I would open with a simple request such as “Tell me what it is like working at your clinic or hospital”. This was to ensure that the interviews did not begin with a narrow focus and to ensure the creation of a climate of open-mindedness and curiosity (Charmaz, 2014). Additionally, I avoided imposing my agenda or assumptions from the outset.

Each interview began with an opportunity for participants to orientate themselves in the interview. They did this by introducing themselves, their experiences of interviews in the past, and some outlined their expectations and reservations. I reminded participants of the bounds of confidentiality, my obligation to share the transcript and findings with them, and my obligation to honour any requests they had. I endeavoured to remain sensitive to the experience of being in an interview. I drew on Charmaz' (2006) descriptions of interviews as “contextual and negotiated” (p. 27) processes. Charmaz talks about interview stories being the construction of reality, but framed by the interview process. I was careful to acknowledge and leave space for the political and interpersonal implications of talking about colleagues and employers. In essence, I attempted to remain sensitive to the experience of talking about an ANZ healthcare service while working and, often quite literally, sitting in one.

During the later stages of analysis, I would often structure interviews around the primary concepts that participants were describing. As the interviews progressed and the developing theory came into focus, I noticed myself asking questions differently. I was more inclined to say, “Others have said that…”; or “something that seems to come up is…” or “I was wondering about… and what do you think? or “What do you think is missing in this description?” These types of questions highlight the nature of a grounded theory inquiry. The process moved to the pursuit of an idea located somewhere within the diverse narratives of the participants (Charmaz, 2014). I was careful to foster a collaborative and inquiring culture in later interviews. I would also describe my tentative interpretations and inconsistencies in the data. I encouraged frank and critical feedback from participants. allowing the participants to truly co-create the theory and even participate in the conceptual elevation of ideas (Losantos et al., 2016).

### Locating the researcher and participants in data collection

From a constructionist perspective, the researcher can never claim to extricate themselves from their research process, but rather the focus should be on acknowledging the researcher's impact on data gathering (Charmaz, 2014). My experiences as a psychologist in the ANZ healthcare service were a contributing factor to the content and tone of the interviews. I had to pay close attention, for example, to my interpersonal style and the impact that may have been having on the interview: I am a psychologist by training, which lends itself to a certain approach to gaining a participant's confidence. Consequently, I had to remain vigilant to any leading or presumptive questions and any tendency to allow the interviews to stray from the research agenda into deeply personalised territory. This was especially challenging in initial interviews, which were more open-ended, and less so as the unfolding theory imposed some structure and direction on the later interviews.

I also made a conscious decision to focus on the interpersonal aspects of psychological therapies, and I did not expressly focus on participants' implementation of evidence-based interventions and protocols. This is an example of the requirement that researchers set parameters for and contain the range of their inquiry to produce a manageable study. It is also an example of how my assumptions, agenda, worldview, or theoretical sensitivity may impact the collected data (Charmaz, 2014).

The following section discusses my approach to analysis of the data. Grounded theory differs from other qualitative research methods because analysis and data gathering happen simultaneously (Charmaz, 2014). While these two sections are presented as discrete processes, they happen in conjunction and simultaneously.

### Analysis and development of the theory

One of the central processes in grounded theory research is the development of increasingly abstract and conceptual codes. The initial codes are collapsed into higher-order focused codes that encapsulate an integrated and encompassing concepts. These form the theoretical codes that become categories of the theory (Birks et al., 2019). This is how grounded theory is constructed from the data: there is an interwoven process of data collection, coding, and analysis.

Grounded theory has a collection of well-established methods for coding and analysis, some of which were utilised in this study. These include conceptual coding devices, memoing, constant comparison of data, and theoretical sensitivity (Birks and Mills, 2015). Charmaz (2014) encourages researchers to keep their coding approach loose and flexible, and, in this way, the voices of participants are not restricted or confined to a rigid coding structure. Nonetheless, Charmaz (2014) propose guidelines and suggestions for meaningful analysis, many of which were invaluable to this analysis.

### Coding techniques in grounded theory

There are variations in coding within the differing schools of grounded theory. Glaser and Holton (2005) provide the foundational framework for grounded theory coding, and suggest that there are essentially only two types of codes in grounded theory studies: these are substantive and theoretical codes. According to Belgrave and Seide (2019b), substantive coding defines structures and the data field, while theoretical coding captures the relationships between substantive codes. Birks and Mills (2015) note that all grounded theorists use this process, and typically use a combination of initial, intermediate, and advanced coding to build their conceptual model of the data. While it is essential to acknowledge the methodological principles that underpin these foundational coding structures, this study primarily draws on Charmaz’ (2006) coding approach.

I used Charmaz’ (2014) model of initial, focused, and theoretical codes to organise my data analysis. I also analysed and developed the codes using constant comparison between and within all the codes, categories, and concepts of the study. The intention was to ensure that the data is robust when reviewed and compared. Any anomalies or discrepancies in the developing assumptions or connections were highlighted and discarded (Charmaz, 2014). Simultaneously, any similarities, differences, and nuances that add to a more abstract and integrative description were refined (Tweed & Charmaz, 2012).

Initial coding involves a line-by-line dissection of the data, and the fracture of the data into smaller pieces, often in the form of *in vivo* codes. An example of my initial line-by-line coding is provided in Appendix H. Charmaz (2014) encourages a high level of detail and a pedantic and meticulous approach to initial coding, which minimises the possibility of discarded important information and ensures that the researcher and analysis stay close to the text. Charmaz (2014) also encourages a close reading of the text by using gerunds (words used as nouns that end in ‘– ing’; for example, *negotiating* or *navigating*). This imbeds a sense of social process in the coding and keeps the focus on the actions of participants.

Building on this phase, Charmaz (2014) suggests that more abstract and encompassing *focused* codes can be developed. These focused codes represent a more conceptual and integrated interpretation of the data and start to form the basis of the theory's theoretical and conceptual codes and categories. *Theoretical* codes emerge from the patterns in the earlier codes and lend form to the focused codes. Theoretical codes form a conceptual narrative that describes significant patterns and concepts that underpin a collection of intermediate or focused codes (Birks & Mills, 2011). Grounded theorists also endeavour to develop a theory or single central idea that encapsulates the social processes illustrated by the categories and sub-categories. The central theory is often the study’s essential point. The fundamental idea integrates the theory into a succinct and meaningful perspective (Corbin & Strauss, 1990).

My initial coding process involved the following stages and processes. I transcribed the first three interviews personally. I did this in sequence, as soon as possible after completing the interviews. This was done to encourage familiarity with the data. Charmaz (2014) suggests that the researcher do the transcribing to ensure a close reading of the data, which helps build an intimate connection to the material. I also coded each transcript before proceeding to the next interview. I did this to stay as immersed in the text as possible and to build a rhythm of data gathering and analysis from the outset. Similarly, I also set aside time to memo my initial impressions on the same day. I hoped to capture both my initial impression and ‘gut’ responses. I wanted to benefit from a comparison with the reflections I would have in the weeks following the interviews. After the first three transcriptions, I re-listened to the interviews and made notes and memos. I then used a transcriber for the remainder of the interviews due to time constraints. I also arranged for some of my supervision sessions to be transcribed to aid my memos.

I was new to coding at the beginning of this project, and my supervisors encouraged me to explore coding methods. In essence, my initial coding of interviews was as much an exploration of the art and science of coding as it was an exploration of participant input. In the early stages of coding, I also experimented with various coding approaches, including strategies such as “versus coding”, “values/attitudes/beliefs coding”, and “dramaturgical” coding (Saldana, 2016). Ultimately the basic tenants of grounded theory were the most instructive in the process. I was primarily informed by Charmaz' (2014) directive to allow space for creativity and intuition in coding, and by her practical and useful techniques. Nonetheless, I contend that the initial experiments in coding served to bring a new lens to the early data: the experimentation encouraged rigour and accountability in my process and sharpened my technique. In this regard, the experiment was invaluable.

Following the approach that Charmaz (2014) suggests, I used in vivo codes in the initial coding process. This ensures that the voice of participants is represented, and the authenticity of their views is maintained. In this study, some of the early in vivo codes remained a prominent part of the analysis even as I moved to a more conceptual description. Examples of this include participant statements like “close the door” or “just keep my head down” and “it’s a journey”. From a constructionist perspective, Charmaz (2014) argues that in vivo codes can also serve to ensure the voice of participants is represented and that they co-create the narrative of the theory in a very practical way.

I also found that using gerunds helped create a reliable and consistent approach to coding and served as a way of anchoring my perspective as I grappled with coding skills (Charmaz, 2014). However, gerunds also served another important analytical function: I noticed that many participants were following a relatively consistent pattern in their descriptions of their experiences. First, they would describe something stressful or incapacitating, and then they would frequently emphasise their responses and reactions. Using gerunds kept the focus on the proactive and resourceful aspects of participants’ reported behaviours, and kept the analysis grounded in actions and reactions. The participants' resourcefulness and proactive stance is a central aspect in this theory. By using gerunds as the fundamental building blocks of the coding process, the analysis embedded this important element from the outset.

I also benefited significantly from focusing on anecdotes and stories inserted in interviews. Charmaz (2016b) argues that the stories participants tell reveal more than just their content. They allow us an opportunity to immerse ourselves in the experience of the participants, and they locate the participant and their experience at a specific time and place of the participant’s choosing: we are privy to viewing the world through their experiences. In this way, anecdotes can be an evocative and immediate way of locating the storyteller in their world. An example of this is one of the participants, Dora’s (a pseudonym) description of her first public healthcare role in rural New Zealand. As a preamble to the interview, Dora described her difficulties in assimilating into a new community illuminating a profoundly personal experience of vulnerability that a professional can feel in a large organisation. Her story conveyed the power of belonging, the experience of being an outsider, and the enormity of the challenge of integrating.

### Moving from initial coding to focused codes

The initial coding stage consisted of groupings of codes, mainly in the form of gerunds and often using direct quotes from participants. As I reflected on the first three interviews, I noticed a few central experiences that seemed consistent across many initial codes. Examples included the impact of training, the power imbalance between psychologists and doctors and the difficulties managing high caseloads.

These initial codes were grouped around loosely connected descriptions using data clustering in visual maps. I used the software package Quirkos which organises coding segments into colour coded bubbles. Quirkos is very helpful in arranging a matrix of codes into a visually integrated visual structure. This also helps facilitate constant comparison in an analysis, as you can see the codes interacting with each other. An example of the role the Quirkos software played in the study is illustrated in Appendices I and J. In appendix I, it is visually obvious that the earlier coding structure was convoluted and cluttered; however, through the process of constant comparison and by conceptually integrating codes, I refined the code structure and distilled the data to its central focused codes: this is demonstrated in appendix J.

As I progressed from my earlier coding structures, I also started to weave in conceptual ideas that are suggested by the initial codes. The following memo illustrates the process of working with a collection of initial codes, a process of constant comparison, and the conceptual developments of the earlier stages of the interviews. In this memo I outlined some provisional ideas that incorporate groups of codes that eventually became the theoretical code of *allying*.

***memo - Unpacking the Codes PART I***

***throughout Feb 2020***

***Aligning** with clients:*

*This is about **bringing in cultural supports to forge a relationship** – aligning is thus about creating a space for the voice of the ancestors, cultural heritage, or community within the therapeutic conversation. Aligning means bringing culture into the therapeutic relationship to forge a new oneness…*

- *“I can definitely see the difference when I have cultural support in the beginning” (KH).*

*This is about **molding your appearance and presentation to make yourself more relatable to your clients.** This might mean changing your appearance, thinking carefully about the clothes you wear, or even the way you talk.*

- *“It’s really important for you to probably dress appropriately for the community” (LS)*

*Going one step further, it is about **being more authentic in your relating**, and even blurring the lines between your personal and your professional identity.*

- *“drop the sense of divide” (JO)*
- *“I’ve got flaws and failings like everyone else” (JO)*

*This is about* ***acknowledging the big themes of life*** *- or making space for some of the human experiences you would never acknowledge in everyday interactions. this aligns you with their real experience.*

- *“You do not want people to, to feel like they, you will not understand their suffering” (LS)*

*This is about relating to people in a very strategic way,* ***where they grow to trust what you offer, and see value in it*** *– it’s about matching what you offer with what people need…*

- *“trust that you are an expert in what you are selling” (LS)*

*The above point also includes an ability to* ***compel or influence the system to meet client’s actual needs, mostly by following your own alignment intentions****. Its about connecting despite the contrary vibe you get from the institution.*

- *“resist at times, and do what’s, what’s best for, for the clients…” (HV)*
- *NOTE: HV also says something similar which is actually coded under “immersing” – look for “whatever process to make it work for them”.*

*It’s also about* ***listening to your intuition,*** *rather than protocols when dealing with client needs.*

- *“it becomes a bit more intuitive” (FC)*

*CONCLUDING NOTE: I note that all three aspects here are underpinned by a sense of vulnerability. Psychologists are either allowing themselves into vulnerable positions, realizing their own frailty and even using it to connect, or feeling the need to counter the impact of institutionalism and potentially personal risk…*

The above memo demonstrates several aspects of my analysis. Firstly, I used the actual verbatim words of the participants. The use of in-vivo codes is a central analytic device in grounded theory. This approach ensures that the voice of the participants is heard, and that the analysis is grounded in the participants world (Charmaz, 2006). Secondly, I highlighted the conceptual leaps I am making in my analysis. The conceptual leaps are the extracts that are highlighted in bold. By structuring my memo this way, I was able to hold my raw data and conceptual perspectives alongside each other. I was trying to stay cognisant of the ideas I was introducing into the analysis, while ensuring a direct link with the data. I did this because grounded theory requires researchers to always demonstrate that their analysis is clearly aligned with the data (Charmaz, 2014). Finally, the “concluding note” is a far more elevated perspective of the data and was added as an additional thought separate from the analysis at this stage. In this memo the idea of vulnerability is introduced in a tentative fashion; but this idea of *being vulnerable* will develop into a far more significant aspect of the theory in due course.

In this way I moved from a collection of initial codes to focused codes that reflected an integration of the data. An example of the development of focused codes from the initial codes is illustrated in appendix K. Notably, some focused codes (such “cloistering yourself”) were not present in the final analysis; while others were subject to slight but significant conceptual changes (for example, “connecting” became “collaborating”). Moving from focused codes to theoretical codes was also challenging as understanding the conceptual shifts in the data was not always straightforward. I noted, for example, that I was hearing contradictory descriptions: empowered staff described feeling vulnerable, well-trained professionals were under-equipped and psychologists with expertise in interpersonal relationships described feeling peripheral and alone. The focused codes being developed were a mixture of descriptions of social challenges, and descriptions of vulnerability and isolation.

The challenge at this stage of the analysis was to integrate these divergent experiences into theoretical codes or categories. Ultimately, I developed a collection of theoretical codes that became the central components of my theory. As I started to develop a comprehensive theory from the data, I began to rely on other conceptual tools that focused on an integrated perspective of my theory. I refined my ideas, for example, by writing out storylines to encapsulate the theory's essence and ensure that the core idea held up to scrutiny (Birks et al., 2009).

According to Birks et al. (2009), storylines are an excellent device for integrating a theory into a complete narrative and ensuring that the theory is conveyed in an emotive and relatable way. A carefully constructed storyline is a vivid and meaningful account of the theory, written in a way that fits with real-world experiences. I challenged myself to write the theory out to see if the therapy was robust. I took my idea to my non-academic friends and family to see how they sounded to a layperson. I also engaged in spirited debates about my ideas with supervisors and fellow students and invited critiques and comments that I would memo immediately.

### Constant comparison

A feature of a grounded theory study is the use of constant comparison of data, which happens at every level and across the length and breadth of the analysis (Corbin, 2013). Grounded theory endeavours to make constant comparisons between and within all the codes, categories, and theoretical concepts of the study. This constant comparison between aspects at the different conceptual levels is essential for a grounded theory analysis (Charmaz, 2014). Tweed and Charmaz (2012) suggest that the intention is to ensure that the data holds up to review and comparison. Any anomalies or red herrings in the developing assumptions or connections are highlighted and discarded. Simultaneously, any similarities, differences, and nuances that can add to a more abstract and integrative description are identified and developed. In this way, constant comparison is a means to progress the analysis empirically and with accountability.

Constant comparison also allows a researcher to guard against imposed assumptions and premature conclusions. It requires that the researcher check their developing ideas and engage in a critical dialogue around the theoretical concepts (Strauss & Corbin, 1990). Strauss and Corbin also suggest that constant comparison encourages greater precision in the analysis. The data is reviewed and challenged, allowing for nuances and aspects to be revealed and accounted for. Charmaz (2014) adds that a process of constant comparison guards against an unsubstantiated theory and ensures that the new idea has earned its place in the analysis. I engaged in constant comparison of the data. I would return to the raw material routinely to see if codes that seemed to fit were represented in the original data. I checked whether a focused code reflected the text and whether one code was no more than a duplicate or extension of another. This process was then influenced by theoretical sampling, as I found gaps and inconsistencies in the tentative theory; in this way, constant comparison was also applied to checking the theory against newer data.

An example of this is the way I coded the initial exasperation of early participants. They would often describe feeling excluded, overlooked, and dismissed by management. However, during the analysis I approached participants involved in leadership, and they were able to describe psychologists' challenges from a different vantage point. Codes such as "being ignored" were compared to similar ideas by psychologists in leadership, and a new higher-level code was constructed that subsumed these: "misunderstanding each other". Suddenly the concerns raised in the initial interviews took on a new, more informed light when comparing the two data sets and encompassing a conceptual understanding of what both groups described.

This is illustrated in the following memo:

***memoMB1 – The tension between psychologists and organisations 20/1/21***

> *MB (*who is later called Max) *jumps right in and highlights a tension and a stand-off between psychologists' and the organisation. He will go on to illustrate this and unpack it further. But it is telling that it is there right off the bat. He sees it as a tension between what the psychologists want to do and what the organisation wants them to do.*
>
> *It is about actionable steps…*
>
> *But MB does acknowledge that "there are different goals" between the two groups. He does acknowledge that psychologists might say what stops them is their "client-centered" and "evidence-based" approach, which is at odds with the service agenda.*
>
> *This is my first memo from the management group and in general I find MB's comments really striking. He is describing some of the key*

> *ideas (productivity, feeling unheard, the struggle to represent therapy, etc.) but from a different standpoint. The psychologists look much less sympathetic! I wonder what else will come up as I interview more in management? Will they all be as challenging of the psychologists? I wonder what psychologists are going to think when they read these comments?*

This memo illustrates how constant comparison contributes to a significant leap forward in analysing and gathering data. Codes from the management group of participants came to represent the perspective of the ANZ healthcare service; but they also engage in a dialogue with the data provided by other psychologist groups. Throughout the analysis, I used constant comparison processes to check, clarify, and shape the analysis and my relationship to the data.

Interestingly, this memo is also the first time that I used the concept of "a tension between what the psychologist wants to do, and what the organisation wants them to do". This concept became a central concept in the study, and it developed from this process. This interview highlighted why the voice of psychologists in leadership roles was vital to the study. It was clear that I would need more juxtaposition and contrast to develop the theory. Constant comparison influenced how I recoded the initial interviews and how I went on to select the following participants.

### Using memos to advance analysis

Many different qualitative research methods use field notes or keep a research journal in the data gathering and analysis phases of a project (Phillippi & Lauderdale, 2018). In grounded theory, this process is called memoing, a process that serves several important functions reflecting the underlying methodological premises of grounded theory (Kenny & Fourie, 2015). I used memoing to assist my analysis of the data. In grounded theory, memoing is an analytic process that happens during every data gathering and analysis stage. Memoing is an analytical technique that involves noting events and processes in the research journey. Memos take the form of self-reflective notes, summaries, or reminders (Charmaz, 2014).

The goal of memoing is to capture thoughts, hunches, interpretations, and decisions throughout the analysis (Tweed & Charmaz, 2012). Strauss and Corbin (1990) argue that memos are not merely ideas; they are related to the gradual development of the theory. Memos represent a rich source of conceptual material that informs the overall study. I eventually wrote copious amounts of memos from the earliest stages of the study. I would mostly write memos as Microsoft Word documents, and I had a complex process of organising and collating my memos. I also found it helpful to supplement my memos with audio clips. Typically, I would take a break and walk the family dog whilst recording my thoughts and reflections via my phone. Many of these were then transcribed, and all were saved onto my laptop.

Memos also support the reflexive processes of a constructivist informed research project. Charmaz (2014) illustrates how memoing can advance constructivist principles. Memos can be a way of drawing attention to a researcher’s assumptions and narratives that form part of the analysis. They can also serve as a tool to express a world view of the researcher's position; and they can be a way of locating the researcher in the analysis.

Mills et al. (2006) suggest that memos also allow a researcher to recognise and account for the unsaid and unacknowledged voices in the data; they can expose prejudices and assumptions and identify the path forward in developing theoretical concepts. Mills et al. (2006) suggest that the words of the participants should be included in the raw data of the memos. This keeps participants’ voices and meaning present in the theoretical outcome.

From Glaser and Holton (2005) perspective, one of the goals of memoing is to segregate the researcher’s bias and assumptions to keep the data clean and unsullied by pre-existing knowledge. However, from a constructionist perspective, Charmaz (2014) would contend that memos are precisely intended to make space for an accountable record of the researcher’s worldview, assumptions, and intuitions.

An example of this reflexive process is illustrated in the following memo extract:

> ***memoG4 - Some thoughts on changing the theory 25/8/20***
>
> *A chat with Elizabeth today. I ran through my study with Elizabeth. This included some sense of my story and how my training and education in SA* (South Africa) *has shaped my study. I also made some comments on the impact the MMH (*maternal mental health) *interviews have had on the study.*
>
> *The following is a summary of some of the main points we raised. They may turn out to be useful in a discussion chapter – especially the second-order issues that came up.*
>
> *The study has evolved from an adversarial stance to a more collaborative/innovative stance… My initial interviews were very much informed by a sense of exasperation and dismay; therapy was seen as an act of sabotage, resistance and something done despite the institution. I may have to own that I would have shared this antagonistic stance. However, the MMH group were more collaborative, gentler, wiser – they seem to see opportunities, they seemed to have patience with a struggling system. They saw the relationships and discourses that presented themselves as opportunities for collaboration and a time to work together. All in all, this is a more sophisticated and integrated perspective… Perhaps I wish I could do this!*

> *Is it possible that this experience of moving from exasperation to opportunistic acceptance is mirrored in everyday working life?*

In this excerpt, I highlight the shift in tone as the interviews progressed. My comment of “perhaps I wish I could do this!” clearly reflects an aspirational assumption I hold. It could also be an ideal that I may be tempted to see in the data and the psychology profession. Memoing this helped clarify this observation; and allowed me to make space to explore this narrative in the theory. Most importantly, this acknowledgement ensured that I was aware of a potential “hopeful stance” and how that could influence my analysis.

### Theoretical sensitivity.

Grounded theory is also characterised by the debate concerning prior knowledge and theoretical sensitivity in a grounded theory analysis. All researchers arrive at their study with a richly developed knowledge base and preconceived assumptions and insights. This theoretical sensitivity serves as a resource to sharpen analysis. According to Charmaz (2006) theoretical sensitivity helps a researcher view the subject of the study from multiple vantage points, make comparisons, and build ideas. Bryant (2017) sees theoretical sensitivity as “developing and applying insightful discrimination to the investigation” (p. 7). One of the central tasks in a grounded theory analysis is applying and utilising one’s theoretical sensitivity in a self-aware and accountable way. Arguably this is one of the most complex research skills to develop (Mills et al., 2006).

As a grounded theorist, I am obligated to be alert to and develop my theoretical sensitivity to ensure it is a resource, rather than a hindrance, to my analysis. Tarozzi (2020) describes some of the central components of nurturing theoretical sensitivity from a constructionist perspective. He talks about nurturing a tolerance for chaos and a willingness to suspend judgement. He refers to the ability to allow the experiences of participants to illuminate understanding, despite our very human need to impose some order onto the social world.

I needed to be constantly alert to this, especially as I also work and was trained in ANZ healthcare service structures, and I am trained as a clinical psychologist. I have a wealth of knowledge about the area of my study and the potential to assume and make presumptive conclusions based on what I ‘know’. The reminder to be comfortable with uncertainty served as a way to avoid falling into the trap of presumption.

Tarozzi (2020) also talks about the importance of a researcher being able to conceptualise a symbolic or philosophical world within the lived reality of a social process. He challenges researchers to remain open to seeing the meaning in what we experience and are exposed to. In this way, I can untether myself from my preexisting knowledge and open my understanding to something new and unexpected in the data. Charmaz (2014) also talks about how engaging in data analysis, especially the constant comparison process, can sharpen our theoretical sensitivity by encouraging the pursuit of a conceptual understanding of phenomena.

## Reaching theoretical saturation and developing a theory

Theoretical saturation marks the conclusion of the data gathering and ushers in the final stages of the analysis. Charmaz (2014) describes saturation as the point when gathering new data does not result in any new properties or insights into the categories. All studies could progress indefinitely and determining the point of saturation is challenging. In my case, I consulted with the supervisors and reviewed my theory closely. I found the main sub-categories were comprehensive enough to incorporate new information. In addition, they were robust in that participants repeatedly referenced them, and no other concepts or social phenomena emerged that contributed substantially. Risk management or coping with death could have been valuable concepts, for example, as they both impact relationship experiences, but both were represented in other ways within the existing theory.

Another way I could be confident that I had reached saturation was in the participants' feedback on the theory. In the final interviews, I would describe my theory in more detail and ask for impressions and critiques. This is a form of *member checking,* an analytic process that involves taking the theory back to participants to check for accuracy and resonance (Birt et al., 2016). I noticed that the participants saw value and insight but did not feel compelled to suggest any further additions. Additionally, later supervisors' meetings for this project would often focus on reviewing my theory. This developed into an opportunity to begin defending my ideas and checking that the data I had gathered held up to debate and scrutiny.

By the end of the data gathering and analysis phase, I have arrived at a conceptual model based on my theoretical codes. My theory was structured around three main categories, their sub-categories, and the conditions of the theory. My main categories contained some shared conceptual uniformity, each with sub-categories that demonstrate that the data had, in Glaser's (1978) words, earned a place in the theory.

However, my study presented an unconventional use of conditions in a grounded theory. Strauss and Corbin (1990b) introduced a detailed framework for the use of conditions and posited that underlying conditions can be a prominent component of their version of grounded theory. They proposed a conditional/consequential matrix to organise the conditions of a theory. In their model, conditions can range from micro-conditions that are located close to the experience of participants, through to macro conditions which are broader and more socio-political in nature (Strauss and Corbin, 1990b). However, Charmaz (2014) cautions against allowing analytic models like the Corbin and Strauss matrix to impede the analysis and flexibility of the theory. Drawing on her guidelines, I adopted a creative approach to the use of conditions. I have subjected them to the same level of conceptual analysis, constant comparison, and theoretical sensitivity as my categories.

Typically, conditions serve to map out the context and account for environmental influences. They have an organisational and facilitative function. For Corbin and Strauss (2008), conditions shape the nature of problems and situations and serve to generate actions, interactions, and emotional responses. Arguably, conditions can be relatively perfunctionary when compared to the conceptual depth of categories. In my study the conditions themselves are elevated to conceptual ideas. This is in keeping with Charmaz' (2014) assertion that grounded theory is about elevating ideas and giving them descriptive and illuminating powers. Unlike in Strauss and Corbin (2008) work, where they serve to organise the theory, in my study they provide significant explanatory power into the context, motives and actions of participants.

In my study, conditions are integrated into the theory in a fundamental and integrated way. There is a precedent for this approach to the conditions of a grounded theory. Ward (2016) used conditions such as *time* and *perseverance*, as they are experienced by her participants, as conditions of her theory of C-PAP compliance. In my study, I have given them prominence as they map out, and indeed co-construct the social world of the ANZ healthcare service. Specifically, the two conditions map out the unique social and emotional environment of a public healthcare service as it is perceived and constructed by psychologists. In this way, I am approaching conditions as socially constructed phenomena that are unique to the context of the theory. The conditions may be different in another study or different context; but in this study, they are essential to understanding the theory.

## Ensuring quality in the study

Corbin and Strauss (2008) suggest that a high-quality grounded theory should demonstrate a collection of characteristics. They suggest that there should be a degree of fit between the theory and the experiences of participants; the findings should apply to the research area; the study should develop illuminating and valuable concepts; and the findings should demonstrate a meaningful link with the context of the study. Strauss and Corbin (2008) also add that rigour is improved if there is a logical flow, a sense of creativity and variation, and a meticulous and thoughtful collection of memos.

Chiovitti and Piran (2003) adopt a constructionist perspective in their guidelines to ensure rigour in a grounded theory study. These include ensuring that the participants guide the research process; and that the constructed theory aligns with the participants' meanings. Chiovitti and Piran (2003) also suggest using the participants' actual words and articulating the researcher’s perspectives, the methods used, and the reasons for recruiting the participants. The study should also clearly describe how literature relates to each category in the study.

However, Charmaz (2006) is more succinct and suggests that four central notions represent quality in a grounded theory study: resonance, credibility, usefulness, and originality. For Charmaz, a grounded theory has *resonance* when it conveys the fullness of the participants' experiences (Charmaz, 2006). This concept is similar to Corbin and Strauss' (2008) notion of *fit* or Chiovitti and Piran's (2003) notion of aligning with participants*. Resonance* means the participants can see the links between the theory, their experience, and broader collective and institutional realities. *Resonance* is about whether the socially constructed world of the study feels authentic and representative to participants.

In my study, I asked some participants to explicitly review the concepts and lines of inquiry that the study pursued. In addition, I engaged many participants in an honest and unvarnished dialogue on how they experienced my theory. This form of member checking proved invaluable in determining the resonance of my theory. Sometimes member checking was undertaken as part of the interview or attended to at the end. Towards the end of the data gathering, I would explicitly outline my tentative thoughts on a theory at the beginning of the interview and ask for feedback and comment.

Similarly, Chiovitti and Piran (2003) suggest that ensuring rigour also means recognising *accountability* for a researcher's influence over the analysis. To prepare for the data collection phase, I completed a presupposition interview with a senior researcher at AUT. The goal was to explore my assumptions, worldview, and biases before they infiltrated the research process unacknowledged. This was a constructive process as it sharpened my focus both on the assumptions I would bring into the interviews and prepared me for some of the relationship dynamics that I would encounter during the process.

In conjunction with *resonance*, a high-quality study needs to be a credible description of the social phenomena in the study. Charmaz (2006) contends that a study has *credibility* when it has an “intimate familiarity with the setting or topic” (p. 182). The concept of credibility refers to the merits of the claims in the study. Credibility requires that there has been a sufficient depth, range, and detail in the observations to warrant the findings; and that the categories cover a wide range of empirical observations. Most importantly, a study has credibility if there is a solid logical link between the gathered data and the final argument and analysis.

Charmaz (2006) also suggests that the analyses must offer interpretations that people can use in their everyday lives; they need to be *useful*. For a study to be *useful* the categories should also be transferable, and the social processes described need to be generic enough to be relevant in similar contexts. Finally, Charmaz says that if the research galvanises other research, the study can be considered *useful*. Much like Corbin and Strauss, Charmaz argues that a quality study needs to contextualise and locate the findings and analysis in the environment of the study. In this study, I take time to explore the relationship between clinical psychologists and their work, their training models, team cultures, and the needs and expectations of their community. This was to ensure that the findings would be useful to both psychologists and the public healthcare system.

The study also needs to balance a spirit of *originality* with the logical structure in the analysis. Charmaz (2006) suggests a rigorous study is balanced between being insightful and evocative, and should challenge, extend, or refine existing ideas and concepts. In this study, the central notion of psychological therapy, and indeed a psychologist, is deconstructed and problematised – from this process, a fresh and innovative concept can emerge, one that may shed light and insight on our delivery of clinical care. Charmaz (2014) asserts the notion of a creative and vibrant study, cautioning against allowing our thinking to settle into established parameters and challenging researchers to question the meaning and construction of the ideas we share and maintain.

## Summary

This chapter describes the methods and steps I undertook in my grounded theory research. It describes my experiences of data collection and engaging with participants, and my approach to coding and analysis. In the final section of the chapter, I explore some of the main grounded theory methods and how they were applied and utilised in my study.

Birks and Mills (2015) note that the data gathering, and analysis phase of a project can be the most daunting phase for a new researcher, and the process was indeed challenging and often somewhat perplexing. I often felt overwhelmed by the volume of information that participants provided. I found that my supervisors' comments about staying close to the words and experiences of my participants and trusting the process were both containing and comforting. Ultimately trusting and leaving space for the process is the essence of a grounded theory study.

I would agree with Charmaz (2006), who often encourages researchers to let the data speak and to remain open and responsive to what transpires. The following section describes the findings of my study and presents my theory that ***Alliance-Building is a Gambit***. I also introduce the main categories and their sub-categories and describe the necessary conditions for the theory to be demonstrated.

# Chapter 5 Findings

The aim of this project was to explore the experiences of psychologists working in the Aotearoa New Zealand healthcare service. Chapters one and two describe the context of public mental healthcare, and the state of mental healthcare in New Zealand. The challenges facing psychologists in New Zealand as they work in community settings are also described. Chapters three and four describe the methodological premises of this study and the rationale for choosing a constructionist grounded theory as a method, with the main methods of grounded theory presented, and their use in the data collection and analysis of this study described.

This next chapter describes the findings from analysis of interviews conducted with clinical psychologists working in the ANZ healthcare service using grounded theory. The findings describe participants' experiences of maintaining a commitment to something as intensely personal and humanistic as therapy, while attempting to function in large and under-resourced organisations. There is an inherent tension imbedded therein that is intriguing. Initially, the research question was, "*How* do clinical psychologists maintain the therapeutic alliance in the context of institutional processes?" However, the analysis revealed a complex relationship between clinical psychologists, the ANZ healthcare service, and the role therapy plays as a mediator. As the study developed, the focus moved to *why* clinical psychologists maintain the therapeutic alliance. The following discussion outlines this process.

Participants in this study described their relationship-building experiences with their clients as complex and convoluted. They described the stressors and compromises inherent in being part of the ANZ healthcare service. They also described organisational pressures that impact on how they see themselves and their role; and on how they connect with their therapy clients. The alliance-building aspects of therapy become a means to dialogue with the organisation, taking on a political and strategic dimension. Alliance-building becomes a statement addressed to the ANZ healthcare service. This is most evident in the psychologists’ comments, “I did that because…” or “I need to retreat because….”. Participants would often describe their clinical choices as a reaction to, or a consequence of, organisational processes. In this context, forging alliances with clients in the ANZ healthcare service takes on a different tone.

The findings of this study are presented as theory predicated on two conditions and framed by three categories and their respective sub-categories. The various labels of the respective categories, sub-categories, and conditions are italicised to highlight their conceptual nature. The codes are not explicitly referenced in the findings. The analysis is supported by anonymised data extracts, with pseudonyms used to identify different participants.

## Theory: Alliance-building is a gambit

This thesis proposes the theory that, for psychologists working in public health, *Alliance-Building is a Gambit****.*** Psychologists unwittingly and indirectly use their therapeutic activity to navigate and manage three distinct but interconnected institutional processes within the ANZ healthcare service. These are the expectation to be relentlessly productive, the obligation to navigate inhibiting power structures, and the need to revisit their inadequate treatment protocols.

These three institutional processes comprise the three categories of the theory: *Being Productive, Navigating Power,* and *Revisiting Protocols*. Each category is comprised of two sub-categories that encapsulate an institutional expectation, and a response by psychologists. In this way, each of the categories are a dynamic process of encountering an institutional expectation and then responding strategically to that expectation. Each category is predicated on two underlying socially constructed conditions that underpin the psychologists' experience of working in the ANZ healthcare service: *feeling vulnerable* and *allying*. These two conditions are ever-present and integral to the experience of working in the public healthcare service; they are the material that fuels the categories. In this way, the conditions create the necessary circumstances to facilitate *Alliance-Building as a Gambit*.

The first condition of this theory is that clinical psychologists working in public mental healthcare service are *feeling vulnerable* in their roles. Psychologists perpetually question their place and legitimacy within the public mental healthcare structure, and they notice an incongruence in their respective values. Two properties encapsulate the experience of *feeling vulnerable*. These are that psychologists are *living with exposure* in that they regularly face professional self-doubt and a fear of feeling incompetent and incapable of meeting the needs of clients. Secondly, they are *operating on the periphery* of the public mental healthcare service, in that they feel increasingly marginalised and excluded from the prevailing mode of care.

The participants report *feeling vulnerable* as they enter their clients' lives and relationships. They describe working without a sense of certainty that they can make a difference. Fundamentally, participants worry that they are at risk of not being the best therapist they aspire to be. They are *living with exposure*. This worry is exacerbated by a difference in values between participants and the ANZ healthcare Service. Consequently, they can never be confident that they have full endorsement from the healthcare services; they feel exposed to the risk of failing their clients.

Their vulnerability is also grounded in their relational position in the ANZ healthcare Service: they are *operating on the periphery* of team life. They see many of their functions being incorporated into other professions, and they have mixed feelings about this. While they operate as specialists, psychological therapy can nonetheless feel like an adjunct role, separate from the core business of case management. They may even react to this by becoming more isolationist and self-protecting when under stress.

*Feeling vulnerable* serves as the first of the two conditions that underpin the actions of the participants in this study. It is an ever-present experience, an emotional context that fuels the efforts made by participants to manage their environment as best they can. The participants describe a subtle interplay between *feeling vulnerable* and then using their relationship skills to address feeling vulnerable. Psychologists carry the experience of *feeling vulnerable* into their clinical work, their relationships with their colleagues, and their dealings with management structures. It is an ever-present emotional context in their working life. *Feeling vulnerable* becomes the lens through which the psychologists make sense of their place in the system, and it motivates them to react by using their *Alliance-Building as a Gambit*. Without an emotional motive, the psychologists may never feel compelled to use *Alliance-Building as a Gambit.* In this way, *feeling vulnerable* is a necessary condition for the theory.

*Allying*, the second condition, refers specifically to the alliance-building aspects of therapy, rather than the intervention or coordination aspects of therapy. This approach to working with clients is so automatic and pervasive that participants refer to it matter-of-factly and assume its natural place in their daily work. The term *allying* is a form of alliance-building that has three components exemplifying its contextual properties. These are *journeying* (or travelling with your client), *immersing* (or participating fully in your client's world) and *aligning* (or situating yourself alongside your client). *Journeying* becomes a comment about the time we need to invest in clients. *Immersing* becomes a comment about how crucial a deep relationship with clients is. *Aligning* is a comment about where psychologists' alliances should lie.

By focusing on *allying***,** the participants enter a dialogue about the nature of therapy in the ANZ healthcare service. They are extending their therapeutic work into an organisational domain and expressing a position on the nature of therapy through their work. In this way, *allying* takes on a political or strategic tone. While *allying* is foremost and primarily an act of healing and resource to progress therapy; in the context of the public healthcare system, it also possesses systemic value.

There are systemic and organisational implications for engaging in *allying*. The essence of all three categories of the theory is an untethering from their allegiance to the ANZ healthcare Service and the restrictive institutional process, and embracing a process of *journeying, aligning,* and *immersing* with their clients. They describe a shift in focus, away from the needs and expectations of their healthcare service and towards the needs and expectations of clients. In a sense, the focus on *allying* serves as a political manoeuvre or gambit. It is a way of reclaiming and using therapy to serve needs other than the express expectations of the biomedical model and the public healthcare service. This act of reclaiming and reframing therapy as a contextual resource ensures that *Alliance-Building is a Gambit* is possible. In this way, *allying* is a necessary condition for the theory.

These two conditions underpin how psychologists encounter three distinct institutional processes. These processes encapsulate the expectations placed on psychologists working in public healthcare services and inform how psychological therapies are provided across the service. The three categories of institutional processes are *Being Productive, Navigating Power* and *Revisiting Protocols*. Each category incorporates two sub-categories that provide descriptive depth, an embedded tension, and a sense of the dynamic process. Psychologists respond to each of the three institutional processes by *allying* with their clients to address and manage expectations placed on them and to deal with *feeling vulnerable*.

In the first category, psychologists are tasked with *Being Productive* by adopting a worldview that differs from their own. They are expected to attend to a high volume of clinical and administrative work. In this way they evidence their value to the healthcare system. This is encapsulated in a sub-category called *doing more*. Being compelled to be *doing more* leaves psychologists *feeling vulnerable*, and they react by *allying* with their clients. Psychologists respond to the need to *Be Productive* by *retreating,* which is the second sub-category of *Being Productive*. *Retreating* involves psychologists extracting themselves from the broader institutional process and investing heavily in *allying* with their clients. They may literally seclude themselves in their consultation rooms, or they may deliberately refocus their attention and efforts on their therapeutic work, even at the expense of organisational priorities. They do this to protect themselves and their clients, and still reconceptualise what it means to be *doing more*. In this way, they demonstrate a different narrative for *Being Productive*.

In the second category, psychologists are *Navigating Power* and confronting the degree of influence they have over the clinical discourse in the public mental healthcare service. Specifically, they need to navigate and address the disproportionate influence that doctors have over both the clinical processes and team dynamics. This is encapsulated in a sub-category called *recognising your place.* Again, *recognising your place* leaves them *feeling vulnerable***,** and they react by focusing on *allying*. In this way, they use their therapeutic insights and the credibility they gain from *allying* with clients to contribute to and influence the clinical formulations within the team. The expertise they gain form *allying* provides the psychologists with a cache of influence over their colleagues; and provides credibility to challenge the doctors' dominance. This is encapsulated in a sub-category of *collaborating* with their teams and doctors*.* By doing so, the participants are using *allying* to demonstrate a different way to *Navigate Power*.

Finally, the third category involves psychologists *Revisiting Protocols***.** This entails adjusting treatment protocols that are not well suited for community mental health settings but are a prescribed aspect of their role. This is encapsulated in the sub-category called *struggling with the real world*; and they are *feeling vulnerable*. And again, they manage this vulnerability by investing in relationships and *allying*. They do this by *allying* with their clients and adapting and advancing their evidence-based treatments by emphasising the relational and engagement aspects of therapy. In this way, they adapt therapy to meet the complex needs of clients, and to account for the limitations of manualised, evidence-based therapy. They demonstrate their value to the public mental healthcare service by developing a richer, more nuanced form of therapy. This is encapsulated in a sub-category of *personalising* their therapy.

The theory *Alliance-Building is a Gambit* suggests that clinical psychologists *ally* with their clients to manage the three institutional processes that they encounter in their work. The three processes each address a different aspect of the relationship-building processes within the ANZ public mental healthcare service. *Being Productive* concerns the expectations the public mental healthcare service has of clinical activity and productivity. *Navigating Power* concerns clinicians' relational credibility with their clients and colleagues. *Revisiting Protocols* concerns the tools and resources clinical psychologists apply to their therapeutic activity. In a sense, the three categories, taken as a collective, map out the socially constructed world within which therapy in public healthcare is enacted. This theory describes how psychologists use *Alliance-building as a Gambit* to enact a relationship and reframe this socially constructed world.

In summary, each category illustrates the tension between the public mental healthcare service and the psychologists. Specifically, psychologists struggle with *Being Productive, Navigating Power,* and *Revisiting Protocols.* Each category addresses a different strand of the institutional processes that inform therapeutic care in the public mental healthcare service. In each case, the psychologists' responses are predicated on two conditions “psychologists are *feeling vulnerable* in their public healthcare roles and respond by *allying* with clients to manage this vulnerability. The relationship between the conditions and categories that make up the theory that *Alliance-Building is a Gambit* are represented in Figure 5. The following sections will describe the various categories and conditions in detail.

**Figure 5**

*Diagram of the Theory that Alliance-Building is a Gambit*

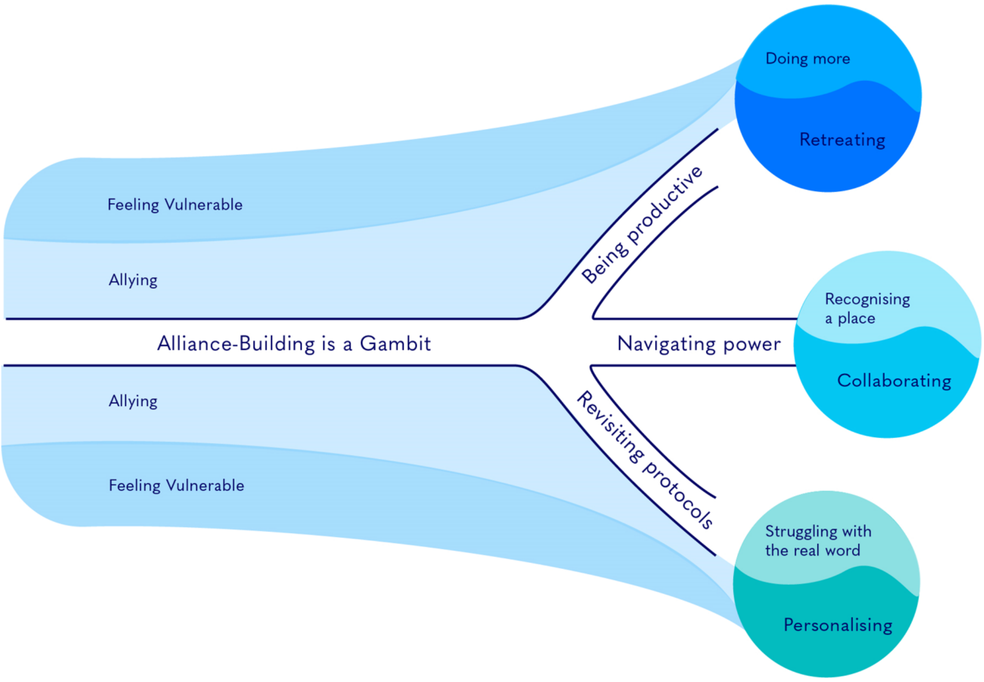


*Figure 5 - Diagram of the Theory that Alliance-Building is a Gambit*

## Condition 1: Feeling vulnerable

The first condition of the theory is that clinical psychologists experience *feeling vulnerable* while participating and functioning in the ANZ healthcare service. The participants describe *feeling vulnerable* as having two properties: *living with exposure* and *operating on the periphery*.

First, clinical psychologists are *living with exposure*. Participants did not describe a fear of incompetence or inadequacy, but rather a fear of not doing enough, or not offering what is required; a fear of being exposed as inadequate. The participants described *feeling vulnerable* because they face the prospect of not meeting their client’s needs and failing in their primary function as a therapist. This experience of professional self-doubt is exacerbated by the differing values between participants and the ANZ healthcare service. As a result, participants can never be sure if they are genuinely being supported.

Second, they describe *operating on the periphery* of clinical life. The clinical psychologists in this study described inter-team collaboration as common and beneficial aspects of their public healthcare role. They also expressed their appreciation for the esteem and regard in which they are held; and they acknowledge the importance attached to psychological interventions. However, they are also concerned that their role is being diluted and subsumed by organisational processes. A psychologist's core tasks often feel like a supplement or even an after-thought within the dominant treatment model. In this way, psychologists *operate on the periphery* in their clinical roles. The following section provides a more detailed exploration of the two properties of the condition of *feeling vulnerable*:

### Living with exposure

Generally, participants described a sense of professional competence and efficacy. Andre noted, for example, that psychologists are often called on to provide informal leadership or support in the clinical development of staff.

Brodie described feeling “respected and appreciated” for her expertise. Other psychologists such as Linda and Jennifer described having enough influence to build clinical resources within their teams.

Despite these positive self-perceptions, many participants in this study described nagging, disquieting worry that they were not adequate in meeting their client’s needs or not offering what was required. The participants returned to the experience of vulnerability routinely:

> (I experience) vulnerability on a professional level. I think there’s a sense of always having to justify what we’re doing. Like, we’re not kind of seen for what is inherently valuable. (Jody)

Moreover, the participants described encountering people in their most vulnerable and agitated state. This alone generated a feeling of vulnerability for participants. Gillian said, “if what you are doing, as a clinician, is not experienced as difficult at some point, then well, you are probably missing the point”. In addition to entering spaces that foster vulnerability, participants also described committing to therapy where the outcome was unclear. Despite the expectation that things would improve following their efforts, this was not guaranteed. Gillian described “having to contain the situation somehow” when she was unsure how to proceed. Henk described the sense of pressure and the sense of feeling exposed as he faced the complexity of his clients:

> There seems to be a little bit of a misunderstanding about what we do, as a profession, and of looking at the complexity of some of our work. The impact that it has on clinicians on a day-to-day basis… I suppose for me… I suppose, I’ve really felt an increased level of stress, pressure, and having to perform miracles. (Henk)

The participants described the emotional investment as draining and emotionally confronting. Jody called this, “emotional leakage”, when she spoke about clients’ feelings or the anxieties of the situation becoming the participants’ own. Clare alluded to the need to access and operate at a “deeper emotional level” required for therapy. She described having an “emotional hangover” after a collection of sessions.

The participants described an intrinsically vulnerable situation where they were required provide a service they are accountable for while still feeling that they cannot provide it effectively. Robin, who spent a few years in private practice before entering the ANZ healthcare service, remembered his initial experiences with community mental health making him “severely anxious”. Despite decades of experience, he still felt intimidated by the demands of community care. Dora described something similar in her first encounter with community mental health after a few years in a different form of healthcare. She described initially feeling that her standards of clinical care may amount to “clinical neglect”. She remarked that “I just can’t do that! I just cannot do that…”. When pressed on the issue of clinical psychologists feeling vulnerable at work, Niles concluded, “if I’m thinking vulnerability, in this context – it [is] sort of, around professional safety”.

The participants also experienced a degree of vulnerability in their relationship with service management. They described an unsettling feeling that the ANZ healthcare service priorities are driven by organisational and political concerns at the expense of clinical aspirations. Taylor, a clinical leader in an ANZ healthcare service, describes her experiences of the tension between management and clinical psychologists:

> It’s about pressures on the system from outside. The managers are trying to meet their targets and the Ministry of Health is trying to meet their targets. It’s an underfunded system which creates pressure. You know; trying to meet this high level of demand, which kind of is impossible to meet. And then along comes the psychologists saying - ‘Hey I want to do therapy I want to do the stuff that I’m specifically trained for’. And the system goes ‘well, bugger you - we’ve got this huge level of demand; we cannot possibly let you just go off and do your little, pretty bits’. (Taylor)

As Taylor suggests, most public healthcare goals and expectations focus on population health priorities. Participants rarely prioritised the organisational or broader community needs of the DHB they were employed in; instead focussing on the clinical activity they were personally responsible for:

> I'll just go put my head down, focus on my work… Um, do what I think is right, and what's important. And try and do a good job. And, but I haven't really been, pulled up on anything, or questioned about anything, so there's just not even a dialogue there. But I don't actually know. I've got no idea how people at that next level feel about what I'm doing. They might have a big issue about it; but they just don't talk to me about it so... (Clare)

Clare seemed to have adopted a strategy of focusing on the client in front of her, and putting the service needs out of her mind. However, other participants were more vocal and assertive about the differing goals of clinicians and organisations. Some participants responded in a more obstructive way to stay true to their clients and their clinical responsibilities:

> What psychologists do is that they fall back on science and evidence and ethics. And use that as an excuse for doing or not doing something. You know. (They might say) 'I couldn't possibly see someone for only five sessions because, there's nothing evidenced based that says you'll be effective in five sessions. So, I refuse to do that. (Max)

The participants described a range of responses to the differing priorities between psychologists and their organisation. The responses ranged from pragmatic to confrontational. These responses were an attempt to manage the emotional demands of therapy while coping with the disconnection between their values and those of the DHB.

### Operating on the periphery

Max described how the DHBs are “vastly more complex than working in private practice”. He attributed this to the range of relationships or “interdependencies” that psychologists need to attend to in their roles. Max noted how psychologists in a public healthcare role work alongside many different professionals, and some of their roles and tasks overlap or are in conflict.

Several participants agreed, commenting on their DHBs healthcare service’s efforts to equip a broad range of mental health workers with skills in providing therapies. Jessica reported that her management team is very supportive of developing skills within her team. Several of her colleagues have been encouraged to do additional papers to advance their skills. Consequently, tasks that once defined and highlighted psychologists’ unique function in the DHB are increasingly becoming common-place skills.

Many participants acknowledged the benefits of psychological therapies being provided by other mental health workers. Many, like Brodie, suggested that all practitioners “need some degree of knowledge about how to deliver therapeutic interventions” if they are going to work in a community mental health team. There is an understanding that basic and robust skills in therapy are essential for a healthy service and the wellbeing of the community at a service delivery level. Several of the participants even expressed an appreciation and deep respect for the skills others bring to relationship-focused practice. Robin, for example, described being “in awe” of the standard of CBT interventions by his colleagues who are not psychologists.

Dora echoed this appreciative stance. She also described her growing realisation that seeing the expertise of her colleagues broadened her concept of what a therapist is. She found herself reframing her impressions of her colleagues and, indeed, the act of therapy:

> I felt that it was always titles that were very important. So, you’re a clinical psychologist! And I find myself just adapting to the word therapist. And it had a very soothing feeling; and a levelling off. You know because you’d find nurses who were therapists. You’d find social workers who are therapists. And you’d find occupational therapists who were therapists. (Dora).

Whilst Brodie, Dora, and others described accepting the diversification of skills within the DHBs, other participants found this concerning. While Robin acknowledged the skills his colleagues had developed, he also noted some concerns. He referred to an “enmeshment of skills”, or a sense that practitioners stretch themselves into other disciplines and ultimately become a shadow of their professional potential. Henk echoed this sentiment, speaking about a gradual “devaluation of skills”. There was a genuine concern that the core identity of some professions and functions risk getting lost in pursuing general skills for all. Other participants noticed an erosion in the roles and function of a psychologist:

> There is certain parts of our job that are being sort of packaged out in other ways. (Being) covered by technology; or being able to be done at the nursing level. (We are) losing different parts of what we do (Niles).

Jules also reflected on the changing boundaries of her role and that of her colleagues. She placed the responsibility with the increasing pressures on the institution, especially with the pressure of high caseloads. She noted that what was once a “discrete role” of clinical psychology has morphed into something broader and encompassing.

In Jules' view, many clinical psychologists are happy to be flexible and adjust their roles to fit the needs of the service. But she did worry that these changes were happening incidentally and slowly. She noted that you might realise that you are “not being a psychologist anymore and actually, just being quite a generic mental health clinician”. Jules added that because this process is often rather subtle, she encouraged clinical psychologists to be vigilant and notice where their boundaries are changing in the face of institutional pressure.

Niles described feeling “expendable” and unsettled about integrating their colleagues into therapeutic functions. Perhaps this is because clinical psychologists occupy what Taylor called “this weird space” between doctors and allied health professionals. Taylor observed that they have a credible skill set and training that is not as advanced as doctors but more developed than other practitioners. Brodie described this space as the “no man's land” between leadership and the rest of the teams; they are not securely located in either camp.

Andre pointed out a further complicating factor, that clinical psychologists frequently provide supervision, consultation, and even informal leadership within their DHBs. The clinical leadership structure struggles to recognise these informal roles, and consequently, clinical psychologists have a great deal of what Andre called “role confusion”. One consequence of this is that clinical psychologists feel invalidated in their perspective. Andre described how clinical psychologists' views are either adopted or ignored at the whim of the formal leadership structure, and clinical psychologists' deeply held values can be undermined.

Some participants felt that a psychologist’s place in healthcare delivery is incidental or an afterthought. Gillian, who worked in a diabetes management clinic in the community, observed that clinical psychologists operate at the “end of the line” after all the “really important” aspects of care have been covered. This notion of psychological therapies as an afterthought was frequently reported by participants who had worked in general health, where medication, or self-care planning, or transferring care to the community is prioritised over psychological therapy. Similar concerns were raised in a mental health setting too. Henk described feeling that clinical psychologists are sometimes expected to just “do therapy, and that is it”.

Niles described how it sometimes feels as if psychological care and clinical psychologists are “bolted on” to the healthcare delivery model. Henk took this a step further, expressing his feeling that clients are “dumped” with him when nothing else seems to work.

> I think there’s also still quite an enduring message that if other professionals can’t do something with that client, then psychology becomes kind of a bit of a waste basket. Um you know, ‘you guys will know what to do with them’. And that seems flattering initially until you kind of think about it because ultimately why didn’t you consult me earlier? (Henk)

Participants who work in adult community health and medical environments described this sense of disempowerment. Vinny said that “everyone is unhappy” in the adult mental health services. However, those who work in specialist areas, like disabilities, child and family, or perinatal care, talk about a far more integrated and collaborative environment. Jessica, who works in a child and family service, mused, “it’s different there”. Jessica's perspective is especially pertinent as she has worked across both areas. When pressed to explain the differences, Vinny compared her experience of adult services to her present work in perinatal teams and suggested that it's “all just medicine” in general adult services.

Some of the participants described actively working to ring-fence their role and function as psychologists to ensure tighter focus on their core tasks and clarity of their role. Niles described how “we have been very successful” in protecting the psychologist’s role in the past. This risks the psychologists isolating themselves in a sub-group within their service; what Paul called creating “teams within teams”. The participants with management experience often echoed the services' frustration with clinical psychologists being too protective of their roles. Brodie, for example, commented that clinical psychologists tend to be “precious” about their time and that this can be frustrating for managers in the public healthcare service. Annie made some interesting comments about the risks of clinical psychologists operating too far on the periphery. She described how the system's stress could lead to “splitting” or fissures in the relationship between practitioners. This can lead to tension, misunderstandings, and relationship breakdowns

### Condition 2: Allying

*Allying* is the second condition of *Alliance-Building is a Gambit*. *Allying* is a form of alliance-building that has three components exemplifying its contextual properties. These are *journeying* (or travelling with your client), *immersing* (or participating fully in your client's world) and *aligning* (or situating yourself alongside your client).

*Allying* involves conceptualising the therapeutic alliance as an activity within the context of a healthcare organisational structure. When a*llying* psychologists are primarily concerned with therapeutic change, and their client's recovery. However, in the context of the public healthcare system, *allying* also possesses systemic value. *Allying* involves clinical work with an awareness of the environment. The participants described maintaining a therapeutic relationship with their clients while they *journey* with them through the public healthcare system. They describe i*mmersing* in their clients' complex lives and communities. They describe *aligning* with clients in their efforts to navigate both their personal stressors and organisational processes.

However, at the heart of *allying* lies the participants' commitment to their clients. The following excerpt highlights the utmost value they place on their interpersonal experiences and their connection with clients:

> Connecting with my clients I think is probably the most fundamental part of therapeutic relationship. I feel (that) if you don't have a good connection with your clients (then) they're not interested in listening to skills or supports or strategies that may help them. (Jessica)

The following sections describe how the participants experience and demonstrate **allying** and its three properties.

### Allying means journeying together

The participants in this study described *journeying* with their clients, or leading clients through recovery and healing and travelling with them as they develop their psychological skills. *Journeying* refers to spending time with clients, and the commitment to progressing with them as they navigate a crisis or life change. Clare offered her perspective on what *journeying* means to her:

> I guess it's about a kind of work - walking alongside your client. (they) come in when they're in a very vulnerable state. And, um, just, just being there with them through that; and hopefully throughout to the other end as well. (Clare)

Gillian expanded on this idea and emphasised the role of the therapist. She suggested, "you have to be no more than a step away from where your client already is". For Gillian, *journeying* involved a willingness to pay close attention to their clients' circumstances and a careful reading of their situation to ensure that the party moved together in their journey.

Other participants indicated that *journeying* requires innate confidence in the journey and an awareness of where the journey is heading. As Layla reflected:

> Once I would have probably sort of joined the panic and gone 'oh my god! This means I'm a bad psychologist'. You know, I can't… I'm not helping this person enough. Whereas now I've

> probably just got that sense of confidence that, yes these are the issues that are there, they're popping up, and we're working with them. And we're trying to work with them in a considered way so that we can you know really make some effective change. (Layla)

A significant factor in this is whether the environment allows participants to have faith in their journey. Sometimes the organisational needs intrude on their therapy plans and disrupt the journey. As an example, Robin described the experience of being "shoulder tapped" and thus pulled away from his routine work. He stated that this is very disruptive and often impacts on his ability to stay connected to his clients. At other times participants were expected to offer brief involvement tailored to stretch limited resources. Taylor, a professional leader in a large DHB, observed this process in her role frequently. She felt that psychologists "struggle to let them go before they're ready - before either the psychologist feels they're ready, or before the journey's really over". Taylor described how a psychologist's need to remain involved can create tension between the profession and the DHBs in the ANZ healthcare service. In this sense, a commitment to *journeying* can be an organisational risk for psychologists.

### Allying means immersing in another's life

The participants in this study also described *immersing* in their clients' lives. They reflected on their efforts to commit emotionally and completely in the world of their clients. In the words of Dora, therapy is about "doing everything in your power to make sure that connection happens". They described a desire to do this wholeheartedly and with conviction and passion. Clinicians like Gillian used terms such as "wrestling with the family" and "finding a common understanding" of a child's problems to illustrate the consuming nature of *immersing*. Gillian also talked about how paying attention to clients can feel "genuinely compelling" to those clients.

Other participants attempted to convey how profoundly they experienced their therapeutic connections. Clare, for example, described entering a therapeutic space where "you are connecting with how they are feeling" and "if they are sad, then you are sad. I think that is when you are doing your job well". Dora talked about creating a space in therapy that strips back the organisational expectations and assumptions clients have of therapists. It is a place where "they can feel like you feel. You can hear them, and then they can hear you".

Layla talked about being willing to go beyond the symptoms and avoid being a "band-aid" that treats the observable. She saw true *immersion* as going beyond observations to something more fundamental. In her words:

> It doesn't feel like we're getting in and doing the real work that needs to be done. We're doing something to take some symptoms off the top. We are not actually changing the way that this person operates in the world… or sees the world. Maybe we're not really seeing them for everything that's going on. We're just seeing them as symptoms that are causing us a bit of a problem. (Layla)

Andre offered a word of caution about another organisational risk from *immersion* in clients' lives.

> My observations have been (that) the team starts to project all kinds of things onto the dyad. (They say) 'It's your patient!' or 'your patient came to the crisis team again, you know...' Or 'what are you doing about this client?'. The client suddenly steps out of the team, and with the psychologist becomes an external dyad.

Andre noted that sometimes the psychologist and client form such a close and intimate bond that they become an exclusive dyad; within and yet separate from the clinical team.

### Allying means aligning with your client

The participants also described a third dimension to their alliance-building activities. They described *aligning* or placing yourself alongside your client in the act of solidarity. This action is about recognising the similarities and commonalities between one's struggles as a psychologist and that of one's clients:

> I think very early on, I sort of dropped the sense of divide between myself as a psychologist and myself as a person because it was just too hard; and it didn't work. And my general philosophy now is that yeah, if I can convey that I am, you know, a safe person, I've got flaws and failings like everyone else, but I kind of do my best to make things work, then that usually works in that context. (Jody)

*Aligning* is also the act of connecting and acknowledging the secrets and fears people hide and the deeper undercurrents that run through people's lives. Many of the participants argued that it is difficult to access the true story of clients' lives without a strong connection. Some participants were especially drawn to moments when connecting to clients allowed them to voice and confront terrifying and shaming thoughts:

> When there's a strong therapeutic alliance, they feel so much more comfortable with sharing with what's… you know… what's going on for them. With saying the really distressing and difficult things that are popping into their mind. (Layla)

*Aligning* also has implications for team relationships within DHBs. Several participants described the impact of locating themselves alongside their clients and how this can mean they would sit at odds with the ANZ healthcare service. As Niles noted,

> It's you know, just putting aside any sort of pressures from management or whatever. It's very much around client needs and doing what we have to do; and adapting whatever process to make it work for them. And then everything else can fit in afterwards.

Others were more explicitly challenging. Henk reflected on a time when he declined to transfer his client to primary care services as he felt was the client was still too vulnerable, despite the expectations of his team leadership. He described being *aligned* with his client and feeling that, ethically, he could not extract himself:

> I suppose one of the aspects is that this is a human being sitting in front of you and if you're able to do something about it or are in a position in that point in time, then it's not really the greatest thing to, kind of, say "no I'm not going to do anything about it..."

## Main category 1: Be productive

The theory of this study is that psychologists use *Therapeutic Alliance-building is a Gambit* to manage feeling vulnerable, and they do so by using their skills in *allying* with their clients. The following sections describe how participants perceive the call to *Being Productive* and how they respond by *allying* to manage the expectation of *Being Productive*.

*Being Productive* is the first main category of *Alliance-Building is a Gambit. This category* comprises two categories; they are  the need to be *doing more,* or being expected to be more productive with less resources; and *retreating,* or withdrawing from organisational process and retreating to therapeutic activity to demonstrate that they are *Being Productive*. Psychologists are expected to provide consistent and effective clinical care and contribute to the maintenance of the ANZ healthcare service; they are tasked with *Being Productive* in their roles.

### Doing more

The Aotearoa New Zealand healthcare system tasks DHBs with a set of organisational procedures and service goals that drive the direction of service implementation. Some participants like Jody view the DHB as a “top-down” system. This is alienating and excluding for practitioners. Henk added that DHBs “make decisions without broadly consulting”. Other participants like Andre reported that there is an inherent and fundamental “disconnect” between practitioners and senior management concerning goals and expectations. These are what Max called the “different goals” between the two groups. Niles admitted that he would rather fit “the system to the client rather than the other way round”. At the same time, others like Jules, called for a “relationship-focused service” that focuses on clients' therapeutic goals, rather than meeting access targets.

*Being Productive* also concerns the need to focus on productivity and output. The participants were nearly universal in their view that DHBs are overly preoccupied with throughput and quality of care outcomes. In the words of Henk, *“*it’s all about bums on seats*”*. Robin described the “pressure from upstairs” to see more face-to-face contact, despite hindrances. Jennifer talked about how key performance indicators are often the overriding priority that dominates clinical life. When asked what is most stressful about working in a DHB, Dora said, "Everyone will say high caseloads, right?” Each of these participants described the messages and expectations they experience from their management, with a focus on the expectation of *Being Productive* by doing more and being more efficient. As Clare noted,

> You need to be shifting this person out even though you know that they’re, not particularly in a space where you want to be discharging them. And they’re likely to be just a revolving door coming in. But there’s this expectation that you know we’ve got more people coming in the door than we’re discharging, so you need to be just getting on with the work and shifting people through.

Regardless of how psychologists responded, a central process that emerged in this study is the participants' concern that the volume of work would impact their core function, the provision of therapy and their ability to **ally** with clients. As Jules noted,

> We're asked to just pick-up cases, or just be a case manager and do assessments and make plans for people, and sort out problems… It's not that any of those things would be a problem in itself; but it's just that they all draw our attention away from being a therapist. Like holding someone in mind in therapy, like having time to plan what you're going to do, and think about, and reflect, and do formulations, or maybe do like a letter for them.

Jules expressed the view that a DHB system is fundamentally poorly equipped to be a place of therapy and is less client-focused than either the DHB or the psychologists would like. As she expressed it, "I think maybe I've noticed it more working in New Zealand than working in the UK but, I don't know if there's a strong an aspect of being a therapist in the - working in the DHB". Jules felt that her previous employer, a UK healthcare service, makes therapeutic engagement the service's primary purpose. She felt that, in comparison, New Zealand DHBs privilege case management, coordination, risk management, and other tasks as highly. An example that the participants often referenced is frequent and abrupt requests to complete an unexpected task. This can often be an urgent assessment, an institutional activity with an impending deadline, or a change in plans necessitated by staff shortages. In Jules' words, high workloads make it "hard to build a relationship", and "go the extra mile".

Several participants claimed that the pressure of *Being Productive* by *doing more* tends to draw attention away from being a therapist to clients. Jules described how additional tasks added to a workload meant that elements of the identity and value of a psychologist are lost. Additionally, some participants described a sense of guilt, and expressed concerns that they were, in Jules' words, unable to "give them what they needed:

> Yeah, I think I personally find it hard. I always want to do my best. I always want to like feel like I've given the service that I needed to do. Like they've got every ounce of me. That means I'll squeeze people in. I'll be like 'oh yeah I can do that'. And I'll go and see someone at home and then suddenly you realise you've driven somewhere, come back, you've got five minutes to prepare your next session. And then you're like 'oh, but I'm not, I'm not giving them what they needed'. I needed more than five minutes to prepare! You almost feel guilty because you haven't actually done the job that you're expected to do because you were so keen to kind of help.

Several participants also commented on the DHBs preference for brief episodes of care and time-boundaried session planning as a way of *Being Productive*. They described this as a shift in conceptual thinking and away from *journeying, immersing,* and *aligning* with clients. Many participants also described feeling that DHBs are less receptive to extended therapy treatments:

> … I'm wondering if that's just looking back like a nostalgic looking back how things were. I wonder whether the changes that have happened now - I sort of wonder if that's shifted that a little bit. I wonder if it's got something to do with the 'episode of care-type model' that they're pushing. Psychology is not always a good fit for that. We might be seen as taking a long time. We are quite an expensive resource. (We are) not seeing as many people as others could in that kind of brief intervention kind of way. (Niles)

Robin expressed his exasperation and described how clinical work has become "a hit and run situation; you stabilise, and you discharge". There was a palpable sense of frustration with being compelled to work this way. He described a feeling of loss and a desire to remain involved for a longer period of time, because "you get something back when you get to see the changes in your client".

## Retreating

The section above describes participants' difficulties with *Being Productive*, and how they respond to *doing more* in multiple ways. In more extreme cases, Taylor described the resignation of psychologists because of their divergent views on organisational processes. Other psychologists persevere and find ways to adapt their values and working habits to fit with DHB needs. Some psychologists with management experience described the varying ways psychologists deal with the organisational expectations of a DHB. Max for example, stated,

> I think there's some rebellion in some people. There are a number of psychologists that I could think of - who openly try and fight against the system, and with what they choose to do. It doesn't actually make them very popular or effective by and large; but they sort of carry the flag of you know, 'I'm going to fight the evil system'.

However, Max felt that other psychologists took a more adaptive, flexible stance and managed this tension differently. These psychologists carry a certain confidence and security in what they offer professionally. He stated,

> Part of it is having a reasonable amount of confidence in who you are as a professional. What you have to offer, and where that might fit. And not feeling that you are having to fight for a place.

Other participants described rising to the challenge of being more efficient and described ways of increasing productivity and *doing more*. Jennifer, for example, developed evidence-based therapy programmes to address wait lists and help with team burnout. Dora started anxiety groups to support her colleagues who do not have advanced skills in this area. These examples suggest a tendency to withdraw from clinical life as a way of coping with *feeling vulnerable*. Psychologists can withdraw, quite literally, by resigning; or they can withdraw by turning their attention to specific and consuming clinical activities like group work. Across the spectrum of responses, another strategy, or gambit, looms large. Psychologists frequently resort to ring-fencing their therapeutic life and extricating this from the organisational agenda in order to focus on being effective therapists – they described *retreating.*

Sometimes this is as specific as retreating to one's office. For some participants *retreating* serves as an opportunity to be efficient by simply getting on with their therapeutic work, despite the stress of DHB. In effect, it becomes a different way to be *doing more*. Brodie, for example, reflected that when organisational life becomes complex and stressful, the response is to "tuck my head back down, and focus on what is in front of me". Similarly, Niles described therapy sessions as where he can "do this specific thing that we are supposed to do". Finally, Jody talked about *retreating* to therapeutic activities and how it felt "safer to get the work actually done" with a closed door.

Other times *retreating* serves a protective function. Niles, for example, noted that he appreciates having a separate office because he can “protect the physical space” by retreating and “blocking out the other stuff” that is not directly relevant to his therapeutic work:

> We (psychologists) can put barriers around that to protect that space. We sort of gravitate towards spending our time there rather than getting tied up in all the political stuff. Where it isn’t as controlled.

Henk was even more explicitly strategic. He talked about having to “manage some organisational component in the therapy room”; and that once he closes the door, it is “ultimately about the client”; the “organisational demands stay outside”. Henk described *doing more* by fostering a different relationship with the organisational processes that impact therapy:

> When you retreat, you are with another human being. Forget about what’s happening outside. I mean, I suppose as much as possible… There are times when, I’ve had to manage some organisational component within a therapy room with someone, just because it’s impacting on them quite directly.

Other participants talked about how *retreating* felt protective and empowering of themselves and their clients. Jody said closing the door and concentrating on therapy “feels protective for the client and me”. Andre also described *retreating* to his therapeutic relationships, and suggested a revealing metaphor to illustrate his perspective. For him *retreating* to therapy is taking his client and “sort of, putting them under a cloak with me”. For Andre, *retreating* creates a safe place for therapy and allows him to be a productive therapist. This becomes his reframe of what it means to be *doing more*.

### Alliance-building is a gambit in being productive

The participants described significant organisational pressures and referred to being expected to adopt the political agenda of the ANZ healthcare service. They described the expectation that they will manage high caseloads and do so concisely and expediently. They respond to these expectations to be *doing more* and *Be Productive* by *retreating*. The participants use *allying* as a mechanism to evidence their productivity while protecting themselves and their clients from DHB expectations. They do this by *retreating* to their therapy and focusing on their investment in their relationships with their clients. They reframe what it means to *Be Productive* as a process of *immersing*, *aligning*, and *journeying* with clients.

## Main category 2: Navigate power

The second main category of alliance-building, *Navigating Power*, describes participants’ experience of being tasked with finding a way to be credible and relevant in their teams. Participants reacted to *Navigating Power* by investing in *allying* to access power and credibility within DHBs. *Navigating Power* comprises the subcategories *recognising your place* and *collaborating*. Participants are tasked with finding a way to be credible and relevant in their teams in the face of their powerful cohorts. The following section examines psychologists' experience of *Navigating Power* and how they react by investing in *allying* to access power and credibility within DHBs.

As with the other main categories *Navigating Power* consists of two subcategories. The first is the dilemma of being expected to *recognise our place,* or accept the power differential and place of psychologists in DHBs. The second is the psychologist’s response in *collaborating;* or *allying* to promote a level of influence over clients' expertise to secure influence.

### Recognising your place

Participants in this study routinely commented on the elevated status of medical practitioners. They described the experience of *recognising your place* in the organisation. Dora made an offhand comment that “he was a psychiatrist, so lots of people had respect for him”, or as Henk stated rather bluntly, “there are doctors, then there is everyone else”. Sometimes these overlapping roles expose the tension within the professions:

> I think we underestimate the strongly ingrained structure of the system in which health is delivered. Um my view is always (that) one has to go back to, the original foundation that things were built on. And, although this might sound (like an) anti-medical comment it’s not. It’s just simply observation that district health boards and hospitals are built around supporting medical specialists. That the human resource structure, the whole structure of the place was initially set up around supporting medical specialists. Psychologists uniquely function as specialists but not as medical specialists. So, I think more than any other allied health group, there’s not a foothold for psychology. The system does not quite understand how to define its (i.e., psychology) value, specifically within mental health. That’s my suspicion about the difference between mental and physical health - in physical health they can be seen as the specialist they are, and they can provide input for psychology or whatever they’re working on. Whereas in mental health they’re in direct competition with the advice and direction given by the psychiatrist. (Andre)

Clinical psychologists are given the message to fit into the medical model hierarchy and *recognise their place*. Sometimes the pressure to comply with the medical structure can be overt, and several participants described the pressure they felt to assimilate. Robin talked about a previous clinic where psychologists were expected to “wear a white coat” (an item of clothing traditionally associated with doctors), and thus how psychologists viewed this directive as problematic, as it implied alignment with the medical community:

> Where I come from (was) very medical model orientated. To the extent that one day after our training we were asked to go to the supply department to all get our white coats. And we were all literally issued a white coat. And we were told to wear this. And for obvious reasons the psychology department along with the social work department just said, ‘there’s no way’. So, we protested and eventually with some research we could speak to the ‘white-coat-induced-hypertension’! (Robin)

Regardless of how effectively psychologists assimilate into the social arrangements of a DHB service, many report being treated differently because they are not doctors. Gillian, for example, talked about a time when her clinical consultation was interrupted because of an overlapping room booking. “I wouldn’t imagine your consultant eye surgeon would have someone knocking on their door of their surgery, saying sorry your surgery time is up now”, she mused.

Frequently the experience of being treated differently also involves feeling dismissed or under-appreciated. For some participants, hospital staff tend to see psychological interventions as extraneous to the primary function of a hospital:

> In hospital and adults absolutely, that’s the case. And you know, I know psychologists in hospital settings where they go back to see their patient and they find the patient’s been discharged. And it’s like, well - ‘no one thought to tell me, let alone ask me or consult with me about it. Thank you very much’. Someone else is making the decisions, someone else is running the show, and psychology is very much an add-on. (Max)

This discrepancy in power and influence extends to the treatment planning and assumptions of the best care. According to Henk, medication is still seen as the “first line of intervention” in community mental health settings. Max went as far as to say that psychologists risk becoming a “dispensing service” with therapy added on. Henk described how medication may still be favoured even if the prevailing evidence supports a psychological intervention. He suggested that medical treatment is often more convenient to administer from an organisational perspective. Jody expressed a similar perspective. In her experience, relationship-based therapy models like dialectal behavioural therapy (DBT), with its emphasis on high-frequency engagement with acutely distressed clients, are seen as “clashing” with the expectations and desires of the rest of the treatment team. Jody also raised issues such as how the “timeframes and expectations of how long you will be working with people” discourage psychological processes in favour of cleaner and more predictable medical protocols. In her words, the DHB is a “medicalised system” that doesn’t fit with relational work.

Others expressed concerns about the privileging of medical interventions; especially in respect to the types of interventions that are favoured in multi-disciplinary teams (MDTs) or case discussions:

> With some of the people presenting for anxiety disorders – I mean first line treatment is obviously psychological intervention first. And there are a number of examples where that’s simply not happening. Where medication is kind of seen as ‘this is the way we’re going to go because this person’s refusing to go to see a psychologist’. I get that. And there needs to be work done to actually get the person the treatment they need rather than a treatment that’s reinforcing the anxiety problem in and of itself. (Henk)

The examples above describe how participants are compelled to react to the dominance of the medical model. Henk, Max, and Robin described their struggles to assert some level of influence over the DHB clinical narrative. The second part of **Being Productive** concerns their response to this power imbalance.

### Collaborating

The participants described an ongoing negotiation with doctors and the power they hold. Some chose to reframe the narrative of their relationship with doctors and the medical model discourse to foster connection and collaboration. Annie offered an example of this reframe. Rather than emphasising the power difference, she saw doctors as “siblings” who are prone to squabble and disagree but are ultimately bound to a common view. In her words “90% (of the time) I have very good relationship with doctors. Because I look at them as my siblings. We are not fighting for our mum’s attention. No, we actually comfort each other!”

But ultimately, there is a constant process of dialoguing and debating as a way of collaborating. Sometimes this dialogue has a challenging stance to it. Jules, for example, talked about the medical model needing critique. She felt that doctors, while very specialised, are at risk of not seeing the full picture. Jules felt it was “really strange” how “sometimes, even a really good psychiatrist just doesn’t see it in the same way that we see it. And it’s almost like they’re just not asking the same questions...

Jules saw the medical model as requiring her participation to work effectively. Others talked about how psychologists have a “responsibility” for voicing an opinion in the MDTs:

> I think it really is important that we are a vocal part of the MDT. I think we have a responsibility and a duty to be an ethical part of the MDT. So that it’s not just about medication and injections and mental health acts. Which sometimes our systems can get dominated by (medical thinking). (Brodie)

These participants argued that despite, or perhaps because of, the dominance of one discourse, psychologists should generate dialogue and discussion about the formulation and the client's presentation. Jules and Brodie conceptualised *collaborating* as enriching the practice of both psychologists and doctors to better serve the client. The above strategy for collaboration raises the question, how do psychologists collaborate? What do they bring to the table as their contribution, and is this contribution enough to sway the medical profession's power over the clinical world of a DHB?

Layla shed some light on the "how". She described forming a parallel but complimentary process to collaborate and to enable *Navigating Power*. From Layla's perspective, the agendas of psychologists and doctors can live in harmony, and they can contribute to the team formulations. They essentially serve two different but complementary functions:

> I just kind of tend to do my thing. Um. I let them do their thing with medications and what not; and you know, talking about symptoms. And then I just bring my part to the conversation. I've seen younger, less experienced psychologists feel like they're sort of, taking direction from the doctors. And I've said you are the psychologist; you know you've done the assessment. You can see what needs to happen based on your formulation, it's not for them to decide.

As Layla expanded her thoughts, her position became clearer, "I don't at all dismiss what doctors bring. But it's just that we need to bring what we bring as well". Layla described how she used her relationship expertise, or her *allying* with clients, to establish herself in the clinical process. Layla's ability to ally with clients a credible role and expertise in the eyes of her colleagues, and a voice in the construction of mental health discourse.

There is an additional way that *allying* can serve the agenda of collaboration and *Navigating Power* dynamics in a DHB. Several participants described the importance of their formulation skills. In Andre's words, the formulation is “our key skill, really”. However, Layla offered an additional perspective. She noted how many of her co-workers take comfort and confidence from the depth of her formulation skills and her close relationship with her clients.

> Well, I think we’ve got the formulation in mind – what is going on for the client. We know what certain behaviours and symptoms represent. And so, if we can share that understanding with other staff, they can then hold that formulation in mind when they interact.

Layla and the participants described a collection of ways that they used their ability to *ally* with clients to consolidate their place in the ANZ healthcare service. They described how *allying* assisted in forging relationships, correcting power imbalances in the team, and demonstrating their clinical credibility to their colleagues.

### Alliance-building is a gambit in navigating power.

The participants described significant power imbalances in DHBs and feeling secondary or marginalised within the ANZ healthcare service. They were critical of the influence their medical colleagues have over team dynamics and clinical formulations. They were compelled to *recognise their place* and then attempt to assert some influence over their clinical teams and especially the most influential members, the doctors.

They described doing so by *collaborating* and thus managing the power distribution in the teams. In this way, they use their therapeutic insights and the credibility they gain from *allying* with clients to contribute and influence the clinical formulations within the team. Their credibility comes from their efforts to *immerse, align,* and *journey* with their clients. By doing so, the participants are using *allying* to demonstrate a different way to *Navigate Power*.

### Main category 3: Revisit protocols

The third institutional process that clinical psychologists need to attend to in DHBs is the need to ***Revisit Protocols*. *Revisiting Protocols***, refers to the expectation that clinical psychologists will utilise evidence-based treatments that appear valid and reliable, but need adaptation and adjustment in practice. Clinical psychologists need to find a way to adapt their clinical resources to meet the needs of their clients or risk appearing incompetent and ineffective by the DHB.

As with the above two categories, the main category of *Revisiting Protocols* consists of two subcategories – one is the dilemma of being expected to *struggle with the real world*, which describes confronting the limitations and gaps in therapeutic protocols and their applicability to DHBs in the ANZ healthcare service community. The second is the psychologist's response, *personalising* to forge effective and meaningful treatment and to ameliorate the implications of *struggling with the real world* of community mental health.

### Struggling with the real world

Some participants in this study suggested that psychologists face difficulties in adapting their training and clinical models in community settings. Paul, a professional leader in a large DHB, described the challenges psychologists have in adapting their academic knowledge to community mental health settings:

> I think it's a huge shift from an academic environment to an applied environment. And I also think that psychologists struggle with that, with that adaptation to a more clinical environment.

He felt that this was due to both the abstract and intellectual nature of psychology training and the emotional difficulties in transitioning from an intellectual to an "applied" environment. Upon graduating, many psychologists described struggling to find guidance and input as they navigated the complexities of a community mental health service. Sometimes it felt like a somewhat bewildering endeavour as they sought out new training opportunities, took matters to their supervisors, and immersed themselves in literature.

> The way I was trained was very much for more of a private practice context, where people are wanting an expert. And, you know, we had dipping in with your psych-education and you know throwing in lots of models. And when I came into DHB-land things are just radically different. So much emotion in the room. So much um… pain and suffering… (Jody)

One of the central concerns that participants raised is the difficulty they experienced in adapting their training to the socio-political nature of community settings. Dora, for example, succinctly stated, "my clinical program did not have a lot of understanding of what happens in black communities". Jennifer was more specific and drew attention to the lack of insight and guidance around subtle and broadly encompassing cultural dynamics of various communities and settings. She described feeling that her university provided a "few token things, but the actual political nature of it (DHBs) was not touched on". The subtleties of institutional life, or the relationship between a DHB setting and its community, are not addressed at university. Instead, they are learned in the everyday practice of a DHB.

This is an experience many participants described the realisation of the need to adapt your practice to provide therapy to vulnerable people within a DHB. One participant talked of her experiences when she moved from a role characterised by assessments and behavioural interventions to a more diverse role in a DHB:

> (I) feel like I have a wider repertoire of skills or resources that (I can use now) … For a long time, I felt a bit stuck. I was taught CBT, and I felt like that was the skill set I was bringing into the room; and then if it wasn't kind of going down that nice, orderly line. (But) then… you are a little bit [screwed]! Like yeah, I'm screwed! Like this is not following my script. Why are you not following my script? And it allowed me to be a bit more flexible as a practitioner, and then kind of expand from there. (Jennifer)

*Struggling with the real world* is intensified when considering the complexity and depth of suffering in an impoverished community setting. Clare made this telling observation that therapy is “not straightforward. It’s not just a magic pill that will suddenly fix somebody’s life”. Others noted the difference between the contained environment of private practice and their experiences in a DHB:

> Actually, I think that’s where the skill set (of a psychologist) shows itself. You know especially in specialist mental health services. We can’t do manualised therapy because the people we see are too complex, there’s too many comorbidities, psychosocial (factors); everything. (Brodie)

The participants described an implicit and explicit expectation to deliver evidence-based treatments with fidelity, consistency, and confidence. Annie noted this experience many times in her career. She described how previous managers had said, “look; you can do six sessions with CBT (and then they are) gone”. Brodie noted that these assumptions have become embedded in the team culture too. She added that “in adult services they (doctors) all just think we’re doing DBT (dialectical behavioural therapy)”.

Other participants expressed concern that the next generation of clinical psychologists is being socialised into this culture of expectation. Henk reflected on his experiences in the training and development of junior clinical psychologists. He described how the “protocol-based” expectations of the

DHB do not marry well with the essential adaptability that clinical psychologists in a DHB require. He talked about the struggle young clinical psychologists have in adhering to evidence-based treatments while seeing a more complex need play out in community life:

> Doing protocol-based intervention is very different to the more integrative work that you need to do when you're in a secondary mental healthcare system. And that, is difficult enough for new grads and for interns to adapt to. With other political systems or a kind of organisation systems that put extra pressure and introduce other discourses into it as well. (Henk)

The participants described beginning to realise that an overly-manualised approach to therapy can also sit uncomfortably with clients:

> If it's a therapy that's quite standardised and there's a bit of a protocol around it, then you know… You can tell sometimes clients they have a reaction to that. They seem to respond better if you're actually allowing them the space to form that connection, and to say what needs to be said rather than ticking the boxes. (Clare)

### Personalising

The participants respond to *struggling with the real world* by *personalising* or adapting skill sets to fit the needs of a DHB. Therapy often competes with other activities like case management, advocacy, and shared care arrangements. As Niles put it, you need to “keep a lot of plates spinning” while you provide care. While this is undoubtedly stressful, participants described creative ways of managing the multifaceted nature of clinical care in real-world settings.

Jules, for example, talked about turning routine case management tasks (e.g., home visits) into opportunities to do therapy. Her experience encouraged her to think innovatively about therapy opportunities in the unlikeliest of places. But at its heart, *personalising* is more than simply skills acquisition and adaptability. It is about bringing something extra to your therapeutic work and, by extension, to the clinical resources of a DHB. It consists of offering more than your training or knowledge. This seems to be a process that some participants had learnt to embrace. As Clare notes,

> I think it’s probably about being a little bit flexible. Weaving both of them (i.e., alliance-building and evidence-based treatments) together if that makes sense? Um, spending a lot of the time like, focussing on trying to connect with the client, hear what’s going on for them, validate them, and then also trying to weave in the model a little bit as well...

Annie described the process rather elegantly, stating how clinical psychologists already have skills; what she called “the ABCs” which they then offer to clients. However, for Annie, sometimes the ABCs are not enough: psychologists also need to “bring the D, F, and G”. Annie described going “beyond the ABCs” of therapy to something more personalised and adaptive. For Annie, the fundamentals (i.e., the “ABCs”) are located through her training; but she also needs to “find a DFG” through lived experience, especially in collaboration and learning from others. Annie viewed this as an essential obligation for a therapist to pursue. This is a process Brodie called “shifting what you’re doing”. In Brodie’s experience of providing therapy, the actual skill set of a psychologist comes from adapting and not getting entrapped in a limiting model of therapy. As Brodie contemplated, “you find your ways through and around”.

Later in her interview, Annie added a caveat to her comments about “finding the D, G, and F”. She felt that there is another element; what she called the “Y”. This is the personality and presence of the therapist as she put it “you are the Y”. Annie described allowing herself to be part of the therapeutic change, to shift the focus from the interventions psychologists apply to themselves as a person in a relationship.

### Alliance-building is a gambit in revisiting protocols

The participants describe realising that their therapeutic models do not fit the needs of their environment. Consequently, they make significant adaptations to be effective in a community setting; and they *struggle with the real world*. The participants demonstrate creativity and flexibility in doing this.

However, the therapeutic relationship serves as their most effective resource in correcting or ameliorating the limitations of therapy in a community setting. They do this by *personalising* their therapy and focusing on the relational aspects. The participants use their efforts to *immerse, align, and journey* with their clients to correct for and compensate for the gaps and limitations in the DHB treatment model. Essentially, participants use *allying* to demonstrate a different way of *Revisiting Protocols*.

### Summary

In conclusion, the participants in this study use therapeutic alliances as a gambit to address three institutional processes, and the demands these place on psychologists. These three institutional processes are *Being Productive*, or to the expectation of *doing more,* despite the pressures; *Navigating Power*, or confronting and managing the power discrepancy within clinical teams; and *recognising your place*. They are also *Revisiting Protocols*, or *struggling with the real world,* as they attempt to apply inadequate therapeutic protocols to a complex environment.

In each case, these processes evoke a sense of *feeling vulnerable* and in each case the psychologists react by *allying* with their clients. First, the participants dealt with the expectation to be *doing more* by *retreating.* Second, participants dealt with *recognising your place* by *collaborating*. Third, participants dealt with *struggling with the real world* by *personalising.* In this way, they used *Alliance-building as a gambit* to address institutional processes.

The next chapter presents these findings and locates my theory within the existing literature. The discussion chapter draws on prominent ideas that underpin the theory's categories and conditions. I also demonstrate how my findings concur, contradict, or elaborate on other extant literature.

# Chapter 6 Discussion

This thesis began by describing the complexities of working as a psychologist in a public healthcare system. The political nature of a healthcare system, along with the challenges placed on psychologists were emphasised. The debate between specific and common factors in therapy, and the role of the therapeutic alliance in therapy was discussed. The inherent flexibility of common factors thinking, allows for therapy to be applied in a contextually sensitive way and this insight contextualises the theory that, for clinical psychologists working in public health, *Alliance-Building is a Gambit*.

The theory that *Alliance-Building is a Gambit* proposes that psychologists use the interpersonal resource of *allying* with their clients to manage *Being Productive*, *Navigating Power* structures, and *Revisiting Protocols*. In this way, therapy becomes a tool or gambit to manage their working environment. The theory is predicated on two central contextual conditions that are ever-present and that create the necessary circumstances to facilitate *Alliance-Building as a Gambit*. These are that clinical psychologists find working in the ANZ healthcare service challenging and confronting and are left *feeling vulnerable*. Second, they adapt their therapeutic approach to be more relational and contextual through a process labelled *allying*.

This chapter places this theory in the context of the current literature and relevant corresponding theories. The first section begins by conceptualising a public healthcare system as a system of power maintenance, with attention to the implications for psychologists. Next, the work of Foucault and social constructionists such as Ahmed and Olle is discussed. These thinkers help explain why psychologists are left *feeling vulnerable* and disempowered in DHBs.

This is followed by a second section that explores how participants make sense of therapy, especially the value and meaning they attach to therapy as an expression of their values and aspirations. One of the central conditions of the study, the concept of *allying*, is explained and contrasted with other established concepts; most notably, Bordin’s (1979) theory of the therapeutic alliance. I then explore the implications of attempting to provide therapy within the ANZ public healthcare service, and how organisational pressures impede the ability to provide effective therapy in this context. The final section of the chapter concerns the three categories of the theory that describe both the complexities of each category, and the way *Alliance-Building is used as a Gambit* by clinical psychologists in dealing with each of these complexities.

## Participants' experience of the ANZ healthcare service

The participants in my study described working in ANZ healthcare service in vivid and confronting terms, and they often seemed conflicted and bemused. They expressed pride and appreciation for the opportunity to be part of community mental health and described finding meaning and camaraderie in work. However, they also described feeling unsettled, marginalised, anxious, and fundamentally vulnerable. They also reported a range of challenges that make their working life daunting, including include high caseloads and work stress, a concern with the political agenda of DHBs, and the overemphasis on outcomes and throughput. They described the frustration of feeling excluded and marginalised by the leadership structure and their medically trained colleagues.

The participants experienced the ANZ healthcare service as vast and political, and capable of exerting a disproportionate influence over their behaviour and moral choices. Sometimes the participants portrayed the ANZ healthcare service as an all-consuming machine, devouring their time, energy, and expertise, an entity with little feeling or regard for its participants. In addition, they described a distinct sense of incongruence and disconnect between themselves and their working environment, leaving them vulnerable and uncertain. In essence, they described a complex relationship with a complex institution.

## A Foucauldian perspective on public health

Foucault wrote extensively on the relationship between the individual and the discursive fields and organisations they inhabit, and he was especially interested in how social structures shape human subjectivity. Foucault (2014) notes that the healthcare structure looked very different 100 years ago. To Foucault, in the 19th century, the healthcare structure was driven by individual initiative, predicated on the principle of supply and demand, and was primarily designed to serve the needs of the elite. He referred to this as a *private liberal medicine*. With the evolution of social improvement initiatives and industrialisation, a different medical management apparatus emerged, one “determined by authorities, supported by administrative apparatus, framed by legislative structures, and addressing the entire collectivity” (p. 113). This new “politics of health” (p. 114) described the collective reaction to the presence of biological illness in society. Foucault argued that population health is as much a political and social movement as a health improvement process.

The ‘new’ politics of health has continued to grow and eventually has come to incorporate more than just disease (Foucault, 2014). It also includes the idea of ‘wellbeing’ and specifically how we are expected to *be* unwell, and how we are expected to *treat* the unwell. The present ANZ healthcare service agenda, and especially the principles described in *He Ara Oranga* (New Zealand Government, 2018), serve as an example of this shift in conceptualising wellness. From a Foucauldian perspective, *He Ara Oranga* promotes a different interpretation of wellness and care. Foucault thought of these social structures as a collection of far-reaching practices to shape and control the population.

Importantly, Foucault did not see these structures as inherently threatening to people or society, but rather as an outflow of expertise and knowledge (Coveney, 1998). According to Coveney, (1998), these structures are always productive, not just in terms of the impact on the public health profile, but also in producing modern subjects. In this case, the subjects are the providers and consumers of healthcare in the ANZ healthcare service. In the context of health, structures define what it is to be healthy and supervise the proper routes to health maintenance. They provide identity to those involved in the structure (Coveney, 1998).

According to Foucault (2014), the healthcare apparatus applies an idea of collective health to the population and, in doing so, generates a system of perpetual observation, measurement, and improvement of the “state of health” (p. 118). The participants in this study were only too aware of being part of an observation and monitoring system. Max noted that DHBs require “bits of reporting” that are “extraordinarily important for the organisation”. He refers specifically to clinical monitoring tools such as the *Health of Nation Outcome Scales* (HoNOS) that are used to track client progress. These reports require regular updating by healthcare workers, and are part of an overarching system of oversight of those in care (and, in a different way, of the *providers* of care).

The participants in this study described a concern that their clinical role in the ANZ healthcare service may be subsumed and overtaken by the need to monitor and manage clients. This can, in turn, impact the quality of care and relationships with clients. Gillian noted that some clinicians get “sucked into the administrative requirements of the system and have devolved themselves of responsibility” for the wellbeing of their clients. In essence, the monitoring aspects of working in a DHB become the role of healthcare workers, rather than a support process for clinical care.

Foucault’s ideas extend beyond observable and measurable monitoring. Much of Foucault’s writing focuses on the interdependent dynamic between knowledge and power in society, especially how power is continually being renegotiated through maintaining social processes that we all participate in (Roberts, 2005). This is elegantly illustrated in the concept of a Panopticon. Foucault (as cited in Peerson (1995) uses the metaphor of a prison organised around a surveillance tower. A guard can observe the prisoners from the tower and identify and regulate their behaviour. With time, the prisoners begin to organise themselves, knowing they are being watched. Eventually, a guard is no longer needed because the very assumption that someone may be watching is sufficient reason to behave appropriately.

The participants in my study repeatedly refer to the experience of being made subject to the structure of a healthcare system. They described the expectation that they will maintain the agenda of the ANZ healthcare service. They felt obligated to achieve goals set by the ANZ healthcare service, and consider themselves socialised into embracing the values embedded in the organisational processes. Gillian relayed an anecdote that illustrates this, describing how a group of graduate nurses in her previous hospital reported feeling uncomfortable with how a suicidal youth was being discharged. Gillian describes how, despite their unease, they were compelled “to take a different tack”, which was “counter-intuitive” to their instincts as nurses. They were made subject to the rules and agenda of an inpatient mental health service. This study will return to the idea of psychologists challenging the surveillance they are under. In all three institutional processes that comprise the categories, alliance-building is utilised as a resource to confront the institutional processes that organise psychological therapies in the ANZ healthcare service.

## The Aotearoa New Zealand healthcare service as contested power

Foucault considered the system of surveillance and oversight as an expression of power. However, in Foucauldian terms, power is never straightforward. Foucault held the view that there were multiple versions of power, and that power is reconfigured, contested, and negotiated (with varying degrees of fairness) within a system (Gallagher, 2008). According to Gallagher, Foucault was not interested in power *per se*, but rather how power is distributed. In Foucauldian terms, power is both a means of control and resistance. The renegotiation of power defines an organisation’s structure and stability (Roberts, 2005). Other contemporary writers have offered a social constructionist-informed interpretation of how organisations maintain power balances and sustain internal integrity. Ahmed (2012) conceptualises organizations as the manifestation of actions and processes that have become habitual, and they are collectively maintained by the participants therein. The organisation is thus the embodiment of the shared, habitual (or at least not overtly contradictory) behaviour of a collective that serves to maintain the system. They have become what she calls a “habitual body” (p. 127).

Olle (2018) draws attention to how participants in the system, in this case, psychologists in a DHB, are expected to maintain their collective habits. Any attempts to behave to the contrary will result in sanctions and even expulsion from the system. According to Olle (2018), the ruling majority “preselect the social environment” (p. 194) and exclude competing messages that doubt the social order. The habitual bodies then sanction anyone who does not work towards maintaining these social habits. In this study, participants regularly described their explicit efforts to avoid or extricate themselves from maintaining the habits of their organisations.

In Foucauldian terms, these actions become the ways by which power is contested. As an example, participants in this study would often ignore the expectation to use a brief episode of care models. Rather than following prescribed approaches to therapy, participants tended to adapt their approach based on their clinical judgement and values. Brodie, Paul, and others described how this aggravates and unsettles the service leadership and leads to psychologists being seen as obstructive and reluctant team players.

For Ahmed (2012), organisational habits are often predicated on the needs, assumptions, and agendas of an elite few who impose the habits on others. Ahmed uses the example of dominant ethnic majorities who hold power over various social organisations. But in healthcare, the participants in my study see the system as maintained by dominant discourses such as the overriding need for productivity and the centrality of biomedical thinking. As a result, participants in my study described feeling the pull to confront and challenge the dominant discourse or the habitual patterns of the ANZ healthcare service.

Andre described disconnect between clinical psychologists and the ANZ healthcare service, which is a disconnection predicated on differing values. At the heart of this diversion are two types of tension between participants and the broader organisational agenda. First, at an organisational level, there is a disconnect between the clinical and operational needs of the ANZ healthcare service (Martinussen & Davidsen, 2021). At a clinical level, there is a disconnection between the biomedical paradigm of care, focusing on symptom reduction and pathology, and the biopsychosocial paradigm focusing on recovery and rehabilitation (Wahass, 2005).

Le Boutillier et al. (2015) provide an example of this disconnect. Using grounded theory, the study explores the impediments and barriers to integrating a recovery-focused practice model in a community hospital. It found that competing priorities vie for influence over the organisational development of the service. Their findings suggest that three types of priorities compete for dominance: business priorities, health process priorities, and staff role priorities. Other researchers have elaborated on the impact of these competing priorities.

In Waldemar et al. (2016) research, participants described struggling with the paradoxical nature of community healthcare. They described being given clinical responsibility for patient safety and wellbeing, consistent with the biomedical model. However, they were also burdened with the expectation of encouraging patient autonomy and agency, which is the intention of recovery-focused care. These priorities are echoed in my research. The participants in my study described struggling to balance their clients' needs with those of the public healthcare service; they described having to make difficult choices and feeling compelled to side with their clients. Frequently this happens through the decision to continue or maintain therapy, despite organisational pressures.

There is some evidence to suggest that psychologists can, and do, reshape their organisational culture through their clinical practice habits. Beidas et al. (2015), for example, conducted a cross-sectional study of 23 mental health organisations and found considerable variation from the prescribed models. The authors hypothesise that therapists were diverging into different models and eclectic practices based on a combination of the population’s needs and the therapist's preferences. These authors call this process “exnovation” (p. 380), or the tendency for participants in an organisation to disinvest themselves from an innovation that the service had previously adopted. Sometimes this disinvestment is at great expense to the service. This is an example of psychologists impacting their organisation through their therapeutic choices.

### The role of organisational commitment

One outcome of living with this tension is the degree of emotional investment psychologists have in their organisation. This is called organisational commitment and refers to the degree of emotional and practical investment employees have in their working environment (Goh & Marimuthu, 2016). Goh and Marimuthu (2016) propose a three-part model that describes the mechanics of why employees would commit to an organisation. This model suggests that psychologists could have an affective, normative and continuance motive for staying and investing in their healthcare service. Affective commitment refers to staying invested because you want to; normative commitment describes staying because you feel you ought to; and continuance commitment refers to staying because you have to.

However, the participants in this study described a different relationship to organisational commitment. They articulated a high degree of affective and normative commitment to their clients and community, and less so to the organisation. Lower organisational commitment predicts higher staff attrition (Gokce et al., 2014). Perhaps unsurprisingly, ten out of the 17 participants in my study have since left their original roles, despite expressing firm commitment to their clinical work. My findings suggest that organisational commitment can focus on the organisation's tasks (i.e., therapy) and content (i.e., clients) and not necessarily to the organisation itself. This refocusing of commitment to clients may also be why participants were readily able to disregard or reframe the organisational activities of the public healthcare service, and why they so heavily invest in client-focused work habits at the expense of organisational approval.

This section considers Foucault’s concept of an infrastructure predicated on power distribution and surveillance through bureaucratic protocols. Ahmed (2012) adds to this the view that habitual processes perpetuate a pattern and reject any divergence, and Le Boutillier et al. (2015) locates this tension in competing priorities within this habitual environment. Finally, the notion of organisational commitment is a way of conceptualising the day-to-day investment of the participants. Psychologists attempt to provide therapy within this complicated and dichotomous world. And consequently, therapy becomes embroiled in these negotiations of power and conflicting institutional processes. The following section outlines the participants’ experiences of providing therapy within this context, with special attention paid to the alliance-building aspects of therapy.

## What therapy means to psychologists

The following section explores the experience of psychologists providing therapy in a public healthcare system. The data suggest that psychologists hold a different narrative in respect to therapy compared to the public healthcare system. Over the past century, therapy has been used both as a clinical intervention in psychological care (Wampold & Imel, 2015b), and as a political instrument to address civil concerns and social injustices (Hayes, 2000). However, the ANZ healthcare service position psychological therapies to serve a different social intention. From the perspective of a public healthcare service, psychological therapies are an instrument of the healthcare apparatus; and can and should be judiciously and strategically implemented.

An example of the ANZ healthcare service's efforts to organise therapy into a service resource is the *distillation and matching model* (Kall et al., 2020). This involves coding and identifying common elements or techniques of evidence-based treatments and organising them into a series of protocols for specific problem areas (Kall et al., 2020). An example of this model implemented in a New Zealand DHB is the MATCH program. MATCH involves combining aspects of several evidence-based treatments to provide a therapy plan that can target multiple mental health presentations in youth (Ng & Weisz, 2016). There is credible evidence to support the claim that the matching and distilling model effectively operationalises therapy for use in a public healthcare service (Kall et al., 2020; Michelson et al., 2020).

Initiatives such as MATCH risk turning psychological therapies into something akin to medical interventions like blood tests or MRI scans. Therapy becomes one of many resources in the collection of tools for the improvement of community health. Some psychologists have expressed concern when healthcare services treat therapy as a form of medical intervention. Bharucha et al. (2006) argues that framing therapy as a medical intervention risks placing restrictive parameters on therapy and negating its flexibility and adaptability to clients' needs. These authors call on organisations to allow clients and practitioners to inform the treatments to be considered, rather than have models imposed on patient-based service policies. For Bharucha et al. (2006), therapy is owned by the people who use it, rather than healthcare organisations or social infrastructure.

The findings of this study support Bharucha’s, as the participants also place a different kind of value on psychological therapies. Therapy becomes a means to express an aspiration or a value stance. The participants described their deep emotional connection to providing therapy in this study. It is perhaps understandable that psychologists may be protective of therapy and describe therapy as a moral imperative, a source of personal pride and esteem, and an expression of expertise. Their relationships with their clients are deeply personal and precious experiences.

### Therapy as a personal experience

The participants in the study are not alone in this perspective. Miller (2007) interviewed a collection of senior therapists to explore the characteristics that encourage longevity in the profession. He notes that psychologists who hold a transcendent approach to their work sustain a long and esteemed career. Miller describes this positioning as being alert to the “unnameable” (p. 175) things that happen in therapy; the powerful transpersonal experiences that therapists encounter; and the sense of participating in something extraordinary and life changing. Similarly, Dlugos and Friedlander (2001) interviewed twelve peer-nominated well-regarded psychotherapists, finding that respected psychologists were also characterised by a particular approach to their therapy. Along with lifestyle qualities such as life/work balance and holding perspective, they frequently described their work as a spiritual or transcendent experience, which instilled a sense of humility and appreciation for the world.

Ronnestad and Skovholt (2001) conducted a similar study on retired therapists and found that their most consistent quality was the ability to learn from their own experiences and to learn from their clients, and integrate this learning into their therapy. The therapists in Skovholt’s study describe a deeply personal experience of providing therapy and state that the ability to fully embrace the process is vital to a sustained and successful therapeutic life. While these various research projects involve psychologists working across various contexts, their perspective is consistent with what the participants in my study conveyed. It is striking to consider how at odds these experiences are with the outcome-focused, evidence-based treatment emphasis on therapy exemplified in a public healthcare context. One of the participants, Jennifer, lamented this disconnection between herself and management: at one point in her description of compelling therapeutic experience, she mused, “gosh, if you guys were just in the room…”.

As expected, participants described using evidence-based treatments such as CBT and working from a scientist/practitioner paradigm. However, upon closer examination, the participants in this study emphasised their need and desire to extend their therapy beyond evidence-based practices. This restless and adaptive approach to therapy is also noted by other researchers. Zarbo et al. (2016) note that therapists increasingly define themselves as integrative in their therapy approaches. Tasca et al. (2015), for example, surveyed over a thousand therapists, and their results found that only 15% of therapists work from a single therapy model. Instead, the average therapist integrated four different theoretical models into their routine practice.

Wachtel (2010) welcomes these developments and argues that, contrary to evidence-based treatments, integration should be embraced and seen as a strength in therapeutic care. The flexible and eclectic attitude among participants may also be explained by their seniority and experience. Hamill and Wiener (2020) found that psychologists with under five years' experience tend to identify with evidence-based practices strongly, but that this positive relationship decreases sharply after five years' experience.

## Allying as a conceptual variation on therapy

The participants in the study repeatedly alluded to the essential value they place on the relational aspects of therapy. Taylor commented that a psychologist's identity is “wrapped up with developing a quality relationship” with clients. To illustrate this, the participants seldom used typical evidence-based terminology to describe their therapy experiences. More often, therapy was described as interpersonal processes such as, “building a relationship” (Jody), or “wrestling with my client” (Gillian). These are examples of the practical and relational aspects that anchor and drive therapy forward and the interpersonal process that underpins and sustains clinical interventions. The participants talked about accessing the power of therapeutic relationships and unlocking a more meaningful connection. They referred to the significance of the therapeutic alliance, the rituals, and the hope instilled in their clients as the essential value of therapy. This philosophy is consistent with common factors thinking, and dates to the foundational origins of therapy (Castonguay et al., 2015; Wampold, 2015).

In this study, the therapeutic alliance is expressed through the activity of *allying*, which is also the second condition of the theory. The concept of *allying* was constructed from the descriptions participants give of their therapeutic processes. However, the concept of *allying* is similar to the concept of a therapeutic alliance. The therapeutic alliance is typically defined as the sharing of tasks and developing an affective bond (Bordin, 1979). *Allying* also shares similarities with Frank and Frank (1993) seminal work on therapy's universal and ritualistic dimensions. According to de Figueiredo (2007), Frank and Frank emphasised the need for the therapist and client to construct a shared collective scheme or myth to establish a sacred and meaningful relationship for therapy. Frank and Frank (1993) argue that these shared myths serve several vital functions, encouraging participation, creating a place of safety and continuity, and fostering a transcendent and meaningful experience.

By developing and using the concept of *allying*, I acknowledge the work of Bordin on the therapeutic alliance, and Frank and Frank ’s ideas on myths and rituals in the process of connecting. However, in the context of data this study also encapsulates the political and relational interdependencies that occur in the process of therapy. The word *allying* has several important connotations. On the one hand, *allying* refers to standing beside another or joining forces for a shared goal. It is also a concept associated with various social justice concerns, as *allying* describes standing alongside someone in the face of injustice (Gibson, 2014).

In this sense, the word conjures up activism, awareness, and solidarity. In the context of this theory, *allying* refers primarily to connecting around a shared agenda and doing so in the face of a complex environment. Once psychologists de-emphasise the symptom-reduction, treatment-fidelity paradigm of therapy, then the therapy has space to carry different meanings. Therapy can serve systemic and contextual functions and become a context for a different type of relationship to public healthcare services.

## The effects of providing therapy in public healthcare

The findings of this study suggest that psychologists experience therapy as an expression of their values and ideals. They are also protective of their skills and the therapeutic process. This emotional agenda has its origins in the underlying sense of vulnerability that psychologists encounter when working as therapists in a healthcare organisation. The following section elaborates on the undercurrent of vulnerability and links this emotional experience to the decision to use alliance-building as a gambit.

### Feeling vulnerable

Data from this study depicts two broad areas of vulnerability: the risk of feeling excluded or located on the periphery, and the perception of not being good enough for the task or *feeling exposed*. Stewart et al. (2014) make a compelling case for the need for psychologists at all levels of ANZ’s healthcare system. They argue that psychologists can offer specialist clinical interventions and support to other mental health providers. However, several participants in my study did not share their optimism. They described psychologists as being in a precarious position.

Some, like Niles and Max, described feeling increasingly marginalised and excluded as a profession, especially as other professions are trained in psychological therapies as a way to increase service capacity. Their concerns are consistent with other literature and publications. Bellamy (2014), for example, published an article describing the advantages and disadvantages of introducing a stepped care model in Aotearoa New Zealand, echoing my participants' concerns about the risk of devaluing psychologists in public healthcare systems. Similarly, Saddington (2021) study found that psychologists felt undervalued and increasingly marginalised by management and that this is a critical factor in staff attrition in the NHS.

Other writers have been even more alarmist. Van Ommen (2014) critiques the increasing neoliberalist tone of the Aotearoa New Zealand political agenda. He calls for the psychology community to be more assertive at a political and societal level. For Van Ommen, to remain passive is to risk being “complicit” in their own “dismantling” of psychological services in the infrastructure of Aotearoa New Zealand’s healthcare system (p. 67). These publications hardly instil a sense of confidence in psychologists working in the ANZ healthcare service.

This is not only a characteristic of mental healthcare in Aotearoa New Zealand. Rous and Clark (2009) note that one of the central concerns described by psychologists working in the NHS is the fear of being replaced following austerity measures and shifts in treatment paradigms. Walsh and Cormack (1994) suggest that psychologists are typically prone to marginalisation and professional insecurity. Walsh suggests that one possible contributing factor may be the relatively small and professionally specific role psychologists play in healthcare settings. Again, this concern is echoed by participants in the study; they often perceived themselves as operating as a small niche service in danger of being subsumed.

### Professional self-doubt

The second condition that facilitates and encourages *Alliance-Building as a Gambit* is a fear of not being practical or meaningful to clients. This is encapsulated in the condition called *feeling vulnerable*. Psychologists in the ANZ healthcare service work with the most complex high-needs clients in healthcare and are confronted with suffering and distress almost daily. These environmental stressors, coupled with organisational stressors, work overload, and administrative frustrations, extract an emotional toll. Most of the literature defines these stressors in terms of occupational stress responses. The most prominent of these is compassion fatigue and burnout, which concern the psychological effects of chronic exposure to trauma (Figley & Figley, 2017) in the former; and overwhelming working environments (Levinson et al., 2021) in the latter.

However, the participants in this study describe feeling vulnerable differently. *Feeling vulnerable* takes on an existential quality and is more about value and purpose than productivity and coping. Boellinghaus et al. (2012) highlight that psychologist are prone to placing unreasonable and overwhelming expectations on themselves. The very nature of being a therapist involves availing oneself of the suffering of others, and psychologists pay a high price for investing their empathy and compassion. The participants in this study exemplified this and described a deep-seated concern that they are not being genuinely effective and that they cannot meet the expectations of their role or clients.

They described fearing incompetence that results from working in an environment that hampers and impedes their capacities. Several studies have explored this innate sense of vulnerability at the heart of being a psychologist. Hannigan et al. (2009) provide an overview of several studies that conclude that along with workload, the complexity of clinical work, and organisational stressors, a leading predictor of burnout and poor job satisfaction is a pervasive and frequently felt sense of professional self-doubt.

Other writers have explored self-doubt as a process of psychological self-reflection within the context of organisational pressures. Tweed et al. (2000) conducted a grounded theory study exploring psychologists' feelings about client non-attendance in a community health service. Their findings suggest that the non-attendance of clients evoked a compounded sense of responsibility towards the healthcare service and the client. They describe a sequential process of making sense of non-attendance. This consists of an initial feeling of personal responsibility that evolves into a sense of dismay, followed by personal reflection and processing emotions, and finally, finding perspective. Tweed's study suggests that psychologists experience non-attendance of clients deeply personally, a scenario that provokes self-doubt and consternation. The event triggers fears that they have failed their clients, their service, and themselves.

Tweed's study hints at the contextual nature of *feeling vulnerable*. Her study suggests professional self-doubt is not purely an issue of personal efficacy but is a consequence of environmental pressures. Self-doubt emerges in the interaction between the organisation and the practitioner. My study does differ from Tweed in one crucial way: my participants did not describe any sequential processes that led to a conscious resolution. Instead, they described feeling concerned that they have let their clients down or have not been sufficient as therapists. They felt angry at being overworked and underappreciated and deeply concerned that their clients may have been compromised by their overworked state. However, they described reacting intuitively and almost unconsciously to this consternation by seeking comfort and perspective in their therapeutic work. Their primary salve is the emotional and professional satisfaction from connecting and caring for their clients.

Another grounded theory study also illustrates the concept of organisational pressures evoking self-doubt. Tickle et al. (2014) explored psychologists' perception of risk and recovery-orientated mental health services. Their study developed a theory that psychologists operate in a conflicting dynamic between the service culture and their professional concerns. The mediating factor is the ability and opportunity to work with management towards a shared conceptualisation of risk in their environment. A vein of vulnerability underpins Tickle's study. The psychologists in that study were caught between two paradigms, which left them concerned with the care they provide. Tickle's study also highlights the tensions between systemic processes and professional processes and how psychologists can be left *feeling vulnerable*. Tickle's participants were left trying to reason their way out of an impasse by adopting a higher order of conceptual thinking. However, in contrast to Tickle, participants in this study enabled and fortified themselves, through therapy, to address tensions that could overwhelm and hinder them.

Psychologists are confronted with messages of their vulnerability both in published literature and in their observations of their daily practice. The stress of *being on the periphery* and *feeling exposed* compels participants in this study to act in defensive and self-preserving ways. They are left managing this unacknowledged affront to their professional security by drawing on their resources. Many participants regularly, and often rather casually, commented that they simply keep their heads down and get on with their work. The participants thus focus their attention on the one thing they have some control over, their clinical activity. The expertise, credibility, and insights they gain from therapy serve to sustain themselves professionally and help them navigate their way within the ANZ healthcare service.

## Introducing the three categories

The sections above examine clinical psychologists' experiences of working in the context of an ANZ healthcare service. The ANZ healthcare service can be seen as a contested space where the tensions between organisational and clinical needs arise. The participants in this study are compelled to navigate this tension and use the resources at their disposal to function effectively. The central resource in their skill set is their ability to *ally* with their clients. The relational aspects of therapy take on a strategic and systemic quality. The following section explores how clinical psychologists use *allying* to address these institutional processes. The difficulties they encounter and the strategies or gambits they employ to participate in the public healthcare system, are discussed as they relate to existing evidence.

## Alliance building is a gambit in being productive

The psychologists in this study described the expectation of *Being Productive*, to think of clients in organisational terms and work rapidly and efficiently. They were being asked to be *doing more*, and this is an experience they find disconcerting. The participants recognised that certain compromises between clinical and organisational priorities need to be made and that high mental health needs necessitate a brisk and suitable level of care. But it is the narrative that drives *Being Productive* that causes them concern. This is an experience common among psychologists in healthcare settings. Multiple studies have highlighted psychologists' concerns that outcomes and budget management are the prevailing priorities in healthcare settings and have reported that the standard of care suffers (Colley et al., 2015; Nutt & Keville, 2016).

Nutt and Keville (2016) explored the impact of high workloads on psychologists' clinical activity in the NHS. Their participants described that coping with the intense pressure of *Being Productive* deprived them of time to think, consult with colleagues, or give clients proper attention. They described feeling constantly flustered, overstretched, and inefficient. Unfortunately, the authors do not offer any pragmatic solutions to the challenge of *Being Productive* in this climate of stress. But the participants in my study do offer a response; they turn to their main resource in managing this consternation. The central finding of this study is that my participants demonstrate their productivity by *allying* with their clients and *retreating* in their clinical relationships. *Retreating* involves ring-fencing their therapy activity and emphasising their commitment to their client relationships, even excluding other organisational functions. It is an act of focused productivity, even at the expense of other organisational priorities. The participants demonstrate and even renegotiate what it means to *Be Productive*, by retreating.

A qualitative study by Colley et al. (2015) describes the interplay between psychologists' concerns, organisational expectations, and how psychologists use their professional skills to navigate organisational stress. Colley concludes that, when faced with the stress and disruption of organisational change, the psychologists in their study retreat to their psychologist identity to cope with uncertainty. Colley also describes some of the strategies they apply. These include drawing on their formulation skills to make sense of the change and manage their fears. Other participants adopted a proactive stance in the face of organisational malaise by attending training, including themselves in leadership meetings, and focusing on serving their clients better under the circumstances.

My data corroborates Colley's (2015) conclusion that psychologists retreat as a way of coping with organisational pressures. In both studies, the focus is on how psychologists respond to organisational influences and expectations of *Being Productive*, specifically, how they utilise the tools of their trade to that end. However, Colley's participants retreat to their conceptual and facilitative skills as a way of *Being Productive*, or at least to prepare for change; whereas data from this study indicates that participants evidence and represent their productivity by providing immersive therapy for their clients. *Retreating* becomes a mechanism to respond to demands and organisational expectations. *Retreating* also becomes a strategy to protect themselves and their clients from the overwhelming pressure to be productive.

By *retreating,* psychologists convert therapy into a mechanism for promoting and instilling depth and quality in clinical care. Psychologists see *retreating* as a means of being effective therapeutically, and still protecting the therapeutic process from organisational pressures. Some of the participants describe their efforts to reframe what therapy can be in the context of the public healthcare service. Henk says, “it is all about the client” when the door closes. Clare talks about the “responsibility to do the best for your client”, including shutting out external forces. Gillian feels focusing on the therapy and drawing clients away from the organisational expectations to the therapy process sends the clients a message – “you are important… This is important”.

Scholars echo this stance with a particular focus on interpersonal therapies. Richardson and Hobson (2006), for example, offer a robust defence of psychodynamic therapy in public healthcare systems. They advocate for the preservation of intensive and long-term therapy, despite the organisational inconveniences this may cause. Richardson acknowledges that the more intensive forms of psychodynamic therapy can be time-consuming, expensive, and difficult to standardise. But they argue that without specialist, interpersonally responsive therapies, many at-risk clients would be ejected from the public healthcare system. And at an organisational level, the depth of what therapy can offer the public is undermined.

Hyde and Thomas (2002) suggest why *retreating* can serve to protect both clients and practitioners with a public healthcare service from the need to be productive. Drawing on the work of Isabel Menzies (1960), they describe how in a state of high distress and vulnerability, patients in hospitals are apt to project their anxieties and fears onto the staff and organisation. Healthcare workers are expected to deal with projected distress and emotional responses, which can be overwhelming. Hyde and Thomas (2002) argue that healthcare workers and institutions respond with an entrenched resistance, or in psychodynamic terms, with a structure of “organisational defences” (p. 409). The staff and organisation are expected to conform to unconscious collective collusion to protect the hospital system from patient distress. These defences are typified in the organisational expectation to maintain a certain emotional distance from patients, or in the privileging of administrative tasks over client contact.

Participants in this study reported being keenly aware of this process of unconscious collective collusion within public healthcare services. They describe feeling disquieted by inadvertent efforts from DHBs to hold clients at a distance or the expectation that psychologists focus on administrative tasks. Henk talks about having “concerns for a therapist” who lets organisational processes into the therapy space. My study differs from the theory described by Hyde and Thomas (2002) in that my participants responded to a culture of organisational defences in an unexpected way. Rather than capitulating to service norms, they dealt with the internal discomfort these defences evoke by *journeying*, *immersing*, and *aligning* more strongly with their clients. They abandoned the organisational defence and the distance this encourages, and they responded by *retreating*.

It is worth noting that sometimes this strategy has unintended implications. Andre describes how psychologists who *retreat* risk becoming isolated from their team, which can lead to the dyad serving as a target and source of projection by colleagues. Hyde and Thomas' (2002) ideas illuminate how a setting like a DHB can see *retreating* as disruptive; and as Andre observed, and Olle (2018) predicted, psychologists can feel sanctioned and marginalised for not participating in this collusion.

The process of *retreating* has interpersonal and social implications for psychologists. On one hand, this strategy can advance the agenda of psychologists, as *retreating* emphasizes and maintains a narrative of expertise, and can elevate the standing of psychologists in the teams. Conversely, *retreating* can also be perceived as isolationist, elitist, and even obstructive. This also shifts the service culture as psychologist can be seen as the outsiders in their teams, and thus there may be at greater risk of disconnect with their working environment.

### Alliance-building is a gambit in navigating power

Jordan et al. (2021) argue that while ANZ healthcare systems may strive for a recovery-focused model of care, they tend to default back to the organisational patterns of the biomedical model. A contributing factor to this defaulting tendency is the power and influence doctors hold over the clinical process. The participants in my study described this experience and reported a lack of power and influence in shaping the clinical processes and contributing to the discourse. This leaves them *feeling vulnerable***.**

The participants described feeling superfluous and peripheral; they felt their skill set was secondary. They were compelled to *recognise their place* in the power structures of the ANZ healthcare service. As Henk noted, therapy is often introduced only after trialling a medicine. Gillian commented that therapy is requested “after all the important bits” are done in medical interventions like diabetes management. The participants describe being exasperated by this imbalance of influence within their clinics and hospitals.

The participants join a chorus of disapproval about the inequalities of power distribution in healthcare settings (Wahass, 2012). However, the participants also adopt a collection of proactive strategies to contribute and influence the clinical activity in their teams, especially the process of developing clinical formulations. The participants demonstrate their value and expertise by *collaborating* with their teams, especially doctors. *Collaborating* involves reframing their relationship with doctors in less power-based terms, adopting an inclusive stance, and seeking similarities and a shared experience. In addition, c*ollaborating* involves using clinical activity, especially the ability to *ally* with clients, as leverage in efforts to contribute to clinical dialogue, and re-negotiate power with the doctors and other colleagues.

Lim and Klein (2006) offer an explanatory model for the psychological processes involved in team collaboration that illuminates my participants’ motives. Lim and Klein suggest that group members are formally and informally socialised into holding a shared cognitive model of their tasks, objectives, and goals. This creates a shared *team-based mental model* that fosters connection and ensures that the team can collaborate (Lim & Klein, 2006). This is true even if they hold different roles and agendas; or if they may not know each other well. To illustrate, Mathieu et al. (2000) explored the role of shared mental models in-flight crews and found evidence of its positive effect on team functioning. In a commercial flight crew, each professional knows the rules and procedures of a commercial flight so well that a new member can slot in seamlessly. This is because they all share a team-based mental model.

The central context where clinical psychologists and psychiatrists contest and are *Navigating Power* is in MDT formats and clinical formulations development. When the participants in my study try to *collaborate* with doctors and their colleagues, they are trying to influence and be part of the shared model. They do this by demonstrating their rich psychological understanding of clients' needs that they have derived from *allying*. The participants in this study also described the importance they attach to *collaborating* and contributing to clinical formulations. Several participants described an ethical and professional responsibility to contribute to the MDTs, even if their contribution felt unwelcome. Research suggests that sometimes psychologists experience this difficulty in contributing and are subtly strategic about how they contribute. To illustrate, Christofides et al. (2012) interviewed psychologists in community hospitals and described how psychologists, much like the participants in my study, regularly contribute to the clinical conversation by "chipping in ideas" (p. 429) during team discussions. This is an effective way of introducing a psychologically orientated discourse into team formulations.

Ebrahim (2021) suggests that psychologists contribute both direct interventions (i.e., their clinical therapies and assessments) and indirect interventions. These indirect interventions support staff in developing resilience, in-service training, and corridor conversations that focus on psychoeducation and formulation insights. Ebrahim argues that psychologists are championing and influencing the development of a biopsychosocial model in healthcare settings by providing these indirect interventions. He suggests that their collaborative efforts are also politically purposeful, institutionally impactful, and serve as an attempt to share and gain power over the clinical landscape.

Several participants described an inherent tension between doctors and psychologists that may amplify that sense of responsibility. The consensus is that psychologist and psychiatrist roles overlap, and they share clinical territory that both could influence. This perspective is consistent with Leventhal et al. (2021), who reports that psychologists develop greater confidence and collaborative skills when working with non-psychiatric doctors and related professions like nurses. However, he also notes that psychologists' confidence is reduced when working with psychiatrists. But despite experiencing this tension between psychologists and psychiatrists, the participants in my study described ways to *collaborate* in their clinical teams. Their collaboration may involve reframing their relationship with doctors in less power-based terms, or they may adopt an inclusive stance and seek similarities and a shared experience.

In each version of *collaborating*, the leading resource that the participants draw on is their alliance with their clients. It is the source of their credibility and expertise. Jude and others described the credibility they gain through their relationships with their clients as a cache of influence. Their efforts to *ally* with clients allow them to contribute to clinical meetings and discussions around formulations confidently. In this way, they can assert some influence on the clinical discourse. At other times participants like Layla use their capacity to *ally* with clients to contain and calm colleagues. In this way, the participants bring reassurance and insight to their colleagues through their client-based expertise.

Janss et al. (2012) offer a theoretical model to illuminate how Layla and Jude use their clinical expertise to influence their environment. Janss et al. introduce the concept of *pre-existing power perceptions* (PPPs). This is the degree of power a practitioner perceives themselves to have, relative to their colleagues. PPPs are based on practitioners' personal history of contributing and their historical relationships with colleagues in previous contexts. Practitioners endeavour to accumulate as much PPP as possible by contributing to teams and demonstrating their clinical skills. They then take this degree of PPP into their reconfigured teams. This is because having a high level of PPP increases the likelihood of being seen as a source of expertise. From this perspective, team members are caught in a perpetual process of upgrading and enhancing their PPP.

Each new team is not so much a collection of professionals but also a collection of ever-developing pre-existing power perceptions. Essentially, one’s professional role and expertise may ensure that you have something to contribute, but PPPs influence whether you feel your colleagues will listen. The concept of PPP is especially relevant to teams that constantly reconstitute themselves, as in clinical teams. The participants in this study are strategically and systematically sharing and demonstrating the clinical insight they gain by *allying* with clients. This enhances their pre-existing power perceptions and reorganises the distribution of influence over clinical decisions. In this way, Layla, Jude, and others are strategically using *allying* with clients to redress the scales and create a clinical environment where psychologists are *Navigating Power* effectively.

Using a process of *collaborating* as a gambit to manage *navigating power* has implications for psychologists, and the public health care system. The gambit may serve to build status and credibility in the eyes of the medical community, and in this way benefit psychologists and their standing. However, *collaborating* may also serve to reinforce the perceived innate embeddedness of biomedical thinking in psychology and emphasize the alliance between medical community and psychology. In this way psychologist remain wedded to a bio-medical model; while in other respects, they hope to unshackle themselves from that discourse. Psychologists’ may be left promoting a relationship with two different paradigms in the public health care space.

## Alliance building is a gambit in revisiting protocols

Psychologists are employed to provide evidence-based treatments in clinics or hospitals. However, these protocols need significant adaptation in real-world settings to be effective. As the participants reconciled their professional training with real-world needs, they described a near-universal experience in their profession’s early years. They described becoming increasingly aware that they are not working with completely reliable and applicable treatment models and interventions.

They realised that public healthcare is complex and unforgiving, and it will take fortitude, flexibility, and above all, a willingness to truly connect, to be of service to their employer, community, and clients. This is true for the scale of the community need (Gibson et al., 2001), and the challenges of working in complex organisations such as public hospitals or clinics (Guy et al., 2012). In this way, they are *struggling with the real world* of their environment and are compelled to re-examine their expertise and tools. They realise that they are not as fit for purpose as they thought, and they are compelled to adjust or *personalise* their practice.

One of the benefits of *personalising* is that this encourages initiative, creativity, and a flexible perspective on therapy. Many participants described gradually developing strategies to meet the challenges of both their complex clients and their complex working environments. Consequently, they found themselves adapting and adjusting therapy for it to be useful. There is an abundance of examples of psychologists adapting their therapy to meet the environment's needs. An example of this adaptability is found in a study by Wood et al. (2019) which explored a clinical team's efforts to adapt their practice to suit a changing client population. Their research suggests that practitioners and teams change their behaviour at multiple levels. Typically, these include changes to the treatment approach, changes to the relationship with the broader client support system, and changes to their everyday working habits and environment. The participants in my study undertook a similar range of adaptations. Several participants described developing treatment models to help colleagues manage workload pressures and resourcing problems. Other participants described forming a relationship with a client's social network by working outside the therapy environment and within their client's community and cultural resources.

Other times the participants adjusted their practice in subtler and more strategic ways. Some of the participants described opportunistic and creative use of organisational activities to foster and extend their opportunities for therapy. For example, some participants described using case management functions as a way to introduce an alliance-building moment. Gillian described bringing her pet dog into a youth correctional facility to help her connect with an agitated youth. Gillian was attempting to create a therapeutic moment in a situation that is not entirely accommodating. Sometimes there is a subtle suggestion of insubordination in these actions.

Often the participants were knowingly challenging the norms of the organisation to create therapeutic opportunities. Gillian, for example, seemed to delight in the unconventional ploy of bringing her pet into an institution for juvenile offenders. This is also a theme echoed in literature. Court et al. (2017) describes, for example, how psychologists cope with the prescriptive National Institute for Clinical Excellence (NICE) guidelines by underplaying and restricting their description of formulations or clinical activity in their clinical notes. They bury their formulations in the institutional/NICE language, and in Court et al.'s (2017) words, they aim to appear "NICE compliant". Another example is Randall-James and Coles (2018) comment that psychologists adapt to clinical environments by "playing the diagnostic game" (p. 450) or using medicalised language, despite the limitations of medical diagnoses in pursuit of a psychosocial agenda.

While adapting practice can be an organisational and systemic process, other participants also adapted by fundamentally adjusting their therapeutic activity to better resonate with the needs of their environment. Clare and Annie described the growing realisation that the relationship experience – the experience of *immersing*, *aligning*, and *journeying* – matters most to clients, and even more so than the protocol they have been tasked with administering.

The participants described starting to realise that there is something about the flexible and immersive relationship processes that may hold the solution to the dilemma of meeting clients' needs within the restrictions of treatment models and public healthcare service expectations. *Allying* with clients serves a different purpose than the delivery of therapy. It becomes a salve or ameliorator that compensates for gaps in care and the expectations inherent in public healthcare delivery. The participants regularly commented that when clinical life gets too complicated and the pressures build, the act of therapy can feel very productive and meaningful.

However, the most important way that the participants *personalise* is by introducing their interpersonal aspects of therapy. For Annie, this is the psychologists' interpersonal efforts, personal commitment, and presence that contribute to the therapeutic process. Annie described bringing her relational self to the therapy process to compensate for the gaps in evidence-based protocols and the organisational guidelines. The literature contains many illustrations of the importance of therapist effects on outcomes in therapy (Goldberg et al., 2016; Johns et al., 2019). However, this study suggests something beyond that, that the relationship aspects of therapy correct for and alleviate the substantial community and organisational pressures that flood the therapeutic process.

There is a precedent for this strategic use of therapeutic relationships to influence an organisation’s service model. Seikkula et al. (2001) developed a model called the “open-dialogue model” for their community mental health service. The open-dialogue model utilises systemic interventions involving the whole clinical team, the patient, and support structure. The open-dialogue model focuses on the immediate and client-defined needs, and the intervention is conducted in a solution-focused and pragmatic way. Therapy is conceptualised as a needs-focused, pragmatic process grounded in a meaningful dialogue with all parties. The emphasis moves from *what* the practitioners and family are talking about to *how* they talk about problems.

Seikkula et al. (2001) conclude that introducing the open-dialogue model had organisational and systemic implications. First, the open-dialogue model’s team-based, non-pathologising approach disrupts the power dynamics within teams. It sidesteps the territorial aspects typical of a collection of healthcare professionals. Second, this model encourages a new pragmatic and client-focused shared language over the typical clinical treatment jargon. Seikkula et al. (2001) are promoting an approach to a therapeutic activity that is not tied to any model and is non-pathologising, thus fostering a different type of service. The open-dialogue model is an example of how adopting a relationally focused approach to therapy can impact and reconstitute an organisational structure.

My participants are very aware of the diagnostic presentations of their clients and regularly reference evidence-based treatments. Still, a closer reading of their transcripts suggests that they are ultimately more focused on the client and client experience than the client's symptoms. The participants concurred with concerns about the overemphasis on psychopathology in evidence-based treatments; they seemed to want to rise to the challenge of conceptualising therapy as a relational process, rather than a symptom-driven process.

In this way, they are diverging from the organisational undercurrent of biomedical care and asserting their commitment to the emerging client-driven, recovery-focused paradigm of public healthcare. However, there is a potential limitation to the participants' strategy. Unlike in the work of Seikkula et al. (2001), the participants in my study are promoting their agenda on a case-by-case basis; there is little suggestion of a coordinated effort to challenge the dominant discourse and assert a different model. In this way, the participants are missing an opportunity to influence the delivery of therapy, by not embracing a more coordinated and deliberate dialogue with the environment.

*Personalising* has significant implications for psychologists and the public health care system. By *personalising* as a way to navigate the limitations of treatment models, psychologists are addressing their vulnerability, and thus becomes an inherently self-protective act. It enables psychologists to retain a sense of meaning and agency in a complex environment and stave off burnout and compassion fatigue. There is also an abundance of evidence to suggest relational depth in therapy significantly improves client outcomes (Wampold, 2021). In this way *personalising* enriches psychologists' work experience and thus organisational commitment; and improves the quality of the care provided in public health care settings.

## Conclusion

This chapter presents a discussion of psychologists' experiences of providing therapy in a public healthcare setting. Public healthcare services are conceptualised as a complex contested space, where power is continually redistributed; and where clinical psychologists can introduce change through their actions. This discussion includes focus on the vulnerability clinical psychologists encounter while working in this contested space and the tools they utilise in order to manage their vulnerability.

The central finding of this study is that psychologists use *Alliance-Building as a Gambit* to address inconsistencies and problems in three institutional processes they encounter. There are three main ways that alliance-building is used as a gambit. First, the participants describe *retreating* to their therapeutic work as a way of *Being Productive*. Second, they describe *collaborating* to contribute to the care and understanding of their clients as a way of *Navigating Power*. Third, they describe pe*rsonalising* their therapy to correct for, and adapt their therapy as a way of *Revisiting Protocols*.

This chapter compares and contrasts existing ideas with the findings of this study. Foucault’s ideas on negotiated power and being made subject are highlighted. These ideas illustrate how the structure of a public healthcare service can influence the actions of psychologists. Contemporary writers such as Ahmed and Olle are introduced to build a better understanding of the politics of public healthcare. Various concepts such as organisational commitment, the transcendent nature of therapy, and the implications of professional self-doubt are discussed. These ideas illustrate the emotionally taxing and politically charged experience of being a psychologist in a public healthcare service.

In the second part of the discussion the three categories are explored. The research of Colley et al. is presented, with a focus on the varying ways that psychologists deal with the expectation to be productive. The ways psychologists manage power dynamics and use their skills to influence team dynamics is also highlighted. The research of Janns and Levinthal is introduced to illustrate how team members use psychological process to share and maintain power in professional group. Finally, the ways that psychologists adapt their therapeutic practice to effect change in an organisation is also explored. Examples like that of Seikkula’s study highlight how other psychologists have adapted therapy to manage this challenge.

The final chapter in this study concludes by exploring both the strengths and limitations of this study. The implications for the theory that *Alliance-Building is a Gambit* are also described.

# Chapter 7 Study Implications

## Strengths and limitations of this study

A strength of this project is adherence to the principles, methods, and ideals of grounded theory research. In this way, I have attempted to give a resonant and respectful account of the experience of being a psychologist in the ANZ healthcare service. However, every study has its inherent limitations and blind spots. Banks et al. (2016) conducted a review of 64 studies in the organisational sciences, and found that over 90% contained some elements of questionable research or reporting practices. My study also has possible areas for improvement and refinement. The main areas to comment on are the limitations associated with a grounded theory study, especially grounded theory's approach to participant recruitment; and the challenges of learning to interview from both a conceptual and constructionist perspective. Other important considerations are the decisions made in the research design. Specifically, the implications for selecting one specific profession, namely psychologists; the decision to focus on one specific working environment; and the focus on ANZ healthcare services. The following is a discussion of these limitations and considerations.

This study has many of the inherent limitations associated with both qualitative research and specifically grounded theory methods. Some of the typical limitations of this type of study concern the nature of participant recruitment and the difficulties in duplicating findings (Queirós et al., 2017).

In grounded theory, participants are recruited based on their capacity to contribute to the developing concepts (Birks & Mills, 2015). Their selection is based on my subjective perceptions, and the participant recruitment developed in a responsive unfolding manner. It is possible that had I selected a different group of participants (e.g, younger practitioners, or those with specific training backgrounds), I may have developed a different theory.

One of the significant limitations of the sample is the lack of Māori representation. ANZ is a bi-cultural society and as expressed in the treaty of Waitangi, the experiences of Tangata Whenua (people of the land) are a crucial aspect of health care delivery. This study does not have any Māori psychologists represented in the sample. There are two reasons for this. Primarily, there are few Maori psychologists in ANZ, and even fewer in long-serving roles. This made recruiting participants with over three years of experience very difficult. In addition, the theoretical sampling process steered the sampling to increasingly niche areas of the public health care structure – namely in leadership and specialist teams. Again, the representation of Māori in these niche teams is very limited. Consequently, as the theoretical sampling process unfolded, the opportunities to include Māori practitioners decreased.

This limitation should be addressed in future studies by using less restrictive sampling criteria to increase the possibility of younger Māori participants. Future studies could also expand on the assumptions of what leadership or treatment can mean in a DHB setting. In this way practitioners offering cultural leadership can be approached. It may also be useful to include senior Māori health care workers or psychologists in other settings to represent a Kaupapa Māori (the collective vision, aspirations, and purpose of Māori ) narrative in the study.

A further limitation of grounded theory studies is that grounded theory results in a very context-specific and unique research process that adapts and adjusts as the theory develops. This makes duplicating the research challenging. Choy (2014) adds that qualitative research is also dependent on a skilled interviewer, and the data are only as useful as the quality of the interviews. My initial inexperience in interviews, especially in the early stage, may have compromised my data gathering. This was mitigated by discussing my interview experiences with my supervisors regularly; exploring my assumptions and personal narratives in conversations with colleagues, supervisors, and other researchers; and reading seminal texts (Charmaz, 2014) in the area of constructionist informed interviews.

Psychologists are a small group in the context of the wider health professional community. Accordingly, this study reflects only psychologists' experiences, who are a small minority of healthcare workers in the ANZ healthcare service. It is possible that other professions, in both medical and allied health, may describe overlapping or divergent experiences. Other professions such as nurses, social workers and psychiatrists have reported some of the challenges described in this study (Chana et al., 2015; Yanchus et al., 2015). However, few have explored the interactive relationship between practitioners' experiences and the way that clinical resources are employed to manage that. Future research may explore these differing approaches among the professions.

Data collection focused primarily on psychologists' therapeutic activity, but their roles also cover other areas, including extensive involvement in assessing and clinical diagnosis. Overly focusing on one aspect of the psychologist's professional scope of practice may potentially misrepresent their professional experience. It is possible that psychologists experience other stressors and supports and that they may employ a different type of strategy or gambit when operating in a biomedical/diagnostic context. Some participants alluded to this by saying that psychologists working in physical health have different experiences. Therefore, future research could compare and contrast findings reflecting psychologists who work in physical health, or the more diagnostic contexts of, for example, forensic psychology or child development clinics.

Finally, this study is particular to DHBs in the ANZ healthcare service. Psychologists working in private practice, primary care, non-governmental organisations, or corporate services may have different views. They may develop and demonstrate other resourceful solutions. Thompson et al. (2014), for example, notes that psychologists in private practice experience less stress and burnout than those employed in public health. The rather particular collection of stressors imposed on a public healthcare service may create a specific reaction in psychologists. Similar studies on the experiences of psychologists in large organisational environments like the ministries of education, social development, or large government structures such as the military, or correctional services, would be illuminating.

## Implications of these findings

The following section explores the implications for public healthcare services, clinical psychologists, and service-users of public healthcare.

## Implications for psychologists

Psychologists are often associated with the clinical and diagnostically focused spectrum of the mental health service. This is unsurprising, as most public healthcare is provided in a clinic or hospital setting with its roots in the biomedical model (Bennett & Liu, 2018). However, participants in this study very clearly demonstrated a strong commitment and fidelity to the humanistic and relational values inherent in therapy. The data suggests that they are more aligned with the common factors model than may be assumed. This is, especially evident in their emphasis on the adaptable and relationally-focused aspects of therapy, which feature prominently in the common factors model (Wampold & Imel, 2015b).

In essence, my study presents a different narrative of the experience of a psychologist working in a public healthcare service. The participants in my study perceive themselves to be far more relationally focused. They also see themselves as less diagnostically orientated than their reputation may suggest. Clinical psychologists working in public healthcare would do well to advocate for this aspect of their profession and ensure a balanced professional identity.

The second implication of this study is that clinical psychologists seem to be struggling significantly with the organisational policies and procedures of ANZ’s public healthcare systems. Specifically, psychologists struggle with the policies driven by political and economic forces, and they struggle with the internal power dynamics in hospitals. This finding is consistent with other studies (Colley et al., 2015) based in other countries, suggesting that this may be a universal struggle.

This study also demonstrates that psychologists may be unconsciously or inadvertently expressing their vulnerability through their clinical work. There was no data to suggest that this process compromises their client’s wellbeing or the standard of their work. However, in psychodynamic terms, a psychologically functional individual (or group) benefits from insight and self-reflection (Yeh & Hayes, 2011). This study encourages psychologists to reflect on the meanings embedded in their actions and the messages they hope to convey to their environment.

The findings of this study indicate that psychologists might have a previously unrecognised resource that may enable them to influence their working environment. Therapy does not, and should not, function as a tool to secure organisational influence. However, this study indicates that psychologists can exert influence over public healthcare services by consolidating and demonstrating their therapeutic expertise. The findings of this study may encourage psychologists to be more assertive and coordinated in their efforts to promote a therapeutic plan within public healthcare services.

Encouragingly, the general zeitgeist is moving in the favour of psychologists. The public healthcare system is moving to a more biopsychosocial model of care, emphasising recovery, individual and community resources, and healthy living (Le Boutillier et al., 2015). Relationally focused therapies are aligned with this agenda as they encourage self-reliance, accessing personal skills, and seeing people as agents of change and actualisation. Much like Rangihuna (2018) and Seikkula (2001) have attempted, psychologists are in a position to promote the relational aspects of therapy as a central resource in how public healthcare is structured. The findings of this study may provide validation and encouragement to organise a more coordinated and strategic discourse with public healthcare services. This study recommends that psychologists adopt a more vocal and assertive stance in advocating for the centrality of relationship processes in mental health treatments.

Recommendations for psychologists working in public health care:

- The recommendation that psychologists be more assertive in advocating for the relational aspects of their clinical skills. They can do this by pursuing research interests and focusing on developing therapy skills in their continual competency programs.

- The recommendation that psychologists be more cognisant of the systemic and political undercurrents to their clinical activities in public healthcare. This may be an area of attention in supervision and case reviews and is an area of further study.
- The recommendation that psychologists be more assertive and coordinated in their efforts to promote relational skills in the cohort of mental health workers. They can do this by introducing peer supervision, mentoring, and training programs to build skills in the workforce.

### Implications for public healthcare

The Ministry of Health in Aotearoa New Zealand (New Zealand Government, 2018) has prioritised the provision of a high standard of psychological therapy in the national healthcare service strategy. Consequently, the importance attached to providing therapy is expressed in various policy documents (Ministry of Health, 2021b, 2021c). It should give pause for thought then, that the participants in this study, and various publications (Levinson et al., 2021; Luther et al., 2017), routinely describe the challenges practitioners face in meeting this goal.

This study has described a collection of factors that impede psychologists and other healthcare workers from forging more effective relationships with their clients. The participants described ideological problems such as the dominance of the medical model discourse and the dominance of organisational priorities over clinical priorities. They also described pragmatic hindrances to providing therapy, such as the lack of time and opportunity for clinical reflection, and the impact of high caseloads, conflicting professional roles, and institutional targets. At an organisational level, they described the stress of high productivity expectations, the disempowering impact of the biomedical model, and the limitations of their training.

According to Kapur (2020), acknowledging these inherent organisational stressors, and supporting the psychologists in therapy would address staff dissatisfaction and burnout. From an organisational perspective, it is also wise to consider all feedback from staff to ensure high levels of organisational commitment (Goh & Marimuthu, 2016). This study is a source of feedback for the healthcare system and may provide insight into the unacknowledged and easily overlooked experiences of psychologists in public healthcare.

My study has also highlighted the difficulties in aligning the respective ideological positions of psychologists and the ANZ public healthcare system. Psychologists describe an unequivocal focus on pursuing therapeutic depth in their clinical work. Conversely, public healthcare services must also consider organisational concerns such as budget restraints and resource distribution. The study's findings mirror the tension between professional-supportive and economic-operational management models (Martinussen & Davidsen, 2021).

On its face, this could be seen as a cause for concern. After all, a service divided is vulnerable to providing inadequate care. However, public healthcare services can choose to acknowledge and embrace the tension between clinical and organisational aspirations. Should they do so, they may find a willing collaborator in the psychologists who are also struggling with this difficulty. From a service development perspective, this approach may also encourage more psychologists to participate in the public healthcare system, increasing organisational commitment.

Recommendations for management and policy makers in public healthcare services include:

- The recommendation that public healthcare organisations review the significant impact of high caseloads, disruptive organisational change, and disempowering power dynamics within clinical teams. Each of these organisational processes can be addressed as a service-development strategy.
- The recommendation that the public healthcare services leadership acknowledge the inherent tension between operational and clinical priorities. In doing so, they can engage in an open and solution-focused dialogue with psychologists.
- The recommendation that public healthcare organisations implement feedback processes to assimilate and acknowledge the experiences of professionals in public healthcare. This may take the form of online

feedback options, discussions in team planning days, and memos from management.

## Implications for the public

The public has indicated that they want a responsive approach to therapy that emphasises choice and participation. According to Kopua and Bracken (2020), Māori and Pasifika place an especially high value on meaningful, respectful, and committed relationships in providing healthcare services.

Several publications focusing on service user experiences of public healthcare were reviewed for this study (Fa’alogo-Lilo & Cartwright, 2021; Graham & Masters-Awatere, 2020; Palmer et al., 2019). All of these publications highlighted the quality of clinician/client relationships as an essential component of an effective and meaningful healthcare service. This is consistent with the feedback from participants in this study. This and other studies contributes thus emphasizes the high priority that both practitioners and service-users place on therapeutic relationships within a public healthcare service.

Recommendations for the public or service users of public healthcare:

- The recommendation that the public have more say in how therapy is developed and implemented in public healthcare. This can happen through community feedback, surveys, and consulting with community leaders.

- The recommendation that any communication with the public or with service users should expressly highlight that the function of therapy is to build and maintain a relationship. Public healthcare services should take on the responsibility for conveying this message and encouraging the public to expect that within healthcare.

## Final thoughts

This study has attempted to illuminate and give a voice to a community of specialists operating in a complex environment. This study explores the stressors and challenges of working in a large healthcare organisation; but also, the initiative and tenacity of those who hold dear to their values, despite the difficulties this can cause. My challenge has been to remain open and curious about the perspective of all parties represented in the research area. In this regard, practitioners in management and clinical roles share one unifying characteristic: every participant described the stress and burden of providing care to the vulnerable. This study suggests that despite the tensions, differences, and ideological clashes inherent in a public healthcare system, the staff do the best they can with the resources at their disposal.

The participants in this study impress me with their intense commitment to the act of providing therapy and their willingness to place themselves in positions of vulnerability for a higher goal. However, I also encountered the vulnerability of the entire system. Resources are inadequate, the political and economic pressures are enormous, and the public healthcare organisational structure represents an effort to contain those pressures as best possible. Perhaps, in the final analysis, the real tension is between the humanistic goals of healthcare providers (in all their different roles), and the harsh realities of a stretched and under-resourced society.

# References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1-33. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1016/S0272-7358(02)00146-0

Adams, E., Goyder, C., Heneghan, C., Brand, L., & Ajjawi, R. (2017). Clinical reasoning of junior doctors in emergency medicine: A grounded theory study. *Emergency Medicine Journal, 34*(2), 70-75. https://doi.org/10.1136/emermed-2015-205650

Addis, M. E., & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68*(2), 331-339. https://doi.org/10.1037//0022-006x.68.2.331

Ahmed, S. (2012). *On being included*. Duke University Press. https://doi.org/https://doi.org/10.1515/9780822395324

Alanazi, A. (2016). A critical review of constructivist theory and the emergence of constructionism. *American Research Journal of Humanities and Social Sciences, 2*, 1-8. https://www.academia.edu/38923049/A_Critical_Review_of_Constructivist_Theory_and_the_Emergence_of_Constructionism?from=cover_page

Aldiabat, K. M., & Le Navenec, C. (2018). Data saturation: The mysterious step in grounded theory methodology. *The Qualitative Report, 23*(1), 245-261. https://doi.org/http://dx.doi.org/10.46743/2160-3715/2018.2994

Alonso, J., Liu, Z., Evans-Lacko, S., Sadikova, E., Sampson, N., Chatterji, S., Abdulmalik, J., Aguilar-Gaxiola, S., Al-Hamzawi, A., Andrade, L. H., Bruffaerts, R., R., C., G., , Cia, A., Florescu, S., de Girolamo, G., Gureje, O., Haro, J. M., He, Y., de Jonge, P., Karam, E. G., ..., & Thornicroft, G. (2018). Treatment gap for anxiety disorders is global: Results of the world mental health surveys in 21 countries. *Depression and Anxiety, 35*(3), 195-208. https://doi.org/10.1002/da.22711

Anderson, T., McClintock, A. S., Himawan, L., Song, X., & Patterson, C. L. (2016). A prospective study of therapist facilitative interpersonal skills as a predictor of treatment outcome. *Journal of Consulting and Clinical Psychology, 84*(1), 57-66. https://doi.org/10.1037/ccp0000060

Andrews, S., & Thorne, F. (2015). What do people need to be resilient in the current NHS? *Clinical Psychology Forum, 276*, 12-15. https://www.researchgate.net/profile/Kristy-Ohare/publication/276077802_A_quantitative_analysis_of_ward_based_activities_engaging_difficult_to_reach_forensic_inpatients/links/570f65ed08aed4bec6fdfcd5/A-quantitative-analysis-of-ward-based-activities-engaging-difficult-to-reach-forensic-inpatients.pdf#page=14

Andrews, T. (2012). What is social constructionism? *Grounded Theory Review, 11*(1), 39-46. https://www.academia.edu/download/46801759/What_is_Social_Constructionism.pdf

Antoniou, S. A., Antoniou, G. A., Granderath, F. A., Mavroforou, A., Giannoukas, A. D., & Antoniou, A. I. (2010). Reflections of the Hippocratic Oath in modern medicine. *World Journal of Surgery, 34*(12), 3075-3079. https://doi.org/10.1007/s00268-010-0604-3

Appleton, J. V., & King, L. (2002). Journeying from the philosophical contemplation of constructivism to the methodological pragmatics of health services research. *Journal of Advanced Nursing, 40*(6), 641-648. https://doi.org/http://dx.doi.org/10.1046/j.1365-2648.2002.02424.x

Arczynski, A. V., & Morrow, S. L. (2017). The complexities of power in feminist multicultural psychotherapy supervision. *Journal of Counseling Psychology, 64*(2), 192-205. https://doi.org/10.1037/cou0000179

Ataera-Minster, J., & Trowland, H. (2018). *Te Kaveinga: Mental health and wellbeing of Pacific peoples. Results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey*. Health Promotion Agency. https://www.leva.co.nz/uploads/files/resources/te-kaveinga-mental-health-and-wellbeing-of-pacific-peoples-june-2018.pdf?msclkid=a70c99baca9411ec87f7dd8fdbec8f5b

Bae, S. (2019). Incredible years for whom? Governing early years parenting as a site of colonisation in Aotearoa New Zealand. *Contemporary Issues in Early Childhood, 22*(3), 254-267. https://doi.org/10.1177/1463949119873765

Banks, G. C., Rogelberg, S. G., Woznyj, H. M., Landis, R. S., & Rupp, D. E. (2016). Evidence on questionable research practices: The good, the bad, and the ugly. *Journal of Business and Psychology, 31*(3), 323-338. https://doi.org/10.1007/s10869-016-9456-7

Barkham, M., Lutz, W., Lambert, M. J., & Saxon, D. (2017). Therapist effects, effective therapists, and the law of variability. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others?: Understanding therapist effects.* (pp. 13-36). American Psychological Association. https://doi.org/10.1037/0000034-002

Barnett, J. E. (2008). The ethical practice of psychotherapy: Easily within our reach. *Journal of Clinical Psychology, 64*(5), 569-575. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1002/jclp.20473

Bastiampillai, T., Allison, S., Castle, D., Beaglehole, B., & Mulder, R. (2019). New Zealand's big psychotherapy programme requires evaluation. *The New Zealand medical journal, 132*(1502), 8-10. https://journal.nzma.org.nz/journal-articles/new-zealands-big-psychotherapy-programme-requires-evaluation

Beaglehole, B., Mulder, R. T., Boden, J. M., & Bell, C. J. (2019). A systematic review of the psychological impacts of the Canterbury earthquakes on mental health. *Australian and New Zealand Journal of Public Health, 43*(3), 274-280. https://doi.org/10.1111/1753-6405.12894

Beidas, R. S., Marcus, S., Aarons, G. A., Hoagwood, K. E., Schoenwald, S., Evans, A. C., Hurford, M. O., Hadley, T., Barg, F. K., Walsh, L. M., Adams, D. R., & Mandell, D. S. (2015). Predictors of community therapists' use of therapy techniques in a large public mental health system. *JAMA Pediatr, 169*(4), 374-382. https://doi.org/10.1001/jamapediatrics.2014.3736

Belgrave, L., & Seide, K. (2019b). Coding for grounded theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of current developments in grounded theory* (pp. 167-185). Sage. https://doi.org/https://dx.doi.org/10.4135/9781526485656

Belgrave, L. L., & Seide, K. (2019a). Grounded Theory Methodology: Principles and Practices. In *Handbook of Research Methods in Health Social Sciences* (pp. 299-316). https://doi.org/10.1007/978-981-10-5251-4_84

Bell, C., Williman, J., Beaglehole, B., Stanley, J., Jenkins, M., Gendall, P., Rapsey, C., & Every-Palmer, S. (2021). Psychological distress, loneliness, alcohol use and suicidality in New Zealanders with mental illness during a strict COVID-19 lockdown. *Australian and New Zealand Journal of Psychiatry*, 1-11. https://doi.org/10.1177/00048674211034317

Bellamy, A., Feather, J., Gibson, K., Howard, F., & Lambrecht, I. (2014). Psychology in Aotearoa 2020: Where are we going? *Psychology Aotearoa, 6*(1), 15 - 18.

Bennett, S. T., & Liu, J. H. (2018). Historical trajectories for reclaiming an indigenous identity in mental health interventions for Aotearoa/New Zealand—Māori values, biculturalism, and multiculturalism. *International Journal of Intercultural Relations, 62*, 93-102. https://doi.org/10.1016/j.ijintrel.2017.05.005

Berberoglu, A. (2018). Impact of organizational climate on organizational commitment and perceived organizational performance: empirical evidence from public hospitals. *BMC Health Services Research, 18*(1), 3-9. https://doi.org/10.1186/s12913-018-3149-z

Bharucha, A. J., Dew, M. A., Miller, M. D., Borson, S., & Reynolds, C. (2006). Psychotherapy in long-term care: A review. *Journal of the American Medical Directors Association, 7*(9), 568-580. https://doi.org/10.1016/j.jamda.2006.08.003

Birchwood, M., & Singh, S. P. (2013). Mental health services for young people: matching the service to the need. *British Journal of Psychiatry. Supplement, 54*, 1-2. https://doi.org/10.1192/bjp.bp.112.119149

Birks, M., Hoare, K., & Mills, J. (2019). Grounded Theory: The FAQs. *International Journal of Qualitative Methods, 18*, 1-7. https://doi.org/10.1177/1609406919882535

Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2 ed.). Sage. https://doi.org/https://doi.org/10.1177%2F0894318417724473

Birks, M., Mills, J., Francis, K., & Chapman, Y. (2009). A thousand words paint a picture: The use of storyline in grounded theory research. *Journal of Research in Nursing, 14*(5), 405-417. https://doi.org/10.1177/1744987109104675

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. https://doi.org/10.1177/1049732316654870

Boellinghaus, I., Jones, F. W., & Hutton, J. (2012). The role of mindfulness and loving-kindness meditation in cultivating self-compassion and other-focused concern in health care professionals. *Mindfulness, 5*(2), 129-138. https://doi.org/10.1007/s12671-012-0158-6

Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. *World Psychiatry, 14*(2), 240-243. https://dx.doi.org/10.1002%2Fwps.20234

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice, 16*(3), 252-260. https://doi.org/https://doi.apa.org/doi/10.1037/h0085885

Boserup, B., McKenney, M., & Elkbuli, A. (2021). The financial strain placed on America's hospitals in the wake of the COVID-19 pandemic. *American Journal of Emergency Medicine, 45*, 530-531. https://doi.org/10.1016/j.ajem.2020.07.007

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., Bhunnoo, S., Browne, I., Chhina, N., Double, D., Downer, S., Evans, C., Fernando, S., Garland, M. R., Hopkins, W., Huws, R., Johnson, B., Martindale, B., Middleton, H., Moldavsky, D., Moncrieff, J., Mullins, S., Nelki, J., Pizzo, M., Rodger, J., Smyth, M., Summerfield, D., Wallace, J., & Yeomans, D. (2012). Psychiatry beyond the current paradigm. *British Journal of Psychiatry, 201*(6), 430-434. https://doi.org/10.1192/bjp.bp.112.109447

Brattland, H., Koksvik, J. M., Burkeland, O., Klockner, C. A., Lara-Cabrera, M. L., Miller, S. D., Wampold, B., Ryum, T., & Iversen, V. C. (2019). Does the working alliance mediate the effect of routine outcome monitoring (ROM) and alliance feedback on psychotherapy outcomes? A secondary analysis from a randomized clinical trial. *Journal of Counseling Psychology, 66*(2), 234-246. https://doi.org/10.1037/cou0000320

Breckenridge, J. P., Gray, N., Toma, M., Ashmore, S., Glassborow, R., Stark, C., & Renfrew, M. J. (2019). Motivating Change: A grounded theory of how to achieve large-scale, sustained change, co-created with improvement organisations across the UK. *BMJ Open Qual, 8*(2), e000553. https://doi.org/10.1136/bmjoq-2018-000553

Bryant, A. (2017). *Grounded theory and grounded theorizing*. Oxford Scholarship. https://doi.org/10.1093/acprof:oso/9780199922604.001.0001

Bushnell, J., McLeod, D., Dowell, A., Salmond, C., Ramage, S., Collings, S., Ellis, P., Kljakovic, M., & McBain, L. (2003). The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). *New Zealand Medical Journal, 116*(1171), 1-15. http://ro.uow.edu.au/smhpapers/1997

Butler, M. (2014). The impact of providing therapy on the therapist: A student's reflection. *Journal of Clinical Psychology, 70*(8), 724-730. https://doi.org/10.1002/jclp.22105

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: World's colliding? *J Ment Health, 25*(3), 217-223. https://doi.org/10.3109/09638237.2015.1101428

Callaly, T., & Arya, D. (2005). Organizational change management in mental health. *Australasian Psychiatry, 13*(2), 120-123. https://doi.org/10.1080/j.1440-1665.2005.02173.x

Campbell, A. F., & Simmonds, J. G. (2011). Therapist perspectives on the therapeutic alliance with children and adolescents. *Counselling Psychology Quarterly, 24*(3), 195-209. https://doi.org/10.1080/09515070.2011.620734

Carmichael, T., & Cunningham, N. (2017). Theoretical data collection and data analysis with gerunds in a constructivist grounded theory study. *Electronic Journal of Business Research Methods, 15*(2), 59-73. https://web-s-ebscohost-com.ezproxy.aut.ac.nz/ehost/pdfviewer/pdfviewer?vid=1&sid=5c18f75b-d517-4072-b409-b09f651beca7%40redis

Carr, E. R., & Miller, R. (2017). Expanding our reach: Increasing the role of psychologists in public and community mental health. *Psychological Services, 14*(3), 352-360. https://doi.org/10.1037/ser0000094

Castonguay, L. G., Eubanks, C. F., Goldfried, M. R., Muran, J. C., & Lutz, W. (2015). Research on psychotherapy integration: Building on the past, looking to the future. *Psychother Res, 25*(3), 365-382. https://doi.org/10.1080/10503307.2015.1014010

Chana, N., Kennedy, P., & Chessell, Z. J. (2015). Nursing staffs' emotional well-being and caring behaviours. *Journal of Clinical Nursing, 24*(19-20), 2835-2848. https://doi.org/10.1111/jocn.12891

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage. https://doi.org/https://doi.org/10.7748/nr.13.4.84.s4

Charmaz, K. (2008). Constructionism and the grounded theory method. In J. A. G. Holstein, Jaber. F. (Ed.), *Handbook of constructionist research* (pp. 397-412). The Guilford Press. https://doi.org/https://doi.org/10.1111/j.1744-6570.2009.01160_2.x

Charmaz, K. (2008b). Grounded theory as an emergent method. In S. L. Hesser-Biber, P. (Ed.), *Handbook of emergent methods* (pp. 155 - 172). The Guilford Press. https://doi.org/http://dx.doi.org/10.1177/1558689808326122

Charmaz, K. (2014). *Constructing grounded theory* (2 ed.). Sage.

Charmaz, K. (2016b). The power of constructivist grounded theory for critical inquiry. *Qualitative Inquiry, 23*(1), 34-45. https://doi.org/10.1177/1077800416657105

Charmaz, K. (2017b). Special Invited Paper. *International Journal of Qualitative Methods, 16*(1), 1-8. https://doi.org/10.1177/1609406917719350

Charmaz, K. (2020). Grounded theory: Main characteristics. In M.-M. N & J. M (Eds.), *Qualitative analysis: Eight approaches to social science research* (pp. 195 - 222). Sage.

Charmaz, K. (2020b). “With constructivist grounded theory you can’t hide”: Social justice research and critical inquiry in the public sphere. *Qualitative Inquiry, 26*(2), 165-176. https://doi.org/https://doi.org/10.1177%2F1077800419879081

Charmaz, K. (2021b). The genesis, grounds, and growth of constructivist grounded theory. In M. J, B. B. J, K. Charmaz, A. Clarke, J. Corbin, C. J. Porr, & P. N. Stern (Eds.), *Developing grounded theory: Second generation revisited.* (2 ed.). Routledge. https://doi.org/https://doi.org/10.4324/9781315169170

Charmaz, K., & Belgrave, L. L. (2019). Thinking about data with grounded theory. *Qualitative Inquiry, 25*(8), 743-753. https://doi.org/10.1177/1077800418809455

Charmaz, K. B., A. (2016a). Constructing grounded theory analysis. In D. Silverman (Ed.), *Qualitative Research* (4 ed., pp. 375 - 393). Sage.

Chiovitti, R. F., & Piran, N. (2003). Rigour and grounded theory research. *Journal of Advanced Nursing, 44*(4), 427-435. https://doi.org/http://dx.doi.org/10.1046/j.0309-2402.2003.02822.x

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy (Chic), 52*(3), 337-345. https://doi.org/10.1037/pst0000015

Choy, L. T. (2014). The strengths and weaknesses of research methodology: Comparison and complimentary between qualitative and quantitative approaches. *IOSR journal of humanities and social science, 19*(4), 99-104. https://doi.org/https://doi.org/10.9790/0837-194399104

Christofides, S., Johnstone, L., & Musa, M. (2012). 'Chipping in': Clinical psychologists' descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research & Practice, 85*(4), 424-435. https://doi.org/10.1111/j.2044-8341.2011.02041.x

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Med, 7*, 1-8. https://doi.org/10.1177/2050312118822927

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic interaction, 26*(4), 553-576. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1525/si.2003.26.4.553

Clarke, A. E. (2005). *Situational analysis*. Sage https://doi.org/https://dx.doi.org/10.4135/9781412985833

Classen, B., Tudor, K., Johnson, F., & McKenna, B. (2021). Embedding lived experience expertise across the mental health tertiary education sector: An integrative review in the context of Aotearoa New Zealand. *Journal of Psychiatric and Mental Health Nursing, 28*(6), 1140-1152. https://doi.org/10.1111/jpm.12756

Cohen, A. (2007). Commitment before and after: An evaluation and reconceptualization of organizational commitment. *Human Resource Management Review, 17*(3), 336-354. https://doi.org/10.1016/j.hrmr.2007.05.001

Cole, C. L., Waterman, S., Stott, J., Saunders, R., Buckman, J., Pilling, S., & Wheatley, J. (2020). Adapting IAPT services to support frontline NHS staff during the COVID-19 pandemic: The Homerton COVID Psychological Support (HCPS) pathway. *The Cognitive Behaviour Therapist, 13*, 1-12. https://doi.org/https://doi.org/10.1017/S1754470X20000148

Colley, R., Eccles, F., & Hutton, C. (2015). Clinical psychologists' experiences of NHS organisational change. *Clinical Psychology Forum, 270*, 14-18. https://eprints.lancs.ac.uk/id/eprint/74051/1/FORUM_WRITE_UP_Pure.pdf

Conlin, S. E. (2017). Feminist therapy: A brief integrative review of theory, empirical support, and call for new directions. *Women's Studies International Forum, 62*, 78-82. https://doi.org/https://doi.org/10.1016/j.wsif.2017.04.002

Cook, S. C., Schwartz, A. C., & Kaslow, N. J. (2017). Evidence-based psychotherapy: Advantages and challenges. *Neurotherapeutics, 14*(3), 537-545. https://doi.org/10.1007/s13311-017-0549-4

Corbin, J. (2013). Strauss' grounded theory. In C. Beck (Ed.), *Routledge international handbook of qualitative nursing research*. Routledge. https://doi.org/10.4324/9780203409527

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research (3rd ed.): Techniques and procedures for developing grounded theory*. Sage. https://doi.org/10.4135/9781452230153

Court, A. J., Cooke, A., & Scrivener, A. (2017). They're NICE and neat, but are they useful? A grounded theory of clinical psychologists' beliefs about and use of NICE guidelines. *Clinical Psychology & Psychotherapy, 24*(4), 899-910. https://doi.org/10.1002/cpp.2054

Coveney, J. (1998). The government and ethics of health promotion: The importance of Michel Foucault. *Health Education Research, 13*(3), 459-468. https://doi.org/https://doi.org/10.1093/her/13.3.459

Cristea, I. A., Gentili, C., Cotet, C. D., Palomba, D., Barbui, C., & Cuijpers, P. (2017). Efficacy of pychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry, 74*(4), 319-328. https://doi.org/10.1001/jamapsychiatry.2016.4287

Cross, S. P., & Hickie, I. (2017). Transdiagnostic stepped care in mental health. *Public Health Res Pract, 27*(2). https://doi.org/10.17061/phrp2721712

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The role of common factors in psychotherapy outcomes. *Annual Review of Clinical Psychology, 15*, 207-231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Davis, S. D., & Hsieh, A. L. (2019). What does it mean to be a common factors informed family therapist? *Family Process, 58*(3), 629-640. https://doi.org/10.1111/famp.12477

de Figueiredo, J. M. (2007). Demoralization and psychotherapy. *Psychotherapy and Psychosomatics, 76*(3), 129-133. https://doi.org/10.1159/000099839

Del Re, A. C., Fluckiger, C., Horvath, A. O., & Wampold, B. E. (2021). Examining therapist effects in the alliance-outcome relationship: A multilevel meta-analysis. *Journal of Consulting and Clinical Psychology, 89*(5), 371-378. https://doi.org/10.1037/ccp0000637

Denzin, N. K., & Lincoln, Y. S. (2011). Introduction: The discpline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4 ed., pp. 1 - 21). Sage. https://doi.org/https://doi.org/10.1111/j.1365-2648.2001.0472a.x

Dereboy, C., Senel, H., Safak Ozturk, C., Sakiroglu, M., & Eskin, M. (2017). Psychotherapy: Playing the three monkeys in mental health service provision? *Noro Psikiyatr Ars, 54*(4), 301-306. https://doi.org/10.5152/npa.2017.13785

Dlugos, R. F., & Friedlander, M. L. (2001). Passionately committed psychotherapists: A qualitative study of their experience. *Professional Psychology: Research and Practice, 32*(3), 298-304. https://doi.org/10.1037//0735-7028.32.3.298

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists.

*Professional Psychology: Research and Practice, 48*(6), 429-437. https://doi.org/10.1037/pro0000160

Dovey-Pearce, G., Rapley, T., & McDonagh, J. E. (2020). Delivering developmentally appropriate health care: Roles for psychologists as members of the multi-disciplinary health care team. *Clinical Child Psychology and Psychiatry, 25*(3), 579-593. https://doi.org/10.1177/1359104520907147

Druzhinin, A. S. (2020). Construction of irreality: An enactive-constructivist stance on counterfactuals. *Constructivist Foundations, 16*(1), 69-80. https://constructivist.info/16/1/069

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy*. American Psychological Association. https://doi.org/https://psycnet.apa.org/doi/10.1037/12075-000

Duncan, B. L., & Reese, R. J. (2015). The Partners for Change Outcome Management System (PCOMS) revisiting the client's frame of reference. *Psychotherapy (Chic), 52*(4), 391-401. https://doi.org/10.1037/pst0000026

Duncan, B. L., & Sparks, J. A. (2015). Systematic feedback through the partners for change outcome management system (PCOMS). In M. Cooper & W. Dryden (Eds.), *The Handbook of Pluralistic Counselling and Psychotherapy* (pp. 55-67). Sage.

Durdy, H., & Bradshaw, T. (2014). The impact of organisational change in the NHS on staff and patients: A literature review with a focus on mental health. *Mental Health Nursing (Online), 34*(2), 16. https://web-s-ebscohost-com.ezproxy.aut.ac.nz/ehost/pdfviewer/pdfviewer?vid=1&sid=8688d877-da7c-4e96-b621-d763280a26fe%40redis

Dyrbye, L. N., Shanafelt, T. D., Sinsky, C. A., Cipriano, P. F., Bhatt, J., Ommaya, A., West, C. P., & Meyers, D. (2017). Burnout among health care professionals: A call to explore and address this underrecognized threat to safe, high-quality care. *NAM perspectives. Discussion Paper, National Academy of Medicine, Washington, DC.* https://doi.org/https://doi.org/10.31478/201707b

Earl, T., Hodgson, E., Bunting, A., & Feather, J. (2014). Talking therapies in times of change. *Journal of the New Zealand College of Clinical Psychologists, 24*(1), 15-24.

https://www.nzccp.co.nz/assets/Uploads/Talking-Therapies-in-Times-of-Change.pdf

Ebrahim, S. (2021). Psychologists' perspectives on the contribution of psychology to acute adult mental health inpatient, crisis response home treatment and mental health liaison services. *J Ment Health*, 1-7. https://doi.org/10.1080/09638237.2021.1875410

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy, 55*(4), 508. https://doi.org/10.1037/PST0000185

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16*(5), 319. https://doi.org/http://dx.doi.org/10.1016/B978-1-4832-0087-3.50019-X

Fa'alogo-Lilo, C., & Cartwright, C. (2021). Barriers and supports experienced by Pacific peoples in Aotearoa New Zealand's mental health services. *Journal of Cross-Cultural Psychology, 52*(8-9), 752-770. https://doi.org/10.1177/00220221211039885

Figley, C. R., & Figley, K. R. (2017). *Compassion fatigue resilience*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780190464684.013.28

Finsrud, I., Nissen-Lie, H. A., Vrabel, K., Hostmaelingen, A., Wampold, B. E., & Ulvenes, P. G. (2022). It's the therapist and the treatment: The structure of common therapeutic relationship factors. *Psychother Res, 32*(2), 139-150. https://doi.org/10.1080/10503307.2021.1916640

Fleury, M. J., Grenier, G., & Bamvita, J. M. (2017). A comparative study of job satisfaction among nurses, psychologists/psychotherapists and social workers working in Quebec mental health teams. *BMC Nursing, 16*, 62. https://doi.org/10.1186/s12912-017-0255-x

Fluckiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy (Chic), 55*(4), 316-340. https://doi.org/10.1037/pst0000172

Foucault, M. (2014). The politics of health in the eighteenth century (R. A. Lynch, Trans.). *Foucault Studies, 18*, 113 - 127. https://rauli.cbs.dk/index.php/fsl/index (Adapted from *Dits et Ecrits*, 1994, no. 257, vol. III, pp. 725-742)

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy*. JHU Press.

Frost, N. D., Baskin, T. W., & Wampold, B. E. (2020). Comparative clinical trials in psychotherapy: Have large effects been replicated? *Epidemiol Psychiatr Sci, 29*, e128. https://doi.org/10.1017/S2045796020000402

Gallagher, A., Bousso, R. S., McCarthy, J., Kohlen, H., Andrews, T., Paganini, M. C., Abu-El-Noor, N. I., Cox, A., Haas, M., & Arber, A. (2015). Negotiated reorienting: A grounded theory of nurses' end-of-life decision-making in the intensive care unit. *International Journal of Nursing Studies, 52*(4), 794-803. https://doi.org/http://dx.doi.org/10.1016/j.ijnurstu.2014.12.003

Gallagher, M. (2008). Foucault, power and participation. *The International Journal of Children's Rights, 16*(3), 395-406. https://doi.org/10.1163/157181808x311222

Gauld, R. (2020). *The New Zealand health care system.* International Profiles of Health Care Systems. New York,

Gelso, C. J., & Hayes, J. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Lawrence Erlbaum Associates, Inc. https://doi.org/https://doi.org/10.4324/9780203936979

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist, 56*(10), 803-813. https://doi.org/10.1037/0003-066X.56.10.803

Gerger, H., Munder, T., Gemperli, A., Nuesch, E., Trelle, S., Juni, P., & Barth, J. (2014). Integrating fragmented evidence by network meta-analysis: Relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. *Psychological Medicine, 44*(15), 3151-3164. https://doi.org/10.1017/S0033291714000853

Gibb, S. J., Fergusson, D. M., & Horwood, L. J. (2010). Burden of psychiatric disorder in young adulthood and life outcomes at age 30. *British Journal of Psychiatry, 197*(2), 122-127. https://doi.org/10.1192/bjp.bp.109.076570

Gibson, K., Sandenbergh, R., & Swartz, L. (2001). Becoming a community clinical psychologist: Integration of community and clinical practices in psychologists' training. *South African Journal of Psychology, 31*(1), 29-35. https://hdl.handle.net/10520/EJC98107

Gibson, P. A. (2014). Extending the ally model of social justice to social work pedagogy. *Journal of Teaching in Social Work, 34*(2), 199-214. https://doi.org/10.1080/08841233.2014.890691

Glaser, B. (1992). *Basics of grounded theory analysis*

Sociology Press.

Glaser, B. G. (1978). *Theoretical Sensitivity*. Sociology Press.

Glaser, B. G. (2007). Constructivist grounded theory? *Historical Social Research/Historische Sozialforschung. Supplement*, 93-105. https://nbn-resolving.org/urn:nbn:de:0168-ssoar-288311

Glaser, B. G., & Holton, J. (2005). Staying open: The use of theoretical codes in grounded theory. *The Grounded Theory Review, 5*(1), 1-20. http://groundedtheoryreview.com/wp-content/uploads/2012/05/GT-Review-vol5-no1.pdf#page=11

Glaser, B. G., & Strauss, A. (1967). *The discovery of grounded theory*. Aldine.

Goh, C. Y., & Marimuthu, M. (2016). The path towards healthcare sustainability: The role of organisational commitment. *Procedia - Social and Behavioral Sciences, 224*, 587-592. https://doi.org/10.1016/j.sbspro.2016.05.445

Gokce, B., Guney, S., & Katrinli, A. (2014). Does doctors' perception of hospital leadership style and organizational culture influence their organizational commitment? *Social Behavior and Personality: an international journal, 42*(9), 1549-1561. https://doi.org/10.2224/sbp.2014.42.9.1549

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*(1), 1-11. https://doi.org/10.1037/cou0000131

Goldfried, M. R. (2013). What should we expect from psychotherapy? *Clinical Psychology Review, 33*(7), 862-869. https://doi.org/10.1016/j.cpr.2013.05.003

Goodyear-Smith, F., & Ashton, T. (2019). New Zealand health system: Universalism struggles with persisting inequities. *The Lancet, 394*(10196), 432-442. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1016/S0140-6736(19)31238-3

Government inquiry into mental health and addiction. (2018). *He Ara Oranga: Report of the government inquiry into mental health and addiction*. New Zealand Government www.mentalhealth.inquiry.govt.nz/inquiry-report/

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health, 44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971

Grant, B. M., & Giddings, L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1), 10-28. https://doi.org/https://doi.org/10.5172/conu.13.1.10

Groot, S., Le Grice, J., & Nikora, L. W. (2018). Indigenous psychology in New Zealand. In *Asia-Pacific perspectives on intercultural psychology* (pp. 198-217). Routledge. https://doi.org/https://doi.org/10.4324/9781315158358

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (Vol. 2, pp. 163-194). Thousand Oaks.

Guy, A., Loewenthal, D., Thomas, R., & Stephenson, S. (2012). Scrutinising NICE: The impact of the National Institute for Health and Clinical Excellence Guidelines on the provision of counselling and psychotherapy in primary care in the UK. *Psychodynamic Practice, 18*(1), 25-50. https://doi.org/10.1080/14753634.2012.640153

Hale, M., & Brennan, L. (2020). Why have psychologists been slow to adopt telehealth. *InPsych, 42*(3). https://psychology.org.au/for-members/publications/inpsych/2020/june-july-issue-3/why-have-psychologists-been-slow-to-adopt-teleheal

Halfon, S. (2021). Psychodynamic technique and therapeutic alliance in prediction of outcome in psychodynamic child psychotherapy. *Journal* *of Consulting and Clinical Psychology, 89*(2), 96-109. https://doi.org/10.1037/ccp0000620

Hallberg, L. R.-M. (2010). Some thoughts about the literature review in grounded theory studies. *International journal of qualitative studies on health and well-being, 5*(3), 5387. https://doi.org/https://doi.org/10.3402/qhw.v5i3.5387

Hamill, N. R., & Wiener, K. K. K. (2020). Attitudes of Psychologists in Australia towards evidence-based practice in psychology. *Australian Psychologist, 53*(6), 477-485. https://doi.org/10.1111/ap.12342

Hamley, L., & Grice, J. L. (2021). He kākano ahau – identity, Indigeneity and wellbeing for young Māori (Indigenous) men in Aotearoa/New Zealand. *Feminism & Psychology, 31*(1), 62-80. https://doi.org/10.1177/0959353520973568

Hannigan, B., Edwards, D., & Burnard, P. (2009). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health, 13*(3), 235-245. https://doi.org/10.1080/09638230410001700871

Harding, S. (1991). *Whose knowledge? Whose science? Thinking from women's lives*. Cornell University Press. https://doi.org/http://dx.doi.org/10.7591/9781501712951

Hathcoat, J. D., Meixner, C., & Nicholas, M. C. (2019). Ontology and epistemology. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 99-116). https://doi.org/10.1007/978-981-10-5251-4_56

Hayes, G. (2000). The struggle for mental health in South Africa: Psychologists, apartheid and the story of Durban OASSSA. *Journal of Community & Applied Social Psychology, 10*(4), 327-342. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1002/1099-1298(200007/08)10:4%3C327::AID-CASP587%3E3.0.CO;2-D

Hayes, J. A. (2014). The beneficial demands of conducting psychotherapy. *Journal of Clinical Psychology, 70*(8), 716-723. https://doi.org/10.1002/jclp.22107

Hazlett-Stevens, H. C., M. G. (2002). Brief cognitive-behavioral therapy: Definition and scientific foundations. In F. Bond, W; Dryden, W (Ed.), *Handbook of brief cognitive behaviour therapy* (Vol. 1). John Wiley & Sons. https://doi.org/DOI:10.1002/9780470713020

Holm, A. L., & Severinsson, E. (2010). The role of the mental health nursing leadership. *Journal of Nursing Management, 18*(4), 463-471. https://doi.org/10.1111/j.1365-2834.2010.01089.x

Holstein, J. A., Gubrium, J. F., Denzin, N., & Lincoln, Y. (2013). The constructionist analytics of interpretive practice. *Strategies of qualitative inquiry, 1*(1), 253-289. https://us.sagepub.com/en-us/nam/the-sage-handbook-of-qualitative-research/book242504#contents

Hoppen, T. H., & Morina, N. (2019). The prevalence of PTSD and major depression in the global population of adult war survivors: A meta-analytically informed estimate in absolute numbers. *European Journal of Psychotraumatology, 10*(1), 1-12. https://doi.org/10.1080/20008198.2019.1578637

Hudson, S., Russell, L., & Holland, K. (2017). *Indicators of mental health and wellbeing of adults: Findings from the 2015 New Zealand Mental Health Monitor*. Health Promotion Agency. http://www.hpa.org.nz/research-library/research-publications.

Hyde, P., & Thomas, A. B. (2002). Organisational defences revisited: Systems and contexts. *Journal of Managerial Psychology, 17*(5), 408-421. https://doi.org/10.1108/02683940210432646

Jaimes, A., Larose-Hebert, K., & Moreau, N. (2015). Current trends in theoretical orientation of psychologists: The case of Quebec clinicians. *Journal of Clinical Psychology, 71*(10), 1042-1048. https://doi.org/10.1002/jclp.22208

Janss, R., Rispens, S., Segers, M., & Jehn, K. A. (2012). What is happening under the surface? Power, conflict and the performance of medical teams. *Medical Education, 46*(9), 838-849. https://doi.org/10.1111/j.1365-2923.2012.04322.x

Johns, R. G., Barkham, M., Kellett, S., & Saxon, D. (2019). A systematic review of therapist effects: A critical narrative update and refinement to review. *Clinical Psychology Review, 67*, 78-93. https://doi.org/10.1016/j.cpr.2018.08.004

Jones, P. B. (2013). Adult mental health disorders and their age at onset. *The British Journal of Psychiatry, 202*(s54), 5-10. https://doi.org/https://doi.org/10.1192/bjp.bp.112.119164

Jordan, L. S., Seponski, D. M., Hall, J. N., & Bermudez, J. M. (2021). "Hopefully you've landed the waka on the shore": Negotiated spaces in New Zealand's bicultural mental health system. *Transcultural Psychiatry*, 13634615211014347. https://doi.org/10.1177/13634615211014347

Jurcik, T., Jarvis, G. E., Zeleskov Doric, J., Krasavtseva, Y., Yaltonskaya, A., Ogiwara, K., Sasaki, J., Dubois, S., & Grigoryan, K. (2020). Adapting mental health services to the COVID-19 pandemic: Reflections from professionals in four countries. *Counselling Psychology Quarterly, 34*(3-4), 649-675. https://doi.org/10.1080/09515070.2020.1785846

Kall, A., Shafran, R., Lindegaard, T., Bennett, S., Cooper, Z., Coughtrey, A., & Andersson, G. (2020). A common elements approach to the development of a modular cognitive behavioral theory for chronic loneliness. *Journal of Consulting and Clinical Psychology, 88*(3), 269-282. https://doi.org/10.1037/ccp0000454

Kapeli, S. A., Manuela, S., & Sibley, C. G. (2020). Understanding pasifika mental health in New Zealand: A review of the literature. *MAI Journal: A New Zealand Journal of Indigenous Scholarship, 9*(3), 249-271. https://doi.org/10.20507/MAIJournal.2020.9.3.7

Kapur, N. (2020). The NHS long term plan. *SUSHRUTA Journal of Health Policy & Opinions, 12*(1), 10-11. https://doi.org/10.38192/12.1.4

Kazantzis, N., & Deane, F. P. (1998). Theoretical orientations of New Zealand psychologists: An international comparison. *Journal of Psychotherapy Integration, 8*(2), 97-113. https://doi.org/https://doi.org/10.1023/A:1023236406807

Kelly, M., Dowling, M., & Millar, M. (2018). The search for understanding: The role of paradigms. *Nurse Researcher, 25*(4), 9-13. https://doi.org/10.7748/nr.2018.e1499

Kenny, M., & Fourie, R. (2015). Contrasting classic, straussian, and constructivist grounded theory: Methodological and philosophical conflicts. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2015.2251

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32-44. https://doi.org/10.1177/1534765608319083

Kim, J. J., Brookman-Frazee, L., Gellatly, R., Stadnick, N., Barnett, M. L., & Lau, A. S. (2018). Predictors of burnout among community therapists in the sustainment phase of a system-driven implementation of multiple evidence-based practices in children's mental health. *Professional Psychology, Research and Practice, 49*(2), 131-142. https://doi.org/10.1037/pro0000182

Koplan, J. P., Bond, T. C., Merson, M. H., Reddy, K. S., Rodriguez, M. H., Sewankambo, N. K., & Wasserheit, J. N. (2009). Towards a common definition of global health. *The Lancet, 373*(9679), 1993-1995. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1016/S0140-6736(09)60332-9

Kopua, M. A., & Bracken, P. J. (2020). Mahi a Atua: A Māori approach to mental health. *Transcultural Psychiatry, 57*(2), 375-383. https://doi.org/10.1177/1363461519851606

Kozan, S., & Blustein, D. L. (2018). Implementing social change: A qualitative analysis of counseling psychologists' engagement in advocacy. *The Counseling Psychologist, 46*(2), 154-189. https://doi.org/10.1177/0011000018756882

Labonte, R., & Stuckler, D. (2016). The rise of neoliberalism: How bad economics imperils health and what to do about it. *Journal of Epidemiology and Community Health, 70*(3), 312-318. https://doi.org/10.1136/jech-2015-206295

Laska, K. M., Smith, T. L., Wislocki, A. P., Minami, T., & Wampold, B. E. (2013). Uniformity of evidence-based treatments in practice? Therapist effects in the delivery of cognitive processing therapy for PTSD. *Journal of Counseling Psychology, 60*(1), 31-41. https://doi.org/10.1037/a0031294

Le Boutillier, C., Slade, M., Lawrence, V., Bird, V. J., Chandler, R., Farkas, M., Harding, C., Larsen, J., Oades, L. G., Roberts, G., Shepherd, G., Thornicroft, G., Williams, J., & Leamy, M. (2015). Competing priorities: Staff perspectives on supporting recovery. *Administrative Policy Mental Health, 42*(4), 429-438. https://doi.org/10.1007/s10488-014-0585-x

Lebow, J., & Sexton, T. L. (2015). The evolution of family and couple therapy. In T. L. Sexton, G. Weeks, & R. Michael (Eds.), *Handbook of family therapy* (pp. 1-10). Routledge. https://doi.org/https://doi.org/10.4324/9780203490419

Lee, C. M., Schneider, B. H., Bellefontaine, S., Davidson, S., & Robertson, C. (2012). Interprofessional collaboration: A survey of Canadian psychologists and psychiatrists. *Canadian Psychology/Psychologie canadienne, 53*(3), 159-164. https://doi.org/10.1037/a0027619

Leventhal, G., Stamm, K. E., Washburn, J. J., Rolston, C., Yozwiak, J. A., Hamp, A., Cash, E. D., Ward, W. L., Hong, B. A., & Williams, A. M. (2021). Patterns of psychologists' interprofessional collaboration across clinical practice settings. *Journal of Clinical Psychology in Medical Settings, 28*(4), 844-867. https://doi.org/http://dx.doi.org/10.1007/s10880-021-09802-3

Levinson, S., Nel, P. W., & Conlan, L.-M. (2021). Experiences of newly qualified clinical psychologists in CAMHS. *The Journal of Mental Health Training, Education and Practice, 16*(3), 187-199. https://doi.org/10.1108/jmhtep-08-2019-0043

Lim, B.-C., & Klein, K. J. (2006). Team mental models and team performance: A field study of the effects of team mental model similarity and accuracy. *Journal of Organizational Behavior, 27*(4), 403-418. https://doi.org/10.1002/job.387

Lincoln, Y., & Guba, E. (2013). *The Constructivist Credo.* Left Coast Press, Inc. https://doi.org/http://dx.doi.org/10.4324/9781315418810

Losantos, M., Montoya, T., Exeni, S., Santa Cruz, M., & Loots, G. (2016). Applying social constructionist epistemology to research in psychology. *International Journal of Collaborative Practice, 6*(1), 29-42.

Luther, L., Gearhart, T., Fukui, S., Morse, G., Rollins, A. L., & Salyers, M. P. (2017). Working overtime in community mental health: Associations with clinician burnout and perceived quality of care. *Psychiatr Rehabil J, 40*(2), 252-259. https://doi.org/10.1037/prj0000234

Mahon, D. (2020). The role of practice-based evidence and feedback informed treatment for improving therapy outcomes. *Counseling and Family Therapy Scholarship Review, 3*(1), 1-6. https://doi.org/10.53309/osqk4162

Malla, A., Frampton, A., & Mansouri, B. I. (2020). Youth mental health services: Promoting wellness or treating mental illness? *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 65*(8), 531-535. https://doi.org/10.1177/0706743720920033

Martin, T. (2020). *Increased counselling support for all students*. https://www.beehive.govt.nz/release/increased-counselling-support-all-students

Martinussen, P. E., & Davidsen, T. (2021). 'Professional-supportive' versus 'economic-operational' management: the relationship between leadership style and hospital physicians' organisational climate. *BMC Health Services Research, 21*(2-11), 825. https://doi.org/10.1186/s12913-021-06760-2

Maslach, C. (2003). Job burnout: New directions in research and intervention. *Current Directions in Psychological Science, 12*(5), 189-192. https://doi.org/https://doi.org/10.1111%2F1467-8721.01258

Mathieu, J. E., Heffner, T. S., Goodwin, G. F., Salas, E., & Cannon-Bowers, J. A. (2000). The influence of shared mental models on team process and performance. *Journal of Applied Psychology, 85*(2), 273-283. https://doi.org/10.I037t/0021-9010.85.2.273

McCade, D., Frewen, A., & Fassnacht, D. B. (2021). Burnout and depression in Australian psychologists: The moderating role of self-compassion. *Australian Psychologist, 56*(2), 111-122. https://doi.org/10.1080/00050067.2021.1890979

McCann, J. J. (2016). Is mental illness socially constructed? *Journal of Applied Psychology and Social Science, 2*(1), 1-11. http://insight.cumbria.ac.uk/id/eprint/2203/

McClintock, K., Tauroa, R., & Mellsop, G. (2013). Te Tomo Mai Appropriate Child and Adolescent Mental Health Service (CAMHS) for an Indigenous Population: Rangatahi (Youth) Perspectives. *Pimatisiwin, 11*(1), 125-131. https://journalindigenouswellbeing.co.nz/wp-content/uploads/2013/07/09McClintockTauroa.pdf

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A Systematic Review. *Frontiers in Psychology, 9*, 1-19. https://doi.org/10.3389/fpsyg.2018.01897

McDonald, R. (2005). Shifting the balance of power? Culture change and identity in an English health-care setting. *J Health Organ Manag, 19*(3), 189-203. https://doi.org/10.1108/14777260510608934

McGorry, P. (2013). Prevention, innovation and implementation science in mental health: the next wave of reform. *British Journal of Psychiatry. Supplement, 54*, 3-4. https://doi.org/10.1192/bjp.bp.112.119222

McGorry, P., Bates, T., & Birchwood, M. (2013). Designing youth mental health services for the 21st century: Examples from Australia, Ireland and the UK. *British Journal of Psychiatry. Supplement, 54*, 30-35. https://doi.org/10.1192/bjp.bp.112.119214

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies, 25*(2), 82-89. https://doi.org/10.1111/j.1470-6431.2001.00183.x

McMichael, A. J., & Beaglehole, R. (2000). The changing global context of public health. *The Lancet, 356*(9228), 495-499. https://doi.org/http://dx.doi.org/10.1016/S0140-6736(00)02564-2

McPherson, S., Hiskey, S., & Alderson, Z. (2016). Distress in working on dementia wards - A threat to compassionate care: A grounded theory study. *International Journal of Nursing Studies, 53*, 95-104. https://doi.org/10.1016/j.ijnurstu.2015.08.013

Mental Health Commission. (2012). Blueprint II: How things need to be. *Wellington: Mental Health Commission*. https://www.wdhb.org.nz/assets/Uploads/Documents/2f2bc04cb3/blueprint-ii-how-things-need-to-be.pdf

Menzies, I. E. (1960). A case-study in the functioning of social systems as a defence against anxiety: A report on a study of the nursing service of a general hospital. *Human relations, 13*(2), 95-121. https://doi.org/http://dx.doi.org/10.1177/001872676001300201

Michelson, D., Malik, K., Krishna, M., Sharma, R., Mathur, S., Bhat, B., Parikh, R., Roy, K., Joshi, A., Sahu, R., Chilhate, B., Boustani, M., Cuijpers, P., Chorpita, B., Fairburn, C. G., & Patel, V. (2020). Development of a transdiagnostic, low-intensity, psychological intervention for common adolescent mental health problems in Indian secondary schools. *Behaviour Research and Therapy, 130*, 103439. https://doi.org/10.1016/j.brat.2019.103439

Mihura, J. L., Roy, M., & Graceffo, R. A. (2017). Psychological assessment training in clinical psychology doctoral programs. *Journal of Personality Assessment, 99*(2), 153-164. https://doi.org/10.1080/00223891.2016.1201978

Miller, B. (2007). Innovations: psychotherapy: What creates and sustains commitment to the practice of psychotherapy? *Psychiatric Services, 58*(2), 174-176. https://ps.psychiatryonline.org/doi/full/10.1176/ps.2007.58.2.174

Miller, S., D. (2012). The outcome rating scale (ORS) and the session rating scale (SRS). *Integrating science and practice 2*(2), 28 - 31. file:///C:/Users/glenl/Downloads/The_Outcome_Rating_Scale_A_Preliminary_Study_of_th.pdf

Miller, S. D., Bargmann, S., Chow, D., Seidel, J., & Maeschalck, C. (2016). Feedback-informed treatment (FIT): Improving the outcome of psychotherapy one person at a time. In W. O'Donohue & A. Maragakis (Eds.), *Quality improvement in behavioral health* (pp. 247-262). Springer. https://doi.org/10.1007/978-3-319-26209-3_16

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: yesterday, today, and tomorrow. *Psychotherapy (Chic), 50*(1), 88-97. https://doi.org/10.1037/a0031097

Mills, C., Reid, P., & Vaithianathan, R. (2012). The cost of child health inequalities in Aotearoa New Zealand: A preliminary scoping study. *BMC Public Health, 12*(1), 1-11. http://www.biomedcentral.com/1471-2458/12/384

Mills, J., Bonner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5*(1), 25-35. http://creativecommons.org/licenses/by/2.0

Ministry of Health. (29 September 2016). *My DHB*. Retrieved 27 April 2022 from https://www.health.govt.nz/new-zealand-health-system/my-dhb

Ministry of Health. (2012b). *Rising to the challenge: The mental health and addiction plan 2012 - 2017*. Ministry of health. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health.govt.nz%2Fsystem%2Ffiles%2Fdocuments%2Fpublications%2Frising-to-the-challenge-mental-health-addiction-service-development-plan-v2.doc&wdOrigin=BROWSELINK

Ministry of Health. (2016). *New Zealand health strategy: Future direction*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

Ministry of Health. (2017). *Office of the director of mental health and addiction services: Annual report 2017.* Ministry of Health. https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-annual-report-2017

Ministry of Health. (2021). *Office of the director of mental health and addiction services annual report 2018 and 2019.* Ministry of Health. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health.govt.nz%2Fsystem%2Ffiles%2Fdocuments%2Fpublications%2Foffice-director-mental-health-addiction-services-annual-report-2018-2019-apr21.docx&wdOrigin=BROWSELINK

Ministry of Health. (2021b). *Kia manawanui aotearoa: Long-term pathway to mental wellbeing.* Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/web3-kia-manawanui-aotearoa-v9_0.pdf

Ministry of Health. (2021c). *Companion document to Kia Manawanui Aotearoa – long-term pathway to mental wellbeing: Implementing the Government's response to recommendations in He Ara Oranga.* Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/web4-kia-manawanui-aotearoa-companion-document-v2.pdf

Ministry of health. (2021d). *Strategic directions 2021 to 2025*. Ministry of health. https://www.health.govt.nz/system/files/documents/publications/strategic_intentions_2021-2025-withcover_9_dec.pdf

Montayre, J., De-Arth, J., Shrestha-Ranjit, J., Neville, S., & Holroyd, E. (2019). Challenges and adjustments in maintaining health and well-being of older asian immigrants in New Zealand: An integrative review. *Australasian Journal on Ageing, 38*(3), 154-172. https://doi.org/10.1111/ajag.12616

Mulder, R., Murray, G., & Rucklidge, J. (2017). Common versus specific factors in psychotherapy: Opening the black box. *The Lancet Psychiatry, 4*(12), 953-962. https://doi.org/10.1016/s2215-0366(17)30100-1

Murray PHN. (2020). *A stepped care approach to mental health*. Retrieved 27 April 2022 from https://www.murrayphn.org.au/information-and-resources-for-health-professionals/mentalhealth/steppedcare/

Naal, H., El Koussa, M., El Hamouch, M., Hneiny, L., & Saleh, S. (2020). Evaluation of global health capacity building initiatives in low-and middle-income countries: A systematic review. *J Glob Health, 10*(2), 2-14. https://doi.org/10.7189/jogh.10.020412

Navab, A., Koegel, R., Dowdy, E., & Vernon, T. (2015). Ethical considerations in the application of the scientist–practitioner model for psychologists conducting intervention research. *Journal of Contemporary Psychotherapy, 46*(2), 79-87. https://doi.org/10.1007/s10879-015-9314-3

New Zealand Government. (2018). *He Ara Oranga: report of the government inquiry into mental health and addiction*. New Zealand Government. www.mentalhealth.inquiry.govt.nz/inquiry-report/

New Zealand Psychologists Board. (2020). *Annual report: 1 April 2019 – 31 March 2020*. New Zealand Psychologists Board. https://psychologistsboard.org.nz/wp-content/uploads/2021/07/NZPB-Annual-Report-2020.-Final..pdf

Ng, M. Y., & Weisz, J. R. (2016). Annual research review: Building a science of personalized intervention for youth mental health. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 57*(3), 216-236. https://doi.org/10.1111/jcpp.12470

Nicolson, M. N., & Flett, J. A. (2020). The mental wellbeing of New Zealanders during and post-lockdown. *The New Zealand Medical Journal (Online), 133*(1523), 110-112. https://journal-nzma-org-nz.ezproxy.aut.ac.nz/

Nienhuis, J. B., Owen, J., Valentine, J. C., Winkeljohn Black, S., Halford, T. C., Parazak, S. E., Budge, S., & Hilsenroth, M. (2018, Jul). Therapeutic alliance, empathy, and genuineness in individual adult psychotherapy: A meta-analytic review. *Psychother Res, 28*(4), 593-605. https://doi.org/10.1080/10503307.2016.1204023

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy (Chic), 55*(4), 303-315. https://doi.org/10.1037/pst0000193

Norcross, J. C., & Phillips, C. M. (2020). Psychologist self-care during the pandemic: now more than ever. *J Health Serv Psychol, 46*(2), 59-63. https://doi.org/10.1007/s42843-020-00010-5

Norcross, J. C., Sayette, M. A., & Pomerantz, A. M. (2018). Doctoral training in clinical psychology across 23 years: Continuity and change. *Journal of Clinical Psychology, 74*(3), 385-397. https://doi.org/10.1002/jclp.22517

Norcross, J. C., Sayette, M. A., & Pomerantz, A. M. (2018b). Doctoral training in clinical psychology across 23 years: Continuity and change. *Journal of Clinical Psychology, 74*(3), 385-397. https://doi.org/10.1002/jclp.22517

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy (Chic), 48*(1), 98-102. https://doi.org/10.1037/a0022161

Norcross, J. C., & Wampold, B. E. (2018). A new therapy for each patient: Evidence-based relationships and responsiveness. *Journal of Clinical Psychology, 74*(11), 1889-1906. https://doi.org/10.1002/jclp.22678

Noss, R., & Clayson, J. (2015). Reconstructing constructionism. *Constructivist Foundations, 10*(3), 285-288. http://www.univie.ac.at/constructivism/journal/10/3/285.noss

Nutt, K., & Keville, S. (2016). '… you kind of frantically go from one thing to the next and there isn't any time for thinking any more': A reflection on the impact of organisational change on relatedness in multidisciplinary teams. *Reflective Practice, 17*(2), 221-232. https://doi.org/10.1080/14623943.2016.1159552

Oktay, J. S. (2012). *Grounded theory*. Oxford University Press.

Olle, C. D. (2018). Breaking institutional habits: A critical paradigm for social change agents in psychology. *The Counseling Psychologist, 46*(2), 190-212. https://doi.org/10.1177/0011000018760597

Palmer, S. C., Gray, H., Huria, T., Lacey, C., Beckert, L., & Pitama, S. G. (2019). Reported Māori consumer experiences of health systems and programs in qualitative research: A systematic review with meta-synthesis. *Int J Equity Health, 18*(1), 1-12. https://doi.org/10.1186/s12939-019-1057-4

Papert, S., & Harel, I. (1991). *Constructionism*. Ablex Publishing.

Patten, M. L., & Newhart, M. (2017). *Understanding research methods: An overview of the essentials*. Routledge. https://doi.org/https://doi.org/10.4324/9781315213033

Peerson, A. (1995). Foucault and modern medicine. *Nursing Inquiry, 2*(2), 106-114. https://doi.org/10.1111/j.1440-1800.1995.tb00073.x

Pehlivan, T. (2017). Compassion fatigue: The known, unknown. *Journal of Psychiatric Nursing, 9*(2), 129-134. https://doi.org/10.14744/phd.2017.25582

Perle, J. G. (2021). Training psychology students for telehealth: A model for doctoral-level education. *Journal of Technology in Behavioral Science, 6*(3), 456-459. https://doi.org/10.1007/s41347-021-00212-8

Phelps, A., Lloyd, D., Creamer, M., & Forbes, D. (2009). Caring for carers in the aftermath of trauma. *Journal of Aggression, Maltreatment & Trauma, 18*(3), 313-330. https://doi.org/10.1080/10926770902835899

Phillippi, J., & Lauderdale, J. (2018). A guide to field notes for qualitative research: Context and conversation. *Qualitative Health Research, 28*(3), 381-388. https://doi.org/doi.org/10.1177/1049732317697102

Pompoli, A., Furukawa, T. A., Efthimiou, O., Imai, H., Tajika, A., & Salanti, G. (2018). Dismantling cognitive-behaviour therapy for panic disorder: A systematic review and component network meta-analysis. *Psychological Medicine, 48*(12), 1945-1953. https://doi.org/10.1017/S0033291717003919

Poulton, R., Moffitt, T. E., & Silva, P. A. (2015). The Dunedin multidisciplinary health and development study: Overview of the first 40 years, with an eye to the future. *Social Psychiatry and Psychiatric Epidemiology, 50*(5), 679-693. https://doi.org/10.1007/s00127-015-1048-8

QualityWatch. (2014). *Cause for concern: QualityWatch annual statement 2014.* Nuffield Trust and The Health Foundation. https://www.nuffieldtrust.org.uk/research/cause-for-concern-qualitywatch-annual-statement-2014

Queirós, A., Faria, D., & Almeida, F. (2017). Strengths and limitations of qualitative and quantitative research methods. *European journal of education studies, 3*(9), 369-386. https://doi.org/http://dx.doi.org/10.5281/zenodo.887089

Randall-James, J., & Coles, S. (2018). Questioning diagnoses in clinical practice: a thematic analysis of clinical psychologists' accounts of working beyond diagnosis in the United Kingdom. *Journal of Mental Health, 27*(5), 450-456. https://doi.org/10.1080/09638237.2018.1437599

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018). Mahi a Atua: A pathway forward for Māori mental health. *New Zealand Medical Journal, 131*(1471), 79-83. https://journal-nzma-org-nz.ezproxy.aut.ac.nz/

Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology, 19*(4), 255-267. https://doi.org/10.1177/1534765612471144

Richardson, P. H., & Hobson, P. (2006). In defence of NHS psychotherapy. *Psychoanalytic Psychotherapy, 14*(1), 63-74. https://doi.org/10.1080/02668730000700061

Rob, M., & Rob, F. (2018). Dilemma between constructivism and constructionism. *Journal of International Education in Business, 11*(2), 273-290. https://doi.org/10.1108/jieb-01-2018-0002

Roberts, M. (2005). The production of the psychiatric subject: Power, knowledge and Michel Foucault. *Nursing Philosophy, 6*(1), 33-42. https://doi.org/http://dx.doi.org/10.1111/j.1466-769X.2004.00196.x

Rodgers, N. (2012). Shifting landscapes of counselling identities in Aotearoa New Zealand. *British Journal of Guidance & Counselling, 40*(3), 191-204. https://doi.org/10.1080/03069885.2012.678287

Ronnestad, M. H., & Skovholt, T. M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology: Research and Practice, 32*(2), 181-187. https://doi.org/10.1037//0735-7028.32.2.181

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*(3), 412. https://doi.org/10.1111/J.1939-0025.1936.TB05248.X

Rous, E., & Clark, A. (2009). Child psychoanalytic psychotherapy in the UK National Health Service: An historical analysis. *Hist Psychiatry, 20*(80 Pt 4), 442-456. https://doi.org/10.1177/0957154X08338338

Rousseau, D. M., & Gunia, B. C. (2016). Evidence-Based Practice: The Psychology of EBP Implementation. *Annual Review of Psychology, 67*, 667-692. https://doi.org/10.1146/annurev-psych-122414-033336

Roy, M. J., Baker, R., & Kerr, S. (2017). Conceptualising the public health role of actors operating outside of formal health systems: The case of social enterprise. *Social Science and Medicine, 172*, 144-152. https://doi.org/10.1016/j.socscimed.2016.11.009

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice, 46*(3), 168-174. https://doi.org/10.1037/a0039297

Rupert, P. A., Stevanovic, P., & Hunley, H. A. (2009). Work-family conflict and burnout among practicing psychologists. *Professional Psychology: Research and Practice, 40*(1), 54-61. https://doi.org/10.1037/a0012538

Saddington, D. (2021). *Burnout and retention among psychological practitioners: A qualitative investigation into the influence of organisational factors* [doctorate, Lancaster University (United Kingdom)]. https://eprints.lancs.ac.uk/id/eprint/161180/1/2021SaddingtonDClinPsy.pdf

Saldana, J. (2016). *The coding manual for qualitative researchers* (3 ed.). Sage. https://doi.org/http://dx.doi.org/10.1108/QROM-08-2016-1408

Schoen, C., Osborn, R., Squires, D., Doty, M., Pierson, R., & Applebaum, S. (2011). New 2011 survey of patients with complex care needs in eleven countries finds that care is often poorly coordinated. *Health Affairs, 30*(12), 2437-2448. https://doi.org/10.1377/hlthaff.2011.0923

Schottke, H., Fluckiger, C., Goldberg, S. B., Eversmann, J., & Lange, J. (2017). Predicting psychotherapy outcome based on therapist interpersonal skills: A five-year longitudinal study of a therapist assessment protocol. *Psychother Res, 27*(6), 642-652. https://doi.org/10.1080/10503307.2015.1125546

Schrecker, T. (2016). Neoliberalism and health: The linkages and the dangers. *Sociology Compass, 10*(10), 952-971. https://doi.org/http://dx.doi.org/10.1111/soc4.12408

Scott, C., & Medaugh, M. (2017). Axial Coding. In J. Matthes, C. Davis, & R. Potter (Eds.), *The International Encyclopedia of Communication Research Methods* (pp. 1-2). Wiley & Sons. https://doi.org/10.1002/9781118901731.iecrm0012

Seikkula, J., Alakare, B., & Aaltonen, J. (2001). Open dialogue in psychosis: An introduction and case illustration. *Journal of Constructivist Psychology, 14*(4), 247-265. https://doi.org/10.1080/10720530125965

Sell, S. K., & Williams, O. D. (2020). Health under capitalism: A global political economy of structural pathogenesis. *Review of International Political Economy, 27*(1), 1-25. https://doi.org/https://doi.org/10.1080/09692290.2019.1659842

Shiffman, J., Quissell, K., Schmitz, H. P., Pelletier, D. L., Smith, S. L., Berlan, D., Gneiting, U., Van Slyke, D., Mergel, I., Rodriguez, M., & Walt, G. (2016). A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning, 31 Suppl 1*, i3-16. https://doi.org/10.1093/heapol/czu046

Shimokawa, K., Lambert, M. J., & Smart, D. W. (2010). Enhancing treatment outcome of patients at risk of treatment failure: Aeta-analytic and mega-analytic review of a psychotherapy quality assurance system. *Journal of Consulting and Clinical Psychology, 78*(3), 298-311. https://doi.org/https://psycnet.apa.org/doi/10.1037/a0019247

Simmonds-Buckley, M., Bennion, M. R., Kellett, S., Millings, A., Hardy, G. E., & Moore, R. K. (2020). Acceptability and effectiveness of NHS-recommended e-therapies for depression, anxiety, and stress: Meta-analysis. *Journal of Medical Internet Research, 22*(10), 2-22. https://doi.org/10.2196/17049

Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9), 752. https://doi.org/https://psycnet.apa.org/doi/10.1037/0003-066X.32.9.752

Stanley, P., & Manthei, R. (2004). Counselling psychology in New Zealand: The quest for identity and recognition. *Counselling Psychology Quarterly, 17*(3), 301-315. https://doi.org/10.1080/09515070412331317594

Stasiak, K., Parkin, A., Seymour, F., Lambie, I., Crengle, S., Pasene-Mizziebo, E., & Merry, S. (2012). Measuring outcome in child and adolescent mental health services: Consumers' views of measures. *Clinical Child Psychology and Psychiatry, 18*(4), 519-535. https://doi.org/10.1177/1359104512460860

Stewart, M., Bushnell, J., Hauraki, J., & Roberts, M. (2014). Evidence and wisdom: The role and value of psychologists in healthcare. *Journal of the New Zealand College of Clinical Psychologists, 24*(1), 3-14. https://www.nzccp.co.nz/assets/Evidence-and-Wisdom-2014.pdf

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?". *American Psychologist, 41*(2), 165-180. https://doi.org/10.1037/0003-066x.41.2.165

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research*. Sage publications.

Strauss, A., & Corbin, J. (1990b). *Basics of qualitative research: grounded theory procedures and techniques.* SAGE.

Sulaiman-Hill, R. C., Porter, R., Tanveer, S., Boden, J., Beaglehole, B., Schluter, P. J., Dean, S., & Bell, C. (2021). Psychosocial impacts on the Christchurch Muslim community following the 15 March terrorist attacks: A mixed-methods study protocol. *BMJ Open, 11*(10), 1-9. https://doi.org/10.1136/bmjopen-2021-055413

Tapsell, R., Hallett, C., & Mellsop, G. (2018). The rate of mental health service use in New Zealand as analysed by ethnicity. *Australas Psychiatry, 26*(3), 290-293. https://doi.org/10.1177/1039856217715989

Tarozzi, M. (2020). *What is grounded theory?* Bloomsbury Publishing. https://doi.org/http://dx.doi.org/10.5040/9781350085275.0007

Tasca, G. A., Sylvestre, J., Balfour, L., Chyurlia, L., Evans, J., Fortin-Langelier, B., Francis, K., Gandhi, J., Huehn, L., Hunsley, J., Joyce, A. S., Kinley, J., Koszycki, D., Leszcz, M., Lybanon-Daigle, V., Mercer, D., Ogrodniczuk, J. S., Presniak, M., Ravitz, P., Ritchie, K., ..., & Wilson, B. (2015). What clinicians want: Findings from a psychotherapy practice research network survey. *Psychotherapy (Chic), 52*(1), 1-11. https://doi.org/10.1037/a0038252

Tatar, M., Shoorekchali, J. M., Faraji, M. R., & Wilson, F. A. (2021). International COVID-19 vaccine inequality amid the pandemic: Perpetuating a global crisis? *Journal of Global Health, 11*, 1-2. https://doi.org/10.7189/jogh.11.03086

Teariki, M. A. (2017). Housing and health of kiribati migrants living in New Zealand. *International Journal of Environmental Research and Public Health,* *14*(10), 1237. https://doi.org/https://doi.org/10.3390/ijerph14101237

The National Centre of Mental Health Research, I. a. W. D. (2012b). *Talking therapies: where to next?* Te Pou o te Whakaaro Nui.

Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58-77. https://doi.org/http://dx.doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Thornberg, R. (2012). Informed Grounded Theory. *Scandinavian Journal of Educational Research, 56*(3), 243-259. https://doi.org/10.1080/00313831.2011.581686

Thornberg, R., & Dunne, C. (2019). Literature review in grounded theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE handbook of current developments in grounded theory* (pp. 206-221). Sage. https://doi.org/https://dx.doi.org/10.4135/9781526485656

Thornberg, R., Halldin, K., Bolmsjö, N., & Petersson, A. (2013). Victimising of school bullying: a grounded theory. *Research Papers in Education, 28*(3), 309-329. https://doi.org/10.1080/02671522.2011.641999

Thorpe, M. (2016). Guest Editorial. *Ata: Journal of Psychotherapy Aotearoa New Zealand, 20*(2), 107-110. https://doi.org/10.9791/ajpanz.2016.10

Tickle, A., Brown, D., & Hayward, M. (2014). Can we risk recovery? A grounded theory of clinical psychologists' perceptions of risk and recovery-oriented mental health services. *Psychology and Psychotherapy, 87*(1), 96-110. https://doi.org/10.1111/j.2044-8341.2012.02079.x

Tolin, D. F. (2014). Beating a dead dodo bird: Looking at signal vs. noise in cognitive-behavioral therapy for anxiety disorders. *Clinical Psychology: Science and Practice, 21*(4), 351-362. https://psycnet.apa.org/doi/10.1111/cpsp.12080

Tracy, S. J. (2019). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. John Wiley & Sons.

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (Vol. 1, pp. 131-146). John Wiley & Sons. https://doi.org/10.1002/9781119973249

Tweed, A. E., & Salter, D. P. (2000). A conflict of responsibilities: A grounded theory study of clinical psychologists' experiences of client non-attendance within the British National Health Service. *British Journal of Medical Psychology, 73*(4), 465-481. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1348/000711200160660

Van Ommen, C. (2014). Where to Psychology in Aotearoa? Choosing between histories. *Psychology Aotearoa, 6*(2), 66 - 67. https://mro.massey.ac.nz/bitstream/handle/10179/9514/van%20Ommen%20-%20Psychology%20Aotearoa%20-%202014.pdf

Velthorst, E., Koeter, M., van der Gaag, M., Nieman, D. H., Fett, A. K., Smit, F., Staring, A. B., Meijer, C., & de Haan, L. (2015). Adapted cognitive-behavioural therapy required for targeting negative symptoms in schizophrenia: Meta-analysis and meta-regression. *Psychological Medicine, 45*(3), 453-465. https://doi.org/10.1017/S0033291714001147

Venugopal, R. (2015). Neoliberalism as concept. *Economy and Society, 44*(2), 165-187. https://doi.org/http://dx.doi.org/10.1080/03085147.2015.1013356

Verger, P., & Dube, E. (2020). Restoring confidence in vaccines in the COVID-19 era. *Expert Rev Vaccines, 19*(11), 991-993. https://doi.org/10.1080/14760584.2020.1825945

Wachtel, P. L. (2010). Psychotherapy integration and integrative psychotherapy: Process or product? *Journal of Psychotherapy Integration, 20*(4), 406-416. https://doi.org/10.1037/a0022032

Wahass, S. H. (2005). The role of psychologists in health care delivery. *Journal of Family and Community Medicine, 12*(2), 63. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410123/

Waitoki, W., & Levy, M. P. (2015). *Māori Psychology Workforce & Māori-Focussed Course Content Review (Report)*. https://hdl.handle.net/10289/9847

Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-oriented practice in mental health inpatient settings: A literature review. *Psychiatric Services, 67*(6), 596-602. https://doi.org/10.1176/appi.ps.201400469

Walsh, S., & Cormack, M. (1994). 'Do as we say but not as we do': Organizational, professional and personal barriers to the receipt of support at work. *Clinical Psychology & Psychotherapy, 1*(2), 101-110. https://doi.org/https://doi.org/10.1002/cpp.5640010207

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270-277. https://doi.org/https://dx.doi.org/10.1002%2Fwps.20238

Wampold, B. E. (2021). Healing in a social context: The importance of clinician and patient relationship. *Front Pain Res (Lausanne), 2*, 1-10. https://doi.org/10.3389/fpain.2021.684768

Wampold, B. E., Fluckiger, C., Del Re, A. C., Yulish, N. E., Frost, N. D., Pace, B. T., Goldberg, S. B., Miller, S. D., Baardseth, T. P., Laska, K. M., & Hilsenroth, M. J. (2017). In pursuit of truth: A critical examination of meta-analyses of cognitive behavior therapy. *Psychotherapy research, 27*(1), 14-32. https://doi.org/10.1080/10503307.2016.1249433

Wampold, B. E., & Imel, Z. E. (2015b). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge. https://doi.org/https://doi.org/10.4324/9780203582015

Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta-(re) analysis of the effects of cognitive therapy versus 'other therapies' for depression. *Journal of Affective Disorders, 68*(2-3), 159-165. https://doi.org/https://doi.org/10.1016/S0165-0327(00)00287-1

Ward, K. (2016). *Bargaining and balancing life with CPAP: A grounded theory* [Doctorate of philosophy in nursing, University of Auckland]. Auckland. https://researchspace.auckland.ac.nz/docs/uoa-docs/rights.htm

Ward, K., Gott, M., & Hoare, K. (2015). Participants' views of telephone interviews within a grounded theory study. *Journal of Advanced Nursing, 71*(12), 2775-2785. https://doi.org/10.1111/jan.12748

Ward, K., Hoare, K. J., & Gott, M. (2015). Evolving from a positivist to constructionist epistemology while using grounded theory: Reflections of a novice researcher. *Journal of Research in Nursing, 20*(6), 449-462. https://doi.org/10.1177/1744987115597731

Watkins, C. E. (2017). Convergence in psychotherapy supervision: A common factors, common processes, common practices perspective. *Journal of Psychotherapy Integration, 27*(2), 140-152. https://doi.org/10.1037/int0000040

Weisz, J. R., Krumholz, L. S., Santucci, L., Thomassin, K., & Ng, M. Y. (2015). Shrinking the gap between research and practice: Tailoring and testing youth psychotherapies in clinical care contexts. *Annual Review of Clinical Psychology, 11*, 139-163. https://doi.org/10.1146/annurev-clinpsy-032814-112820

White, M. K., & Morgan, A. (2006). *Narrative therapy with children and their families*. Dulwich Centre Publications https://www.dulwichcentre.com.au/wp-content/uploads/2020/01/Chapter_by_Michael_White_from_NARRATIVE_THERAPY_WITH_CHILDREN_AND_FAMILIES.pdf

Williams, M. W., Haarhoff, B., & Vertongen, R. (2017). Mental health in Aotearoa New Zealand: Rising to the challenge of the fourth wave? *New Zealand Journal of Psychology, 46*(2). https://www.psychology.org.nz/journal-archive/NZJP-Vol-46-No-2-2017-2.pdf#page=16

Wood, L., Williams, C., Billings, J., & Johnson, S. (2019). Psychologists' perspectives on the implementation of psychological therapy for psychosis in the acute psychiatric inpatient setting. *Qualitative Health Research, 29*(14), 2048-2056. https://doi.org/10.1177/1049732319843499

World Health Organization. (2020). *Primary health care on the road to universal health coverage: 2019 monitoring report.* World Health Organization;. https://apps.who.int/iris/bitstream/handle/10665/344057/9789240004276-eng.pdf?sequence=2

Wu, T., Jia, X., Shi, H., Niu, J., Yin, X., Xie, J., & Wang, X. (2021). Prevalence of mental health problems during the COVID-19 pandemic: A systematic review and meta-analysis. *Journal of Affective Disorders, 281*, 91-98. https://doi.org/10.1016/j.jad.2020.11.117

Yanchus, N. J., Periard, D., Moore, S. C., Carle, A. C., & Osatuke, K. (2015). Predictors of job satisfaction and turnover intention in VHA mental health employees: A comparison between psychiatrists, psychologists, social workers, and mental health nurses. *Human Service Organizations Management, Leadership & Governance, 39*(3), 219-244. https://doi.org/10.1080/23303131.2015.1014953

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy, 57*(3), 426. https://doi.org/10.1037/PST0000317

Yeh, Y.-J., & Hayes, J. A. (2011). How does disclosing countertransference affect perceptions of the therapist and the session? *Psychotherapy, 48*(4), 322. https://doi.org/10.1037/A0023134

Yoder, E. A. (2010). Compassion fatigue in nurses. *Applied Nursing Research, 23*(4), 191-197. https://doi.org/https://doi-org.ezproxy.aut.ac.nz/10.1016/j.apnr.2008.09.003

Zarbo, C., Tasca, G. A., Cattafi, F., & Compare, A. (2016). Integrative psychotherapy works. *Frontiers in Psychology, 6*, 2021. https://doi.org/http://dx.doi.org/10.3389/fpsyg.2015.02021

Zhao, H., Falkheimer, J., & Heide, M. (2017). Revisiting a social constructionist approach to crisis communication–investigating contemporary crises in China. *International Journal of Strategic Communication, 11*(5), 364-378. https://doi.org/10.1080/1553118X.2017.1363758

Zhou, X., Lee, R. M., & Ohm, J. (2021). Evaluating the feasibility of the Incredible Years Attentive Parenting Program as universal prevention for racially diverse populations. *Journal of Prevention and Health Promotion, 2*(1), 32-56. https://doi.org/DOI:10.1177/2632077020976401

# Appendices

## Appendix A: AUTEC letter of approval

AUT

**AUTEC Secretariat**
Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

12 March 2018

Brian Rodgers
Faculty of Health and Environmental Sciences

Dear Brian

Re Ethics Application: **18/63 At the coal face of the politics of mental health: Exploring how psychologists maintain the therapeutic alliance in the context of institutional processes**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 12 March 2021.

**Standard Conditions of Approval**

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

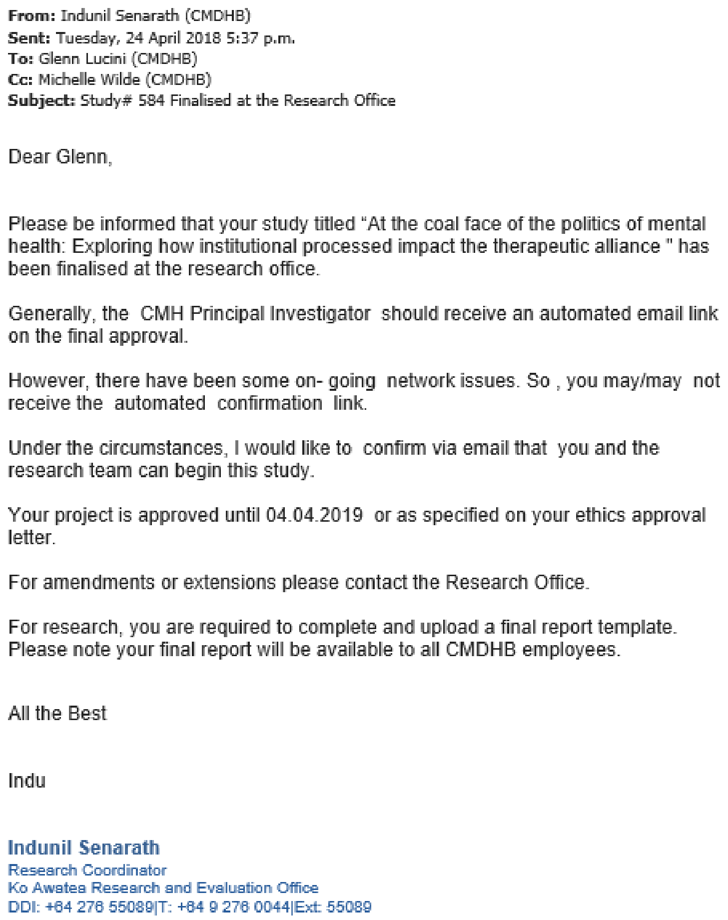
For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
**Auckland University of Technology Ethics Committee**

Cc: qpf5026@autuni.ac.nz; Liz Smythe

# Appendix B: Localities approval



**From:** Indunil Senarath (CMDHB)
**Sent:** Tuesday, 24 April 2018 5:37 p.m.
**To:** Glenn Lucini (CMDHB)
**Cc:** Michelle Wilde (CMDHB)
**Subject:** Study# 584 Finalised at the Research Office

Dear Glenn,

Please be informed that your study titled "At the coal face of the politics of mental health: Exploring how institutional processed impact the therapeutic alliance " has been finalised at the research office.

Generally, the CMH Principal Investigator should receive an automated email link on the final approval.

However, there have been some on- going network issues. So , you may/may not receive the automated confirmation link.

Under the circumstances, I would like to confirm via email that you and the research team can begin this study.

Your project is approved until 04.04.2019 or as specified on your ethics approval letter.

For amendments or extensions please contact the Research Office.

For research, you are required to complete and upload a final report template.
Please note your final report will be available to all CMDHB employees.

All the Best

Indu

**Indunil Senarath**
Research Coordinator
Ko Awatea Research and Evaluation Office
DDI: +64 276 55089|T: +64 9 276 0044|Ext: 55089

# Appendix C: Information sheet

## Participant Information Sheet

**Date Information Sheet Produced:**

12 February 2018

**Project Title**

**At the coal face of the politics of mental health: Exploring how psychologists maintain the therapeutic alliance in the context of institutional processes**

**An Invitation**

My name is Glenn Lucini I am presently completing a Doctor of Health Science through AUT. I have undertaken this research to extend my understanding of psychological processes, and to improve my leadership and service-development expertise. I am a registered clinical psychologist with over thirteen years' experience, and I have been working at Counties Manukau District Health Board for the past ten years. Much of my professional life has involved clinical leadership and assisting mental health workers develop clinical skills and manage their clinical work.

My study is fundamentally aimed at exploring and promoting therapeutic relationship skills within health care institutions. Many psychologists place a high priority on their capacity to build and sustain an alliance with their clients. However, in modern health care settings multiple factors can compromise clinicians' capacity to build effective therapeutic alliances. This study will explore how psychologists maintain this central component of their profession while working with a strained population, and while collaborating within organisations that must manage a broader collection of priorities. The study looks at alliance building as a socially constructed process – and as a context where the personal values and ideals of a therapist intertwine with the institutional and contextual processes of our working environments. Counties Manukau DHB is providing an emerging research funding grant for this study.

**What is the purpose of this research?**

The insights gained from the participants and the integrated theory that emerges from this study may assist institutions in supporting their staff in working in a relationship-focused way. At the very least the study may serve to alert managers and institutions to practice problems that are not easily acknowledged.

This study focuses on the experiences of local psychologists and in this way the study may generate a richer understanding of our local interpretation of therapeutic processes and practice habits. This may add to the advancement of psychology in New Zealand.

Personally I have long advocated for the importance of relationship processes in mental health work. This study can equip me with extensive academic knowledge and a well-developed perspective that I can apply to my working environment.

Upon completion I will be awarded a doctorate in health science, and I hope to publish some of the findings in journals and publications. I will also present my findings to academics and professionals in my field.The insights gained from the participants and the integrated theory that emerges from the study may assist institutions in supporting their staff in working in a relationship-focused way. At the very least the study may serve to alert managers and institutions to practice problems that are not easily acknowledged.This study focuses on the experiences of local psychologists, and in this way the study may generate a richer understanding our local practice habits and principles. This may add to the advancement of psychology in New Zealand.Personally. I am a clinical leader and I have long advocated for the importance of relationship processes in mental health work. This study can equip me with extensive academic knowledge and a well-developed perspective that I can apply to my working environment

**How was I identified and why am I being invited to participate in this research?**

I have approached you as I am interested in the perspective of experienced psychologists who have had time to develop a mature position on the challenges of providing therapy in complex settings. I am interested in your lived experiences and the way you have made sense of alliance maintenance over your career.

I have contacted you directly as I am using purposive sampling, which involves contacting potential participants who may hold specialist knowledge or are well-place to contribute to the research question.

25 April 2022 page 1 of 3 This version was edited in July 2016

Please note, I have elected to not approach any practitioners from my work place, as I do not want my professional role in my service to impact the relationship.

**How do I agree to participate in this research?**

I am including a consent form for your consideration. If you are interested in participating, please contact me via email or telephone within the next month and we can discuss the next steps. If you agree to participate, you may also complete and email or bring the consent from along to the meeting, or we can complete one when we meet. I will provide you with a copy of the form too. If I do not hear from you, then I will assume you do not want to participate and after sending reminder via email in a few weeks, I won't contact you in this regard again.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

**What will happen in this research?**

This research project consists entirely of gathering qualitative data through unstructured interviews. I plan to meet up with approximately 20 psychologists and conduct an interview that may last as much as 90mins. During this interview I ask only that you adopt a reflective and conversational approach to talking about your profession and your experiences of providing therapy. I am particularly interested in how you maintain relationships with clients, what you use to achieve this and how you conceptualise the challenges of maintaining an effective alliance in therapy.

Later, I will send you a copy of the transcripts for your comments and corrections.

**What are the discomforts and risks?**

I do not anticipate that the process will be uncomfortable; in fact, quite the opposite, I would like to interview to be a pleasant and stimulating conversation that recognises your expertise and experience. There is a chance you may feel somewhat conflicted when commenting on institutional processes (especially if you have concerns or criticisms).

**How will these discomforts and risks be alleviated?**

If the process is in some way uncomfortable, please let me know and we can make adjustments to the process; or discuss ways to alleviate your distress. We will also take some time at the end of the interview to debrief and check that you feel comfortable with the interview and properly represented by the process.

**What are the benefits?**

I would hope that your participation will be an opportunity for reflection on your professional life and thus a rewarding experience for you. I will also use this information to encourage a better environment for psychologists and in this way, you may be contributing to a better future for the profession. On a personal level, I will obtain a doctoral degree for this study, and in this regard, you will be assisting a colleague in his development

**What compensation is available for injury or negligence?**

None is anticipated. However, in the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

**How will my privacy be protected?**

No identifying information (name, position, affiliations, etc.) will be reported on. Each participant will be given a pseudonym; and a key to unscramble the true name of the participant will be kept in an encrypted electronic file. I will change any identifiable data (including the names of institutions and places) following your review of the transcripts, where I will give you a chance to highlight any identifying data that you are uncomfortable with.

**What are the costs of participating in this research?**

I am happy to travel to a location that is convenient to you; we can also consider a Skype interview if that is more convenient. The cost of participating is primarily your time. The interviews are likely to be one hour, but I am going to allow for 90min ensuring enough time. This may also include ~~some time~~ later on to review the transcripts and provide comments or corrections when they are sent to you. I would welcome corrections and clarifications; in fact your comments and reflections on what was said are important to me; and after-thoughts, updates, or re-thinks can add to the richness of the study.

I may approach you at a later stage for a briefer follow up conversation if some of the themes that emerge in the initial analysis need clarification.

**What opportunity do I have to consider this invitation?**

While I would prefer some feedback on your participation within a few weeks, the invitation is open for one month.

**Will I receive feedback on the results of this research?**

If you would like an executive summary of the research, please indicate this on the consent form.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Brian Rodgers; 921 9999 ext 7012; brian.rodgers@aut.ac.nz.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

***Researcher Contact Details:***

Glenn Lucini email address: qpf5026@autuni.ac.nz

***Project Supervisor Contact Details:***

Dr Brian Rodgers; 921 9999 ext. 7012; brian.rodgers@aut.ac.nz.

**Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.**

# Appendix D: Consent form

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

## Consent Form

| | |
|---|---|
| *Project title:* | **At the coal face of the politics of mental health: Exploring how psychologists maintain the therapeutic alliance in the context of institutional processes** |
| *Project Supervisor:* | **Dr Brian Rodgers** |
| *Researcher:* | **Glenn J Lucini** |

○ I have read and understood the information provided about this research project in the Information Sheet dated 12 January 2018

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-recorded and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....................................................................................................................

Participant's name: .....................................................................................................................

Participant's Contact Details (if appropriate):

.....................................................................................................

.....................................................................................................

.....................................................................................................

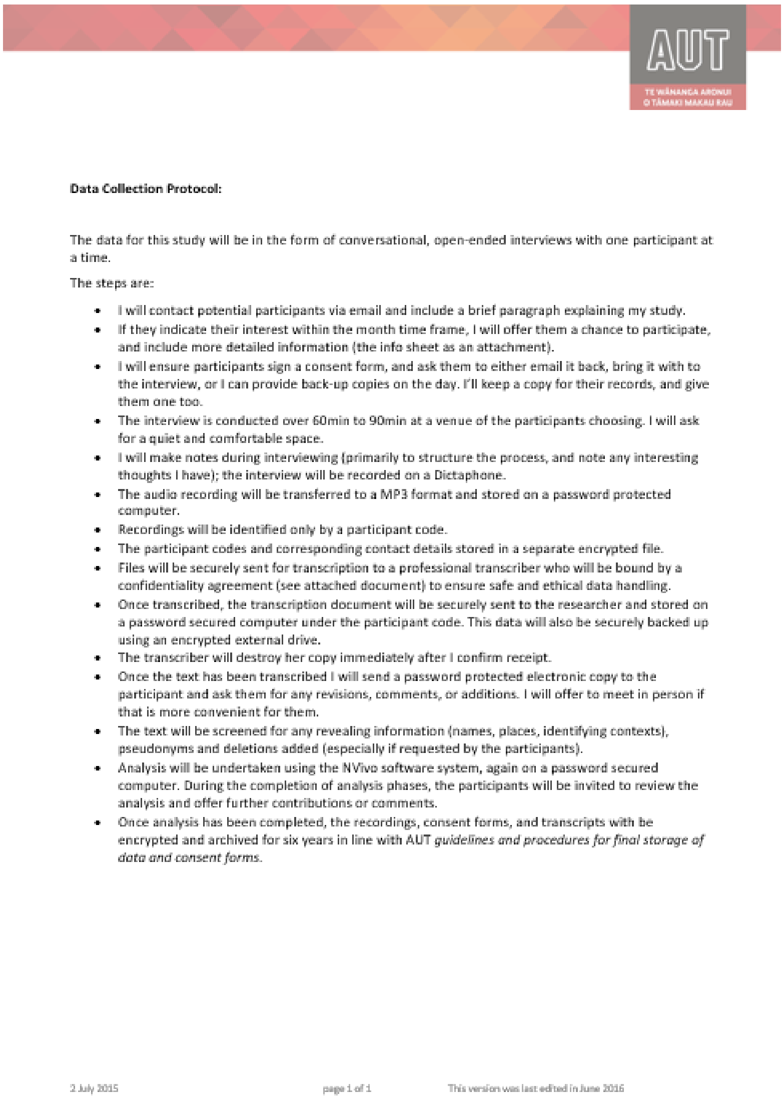
.....................................................................................................

Date:

***Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted** AUTEC Reference number **type the AUTEC reference number***

*Note: The Participant should retain a copy of this form.*

# Appendix E: Data collection protocol



AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

**Data Collection Protocol:**

The data for this study will be in the form of conversational, open-ended interviews with one participant at a time.

The steps are:

- I will contact potential participants via email and include a brief paragraph explaining my study.
- If they indicate their interest within the month time frame, I will offer them a chance to participate, and include more detailed information (the info sheet as an attachment).
- I will ensure participants sign a consent form, and ask them to either email it back, bring it with to the interview, or I can provide back-up copies on the day. I'll keep a copy for their records, and give them one too.
- The interview is conducted over 60min to 90min at a venue of the participants choosing. I will ask for a quiet and comfortable space.
- I will make notes during interviewing (primarily to structure the process, and note any interesting thoughts I have); the interview will be recorded on a Dictaphone.
- The audio recording will be transferred to a MP3 format and stored on a password protected computer.
- Recordings will be identified only by a participant code.
- The participant codes and corresponding contact details stored in a separate encrypted file.
- Files will be securely sent for transcription to a professional transcriber who will be bound by a confidentiality agreement (see attached document) to ensure safe and ethical data handling.
- Once transcribed, the transcription document will be securely sent to the researcher and stored on a password secured computer under the participant code. This data will also be securely backed up using an encrypted external drive.
- The transcriber will destroy her copy immediately after I confirm receipt.
- Once the text has been transcribed I will send a password protected electronic copy to the participant and ask them for any revisions, comments, or additions. I will offer to meet in person if that is more convenient for them.
- The text will be screened for any revealing information (names, places, identifying contexts), pseudonyms and deletions added (especially if requested by the participants).
- Analysis will be undertaken using the NVivo software system, again on a password secured computer. During the completion of analysis phases, the participants will be invited to review the analysis and offer further contributions or comments.
- Once analysis has been completed, the recordings, consent forms, and transcripts with be encrypted and archived for six years in line with AUT *guidelines and procedures for final storage of data and consent forms.*

2 July 2015 page 1 of 1 This version was last edited in June 2016

# Appendix F: Confidentiality agreement

AUT
TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

## Confidentiality Agreement

| | |
|---|---|
| *Project title:* | **At the coal face of the politics of mental health: Exploring how institutional processes impact the therapeutic alliance** |
| *Project Supervisor:* | ***Dr Brian Rodgers*** |
| *Researcher:* | ***Glenn Lucini*** |

- ✓ I understand that all the material I will be asked to transcribe is confidential.
- ✓ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: ……………………………………………………………………………………

Transcriber's name: ……..Shoba Nayar……………………………………………………………………

Transcriber's Contact Details (if appropriate):

…Email: snayar19@gmail.com……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

……………………………………………………………………

Date: 12 January 2018

Project Supervisor's Contact Details (if appropriate):

Dr Brian Rodgers

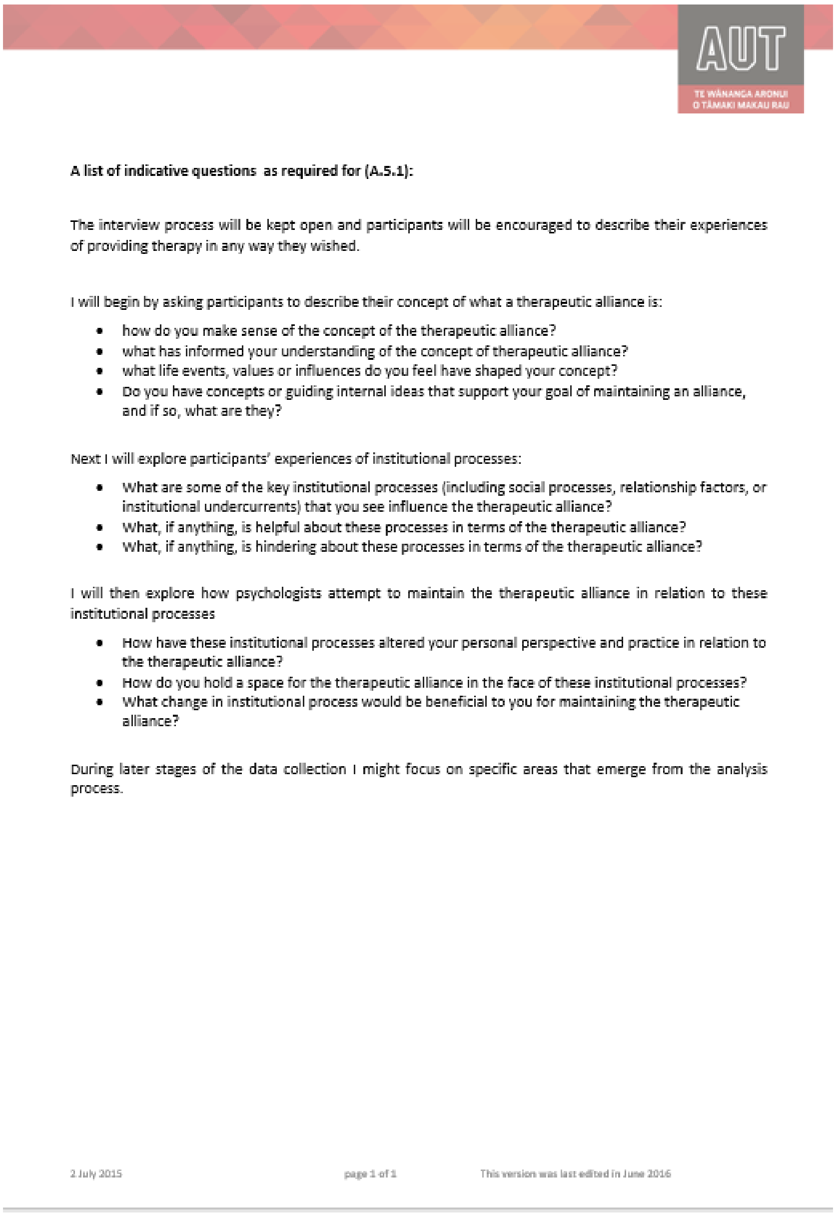
021 034 2071

Brian.rodgers@aut.ac.nz

***Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number***

*Note: The Transcriber should retain a copy of this form.*

# Appendix G: List of indicative questions



**A list of indicative questions as required for (A.5.1):**

The interview process will be kept open and participants will be encouraged to describe their experiences of providing therapy in any way they wished.

I will begin by asking participants to describe their concept of what a therapeutic alliance is:

- how do you make sense of the concept of the therapeutic alliance?
- what has informed your understanding of the concept of therapeutic alliance?
- what life events, values or influences do you feel have shaped your concept?
- Do you have concepts or guiding internal ideas that support your goal of maintaining an alliance, and if so, what are they?

Next I will explore participants' experiences of institutional processes:

- What are some of the key institutional processes (including social processes, relationship factors, or institutional undercurrents) that you see influence the therapeutic alliance?
- What, if anything, is helpful about these processes in terms of the therapeutic alliance?
- What, if anything, is hindering about these processes in terms of the therapeutic alliance?

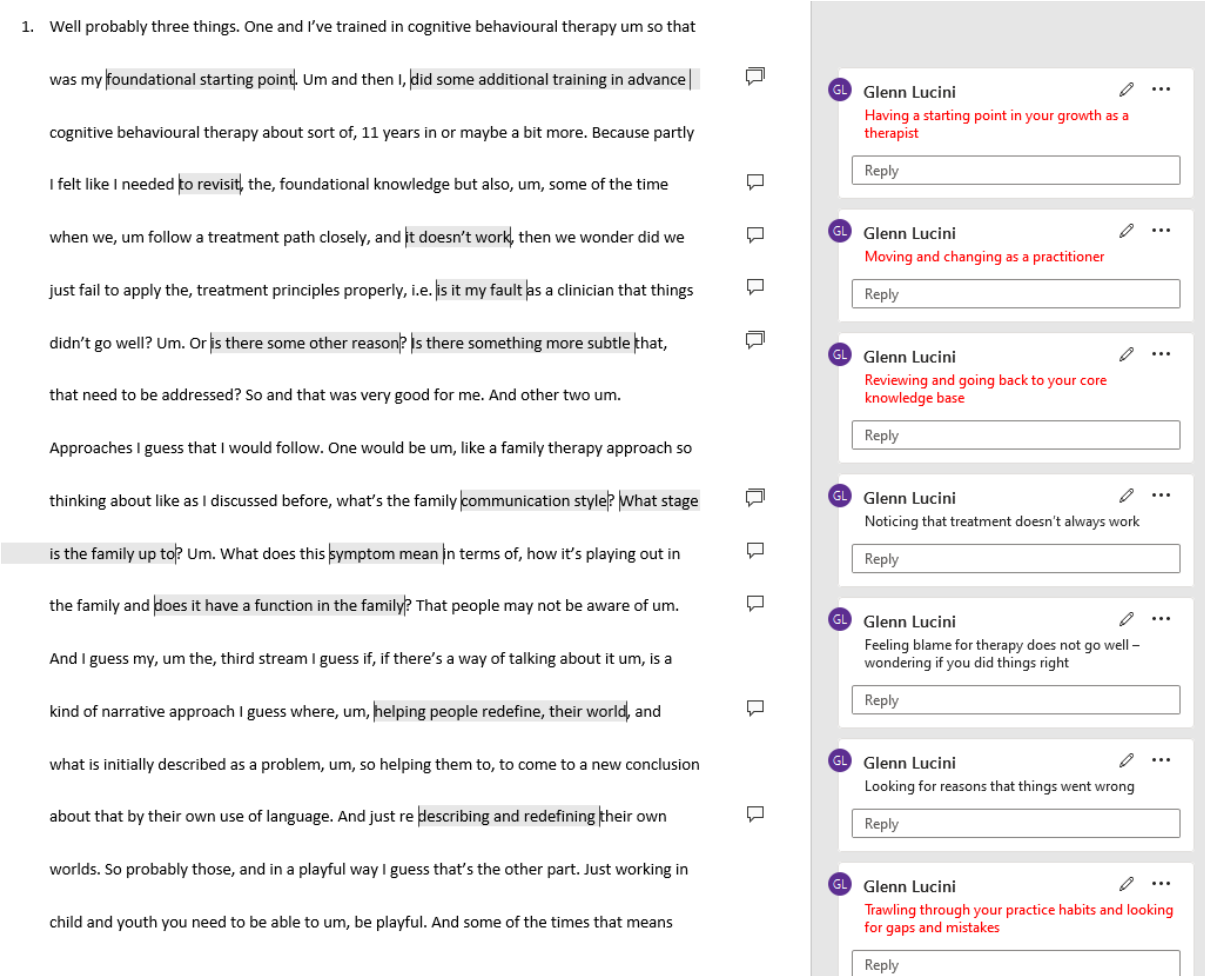
I will then explore how psychologists attempt to maintain the therapeutic alliance in relation to these institutional processes

- How have these institutional processes altered your personal perspective and practice in relation to the therapeutic alliance?
- How do you hold a space for the therapeutic alliance in the face of these institutional processes?
- What change in institutional process would be beneficial to you for maintaining the therapeutic alliance?

During later stages of the data collection I might focus on specific areas that emerge from the analysis process.

2 July 2015 page 1 of 1 This version was last edited in June 2016

# Appendix H: Example of line-by-line coding



1. Well probably three things. One and I've trained in cognitive behavioural therapy um so that was my foundational starting point. Um and then I, did some additional training in advance cognitive behavioural therapy about sort of, 11 years in or maybe a bit more. Because partly I felt like I needed to revisit, the, foundational knowledge but also, um, some of the time when we, um follow a treatment path closely, and it doesn't work, then we wonder did we just fail to apply the, treatment principles properly, i.e. is it my fault as a clinician that things didn't go well? Um. Or is there some other reason? Is there something more subtle that, that need to be addressed? So and that was very good for me. And other two um. Approaches I guess that I would follow. One would be um, like a family therapy approach so thinking about like as I discussed before, what's the family communication style? What stage is the family up to? Um. What does this symptom mean in terms of, how it's playing out in the family and does it have a function in the family? That people may not be aware of um. And I guess my, um the, third stream I guess if, if there's a way of talking about it um, is a kind of narrative approach I guess where, um, helping people redefine, their world, and what is initially described as a problem, um, so helping them to, to come to a new conclusion about that by their own use of language. And just re describing and redefining their own worlds. So probably those, and in a playful way I guess that's the other part. Just working in child and youth you need to be able to um, be playful. And some of the times that means

Glenn Lucini
Having a starting point in your growth as a therapist
Reply

Glenn Lucini
Moving and changing as a practitioner
Reply

Glenn Lucini
Reviewing and going back to your core knowledge base
Reply

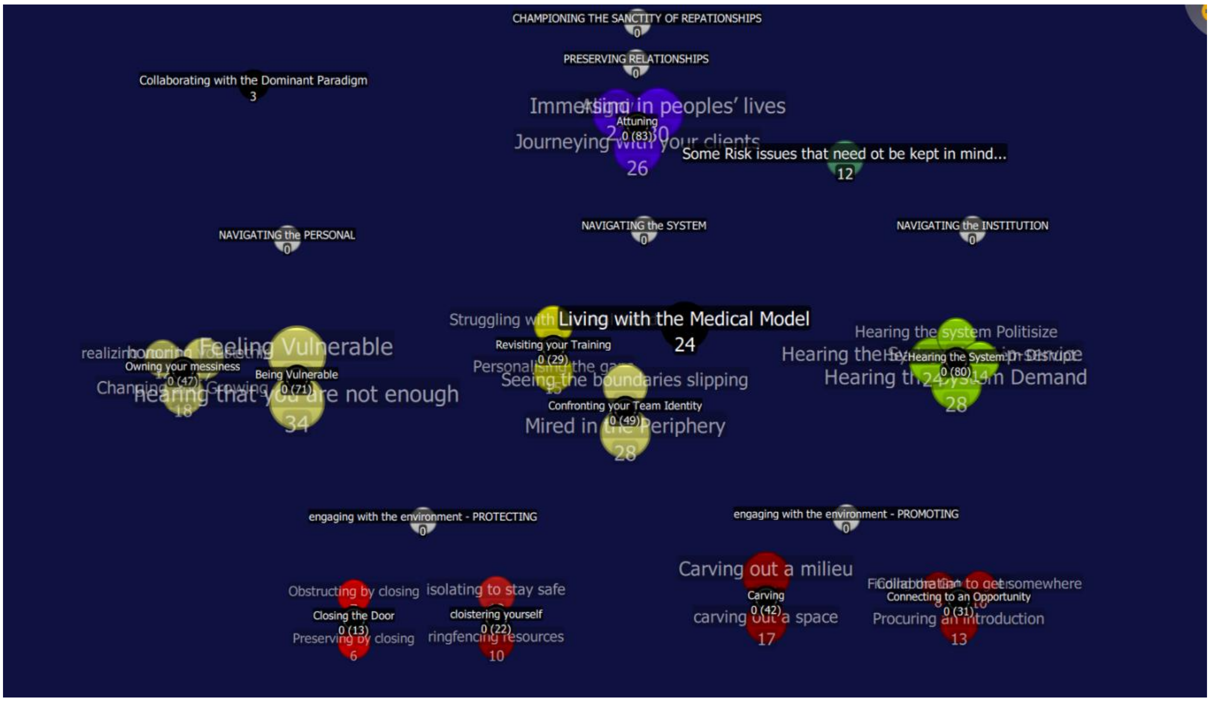
Glenn Lucini
Noticing that treatment doesn't always work
Reply

Glenn Lucini
Feeling blame for therapy does not go well – wondering if you did things right
Reply

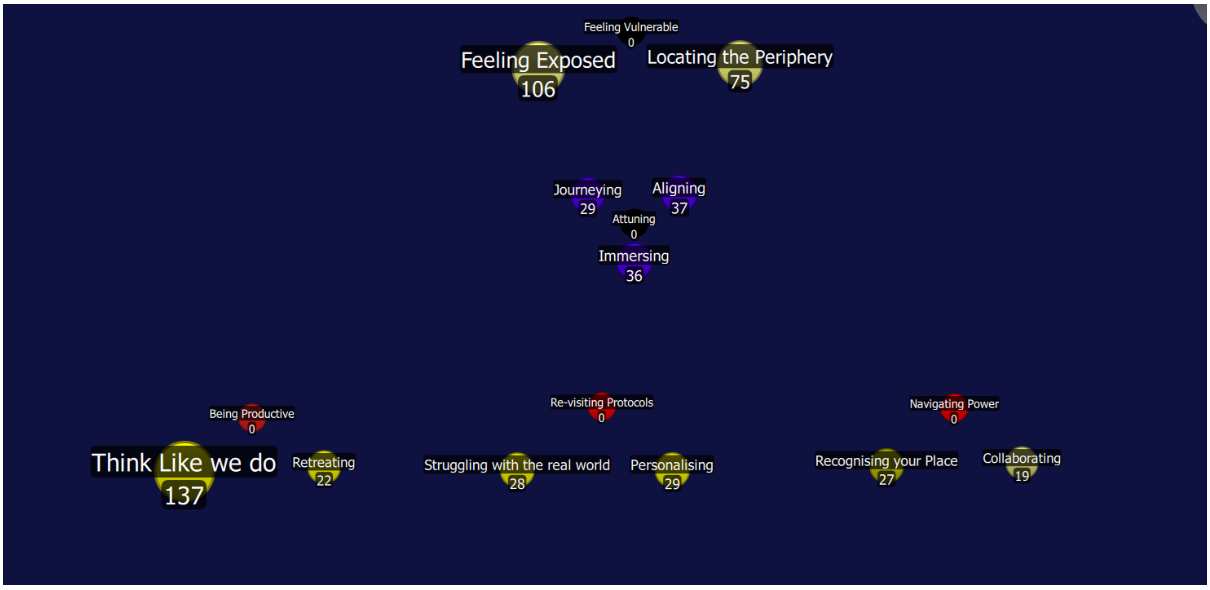
Glenn Lucini
Looking for reasons that things went wrong
Reply

Glenn Lucini
Trawling through your practice habits and looking for gaps and mistakes
Reply

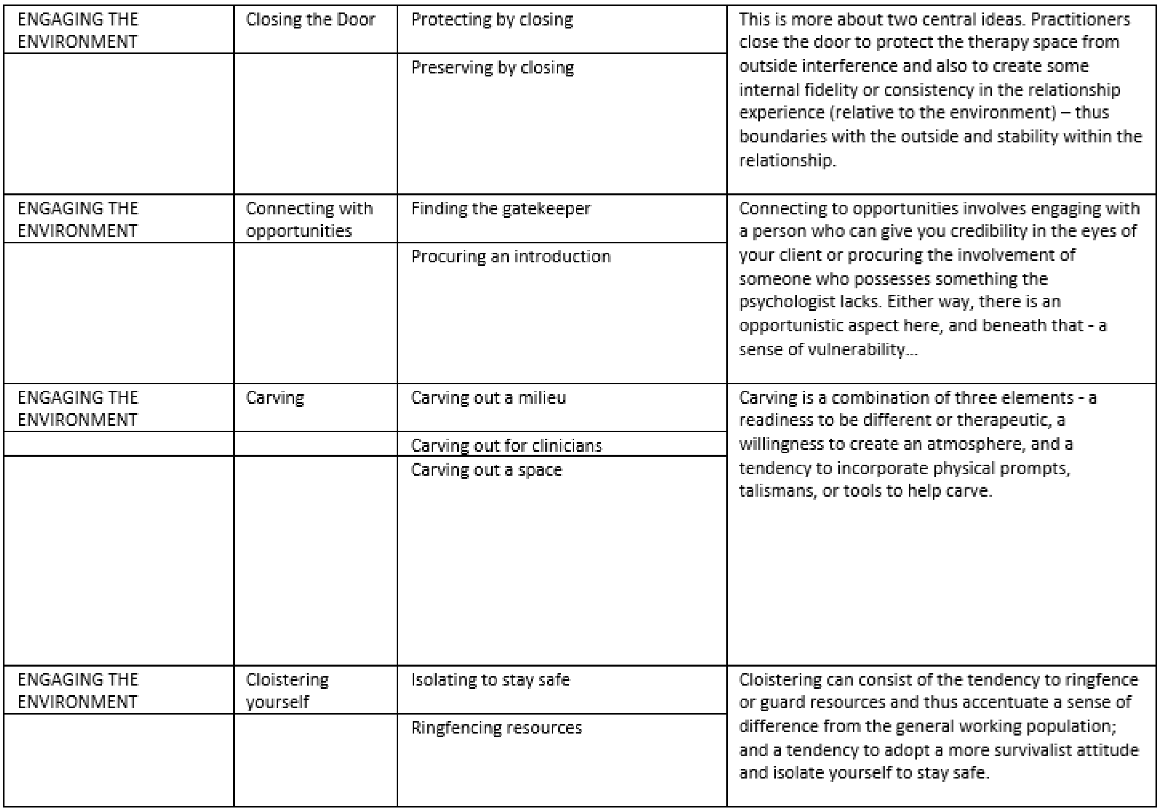
## Appendix I: Example of earlier Quirkos coding



## Appendix J: Example of later Quirkos Coding



## Appendix K: Example of developing initial codes into focus codes



| | | | |
|---|---|---|---|
| ENGAGING THE ENVIRONMENT | Closing the Door | Protecting by closing | This is more about two central ideas. Practitioners close the door to protect the therapy space from outside interference and also to create some internal fidelity or consistency in the relationship experience (relative to the environment) – thus boundaries with the outside and stability within the relationship. |
| | | Preserving by closing | |
| ENGAGING THE ENVIRONMENT | Connecting with opportunities | Finding the gatekeeper | Connecting to opportunities involves engaging with a person who can give you credibility in the eyes of your client or procuring the involvement of someone who possesses something the psychologist lacks. Either way, there is an opportunistic aspect here, and beneath that - a sense of vulnerability… |
| | | Procuring an introduction | |
| ENGAGING THE ENVIRONMENT | Carving | Carving out a milieu | Carving is a combination of three elements - a readiness to be different or therapeutic, a willingness to create an atmosphere, and a tendency to incorporate physical prompts, talismans, or tools to help carve. |
| | | Carving out for clinicians | |
| | | Carving out a space | |
| ENGAGING THE ENVIRONMENT | Cloistering yourself | Isolating to stay safe | Cloistering can consist of the tendency to ringfence or guard resources and thus accentuate a sense of difference from the general working population; and a tendency to adopt a more survivalist attitude and isolate yourself to stay safe. |
| | | Ringfencing resources | |