

Portfolio Volume 1: Major Research Project

**Experiences of Workplace Bullying from the perspectives of Trainee Clinical  
Psychologists: A Qualitative Study**

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## **Abstract**

Research has identified that workplace bullying is a significant problem within healthcare, with healthcare trainees at particular risk. However, there are no studies of workplace bullying within clinical psychology or of trainee clinical psychologists. The aim of the current study was to explore the experiences of workplace bullying from the perspectives of trainee clinical psychologists. Fourteen trainee clinical psychologists were recruited from UK universities and participated in semi-structured telephone interviews. Data was analysed using thematic analysis within a critical realist epistemology. The analysis generated four main themes: workplace bullying 'activating threat responses', the process of trainee clinical psychologists 'making sense of bullying', 'difficulties navigating power within the system' when experiencing and reporting bullying, and 'finding safety and support' within and outside of work contexts. The results are considered in relation to existing research, as well as Compassion Focussed Therapy theory and the Power Threat Meaning framework. Clinical implications are recommended at an individual level, within the profession of clinical psychology and for the wider healthcare system.

## **Chapter 1: Introduction**

The introduction will highlight the researcher's personal interest in the research topic, and epistemological position in relation to the research. This is followed by definitions of workplace bullying used in the research, the challenges to these definitions, as well as psychological theories of workplace bullying and, finally, an overview of research on workplace bullying amongst healthcare professionals in the UK.

### **1.1 Personal and epistemological positions**

#### **1.1.1 Personal interest**

My interest in undertaking research in workplace bullying arose from reading media accounts and surveys of workplace bullying amongst healthcare professionals within the NHS (e.g. Johnson, 2016a; Johnson, 2016b; Barbour, 2017), as well as hearing about examples of clinical psychologists who had experienced or engaged in bullying behaviours. This connected with some of my own experiences of negative behaviours within pre-qualified psychologist roles. I particularly identified with the changing levels of uncertainty about whether the behaviours I was experiencing would be considered workplace bullying whilst I was in those work environments, and the difficulty faced when challenging the behaviours. I found that whilst there was research on workplace bullying within other fields of healthcare professions, especially medicine and nursing, there was no comparable research within clinical psychology. This lack of research led me to developing a project to explore workplace bullying within the profession of clinical psychology. I hoped this would contribute to a greater understanding of the issue in the profession and potentially inform responses to workplace bullying within clinical psychology.

### **1.1.2 Epistemological position**

The contested and subjective nature of definitions of workplace bullying suggest that it is a socially constructed phenomenon. Understandings of workplace bullying are shaped by social phenomena, from workplace cultures and colleagues' perspectives to media representations and neoliberal ideology (Lewis, 2003). However, whilst bullying is shaped by social representations, I am also interested in the way in which these perceptions shape the "reality" of how individuals experience the effects of workplace bullying, such as the emotional, cognitive and physically embodied impact of bullying on an individual. Thus, the epistemological position of the study can be described as critical realist. This acknowledges the way broader social context impacts on the meanings that individuals make of their experiences, whilst maintaining a focus on the material reported from participants and other limits of this given "reality" (Willig, 1999). Furthermore, as an individual's beliefs and values are likely to influence their perception of bullying (Rai & Agarwal, 2016), my own experiences, beliefs and values shape the way in which I approach and interpret the research.

## **1.2 Definitions of workplace bullying**

In the research literature, there have been challenges to providing an agreed comprehensive research definition of workplace bullying, particularly as definitions of workplace bullying may overlap with other related concepts, such as incivility, abusive supervision and social undermining (Nielsen & Einarsen, 2018). However, most attempts to operationalise the term "workplace bullying" in the research include

reference to duration and frequency of behaviours, an imbalance of power and may also include examples of bullying behaviour (Einarsen, Hoel, Zapf & Cooper, 2011).

The concepts included in definitions in workplace bullying research have been shaped by earlier research in the field. However, the topic of workplace bullying as a subject of research is relatively recent. Leymann (1990) provided one of the first systematic deconstructions of the problem through analysis of interviews with targets of bullying in Sweden, and this was the first English language article in an international peer reviewed journal on the topic. The influence of earlier research in the field will be considered in the following central areas in definitions of workplace bullying in current academic research: frequency and duration, imbalance of power and types of behaviour.

### **1.2.1 Frequency and duration**

Early research tended to be relatively prescriptive in delineating frequency and duration of negative behaviours understood as workplace bullying. Leymann (1990, 1996) suggested that in order for negative behaviours in the workplace to be considered bullying, they should occur at least once a week and for more than six months. This timeframe was chosen as Leymann (1990) argued that workplace bullying leads to psychiatric distress, and therefore used the six-month time frame frequently used in assessment of psychiatric disorders. His motivation for a psychiatric framework in understanding workplace bullying was to differentiate between social stress at work and bullying, and to argue that workplace bullying leads to severe psychiatric and psychosomatic impairment. Whilst the specific frequency and duration of behaviours described by Leymann are not always used in

research definitions, the elements of persistence and duration are regularly included. Key researchers in the field argue that the elements of repeated and enduring behaviours differentiate it from interpersonal aggression, which can take the form of an individual episode (Nielsen & Einarsen, 2012). Rather than being an either/or phenomenon, they argue it is a gradually evolving process of prolonged exposure to repeated behaviours (Einarsen, 2000). These conceptualisations reflect Leymann's (1990, 1996) proposition that whilst individual negative acts may be detrimental, it is the accumulated pattern of behaviour that constitutes workplace bullying.

### **1.2.2 Imbalance of power**

A key aspect of research definitions of workplace bullying is the power disparity between perpetrator and target, where the target finds it difficult to defend themselves from negative acts (Leymann, 1996; Rai & Agarwal, 2018). The imbalance of power can mirror the formal power structure of an organisational hierarchy, but may also be more informal, based on knowledge, experience and access to support and networks of people (Hoel & Cooper, 2000). A power differential may also reflect a dependence on the perpetrator that is social, economic, physical or psychological (Niedl, 1995). Some conceptualisations of workplace bullying argue that rather than bullying occurring from a perpetrator in a position of relative power, it may be from the process of bullying itself that a power differential can emerge (Einarsen, Hoel, Zapf & Cooper, 2011).

### **1.2.3 Types of behaviour and measures**

Many definitions in the research literature include reference to negative acts or behaviour. Whilst there is no definitive list of behaviours considered to be bullying

at work, there exist examples of types of behaviours. These may be direct actions e.g. verbal abuse, or indirect e.g. rumour and social isolation (O' Moore, Seigne, McGuire, & Smith, 1998). Other distinctions have been made between task attack (such as persistent criticism of work, being given an unmanageable workload), person attack (for example related to someone's appearance), social isolation and physical attack (Rayner & Dick, 2005).

Specific measures have been developed from the different types of workplace bullying behaviours identified. From his analysis of interviews, Leymann (1990) developed an inventory of common behaviours of workplace bullying called the Leymann Inventory of Personal Terror (LIPT). The LIPT has formed the basis of most quantitative investigation in the field (Rayner & Cooper, 2006). This has included the development of subsequent measures that have been influenced by earlier research, including the Negative Acts Questionnaire and Negative Acts Questionnaire- Revised (NAQ and NAQ-R; Einarsen, Hoel & Notelaers, 2009). The NAQ and NAQ-R lists behaviours typically associated with workplace bullying, and are the most widely used measures in quantitative research of the topic (Nielsen & Einarsen, 2018). Another measure used to measure incidents of workplace bullying is the Quine questionnaire, based on five categories: threat to professional status, threat to personal standing, isolation, overwork and destabilisation. The Quine questionnaire has been used in prevalence studies of workplace bullying amongst healthcare professionals in the UK (Quine, 1999, 2001, 2002, 2003; Steadman, Quine, Jack, Felix, & Waumsley, 2009).

### **1.2.4 Example research definition of workplace bullying**

An example of a definition that incorporates the ideas of persistence, duration, imbalance of power and negative behaviours (as well as perception of the target), is that by Nielsen & Einarsen (2012, p.309), which is widely used in the research literature:

“Workplace bullying is defined as a situation in which one or several individuals persistently, and over a period of time, perceive themselves as being on the receiving end of negative actions from superiors or co-workers, and where the target of the bullying finds it difficult to defend him or herself against these actions.”

### **1.3 Challenges to measurement of workplace bullying**

The way in which workplace bullying is defined affects the nature of the research on the phenomenon. Research in the area has primarily been from a quantitative perspective and is dominated by prevalence studies. There are three main approaches to measure bullying: self-labelling without a definition, self-labelling with a definition, and the behavioural experience method (Illing et al., 2016). In the self-labelling approach, a study will typically ask a respondent to identify themselves as a target of bullying, (e.g., “Have you been bullied at work?” with a yes/no response, or “How often have you been bullied at work?” with a frequency scale such as never/occasionally/monthly/weekly/daily). This may be without a definition or following a definition of workplace bullying. The behavioural experience method will ask respondents to rate the frequency that they have experienced different negative behaviours, such as in the LIPT, Quine and NAQ-R questionnaires. In a meta-analysis of 102 prevalence estimates of bullying, Nielsen, Matthiesen, & Einarsen (2010) found a rate of 11.3% in studies using self-labelling with definition method,

14.8% for behavioural measure studies (using Leymann's (1990b) criteria of at least one negative act per week for at least 6 months), and 18.1% for self-labelling studies without a given definition. Nielsen et al. (2010) suggest using the self-labelling with definition approach, as this operationalises the theoretical definition of bullying and provides a measure of employees who identify as targets of bullying according to this definition. They also recommend combining this with the behavioural experience approach, as the latter can provide information about number of employees exposed to bullying behaviours. Thus, the different approaches seem to assess different facets of workplace bullying.

Even when combining the self-labelling and behavioural experience approaches, Fevre, Robinson, Jones, & Lewis (2010) found methodological difficulties when attempting to measure the prevalence of workplace bullying, and advocate the use of qualitative data to inform understanding of quantitative methodology. Fevre et al. (2010) used a form of qualitative interviewing called 'cognitive testing' to examine how far questions are understood by respondents and to systematically capture the mental processes that respondents use to answer survey questions, such as the heuristics used to formulate an opinion (Jobe & Mingay, 1991). They used this to understand respondents' interpretations of different research definitions of workplace bullying, as well as the questions used in the NAQ. Fevre et al. (2010) found that respondents would not always read and digest bullying definitions as they said that they had already decided what bullying meant to them. Fevre et al. (2010) also argue that combining a questionnaire with a definition question may result in one influencing the other, depending on the order that the self-labelling definition question and questionnaire were presented. Many respondents also reported that they felt that context of the behaviours found in the

NAQ was important to understanding whether they could be understood as bullying. Indeed, workplace bullying inventories, such as the NAQ and LIPT, do not include the key elements of power imbalance found in the theoretical definition of bullying (Nielsen et al., 2010), which may be central to whether behaviours are experienced as bullying.

### **1.3.1 Challenges to research definitions of workplace bullying**

As Fevre et al. (2010) found, differences seem to exist between how workplace bullying is conceptualised within academia, and how it is understood by employees and within workplaces, and these different conceptualisations may impact on research of the topic. Saunders, Huynh, & Goodman-Delahunty's (2007) analysis of 1095 lay definitions of workplace bullying found that lay definitions often excluded central elements found in formal, research definitions. Whilst most included perpetration of negative behaviour as in academic definitions, only 15.2% of the participants included power imbalance, and only 14.7% included persistency. Additionally, many lay definitions included elements, such as fairness and respect, that are not found in academic definitions. Definitions of workplace bullying by human resource (HR) practitioners may also not reflect the definitions found in academic research. Rayner and Cooper (2006) reported on HR concerns that stressing persistency "disempowers" investigations in which a single event is reported, and at the extreme, may give a perpetrator permission to continue. This may explain why definitions applied by practitioners and unions may emphasise types of behaviours and the negative effects of workplace bullying (Saunders et al., 2007), rather than focus on persistency. An example is the definition of workplace bullying by the Advisory, Conciliation and Arbitration Service (Acas), a UK executive

non-departmental public body that provides advice on workplace relations. The definition is also used on the NHS Employers website (n.d.).

“Bullying may be characterised as offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means that undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual” (Acas, 2014)

Some qualitative research, such as Lee's (2000) analysis of 50 semi-structured interviews with employees affected by workplace bullying, also criticises mainstream research definitions as too narrow and that a ‘one-off’ serious incident of workplace aggression as well as a pattern of lower level incidents can constitute bullying. Thus, whilst workplace bullying often is conceptualised in terms of certain parameters in much of the research, there are challenges to these definitions from beyond and within academic research.

### **1.3.2 Other conceptualisations of workplace bullying in the research**

Most research into workplace bullying has focussed on quantitative studies from a realist perspective (Samnani, 2013). However, as seen from qualitative studies, phenomenological understandings of workplace bullying can contrast with definitions found in quantitative surveys (Lee, 2000). In response, there have been calls for more qualitative, interpretivist approaches (Rai and Agarwal, 2016), especially given the contested and subjective nature of the phenomenon. Niedl (1996) has argued that perceptions are central to bullying and are part of complex

processes at organisational and individual levels. These perceptions may vary across contexts, individuals and organisations as well as throughout the process of workplace bullying.

Researchers of workplace bullying, such as Rayner (1999), have advocated for flexibility in methodological approaches, including the use of qualitative methods that incorporate different realities and perceptions as part of the process of studying workplace bullying. Some researchers, such as Fevre et al. (2010), have responded by incorporating qualitative interviewing to revise quantitative measures and including case studies in their research. Fevre et al. (2010) also suggest adopting a qualitative or ethnographic approach when studying non-representative samples to understand the contextual issues relevant to particular settings. Others have used alternative epistemological lenses to the realist approaches often found in the workplace bullying literature (Samnani, 2013). This includes the interpretivist perspective used in Tracy, Lutgen-Sandvik and Alberts's (2006) grounded theory study that explored the meanings that individuals attach to their experiences. They analysed the metaphors that targets of workplace bullying used to describe their experiences. These included participants likening themselves to vulnerable children, slaves and prisoners, and bullying feeling like a battle, water torture, nightmare or noxious substance. Tracy et al.'s (2006) research aimed to highlight the felt and emotional experience of those affected by workplace bullying to contextualise and enrich survey-based research.

Other approaches using a critical paradigm have examined how power may be located within organisational practices, as well as within individual agents. Liefoghe & MacKenzie-Davey's (2003) study extends the view of interpersonal bullying being facilitated by organisations to regarding organisations playing an

active role, by examining how employees understood bullying within their organisation. They found that employees contrasted understandings of school bullying, which they equated with interpersonal bullying, with workplace bullying that was more associated with organisational practices. This included ways in which an organisation used disciplinary practices and threats of dismissal as forms of bullying. Liefoghe and MacKenzie-Davey (2003) found that employees' understanding of bullying placed the organisation and its system as central to their definition, changing the focus from individuals to more systemic ideas of organisational power and control. Thus, more critical approaches may extend understandings of bullying beyond individually oriented explanations to social and organisational theories.

#### **1.4 Psychological models and workplace bullying**

A wide range of psychological models and theories are relevant to understanding workplace bullying. Some of these theories, which help to widen understandings of workplace bullying from merely an individualising approach to including environmental and organisational factors, are outlined below.

##### **1.4.1 Social Learning theory**

Social learning theory (Bandura, 1973) predicts that individuals learn by observing others' behaviours and consequences; if there are no negative outcomes for bullies, negative behaviours may be encouraged. Individuals' aggressive tendencies and the workplace environment may exert mutual influence on each other. Employees may observe others engaging in bullying and model similar types of behaviour. Individuals may also influence the organisation's culture, particularly if they hold senior positions on a team or in the broader organisation. On a broader

scale, social learning theory may explain how the environment in which an organisation exists can influence the behaviour of members of that organisation.

#### **1.4.2 Ecological Systems theory**

Bronfenbrenner's (1979) ecological systems theory has been used to understand workplace bullying (Johnson, 2011). Johnson's (2011) use of the ecological systems model describes the wider society outside of the organisation as the macrosystem, the organisation is the exosystem, the coworkers of the perpetrator and target form the mesosystem, and finally the perpetrator and target form the microsystem. The model recognises that workplace bullying occurs across multiple levels and not in isolation. As well as each of these levels having their own antecedents and outcomes to workplace bullying, the theory may also help to understand how people come to label and interpret their experiences as bullying. Lewis's (2003) study of workplace bullying amongst UK university lecturers explored the impact of media representations, trade union accounts and colleagues influences on individuals' understandings of workplace bullying. The media, trade unions and colleagues could represent the macro-, exo- and meso- systems, respectively. They found that each of these levels impacted on workers' awareness of bullying. However, in this study, colleagues appeared to play the strongest influence by justifying what they were experiencing because they were 'close to the action'.

#### **1.4.3 Compassion Focussed theory**

Gilbert's (2009) compassion-focussed therapy (CFT) model suggests that we have three key emotion-regulation systems. The "threat" system directs attention and responds to threats, and contains threat-based emotions (e.g. anxiety, anger) and

behaviours (fight/flight, freezing). The “drive” system enables us to seek out resources to survive, which can give feelings of motivation, excitement and pleasure. The “affiliative” system enables state of peacefulness when individuals are no longer focused on threats or seeking out resources, and gives us feelings of well-being associated with connectedness to others. Bullying is likely to over-activate the threat and self-protection emotional regulation system, and under-activate the affiliative system. Using the CFT model as a theoretical basis for their research, Henshall, Alexander, Molyneux, Gardiner and McLellan's (2018) mixed methods study of NHS staff found a negative correlation between perceived organisational threat and compassion for others i.e. the greater the perceived organisational threat, the lower the compassion for others. This is likely to impact on service users and other colleagues within the organisation. The study used thematic analysis of qualitative data to explore the nature of perceived organisational threat, which included interpersonal bullying work relationships and wider work cultures of blame, judgement and punishment. Henshall et al.'s (2018) research is situated in the context of the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), which highlighted the need for a caring and compassionate culture within the NHS, and the significant risks where this fails to happen.

## **1.5 Workplace bullying amongst healthcare professionals in the UK**

### **1.5.1 Prevalence studies and economic costs of bullying**

Despite the difficulties of measuring the prevalence of workplace bullying, most research on workplace bullying amongst healthcare professionals in the UK and NHS has focussed on prevalence rates. Studies have been undertaken amongst specific groups of healthcare professionals, although there have been no studies of

clinical psychologists or pre-qualified clinical psychologists. Several studies using the behavioural experience method with UK healthcare professionals have used the Quine questionnaire. Quine questionnaire studies reported the percentage of healthcare professionals reporting experiencing one or more bullying behaviours over the last year, including 47% of trainee psychiatrists (Hoosen & Callaghan, 2004), 40% of palliative medicine trainees (Keeley, Waterhouse, & Noble, 2005), 54.7% of staff at NHS therapeutic communities (Stein, Hoosen, Brooks, Haigh, & Christie, 2002), and 60% of postgraduate hospital dentists (Steadman et al., 2009). The Steadman et al. study (2009) also used a self-identification with definition method, which found a 25% prevalence rate amongst the same dentist participants, highlighting the disparities associated with different methodologies (Nielsen, Matthiesen, & Einarsen, 2010), as outlined in section 1.3.

A non-peer reviewed British Psychological Society survey of 1678 psychological health staff in 2017 using a self-labelling without definition method found 13% of participants reported bullying and harassment from managers occurring at least once in the past 12 months, with 34% reporting observing bullying of colleagues (Rao et al., 2018). Similar surveys in 2015 and 2016 found that 17-18% of staff reported bullying by their manager or colleagues and over 30% reported observing bullying of colleagues (Rao et al., 2017).

Of NHS staff more generally, since 2003 there have been annual NHS staff surveys that include questions on whether staff have experienced bullying from managers or colleagues using a self-labelling without definition method. In the latest 2018 NHS staff survey of over 497,000 NHS staff (a response rate of 46%), 24% of staff reported that they have experienced bullying, harassment or abuse from other staff one or more times in the last 12 months (NHS Staff Survey 2018). These rates

are similar to ranges in recent NHS surveys of 24 – 25% between 2015 – 2017 (NHS Staff Survey 2015; 2016; 2017).

Kline and Lewis (2018) have used the NHS staff survey results amongst a spectrum of other measures to estimate the financial costs of bullying and harassment to the NHS in England. They used estimates of specific impacts to staff health, sickness absence costs to the employer, employee turnover, diminished productivity, sickness presenteeism, compensation, litigation and industrial relations costs. Using these measures, they estimated bullying and harassment to cost the taxpayer £2.281 billion per annum. Whilst a high figure to the NHS, Kline and Lewis (2018) believe the estimate to be very conservative as several costs are not included, such as the impact of witnessing bullying at work and the costs of investigating the consequences of bullying.

Research has highlighted a high prevalence of reported workplace bullying in healthcare compared to other employment sectors (Zapf, Escartin, Einarsen, Hoel & Vartia, 2011; Fevre, Lewis, Robinson, & Jones, 2012). Studies have suggested that healthcare trainees are particularly at a heightened risk of bullying (Berry, Gillespie, Gates, & Schafer, 2012; Stubbs & Soundy, 2013). Timm's (2014) questionnaire survey of medical and nursing undergraduate students found that within 8 months of starting clinical placements, a fifth of medical and a quarter of nursing students reported experiencing bullying and harassment using a self-labelling with definition method.

### **1.5.2 Responses from healthcare organisations**

As well as more quantifiable data, the impact of bullying on the working environment and culture has been highlighted in poor practice and patient care at

certain NHS Trusts - a bullying culture was named as a significant issue in the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), and more recently in investigations at NHS Lothian (Academy of Medical Royal Colleges and Faculties in Scotland, 2018). More specifically in mental health services, a statement from the British Association for Behavioural and Cognitive Psychotherapies President, Professor Rob Newell, in 2014 highlighted the “bullying and coercive environment that our members are describing to us” (BABCP, 2014).

In response to levels of bullying within the NHS, some healthcare professional organisations have responded by publishing recommendations on workplace bullying within their professions. These include the British Medical Association’s (BMA, 2017) “Workplace bullying and harassment of doctors: A review of recent research” with recommendations, the Royal College of Nursing’s (RCN, 2015) “Bullying and harassment: good practice guidance for preventing and addressing bullying and harassment in health and social care organisations”. The RCN has also published a guide for students, “Dealing with Bullying and Harassment—a guide for nursing students” (2005), as has the Chartered Society for Physiotherapy “Dealing with Bullying: A Guide for Physiotherapy Students on Placement” (2015). There is currently no similar guidance from the British Psychological Society (BPS).

## **Chapter 2: Systematic Literature Review**

As highlighted in the Introduction there are several prevalence studies of workplace bullying of healthcare staff in the UK (e.g. Carter et al., 2013; Cooper & Curzio, 2012; Farley, Coyne, Sprigg, Axtell, & Subramanian, 2015; Gillen, Sinclair, Kernoban, & Begley, 2009; Hoosen & Callaghan, 2004; Keeley, Waterhouse, & Noble, 2005; Nyhsen, Patel, & O'Connell, 2016; Paice & Smith, 2009; Quine, 1999; Quine, 2001; Shabazz, Parry-Smith, Oates, Henderson, & Mountfield, 2016; Steadman et al., 2009; Stebbing et al., 2004; Stein, Hoosen, Brooks, Haigh, & Christie, 2002; Stephen Wood, Niven, & Braeken, 2016; Stubbs & Soundy, 2013; Woodrow & Guest, 2012).

However, only some studies have gone beyond researching the prevalence of bullying and types of negative behaviours to investigate how workplace bullying is experienced and its impact. This provided a rationale for a systematic literature review to search for articles that explored UK healthcare staff experiences of workplace bullying with a focus on the impact of bullying. The focus on UK studies reflects the unique context of the UK healthcare system, in particular the NHS system and culture, as well as the UK specific training of healthcare professionals. Furthermore, there are no known systematic reviews that focus specifically on UK healthcare staff experiences of workplace bullying.

### **2.1 Inclusion and Exclusion Criteria**

Inclusion and exclusion criteria for the systematic review are detailed in Table 1. Scopus, PubMed and CINAHL Plus databases were used for the searches with a wide range of search terms related to 'workplace', 'bullying' and 'healthcare'. The search yielded 11,065 results, a total of 883 titles and 409 abstracts were screened,

with 84 full text articles retrieved, and fifteen papers retained for the final review. A detailed summary of the systematic literature review search process can be found in Appendix A.

*Table 1: Inclusion and exclusion criteria for Systematic Literature Review*

Inclusion Criteria	Exclusion Criteria
Research investigating healthcare staff experiences of workplace bullying and/or impact of workplace bullying on healthcare staff.  Peer reviewed.  UK only.  Available in English.  Date range between 1970 to 2019.	Study of bullying prevalence or types of bullying behaviour prevalence (without further investigation of experience or impact of bullying).  Research on workplace bullying solely from patients/relatives/public.  Research solely on intervention for prevention and management of workplace bullying or harassment.  Reflective or opinion pieces on workplace bullying.

## 2.2 Summary of Findings of Systematic Literature Review

Fifteen studies were included in the literature review. Nine studies used a quantitative design (Farley, Coyne, Sprigg, Axtell, & Subramanian, 2015; Gillen, Sinclair, Kernoban, & Begley, 2009; Paice & Smith, 2009; Quine, 1999; Quine, 2001; Shabazz, Parry-Smith, Oates, Henderson, & Mountfield, 2016; Stubbs & Soundy, 2013; Stephen Wood, Niven, & Braeken, 2016; Woodrow & Guest, 2012), five studies used a qualitative design (Allan, Cowie, & Smith, 2009; Hoel, Giga, & Davidson, 2007; Randle, 2003; White, 2013; Whiteside, Stubbs, & Soundy, 2014) and one study was a mixed methods study (Carter et al., 2013). All quantitative and mixed method studies also included bullying prevalence rates. The systematic review focuses on the impact of workplace bullying on health care staff in the UK. It is subdivided into the roles of healthcare staff that participated in the research, including wider studies of NHS staff, as well as those that focus on nurses, student

nurses, medical doctors and physiotherapy trainees. Within each subsection, the quality of the studies are summarised.

The quality of the studies was evaluated depending on the type of research. The nine quantitative studies were evaluated using the National Institute of Health Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2017) with a subsequent review table in Appendix B. The five qualitative studies were evaluated using Mays and Pope's (2000) qualitative criteria summarised in Appendix C, and the one mixed method study was evaluated using the Mixed Methods Appraisal Tool (Pluye et al., 2011) found in Appendix D. These three quality criteria were chosen as they were relevant to the type of studies included and have been used in previous healthcare research. An overall summary of all the studies and the evaluation of studies can be found in Appendix E.

### **2.2.1 Impact of workplace bullying on NHS staff**

The impact of workplace bullying on NHS staff was examined in three studies, two of which used quantitative methodology (Quine, 1999; Wood, Niven, & Braeken, 2016), and one which used a mixed methods methodology (Carter et al., 2013). Quine's (1999) questionnaire survey of 1100 employees of an NHS community trust examined the association between bullying and a number of occupational health variables. Staff who reported being bullied had significantly lower levels of job satisfaction and higher levels of job induced stress and intention to leave their job. They were significantly more likely to report suffering clinical levels of anxiety and depression. The study also measured support at work and found that there were moderating effects on job satisfaction, propensity to leave and depression, such that a supportive work environment may protect from some of the harmful effects of

bullying. With a high response rate (70%), Quine's (1999) research highlighted the impact of workplace bullying in the NHS and the moderating impact of support at work, albeit in one community trust. The study appears to be the first of its kind to highlight the possible impacts of workplace bullying on NHS staff.

Carter et al.'s (2013) mixed methods study developed Quine's (1999) research to examine the impact of workplace bullying on staff across seven NHS trusts through both a questionnaire survey (n=2950) and semi-structured interviews (n=43). Carter et al. (2013) found that staff who had reported experiencing higher levels of bullying in the workplace reported higher levels of psychological distress, increased intentions to leave and lower levels of job satisfaction, as well as higher rates of sickness absence. Carter et al. (2013) found that *witnessing* higher levels of bullying behaviours were also associated with these negative outcomes. Qualitative thematic analysis of interview data supported and extended these findings with participants reporting behavioural, emotional and physical effects as a result of bullying. Whilst the analyses reported are based on cross-sectional data, and therefore cannot assume causality, the qualitative findings indicated that targets perceived bullying to precede negative outcomes. The qualitative data also pointed to performance impairments at both an individual and group level that could affect patient care, as well as the impact of workplace culture. Interviewees described cultures where staff were frightened to speak up and where bullying behaviours were not challenged.

Wood et al.'s (2016) quantitative questionnaire survey study of 1472 mental health workers across nineteen mental health trusts investigated absence from work and managerial abuse (which they defined as encompassing bullying and discrimination). They found that those who had reported experiencing managerial

abuse were 3.49 times more likely to report being absent from work. They also investigated whether this absence from work was affected by reported psychological strain (anxiety and depression), and organisational justice (perception of justice and fairness within an organisation). Managerial abuse and absence measures correlated positively with psychological strain measures, particularly depression, and negatively with organizational justice measures. Overall, 40 per cent of the effect of abuse on absence was explained by organizational justice perceptions and psychological strain. Thus, as well as identifying that reported bullying and discrimination from managers is associated with absenteeism, Wood et al. (2016) suggest this is due to the abuse affecting people's levels of psychological strain and perceptions of organisational justice, and hence their ability and willingness to attend work.

Collectively, these three studies used data from a large number of NHS participants (n=5,522) across 27 NHS trusts, which may contribute to the generalisability of the research findings. However, the published results also span across a large time frame (between 1999 and 2016), during which structural changes in the NHS may have affected the experiences of workplace bullying. The studies used differing methodology to identify staff who had experienced workplace bullying, which may have impacted on the results. Only Carter et al. (2013) used both a self-labelling with definition and a validated measure, the Negative Acts Questionnaire (NAQ-R), which has been identified as best practice in bullying research (Nielsen et al., 2010). With the NAQ-R, Carter et al. (2013) also measured how higher levels of bullying behaviours experienced correlated with differing levels of outcome. While Quine identified different types of bullying behaviour, this was analysed as a discrete variable in relation to possible outcomes on staff. Wood et al. (2016) identified bullied

staff from a yes/no question with no definition of bullying, but was the only study of the three that controlled for other variables, including total hours worked per week, job demands, control and support. All three studies used cross-sectional data that limit conclusions on causality of bullying on other outcomes. Carter et al.'s (2013) use of a mixed methods approach allowed triangulation of qualitative and quantitative information in the interpretation of the data with interview data supporting and extending quantitative findings.

### **2.2.2 Impact of workplace bullying on nurses**

Three studies have examined the impact of workplace bullying on nurses in the UK, two of which used quantitative methodology (Quine, 2001; Woodrow & Guest, 2012), and one which used qualitative methods (Allan et al., 2009). Quine's (2001) research used the same data set as the Quine (1999) study reported on above on NHS staff, but specifically focussed on the experiences of nursing staff (n=396). As found overall for NHS staff, Quine (2001) found that nurses who had reported being bullied also reported significantly lower levels of job satisfaction and significantly higher levels of anxiety, depression, job stress and propensity to leave. They also reported taking significantly more sickness absence. As in Quine (1999), nurses who reported good support at work were protected from some of the harmful consequences of bullying, namely support having a moderating impact on reported job satisfaction, propensity to leave and depression. In addition, Quine (2001) highlighted that nurses who reported experiencing one or more types of bullying were more likely to be critical of aspects of the organisational climate of the Trust, including reporting greater role ambiguity, lower job control, and less participation in decision making, than other nurses.

Woodrow and Guest (2012) examined the impact of staff harassment (including bullying or abuse from colleagues or managers) on nurses' wellbeing on measures of job stress, job satisfaction and intention to leave. The data used for the analysis was drawn from the National Survey of NHS staff and included information from 48,365 nurses in 2006 and 55,381 nurses in 2009. The study also compared this to the impact of physical violence from patients, service users or their relatives. Woodrow and Guest (2012) found that staff who reported experiencing any form of aggression at work also reported significantly lower levels of job satisfaction, significantly higher intentions to leave and were significantly more likely to report job stress. Staff harassment also had a stronger negative association with wellbeing measures than public violence. Unlike Quine (2001), however, Woodrow and Guest's study showed that negative associations between staff harassment and wellbeing were strongest for individuals who reported better support, albeit with a very small effect size. Woodrow and Guest focused on supervisory support rather than workplace support per se, and post hoc analysis found that increased strain was related to individuals who reported harassment from a supervisor. It may be that higher levels of support increase the level of interaction with a supervisor, who may also be a source of bullying, resulting in increased strain.

Allan et al.'s (2009) study used three case studies from a qualitative interview study of 93 overseas nurses to illustrate the concept of racist bullying, which they defined as bullying that is aggravated by racism. The thematic analysis includes examples of these behaviours characterised by abuses of power that appear to be underpinned by racism. It also includes participants' differing emotional and behavioural reactions to bullying including participants reporting lowered self-esteem, not going for promotions, and questioning oneself and one's competencies.

Allan et al.'s (2009) research highlighted how overseas nurses' experiences of social isolation due to cultural differences may exacerbate the impact of bullying. It also used analysis from the main study report to illustrate how negative behaviours in nursing, including racist bullying, may be unchallenged, unrecognised and normalised at the organisational level.

As in the studies of NHS workers, the quantitative studies of nurses also have the limitations associated with cross-sectional analyses. Woodrow and Guest (2012) used data from every NHS trust in England with a particularly large number of participants and a response rate of over 50%. However, its measurement of bullying used a dichotomous single item self-report measure with no definition of bullying, and some of the variables were similarly assessed using a single dichotomous question, such as work stress. Allan et al. (2009) only involved three participants, but usefully introduced the concept of racist bullying and how racism interacts with bullying behaviours for nurses. The study gave a detailed description of the data collection, analysis and re-analysis, which included a final analytic stage where the data was presented to an audience, and subsequent feedback incorporated. However, the analysis does not include reflexivity of the researchers' relationship to the research, including how their professional and racial identities may interact with the analysis in this study.

### **2.2.3 Impact of workplace bullying on nursing and midwifery students, and nurse academics**

Four studies investigated the impact of bullying within a nursing and midwifery educational context, three of which focused on students (Gillen et al., 2009; Hoel et al., 2007; Randle, 2003) and one on academic staff (White, 2013). Gillen et al.'s

(2009) research was the only study of the four to use quantitative methods. The study included reported effects of workplace bullying at university and placement on 164 student midwives who were recruited at a student midwifery conference. The third of participants who reported experiencing workplace bullying identified different impacts of the negative behaviours including loss of confidence (71%), loss of self-esteem (61%), anxiety (51%) and thinking about leaving the course (42%). Other reported effects included losing sleep (27%), taking time off work (17%) and feeling unwell (12%) with one participant attributing suicidal ideation to workplace bullying.

Randle's (2003) qualitative study of nursing students reflects some of Gillen et al. (2009) findings. Participants in Randle's (2003) study reported that experiences of bullying negatively affected their sense of self and competence at work, as well as reported increasing emotions such as anger, anxiety and stress, particularly if they were unable to take any action. Randle's (2003) study used longitudinal data from a larger, grounded theory project on student nurses' self-esteem, and explored the theme of bullying from the data. Participants were from one UK nursing programme representing all four branches of nursing; unstructured interviews were conducted with 56 students at the beginning of the course and 39 participated at the end.<sup>1</sup> Randle's (2003) findings go beyond Gillen et al.'s (2009) study by highlighting contextual issues of power with students describing being under pressure to comply with norms of nursing staff, whose assessments would affect students' progression on the course. The use of longitudinal data at the start and the end of the 3-year course also highlighted how some students assimilated some of the negative behaviours they had experienced or witnessed into their own practices towards

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<sup>1</sup> Reduced numbers were reported as a consequence of theoretical sampling from a grounded theory approach.

those with less power. These included examples of behaviour that could be humiliating, belittling or isolating towards patients, and even one example where a student admitted practising administration of a medication that was no longer part of the patient's treatment. Randle (2003) highlighted students' cognitive dissonance at the beginning of the course between their perspective of a caring image of nurses which did not always match how they described the "reality" on placement. By the end of the course students reported going on to adopt working practise that had initially shocked or confused them. Randle (2003) argues that this assimilation of behaviours is part of students' socialisation into the nursing profession that is relatively subordinate within the healthcare professional hierarchy and reflects Freire's (1972) theories of how oppressed groups can become like their oppressors. Randle goes on to argue for radical social structural changes to tackle bullying within nursing.

Hoel et al. (2007)'s research builds on Randle's (2003) study by exploring nursing students' perceptions of negative behaviour and bullying in clinical placement against expectations at the start of their education, and the impact this has on their professional socialisation. Hoel et al.'s study used ten focus groups with a total of 48 nursing students recruited through two universities in England and an advertisement in a UK nurses' magazine. The data was analysed by identifying key themes through content analysis. Like Randle (2003), Hoel et al. (2007) found that some students' expectations of nursing as a caring profession conflicted with their reported experiences on placement. Some students described their responses to negative behaviours and bullying included suppressing their feelings and developing a "hard" front. Such responses may contribute to a replication of such behaviour, reflecting Randle's (2003) socialisation to nursing theory, with implications for staff

wellbeing and retention rates. However, Hoel et al. (2007) found very few students reported direct experience of bullying; witnessing bullying was far more commonly cited. Low levels of direct bullying was hypothesised as related to the relatively short time spent in each placement, which may have protected students from more severe treatment.

Finally, White's (2013) research examined reported bullying of nurse academic faculty by nursing university students, the first study to do so in the UK. White (2013) used a narrative analysis of semi-structured interviews with 12 nursing faculty from different universities in England. White's participants (2013) identified that verbal attacks as well as cyberbullying through email caused distress and offence. They attributed some students' negative behaviours to the commodification of higher education where students are viewed as customers, leading to some becoming reportedly more demanding and disrespectful, especially in the context of greater pressures on students to achieve high grades. Participants reported that this impacted on elevated stress for academic staff facing new challenges that left them feeling out of control. However, unlike research on bullying of student nurses, White (2013) highlighted how reported bullying also motivated academic staff to describe their active responses, such as setting up email and mobile phone policies. Thus, whilst a consumer approach to education may mean that nursing students appear to hold a certain level of power over staff, it seems that the position of authority of academic staff also enabled them to take proactive measures in response.

In evaluating the research on nursing students and academics, Gillen et al.'s (2009) study had a number of limitations including a small, self-selecting sample size and a lack of clarity in how variables were measured, although its focus on UK midwifery students was unique amongst the studies. Of the three qualitative studies,

none included a detailed description of their analysis, and Hoel et al.'s (2007) study, in particular, gave no information on how the content analysis was undertaken. Similarly, none of the qualitative studies included consideration of reflexivity in the write-up, for example the impact of Randle's (2003) position as lecturer on the participants' university course or White's (2013) position as a nurse researcher conducting qualitative research on other academic nurses. However, each of the qualitative studies had unique strengths that contributed to the knowledge base, such as the use of longitudinal data in Randle's (2003) research capturing change over time, the large sample in Hoel and colleagues (2007) study, and the exploration of student power interacting with that of nurse academics in White's (2013) analysis.

#### **2.2.4 Impact on trainee doctors and medical consultants**

Three quantitative studies examined the impact of bullying on doctors, including trainees and consultants (Farley et al., 2015; Paice & Smith, 2009; Shabazz et al., 2016). Paice and Smith's (2009) cross-sectional national survey of 33,329 trainee doctors across all grades, specialities and settings of training included a question on bullying based on a definition by the British Medical Association. The study found that trainees who reported bullying were more likely to report poor clinical supervision and thought about leaving medicine more frequently. They also were more likely to report having made one or more serious, or potentially serious, medical errors in the last month. Bullied trainee doctors also reported a higher workload and sleep deprivation. Statistical associations do not imply causality, and it is not possible to determine whether reported bullying led to an increased probability of reporting making errors, or vice versa. It may be that they both were outcomes of poor clinical supervision, which was also associated with higher reported bullying.

However, the research suggests that bullying of trainee doctors is associated with greater risks for patient safety.

Farley and colleagues (2015) examined the impact of cyberbullying among trainee doctors and how attributions of blame for cyberbullying may influence individual and work-related outcomes. Using a validated and reliable measure of cyberbullying, the Cyber Negative Acts Questionnaire (CNAQ), they found that reported cyberbullying adversely impacted on reported job satisfaction and mental strain. They also measured negative affect and blame attributions for the bullying (self-blame or perpetrator blame) and found that negative affect mediated the relationship between self-blame and mental strain. This suggested that when trainee doctors blame themselves for experiencing cyberbullying, a negative affective reaction occurs which may lead to mental strain. Furthermore, Farley et al. (2015) measured interactional justice (the extent to which participants feel themselves to be treated with dignity and respect at work) and found that perpetrator blame mediated the relationship between cyber bullying and interactional injustice, and interactional injustice mediated the relationship between perpetrator blame and job satisfaction. This suggests that when blame is attributed externally, a violation of dignity may occur, which may lead to a negative attitude towards work. Whilst trainee doctors who make external attributions for cyberbullying may be less affected in terms of psychological distress, an adverse effect is still seen in their perception of and reported satisfaction in work.

Finally, Shabazz et al.'s (2016) research, exploring bullying of 664 obstetrics and gynaecology consultants, was the first study of UK consultant doctors as targets of bullying. The cross-sectional questionnaire survey included a free-text box for participants to comment on how bullying and persistent undermining behaviours

impacted on their professional and personal life. The 236 comments were placed into four categories: major (including suicidal ideation, sick leave, depression requiring medication or therapy, moving post), moderate (struggle to work, resign from a position in the Trust, significant sleep disturbance, reduced confidence, home life problems), minor (demoralised, sleep loss, stress but not affecting patient care, isolation) and coping (stand up to it, avoid certain individuals, no effect). Of the 44% of consultants who reported bullying, two thirds reported experiencing major or moderate effects according to this methodology. Like Paice and Smith's (2009) research, these consequences on medical staff have implications for patient care.

The cross-sectional, quantitative studies of doctors had a number of strengths and limitations. Paice and Smith's (2009) research used a large sample with a good response rate (66%). To identify participants who had been bullied, they used a question based on a definition of bullying; however, it was unclear whether participants would have labelled their experiences as bullying themselves. Farley et al.'s (2015) had a very low response rate of 7.9% (n=158) of trainee doctors across 8 NHS trusts, which was the lowest response rate of all the quantitative studies in the systematic review, potentially biasing the results. However, it was also one of the few studies to include control variables, such as general job stress, with a specific and validated measure of bullying. Shabazz et al.'s (2016) research also had a low response rate (28%), although all consultants within the Royal College of Obstetricians and Gynaecologists were invited to participate, and so the participants reflected a substantial sample of obstetricians and gynaecologists in the UK. The impact of bullying was categorised from the researchers' perspective; a mixed methods or qualitative approach may have provided a more phenomenological approach from participants' perspective.

### **2.2.5 Impact on physiotherapy students**

Finally, two studies explored the impact of workplace bullying on physiotherapy students, one quantitative (Stubbs & Soundy, 2013a) and one qualitative (Whiteside et al., 2014). Stubbs and Soundy (2013) used a cross-sectional questionnaire survey with 52 final-year undergraduate physiotherapy students at a UK university. From the quarter who reported at least one incident of bullying behaviour, half of these also reported negative psychological consequences mainly associated with anxiety, loss of confidence and stress. Whiteside et al. (2014) used a thematic analysis of semi-structured interviews with eight final year physiotherapy students from one university who reported experiencing workplace bullying on clinical placements. Participants described feelings of isolation and inferiority and how bullying affected their willingness to attend placement and their ability to learn. A number of students also viewed their placement supervisor, who was primarily the source of bullying, as unapproachable and unsupportive. Students frequently referred to internalised negative cognitions of their bullying experience, including self-doubt in their competence. Often students appeared to interpret the behaviour as their “fault” and question their ability. Indeed, many students described not initially being able to recognise the experience as bullying. They also described feeling unable to report their experiences, as for many the identified bully was responsible for assigning a clinical mark to the participants and they referred to fearing consequences to their professional qualification. Furthermore, some reported believing that the problem might escalate if formal proceedings took place by involving the university in reporting the bullying.

Stubbs and Soundy (2013) used a small sample from one university, which included a limited number overall who reported bullying and its consequences (n=6), limiting the generalisability of the results to the wider physiotherapy trainee population. Whiteside et al. (2014) gave a rich account of eight physiotherapy trainees reported experiences of bullying with a detailed description of the analysis and full audit trail of codes and themes within the appendices. However, like the other qualitative studies in the systematic review, the researchers did not include reflexivity in the write up. Aside from identifying that it assisted recruitment, the position of the primary author as a student at the university was not considered in how it may have reflexively impacted on the research.

### **2.3 Synthesis of Findings**

As may be expected, research investigating healthcare staff experiences of workplace bullying suggested a number of negative associations with bullying. For those that reported being bullied, these associations included reported lower levels of job satisfaction, and reported higher levels of job induced stress, intention to leave their job, levels of anxiety and depression, medical errors, sickness absence and sleep difficulties, as well as loss of confidence and self-esteem. These negative reported consequences on healthcare workers may also have deleterious effects on patient care. Yet as well as these more expected results, the research also highlighted some less well known findings. These included the negative experiences of witnessing bullying behaviours (Carter et al., 2013), the impact of cyberbullying (Farley et al., 2015; White, 2013) and the interaction between bullying and racism (Allan et al., 2009). The contradictory findings of research on the impact of support at work mediating the impact of bullying (Quine, 1999; Woodrow & Guest, 2012) also

reveals the importance of understanding the workplace context. Power played an important role in the experience of workplace bullying, especially for trainee healthcare professionals. This was seen in the way student healthcare professionals described finding it difficult to report their experiences as they feared the repercussions on their progress to qualification, as well as some students describing replicating bullying behaviours towards patients with less power (Hoel et al., 2007; Randle, 2003). However, there were also reported examples of workplace bullying exercised across hierarchical power structures, such as in the research on academic nursing staff (White, 2013) and medical consultants (Shabazz et al., 2016).

#### **2.4 Summary of Evaluation of the Literature**

As in many reviews of workplace bullying, bullying is measured in many different ways in the research studies of this review, which is likely to impact on the specific findings of each study. Of the quantitative research, only Carter et al. (2013) used a validated and reliable measure for bullying behaviours, as well as a self-labelling question with a definition of bullying, which has been identified as best practice (Nielsen et al., 2010). All of the quantitative research used a cross-sectional design that limited conclusions on causality of bullying on other outcomes. For example, higher work absence associated with bullying in these studies may be due to those with more absences being more likely to be bullied, or an interacting dynamic between different variables. Other workplace bullying studies with longitudinal data over a period of up to two years provide evidence that bullying predicts poorer mental health, but also that baseline mental health difficulties are associated with an increased risk of subsequent reports of bullying, which suggest other variables are involved in the associations (Nielsen & Einarsen, 2018). Few of

the quantitative studies in the systematic review controlled for other key potential variables.

Whilst the qualitative research provided some of the contextual information lacking in the some of the quantitative studies, none of the qualitative studies included a consideration of self-reflexivity in the write-up. This includes how researchers specify their position to the research, and the roles this may play in their understanding of the phenomenon under study (Elliott, Fischer, & Rennie, 1999). This lack of reflexivity in the accounts may explain why many of the qualitative accounts include references to themes “emerging” from the data (e.g. Allan et al., 2009; Randle, 2003; White, 2013), rather than highlighting the way themes are identified and understood by researchers from the data.

## **2.5 Rationale for the Current Research Project**

Research in workplace bullying has highlighted high levels of reported workplace bullying within UK healthcare workplaces, including the NHS, with associated negative outcomes. These potential outcomes have significant implications on clinical care, individuals, teams, and the wider organisation, including a financial impact (Kline & Lewis, 2018; Paice & Smith, 2009). A recent NHS Health Education England report highlights the lack of research on factors that influence the wellbeing of trainee psychologists in the NHS, including workplace bullying (NHS Health Education England, 2019).

From my literature search, there are no known studies that have specifically investigated workplace bullying of clinical psychologists or trainee clinical psychologists in the UK, or indeed internationally. A study on the experiences of

trainee clinical psychologists<sup>2</sup> would also expand the research on trainee healthcare professionals' experiences of workplace bullying. As highlighted in the Introduction and literature review, trainees in other UK healthcare professions have been found to be at particular risk, including in medicine, nursing and physiotherapy (Randle, 2003; Stubbs & Soundy, 2013; Timm, 2014). There are also no known studies on workplace bullying of pre-training clinical psychologist roles, such as assistant psychologists, who may also be at risk given their relative lack of power in their pre-qualified status in the workplace.

Therefore, the present study aimed to investigate the following research question:

- How have trainee clinical psychologists experienced workplace bullying during their training and in pre-qualified psychology roles prior to training?

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<sup>2</sup> There are approximately 1785 trainee clinical psychologists training in the UK (Clearing House, 2019). Trainee clinical psychologists are employed by the NHS and undertake doctoral level training (DClinPsy) through a university over a three year period. They undertake 5-6 placements primarily in NHS settings within child and adolescent, learning disability, older adults, adult mental health and specialist populations with a clinical caseload within each placement. Within the training placements, trainees are supervised by a clinical psychologist. They also complete taught research, clinical teaching, academic assignments and doctoral level research through the university and are supervised by clinical psychologist university course staff. Trainee clinical psychologists require a British Psychological Society accredited psychology degree and clinically relevant experience to be accepted onto training; acceptance onto the course is competitive with 15% of applicants being accepted onto training each year (Clearing House, 2019).

## **Chapter 3: Methodology**

### **3.1 Design**

#### **3.1.1 Rationale for a qualitative approach**

As highlighted in the Introduction and Literature review, most research into workplace bullying has focussed on quantitative studies from a realist perspective (Rai & Agarwal, 2016; Samnani, 2013), despite calls from within the field that more qualitative perspectives are needed to provide a fuller understanding of the phenomenon and processes (Rayner, Sheehan, & Barker, 1999). The open and exploratory nature of the research question regarding the experiences of workplace bullying from the perspectives of trainee clinical psychologists also lends itself to a qualitative approach. A qualitative method was chosen to reflect the nature of the research question, and to enable participants' greater possibility to generate their own responses and ideas to develop a broader account than might be generated from a quantitative method. The systematic literature review also highlighted the lack of qualitative research within workplace bullying of UK healthcare professionals that include a reflexive understanding from the perspective of the researcher.

#### **3.1.2 Rationale for thematic analysis and consideration of other methodology**

Thematic analysis (TA) was chosen to analyse the data. TA is a method for identifying, analysing and reporting patterns within qualitative data (Braun & Clarke, 2006). TA is well suited to examining the nature of a given group's conceptualisation of a phenomenon (Joffe, 2012), here trainee clinical psychologists' conceptualisations of workplace bullying. TA was also chosen for its theoretical flexibility, as it can be applied across a range of theoretical and epistemological

perspectives (Braun & Clarke, 2006). This includes a critical realist approach, which incorporates aspects of both realist and constructionist approaches, and best describes the epistemological position of this study. This reflects the approach taken in this study in which the data generated by participants' interviews formed the basis of the analysis at a semantic level. However, participants are likely to take different perspectives on workplace bullying, informed by their own experiences and contexts. Similarly, the data collection and analysis will be shaped by the interactions and interpretations of the researcher. As such, the data produced cannot be considered to be a direct reflection of an underlying 'true' concept (Willig, 2013).

Thematic analysis also allows for an inductive analysis, where themes are strongly linked to the data, or a deductive analysis, where the analysis is driven by the researcher's theoretical or analytic interest, or a mixed approach (Braun & Clarke, 2006). In practice, it is not possible to adopt a purely deductive or inductive approach (Braun & Clarke, 2013), as the study will be grounded in the data, but will be influenced by prior knowledge of the research area, such as through the write-up of the introduction and literature review. Therefore, the analysis for this research can be best described as primarily inductive. An inductive approach was chosen as there are few theories guiding workplace bullying research (Nielsen & Einarsen, 2018), and the theoretical development of the subject has been referred to as weak (Rai & Agarwal, 2016), and thus an approach using a pre-existing framework was not indicated by the existing theory and literature.

The other qualitative methodology considered for this research was Interpretative Phenomenological Analysis (IPA). The aim of IPA is to understand the meaning individuals attach to their experiences and how they make sense of their personal and social worlds (Smith & Osborn, 2008), which reflected the purpose of

the research. IPA tends to have an idiographic focus (McLeod, 2001) and is attached to a phenomenological epistemology (Smith & Osborn, 2008), which did not reflect the inductive critical realist approach of this research. Furthermore, the homogeneity of participants that is required of IPA meant themes from participants who have experienced bullying in different contexts (e.g. assistant or trainee positions, NHS or private) may be more difficult to analyse in this approach. TA allows for a larger sample and a more diverse range of participants than IPA, providing a greater breadth to the study. Yet this greater breadth will have provided less in-depth phenomenological accounts than would have been achieved through an IPA study.

### **3.2 Consultation**

Whilst service-user and carers were not involved in the study, as the research was not directly related to service-user experience, trainee clinical psychologists were involved at several stages of the research project. These 'peer' or 'expert by experience' consultants were trainee clinical psychologists who identified that they had been bullied on training or in pre-qualified positions, and were known personally to the primary researcher. At the design stage, three peer consultants were invited to provide separate comment via email on the information sheet and consent forms, as well as the interview schedule. These peer consultants identified that examples of specific bullying behaviours (from Rayner & Hoel, 1997) used in the draft information sheet to enable potential participants to identify workplace bullying could also influence what type of behaviours participants may choose to talk about in their interviews and therefore the themes of analysis. For this reason, these specific examples were removed, and a broad definition of workplace bullying used in other research was retained in the information sheet. In the interview schedule, this led to

the addition of questions about later effects of bullying on training, and possible projected effects in the future, as well as advice for universities and workplaces from participants. As these peer consultants were personally known to the researcher, it could be that the feedback may have also been shaped by their knowledge of the researcher's personal interest, including the researcher's hopes for the project to enable greater awareness of the issue of workplace bullying within the profession and amongst training providers. Another trainee psychologist who was not personally known to the researcher undertook a pilot interview and provided feedback at the end of the interview. This clarified the importance of providing feedback in the form of oral cues that can be communicated across the telephone (e.g. "mmhmm" sounds), which demonstrate the researcher is listening. Pilot interview feedback also led to the addition of questions to 'warm the context' (Burnham, 2005), before asking more directly about the experiences of bullying.

### **3.3 Ethics**

#### **3.3.1 Applying for ethical approval**

The research was approved by the University of Hertfordshire Ethics Committee (Appendix F) with final protocol number aLMS/PGR/UH/03440(2). Two modifications to the initial ethics application were made during the course of the study; one amendment was to include the secondary supervisor and the other was to allow participants currently involved in investigatory proceedings related to workplace bullying to take part in the research study. This latter amendment was added as this situation applied to some participants, and it was felt that their contribution would provide a valuable perspective to the research study.

### **3.3.2 Issues considered**

#### ***Confidentiality and anonymity***

Confidentiality and anonymity were important considerations, particularly as the research was undertaken with participants from within a relatively small population, namely trainee clinical psychologists in the UK. The participants were also sharing sensitive information about their work experiences with a researcher from the same professional context. Several steps were taken to ensure confidentiality within the research project. The participant information sheet sent to all potential participants prior to taking part in the research explained that no names of individuals or actual organisations where the alleged bullying took place would be requested (Appendix G). This was re-iterated verbally prior to the start of the interview, and also as part of the questions in the interview (Appendix L). Full names of participants were not requested, and participants' names and demographic information were kept securely and separately from audio-recordings and the subsequent data analysis. All data collected was stored electronically in a password protected environment. Interview transcripts were anonymised with any identifiable details removed before being seen by anyone else in the research team. Data was analysed using anonymised transcriptions, and any verbatim extracts of interview transcripts in the research report were fully anonymised, and pseudonyms used. Some of the interviews were transcribed by professional transcribers, which was outlined to participants. Data was transferred securely, and the service signed a non-disclosure, confidentiality agreement (Appendix H). Interviews were conducted on the telephone to increase anonymity based on appearance. The limits to confidentiality were also explained to the participants in the information sheet, verbally prior to the interview, and were part of the Participant Consent Form

(Appendix I). It was explained that if participants disclosed information that led to sufficient concern about their safety or the safety of others, it may be necessary to inform an appropriate third party without formal consent. All data collected (recordings and participant information) will be destroyed after completion of the study. Participants were also informed that they could choose to withdraw their data within two weeks of interviews taking place without giving a reason, although none chose to do so. Anonymised transcripts will be kept for up to 5 years after the completion of the study to support any further analysis for publication/s.

### ***Possibility of distress***

It was acknowledged with participants that talking about experiences of workplace bullying may be a difficult process. It was explained to participants in the Information Sheet and verbally prior to the interview that they would not have to answer any questions they did not want to, could stop the interview at any time, and would be given information about sources of support after the interview. The researcher also explained to participants that they would be offered an opportunity to speak about the experience of the interview in a debrief following the interview. A debrief sheet (Appendix J) with support information outlined contacts for emotional support, and for support related to workplace bullying was emailed to all participants after the interview.

The researcher used their skills as a trainee clinical psychologist to conduct the interview in an empathic and respectful way. As a trainee clinical psychologist, like the participants, the researcher was likely to be understood as an 'insider' researcher by the participants, which can bring both advantages and disadvantages (Berger, 2015). One of the advantages of being in a similar position was potentially

increasing rapport and empathy with participants. A disadvantage may have been an overidentification with the content of participants interviews, particularly if they reflected elements of the researcher's experiences (Hofmann & Barker, 2017). Further details on this issue are explored in section 3.8 'Self-Reflexivity'.

### **3.4 Participants**

#### **3.4.1 Inclusion and exclusion criteria**

The study was open to UK based trainee clinical psychologists and recently qualified clinical psychologists (up to two years post qualification) who self-identified as having experienced workplace bullying previously, either as a trainee clinical psychologist, or in a psychology-related role prior to training. Psychology roles prior to training could include roles such as assistant psychologist, psychological wellbeing practitioner and research assistant roles. Bullying may have been from a manager, a supervisor, university course staff, multi-disciplinary staff colleagues and/or peers.

The cut-off of two years post qualification was chosen to ensure a degree of homogeneity in the sample in terms of relative recency of the recalled events. Further the two-year time frame would also preclude those who might now be in a role of placement supervisor and therefore have a potentially different perspective on their previous experiences.<sup>3</sup> Participants who had faced workplace bullying both during training and in psychology roles prior to training were included. As highlighted in the Introduction and Systematic Review, trainee healthcare professionals appear particularly at risk of workplace bullying. Further, it was recognised that the

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<sup>3</sup> BPS Guidelines on Supervision (2010) advise that placement supervisors should have at least two years post-qualification experience.

competitiveness and potential lack of power in pre-training psychology roles could also be a risk factor for workplace bullying. Therefore, experiences in psychology roles prior to training were also included in the recruitment criteria.

A broad definition of workplace bullying as used in previous research (e.g. Einarsen, Raknes, & Matthiesen, 1994; Glambek, Skogstad, & Einarsen, 2014; Lewis, 2006) was used in the Information Sheet for participants to identify workplace bullying.

“A person is bullied when they feel repeatedly subject to negative acts in the workplace, acts that the bullied person may find it difficult to defend themselves against.”

Exclusion criteria were those who were currently experiencing workplace bullying. This was to minimise potential distress relaying information about ongoing experiences of workplace bullying. Potential participants who had solely experienced bullying behaviours from service users or carers were not recruited, as the literature related to workplace bullying distinguishes between bullying and harassment from other staff and that from patients, service users, carers and the public.

### **3.4.2 Recruitment of participants**

A purposive sampling approach was used, as well as a snowballing recruitment technique (where existing participants recruit other potential participants from among their acquaintances). The pilot interview was with a participant previously known to the researcher; otherwise the researcher had no previous contact with all other participants. Two participants were recruited via snowballing, and one through another trainee clinical psychologist. All other participants were recruited following email contact with Programme Directors of Clinical Psychology

courses in the UK listed on the Clearing House website for Postgraduate Courses in Clinical Psychology<sup>4</sup> (Appendix K). This was a total of 29 courses, as participants were not recruited from the researcher's own course in order to maintain confidentiality within the research team. Twelve courses responded to the initial email contact to share information about the project with their trainees (and of these, three courses also specified that they had shared the information with recently qualified trainees). Two further courses also responded to explain that their university regulations would not permit them to share trainee research requests. Courses who did not respond to the initial email contact were emailed again several months later, and a further three courses shared the project information with their trainees, making a total of fifteen courses.

### 3.4.3 Participant information

Fourteen participants were recruited to the study, within the range recommended for a professional doctorate project using thematic analysis (Clarke, Braun & Hayfield, 2015). Three further potential participants contacted the researcher but were not included due to time constraints on the research project. In order to maintain anonymity, a collective overview of participant demographics and information will be provided (Thompson & Chambers, 2012) below in Table 2.

*Table 2: Participants' collective demographic information*

Demographic information	Number of participants
Gender	
Female	12

<sup>4</sup> Retrieved from <https://www.leeds.ac.uk/chpccp/courses.html>

Male	2
<b>Age range</b>	
25 – 29	1
30 – 34	9
35 – 39	3
40 - 44	1
<b>Ethnicity</b>	
White British	7
White Irish	1
White European	1
White (not specified)	3
Asian Indian	1
Mixed Black Caribbean White	1
<b>Current Year of Training/ Year since Qualifying</b>	
Year 1	3
Year 2	2
Year 3 / Final year	4
First year after qualification	5
<b>Role when bullied</b>	
Assistant Psychologist (pre-training)	3
Associate Lecturer (pre-training)	1
Clinical Research Worker (pre-training)	1
Trainee Clinical Psychologist	9
<b>Role of identified bully*</b>	
For participants who experienced bullying on training:	
- Clinical Psychologist (placement supervisor)	6
- CBT Therapist (placement supervisor)	1
	1

- Senior clinical psychologist on placement (not supervisor)	2
- Course Staff (Clinical Tutor)	
For participants who experienced bullying pre- training:	2
- Clinical Psychologist (Supervisor)	
- Senior Clinical psychologist (Not supervisor)	1
- Trainee Clinical Psychologist	1
- Manager/ Supervisor (CBT therapist)	1
- Manager and HR	1
- Clinical Research Worker	1

\*for some participants there was more than one identified role

Twelve of the participants identified as female (86%) and two as male (14%), and twelve participants identified as White (86%). These represent similar percentages of applicants accepted onto training in Clinical Psychology (male 15% and female 85%; White ethnicity 87%; average over last three years of publicly available data 2015-2017; Clearing House, n.d.).

### 3.5 Development of Interview Schedule

A semi-structured interview schedule (Appendix L) was developed for the research interviews. The interview schedule was informed by existing research on workplace bullying, 'expert by experience' consultants (as highlighted in section 3.2), and the knowledge and experience of the research team. A number of interview schedules from published articles and unpublished theses in the field of workplace bullying were also consulted (Carter et al., 2013; Lewis & Orford, 2005; Lewis, 2006; Shaw, 2014; Whiteside, Stubbs, & Soundy, 2014). The questions for the interview

schedule were then developed in line with the research aims of the project. The questions were clustered around topics of understanding the bullying process, the reporting of bullying and the impact of bullying, which also reflected the researchers' interest in understanding the process of workplace bullying and responses to it within the profession, and thus shaped the nature of the interview. Following guidance by Braun and Clarke (2013), questions were open and clustered into topic-based sections. Follow-up questions were included to encourage participants to expand on their answers depending on the detail in participants' responses.

### **3.6 Procedure and Data Collection**

Participants contacted the researcher via email following recruitment through their course or from other participants. The researcher shared the participant information sheet, which had been sent previously in recruitment emails, and a consent form by email, with an invite to ask any questions in the email. The researcher also arranged a time for the telephone interview by email with the participant. The researcher verified eligibility for the study through three screening questions via email or prior to the interview on the telephone (Appendix M). Prior to the interview, the researcher verified whether participants had read the consent form and information sheet, provided an opportunity for participants to ask questions, and reminded them of key information that was outlined in the information sheet (see section 3.3.2 for further details). Demographic information was also gathered before the interview. Participants were reminded that interviews would be audio recorded, and consent was requested to record the interview. Participants verbally recorded their consent to take part in the research by confirming that they had read and consented to the nine points on the participant consent form (Appendix I), and

agreed to take part in the study. The interviews lasted between 50 and 92 minutes. All interviews were audio recorded using a Dictaphone and telephone ear piece. Audio recordings were either transcribed by the researcher or using a transcription service. The accuracy of transcriptions was verified by cross reference with audio recordings.

### **3.7 Data Analysis**

The process for undertaking a thematic analysis of the data followed guidelines (Braun and Clarke, 2006; 2018) using a recursive six phase process.

#### **3.7.1 Familiarisation with the data**

The data was transcribed using a simple orthographic notation, suggested by Banister et al. (2011). The first step was to become familiar with the data through transcription, and through checking the transcripts with the original audio recordings. Each interview was read through in its entirety, noting initial ideas.

#### **3.7.2 Coding**

Codes are the most basic element of the data that can be assessed in a meaningful way regarding the phenomenon (Boyatzis, 1998). Coding of the transcripts was focussed at a semantic level in relation to the research question about participants' experiences of workplace bullying. Codes were identified using an inductive approach, where codes were closely linked to the data. This process was initially completed using Microsoft Word (Appendix N for examples of transcripts). At this stage, a transcript was coded by the principal supervisor, and discussions in supervision were used to explore interpretations. Rather than this being a process of

coding reliability as in other types of thematic analysis (Boyatzis, 1998), this was to explore researchers' perspectives on the analysis and their interpretative lenses, commensurate with a Braun and Clarke (2018) 'reflexive' analysis. The initial codes were then transferred onto NVivo software, which is recommended to manage the large amounts of qualitative data generated from 14 interviews (Guest, MacQueen & Namey, 2012). Using NVivo, similar codes were amalgamated to produce an initial list of 185 codes (Appendix O).

### **3.7.3 Generating initial themes**

After interviews had been coded, the analysis was re-focused at a broader level, where different codes were sorted into potential themes, and sub-themes, noting relationships between them. The initial list of codes were printed from NVivo, and the analysis moved to paper form to allow for mapping of different potential thematic structures with sub-themes (Appendix P).

### **3.7.4 Reviewing themes**

Initial thematic structures were discussed in supervision, and refined to produce a thematic map with sub-themes. This moved the themes from "domain summaries" that were more clearly linked to data collection questions to interpretative "storybook" themes that captured patterns of meaning that were underpinned by a central concept and reflected the researchers' interpretations (Clarke, 2017). Once the codes were sorted into potential themes, they were reviewed and refined at the level of the coded extracts, and in relation to the entire data set. This was to ensure the themes were reflections of the data collected, and

answered the research question. Themes were also reviewed on internal homogeneity and external heterogeneity (Braun & Clarke, 2006).

### **3.7.5 Defining and naming themes**

The overall story of the analysis was refined by re-visiting the themes and their collated data extracts, and generating definitions and names for each theme.

### **3.7.6 Writing up**

The final analysis was through the write-up of the report, with extract examples that evidenced the themes. The analysis was a “recursive process” (Braun & Clarke, 2006), moving back and forth between the different phases associated with data, codes, themes, and the write-up through the analytical procedure. For example, data continued to be coded as themes were refined and re-visited, and sub-themes were adjusted and thematic map changed during write-up. This also reflects the way in which the analysis of earlier interviews affects the coding of subsequent ones, which in turn impact on revisions of codes and themes of the earlier data. A final thematic map that represented the write-up of the thematic analysis was also produced (See Figure 1 in Results).

## **3.8 Self-Reflexivity**

As a researcher with personal experience of the research topic, I was aware of the emotional risks as a qualitative researcher that have been identified by both trainee clinical psychologists undertaking research (Hofmann & Barker, 2017), and within the field of workplace bullying research (Fahie, 2014). I used supervision and a research diary (see Appendix Q) to reflect on my own experiences of workplace

bullying prior and during the data collection period, as a way of 'bracketing' my experiences during the research process (Ahern, 1999), as some of the participants' experiences had some resonances with my own. Supervision made me aware of other perspectives on the data that may have been obscured by my own 'insider' status as a researcher, for example the perspective of course staff or managers when dealing with negative behaviours in the workplace.

Within the interviews, there were no specific questions that focussed on the intersection of workplace bullying and personal characteristics, such as racist bullying. This reflected many of the interview schedules of prior research that were consulted as well as my own experiences of negative workplace experiences that did not overtly incorporate bullying around personal identity. Yet several participants responses incorporated an understanding of how personal or social circumstances interacted with bullying, particularly around gender and health, without explicitly being asked. Thus, a specific focus on these areas in the interview schedule may have generated a different thematic map with a greater focus on the intersectional experience of workplace bullying.

During the interviews with participants, I noticed I sometimes wanted to reflect or make a comment to what participants were saying, especially when an experience seemed very unjust, perhaps reflecting a validating stance influenced by my personal context and also training in therapy. I found it helpful to explain prior to the interview that I would be making limited comments during the interview, but there would be an opportunity to debrief and ask questions at end. Yet whilst I was making limited comments within the interview, it is inevitable that my personal relationship to the topic will have shaped the nature of the interview (Ortlipp, 2008). For example, when listening to participants in the same profession sharing personally recognisable

experiences I may have demonstrated that I connected with the narrative or the injustice of the stories they were recounting through oral cues (e.g. mmhmm sounds), which may have encouraged participants to share further in this way.

I sometimes also became aware that I may have been less conscious of participants' own non-verbal cues during the interview. During the process of debriefing, one participant shared that they had silently been tearful at some points of recounting their experiences of workplace bullying, which I had been unaware of during the telephone interview. This made me mindful of some of the potential limitations of the telephone methodology, where I may have been less cognisant of the affective impact on the participants. In a face-to-face interview, I would have responded differently offering to stop the interview at that time, which in turn may impacted on the narrative that was shared. The same participant and others also expressed that a telephone interview facilitated talking about a sensitive topic, as it provided a level of distance and anonymity within the research with an 'insider' researcher within a small professional context.

The debriefing space allowed time to explore the impact of taking part in the research, as well as an opportunity for participants to ask questions. This would sometimes include questions about the research process, such as the type of analysis I would be using. Some participants shared advice of undertaking research as a trainee, continuing the rapport with an 'insider' researcher, as well as possibly providing an opportunity to 'de-role' from a position of 'victim' in a narrative about bullying to a more 'equal' peer (Josselson, 2013). I was aware of some participants concerns about whether their experiences matched the definition of workplace bullying, and so debriefing also became a space for some participants to discuss how workplace bullying is defined and ask about my perspective on the topic.

### **3.9 Quality Assurance**

Several steps were used to ensure the quality of the research project, including the use of quality criteria specifically developed for qualitative research. Yardley (2008) highlights four main areas of quality in qualitative research, which share many guiding principles of other appraisal criteria assessing the contribution, credibility and rigour of qualitative research (Spencer and Ritchie, 2012). Yardley's (2008) criteria will be referred to here. Additionally the Mays and Pope (2000) criteria used to evaluate qualitative research in the systematic review will be used to evaluate this study (Appendix R).

#### **3.9.1 Sensitivity to context**

Sensitivity to context can be developed through an awareness of relevant literature and the socio-cultural setting of the study (Yardley, 2008). The relevant development of workplace bullying research as well as the UK healthcare context was outlined in the Introduction and Systematic Literature Review. The social context with participants and the researcher's personal relationship with the topic was also reflected upon in a reflective diary, in supervision, and within the thesis (e.g. see Appendix Q and section 3.8). The social context was considered in the design and piloting of the study in consultation with 'experts by experience' at design and piloting stage (see section 3.2). The research team included a clinical psychology course staff member as well as a researcher who was not affiliated to clinical psychology training; this provided a range of insider and outsider perspectives to a project on the experiences of trainee clinical psychologists.

### **3.9.2 Commitment and rigour**

The concept of commitment encompasses prolonged engagement with the topic, skills in methodology and immersion in data (Yardley, 2008). Researcher engagement with the topic was over a period of nearly two years, and personal engagement prior to that. Immersion in the data involved transcription, listening, re-reading, coding and thematic analysis of 20 hours of data from 14 participants in a 'recursive' process, outlined in section 3.7. Rigour refers to the resulting completeness of the data collection and analysis (Yardley, 2008). The study included a sample across the UK that included divergent perspectives on the topic and pre-training experiences both during and prior to training. As well as a transcript coded and discussed with the principal supervisor, a portion of a fully anonymised transcript was coded, analysed and discussed with other trainee clinical psychologists during an advanced methodology thematic analysis workshop.

### **3.9.3 Coherence and transparency**

Coherence describes the "fit" between the research question, the philosophical perspective adopted, and method of analysis undertaken (Yardley, 2008). The study delineated the rationale for a critical realist epistemology, inductive analysis of the data and the thematic analysis methodology in relation to the research question which aimed to explore the perspectives of the participants' experiences. Transparency was demonstrated in the detailed data collection process, and examples of transcript material, coding procedures (Appendices N-P) and a write-up grounded in interview examples, as well as personal reflexivity in relation to the research.

### **3.9.4 Impact and importance**

The literature reviewed highlighted a significant gap in knowledge regarding workplace bullying in clinical psychology that shaped the research question. Dissemination of the research is hoped to make an impact on trainee clinical psychologists' experiences of workplace bullying through presentations and workshops, such as at the Group of Trainers in Clinical Psychology Annual Conference so that staff at training courses are aware of the issues of workplace bullying in training, which may lead to further interest, projects and resources in the area.

## Chapter 4: Results

The study aimed to explore how trainee clinical psychologists experienced workplace bullying during their training and in pre-qualification psychology roles prior to training. In this chapter the results of the thematic analysis will be presented. To provide context, examples of bullying and negative behaviours identified by participants will be highlighted in section 4.1. The thematic analysis in sections 4.2 – 4.5 will then outline the themes generated from the data and explore the themes and sub-themes in depth. The four main themes are ‘Activating the Threat System’, ‘Making Sense of Bullying’, ‘Difficulties Navigating Power within the System’ and ‘Finding Safety and Support’. Figure 1 provides a map of the thematic analysis with themes and sub-themes.

### 4.1 Bullying and Negative Behaviours

In order to provide a background to the thematic analysis, examples of bullying and negative behaviours that participants identified are presented in this section 4.1.

#### 4.1.1 Persistent and unjustified criticism

The most common examples of bullying and negative behaviours that participants identified were persistent or repeated criticisms of their work, which were felt to be unjustified.

*Every kind of aspect of what I had done or had not done would be under scrutiny and criticised and it was done with a lot of angry emotion in the room. The person was not shouting at me but very abrupt and the body language*

*was quite cold and any explanation of what had happened for example and why I had done the things I had done was met with resistance. (Gabby)*

*I think just kind of constant put downs, sort of trying to, I guess put you on the spot in front of the team members and then raising her voice and also, kind of criticising, being very critical of my standards of work and what she thought were... how she perceived that I would get on in the placement. (Joy)*

*There was a spread sheet she had written on literally every single thing I had ever done in the years since I had been working there that she had felt wasn't quite right ...there was a whole list with a tick box like if any of them ever happen again I would be ticked off. (Ellie)*

*In every supervision session he would ask me what, how I work with someone. And he consistently talked about how he thought that was completely the wrong approach. (Lucy)*

*She said all of these things about how they were disappointed with my performance, they thought I was ungrateful, they thought I was missing opportunities, that I was unprofessional, that I was unprepared... and a lot of the things they were saying I thought were lies. (Laura)*

For some participants, they described criticism not only of their work, but also criticism that they felt was more personal.

*I was told a lot of very personal, critical comments and anything that would have been a challenge was all because of who I was and the way I think, and the way I approach things. (Fiona)*

*It went from I guess hostility to raising voices at me to kind of very personal attacks. Some of it kind of felt like it was erm personal, which didn't seem like it was kind of founded and it seems were deliberately undermining what I was saying. (Sara)*

Some participants gave examples of criticism that they felt was unjustified or personal. Examples participants gave included a participant who was told that they only received an interview for the DClinPsy programme because they had a disability, a participant who was told that women who wanted to have families should not be psychologists, and a participant who was criticised for asking not to work with a client who had been sexually inappropriate in a joint assessment session.

Three participants also reported being shouted at and one participant being sworn at when criticised.

#### **4.1.2 Changing the goals**

Some participants referred to shifting work goals that were set and then changed without notice.

*And at points there were things that my supervisor had asked me to do in writing and I had done them, then in the next meeting I would be criticised for doing it, then they denied having the email. (Gabby)*

*She'd do that thing that you tell one thing one day and then change her mind the next day and blame the person got it wrong and they haven't. They have done the thing that was asked to be done but then she changed her mind.*

*(Beth)*

*The week later the goal posts would have moved and she would be no you are not managing this and it was the very thing she said I was managing in the first place. So it was disorientating. (Ellie)*

#### **4.1.3 Excessive monitoring**

Some participants described monitoring of their work that they felt was excessive, such as their time or tasks at work.

*He wanted me to account for every single hour of placement... It was even more difficult when some of that time was just taking a breath of fresh air so I could carry on with my work. I felt even that was being scrutinised which was really difficult. (Lucy)*

*Any kind of task I knew it would be scrutinised to the nth degree by my supervisor so it it just felt suffocating really um like everything had to be exact cos she was just picking on anything. (Michael)*

#### 4.1.4 Being ignored

Some participants referred to feeling ignored or isolated by the perpetrator.<sup>5</sup>

*I wasn't allowed to ask, or speak to her outside of supervision, ever... And she completely ignored me outside of it, like she didn't say hello, didn't look at me, didn't acknowledge I existed outside of actual supervision and so I was like, at least outside supervision I'm alright. (Joy)*

*It was not speaking to me or not looking at me in meetings or basically any suggestions or any thoughts I had, dismissing them in front of others. (Ellie)*

#### 4.1.5 Preventing access

Some participants reported being prevented access to work opportunities, such as speaking in a presentation or professional development.

*He would take work away from me. We were supposed to be doing a joint presentation to the MDT and slides of a case I was dealing with and he ended up doing the whole presentation by himself and did not even invite me to share platform with him. (Lucy)*

*I started presenting and she completely, in front of everyone, stops me talking, completely interrupting me. I kept trying to do it, I kept trying to then*

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<sup>5</sup> As in other academic literature in workplace bullying, the term 'perpetrator' will be used to denote the person (or persons) that engaged in bullying behaviour/s as identified by participants.

*re-speak or say something else or add to it or sort of do this jointly thing and she didn't let me. (Isabelle)*

*She didn't give me opportunities that others got....We had an away day where everyone in the service went apart for me for some reason. I didn't get an invite to go. Everybody else was there. (Ellie)*

#### **4.1.6 Unfair practices**

Some participants referred to practices that appeared to be unfair and discriminatory in relation to participants' health. These included being pressured to work when unwell, expecting the same levels of productivity when hours were reduced due to ill health, expecting overtime including in the context of ill health, and breaking expected confidentiality regarding a health condition when it was shared with others in the team.

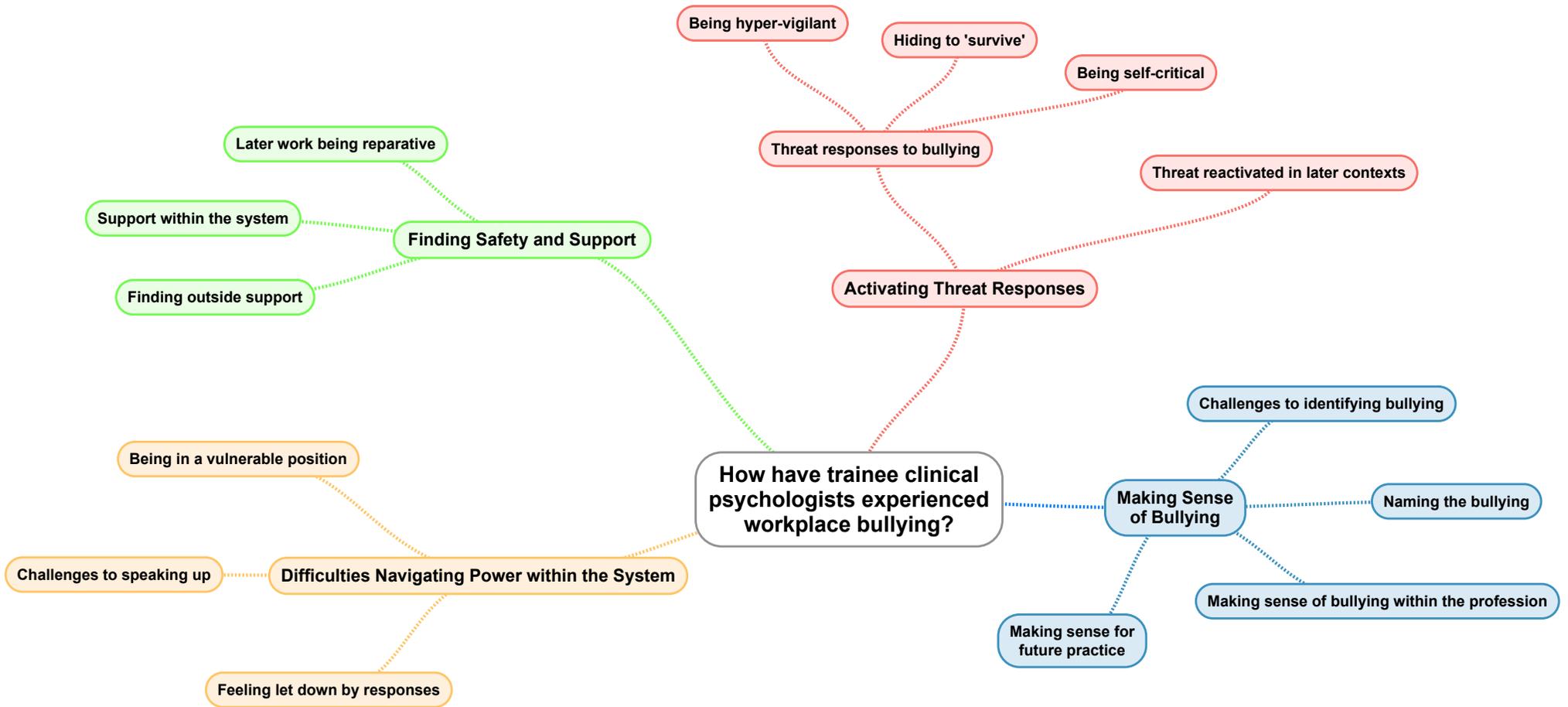


Figure 1: Thematic analysis map with themes and sub-themes

## **4.2 Activating Threat Responses**

This first theme captures the way in which participants described experiencing threat both as a response to perceived bullying behaviours, as well as in later contexts. Many participants conveyed how threat responses elicited from bullying could continue beyond the immediate context of bullying to other “safer” work situations, and also in retelling their story.

### **4.2.1 Threat responses to bullying**

Participants identified a number of threat responses to their experiences of bullying, including hypervigilance at work, responses where participants sought to “keep their head down” to avoid further threat, and the way in which some participants internalised bullying behaviours and became self-critical in their thinking.

#### ***4.2.1.1 Being hypervigilant***

Participants highlighted the way in which experiencing negative behaviours led them to being hypervigilant to further threat. Gabby and Fiona demonstrate how this hypervigilance affected interactions in supervision in response to feeling under threat.

*I would be more alert in the room, more awake and looking out for body language and trying to get the perfect words out of me because I wanted to avoid, you know walking on eggshells kind of thing. I wanted to avoid upsetting or annoying her. (Gabby)*

*I felt like I had to be extra careful with my clinical plans because I couldn't afford for anything to go wrong because I was already under attack. (Fiona)*

For some participants this hypervigilance appeared to generalise beyond the experiences of supervision to permeating wider experiences at work, including participants' physical sense of safety, and their ability and decisions at work.

*I would get to work, and then just feel on edge, like jumpy, like the door would open and I was like who is going to be there. Because my supervisor might come in. (Isabelle)*

*I think I made more mistakes because I was very anxious and I would lack confidence in the decisions I made because the decision would be wrong whatever, you know. I was constantly seeking ways, ways of pacifying her, doing everything to make her not angry or cross with us. (Beth)*

This hypervigilance led some participants to report overpreparing and overworking as an anxious response to bullying behaviours.

*I would over prepare for things, that was the big thing. I would spend a lot of time checking emails, running it past colleagues "Is this ok? Does this come across alright?" (Gabby)*

*I was writing letters and stuff and I was really anxious about how she would respond to them. Like nothing was ever, it was never good enough. So*

*I would read over them a thousand times and have different versions of them that I would write so that hopefully one of them would meet her requirements. (Isabelle)*

#### **4.2.1.2 Hiding to ‘survive’**

Many participants reported responding to threat within the workplace by hiding their experience from perpetrators and also others in the workplace so as not draw attention to themselves. Becoming secretive and masking their feelings about the bullying was identified as a strategy to manage the experience, and also as a way of preventing others from considering that they were a “problem” at work.

*I learnt how to survive on that placement. I learnt to be submissive and do whatever they said and smile and nod and say how great it was and how grateful I was and thankful I was. (Laura)*

*It also made me feel like I couldn't talk about it and I had to hide everything because otherwise everybody would see me as a problem. (Isabelle)*

Some participants articulated how suppressing their feelings physically manifested for them. Ellie and Keith highlight the physical impact of hiding their feelings of anger or ‘fight’ response at work.

*I did not want to jeopardise things at work, just grit my teeth and smile and “OK I will do that for you now”. She would sit behind me and she would say*

*something and I could feel my teeth just like gritting and I was ok like relax, relax. (Ellie)*

*The blood pumping and almost shaking with anger and having to perhaps suppress that in the moment. Not to let the anger out in an unhelpful way to me and others. (Keith)*

In this example, Danielle seems to demonstrate an embodied sense of wanting to hide from the bullying experience.

*Like a curling in of myself, feeling like I just wanted to curl up in a ball and cry and not have to speak to anyone and not have to explain anything. (Danielle)*

As well as a hypervigilant response in sub-theme 4.2.1.1, Laura refers to overworking and overpreparing as an attempt to avoid further attention and negative behaviours.

*You know I sort of upped my game and was there from eight in the morning until seven at night and I was commuting for this as well. I learnt just to do all of that, and it seemed to keep me under the radar just enough to get me through. (Laura)*

However, avoidance strategies to maximise safety in an unsafe environment could maintain a negative cycle for some participants and their work. Fiona highlights

the anticipated fear that seeking support might trigger further negative behaviours, further exacerbating the sense of unsafety in her clinical work.

*Holding quite a complex, risky caseload with minimal support, and then it was just having to come out of a crisis situation and then feel like I had nowhere to turn, because it was so attacking and unsafe that if something wasn't going well, it just seemed like it would become ammunition. (Fiona)*

#### **4.2.1.3 Becoming self-critical**

Several participants described responding to the sense of threat by becoming self-critical, with some participants referring to this as “internalising” criticism from a perpetrator.

*It was hard not to internalise it. I think I still have in some ways. I think I left feeling really deskilled. (Ellie)*

*When someone is bullying and saying, actually, you know, this is you. This is something wrong with you. So, there is something about that, you start internalising that (Joy)*

The process of becoming self-critical often appeared to develop from critical comments from a perpetrator that were incorporated into a self-critical inner voice.

*There were times that the comments she said to me kept floating inside my head, and some of them were pretty hard to shake (Fiona)*

*I definitely have more of a, not that I didn't ever, but more of that critical voice because I think it is sort of like, like if you are criticising yourself or like you are looking for evidence of how you can prove it, I've got so much evidence from her. (Isabelle)*

Participants reported that this self-criticism could lead to participants' loss of confidence in their work, and questioning of their abilities.

*I think it really ground down my confidence in my ability as a practitioner as well for quite some time and I think because you do kind of you know, however hard you try, especially if you don't get the support you need or you expect, I think you do tend to internalise some of the, some of the bullying. (Joy)*

*Doubting myself, doubting my ability erm thinking erm, I don't know, really knocking my confidence, just knocking my confidence really. Erm makes you question everything you do. (Beth)*

Some participants explained that this self-criticism and lack of confidence developed beyond their clinical work and into other aspects of their lives.

*I found I was questioning other things as well, my uni work and my behaviour. How I would come across to other the people because of the criticisms she*

*would make in a work context I would generalise them into other situations as well, become quite unconfident in other situations. (Gabby)*

*I guess I certainly lost confidence and I think that translated into different areas of my life. Even in my external, like outside psychology, relationships, I felt I lost a lot of confidence. That was quite kind of marked. (Sara)*

One way participants reported resisting this impact on their identities was to try and minimise the perceived effect of bullying behaviours on participants' clinical work. Keith and Fiona illustrate how they tried to protect their client work to maintain confidence in their work, and thereby support a more positive work identity and motivation for the job.

*I really tried hard for it not to affect my work. So I almost took it on as a personal boundary. I did not want it to affect my work because that would be almost another layer of damage done by it. You know I am affected by this and I cannot do my job properly. The extra effect that has on your identity of yourself and your commitment. (Keith)*

*Really trying to do the best job I could for them [clients], not for the team, not for my supervisor, just knowing that actually I could go to bed with a good conscience knowing they got the best care I could offer, so that really kept me going. (Fiona)*

However, Sara highlights that working hard in an attempt to protect clinical work also contained risks for participants.

*I think the problem was that I had to work so hard to stop it from affecting my [clinical work]. Like I completely kind of, like really, really burned myself out and felt like quite traumatised at the end of training. (Sara)*

#### **4.2.3 Reactivating threat responses**

As well as experiencing threat responses to bullying behaviour at the time, many participants referred to similar responses recurring after the events had passed, both in later work or when retelling their experiences of bullying.

Several participants referred to the effect that bullying behaviours in previous work had on their responses in later work situations where they were no longer directly experiencing threat. Here Fiona's descriptions of being more placatory in her interactions with others echo Laura's earlier 'submissive' approach in sub-theme 4.2.1.2 "Hiding to 'survive'".

*I'm really conscious about not rubbing people the wrong way. So I've definitely gone more into appeasing mode. (Fiona)*

Similarly, Isabelle's hypervigilance in supervision in later work mirrors the hypervigilance that Gabby and Fiona articulated of supervision at the time of bullying in sub-theme 4.2.1.1 "Being hypervigilant". She also demonstrates a change in her attitude to supervision from appreciating to associating supervision with criticism.

*I don't really like being supervised. Erm, which I did before. It depends, I think I'm much more aware, more vigilant of what my supervisors are like....I'm like 'they're looking to criticise me'. (Isabelle)*

Joy highlights how she appeared to overcompensate in her work in order to demonstrate her capability as a trainee.

*And I think I found that I was doing more work or kind of stretching myself a bit further that to show that I was a competent and willing trainee. (Joy)*

Other participants reported adopting avoidance strategies to prevent coming into contact or working with a perpetrator of bullying, and anticipated ways of trying to prevent working with someone similar in the future.

*I was terrified that people from the organisation would turn up at the conference and I told my supervisor about it and said if, can we check the attendance list and if they are there I can't go. (Danielle)*

*I would probably ask to speak to other members of the team and get a sense of how things are. Just because I know how painful it can be to try and avoid. I would definitely avoid working in a service where she was working. (Gabby)*

Participants also highlighted a sense of emotional threat in retelling their experiences of bullying for the research interview; some participants had not expected this prior to participating.

*I found in the beginning I was actually quite flustered talking about it which I was not really expecting. I thought I would be, I don't know why I felt this, be quite detached, that this is bearable but er, yeah it wasn't so much like that. (Ellie)*

*It has shaken up the emotions more than I thought it would do. (Keith)*

Other participants highlighted how they anticipated the emotional difficulty before participating and had prepared in advance, or became aware that they would need to find ways of managing the emotional aspect of participating afterwards.

*I chose very carefully from when our conversation would be because I did not want to go straight from our conversation into a difficult session with a client because I knew it could leave me feeling a little bit raw afterwards. (Danielle)*

*I know after this conversation now it will be more on my mind and I'll be a bit more ruminative about it and I'll, and I'll need to find a way to calm my head down and move on from it. (Michael)*

Some participants identified that the telephone interview methodology created a distance from the emotional content, which mitigated the sense of emotional threat within the interview.

*If I talk to somebody that I knew in person, it would probably still upset me...It feels easier because we don't really know each other and I'm on the phone and it's a phone interview, but it probably would still upset me now. (Holly)*

*Because we're on the phone I've been like doodling and playing with things with my hands and I wonder whether that's to like stop me engage emotionally because I think that maybe I'd kind of anticipated that it might be kind of be a bit difficult. (Sara)*

Whilst participants demonstrated various expectations and strategies for managing distress in the interview, it seems that for many the process of speaking about their experiences had the potential to reactivate a threat response associated with the bullying.

### **4.3 Making Sense of Bullying**

Another theme generated through the analysis was the way in which participants made sense of experiences of bullying. Participants identified challenges to conceptualising bullying, as well as the processes that led them to naming their experiences as workplace bullying. Identifying that they had experienced bullying within clinical psychology changed some participants' relationship with the profession. Participants' understanding of bullying within psychology also provided a perspective on which to which to develop their own future practice.

### 4.3.1 Challenges to identifying bullying

In making sense of bullying, participants referred to the challenges in identifying their experiences as bullying. Several factors contributed to this difficulty: the often subtle, gradual and accumulative process of experiencing bullying behaviours, the subjectivity inherent within the definition of bullying, and the connotations of the word itself.

Lucy, Fiona and Sara point to the subtle, insidious nature of the bullying behaviours, which were often gradual in nature. This seemed to make it more challenging for participants to label their experience as bullying, especially as their understanding of bullying may be associated with actions that were more discernible.

*Often things felt quite subtle and more emotionally manipulative. Whereas I think of bullying as something more explicit like you know kind of more verbal aggression, slurs maybe going as far as violent. I think what I experienced was someone who was more manipulative and narcissistic and shaming.*

*(Lucy)*

*In the beginning I did not realise she was bullying me. I guess it was always that like when does bullying become bullying? Because it was quite insidious.*

*(Fiona)*

*It felt like it started quite gradually. And it started as a kind of very kind of subtle hostility which would have been quite difficult to evidence. (Sara)*

This was also reflected in the research interviews; the subtle, gradual nature of the bullying meant that some participants became aware of the challenges in providing a coherent narrative for the research interview.

*I thought it would be a lot easier to quite coherently sum it up and have it all laid out but it has been quite difficult to get it all in order. It feels like it is quite a big thing I can't quite neatly package up for you and give to you. (Ellie)*

In contrast, for Danielle, it was the definitive experience of being dismissed from her work that she said made her uncertain if her experience matched a typical perception of bullying.

*I suppose what I would typically label as workplace bullying would be more sustained and more insidious and less easy to tell a story about. Because when other people have spoken to me about bullying it has been like snide remarks and remarks making you feel weird, but not having a clear story of oh I was fired. So maybe that is what makes me hesitate. (Danielle)*

The lack of clear definition and the subjectivity in delineating whether behaviour may be considered bullying provided another challenge to participants. Participants highlighted how the phenomenological experience of bullying and interpretations of behaviour may differ between people.

*And of course part of the definition is it's personal, it is down to personal, it is down to how you are impacted or your experience of it, different people might experience something as bullying but other people wouldn't. (Sara)*

*But again it is hard, at what point to define bullying? At what point does it become an issue of malpractice and, or is it just personality clashes and people learning to work together in difficult circumstances? (Lucy)*

This could be further compounded when others, including the perpetrator, questioned participants' interpretation of behaviours.

*I didn't kind of trust my own judgement because he was like, oh you're being crazy, you're not allowed to be upset about this, you're being so unreasonable, so I was like, am I being unreasonable? (Lily)*

Participants pointed to a lack of clear examples, training and agreed definition in further challenging their own understanding and use of the term to express what they had experienced.

*You don't get any training on what bullying is or how to spot it and the fact of how it is interpreted, so the question is it me being sensitive or is it trying to undermine or demean me? (Keith)*

*Because it is not well defined and there isn't, there aren't a majority that agree with this kind of thing in the work place. It has not been talked about enough. I haven't got case examples or vignettes. (Fiona)*

This uncertainty linked to subjectivity and interpretation highlights participants' sense-making of bullying as a dynamic process which may change during the experience, and also in the retelling. Gabby and Danielle illustrate how during their narrative in the research interview, they continued to have questions about whether they had experienced bullying.

*I still do have doubts about whether it was or it is. Now I am labelling it to you over the phone I got like do you think it is bullying? Would there be a majority in a jury that think it is bullying? Is it something else? Have I misunderstood it? And so it is quite a nebulous thing in my mind. (Gabby)*

*And in my mind I am noticing as I am talking, talking to you now, what if you don't think that is bullying? Maybe it wasn't bullying, maybe it was just the processes. I clearly still have a lot of questions about it in my mind. (Danielle)*

The connotations of the word, bullying, also presented a barrier to participants in using it to make sense of their experiences. Gabby's associations with school bullying meant that she found it difficult to use in a workplace context.

*I think the biggest barrier is a general belief is it shouldn't happen when you are an adult. Maybe when you are a kid at school. I know logically, rationally bullying exists but normally the narrative is that bullying happens at school (Gabby)*

Using the word bullying seemed to re-emphasise the power differential between participants and perpetrators. Participants said that the word positioned them in the role of victim, which might not correlate with their self-identity, and contributed to their uncertainty in using the term.

*And I guess I am reluctant to say I was bullied because it feels like you're pushed into the victim role by saying I was bullied. I was the subject of bullying behaviour. Yeah. Maybe that's just playing with semantics. I don't know. (Michael)*

*Just sort of saying I'm being bullied, it felt like I was pushing myself even more into like being vulnerable and being a victim of something that I couldn't manage which is ironic because I couldn't manage it. (Holly)*

*I think I find it quite difficult to admit as well because it isn't in my character to accept being bullied. (Isabelle).*

#### **4.3.2 Naming the bullying**

Participants identified a number of influences in naming their experience as workplace bullying, including previous incidents of bullying, a particular episode with

a perpetrator, examining definitions of bullying, and through identifying their experience as bullying with others.

Joy and Keith illustrate how labelling previous experiences as workplace bullying can help them to identify a later episode, by clarifying unacceptable behaviour or challenging beliefs about the profession.

*It's just having experienced it before and just being aware or more kind of firm in my idea of, you know, what is and what isn't an acceptable way to treat someone else in the work team. (Joy)*

*There was some uncertainty but I think from previous experience from prior knowledge that it does happen there was less question in my mind that a psychologist would bully. (Keith)*

Sometimes it was a specific encounter with a perpetrator that participants described as a trigger to labelling their experience as bullying, as the behaviour was felt to be more threatening.

*There was one particular meeting that for me was definitely the worst of it and the thing that for me tipped it over into bullying... I think it was more extreme in its nature. I think because there hadn't been raised voices before then. I think the attacks were much more personal. (Sara).*

*So after she swore at me, um, I was like this isn't appropriate, you can't talk to me like this, um this is not right, um and I was like this is what bullies do, bullies shout at you to try and intimidate you. (Fiona)*

Fiona's identification of her experiences as bullying appears to put her in a stronger position that she does not need to tolerate the behaviour. Whereas for Ellie, the same recognition seems to accentuate her lack of control in the situation.

*When I thought maybe I am being bullied it got worse at work, because before I was blaming myself and that was kind of easier to manage. Whereas when I accepted that a lot of it was her and not me and I was then angry. (Ellie)*

Referring to workplace policies with definitions of workplace bullying, or finding case examples was highlighted by some participants as providing evidence in order to interpret their own circumstances.

*I read some examples of workplace bullying and gaslighting by employers and some of the examples were almost directly what I had experienced. (Fiona)*

*I found the institution's bullying at work or bullying and harassment policy. Erm I do remember looking up different definitions of bullying and thinking that does fit. (Isabelle)*

For some it was the definition within the research information sheet that they described as prompting a recognition of workplace bullying.

*My friend forwarded it to me, the information about your study, it made me think oh actually maybe I meet that criteria actually. (Danielle)*

*I kind of thought this is relevant, I will have a look at the info sheet from the original recruitment email, then looked through the definitions in there, which helped me to think about it kind of more broadly. (Gabby)*

Many participants described their interpretation of bullying as developing within a relational context through others identifying difficulties or labelling their experiences as bullying. This might be through people who were more directly involved with their work, such as course staff, or others outside work, such as friends.

*There was a point in that placement where I was talking about how I was worried, about making sure that I don't upset my supervisor... wondering if I was doing something wrong, and my MPR visitor stopped me and said that I sounded like a person in an abusive relationship. And that was a bit of a penny drop moment for me. (Fiona)*

*Since getting other people's reaction of "Oh that is awful, I can't believe they would do that to you" that has increasingly made me feel maybe it was out of order, maybe it was not me, maybe that was an unjust outcome. (Danielle)*

Sometimes participants reported experiencing the behaviours with others where the perspectives on workplace bullying became a shared understanding.

*Because I had colleagues who were experiencing it as well, we were like this is definitely bullying, this is not just poor management. (Beth)*

Some participants described later becoming aware that others were facing or had faced similar difficulties with a perpetrator. In this context, participants moved from a position of focussing on self-criticism or self-blame to feeling validated that they were not alone in their experience. Yet this validation was not uniformly positive; Laura and Gabby highlight the tension in speaking about feeling 'good' or 'comforted' that others were also facing difficulties by also referring to this situation as 'sick' and 'awful'.

*So in some ways when I did hear people having similar experiences it was actually quite validating because I thought it really wasn't just me, this really was a problem at that placement. So in some ways comforted, as awful as that sounds. (Laura)*

*So no I wasn't the only one. So that in a sick way made me feel quite good I was not alone...to understand it was not all my problem. I should not blame myself totally. (Gabby)*

### 4.3.3 Making sense of bullying within the profession

After experiencing bullying within psychology, participants referred to a changing perspective towards the profession that challenged their previous assumptions. In hindsight, participants identified an idealistic image of psychologists due to the caring nature of the work of supporting others. By the time of the research interview, this had developed into a more nuanced view that participants perceived as more realistic.

*I'm probably more realistic because I kind of assumed that psychologists were generally brilliant people to work with because they were empathetic and understood what was going on for people...I think now I know that psychologists aren't always great [laughs] and they can be quite damaging as well. (Gabby)*

*I think psychology is a world where we're all supposed to be really open and reflective and everything, but I don't think it really works like that in practice....these things do happen even in um a profession that supposed to be, you know, very encouraging and supportive. (Holly)*

Indeed, Sara suggests that the reflective, personal nature of clinical psychology that Holly identifies in the extract above could itself also be implicated in workplace bullying within the profession, if misused.

*There's something quite abusive about maybe being like encouraged to like be quite reflective or disclose quite personal things or get into quite a deep*

*relationship, you know professional but deep relationship with like supervisors or tutors or whoever. Erm and the kind of level of trust that that requires and what happens when that trust is broken like it almost feels like a slightly different kind of betrayal as well or a different kind of emotional consequences that happen with psychology. (Sara).*

For some, this change in beliefs about the profession meant they had a developed more disillusioned attitude and questioned their role within it.

*I don't believe in the profession as much. And I am slightly more ambiguous about what I am doing because do I really want to do what I am doing. Is it sort of profession I want to be involved in? (Keith)*

#### **4.3.4 Making sense for future practice**

Participants shared how they made sense of their experience in ways that would shape their future attitudes and behaviours. Participants achieved this through a number of ways; by situating the bullying experience in the past, being aware of their values and boundaries, and learning how to support others.

Whilst acknowledging the ongoing emotions associated with the bullying, situating the events in the past appeared to help participants accept that they were no longer experiencing the same events providing hope for a different future.

*I am quite angry about the fact that it happened, and you know it's compromised a lot of my final year of training um but now it does feel like it's*

*in the past and it's a nice shift to know it's not still happening. Um and things can be different. (Fiona)*

*Researcher: How has it felt talking about your experience today?*

*It was quite cathartic. It made me realise there is still quite a bit of anger, frustration that that happened, but some of it is quite good to feel how it's in the past as well. (Lucy)*

Participants spoke about how the difficulties of the bullying situation clarified their values and boundaries for the future, and what they were willing to accept and challenge in future work.

*It pushed me to think, to be honest, what my professional values were. And know what is right and what is wrong in how a service is run. And what where sort of my line is, and think about what I'm actually going to put up with, when I need to say I think something's wrong you know. (Fiona)*

*I feel more confident in knowing what to look out for or what doesn't feel okay for me. And also like my boundaries in terms of what I would allow from somebody else now, even somebody really senior. (Holly)*

Participants also outlined how it enabled them to be more understanding of the needs of clients on an emotional level.

*It has helped me be more empathetic to clients I work with who are feeling really low or suicidal. It didn't make me suicidal, but I can see how it could get to that point, but without that I would have found it harder to make that jump. (Danielle)*

Holly describes how experiencing bullying increased her awareness of the power and privilege within the role that not all clients may share, contrasting to the powerlessness that was mostly associated with participants' pre-qualified position.

*I think we're really privileged to be on the training but privileged in general so we have quite a loud voice but it's made me reflect a lot on people and their employments and their job roles and how much they do feel able to speak up if there's a problem... So in a twisted kind of way it was quite a good insight into how a lot of my clients feel. (Holly)*

Participants noted how the bullying experience shaped their intentions of working when in a more powerful position in the future, such as when working as a supervisor.

*I think that if I was to like witness that sort of behaviour or someone was to tell me about it like, particularly a junior colleague or a supervisee in future, I would like to think that I would always have like, you know tried to act appropriately and not just brushed it under the carpet. (Sara)*

*I have been thinking about it a lot since started training how I would be when I was qualified and how I would try to nurture an assistant. (Ellie)*

#### **4.4 Difficulties Navigating Power within the System**

Participants referred to the difficulties they faced in navigating power within the system both in experiencing bullying behaviours and reporting workplace bullying. Participants perceived their pre-qualified position as holding relatively little power in the system, which meant they felt especially vulnerable when they experienced bullying behaviours. Participants' perceptions of reporting systems also hindered their ability to speak up and report their experiences to those in a position of power to support them. When they did choose to report, participants often felt let down by the lack of action or acknowledgement of the difficulties they were facing.

##### **4.4.1 Being in a vulnerable position**

This sub-theme encompasses how participants reported experiencing bullying behaviours in a context of perceived powerlessness and vulnerability both in relation to their hierarchical position at work and in relation to personal circumstances. Participants perceived their position as trainee clinical psychologists and within pre-training roles as inherently a position of limited power within a larger system. Experiencing negative bullying behaviours seemed to exacerbate a position where participants felt they held little power into a role where they felt vulnerable. Participants expressed their lack of power in the role in different ways. The competitive route and investment to follow clinical training meant that some participants felt that they had to accept unacceptable behaviours in order to continue and qualify in the profession, both before and during training.

*I think the investment to follow this path and the dysfunctional way of recruiting people into the profession, that we should feel grateful to be in the profession and therefore have to accept whatever is thrown at you. (Keith)*

Some participants highlighted the particularities of training that meant that they felt they had less control over their work, such as the location and duration of placements, and type of work.

*It is very different when you are a trainee on placement because if you were in a normal job you would leave within your probationary period...It is very hard when you don't have licence to say I am not going to work there. (Beth)*

The power invested in specific people to affect participants' progression in their training was identified, as well as its potential to be abused.

*Also someone holds the power, you know he held it over me that he had the power to pass or fail me... like the Sword of Damocles, just hints of the power, you know the use of power to put someone in their place (Lucy).*

Some participants situated their position within wider power structures. Sara and Fiona view their roles as trainees as holding the least power. Whilst Sara explicitly states this, Fiona demonstrates this by locating difficulties at a systemic level affecting her supervisor's behaviour towards her.

*Because obviously everyone has different roles and different amounts of power within that system. And as a trainee I felt I had the least amount of power out of everyone who was involved. (Sara)*

*For the larger organisation there was quite a few challenges in terms of management and communication with teams, which the knock on effect was felt at the team level, and then I guess if I were to formulate it, it was also fed into my supervisor's behaviour. (Fiona)*

Yet whilst participants highlighted the sense of vulnerability and powerlessness within their role, some participants contrasted their pre-training role where they experienced bullying to their current training role, where they were no longer experiencing bullying. For these participants, the trainee clinical psychologist position was not constructed in such powerless terms, rather it provided a contrast to the vulnerability that they had previously experienced.

*I think it is different now being a trainee as the power has shifted slightly. So like even though the qualified has more power, I feel I have more power than I did and now with the training it is about me developing into the qualified that I will become. (Ellie)*

*It just feels like maybe the nature of psychology until you get on the training, you are on the back foot a lot. Maybe you have to put up with stuff or people think they have power, use power over you perhaps. (Beth)*

Thus, the sense of powerlessness seems less inherent to the pre-qualification roles themselves, but rather it is the negative experiences within those positions that create the sense of vulnerability for participants.

Some participants expressed that they not only experienced a lack of power in relation to their position and experiences of bullying behaviours, but that this also interacted with their personal characteristics and social circumstances, including mental and physical health, gender and family situations.

*I have a diagnosis of PTSD as well erh so there was a time when I was quite anxious and I disclosed that to her...and I felt she was using that to discriminate against me. (Ellie)*

*I live with a chronic health condition, which means doing long hours isn't good for me. Which it isn't for anyone, but it was something the course wanted me to address at the start of the placement so I did, and the boundaries around that were never respected [on placement]. (Fiona)*

Participants highlighted a dilemma between sharing personal information that risked contributing to negative behaviours and keeping it private to protect themselves.

*I also had a miscarriage on placement and did not feel able to tell him which I think gives a sort of sense of how difficult the environment it was. I felt this would be something for him to kind of beat me with. (Lucy)*

These experiences of intersectionality highlight how workplace bullying is not only related to power differentials within the role, but that other differences in power can be potentially implicated. It appears that the misuse of power within bullying aggravates a lack of control in the role that creates distress, which can be further exacerbated by personal circumstances.

*I just had loads of life events, just like loads of stuff was going on and the last thing I needed was to have this going on...I felt like life-wise I was out of control and work-wise I didn't have any control, I just had no power anywhere to do anything. It was awful. It was really upsetting. (Holly)*

#### **4.4.2 Challenges to speaking up**

Participants spoke about the way in which their perceptions of power within the system challenged their decisions to report the bullying behaviours. Participants were concerned about the neutrality of the reporting structures, and their lack of knowledge of the system. They also outlined worries about their reputation with those in positions of power if they chose to speak up, and the consequences on their job and career.

Participants were concerned about connections between the perpetrator and those who they were reporting the bullying to. Lily highlights the possible lack of neutrality due to inter-professional power and alignments.

*In the back of my head I was a bit like, my supervisor is a medic too so he will always take his side, and not mine. (Lily)*

For some, it was the lack of knowledge of the relationships between perpetrator and reporting systems that fuelled concerns about the process.

*Like it felt like the people who were carrying out all the processes were probably friends with the person who was bullying me but not really knowing for sure. (Sara)*

*We were not really clear what the process was. Maybe having someone we could talk to that was independent from the programme would have helped. (Beth)*

As well as fears of impartiality, some participants outlined their lack of knowledge of the reporting structures themselves.

*It felt to me there was nowhere to go because it was not an NHS organisation, so I just could not take it higher up. I felt that the person at the top of the organisation was entirely aware of what was going on although I did not have contact with them personally...Outside the organisation I had no clue of where to go. (Danielle)*

Participants highlighted that even when they were aware of the structures, a lack of knowledge of how those in power would respond and how the ensuing decision making would operate led to a perception of unsafety in the process.

*About how they believe you, about how they weigh up what is happening.*

*About how they make decisions about what to do just so you, you know, feel you are not scared of what will happen. (Gabby)*

*It felt like I was very vulnerable and you don't really know how they're going to react or what they're going to think of you and what they were going to do with all this sort of, this really personal story that you gave to them. So that just felt kind of unsafe. (Sara)*

The word bullying also seemed to assert its own power by interacting with reporting structures to trigger certain procedures that some participants said they were unsure about engaging in.

*He was saying well ok are you accusing her of bullying? Because if you are I'm going to have to do this and this and this procedure. (Michael)*

*I think bullying is quite a loaded word and I think there is something about not wanting to open perhaps a can of worms that I wouldn't be able to deal with. (Holly)*

As well as the lack of knowledge of processes, participants showed a concern for their reputation within the organisation. Trainees pointed to the desire to be viewed as competent, particularly in the context of continual assessment, with a worry that raising difficulties might compromise this.

*With evaluation coming at you from all angles on training um there is a lot about professional reputation I guess and wanting to make sure that you know, you come across well. (Fiona)*

*I was just trying to be accepted and show myself as somebody that was worthy to be on the course and competent and all these things so I didn't really want to be ruffling feathers, and be like oh this is going on. (Holly)*

*You're in this sort of battle of power, especially if you're a first year trainee where you've not got evidence with them that you're an alright person, and it's not about you, it's about the situation and everything. (Isabelle)*

In addition to the subtler forms of power that participants highlighted as challenges to speaking up, there were more tangible forms of power that participants said obstructed their willingness to raise issues. Participants emphasised the fear of potential consequences on their career on speaking up. This seemed to be exacerbated by the small and competitive clinical psychology field, and also reflects the perceived vulnerability of their position as in sub-theme 4.4.1.

*The person made me feel like they could ruin my career if I spoke out about it. So because psychology is quite a small world, they could have done that, in a different profession it might seem different. (Beth)*

*You know that person could be a reference, would be a reference. They work in the field. You are in much more disadvantaged, disempowered position to say anything. (Keith)*

*Because they're assessing you and because my tutor made it very clear they're assessing me, that, I don't know, that I needed to pass their placement if I wanted this career. (Isabelle)*

#### **4.4.3 Feeling let down by responses**

Despite the challenges in raising difficulties related to workplace bullying, many participants described attempting to speak about their experiences to others in a position of power. Most participants said they felt that those who had the potential to influence the situation did not acknowledge or ignored the difficulties participants were raising, which negatively affected their relationship with those whom they had sought support.

Some participants perceived that those in a more powerful position, including managers or university course staff, were aware of difficulties but chose to ignore them.

*People knew really what was going on but nobody else had the, I don't know, will or strength or courage to do anything about it either or perhaps they just didn't think it was a big enough issue. (Holly)*

*So it was very frustrating because we thought we were being really brave by coming forward and doing the right thing and putting ourselves at risk. It was*

*the right thing to do but we were really scared doing it but then for nothing to come of it, it just felt like what is the point...still to this day I feel really let down. (Beth)*

For some, this seemed to be a repeated ignorance to a pattern of behaviour, when they became aware that others had faced similar difficulties, reinforcing a sense of powerlessness.

*So it's like there is a pattern and they're just ignoring it. So really frustrating, really, really infuriating, but powerless again, there's just nothing I can do to help other than being an emotional support for the person. (Laura)*

Yet even when there was a procedural response, some participants perceived a lack of emotional acknowledgement of the difficulties, which they named as important as part of the response.

*The procedure about what to do next was the important thing. And I think it is making the person feel like their feelings is an important thing in it. I think things will flow much better from that. (Keith)*

*So I think university went into slightly more management approach at that point... and it would've been nice to have a bit more warmth and that this is really awful, I'm so sorry this happened to you. Um which I think was missing at the time. (Fiona)*

Several participants identified a response that seemed to put an onus back on the participant to manage the difficulties. For some this was couched in terms of participants “reflecting” on the situation.

*They just told me that I was lacking introspection. So there was absolutely no way I could defend myself, because any time I tried they just told me I was not reflecting enough. (Laura)*

*Um placement and the Trust came back with saying well, Fiona needs to learn from this, and she needs, she needs her own reflection on how to handle things differently in the future. (Fiona)*

For Isabelle, the emphasis seemed to be on finding individual coping skills, rather than acknowledging the difficulties within the interpersonal interactions.

*There was nothing about it not being OK, what they were doing. It was, ‘How can you manage this?’ And there was talk about building my resilience or like finding tools to manage and cope and stuff like that. (Isabelle)*

For Sara, the power within the bullying relationship was not acknowledged, and she appears to feel pressured to understand the difficulties from the perspective of the perpetrator.

*I almost felt they were trying to be therapeutic about it and see it as an expression of anger and they tried to encourage me perhaps too much to*

*empathise with why this person might be feeling angry and ignored, I think, not the power dynamic and the kind of abusive nature of that relationship.*

*(Sara)*

In each of these four examples, the language participants used to describe the responses of those in power seems associated with psychological discourses, “reflecting”, “resilience”, “therapeutic” and “empathetic”. Yet despite these ‘psychological’ responses, there was a sense that the difficulties participants were raising were not acknowledged or responded to, and instead there seemed to be an individualising focus on the participant.

Some participants situated the lack of meaningful response within a wider framework of power; that those whom they had sought support from were themselves influenced by power within the system. Laura and Michael located the lack of clinical placements as reducing the power of university staff to respond to difficulties with placement staff.

*I sort of thought about it and they take on quite a lot of trainees and they struggle for placements as it is, so in some way this placement also has the university over a barrel. (Laura)*

*With clinical placement supervisors they want to keep them on side because they need to make sure they get enough for all the students and I don't think they hold them to account really. (Michael)*

Keith questioned whether those in a position of power, such as managers, might not themselves receive enough support within the system, affecting their capacity to respond.

*I don't know if organisationally there is not that culture of self-care to support managers who are told about these things and to show them that they have got the capacity and time and all of that support to deal with it. (Keith)*

When participants felt that their difficulties were not acknowledged by those to whom they had reported it, participants identified changes to their relationship with those people and organisations. Laura and Joy highlight that the perceived lack of response from their course meant that they became less invested in their training, although Joy's relationship with an individual tempered this wider attitude.

*So after that it was a pretty sterile relationship with the university, you know it became a box ticking exercise the rest of training after that. It was jump through the hoops, tick the boxes, get out and then at some point I'll be able to learn what I need to learn later. (Laura)*

*And so, I guess you kind of lose interest in the course as well. So, it affects you then throughout the remainder of your training. On the other hand, you know, because of my MPR tutor who's incredibly helpful and that helped to balance it out a bit. (Joy)*

As well as disengaging from the organisation, the sense that those in a position of power were ignoring the difficulties meant that some participants felt that they would disengage from the process of raising difficulties in the future and ignore bullying behaviours.

*I am not as motivated probably to raise it in the future either with a manager or the person themselves. I would probably be much more likely to just ignore it. Which is a shame because that person could be doing it to other people as well. (Keith)*

#### **4.5 Finding Safety and Support**

This theme encapsulates the way in which participants reported finding safety and support that mitigated some of the threat responses associated with the bullying. These included finding support through later work experiences, and support within and outside of work contexts.

##### **4.5.1 Later work being reparative**

Participants referred to later jobs or placements after the bullying being reparative through restoring participant's sense of self and belief in their work practice that had been threatened through bullying.

In this extract, Beth outlines how she no longer experienced a sense of threat in a subsequent job. She contrasts how the relationships in her new work means she is no longer fearful of criticism or having to hide mistakes.

*And I felt I could make a mistake and it would be ok. The first question with them was always what has happened? Let us think about this, ok we can sort this out. It was always we, it was not like you have done something wrong, you have made a mistake. I was safe, I felt very safe. (Beth)*

Another way in which participants identified that later work could prove to be reparative was through providing alternative perspectives to those elicited by the bullying. Participants described this as helping them to develop more positive self-perceptions and to understand the bullying experience as not indicative of their self-worth at work.

*These people were telling me, actually, the opposite to what this woman had said. And they did help me to actually change some of those thoughts that were there... it doesn't you know, affect on my self-esteem or how I think about myself as a psychologist. (Joy)*

*My new placement they seem really pleased, lovely relationships and everything is going fine and the more that is going on the more I take that as confirmation you know that was a one-off incident, this is not a representation of who you are and what you elicit in others. (Gabby)*

*Having had good experience since and before, I think even though I was wondering whether this was going to be an issue again, you know I think I've been able to make sense of it as a blip...so it feels less personal in that way, it did a lot of healing. (Laura)*

Whilst not all participants pointed to later reparative work, for those who did these experiences seemed to provide a sense of safety that contrasted to the threat responses highlighted in the sub-theme, 4.2.1 'Activating threat responses'. Beth's sense of feeling "safe" is related to no longer being hypervigilant to criticism and not having to hide difficulties in her work. Similarly Joy, Laura and Gabby's more positive sense of self at work are shaped by affirmations in later jobs; this seems to be the inverse of the 'internalisation' of self-critical messages from bullying behaviours in the 4.2.2.3 'Becoming self-critical' sub-theme.

#### **4.5.2 Support within the system**

Although many participants referred to being disappointed by the reactions when they reported the bullying experiences, as seen in the 4.4.3 'Feeling let down by responses', some participants recounted accessing support within the system. Moreover, even amongst those who felt discouraged by the response to reporting bullying, some participants described finding elements of support either within reporting structures or other work relationships.

Gabby gave an example of her university supporting her in response to workplace bullying.

*They were really proactive and very genuine and very warm and empathetic, and they offered me solutions and options made me feel whatever decision I would make involving reporting it or escalating it I would be safe. My placement and passing my placement would not be affected by, my*

*reputation on the course would not be affected by it. So that made it a lot easier to have the conversation. (Gabby)*

The aspects that Gabby identifies as supporting her conversation in reporting difficulties seems to be the antithesis of what participants highlighted in 'Challenges to speaking up' (sub-theme 4.4.1). Gabby highlights the "solutions and options" that were offered that provide knowledge of the possible processes, as well as the autonomy associated with making her "decision", which contrast with the lack of knowledge of the decision making process in 'Challenges to speaking up'. Participants' worries about reputation and consequences on training in 'Challenges to speaking up' seem to be alleviated in the assurances that Gabby receives here. Rather than feeling reporting of bullying was ignored, as participants in 4.4.2 'Feeling let down by responses', Gabby emphasises the "proactive" and "empathetic" response.

Some participants presented a more mixed response, and suggested that support could vary within the same system. Fiona points to the change in attitude from her course when the behaviours reached a certain threshold.

*But then the course instantly accepted that um it's not acceptable to be sworn at and shouted at on placement, and I think once I said that I didn't feel safe returning to supervision, I think at that point I did say I felt bullied, um and that's I think the time they changed. (Fiona)*

Others spoke about other course staff later providing the support that they felt was lacking previously.

*If I was to say I'm not allowed to sit in an office or I'd cried every supervision or my supervisor has said this to me or did this, he [course tutor] would not allow me to stay in it even if I wanted to. He is very clear about stuff like that and speaks about it being very traumatic and not OK. (Isabelle)*

*She said, "You know, I know we've let you down before and I don't want you to feel let down again" and I just thought- in fact, that made me cry because I just thought that is so validating for you to recognise that actually yeah, the university did completely let me down and you're really working hard to make sure that I feel supported now. (Holly)*

When participants felt that there were individuals within the system that provided support, this could positively affect their relationship with the wider organisation, contrasting with the negative perspectives of the system in 'Feeling let down by responses' (sub-theme 4.4.2).

*I think I guess it also gave me a bit more faith in the institution that there were some people who were working to change the culture in parts of it. (Sara)*

However, some participants felt that those who provided support within the system were not those who possessed the power to significantly change the situation.

*The personal professional development tutor was very supportive, he was, offered supportive words but it had no impact on what was actually happening on the placement. (Michael)*

*My mid-placement review tutor, was actually incredibly helpful, but less kind of [pause] yeah, less able to I guess do anything to change, you know, to help me in the situation. (Joy)*

Participants also described seeking support from others at work, such as colleagues or a supervisor, who provided practical advice and supported participants in reporting the bullying, as well as helping participants identify their experiences as bullying as highlighted in 4.3.2 'Naming the bullying'.

*I don't know what I would have done without other colleagues, it would have been so much harder to unpick. Practical advice from other people saying look keep a record of everything, write everything down because if it goes to a HR thing you need to prove that. (Ellie)*

*I am really grateful to the psychologist who did stand up for me and I don't think it finally made any difference other than make her life more difficult but it meant a lot for me that she put her neck on the line for me when she didn't need to. (Danielle)*

For Holly, this support took the form of using psychological formulation with a supervisor to better understand the dynamics of a work relationship where she was experiencing negative behaviours.

*Once I understand something I can deal with it much better. But it's when I don't really get it or don't understand it or can't make sense of it, and so we did a CAT [Cognitive Analytic Therapy] map. Which was really useful, it was really useful. And it showed me how like I was feeding into it almost. (Holly)*

#### **4.5.3 Finding outside support**

Many participants highlighted support from those unconnected to their work, such as family, friends and through therapy. Laura identified that difficulties speaking up and finding support within the system meant that speaking with those outside provided another space to do so.

*I couldn't talk about it at placement, I couldn't talk about it with the university, so I had to talk about it somewhere else, and that was thankfully my friends and family who were very, very supportive. (Laura)*

Participants also referred to choosing who to speak to within their support networks, and sometimes only being able to share with certain people.

*It felt too difficult to maintain close social relationships and perhaps to be as vulnerable and broken as I was feeling I didn't feel able to do that with people other than my husband. (Danielle)*

However, participants perceived the consequences of seeking support outside the system meant that emotions related to workplace bullying could also impact others at home, and were not contained within the working environment.

*Our partners were very frustrated as well. I was going home and he would get the brunt of my frustrations ... they felt the power she had over us at work was happening in our own lives. (Beth)*

*I realised that I couldn't really share it with her [partner] because it was too much off-loading on her...and it was having an impact on her if I was sharing too much of it (Michael)*

Participants also reported utilising therapy and counselling in order to process the threat responses that were identified in the 'Activating threat response' sub-theme (4.4.2), such as hypervigilance and self-criticism, as well as to situate the bullying experience in the past as in 'Making sense for future practice' (4.3.3).

*I have actually done some trauma re-living work on those memories, which was very effective, and I no longer get the flashbacks. (Danielle)*

*Why did I stay in that situation, why did I allow myself to be bullied, that's not OK in my head...And just being quite hard on myself I think, and I'm aware I've thought about that quite a lot in therapy. (Isabelle)*

*My counsellor was saying was well through your really hard experiences of life there's a real opportunity to learn from those experiences. And that's been my experience too. Um it was a useful process, I feel more distance from it now.*

*(Michael)*

## Chapter 5: Discussion

### 5.1 Revisiting the Research Question

The research aimed to understand trainee clinical psychologists' perspectives on their experiences of workplace bullying in pre-qualified psychology roles, during and prior to training. The analysis generated four core themes summarising participants' perspectives. The first theme, "Activating Threat Responses", highlighted participants' descriptions of threat responses to workplace bullying. These responses included hypervigilance at work, which could manifest physically and through interactions with others, and lead to overworking. Participants related how they would hide their experiences from others, suppress feelings and use avoidance strategies to mitigate threat. They also demonstrated how experiences of workplace bullying could lead to participants developing or accentuating a self-critical attitude. These threat responses, whilst initially activated by the workplace bullying could be reactivated in later work contexts, as well as in the process of recounting their experiences in the research interview.

The second theme, "Making Sense of Bullying", captured the way participants described a subtle and gradual build-up of bullying behaviours that created difficulty in identifying experiences as bullying, which was sometimes reflected in their narratives in the research interview. Other reported challenges to identifying bullying included a lack of agreed definition of workplace bullying, and the connotations of bullying that participants' felt placed them in a victim position. Participants identified a number of processes that led them to name their experiences as bullying, including prior experiences of workplace bullying, a particular more threatening event, finding examples of workplace bullying definitions, and in relation with others both within and

outside the workplace. Identifying the experience as workplace bullying could lead to a change in attitude to the profession of clinical psychology that participants said was more “realistic” or cynical. Participants demonstrated how this could shape their understanding of their practice as psychologists through clarifying their own values, and influencing how participants engaged with clients and others in positions of less power.

The third theme, “Difficulties Navigating Power within the System”, highlighted the perception that participants were in a vulnerable and powerless position in relation to the perpetrator of bullying, both within the workplace system and in relation to some participants’ personal circumstances. This exacerbated the challenges of speaking up about bullying with participants citing a lack of understanding the reporting process and system, as well as the fear of the consequences of reporting workplace bullying on their reputation and career. When participants did report their experiences, many said that they felt that those in a position of power did not acknowledge or respond to the reports of bullying, or responded in a way that placed responsibility on the participant to manage the difficulties. Participants identified that these responses to reporting could also negatively influence participants’ relationships with the people and institutions they had sought support from.

The final theme, “Finding Safety and Support”, encapsulated participants’ description of finding support within and outside of work contexts. Participants gave examples of support that they found within the system, including from those in power with whom they had reported their experiences, as well as others within the workplace, such as colleagues. Later “safer” work experiences could also challenge the bullying experiences that participants had previously encountered by providing

an alternative narrative of their sense of self at work. Participants highlighted the support of friends and family, although bullying could also negatively impact on these personal relationships, as well as help offered through personal therapy.

## **5.2 Links with Existing Research**

### **5.2.1 Theme 1: Activating threat responses**

Studies within the NHS have highlighted impacts of workplace bullying that appear to reflect threat responses to their experiences, such as the higher levels of job induced stress, clinical levels of anxiety and depression, and greater psychological distress amongst those who report being bullied at work (Quine, 1999; Quine, 2001; Carter, 2013). Qualitative studies of UK healthcare professionals and trainees provide a context to these threat responses. Like the participants in this study, research on surgical and physiotherapy trainees and nurses highlights hypervigilance and self-criticism as a response to workplace bullying. Kamali & Illing's (2018) study of negative trainer feedback to surgical trainees, including some of which was considered bullying, demonstrate the consequent reduced confidence that can jeopardise workplace performance, "you then are second guessing yourself, you're slower, you're, you know you are more shaky you've not, you just don't perform to the same kind of standard" (Kamali & Illing, 2018; p. 6). Whiteside's (2014) thematic analysis of physiotherapy trainees' interviews found that participants frequently internalised negative comments, were hypervigilant about their work performance, and questioned their ability and future in the profession. Similarly, Allan's (2009) study of nurses found participants questioned their competencies and value at work. Research of workplace bullying beyond healthcare staff experiences also reflects some of the findings of the current research. Lewis's (2006) grounded

theory research on workplace bullying of UK public sector workers found that participants hid their difficulties at work in order to avoid appearing incompetent. Similarly, participants strove to maintain their standards at work in order to preserve their own sense of self-worth.

Whilst workplace bullying activating threat responses is found in the wider literature, fewer studies highlight how this threat response may be re-activated beyond the immediate workplace bullying context. Hallberg and Strandmark's (2006) grounded theory study of Swedish public sector workers is an exception. It conceptualises bullying in terms of trauma with a core category of "remaining marked for life", where participants refer to the triggering of memories and physical symptoms beyond the experience of the bullying. Indeed some studies have demonstrated that exposure to workplace bullying is associated with symptoms of PTSD, although the lack of longitudinal studies means it is not possible to determine causal associations (Nielsen, Tangen, Idsoe, Matthiesen & Magerøy, 2015). The current study offers another understanding of reactivation of threat responses to demonstrate the emotional threat associated with retelling the experience within the research interview itself. As well as the reactivation of threat, the current study reveals participants' differing expectations of threat reactivation prior to participating in the research, as well as how participants describe managing the emotional aspect of participating and discussing their experiences.

### **5.2.2 Theme 2: Making sense of bullying**

As in this study, participants in other research on workplace bullying have used definitions of the phenomenon to make sense of their own experiences (Lewis, 2006), as well as in relationship with others in and outside the workplace (Lewis &

Orford, 2005; van Heugten, 2012). Like the student nurses in Randle's (2003) and Hoel et al.'s (2007) research, and the public sector workers in Lewis's (2006) study, experiences of workplace bullying in this study were also reported as challenging participants' understanding of their profession as caring and compassionate. Yet this changing perspective towards the profession after workplace bullying is not reflected in all research of healthcare professionals. Kamali and Illing (2018) highlight a 'surgical culture' which is associated with undermining and bullying behaviours, although trainee participants acknowledge that they would like to change that culture when they become trainers. Seabrook's (2004) ethnographic study of medical training highlights intimidation of medical students as an accepted part of professional socialisation into the medical hierarchy, which may relate to the historically male dominated and continuing autonomy of the profession. Thus, whilst workplace bullying seems to challenge perceptions of participants' professions particularly in healthcare and the public sector, there may be some exceptions to these expectations of professional culture, notably in medicine.

Challenges to understanding experiences as workplace bullying are also reflected in the wider literature. The connotations of the term, 'bullying', have presented barriers to labelling experiences in this way in other professional contexts, including its associations with victimhood (Salin, 2001), and the school playground (Liefoghe & MacKenzie-Davey, 2003). The often subtle and gradual process of negative behaviours is identified as a challenge in recognizing workplace bullying in the existing literature (Lewis, 2006; Saunders et al., 2007; Samnani, 2013). Dzurec and Bromley (2012) highlight the challenges in providing cogent explanations of the effects of workplace bullying to others, particularly when it is subtle. In the current research, this difficulty in making sense of workplace bullying is highlighted in the

participants' research interviews. Participants referred to difficulties in presenting a coherent or "neatly packaged" account of their experiences, which seemed to reflect the subtle and gradual build up of behaviours. For some participants, the questioning of their experience as bullying was revisited whilst speaking about workplace bullying in the research interview, demonstrating how making sense of bullying can be a continual and dynamic process both during the experience and in the retelling. Some participants also referred to using the definitions provided by the research invitation to understand their experience as bullying. Thus, the current study builds on previous research that highlights how individuals understand their experiences as bullying to show how the process of participating in research on workplace bullying can also contribute to an individual's sense-making.

### **5.2.3 Theme 3: Difficulties navigating power within the system**

Like the participants in this study, the relative powerlessness of targets of bullying is identified as a challenge to raising concerns about their treatment, particularly amongst trainee healthcare professionals. Qualitative studies of bullying of trainee healthcare professionals have highlighted a reluctance to speak about experiences of bullying or intimidating behaviour, particularly to those in a position of power. These include studies of trainee physiotherapists (Whiteside et al., 2014), medical students (Seabrook, 2004), surgical trainees (Kamali & Illing, 2018) and nursing students (Courtney-Pratt, Pich, Levett-Jones, & Moxey, 2018). Difficulties in reporting bullying behaviours mirror some of those raised in this study, including fears on the impact on clinical assessment and relationship with supervisor (Kamali & Illing, 2018; Seabrook, 2004; Whiteside et al., 2014), worry about professional reputation and impact on later career (Courtney-Pratt et al., 2018; Kamali & Illing,

2018; Seabrook, 2004) and lack of understanding of the processes after reporting (Courtney-Pratt et al., 2018; Seabrook, 2004; Whiteside et al., 2014). Whilst the relative powerlessness of trainee healthcare professionals seems to contribute to difficulties in reporting bullying behaviours, similar themes have been found amongst studies of wider healthcare staff. Carter et al.'s (2013) mixed method study of NHS staff found that most did not report bullying, and barriers to reporting included uncertainty about how the organisation would implement policies, fear of adverse outcomes on work and professional reputation, and lack of action from management. What the current research adds to these studies is how difficulties in navigating power can be further exacerbated when individuals feel they are in a vulnerable position not only in relation to power hierarchies but due to personal characteristics, such as mental and physical health.

As in this study, even when bullying is reported, the response can be disappointing according to participants. Shabazz et al.'s (2016) study of bullying of medical consultants found that whilst almost half had reported their experiences to their healthcare Trust, only 4% felt that the response resolved difficulties, and many reported feeling that the onus was placed on those raising concerns to accept behaviour that should be considered unacceptable. This individualising focus on the target of bullying when reporting bullying mirrors perceptions of participants in this study, who also highlighted how language associated with psychology was used in this way. The current study also contributes insights into how responses from those in a position of power then impacts on those who report bullying, which is generally not considered in the wider literature on workplace bullying in healthcare. This study highlights how these responses to reporting bullying can affect trainees' motivation

and investment in training, as well as reduce their propensity to raise workplace issues in the future.

#### **5.2.4 Theme 4: Finding Safety and Support**

The workplace bullying literature has generally focussed on the lack of support that targets experience, reflecting the difficulties in navigating power found in Theme 3. Few studies of healthcare professionals' experiences of workplace bullying explore how participants seek or receive support, although there are some exceptions. In Quine's (1999; 2001) studies of staff at an NHS community trust, workplace support moderated some of the damaging effects of bullying. Courtney-Pratt et al. (2018) found that whilst student nurses were reluctant to report experiences of bullying to university or workplace staff, they did utilise alternative sources of support including other student nurses, friends, family and counselling services. Allan's (2009) case study research on overseas nurses highlighted how previous positive work experiences could mitigate the effects of workplace bullying, in contrast to this study where later work experiences were highlighted as reparative. Beyond the healthcare professional literature, van Heugten's (2012) study of social workers found that support from family, friends, colleagues and medical practitioners could enhance resilience by helping participants to name and externalise bullying, reducing participants' personal sense of failure. Lewis and Orford's (2005) grounded theory research on public sector workers provides a more nuanced view of finding support. Like van Heugten (2012), support from others, primarily outside the workplace, enabled participants to externalise difficulties and resist self-blame. However, as in this study, the stress of workplace bullying could risk negatively

impacting on personal relationships, which Lewis and Orford call the 'ripple effect', particularly as bullying continued over time.

Previous research also supports findings in this study that later work experiences could counteract the negative effects of workplace bullying by restoring participants' confidence in their competence at work (Shaw, 2014; van Heugten, 2012). The current study develops this understanding by offering an insight into the processes in which later work experiences can prove to be reparative, namely by offering a sense of safety that contrasts to the previous threat associated with bullying, and by providing affirmation of participants' competence that challenges the self-criticism activated by bullying.

### **5.3 Links to Theory**

As well as models that have been used in previous workplace bullying research such as social learning and ecological systems theories, this research includes models from clinical psychology such as Compassion Focussed theory (CFT) and the Power Threat Meaning framework (PTM) that can contribute to understandings of workplace bullying. The clinical psychology background of the researcher and primary supervisor has contributed to the use of these theories in understanding the current research. CFT was chosen as a potential theory following a previous study on organisational threat in the NHS as part of the literature review outlined in the Introduction (Henshall et al., 2018). Following the write-up of the results and thematic analysis map, the researcher and primary supervisor identified connections between the PTM framework and the current study in supervision, which were further explored with reference to Johnstone et al. (2018) in the Discussion.

### **5.3.1 Social Learning and Ecological Systems theory**

Social learning theory posits that people learn through observing others' behaviour, attitudes, and outcomes of those behaviours (Bandura, 1977). In this study, participants' understanding of workplace bullying was shaped by the attitudes and behaviour of others they described in response to the bullying or hearing about the bullying. Bronfenbrenner's (1979) ecological systems model can extend this understanding to demonstrate how attitudes at different levels of the workplace impacted on how participants expressed their understanding of and responses to workplace bullying. Colleagues and peers' understanding of the negative behaviours as bullying at the 'mesosystem' was identified by some participants as giving them confidence to raise issues at the organisational or 'exosystem' level. Participants highlighted how responses at the 'exosystem' could also affect how participants felt at the 'microlevel' from feeling powerless and frustrated to safe and supported. Some participants also understood negative behaviours of bullying at the 'microlevel' as shaped by pressures at the 'exosystem' or organisational level. In addition to these models used in previous workplace bullying research, other models from clinical psychology provide an insight into themes in this study, particularly related to threat and safety (CFT) and the interaction of threat and power (PTM).

### **5.3.1 Compassion Focussed theory**

As outlined in the Introduction chapter, Gilbert's (2009) compassion-focussed therapy (CFT) model could be used to understand responses to workplace bullying. The three systems model of emotional regulation in CFT may provide a theoretical understanding to the results of the current study, particularly through considering the "threat" and "soothing" systems. The threat emotion regulation system provides

abilities to detect and respond to threat (LeDoux, 1998), and workplace bullying has the potential to over-activate the threat system (Henshall et al., 2018). The responses identified in the current study such as hypervigilance and self-criticism are common responses to threat (Beck, Emery & Greenberg, 2005; Gilbert & Proctor, 2006). Rather than the sense of safeness associated with the “soothing” system, the “threat” system engenders safety seeking behaviours (Gilbert, 2005), which can be seen in the way participants described “hiding” their experiences of bullying as a protective strategy. Self-criticism can also be seen as a safety seeking process, particularly in the context of social power. Whilst it may be difficult to challenge a powerful other, attention may instead be directed to the self, and lead to submissive responses including self-blame, hiding and appeasing (Gilbert & Irons, 2005). This may explain the responses to bullying identified by participants where they felt in a position of less power and vulnerability. Perfectionistic striving can also be a response to threat from others (Gilbert & Irons, 2005), which was demonstrated in the way participants described overworking and overpreparing to avoid further negative behaviours. Yet these responses also contain risks to trainees’ well-being found in other research; Richardson, Trusty and George (2018) found that doctoral trainees in psychology who reported higher levels of self-critical perfectionism also reported higher levels of depression and burnout.

The CFT model incorporates understanding of “new brain” functioning that allows humans to reflect on the “old brain” (three emotion regulation systems), and is associated with thinking, imagination, learning and language (Gilbert, 2009). The “new brain” can maintain the threat system when there is no longer a threat, seen in the way the threat system was reactivated for participants when they were no longer

experiencing bullying in new work situations and when recounting their bullying experiences.

As well as the “threat” system, the three systems model includes the “soothing” or “affiliative” system characterised by feelings of contentment and peacefulness when we are neither threatened nor striving to achieve, and gives us feelings of well-being associated with connectedness to others (Gilbert, 2009). Participants described experiences within the theme “finding safety and support” that relate to this “affiliative” system. Participants referred to the positive regard by others in new work environments and the support found from others when reporting workplace bullying eliciting a sense of safeness. This sense of safeness allowed participants to maintain a more compassionate sense of self, which contrasted to the self-criticism associated with bullying. These findings support Henshall et al.’s (2018) study of NHS healthcare professionals, which used the CFT model as a theoretical basis for the research, and found a positive correlation between perceived organisational compassion and self-compassion.

Whilst the CFT model provides a useful theoretical basis to understanding the findings of this study, particularly in relation to the “activating the threat system” and “finding safety and support” themes, it provides less of an understanding of the themes that related to navigating power within the system and making sense of bullying experiences. Whilst an understanding of power is used to understand threat responses in CFT, other theoretical models may contribute to a more contextualised and thorough understanding of how power operates in workplace bullying.

### 5.3.2 The Power Threat Meaning Framework

In addition to the Social Learning, Ecological Systems and Compassion Focussed theories highlighted in the introduction, an additional theory the Power Threat Meaning Framework (PTM) is included in the Discussion as this theory provides an understanding of how participants described the influence of power in understanding bullying. The PTM by Johnstone et al. (2018) highlights the impact of wider types of power on understanding distress. The PTM focuses on four main areas: the relationship between misuses of power, the threats these pose to human needs, the meaning made from these misuses of power and threats, and the subsequent threat responses (Johnstone et al., 2018). Johnstone et al. (2018) highlight types of power that seem particularly pertinent in this study of workplace bullying, including “coercive power” where threats are used to ensure compliance and “interpersonal power” encompassing power used through relationships to undermine others. These negative uses of power can pose threats to core human needs, described as “core threats” (Johnstone et al., 2018). Participants identified a number of threats as responses to misuses of power in workplace bullying, which correlate with Johnstone et al.’s (2018) “core threats”. These included emotional threats of feeling emotionally overwhelmed and unsafe, social threats of unfairness, exclusion and loss of work role, and relational threats to boundaries, self-concept and also invalidation.

The PTM also attends to the role of meaning in shaping experiences of power, threat and threat responses. Johnstone et al. (2018) argue that meaning is constituted socially, relationally and personally through beliefs, emotions and bodily reactions. In this study, participants’ understandings of threat through workplace bullying was inextricably linked to power through their understanding of themselves

being in a relatively powerless position, seen in the sub-theme 4.4.1 “Being in a vulnerable position”. The competition related to accessing training, the lack of control associated with the work, and the reliance on certain people in a position of power to progress contributed to the meanings that participants made of the bullying experiences. Johnstone et al.’s (2018) examples of meanings that may be made after experiencing misuses of power and core threats, include feeling unsafe, helpless, trapped, controlled, and a sense of unfairness, all of which resonate with the sense-making of participants in this study.

Johnstone et al. (2018) contend that faced with threat and the negative impact of power, humans respond with a variety of threat responses depending on their access to power resources and cultural meanings. In considering threat responses for intervention purposes, the authors of the PTM note that threat responses may be adaptive in the current circumstance. Therefore, consideration must be given as to how far to direct attention to the responses and how far towards the circumstances in which these responses develop (Johnstone et al., 2018), thus also posing questions for interventions in workplace bullying. The examples of threat responses described in the PTM include those that overlap with sub-themes in the overall first theme of “activating threat responses” in this study including hypervigilance, seeking safety, avoiding threat triggers, as well as striving and perfectionism.

Johnstone et al.’s (2018) PTM provides a useful model of understanding the interaction between threat, power, meaning and how it impacts on emotional distress, which correlate with several themes in the current study. However, whilst the PTM acknowledges that power can operate positively, for example through access to resources, the focus is on misuses of power and the consequent threats. In this study, participants outlined some ways in which they were able to access

support within power structures, and also the processes in which reparative experiences provided an alternative to previous threat responses. Similarly, the examples of sense-making that Johnstone et al. (2018) identify as responses to power and threat are predominately negative. The current study provides a more nuanced understanding of sense-making as a response to misuses of power. As well as the negative meanings associated with workplace bullying, participants also referred to a more “realistic” understanding of their profession, the clarification of participants’ values and boundaries, and a greater empathy with those in positions of less power.

#### **5.4 Clinical Implications**

The current research points to a number of clinical interventions at different levels of practice; at the organisational level, within the profession of clinical psychology and at an individual level.

The project adds to the body of literature on bullying within the NHS and on trainee healthcare professionals, and supports focussing awareness of bullying in healthcare and ways of responding. Participants highlighted a lack of knowledge both of how to report bullying and also how others in a position of power would respond to the reporting of bullying. In order to develop system wide awareness in healthcare Trusts and organisations, this could include training on workplace bullying as part of staff inductions, as well as ensuring that the organisation’s formal and informal processes in response to bullying are accessible and well-publicised within the organisation.<sup>6</sup> As highlighted in the Introduction, healthcare professional bodies

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<sup>6</sup> An example is the bullying and harassment confidential helpline staffed by external impartial advisors offered by Hertfordshire Partnership University NHS Foundation Trust, which is introduced at staff induction and advertised within the Trust.

in the UK, such as the BMA, RCN and Chartered Society for Physiotherapy, have responded to workplace bullying research by highlighting the issue within their professions. Resources and campaigns, such as the #LetsRemoveIt workplace bullying campaign<sup>7</sup> and associated website with resources on the topic (The Royal College of Surgeons of Edinburgh, n.d.) have led to an anti-bullying alliance to share ideas and interventions across the NHS, supported by a range of healthcare bodies (An Alliance Against Bullying, Undermining and Harassment in the NHS, 2019). However, there is no equivalent response or involvement from a professional psychology body, such as the BPS.

This research project emphasises the importance of wider recognition of workplace bullying within clinical psychology. Resources on workplace bullying within clinical psychology should include definitions and examples of negative behaviours, which participants identified as useful to consider whether their experiences corresponded with bullying. This could include case examples or vignettes that are relevant to a clinical psychology context, as some participants highlighted issues that were more specific to clinical psychology. This included potential vulnerability associated with the reflective nature of supervision and training of clinical psychologists. It also would be important to recognise the power differential that is linked to workplace bullying of pre-qualified psychologists.

The research highlights the need for training within clinical psychology about workplace bullying. This includes training for groups of clinical psychologists, such as supervisors, course staff of clinical psychology training programmes and trainee psychologists. Training on bullying, harassment and negative behaviours in the

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<sup>7</sup> Other similar workplace bullying campaigns from healthcare professionals include #knockitout (anaesthetists), #hammeritout (orthopaedic surgeons) and #cutitout (surgery).

workplace could form part of wider programmes, such as supervision training and induction to the doctorate in clinical psychology for trainees and staff. In addition to definitions and examples, it would be useful to include the processes for reporting and responding to bullying and other negative behaviours. Reflecting the difficulties participants identified in speaking up, this should include both formal procedures and informal approaches that are available. As well as a presentation at the Group of Trainers in Clinical Psychology conference (Mason, 2019), other initiatives could include a workshop on good practice in responding to workplace bullying within clinical psychology, for example as a part of the BPS Continuing Professional Development programme.

In line with the connections between CFT theory and the results of the current research, which found that self-criticism is reported as a common response to workplace bullying, compassionate mind training could be offered to trainee clinical psychologists as recommended by Beaumont and Martin (2016) to support student therapist self-care and wellbeing by developing the “soothing” system. However, it would be important to also provide interventions at different levels, not only at the individual; otherwise this risks the problematic individualising response that some participants identified when reporting bullying. A compassionate environment is important to self-compassion (Henshall et al., 2018), and having a ‘relaxed’ and caring self may not always be adaptive in a hostile environment (Gilbert, 2005). Research on workplace bullying within the NHS has highlighted the importance of a multi-level approach to interventions (Illing et al., 2013), and indeed compassionate leadership at every level of the organisation has been identified as a key factor in stimulating innovation within the NHS (West, Eckert, Collins & Chowla, 2017).

## **5.5 Consideration of the quality of the study**

### **5.5.1 Strengths of the study**

One of the main strengths of the research was that it explored an area of study that had not previously been researched before, namely workplace bullying from the perspectives of trainee clinical psychologists. The research generated findings that challenge assumptions, such as the perspective that workplace bullying is not a significant issue within clinical psychology, which some participants referred to in their interviews. The findings lead to several implications to improve practice within clinical psychology as well as the wider healthcare system.

The rigour of the research process is another strength of the study with clear description of data collection and analysis, triangulation of analysis with other researchers, and the findings illustrated with numerous examples of data. Quality guidelines were used and presented in the research, including Yardley's (2008) criteria in the Methodology, and Mays and Pope (2000) in the systematic review and Appendix R. Furthermore, other researchers and 'experts by experience' were involved in design of the research project including at recruitment and interview.

The fourteen participants were recruited from several universities; half of universities that offer the DClinPsy in the UK shared the research project with their trainees, as well as the project recruiting through snowballing, with trainees represented from all years of training and first year post-qualification. Participants were generally representative of gender and ethnic demographics of the wider trainee clinical psychologist population.

Finally, the systematic review highlighted that existing research on workplace bullying within the UK healthcare system lacks researcher reflexivity. Reflexivity was central to this study with the researcher's personal and epistemological position in

relation to the research stated at the outset. A reflective diary and reflexive conversations with supervisors and within research study groups supported the researcher's understanding of their position to the research, and how this may interact with their own perceptions of the topic (Elliott, Fischer, & Rennie, 1999).

### **5.5.2 Limitations of the study**

Whilst participants were recruited from a range of universities, potential participants who may have experienced bullying in a pre-qualified psychologist role, but who had not trained in clinical psychology, were not included in the study. Whilst this allowed for a focus on the experiences of trainee clinical psychologists, the inclusion of participants who had not experienced DClinPsy training may have provided other perspectives on workplace bullying within clinical psychology, for example the potential impact of discouraging applications for clinical psychology training.

Furthermore, whilst the gender and ethnic demographics of participants were similar to the population of trainee clinical psychologists in terms of male: female ratio and non-White and White trainees, this also meant that the sample was predominantly White and female. Therefore, perspectives from participants with minority identities within clinical psychology may not have been as widely represented in the research. Furthermore, other demographic information such as sexual orientation, disability and socio-economic background were not requested, and therefore it is unclear how diverse the sample was in relation to these characteristics. However, some participants did refer in their interviews to characteristics that were not requested within the demographic information, such as

physical and mental health status, which were incorporated into the analysis of the data.

## **5.6 Suggestions for further research**

There are number of avenues for further research to develop the findings of the current project, particularly of investigating related populations and considering the use of different methodologies.

This is the first known study of workplace bullying from the perspective of pre-qualified clinical psychologists; future research could encompass workplace bullying of qualified clinical psychologists, which is also an area where there is no known research. Other related populations that have not been investigated within clinical psychology include witnesses of workplace bullying, which was highlighted as an important role by participants in this research as well as in studies of other professionals (Carter et al., 2013; D'Cruz & Noronha, 2011). Research on perpetrators of workplace bullying within clinical psychology could contribute to the small body of research from the perspectives of those accused of bullying (Jenkins, Zapf, Winefield & Sarris, 2012; Baillien, Griep, Vander Elst, & De Witte, 2019). Furthermore, the perspectives of those who have bullying reported to them within clinical psychology training or the workplace provides another area for research. Finally, research was primarily from a White female perspective, and studies have shown that minority groups within clinical psychology face particular challenges (Shah, Wood, Nolte & Goodbody, 2012; Wood & Patel, 2017). Future research could focus on workplace bullying of trainee and qualified clinical psychologists who identify with a minority identity within clinical psychology to further explore the context of workplace bullying and personal identity.

As well as researching related populations, other directions for future research include diversifying the methodologies used to understand other aspects of the phenomenon. Whilst the introduction highlighted some of the challenges of measuring workplace bullying, it would be useful to research the prevalence rate of workplace bullying within trainee and clinical psychology populations, as well as identifying specific behaviours that are most prevalent within these contexts to inform future interventions. Utilising both the self-labelling with definition method and a validated measure, such as the Negative Acts Questionnaire (NAQ-R), is recommended to reflect best practice in bullying research (Nielsen et al., 2010).

The current project was a cross-sectional study of workplace bullying. Further studies could explore a longitudinal design, such as research on participants who have very recently experienced workplace bullying and then at a later time point to explore any changes and similarities in perspectives. The thematic analysis methodology of the current project generated several themes on workplace bullying; future research could develop this understanding further through using grounded theory methodology to generate theories from the data, particularly as there is a need for theoretical models in the field of workplace bullying research (Nielsen & Einarsen, 2018). Finally, a participatory action research design, such as Thomson et al.'s (2017) focus groups of physiotherapy students who reported being bullied, would present a way of developing strategies and interventions to respond to bullying within clinical psychology.

## **5.7 Final self-reflections and conclusion**

As I come to the end of completing this thesis, I am aware of the challenges, sacrifices and privileges associated with training as a clinical psychologist. This

mixture of challenge and privilege has also resonated with the experience of undertaking the research. Within the demands of clinical training, embarking on this project as an “insider” researcher with a personal connection to the topic and to hear the stories of those who have faced difficulties within the profession was both a challenge and a privilege. I am aware that undertaking this research has highlighted the values I wish to strive for as a clinical psychologist working in the NHS where workplace bullying exists. Although the topic of workplace bullying may not be obviously linked with the concept of compassion, I have found evidence through undertaking this research that compassionate attitudes and practices at an individual, team and organisational level appear to be key to responding to and preventing workplace bullying within clinical psychology and healthcare. Despite being a core value of the NHS constitution, unfortunately there are circumstances such as workplace bullying where these values are not being upheld. I am encouraged by the growth in awareness, research and responses to workplace bullying amongst healthcare professionals and hope that this project will contribute to a similar understanding within the profession of clinical psychology. Undertaking this thesis has also highlighted the value of research itself as way to reflect on the nature of workplace bullying through self-reflection, in dialogue with participants, with supervisors and with others interested in the project. As I saw through some of the participants whose own understanding of their experiences was partly shaped through involvement in the research project, research can provide examples, language and narratives for our experiences and potentially connect with those of others.



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## Appendices

### Appendix A: Systematic Literature Review Search Process

#### Part One

Searches were undertaken between December 2018 and February 2019 using Scopus, PubMed and CINAHL Plus databases. A number of search terms were trialled to identify which terms generate the most comprehensive searches and included using search terms from previous research in workplace bullying (e.g. Illing et al., 2013). A record of the search terms used are shown in table A1 below; the four search areas were combined for each database. Searches were then limited to UK studies. Email alerts were set up to ensure more recent publications from these search terms were included.

*Table A1: Search strategy with search terms used for literature review*

Search 1 Bullying	bullying OR bully OR bullied OR harassment OR intimid* OR “negative acts” OR “negative behaviour” OR “abusive supervision”
Search 2 Workplace	Work OR Workplace OR Worker OR Working OR Workers OR Organisation OR Organisations OR Organisational OR Occupation OR Occupations OR Occupational OR Employment OR Employed OR Employee OR employees OR Staff OR Professional OR professionals OR trainee OR trainees
Search 3 Healthcare	NHS OR “National Health Service” or “healthcare” OR “mental health” OR (Medic*) OR doctor OR “general practitioner” OR (Nurs*) OR (Physio*) OR (Therap*) OR (Psych*) OR (midw*) OR counsel* OR “allied health” OR dental OR dentist* OR pharmac*

Search 4	AND NOT school
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## Part Two

The search outcomes were combined, and inclusion and exclusion criteria were chosen to focus the scope of the literature review on the topics of interest (Table A2).

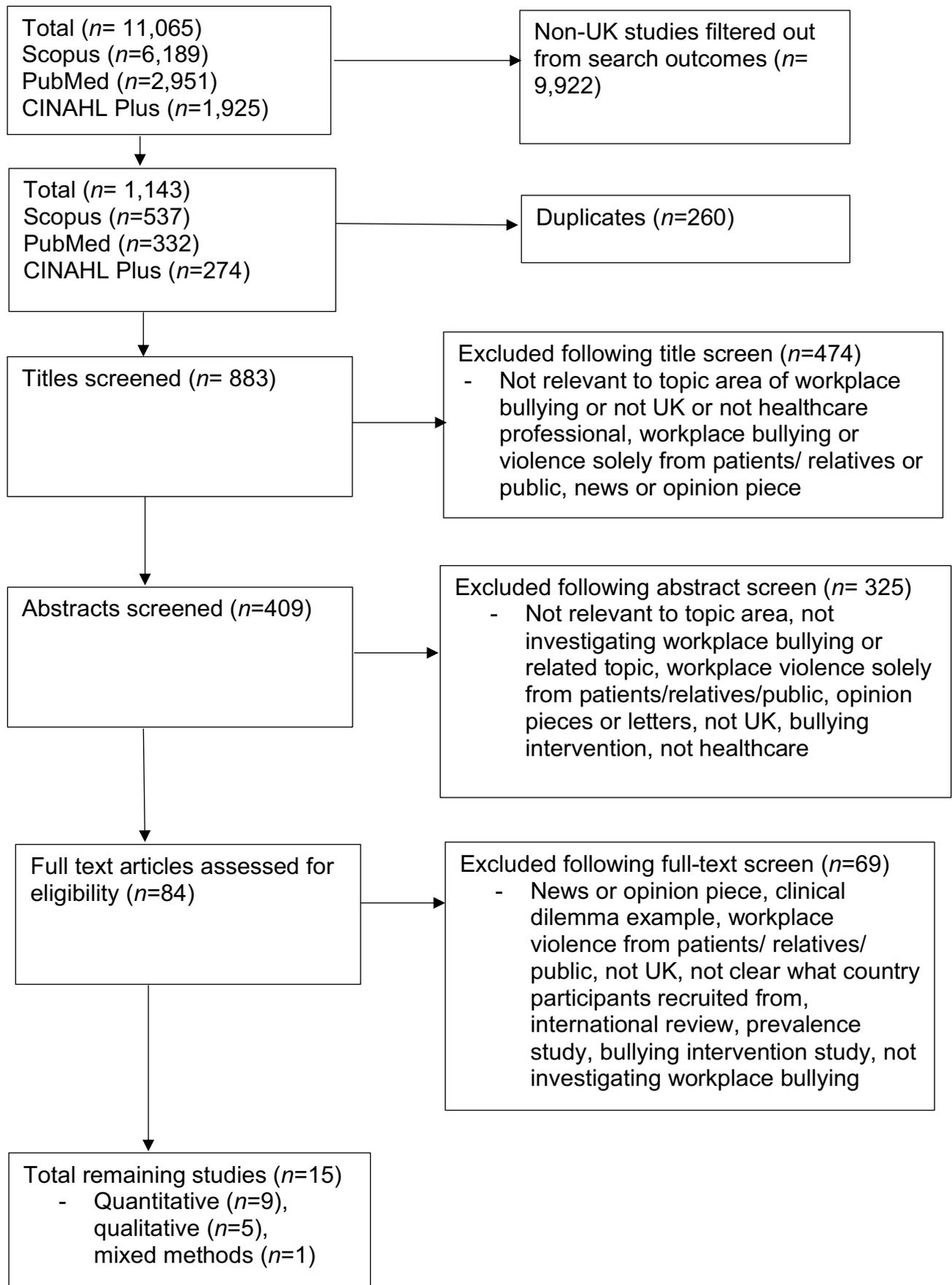
*Table A2: Inclusion and exclusion criteria for Systematic Literature Review*

<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
Research investigating healthcare staff experiences of workplace bullying and/or impact of workplace bullying on healthcare staff.	Study of bullying prevalence or types of bullying behaviour prevalence (without further investigation of experience or impact of bullying).
Peer reviewed.	Research on workplace bullying solely from patients/relatives/public.
UK only.	Research solely on intervention for prevention and management of workplace bullying or harassment.
Available in English.	Reflective or opinion pieces on workplace bullying.
Date range between 1970 to 2019.	

## Part Three

Titles were screened for papers that were relevant to the topic, and then abstracts of the remaining papers. Finally, full copies of research were retrieved and assessed for eligibility. Inclusion and exclusion criteria were used at each step. Figure A identifies this process of article selection and exclusion.

Figure A: Flow Diagram of Systematic Review Process



**Appendix B: Systematic Literature Review Study Evaluation for Quantitative studies based on National Institutes of Health Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (2017)<sup>8</sup>**

Y = Yes N = No ? = Other (CD-cannot determine, NR – not reported, NA – not applicable)	Farley, S., Coyne, I., Sprigg, C., Axtell, C., & Subramanian, G. (2015). Exploring the impact of workplace cyberbullying on trainee doctors.	Gillen, P., Sinclair, M., Kernoban, W. G., & Begley, C. (2009). Student midwives' experience of bullying.	Paice, E., & Smith, D. (2009). Bullying of trainee doctors is a patient safety issue. <i>The Clinical Teacher</i> , 6(1), 13-17.	Quine, L. (1999). Workplace bullying in NHS community trust: Staff questionnaire survey.	Quine, L. (2001). Workplace bullying in nurses.
1. Was the research question or objective in this paper clearly stated?	Yes	Yes	Yes	Yes	Yes
2. Was the study population clearly specified and defined?	Yes	Yes, demographics included	Yes	Yes	Yes
3. Was the participation rate of eligible persons at least 50%?	No (7.9%)	No (41%)	Yes (66%)	Yes (70%)	NR – 70% response rate from all participants but does not specify % for nurses, which this study focused on
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study	Yes	Yes (distributed at student midwives conference in 2005, n=400). Demographics included (age, gender, ethnicity, marital status, type of training, and academic achievement).	Yes	Yes	Yes

<sup>8</sup> National Institutes of Health. (2017). Quality assessment tool for observational cohort and cross-sectional studies. *National Heart, Lung, and Blood Institute*. Available from: [www.nhlbi.nih.gov/health-pro/guidelines/indevelop/cardiovascular-risk-reduction/tools/cohort](http://www.nhlbi.nih.gov/health-pro/guidelines/indevelop/cardiovascular-risk-reduction/tools/cohort)

prespecified and applied uniformly to all participants?					
5. Was a sample size justification, power description, or variance and effect estimates provided?	No	No	No	No	No
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	No	No	No	No	No
7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	No	No	No	No	No
8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?	Yes, exposure and outcomes measured as continuous variable.	No	No (yes/no question to 'Have you been subjected to persistent behaviour in this post that has undermined your professional confidence and/ or self-esteem?')	No	No
9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently	Yes (Used validated and reliable Cyber Negative Acts Questionnaire; CNAQ).	Bullying measures used both self-labelling with definition and types of behaviour - clearly defined and implemented consistently. Bullying	Implemented consistently and clearly defined question but not clear if valid or reliable (question based on BMA definition of bullying).	No Clearly defined and implemented consistently, but a new measure of workplace	No Although reliability of measures satisfactory.

across all study participants?		behaviour measure had good reliability, and was piloted and reviewed.		bullying that had not been validated.	
10. Was the exposure(s) assessed more than once over time?	No	No	No	No	No
11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?	Clearly defined and implemented consistently.  Some of the measures are validated with reliability score.	No – unclear how measured.	Implemented consistently and clearly defined questions but not clear if valid or reliable.	NR if measures were validated.  Clearly defined with satisfactory reliability, and consistently implemented.	NR if measures were validated.  Clearly defined with satisfactory reliability, and consistently implemented.
12. Were the outcome assessors blinded to the exposure status of participants?	Yes	Yes	Yes	Yes	Yes
13. Was loss to follow-up after baseline 20% or less?	NA	NA	NA	NA	NA
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	Yes, controlled for general job stress, age and gender.	No	Yes, controlled for speciality group and grade group.	No	No

**Appendix B: Systematic Literature Review Study Evaluation for Quantitative studies (continued)<sup>9</sup>**

<b>Y = Yes</b> <b>N = No</b> <b>? = Other (CD-cannot determine, NR – not reported, NA – not applicable)</b>	Shabazz, T., Parry-Smith, W., Oates, S., Henderson, S., & Mountfield, J. (2016). Consultants as victims of bullying and undermining.	Stubbs, B., & Soundy, A. (2013). Physiotherapy students' experiences of bullying on clinical internships: an exploratory study.	Wood, S., Niven, K., & Braeken, J. (2016). Managerial abuse and the process of absence among mental health staff.	Woodrow, C., & Guest, D. E. (2012). Public violence, staff harassment and the wellbeing of nursing staff: An analysis of national survey data.
1. Was the research question or objective in this paper clearly stated?	Yes	Yes	Yes	Yes
2. Was the study population clearly specified and defined?	Yes	Yes	Yes	Yes
3. Was the participation rate of eligible persons at least 50%?	No (28%)	Yes (72%)	Yes (63.7%)	Yes (52% for acute trusts, 49% for ambulance trusts, 54% for mental health and learning disability trusts, and 58% for primary care trusts for 2006 data set; overall response rate of 55% for 2009 data set).
4. Were all the subjects selected or recruited from the same or similar populations (including the same time period)? Were inclusion and exclusion criteria for being in the study prespecified	Yes	Yes	Yes	Yes

<sup>9</sup> National Institutes of Health. (2017). Quality assessment tool for observational cohort and cross-sectional studies. *National Heart, Lung, and Blood Institute*. Available from: [www.nhlbi.nih.gov/health-pro/guidelines/indevelop/cardiovascular-risk-reduction/tools/cohort](http://www.nhlbi.nih.gov/health-pro/guidelines/indevelop/cardiovascular-risk-reduction/tools/cohort).

and applied uniformly to all participants?				
5. Was a sample size justification, power description, or variance and effect estimates provided?	No	No	NA	No
6. For the analyses in this paper, were the exposure(s) of interest measured prior to the outcome(s) being measured?	No	No	No	No
7. Was the timeframe sufficient so that one could reasonably expect to see an association between exposure and outcome if it existed?	No	No	No	No
8. For exposures that can vary in amount or level, did the study examine different levels of the exposure as related to the outcome (e.g., categories of exposure, or exposure measured as continuous variable)?	No	No	No	No
9. Were the exposure measures (independent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?	Clearly defined, and implemented consistently, but not validated measure and reliability unclear. (Self-labelling using list of bullying behaviours)	Clearly defined and implemented consistently. Unclear if valid or reliable measure.	No - The bullying measure was based on asking: 'Do you believe that you have experienced any bullying from a manager at work in the past 12 months?' The response categories were yes (=1) and no (=0).	No - the staff harassment item asked whether respondents had experienced any bullying, harassment or abuse from colleagues or managers in the previous 12 months.
10. Was the exposure(s) assessed more than once over time?	No	No	No	No

11. Were the outcome measures (dependent variables) clearly defined, valid, reliable, and implemented consistently across all study participants?	Implemented consistently and defined, but no validated or reliable measure.	Unclear how measured.	NC if measures were valid and reliable.	No
12. Were the outcome assessors blinded to the exposure status of participants?	Yes	Yes	Yes	Yes
13. Was loss to follow-up after baseline 20% or less?	NA	NA	NA	NA
14. Were key potential confounding variables measured and adjusted statistically for their impact on the relationship between exposure(s) and outcome(s)?	No	No	Yes – total hours worked per week, job demands, job control and job support.	No

**Appendix C: Systematic Literature Review Study Evaluation for Qualitative studies based on Mays and Pope criteria (2000)**

	<b>Worth/ relevance?</b>	<b>Clarity of research question?</b>	<b>Appropriateness of design?</b>	<b>Context adequately described?</b>	<b>Sampling?</b>	<b>Data collection and analysis?</b>	<b>Reflexivity?</b>
Allan, H. T., Cowie, H. & Smith, P.(2009). Overseas nurses' experiences of discrimination: a case of racist bullying?	Yes. Contributed usefully to the concept of racist bullying, and experiences of bullying from the perspective of overseas trained nurses in the UK.	Yes. Exploring the concept of racist bullying through examples of discriminatory practices in the workplace.	Yes. The qualitative method was appropriate to the question.	Yes. Context of data collection described in detail.	Three interviews selected purposively from a national study of overseas nurses because they illustrate in detail racist bullying practices as well, as a range of emotional reactions and coping strategies. Demographically representative of the wider study.	Yes systematic and detailed description of data collection analytic process.	No. Consideration of how findings relate to researchers' influence not included in the study write up.
Hoel, H., Giga, S. I., & Davidson, M. J. (2007). Expectations and realities of student nurses' experiences of negative behaviour and bullying in	Yes. Contributed to knowledge of bullying in nursing education, developing previous research.	Yes. Clarity of the three research questions.	Yes. Qualitative and focus group study appropriate to research questions.	Brief description of context.	Good number of participants in focus groups (n=48). However convenience sampling without any information on demographics of participants.	Very brief description of data collection and analysis. No information on how content analysis was undertaken.	No consideration of reflexivity in study write up.

clinical placement and the influences of socialization processes.							
Randle, J. (2003). Bullying in the nursing profession.	Yes, adds to knowledge of bullying research by suggesting that nursing students who are bullied may engage in behaviours that can detrimentally affect patients.	Yes. Explore in detail the theme of bullying from qualitative, longitudinal data of a larger study.	Yes. The qualitative method was appropriate to the question. Also longitudinal design allowed exploration of changes over training.	Yes. Context of study adequately described.	Convenience sampling used. Good sample size of 56 students from larger study, although unclear how many of these included themes of bullying in this study. Demographics of age, gender and branch of nursing included. Two cohorts of students included from all four branches of one UK nursing programme.	Adequate, but not detailed, description of data collection and analysis. Included credibility checks through the use of two independent coders arriving at consensus via discussion and analysis. Did not include disconfirming cases.	No. Identified that author was known to participants as lecturer on program of study but no reflection of impact of this on participants or researcher.
White, S. J. (2013). Student nurses harassing academics.	Yes, only UK study found that explored academic nurses' perspectives on bullying from student nurses	Yes, to examine bullying and harassment of university nursing faculty by nursing students.	Yes, qualitative, semi-structured interview design appropriate to exploratory study.	Yes. Context adequately described.	Self-selected samples responded to research adverts to universities. Demographics of participants included age range, gender, job role, range of years in present	Adequate description of data collection. Description of identification of themes, but not detailed description of narrative analysis method.	No consideration of reflexivity or author's position in relation to participants in research write up.

					institution, range of nursing student numbers.		
Whiteside, D., Stubbs, B., & Soundy, A. (2014). Physiotherapy students' experiences of bullying on clinical internships: A qualitative study.	Yes, first qualitative study on physiotherapy students' experiences of workplace bullying.	Yes, to investigate experiences of workplace bullying of physiotherapy students.	Yes, qualitative, semi-structured interview design appropriate to exploratory study.	Yes. Context of adequately described of university, course and representation of final year students.	Purposive sampling with clear selection criteria.	Yes, included interview questions within online appendix of article. Detailed description of analysis and included use of two coders. Included initial and final codes and themes audit trail in online appendix. Did not search for disconfirming cases.	Identified that primary author was a university student at time of data collection. No consideration of position of researcher impacting research in article.

## Appendix D: Systematic Literature Review Study Evaluation for Mixed Method studies based on Mixed Methods Appraisal Tool (MMAT; Pluye et al., 2011)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?	X			
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).	X			
<i>Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?	X			
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?	X			
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?	X			
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?		X		
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcomes data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?	X			
	4.2. Is the sample representative of the population under study?	X			
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?	X			
	4.4. Is there an acceptable response rate (60% or above)?		X		46%
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?	X			
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?	X			
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?		X		
<i>Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.</i>					

## Appendix E: Summary and Evaluation of Studies in the Systematic Literature Review

Author/s, Year & Title	Participants	Aims & Methodology	Summary of Key Relevant Findings for Systematic Review	Strengths and Limitations
<p>Allan, H. T., Cowie, H., &amp; Smith, P. A. M. (2009). Overseas nurses' experiences of discrimination: a case of racist bullying?. <i>Journal of nursing management</i>, 17(7), 898-906.</p>	<p>Three nurses from overseas in the UK</p>	<p>Three case studies of discrimination to illustrate how racist bullying as discriminatory practices operates in the workplace.</p> <p>Qualitative</p> <p>The three interviews were selected purposively from a national study of 93 overseas nurses because they present strong examples of the phenomenon of workplace bullying. The data on which this paper draws were collected through semi-structured, audio-recorded interviews and thematically re-analysed using NVIVO V2.</p>	<p>The findings suggest that racism can be understood by the concept of racist bullying through participants experiences of bullying that was influenced by racism. There are four key findings which illustrate racist bullying in the workplace: abusive power relationships, communication difficulties, emotional reactions to racist bullying and responses to bullying.</p>	<p>One of the few studies that considers how racism interacts with bullying behaviours.</p> <p>Detailed description of the analysis of the original results, and re-analysis of three case studies.</p> <p>Small number of participants chosen to illustrate bullying from the larger study of overseas nurses.</p> <p>Reflexivity of the account e.g. positioning of researchers and influence on findings not included in the study.</p>
<p>Carter, M., Thompson, N., Crampton, P., Morrow, G., Burford, B., Gray, C., &amp; Illing, J. (2013).</p> <p>Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to</p>	<p>2950 NHS staff, of whom 43 took part in a telephone interview from 7 NHS trusts in the North East of England.</p> <p>A range of occupational groups were represented and the largest groups were medical and dental staff, registered</p>	<p>To examine the (prevalence and) impact of bullying behaviours between staff in the NHS workplace, and to explore the barriers to reporting bullying.</p> <p>Mixed methods.</p> <p>Impact of bullying was measured using indicators of psychological distress (General Health Questionnaire, GHQ-12), and 33 item</p>	<p>Bullying and witnessing bullying were associated with lower levels of psychological health and job satisfaction, and higher levels of intention to leave work. Managers were the most common source of bullying. Main barriers to reporting bullying were the perception that nothing would change, not wanting to be seen as a trouble-maker, the seniority of the bully and uncertainty over how policies would be</p>	<p>One of the few mixed methods studies of workplace bullying in the NHS with large number of participants.</p> <p>Qualitative data extended findings of quantitative data.</p> <p>Cross-sectional so cannot assume causality of workplace bullying on outcomes.</p>

reporting. <i>BMJ open</i> , 3(6)	nurses, and the wider healthcare team (including admin, central/corporate services, maintenance and facilities).	questionnaire to examine intentions to leave work, job satisfaction and self-reported sickness absence, barriers to reporting bullying and sources of bullying.  Semi-structured telephone interviews were conducted to investigate experiences of bullying in greater depth. The transcripts analysed at a semantic level in accordance with inductive thematic analysis.	implemented and bullying cases managed.  Data from qualitative interviews supported these findings and identified workload pressures and organisational culture as factors contributing to workplace bullying.	Overall estimated response rate below 50% (46%).
Farley, S., Coyne, I., Sprigg, C., Axtell, C., & Subramanian, G. (2015). Exploring the impact of workplace cyberbullying on trainee doctors. <i>Medical Education</i> , 49(4), 436–443.	158 trainee doctors at over 6 months into training.	To examine the impact of cyberbullying among trainee doctors, and how attributions of blame for cyberbullying influence individual and work-related outcomes.  Quantitative questionnaire survey.	Cyberbullying adversely impacted on job satisfaction and mental strain, although attributions of blame for the cyberbullying influenced its impact and the path of mediation.  Negative emotion mediated the relationship between self-blame for a cyberbullying act and mental strain, whereas interactional injustice mediated the association between blaming the perpetrator and job dissatisfaction.	Focuses investigation on an area of workplace bullying where there is little previous research – cyberbullying, using a validated and reliable measure the Cyber Negative Acts Questionnaire (CNAQ).  Controlled for variables including general job stress, age and gender.  Cross-sectional design prohibits investigation of causal processes between study variables.  Low response rate (7.9%).
Gillen, P., Sinclair, M., Kernohan, G. W., & Begley, C. (2009). Student midwives'	164 student midwives at a student midwifery conference.	To examine the nature of bullying as experienced by a cohort of student midwives in the UK.	Experiences of bullying were reported as resulting in lost confidence, <u>self-esteem</u> and sleep, anxiety, consideration about leaving	Study uses both a self-labelling with definition measure of bullying as well as types of behaviour,

<p>experience of bullying. <i>Evidence-Based Midwifery</i>, 7(2), 46-54.</p>		<p>Quantitative questionnaire survey.</p>	<p>the course, needing to take time off and generally feeling unwell.</p> <p>Many of the students spoke with other student midwives about their experience and family and friends. Some spoke with their mentor or a supervisor of midwives. A quarter had spoken to the bully about their behaviour.</p>	<p>clearly defined. However, unclear how effects of bullying were measured in study.</p> <p>National spread of participants, but only those who attended conference.</p> <p>Small sample size, and participation rate below 50%.</p> <p>Cross-sectional design prohibits investigation of causal processes between study variables.</p> <p>No confounding or mediating factors investigated.</p>
<p>Hoel, H., Giga, S. I., &amp; Davidson, M. J. (2007). Expectations and realities of student nurses' experiences of negative behaviour and bullying in clinical placement and the influences of socialization processes. <i>Health Services Management Research</i>, 20(4), 270-278.</p>	<p>A total of 48 nursing students took part in 10 focus groups, each consisting of 3-6 people. In addition to this, one-to-one interviews were conducted with two people. Recruited from two universities in NW England and an advertisement in a UK nurses' magazine.</p>	<p>To explore nursing students' experiences and perceptions of negative behaviour and bullying in clinical placement measured against expectations at the start of their education.</p> <p>(Q1) To what extent does student nurses' experience in clinical placement correspond with their expectations?  (Q2) What are nursing students' experiences and perceptions of abusive behaviour and 'bullying' in clinical placement?  (Q3) How do student nurses make sense of and deal with their negative experiences and</p>	<p>Many students felt exploited, ignored or were made to feel unwelcome, although few reported personal experience of bullying. These frequent but less severe negative experiences appear to play a key role in institutionalizing an unwelcoming culture within which bullying could easily be triggered or take hold. Students' coping mechanisms may also contribute to reproducing such negative behaviour.</p>	<p>Developed previous research in workplace bullying of UK nursing students e.g. Randle (2003).</p> <p>Clarity of research questions, and large sample of participants for qualitative study.</p> <p>No information on how content analysis was undertaken, demographics of nursing students, or consideration of reflexivity.</p>

		<p>what impact does this have on their professional socialization?</p> <p>Content analysis of focus groups.</p>		
<p>Paice, E., &amp; Smith, D. (2009). Bullying of trainee doctors is a patient safety issue. <i>The Clinical Teacher</i>, 6(1), 13-17.</p>	<p>National survey of UK trainee doctors N= 33,329</p>	<p>To determine prevalence of bullying across all grades and specialities of doctors in training, and in all settings in which the training occurred. Also to explore which trainees most affected, source of this behaviour, and impact this behaviour had on educational experience, clinical practice and intention to leave medicine.</p>	<p>Trainees who reported bullying were more likely to report poor clinical supervision and a higher workload, sleep deprivation, and thought about leaving medicine more frequently.</p> <p>Trainees who reported being bullied were more likely to report having made one or more serious, or potentially serious, medical errors in the last month.</p>	<p>Large sample size in study, and good response rate (66%).</p> <p>Highlights associations between bullying and a number of negative outcomes.</p> <p>Associations rather than causality in cross-sectional study.</p> <p>Bullying measured on one yes/no question (based on a definition of bullying).</p>
<p>Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. <i>BMJ</i>, 318 (7178), 228-232.</p>	<p>Employees of NHS community trust in the south east of England. N=1100 (including administrative and unqualified).</p>	<p>To determine the prevalence of workplace bullying in an NHS community trust; to examine the association between bullying and occupational health outcomes; and to investigate the relation between support at work and bullying.</p> <p>Quantitative questionnaire survey.</p> <p>Measures included a 20 item inventory of bullying behaviours designed for the study, the job induced stress scale, the</p>	<p>Staff who had been bullied had significantly lower levels of job satisfaction, and higher levels of job induced stress, depression, anxiety, and intention to leave the job. Support at work seemed to protect people from some of the damaging effects of bullying.</p> <p>Two thirds of the victims of bullying had tried to take action when the bullying occurred, but most were dissatisfied with the outcome.</p>	<p>One of the first studies to examine prevalence and impact of bullying in the NHS.</p> <p>High response rate of 70%.</p> <p>Cross-sectional so cannot assume causality of workplace bullying on outcomes.</p> <p>Unclear whether the measures have been validated e.g. measure of workplace bullying designed</p>

		hospital anxiety and depression scale, the overall job satisfaction scale, the support at work scale, and the propensity to leave scale.		for study and outcome measures.
Quine, L. (2001). Workplace bullying in nurses. <i>Journal of Health psychology</i> , 6(1), 73-84.	As study above, but focusing analysis on nurse responses. N=396	As above focusing on nurse responses.	Forty-four percent of nurses reported experiencing one or more types of bullying in the previous 12 months, compared to 35 percent of other staff. Fifty percent of nurses had witnessed the bullying of others. Nurses who had been bullied reported significantly lower levels of job satisfaction and significantly higher levels of anxiety, depression and propensity to leave. They were also more critical of aspects of the organizational climate of the trust. Support at work was able to protect nurses from some of the damaging effects of bullying.	One of the first studies to examine prevalence and impact of bullying on nurses in the NHS.  Scales were constructed of all the main measures and their reliability was investigated using Cronbach's alpha. Satisfactory alphas were found for all scales.  Cross-sectional so cannot assume causality of workplace bullying on outcomes.  Unclear whether the measures have been validated e.g. measure of workplace bullying designed for study and outcome measures.
Randle, J. (2003). Bullying in the nursing profession. <i>Journal of advanced nursing</i> , 43(4), 395-401.	Cohort of preregistration nursing students in England.  At the beginning of the course 56 students participated in	The aim of this paper is to discuss one major theme, bullying, emerging from qualitative data in a larger grounded theory study of self esteem.	Bullying was found to be commonplace in the transition to becoming a nurse. Students were bullied and also witnessed patients being bullied by qualified nurses. The internalisation of nursing norms	Data was longitudinal so included change over duration of training.  Contributed to understanding of how bullying may affect patients

	interviews, and 39 participated at the end. The reduced numbers were a consequence of theoretical sampling.	Students participated in unstructured qualitative interviews at the beginning and end of their 3-year preregistration course and a grounded theory approach was used for data collection and analysis.	meant that students then bullied others, including patients. Students' self-esteem was low.	within socialisation of nursing students.  Unclear whether all participants perceived the behaviours as bullying.  Unclear how many students from the larger sample identified bullying within their data.  Identified researcher's position as lecturer on the course, but not how this may have impacted on study.
Shabazz, T., Parry-Smith, W., Oates, S., Henderson, S., & Mountfield, J. (2016). Consultants as victims of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences. <i>BMJ open</i> , 6(6),	664 Obstetrics and Gynaecology consultant members/fellows of the Royal College of Obstetricians and Gynaecologists (RCOG) working in the UK.	To explore incidents of bullying and undermining among obstetrics and gynaecology (O&G) consultants in the UK,  Questionnaire survey  Primarily a prevalence survey of behaviours, perpetrators, duration and frequency. Also question on outcome of reported cases with direct quote examples.  Free text section on impact of bullying categorised 236 comments into four categories, namely major, moderate, minor and coping.	The reported impact on professional and personal life spans a wide spectrum from suicidal ideation, depression and sleep disturbance, and a loss of confidence. Over half reported problems that could compromise patient care. When victims were asked if the problem was being addressed, 73% of those that responded stated that it was not.	First college-level investigation into bullying and undermining at level of senior physicians. Previous studies of consultants as perpetrators of bullying; no previous study of UK consultants as targets.  Bullying measured on one yes/no question (based on a definition of bullying). Included definition of bullying in self-labelling yes/no question on bullying.  Low level response rate (28%). Cross-sectional questionnaire.
Stubbs, B., & Soundy, A. (2013). <i>Physiotherapy</i>	Fifty-two final-year undergraduate physiotherapy	To consider the prevalence and type of bullying behaviours experienced whilst on clinical	Twenty-five percent of students reported at least one incident of	First study of workplace bullying of physiotherapy

<p>students' experiences of bullying on clinical internships: An exploratory study. <i>Physiotherapy</i>, 99(2), 178-180.</p>	<p>students at one university.</p>	<p>placement in a cohort of final-year BSc undergraduate students.</p> <p>Cross-sectional survey. Primarily prevalence.</p>	<p>bullying behaviour. The perpetrator of the bullying behaviour was most often the clinical educator (8/13, 62%). Despite the negative effects caused, the majority of students (11/13, 84%) did not report this experience to the university.</p> <p>Six students (6/13, 46%) suggested that their experience of bullying resulted in negative psychological consequences. These consequences were mainly associated with anxiety (3/6, 50%), loss of confidence (2/6, 33%) and stress (1/6, 17%). Somatic experiences were reported less frequently; one student identified a negative impact on their irritable bowel syndrome.</p>	<p>students on clinical placement.</p> <p>Small sample from one university.</p> <p>Cross-sectional design.</p>
<p>White, S. J. (2013). Student nurses harassing academics. <i>Nurse Education Today</i>, 33(1), 41–45.</p>	<p>12 faculty staff working in schools of nursing undergraduate education in Health and Social Care in Post-1992 Universities in England.</p>	<p>To explore academic staff experiences of harassment by undergraduate nursing students.</p> <p>Qualitative.</p> <p>Narrative analysis of individual semi-structured interviews.</p>	<p>Three main themes identified in the study: verbal and task attack, personal attack, and communication devices used to harass. Findings showed that faculty perceived that harassment occurred when student stress levels were high, which was associated with course and social demands, the changing nature of society, and the social political agenda of education.</p>	<p>First study on UK academic nursing staff experiences of workplace bullying.</p> <p>Explored themes of power in bullying that are not usually considered in relation to bullying of staff from students.</p> <p>Did not clarify how narrative analysis was used.</p> <p>No consideration of reflexivity in write up.</p>

<p>Whiteside, D., Stubbs, B., &amp; Soundy, A. (2014).</p> <p>Physiotherapy students' experiences of bullying on clinical internships: a qualitative study. <i>Physiotherapy</i>, 100(1), 41-46.</p>	<p>8 undergraduate physiotherapy students who had experienced one incident of bullying on a clinical internship from a university in the Midlands region of the UK.</p>	<p>To consider the experiences of final-year physiotherapy students who have experienced workplace bullying on a clinical internship.</p> <p>Qualitative.</p> <p>Thematic analysis of individual semi-structured interviews.</p>	<p>Bullying had a range of adverse effects on the students, with many expressing self-doubt in their competence and viewing their supervisor as unapproachable and unsupportive. In addition, students did not feel able to report the experience and use the support mechanisms in place. This seems to have been a result of having concerns that the problem would escalate if they reported the experience and, as a consequence, have a negative effect on their grade.</p>	<p>First qualitative study of physiotherapy students' experiences of bullying.</p> <p>Detailed description of analysis with full audit trail of codes and themes within appendix.</p> <p>No consideration of reflexivity in write up.</p>
<p>Wood, S., Niven, K., &amp; Braeken, J. (2016).</p> <p>Managerial abuse and the process of absence among mental health staff. <i>Work, employment and society</i>, 30(5), 783-801.</p>	<p>Data from a sample of 1472 mental health workers within 19 mental health trusts.</p>	<p>Questionnaire survey. Quantitative.</p> <p>Measures used: Managerial abuse: bullying and discrimination from managers – separately measured. Psychological strain. Organizational justice. Absenteeism.</p>	<p>Managerial abuse is found to be associated with the occurrence of absence through both perceptions of organizational justice and psychological strain. Distributive justice and depression are especially significant in explaining the relationship between abuse and absence. Once absent, duration of absence is not further affected by managerial abuse but is still linked to depression and distributive justice, whereas frequency of absence is linked to bullying and depression.</p>	<p>Single item self-report measure of bullying.</p> <p>Cross-sectional design prohibits investigation of causal processes between study variables.</p> <p>Only focussed on managerial bullying, rather than other forms of bullying.</p> <p>Self-reported sickness absence (although strong correlation between self-reported and objectively recorded absence previously found).</p>
<p>Woodrow, C., &amp; Guest, D. E. (2012).</p>	<p>The final data-sets consisted of responses from 48,365 NHS nurses in 2006 and</p>	<p>The study compared the consequences of public violence and staff harassment for</p>	<p>While both types of aggression were related to decreased levels of staff wellbeing, staff harassment</p>	<p>The study used a very large data set of NHS nurses.</p>

<p>Public violence, staff harassment and the wellbeing of nursing staff: An analysis of national survey data. <i>Health Services Management Research</i>, 25(1), 24–30.</p>	<p>55,381 nurses in 2009 from the National Survey of NHS staff.</p>	<p>wellbeing in two large samples of English nurses.</p> <p>Questionnaire survey. Quantitative.</p> <p>Measures used: Public violence and staff harassment. Moderator variable: perceived supervisory support. Dependent variables were three indicators of staff wellbeing: serious stress, job satisfaction and intention to leave.</p>	<p>had a stronger negative association with wellbeing than public violence.</p> <p>The relationships between each of the types of aggression and some aspects of wellbeing were moderated by perceived supervisory support, such that the negative effects on wellbeing were greater for those with higher levels of support.</p>	<p>The analysis was based on cross sectional data and, as a result, the direction of causality remains unclear.</p> <p>Single item self-report measure of harassment/ bullying (with no definition included).</p> <p>Single item self-report measure of work-related stress.</p> <p>Datasets analysed did not contain other variables, such as the location of the participant.</p>
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## Appendix F: University of Hertfordshire Ethics Committee Approval Notification



HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

### ETHICS APPROVAL NOTIFICATION

**TO** Lan Rachel Brown  
**CC** Dr Barbara Mason  
**FROM** Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.  
**DATE** 19/02/2019

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Protocol number: **aLMS/PGR/UH/03440(2)**

Title of study: Experiences of Workplace Bullying among Trainee Clinical Psychologists: A Qualitative Study.

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

**Modification:** Detailed in EC2

This approval is valid:

From: 19/02/2019

To: 16/06/2019

**Additional workers:** Dr Madeline Carter, Northumbria University

**Please note:**

**If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page <http://www.studynet1.herts.ac.uk/ptl/common/ethics.nsf/Teaching+Documents?Openview&count=9999&restricttcategory=Application+Forms>**

**Any conditions relating to the original protocol approval remain and must be complied with.**

**Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.**

**Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1/EC1A or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study,**

## **Appendix G: Participant Information Sheet**

### **“Experiences of Workplace Bullying among Trainee Clinical Psychologists: A Qualitative Study”**

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

My name is Lan Rachel Brown ([Lb16acw@herts.ac.uk](mailto:Lb16acw@herts.ac.uk)) and I am a Trainee Clinical Psychologist at the University of Hertfordshire. I am conducting this research as part of my professional Doctorate in Clinical Psychology.

#### **What is the purpose of the study?**

The research aims to develop an understanding of trainee clinical psychologists' experiences of workplace bullying during training and during pre-qualified psychologist positions on their route to training.

Research has highlighted that workplace bullying is a significant issue in the NHS, and there have been studies on the experiences of workplace bullying within some areas of healthcare and training, including medicine, nursing and physiotherapy. Studies have suggested that healthcare trainees are particularly at a heightened risk of bullying. As yet there are no known studies exploring clinical psychologists' or trainee clinical psychologists' experiences of workplace bullying.

#### **What does the research involve?**

To participate, you would be asked to take part in one audio-recorded interview lasting approximately 1 hour by telephone.

The meeting will involve talking to the researcher about your experience/s of workplace bullying as a trainee clinical psychologist or during pre-qualified psychologist role/s prior to training.

If you consent, you may be contacted at a later date to ask if you wish to comment on our research findings. You can decline this offer without giving a reason.

#### **What are the possible benefits of taking part?**

The possible benefits of taking part in the research are an opportunity to have your experience heard and included in research, as well as to represent other people who may share similar experiences. It is hoped that the research will enable training providers and psychologists to develop a greater understanding of workplace bullying within the training of clinical psychologists. The aim of this is to influence future support available for trainees, and guidance for clinical psychologists and training courses.

#### **What are the possible disadvantages of taking part?**

It is fully acknowledged that talking about your experience may be a difficult process. You would not have to answer any questions you did not want to, can stop the interview at any time, and would be given information about sources of support after the interview.

### **Who can take part?**

The study is open to UK-based trainee clinical psychologists and recently qualified clinical psychologists (up to two years post qualification) who have experienced workplace bullying previously, either as a trainee clinical psychologist, or in a psychology-related role prior to training. Roles prior to training may include, for example, assistant psychologist, psychological wellbeing practitioner and research assistant roles. Bullying may have been from a manager, a supervisor, university course staff, multi-disciplinary staff colleagues and/or peers.

It is recognised that the term “workplace bullying” is broad, and research in the area suggests that it can sometimes be a subtle and complex process that is difficult for people to identify. In this study, we will use a definition based on that adopted in other research, “A person is bullied when they feel repeatedly subject to negative acts in the workplace, acts that the bullied person may find it difficult to defend themselves against.”

### **Are there any restrictions that may prevent me from participating?**

For this study, we will not be interviewing those who are currently experiencing workplace bullying. We are also not recruiting psychologists who have solely experienced bullying behaviours from service users or carers.

### **Do I have to take part in the study?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be asked to sign a form recording your consent. If at any stage before or during the interview, you decide you no longer wish to continue, you are free to withdraw. You can also request that your data is destroyed and not included in the research for up to two weeks after the interview. You do not have to give a reason for any of these decisions.

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

All information collected about you throughout the course of research will be kept strictly confidential. Your name and any identifying information will be kept securely and separately from your audio-recording and the subsequent data analysis. No names of individuals or actual organisations where the alleged bullying took place will be requested. Due to the time constraints on this project an approved transcription service may be used to transcribe your interview. The service will sign a non-disclosure, confidentiality agreement, and recordings will be encrypted.

The data collected will be stored electronically in a password-protected environment, and consent forms stored in a securely locked environment. Personal information, audio recordings and consent forms will be destroyed on completion of the study.

Interview transcripts will be fully anonymised. Any identifiable details regarding the participant or work situation, including course or region of the country, will be removed

before the transcript is seen by anyone else in the research team. Any verbatim extracts of interview transcripts in the research report or any publications will be fully anonymised, and carefully selected to ensure other people cannot identify you. Fully anonymised transcripts will be kept up to five years after completion of study to support any further analysis for publication/s.

**Are there any reasons where confidentiality may be breached?**

As all participants will be regulated by the Health & Care Professions Council and the British Psychological Society due to your professional status, the following code of conduct will be followed with regards to confidentiality:

1. If you disclose information which leads to sufficient concern about your safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent.
2. Prior to this occurrence the researcher's project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.

**Who has reviewed this study?**

This study has been reviewed and approved by the University of Hertfordshire (UH) Health, Science, Engineering & Technology Ethics Committee with Delegated Authority.

The UH protocol number is aLMS/PGR/UH/03440(2).

**What happens next?**

If you have any questions, please feel free to contact me to discuss these ([Lb16acw@herts.ac.uk](mailto:Lb16acw@herts.ac.uk)). If you would like to participate in the study, please contact me and we can arrange an interview. You will be asked to sign or record verbal agreement to a consent form prior to your participation. Please retain this invitation letter for reference.

**Thank you very much for taking the time to read this information.**

**Principal Investigator:**

Lan Rachel Brown ([Lb16acw@herts.ac.uk](mailto:Lb16acw@herts.ac.uk))

If you have any questions or concerns about how the study has been conducted, please contact:

**Principal Supervisor:**

Dr Barbara Mason ([b.l.mason@herts.ac.uk](mailto:b.l.mason@herts.ac.uk))

Consultant Clinical Psychologist & Senior Clinical Tutor

Doctorate in Clinical Psychology, University of Hertfordshire, College Lane, Hatfield,  
AL10 9AB

or

**University of Hertfordshire Secretary and Registrar:**

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts, AL10 9AB

# Appendix H: Transcription confidentiality/non-disclosure agreement with transcription service



Doctorate in Clinical Psychology  
University of Hertfordshire

### Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Lan Rachel Brown ('the discloser')

And

Transcription service ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient agrees to stop transcription immediately if they recognise any parties mentioned on the audio recording, and to return the recording to the discloser.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:.....

Name:... Daryl Leigh on behalf of dictate2us..

Date:..... 20/4/19.....



Major Research Proposal

Student No:

## Appendix I: Participant Consent Form

### Participant Consent Form

#### “Experiences of Workplace Bullying among Trainee Clinical Psychologists: A Qualitative Study”

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that I am free to decline entry into the study and I am able to leave the study without giving a reason before or during the interview. I can also have my data withdrawn from the study and destroyed for up to two weeks after the interview.
3. I consent to the audio recording of my interview.
4. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will be used.
5. I understand that if I disclose information which leads to sufficient concern about my safety or the safety of others it may be judged necessary to inform an appropriate third party without formal consent. Prior to this occurrence the researcher’s project supervisor will be contacted to discuss any possible concerns, unless the delay would involve a significant risk to life or health.
6. I agree that quotes from my interview may be used in research reports and publications, where all data used will be treated as anonymous and confidential.
7. I agree to be contacted for my comments on the findings of the study. I am aware I can decline my involvement with this.
8. I agree that involvement in the research project will not be used in any investigatory or legal process related to workplace bullying.
9. I agree to take part in the above study.

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

Name of participant.....

Signature of principal investigator.....Date.....

Name of principal investigator: Lan Rachel Brown, Trainee Clinical Psychologist

## Appendix J: Participant Debrief Sheet

### Debrief Sheet

Thank you for giving your time to take part in this research project.

If participation in this research has caused you any distress or discomfort, you may wish to contact immediate sources of support such as your family, friends, GP or a therapist. If you are a trainee clinical psychologist, your course tutor or personal advisor may be able to support you or help you access support, such as therapy.

#### Psychological therapies

To find your nearest local psychological therapies service, you can search on the NHS choices webpage:

[https://www.nhs.uk/Service-Search/Psychological-therapies-\(IAPT\)/LocationSearch/10008](https://www.nhs.uk/Service-Search/Psychological-therapies-(IAPT)/LocationSearch/10008)

#### NHS Choices

**If you're worried about an urgent medical concern, call 111 and speak to an adviser.**

Website: <https://www.nhs.uk/pages/home.aspx> Helpline: 0113 825 0000

**Samaritans** A 24 hour a day, free and confidential helpline for anyone experiencing any emotional distress.

Freephone: 08457 90 90 90 Website: [www.samaritans.org](http://www.samaritans.org)

Below are other sources of support in relation to workplace bullying:

**Acas** (Advisory, Conciliation and Arbitration Service) provides free and impartial information and advice to employers and employees on all aspects of workplace relations and employment law.

Acas have guidance regarding workplace bullying:

<http://www.acas.org.uk/index.aspx?articleid=1864>

They also provide a Helpline on 0300 123 1100 for free and impartial advice. The Acas helpline phone service is available Monday - Friday 8am-6pm.

**Citizens Advice** provide free, confidential and impartial advice, including on employment problems. To find details of your local Citizens Advice:

<https://www.citizensadvice.org.uk/about-us/how-we-provide-advice/advice/>

If you are a member of a workers union, you can contact them for advice in relation to work related issues. Examples of unions include **Unison** (<https://www.unison.org.uk>) and **Unite** (<http://www.unitetheunion.org>).

Thank you again for your participation and support.

## **Appendix K: Email contact to Programme Directors of Clinical Psychology courses**

Dear XXX,

My name is Lan Rachel Brown and I am a third year trainee clinical psychologist at the University of Hertfordshire. I'm emailing to ask if you would consider sharing the attached information regarding my doctoral research project with your current (and recently qualified) clinical psychology trainees.

The study involves completing a semi-structured interview and aims to develop an understanding of trainee clinical psychologists' experience of workplace bullying. The study is open to current trainees and recently qualified clinical psychologists (up to two years post qualification) who have experienced workplace bullying during training and/or in pre-qualified psychologist roles prior to training. The information sheet attached provides a definition of workplace bullying and examples of bullying behaviour.

Research has highlighted that workplace bullying is a significant issue in the NHS, and that healthcare trainees are particularly at a heightened risk of bullying. Whilst there have been studies within other areas of healthcare training, such as medicine, nursing and physiotherapy, there are no known studies of clinical psychology training. Research on workplace bullying suggests that it can be a subtle and complex process that is difficult to identify. It is hoped that this project will enable training providers and psychologists to better understand issues of workplace bullying, and inform both future guidance to courses and support available for trainees.

I would be grateful if you would consider circulating the attached information sheet to your current trainees, which includes further information on taking part.

Please do contact me at [Lb16acw@herts.ac.uk](mailto:Lb16acw@herts.ac.uk) if you have any questions or concerns.

Thank you very much for your time.

Kind regards,

Lan

Lan Rachel Brown  
Trainee Clinical Psychologist  
University of Hertfordshire

## Appendix L: Semi-structured Interview Questions

### Understanding the bullying experience and process

\*\*What led you to decide to take part in the research?

\*\*Without naming the specific service or organisation, could you tell me about the type of organisation you worked in? What was your experience of that organisation like in general?

\*\*Can you tell me about your experience of bullying in the workplace?  
- In what way...? What was that like? How did you feel about that?

\*\*When did you start to think of it as 'bullying'?  
- Were there any barriers to identifying the experience as bullying?

Were there any others who witnessed the (bullying) behaviour/interactions? How did they respond? How did that impact you?

### Reporting

\*\*Did you report your experiences formally?

If yes:

\*\*What helped you to report the bullying?

\*\*Were there any barriers to reporting?

Did you label your experience explicitly as 'bullying'? (Why?)

How did others respond to you reporting your experience of being bullied? How did that impact on you?

(If no:

\*\*Did you consider reporting it? Were there reasons why you didn't report it?)

\*\*How would others have ideally responded to your reporting of bullying?

### Impact

\*\*Can you tell me how the bullying impacted you at the time?

- Psychologically/emotionally  
-> thoughts about yourself, others, work
- Physically (e.g. sleep, appetite, sickness)
- Physiological e.g. at the time – stress response, concentration
- Relationships  
(at work and outside of work)

- Behaviourally (at work and outside of work)

\*\*Can you tell me how the experience of bullying has affected you as a person now?

- thoughts about yourself, others, work
- behaviourally e.g. at work
- relationships/interpersonal

What have you learned from this experience?

### **Reflections**

Do you have any suggestions as to how workplaces and training courses could improve how they manage workplace bullying?

\*\*Was there anything that was important for you that I did not cover today?

\*\*How has it felt talking about this today?

\*\* Key questions to ask – other questions asked if time available within interview. Prompt/follow-up questions below the questions may be used as appropriate.

### **Appendix M: Screening questions for participant eligibility prior to interview**

1. Without identifying any person or organisation, what was your role or roles where you experienced workplace bullying?
2. Without identifying the name of any person, what was the role/s of the person or people involved in the bullying?
3. Are you currently experiencing workplace bullying?

**Appendix N: Portions of coded transcripts (Example 1 and 2)**

- Removed from publicly available thesis to protect confidentiality of participants.

**Appendix O: Initial list of amalgamated codes on NVivo**

Feeling unsafe

Having a lack of opportunities to talk

Difficulty to stand up for myself

Living with regret

Trying to prevent it happening again in a safe way

Being in a position of little power

Other people's power influencing your outcomes

Putting on a compliant mask to get through the training

Worrying about negative consequences of not complying

Navigating a complicated system

Taking responsibility for what happened

Impacted by personal circumstances

Feeling unwell

Starting with a shock

Difficulty starting placement

Lack of understanding and clarity in the system

Feeling overwhelmed

Not receiving support

Adapting to a stressful situation

Not complaining

Feeling unsupported

Feeling hurt as already being compliant

Being submissive

Wanting opportunities as a trainee

Hopes for training

Missing out on learning opportunities

Feeling disappointed by the lack of learning opportunity

Lack of honesty

Lack of clarity

Speaking with someone in a similar position

Venting about the situation

Being criticised for work performance

Being lied to

Being accused of things I hadn't done

Being hurt by lies

Lack of transparency

Unjustified criticism

Escalating the consequences

Being lucky to get away unscathed

Others having a more difficult situation

Being unsupported by tutors

Being criticised unfairly

Being criticised for not reflecting

Feeling powerless to defend myself

Staying compliant

Having to self-criticise

Hating the placement experience

Feeling angry at lack of reflective capacity

Bullying not a unique situation

Position of the university in a lack of power

Lack of power and its consequences

Strategies to survive

University not a neutral support system in training

Lack of transparency on appraisal  
Bullying a new experience for me  
Usually relying on colleagues for support  
Not expecting ruptures on placement  
Feeling grateful that it's not worse  
Critical workplace culture  
Domino effect of criticism  
Acting in a submissive way  
Regrets of not supporting or protecting others  
Witnessing bullying of others  
Others might be submissive to get by  
Trying to protect myself  
Others being submissive  
Regretting not supporting bullied others  
Trying to survive / protect myself  
Feeling angry about being powerless  
The influence of the workplace culture  
Confusion over whether being bullied  
Not concrete, subtle build up makes it unclear  
Start to question yourself  
Demands of training  
Being believing you've done something very wrong  
Lack of confidential space to speak about what is happening  
Lack of safety in raising issues  
Turning a blind eye to concerns  
Staying quiet after a lack of support and compliant  
Lack of safety to raise concerns

Feeling guilty because others have suffered

Not believing I would be supported because of ignored before

Strategies to protect myself

Staying submissive

Staying submissive and putting on a false, positive front

Working harder in order to get through the placement

Not being transparent, being uninformed

Being in the outgroup

An experience that's not happened to me before

A learning experience for the future

Others outside the situation being shocked

Others being disappointed with the university

Advised by others to do what it takes to survive

Being protected in the ingroup

Feeling unable to be critical (whilst being criticised)

Trying to protect myself so not protecting others

Hoping other targets are unaware of the bullying

A strategy to survive

Feeling powerless in the team

Where the power lies in the system

Having a safe space

Falling into a grey area between different systems – affects support

Having an independent, neutral body

Having a neutral body that does not have a conflict of interests to support trainees

Not speaking is a way of surviving

Pretending that everything is fine

Speaking with others outside the situation

Blaming yourself for what's happened

Feeling powerless and attacked

Validated by others having a similar experience

Feeling angry and guilty that others have experienced bullying too, and also validated.

Seeing a pattern of bullying behaviour on a placement

Feeling ignored by the university

Feeling powerless to help others

Silence around the experience

Overwhelming, frightening emotions when hearing others have experienced bullying

Turning to friends and family for support

Looking for powerful allies

Others advising me to keep my head down to survive

Helpful to learn how to survive

Lack of support for physical impact

Lack of compassion from others

Pressured to put the needs of clients above myself

Living in a survival mode

Becoming robotic to survive

Numbing the emotional side to work

Appearing strong so as to not be criticised

Personal information used against me

Affecting learning opportunities on placement

Living in a survival mode

Becoming robotic to survive

Numbing the emotional side to work

Feeling angry at the university for not being supported

University knowing but doing anything

Feeling angry and accepting

Appreciating the support outside of work

Being closer to family and friends

Trying not to be in the outgroup as a survival strategy

Severing relationship with university

Not trusting university with personal information

Worrying about consequences of telling university from past experience

Keeping university at a distance

Keeping on a false mask

Having no faith in the university to support us

Training becoming a box ticking exercise

Jumping through the hoops

Having to learn later

Being naïve and excited at the start of training

Having an idealistic view of training at the start

Prioritising the relationships rather than content of placement

Ensuring supervisors would be fair in future placements

Having later positive placements helps to heal the previous bullying

Doubting your abilities at work

Sensing the experience was an exception 'blip'

Being aware that bullying may happen in the future

Experiencing bullying as less personal when others also experienced it

Becoming less trusting

Becoming more cynical

Questioning whether training was right for me

Being unsure of work relationships

Becoming more questioning

Finding out about the workplace culture before joining

Realising the importance of colleagues

Realising the importance of colleagues

Workplace culture normalising negative behaviours

Minor behaviours being criticised

Workplace having a lack of compassion

Being unfairly criticised in the outgroup

Being not treated as a human in the outgroup

Prioritising the ingroup

Having more placements creates more choice

Being less desperate for training places

Campaigning for more trainee placements

Universities being desperate for placements

Having a more transparent process

Universities having more choice to choose between placements

Submitting to survive

Not having a space to talk about the bullying

Having a bad experience doesn't negate the positive ones

Reinforcing the importance of maintaining good self-care

Being able to share my experiences

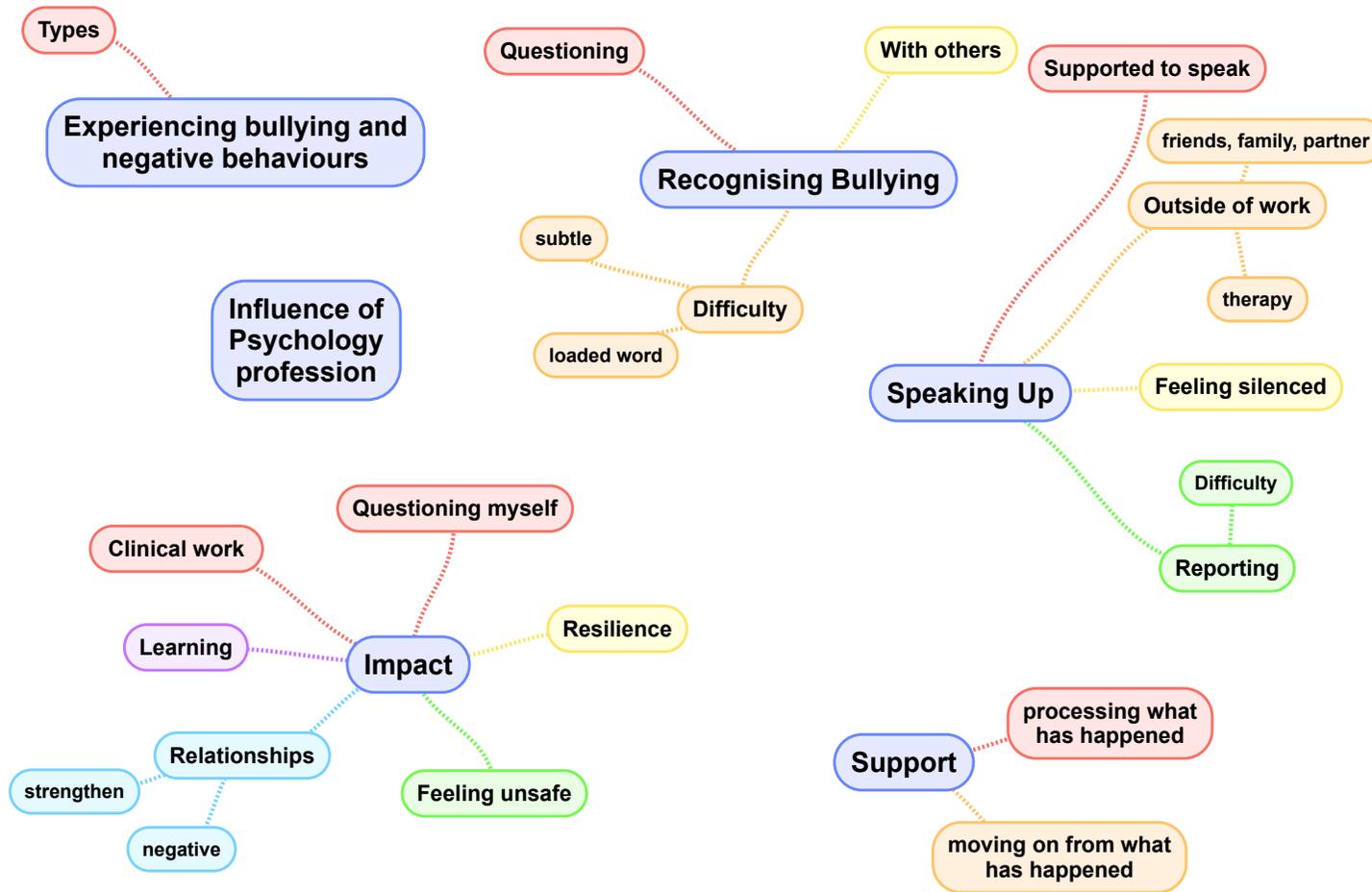
Feeling rebellious in talking about bullying experiences

Being less protected than other employees

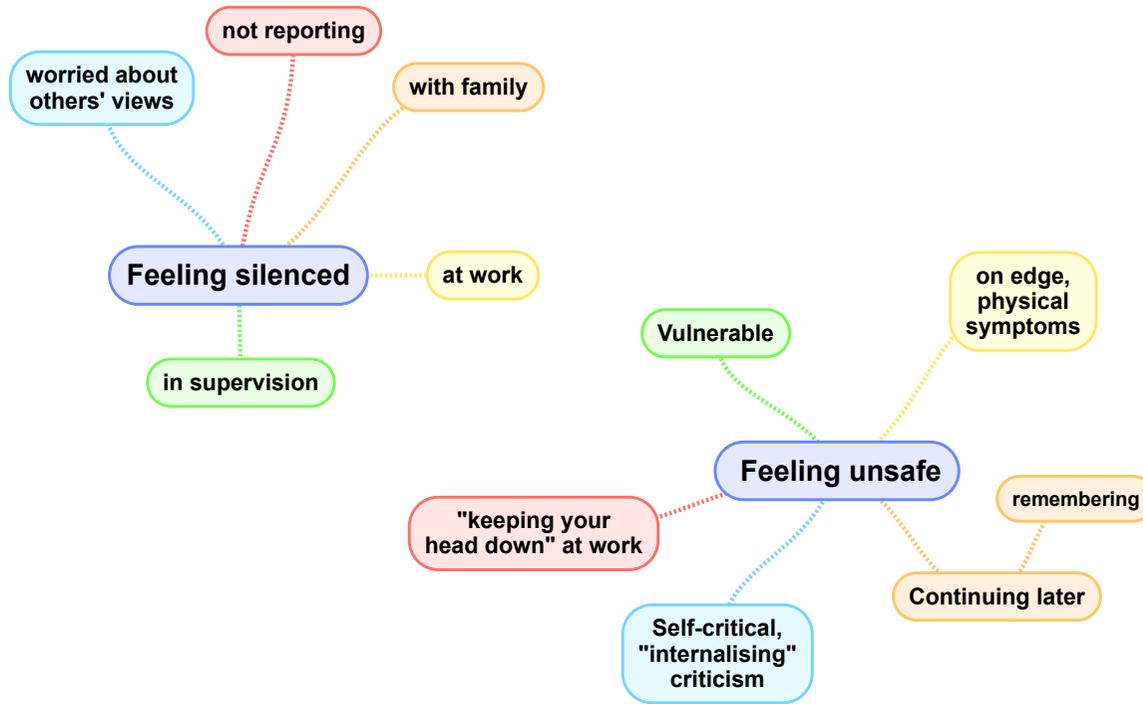
Impacting the NHS through the training of psychologists



i) example of an initial clustering

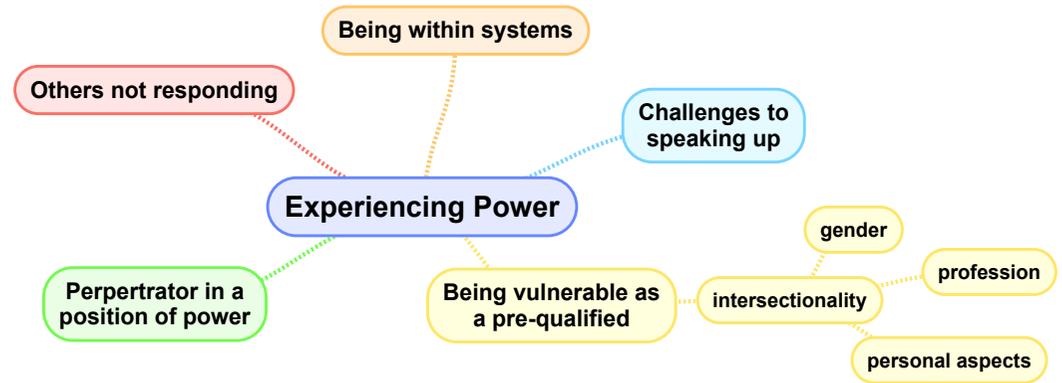
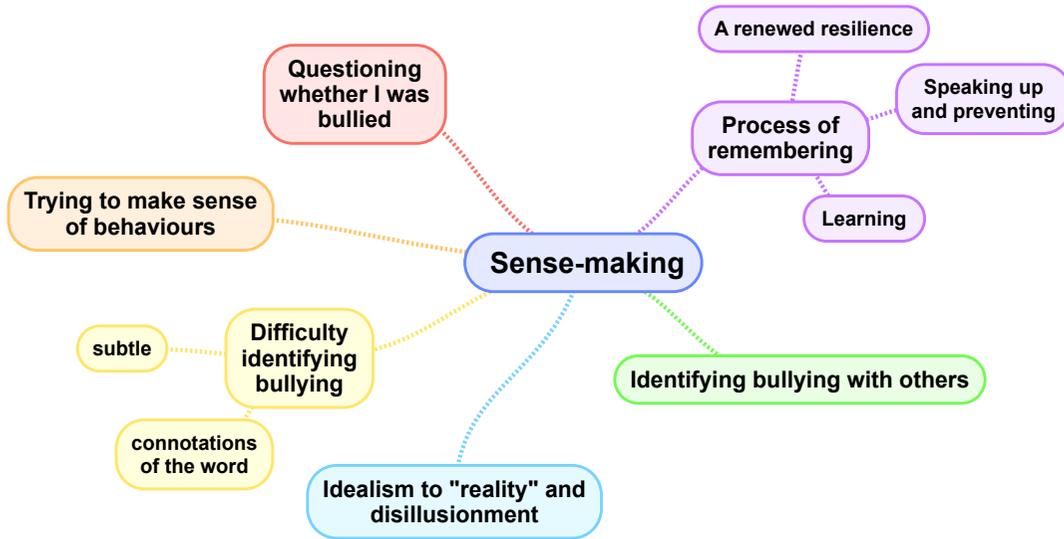


ii) an example of some of the sub-themes within sub-themes



iii) Further developed clusterings used during write-up





#### iv) Reflections on the process of generating themes

The initial list of 185 amalgamated codes (Appendix O) were cut out and used to “map” out potential themes. Appendix P i) shows an example of an initial clustering of potential themes. Within each of these sub-themes were possible further sub-themes (appendix P ii). For example, the sub-theme “feeling silenced” related to a number of other sub-themes that connected to codes in the data, and could potentially be found in more than one theme e.g. “feeling silenced” could potentially be found in the “Impact” sub-theme and the “Speaking Up” sub-theme.

In supervision whilst discussing initial clustering of data it became clear that many of the themes I had generated were comparable to a “domain summary” as they were close to some of the data collection questions, for example the different types of “Impact” theme closely mirrored some of the interview questions (Appendix L). Domain summaries are organised around a shared topic but not shared meaning (Braun & Clarke, 2019). Instead in a “reflexive” thematic analysis, themes are interpretations of the data by the researcher/s around a central organizing concept (Braun & Clarke, 2018). Using the initial clusterings and discussion in supervision, I further developed the themes so that data within the themes cohered together, with more identifiable distinctions between the themes (Braun & Clarke, 2006). This moved from more superficial summaries of data to generating themes that also captured more abstract, implicit meaning in the data, which reflected my interpretations of the data.

Appendix P iii) shows the thematic map that shaped the write-up of the results. Reflecting the “recursive process” of analysis (Braun & Clarke, 2006), this thematic map was further refined and developed in the process of writing up the

results, which produced the final thematic map in the Results section (Figure 1, p.71).

### **Appendix Q: Excerpts from research diary**

Having completed some research interviews now has made me aware not only of the gap in the research, but also the gap that some participants feel about not having a “safe enough” space to talk about their experiences. It’s given me a sense of purpose for this research that it will potentially highlight perspectives that are not often spoken about. I’ve also felt inspired by some of the responses that participants have chosen to report what they’ve experienced even though it’s been personally very challenging.

I’ve noticed a sense of wanting to make validating comments on some participant’s experiences, but also that this is a research interview and not a clinical interview. It’s been really helpful to be able to remind people that we can have a more reflective conversation at the end in the debrief. I’ve noticed that this can be a place to have those conversations about whether people’s experiences matches the definition of workplace bullying, which seems to make some of the participants concerned that maybe their experiences aren’t valid or that they’re not useful for the research. It seems reassuring for some participants to hear about the research definitions in the debrief and also that other research has highlighted that it’s difficult for people to identify if they are being bullied or not. It’s also interesting that some people don’t seem to question if they’ve been bullied or not; this doesn’t seem so related to the behaviours they’ve experienced – it seems more related to how others have responded to them.

Having conversation in supervision about coding having looked at a transcript.

Rather than a coding reliability check, it's more of a reflexive conversation on the lenses that we are viewing the transcript through. My lens and position as a trainee clinical psychologist who has undertaken the interview with participants and built a rapport and has a sense of the tone of the interview, and my supervisor as a member of a course team without the relational aspect of the interview. This led to discussions on how we related to some of the experiences highlighted, and our varying perspectives depending on our respective lenses – both similarities and differences. In a thematic analysis workshop, other trainee psychologists also coded part of this transcript and spoke about the areas they related to. Yet despite these different lenses the coding on the transcripts is not markedly different, perhaps reflecting the inductive approach to analysis.

## Appendix R: Evaluation of the Present Study Based on Mays and Pope's (2000)

### Criteria for Evaluating Qualitative Research

Worth or relevance	This study was worthwhile. There are no known studies of workplace bullying within clinical psychology, and no known studies of pre-qualified clinical psychologists. Furthermore, the study contributes to the literature on workplace bullying of trainee healthcare professionals from another profession. Previous research has demonstrated high levels of reported workplace bullying of and negative impacts on trainee healthcare professionals, and within the UK healthcare system.
Clarity of research question?	The research question was clearly stated and was developed through the information presented in the introduction and the systematic literature review: How have trainee clinical psychologists experienced workplace bullying during their training and in pre-qualified psychology roles prior to training?
Appropriateness of the design?	The qualitative design reflected the open and exploratory nature of the research question on a topic that has not been previously researched. Thematic analysis is an appropriate method of qualitative analysis for the study as it is consistent with the critical realist epistemology of the research, and allows for a relatively diverse sample. An inductive approach was chosen as there are not established theoretical frameworks on the topic indicated by the existing literature.
Context adequately described?	The context of healthcare training, workplace bullying of healthcare professionals and trainees within the UK and the clinical psychology context is described in the research.
Sampling?	Fourteen participants were recruited to the study which is within the range recommended for research as part of a professional doctorate using thematic analysis. All clinical psychology courses were contacted for recruitment, and half of the courses responded by sharing information about the study with trainee psychologists from their course. Additionally participants were recruited via snowballing. Therefore a large proportion of current trainee clinical psychologists were contacted for recruitment. Participants were generally representative of the gender and ethnic demographics of trainee clinical psychologists.

Data collection and analysis?	The method is clearly justified and described in a step-by-step process with further details provided in appendices. The description highlights the analytical steps taken allowing for replication, with quality checks to ensure coding accuracy.
Reflexivity?	The epistemological position and primary researcher's personal experience of the topic are made transparent. The author demonstrates reflexivity through the use of a research diary and within the account of the research.