Portfolio Volume 1: Major Research Project

The experience of moral injury in mental health clinicians with lived experience of systemic injustice

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List of Abbreviations:

CA – critical appraisal

CAMHS – child and adolescent mental health services

CGT – constructivist grounded theory

CMHT – community mental health team

GP – general practitioner

IAPT – improving access to psychology therapies

LTC – long term condition

MD – moral distress

MH – mental health

MI – Moral Injury

MI/D – moral injury/distress

MRP – major research project

NHS – national health service

PFS – publicly funded services

PWP – psychological wellbeing practitioner

SLR – systemic literature review

SU – service user

UK – United Kingdom

Abstract

Background

Publicly funded services across the UK are under significant pressure, and the demand for mental health care is increasing. This is against the backdrop of numerous reports stating that health inequalities are widening for those from minoritised communities. The NHS has put forward commitments to addressing inequalities under the NHS long term plan and NHS long term work force plan. Furthermore, there is growing evidence that those working within publicly funded services are experiencing discrimination based on their minoritised status. There is also evidence showing increased experience of moral injury and distress among healthcare staff nationally. Minimal research has been conducted to think about how systemic inequalities and moral injury may be intersecting for those working in mental healthcare in the UK.

Methodology

This study used a constructivist grounded theory methodology, underpinned by a modernist social constructionist stance. 10 participants took part in in-depth interviews, followed by a focus group comprising of 2 of the 10 participants who were able to take part. All the participants self-identified as having lived experience of systemic injustice and professional experience of moral injury while working in publicly funded services.

Results

A constructivist grounded theory (CGT) model was constructed which spoke to multiple processes across macro, meso, micro and individual levels that contributed to their experience of moral injury. Core to this model was the idea that in being part of services that function under kyriarchy which contributes to health inequalities, professionals were in the position of being both a helper and a harmer by sheer virtue of their professional roles. This led to cognitive dissonance for most, and moral distress for all participants.

Conclusion

This research has contributed to our understanding of moral injury experienced by mental healthcare workers. It also invites us to move away from thinking about distress as being about an individual, or within the small systems that create our context. Instead, this model encourages us to consider wider, systemic factors and how this plays out in our services. Finally, we can think about the impact of this and how it feeds back into upholding systems that create inequalities.

Key Words

Moral Injury, Moral Distress, Publicly Funded Services, Mental Healthcare, Mental Healthcare workers, systemic injustice, kyriarchy.

Chapter 1: Introduction and SLR

1.1 Introduction:

1.1.1Overview:

In this chapter I set out my position and my understandings of contexts related to my research. I talk about my ontological and epistemological perspectives and outline key ideas and terminologies relevant to moral injury and systemic injustice. I introduce my theoretical lens, kyriarchy. Finally, I discuss relevant literature related to moral injury in healthcare and system injustice more broadly. I have chosen to thread my voice, and the voice of my participants throughout this thesis as much as possible as a way of welcoming various forms of knowing, and a move away from a more positivist understandings and formulation of research and 'truth'.

1.1.2 Why I am doing this?

Part of my hope in doing this piece of research is to move away from ideas of distress that position the difficulties within the individual. Concepts such as burnout and compassion fatigue by their definition lean towards this way of thinking. Compassion fatigue can be defined as a "decline in the ability to feel sympathy and empathy, and accordingly, act from a place of compassion" (Stoewen, 2020, pp. 1207), who said this was the 'classic' presentation. Burnout is described as distress resulting from chronic and unmanaged workplace stress, leading to depersonalisation, reduced professional efficacy and depleted energy (Eisenberg, 2022; World Health Organization, 2022). While I imagine these feelings are accurate, they do not adequately consider the role of the systems and organisations that perpetuate these experiences in individuals. I wish to think about the wider systems that create the environments in which mental health (MH) professionals experience this.

1.1.3 Myself in relation to my research:

I was born and raised in Ireland but left when I was 15. From there I lived in Kenya, South Africa and Lebanon for around 9 years before moving to the UK. I have worked in the NHS since 2017, 3 years after moving here and so I had no real sense of how it all worked. It was a world, a system, a language unto itself. Public services were new to me too, and I remember the first time I went to the GP here. After my appointment I went back to the reception to pay and they (kindly) laughed at me, telling me I didn't have to. I left but felt *so* uncomfortable about it. I was also very grateful that my accent at the time would not have been mistaken for British. I told my friends abroad about the NHS. I told people here about it too, but they were less excited. Later I also learnt that the NHS would pay for me to do a doctorate, this one as it turns out. I was genuinely in awe.

Living in Global South countries was where I began to learn about systemic injustice, colonial legacies, and collective ideologies. When I moved to the UK I, naively, assumed that there would be far less of a disparity between people with privilege and access to power, and those who haven't been afforded it - "In this way, people with privilege are like fish in water, in that they do not recognize the water until (or unless) they are removed from it." (Brown et al., 2003). Since living and working here, I have come to learn about how power operates and how systems maintain power, which I will speak to more throughout this thesis. And so, I come to this research as an insider and an outsider (Dwyer & Buckle, 2009). I'm queer, I'm white, I'm not from the UK, I work in mental health for the NHS, I have experienced discrimination, and I have enacted it both personally and professionally and this is a part of my identity that I share with the participants in this piece of research. I'm sure there's much more about my experience (and theirs) that relates to this topic. In fact, in my view, this research relates to *every* aspect of me in some way or other. I am wholly within these systems, both as an active and passive participant.

1.1.4 Reflexivity:

Reflexivity aims to make explicit the relationship between the researcher and their research, acknowledging that qualitative research is contextual (Dodgson, 2019). It acknowledges my role in constructing the research, creating the relationships, interpreting the findings and thinking about *me* and my influence within these processes (Pillow, 2003). Within CGT this is partly achieved through memo writing (Charmaz, 2014).

CGT acknowledges that meaning is created between the researcher and participants, and beyond just data collection (Charmaz, 2014). In this, power has been something I have strived to continuously consider and make explicit where possible. I have wanted to create a project which considers the influence of power within the knowledge we create, but have felt stuck at multiple points, especially when faced with the practicalities of doing a doctoral thesis. Limitations such as time, resource and 'clinical psychology perspectives' shape my work in ways that lean towards a more positivist view of the world. For example, the requirement of conducting a systemic literature review, or the 'end product' being akin to a new 'theory'. I've engaged in reflexivity to try and create something more 'valid' or 'accurate', while trying to hold a social constructionist epistemology which rejects overarching, objective truths. In considering these positions throughout my research I hope to make clear that my work is my experience, my interpretation and my shared learning and understandings created with those who have been involved in the processes; participants, colleagues and my research team alike. While I hold that what I have written acknowledges a view of the experience of MI and systemic injustice in mental healthcare, it is far from an exhaustive examination.

I have also made decisions along the way that have tried to ensure I share some of the power with my participants, and create more reciprocal relationships where possible (Pillow, 2003). I have engaged in theoretical sampling, participants have shared research papers with me that they felt was important to what we discussed together, and these have been included in my write up. Participants expressed that they felt the spaces we shared were cathartic and validating, and I hope some of these decisions successfully deconstructed some of my authority as a doctoral student, soon to be clinical psychologist. In short, "reflexively connect our experiences in ways that use [Abbie's life story] to challenge and deepen my understanding of my own life, and my own experiences to heighten my comprehension of hers" (Kiesinger, 1998, pp. 72).

1.1.5 Ontology and Epistemology:

Ontology can be defined as '*what exists',* whereas epistemology is concerned with the nature of knowledge – *how* do we 'know' what we 'know'? (Crotty, 1998). This piece of research takes a 'moderate social constructionist' stance which tells us that we can know *something* about reality, but there is not an objective truth or reality that exists (Harper, 2011). More broadly, social constructionism is the idea that knowledge is not an objective or innate truth, but rather knowledge is created through social interactions, processes, and language, and truth comes from socially 'agreed' ideas (Berger & Luckmann, 1991). Social constructionism suggests that what we understand as 'truth', is actually influenced by power, historical and cultural contexts, is enforced by the language we use, and those with more power tend to be more successful at having their version of events taken as ‘true’ (Berger and Luckmann, 1991; Burr, 1995), rather than existing as an ‘objective’ reality.

Social constructionism offers a criticism of essentialising knowledge which describes how, when we are so focused on essentialist ideals and categorisations (on fixed categories) that hold their own truths regardless of who we are, we run the risk of missing out on the complexities of our and others lived experience. Taking a post-modernist stance allows for the interrogation of what we understand as ‘knowledge’, allowing us to engage in a more complex or nuanced understanding of how knowledge and ‘truth’ looks different based on the way that different people engage in ‘meaning making’. In short, we do not assume that what is understood through research represents a universal ‘truth’ and we situate ourselves in relation to our contexts (Gunarathnam, 2003). Social constructionism does not speak to ontology, it does not deny that there could be an objective reality, but rather it concerns itself with the ways in which we construct and interpret truths (Andrews, 2012). However, in engaging with my participants I want to be able to reflect that their experiences do reflect *a* reality or truth which relates to how they experience it. This needs to be balanced with the idea that our knowledge cannot be absolute or final, and is dynamic, often changing or responding to discourses (Burr & Dick, 2017). Furthermore, they argue that more dominant discourses are privileged, and are influenced by time, culture and place (ibid). What this research does offer however, is a challenge to normative, essentialist understandings of power, ‘objective truth’ and knowledge that clinical research often represents.

<u>1.1.6 Theoretical Lens:</u>

Kyriarchy is a term developed by Elisabeth Schüssler Fiorenza (1992), a feminist theologian. The choice to use this lens was motivated by my view that it adeptly highlights how wider systems and non-human entities impact things such as healthcare access, delivery and health outcomes for the individuals working in and accessing services.

The term was developed to move beyond patriarchy (which only presented an analysis of gender binaries as locations of power and oppression), and consider how oppression is a series of structures that create inequity and domination, such as race, class, gender, disability, colonialism, sexuality etc. This allows us to focus on how systems of oppression are interconnected. It also creates space for us to understand multiple structures of oppression and recognises that identity features do not function alone, but that intersecting categories interact with intersecting structures of oppression (Cobb, 2024). This lens argues that depending on context, and which element of your identity is 'activated', how power operates can change. For example, a white patient[1] is unwell and being treated by a clinician who holds a minoritised identity. The clinician may hold power over a patient related to decision making within a *hospital setting*[2]. Should they meet in another setting like a *cafe*, and the white patient is now just a white person, no longer unwell and reliant on the clinician. The clinician is now a minoritised person and so the power changes. The white person (no longer a patient – temporary element of their identity) now holds more power based on race. i.e. the 'active' identity characteristics are different due to the context.

Ideological Oppression	Beliefs and ideas that govern or justify the maintenance of systems that perpetuate oppression.
Internalised Oppression	How individuals within society internalise beliefs, narratives and ideas about themselves or their identities. For example, internalised homophobia - queer bodies feeling disgust or distain towards their sexuality.
Interpersonal Oppression	This plays out between peoples and groupings. It refers to the direct and indirect ways in which those that hold power oppress so called marginalised people and communities e.g. racism.
Institutional Oppression	These are the laws, policies, systems and institutions that reinforce, maintain and further creative oppressive practices.

Table 1. Bell's Four I's of Oppression (2013)

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[1] Underlined text shows the 'active' identity characteristic.

[2] Italicised denotes the context

To take this idea further, we might hold it together with Bell's (2013) four I's of oppression. Regardless of context, oppression is continuously operating on multiple levels; ideologically, individually internalised, institutionally and interpersonally. In the example above, practically speaking, power is moving between both individuals. But Bell's lens would invite us to consider how other elements of the context are interacting for each person in the example. On 'paper' the clinician is in charge, theoretically. However, what could happen if the white patient chose to mobilise their privilege and power against the minoritised clinician for whatever reason. This would necessarily change the power dynamic, and I would argue that the minoritised clinician will be aware (internalised & interpersonal) of this and therefore likely influenced by it in some way, changing the interaction. Thus, kyriarchy speaks very well to the way in which power and identity intersect and interact and can be fluid. It also highlights the need to focus on addressing the core systemic inequalities to create meaningful positive social change. However, I am concerned that kyriarchy has the potential to oversimplify how we view the ways in which people as individuals hold and use power when considered in isolation therefore downplaying structural or systemic inequalities. Thus when thinking about how it operates, it's useful to consider other understandings like Bell's four I's of oppression to get a more rounded and nuanced understanding.

In relation to healthcare more specifically, a study completed by Griscti et al. (2016) found that in selected hospital settings commissioned to treat chronically ill patients there are a multitude of discourses at play. For example, ideas that took power away from those with chronic illness and highlighted assumptions they were unable to meaningfully negotiate their care needs. Voices of healthcare experts were privileged and the hierarchies within the healthcare system supported this authority, leading at times to oppressive practices, not necessarily intentional but rather how the design of our systems naturally play out. However, it was also acknowledged that there were moments of liberation for patients. Patients have the power to complain, to disengage, to create anger and tension if they're unhappy, and staff (nurses in this case) were seen as disempowered.

In CAMHS's services, LeFrancois (2013), discourses around age, gender, whiteness and other forms of normativity governed how the young people were pathologised or denied care that didn't align with said normative ideals. An example given in the paper was a girl feeling ostracised from her peers. She was jeered for her scars from self-harm, being told this would hinder her from finding a suitable husband in the future – reinforcing beauty standards, stigmatising expressions of distress, and enforcing expected or 'necessary' heteronormative life goals for girls.

It is important to highlight that often oppressive action is not necessarily a conscious choice made by those holding power. Those who benefit from the systems that govern our worlds internalise privilege, the same way those that are oppressed internalise negative discourses.

Ultimately, kyriarchy is a powerful tool to examine power and identity, but it risks oversimplifying individual dynamics if not balanced with other frameworks. Oppression is often (but not always) internalised and systemic rather than intentionally and individually enacted, underscoring the need for critical reflection and systemic thinking to foster lasting change.

1.2 Key Terms and Use of Language:

1.2.1 Systemic Injustice:

The meaning of systemic injustice feels both obvious and illusive when one sits down to come up with a clear definition. There does not appear to be one agreed definition, and authors and researchers speak to structural, social and systemic injustice. In my reading of these concepts, while there is some nuanced differences, they speak to similar ideas. I will use systemic injustice as defined below. My aim is to explore how wider social and political systems impact mental health workers and their experience of moral injury. I am thinking about the individuals within the systems and systems positioning of said people within it. This differs from thinking simply about individuals as isolated entities (e.g. Bronfenbrenner's, 1979, ecological systems theory – it is all interlinked). I think about the process between what we experience in our personal lives and how this might come up in our professional lives too, locating how the wider systems come to influence the lives of the individuals within it – and this point is key for this piece of research.

Systemic injustice emphasises the involvement of whole systems (political, healthcare, legal etc) (Braveman et al., 2022) in perpetuating discrimination, the systems are often historic and self-sustaining with no core power or governing entity

(Haslanger, 2022). Systemic oppression is so embedded within our norms that it is often assumed to reflect the ‘natural’ order of things, such as Eurocentric ideals or heteronormativity. This does not refer to the individual acts of discrimination but rather it is a widespread, often subtle practices that disadvantage so-called ‘minority’ groups and deprives those grouping from accessing opportunities to live well (Young, 2011). Levy and Sidel (2013, p. 3) include the concept of power in their definition of social injustice, defining it as “the denial or violation of human rights...of specific populations or groups in society based on the erroneous perception of their inferiority by those with more power or influence.”

Sally, when asked how she would define systemic injustice stated that:

> Um, I think my, my way of seeing it is, because I feel it sometimes like when I working and like now when I work I feel it sort of like, bodily. But this like sense of like being, like my chest is being like squashed. And I feel like both extremely angry, but also like like being made to feel small...So like the feeling of being made to feel small, but also feeling extremely discomfited and not necessarily able to like articulate why that might be when I see it happening. And I think it's it's something that's almost like intangible. And that tends to happen when I see, in the...in my context, when I see like clinicians speak about people with lived experience.

I was stuck by the felt sense she shared, and curious about that which we feel but struggle to give language to. We as clinical psychologists need to hold this for the people and communities we work with so we can create space for understanding and growth.

1.2.2. Moral Injury:

Moral injury (MI) was initially developed in the context of veterans in the United States of America. More recently studies have begun to examine the experience of MI in healthcare workers. MI occurs when a person is in a situation in which they feel they cannot uphold their core values or morals (Archer, 2022). Shay (2012) defines it as a violation of what’s right, occurring in a high-stakes situation, by oneself or an authority figure, and it can be due to action or inaction (French et al., 2021). MI tends to manifest in situations whereby institutional boundaries, norms or cultures stop individuals from being able to do what they know to be right (Jameton, cited in Epstein & Hamric, 2009). MI can occur due to acts of omission, perceived betrayal-based action or inaction and witnessing or causing harm.

MI has not been developed as a diagnostic label, but rather a set of experiences that capture the existential or spiritual impact of distress, as well as the cumulative psychological impact of these experiences. Research has shown that moral injury elicits similar patterns of distress and symptomology to post traumatic stress disorder (PTSD), including avoidance, maladaptive behaviours, psychological distress, self-blame, and social withdrawal (Hall et al., 2022; Jinkerson, 2016; Litz et al., 2009).

This conceptualisation of an experience of distress, while imperfect, helpfully moves us away from categorisations and more positivist ways of explaining distress in ways that align with medicalised understanding and diagnostic labels. I am speaking specially about moral distress (MD), however, more generally I find it helpful to build a lexicon of experiences related to distress that attempt not to pathologise but instead try to move to considering layers of experience. Diagnostic labels search for "truth" and a homogenous understanding of distress, failing to recognise distress that veers too far away from a diagnostic conceptualisation which was constructed mainly within Western contexts (McCann, 2016). This limits our ability to sit with nuance and engage in others' understanding of their own distress. It also means we do not make space to adequately consider culture, history and context that perhaps differ from our own, or at the very least differs from dominate frameworks that define and dictate normative expectations.

Stella defined MI as:

> Moral injury is this kind of <pause> I would say you feel it. You feel that something is *off*. You're doing something, or you *have* to do something and you feel that it's off. And you don't really understand why, or maybe you do, or maybe sometimes you understand why. And then after they reach one year [after the event/action],

> whatever, you're like, 'Oh, damn, that why it was wrong. I'm like, oh, damn, that…it felt off.'

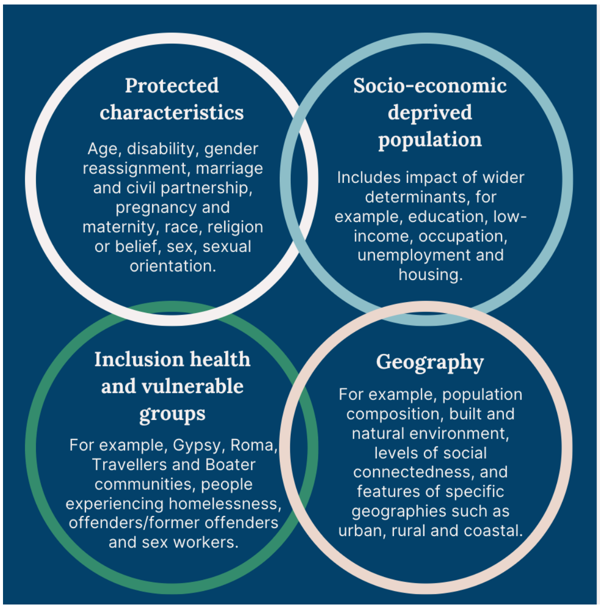
MI oftentimes leads to feelings of anger, frustration, apathy and a sense of helplessness, impacting morale and work performance (Rodrigues et al., 2023; Mitton et al., 2010). It has been found that those who self-reported instances of MI also reported higher rates of depression, burnout and a lower sense of wellbeing (Nieuwsma et al., 2022; Rabin et al., 2023). Overall, the literature indicates that those experiencing MI 'do worse' at work due to apathy and the need to disengage, and struggle to maintain well-being outside work too (Hagarty et al., 2022; Zangaro et al., 2023; Archer, 2022).

1.2.3 Systemic Gaslighting:

The term gaslighting comes from a 1939 play Gas Light, later adapted into a film Gaslight (1944), where an abusive husband dims gaslights in the home he shares with his wife. He denies that it is happening, a theatrical representation of the way in which he distorted his wife's sense of reality. It is now recognised as a form of psychological abuse and was typically referred to in the context of interpersonal relationships. However, this idea has developed to consider social and cultural gaslighting that incorporates "…subtle control tactics aimed at silencing resistance. This can be seen as reminiscent of structural silencing, such as the repression of minority voices and promotion of dominant narratives." (Darke et al., 2025) over those who may not conform to, or share the lived experience of those who conform to, or accept these dominant narratives. Furthermore, Johnson et al. (2021, pp. 1029) argue that "Gaslighting is used not only to maintain or gain power in intimate relationships but also to uphold power structures of White supremacy, patriarchy, heteronormativity, and transphobia.", "…especially for those who do not move through the world inhabiting bodies and identities that afford them unmarked privilege and access to legal and cultural systems designed to serve them." (Drexler, 2023, pp. 64). For me, this again connects to ideas of 'normal' and maintenance of the status quo, ideas related to whiteness and heteronormativity, for example.

1.3 Context:

Systemic injustice speaks to a society whereby there are significant power differentials, and people face discrimination, oppression and inequality based on characteristics beyond their control. Characteristics that may objectively exist in some sense, but that meanings have been attached to create difference. We can see examples of this throughout our society, with minoritised communities suffering worse health outcomes overall. NICE (2022) states that those experiencing poverty, living in vulnerable or excluded groups, or sharing certain protected characteristics experience health inequalities. They also acknowledge that those with intersecting identities can compound the experience of inequality.



Protected characteristics

Age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Socio-economic deprived population

Includes impact of wider determinants, for example, education, low-income, occupation, unemployment and housing.

Inclusion health and vulnerable groups

For example, Gypsy, Roma, Travellers and Boater communities, people experiencing homelessness, offenders/former offenders and sex workers.

Geography

For example, population composition, built and natural environment, levels of social connectedness, and features of specific geographies such as urban, rural and coastal.

Fig. 1. NICE (2022) – population groups commonly considered for health inequalities.

Kinouani (2021) in her book “Living while black” writes from the perspective of a Black woman and a psychologist. She speaks about how psychology fails to recognise Black voices and therefore our professions and mental health systems, as a whole, perpetuate this silencing within services and within therapy spaces. And perhaps worse, facilitate harm and psychological distress. Frazer-Carroll (2023) wrote about a study she conducted as a student welfare officer in 2017. One hundred and forty seven students of colour completed questionnaires asking about their experiences of student counselling services. Students reported that they were stereotyped by their white therapists and had their reports of experiences of racism questioned. Fearon et al.

(2006) found that Black men are nine times more likely to be diagnosed with schizophrenia than their white counterparts. Pinto et al., (2008) conducted a literature review to understand why this might be the case and found that biological or genetic factors cannot explain the susceptibility to increased instances of psychosis. Instead, they suggest that sociopolitical factors are far more likely to explain the disparity.

It has been widely reported that people within the LGBTQ+ community are less likely to engage in services because when they do, they often face discrimination, poor understanding of needs and lower quality of care (Bachmann & Gooch, 2018; Leven, 2022; Kneale et al., 2021). Furthermore, 25% of trans people have experienced homelessness (Frazer-Carroll, 2023). If we go back to the diagram above we can see that the intersection of gender identity and homelessness increases the risk of the person facing health disparities. Forty one percent of trans people have experienced hate crime due only to their gender identity.

Lindsay et al. (2022) conducted a systematic review of the impact of ablism on healthcare providers with disabilities and concluded that ablism experienced due to systemic failings and on an individual level leads to poorer wellbeing and stunted career development. Furthermore, during the Covid-19 pandemic 59% of Covid related deaths were people with a disability, despite only making up 16% of the population based on the 2011 census (Office for National Statistics, 2020).

These are just some examples of how social injustice plays out in our communities in the context of health care alone. Health care workers are positioned as potentially being discriminated against, but also those potentially (knowingly or unknowingly) discriminating against others.

1.3.1 Moral Injury in the context of health care professionals:

From the literature concerning healthcare workers, potentially morally injurious events (PMIEs) tend to take the form of situations where clinicians witness the impact of not being able to do what they believe to be right by their patients (Hagarty et al., 2022; Rodrigues et al., 2023; Zangaro et al., 2023). The COVID-19 pandemic brought this more into the mainstream. We were shown reports in the media of clinicians frequently faced with choices that would result in someone dying, and/or dying without the presence of family. However, research conducted outside the context of the pandemic showed evidence MI was prevalent for healthcare workers due to the nature of their jobs (Rodrigues et al., 2023). They interviewed Canadian emergency response clinicians who reported the types of PMIEs they experienced often centred around failures in leadership or the systems they worked in. The research shows that betrayal-based MI was the main subtype of moral injury experienced by health care workers (French et al., 2021; Williamson et al., 2022, Park et al., 2023; Rabin et al., 2023).

MI oftentimes leads to feelings of anger, frustration, apathy and a sense of helplessness, impacting morale and work performance (Mitton et al., 2010; Rodrigues et al., 2023). Nieuwsma et al., (2022) found that those who self-reported instances of moral injury also reported higher rates of depression, burnout and a lower quality of life. Overall the literature indicates that those experiencing MI ‘do worse’ at work due to apathy and the need to disengage and struggle to maintain well-being outside work too (Archer, 2022; Hagarty et al., 2022; Zangaro et al., 2023).

Nieuwsma et al., (2022) reported they found indications that the experience of MI may be related to less social empowerment e.g. being female, non-white, younger in age. MI, different to burnout, was thought about in the context of understanding distress not just within the individual but understanding the impact and context of wider social and contextual factors. While there is some recognition of this, clinicians often speak of needing to find more ‘individual’ solutions or coping strategies, which fails to capture the context in which clinicians are being asked to work in. The participants in Hegarty et al’s. (2022) study expressed that until organisations acknowledged and engaged with the systemic issues, MI would only continue to accumulate and that any resolution to their experiences of moral distress was not possible without wider, organisational change.

1.3.2 Current Landscape:

The NHS long-term plan has committed to “stronger NHS action on health inequalities” (NHS, 2019), thus explicitly acknowledging the systemic factors such as race, gender and socioeconomic status that influence people’s likelihood of experiencing poor mental health. The NHS is already under immense pressure to provide care, but this is further complicated by the significant increasing demand for care which mental health services are not currently resourced to provide (BMA, November, 2023a). The Care Quality Commission (CQC) annual report assessing the quality of health and social care services in England showed that 40% of providers were rated as “requires improvement” or “inadequate” for safety (CQC, 2023). They also reported that system failures and lack of funding meant that budgets are prioritised over patient-centred care, negatively impacting minoritised communities more.

Furthermore, staff reported that they are overworked, exhausted, and at the point of becoming unwell meaning they were considering leaving their jobs due to the level of distress (CQC, 2023). The NHS long-term workforce plan (NHS England, 2023) commits to widening access to minoritised professionals. However, Cushen-Brewster et al., (2024), found that advanced practitioners from racially minoritised communities still faced discrimination and harassment, and less opportunity to develop their careers. If we are unable to address systemic inequalities, we continue to perpetuate distress and challenges faced by staff and SUs alike, who form the NHS.

I acknowledge at this point that there is room to question the impact of clinicians’ potential ill-health on service users (SU). However, there is still significant stigma faced by healthcare workers who experience difficulties with their mental health (Knaak et al., 2017; Ross & Goldner, 2009; Tay et al., 2018; Stuetzle et al., 2023). I do not want to contribute to a discourse that puts into question our ability to provide care if we have a history of mental health difficulties ourselves given the landscape of stigma that currently exists for many. I do not want to contribute to a discourse that places the individuals as holding the responsibility for ‘fixing’ what I understand to be widespread systemic failings across our healthcare and social systems. A position I vehemently disagree with.

1.3.3 Rationale:

Professionals within the public sector health and social care services were already struggling to cope due to the impact of Austerity and the Covid-19 pandemic (Scott, 2023; CQC, 2023; BMA, 2023b), and Austerity measures impact deprived groups the most (Stuckler et al., 2017). Thinking about the role of being an insider and an outsider, I want to understand how that looks for professionals who have been impacted by systemic injustice personally and are working within systems that are struggling to cope, thus adding to inequalities. How does one experience being impacted by, and being part of the system?

Archer (2022), a male Black American doctor, summarises the distress of sharing experiences of systemic injustice with clients, and how that compounded moral injury:

> any of the people I care for have been systematically preyed on by hundreds of years of exploitation due to the color of their skin, perpetuating states that foster sickness. I care for people educated in under-resourced school systems, who have difficulty reading medication instructions and understanding nutrition labels. I care for people who have direct experience with the prison-industrial complex, who then struggle to re-enter society as full citizens. I care for people who live in food swamps, where it is easier to purchase alcohol, cigarettes, and potato chips than fresh produce. I care for people whose communities have been deliberately divested of resources and who cannot afford stable phone plans, let alone housing, while neighboring police departments continue to grow.
>
> *These are the inhospitable conditions from which I begin the work of trying to care for people.*

We can see that there is some discussion in the current literature relating to the wider factors that influence MI, but there is little that explores the role of systemic injustice. This piece of research hopes to think more directly about the role of systemic injustice in relation to MI. It also focuses on the experience of those working in mental health services as there is minimal research on MH clinicians specifically.

1.4 Systematic Literature Review

1.4.1 Overview:

This chapter is the systematic literature review (SLR) that was completed as part of my thesis. In this section I speak to the aims of the SLR, the search strategy, methodology and quality appraisal undertaken. I go on to discuss the main themes using thematic synthesis. Finally, I highlight the main conclusions and implications for my research.

1.4.2 Aims:

A systematic literature review is “A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review” (Higgins et al., 2024). The overall purpose of an SLR is to learn about what is currently understood about a given topic and consider what gaps, if any, exist (Davis et al., 2014). The following questions were developed with those considerations in mind;

What are the key contextual factors discussed in relation to the experiences of moral injury in health care settings pre the Covid-19 pandemic?

- *i.e. Are wider systems highlighted as a significant contributor within the participant’s reports?*

1.4.3 Defining ‘context’ and position:

To adequately speak to the research aims, both thinking about what context is, and thinking about how broad the consideration of context is, I will define context within understandings that relate to critical psychology and liberatory practices. Strong et al., (2008, p.183) posit that people and things should be "understood in a relational context, as products and processes of patterns of relational interaction." The relational and contextual aspects are how I have chosen to come to this review with relational referring to both human and non-human actors. Furthermore, kyriarchial structures will also be considered. This refers to the idea of multiple identities intersecting that serve to create oppressive systems e.g. race, sexuality, gender, class etc (Cobb, 2024). Similar to patriarchy in how oppressive practices are based on binary gender, kyriarchy consider the intersecting lenses that create disenfranchisement.

According to the APA (2018) social context refers to “the specific circumstance or general environment that serves as a social framework for individual or interpersonal behavior [sic]. This context frequently influences, at least to some degree, the actions and feelings that occur within it.”. Bronfenbrenner (2009) expands on this stating that our contexts influence our developmental outcomes, as well as our thoughts, feeling and behaviours as we spend a significant proportion of our time attending to context, either directly or indirectly. ‘Truth’ is influenced by power, historical and cultural contexts, and it is enforced by the language we use. Those with more power tend to be more successful at having their version of events taken as ‘true’ (Berger and Luckmann, 1991; Burr, 1995).

Psychology, as a discipline, has a long history of situating it’s understandings in the examination of the individual, but here we can see that the individual should be understood in relation to their context. Parker (2007) calls for more critiquing of mainstream psychological thinking so we take into account “how dominant accounts of “psychology” operate ideologically and in the service of power.” (pp. 2). Power being defined as a “construct of society and a product of the systems and institutions humans have created to maintain control and order among the masses.” (Haddock-Lazala, 2020, pp. 152). However, power is dynamic, relational and contains multiplicity, and can be used as a force for domination as well as for resistance and change (Hunjan & Pettit, 2011). Parker (2007) goes on to say that within critical psychology we need to “study the forms of surveillance and self-regulation in everyday life…” (pp. 3). I take this to emphasise the importance of understanding how power *is* a core part of the contexts in which we operate. Understanding our context and the role of power can serve to liberate forms of oppressive practice, which, in relation to experience of MI and distress, brings hope. Therefore, when I speak about context I mean this to be understood at multiple levels; intrapersonal, interpersonal, institutional factors and systemic influences. Note, these categories were influenced by my interpretation of the factors spoken to within the research.

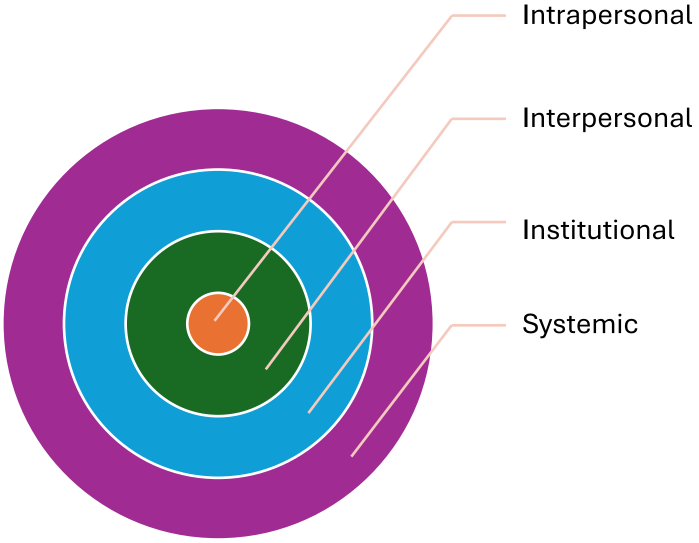


Fig. 2. Pictorial representation of level of influences considered in this review

1.4.4 Ontological and epistemological position:

As previously discussed, I will be taking a ‘moderate social constructionist’ stance (Harper, 2011). In relation to my SLR this means that the research presented can, and does, tell us something about the world, but that it is not an objective ‘truth’. All of the participants in the studies identified have spoken to MI/D, which I take to be a very real reflection of their experiences. However, the context is important. As is the consideration that it has also been influenced by the researchers’ initial interpretations of participants experiences, and further again influenced by my interpretation of those interpretations. Multiple meanings and assumptions have been made and will continue to be made in relation to these pieces of research and my presentation of them. Within the multiple meaning makings of writing, reading and interpreting research the context changes, further creating different lens at which other readers will understand any piece of work.

1.5 Methodology:

1.5.1 Scoping (and the development of my curiosity):

Initial scoping searches took place during the process of preparing my research proposal in April 2024. At this stage I began to notice that a significant proportion of research related to moral injury in healthcare settings was conducted post-2020 i.e. during or after the Covid-19 pandemic (e.g. French et al., 2021; Hagarty et al., 2022;

Nieuwsma et al., 2022; Park et al., 2023; Rabin et al., 2023; Rodrigues et al., 2023; Williamson et al., 2022; Zangaro et al., 2023). This was later confirmed by the publication of a systematic literature review titled “Triggers and factors associated with moral distress and moral injury in health and social care workers: A systematic review of qualitative studies.” by Beadle et al., 2024. See Beadle et al.’s table below regarding publication timeline of moral injury and moral distress in health and social care research.

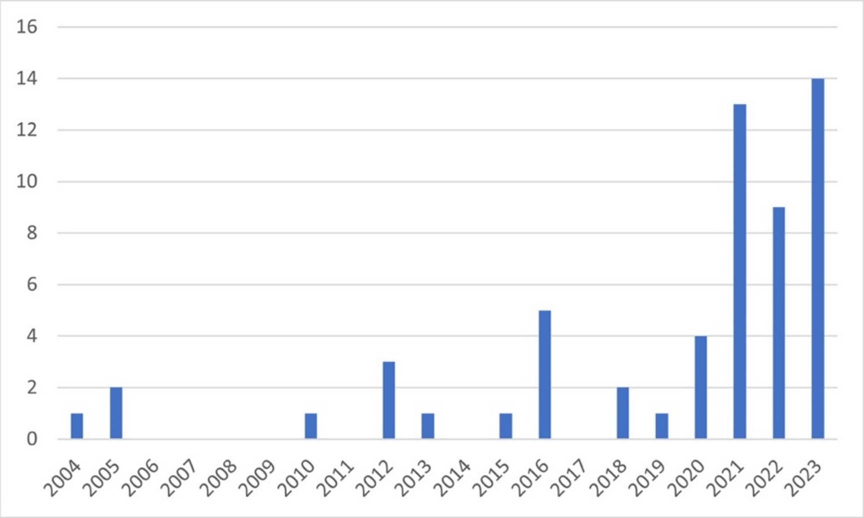


Fig. 3. Table as reported in Beadle et al, 2024.

Given the rise in popularity of moral injury research within healthcare I became curious about moral injury enquiry pre-pandemic. From research presented in the introduction chapter we can see that MI was discussed in relation to how healthcare services work, and MI was experienced also regardless of the extra pressures of the pandemic. Anecdotally, I understood many of the issues being highlighted by the strain of services due to the pandemic to be preexisting, rather than caused by.

The term moral injury was originally coined in the 90s by Jonathan Shay (1994) in the context of combat veterans. According to Shay (2014); “Moral injury is present when there has been (a) a betrayal of “what’s right”; (b) either by a person in legitimate authority (my definition) [sic], or by one’s self; (c) in a high stakes situation.”. Jameton (1984, pp. 6) spoke to the concept of moral distress and defined it as; “Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.".

I was particularly drawn to the idea of “legitimate authority” in Shay’s definition, and “institutional constraints” in Jameton’s, and was left with several questions; why now (this will not be answered within the current review)? How did we engage with these ideas prior to the pandemic given how long they have been around? And does the research stay with these wider, contextual ideas that are necessary within the conceptualisations of moral distress and moral injury?

Initially my intention was to examine MI/D literature in relation to mental healthcare specifically, but preliminary searches did not produce sufficient research literature within this period. It was also noted in preliminary searches that MD was more often use in older pieces of research, likely related to Jameton’s work on MD in nursing, and hence why it has been included. I then searched Prospero in July 2024 to ensure I would not be repeating work already underway or near completion.

1.5.2 Review Strategy:

I chose to use a thematic synthesis for this review to find commonalities across the research. I examined and coded what participants quoted within research, as well as the researchers’ interpretations and understandings of their stories. Montouri (2005, pp. 374) understands literature reviews to also “*explore the deeper underlying assumptions of the larger community or communities of inquiry one is joining and one’s own beliefs, assumptions, and attachments.”.* We are engaging in a conversation with the research and making meaning based on multiple contexts; participants, myself and the authors. Aligned with a social constructionist epistemology, our understandings of the world is context dependent (Philips, 2023). In conducting and writing this review I was invited, at multiple points, to reflect on my own subjectivity and emotional or embodied responses to what I was reading. Or better asked by Montouri (2005, pp. 390) “Who is the “I” that is inquiring? To what extent is the knowledge we are presenting functioning to maintain the self ’s story of self- identity?”, and I would add, personal assumptions? We do not come at knowledge objectively, but we can offer transparency in the ‘how’ and ‘why’.

1.5.3 Search strategy:

The search was structured according to ‘SPIDER’ criteria (Methley et al., 2014), see table 1. below. SPIDER criteria was developed to identify relevant qualitative and mixed-method studies (Ibid.). Search terms were developed from this and the Medical Subject Heading site was used to ensure a good variety of terms were developed.

SPIDER Criteria	
Sample	Healthcare Workers
Phenomenon of Interest	Moral Injury/Moral Distress
Design	Qualitative study designs
Evaluation	Participant and researchers views on contextual influences
Research Type	Qualitative methodologies

Table 2. SPIDER criteria

Scopus, Medline, Cinahl and Psychatricles were the chosen data based after a conversation with the university librarian. Each database is international and healthcare focused, and holds research that takes a social science angle, aligning well with my epistemology, making them appropriate choices for this review. The final search terms were chosen based on the SPIDER criteria and to ensure the research question could be answered. See table below:

Contextual Factors	**Moral Injury**	**Health Care**
	Moral distress or PMIEs or Potentially Morally Injurious Events and	NHS or National health service or Healthcare or Health services Or Health care
“contextual factor*” OR “social influence*” OR context OR “situational factor*” OR “systemic” AND “moral injury” OR “moral distress” OR “PMIE” OR “potentially morally injurious events” AND healthcare OR NHS OR “national health service” OR “health care” OR “health services”		

Table 3. final search terms[3]

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[3] Note. Truncation (e.g. factor* = factors, factoring etc) and quotation marks (e.g. “moral distress” or “moral injury”) were used to ensure that differing word endings and whole phrases were captured. Initial searches of each concept were conducted to explore the results generated. Boolean operators such as ‘OR’ / ‘AND’ were then used within and across search terms to yield further papers.

1.5.4. Screening and Eligibility Criteria:

A total of n=196 articles were retrieved via the four data bases named above, as well as n=11 ‘other’ papers included based on papers send via colleagues or mentioned in reference lists of systemic reviews close to the topic of moral injury. Medline produced n=70 papers, Scopus n= 65, CINAHL n=48 and PsycArticles n=2. These were then imported to Covidence which removed a total of n=84 papers leaving n=112 to be screened based on the eligibility criteria as outlined below in table 3 below.

Inclusion Criteria	**Exclusion Criteria**
Healthcare staff	Not related to healthcare staff or related to healthcare staff working in other contexts such as military or humanitarian aid
Directly related to moral injury or moral distress	Study does not explicitly address moral injury or moral distress
Qualitative research or mixed methods	Quantitative only
Discusses contextual factors related to moral injury or moral distress	Published during or after the Covid-19 pandemic
Published between 2010 - 2020	Only available in a language other than English
Empirical research	
Written or translated to English	

Table 4. Inclusion and exclusion criteria

Title screening removed a total of n=34 papers, leaving n=67 eligible for abstract screening. Both title and abstract screening was completed by two reviewers which lead to n=28 conflicts, resolved through discussion and review of the eligibility criteria. A final n=27 papers were included for full text screening which resulted in n=11 papers being included for the review. The full text screening was also conducted by another reviewer to ensure consistency.

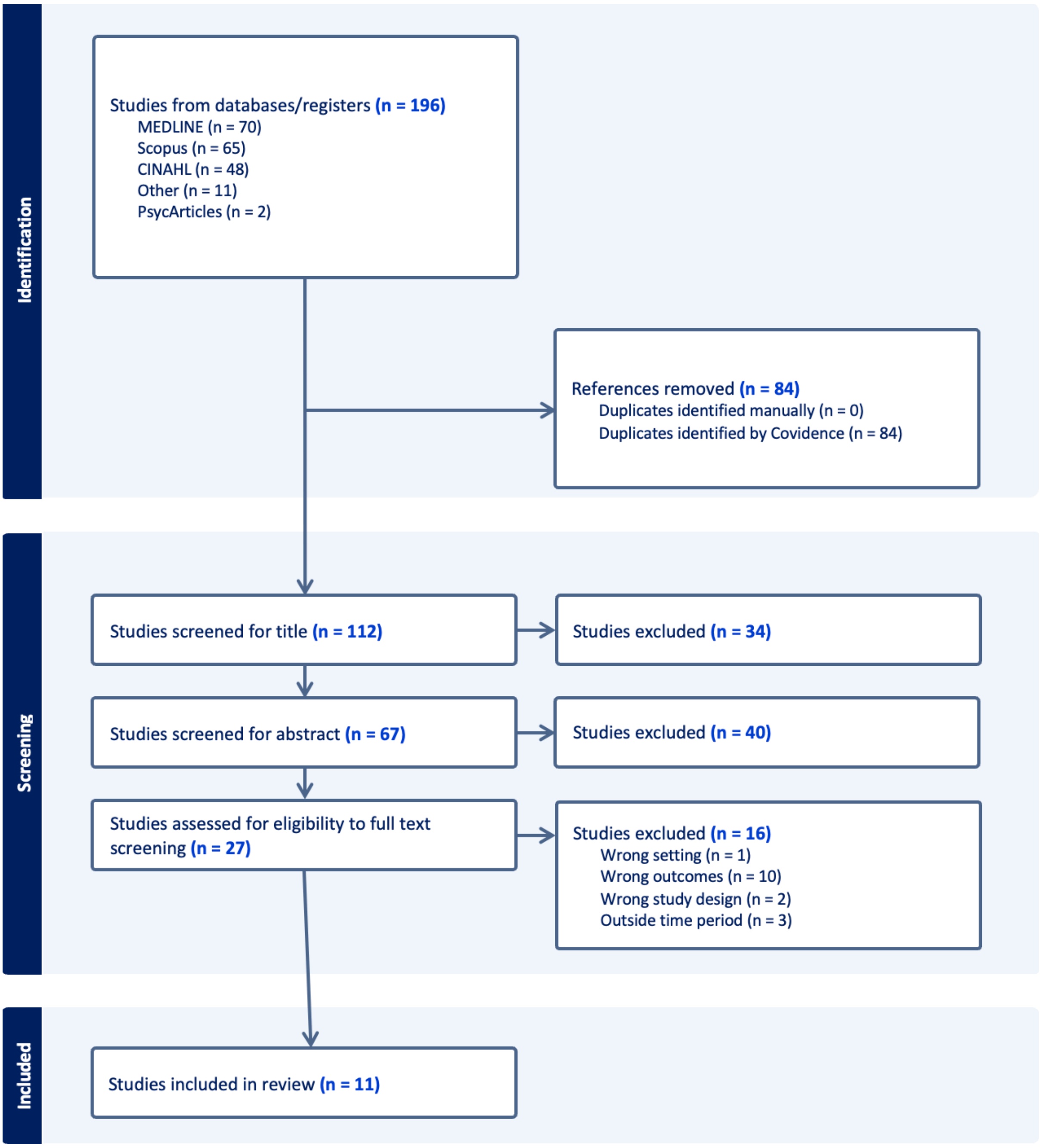

Figure 4. Prisma diagram

To remain close to the research question and the overall topic of this thesis, papers needed to explicitly aim to address moral injury or distress or speak about it as a key finding. The time period was chosen based on pre-pandemic research and 10 years before, i.e. 2010 – 2020. This was because even if papers completed data collection prior to 2020 but was published during or after it could be too complex to unpick the influence of the pandemic on the final publication. Given the change in terms related to healthcare workers experiences of distress, language is every changes and thus the lower date (2010) was chosen to ensure research included reflected more contemporary understand of MI/D. Unfortunately, no other researcher spoke a language other than English nor was there time or financial resource to seek translation services, and therefore only papers written in, or translated to English could be included. Given MI is based on the idea of being unable to work in ways that align with ones personally held beliefs about what's 'right', it would have been beneficial to have been able to consider how moral injury was researched in as wide a variety of contexts as possible. However, it should be noted that included papers represent experiences from healthcare settings in both the Global North and Global South.

1.6 Critical Appraisal:

While there is considerable debate about whether or not there is a place for critical appraisal (CA) of qualitative research, multiple frameworks have been developed to do so. A CA is the activity of examining research for its trustworthiness, its value and relevance in a particular context (Critical Appraisal Skills Programme, 2018). When conducting a CA one is thinking about whether or not the piece of research addresses what it sets out to, as well as making clear any influencing factors such as context of the research for example (Hannes, 2011). Given how widely qualitative research is used within health research, and it's influence on clinical practice, there is absolutely a need to be able to understand the validity and reliability of qualitative research (Williams et al., 2020). Furthermore, qualitative research is not a single, unified approach and therefore it feels appropriate to be able to engage in, and develop, how we consider the utility of qualitative methodologies.

I chose to use the Critical Appraisal Skills Programme (CASP; 2018) tool for qualitative research, frequently employed within health and social care-related qualitative syntheses (Hannes & Macaitis, 2012). The CASP (2018) tool includes 10 questions that are centred around three main aims: the validity of the study (relating to the soundness or rigour), the findings and its value or contribution. A summary of the quality appraisal is shown below, table 1.

	A. Are the results valid? 1. Was there a clear statement of the aims of the research?	2. Is a qualitative methodology appropriate?	(Is it worth continuing?) 3. Was the research design appropriate to address the aims of the research?	4. Was the recruitment strategy appropriate to the aims of the research?	5. Was the data collected in a way that addressed the research issue?	6. Has the relationship between researcher and participants been adequately considered?	**B. What are the results?** 7. Have ethical issues been taken into consideration?	8. Was the data analysis sufficiently rigorous?	9. Is there a clear statement of findings?	**C. Will the results help locally?**
Bruce et al., 2015	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Yes	Yes	Yes - clear practical and research implications outlined. They also conducted the research across professions working in ICUs which is beneficial, however, it unclear how the results could (or could not) relate to other medical settings.
Biondi et al., 2019	Yes	Yes	Yes	Yes	Yes	No	Yes	Can't tell	Yes	Yes - this study highlighted the need to consider the moral distress on clinicians, as well as the impact services have on SUs that they care for. The implications were well rounded in that it looks at the impact across a service rather than just focusing on the impact of clinicians only. Further research was also suggested.

Cervantes et al., 2018	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes - this study spoke well to the complexity of the positions of the clinicals working with undocumented migrants, as well as addressing strengths and hopes within the role. They also engaged in member checking and triangulation ensuring robustness of the findings.
dos Santos et al., 2018	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	Yes - the implications of this study were threaded throughout rather than clearly discussed. It would have been helpful for the researchers to have presented a clear idea of the implications for the research.
Edwards et al., 2013	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes - clear next steps for further research outlined, as well and consideration of changes that can be made to services to support staff facing potentially morally injurious situations. Breath of considerations offered about practical changes, education and further research offered.
Harrowing & Mill, 2010	Yes	Yes	Yes	Can't tell	Yes	No	Yes	Yes	Yes	Yes - The study spoke well to the moral conflicts experienced by the healthcare staff, and managed the complexity of beliefs and experiences well. Much more consideration was needed about the role of the researchers in relation to the

										topic and the context of cross cultural research. Clearer implications for the research would have been useful.
Matthews & Williamson, 2016	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes - the research adds value and highlights the needs of a population of healthcare works often not included in such studies.
McLean et al., 2019	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes - this was quite a controversial topic between the participants and more widely, therefore the depth of the data presented was particularly useful and speaks well to the development of the data collection and analysis. Clear indication of further consideration clinically and in research, and stays true to the need to consider the complexities and how ones values may not always align with what is needed within the role.
Oelhafen et al., 2018	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	The concept of moral distress, in my view, was not well fleshed out and therefore arguments as to how this came up in the data did not always feel clear - though this is acknowledge within the paper "It is striking that the triggers leading to the experience of moral distress and leading to general work-related stress seem to overlap largely. Again, our

										methodological approach of using a very broad definition of moral distress might have influenced our results to a certain extent" pp 1383. There are multiple contributed explicitly discussed and suggested emerging from this research in relation to moral considerations with in the work of midwifery - this was not widely studied at the time of publication (moral distress as related to midwifery).
Shahbazi et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes - there are several clear statements about what could come from this, as well as suggestions for further research. The implications are discussed in relation to clinical practice as well as research need.
Thorne et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The study thought about implications and the complexity of needs which is important when considering values and 'safe' productivity in high intensity work places. Throughout the discussion they suggested where change or considerations need to be focused e.g. bully cultures needing more policies and mechanisms in place to support those who are not being heard - with consideration of power dynamics within a team.

Table 5. CASP Quality Apprasial Checklist (2018) completed for this SLR

1.6.1 Are the results valid?

All studies included in this review, based on my assessment, were valid according to the above CASP criteria. There was a clear statement of aims, and appropriate methodological considerations acted upon in order to ensure the aims of the research was clearly addressed. However, of the 11 studies, only three spoke explicitly to the relationship between the researcher/s and participants (Shahbazi et al., 2018; Thorne et al., 2018; Edwards et al., 2018). From a social constructionist perspective our ideas and meanings are constructed within relationships and are a collaborative process. Meaning is also influenced by elements such as (but not limited to) culture or sameness and difference, and therefore it felt important to understand how this might have been navigated within the research. Harrowing and Mill (2010) both listed the university they're affiliated with as one based in Canada, but the research was conducted in Uganda. As a reader I was left wondering what their position in relation to health care in Uganda was, and what the influence of the cross-cultural understandings may have had the research planning, implementation and interpretation.

1.6.2 What are the results?

All studies sought and were granted ethical approval, and it is for that reason that I concluded ethical issues were sufficiently taken into consideration. The assumption being that if ethics was granted the researchers would have addressed issues around consent, informed decision making, right to withdraw etc.

The CASP criteria invites the reviewer to consider positions over and above just seeking ethical approval, such as detailing how the research was explained, how issues were managed between researchers and participants, or between participants where appropriate. This was rarely explicitly stated within the included papers. Considering this, I am of the view that this is where the CASP criteria falls down somewhat in its rating scale. It would be useful to have something like a 'partially' category. In this case it would acknowledge that the researcher/s sought the appropriate ethical approval needed to go ahead with the research, but more nuanced considerations could be more openly addressed, such as conflict or power differentials.

Data analysis and statements of findings were strong among most papers. Typically researchers spoke explicitly about the ways in which they crossed referenced themes and results across the teams, increasing the validity of the results and limiting bias (as much as one can) in the interpretation of findings. Cervantes et al., (2018) and Shahbazi et al., (2018), went a step further in ensuring rigor and engaged in member checking. This is the process of verifying the results and interpretation of the data with the participants to ensure credibility, thus increasing trustworthiness (Birt et al., 2016).

Dos Santos et al. (2018), presented a table of direct quotes which related to the themes discussed in the results section, however, within the narrative of the results section just the interpretation was written. Harrowing and Mill (2010) spoke well to the moral conflicts experienced by healthcare staff and managed the complexity of personal or moral beliefs, however within the statement of findings not all assertions made by the researchers seemed adequately supported by the direct participant quotes. For example:

> None felt that terminating their employment was a viable option, as the chances of finding other employment were minimal at best and all participants depended heavily on the income to support family and extended family members. Sandra spoke for all when she said “I wouldn’t think of [giving up].’’ Ruth noted that if you did what you could do under the circumstances, then “you feel contented.’’ Christine concurred, saying that “sometimes I also fail, but I say I did the best, I did what I could do. I can do nothing more. . . so I’m not going to cry over that.’’ Eunice shared her strategy of “closing the door’’ and delegating work to other staff when she was overwhelmed and needed time to recover. (Harrowing and Mill, 2010, pp 728)

In my interpretation, these quotes used did not speak to participants expressing concerns regarding alternative employment options.

1.6.3 Will the results help locally?

The final section of the CASP criteria invites engagment with the overall findings and discussion in relation to potential impact of the study. Each paper spoke to the lived experience of the participants, and key element of research is to highlight how something functions – which is the case of all of the papers. Further than this however, each paper made valuable suggestions around the implications or research, and potential next steps either for further research, or by what considerations could be useful when supporting staff.

1.7 Results:

As can be seen in the Prisma diagram (fig. 4) 11 papers were included in the final analysis. The criteria for this review was that the researchers used qualitative methodologies, but the method of data collection and analysis varied across the papers. Eight papers conducted interviews with their participants (Biondi et al., 2019; Bruce et al., 2015; Cervantes et al., 2018; dos Santos et al., 2018; Edwards et al., 2013; Oelhafen et al., 2018; Shahbazo et al., 2018; Thorne et al., 2018). While Bruce et al., (2015) interviewed their participants, they used real case studies to structure the discussion. All members interviewed had worked in some capacity on the cases presented. McLean et al., (2019) conducted interviews followed by focus groups, Harrowing and Mill (2010) used interviews, direct observations and focus groups, and Matthews and Williamson (2016) asked participants to keep diaries for a period and then followed up with interviews.

The service context and professionals varied across studies. All of the studies but one took place in physical healthcare settings; Matthews and Williamson's (2016) paper was based on healthcare assistants working within an adolescent acute mental health inpatient service in the U.K. Bruce et al., (2015) and Cervantes et al., (2018) studied the experience of interdisciplinary professionals (i.e. ancillary and clinical staff) based in emergency care facilities in the U.S.. Shahbazi et al., (2018) studied preceptor nurses in a paediatric hospital in Iran and dos Santos et al., (2018) spoke with nurses in a paediatric hospital in Brazil. Biondi et al., (2019), Oelhafen et al., (2018), and Thorne et al., (2018) focused on maternity or neonatal care, staff included nurses and interdisciplinary professionals in Brazil, Switzerland and Canada respectively.

Harrowing and Mill (2010) explored the experience of nurses providing HIV related care in Uganda. Edwards et al., (2013) studied nurses in a long-term care facility in Canada, and McLean et al., (2019) looked at the experience of interdisciplinary professionals providing abortions in Ethiopia. In summary, five papers spoke to the experiences of interdisciplinary professional, five spoke to nurses only, and one spoke to healthcare assistants.

Overall, the quality appraisal has encouraged me to reflect on what I find valuable to consider within my research, but also to think about how I present and make explicit to the readers my decisions, thinking and ethical dilemmas. A summary table 6 below outlines the main results as written by the researchers, as well as the key strengths and limitations where provided.

Author, title, year, location	**Definition used for Moral Injury/Distress**	**Population and context**	**Data collection and analysis**	**Key findings**	**Strengths and limitations**
Biondi, Barlem, Pinho, Tavares, Kerber & Tomaschewski, 2019 Moral suffering in assistance to childbirth: situations present in the work of nurses of obstetric centers and maternities. Brazil	Moral suffering, characterized by painful psychological imbalance resulting from the impediment brought about by the environment so that the same their conduct in accordance with the ethical conduct they deem appropriate	14 **nurses** working in maternity hospitals and obstetric centres.	**Interviews** Content analysis	Moral suffering: the multiplicity of tasks and withdrawal of assistance; need to focus on administrative over direct care due of lack of professionals available to provide the care 2. Moral suffering from the interpersonal relationships of the multi-professional team: faces of restricting the autonomy of the nurse: unequal power relations within an MDT, nurses not being taken seriously or needing to adhere to desires of doctors for example 3. The emergence of moral suffering in the face of the perpetuation of dehumanising practices: social discourses that disenfranchise women are played out, not respecting the autonomy of the mother and using power to enforce decisions. Discourses playing out that cause harm e.g. the assumption that c-section is better despite that not being the case.	- One understands as a limitation of the study the fact that it has been performed in just two hospitals, which represent a small universe in the national reality, and also, because for using data from an interview script that does not explicitly address questions about moral suffering, a fact that evokes more complete investigations. - It should be noted that the participants were generalist nurses and that the non-training in the obstetrical specialty becomes an impediment to for determining some obstetric behaviours during the childbirth by these professionals, being this aspect collaborative with regard to their lack of autonomy, which constitutes a limitation of this study.
Bruce, Miller & Zimmerman, 2015 A Qualitative Study Exploring Moral Distress in the ICU Team: The Importance of Unit Functionality and Intrateam Dynamics America	...MD occurs when a healthcare professional believes he or she knows the ethically correct action but cannot follow that action because of an interpersonal, intuitional, regulatory, or legal constraint	29 **Interdisciplinary Healthcare** Professional working in an Intensive Care Unit (ICU) (chaplains, social workers and case managers and nurses and physicians)	Interviews conducted based on real-life **case studies.** Yin's conceptual framework	1. Sources of Moral Distress; discordance most prominent was intrateam discordance. 2. Lack of disclosure leading to clinicians feeling that patients and families were ill-prepared for what to expect in regards to treatment/surgery. 3. Managing Moral Distress; maladaptive behaviours and constructive behaviours.	Strengths: + Discussed instances close to time of them actually happening thus avoiding recall bias and capturable compounded experiences. + All clinicians spoke about the same case meaning they could make some more general observations. + Various professions interviewed. Limitations: - Qualitative studies; non-generalisable, no definitive casual assertions and empirical comparisons. - Gendered; mainly female nurses and male physicians

Cervantes, Richardson, Raghavan, Hou, Hassain-Wynia, Wynia, Kleiner, Chonchol & Tong, 2018 Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants: A Qualitative Study. America	...Moral distress is traditionally defined as knowing the morally right thing to do but being unwilling or unable to do it because of external constraints.	50 **Interdisciplinary Healthcare professional** working in an emergency care that provides emergency only haemodialysis to undocumented immigrant (physicians, nurses and allied health professionals).	**Interviews** with results member checked. Thematic analysis with principals of Grounded Theory	1. Drivers of professional burnout; organisational and system-level barriers to providing care led to unnecessary suffering of pts., betrayal of pts trust and detachment. Unable to provide care 2. Moral Distress from propagating Injustice; medical decisions being made based on non-medical factors such as social status. Volume at the expense of quality of care 3. Confusing and perverse financial incentives; because they can only provide emergency care there was a lot of resource used to decide if this was an emergency or not. 4. Inspiration towards advocacy; sense of altruism and drive to push for equality in care.	Whether the findings apply to other settings is un- known, and social desirability response bias might have reduced reporting of negative perceptions and experiences.
dos Santos, Neves & Carnevale, 2018. The moral experiences of pediatric nurses in Brazil: Engagement and relationships. Brazil	Moral distress, when nurses feel prevented, for different reasons, of taking a course of action that they consider to be ethically correct	9 **Nurses** in a paediatric teaching hospital	Narrative **Interviews** IPA	1. Moral experiences and relationships among healthcare professionals in paediatric units 2. Moral experiences and relationship between the nurse and the family in paediatric units 3. Moral experiences and relationship between the nurse and the child in paediatric units	This study has limitations related to the nature of the empirical data described, which are directly linked to professionals who work in paediatric hospital services, making their transfer to other scenarios question- able. Still, it is possible to assume that these results are embedded in the cultural context of Brazilian nursing. As follows, it is up to the reader to consider relevant, or not, the use of these findings in other environments.

Edwards et al., 2013 Nurses' responses to initial moral distress in long-term care. Canada	In nursing literature, moral distress was first described by Jameton as arising "when one knows the right thing to do, but institutional constraints make it nearly im- possible to pursue the right course of action" (1984, 6).	15 registered **nurses** with at least one years experience Long term care facility	Thematic analysis - each nurse having two **interviews**	1. The context of the situation matters 2. The value of coming together as a team 3. Looking for outside direction.	Limitations: - Mainly nurses from publicly funded services, some from private. There may be differences in nurses' practice and response to moral dis- tress between these two types of facilities and this warrants exploration - Our sample size was small and the nurses we interviewed were quite experienced.
Harrowing & Mill, 2010 Moral distress among Ugandan nurses providing HIV care: A critical ethnography. Uganda	Jameton (1984) as the painful emotions experienced by nurses in situations when they are cognizant of the morally appropriate actions to take but find themselves limited by institutional barriers.	24 **Nurses** in both critical care and public healthcare providing care to patients with HIV	**Interviews, observation** and **focus group** discussion. Critical ethnography	Themes: 1. 'Called to service' - pride and value of their jobs. 2. Hurting and haunting - feeling unable to provide good quality care due to lack of resources. 'too much work, not enough nurses'. Nurse received two critically ill patients and was forced to choose one to attend to, the other died. 3. Losing the essence - 'nurses in Uganda are traumatised'. Eunice concurred: ''When you get used to doing things sub- standard it can become a habit I think. You then lose the essence of doing it fully right.'' Poor public perception of the profession (due to lack of resource to do the job well). 4. Counting for something - committed to the job and acknowledging small succussed where possible. Engaging in political action to raise awareness of the systemic challenges. Developing strategies to cope, relying on team possible.	Not explicitly listed

Matthews & Williamson, 2016 Caught between compassion and control: exploring the challenges associated with inpatient adolescent mental healthcare in an independent hospital. UK	...moral distress refers to the psychological, emotional and physiological suffering that healthcare professionals experience when they act in ways that are inconsistent with deeply held ethical values, beliefs or commitments	10 **Healthcare assistants** (HCAs) working in an adolescent inpatient unity	**Diary entries** and **interviews**	The findings illustrated how inpatient mental healthcare is a unique and distinctive area of nursing, where disturbing behaviour is often normalized and detached from the outside world. Healthcare assistants often experienced tension between their personal moral code which orientate them towards empathy and support and the emotional detachment and control expected by the organization, contributing to burnout and moral distress.	Limitations: - A limitation of this study is the sample used permanent and causal employees who worked regularly in a ward for a minimum of 6 months, although burnout and moral distress were prominent themes, permanent staff and nurses who worked in this environment for a considerable period of time may experience substantially higher levels of burnout and moral distress. - Furthermore, the majority of participants were degree-educated and many were under- taking the healthcare assistant role as experience for accessing better paid and higher status careers. - Younger age of participants, thus less time spent in the role/profession. Strengths: + Use of diaries allowed healthcare assistants to describe their experience in their own words, provided a breath of important clinical issues and fostered individual reflection. It also meant thoughts and feelings could be captures soon after an event. + Interviews allowed for reflection and provided participants with an opportunity to explain the meaning of their experiences, providing a richer level of understanding and data. The use of two methodologies allowed for data triangulation, an extended understanding of the phenomenon and a more in-depth, multidimensional insight to the complexity of the social world.

McLean, Desalegn, Blystad, Miljeteig, 2019 When the law makes doors slightly open: ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia. Ethiopia	…described as doing something against one's moral values.	24 **Interdisciplinary clinicians** (nurses, doctors, health officers, medical students) working as abortion providers	**Interviews** and **focus groups**	Themes: 1. the law might be clear but the reality is not; meaning choices around when to provide abortions, knowing a woman is lying and choosing to believe her (or not), what reasons are acceptable etc. 2. Am I conducting a crime?: religious beliefs causing sense of shame and confusion about this new part of their role. Culturally/socially abortions are seen as taboo. 3. I don't tell them i conduct abortions: for fear of social mores and discrimination from other colleagues 4. A way to save our clients lives: as a way of justifying providing abortions in situations where it went against their moral beliefs.	- A potential limitation to our study is that we only inter- viewed abortion service providers in the city of Addis Ababa. '- Moreover, assuming that ethics is coloured by the context, experienced dilemmas and challenges are likely to vary, and hence one should be careful with generalizing our findings. '+ Nonetheless, we believe that our study provides an important glimpse into the dilemmas that abortion service providers are likely to experience beyond Addis Ababa, as the law and the clinical guidelines regulating the field of abortion are the same throughout the country.
Oelhafen, Monteverde & Cignacco, 2018 Exploring moral problems and moral competences in midwifery: A qualitative study. Switzerland	…moral distress, that is, negative emotional and physical reactions, which, in turn, may result in impaired quality of care, reduced job satisfaction, and increased attrition rates.	10 **Interdisciplinary Clinicians** (8 midwives, 1 nurse, 1 physician) in maternity care.	**Interviews** It should be noted this piece of research was written up as a singular study, but was conducted as part of a wider, mixed methods study. The aim of	1. External constraints limiting the midwife's and the patient's autonomy and resulting interpersonal conflicts were found to be the most relevant ethical issues encountered in clinical practice and were most often associated with moral distress. 2. These conflicts often arise in the context of medical interventions midwives consider as not appropriate and situations in which less experienced midwives in particular observe a lack of both interprofessional communication and trust in their professional competence. 3. Ethical issues related to late abortions or prenatal diagnostics and selective abortions were also frequently addressed, but many midwives involved had learned to cope with them.	Not explicitly listed

Shahbazi, Valizadeh, Borimnejad, Rahmani, & Vaismoradi, 2018 Living With Moral Distress: The Perspectives and Experiences of Iranian Nurse Preceptors. Iran	Not given	6 **Nurse preceptors** in a paediatric teaching hospital.	**Interviews**	Themes: 1. Asking for and being unable: This theme described the preceptors' inclination to support and educate new nurses in some situations. 2. The experience of conflict: Different ideas, values and perspectives of the preceptors and new nurses with regard to patient care led to the development of conflicts.	Not explicitly listed
Thorne, Konikoff, Brown & Albersheim, 2018 Navigating the Dangerous Terrain of Moral Distress: Understanding Response Patterns in the NICU Canada	...moral distress, when one knows the right course of action, but institutional or cultural constraints prevent one from pursuing it.	28 **Interdisciplinary health professionals** (neonatologists, clinical associates, clinical fellows, nurses, respitory therapists, social workers and pharmacist)	**Interviews**	What we learned from these study participants was that moral distress was a prominent and pervasive experiential aspect of work in the NICU context. We also learned that it was difficult to discuss. The tone of the interviews was often intense, with considerable expression of emotion, including tears in a majority (~80%) of the interviews. Themes: 1. Nature of the problem: "certain kinds of ethically complex clinical scenarios, and also a set of organizational and relational conditions within the workplace culture in which those complex clinical scenarios were managed." 2. Human impact patterns: Responding and Reacting: "What we heard from these clinicians was that managing moral distress was very much a part of managing the entirety of the emotional residue of their work. We heard narratives of bursting into tears, nightmares, broken relationships, depression, anxiety, and self-medication."	Limitations: - [Can] not have captured here all possible clinical scenarios or responses to them that might contribute to distress among those who work in such a setting. - [E]ach NICU will have its own distinctive culture and working climate, as well as its history of attention, or lack of attention, to the emotional well-being of its staff. - [W]e recognize that, as those who expressed their willingness to be interviewed reflected a subset of the total available population, they may have had different experiences from those who preferred not to participate in the interviews. Strengths: + [T]hese findings reveal a glimpse into the

					enormity of the challenge faced by health professionals working in a health care context that will inevitably be characterized by complexity where care of fragile newborns and their families is concerned. + [The] findings add to the available understanding of when, why, and how moral distress occurs in this setting, and the manner in which it is played out, and potentially managed, in the individual and collective workplace experience.

Table 6. data extraction table

1.7.1 Thematic Synthesis:

Thematic synthesis was used to pull out the main themes and commonalities across the papers. The research question for this SLR was to consider the contextual factors discussed that related to participants experience of MI, and the themes have been divided into; intrapersonal factors, interpersonal factors, institutional factors and systemic as depicted in fig 2. I will also discuss these themes in relation to power and context, as, from my interpretation, there are themes discussed in the intrapersonal level that speak to wider power dynamics or cultural contexts. From the position of social constructionism, one cannot separate the person from the context, and dominant discourses. It is important to note here that I have chosen these categories as there is a need within the framework of a systematic literature review to definitively categorise themes and ideas. I find this quite challenging in speaking about factors or influences of MD because my understanding of the world is that the personal necessarily *is* cultural and political. Thus, what I describe as intrapersonal could also reasonably be considered institutional or systemic for example. I will speak more directly to this with examples further on. It also highlights the need to constantly hold in mind the various ways in which we see the influence of power.

1.7.2 Intrapersonal (internal narratives and conflicts; influenced by wider discourse typically)

Here participants spoke to internal conflicts or ideas about themselves in their personal and professional identities. The constraints or contradictions coming from within in relation to how the individuals experienced their roles. I did not interpret this theme to be discussed across all the papers - five of the 11 (dos Santos et al., 2018; Harrowing & Mill, 2010; Mclean et al., 2019; Oelhafen et al, 2018; Shahbazi et al., 2018). Furthermore, in the discussion regarding intrapersonal factors, only one paper related this to wider cultural or contextual influences (McLean et al., 2019).

“If it is rape I think it’s better [for her] to keep the pregnancy, because I’m a Protestant, and I think it is a sin to terminate a pregnancy that is alive.”(5, ID)” (participant quote, McLean et al., 2019, pp. 6). Of course, there are wider systemic implications about the influence of religion – religion influences culture, and is simultaneously influenced by culture (Beyer, 2000). However, here the participant is speaking to her personal, religious views conflicting with her professional responsibilities as an abortion provider. They are speaking about their internal views causing them distress, and their professional and personal values are in conflict. “They will claim to be raped, but you can just see … From their physical stature, the emotional and the psychological appearance, you will know that it’s not the case, but you still would have to provide the service…(6, ID)” (participant quote, McLean et al., 2019, pp. 5). This quote highlights subjective, personal assumptions made about how someone who has been raped should present, or perform, the ‘victim’ identity attached to those who have experience rape or unwanted sex (O’Shea et al., 2024).

1.7.3 Interpersonal Factors (between team members, teams and patients, etc. – micro level)

1.7.3.1 Discordance that directly included patients:

dos Santos et al. (2018), Oelhafen et al. (2018) and Thorne et al. (2018) spoke to instances whereby clinicians felt that patients were making choices about their or their children’s care that was either medically futile or caused direct harm. Thorne et al., (2018) reported a situation whereby “Nursing would refuse to take care of that baby, they would leave their shifts crying.” (pp, 688). This referred to a baby who was painfully dying on the ventilator, but the parents, understandably, couldn’t let the baby go. Sometimes that sense of futility was difficult for staff, needing to respect the families wishes but knowing it is just using resource and causing pain. “And it’s the little things, because I know that whatever way it is done the outcome will be the same. (Nurse 5, PICU)” (dos Santos et al., 2018 pp. 1572). It makes me consider the conflict this may bring up for clinicians who working in teams and organisations that are struggling with a lack of resource, but are in a position where they have to keep pulling from a limited supply to provide care they medically ‘know’ (as much as one can know anything) that there is little to no hope of a different outcome. The flip side of this was seen in McLean et al (2019) when clinicians felt that patients were lying about their care needs in order to get care. Again, knowing there is limited supply, but that being challenged by having to provide care when the clinician is not sure it’s indicated.

The final two codes that emerged under this theme related to more discriminatory based practice. In Biondi et al. (2019), clinicians often reported sexism within the teams, more often from those perceived to have more power, like physicians over midwives. Midwives in the studies felt that their care was more humanising and found it hard to watch sexism and harm play out when patients were under the care of clinicians adopting a more medical ways of working. Thorne et al (2018) reported that clinicians would notice parents being shamed when they agree that lifesaving care should be removed when there was little hope of recovery. The dominant narrative was that parents would beg for anything to be done, but in the few instances parents went along with the advice that meant 'letting' (so to speak) their child die, clinicians found it odd or uncomfortable. Which contradicted the distress clinicians described when they were made to provide care that they knew couldn't or wouldn't help. Its interesting here to consider that the response to the same, or very similar circumstance, is changed or altered depending on who made the decision [power]. Was it the clinician, who is expected to make medically backed choice, or the patients and families who are supposed to make emotional choices? When the narratives are subverted, it seems to have bring discomfort when considering how different people are positioned in different contexts – adhering to dominant narratives.

1.7.3.2 Inter-team and intra-team discordance:

Many of the studies spoke to this - either difficulties in making a shared decision (Bruce et al., 2015; Biondi et al., 2019; Cervantes et al., 2018; McLean et al., 2019; Thorne et al., 2018), bullying culture (Thorne et al., 2018), the feeling managers are not involved in direct care (Edwards et al., 2013) or hierarchies and power causing those to feel subordinate within the team or due to their profession (Biondi et al., 2019; Bruce et al., 2015 dos Santos et al., 2018; Matthews & Williamson, 2016; Oelhafen et al., 2018; Thorne et al., 2018).

There was a sense that when it came to decision making there was at times a misalignment of the procedures of care and therefore clinicians would often feel as if they were fulfilling another clinician's decision that they ultimately didn't agree with (Biondi et al., 2019; McLean et al., 2019; Thorne et al., 2018). Alternatively, there were feelings that the "team just couldn't get on the same page…" (Biondi et al., 2015, pp. 826). At times, clinicians in Thorne et al., (2018) felt stuck between institutional discourses and the relational dynamics.

Oelhafel et al., (2018), spoke to the impact of power differentials within interdisciplinary team members. In their study, midwives reported that physicians were ultimately responsible for patient care. But, when the physician was less experienced, midwives noticed them becoming more controlling or intervening more often causing the birthing parent further distress. Midwives would feel, due to the power differential, that they could not speak up, leaving them often feeling silenced or powerless within their role (Oelhafen et al., 2018), or at times helpless (dos Santos et al., 2018). Nurses in Biondi et al (2019) felt they were not treated at equal, and often delegated *to*, regardless of their professional views. Participants in Matthews and Williamson (2016) directly stated they felt “subordinated to those above them” (pp 1048).

1.7.4 Institutional factors specifically related to healthcare (meso level):

Power plays a core role in within this theme, and again, it becomes more challenging to unpick the wider sociocultural elements from healthcare as an institution. This overall theme can be categorised into two sub-themes: narratives within healthcare and practical limitations. However, the practical limitations will be influenced by certain narratives and visa versa.

1.7.4.1 Narratives within healthcare settings:

This was relevant across all papers but was noticed or played out differently within the research presented. Typically participants felt that the narratives they were working to were at odds with their own views of care. This came out quite starkly in Matthews & Williamson (2016). Participants were healthcare assistants working in adolescent inpatient mental healthcare. One participant stated they “…find that institutional constraints do not promote person centred values, but rather are punitive to a group of vulnerable, damaged young people…” (pp. 1047). Here we can see the internal conflict cause by being in a helping role within an institution perceived to be causing harm due to the institutional culture [systemic/macro factor]. The researchers interpreted this as “The discourse of the profession and the organization where he works are largely counterintuitive, resulting in a range of negative emotions” (Ibid, pp. 1047).

In Harrowing and Mill (2010), nurses felt that due to resourcing limitations they felt they faced while providing care, they were unable to provide adequate care to the community the served. Consequently they developed negative reputations within their community. Further increasing their frustration and distress, they felt that the managers did little to combat this or raise awareness about the realities they were working under. There was a sense that the managers should have protected them from this reputation, and that they hold the power to make clear the constraints they were working within. There was a sense that the nurses felt scapegoated by management, rather than an acknowledgment that resource was not being provided by the healthcare services. Here we can see the systemic factors being an individual problem, akin to responsibilization as discussed in the CGT model presented later in this paper.

Participants in Cervantes et al. (2018) felt that due to legal limitations, care could only be provided if the undocumented migrants they were working with were ‘bad enough’. One participant likened it to “torturing them” (pp. 80) and that it felt as if “some [patients] are worthy, and some are not” (pp. 82). This was typically based on what the participants perceived to be trivial or conflicting medical definitions or rules, influenced at times by the availability of resource, rather than patient need. Again we see wider, political factors causing conflicting narratives for healthcare providers – wanting to provide care but believing that was not the core motivation of the services they worked with. There was also a sense that participants were worsening the lives of an already marginalised community of people.

Similarly, participants in McLean et al. (2019) spoke to the imbalance between the rules and laws, versus what was actually done. They shared that abortions were provided to those with “reasonable” or “good enough reasons” (Ibid, pp. 5) but that “such an assessment did not always follow the rule of law” (Ibid, pp. 5). In my reading of this there is a significant amount of subjective judgment in the terms ‘reasonable’ or ‘good enough’. As participants (the abortion providers) within the study already spoke to the stigma surrounding abortion care, it makes me question the weight of care seekers (abortion seekers) needing to ‘prove’ their reasons were ‘good enough’. It seems as if this could relatively easily result in an unfair or inequitable healthcare provisions. This also placed clinicians in morally distressing positions. Participants were willing to provide abortions when it means aligning with the professional duties and the law. However, due to the limited clarity and guidance, they often felt as if they were placed in the position of needing to make the decision themselves based on subjective decision making, rather than being able to simply rely on the rule of law. Edwards et al., (2013) and Thorne et al., (2018) spoke to a "culture of silence" (Thorne et al., 2018, pp. 693). Edwards et al., (2013) quotes clinicians speaking about messaging that made participants feel they should also be silence, and that they were told "you need to be tougher" (pp. 330).

The narratives that exist and wield power within the institutions caused participants moral distress and conflict in all the studies.

1.7.4.2 Practical limitations:

The main practical limitations within institutional constraints related to participants feeling as if they needed to attend to non-patient facing work more than patient facing work (Biondi et al., 2019; dos Santos et al., 2018; Shahbazi et al., 2018) and lack of resource (Biondi et al. 2019; Cervantes et al., 2018; Edwards et al., 2013; Harrowing and Mill, 2010; Oelhafen et al., 2018; Shahbazi et al., 2018; Thorne at al., 2018). Resource here referred to time, medical equipment, staffing, funding etc.

Participants across papers spoke about administerial tasks taking up too much time. This led to a sense of dissatisfaction and frustration among staff across disciplines and settings. In Biondi et al.'s (2019) paper one nurse reported "Sometimes I want to stay directly with the patient…but I cannot because the bureaucracy itself will not let me do that… (E8)" (pp. 5). This sentiment was common, the idea that the bureaucracy was more important than patient care.

Other ideas emerged within this theme; Cervantes at al., (2018) and Thorne et al. (2018) stated that ambiguity around rules (within services) for patient care was a significant challenge, leading to distress and a sense of "powerlessness" (Thorne et al., 2018, pp. 690). The upset was around this feeling of unfairness that came as a result of the ambiguity, rather than feeling there was any flexibility in how clinicians could work. I'm drawn to the idea of powerlessness. In Cervantes et al. (2018), the researchers commented that "Participants also said the criteria could vary across disciplines (for example, ED vs. nephrology), often without a clear rationale. (pp. 80)". ED referring to emergency departments and nephrology referring to clinicians who specialise in kidney diseases. Inequity between professionals came up in Edwards et al. (2013) when referring to the conflict felt between middle managers wanting to support front line staff but also needing to "toe the party line" (pp. 334). It makes me consider which professions hold more power, and which levels of management hold control?

Furthermore participants didn't feel that their wellbeing was adequately supported (Matthews & Williamson, 2016; McLean et al. 2019; Oelhafen at al., 2018; Thorne et al. 2018). Participants felt that there was inadequate provisions or time to manage the emotional toll of the job, and that even if support was offered by the organisation there is no time to utilise it; "It causes a whole bunch of new distress trying to find the time to do a debrief. (Neonatologist)" (Thorne et al., 2018, pp. 692). Participants felt that there wasn't enough time to recover on days off (Oelhafen et al., 2018) or that they spent their time worrying about patients doing something desperate and making themselves because they hadn't been able to provide adequate care as they were (McLean et al., 2019). Over and above impacting clinicians, we know that burnout is associated with lower quality of care and patient safety, as well as patient satisfaction (Li et al., 2024).

1.7.5. Systemic Factors (wider cultural, or sociopolitical narratives – macro level):

This was not explicitly spoken to across all the papers. The themes emerged in five of the 11 papers; Biondi, 2019; Cervantes et al., 2018; dos Santos et al., 2018; McLean et al., 2019 and Thorne at al., 2018. This theme can be divided up into two sub-categories: social inequity and social stigma.

1.7.5.1 Social inequity:

I define this to mean the experience of unequal access to resource based on one's status within society, and is impacted by power (defined earlier in this chapter). The main characteristics that were highlighted in the papers were poverty or economic status, age, gender and citizenship or immigration status.

One of the participants in Thorne et al. (2018) stated "When they leave the cocoon of the nursery, their child survived, but then it's a really lonely big world." (pp. 689). I was struck by the imagery generated by the two contrasting ideas of the safety of the "cocoon" vs. "really lonely big world". Here the participant was speaking about the hospital environment being comparatively resource rich, and so long as the patient and their baby had access to those resources they were 'safe'. But that this is in contrast to the reality of the world outside, an environment would not be able to provide in the same way. Here I'm drawn to consider which factors make the world so 'big and lonely', and what the participant felt or knew that family would not have access to. My assumption was tangible resources such as wealth and/or social networks that would provide hands on care and respite or perhaps suitable housing and medical supplies. According to Marchildon et al.'s (2020) report on healthcare in Canada, while there is the availability of public healthcare the "Socioeconomic inequalities in health are significant..." (pp. xvii). This speaks to me about the inequalities related to poverty and access to resource, not dissimilar to difficulties faced by healthcare provision in the UK, where scarcity and socioeconomic inequality has a significant impact on those who are marginalised within society. Marchildon et al.'s (2020) report went on to say these inequalities impacted Indigenous community most starkly (Ibid.). The MD for participants in Thorne et al.'s (2018) study came from the upset caused by knowing that institutions outside the care of the hospital likely would not keep the family safe, and there was a fear the family would experience harm going back out into the world.

Poverty and scarcity came up again in McLean et al.'s (2019) paper on abortion care in Addis Adaba, Ethiopia. "Many of the abortion service providers felt particularly sympathetic towards young women, especially students and poor young women. They expressed that they felt responsible for helping such women as an abortion could prevent them from dropping out of school, being ostracized by their communities, or falling into even deeper poverty." (pp. 5). The MD here was related to the sense that unless these woman could 'prove' their pregnancy was a result of rape, they were not entitled to an abortion. If these women had to have their babies it would cost them financially, or mean that they could have to give up their education. Despite this, papers representing views that abortions are wrong, those women described in the above quote were viewed as "reasonable women" who were "in dire need of help" (Ibid. pp. 5) but the legal framework to provide an abortion was not available to them. "Sometimes I'm satisfied with what I'm doing in the abortion case. For some clients, maybe they are very poor, the poorest. Most people with unwanted pregnancy are the poorest ones."(23, ID)" (Ibid., pp. 5). The distress arose when they couldn't be offered abortion care, despite many participants feeling that abortions went against their religious or cultural norms. Alongside poverty, their gender (by sheer virtue of it being abortion care) and their age were also seen as vulnerability factors, intersecting with their economic status, or rather, economic instability. It also highlights the role of subjectivity in deciding when providing an abortion is reasonable or fair, and ones context dictating that for patients and carers alike.

Cervantes et al.'s, (2018) study focused on MD felt by healthcare workers caring for emergency haemodialysis, mainly caring for undocumented migrants in the US. Participants shared that they often encounter situations whereby they're forced to make medical decisions based on non-medical factors such as "social status" (pp. 80). "It's kind of ridiculous that this group of patients have to go through a system that we know doesn't provide good care because of immigration paperwork." (participant quote, pp. 81). During the period of data collection, September 2016 to May 2017, Former President Donald Trump was elected president and inaugurated in January, 2017. Immigration in the USA was already a contentious topic, but Trump was reported to have "pioneered a new politics of perpetual culture war, relentlessly rallying his supporters against kneeling black athletes, undocumented Latino immigrants and soft-on-crime, weak-on-the-border Democrats." (Grunwald, 2018). I think it would be remiss not to consider the impact of the sociopolitical factors that would likely have influenced this piece of research, and the lives of those living undocumented at the time. Cervantes et al. (2018) cited that participants knew that their patients would put their health at risk so that they could receive emergency care as there were no other options.

1.7.5.2 Social Stigma:

This was discussed in three papers. Biondi et al. (2019) where participants referred to sexist views expressed by professionals towards women. And in McLean et al. (2019) participants spoke about fear of reprisals from their communities due to providing abortions. Overall research has shown that stigma can influence health and wellbeing outcomes, lead to the development of maladaptive coping strategies and poorer performance academically or professionally (Frost, 2011). In both papers these experiences of witnessing or fearing stigma contributed to participant's moral distress. The researchers in Biondi et al. (2019) commented that "Disrespectful positions toward women, committed by members of the multiprofessional team, through coercion and exposure to derogatory experiences, conflict with the humanizing ideals and moral values of nurses." (pp. 7). More poignantly, one participant stated "Women feel as 'garbage' [...] (E4)" (Biondi et al., 2019, pp. 7). Cervantes et al., (2018) stated "they also worried that EOHD policies normalized, and could even generate disrespect for and unequal treatment of other disadvantaged groups." (researchers words, pp. 80).

In McLean et al (2019) participants spoke to hiding what they do for fear of judgment or ostracisation from their communities. "Some described how they would jokingly be called "antigeneration" or "child killer" by colleagues who were not performing abortions." (McLean et al., 2019, pp. 6). This, coupled with reports of participants already feeling shame due to having to provide abortions in the first place, presents quite a complex picture. This is also a good example of when it becomes more challenging to unpick the systemic from the intrapersonal. Here one could argue that the stigma professionals face are likely to be internalised, or at the very least, their distress heightened by having their social networks 'confirm' the negative beliefs about their roles. This stigmatisation of a core duty of their role cause participants MD.

1.7.6 Conclusion:

In summary, this review found that the main factors influencing moral distress prior to 2020 could be broken down into the four categories discussed: intrapersonal factors, interpersonal factors, institutional factors and systemic factors. Systemic factors were discussed across the papers presented, but this was not typically highlighted as the main source of discordance or distress contributing to MI/D. Participants and researchers tended to think relationally, within the more immediate settings, rather than considering the wider context too. It should be noted that there were wider contributing factors beyond the scope of this review which have not been included as they did not speak directly to the aims of this review.

Intrapersonal influences on MD could be connected the participants cultural or contextual situation, often causing a sense of internal conflict. The source of distress intersected across cultural, religious, personal and legal frameworks influencing how they saw the world and created ideas of moral or immoral. When considering the interpersonal factors this most often related to a lack of resource or a sense of power differentials within or across teams. It was noted that difference often led to discrimination against others, and that the more dominant discourse was favoured e.g.

more medicalised stances being held in higher esteem and therefore dismissive of more humanising practice.

Within the institutional factors, one of the key themes was a sense of conflict between the expectations of care in health care versus the perceived reality. Participants expected to be enabled to deliver humanising and person centred care, but often found that this was not the case. The felt they faced expectations that favoured the needs of their institutions over the needs of their patients which, at best hindered professionals from providing adequate care, and at worst actively caused harm to patients. Finally, systemics factors were most explicitly discussed in research that focused on clinicians working with marginalised communities (e.g. undocumented migrants, or in HIV care), or in countries with wider margins of systemic injustice. I find it interesting that systemic injustice was more overtly discussed in contexts where inequities were wider or there was more scarcity of resource.

It should also be noted that only one paper (Matthews & Williamson's, 2016) focused on mental healthcare.

1.7.7 Implications:

The idea of this SLR was to consider MI outside of the context of the Covid-19 pandemic and it should be noted here that conclusions made are based on data pre 2020. While there has been more published on MI during and post-pandemic, the focus on this current MRP is to consider MI now, five years after the pandemic. While one cannot totally unpick the influence of the Covid-19 pandemic, it is important to note that while the global pandemic highlighted the layers of systemic injustice within healthcare, these factors were still pertinent before 2020, as they are now in a post pandemic landscape.

From this SLR, the implications of further research are as outlined below:

1. Most studied within the SLR focused on healthcare in physical health setting bar Matthews and Williamson (2016). This highlights the gap in literature pertaining to the experience of mental health clinicians' experience of MI.
2. Minimal research has been conducted in the UK context despite the growing body of literature surrounding systemic injustice and health inequalities in the UK (Gilburt & Mallorie, 2024).

3. In my reading and interpretation of the researched presented, the context in which moral distress is experienced cannot be separated from the instances or actions discussed by participants. When participants spoke to specific instances that caused distress, power and hierarchical structures were highlighted more often than not.

1.7.7 Research Question:

What is the experience of moral injury in mental health professionals with lived experience of systemic injustice?

Chapter 2: Methodology

2.1 Methodology:

2.1.1 Why Qualitative?

Qualitative research allows researchers to explore their topics and allow ideas to emerge and unfold naturally, with an aim of describing and gaining a depth of understanding about a given topic or interest (Cypress, 2015). As researchers we also tend to "…reflect their philosophical beliefs and interpretations of the world prior to commencing research." (Tie et al., 2019, pp. 1) which will likely influence the methodologies we choose. This rings true for me as someone who understands knowledge from the point of social constructionism. It would be incongruous to choose a methodology that aligned with more positivist ideas or to attempt to understand something as an absolute truth.

Grounded theory methodologies are useful when there is limited existing knowledge, and one wants to learn more about the specific social processes of a phenomenon (Charmaz, 2014). This feels particularly relevant in thinking about MI within mental healthcare as there is minimal research on the topic. Coupled with understanding the influence of systemic injustices on clinician's experience of MI, I was interested in the processes that informed and interacted with the dual identities held.

Co-production within research where those with lived experience have equal weight within the research process such as formulating the research design, setting questions, collecting data and analysis. The core principals of co-production are; equality, diversity, accessibility and reciprocity (Social Care Institute for Excellent, 2022). Power is distributed equally across those involved, using a strengths-based approach rather than assumptions that the researcher being the person/people that hold the knowledge or control. While there were multiple ways in which I attempted to share power and honour various forms of knowledge across my research team and with my participants, this piece of research was not co-produced. It does not meet the threshold of a co-produced piece of work for several reasons, but the main point here is that I held the final say in the decision making, and support was offered by way of consultation with my research team and participants, rather than a truly equal or reciprocal relationship. And my participants nor my research team were not renumerated for their input into my research.

2.1.2 Constructivist Grounded Theory:

Traditionally grounded theory (GT) positions the researcher as someone who has no preconceived ideas about the topic of phenomenon they are studying. This was challenged by Charmaz (2014) who asserted that we as researchers are part of the construction of the theories we create, we are a core part of the meaning-making. This position acknowledges that us as researchers, our context and our experiences influence the ‘type’ of data we collect and the meaning we and our participants create. This foundation fits well with a social constructionist epistemology.

I had initially intended to use situational analysis which goes further again to consider the contextual factors that may influence the individual experience, with the goal of capturing the complexities rather than simplifications (Clarke, 2005). It integrates social worlds, social discourses, historical influences and context. This thinking was utilised throughout the process, however, due to time pressure and limited availability of expertise in this methodology it was not possible to fully utilise this methodology.

2.2 Ethical Considerations:

2.2.1 Ethical Approval (UH):

Participants were recruited via non-NHS routes such as social media, personal and professional networks and via organisations newsletters or bulletins. The thinking here was to ensure that a wide breath of participants could be reached, working across various regions of the UK. Ethical approval was sought from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee and formally granted on 10/5/2024, protocol number: **LMS/PGR/UH/05637** (appendix a.). As such, this research meets the criteria for the school of Life and Medical Sciences risk assessment and adheres to the BPS Code of Human Research Ethics (2014).

2.2.2 Informed Consent and Confidentiality:

Prior to the interviews participants were given a participant information sheet outlining; the details of the project, confidentiality and anonymity, right to withdraw, insider/outside positions of the researcher and research team, rationale for the study and potential impacts (appendix e.).

I met with all but one of the participants for an initial call to discuss the study, check eligibility and discuss confidentiality. The participant who did not have this initial call read the participant information sheet and opted out of the call. This initial call also felt important as a way of forming good relational connections with potential participants, and to have the opportunity to have an informal conversation before engaging in what could potentially be quite an emotionally tense conversation. This also gave us an opportunity to discuss distress management should that be appropriate at any stage during the interview.

Once we decided to go ahead with the interview participants were emailed a copy of the consent form (appendix h.) which they electronically signed and emailed back prior to beginning the interview. For those who did not meet eligibility criteria or changed their mind about participating, all correspondence was deleted, and this was verbally confirmed, or via email – depending on how we were already communicating.

On the day of the interview, before recording started participants were reminded of their right to withdraw, confidentiality and anonymity, with each participant choosing their own pseudonym (see appendix j. - interview schedule for a guide of the pre-interview conversation). They were assured that should they use any identifiable information they this would be redacted in the transcription and reminded that once the transcriptions were completed the video files would be deleted. Given the nature of the conversation participants were invited into, I had a conversation with participants about their choice in responding to questions (or not responding), or a question was asked that they felt they didn’t want to discuss. For those who shared that they could find it hard to say no, we discussed potential verbal and non-verbal cues I could look out for that. These cues would indicate they were becoming too uncomfortable which should prompt me to check in with them about the direction of the conversation.

Confidentiality was in line with the Data Protection Act (2018). Participant information was stored on my University of Hertfordshire encrypted OneDrive.

Transcripts were anonymised using the participants chosen pseudonyms. Contact details, consent forms, recordings and transcripts were all stored separately so there was no crossover or way of connecting the identifiable information. Video files were deleted as soon as the transcripts were completed, and the research team only knew the participants by their pseudonyms. Transcripts will be kept securely for five years and destroyed thereafter.

2.2.3 Participant Wellbeing:

2.2.3.1 Pre interview:

Participants were sent the information sheet as detailed in the section above, and offered the opportunity for a pre-interview conversation. It was made clear that having this conversation with me did not necessarily mean we would go through with the interview, this would be something we would decide together. All participants who took part signed a consent form and aware of their right to withdraw.

2.2.3.2 During interview:

Prior to the formal interview commencing consent to partake was verbally confirmed. I went over the confidentiality, anonymity, right to withdraw and note taking during the interview. As mentioned we used this time to discuss how to say no, how to move away from topics that felt too emotive, including verbal and non-verbal cues (see appendix j. for pre-interview conversation). I also invited participants to use whatever strategies or expression of emotions they felt they wanted during the interview (vaping, music, moving around, taking breaks etc). And finally, after the interview we had a debrief and all participants were sent a debrief sheet via email (see appendix k.).

2.2.3.3 Focus Group:

Participants were informed that by agreeing to take part that their anonymity would not be maintained within the participant group and a consent form was signed by all those who took part. They all agreed to confidentiality within the group and had no access to each other's contact or personal information. They were also made aware that they did not need to share any personal information, and the purpose was to feedback on the theoretical model and results.

2.2.4 Research Team/EbE:

The research team and I came at this piece of research as both insider/outsider researchers (Dwyer & Buckle, 2009). The research team included two supervisors and two research consultants, all of whom have experience of either working in publicly funded services and experiencing MI, and/or have lived experience of systemic injustice. Insider research can come with complexities and invited a continued need for reflexivity. However, insider researchers also "have to live with the consequences of their processes on a day-to-day basis…" (Smith, 1999, pp. 137) which in my view is a strength of this position. When considering theories such as standpoint epistemologies and other critical theories, knowledge is situated within context and we as insiders sit with bringing a version of that knowledge into our chosen fields.

My primary supervisory is currently working for the Clinical Psychology doctoral programme, with previous experience working in NHS service. My secondary supervisor is a writer, thinker and activist working in community leader development and social justice. She has never worked directly for the NHS but has worked alongside statutory services in certain consulting roles. My research consultants consisted of one NHS mental health professional working in primary care mental health in a managerial position. And my second consultant studied at the University of Hertfordshire and completed their thesis using CGT, with previous NHS experience. They are currently working as a lecturer abroad. The research team was involved throughout the project, and at various stages depending on the capacity of the individual, and needs of the project. The consultants offered their expertise on an ad hoc basis, depending on availability. They gave input on the participant information materials, interview schedule, development of themes, development of the model, the SLR (e.g. reviewing the coding), and overall advice as needed.

Patai (1991) cautions, "the researcher's desire to act out [feminist][4] commitments, relinquish control, and involve the researchers in all stages of the project runs the risk, however, of subtly translating into the researcher's own demand for affirmation and validation" (p. 147). While they were speaking to sharing power with

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[4] Here the author of the quote is referring specifically to their lens and perspective as a feminist researcher. I am using this quote to more broadly speak to the way in which our theoretical stances may influence our work and our research.

participants I think this also fits with how we, or how I, came to be with my research team. I chose my team, and they chose to be part of my team because of a shared interest, and a relatively shared view of the world. Have I then, set up a team that will challenge my thinking, but just enough to so as to feel that there is sufficient rigor and reflexivity? Given the breath of experience, various lenses and experiences, and alternative views expressed by my research team throughout the process, I do think that there has been space for multiple views and disagreements that have positively contributed to the research process and reflexivity.

2.3 Recruitment:

I used both purposive and theoretical sampling in which participants were selected based on lived experience and self-defined identity characteristics. Recruitment took place between July 2024, ending in December 2024. Theoretical sampling was employed in April 2025 to thicken some of the less developed ideas and process emerging from the research. This was done in the form of a focus group session.

Recruitment was primarily done via social media (myself and members of the research team), disseminating the research recruitment poster (appendix b.) to professional networks and contacting organisations directly who work with those with lived experience or professionals working in publicly funded services e.g. NSUN or Unison. In total, 21 people contacted me expressing interest in participating in the study. Of the 21, 10 people met the eligibility criteria and decided to go ahead with the interview. No participants pulled out of the study following the interview. However, of the 11 who did not participate, this was a mixture of not meeting the criteria, not getting back to me after being sent the participant information sheet or deciding they no longer wanted to participant. I did not ask why participants changed their minds. Typically the reason those who expressed interest did not meet the inclusion criteria was because they did not have experience working in publicly funded services (n = 3).

By sheer virtue of the inclusion criteria (i.e. lived experience of systemic injustice) this piece of research endeavoured to avoid focusing just on WEIRD populations and consider the views and experiences of people often excluded from mainstream research (Heinrich et al., 2010).

2.3.1 Inclusion and Eligibility:

I recruited mental health professionals who had or who currently work directly with SUs in supporting their mental health and distress. Participants self-identified as having lived-experience of systemic injustice such as racism, heterosexism, ablism, sanism, transphobia, or gender-based violence. Note, this is not an exhaustive list. Participants may have held multiple protected characteristics, however, I veered away from the idea of demographics and thought more about identity theory and intersectionality. I'm speaking here to the roles we occupy in society, and the meaning and expectations these identities hold in interactions and understandings of ourselves and the world (Gupta et al., 2023). I did not measure their experience or question participants who self-identify with it, but rather I provided a working definition or guidance on systemic injustice. Participants also self-identified as having experienced MI/D. The definition of MI is based on current available research, but again this was not a 'hard' definition, it acted as guidance for participants to consider how it might relate to their own experiences.

Inclusion criteria	**Exclusion criteria**
Working with people who are experiencing mental health related distress, with the aim of reducing their distress.	Only working in setting related to supporting those with physical health concerns or practical support (housing, probation for example).
Have worked or currently work in publicly funded services.	Have only ever worked privately.
Self-identified as having been exposed to PMIEs and experienced consequences that could be explained by moral injury.	Currently experiencing high levels of ongoing distress which may make a research interview highly distressful and/or triggering.
Able to speak English at a level which enables participation in the interview (due to limited resources).	
Self-identify as having lived experience of systemic injustice in their personal lives.	

Table 7. inclusions and exclusion criteria

2.3.2 Demographics:

Participants were asked a series of questions related to what could be defined as demographic questions, but I chose to take this further and also ask participants about experiences they felt may have shaped the way in which they live in the world, i.e. identity. Kyriarchy and intersectionality refers to all forms of oppression and how multiple facets of our identities create a platform of subordination or privilege. If we create categories that imply a hegemonic view or experience, how then do we adequately think about difference within experience? (Gunarathnam, 2003). As Sayyid (2000) writes; “Any attempt to think about social identities is based on an erasure of internal difference and division…How populations are classified and formed into clusters is ultimately a political process” (pp. 40). Thus we need to make more room for nuance when we think about how the world is experienced by all of us who hold multiple identities and experiences. See appendix j. for the interview schedule which lists the identity and experience questions asked.

Also, because of the number of questions asked of participants, reporting their identities in a more traditional way (table of characteristics for example) also runs the risk of breaching their anonymity. It is for these reasons I will give a narrative description of my participants in the results section instead. This will be explained further in the results section. Below is a table of the participants pseudonyms and professional roles. The individuals who took part in this study represent a group of people who aligned with the experiences of MI and of having lived experience of systemic injustice. They were based in both rural and urban locations across the UK. Some of the participants held leadership or senior roles.

	Current Role/band – at time of interview	**Previous experience in Publicly Funded Services**
Stella	Trainee Clinical psychologist (NHS band 6)	PWP (and working in charities)
Sarah	Mental Health Nurse (NHS band 7)	

R	Lived experience peer-support worker and Apprentice student MH nurse (NHS Band 3)	
Louise	Clinical Psychologist (NHS band 7 – preceptorship to band 8a)	Trainee clinical psychologist and Assistant Psychologist
Jodie	Clinical Psychologist (NHS band 7)	Unrelated to MH
Lara	Social worker – community MH practitioner (NHS band 6)	Support worker (and admin roles)
Sally	LE researcher and MH Nurse (NHS band 6)	Prison Nurse (B5) and psychiatric inpatient care (B6) Nursing education, research and development.
Micheal	Wrap around care manager in a primary school now – discussed experiences of play therapist in schools for interview (no banding)	Learning support assistant in schools – 'behavioral' management – anger, learning needs, trauma and PTSD.
John	Working in a charity now – discussing experiences of PWP (NHS Band 5) in interview	
Aminat	Trainee Clinical psychologist (NHS band 6)	Clinical associate in psychology, honorary AP, volunteered in school to support w/ reading, homework etc.

Table 9. Participants pseudonyms and professional roles

2.3.3 Sample Size:

In CGT typically, data collection ends when theoretical or conceptual saturation is reached, meaning no further theoretical insights are emerging (Charmaz, 2006). By interviews 6-8 no new ideas appeared to be developing from the data. At this point I was able to refer to concepts that had been developed, and check these with new participants, and continued to do so until interview 10, the final one. However, in meaning making that aligns with social constructionist ideas this is more tricky – different researchers, different participants and different contexts would likely have constructed alternative meanings or ideas in making sense of the data. Thus saturation is subjective. In concluding to end data collection, this was discussed and decided in conversation with both supervisors on the team.

For the focus group, the suggested number of people for a focus group is 6-10, with a minimum number of 5 attending (Klagge, 2018). I did not meet this guidance due to availability of participants at this stage of the research, however, in thinking about theoretical sampling it was agreed that it was best to continue with the focus group anyway.

2.4 Data collection:

2.4.1 Resources:

Interviews took place via Microsoft Teams. Participants were made aware that arrangements for face-to-face interviews were possible but none opted for this. The in-built transcription and recording feature was used. From one week after the interview I then used the transcripts and video recordings to quality check and manually finalise the transcripts of the interviews, as the inbuilt feature on teams is AI software that does not accurately capture the full transcript. Once completed, transcriptions were uploaded into Nvivo 14 and coded. The video file was deleted immediately following the completion of transcription. All data was kept on the secure OneDrive server. I also used OneDrive to create files for my research diary and memo-ing notes.

2.4.2 Interview Procedure:

Interviews were semi-structured, and in accordance with CGT methodology, adapted as needed along the way – researcher should always look to “reevaluate, revise and add questions” (Charmaz, 2014, p. 66). The interviews took place online, with video and audio enabled for all participants. This format meant that I was able to invite participants from across the U.K., and it brought more flexibility relating to when and where participants wanted to conduct the interview. Furthermore, it has been suggested that it allows participants more autonomy over the interview process as they are in a space that is safe and familiar for them, as opposed to potentially being invited to a physical space they don’t know (Brown, 2022).

I used ideas from intensive interviewing techniques which creates a more interactional space. It also allowed for a more nuanced conversation, holding onto complexity and the nuance, and inviting participants to bring both their experience as well as their interpretations of their experiences (Charmaz, 2014). All participants had experiences of MI/D as per the inclusion criteria, but through the interviews we were able to delve in-depth into the meaning making aspect of that experience. Initially, I utilised the idea of “instilling a spill” (Glaser, 2009, p. 22) as I wanted to allow the participants to shape and lead the discussion. After going through the identity questions, I asked participants “Thinking about moral injury and systemic injustice, what drew you to want to take part in this?”. However, what I noticed was that participants were speaking about injustice, and it was harder to think together about how they understood their experiences to be morally injurious, or what MI was for them. I began to start by asking them what they understood by moral injury and systemic injustice and then asked them why they wanted to take part following those conversations.

Throughout our conversations I used prompts to encourage more exploration of the processes going on throughout their experiences and inviting their explanations for why they believed things happened in certain ways. For example, when participants spoke about a lack of resources within mental healthcare, my bias would likely explain that through Austerity measures. Instead I would ask why they felt services were under resourced rather than leave the answer at ‘underfunding causes poorer patient care’. This example, and the conversations surrounding it will be fleshed out further in the results section. As interviews progressed, and theoretical categories developed I would ask participants more direct questions, inviting their perspectives on what came up in other interviews. This was to develop new ideas or consolidate the existing ones (Charmaz, 2014).

I stopped recruiting and inviting participants when theoretical sufficiency was reached, meaning that there was a sufficient depth of understanding reached to enable myself and the research team to build a theory (Dey, 1999). The key here is that theoretical sufficiency does allow for the possibility that if many more participants were interviewed a novel concept or idea *could* emerge, but based on the available data there are no new obvious concepts emerging. This moves away slightly from the ideal of theoretical saturation which suggests that no new insights *can* be reached on the topic by collecting more data. It also suggests there is there is some fixed end point, or ‘completeness’ that exists, which does not align well with the stance of this piece of research – knowledge is not fixed it is constructed.

2.4.3 Renumeration:

Participants were not renumerated for their participation in my study. This is based on a personal belief that there is an element of tokenism in offering vouchers to participants and it does not recognise their contribution to research. I do recognise that this will not be everybody’s view and that there are also limitations to not offering renumeration. This same dilemma was also discussed with my consultants on the team. I offered to apply for the vouchers if it felt meaningful for them, but it was agreed this was not necessary.

2.4.4 Theoretical Sampling via focus group:

At the pre-interview stage, participants were told about the focus group and asked if they would like to take part in that. Of the 10 participants 8 decided they would like to be contacted. Information about the purpose of the focus group was outlined in the participant information sheet and further discussed in the pre-interview conversation. Participants were contacted with potential times and dates, and those who were able to partake, and who still wanted to be, were invited to an online group meeting. The purpose of this was to review the model and feedback on how this fit with their experiences. Two of the eight participants were able to take part. This session was transcribed and further developed the model as presented in the results section. See appendix q. for the pre focus group model presented and changes made during the interview. Participants were shown quotes that related to the themes presented to help them make sense of the categories and bring more discussion.

2.5 Data Analysis:

2.5.1 Reflexivity:

Reflexivity considers how the researcher’s own interests, experiences, beliefs and values can shape aspects of the research process (Finlay, 2002). Within the CGT and situational analysis, meaning making is shared between the researcher and the participants. Therefore, it feels important to understand and make transparent my position in relation to the research, to the research team, to completing this as part of a doctoral requirement, to why I chose my topic and to my participants who chose to take part, as has been discussed in the introduction chapter of this thesis. Over and above this, I kept a reflective diary (see appendix p. excerpts) from the start of my developing the project and remained in conversation with my research team throughout the process. In doing this my position, bias and lens was continuously examined to highlight gaps in my reading and understanding of data and surrounding literature, as well as consider multiple perspectives and explanations.

2.5.2 Memo Writing:

Memo writing is a key method within CGT and is a continuous process throughout the project that informs your thinking and analysis. It is the process of writing 'memos' describing your initial thoughts, reactions or ideas you have about your data and allows you to keep track of your thinking and process, making room for reflexivity (Charmaz, 2006). I wrote and voice recorded memo's throughout the research process. "Every interview, observation sessions, reading of project related documents, and analytic session (done alone or with others) should provoke one or more project memos about it" (Clarke et al., 2018, pp. 106). Given the research topic and my insider(/outsider) position, I also found myself making memo's during placement conversations with colleagues, during lectures and in conversation with peers (see appendix p. for examples of this process).

2.5.3 Initial Coding:

Once transcribed word-for-word, interviews were analysed using line by line coding via Nvivo-14. In aligning with CGT, codes were developed using gerunds, verbs in an '-ing' form (Charmaz, 2014). This enabled me to stay close to the data, and the stories of my participants however, my standpoint will still influence *how* I see the data, and *what* I see in it (Charmaz et al., 2011).

2.5.4 Focused Coding:

This phased of coding is the process whereby we "sort, synthesise, integrate and organise large amounts of data" (Charmaz, 2006 p.113). Once these codes were developed it allowed me to compare my data and consider similarities and gaps. Practically speaking it is a way of keeping tracks of the hundreds of codes developed through the initial coding process. It also allowed me to have key ideas to introduce to my participants in the mid and later stages of interviews. I presented extracts of these codes to my research team, and to colleagues within my advanced methods group to check coherence and salience and checking my own preconceptions about the topic.

2.5.5 Theoretical Coding:

This is the final coding stage whereby you examine the relationships between the focused codes or main categories (Hernandez, 2009) and thinks about the core processes in the data (Charmaz et al., 2011). This part of the process is seen as "weaving the fractured story back together again" (Glaser, 1978), to tell a "coherent, comprehensible and analytical story" (Charmaz, 2014). One focuses on the overarching themes and processes that have emerged from the data by synthesising and integrating the large amount of data collected. This process is when I began forming the model created, thinking about my understanding of the related processes and ideas that emerged from the data and analysis. Through a series of mapping and diagramming I was able to explore the relationships between the categories, the relationships and the directionality, as well as consider the context it's positioned in. I repeatedly reviewed this with my research team and with the two participants who were able to attend the focus group.

2.5.6 Situational analysis:

This is a post-modern take on grounded theory, it follows the steps above and includes mapping processes that look at wider factors that could influence that data and meaning making of said data. This is taken from Clarke (2005). This was done with various members of the research team throughout the research process. It included shared conversations from our own perspectives and experiences, academic, professional and lived experience knowledge, and perspective shared by participants.

1. *Situational maps*: consider the main elements of the situation being studied (human, discursive etc), and allow you to study how they relate to each other.
2. *Social world maps:* major non-human elements that factor into the situation, considering wider discourses and non-human actors. What is the collective or organisational level/influence?
3. *Positional maps:* major positions taken or not taken on discussions, debates or experiences of important issues.

While not used in their entirety, they informed various parts of the analysis, and the development of the final theory as it gives the wider context more room to be considered and integrated into the understandings developed. My consultants and I created several maps at the beginning of the process. I then individually used mapping to understand and make sense of my data at various stages.

Chapter 3 – Results

In this chapter I will further introduce my participants and the CGT model created from our interviews and discussions. I will then speak to the themes laid out in the model and how they interlink, with some examples of how they manifest. What is important to hold in mind in reading this chapter is section 1.4.3 in the SLR that outlines the definition of context and my position for this piece of research and the importance of moving away from understanding psychology just on an individual level. Taking a social constructivist view means that we understand the fundamental nature of 'truth' as being relationally produced, with inequality being a key factor that enables or constrains our fundamental agency in an unequal system. I am of the view that we need to think about the multiple levels that influence how we experience the world and are influenced by our world and our contexts.

3.1 Who are the participants?

Typically, participant information would be written in the methodology section. However, I have chosen to add most of the participant information to the results section as there is much more to report over and above what is typically reported regarding participant demographic information. Here I consider identity more broadly. As Evans (1979) wrote:

> I am not one piece of myself. I cannot be simply a Black person and not be a woman too, nor can I be a woman without being a lesbian…there have always been people in my life, who will come to me and say, "Well, here, define yourself as such and such," to the exclusion of the other pieces of myself. There is an injustice to self in doing this…(pp. 72)

Furthermore, participants identities, what I chose to ask and how they chose to describe themselves, is an integral part of the results. Our culture, values, diversity and difference shape our experiences, how we make meaning, and social processes (Irwin, 2008). We understand that our experiences, our contexts and our personal beliefs influence how we understand the world. Therefore, in reporting how the participants and I made sense of the world, it felt appropriate for me to report and expand on how they made sense of themselves too. Below table 10 table outlines some characteristics related to the participants identities, but I have also expanded on certain categories and given more of a narrative around how we made sense of identity together throughout the interviews.

For the rest of the information shared regarding their identities, I have also reported characteristics collectively because there is a risk of breaching confidentiality given the amount of personal information discussed about each person.

Age	26-42, mean age of 32.8
Dis/ability or LTC	7/10, though 1/7 having symptoms under long term investigation.
Gender expression	2 transmen, 6 cis-women, 1 non-binary person, 1 gender questioning female.
Mental Health	4/10 identified as having a diagnosis on a MH condition but did not necessarily align with diagnoses as a concept. 1/10 identified as have a MH condition/s but chose not to disclose specifics. 2/10 identified as having had MH difficulties, but non-specific diagnosis. 3/10 said they did not experience specific concerns re their MH.
Nationality	7/10 British, 1/10 German, 2/10 Italian.
Neurodiversity	4/10 diagnosed with ADHD, 1/10 ADHD being queried, 1/10 self-identified as neurodiverse, 1/10 diagnosed with Autism, 1/10 neurodiverse but chose not to disclose specifics, 2/10 not neurodiverse.
Racial/ethnic identity	8/10 white - British, 'other', European, Irish or Italian. 1/10 black-mixed, 1/10 black African.
Religion	1/10 identified as 'visibly' Muslim, 1/10 undisclosed minoritised faith, 1/10 chose not to disclose, 1/10 atheist, 6/10 did not align with any religion.
Sexuality	Queer identifying 6/10, heterosexual 4/10
Social Class	Growing up 6/10 identified as working class. 1/10 identified with lower class. 2/10 middle class. 1/10 lower middle. 5/10 felt that technically they now identified as middle class

Table 10. Participant information

3.1.1 Expansion on identity from conversations:

Most participants found social class to be a complicated characteristic to speak to. They spoke a lot about its meaning within a UK context and it differing from other contexts, especially for those who weren't born in the UK. We discussed the nuances of social class as an identity vs. social class as an economic category – both how those ideas align and are in conflict. Several people felt their social class changed in terms of certain identifiers such as job, earning potential, where they could now live etc. But they often expressed that their values and understanding of the world remained aligned with the social class they grew up in. Some also shared that they felt that, even though their social class had changed, their families' had not, and this was a key part of how they made meaning of the world now i.e. their family and family values were still a core facet of their identity. Five of the ten participants felt their economic status related to class had moved, but that in many ways they were firmly imbedded in the class values they grew up with.

Several participants spoke to other aspects of how they're seen and viewed by others. One participant spoke about fatness being a core part of their identity in both a positive and negative way. But specifically, how they felt positioned by others as a result. In a way of needing to be the 'good, confident fat person' –

> "And almost, I think that people are like, in a slightly fat phobic way, being like oh, but I was kind of looking to you to be like the confident fat person so that I could also feel good. Like, if *you* feel good, it's OK for me to feel good at my smaller size, you know?" (participant quote).

If they were seen to waver in their confidence as a fat person that seemed to mean something to others, "'like, I was looking to *you* for confidence'. And I'm like, 'OK, well, I don't always have it.'" (participant quote).

One participant spoke to colourism and perceived desirability based on skin tone within the Black community: "So just thinking about just think about anti-Blackness like like you know for example in the Black community we've got colourism and thinking about who's like, who's considered desirable and who is not" (participant quote). Thus, plainly stating someone's racial category greatly misses this nuance that speaks in more depth to how they are positioned in the world. Another participant spoke to being a Black Muslim, and how they felt viewed as 'less Muslim' due to preconceptions or erroneous assumptions that Muslim people are not Black.

One person's explanation captures the complexity of trying to navigate identity, speaking to self-perception v. social or external perception:

> "…maybe this is relevant as well for your research, but personal and social identity. Because like socially I imagine I'm, I can probably objectively considered to be, like, white British, heteronormative presenting, like female presenting, but actually I think…so my mum's Portuguese. So when I say like White British doesn't really, it's like kind of strange to say like, it doesn't really capture, because I feel like Portuguese, I've got Portuguese surname. And also, especially like with [being] queer as well. It like doesn't necessarily present, which I always find interesting with these sorts of questions, that's just a point I was just thinking about…So it's like this, like, weird dissonance between like how I feel and then how I present." (participant quote).

I think this speaks well to various version of the 'unseen' aspects of experience and identity that my participants shared with me about themselves. Their family histories, generational stories and lived experience of distress that can only be known should they choose to share it. When I report that, for example, one participant identifies as a cis-middle-class female, we miss so much about who they are in the world.

Participants shared experiences from their past, and experiences that lived within their families' narratives. They spoke to trauma, abuse, homelessness and loss – loss of identities, of close family members and of childhood. While no one asked me not to share the details of their experiences, I have chosen to honour their privacy and not share those details. For the purpose of this piece of research, I believe that it is enough for the reader to know that each and every person that chose to take part in this study identified with having a multitude of unseen and seen shared experiences with SUs they meet with in their professional lives. They all identified as having lived-experience of systemic injustice. This will become more evident with the quotes used throughout this section too.

3.2 The CGT Model:

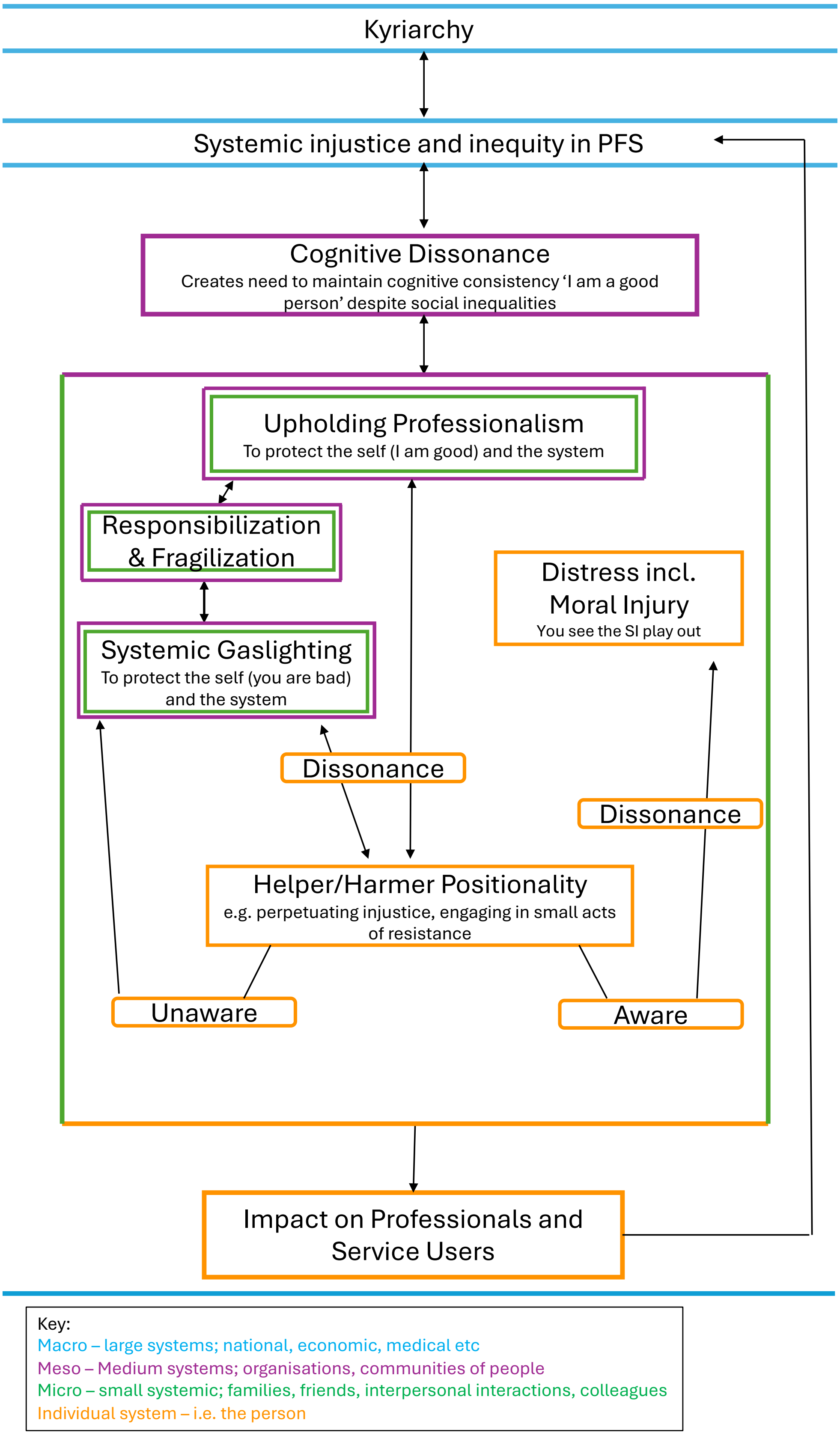


Fig. 5 CGT Model

3.3 Themes:

3.3.1 Contextualising the Model

One of the core threads that runs throughout this model is that, often, in order for an individual to protect themselves or their own self-interests, they need to protect the systems they're in. Or that by looking after their own needs and boundaries, they are, intentionally or otherwise, upholding the system. My participants nor I are here to cast blame on individuals, and we recognise that all of us maintain the systems that we're in to some degree. Rather the purpose is to utilise the interviews and shared knowledges to develop a model that can begin to make sense of the complex relationships between the various processes that create and maintain MI/D in the context of MH clinicians with personal experience of systemic injustice.

When thinking about why we all uphold these systems, Lara, after I asked why, felt that

> maybe because they've not been in that position themselves as well [lived experience of harmful care], they don't feel strongly. Because we all know that if you speak up too much in the NHS, you end up getting sacked or managed out. So I think people are worried about their jobs.

Sally went further to explain that "...in terms of mistakes generally, I think that is across institutions because of the idea of like, if you admit to a mistake, then there's like, litigious consequences.". This feeds into reinforcing the importance of being 'good' or 'right', removing the incentive to take positive risks or admit mistakes.

The model and these themes speak to the complexity of being in a position where one's ability to protect themselves often relies on upholding the system. And that personal success is often contingent on that too. Kyriarchy speaks to the varying landscapes of privilege and power, and that context is core to how we access power. Having power over others in one way can elevate us, but we are powerless in other aspects, and this *necessarily* creates further oppression and scarcity. Furthermore, our services are often based on this need for hierarchies and power:

> But also, clinicians have a right to literally forcibly take someone away and lock them up and like, observe them 24 hours a day. If you have that ability, there is no equity. You can pretend all the living long day, but there's no equity in that. (Sally)

There are three overarching elements of this model that 'press down' on the individual and institutional processes, operating at various levels. In the macro level: kyriarchy, systemic injustice and social inequity and the meso level: cognitive dissonance. These themes came through throughout the interviews when speaking about the processes. Louise spoke about the development of some MH services being created with economic priorities at the fore and connected this directly to kyriarchy. In fact it was Louise who introduced me to the term. Louise said:

> Yes, they might have thought they had people's interests at heart, but like, obviously, you know, they let so many people get excluded from that. Like, so it just like, served to uphold the, what's that? What's that word? It's like, is it like the kyriarchy or something?

Participants spoke to other macro factors such as their understanding of how mental health services were created based on economic ideals. "if within that we had a healthcare system that behaved in an ethical way, you know, in an ethical way and did not behave according to economic rules." (Stella), things could be different. Participants also identified stigma surrounding MH as a factor that maintained inequity "It's disempowering to have a mental health diagnosis like, for example, borderline personality disorder." (R). And Aminat spoke to the history and context of MH, how it was developed based on whiteness "Eh, in short white people. Or when I say white people as well though I think is…how do I expand on that? I think I think the elites of our society". She went on to say:

> And I think that that's, but that is about that space, that extends to who the health system thinks about as the, or has thought about for a very long time, as the kind of prototypical patient. Just all about our teachings and even like

> medical school and you know, yadda yadda yadda, those kinds of things are are all, those early teachings were all based on white people

But put simply – “It's the system. It needs a complete overhaul.” (Sarah).

The terminology and definition of the macro processes were ‘solidified’ during the focus group discussion, and the model was adapted accordingly. See appendix q. for the version presented to the focus group and the changes made within the group discussion, that led to the final model presented in this paper. Please this was not the only space in which the model was discussed and adapted.

I start with this as I want us to hold in the mind the contexts and positions the participants felt were core to their understanding of services, MI/D and systemic injustice for themselves and for SUs. We are thinking how these layers are experienced and enforced on multiple levels. And of course, the individual within it will be influenced and impacted by said context/s.

3.3.1.1 Explanation of interlinking of processes and themes

In the pictorial representation of the model, there are bidirectional arrows as well as singular direction ones. The bidirectional arrows indicate that the stated processes feed back into each other. For example, the act of upholding professionalism leads to one inhabiting the helper/harmer position, and part of being a helper/harmer is needing to uphold professionalism. Both themes are explained further on in the results section.

The model suggests that everyone who holds a professional position in publicly funded MH services will engage in, to some degree, upholding professionalism, responsibilization and fragilization, and systemic gaslighting which leads individuals to inhibiting a helper/harmer positionality. Being a helper and a harmer creates dissonance for everyone as well. The model then suggests that the experience of dissonance will interact with the individuals’ personal experiences and beliefs. Those who are aware of the ways in which individuals and institutions uphold inequity will likely experience distress, MI/D, and those who are unaware will continue to action the processes that maintain inequity. Even those that are aware of the harm they are causing will maintain the systems, but they will feel distress because of they are aware of the harm it is causing. This, for example, is demonstrated by the bidirectional arrow between helper/harmer and upholding professionalism – that all people will feedback in to upholding systems.

Those who are unaware of systemic injustice will maintain the systems but are less likely to experience distress as a result. Cognitive dissonance theory suggests that in response to discomfort caused, typically, individuals will change their beliefs or change their actions (Festinger, 1957). In this case individuals sitting with the helper/harmer position may engage in small acts of resistance to neutralise the discomfort, or they will align their beliefs with their actions which could, for example, feed back into the upholding professionalism theme.

3.3.2 Distress and Moral Injury:

Given the question being asked by this research, it feels useful to begin by understanding how participants conceptualised general experiences of distress and MI/D. While this research aimed specifically to explore about MI, it's difficult to separate distress from moral distress. This is in part related to what was expressed by the participants, that just being part of services they perceived to cause harm and create inequity was morally injurious. “It's just like, that's to me, that's systemic injustice is that we set up systems and they're actually hurting people rather than helping” (Louise). When I asked John “Are you understanding your experience of moral distress as being complicit within a system?” she responded “Yeah, absolutely! I felt like I was complicit in something I didn't agree with…” referring to her role as a PWP. Lara stated that “when I first heard the term moral injury, I was like, never has there been a term that describes so well like exactly how I feel at work on an almost daily basis.” working as part of a CMHT. And Jodie went as far as to say “I have sat the whole way through psychology [trainee and professional roles]. That this is the biggest moral injury I've ever experienced in my entire life.”.

While people spoke to specifics, there was an overall sentiment that “it's like the everyday experience of seeing like in services, just how we treat people” (Lara). The whole system (publicly funded services - PFS) is injurious because we, everyone, inevitably cause harm within it

> a system that's churning and harming people is going to cause me moral injury....I think even if you're doing everything you can to not cause harm, if the system you work inside is causing the person harm, like you may not be directly contributing to the person being harmed, but you're still part of that system." (Jodie)

As mentioned, participants spoke to their upset and frustration at services being modelled on economic values "So there's no again real incentive to them truly fixing the problem when it's bringing in such a huge income." (John). And Jodie expression the view that "CBT of all the mental health interventions is probably the biggest feeder into capitalism. How do you change people's behaviour? i.e. how do you get them back to work faster by getting them to behave differently?". Participants were expressing MD at the understanding that services were not functioning or set up in ways that prioritised the needs of the person but were rather serving the needs of the state – this links to the idea of making the systemic failings an individualised problem. Who are we really serving versus what are we saying we're mandated to be doing? We say we provide care, but when and how it's provided is dependent on needs that don't necessarily serve the individual.

Louise's expressed frustration at MI felt by herself and SUs simultaneously:

> And that is moral injury, like you shouldn't be feeling like that about systems and you shouldn't be feeling like that when you're a therapist sat in the fucking chair talking to the client and hearing the systemic injustice they've experienced

MI presented as being part of harmful systems, but there were other ways in which participants experienced it. However, trying to explicitly define MI within these systems often felt messy, in part because of the frustration of what it meant to the participants to be part of something that they felt reproduced continuous injustice. Stella demonstrated this messiness when they said "That's, that, that's more what you call moral injury, I don't know what you call it. To me I would just call it bullshit. Sorry I'm getting angry, but I just call it bullshit.".

Sally also spoke about a fragmentation of self she experienced. This sense of fragmentation was created because she felt her personal values and understanding of care were completely different to how she was taught to provide care as a ‘professional’. “And I think that like, fragmentation I think caused me so much damage. Because I think that, because I did develop post-traumatic stress [disorder]”. Sally spoke of having to restrain people, force people to eat and have the power to remove someone’s autonomy and feeling pain at having to be part of this – “I remember thinking like, this is so bad! It was white prison staff and he was a Black man. And it was six men restrained him for hours.”. Sally was the observing nurse in this scenario, her professional duty during this was ensure this was ‘safe’ for the prisoner, which she felt was impossible. The fragmentation was the rules of the job versus her confusion and disgust at what was happening. That coupled with it being something that was deemed acceptable and normal due to the professionalisation of the actions.

Distress manifested in other ways, not just MI. “It's difficult. It really is. Like I feel, I think I feel ashamed sometimes” (R). Micheal expressed a sense of exasperation, and had left his profession as a result, though is still working in schools in a different capacity – “you also hit the…you hit the point where you're like, I can't do this anymore. You know, you’re so burned out and rundown”. John and R felt that despite burnout, healthcare workers were unsupported by services. “And I also think it's the lack of support for people when they do experience burnout as well.” (R) and “there's the irony of us looking after other people but failing to look after the workforce that are looking after other people.” (John).

Participants spoke to the experience of MI as being part of and complicit within systems that perpetuated systemic injustice. They also spoke to the fact they because they were aware of systemic injustice, in referring to the model, and aware of their helper/harmer position, this was a major factor contributing to their MD.

> But I feel like as you start taking your rose-tinted glasses off as you age, that is probably when you're at the greatest risk of moral injury and other kinds of harm because you can't get the glasses back on. (Jodie)

In understanding how distress is experienced in relation to those with lived experience of systemic injustice, we can now think about the processes that maintain and reproduce distress and MI.

3.3.3 Upholding professionalism:

This theme speaks to the need to uphold a professional image to preserve our own self-image, our jobs and livelihoods, or to avoid blame and condemnation. It also serves to protect the needs of the service or institutions we find ourselves working in. This was touched on in Sally expression of feeling fragmented, of needing to uphold professional mores regardless of personally held beliefs of what is right. This theme sits within both the meso and micro levels, i.e. interpersonally and institutionally.

Multiple people spoke to the idea of our professions being held in such high regard, this aggrandising of our professional roles so that "…it becomes your identity. And it's almost like this coat of armour that you can then wear." (Sally). But, as Jodie states, "It's just a job!". Sarah and Sally spoke to their perceived importance of maintaining an image either of the profession itself, or of the institution. Sarah felt that "…it's, it's all about looking good. It's all about good press and you know, showing the big cheeses…that we've got the numbers right.". Sally spoke more specifically to nursing in saying;

> I think possibly self-preservation and also a sense because nursing has strived to be taken as seriously as medicine so there is, they try to instil in you a sense of like you know, 'You are a nurse!'. … You should be proud to be a nurse.", you know 'You uphold the institution'…

Multiple people spoke to the idea that because of this need to uphold the right 'image' that there is a lack of transparency when mistakes are made - "And there was never a sense of yeah, here was never a sense of like mistakes or, and that's true of all healthcare actually, but never any sense of transparency with mistakes" (Sally). Louise echoed this during our focus group stating that

> Yeah, transparency, back to the emperor's new clothes thing like that. You. There's just so much pretence. There's just sooo much pretence. And I guess that is what you're saying, that, yeah, professionalism is kind of *professionalism*. Like it's just this structure we hold on to…

This does at times also tie into what was understood as perhaps a lack of resourcing and therefore the service need outweighed the individual need as a result. Lara explained it in saying;

> I mean you have this narrative of it all being about the person and person centred, but actually when it boils down to it, sometimes I just sit in meetings and I'm like, am I the only one that's actually registering, like how awful this is? The way we're speaking about people and the fact that we make decisions not based on what the person actually needs, but what we need as a service [need] and how much money we've got and the fact that we're forced to, like, lie and like, just do completely unethical things all the time...

Lousie noticed a similar thing occurring in services she's worked in

> And you know those things about what they've had two lots of therapy so they can't have a third. You know, on a on a resource basis I get it, I logically understand it. But I'm like, they're still not well.

This highlighted a limit to caring, connected to the idea posed – 'who are services set up to serve'? The person or the state/institution? That we as professionals are free to offer care and support, but when this infringes on the needs or ability to provide on a service level we start to remove that care or make it contingent on other factors related to service need. This did not sit well with the participants.

On a more personal or individual level there was a sense that we as professionals need to uphold our own self-image as a. "And I think that maybe that's what it comes down to is like this sort of desperate wanting to solve it and people, people putting themselves on a pedestal to try and solve it..."(Sally). That sense of dissonance and power. Because as clinicians we are helpers, we need to feel that to be true. Micheal felt that others would take credit for their colleagues work, another example of needing to seen as helpers and good, competent professionals. This also speaks to hierarchies of power;

> Or like the professionals, they were just come in and get an update and be like, 'Oh, try and do this thing'. That wouldn't work and [I'd] kind of like go trial and error, and then if there's any improvement they'll just be like, 'Yeah, this is because I said that', you know, 'Because I found that!' [i.e. not because of what Micheal had done as 'lower' in the hierarchy].

Stella felt it boiled down to "Protecting the crumbling of the self and protecting one's job and survival.". This highlights that the contextual is often personal or individual too, and so can be challenging to separate them into discreet categories.

3.3.4 Responsibilisation & Fragilization:

Responsibilisation refers to the process whereby people "are rendered individually responsible for a task which previously would have been the duty of another – usually a state agency – or would not have been recognized as a responsibility at all." ('Responsibilization', 2009). It is closely linked to neoliberal policies, which within mental healthcare can be understood as closely aligning practices and service delivery with "labelling [sic], diagnoses, use of DSM, biomedical model [and] neuroscience" and "biomedicalization, pathologization, individualization [and] responsibilization", i.e. how we work is closely linked to the needs of the state (Brown, 2021) as demonstrated earlier in this chapter. The process of responsibilization is when the mandate of an organisation or wider entity is not being fulfilled for whatever reason. The responsibility is then put back on the individual/s or community to take over, without the power or resource to do so. This then leaves the wider issues (poverty, discrimination etc) unaddressed. A key aspect of the technology of responsibilization comes when we label an individual as personally deviant, deficient in ability or unwilling to change their circumstances or behaviour – rather than seeing the presentation of their distress as co-created by the social contexts/inequalities that direct their lives or experience of the world. For example, telling staff to look after their own MH and wellbeing by 'taking breaks' or having a good work life balance, without addressing the lack of resourcing, high caseloads and limited support and flexibility while working within services. What is key to hold is this is related to having non-human actors and systems manifest through and against individuals. This is far less about the individual action itself.

John again speaks directly to this when she says

> How even IAPT service was designed by an economist. So I found that interesting. So I think that in itself shows if we're looking at economy and mental health, you know, it is about people being productive, being useful to society.

Aminat reported that "I feel like a big reason why we are not able to make change is because of this this relationship between like, money and outcomes". Here we can see again that the priority lies not on providing person-centred care but in looking after the needs of the system and expecting those accessing and working within services to produce positive results anyway.

Participants spoke about how clients were blamed for not fitting into our policies and procedures properly without consideration about the needs of an individual – a sense that one size or way of doing things needs to fit all. I.e. if it is understood that there is an 'ideal' way to do things, and someone is not aligned with that this, they are constructed *as* the problem. "I hear a lot, I guess, is um, 'Oh, they just don't want to engage and not trying hard enough to engage'. And that really frustrates me because it's pretty fucking difficult to engage." (R). Or SUs are too 'complex' for us, but "Maybe a strong attempt wasn't made, in my opinion, to really work with them because of the, they're, quote/unquote, 'difficult'. They're too difficult for the system or or the services that we are able to offer. They're too complex" (Aminat). Aminat was speaking about a Black man accessing care, and felt that his race, among other factors, also played a role in how he was perceived in his 'complexity'.

Louise felt this also connected to the wider culture of the UK, of Western ideals of individualisation "...certainly in the Western world as well, like, we're just very, yeah, individualistic. And it's like, if you're struggling, that's *your* problem, you know, and *you* need to solve that. Preferably with CBT, <said tongue in cheek, laughing>". The expectation and responsibility put on people to achieve, engage, recover etc. felt too much, "...You're asking us to be superhumans!" (Stella). We're dehumanising people, putting the onus on them when they're not 'getting better', and blaming them for it as a result. Concepts like 'recovery' for example, was frequently highlighted as a way in which the participants themselves felt they were being made to responsibilize SUs, which they felt to be unfair, unhelpful and unethical.

Fragilization is the way in which we assume another to be fragile, often placing a moral judgement of a person being ‘deficient’ as a result of this perceived fragilization. In the case of this research participants spoke to it being related to their perceived ability to cope due to their own lived experience of mental health difficulties or assumptions made based on their identities. This was often done not out of malice, but in a more paternalistic way, with ‘kind’ intent. But participants, while able to recognise this, also spoke to how harmful this is “But it's not about intention, it's about impact.” (Jodie). She went on to express that “…the classic example is when you work in a mental health team and if you've got lived or living experience yourself, the way you can be treated and responded to by other people in the team - viewed as incompetent, incapable, this, that and the other.”. R also felt coddled by colleagues in that “…sometimes there's a bit of babying…like, ‘oh, God, are you really going to be capable of doing this and that and stuff?’” Even when doing what they felt was best for their SUs, Lara reported this sense that “…there's kind of this narrative that whenever I advocate really strongly for someone, it's like, ‘Oh, is she OK? Is she unwell?’. Like meaning me.” Louise in the focus group shared this in relation to lived-experience professionals more generally, “It's like, bad both ways, isn't it? But either you just ignore the fact that you have been hired because you've got this lived experience or yeah, you're kind of babied.”. They felt that this was also seen in how we view SUs which will be spoken to more under the theme impact on SUs.

I have connected these two themes because of the way in which they both put the responsibility back on a person for something in which they have no agency or power to control. Both concepts position individuals as needing to take on the onus of something without allowing them autonomy or power to do so. Either their position as someone with lived experience meant that there were insufficient in some way. Or if, like Lara when she asked for reasonable adjustments, it was seen as an inconvenience to the service that she couldn’t just ‘slot’ into the standardised way of doing things [responsibilized]. Both processes occurred between professionals and professionals, and professionals and SUs. This idea of blaming individuals for something they have no power to do anything about, links closely to the next theme, systemic gaslighting. We’re being made to feel as if we should be doing things we have no power or autonomy to actually achieve and then blamed as a result.

3.3.5 Systemic Gaslighting:

Systemic gaslighting refers to the process of systems gaslighting individuals within it. The assumption of a universal 'truth' is such that it depends on there being an infrastructure to uphold it and an assumption that we all live according to one, singular version of reality. Importantly it misses the "important affective and structural elements of how gaslighting works, especially for those who do not move through the world inhabiting bodies and identities that afford them unmarked privilege and access to legal and cultural systems designed to serve them." (Drexler, 2023). In turn, we often pathologise those that resist by holding "…a position of power designed to manipulate less powerful others to doubt themselves or question their own sanity or memory." (Johnson et al., 2021) – "Because what is the best way to undermine somebody? Call them mad." (Jodie), which is very grey given our professions.

Participants felt there was this constant duality or failure on the part of services. They [services] would create messaging about person-centred care, but actions and policies, for example, suggested otherwise. Sarah commented:

> Oh, it's all about patient safety." And you know, there's freedom to speak up guardians now, who are useless in my experience. And you know, it just very much seems to be like 'you can speak up, you can say this, it's an honest culture. We're all kind of like a family here. We just want the best for the patient. We want the best for the staff', but there is so much that goes on that gets swept under the rug.

Sarah also shared a situation where she was directly gaslit about the series of events related to a coroner's enquiry. "but he admitted to me and to one of the admin staff as well that he used the terms. "Oh, I perjured myself" and "The lawyer was there and heard what he said and he said to me 'that's not what he meant' and I'm like, we all know that's what he meant. He even admitted it to me.". Sarah was made to feel by those who hold more power than her, that despite knowing what she heard, her understanding was wrong.

Jodie spoke specifically around her experiences of racial gaslighting:

> Yeah, I mean, I have been treated in a hostile, racist, ablest, bullying, harassing manner. Whether that's working in different services, by other people in the field. Em I felt that's quite normal in our field. Everybody pretends that it's not what the reality is.

Later Jodie spoke about scenarios where she's

> worked in teams and I've only been allocated service users that are Black and Brown. Which I personally don't have an issue with working with any of those people. I do not have an issue at all. For...when the whole team's white and I'm not...what's going on in the decision making there? Like the underlying, it may not be being said, it may not be being voiced, but there is an underlying; "oh, you look like these people, so you need to work with them"

R shared experiences of his identity being weaponised against him

> Um, I think it can...the fact that I'm within the sort of 'groups', if you like, can affect my own confidence in talking out about things because I'm worried that I will be seen as either, 'Oh well, typical R, he's being really sensitive and emotional because he's got a personality disorder diagnosis' or, 'oh, trans people are so dramatic'.

Louise spoke to this happening to SUs as well, "So like your sexuality as a service user could, this is, you know, not saying it's obviously always the case, but could be more pathologized and more like, you know, part of your risk profile and all this kind of stuff.". We as professionals hold power in what we say, and we hold authority of the institution of psychiatry, and thus giving us the power to impose our concepts of distress and how we expect people 'should' respond. This can be in the case of colleagues or SUs. Lara was advocating for herself in requesting reasonable adjustments, which were initially denied, and then only granted after she had a period of sick leave. They were initially denied because she was not seen as aligning with the needs of the service. When she was off sick for a period, only then were the adjustments allowed. She felt this was conditional generosity, where she was made to feel like she should be grateful - “And at that point it felt like I…they were like ‘sacrificing’ something for me. Do you know what I mean? It's almost like I was made to feel guilty.”. Lara felt this experience replicated systemic injustice she had experienced in the past, that her MH status was a limitation and she was being responsibilized. But at the same time told that she was actually being supported despite feeling very unsupported.

John spoke to how it played out institutionally too

> So they would see standing up against the genocide [Gaza] as being political. However, when they are working to the government's agenda, they are clearly being political. And they're having to follow certain policies and procedures that are in line with the political party. But they wouldn't see that as political. So as soon as something is considered, I don't, I don't know, I don't know. I don't get it! I honestly do not get it. And it's very gaslighting.

Participants recounted multiple ways in which they felt the institutions and actors within it caused them to question their versions of reality though embedded norms, policies and narratives within their organisations. This furthered the sense that they were causing harm within helping roles.

3.3.6 Helper/harmer positionality:

3.3.6.1 As being part of the system:

This theme can be summed up very succinctly by Lara when she says

> Because I know deep down that I'm, I'd like to think, a good, fairly good person in the sense of like, you know, I'm kind and I'd never do anything to deliberately harm anyone. But I'm also aware I work for an organisation that is harming people.

There was a sense throughout the interviews and focus group that, generally speaking, people were not intentionally causing harm. The difference was not ‘good people’ vs. ‘bad people’, but rather than those who knew and those who didn’t i.e. aware or unaware. “There's a lot of people that are very well meaning, and really want to help and really care, but the systems are not allowing them to do what they want to do.” (John). Aminat felt this was the case too, but of others, highlighting that position of knowing and not knowing “And just thinking about, yeah, like, maybe how sometimes you knowingly or unknowingly join in with practises that are actually oppressive”.

Louise spoke about a professional on her team who expressed an anti-trans rhetoric which Lousie believed to be harmful. She shared “…because there's a very transphobic clinician who is linked to, linked to the CASS report. They actually genuinely believe that they are helping young children.”. I think this is hard to sit with, at least I feel it is. We are all helpers and harmers, and we all believe we’re ‘good’. But who defines what ‘good’ support actually is? Those who wrote the CASS report, or those that protested it?

This duality often presented as quite painful for participants. Aminat was reflecting on a project she worked on which she felt a lot of MI in being part of. She reflected that

> Just thinking about taking time with people and thinking about being able to fully support someone's needs holistically, getting to know them as well. Or just, not being able to really, you know, talk about my concerns about colleagues that, that, that were working on the project, yeah, I just think I just think it was very…I think what was painful about it was thinking about did we leave people, more, more helped or more unhelpful?

Sally spoke her time working in services support SUs with eating distress

> Like because I work with people that [have] eating distress and like you would have to like, enforce mealtimes. They had to complete all their meals. Which now I think is like the most horrible punitive thing I could imagine. I've never want to do that again.

Micheal shared his experience of this duality working with children and families, while also holding safeguarding responsibilities.

> it's always like kind of a tricky thing because you, you are the person they trust, but then depending on who or what kind of, you know, what you're doing, and sometimes you're also the person they need to be wary of…Because you're the person who's gonna, speak to like, cause now you know, you do safeguarding reporting and that's the conversation you have to have with the child. And that is like, you know, put them in this thing where like, they're like, yeah, yeah, throw them into the um, care system which is…it's difficult.

Even when we're doing all we can, "it still looks like you're fobbing them off because you're just being told no from people you're trying to refer to." (Sarah). "I'm helping inside a harmful system, so am I really helping?" (Jodie).

3.3.6.1 In aligning with values through small acts of resistance:

Some participants felt there were spaces within the systems we work in to honour what they felt was right or moral which was a small act of resistance. Others felt that their mere presence within the systems were acts of resistance or disruptive in and of itself. There was a sense that it was important to find these ways of aligning with values to hold on to hope, to hold on to the helper aspect of who we are as professionals

> the reason why I'm not hopeless 24/7 is because I think about OK, this is the context, these are the values of the organisation, these are my values, what can I do to focus on the person that I have in front of me? (Stella)

Jodie referred to having tattoos that represented her lived experience to those who recognised them "Emmm…then what I've done is name that for that person, and particularly with tattoos that represent surviving particular types of abuse…We've got something shared.". Louise, who described how she looks as against the normative

> I also love that I love messing with people's perceptions in that way of kind of like, yeah, you didn't expect me, did you? Like, I really I do. You know, I said it's annoying, but I also enjoy it because I like to disrupt the systems in my work life.

And finally Lara, who had been told by one of her care coordinators she could never work as a professional in mental health shared that

> I kind of feel like if I was to just quit, then I'm not only would I be quitting on myself, but I'd be quitting on them as well and I feel like if anything's going to make me quit, it should be that the patient work is not for me. It shouldn't be that the system itself is making me feel like I don't belong.

Other small acts included bending the rules where you could, even if you knew there was limitations to that "Both more bearable for you and what you hope is is, is more ethical and better for the client. But you can only bend the rules and expectations so much" (John). Sarah spoke to this too "Yeah. But I don't feel like I, you know, I wouldn't say that I consistently break rules like that. Just little, little things, you know." Participants spoke about writing supporting letters for benefits claims even though this wasn't allowed, or at times, depending on the service, they were supposed to charge for. Another example was providing care to those who technically did not have recourse to public funds, but were unwell.

Sally took joy and pride in watching SUs defy the system

> She [SU] was like, 'Nah, I don't want that.'. And I was so proud of her because she was young as well. And he was like an old white guy. And I remember feeling even now, I feel like, pride at watching her do that.

3.3.7 Impact:

Impact in this case considers the impact of the whole central part of the model. Within that central part we can see there are several processes, but here I am speaking to overall impact of that distress, that feeds back into upholding a culture of systemic injustice. However, it should also be recognised that there is some messiness in separating the impact on staff and the impact on SUs. As R highlighted, there's a cyclical nature to the problem

> there's a lot of burnout in mental health teams, community mental health teams and people [professionals] end up going off sick or leaving the team. And people [SUs] end up going through care coordinators one after the other after the other and they [SUs] can end up feeling like, 'am I the problem?'

3.3.7.1 Impact on SUs:

One of the core injustices expressed by the participants in how the systems of care negatively impact SUs was the way in which diagnostic labels put people at further risk of harm and feed into limiting narratives about those who experience mental ill-health. Sally felt that systems position "the person who has lived experience is like deficient, both like morally and like intellectually. But also the fact that they should just be grateful for the care they receive that may involve like restriction and coercion." This lead to "the person doesn't get the service that they deserve as a result, because the professionals' holding something back" (R) at best, or "And yeah, it just fell on deaf ears, like my concern [fell on deaf ears], just because of the label that they have and the way that they're viewed as, I guess because of their characteristics, shall we say", Lara speaking about a SU with a 'personality disorder' who had recently completed suicide.

There was a strong sense that services are just not fit for purpose. Sarah felt "like I'm letting everyone down because I can't give patients what they need." because, as Stella shared "systemic injustice is kind of a given". It was felt that this led to worse outcomes, especially for minoritised communities, as expressed by Louise "But you know, down to, yeah, very minoritised identities, you know, being like in poverty because the system just doesn't work for them in, in any way. And actually it [the system] makes it worse." Jodie really questioned our versions of help, or rather how much we felt the SUs we work with could really be supported to achieve

> Em, because we might be really invested in helping our service users, we might really want to help them, you know, be able to get out of their house more or make

> friends or whatever it might be. But when we think about it, would we want to help them to the point that they can do our job?

I find this particularly interesting when thinking about Lara's experience of being told by her care coordinator that she could never be a MH professional due to her own living experience. That is a stark example of the assumptions we as professionals make about the people we support.

Stella also questioned the way in which services are set up, meaning people are frequently moved between services leading to "people having to retell their stories and this being retraumatising cause they've been, eh maybe they moved or maybe they moved from, I don't know, crisis to primary care or whatever". Again, the way services function necessarily cause more harm for many.

3.3.7.2 Impact on Professionals:

Several participants spoke about leaving as a result, feeling like they were no longer able to work within PFS any longer. As mentioned, Micheal had already left and was no longer working as an art therapist. Sarah reported that she was actively looking for roles outside of nursing and the NHS. Aminat and Stella also both spoke about considering it too, but hadn't made any choices yet. Stella also felt that taking on private work would sit uncomfortably with them as they believed in the public health system. "And maybe I need to go private and then, but that how does that work out? So these are all…? And and then there is that aspect of sadness and having let a community down for going private." (Stella). Even if the participants themselves weren't necessarily thinking about leaving, it was something that was commented on frequently, high staff turnover within teams. Sarah sharing that she saw "People were getting pissed off and people were leaving". Or Jodie highlighting

> Why don't you have enough staff? Because it's a toxic workplace. It's an awful work environment. People come into the space - because you're all burnt out, worn down, don't have any support, which is completely valid. But people then walk into a space where they're not treated like a person. It's kind of like; 'get on the get on

> the factory floor, do your bit in the line up'. Em, there's also an awful bullying culture, which I think largely feeds into people not wanting to work there, people only wanting to work part time. You always have services where the staff are like going through a revolving door. And you know, the reality is it's not because of the service users! They are not the primary reason for this happening because if it was them, people wouldn't apply for these jobs in the first place.

There was a personal impact too, a sense of shame and discontent. "You're stuck between these two really shit choices, right? Either I burn myself out doing what aligns with what I believe and what I think is right, or I don't do these things, and I just feel like shit about myself" (Micheal). And Lara

> As in like the impact on you personally and like the amount that you notice and the amount that you pick up cause it just feels like you're just dragging around this like weight of just shame on behalf of the organisation.

Chapter 4 - Discussion:

Here I will speak to how my research answers the original research questions posed, and how the results of this study relates to already existing literature on moral injury in healthcare. I will then highlight the strengths and limitations, consider the clinical and research implications and offer some finals reflections and conclusions.

4.1 Overview:

What is the experience of moral injury in mental health professionals with lived experience of systemic injustice?

I have been able, through this piece of research, to focus on the experience of moral injury experienced by mental healthcare workers which has been far less studied. Further to this, I have also brought a novel way of thinking about MI/D experienced by healthcare workers. I have done so by looking at how the wider systems influence individual experiences, using the lens of kyriarchy to make sense of this. This piece of research moves away from a narrative of distress and challenge faced by MH clinician that positions the problem within the individual, by inviting us to more critically think about the wider systems that govern our profession. Concepts such as compassion fatigue and burnout, in their definition, place the problem within the person. The aim of this study was to think about the wider factors that can be attributed to experiences of distress, specifically MD.

Existing research as reported in this study, showed that MI experience by healthcare clinicians can be experienced as betrayal-based MI, acts of omission and witnessing or causing harm. The participants in this study all spoke to a wide-reaching understanding of systemic injustice both via personal experience and by witnessing it. Thus, identified directly that working in services that participants recognise as perpetuating inequalities and continuously witnessing and being part of unjust systems was, in and of itself, morally injurious. The emergent theory presented in this study speaks to the processes at play when working and existing in kyriarchial systems. The participants themselves identify as promoting and maintaining hierarchies and dominant ideologies such as the medicalisation of distress or enacting racism and sexism. Core to this idea was the helper/harmer concept that came through in the results. The argument being that as a MH professional we are in a position whereby we all, by sheer virtue of the professional, will always be in position where we provide care and/or cause harm.

Below I will present how my results relate to the preexisting literature as described in chapter one of this paper. It will be broken up so that it aligns with the SLR as well as the levels outlined in the CGT model developed from the research.

4.2 Relationship between my research and existing research

4.2.1 Systemic (macro):

I think it's useful to start with thinking about the macro level, the influence of dominant narratives that underpin kyriarchial systems because this bleeds into everything else. If we think about Bronfenbrenner's (1979) ecological systems theory, the macro level encompasses all other levels. I have chosen to depict my model similarly, with all other processes happening under the umbrella of kyriarchy.

Minor changes at the macro level can have major impacts at the meso and micro levels. Over and above this, the initial design of policies or creation of ideas have significant and far-reaching implications for future ideas and designs as it creates pre-established patterns and norms in a given field (Schmidt, 2001). If we think about the language and development of MH distress, we still consider people who experience distress, often from understandable human reactions to life events, as 'disordered' (Engler et al., 2022; Hillen et al., 2012; Jones, 2013). Our conceptualisations prioritise diagnosis, medication, and professional authority over the lived truths of individuals we serve. Within MH services, there tends to be an emphasis on 'expert' versus 'patient' or 'helper' versus 'helped', with a stark division between professionals and SUs (Foucalt, 1973; Freeth, 2007). This created even more distress when participants who held both identities were interacting with services as professionals, thus further contributing to their experiencing MI/D.

Stigma was found to be a contributing factor across some of the papers presented in the SLR as well (Bondi et al., 2019; Cervantes et al., 2018; McLean et al., 2019). However, what this current research adds is an understanding and descriptive analysis of the layer between personally experiencing systemic injustice and thus being more able to identify how it works, or more cognisant of its function with the experience of then being able to identify the ways in which practitioners may also personally enact it.

The biopsychosocial model acknowledges some social influences, but it fails to adequately address broader societal structures such as socioeconomic status, systemic inequalities, and cultural norms, all of which are understood to significantly impact health outcomes (Marmot, 2005; Marmot et al., 2012). On top of this, mental health inequalities persist, with services consistently accessed at lower rates by racially minoritised children and adolescents for example (Bains & Gutman, 2021; Sin et al., 2010). It's one thing to increase access rates for minoritised communities, but if our services are not providing good enough care once they enter our care, then we just perpetuate systemic harms – for professionals and SUs alike. Services at present are facing increasing demands alongside a reduction in resources and preventative measures (McGrath et al., 2015; Mental Health Foundation, 2016), and these challenged need to be tackled at multiple levels within the system to truly make impactful and wide-reaching change.

4.2.2 Intrapersonal (individual):

This idea speaks to the internal experiences and beliefs of individuals, but as impacted by the persons' context and position within the wider structures resulting from kyriarchy. We internalise our ideas, norms and values from our contexts. Central to this process within the CGT model was participants descriptions of being both a helper *and* a harmer. Existing literature spoke to this overarching idea, that their internal views conflicted with their professional role (McLean et al., 2019). Participants described the impact of feeling trapped in this position of being a helper and a harmer felt intolerable, often leading to participants in this study considering leaving their profession. Research has found that healthcare professionals are leaving because they feel unable to do their jobs in a values-based way and feel that the way in which services are operating is ultimately unsafe for them and for their patients (Leary et al., 2024). While participants spoke to lack of resourcing as a factor that explained possible barriers to providing good care as is often highlighted in existing literature, they also brough in more nuanced explanations. This included damaging and limiting narratives about MH experiences, economic motivations for service provisions and policies, and social inequity as a fundamental reason for failing SUs.

This inability to align with values and work in morally sound ways caused shame, often leading to feelings of dissonance. Cognitive dissonance theory suggests that in response to the discomfort caused, typically, individuals will change their beliefs or change their actions (Festinger, 1957). As mentioned, consideration of leaving their job was frequently reported in the current study. One way we can make sense of this is that personal feelings of shame have been connected to social withdrawal, isolation and inhibits meaningful social interactions (De Hooge, 2018). This dissonance was understood to be experienced by everyone working in PFS, but that how we responded depended on how aware we were of being a helper and harmer. And how aware we are of how injustice and oppression plays out. For the participants they believed that if you were aware of the levels of injustice within systems, this was what led to MI/D. For those that were unaware, their response to dissonance would be to feed back into, and uphold the systems.

The overall impact of this was felt to be a continuation of distress and the upholding of systemic inequalities within services. For professionals this aligned with the literature, with a wealth of literature reported that MI relates to burnout, depression, apathy, anger among other experiences of poor wellbeing (Mitton et al., 2010; Nieuwsma et al, 2022; Rodrigues et al., 2023). For the impact on service users, it was understood that our healthcare systems are perpetuating health and social inequalities, which too aligns with current literature as outlined in the previous section, 4.2.. While participants felt that they, lost the trust of SUs for example, as described by Sarah, the impact was generally spoken to at a broader level.

Participants in this study spoke to trying to align more with their morals and values through small acts of resistance. This highlighted that often they felt that sticking to the rules set out by institutions would necessarily lean them away from values-based working.

4.2.3 Interpersonal (micro):

The ideas under this theme typically related to the subtype of MI; witnessing harm and unjust action as the precursor of experiencing MI i.e. I see something playing out in the system, and that hurts. It also related to a sense of betrayal participants felt when other professionals and colleagues were engaging in practices that they felt diminished or disempowered them (the participants) or SUs. This came in the form of feeling babied or coddled, and as if others assumed them incompetent due to their own lived experiences of systemic injustice. Participants too, spoke to a lack of transparency or honestly in how we make decisions, provide care or manage mistakes within services. The lack of transparency also related to presenting medicalised or other dominant ideologies as 'correct' and not valuing person centred knowledges despite messaging suggesting we (as service providers) do. This was highlighted when participants spoke about the messaging around person-centred care against the backdrop of being in services and witnessing decisions being made based on bureaucratic needs.

This was often seen to play out at macro or meso levels as well as being 'performed' between individuals, therefore it's challenging to speak to in a discreet theme in and of itself. This can be seen when Aminat spoke about an example of struggling to support a SU because they were deemed 'too complex' for the service to support well. Such language can be said to create an idea of what we consider a 'normal' in response. This fails to consider the absence of autonomy or the experiences of oppression, instead framing it as a failure on the part of the patient, or as further evidence towards their illness (Conrad, 1985; Vaughn et al. 2009). The service ability to support SUs related to policies and narratives which sit at a meso level, but this gets enacted by, in this case, Aminat's supervisor and service manager. Again, there is a sense of dissonance here, that managers or those holding middle level power are enacting the will of the institutional mandate while at the same time having to bear witness to the impact front line staff and SUs. Galura (2020) speaks to this concept of managerial dissonance and about harms caused when holding this position. For example needing to manage access rates and therefore having to deny care to some. Galura (2020) reported that the perception of being a harmer related to the managers belief in the 'good' of the system, action or choices that were being implemented. Meaning that if they believe the harm caused could be justified by the overall 'good' or that they aligned with the institutional decision making, they would not experience distress. If they did not align with the decisions they felt forced to implement, this could cause distress. To go back to Aminat's example, if her supervisor felt they were righteous in limiting support they wouldn't experience distress in enforcing the decision. If they didn't think that, that's when the harm would be felt. This echo's the CGT model in that distress is experienced only when you're aware of the impact and how systemic injustice plays out.

Other decisions that were made were highlighted by Jodie. For example, when she reported that would often be assigned the Black and Brown SUs when working in majority white teams. But also about times she had experience more blatant racism. This discrimination was reported by participants in relation to their own mental health status or sexuality, gender as well (their minoritised identity characteristics). We can see this in the existent literature. Thorne et al. (2018) spoke about a bullying culture within services. We know that bullying and discrimination is unfortunately not uncommon within the NHS, and research has shown that women and those holding minoritised identities are more likely to experience this (Munroe & Phillips, 2023).

Studied also showed that professional hierarchies led those to feel insubordinate, however in the existing research this was related to professional banding (to use NHS based language), rather than elements of identity (Biondi et al., 2019; Bruce et al., 2015 dos Santos et al., 2018; Matthews & Williamson, 2016; Oelhafen et al., 2018; Thorne et al., 2018). The participants in this study felt dismissed or fragilized based on their lived/ing experience of mental health for example. Oelhafen et al. (2018) reported that midwives in their study felt unable to speak up even if they disagreed with clinical decisions which highlights the role of hierarchies in service. This came through in this study too, for example R and Lara having their clinical judgments questioned (fragilization) based in their lived experience of so called long and enduring MH distress or other identity characteristics. They went on to describe an 'us versus them' narrative within teams, i.e. those with lived experiences of systemic injustice verses those without. Current research again shows this happening based on professional role, where this piece of research shows it as being born from our personal *and* professional identities.

4.2.4 Institutional (meso):

Participants reported that the narrative of person-centred care or caring environments for staff was mere image, and in contrast to their experiences working in services. This came through in existing literature when studies spoke about ambiguity in policies and dominant narratives in services (Cervantes et al., 2018; Matthews and Williamson, 2016). This was highlighted when participants reported situations where care for SUs was based on service need, for example, Louise speaking SUs only being offered a certain amount of therapy despite still being unwell. Or when Lara reported sitting in meetings listening to staff speak about offering care based on the needs of the service rather than the person.

According to the BMA (2024) society as well as services are not set up to support peoples MH, citing problems such as poverty, poor housing and unemployment as factors. These social determinants of MH are further exacerbated by MH services purporting to have people in 'recovery' after x number of sessions. This goes back to the idea of responsibilization, the individual must take the responsibility for getting better despite society not being able to support a good level of wellbeing. We also know from NICE (2022) guidance that those experiencing social difficulties or are from minoritised community fare worse when it comes to overall health and wellbeing. Individuals are positioned as needing to manage their own mental health without the necessary consideration of the ways in which social and economics determinants can significantly limit their choices and opportunities to live well (Harper & Speed, 2012).

In upholding professionalism, participants reported that we are upholding either a self-image or the image of the profession, regardless of perceived or real impact on SUs and clinicians. Cognitive dissonance has also been shown to threaten our overall sense of self-esteem (Klein and McColl, 2019). If we make decisions that we later learn were 'wrong' we might feel stupid or incompetent, and therefore this sense of upholding the morality and correctness of our professionalism can shield us from that. Participants in this study spoke to a strong need to hold on to this "coat of armour", or this sense of being 'right'. Furthermore, research has shown that higher status is associated with less communal and prosocial behaviours, and less likely to endorse more egalitarian life goals (Tobore, 2023). Tobore (2023) also reported power can decrease compassion and empathy. Aligning with these ways of being are easier when we align with the dominant medical and social discourses. But when we have experienced and see systemic injustice, or value other ways of being this becomes much more harmful. We are aware of the harms caused within the system and thus are unable to hold the belief that we are only helpers. Again, connecting back to the distress experienced by the helper/harmer position.

4.3 Strengths and Limitations

4.3.1 Strengths:

A core aim of this study was to move away from thinking that positions distress within the person, and to consider how the systems we inhabit play a crucial role. The CGT model presented in this study highlights a novel perspective for conceptualising MI/D. In understanding our contexts and where power lies, i.e. not within the individual, it brings hope and opens a framework of systems thinking that can create meaningful and lasting change. As clinical psychologists it supports us in taking a more critical perspective when engaging in psychological thinking around MD. We can better support and engage in the nuances of difference and diversity of experience and bring this back into services.

The participants in this study represented a diversity of professional and personal experiences/identities. Such an approach promotes higher quality research and practice and goes further in supporting positive social change (Reich & Reich, 2006).

The research team held multiple positions in relation to working within publicly funded services. Some of us felt that the most powerful changes could be made from within, while others felt unable to remain as part of NHS systems, for example. This added to depth of reflexivity as we all held both opposing and aligned ideas about care, change and social change.

Finally, the depth of the interviews, followed by theoretical sampling via the focus group ensured more theoretical sensitivity and a deeper understanding of the theory and research topic. It also reduced bias and increases the validity of the results. I think the level of depth was further facilitated by my own outsider/insider research position. There were several moments with participants where that shared understanding came through, facilitating a sense of rapport and trust building within the relationships. Having had an initial pre interview conversations with all bar one participant enhanced this too based on verbal feedback from participants.

4.3.2 Limitations:

How we use language changes, adapts and evolves and the term 'moral injury' is relatively new, especially in the context of healthcare. There was a spike in the research on MI in this context around the time of the Covid-19 pandemic beginning in 2020 (Beadle et al, 2024). There were periods during recruitment that finding participants was challenging. In my research diary I began to think about the impact of using the language of MI and wondered how that was sitting with people. Would there have been more uptake if I had terminology in my advertisement such as burn-out, or compassion fatigue? While I cannot be sure, I do believe that choosing to use the language of MI could have been a barrier to those who may have connected well to the topic, but not the terminology.

Furthermore, on the point of language, my questions and concepts were based on people being able to access language in expressing and making sense of complex, and at times painful, experiences and processes.

The total number of participants in this study was 10. Typically, in a GT study, the suggested number is between 20-30 participants (Thomson, 2011). However, in the context of a DClinPsy thesis, given practical constraints, it is not typical to reach this number. As well that, through discussion with my research team and the examination of emerging concepts it was felt that theoretical sufficiency had been reached. Further to this the focus group session to collect more in-depth information (theoretical sampling) and feedback on the model only consisted of two of the participants – which is a limitation in and of itself. It should be noted that feedback on the model, and changes made, were not just based on the focus group session but also through consultation with the full research team (supervisors and consultants) and feedback from colleagues within my advanced methods group.

In terms of the application of this research to clinical services and within research, as it is a novel way of thinking about our services and systems it challenges homeostasis within mainstream thinking of distress. While positive, it could also be a challenging in relation to promoting change within services and in how we research MI/D.

4.4 Quality Appraisal (CASP):

It doesn't feel comparative to apply the CASP framework to my 30,000-word thesis in how one does to a published 3-5000 word paper as I have more space to speak in further depth across the research. However, there is still merit in considering whether this piece of research did what it set out to do to a good standard.

A. Are the results valid? **1. Was there a clear statement of the aims of the research?**	**2. Is a qualitative methodology appropriate?**	**(Is it worth continuing?)** **3. Was the research design appropriate to address the aims of the research?**	**4. Was the recruitment strategy appropriate to the aims of the research?**	**5. Was the data collected in a way that addressed the research issue?**	**6. Has the relationship between researcher and participants been adequately considered?**	**B. What are the results?** **7. Have ethical issues been taken into consideration?**	**8. Was the data analysis sufficiently rigorous?**	**9. Is there a clear statement of findings?**	**C. Will the results help locally?**
Yes	Yes – the question was to think specifically about the experiences of the participants, which could only have been done via qualitative methods.	Yes	Yes – however, larger sample size would have been beneficial.	Yes – utilising both intensive interviewing and a focus group. However, the small size of the focus group is a limitation.	Yes	Yes	Yes – in the process of theoretical sampling and regular support and supervision by research team.	Yes	Yes – But as noted in the limitations section is it a deviation away from mainstream thought and thus could make implementing suggested, wider scale changes more challenging.

Table 10. CASP Quality Appraisal for my research

4.5 Implications:

Given the presented research this has implications for how clinical psychologists can position themselves with PFS and utilise the power we hold.

Within therapeutic spaces:

- This research suggests that moving away from tradition conceptualisations of distress and take a more critical stance in how we understand current frameworks that individualise distress. This applies both in individual therapy models and how we support staff within systems.
- There is a growing body of clinical research around formulation-based understanding of distress such as the power threat meaning framework (Johnson and Boyle, 2018).

Within leadership positions:

- It also suggests that we need to become more aware of diversity and difference. This can be done in a multitude of ways. Being more open to a variety of knowledges such as lived-experience knowledge, but also in consider how community-based practices the decentres medicalised understandings of distress.
    a. This can look like a more public health approach which directly highlights and challenges social inequities. There is an existing evidence base that supports this (Friedli, 2009; Shim et al., 2014; Wilkinson & Pickett, 2010; World Health Organisation, 2014). We need to advocate strongly for improved social resources on all levels.

In service development:

- For me, and most of the participants, there is a need for power to be handed to those with lived experience to meaningfully design their care on all levels, not just in one-on-one spaces. Co-production is increasingly recommended, especially to more meaningfully engage marginalised groups. This is recommended in the Health Equalities Strategy (2020) for MH services. However, we need to create services that can do this in ways that truly share power. This means giving professionals and consultants time and resource to do so.
    a. This can be achieved by the above suggestions being embedded into policy, giving time for relationship and trust building, money and physical resource and working at truly sharing power and flattening existent hierarchies.

At all levels

- We can create language and understanding that moves away from positioning the problem within people and create alternatives truths around the impact of power. This can look like explicitly recognising the impact of inequalities such as racism, sexism, sanism etc., and giving language and knowledge to ourselves and to those impacted by it. This will directly counter the distress and impact of systemic gaslighting.
    a. In terms of addressing language and power, we should apologise when we make mistakes.

Within research

- When we engage in research our evidence based should include a breath and wealth of experience, while also incorporating activism and inclusivity, and considering social and historical context. For example, Mad Studies which promotes research across experiences and contexts.
- Further research on MI/D should consider the wider systemic factors that contribute to distress. It would also be useful to think about these factors with participants who do and do not report having personal experience of systemic injustice.

4.6 Dissemination:

As per meeting the requirements of the doctorate this pieced of research will be submitted for publication with a peer reviewed journal. I intent to publish this with open access.

I have also been in conversation with another researcher about potential future conferences on the topic of moral injury.

Further than this I hope to be able to disseminate in non-academic ways. For example, there have been some conversations with my research team about creating a webinar aimed at clinicians with lived experience of systemic injustice.

I want to consider non-academic publication pathways which could include podcasts, workshops, non-academic publications or articles

4.7 Final reflections:

This has been a challenging project, but one I'm incredibly proud to have completed. As much as any one thing can ever be 'complete' at least. And I hope it's a pride that my participants can share with me, without them this wouldn't exist. Throughout the process I was conscious of what it means to hear stories and make meaning of them. And I hope I have managed to do so in a way that aligns with, and honours how the stories were told to me. I'm even more conscious that others will make new meanings from what was written and told. CGT intends to be an iterative process, ideas are created from the ground up. But there's so much knowledge unspoken in our own histories, identities and contexts, that brings nuance that may simply not always have language.

This also makes me think about how much about the participants and their stories I haven't been able to share. I laughed so much during all the interviews and really enjoyed getting to know everyone I spoke to. I remember feeling such deep empathy and connection too. I remember one person sharing how in order to cope they would spend hours on their phone trying to switch off from the pain they felt sometimes. I remember people's fairytale coming out stories, and not so fairy tale ones too. I remember small acts of defiance and feels smugness when these happened – it was joyful! I hope I've captured the stories well, but I also know so much is missed when we have a set 'task' to do, question to answer.

During the focus group discussion myself, Louise, and R discussed what it meant to define oneself as having 'lived-experience'. This conversation has really sat with me. One of us shared an idea that there are probably many people in the profession who have lived experience, but for whatever reason wouldn't identify with that label. Or perhaps if they did recognise it intrapersonally, there are still barriers to acknowledging that openly. As much as this piece of research speaks to the experience of those with lived experience of systemic injustice, a broad enough concept as it is, I'm left frequently wondering about who else this might resonate with in some way?

It has been interesting grappling with holding a social constructionist position, while working in a framework that more easily aligns with a more positivist understanding. The need to categorise, to define, produce a model and simplify and ensure I don't miss-speak and present it as a final truth has been challenging. And if I'm totally honest, there been periods where I've deeply wanted to assert a version of truth as absolute because I hold certain views so strongly. I'm grateful to my research team for walking alongside me through these moments and conversations.

I really believe this conceptualisation of MI/D and systems thinking holds power and hope for a different and more equitability reality. And I hope this is something I can continue to carry with me as I keep learning and growing as an (almost) clinical psychologist.

4.8 Conclusions:

In conclusion, this study has created a framework that broadens how we might think about the wider systems and social process at play that contribute to the experience of MI/D. In thinking about MH services through the lens of kyriarchy we can start to move away from understanding the challenges faced by MH professionals as a problem or difficultly that needs to be solved by any one individual. While we might individually experience distress, this highlights the need for systems change to really meet the goals of having an equitable and healthy workforce. It has identified crucial ways we can begin to make these changes and offers a perspective that challenges dominant and individualised notions of distress. Through sharing some language and understanding around these experiences, that can expand our understandings around MD. And I hope to be part of the wider community in promoting an approach that fosters diversity, community and meaningful social change.

References:

American psychological association (2018). APA dictionary of psychology. https://dictionary.apa.org/social-context retrieved 10 Dec 2024.

Andrews, T. (2012). What is Social Constructionism? Grounded Theory Review, 11(1), 39–46.

Archer, C. A. (2022). Expanding Moral Injury: Why Resilience Training Won't Fix It. JAMA, 328(12), 1199. https://doi.org/10.1001/jama.2022.15721

Bains, S., & Gutman, L. M. (2021). Mental health in ethnic minority populations in the UK: Developmental trajectories from early childhood to mid adolescence. Journal of Youth and Adolescence, 50(11), 2151-2165.

Beadle, E. S., Walecka, A., Sangam, A. V., Moorhouse, J., Winter, M., Munro Wild, H., Trivedi, D., & Casarin, A. (2024). Triggers and factors associated with moral distress and moral injury in health and social care workers: A systematic review of qualitative studies. *PLOS ONE*, *19*(6), e0303013. https://doi.org/10.1371/journal.pone.0303013

Bell, J. (2013). The four "I's" of oppression. Somerville, NJ: YouthBuild USA.

Berger, P., & Luckmann, T. (1991). *The Social Construction of Reality.* Penguin Books.

Beyer, P. (2000). *Religion and Globalization*. SAGE Publications Ltd. https://doi.org/10.4135/9781446222294

Biondi, H. S., Barlem, E. L. D., Pinho, E. C. D., Tavares, D. H., Kerber, N. P. D. C., & Tomaschewski-Barlem, J. G. (2019). MORAL SUFFERING IN ASSISTANCE TO CHILDBIRTH: SITUATIONS PRESENT IN THE WORK OF NURSES OF OBSTETRIC CENTERS AND MATERNITIES. *Texto & Contexto - Enfermagem*, *28*, e20180052. https://doi.org/10.1590/1980-265x-tce-2018-0052

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

BMA. (2023a). *BMA Covid Review 3: Delivery of Healthcare During the Pandemic*. British Medical Association.

BMA. (2023b). *Mental Health Pressures in England*. British Medical Association. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis

BMA. (2024). *"It's broken": Doctors' experiences on the frontline of a failing mental healthcare system*.

Braveman, P. A., Arkin, E., Proctor, D., Kauh, T., & Holm, N. (2022). Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches To Dismantling: Study examines definitions, examples, health damages, and dismantling systemic and structural racism. *Health Affairs*, *41*(2), 171–178. https://doi.org/10.1377/hlthaff.2021.01394

British Medical Association. (2021). *Moral distress and moral injury: Recognising and tackling it for UK doctors*. https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf

Bronfenbrenner, U. (2009). The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press.

Brown, M. K., Carnoy, M., Currie, E., Duster, T., Oppenheimer, D. B., Shultz, M. M., & Wellman, D. (2003). *Whitewashing race: The myth of a color-blind society*. University of California Press.

Brown, R. (2022). Online Interviews During a Pandemic: Benefits, Limitations, Strategies and the Impact On Early Career Researchers. *PsyPag Quarterly*, *1*(123), 32–36. https://doi.org/10.53841/bpspag.2022.1.123.32

Bruce, C. R., Miller, S. M., & Zimmerman, J. L. (2015). A Qualitative Study Exploring Moral Distress in the ICU Team: The Importance of Unit Functionality and Intrateam Dynamics*. *Critical Care Medicine*, *43*(4), 823–831. https://doi.org/10.1097/CCM.0000000000000822

Burr, V. (1995). *Social Constructionism* (2nd ed.). Routledge.

Burr, V., & Dick, P. (2017). Social Constructionism. In B. Gough (Ed.), *The Palgrave Handbook of Critical Social Psychology* (pp. 59–80). Palgrave Macmillan UK. https://doi.org/10.1057/978-1-137-51018-1_4

Cervantes, L., Richardson, S., Raghavan, R., Hou, N., Hasnain-Wynia, R., Wynia, M. K., Kleiner, C., Chonchol, M., & Tong, A. (2018). Clinicians' Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants: A Qualitative Study. *Annals of Internal Medicine*, *169*(2), 78. https://doi.org/10.7326/M18-0400

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

Charmaz, K., Wertz, F., Charmaz, Kathy, Mcmullen, L., Josselson, Ruthellen, & Anderson, R. (2011). *A Constructivist Grounded Theory Analysis of Losing and Regaining a valued Self* (pp. 165–204).

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Sage Publications.

Clarke, A. E., Friese, C., & Washburn, R. (2018). *Situational analysis: Grounded theory after the interpretive turn* (Second edition). SAGE.

Cobb, C. (2024). Enslaved Women, Women Enslavers: Kyriarchy and Intersectionality in the New Testament. Journal of Feminist Studies in Religion, 40(1), 43–60. https://doi.org/10.2979/jfs.00004

Conrad, P. (1985). The meaning of medications: Another look at compliance. Social Science & Medicine, 20(1), 29-37.

CQC. (2023). The State of Health Care and Adult Social Care in England 2022/2023. Care Quality Commission.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

Crotty, M. (1998). The Foundations of Social Research: Meaning and Perspective in the research process. Allen & Unwin.

Cushen-Brewster, N, Arahant, A, Brewer, Nand Malloy, E (2024). *Exploring the barriers that may be affecting ethnic minority groups accessing or developing into Advanced Practice Roles in the NHS within the East of England.* Project Report. NHS England, Ipswich, England.

Cypress, B. S. (2015). Qualitative Research: The "What," "Why," "Who," and "How"! *Dimensions of Critical Care Nursing*, *34*(6), 356–361. https://doi.org/10.1097/DCC.0000000000000150

Darke, L., Paterson, H., & Van Golde, C. (2025). Illuminating Gaslighting: A Comprehensive Interdisciplinary Review of Gaslighting Literature. *Journal of Family Violence*. https://doi.org/10.1007/s10896-025-00805-4

Davis, J., Mengersen, K., Bennett, S., & Mazerolle, L. (2014). Viewing systematic reviews and meta-analysis in social research through different lenses. *SpringerPlus*, *3*(1), 511. https://doi.org/10.1186/2193-1801-3-511

De Hooge, I. E., Breugelmans, S. M., Wagemans, F. M. A., & Zeelenberg, M. (2018). The social side of shame: Approach versus withdrawal. *Cognition and Emotion*, *32*(8), 1671–1677. https://doi.org/10.1080/02699931.2017.1422696

Dey, I. (2008). *Grounding grounded theory: Guidelines for qualitative inquiry* (Repr). Emerald.

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation*, *35*(2), 220–222. https://doi.org/10.1177/0890334419830990

dos Santos, R., Neves, E., & Carnevale, F. (2019). The moral experiences of pediatric nurses in Brazil: Engagement and relationships. *Nursing Ethics*, *26*(5), 1566–1578. https://doi.org/10.1177/0969733017753744

Drexler, E. F. (2023). Seeing Gaslighting: Photo-Dialogues and Structural Injustice. *Visual Anthropology Review*, *39*(1), 58–81. https://doi.org/10.1111/var.12286

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, *8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Edwards, M. P., McClement, S. E., & Read, L. R. (2013). Nurses' Responses to Initial Moral Distress in Long-Term Care. Journal of Bioethical Inquiry, 10(3), 325–336. https://doi.org/10.1007/s11673-013-9463-6

Eisenberg, R. L. (2022). Burnout. Academic Radiology, 29(2), 284–286. https://doi.org/10.1016/j.acra.2021.10.003

Engler, A. D., Sarpong, K. O., Van Horne, B. S., Greeley, C. S., & Keefe, R. J. (2022). A systematic review of mental health disorders of children in foster care. Trauma, Violence, & Abuse, 23(1), 255-264.

Epstein, E. G., & Hamric, A. B. (2009). Moral Distress, Moral Residue, and the Crescendo Effect. *The Journal of Clinical Ethics*, *20*(4), 330–342. https://doi.org/10.1086/JCE200920406

Evans, M. (1979). 'My Words Will be There'. *In* Wylie Hall, H (ed.) (2004) *Conversations with* Audre Lorde. Jackson, MS: University Press of Mississippe pp. 71 – 8.

Fearon, P., Kirkbride, J. B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Lun Alan Fung, W., Holloway, J., Mallett, R., Harrison, G., Leff, J., Jones, P. B., & Murray, R. M. (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: Results from the MRC AESOP Study. *Psychological Medicine*, *36*(11), 1541–1550. https://doi.org/10.1017/S0033291706008774

Festinger, L. (1957). A theory of cognitive dissonance. Stanford University Press.

Fiorenza, E. S. (1992). *But She Said: Feminist Practices of Biblical Interpretation*. Boston: Beacon.

Fiorenza, E.S. (2001). Wisdom Ways: Introducing Feminist Biblical Interpretation. Orbis Books, New York, NY.

Foucault, M. (1973). The Birth of the Clinic: An Archaeology of Medical Perception.

Frazer-Carroll, M. (2023). Mad world: The politics of mental health. Pluto Press.

Freeth, R. (2007). Humanising Psychiatry and Mental Health Care: The Challenge of the Person-Centred Approach.

French, L., Hanna, P., & Huckle, C. (2022). “If I die, they do not care”: U.K. National Health Service staff experiences of betrayal-based moral injury during COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(3), 516–521. https://doi.org/10.1037/tra0001134

French, L., Hanna, P., & Huckle, C. (2022). “If I die, they do not care”: U.K. National Health Service staff experiences of betrayal-based moral injury during COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy*, *14*(3), 516–521. https://doi.org/10.1037/tra0001134

Friedli, L. (2009). Mental health, resilience and inequalities. World Health Organization Europe.

Frost, D. M. (2011). Social Stigma and its Consequences for the Socially Stigmatized. Social and Personality Psychology Compass, 5(11), 824–839. https://doi.org/10.1111/j.1751-9004.2011.00394.x

Galura, S. (2020). On the Frontlines of Nursing Leadership: *Nurse Leader*, *18*(5), 476–480. https://doi.org/10.1016/j.mnl.2020.05.012

Glaser, B. (2009). Jargonizing Using the Grounded Theory Vocabulary.

Gov.uk (n.d). Guidance: Public Bodies. https://www.gov.uk/guidance/public-bodies-reform#what-is-a-public-body

Griscti, O., Aston, M., Warner, G., Martin-Misener, R., & McLeod, D. (2017). Power and resistance within the hospital’s hierarchical system: The experiences of chronically ill patients. Journal of Clinical Nursing, 26(1–2), 238–247. https://doi.org/10.1111/jocn.13382

Grunwald, M. (2018, December). How Everything Became the Culture War. *Politico Magazine*. https://www.politico.com/magazine/story/2018/11/02/culture-war-liberals-conservatives-trump-2018-222095/

Gunaratnam, Y. (2003). *Researching race and ethnicity: Methods, knowledge and power* (1. publ). SAGE.

Gupta, V., Eames, C., Golding, L., Greenhill, B., Qi, R., Allan, S., Bryant, A., & Fisher, P. (2023). Understanding the identity of lived experience researchers and providers: A conceptual framework and systematic narrative review. *Research Involvement and Engagement*, *9*(1), 26. https://doi.org/10.1186/s40900-023-00439-0

Haddock-Lazala, C. M. (2020). Urban liberation: Postcolonial intersectional feminism and developing a socially conscious therapeutic practice. In L. Comas-Díaz & E. Torres Rivera (Eds.), *Liberation psychology: Theory, method, practice, and social justice.* (pp. 149–168). American Psychological Association. https://doi.org/10.1037/0000198-009

Hall, N. A., Everson, A. T., Billingsley, M. R., & Miller, M. B. (2022). Moral injury, mental health and behavioural health outcomes: A systematic review of the literature. *Clinical Psychology & Psychotherapy*, *29*(1), 92–110. https://doi.org/10.1002/cpp.2607

Hannes K. Chapter 4: Critical appraisal of qualitative research. In: Noyes J, Booth A, Hannes K, Harden A, Harris J, Lewin S, Lockwood C (editors), Supplementary Guidance for Inclusion of Qualitative Research in Cochrane Systematic Reviews of Interventions. Version 1 (updated August 2011). Cochrane Collaboration Qualitative Methods Group, 2011. Available from URL http://cqrmg.cochrane.org/supplemental-handbook-guidance

Harper, D. (2011). Choosing a qualitative research method. In Qualitative research methods in mental health and psychotherapy (1st ed., pp. 83–98). Wiley-Blackwell.

Harper, D., & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. Studies in Social Justice, 6(1), 9-25.

Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: A critical ethnography. *International Journal of Nursing Studies*, *47*(6), 723–731. https://doi.org/10.1016/j.ijnurstu.2009.11.010

Haslanger, S. (2023). Systemic and Structural Injustice: Is There a Difference? *Philosophy*, *98*(1), 1–27. https://doi.org/10.1017/S0031819122000353

Hegarty, S., Lamb, D., Stevelink, S. A. M., Bhundia, R., Raine, R., Doherty, M. J., Scott, H. R., Marie Rafferty, A., Williamson, V., Dorrington, S., Hotopf, M., Razavi, R., Greenberg, N., & Wessely, S. (2022). ‘It hurts your heart’: Frontline healthcare worker experiences of moral injury during the COVID-19 pandemic. *European Journal of Psychotraumatology*, *13*(2), 2128028. https://doi.org/10.1080/20008066.2022.2128028

Henrich, J. P. (2020). The WEIRDest people in the world: How the West Became Psychologically Peculiar and Particularly Prosperous (First edition). Farrar, Straus and Giroux.

Higgins JP, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA, editor(s). *Cochrane Handbook for Systematic Reviews of Interventions* Version 6.5 (updated August 2024). Cochrane, 2024. Available from cochrane.org/handbook.

Hillen, T., Gafson, L., Drage, L., & Conlan, L. M. (2012). Assessing the prevalence of mental health disorders and mental health needs among preschool children in care in England. Infant Mental Health Journal, 33(4), 411-420.

Hunjan, R., & Pettit, J. (2011). *Power—A practical guide for facilitating social change.*

Irwin, S. (2008). Subjectivity and social structure. *International Journal of Sociology and Social Policy*, *28*(7/8), 273–284. https://doi.org/10.1108/01443330810890682

Jameton, A. (1984). *Nursing practice: The ethical issues*. Prentice-Hall.

Jinkerson, J. D. (2016). Defining and assessing moral injury: A syndrome perspective.

Johnson, V. E., Nadal, K. L., Sissoko, D. R. G., & King, R. (2021). “It’s Not in Your Head”: Gaslighting, ‘Splaining, Victim Blaming, and Other Harmful Reactions to Microaggressions. *Perspectives on Psychological Science*, *16*(5), 1024–1036. https://doi.org/10.1177/17456916211011963

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Jones, P. B. (2013). Adult mental health disorders and their age at onset. The British journal of psychiatry, 202(s54), s5-s10.

Kiesinger, C. E. (1998). From Interview to Story: Writing Abbie’s Life. *Qualitative Inquiry*, *4*(1), 71–95. https://doi.org/10.1177/107780049800400105

Kinouani, G. (2021). *Living while black: The essential guide to overcoming racial trauma*. Ebury Press.

Klagge, J. (2018). *Guidelines for Conducting Focus Groups*. https://doi.org/10.13140/RG.2.2.33817.47201

Klein, J., & McColl, G. (2019). Cognitive dissonance: How self-protective distortions can undermine clinical judgement. *Medical Education*, *53*(12), 1178–1186. https://doi.org/10.1111/medu.13938

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, *30*(2), 111–116. https://doi.org/10.1177/0840470416679413

Kneale, D., Henley, J., Thomas, J., & French, R. (2021). Inequalities in older LGBT people's health and care needs in the United Kingdom: A systematic scoping review. *Ageing and Society*, *41*(3), 493–515. https://doi.org/10.1017/S0144686X19001326

Leary, A., Maxwell, E., Myers, R., & Punshon, G. (2024). Why are healthcare professionals leaving NHS roles? A secondary analysis of routinely collected data. *Human Resources for Health*, *22*(1), 65. https://doi.org/10.1186/s12960-024-00951-8

LeFrançois, B. A. (2013). Queering Child and Adolescent Mental Health Services: The Subversion of Heteronormativity in Practice. *Children & Society*, *27*(1), 1–12. https://doi.org/10.1111/j.1099-0860.2011.00371.x

Leven, T. (2022). *Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people* [Needs Assessment]. NHS Greater Glasgow and Clyde.

Levy, B. S., & Sidel, V. W. (2013). *Social injustice and public health* (2nd ed). Oxford University Press.

Li, L. Z., Yang, P., Singer, S. J., Pfeffer, J., Mathur, M. B., & Shanafelt, T. (2024). Nurse Burnout and Patient Safety, Satisfaction, and Quality of Care: A Systematic Review and Meta-Analysis. *JAMA Network Open*, *7*(11), e2443059. https://doi.org/10.1001/jamanetworkopen.2024.43059

Lindsay, S., Fuentes, K., Ragunathan, S., Lamaj, L., & Dyson, J. (2023). Ableism within health care professions: A systematic review of the experiences and impact of discrimination against health care providers with disabilities. *Disability and Rehabilitation*, *45*(17), 2715–2731. https://doi.org/10.1080/09638288.2022.2107086

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*(8), 695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Marchildon, G., P., Allin, S., & Merkur, S. (2020). Canada: Health System Review 2020. Health Systems in Transition, 22(3), i–194.

Marmot, M. (2005). Social determinants of health inequalities. The Lancet, 365(9464), 1099-1104.

Marmot, M., Allen, J., Bell, R., Bloomer, E., & Goldblatt, P. (2012). WHO European review of social determinants of health and the health divide. The Lancet, 380(9846), 1011-1029.

Matthews, H., & Williamson, I. (2016). Caught between compassion and control: Exploring the challenges associated with inpatient adolescent mental healthcare in an independent hospital. *Journal of Advanced Nursing*, *72*(5), 1042–1053. https://doi.org/10.1111/jan.12889

McCann, J., J. (2016). Is Mental Illness Socially Constructed? Journal of Applied Psychology and Social Science, 2(1), 1–11.

McGrath, L., Griffin, V., & Mundy, E. (2015). The Psychological Impact of Austerity: A Briefing Paper. Psychologists Against Austerity.

McLean, E., Desalegn, D. N., Blystad, A., & Miljeteig, I. (2019). When the law makes doors slightly open: Ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia. BMC Medical Ethics, 20(1), 60. https://doi.org/10.1186/s12910-019-0396-4

Mental Health Foundation. (2016). Austerity and Mental Health: A Collective Failure. Mental Health Foundation.

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: A comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*(1), 579. https://doi.org/10.1186/s12913-014-0579-0

Mitton, C., Peacock, S., Storch, J., Smith, N., & Cornelissen, E. (2010). Moral Distress among Healthcare Managers: Conditions, Consequences and Potential Responses. *Healthcare Policy | Politiques de Santé*, *6*(3), 99–112. https://doi.org/10.12927/hcpol.2010.22036

Montuori, A. (2005). Literature Review As Creative Inquiry: Reframing Scholarship As a Creative Process. *Journal of Transformative Education*, *3*(4), 374–393. https://doi.org/10.1177/1541344605279381

Munro, C. E., & Phillips, A. W. (2023). Bullying in the workplace. *Surgery (Oxford)*, *41*(8), 516–522. https://doi.org/10.1016/j.mpsur.2023.05.007

NHS England (2019). The NHS Long Term Plan. Available at: www.longtermplan.nhs.uk/publication/nhs-long-term-plan

NHS England (2023). NHS Long Term Workforce Plan. See www.england.nhs.uk/wp-content/uploads/2023/06/nhs-long-term-workforce-plan-v1.2.pdf).

NICE (2022). NICE and health inequalities. https://www.nice.org.uk/about/what-we-do/nice-and-health-inequalities

Nieuwsma, J. A., O'Brien, E. C., Xu, H., Smigelsky, M. A., VISN 6 MIRECC Workgroup, HERO Research Program, & Meador, K. G. (2022). Patterns of Potential Moral Injury in Post-9/11 Combat Veterans and COVID-19 Healthcare Workers. *Journal of General Internal Medicine*, *37*(8), 2033–2040. https://doi.org/10.1007/s11606-022-07487-4

Nieuwsma, J. A., O'Brien, E. C., Xu, H., Smigelsky, M. A., VISN 6 MIRECC Workgroup, HERO Research Program, & Meador, K. G. (2022). Patterns of Potential Moral Injury in Post-9/11 Combat Veterans and COVID-19 Healthcare Workers. *Journal of General Internal Medicine*, *37*(8), 2033–2040. https://doi.org/10.1007/s11606-022-07487-4

O’Shea, B., Feicht, R., Brown, M., & Numer, M. (2024). Rethinking sexual violence labels: Exploring the impact of ‘victim’ and ‘survivor’ discourse. *European Journal of Psychotraumatology*, *15*(1), 2296329. https://doi.org/10.1080/20008066.2023.2296329

Oelhafen, S., Monteverde, S., & Cignacco, E. (2019). Exploring moral problems and moral competences in midwifery: A qualitative study. *Nursing Ethics*, *26*(5), 1373–1386. https://doi.org/10.1177/0969733018761174

Park, S., Thrul, J., Cooney, E. E., Atkins, K., Kalb, L. G., Closser, S., McDonald, K. M., Schneider-Firestone, S., Surkan, P. J., Rushton, C. H., Langhinrichsen-Rohling, J., & Veenema, T. G. (2023). Betrayal-Based Moral Injury and Mental Health Problems Among Healthcare and Hospital Workers Serving COVID-19 Patients. *Journal of Trauma & Dissociation*, 1–16. https://doi.org/10.1080/15299732.2023.2289195

Parker, I. (2007). Critical Psychology: What It Is and What It Is Not. *Social and Personality Psychology Compass*, *1*(1), 1–15. https://doi.org/10.1111/j.1751-9004.2007.00008.x

Patai, D. (1991). U.S. Academics and Third World Women: Is Ethical Research Possible? In S. Berger Gluck & D. Patai (Eds.), *Women’s Words: The feminist practice of oral history* (pp. 137–153). New York: Routledge.

Phillips, M. J. (2023). Towards a social constructionist, criticalist, Foucauldian-informed qualitative research approach: Opportunities and challenges. *SN Social Sciences*, *3*(10), 175. https://doi.org/10.1007/s43545-023-00774-9

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International Journal of Qualitative Studies in Education*, *16*(2), 175–196. https://doi.org/10.1080/0951839032000060635

Pinto, R., Ashworth, M., & Jones, R. (2008). Schizophrenia in black Caribbeans living in the UK: An exploration of underlying causes of the high incidence rate. *British Journal of General Practice*, *58*(551), 429–434. https://doi.org/10.3399/bjgp08X299254

Rabin, S., Kika, N., Lamb, D., Murphy, D., Am Stevelink, S., Williamson, V., Wessely, S., & Greenberg, N. (2023). Moral Injuries in Healthcare Workers: What Causes Them and What to Do About Them? *Journal of Healthcare Leadership*, *Volume 15*, 153–160. https://doi.org/10.2147/JHL.S396659

Reich, S. M., & Reich, J. A. (2006). Cultural Competence in Interdisciplinary Collaborations: A Method for Respecting Diversity in Research Partnerships. *American Journal of Community Psychology*, *38*(1–2), 1–7. https://doi.org/10.1007/s10464-006-9064-1

Responsibilization. (2009). In A. Wakefield & J. Fleming, *The SAGE Dictionary of Policing*. SAGE Publications Ltd. https://doi.org/10.4135/9781446269053.n111

Rodrigues, S., Mercier, J.-M., McCall, A., Nannarone, M., & Hosseiny, F. (2023). 'Against everything that got you into the job': Experiences of potentially morally injurious events among Canadian public safety personnel. *European Journal of Psychotraumatology*, *14*(2), 2205332. https://doi.org/10.1080/20008066.2023.2205332

Ross, C. A., & Goldner, E. M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *16*(6), 558–567. https://doi.org/10.1111/j.1365-2850.2009.01399.x

Sayyid, S (2000). Beyond Westphalia: Nations and diasporas – the case of the Muslim Umma. In B Hesse (ed.*), Un/settled Multiculturalisms: Diasporas, Entanglements, Transruptions*. London: Zed Books, pp. 33-50.

Schmidt, V. H. (2001). Social Justice. In *International Encyclopedia of the Social & Behavioral Sciences* (pp. 14338–14341). Elsevier. https://doi.org/10.1016/B0-08-043076-7/01906-9

Scott, E. (2023). Mortality Rates Among Men and Women: Impact of Austerity. *House of Lords*. https://lordslibrary.parliament.uk/mortality-rates-among-men-and-women-impact-of-austerity/#:~:text=This%20study%20argued%20that%20austerity,a%20result%20of%20reduced%20funding.

Shahbazi, S., Valizadeh, S., Borimnejad, L., Rahmani, A., & Vaismoradi, M. (2018). Living With Moral Distress: The Perspectives and Experiences of Iranian Nurse Preceptors. Research and Theory for Nursing Practice, 32(4), 355–369. https://doi.org/10.1891/1541-6577.32.4.355

Shay, J. (1994). Achilles in Vietnam: Combar Trauma and the Trials of Homecoming. Simon & Schuster.

Shay, J. (2014). Moral injury. Psychoanalytic Psychology, 31(2), 182–191. https://doi.org/10.1037/a0036090

Shim, R., Koplan, C., Langheim, F. J., Manseau, M. W., Powers, R. A., & Compton, M. T. (2014). The social determinants of mental health: An overview and call to action. Psychiatric annals, 44(1), 22-26.

Sin, C., Francis, R., & Cook, C. (2010). Access to and experience of child and adolescent mental health services: barriers to children and young people with learning disabilities and their families. Mental Health Review Journal, 15(1), 20-28.

Smith, L. T. (1999). Decolonizing methodologies: Research and indigenous peoples. Zed Books ; University of Otago Press ; Distributed in the USA exclusively by St. Martin’s Press. Sociology Press.

Social Care Institute for Excellence. (2022). Co-production: What it is and how to do it. Social Care Institute for Excellence (SCIE).

Stoewen, D. L. (2020). Moving from compassion fatigue to compassion resilience Part 4: Signs and consequences of compassion fatigue. The Canadian Veterinary Journal = La Revue Veterinaire Canadienne, 61(11), 1207–1209.

Strong, Tom; Sutherland, Olga; Couture, Shari; Godard. Greg & Hope, Tom (2008). Karl Tomm's collaborative approaches to counselling. Canadian Journal of Counselling, 42(3), 174-191 http://files.eric.ed.gov/fulltext/EJ818439.pd

Stuckler, D., Reeves, A., Loopstra, R., Karanikolos, M., & McKee, M. (2017). Austerity and health: The impact in the UK and Europe. European Journal of Public Health, 27(suppl_4), 18–21. https://doi.org/10.1093/eurpub/ckx167

Stuetzle, S., Brieger, A., Lust, C., Ponew, A., Speerforck, S., & Von Peter, S. (2023). Internalized stigma in mental health staff with lived experience of mental crises–Does the professional role protect against self-stigmatization? Frontiers in Psychiatry, 13, 1078478. https://doi.org/10.3389/fpsyt.2022.1078478

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. Journal of Clinical Psychology, 74(9), 1545–1555. https://doi.org/10.1002/jclp.22614

Thomson, S. B. (2011). Sample Size and Grounded Theory. JOAAG, Vol. 5. No. 1

Thorne, S., Konikoff, L., Brown, H., & Albersheim, S. (2018). Navigating the Dangerous Terrain of Moral Distress: Understanding Response Patterns in the NICU. Qualitative Health Research, 28(5), 683–701. https://doi.org/10.1177/1049732317753585

Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. SAGE Open Medicine, 7, 2050312118822927. https://doi.org/10.1177/2050312118822927 Traumatology, 22(2), 122.

Tobore, T. O. (2023). On power and its corrupting effects: The effects of power on human behavior and the limits of accountability systems. *Communicative & Integrative Biology*, *16*(1), 2246793. https://doi.org/10.1080/19420889.2023.2246793

Vaughn, S., Jacquez, F., & Baker, R. C. (2009). Cultural health attributions, beliefs, and practices: Effects on healthcare and medical education. The Open Medical Education Journal, 2, 64-74.

Whisker, C. (2018a). Review: Adele E. Clarke, Carrie Friese & Rachel S. Washburn (2018). Situational Analysis: Grounded Theory After the Interpretive Turn. Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, Vol 19, No 3 (2018): Research Ethics in Qualitative Research. https://doi.org/10.17169/FQS-19.3.3138

Wilkinson, R. G., & Pickett, K. E. (2010). The Spirit Level: Why Equality is Better for Everyone. Penguin Books.

Williams, V., Boylan, A.-M., & Nunan, D. (2020). Critical appraisal of qualitative research: Necessity, partialities and the issue of bias. BMJ Evidence-Based Medicine, 25(1), 9–11. https://doi.org/10.1136/bmjebm-2018-111132

Williamson, V., Lamb, D., Hotopf, M., Raine, R., Stevelink, S., Wessely, S., Docherty, M., Madan, I., Murphy, D., & Greenberg, N. (2023). Moral injury and psychological wellbeing in UK healthcare staff. Journal of Mental Health, 32(5), 890–898. https://doi.org/10.1080/09638237.2023.2182414

Woodson, P. B., Schlapfer, W. T., Tremblay, J. P., & Barondes, S. H. (1976). Resting and stimulated values of model parameters governing transmitter release at a synapse in

Aplysia californica. Brain Research, 109(1), 21–40. https://doi.org/10.1016/0006-8993(76)90378-4

World Health Organization. (2014). Social Determinants of Mental Health. World Health Organization.

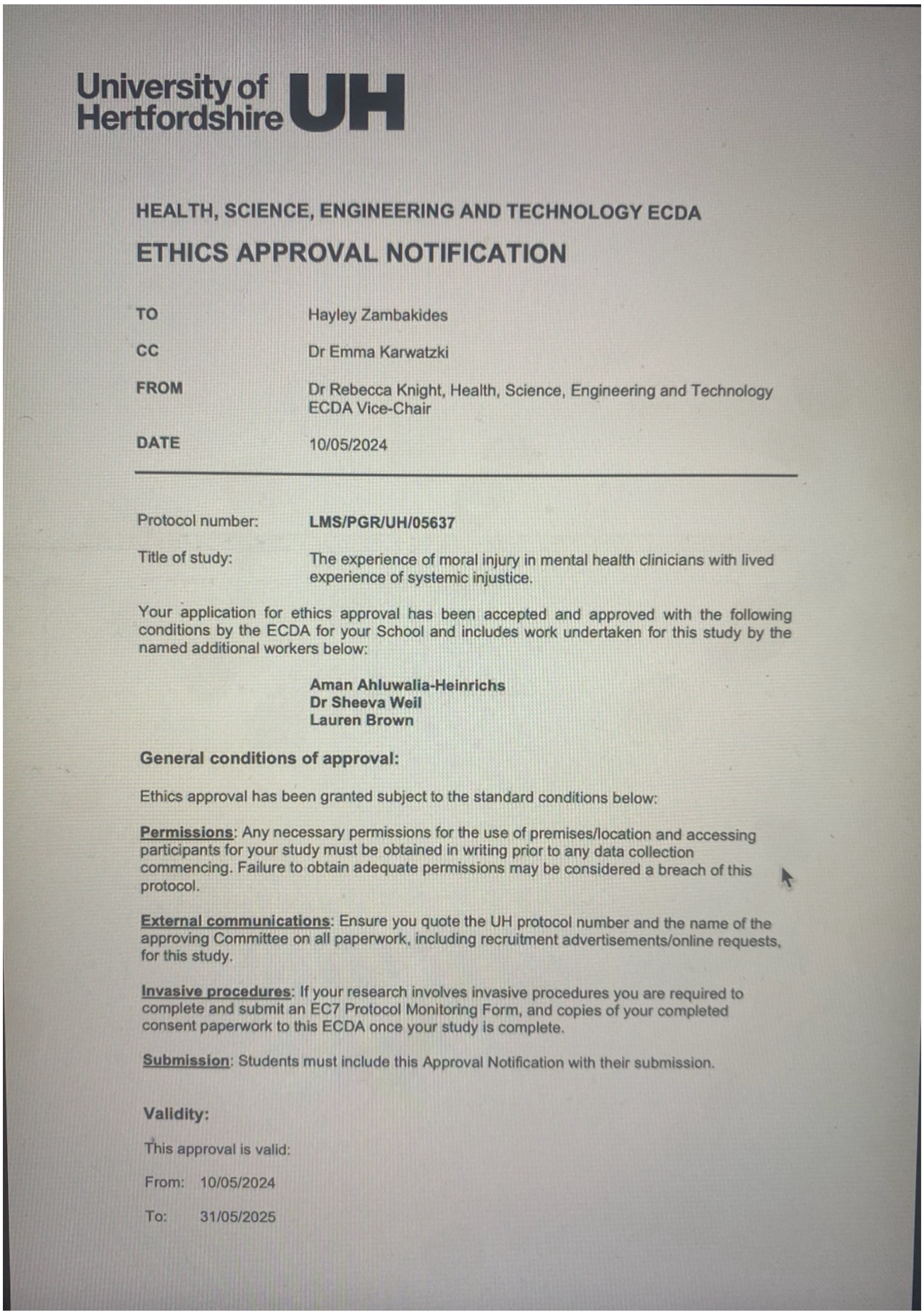
World Health Organization. (2022). *ICD-11: International classification of diseases* (11th revision). https://icd.who.int/

Young, I. M., & Nussbaum, M. (2011). Responsibility for Justice. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195392388.001.0001

Zangaro, G., Manaoat Van, C., & Mossburg, S. (2023). Impact of System Failures on Healthcare Workers (Annual Perspective). Patient Safety Network. https://psnet.ahrq.gov/perspective/impact-system-failures-healthcare-workers#:~:text=Healthcare%20workers%20may%20also%20be,is%20fundamentally%20rooted%20in%20systems.

Appendix:

a. Ethics approval notification:



University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Hayley Zambakides
CC	Dr Emma Karwatzki
FROM	Dr Rebecca Knight, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	10/05/2024

Protocol number:	**LMS/PGR/UH/05637**
Title of study:	The experience of moral injury in mental health clinicians with lived experience of systemic injustice.

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Aman Ahluwalia-Heinrichs
Dr Sheeva Weil
Lauren Brown

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: 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.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

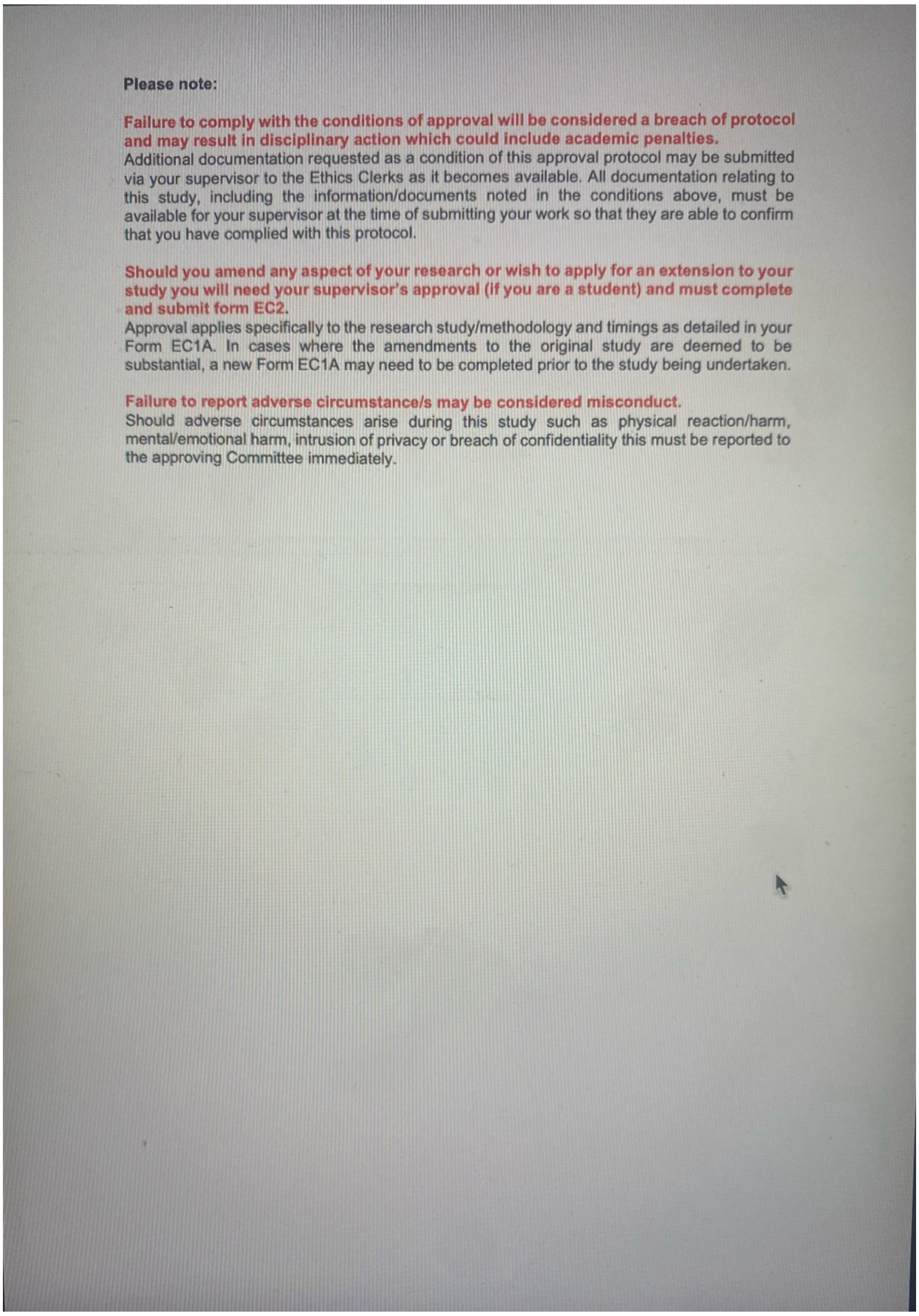
Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 10/05/2024

To: 31/05/2025



Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

b. Supervisor contract:

Doctorate in Clinical Psychology

MRP SUPERVISION CONTRACT

Please complete this supervision contract and submit with the MRP proposal.

Please note that **both supervisors and the trainee need to complete and sign the contract**.

This contract is intended to support conversations within the supervisory team to ensure clarity from the outset of your project regarding supervisor roles and responsibilities. **Please modify this document to fit the specific needs of your project.**

Principal Supervisor

Please fill in ALL the details below, as these will be needed to register the MRP on the University's online system RSMS.

Principal Supervisor details

Title, First name and Surname:	Dr. Emma Karwatzki
Work Address:	Health Research Building, College Lane campus
Telephone number:	
Email address:	e.karwatzki@herts.ac.uk
Number of current doctoral supervisions: *(This includes the current trainee's project.)*	7
Number of successful doctoral supervisions: *This refers to how many thesis/ MRP's you've supervised in the past*	6
Number of previous examinations at doctoral level: *This may not apply to all- this refers to how many viva's you've held as an examiner.*	*29*
Have you attended University of Hertfordshire Supervisor Training?	Yes
Brief overview of expertise to supervise current project	Leadership, qualitative methodology and staff wellbeing.

Principal Supervisor role

X	**I agree to have at least six joint meetings across the span of the project as stipulated by the University of Hertfordshire Research Degrees Board**
	In addition, I agree to the following:
	Please tick the areas that this supervisor has agreed to:
X	Providing specialist knowledge and advice through regular supervision.
X	Advise on the research proposal and any modifications following review by staff.
X	Provide support to obtain ethical and research governance approval.
X	Help respond to problems that occur in the course of carrying out the study.
	Facilitate access to participants.
x	Help with timetabling and time management.
X	Provide input and clarification on methodology and analyses.
X	Read and provide feedback on each section of the MRP.
	If specific section only- please list:
X	Help with viva preparation on issues specific to the project.
X	If required, assisting with revision or resubmission.
	Provide support in disseminating the findings, including:
X	Support preparing a paper for journal submission for the Sept course deadline.
X	If required, support responding to reviewer comments

Secondary Supervisor

Please fill in ALL the details below, as these will be needed to register the MRP on the University's online system RSMS.

Secondary Supervisor details

Title, First name and Surname:	Ms. Aman Ahluwalia-Hinrichs
Work Address:	
Telephone number:	
Email address:	aman@birthingourselves.co.uk
Number of current doctoral supervisions: *(This includes the current trainee's project.)*	0
Number of successful doctoral supervisions: This refers to how many thesis/ MRP's you've supervised in the past	0
Number of previous examinations at doctoral level: *This may not apply to all- this refers to how many viva's you've held as an examiner.*	*0*

Have you attended University of Hertfordshire Supervisor Training?	No
Brief overview of expertise to supervise current project	Works as a lead consultant specialising in trauma informed management practices and lived experience leadership.

Please tick the areas that this supervisor has agreed to (typically a secondary supervisor will tick fewer boxes than the principal, but if possible, the two supervisors should cover all the areas outlined between them):

Secondary Supervisor Role	
	I agree to have at least six joint meetings across the span of the project as stipulated by the University of Hertfordshire Research Degrees Board
	In addition, I agree to the following:
	Please tick the areas that this supervisor has agreed to:
X	Providing specialist knowledge and advice through regular supervision.
x	Advise on the research proposal and any modifications following review by staff.
x	Provide support to obtain ethical and research governance approval.
x	Help respond to problems that occur in the course of carrying out the study.
x	Facilitate access to participants.
x	Help with timetabling and time management.
x	Provide input and clarification on methodology and analyses.
x	Read and provide feedback on each section of the MRP.
	If specific section only- please list:
x	Help with viva preparation on issues specific to the project.
x	If required, assisting with revision or resubmission.
x	Provide support in disseminating the findings, including:
x	Support preparing a paper for journal submission for the Sept course deadline.
x	If required, support responding to reviewer comments

Trainee Name: Hayley Zambakides

The trainee will need to take responsibility for the following:

- Take the lead for organising supervision meetings.
- Prepare for supervision meetings as guided by the supervisor(s).
- Develop a plan for the MRP with guidance from the supervisor(s).
- Send draft chapters to the supervisor(s) for feedback by agreed deadlines.
- Inform the supervisor(s) within 24 hours (or as soon as possible thereafter) of any ethical issues that arise during the project.

- Develop a dissemination plan with the supervisors and take the lead on writing presentations and publications, unless negotiated otherwise.
- Provide both supervisors with a final electronic copy of the MRP when submitted for marking.

Authorship:

We agree that when this project is submitted for publication or presentation, authorship will be as follows (list surnames as agreed for publication submission):

Zambakides, Ahluwalia-Hinrichs, Karwatzki, Weil, Brown

Should we consider publishing the SLR the names would not include the consultancy team.

Zambakides, Karwatzki & Ahluwalia-Hinrichs

Please note, it is assumed that the trainee will be first author. Since prompt publication of research is of crucial importance, the lead supervisor reserves the option of writing the paper as first author if it has not been accepted for publication within six months of project completion. By signing this form, you agree to abide by this stipulation**.**

Emma Karwatzki will remain as the corresponding author.

Signatures:

We have read the relevant programme guidelines and agree to the respective roles and responsibilities, along with the contents of this contract.

Name and Signature of trainee: Hayley Zambakides **Date:** 28/1/2024

Name and Signature of supervisor:

Date: 1.2.2024

Name and Signature of supervisor: Date:

Please provide a copy of this form to both supervisors and to the Research Team, via dclinpsy-research@herts.ac.uk.

c. Consultant Agreement:

Consultant Agreement

This agreement is intended to support conversations between the lead researcher with the supervisory team and consultants to ensure clarity from the outset for this project.

Title of research project:
The experience of moral injury in mental health clinicians with lived experience of systemic injustice.

Research Team

Main Researcher: Hayley Zambakides

Consultants:
Dr. France Sheeva Weil – Clinical psychologist

Lauren Brown – Senior PWP at iCope IAPT service.

Supervisory Team:
Dr. Emma Karwatzki – Clinical psychologist and programme director for UH doctorate in clinical psychology

Aman Ahluwalia-Hinrichs – Founder and lead consultant of Birthing Ourselves.

Agreement

As the main researcher on this project, I agree to:

- Take the lead on organising any meetings with supervisors & consultants
- Send drafts to consultants for feedback with clear notice of deadlines
- Provide feedback of research findings
- Provide final electronic copies of the research to all consultants
- Acknowledge consultants in thesis write-up and include consultants as co-authors in subsequent research publication. This will not include the SLR as consultants will likely not be part of this aspect of the project.
- Offer opportunities to collaborate on presentations, posters, publications, and any other dissemination – this will be discussed as and when opportunities arise.
- Consider and support consultants' wellbeing throughout this collaborative process

Consultant One – Dr. Sheeva Weil.

As a consultant to this project, I understand that:

- Involvement as a consultant is purely voluntary however at this stage I forsee no reason as to why I would be unable to consult for the duration of the project. Should that change for any reason this will be discussed with the main researcher.

And agree to:

- Provide feedback and input on participant information documents e.g. consent forms, debrief forms etc.
- Provide input and considerations on data analysis; may include things such as verifying coding definitions, considering outliers.
- Provide input on the diagrammatic model.

- Offer guidance on the Grounded Theory approach from experience using the approach.
- Offer guidance and expertise on any ethical concerns or considerations at the earliest convenience
- Maintain anonymity of participants and abide by the ethical principles as outlined in the information sheet given to participants
- Prioritise my wellbeing over and above collaboration in this project
- Support recruitment.

Consultant 2 – Lauren Brown

As a consultant to this project, I understand that:

- Involvement as a consultant is purely voluntary however at this stage I foresee no reason as to why I would be unable to consult for the duration of the project. Should that change for any reason this will be discussed with the main researcher.

And agree to:

- Provide feedback and input on participant information documents e.g. consent forms, debrief forms etc.
- Provide input and considerations on data analysis; may include things such as verifying coding definitions, considering outliers etc.
- Provide input on the diagrammatic model.
- Offer guidance and expertise on any ethical concerns or considerations at the earliest convenience
- Maintain anonymity of participants and abide by the ethical principles as outlined in the information sheet given to participants
- Prioritise my wellbeing over and above collaboration in this project
- Provide feedback on written sections of the final dissertation (or not)
- Support with recruitment of participants

Authorship:

We agree that when this project is submitted for publication or presentation, authorship will be as follows (list surnames as agreed for publication submission):

Zambakides, Ahluwalia-Hinrichs, Karwatzki, Weil, Brown

Should we consider publishing the SLR the names would not include the consultancy team.

Zambakides, Karwatzki & Ahluwalia-Hinrichs

Please note, it is assumed that the trainee will be first author. Since prompt publication of research is of crucial importance, the lead supervisor reserves the option of writing the paper as first author if it has not been accepted for publication within six months of project completion. By signing this form, you agree to abide by this stipulation.

Emma Karwatzki will remain as the corresponding author.

Signatures

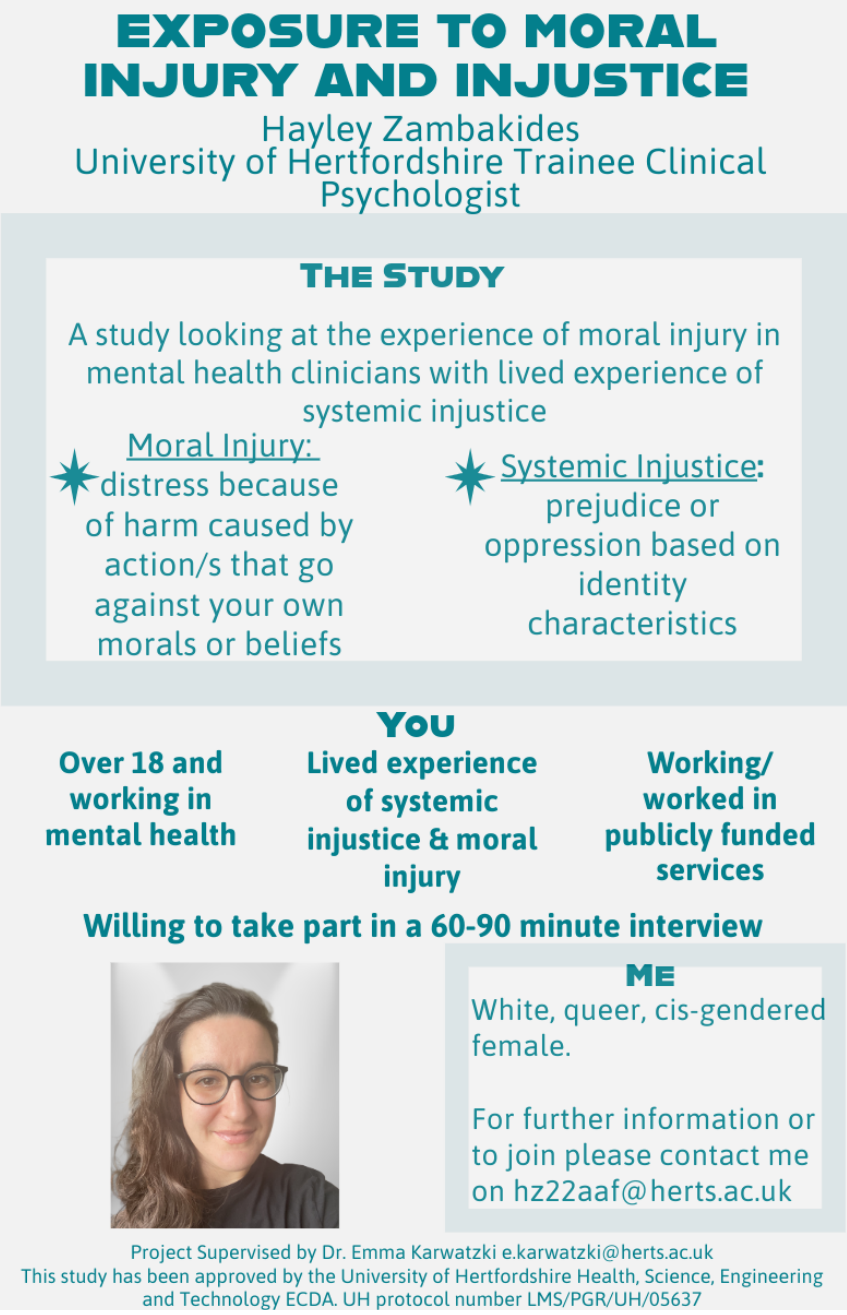
Signature of main researcher: Hayley Zambakides

Date: 31/1/2024

Signature of Consultant: Sheeva Weil SWeil
Date: 05/02/2024

Signature of Consultant: Lauren Brown LBrown
Date: 05/02/24

d. Recruitment Poster:



EXPOSURE TO MORAL INJURY AND INJUSTICE

Hayley Zambakides
University of Hertfordshire Trainee Clinical Psychologist

THE STUDY

A study looking at the experience of moral injury in mental health clinicians with lived experience of systemic injustice

✦ Moral Injury: distress because of harm caused by action/s that go against your own morals or beliefs

✦ Systemic Injustice: prejudice or oppression based on identity characteristics

YOU

Over 18 and working in mental health

Lived experience of systemic injustice & moral injury

Working/ worked in publicly funded services

Willing to take part in a 60-90 minute interview

ME

White, queer, cis-gendered female.

For further information or to join please contact me on hz22aaf@herts.ac.uk

Project Supervised by Dr. Emma Karwatzki e.karwatzki@herts.ac.uk
This study has been approved by the University of Hertfordshire Health, Science, Engineering and Technology ECDA. UH protocol number LMS/PGR/UH/05637

e. Participant Information Sheet:

Participant information sheet

Project title: The experience of moral injury in mental health clinicians with lived experience of systemic injustice.

The study:
My goal for this study is to explore the relationship between mental health clinicians' experiences of systemic injustice and moral injury.

Systemic injustice refers to injustice or oppression experienced by people due to an aspect/s of their identity. It refers to policies or practice that exist throughout a whole society or organisation. For example, racism, ablism, transphobia etc.

Moral injury is the experience of distress related to having to act, or witness others acting in ways that go against your personal morals and beliefs. These acts cause harm to others, including emotional, psychological and physical harm.

Below I will explain more about myself, why I am doing this piece of research, what it means for you if you decide to take part, what your choices and rights are as a participant and what you can expect throughout the process of this project.

Please make sure to read this sheet carefully before you decide if you want to go ahead. I will add contact details at the end of this sheet should you wish to get in touch to ask more about the study. The definitions I have set are a loose guide to understanding these concepts, but I acknowledge they are complex. With this in mind, if you feel these concepts relate to you, but how I've defined them doesn't, please do get in touch to discuss your interest in participating anyway.

Me:
I'm Hayley, a trainee clinical psychologist at the University of Hertfordshire. I am white Irish, English-speaking, cis-gendered, able-bodied, pansexual, well-educated, and dyslexic. I have worked in various publicly funded services since 2016. During this time I have been in positions where I have felt compelled or forced work in ways that I believed could have been harmful to service users.

Why am I doing this?
Multiple concepts have been developed in attempt to describe the distress experienced by healthcare workers. For example, burn out, or compassion fatigue. However, these definitions tend to centre the 'problem' within the individual – the healthcare professional is usually held responsible when it comes to managing these difficulties.

The concept of moral injury recognises the impact of distress when we are placed in situations that force us to act in ways that clash with our personal beliefs and values. I want to explore the wider, external factors that could be contributing to moral distress.

Can you participate?
You can take part if:

- You are aged above 18 and live in the UK.
- Your main professional role is to support clients with their mental health.
- You work/have worked in publicly funded services.
- You hold an identity characteristic that you believe has led to you experiencing injustice or discrimination based on said aspect/s of your identity. For example (but not limited to): ableism, racism, classism, transphobia, heterosexism.
- You can think of experiences you've had in your role as a professional where you felt compelled or forced (directly or indirectly) to act in a way that went against your own personal values or morals and caused you to feel a level of discomfort or distress.

Please note that if you have experienced acute distress within the past 6 months you may not be eligible for this study. Acute distress might include a recent suicide attempt, regular self-harm or severe flashbacks or nightmares. This is because the topics discussed may feel difficult at times. My research team and I will work to reduce harm as much as possible. However, distress is rarely clear cut so if you feel that you wish to take part, please do get in touch to arrange an initial call/conversation.

Your participation in this study is completely voluntary. You will be able to withdraw your consent to take part / have your interview removed from the study at any point up until 1 week after the interview. Thereafter, we will be unable to remove your (anonymised) information because data analysis will have begun. Your interview will contribute to the results from an early stage in the research process.

What is the process if I do choose to take part?
If you agreed to take part in this study, you first be invited for an initial call. This is to answer any questions you have about the study and to confirm your eligibility. Please note you are welcome to have this call, then decide you would rather not take part. If we both agree to go ahead, we will then arrange a time to meet for an interview. The interview can be in person or online, depending on your preference. Please note that all interviews will be recorded and stored on the University of Hertfordshire's secure One Drive.

I will be asking all participants if they would like to be invited back to participate in a focus group towards the end of the project to feedback on the results and theory that has been created based on all the interviews. The purpose of this focus group is for feedback only, to see if the theory and resulting model fit with your experience and feel true to what you shared. My hope is that the theory will create a broader understanding of processes that occur when those with experiences of systemic injustice are exposed to potentially morally injurious events. In other words, what happens when someone who has experienced a form of oppression, like racism or sexism, is then forced to work in a way that clashes with their personal values

What are the advantages and disadvantages of taking part?
I hope that this study can start to open conversations that move away from putting the responsibility on mental health care workers for dealing with the impact of our jobs by

ourselves, and begin to think about other factors might also play a role in how we are exposed to and experience moral distress.

However, these are not always easy conversations; they could bring up pain and/or upset. While these are very typical reactions given the topic, you may not feel you can engage with this level of upset at this time. Nevertheless, I will do what I can to make these conversations as manageable and as comfortable as possible. You can always let me know if there is a topic you don't want to talk about in depth, and I will not push you to keep talking about it (regardless of whether I initially asked you about it, or it came up organically in our conversation). I want to work with you to have a conversation you feel willing and/or able to have with me around these topics, and how this looks is different for all of us.

Confidentiality and keeping you safe:
All information will remain confidential. Demographic information will be collected, and published as a collective statistic (e.g. 10 of the 14 participants identified as queer, 2 of the 14 identified as having a disability, etc.) You will be assigned a pseudonym and this will be how we identify recordings or transcripts within the research team. Audio recordings and transcripts will be securely stored on the University of Hertfordshire secure OneDrive. Your name and contact information will not be stored alongside the interview data. Once the audio files have been transcribed, the audio files will be deleted.

All qualitative data (i.e. interview, focus groups etc) is limited, in that quotes used within the research write-up could lead to self-identification or recognition based on direct quotes. I will do my best to anonymise any possibly identifying information (e.g. service name, time worked in a specific team, job title, year / location of incident…).

I may consider using a reputed transcription service to support with my time management of the project, and will ensure they have a rigorous confidentiality policy in line with the University's requirements.

As part of learning, all those on the University of Hertfordshire Doctorate of Clinical Psychology course take part in specialist workshops to support our project development. During these workshops we are invited to bring anonymised data to share with others to support our learning in the analysis process.

Please note all data will be kept for 5 years in line with University of Hertfordshire policy. In that time, it is possible that I will re-analyse this data. The transcriptions and all personal information will be destroyed after this.

I intend to publish the results of this study. As previously stated, your quotes will be anonymised, and accompanied by the pseudonym you have chosen. You will be able to request a soft copy of the final dissertation as is, or a summary of results if you prefer.

Please note there are circumstances in which confidentiality may have to be broken. In the unlikely event that there is evidence of harm to yourself or to someone else I will have to break confidentiality, usually by contacting relevant statutory services, with the aim of keeping you and others safe. I will always try have this conversation with you before I do anything but depending on circumstances this may not always be possible.

Ethics:
This study has been approved by the University of Hertfordshire Health, Science, Engineering and Technology ethics committee with delegated authority. The UH protocol number is LMS/PGR/UH/05637.

For more information please contact myself, Hayley Zambakides (hz22aaf@herts.ac.uk) or my supervisor Dr. Emma Karwatzki (e.karwatzki@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

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University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

<u>f. Focus Group Info Sheet:</u>

<u>Focus Group Info Sheet</u>

Project title: The experience of moral injury in mental health clinicians with lived experience of systemic injustice

Aims:
Based on the interviews carried out to date, I have produced a map / diagram that illustrates the processes involved in mental health clinicians' experiences of systemic injustice and their exposure to potentially morally injurious events. We (myself and the research team) have created this map through the analysis and interpretation of the information shared with me during the interviews, considering the wider societies and systems we live and work in.

As a team we believe that our biases and experiences influence our learning and understanding. As such, it is important that what we produce is as true to participants' experiences as possible. One of the ways in which researchers do this is via 'member checking'. This focus group is just that – verifying that our understanding and interpretations fit with what you shared in your interview.

This focus group is one session that will take place over video using Microsoft Teams, and you will be asked to keep your camera on. However, you are welcome to just use your first name and do not need to reveal where you work or what your role is. There will be between 6 – 10 participants in the focus group and I aim to ensure that no one from the same team is in the group. This might not be possible, but you will be informed if this is not the case and we can discuss the options at that stage.

Confidentiality and Keeping You Safe:
I will be taking notes throughout the session and I will record the session for my reference, this is to ensure I do not miss anything important or forget things. I may choose to play parts of the audio to my research team, or transcribe sections to share with them. Your personal information will not be shared alongside these clips or transcriptions. The focus group session recording will be held securely on the encrypted UH OneDrive and no personal data is kept alongside that.

Microsoft Teams automatically transcribes sessions and this rough will be kept for 5 years as per the UH research policy. However, I will delete the recording once the results have been finalised.

If you agree to participate in the focus group you are also agreeing to keep the identity of all the other participants, and anything they share, private and confidential. You are agreeing not to discuss the participants or what is shared with anyone outside the focus group session.

Do I have to take part in this?
Absolutely not! This is optional and there is no obligation to take part in member checking. However, if you do decide the join the focus group any feedback you share will be included in the final results. Should you feel you need to leave early at any point during the focus group you can, but you'll need to let me know. As I'm responsible for keeping all participants safe we may arrange a debrief after if you've needed to leave early.

It is important to note that your identity will revealed to all those within the focus group session, but people within the group specifically will not know any specific information about you over and above what you choose to share, nor will they know what your pseudonym is. Specific quotes will not be mentioned at this point. Confidentiality will be agreed upon within the session meaning that everyone who participates agrees not to share any personal information outside the group.

What will I be asked to do if I agree to take part?
You will be invited to an online feedback session. During the session I will share a 'situational map' and a model: a visual representation of the processes of systemic injustice and moral distress experienced by mental health clinicians. This will include information analysed and interpreted from the interviews, as well as considerations of the wider systems we live and work in. What I want at this point is for us to reflect on what we've created together and think about whether or not you agree that this represents your experience. I would like to think about why and why not, what could be missing and what needs to be made clearer, as well as whether the map makes sense and could be improved upon (format, colours, arrows whatever feels relevant) You will not be expected to share any personal experiences during the focus group.

Ethics:
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For more information please contact myself, Hayley Zambakides (hz22aaf@herts.ac.uk) or my supervisor Dr. Emma Karwatzki (e.karwatzki@herts.ac.uk).

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

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<u>g. Recruitment email template and list of contacted organisations:</u>

Good morning,

My name is Hayley and I'm currently doing my clinical psychology doctorate at the university of Hertfordshire. I'm conducting my thesis research on the experience of moral injury for mental health professionals with lived experience of systemic injustice - specifically those who have or do work in publicly funded services. I'm currently in the recruitment phase and have been reaching out to various organisations to see if they would be will/able to share my recruitment poster and participant information with their members.

The experience of moral injury and systemic injustice would be self-defined based on loose definitions I provide on the participants info.

If appropriate please let me know and I can email the details over directly.

Warmly,
Hayley Zambakides

Contacted:

1. Unison
2. Unite
3. Black and Asian therapists network
4. Pink therapy
5. Nursing times
6. ACP-UK
7. AFT
8. Emrock – Aman
9. Lead – Aman
10. NSun

h. Consent form for interview:

Consent form for interview

University of Hertfordshire UH Ethics Committee

Project title: The experience of moral injury in mental health clinicians with lived experience of systemic injustice.

Research Team:

Main Researcher: Hayley Zambakides (hz22aaf@hert.ac.uk)

Supervisory Team (contract in Appendix 1):

Dr Emma Karwazki: (e.karwatzki@herts.ac.uk)

Aman Ahluwalia-Hinrichs

Consultants (contract in Appendix 2):

Dr. Sheeva Weil

Lauren Brown

1. I have read the information sheet for this study. I have had time to think and ask questions, and I feel happy to participate based on this. ☐

2. I understand that it is my choice to participate and that I am free to opt out or withdraw at any time during the study and up to one week after the interview, without giving any reason and no questions will be asked. ☐

3. I understand that data collected during the study will have my name and details removed. The data will be stored on a secure drive. Once my name is removed, the data may be looked at by people working/studying with the University of Hertfordshire, the research team and potentially transcription services. I permit these people to have access to my anonymised data. ☐

4. I give permission for this researcher to re-analyse this data at a later date (up to 5 years from today). ☐

5. I understand that the write-up may include direct quotes which will not have my name, or any identifiable information attached, but rather a pseudonym of my choice. ☐
6. I have been told that I may be contacted again in connection with this study. ☐
7. I agree to take part in this study. ☐

Name of Participant	Date	Signature
Main Researcher	Date	Signature

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

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AL10 9AB

i. Consent form for focus group:

Consent for Focus Group

University of Hertfordshire UH Ethics Committee

Consent form for focus group

Project title: The experience of moral injury in mental health clinicians with lived experience of systemic injustice

Research Team:

Main Researcher: Hayley Zambakides (hz22aaf@hert.ac.uk)

Supervisory Team (contract in Appendix 1):

Dr Emma Karwazki - (e.karwatzki@herts.ac.uk)

Aman Ahluwalia-Hinrichs

Consultants (contract in Appendix 2):

Dr. Sheeva Weil

Lauren Brown

1. I understand that I am participating in a focus group that is aimed at giving my feedback and opinions on the results of the whole study, and the model developed by the research team. ☐

2. I understand that it is my choice to participate and that I am free to opt out at any point before or during the focus group. We will not be able to remove your input from the focus group after it has been given. ☐

3. I understand that data collected during the study will have my name and details removed. The data will be stored on a secure drive. Once my name is removed, the data may be looked at by people working/studying with the University of Hertfordshire, the research team and potentially transcription services. I permit for these people to have access to my anonymised data. ☐

4. I give permission for this researcher to re-analyse this data at a later date (up to 5 years from today). ☐

5. I understand that the write-up may include direct quotes which will not have my name or any identifiable information attached. ☐

6. By participating in the focus group I am agreeing to ensure that I keep the identity of all of the participants in the focus group confidential. Furthermore, I am agreeing not to disclose any information that is shared during the focus group. ☐

______________________	______________________	______________________
Name of Participant	Date	Signature
______________________	______________________	______________________
Main Researcher	Date	Signature

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

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<u>j. Interview schedule:</u>

Interview schedule:

We're here to talk about the experience of moral injury in the context of being a MH professional with experience of systemic injustice, is this what you're expecting. Just to check you're in a private place where you feel able to speak openly?

Just to reiterate I'll be recording this interview in order to later transcribe it. Once the transcription has been completed the audio file will be deleted. As we go I may take some brief notes, I'm happy to share those with you if you'd like. Everything we discuss today will remain confidential unless I become concerned for your safety or the safety of someone else. I will later ask you to choose a pseudonym to keep your identity confidential, however, during the write up of this piece of research there will likely be direct quotes alongside your chose pseudonym.

All data and recordings will be securely stored on my university's encrypted server and deleted after 5 years. Remember that you can stop the interview at any point in time; we can always pick back up at another time or just end it there entirely, that is also completely fine. You can remove your data at any time up to a week after the interview.

I'm expecting we'll talk for about an hour to an hour and a half in total, but just to check are you able to run over or do we need to make sure we stick to time?

Remember you only answer and discuss what you feel comfortable sharing, at any point it's fine if you tell me you don't want to discuss something, or to continue discussing something anymore. I may (or may not) jump between topics a little, move us on and/or bring us back. Because I don't know what exactly we'll discuss or where our conversation will go, it's very possible we'll both come up with various thoughts and ideas as we go meaning it won't always be linear – and that's absolutely fine.

As we discussed before, these can be hard conversations to have. If you need a break, to have your camera off, to take a couple of minutes out, play some music, vape – what every it is you need just let me know and we can work together to make sure this is a manageable as possible. I welcome any and all tears, humour, anger and happiness as we go.

How do you find saying no more generally? If this is something difficult can we create a safe word? Or are there certain cues (verbal or non-verbal) I can look out for that could indicate you're becoming uncomfortable with the direction of the conversation?

I need to press record now so long as you don't have any more questions. Once I press record I'm going to ask again that you consent to participating and to it being recorded just so I have that on record.

record button

Question/topics/prompts.

1. Demographic Questions
- Age
- Gender expression
- Sexually orientation
- Racial and ethnic identity
- Nationality
- Dis/Ability
- Mental health
- Neurodiversity
- Religion
- Occupation currently, band/level.
- Experience/roles you've held in publicly funded services.
- Do you consider your social class? How would you define it?
- Anything else about your identity characteristics you think would be useful to me to know at this point? E.g. skin tone, body shape, languages spoken, economic status/wealth?
- Early experiences; care (foster care eg.), carers, prison systems, DV

2. Thinking about moral injury and systemic injustice, what drew you to want to take part in this?
3. In what way do you feel your personal experiences of systemic injustice relates to your professional experiences?
    a. Colleagues?
    b. Services users?
    c. Wider communities?
    d. Funding bodies (if relevant)?
4. Can you tell me about a time that caused you moral distress?
    a. How did this impact you?
    b. Service users?
    c. Why do you think it happened like that?
    d. What do you think influence that decision? From where?
5. Can you talk about an experience that has caused strong emotional responses (shame, guilt) at work?

ending

Have a conversation about something else to change the space, offer space to do a relaxation exercise, move around, listen to some music together and talk about the rest of the day.

k. Debrief sheet:

Debrief Sheet

Debrief form with list of services

It is completely understandable if you leave this interview feeling absolutely fine or feeling really upset – and all the reactions within and outside that too. If you do feel that participating has brought up difficult feelings or things you maybe just want a space to be able to process please find a list of services below.

Thank you again for your time, your expertise and your openness to sharing your experiences with me.

General mental health support

- NHS 111
    - NHS 111 will tell you the right place to get help if you need to see someone. You may be able to speak to a nurse, or mental health nurse, over the phone. A GP can advise you about helpful treatments and also help you access mental health services.
    - Use the NHS **111** online service or call **111**.

- GP:
    - You may find it helpful to contact your GP if you experience psychological distress or discomfort after the study. They may be able to advise you for further sources of support, such as a referral to an NHS therapeutic service for counselling or another type of talking therapy.

- Samaritans
    - The Samaritans provide emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland
    - Telephone number: 116 123 (24 hours, any day of the year)
    - Email: jo@samaritans.org (response time: 24 hours)

- Shout
    - Shout 85258 is a 24/7 UK text messaging service for times when people feel they need immediate support.
    - Text SHOUT to: 85258

- Nafsiyat:
    - A charity offering intercultural therapy in over 20 languages to people from diverse cultural communities.
    - Telephone number: 020 7263 6947
    - Email: admin@nafsiyat.org.uk

- The Black, African and Asian Therapy Network (BAATN)
    - BAATN provide an online directory of private, qualified and registered professional Black, African and Asian counsellors, psychotherapists and psychologists. There is a choice of face to face or online counselling via Skype/Telephone/Email.
    - Website: https://www.baatn.org.uk/

- The Lapis:

  - The Lapis provides specialist counselling and psychotherapy to those affected by disability and life-changing health conditions, included families, loved ones and carers.
  - Website: https://lapis.org.uk/

- Pink Therapy
  - They are a directory of qualified LGBTQIA+ friendly therapists and counsellors. Their website provides information about websites and others sources of support if that felt more useful.
  - Website: https://pinktherapy.com/

- Frontline19:
  - They are a service offering emotional and mental health support for frontline workers.
  - Website: https://www.frontline19.com/
  - Facebook: https://www.facebook.com/frontline19/

l. Examples of thematic synthesis coding for SLR:

Bruce et al

Quote/reference	Code
Intrateam discordance served as a key source of distress for all healthcare disciplines	Intrateam discordance

'situations involving lack of full disclosure' 'informed consent processed were compromised by a lack of disclosure of salient facts and prognoses'	Lack of disclosure
'initiation or maintenance of nonbeneficial life-sustaining treatments'	Non-essential procedures?/nature of procedures
825 – 3 sources of moral distress – patient and HC, HC and HC or patient and patient	Structure of patient-carer relationships
'more the team just couldn't get on the same page about whether to continue or not'	Disagreement within team about tx (practical intervention)
'need to accommodate surgical perspectives may derive from an implicit recognition that maintain collegial relationships with surgeons is important for hierarchical reasons'	Hierarchical reasons

Note - They are stating that they are expanding on the literature, which they are, but did they ask wider than team dynamics to understand sources of moral distress?

Matthews and Williamson

'focusses on the physical and physiological aspects of a patient's condition, rather than assessing all dimensions of the person'	Demands/attitudes of the place of work
Loss of autonomy experienced most by those at the bottom of the hierarchy	Hierarchical reasons
'discourse of the profession and organisation where he works are largely counterintuitive'	Personal/organisationsal discordance
'he believes he should comply with institutional norms and formal decision making' (all of this exacerbated by unique environment)	Lack of autonomy
'described feeling inferior and constrained by a senior's decision'	Hierarchical reasons/disagreements with team about tx (personal morals)
Attempts to disengage her conscious and primal instincts to engage a professional persona. However, she struggles to disengage entirely and adopt the approach of the organisation	Personal/organisationsal discordance
	Also related to societal norms not matching organisational expectations (contrast with McLean)

Note - The HCA speaks about needed to be desensitised to distress to cope, and that that is how resilience is enacted within the profession - how does this relate to complete adherence to the model?

and also - how do that relate to needed to protect yourself by upholding the system? Because he/she/they need to think that what is happening is ok and normal to be able to cope with it. Speaking about self-harm

Note - What does this say about role of hierarchy within medical care? Why is it 'lower' team members can vent and utilise emotional support but 'higher' team members cannot? What does this say about resilience and 'firm' views on coping i.e. thinking about peer support workers being band 3 - it's expected they'll have to talk, reflect and be open. But the further up we get, the less of a culture there is .

Is there gender implications too?

Cervantes

‘participants often felt forced to deny EOHD even for visibly ill patients, especially when chairs were not available.’ Felt guilty when denying patients…reported numbing…felt powerless to change the situation	Personal/organisationsal discordance/organisational restraints
Criteria used to determine suitability was vague and inconsistent	Disagreement within team about tx (practical intervention)/nature of procedures
ED physicians were frustrated when nephrologists questioned their decision about the criteria. Unable to explain criteria to patients	Disagreement within team about tx (practical intervention)/lack of disclosure
‘gaming the system made them worry about their personal integrity’	Decision making -ethical dilemma Personal/organisational discordance
Focus on volume at the expense of quality	Personal/organisationsal discordance
Wasting resources	Practical restraints /external

Oelhafen

‘external constraints limiting the midwife’s and patient’s autonomy and resulting interpersonal conflicts were found to be the most relevant ethical issues encountered in clinical practice and were most often associated with moral distress	

Participants described situations where physicians proposed to carry out interventions such as induction of labour, caesarean section…’	Non-essential procedures?/disagreement in team about tx (practical)
One of the most important values, when this not possible could cause moral distress>	Autonomy/shared decision making
‘Any interference by doctors, or parents themselves’	Structure of patient-carer relationships
‘physicians are ultimately responsible’	Hierarchical reasons
Do not have enough resources to take care of the woman as they should, staffing issues or other tasks	Lack of autonomy/resources
Too strict adherence to guidelines/covert research interests were potentially conflicting with the women’s autonomy	Systemic factors
Midwives expressed discomfort related to the possible violation of the principle of informed choice	Lack of being able to gain consent
‘lack of interprofessional communication/lack of influence in decision-making and lack of trust in professional competence’	Hierarchical factors/interpersonal dynamics
Inexperienced midwives less likely to speak up	Hierarchical/power
Reported conflicts of loyalty (midwives and physicians)/differences in experience, expertise and responsibility	Struggle between meeting needs of other clinicians and patients – structure of parent carer relationships
Raises new ethical questions	New developments in procedure
Late abortions – structure of patent carer relationships. Parents wishes vs rights of the newborn	Purposeful induction of moral dilemas
Midwives having to induce abortions on the wish of the parents	Personal moral values conflicting with procedures
Quitting due to questionable practices and values of their institution	Personal/organisational discordance –
Conflict leading to feelings of being silenced or being powerless	Interpersonal dynamics
Deviates from expectations due t time pressure, limited resources, limited autonomy. Not trained to deal with different situations	Practice/knowledge vs reality
Novice midwives and physicians dynamic	Hierarchy

Thorne

Page 687 – not able to influence decisions, preventable errors may have occurred	Powerlessness
'a fairly predictable organizational factor that arose in the moral distress accounts of several of these health care professionals were challenges associated with access to resources, primarily adequate equipment and staffing	Lack of resources
Prioritising medical approach and short-term decisions rather than longer term psychosocial support	Organizational structure (priorities)
Being able to 'pass the buck' when it comes to responsibility and decision making	structure
Being the second person to meet a family after someone else has (distress caused by wondering if the info that family have received then influenced their decision)	Structure/organisational practice
Legislation, regulation and ethical guidelines for practice were not always in alignment, and therefore inadequate in supporting the practice decisions and each clinician believed most reasonable and ethical	Systemic/organisational procedure vs personal morals
Attitudes, actions, approaches of individuals/lack of professionalism or of disrespectful behaviour	interpersonal
'some people, based on their seniority just make some decisions and throw nasty words on me' – described as ridiculous and dangerous	Hierarchy
Vicarious effects of disrespectful behaviour – witnessed or learned of indirectly	Interpersonal
Many of the accounts charaterised by power struggles between various members of the team. 'problematic behaviour clearly attributed it to a sense of hierarchical privilege and legitimized authority on the part of the staff with more seniority or perceived importance	Interpersonal/hierachy

Overall quote – it was also apparent that the relational and organisational aspects of the work place culture featured prominently in differentiating those cases that were merely difficult from those that triggered moral distress… moral distress was a product of the interaction between the complex cases that were the inevitable focus of their professional lives and the workplace dynamics that were not

McLean

'experienced a gap between the law and the working reality at that clinic, which continuously forced them into ethically challenging situations	Systemic/organisational procedure vs personal morals
Consequences if refuse an abortion	Weight of decision making/responsibility
Having to follow guidelines that say have to offer abortion due to rape, even if this isn't true	Procedure vs personal morals
'Assessment of unreasonable vs reasonable abortion does not follow the law '	Legal pressures – conflict between organisational procedure and law
Organisational procedure going against 'religious beliefs, perceptions about life and societal norms'	Organisational/systemic/legal procedure vs own morals
	Procedure not in line with religious beliefs/societal norms
'negative perceptions of health workers caused many to hide the nature of their work from family and friends	Interpersonal
Stigmatisation of their work and the feeling of being alone in decision making	Stigma

Passos dos Santos

Other healthcare providers, families and children – concerns in these relationships	Relational
'when actions considered wrong receive no punishment or warning, she experiences feelings of lack of commitment to the right attitudes, and consequently, moral distress	attitudes
Problematic working relationships with physicians may prevent nurses from acting in a manner that they consider correct	relationships/interpersonal
Lack of competence of resident physicians	Systemic?
Not being able to support families	Helplessness (nature of work rather than systemic factor)
Nurses having to manage situations where relationship breaks down between physician and family	dynamics

Distress when families question the decisions of the team (team focussed vs family focussed)	dynamics
'an excessive number of activities in the unit limit the nurses' ability to properly perform this practice, resulting in feelings of guilt for not addressing their own nursing concerns	Organisational restraints

Edwards

Stigma of 'you don't want to get the dr upset' so talk amongst ourselves, but we all go ahead and do it anyway	dynamics
Experience of MD depended on pre existing relationships – family, staff	relationships
Lack of budget influencing decisions	resource
Lack of support particuarly evenings and nights /not able to discuss challenges	resource
Lack of access to external resource – human, educational	Resource/structure
Managers being removed/not involved and therefore not able to provide support	Dynamics/hierarchy

Biondi

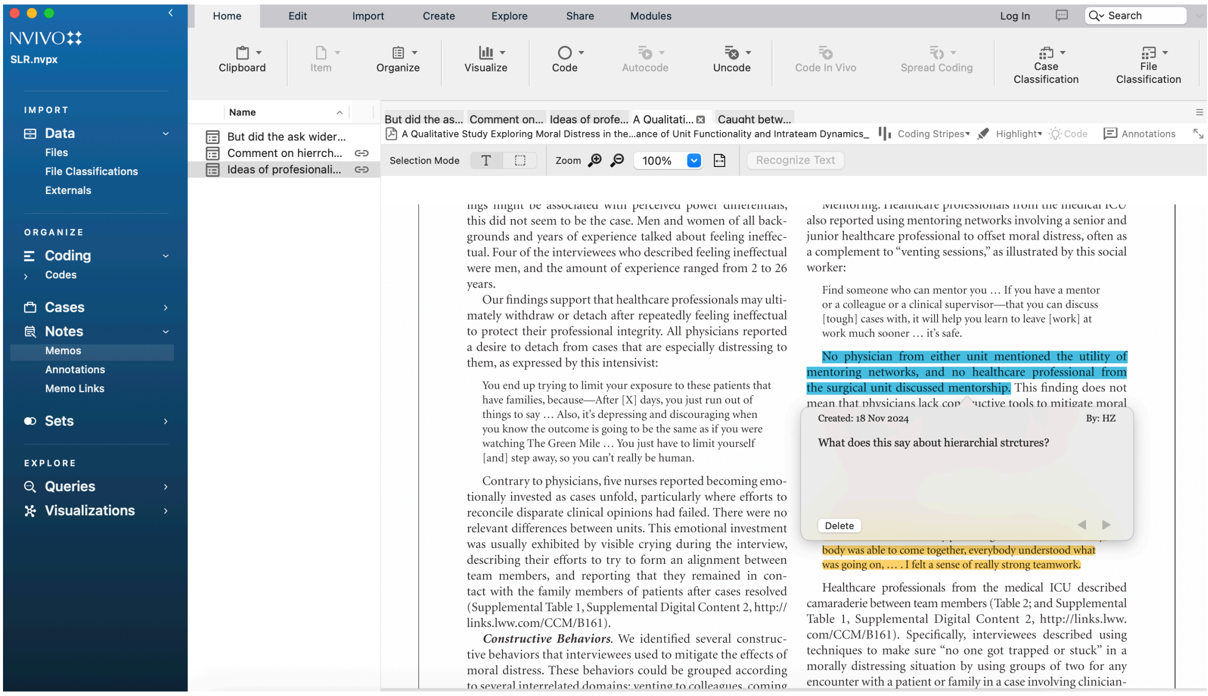
Prioritisation of some activities to the detriment of others. The administration of some elements is difficult when there is an inadequate number of professionals which potentiates the nurse distancing from direct actions to users	Resource/organisatonal restraint
Prioritising administrative/managerial tasks	
Solving team problems distracting from nursing. The way the organisation is set up moves the nurses away from th users	Occupational organisation
Paperwork required to carry out tasks	
Disagreements in the team, lack of autonomy of the nurses	relational
Lack of freedom to make choices and follow training	Power dynamics
Attempting to advocate for patients	
Disrespectful positions towards women, committed by members of the team,	Systemic attitudes and beliefs

through coersion and exposure to derogatory practice conflict with the humanizing ideals an moral values of nurses	
Nurses do not feel instrumental in chnaging a paradigm due to virtue of of the power relations	Power dynamics
Page 7/16 - quote about nurses attempting to protect autonomy of women	
Despite legal framework still not able to advocate e.g. letting others into the room	Power vs legal policy
The way the work has been organised is often marked by the split between the care and management dimension, generating conflicts in the nurses work – own practice or relationships	Occupational organisation
The way care is delivered is oriented to the resolution of child birth quickly than to the satisfaction of the user and family, with priority given to procedures to the detriment..	Attitudes and priorities
Lack of nurse autonomy leads to lack of visibility of nurse work – exaserbating power dynamics	attitudes

Notes

- Triadic relationships? The participants and either parents/carers and children OR participants and those higher up the hierachy

E.g. in Nvivo



ings might be associated with perceived power differentials, this did not seem to be the case. Men and women of all backgrounds and years of experience talked about feeling ineffectual. Four of the interviewees who described feeling ineffectual were men, and the amount of experience ranged from 2 to 26 years.

Our findings support that healthcare professionals may ultimately withdraw or detach after repeatedly feeling ineffectual to protect their professional integrity. All physicians reported a desire to detach from cases that are especially distressing to them, as expressed by this intensivist:

> You end up trying to limit your exposure to these patients that have families, because—After [X] days, you just run out of things to say … Also, it's depressing and discouraging when you know the outcome is going to be the same as if you were watching The Green Mile … You just have to limit yourself [and] step away, so you can't really be human.

Contrary to physicians, five nurses reported becoming emotionally invested as cases unfold, particularly where efforts to reconcile disparate clinical opinions had failed. There were no relevant differences between units. This emotional investment was usually exhibited by visible crying during the interview, describing their efforts to try to form an alignment between team members, and reporting that they remained in contact with the family members of patients after cases resolved (Supplemental Table 1, Supplemental Digital Content 2, http://links.lww.com/CCM/B161).

Constructive Behaviors. We identified several constructive behaviors that interviewees used to mitigate the effects of moral distress. These behaviors could be grouped according to several interrelated domains: venting to colleagues, coming

Mentoring. Healthcare professionals from the medical ICU also reported using mentoring networks involving a senior and junior healthcare professional to offset moral distress, often as a complement to "venting sessions," as illustrated by this social worker:

> Find someone who can mentor you … If you have a mentor or a colleague or a clinical supervisor—that you can discuss [tough] cases with, it will help you learn to leave [work] at work much sooner … it's safe.

No physician from either unit mentioned the utility of mentoring networks, and no healthcare professional from the surgical unit discussed mentorship. This finding does not mean that physicians lack con uctive tools to mitigate moral

Created: 18 Nov 2024

By: HZ

What does this say about hierarchial strctures?

> body was able to come together, everybody understood what was going on, … . I felt a sense of really strong teamwork.

Healthcare professionals from the medical ICU described camaraderie between team members (Table 2; and Supplemental Table 1, Supplemental Digital Content 2, http://links.lww.com/CCM/B161). Specifically, interviewees described using techniques to make sure "no one got trapped or stuck" in a morally distressing situation by using groups of two for any encounter with a patient or family in a case involving clinician-

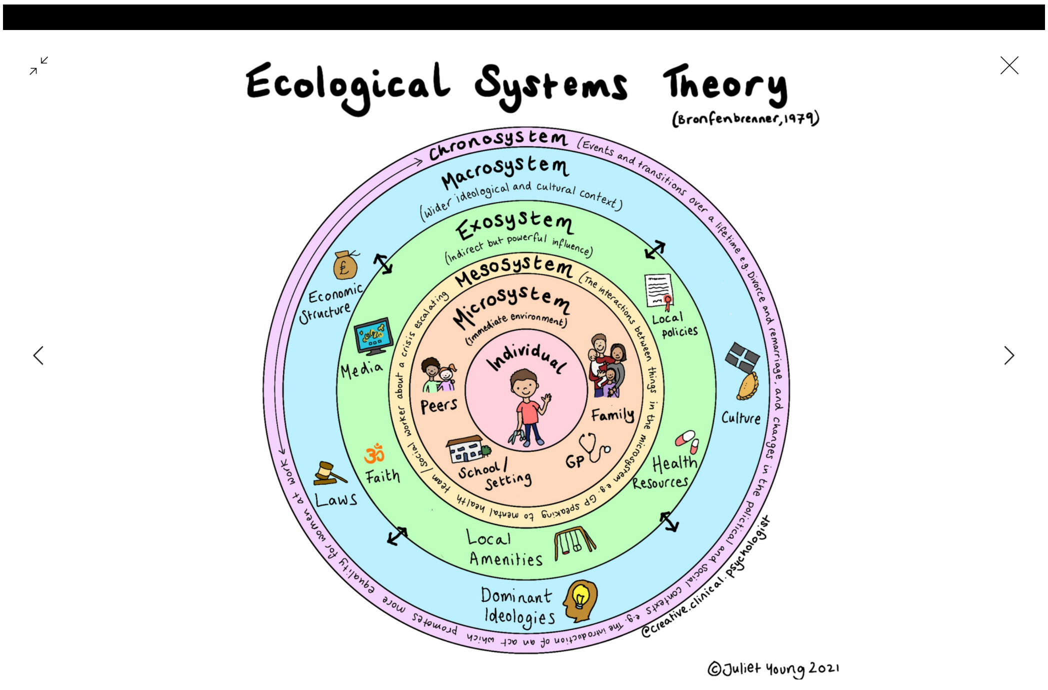
m. Mapping session with consultant team and second supervisor pre data collection:

Questions guiding the process

- **Situational maps** = the relations between all the elements of study; human, nonhuman, discursive, historical, symbolic, cultural, political and any other elements related. The aim is to capture the complexities surrounding the situation of enquiry MORAL INJURY as experienced by those with lived experience of systemic injustice.
- Questions:

- What and what are in the situation?
- Who and what else matters in this situation?
- What other elements make a difference in this situation?
- What nonhuman elements are present, and place a demand on the human elements due to the conditions of the situation?

While holding in mind –



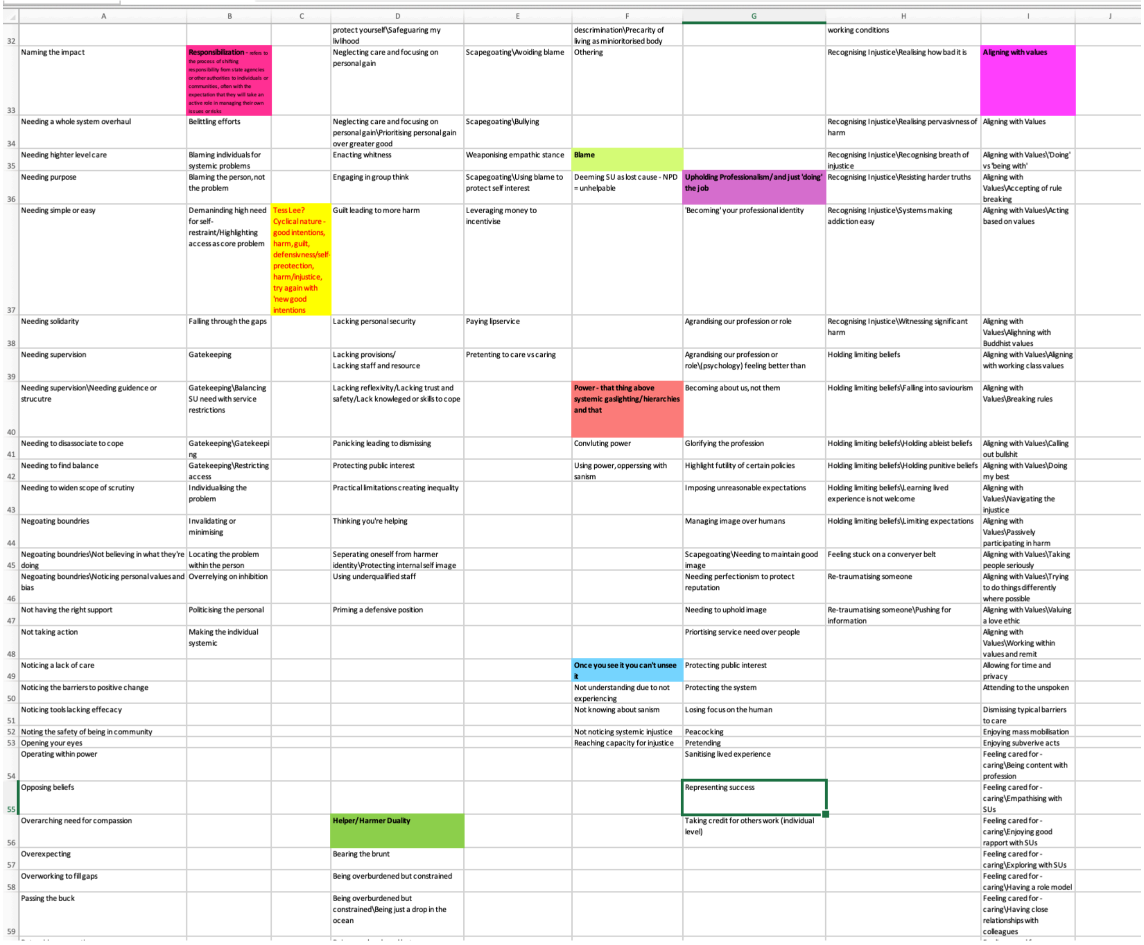
And we thought together about –

- MORAL INJURY – 21/06/2024 – Aman Lauren Hayley Sheeva ☺
- Service pressures; long wait lists (immediate), shorter sessions (policy change), covid (working outside competencies and remit).
- Working within capitalist structures (aim of treatment is to focus on ideas of able/'functional')
- Depends on who we're interviewing:
  - Socioeconomic background / wage – how does this impact on their experience – less power. How does this then impact on your time / space to do work / reflect on your work / take care of yourself.
  - Temp / bank worker might not be involved in any meetings / spaces to reflect or learn.
  - Seniority would impact on sense of power / ability to speak up or even know whether you can say no to something.
  - Different clinicians – different networks: are you networked or are you existing on your own? Supervision / sharing of grievances / sense of power.
  - Also would depend on the type of client that you're working with.
  - Different models / paradigms of work (medical model vs systemic vs…) and how do this impacts your agency / sense of agency within the workplace.
- Policy impact
- Where is the directive coming from? Government? Trust? Service? Ward? Manager? Nurse in charge? … How might that change and impact a person's experience of those injurious directives, and how likely might they be to say no to something like that (or feel empowered to).
- CONTEXT – what is happening in the world? COVID, geopolitical issues… Brought moral injury into the light. BUT also – probably existed before too, just more surreptitiously. Are we just rehashing? Or bringing light to trauma in a non-pathologising manner?
- Diagnosis – Moral injury – Compassion Fatigue – Vicarious Trauma - "too sensitive" – "not cut out for the job". Do these labels allow more people to come forward in a less pathologizing way?
- Internal resources: geopolitical understanding, self-work, etc – how do these things support / hinder the process of moving through moral injury.
- "Resilience" / Vulnerability (who is allowed to be vulnerable and in what ways) / Identities and ideas that are allowed or not allowed to be explored.
- How does risk come into this? Tend to default to medical model when risk increases. Something about the kind of service / service setting you're working within – how you then think about / respond to issues. Impacts on how you see your resources / understand their utility / effectiveness (e.g. risk management).
- Something about fixing things – relates back to paradigm of work / identity / understanding of your role -> what happens when that no longer works?
- If someone is really unwell and the system can't do anything for them (and the distress is situational) and you're supposed to be part of the system that puts the solutions in place and you have a sense that you should be able to help -> what are we having to hold? E.g. severity of the people you're working with / level of crisis. What you at your level of competence should be expected to work with. No space in the system. And then there is what is causing that severity of experience.
- In times of acute social crisis – the requirements of professionals are higher (shared exp). Austerity, funding cuts, pandemic, cost of living crisis, systemic injustice (often not seen as a social crisis), Palestine.
- Shared identity / lived experience – what about when those oppressions we have experience are neglected in our work / workplaces / policies.
- Something about how "wounded healers" are liable to be seen – conscious of this in the research question.
- Interesting observation: H thinking a lot about therapists! But L thinking more about HCAs / bank workers. S thinking more about doctors.
- Language as a construct – English – power of language – how it's used in policy / elsewhere.
- Dominant narratives:
- "You're not cut out for this job" – "Maybe you should think about whether this is right for you" – "Are you sure you're ready / able / "healed" / competent enough to do this work?"
- Positivist ideas / conceptualisations of diagnoses / treatments / care – "robust scientist-practitioner" – "empirical" views – "evidence-based practise vs practise-based evidence" – mental health is chemical / neurological / biological – you can treat anything as long as you get the right meds – addiction as an organic issue.
- Tension / cognitive dissonance between what you "know" to be "true" and what you experience (e.g. family tree example). How does that show up? How does that impact your distress? How do you understand yourself?
- "In the moment" vs "later on". "Inside the setting" and "back home". Own trauma and its impact – e.g. nurse assaulted by a patient. Something about existing in two spaces that can be diametrically opposed – how do you make sense of this / integrate this.
- Media/social media

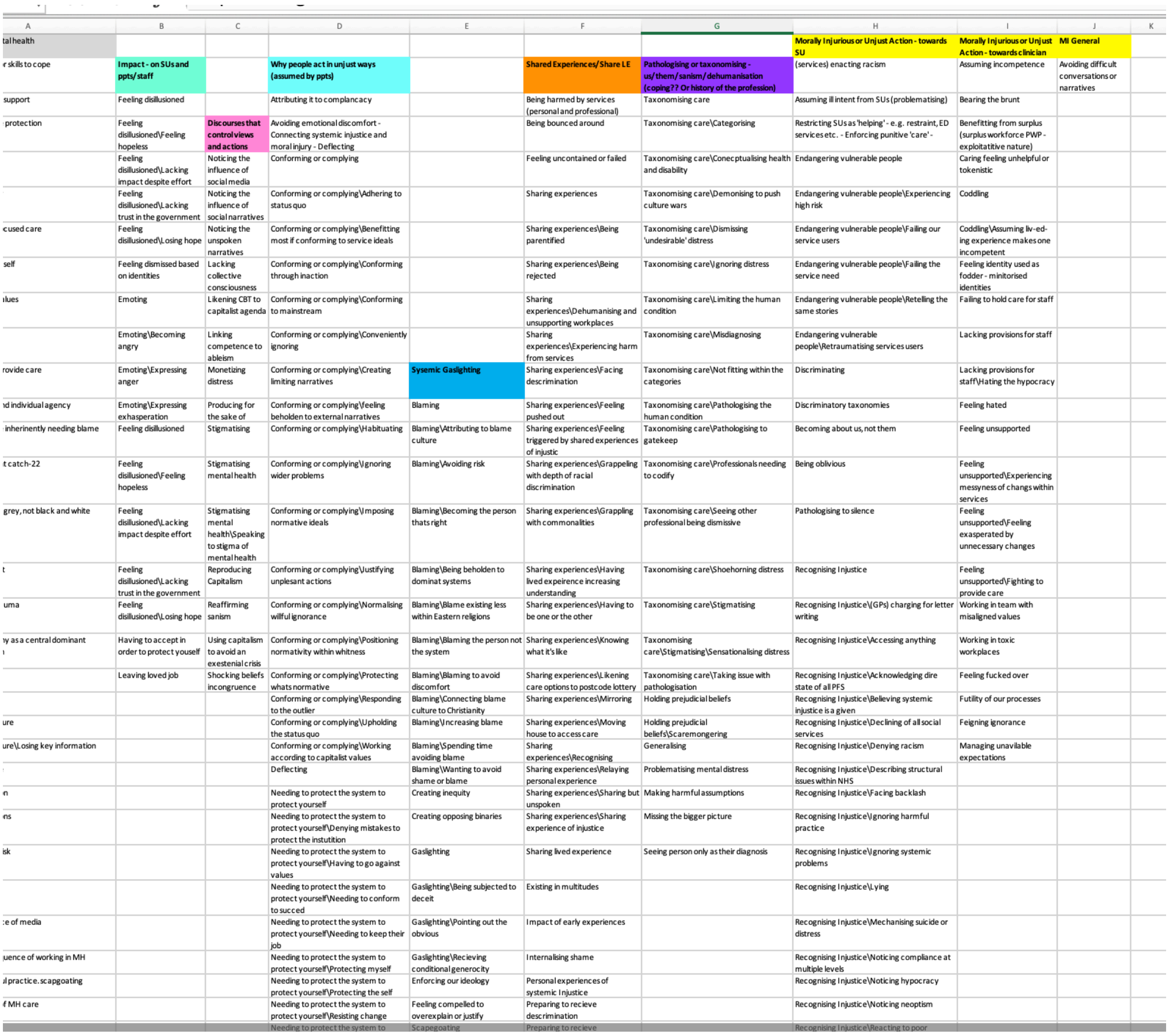
n. Example of line-by-line coding:

Sarah 3:23 I think it was there for a long time.	Sitting with disillusioned for a long time	
Hayley 3:24 Right, yeah.		
Sarah 3:26 So I think what I started it was so back in 2022 of my previous job, I went to an inquest just to support a staff member that I was the line manager of.	Starting point for disillusion Managers – supporting staff member at inquest.	She needed to emphasis how much power was there, how high up the people involved in this situation are. ??
Hayley 3:32 Mm hmm.		
Sarah 3:38 Because she had been called to give evidence and em, the borough director was there all the assistant director, who was kind of like my boss. And he lied in that inquest. *Note: voice when up here, my understanding of the change in tone was a note of exasperation/upset.*	Holding so much power Lying	
Hayley 3:51 Oh wow.		
Sarah 3:53 Yeah. Admitted to it to me, well I was there, I saw it (gently laughing), but he admitted to me and to one of the admin staff as well that he used the terms. “Oh, I perjured myself”	Admitting the lie – brazen disregard? Laughing about the lie Admitting to two stff members exacting power over staff are much lower rank to him.	Role of power here is huge – assistant direct, legal professional . Freedom to speak up guardians in the NHS – is this the reality? POWERLESSNESS
Hayley 4:04 Oh wow.		
Sarah 4:06 Yeah, so I escalated this and it ended up with me, him, the medical director and a lawyer for the trust in this team's meeting just completely gaslighting me about it.	Escalating it the lie. Gaslighing by people in power	
Hayley 4:17 Oh, OK.		GASLIGHTING
Sarah 4:18 The lawyer was there and heard what he said and he said to me ”that's not what he meant” and I'm like, we all know that's what he meant. He even admitted it to me. (gently laughing again).	Covering up Gaslit again – everyone aware what was said but covering it up.	
Hayley 4:27 Yeah.		
Sarah 4:28 And to two other staff as well. And we all heard him and the lie was basically about... So what had happened was em, this lady had seen our service and she jumped off a building.	Collective gaslighting. Everyone knowing the truth (context)Patient suicide [enquiry]	

o. Focused Coding:



	A	B	C	D	E	F	G	H	I	J
32				protect yourself\Safeguarding my livlihood		descrimination\Precarity of living as minioritorised body		working conditions		
33	Naming the impact	**Responsibilization** - refers to the process of shifting responsibility from state agencies or other authorities to individuals or communities, often with the expectation that they will take an active role in managing their own issues or risks		Neglecting care and focusing on personal gain	Scapegoating\Avoiding blame	Othering		Recognising Injustice\Realising how bad it is	**Aligning with values**	
34	Needing a whole system overhaul	Belittling efforts		Neglecting care and focusing on personal gain\Prioritising personal gain over greater good	Scapegoating\Bullying			Recognising Injustice\Realising pervasivness of harm	Aligning with Values	
35	Needing highter level care	Blaming individuals for systemic problems		Enacting whitness	Weaponising empathic stance	**Blame**		Recognising Injustice\Recognising breath of injustice	Aligning with Values\'Doing' vs 'being with'	
36	Needing purpose	Blaming the person, not the problem		Engaging in group think	Scapegoating\Using blame to protect self interest	Deeming SU as lost cause - NPD = unhelpable	**Upholding Professionalism/ and just 'doing' the job**	Recognising Injustice\Resisting harder truths	Aligning with Values\Accepting of rule breaking	
37	Needing simple or easy	Demaninding high need for self-restraint/Highlighting access as core problem	Tess Lee? Cyclical nature - good intentions, harm, guilt, defensivness/self-preotection, harm/injustice, try again with 'new good intentions	Guilt leading to more harm	Leveraging money to incentivise		'Becoming' your professional identity	Recognising Injustice\Systems making addiction easy	Aligning with Values\Acting based on values	
38	Needing solidarity	Falling through the gaps		Lacking personal security	Paying lipservice		Agrandising our profession or role	Recognising Injustice\Witnessing significant harm	Aligning with Values\Alighning with Buddhist values	
39	Needing supervision	Gatekeeping		Lacking provisions/ Lacking staff and resource	Pretenting to care vs caring		Agrandising our profession or role\(psychology) feeling better than	Holding limiting beliefs	Aligning with Values\Aligning with working class values	
40	Needing supervision\Needing guidence or strucutre	Gatekeeping\Balancing SU need with service restrictions		Lacking reflexivity/Lacking trust and safety/Lack knowleged or skills to cope		**Power - that thing above systemic gaslighting/ hierarchies and that**	Becoming about us, not them	Holding limiting beliefs\Falling into saviourism	Aligning with Values\Breaking rules	
41	Needing to disassociate to cope	Gatekeeping\Gatekeeping		Panicking leading to dismissing		Convluting power	Glorifying the profession	Holding limiting beliefs\Holding ableist beliefs	Aligning with Values\Calling out bullshit	
42	Needing to find balance	Gatekeeping\Restricting access		Protecting public interest		Using power, opperssing with sanism	Highlight futility of certain policies	Holding limiting beliefs\Holding punitive beliefs	Aligning with Values\Doing my best	
43	Needing to widen scope of scrutiny	Individualising the problem		Practical limitations creating inequality			Imposing unreasonable expectations	Holding limiting beliefs\Learning lived experience is not welcome	Aligning with Values\Navigating the injustice	
44	Negoating boundries	Invalidating or minimising		Thinking you're helping			Managing image over humans	Holding limiting beliefs\Limiting expectations	Aligning with Values\Passively participating in harm	
45	Negoating boundries\Not believing in what they're doing	Locating the problem within the person		Seperating oneself from harmer identity\Protecting internal self image			Scapegoating\Needing to maintain good image	Feeling stuck on a converyer belt	Aligning with Values\Taking people seriously	
46	Negoating boundries\Noticing personal values and bias	Overrelying on inhibition		Using underqualified staff			Needing perfectionism to protect reputation	Re-traumatising someone	Aligning with Values\Trying to do things differently where possible	
47	Not having the right support	Politicising the personal		Priming a defensive position			Needing to uphold image	Re-traumatising someone\Pushing for information	Aligning with Values\Valuing a love ethic	
48	Not taking action	Making the individual systemic					Priortising service need over people		Aligning with Values\Working within values and remit	
49	Noticing a lack of care					**Once you see it you can't unsee it**	Protecting public interest		Allowing for time and privacy	
50	Noticing the barriers to positive change					Not understanding due to not experiencing	Protecting the system		Attending to the unspoken	
51	Noticing tools lacking effecacy					Not knowing about sanism	Losing focus on the human		Dismissing typical barriers to care	
52	Noting the safety of being in community					Not noticing systemic injustice	Peacocking		Enjoying mass mobilisation	
53	Opening your eyes					Reaching capacity for injustice	Pretending		Enjoying subverive acts	
54	Operating within power						Sanitising lived experience		Feeling cared for - caring\Being content with profession	
55	Opposing beliefs						Representing success		Feeling cared for - caring\Empathising with SUs	
56	Overarching need for compassion			**Helper/Harmer Duality**			Taking credit for others work (individual level)		Feeling cared for - caring\Enjoying good rapport with SUs	
57	Overexpecting			Bearing the brunt					Feeling cared for - caring\Exploring with SUs	
58	Overworking to fill gaps			Being overburdened but constrained					Feeling cared for - caring\Having a role model	
59	Passing the buck			Being overburdened but constrained\Being just a drop in the ocean					Feeling cared for - caring\Having close relationships with colleagues	



A	B	C	D	E	F	G	H	I	J	K
tal health							**Morally Injurious or Unjust Action - towards SU**	**Morally Injurious or Unjust Action - towards clinician**	**MI General**	
r skills to cope	**Impact - on SUs and ppts/staff**		**Why people act in unjust ways (assumed by ppts)**		**Shared Experiences/Share LE**	**Pathologising or taxonomising - us/them/sanism/dehumanisation (coping?? Or history of the profession)**	(services) enacting racism	Assuming incompetence	Avoiding difficult conversations or narratives	
support	Feeling disillusioned		Attributing it to complancacy		Being harmed by services (personal and professional)	Taxonomising care	Assuming ill intent from SUs (problematising)	Bearing the brunt		
protection	Feeling disillusioned\Feeling hopeless	**Discourses that control views and actions**	Avoiding emotional discomfort - Connecting systemic injustice and moral injury - Deflecting		Being bounced around	Taxonomising care\Categorising	Restricting SUs as 'helping' - e.g. restraint, ED services etc. - Enforcing punitive 'care' -	Benefitting from surplus (surplus workforce PWP - exploitatitive nature)		
	Feeling disillusioned\Lacking impact despite effort	Noticing the influence of social media	Conforming or complying		Feeling uncontained or failed	Taxonomising care\Conecptualising health and disability	Endangering vulnerable people	Caring feeling unhelpful or tokenistic		
	Feeling disillusioned\Lacking trust in the government	Noticing the influence of social narratives	Conforming or complying\Adhering to status quo		Sharing experiences	Taxonomising care\Demonising to push culture wars	Endangering vulnerable people\Experiencing high risk	Coddling		
cused care	Feeling disillusioned\Losing hope	Noticing the unspoken narratives	Conforming or complying\Benefitting most if conforming to service ideals		Sharing experiences\Being parentified	Taxonomising care\Dismissing 'undesirable' distress	Endangering vulnerable people\Failing our service users	Coddling\Assuming liv-ed-ing experience makes one incompetent		
self	Feeling dismissed based on identities	Lacking collective consciousness	Conforming or complying\Conforming through inaction		Sharing experiences\Being rejected	Taxonomising care\Ignoring distress	Endangering vulnerable people\Failing the service need	Feeling identity used as fodder - minitorised identities		
lues	Emoting	Likening CBT to capitalist agenda	Conforming or complying\Conforming to mainstream		Sharing experiences\Dehumanising and unsupporting workplaces	Taxonomising care\Limiting the human condition	Endangering vulnerable people\Retelling the same stories	Failing to hold care for staff		
	Emoting\Becoming angry	Linking competence to ableism	Conforming or complying\Conveniently ignoring		Sharing experiences\Experiencing harm from services	Taxonomising care\Misdiagnosing	Endangering vulnerable people\Retraumatising services users	Lacking provisions for staff		
rovide care	Emoting\Expressing anger	Monetizing distress	Conforming or complying\Creating limiting narratives	**Sysemic Gaslighting**	Sharing experiences\Facing descrimination	Taxonomising care\Not fitting within the categories	Discriminating	Lacking provisions for staff\Hating the hypocracy		
d individual agency	Emoting\Expressing exhasperation	Producing for the sake of	Conforming or complying\feeling beholden to external narratives	Blaming	Sharing experiences\Feeling pushed out	Taxonomising care\Pathologising the human condition	Discriminatory taxonomies	Feeling hated		
inherinently needing blame	Feeling disillusioned	Stigmatising	Conforming or complying\Habituating	Blaming\Attributing to blame culture	Sharing experiences\Feeling triggered by shared experiences of injustic	Taxonomising care\Pathologising to gatekeep	Becoming about us, not them	Feeling unsupported		
t catch-22	Feeling disillusioned\Feeling hopeless	Stigmatising mental health	Conforming or complying\Ignoring wider problems	Blaming\Avoiding risk	Sharing experiences\Grappeling with depth of racial discrimination	Taxonomising care\Professionals needing to codify	Being oblivious	Feeling unsupported\Experiencing messyness of changs within services		
grey, not black and white	Feeling disillusioned\Lacking impact despite effort	Stigmatising mental health\Speaking to stigma of mental health	Conforming or complying\Imposing normative ideals	Blaming\Becoming the person thats right	Sharing experiences\Grappling with commonalities	Taxonomising care\Seeing other professional being dismissive	Pathologising to silence	Feeling unsupported\Feeling exasperated by unnecessary changes		
t	Feeling disillusioned\Lacking trust in the government	Reproducing Capitalism	Conforming or complying\Justifying unplesant actions	Blaming\Being beholden to dominat systems	Sharing experiences\Having lived expeirence increasing understanding	Taxonomising care\Shoehorning distress	Recognising Injustice	Feeling unsupported\Fighting to provide care		
uma	Feeling disillusioned\Losing hope	Reaffirming sanism	Conforming or complying\Normalising willful ignorance	Blaming\Blame existing less within Eastern religions	Sharing experiences\Having to be one or the other	Taxonomising care\Stigmatising	Recognising Injustice\(GPs) charging for letter writing	Working in team with misaligned values		
y as a central dominant	Having to accept in order to protect youself	Using capitalism to avoid an exestenial crisis	Conforming or complying\Positioning normativity within whitness	Blaming\Blaming the person not the system	Sharing experiences\Knowing what it's like	Taxonomising care\Stigmatising\Sensationalising distress	Recognising Injustice\Accessing anything	Working in toxic workplaces		
	Leaving loved job	Shocking beliefs incongruence	Conforming or complying\Protecting whats normative	Blaming\Blaming to avoid discomfort	Sharing experiences\Likening care options to postcode lottery	Taxonomising care\Taking issue with pathologisation	Recognising Injustice\Acknowledging dire state of all PFS	Feeling fucked over		
			Conforming or complying\Responding to the outlier	Blaming\Connecting blame culture to Christianity	Sharing experiences\Mirroring	Holding prejudicial beliefs	Recognising Injustice\Believing systemic injustice is a given	Futility of our processes		
ure			Conforming or complying\Upholding the status quo	Blaming\Increasing blame	Sharing experiences\Moving house to access care	Holding prejudicial beliefs\Scaremongering	Recognising Injustice\Declining of all social services	Feigning ignorance		
ure\Losing key information			Conforming or complying\Working according to capitalist values	Blaming\Spending time avoiding blame	Sharing experiences\Recognising	Generalising	Recognising Injustice\Denying racism	Managing unavilable expectations		
			Deflecting	Blaming\Wanting to avoid shame or blame	Sharing experiences\Relaying personal experience	Problematising mental distress	Recognising Injustice\Describing structural issues within NHS			
n			Needing to protect the system to protect yourself	Creating inequity	Sharing experiences\Sharing but unspoken	Making harmful assumptions	Recognising Injustice\Facing backlash			
ns			Needing to protect the system to protect yourself\Denying mistakes to protect the instutition	Creating opposing binaries	Sharing experiences\Sharing experience of injustice	Missing the bigger picture	Recognising Injustice\Ignoring harmful practice			
isk			Needing to protect the system to protect yourself\Having to go against values	Gaslighting	Sharing lived experience	Seeing person only as their diagnosis	Recognising Injustice\Ignoring systemic problems			
			Needing to protect the system to protect yourself\Needing to conform to succed	Gaslighting\Being subjected to deceit	Existing in multitudes		Recognising Injustice\Lying			
e of media			Needing to protect the system to protect yourself\Needing to keep their job	Gaslighting\Pointing out the obvious	Impact of early experiences		Recognising Injustice\Mechanising suicide or distress			
uence of working in MH			Needing to protect the system to protect yourself\Protecting myself	Gaslighting\Recieving conditional generocity	Internalising shame		Recognising Injustice\Noticing compliance at multiple levels			
l practice. scapgoating			Needing to protect the system to protect yourself\Protecting the self	Enforcing our ideology	Personal experiences of systemic Injustice		Recognising Injustice\Noticing hypocracy			
f MH care			Needing to protect the system to protect yourself\Resisting change	Feeling compelled to overexplain or justify	Preparing to recieve descrimination		Recognising Injustice\Noticing neoptism			
			Needing to protect the system to	Scapegoating	Preparing to recieve		Recognising Injustice\Reacting to poor			

p. Examples of memo-ing/note taking/idea development:

Sept 24 - MRP Supervision w/ Emma reading through interview 1.

Hi Hayley,
Super interesting!
I have made a list of my thoughts as I read through the transcript. We can talk them through next meeting.
Gaslighting - curiosity about the meaning behind this, asking participant to say more - risk in making assumptions about this.
Consider the levels of explanation and tap into each - individual, contextual, organisational factors.
Really nice question - how does your job align with that value.
Could you ask what the laughing might be about? What does it enable for the participant?
Ask more about the feelings of not being able to meet the expectation - there is quite a lot about what gets in the way, less about the impact and experience - thecoldness.
Not wanting to get into the EUPD diagnosis - what might happen if the participant did? What are they concerned about? What might be reasons for reining themselves in?
Ask about the apologising? How does this connect with the experience of being a practitioner?
Zoning out - would be interested to see if more participants talk to this experience.

Oct 24 - Memo's/ideas:

- Duality and paradox; out of the interviews (3) so far I'm noticing a constant duality – we think about good and bad, right and wrong and that is being centered as a big problem people face. When they talk, they talk more in a sense of dual meaning/experience of the same thing.
- Interview 1 main theme: disillusionment, 2: blame, 3: capitalism & avoidance (avoiding acknowledging our actions, doing something racist, but not admitting that's what it is).

Nov 24 - Handwritten memo's, notes, ideas as and when they've come up

- Are my participants defining moral injury?
    - How explicite is it?
    - How general or all emcompassing it is?
    - How close to the 'definition' is it?
- Are they saying that the mere fact they work in PF MH services enough (by sheer virtue of the systems) enough to be moral injury?

- Noticing in the interviews that there's something about drug use and there's something about neurodiversity – but specifically ADHD and Autism. What is that??
    - Is it something to do with the fact social discourses and health care models have classified them as something other than a MH related concept? And now we can use those diagnosis to gatekeep??

Dec 24 - Stella Interview thoughts (while coding)

- Narratives and constructs of time

  - Sober time discussed in Stella's interview. Normativity and conformity usually means you stand to get the most out of services – what's that about????

- Stells'a eg. Of the letter writing – they state it's a small example, but also big. Why is it both big and small?
  - What social narrative and personal values is it tapping into?

Jan 24 - Jodie interview thoughts (while transcribing) -

- What is Jodie bringing up in me or what is happening relationally that means I'm laughing more? What, if anything, am I connecting to in terms of how we/I manage lived experience and distress through humour?
  - Is there something working class about that?
  - Is it easier to speak about something so bleak when we can laugh at how outrageous it is?
  - Is it safer to speak about things when we laugh because laughing is a safe reaction?
- Coding thoughts
  - 24.19 – Hierarchies of 'goodness'. Psychology profession on a pedestal, we're not more skilled we're just differently skilled'.
  - 52.13 – lived experience tattoos as overt representation of shared lived experience, Jodie representing SUs too. i.e. seeing someone with lived experience in the helping room, what does that say to people with MH difficulties? Breaks the us v them narrative??
- Theme that ran through; us v them, blatant oppressive action vs. unspoken enactment of oppression? E.g. giving black clinicians black and brown SUs to work with. Overtly enacting racism, but not labelling it as such or speaking to what's happening. We'll ignore the problem, but enact it at the same time – THIS is how we gaslight!!!!!!

Jan 24 - Relates to interview 6

Conversation with Rosie (friend)about leftist politics and the focus on capitalist agenda's being our downfall. To doom and gloom and there are so many who may align with this but it's too much to take on so avoid (is that a type of cog dissonance?). We need to stop trying to get people to realise that capitalism is the problem because realistically that isn't changing any time soon. So what are the solutions we can look to that align with our values?

- Stella speak to this too when I asked them if they thought that clinicians with lived experience of SI would respond to a particular example differently. They said that's too reductive, because first the person responding has to be aware of so much before they even need to think about the ways in which denial and experience might cause harm. And honestly, why bother?

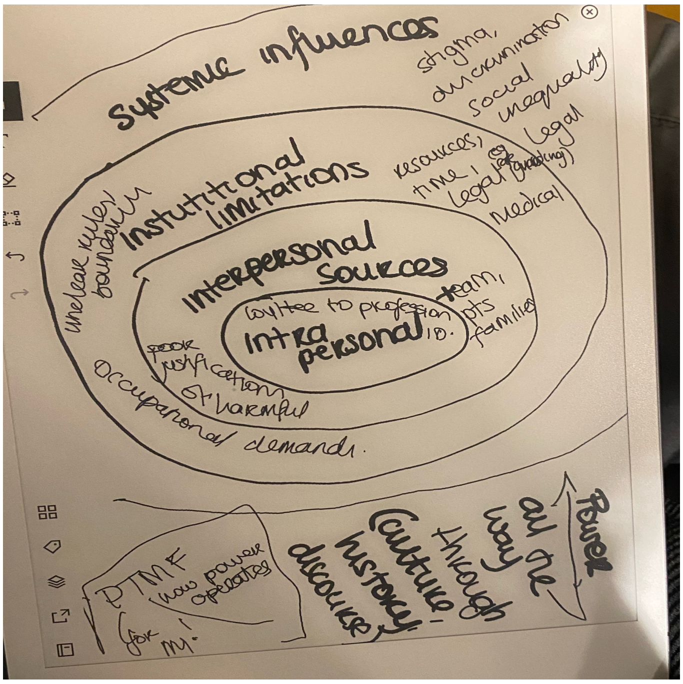
Jan 24 - Related to Lara's interview

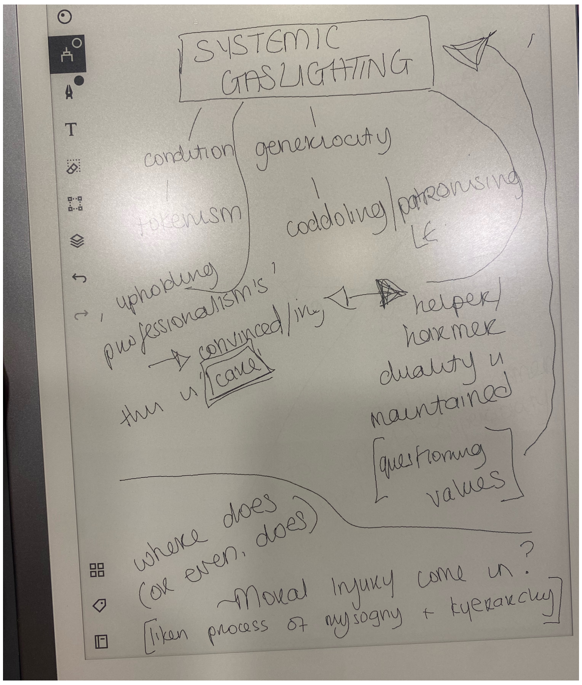
Just finished transcribing Lara's interview – really moved me. She spoke so well and honestly feel like her interview is the one that makes the model make the most sense.

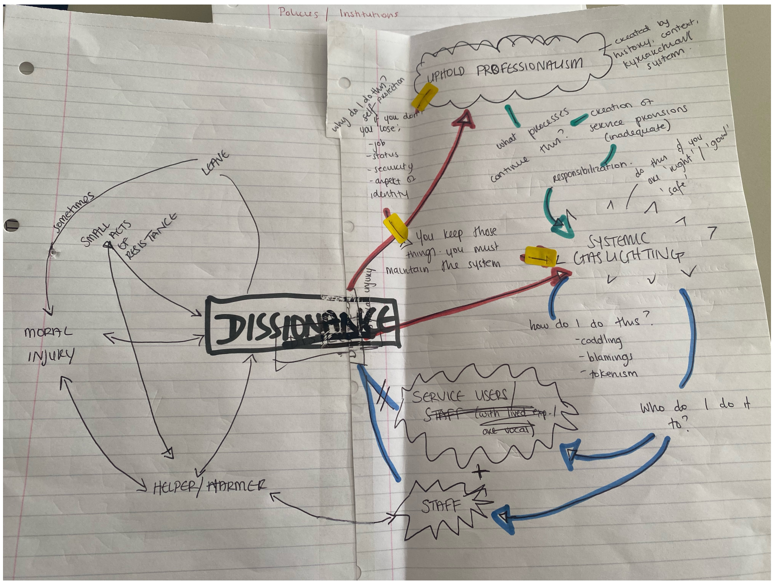
System vs individual is really brought out beautifully in what she said. And how she contrasts how her own lived experience wasn't 'hard' but that seeing it happen to others is? I'm really curious about this – why not?? What was her understanding of what she deserved? Or internalised stigma and shame about her MH?

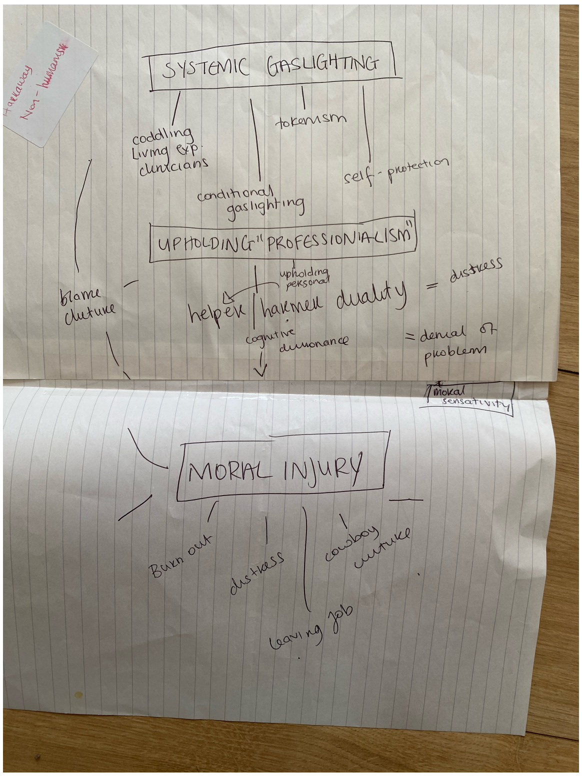
q. Diagramming and model development:

Pre focus group versions:

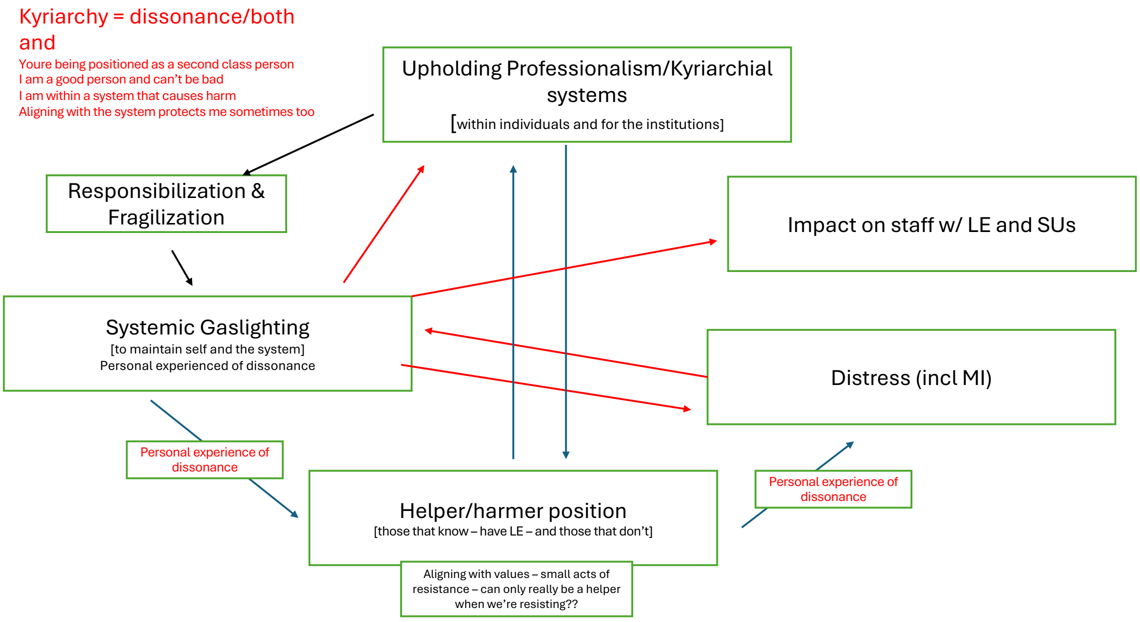

Systemic influences
stigma, discrimination
social inequality
Legal
Institutional limitations
resources, time, eg legal (guarding) legal medical
unclear rules/ boundaries
Interpersonal sources
team, pts families
loyalty to profession
Intra personal
ID.
poor justification of harmful
Occupational demands.
PTMF
(how power operates
for me!
Power all the way through culture, history, discourse


SYSTEMIC GASLIGHTING
condition
tokenism
genericity
coddling
patronising LE
upholding 'professionalism's'
convinced/ing
this is 'care'
helper/ harmer duality is maintained
questioning values
where does (or even, does)
Moral Injury come in?
[liken process of mysogny + hyerarchy]





During the focus group (red text and lined denotes what was added during the focus group with the participants)



Kyriarchy = dissonance/both and

Youre being positioned as a second class person
I am a good person and can't be bad
I am within a system that causes harm
Aligning with the system protects me sometimes too

Upholding Professionalism/Kyriarchial systems
[within individuals and for the institutions]

Responsibilization & Fragilization

Impact on staff w/ LE and SUs

Systemic Gaslighting
[to maintain self and the system]
Personal experienced of dissonance

Distress (incl MI)

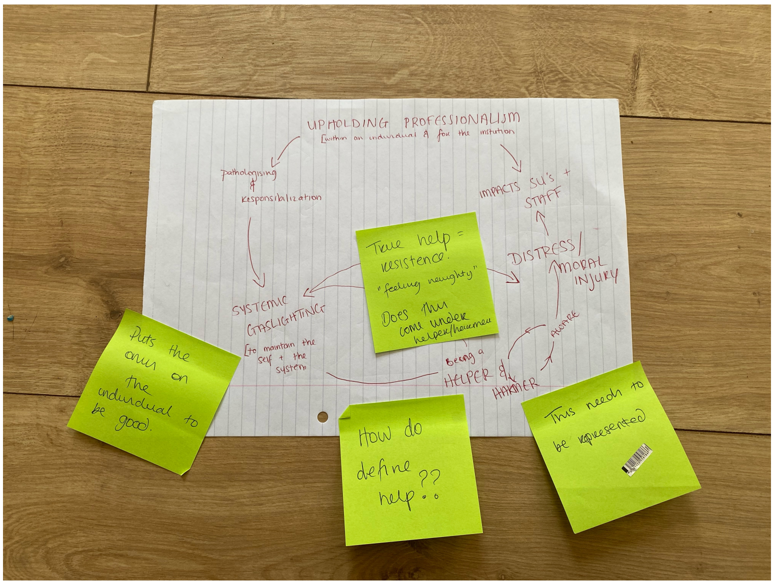
Personal experience of dissonance

Helper/harmer position
[those that know – have LE – and those that don't]

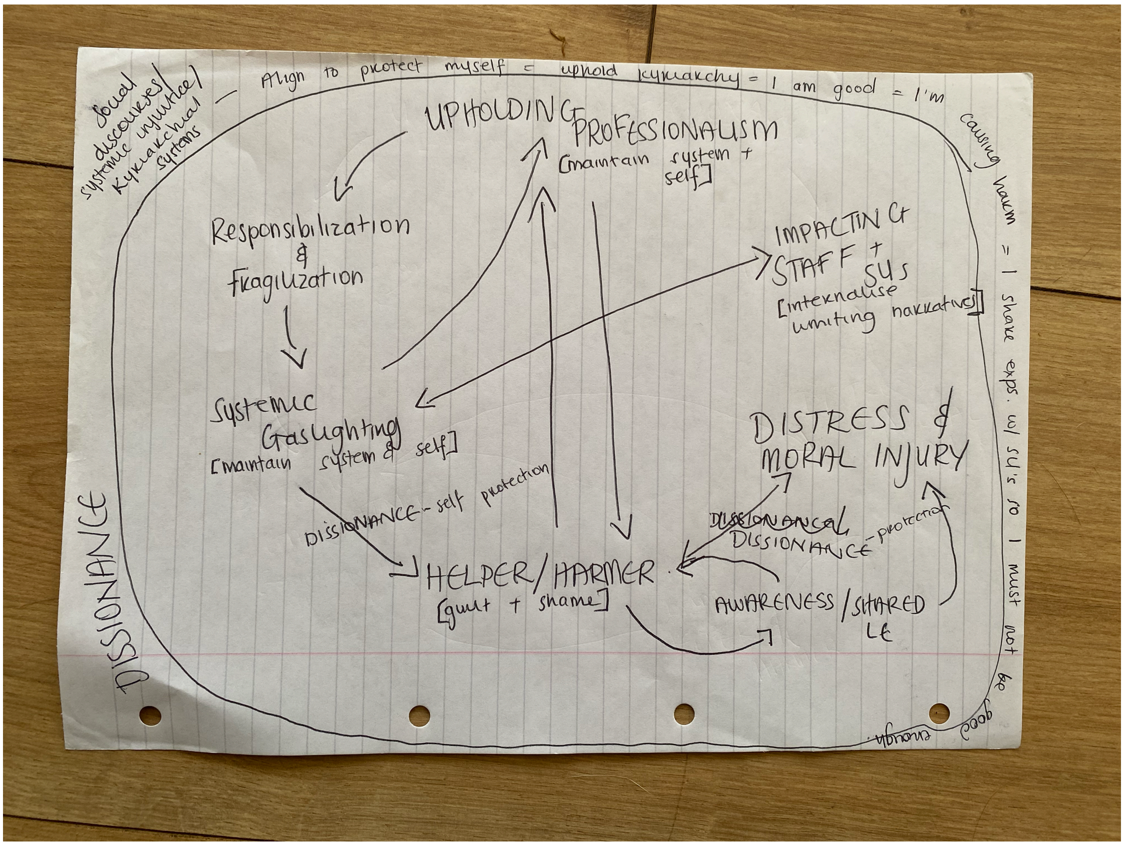
Personal experience of dissonance

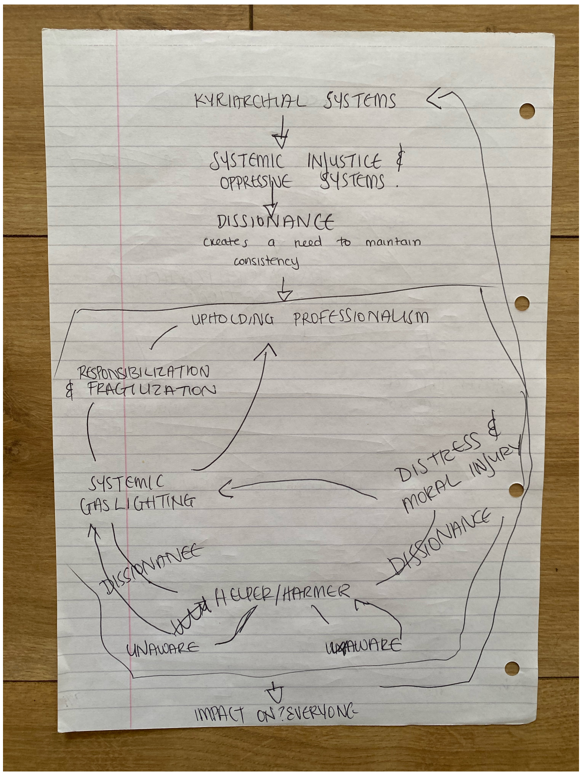
Aligning with values – small acts of resistance – can only really be a helper when we're resisting??

This version was also presented, with sticky notes added with participants too

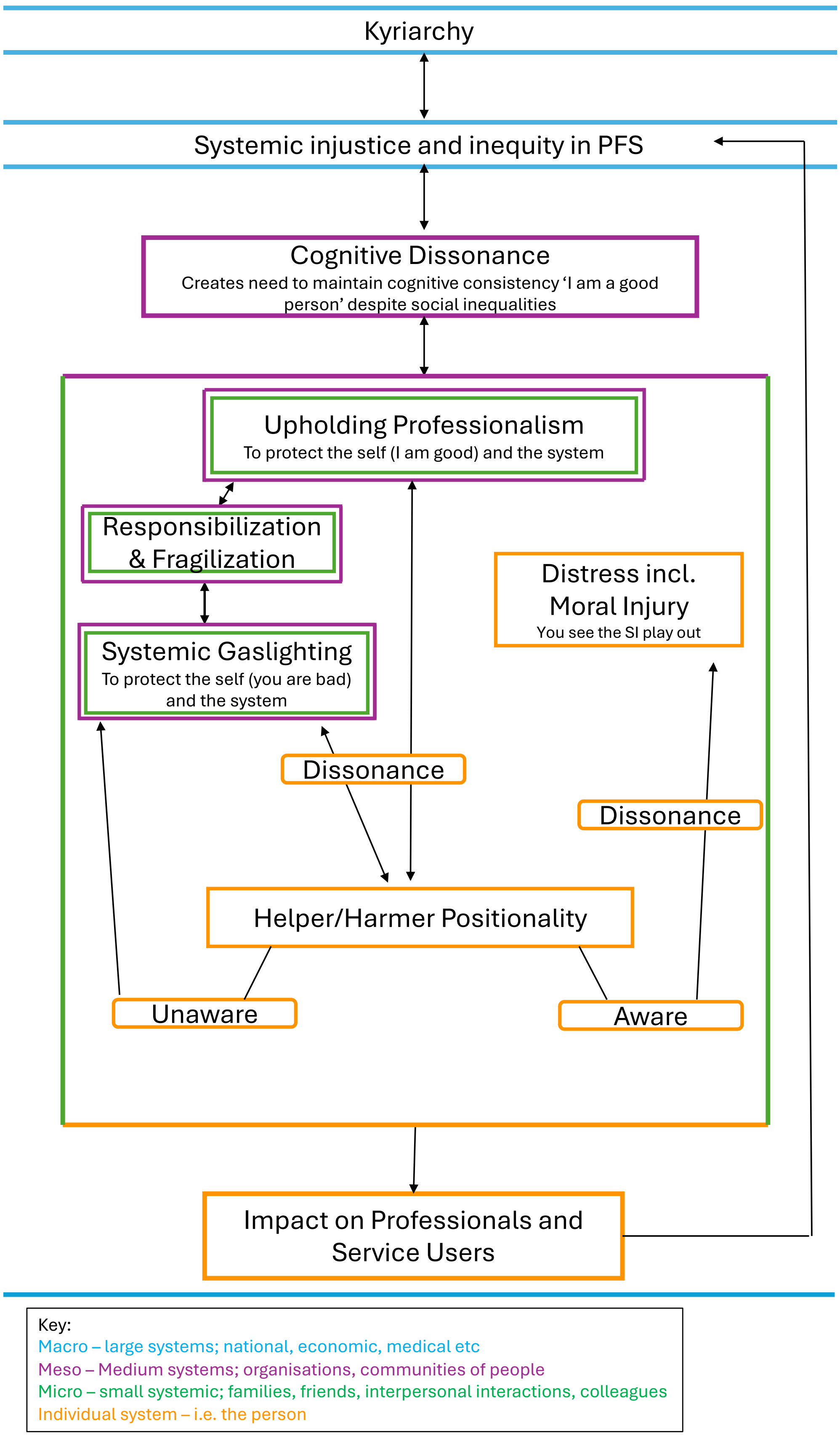


After the focus group with input from supervisors and advanced methods group:


Social discourses/ systemic injustice/ Kyriarchial systems
— Align to protect myself = uphold kyriarchy = I am good = I'm causing harm = I share exps. w/ SU's so I must not be good enough
UPHOLDING PROFESSIONALISM
[maintain system + self]
Responsibilization & Fragilization
Systemic Gaslighting
[maintain system & self]
IMPACTING STAFF + SUs
[internalise limiting narratives]
DISTRESS & MORAL INJURY
DISSIONANCE - self protection
HELPER/HARMER
[guilt + shame]
~~DISSIONANCE~~
DISSIONANCE - protection
AWARENESS/SHARED LE
DISSIONANCE


KYRIARCHIAL SYSTEMS
SYSTEMIC INJUSTICE & OPPRESSIVE SYSTEMS.
DISSIONANCE
creates a need to maintain consistency
UPHOLDING PROFESSIONALISM
RESPONSIBILIZATION & FRAGILIZATION
SYSTEMIC GASLIGHTING
DISTRESS & MORAL INJURY
DISSIONANCE
DISSIONANCE
HELPER/HARMER
UNAWARE
~~UN~~AWARE
IMPACT ON ? EVERYONE

Final model



r. Glossary – how I use these terms. They are not always set definitions.

‘The system’	Various structures that exist in our society that interconnect such as political, legal, religious, cultural etc. The systems hold power and create norms which often feeds oppression and subordination
Black (upper case)	It is capitalised as it is a politicised term used to describe shared cultural identity with denoting a history and community, rather than a skin colour.
Cognitive dissonance	When a person’s actions are in conflict or contradict with their beliefs. This causes discomfort which motivates the individual (typically) to change the behaviour or the belief or engage in other defence mechanisms e.g. avoidance.
Identity	I use identity to refer to aspects of ourselves, both seen and unseen, that shape how we make meaning in the world, and how the world makes meaning of us.
Minoritised	Instead of minority. This describes groups that have been positioned as a minority, usually through social and political processes. It also highlights that these groupings are not simply motivated by statistics, it is usually an active process of discriminatory practices.
Normativity	Social norms and the way in which they influence us to conform to certain ideals or beliefs within wider society. E.g. assumptions that parents will necessarily be the opposite, binary genders – (hetero)normative assumption.
Publicly funded services (PFS)	These are services that are funded by the government by taxpayers’ money, but is not a ministerial department (gov.uk, n.d.). Relevant to this piece of research this refers to NHS, social care, criminal justice facilities and education.
Queer	Reclaimed umbrella term used to refer to people who may hold a wide range of sexual or gender identities. More inclusive, and less exposing as it does specify what kind of ‘queer’ you are. Terms like bisexual, a-gender etc give strangers a lot of insighted into your identity without the person necessarily wanting to share that level of detail.
Social capital	Shared values and/or resources that allow communities to align towards particular goal. When coupled with power, it typically allows us to exert influence towards said goals for the benefit of the person or group holding the power.
white (lower case)	Typically referring just to skin colour.
Whiteness	A social construct or broad understanding of values, norms and ideals that are often associated with white culture and identity. Persons of colour can also enact whiteness in this way.