



**Exploring the interface between Clinical Psychology and the benefits system**

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## Acknowledgements

I would like to dedicate this thesis to my parents, who have always done all that they can to support me on my journey. I could not have done it without you.

Thank you to my dear friends and peers for standing by me and supporting me personally and professionally. My deepest gratitude to Tom, Charli and Patricia! Thank you for your kindness and understanding through the hard times, along with all of the fun and laughter.

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*In memory of Harvey- a beautiful soul and loyal companion.*

*I am deeply grateful for all that you brought to my life and you will always remain in my heart.*

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### Word Count

<b>Thesis section</b>	<b>Text (incl. tables &amp; figures)</b>	<b>References</b>	<b>Total</b>
Thesis overview	256	-	256
Systematic Review	10,235	1636	11,871
Empirical Research	7,275	1,355	8,630
Appendices	6,978	-	6,978
<b>Total</b>	<b>24,744</b>	-	-

## **Thesis overview**

Clinical Psychology is a relatively young and developing profession. As the profession continues to explore and adapt its identity, it is important to understand how clinical psychologists can effectively apply their knowledge and skillset to promote psychological wellbeing in society. This thesis acknowledges that socioeconomic pressures are impacting psychological wellbeing in society and mental health service provision. The particular point of focus for this thesis is the interaction between Clinical Psychology and the benefits system.

A systematic search of literature regarding the psychological outcomes of claiming benefits in the UK was conducted. Thematic synthesis was used to analyse the resulting ten qualitative studies (eleven papers) on this topic. This resulted in a higher-order theme labelled 'The psychological toll of self-preservation'. This contained four analytical themes: 'The strain of survival', 'Protecting one's sense of self', 'Losing one's sense of self', and 'Defeat and entrapment'. The resulting distress and threatened sense of self for people who have claimed or attempted to claim benefits are discussed, along with implications for promoting psychological wellbeing in this population.

For the empirical paper, fifteen clinical psychologists from a range of services across England were interviewed about their experiences and perceptions of the profession's role in relation to the benefits system. Thematic analysis of the interviews allowed insights into how the adverse financial and psychological outcomes related to claiming benefits can impact clinical psychologists, both personally and professionally. The paper highlights areas that are problematic for clinical psychologists working in this context, along with associated avenues for intervention and further exploration.

# **The psychological toll of self-preservation when claiming benefits in the UK.**

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Prepared for submission to Social Science and Medicine (*Appendix 1*).

## **Abstract**

### **Background**

Over the last decade, changes to the benefits system in the UK have been associated with worsening mental health and an increased prevalence of suicides. Understanding the broad range of factors that influence psychological distress in society is essential for promoting psychological wellbeing and reducing health inequalities. This systematic review sought to gain a further understanding of the psychological outcomes of claiming benefits in the UK.

### **Methods**

Four electronic databases (PsycInfo, MEDLINE, CINAHL and PubMed) were searched in February 2020 for papers that explored the psychological outcomes for people who had claimed or attempted to claim benefits in the UK. The database search was supplemented with searches of the references lists of included studies. The search returned 826 non-duplicate records from which, ten qualitative studies were included.

### **Results**

The included studies were quality assessed and analysed using thematic synthesis methodology. This highlighted four key psychological outcomes: the strain of survival; protecting one's sense of self; losing one's sense of self and defeat and entrapment.

Psychological distress resulted from adverse experiences of claiming benefits and being stigmatised by society, with social support acting as a protective factor against adverse psychological outcomes.

### **Conclusions**

The results of this review suggest that mental health policies and care provision need to attend to these broader influences on mental health. Adaptations to the benefits system will

allow the basic needs of people who claim benefits to be met and to reduce unnecessary psychological distress amongst this population, but practitioners could take due regard of the psychological pressures and options for social support in the planning and delivery of care for people who claim benefits. Further research into the relationship between claiming benefits and psychological outcomes will strengthen our understanding of this association and the interventions that are likely to be most effective.

**Key words**

Benefits, welfare, mental health, distress, self, stigma, qualitative, systematic review

## Introduction

A social gradient exists in health, with lower socioeconomic status being associated with worse physical and mental health (Marmot 2010; Wilkinson & Pickett, 2018). Marmot (2010) argued that reducing health inequalities is “a matter of fairness and social justice”. Yet health inequalities have grown since the 2008 financial crisis and the subsequent introduction of austerity policies (Nelson & Tøge, 2017; van der Wel et al., 2018). Amongst the impact on health across Europe has been an increase in the prevalence of mental health problems and suicides (Parmar et al., 2016). Similar trends have been found in UK studies, with the most significant increases in mental health problems being experienced by people who were out of work (Barr et al., 2015).

The growth in mental health inequalities in the UK has been associated with changes to the benefits system (Barr et al., 2015). This has included the introduction of Employment and Support Allowance (ESA) in October 2008, which requires participation in the Work Capability Assessment (WCA) to prove eligibility for disability or sickness-related benefits. In April 2013, Disability Living Allowance (DLA) was replaced with Personal Independence Payment (PIP), which requires the assessment of daily living and mobility issues by a healthcare professional. Universal Credit (UC) was also introduced in 2013, to replace numerous benefits non-specific to disability, including Job Seekers Allowance (JSA) and Housing Benefit. Spare room subsidy was removed (also known as *bedroom tax*) for those who were living in housing, which was considered to have one or more spare bedrooms.

The reported intentions behind welfare reforms have included a reduction in benefit expenditure, preventing fraud, and increasing ‘responsibility and self-sufficiency’ of people who claim benefits (Department for Work and Pensions, 2008; National Audit Office, 2018). This is despite evidence from the Department of Work and Pensions (DWP) suggesting that

fraud rates were only 0.5% for sickness benefits (DWP, 2012). Increased ‘conditionality’ has been introduced, including compulsory reassessments, engagement in work related activities and sanctions, whereby benefits are reduced or stopped if the requirements are not met (DWP, 2010, 2011; Dwyer, 2019).

Changes to the benefits system have been reported to cause ‘preventable harm’ and healthcare professionals have expressed concerns from their experiences with patients who claim benefits (Arie, 2018; Stewart, 2019). The anecdotal accounts from healthcare professionals have been supported by increasing empirical evidence. A large-scale longitudinal study found an increase in psychological distress among people who were eligible for UC and estimated that due to the introduction of UC, 21,760 people would have meet the diagnostic threshold for depression between April 2013-December 2018 (Wickham et al., 2020). Methods of assessing eligibility for benefits, most notably the WCA, have been associated with increased mental health problems, antidepressant prescribing and suicide (Barr et al., 2016). In addition, being deemed ‘fit for work’ following reassessments and receiving benefits sanctions have been linked to self-harm and suicide (Barnes et al., 2016).

A briefing paper from Psychologists for Social Change (previously known as Psychologists Against Austerity) indicated key avenues through which austerity measures impact psychological wellbeing (Psychologists Against Austerity, 2015). Themes included: humiliation and shame; fear and distrust; instability and insecurity; isolation and loneliness; and being trapped and powerless. For people who claim benefits, stigmatisation and experiences of shame have been exacerbated through changes in welfare policies and negative portrayals of people who claim benefits in the media (Baumberg, 2016; Patrick, 2017). Evolutionary perspectives provide an understanding of this process by highlighting the relational nature of shame and its association with feeling helpless and inferior in comparison to others (Gilbert, 1989). People may experience alterations in how they believe that others

perceive them (external shame) and/or how they think about themselves (internal shame). As humans have evolved to function most effectively in the context of social groups, shame and its associated threat of rejection can strongly impact people's emotional and behavioural responses.

In addition to the psychological consequences of claiming benefits, people claiming disability benefits due to their mental health are also more likely to be denied benefits than those claiming for physical health reasons (Pybus et al., 2019). Taken together, the literature suggests that the current benefits system may be causing psychological harm and perhaps making it less likely that people will enter employment due to worsening rather than improving wellbeing.

The growing body of literature associating the benefits system with psychological distress has implications for mental health services (Cummins, 2018). The individualistic approach to improving mental health in the UK has been criticised for neglecting to acknowledge the influence of larger systems on psychological distress (e.g. Boyle, 2011; Read & Dillon, 2013). This approach has been applied to people affected by austerity and welfare reforms, as psychological distress arising from these issues has been pathologised and responsibility has been placed on individuals to overcome their 'internal' struggles (Thomas et al., 2018). However, healthcare professionals are increasingly acknowledging the impact of socioeconomic issues and the need to attend to these (e.g. Arie, 2018; Hutton, 2020; Welch, 2019). This can be seen in the profession of Clinical Psychology, with guidelines from the British Psychological Society (BPS) and Health and Care Professions Council (HCPC) identifying that clinical psychologists should attend to issues of social context and social exclusion within their role (BPS, 2017; HCPC, 2015).

Developing a detailed understanding of why there is a high prevalence of mental health difficulties in the population who claim benefits would contribute towards an understanding of how to promote psychological wellbeing. It could provide mental health professionals with a greater understanding of this issue and support them to work more effectively in this context. It could also provide implications for developing policy and practice that attends to issues of mental health, including the implementation of the benefits system. Existing quantitative research provides large-scale evidence to suggest that claiming benefits has adverse effects on mental health. However, qualitative research generates rich data regarding emotional, cognitive and behavioural experiences, which allows this relationship to be further understood (Guba & Lincoln, 1994). It is important to attend to the voices of people who are marginalised by understanding their experiences of distress, which qualitative methodologies facilitate (Thomas et al., 2018). To our knowledge, no systematic reviews have synthesised qualitative studies that focused on the relationship between claiming benefits and mental health. Therefore, a thematic synthesis was conducted to understand the psychological outcomes associated with claiming benefits in the UK. A broad definition of ‘benefits’ was used to cover any aspect of working age benefits but the review predominantly attended to out-of-work, disability and housing benefits, as this is where the majority of the literature was focused. This systematic review explored the following question: What are the psychological experiences and outcomes of claiming (or attempting to claim) benefits in the UK?

## **Method**

### *Search strategy*

The PICo framework was used to guide the search process, which is recommended as a tool for guiding searches of papers relating to the experiences of a particular phenomenon

(Lockwood et al., 2015). The ‘Population’ was people who claim benefits, the ‘phenomena of Interest’ were psychological outcomes and the ‘Context’ was the United Kingdom (UK). Following multiple scoping searches, four electronic databases were searched in February 2020 (PsycInfo, MEDLINE, CINAHL and PubMed). Search terms were developed through discussions within the research team and in consultation with an Evidence Reviewer. Table 1. presents the search terms inputted into the databases, which were combined using the “AND” syntax. Inclusion and exclusion criteria were applied to select relevant papers. Reference lists of included papers were searched, which revealed five further papers for inclusion.

**Table 1.** Search terms.

Psychological outcomes terms	("mental health" OR "wellbeing" OR well-being OR psychol* OR psychiat* OR "mental disorder*" OR stigma* OR stress* OR sham* OR distress* OR self-esteem OR "self esteem" OR self-worth OR "self worth" OR identity OR anxiety OR depress* OR affect)
Benefits terms	("disability living allowance" OR "personal independence payment" OR "work capability assessment*" OR "universal credit" OR "employment and support allowance" OR "sickness benefit*" OR "incapacity benefit*" OR "disability benefit*" OR "social security benefit*" OR "welfare reform")

*Study selection*

The titles and abstracts of papers identified through the search were screened for relevance. Full-texts of potentially relevant papers were then reviewed. The primary researcher conducted the search and the results were verified by another member of the research team. Studies were included if they were: (a) Published in a peer-reviewed journal; (b) Qualitative studies; (c) Focused on the benefits/welfare system; (d) Focused on personal accounts of psychological outcomes, related to claiming or attempting to claim benefits; (e)

Accounts were provided by people who were claiming or had attempted to claim benefits; (f) Related to the UK benefits system only or where data regarding the UK benefits system could be identified and analysed independently from information regarding benefits systems in other countries; (g) Available in English; (h) Published since October 2008. The publication date was chosen to include papers published in the context of the economic recession of 2008 and the changes to the benefits system which followed, including the introduction of ESA and the WCA in October 2008.

### *Quality assessment*

The Critical Appraisal Skills Programme (CASP) checklist for qualitative studies was used to assess the quality of included studies (CASP, 2018; Appendix 2). The ten questions were answered for each study and scores were given to quantify the achievement of each criteria: 0= not met, 1= partially met/unclear or 2= fully met. Individual question scores were added to produce an overall quality score. The two papers that originated from the same study were quality assessed as one. A second reviewer independently quality assessed each paper and through discussion, both reviewers reached a consensus on the scores. Studies were not excluded on the basis of rigour of methods used and reported but the quality assessment informed the interpretation of the results and was reviewed in the discussion.

### *Data extraction and synthesis*

Key demographic, methodological and outcome data were extracted from each paper (Table 2). For the purposes of transparency and rigour, a well-established approach of thematic synthesis of qualitative research was followed to analyse the papers identified (Thomas & Harden, 2008). In line with the aims of the review, thematic synthesis allowed the voices of people who claim benefits to be included, as this approach incorporates participants' quotes in the analysis. The approach also allowed flexibility in synthesising

studies from various epistemological positions and methodologies. All data in the results or findings sections were analysed, including participant quotes and authors' comments.

The three key stages of analysis involved: line-by-line coding of the findings, the organisation of codes into related areas to create descriptive themes and the development of analytic themes, involving the researcher interpreting the results to generate concepts beyond those stated in the primary studies (Thomas & Harden, 2008). NVivo 12 software was used as a platform for coding and grouping the data but the analytic process was conducted by the primary researcher (NVivo, 2018). The analytic process was facilitated by consultation with another member of the research team, who provided their perspective on where themes could be refined. The final themes and corresponding data extracts were reviewed by all members of the research team before producing the final report. Reflexivity was exercised using a reflexive diary and discussions in the research team, which allowed the researchers to remain attentive to the potential influence of their pre-existing beliefs and experiences in the design, conduct and reporting of the synthesis (Walsh & Downe, 2006).

## **Results**

### *Number of studies identified and included*

The database searches identified 1363 papers. After duplicates were removed, 826 papers were screened and 47 full-text papers were reviewed for eligibility. Six papers were identified for inclusion and a further five papers were identified from reference searching. As a result, ten studies (eleven papers) were included in the review. PRISMA guidance informed the reporting of this review, including the search and study selection process (Figure 1; adapted from Moher et al., 2009).

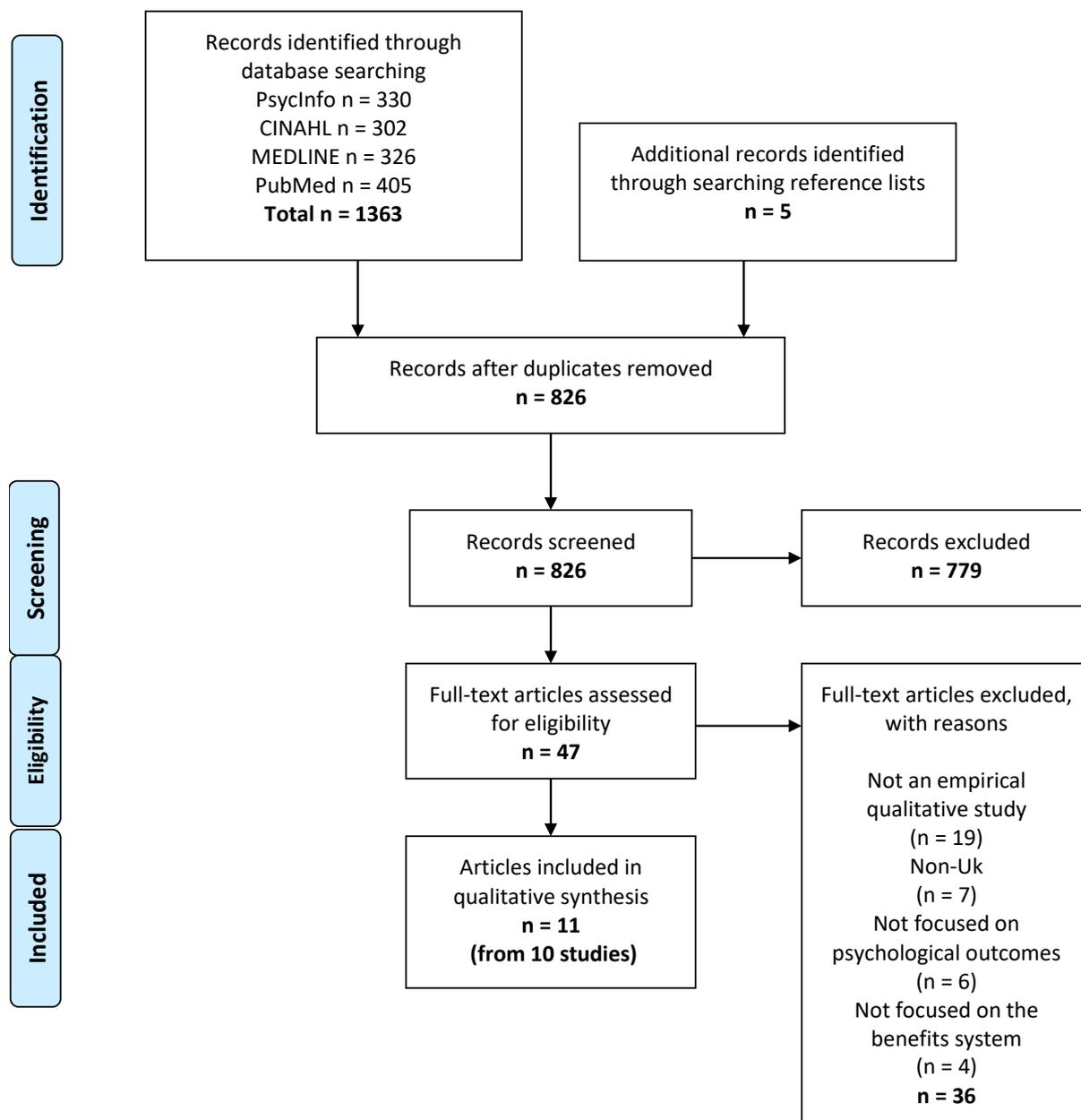
### *Outcome of quality assessment*

A scoring system was used when completing the CASP, which categorised the studies as *high-quality* (16-20), *moderate-quality* (13-15) or *low-quality* (below 13) (adapted from Butler et al., 2016). The studies ranged in quality (Appendix 3), with four studies scoring as high-quality (Cheetham et al., 2019; Garthwaite et al., 2014; Saffer et al., 2018; Secker et al., 2012), three studies scoring as moderate-quality (Moffatt et al., 2015; Wilkinson & Ortega-Alcázar, 2019a & 2019b; de Wolfe, 2012) and three studies scoring as low-quality (Clifton et al., 2013; Patrick, 2016; Shefer et al., 2016). One study scored below 10 but this was deemed to be due to the brevity of the published paper and reviewing the unpublished report revealed greater quality (Clifton et al., 2013). Thus, it should be noted that the quality scores of the published papers might underrepresent the quality of some studies.

In addition to assessing quality of each study, each CASP item was scored to understand the issues in quality across the papers (Appendix 3). Overall, the studies did not adequately demonstrate consideration of the relationship between the researcher and participants, ethical issues or evidence sufficiently rigorous data analysis. As most researchers did not reflect on their positionality and the potential influence of this on the results, this might have influenced the findings presented in the studies. Therefore, the results of this systematic review should be interpreted with consideration to these limitations. In the papers that scored as low-quality, additional quality criteria that were partially or completely unmet were: justification of qualitative methodology (Clifton et al., 2013), demonstration that the design (Clifton et al., 2013; Shefer et al., 2016), recruitment strategy (Clifton et al., 2013; Patrick, 2016; Shefer et al., 2016) and the data collection were appropriate to the aims (Clifton et al., 2013; Patrick, 2016; Shefer et al., 2016), a clear statement of the findings, including a discussion of credibility (Clifton et al., 2013; Patrick, 2016; Shefer et al., 2016) and a limited discussion of the implications and recommendations from the research (Clifton et al., 2013; Patrick, 2016).

This suggests that the low-quality papers did not adequately justify the approach that they took to the research and the findings were not presented with reference to their credibility. For ease of identification, each mention of the low-quality papers in the results section has been highlighted using an asterisk next to the reference (\*). Where findings are presented that heavily or solely rely on the results of a low-quality paper, issues of quality that might have impacted the finding are highlighted, so the reader can interpret the findings with reference to these.

The studies that contributed to each theme are stated in the main findings section, with most studies contributing to every theme. Thus, no theme has heavily relied on data from studies that scored as low-quality. Nevertheless, quality assessment was not used as a formal quantitative tool, rather to highlight areas for consideration when interpreting the results of the review.



**Figure 1.** PRISMA flow diagram

*Characteristics of included studies*

Key characteristics from each included study are presented in Table 2. All studies were UK-based. Data was collected using interviews, focus groups and/or qualitative questionnaires. A range of methods of qualitative analyses were used yet five studies did not specify the framework for analysis in the published paper. Six of the papers were primarily related to disability benefits (Clifton et al., 2013; Garthwaite, 2014; Saffer et al., 2018; Secker et al., 2012; Shefer et al., 2016; de Wolfe, 2012). One of these papers was an

evaluation of the Condition Management Programme (CMP), which was rolled out for people with physical or mental health difficulties, to support them in understanding and managing their condition in preparation for (re-)entering employment (Secker et al., 2012). Three papers (from two studies) focused on housing benefits, including bedroom tax (Moffatt et al. 2015; Wilkinson & Ortega-Alcázar, 2019a & 2019b). One paper focused on Universal Credit (Cheetham et al., 2019) and another included people who were affected by changes to claiming Income Support, Incapacity Benefit and Jobseeker's Allowance (Patrick, 2016).

**Table 2.** Main characteristics of included studies.

Author(s) Year	Method	Location / setting	Qualitative analysis	Participant demographics (age, gender & ethnicity)	Benefits/employment status	Conclusions relating to psychological outcomes
Cheetham et al. 2019	Semi- structured interviews	North East England	Thematic analysis.	33 participants (13 female & 20 male). Aged 21-63 years. Ethnicity not stated.	32 participants received UC, 3 received PIP and 1 received ESA.	Processes associated with claiming UC adversely impacted mental health and led to self-harming and suicidal ideation for some.
Clifton et al. 2013	Questionnai re and focus group	North East England	Not stated in published summary paper.	15 participants. Demographic details not provided.	Focussed on Work Capability Assessments (WCA) and Employment and Support Allowance (ESA). Bedroom tax and other issues relating to the Welfare Reform (2012) were discussed by participants.	Changes that emerged from the Welfare Reform (2012) led to negative impacts on people's psychological and emotional wellbeing.
Garthwaite. 2014	Semi- structured interviews	North East England	Grounded theory and thematic analysis.	25 participants (15 female & 10 male). Aged 32-63 years. Ethnicity not stated.	Participants were long-term IB recipients, due to various physical or mental health problems.	Claimants expressed issues of stigma and anxieties associated with claiming benefits were common (including 'fear of the brown envelope'). The anxiety experienced impacted physical and mental wellbeing and sometimes led to suicidal ideation.

Moffatt et al. 2015	Semi-structured interviews and a focus group	North East England	Grounded theory (referenced)	38 participants (25 female & 13 male). Up to 60 years old. Ethnicity not stated.	27 unemployed, 9 part-time work (1 also a student), 2 students and 1 self-employed. 20 participants received “welfare sickness payments”, 6 unemployment benefits, 2 received carer allowances and 10 received tax credits or supplementary income. Focus group demographics not provided.	Bedroom tax negatively impacted psychological wellbeing and opportunities for social support.
Patrick. 2016	Semi-structured interviews, over three time points	Leeds, England	Cross-sectional and longitudinal analysis, using NVivo. Method of analysis not explicitly stated.	15 participants (9 female & 6 male), 1 participant dropped out between the second and third interview. Other demographic details not provided.	The study included single parents affected by changes to Income Support, disabled people being moved from IB to ESA and “young jobseekers experiencing the reformed welfare conditionality regime”.	Participants experienced various forms of stigma, associated with claiming benefits. These included stigma associated with the claiming process and societal narratives. Participants responded with accepting and internalising the stigma, resisting or deflecting stigma to other benefits claimants.
Saffer et al. 2018	Semi-structured interviews	UK	Constructivist grounded theory.	15 participants (11 female & 4 male). Aged 28-68 years. Participants were from “various diverse ethnic and	Disability benefits. People claiming disability benefits for physical health problems, who had received a loss or change in these.	Participants experienced the benefits system as dehumanising and described facing judgement and discrimination in society.

				socio-economic backgrounds”.		This negatively impacted identity and psychological wellbeing.
Secker et al. 2012	12 Focus groups	UK	“A text analysis framework was used”. NVivo was used to support this.	39 participants (22 males & 17 females). 38 participants were White British and one was from another ethnic background (not specified). 31 of the participants were “in their middle years”.	The majority of participants had worked for most of their lives and claimed IB due to the development of physical and/or mental health problems in their 40s or 50s.	Participants reported improvements in psychological wellbeing from participating in the Condition Management Programme (CMP). Factors such as, practical advice, social support and achievements were helpful for this.
Shefer et al. 2016	Interviews	London, England	Thematic.	17 participants (10 female & 7 male). Aged between early 20s and those “nearing retirement age”. 10 White British, 1 Black British, 1 Black Caribbean, 2 South Asian and 1 Polish. 2 participants did not provide details of ethnicity.	Disability benefits (ESA and IB) claimed due to mental health difficulties, although some also had physical health problems. Participants’ benefits claims had initially been rejected then reinstated after appeal. Participants also discussed the removal of other benefits, such as, Disability Living Allowance, Housing Benefit and Income Support.	Being denied disability benefits caused a negative psychological impact for people who already had difficulties with their mental health. This included: stress and anxiety, anger and frustration, self-stigma and helplessness.
Wilkinson & Ortega-	Biographical interviews	England and	Thematic.	40 “young people”. Included people	Focus on the Shared Accommodation Rate of Local	A lack of safety and feeling isolated in shared

Alcázar. 2019a		Wales		from protected equalities groups (e.g. those with disabilities, LGBT people and black and minority ethnic groups).	Housing Allowance.	accommodation, which people lived in due to housing benefits, contributed to poorer mental health. People from protected equalities groups might be at particular risk of harm from sharing accommodation with strangers.
Wilkinson & Ortega-Alcázar. 2019b	As above (same study)	As above	As above	As above. Aged between 18-35. Stories of two participants are focused upon.	As above	Experiences of ‘weariness’ are discussed as a more subtle psychological outcome and way of coping in the context of housing issues (related to housing benefits).
de Wolfe. 2012	Semi-structured interviews and email responses	UK	Not specified.	23 participants (18 emails and 5 interviews). Demographic details unknown.	Disability benefits. People claiming disability benefits (IB, ESA and/or DLA) due to myalgic encephalomyelitis or chronic fatigue syndrome.	Participants struggled with the effort, anxiety and stigma associated with claiming benefits. This impacted their self-view. The issues of effort and anxiety were worse for ESA than IB.

## *Main findings*

A higher order theme was derived from the data and labelled '*The psychological toll of self-preservation*'. Within this over-arching theme were four analytical themes:

- 1) The strain of survival
- 2) Protecting one's sense of self
- 3) Losing one's sense of self
- 4) Defeat and entrapment

### **The psychological toll of self-preservation**

This overarching theme captures the adverse psychological outcomes associated with claiming benefits. These were reported in all nine non-intervention studies. The intervention study provided insights into how the CMP supported people who claim benefits with psychological difficulties (Secker et al., 2012). Although this study reported negative psychological experiences of participants, it was unclear whether these directly related to claiming benefits. Two studies reported that all participants in their studies experienced psychological distress as a result of claiming benefits (Moffatt et al., 2015; Shefer et al., 2016\*), although the latter study did not adequately describe data collection, including the consideration of sampling bias. For some participants who already experienced mental and/or physical health difficulties, the psychological toll of claiming benefits was reported to worsen these: "*The system makes us more ill*" (Clifton et al., 2013\*) and "*it's like them picking at a scab*" (Shefer et al., 2016\*). Although these are direct quotes from participants, these findings need to be considered in the context of these studies having shown limited discussion of data collection (including no discussion of sampling bias), credibility of findings and no description of the researcher's potential influence. One study highlighted that

for some participants, the difficulties associated with claiming benefits were worse than all other illness-related experiences (de Wolfe., 2012). Another study highlighted further experiences of traumatisation and exclusion of people who had already experienced marginalisation in society (Wilkinson & Ortega-Alcázar, 2019a). The adverse impacts of bedroom tax were highlighted as being “*contrary to government assertions*”, as the government’s Impact Assessment had suggested that there would be no impact on health and wellbeing (Moffatt et al., 2015).

The following themes provide further insights into the psychological outcomes of claiming benefits, including contributing factors and participants’ attempts to manage the psychological consequences.

### **The strain of survival**

This theme reflects the stress, anxiety and fear responses in relation to claiming benefits, which featured in all nine non-intervention studies. These responses are explored in relation to aspects of claiming benefits, which ultimately threaten the basic needs of people who claim benefits and their dependent others.

A key source of anxiety associated with claiming benefits was the process. The repetitive need to have contact with the benefits agency was identified as a significant issue, which was described in one paper as “*‘revolving door’ or ‘vicious cycle’ of forms, appeals, tribunals and reassessments*” (Clifton et al., 2013\*). The persistent experiences of insecurity and uncertainty resulting from stressful assessments led participants to describe being “*held in this climate of fear*” and “*living on a knife edge*” (Saffer et al., 2018). In this study, it was highlighted that hearing “*horror stories*” of other peoples’ experiences (including deaths after losing benefits) further exacerbated their fears. Another source of fear for participants was being observed in acts that deviated from the stereotype of a ‘benefits claimant’ and

subsequently being reported to the benefits agency (Cheetham et al., 2019). One paper reported that all participants sought support from an advice service in an attempt to cope with the bureaucracy involved and that the process was not suitable for assessing people with mental health difficulties (Shefer et al., 2016\*), although this finding might have been influenced by sampling bias, as consideration of such issues were not provided in this study.

The key threat associated with these processes was the inability to meet one's basic needs. As a result, participants were stuck in a cycle of worry. This would reduce if the benefits were granted but participants would soon acknowledge that the process would be ongoing and their current situation was unstable. One study reported that for some participants, the financial implications of UC delays led to threats of homelessness (Cheetham et al., 2019). Other realistic fears led to psychological distress for people affected by bedroom tax:

*Worries about potential re-location, not being able to provide healthy food for themselves or their children, living in inadequately heated homes and spiralling rent arrears contributed to mental health problems. All participants reported feelings of stress, many recounted symptoms of anxiety.* (Moffatt et al., 2015)

Some worries directly related to communication from the benefits agency. Participants feared the contents of letters from the benefits agency and sometimes avoided opening them, as the associated anxiety was too difficult to face. One paper characterised this as 'fear of the brown envelope' (Garthwaite, 2014). This study explains that the anxiety associated with the brown envelope was exacerbated by mistrust in the system and its intentions. Some participants described believing that the benefits system did not have their best interests at heart: *"I panic when any of the brown envelopes come through the door 'cos if you're capable of walking from the door to the chair they say you're capable of work,*

*that's how they look at it*". Support from professionals was seen as an asset here, despite still experiencing heightened stress and a sense of not being valued by the benefits system:

*They send a letter to say I've passed or I haven't passed, if it's passed then all well and good but if its failed... I've got a worker, a something officer I have to see at the psychiatric hospital and she does appeals and claims against decisions and she will handle my case, she's assured me that I'll be ok ultimately because my consultant will write a letter to them saying I'm unable to work as simple as that but all this rigmarole you have to go through... they don't realise how stressful it is, just waiting and waiting for a sword of Damocles hanging over you. They don't realise how it eats away at you and how people worry... they don't give a shit as far as I'm concerned. (Garthwaite, 2014)*

The anxiety and stress associated with claiming benefits had physical health implications for some: *"It has caused a great amount of stress to me...which affects... ME [chronic fatigue]... obviously stress makes the symptoms worse"* and *"I had a heart attack, through the stress of all this"* (Moffatt et al., 2015). The worries about insecure tenancies and further cuts to housing welfare compounded existing mental health difficulties for some, making it *"too much to bear"* (Wilkinson & Ortega-Alcázar, 2019a).

These issues resulted in vicious cycles, whereby mental and physical health difficulties, combined with financial constraints, impacted participants' ability to improve their wellbeing (Saffer et al., 2018). For example, participants were unable to engage in social connection. Although it was unclear whether the psychological difficulties experienced were a direct result of claiming benefits, the CMP study highlighted some key factors that were helpful for psychological wellbeing (Secker et al., 2012). These included: flexibility of the length of time in the programme, having one-to-one support from a CMP practitioner and the informality of this contact. Receiving practical advice and knowledge was associated with

feeling more in control of their difficulties. These factors may oppose some of the issues highlighted with the benefits system, giving a sense of control, certainty and support that many felt were missing in the system.

### **Protecting one's sense of self**

This theme describes participants' attempts to protect their sense of self from being adversely impacted by factors associated with claiming benefits. All ten studies included experiences relating to participants' sense of self, including issues of identity and self-worth. Within the accounts were experiences of abuse, dehumanisation, disempowerment, injustice, stigma and mistrust. Examples of these experiences are presented and the associated outcomes are described.

Some participants experienced anger as a result of dehumanisation and mistreatment. In one study, participants described being “*shoehorned*” into categories that were an incorrect fit (Clifton et al., 2013\*). There was a resistance to being treated in such ways and an anger towards financial incentives for removing benefits: “*It can't be right that the people who are assessing you are going to make financial gain out of you*”. Experiences of humiliation were described and one author suggested that participants experienced a strong reinforcement of “*not being valued as equal citizens in society*”, which created feelings of anger for some:

*... you have to take all your tablets in [to the benefits assessment]. And I take quite a lot so basically I've got a bag full of tablets and she managed to tip them all on the floor and then watched me for five minutes trying to pick them up before she bothered offering any help...These painful experiences angered the participants... (Saffer et al., 2018)*

Another participant experienced this when attending a tribunal, where she received an uncaring response to sharing her experiences of trauma:

*You are sitting there talking to them and you can see they are not listening to you. Hello, I am talking to you about something that is really intimate about me. And they are like zombies and then tick that box because they get commission or something for getting people off it so there you go, they are thinking about lining their pockets aren't they? Which makes me angry. (Shefer et al., 2016\*)*

Some participants also experienced anger in response to the rejection of claims and the implication that they were being dishonest:

*[Job Centre staff] do look down at you... last week when I went down, she went, "have you applied for any jobs?", I went "yeah, 23". And she looked at me as if to say "right okay, whatever"... basically they look at us like rubbish 'cause we are on benefits... it's like they put you in a category or something... like low-lives or something like that. It does get you mad. (Patrick, 2016\*)*

Some participants expressed direct resistance to the disrespectful and dehumanising experiences with the benefits system, *"I might be on benefits but I'm also a human being"* (Patrick, 2016\*). One participant expressed resistance but also suggested that they are powerless without professional support:

*I am not a number, I am an individual, I am a person. You feel as though when you've been dealt with that you're just another person... a number... and it's only when you've got an organisation or a mental health team on your side that they will listen to what you have to say. (Shefer et al., 2016\*)*

Some participants sought to challenge the dominant narratives about people who claim benefits, including their deservedness and highlighted that cases of fraud were the minority (Patrick, 2016\*; Shaffer et al., 2018). One participant drew comparisons with people at the opposite end of the economic scale and argued: *"I'm willing to conceive that there's an*

*awful lot of people claiming benefits that perhaps shouldn't like there's a lot of bankers claiming bonuses who shouldn't*" (Patrick, 2016\*). The above results relating to anger and resistance to how participants believed that they were perceived and treated by others should be considered in relation to issues of quality with these studies (Clifton et al., 2013\*; Patrick, 2016\*; Shefer et al., 2016\*). Some issues that might have influenced these findings were an inattention to sampling bias, a limited description of data collection, an insufficient demonstration of rigour in analysis and not providing consideration of the researcher's potential influence on the data.

Three studies attended to the process of *othering*, which can be conceptualised as a strategy to protect one's self-esteem and identity, by deflecting stigma, blame and anger towards other people who claim benefits (Garthwaite, 2014; Patrick, 2016\*; Saffer et al., 2018). Other people who claim benefits were labelled as "*scroungers*", "*fake*", "*lazy*", "*no hoppers*" and "*layabouts*" (Garthwaite, 2014). They were criticised for engaging in ordinary or enjoyable activities, such as, going on holiday or mowing the lawn. Some described observing others to assess whether they were "*genuinely disabled*" (Saffer et al., 2018). Some participants welcomed the welfare reform, as they were confident in their genuineness and believed that "*it'll separate the wheat from the chaff*" (Garthwaite, 2014). In doing so it was hoped that the stigma surrounding people who claim benefits would be reduced, as they believed that they were stigmatised due to others' fraudulence. Some participants differentiated those who they perceived to be deserving from others who had characteristics that differed from their own. This included people who claimed benefits for conditions different to their own, people who had never worked, and immigrants (Patrick, 2016\*).

Alternatively, some participants attempted to preserve or enhance their identity through political involvement and activism (Saffer et al., 2018). Some attributed issues that they encountered to policy design which is "*deliberately designed*" to reduce the number of

people claiming benefits, thus preventing the internalisation of their negative experiences. Others took the role of an ‘activist’, which perhaps served to positively enhance their existing identity. This included campaigning, supporting others with claims and participating in research. Contrary to experiences of othering, connecting with people with similar experiences “...reduced isolation, and increased access to support, allowed the sharing of experiences and enabled collective resistance”. This was also an outcome of the CMP, whereby meeting people and making friends through group sessions was associated with motivation and increased confidence (Secker et al., 2012). Shared experiences, mutual support and seeing others’ achievements facilitated this: “*You could see each other getting better and it bucked you up*”. Social support and community networks also helped participants to protect their sense of self, safety and emotional resilience (Garthwaite, 2014; Moffatt et al., 2015; Saffer et al., 2018). It appeared that although support from others could be helpful, a reliance on others could be detrimental for some. An additional factor that led to improvements in sense of self and confidence for CMP ‘customers’ was the achievement of goals, which allowed them to regain a sense of purpose and to feel more “*in control of their life and less reliant on other people*” (Secker et al., 2012).

### **Losing one’s sense of self**

This theme presents the adverse impacts on participants’ sense of self, or aspects of this, as a result of factors relating to claiming benefits. The internalisation of mistreatment by others is presented, along with issues of identity. All nine non-intervention studies reported negative consequences for participants’ view of themselves, including self-stigmatisation, shame and an impacted identity.

Some participants appeared to internalise stigma and mistrust regarding their benefits claims. Due to having to prove their right to claim benefits or being denied benefits, some

participants experienced self-doubt and questioned their entitlement: “*It makes you think, ‘Am I lying?’*” and “*I began to wonder if I was a fraud myself*” (Clifton et al., 2013\*; Garthwaite, 2014; de Wolfe, 2012). Others judged themselves for claiming benefits: “*I should be able to cope by myself, I should be able to do something to enable me to earn enough money but I can’t*” (Patrick, 2016\*). The repetitive nature of the claiming process, in which the participant had to ‘prove’ her entitlement, served as a reminder that she was not being able to meet her family values of being financially independent. This resulted in a loss of confidence and her self-image shifting from a being a “*good girl*” (when employed) to “*sponging of society*”. Self-stigma was sometimes expressed using derogatory language from public narratives and media representations of people who claim benefits (Saffer et al., 2018). Participants described themselves as “*scrounging*”, feeling “*like a bum*” and “*useless*”, which led to feelings of “*worthlessness*”. One participant described feeling “*ashamed*” and “*embarrassed*” when comparing himself to others and as a result of not being able to socialise due to financial restrictions.

Some participants who claimed housing benefits were forced to live in shared accommodation and described their home as a shameful place due to poor housing conditions and their guests having to interact with strangers who shared their home (Wilkinson & Ortega-Alcázar, 2019a). One participant in this study described herself as “*useless*” and that she “*ought to be doing more*”. This was characterised as her internalising narratives regarding the need to be ‘productive’ and blaming herself “*for wider structural failures (such as lack of employment opportunities and affordable housing)*”. In addition, some explicitly named and accepted negative public narratives: “*I think a lot of people who work do resent people who are on benefits ‘cause it’s like they’re getting a chunk out of their wage... getting put into the system for the benefits... I’d probably feel the same*” (Saffer et al., 2018).

Additionally, in having to meet the requirements of the benefits system and prove their eligibility for disability benefits, participants were required to focus on their limitations (Clifton et al., 2013\*; Saffer et al., 2018; de Wolfe, 2012). Focusing on their ‘divergence from the norm’ impacted participants’ identity and mood. Another key impact on identity related to social roles of participants (Cheetham et al., 2019; Moffatt et al., 2015; Saffer et al., 2018). Due to financial restrictions and the concern of being a burden to others, participants were less able to fulfil social roles, which were protective to their identity and psychological wellbeing. Participants described a “*great sadness*” in not being able to fulfil these roles: “*It has a huge impact. You cannot do things. It’s so frustrating. I want to cry sometimes, because, like my grandkids, you know, I cannot give them what I want*” (Cheetham et al., 2019).

One strategy to cope with the stigma that they felt for claiming benefits was concealing their status: “*...she still tells family and friends that she has been signed off sick rather than admitting to being unemployed, a status she finds demeaning*” (de Wolfe, 2012). Some chose this strategy as an attempt to manage layers of stigma associated with being a ‘benefits claimant’ and having been given other stigmatised labels (Patrick, 2016\*): “*I don’t tell anyone I’m on benefits, apart from me close mates and stuff... Well I don’t tell them about me illness ‘cause everyone reacts wrongly when they hear schizophrenia... people do judge, if you’re on benefits and stuff*”.

Others attempted to escape issues of stigma and identity by avoiding or under-claiming benefits: “*I felt ashamed because I’d done three jobs... why should I go begging... and that’s the way I felt and I only went the once and I never gan [went] again...*” (Moffatt et al., 2015). One participant described under-claiming benefits due to the language of benefits, which increased her sense of stigma: “*Disability Living Allowance I’ve never applied for it ‘cos I don’t want to put my hand up and say ‘I’m disabled’*” (Patrick, 2016\*). Indeed, some

participants expressed a desire to work to escape the stigma and when their claiming status changed, some expressed relief at regaining a more 'acceptable' and less marginalised social identity:

*Catherine, who, despite no problems with her claim, had found her years on IB [Incapacity Benefit] a source of profound stigma she says she can neither properly explain nor express, felt the easing of a huge burden as she had gone from being a 'scrounger' to a 'respectable pensioner'. Eileen, 'absolutely delighted' at ceasing to be a claimant, feels that, now being in receipt of a universal benefit, she has joined a 'mainstream minority' of retired people. (de Wolfe, 2012)*

### **Defeat and entrapment**

This theme captures how adverse experiences relating to claiming benefits led to low mood, depression, hopelessness and/or suicidality for some participants, which was reported in eight studies (Cheetham et al., 2019; Garthwaite, 2014; Moffatt et al., 2015; Patrick, 2016\*; Saffer, 2018; Shefer et al., 2016\*; Wilkinson & Ortega-Alcázar, 2019a & 2019b; de Wolfe, 2012). Perceived maltreatment by the benefits system and feeling mistrusted were contributing factors: *"I really was at the lowest ebb that I've ever been in my life I think... Universal Credit was the straw that broke the camel's back. It really did sort of drag me really, really to a low position"* (Cheetham et al., 2019). The fear of benefits removal was so threatening that some participants would not challenge maltreatment in the benefits system, creating a further sense of powerlessness and a perceived inability to protect themselves from experiences of dehumanisation and abuse (Saffer et al., 2018). For some participants, the impact on their sense of self contributed to low mood and depression:

*I've been poorly through depression every time I've been on benefits. Because my mum and dad have worked hard all their lives to be where they are and so that's the impression I get, that you need to work hard and earn your money. (Patrick, 2016\*)*

The sense of hopelessness, powerlessness and fear of the consequences of losing benefits led some participants to consider or attempt suicide (Cheetham et al., 2019; Garthwaite, 2014; Saffer et al., 2018; Shefer et al., 2016\*; Wilkinson & Ortega-Alcázar, 2019b). However, some described social support as a facilitator of hope and a protective factor against suicide (Secker et al., 2012; Garthwaite, 2014). One paper reframed the experience of 'weariness' as an act of resistance, where efforts to repeatedly oppose the difficulties related to claiming benefits are replaced with 'getting by' (Wilkinson & Ortega-Alcázar, 2019b). For some, this might be a necessary alternative to strategies that are not effective with the limited power and resources that they possess:

*Beth's story highlights the importance of what we term "the right to be weary," a perhaps somewhat paradoxical claim of not having to live our lives in constant oppositional struggle, of not always having to resist and fight back. But rather than see weariness as simply a closing down, it could instead be thought of as a form of action, a redirection of energy. (Wilkinson & Ortega-Alcázar, 2019b)*

## **Discussion**

This systematic review synthesised findings from ten studies to explore psychological outcomes related to claiming benefits in the UK. The qualitative methodology of the studies included in this review allowed a more nuanced exploration of these outcomes, compared to quantitative studies that had found more general trends of increased psychological distress in people who claim benefits (Barr et al., 2016; Wickham et al., 2020). Overall, experiences related to claiming benefits had adverse psychological outcomes for participants. These

included enduring experiences of anxiety, anger and low mood. For some participants, ongoing adverse benefits-related experiences and the associated distress resulted in hopelessness and suicidality. The review highlighted that issues relating to participants' sense of self were pertinent, with some participants resisting adverse impacts on their sense of self and others internalising stigma and mistreatment. Mental health difficulties and marginalisation were exacerbated for people who already experienced these for reasons separate from claiming benefits. Participants attempted to cope with these experiences using various strategies and resources; social support in particular was found to be a key protective factor.

Participants experienced heightened anxiety and stress in response to threats of losing their benefits. The claiming process was key to this association, as participants felt a significant lack of control regarding repeated eligibility assessments and in awaiting the outcomes. This resulted in enduring experiences of worry and anxiety. This is consistent with previous literature, which has established the strong influence of uncontrollability and unpredictability in experiencing psychological distress (Marmot, 2004; Mineka & Kelly, 1989). In social cognitive theory, Bandura's (1986) concept of self-efficacy highlights the importance of perceived control over threatening events as key to regulating anxiety. This theory can support us to understand why some people experience heightened anxiety in response to threatening situations and others do not. As participants experienced a lack of control in the claiming process, this might explain why heightened anxiety and stress were prevalent in all nine non-intervention studies in this review. Indeed, two of the studies reported that having support, certainty and control were associated with reduced distress (Garthwaite, 2014; Secker et al., 2012).

Given the increasing difficulties in being deemed eligible for benefits following changes to the benefits system, participants' worries about losing their benefits and the

consequences of this were realistic. Thus, caution should be exercised in the approach to anxiety associated with claiming benefits. These realistic threats to survival must not be pathologised or approached as a product of an individual's internal problems (Thomas et al., 2018). People who are already in mental health services and receiving support for psychological distress might be more at risk of these realistic fears being internalised and invalidated by suggestions of these being a consequence of pre-existing psychological difficulties.

In line with quantitative research, this review found that the threats associated with claiming benefits related not only to losing benefits but experiences that threatened participants' sense of self (Baumberg, 2016). Participants described experiences of dehumanisation, mistrust and stigmatisation. These experiences reinforced messages that people who claim benefits have less inherent value in comparison to others in society and evoked feelings of shame. This was consistent with existing literature, which identified shame as a prevalent experience amongst people living in poverty, including those claiming benefits (Baumberg, 2016; Walker et al., 2013). Shame is recognised as a social emotion, which reflects a perceived deviation from societal norms, and it is suggested to underlie a range of emotional reactions including depression and anxiety (Gilbert, 2000).

This review highlighted a variety of emotional, cognitive and behavioural responses that people who claim benefits might experience when faced with threats to their sense of self. The two key trends found in this review were resistance and internalisation of threats to their sense of self. Some participants expressed anger at the perceived injustices relating to claiming benefits and re-affirmed their personal value. Other strategies were arguing against negative public narratives or projecting blame and anger towards other people who claim benefits, as an attempt to protect their sense of self ('othering'). Often through solidarity with others, some described experiences in line with 'post-traumatic growth', whereby they

experienced personal growth through the adversity associated with claiming benefits (Joseph, 2012).

Public narratives towards people who claim benefits, which have been identified in previous literature, appeared to have been internalised and expressed by some participants in this review. They expressed doubts regarding their right to claim benefits, questioned their self-worth and used derogatory language to describe themselves. They identified themselves as different to others and to the person who they believed they should be. Gilbert (2017) describes an evolutionary perspective, which highlights the role of social ranking in the experiences of psychological distress and how people attempt to manage this. Unlike those who were able to express their anger and find empowerment in social support and collective action, some perceived themselves as being of lower 'social rank' than others. They perhaps felt unable to challenge dominant powers and submitted to these, experiencing ongoing anxiety and low mood. Due to it being challenging or risky to express anger up the 'social rank', this might explain why some participants internalised these thoughts and feelings (self-stigmatisation and shame).

Stigma contributed towards the psychological distress already experienced as a result of the benefits claiming process, which was consistent with the description of stigma as a 'second illness' in the mental health literature (Finzen, 1996). A vicious cycle was created for some, as the shame associated with claiming benefits led to avoidance of others, which further impacted opportunities to feel connected, supported and to maintain their social identity. Understanding the reasons behind differing responses between participants and whether intrapersonal variability in responses existed was not possible in this review and could be better understood by future research focused on this area. Nevertheless, this review suggests that the stigmatisation and mistreatment of people who claim benefits should be a key area for intervention due to its association with psychological distress. Specific

recommendations for intervention in this area are beyond the scope of this review but broad avenues for intervention, such as, the portrayal of people who claim benefits in the media and welfare policies are likely to be crucial.

Eventually, repeated experiences of powerlessness, threats to their sense of self and reduced personal resources led some participants to experience low mood, hopelessness and/or suicidality. These experiences were summarised as ‘defeat and entrapment’. Suicide research has suggested that appraisals of situations being defeating and entrapping lead to an increase in suicidality (Johnson et al., 2010). Self-appraisals (relating to social support, emotion coping and situation coping) were found to moderate the relationship between adverse experiences and suicidality, with positive self-appraisals being protective. This might help to explain the issues of suicidality in people who claim benefits found in this review and previous research (Barnes et al., 2016; Barr et al., 2016). In this review, experiences of being mistreated by others, being denied benefits and being stigmatised contributed towards experiences of defeat in participants. Participants also described feeling trapped in cycles of assessments and for many there was no alternative to meet their basic needs. For some participants, self-appraisals might have become more negative through the process of claiming benefits, as some described a more negative sense of self, less agency and lessening social resources.

Further research is needed to provide stronger evidence for the pathways through which claiming benefits is associated with suicide. However, the existing research suggests that changes to the benefits system and the treatment of people who claim benefits will be necessary as part of addressing the public health crisis of suicide. A facilitator of effective change would be to involve people who claim benefits in making changes to the benefits systems, for example, consulting them as experts by experience and actively seeking and responding to feedback. Listening to people’s experiences and allowing meaningful

collaboration in service design and delivery would support people who claim benefits to feel more empowered, valued and allow the system to become more effective in meeting their needs.

### *Clinical implications*

This review highlights that health inequalities relating to psychological distress are experienced by people who claim benefits. Thus, it is vital for practitioners to attend to this in services that support people who are experiencing psychological distress, including mental health services. This will allow practitioners to assess the impact of such difficulties and avenues for support. It is important that these threatening experiences are not pathologised, as practitioners could unintentionally blame and invalidate their clients' experiences, for example, in classifying the fear of the brown envelope as an 'anxiety disorder'. Approaches that seek to understand and validate individuals' experiences would facilitate this. An example of this is the Power Threat Meaning (PTM) framework, which could serve as a useful tool for practitioners and people who claim benefits, in understanding how adverse experiences (or operations of power) can lead to psychological distress and 'survival strategies' (Johnstone et al., 2018). Examples of the four components of the PTM framework, relating to the experiences of participants in this review are presented in Table 3 (adapted from Johnstone et al., 2018). Being mindful of issues of power in the helping relationship would be important to prevent potential reinforcement of powerlessness.

**Table 3.** A conceptualisation of the review findings using the PTM framework.

<b>Power</b> <i>What has happened to you?</i>	<b>Threat</b> <i>How did it affect you?</i>	<b>Meaning</b> <i>What sense did you make of it?</i>	<b>Threat response</b> <i>What did you have to do to survive?</i>
<b>Economic/material</b> (not having the financial resources to meet basic needs)	<b>Relational</b> (humiliation, rejection, entrapment, invalidation and lack of control)	Powerless	Anxiety
<b>Interpersonal</b> (mistreatment by others and denial of benefits)	<b>Social/community</b> (isolation, exclusion, hostility, injustice and social defeat)	Hopeless	Worry
		Unworthy	Anger
<b>Coercive</b> (surveillance)	<b>Economic/material</b> (inability to meet one's basic needs)	Trapped	Avoidance
		Inferior	Distrust of others
<b>Ideological</b> (stigmatisation)	<b>Environmental</b> (lack of safety or control in the home)	Responsible	Self-blame
		Injustice	Altered sense of self
			Avoidance of others
			Seeking support from others
	<b>Identity</b> (devalued, stigmatisation and loss of identity/roles)		Loss of hope
	<b>Threats to values</b>		Suicidality
	<b>Feeling emotionally overwhelmed</b>		

Input from practitioners was a key source of support and resilience for participants. Providing support in line with the facilitators and barriers to psychological distress highlighted in this review might be protective for clients' wellbeing. This might include supporting clients in engaging with social networks and activities that will support them towards achieving a positive sense of self and gaining a sense of agency in their lives. Such changes might help to reduce perceptions of low self-worth, defeat and entrapment, while acknowledging the reality of clients' experiences in relation to the benefits system. Attending

to issues of suicidality through risk assessment and management might be particularly pertinent in this client group.

As a range of levels of influence impacted participants, practitioners could play an important role in highlighting these issues and contributing towards higher-level change (Bronfenbrenner, 1979). Providing consultation and training to benefits system staff could be one avenue for intervention. This review highlighted issues relating to processes and conduct in the benefits system and that it is important for systems that intend to support people not to exacerbate distress and marginalisation. Trauma-informed approaches (or psychologically informed environments) can be implemented to prevent such consequences, by supporting systems to attend to the psychological needs of both service users and staff (Johnson & Haigh, 2010; Sweeney et al., 2016). Key elements to this approach are: safety, empowerment, choice, collaboration and trust. In line with the findings of this review, such approaches view relationships as fundamental to effective practice and healing for people who have experienced adversity. Collaboration between services can form a fundamental part of such approaches and can support a holistic approach to clients' needs. Some clinical psychologists currently work in such ways, for example, implementing psychologically informed environments in homeless hostels. However, there remains a need to acknowledge the value of such approaches in mental health policy and funding. Much of the recent funding to promote psychological wellbeing has focused on individual-level approaches, for example, the Improving Access to Psychological Therapies (IAPT) initiative (Clark, 2011). Piloting and evaluating broader approaches to psychological wellbeing would be helpful in evidencing the need for these methods of promoting psychological wellbeing. In addition to arguments of social justice and improved psychological wellbeing in society, a more effective benefits system would increase the likelihood of people returning to work (where possible), as this review suggests that the current system is making this less likely for many.

Lastly, practitioners can exercise collective power in raising awareness and advocating for change at higher levels, such as, media portrayals of people who claim benefits and political agendas and policies that are adversely impacting them. The greatest power lies in the higher-level systems and it has been suggested that more substantial change will occur with intervention at this level (Smail, 1993). There is some evidence of professions taking a stance with these issues (Arie, 2018; BPS, 2016). However, it remains unclear where professions stand on their perceived role with the benefits system, which further research could help to understand.

### *Limitations*

The quality assessment highlighted variability in the quality of papers included. Overall, there was very limited discussion of the researchers' own influence and how this was managed. This highlights a potential issue of rigour in the studies, as researchers might have influenced the findings due to an unacknowledged positionality. This threat to quality was exacerbated due to limited descriptions and justification of analysis across many of the studies. The results of the three low-quality studies (Clifton et al., 2013\*; Patrick, 2016\*; Shefer et al., 2016\*) should be interpreted in the context of further issues of quality, such as, a limited description of how the data was collected and a limited discussion of the credibility of their findings. Studies that were not published in a peer-reviewed journal were excluded from the review, which was hoped to enhance the quality of the review but this might have meant the exclusion of additional relevant data. Considering the highlighted issues of quality, the results of this review cannot be assumed to capture the full range of experiences of people who claim benefits. The assessment of quality in this review highlights the need for more high quality studies in this area. Although the inclusion of authors' comments was suggested by the method of thematic synthesis used, it is important to note that analysing this data

involved interpreting information that was already another researcher's interpretation and distanced somewhat from the voices of people affected by the benefits system.

Although this review was able to capture nuances that built upon the results of quantitative research, it was unable to examine some important factors in depth. Different benefits were considered together, which provided an overall understanding of the experiences of people who claim benefits. However, most studies in this review focused on disability benefits, meaning other benefits were underrepresented. Together with the qualitative methodology, this posed limits on the ability to draw conclusions about the impact of specific benefits and changes that could be applied to these.

The thematic synthesis allowed the identification of themes, which highlighted potential mechanisms through which claiming benefits can increase the likelihood of adverse psychological outcomes. However, due to a limited number of studies and depth of data, it was not possible to draw firm conclusions about specific mechanisms. Future research could explore issues relating to why some people who claim benefits responded differently to threats to their sense of self and why some experienced suicidality. This could also help to build a greater understanding of the relationship between the themes found in this review and to develop a model of how issues related to claiming benefits impact psychological distress.

### *Conclusions*

This thematic synthesis provides an understanding of the adverse psychological outcomes that can be experienced when claiming benefits in the UK. These included emotional distress, a threatened sense of self and suicidality. Social factors had a key influence on outcomes, with positive relationships reducing psychological distress. The adverse impact on participants' mental health has implications for the provision of mental health and benefits services. Higher level changes are likely to be necessary to facilitate such

interventions, as well as addressing the harmful issue of stigma. Future large-scale research, exploring the factors that associate claiming benefits with psychological distress, could provide a further contribution towards understanding the mechanisms through which adverse psychological outcomes arise and where interventions can be most helpfully implemented. Evaluating the effectiveness of interventions to promote psychological wellbeing in people who claim benefits will be important in considering how best to support this population.

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**Clinical psychologists' experiences and identity in the context of the benefits system.**

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## **Abstract**

### Objectives

This study aimed to explore the interaction between the benefits system and the work of clinical psychologists. The perceived impact of the benefits system on the practice of clinical psychologists and their perspectives on how clinical psychologists can work effectively in this context were explored.

### Design

The qualitative design facilitated an in-depth understanding of clinical psychologists' experiences and perspectives. Data was collected through individual semi-structured interviews and thematic analysis was used to identify patterns in the data.

### Methods

Clinical psychologists who worked in a variety of NHS services across England were recruited. Fifteen clinical psychologists participated in face-to-face or Skype video interviews.

### Results

Four themes were identified from thematic analysis of the data: (1) *Salt in the wound*: an additional burden for clients and clinical psychologists, (2) *Trapped in a sick role*: therapeutic work at a standstill, (3) *A constant set of ethical dilemmas*: conflicting demands in meeting clients' needs, and (4) *What am I doing here?*: questioning one's role and profession.

### Conclusions

Adverse effects on clients' and clinical psychologists' psychological wellbeing were reported. Clinical psychologists were faced with dilemmas of how best to practice in this

context and felt uncertain of their role. They wanted more support and guidance to help them in understanding their role and how they could effectively support clients affected by the benefits system. Most participants interacted with the benefits system on an individual-level but believed that clinical psychologists should influence higher-level change, with adequate support and a collective stance.

**Key words**

Benefits, welfare, Clinical Psychology, psychologists, identity, mental health, qualitative

## **Introduction**

A strong association between socioeconomic status and health outcomes has been evidenced, including the relationship between lower socioeconomic status and poorer psychological wellbeing (e.g. Marmot 2010; Wilkinson & Pickett, 2018). Amongst the socioeconomic issues that have impacted on the mental health of the nation, were controversial changes to the benefits system following the 2008 financial crisis in the UK. This included the introduction of Employment and Support Allowance (ESA) and the Work Capability Assessment (WCA), which was introduced to assess ESA eligibility for people unable to work due to physical or mental health difficulties. Following the Welfare Reform Act (2012), Universal Credit (UC) began to replace six existing benefits, including Jobseeker's Allowance (JSA) and housing benefits, and Personal Independence Payment (PIP) replaced Disability Living Allowance (DLA).

The changes were influenced by an agenda to reduce benefits 'dependency' and increase individual responsibility for self-sufficiency, which have been argued to make it more difficult for people to access benefits (Department for Work and Pensions, 2008; National Audit Office, 2018). People who are claiming benefits are required to comply with processes that have been described as punitive and demeaning, including attending repeated assessments and receiving benefits sanctions (Disability Benefits Consortium, 2017).

Health professionals and researchers have provided evidence that has associated changes to the benefits system with worsening mental health in the UK, including an increased prevalence of depression and suicide (Arie, 2018; Barr et al., 2016; Wickham et al., 2020). Qualitative studies have explored this association in more depth, highlighting that threats to benefits claims can provoke enduring experiences of anxiety, low mood and hopelessness (Cheetham et al., 2019; Clifton et al., 2013; Garthwaite, 2014; Moffatt et al.,

2015; Saffer et al., 2018; Shefer et al., 2016; de Wolfe, 2012). The impact on their sense of self is also evident, as the stigmatisation and mistreatment of people who claim benefits provoke feelings of shame and perceptions of low self-worth (Baumberg, 2016; Patrick, 2016). Some people who claim benefits experience suicidality when feeling defeated and powerless to escape their circumstances (Cheetham et al., 2019; Garthwaite, 2014; Saffer et al., 2018; Shefer et al., 2016; Wilkinson & Ortega-Alcázar, 2019). There is also evidence to suggest that people with mental health problems are discriminated against within benefits assessments, as they are less likely to be deemed eligible for disability and sickness benefits than those claiming for physical health reasons (Pybus et al., 2019). This evidence suggests that issues relating to the benefits system are pertinent to psychological distress and should be attended to in policy and practice intending to promote psychological wellbeing and reduce health inequalities.

Indeed, attending to social inequalities has been identified as a fundamental part of a psychologist's role (British Psychological Society, 2017). The British Psychological Society's (BPS) *Practice Guidelines* suggests that psychologists should promote social inclusion through addressing "wider structural issues in society which maintain excluding processes and power differentials". They are encouraged to acknowledge and promote social inclusion at various levels of influence, from individual client work to engaging with the media and influencing policy. Similarly, the Health and Care Professions Council's (HCPC) *Standards of Proficiency* state that clinical psychologists should attend to social context in assessment and formulation, and understand social approaches, such as community and critical perspectives (HCPC, 2015). These perspectives challenge the notion that it is possible to understand and support people without attending to their context and highlight issues with individualising distress (Kagan et al., 2011; Nelson & Prilleltensky, 2010; Read & Dillon, 2013; Thomas et al., 2018).

Yet, it is unclear how the data and professional guidance are translating into practice for clinical psychologists working in the National Health Service (NHS). Clinical psychologists have critiqued their profession for limited involvement in socioeconomic and political issues and offered suggestions of how they can influence these areas (Hutton, 2020; McClelland, 2014; Rahim & Cooke, 2020; Randall, 2020). However, professionals in the current climate of the NHS are facing a range of their own personal, professional and systemic burdens. These burdens might be impacting clinical psychologists and their ability to work with issues relating to the benefits system.

Austerity in the UK has meant that clinical psychologists have faced increased demands and threats in their roles (Cummins, 2018; Higson et al., 2016; Longwill, 2015). Clinical psychologists have reported increased workloads while receiving the same pay, increased pressures resulting from a shortage of clinical psychologists, increasing waiting lists and having to adhere to targets (Longwill, 2015). They also reported ongoing job insecurity due to service reviews, down banding and uncertainty about the future of the profession in the NHS. These issues have led some clinical psychologists to feel burnt out, stressed and demoralised. For some, this has resulted in feeling forced out of practicing in the NHS. In addition, practitioners working in more disadvantaged areas (with a higher proportion of people claiming benefits) are likely to be experiencing the greatest stress and pressures in their roles (Hoggett, 2006; Marmot, 2010).

Personal factors relating to the individual practitioner might also play a role, as emotional (anxiety, anger and guilt) and relational (wanting to be seen positively by colleagues) barriers to therapists approaching issues of social justice have been identified (Bemak & Chung, 2008). Understandably, services and practitioners can develop systems or defences to manage their anxieties in the face of the highlighted threats (Menzies Lyth, 1988). This includes the rigid adherence to procedures at the cost of being client-centred or

creative, and the possibility of change. An example of this could be a narrow focus and devotion to individualistic therapeutic models and therapies (Ivey & Collins, 2003).

The literature reviewed highlights an ongoing debate but a paucity in evidence regarding the interface between Clinical Psychology and the benefits system. Therefore, this study aimed to explore the perceived impact of the benefits system on the work of clinical psychologists, including the impact on clients and professionals, and perceptions of their role in relation to the benefits system. Due to the lack of research in this area, a qualitative design using thematic analysis was employed to allow an in-depth exploration of clinical psychologists' experiences and perspectives.

## **Method**

### *Participants*

Purposive sampling was used to recruit HCPC registered clinical psychologists who were working in the NHS with people aged 16 and over. The inclusion criteria were intentionally broad, as the study sought to recruit clinical psychologists from a variety of services and a diverse range of client populations. All clinical psychologists who initially volunteered and met the inclusion criteria were recruited. As recruitment progressed, clinical psychologists who worked in areas of limited representation in the sample were prioritised for recruitment. The concept of 'theoretical sufficiency' guided recruitment, with the depth of data collected by the end of recruitment being sufficient to form meaningful themes (Dey, 1999). Fifteen clinical psychologists from a diverse range of NHS services across England took part in the study. One participant declined to provide personal demographic details. Of the fourteen participants who provided demographic details, twelve were female and two were male. Fourteen participants identified as White British and their ages ranged from 29-50 years old. Table 1. provides details of participants' service, location, number of years

qualified and whether they had personal experience with the benefits system (either themselves or somebody close to them).

**Table 1.** Participant information.

Pseudonym	Current area of work	Location in England	Approximate number of years qualified	Person experience with the benefits system?
Laura	Neuropsychology (outpatient)	East	1.5	No
Claire	Learning disability (community)	South-East	2.5	No
Lucy	Adult secondary care	South-West	3	Yes
Zara	Stroke rehabilitation (community)	North-West	16	No
Anna	Weight management	North-West	5	No
David	Adult secondary care	North-West	2.5	Yes
Alice	Child and Adolescent Mental Health Service (CAMHS)	East	2	No
Andrea	Renal service	East Midlands	12	Yes
Sophie	Pain management	North-West	7	No
Jenny	Acute adult inpatient	North-West	11	Yes
Stephanie	Learning disability (inpatient)	North-West	10	No
Jo	Adult inpatient	North-West	9	No
Jasmine	Early intervention (2 months) Adult secondary care (2 years prior)	South-East	2	Yes
Chris	Adult services	North-West	20+	Yes
Tom	Neuropsychology (inpatient and outpatient)	North-West	4	Yes

### *Procedure*

Ethical approval was granted by the University of Liverpool's research ethics committee (Appendix 5). Members of an 'experts by experience' group at the University of Liverpool were consulted in the initial stages of refining the focus of the study and in design of the interview topic guide to ensure that the areas covered in the study were meaningful to service users, as well as clinical psychologists. The study was advertised through social

media, third-sector organisations and university email groups (Appendix 6). Participants were provided with an information sheet and had the opportunity to ask questions before agreeing to take part in the study (Appendix 7). This was revisited at the start of interviews and participants gave written informed consent or audio recorded consent for Skype interviews (Appendix 8). Participants also completed a demographic details sheet (Appendix 9).

### *Data collection*

Interviews were conducted between March and December 2019. Individual interviews were deemed to be more suitable in facilitating the open expression of experiences and perspectives, as interviews focused on participants' professional practice. Semi-structured interviews were conducted with the use of a topic guide to allow experiences relating to the study aims to be explored with some flexibility (Appendix 10). The topic guide covered areas such as: the impact of the benefits system on participants' practice, how working in this context fitted with their values, how they interacted with the benefits system in their work, their perspectives on the role of Clinical Psychology with the benefits system and the associated barriers and facilitators.

Interviews were held in a private room and lasted between 37 and 90 minutes. Nine face-to-face interviews were conducted in the North-West of England and six interviews were conducted via Skype video call with participants across various regions in England. A digital voice recorder was used to audio record the interviews and data was handled in accordance with the University of Liverpool's policies. All members of the research team were trained in working with psychological distress and a distress protocol was developed for use should participants experience distress during the interviews (Appendix 11). Once interviews were completed, participants were provided with a debrief and were offered the option to receive a

summary of the results (Appendix 12). Pseudonyms have been used to protect participants' identity.

### *Analysis*

The study sought to identify patterns across participants' experiences and perspectives, which was facilitated through thematic analysis (Braun & Clarke, 2006). Thematic analysis allowed researchers to take a realist epistemological stance, whereby participants' experiences were assumed to reflect their reality (Tebes, 2005). Approaches to understanding how participants made sense of their experiences or developing a theory were not relevant to the primary aims of this research (Glaser & Strauss, 1967; Smith, 1996).

The analysis was inductive, as it was not grounded in prior knowledge or theory. This approach allowed greater flexibility in the analysis and interpretation of the results. Braun and Clarke's (2006) six phases of thematic analysis were followed:

1) *Familiarisation with the data*. The primary researcher conducted all of the interviews and transcribed three of these to immerse herself in the data. The remaining transcripts were completed by an accredited transcriber. Prior to coding, the primary researcher read all of the transcripts for further data familiarisation and made notes regarding what the data appeared to be demonstrating.

2) *Generating initial codes*. NVivo 12 software acted as a platform for coding and theme development (NVivo, 2018). The primary researcher read and re-read the transcriptions and before assigning a descriptive label (initial code) to capture what each section of data appeared to be demonstrating. Extracts of initial coding were reviewed by other members of the research team to enhance the rigour of the analysis. Appendix 13 provides an insight into the coding process, including sections of interview transcripts, two

initial codes with example data extracts and a table containing data extracts with the corresponding initial code and theme.

3) *Searching for themes.* The codes were then reviewed and patterns across the these were identified. This led to the initial grouping of codes into themes that provided them with higher-order labels. Codes that were not captured by an initial theme were listed at the end and reconsidered during later stages of the reviewing process. Appendix 14 provides extracts to further illustrate the process of data analysis.

4) *Reviewing themes.* The data within the codes were reviewed to check whether they fitted in their assigned theme. Codes that represented the same concept were combined under one code name that captured all of the data that it contained. The primary author met with another member of the research team to review the themes and codes, which provided feedback and enhanced the face validity of the initial findings. The themes and codes were continuously reviewed and revised to ensure that they accurately represented the data within them. The primary researcher checked that the data in each theme and code were sufficiently distinct to warrant them being categorised separately from other data.

5) *Defining and naming themes.* The reviewing process allowed the names of the themes to be finalised. This was reached when the themes were considered to accurately label all of the data within them and the themes were considered to be sufficiently distinctive.

6) *Producing the final report.* The themes and data extracts in the final report were considered to most effectively evidence the results of the analysis. The final report was reviewed by other members of the research team and adapted following feedback.

### *Rigour*

Issues of rigour and transparency were attended to throughout the study (Yardley, 2008). The primary researcher engaged in reflexive practice during the research process,

through regular discussions with other members of the research team and the use of a reflexive journal (Ortlipp, 2008; Appendix 15). This allowed her to consider her background and influences during the choice of research topic, interviews and analysis (Appendix 16). This included reflecting on her personal and professional connections with the topic, considering her identity and practice as a trainee clinical psychologist, the challenges of taking an interviewer role with qualified clinical psychologists and ensuring that she attended equally to all relevant data, rather than being influenced by her own perspectives during analysis. Acknowledging her own internal experiences allowed the primary researcher to own her position and reduce inadvertent impacts on the results through holding them in awareness. This also supported the primary researcher in consistently maintaining an 'interviewer' role in her approach to interviewing two participants, whom she had previously met through the profession. Attempts to reduce social desirability bias were made, including reassuring participants that there were no right or wrong answers, at the beginning of interviews (Richman et al., 1999).

A well-established framework for thematic analysis was used to enhance quality and transparency in the development of themes (Braun & Clarke, 2006). The analysis included attention to contradictory data to capture the full range of experiences and perspectives. Another member of the research team independently reviewed and agreed with codes applied to the data and provided an additional perspective during theme development (Patton, 1999).

## **Results**

Four key themes were developed through thematic analysis (Table 2). The first two themes illustrate participants' perceptions of the psychological impact of claiming benefits for their clients and the effect of these experiences on their practice (*Salt in the wound* and *Trapped in a sick role*). The latter two themes focused on the dilemmas and uncertainty of

their role in relation to the benefits system, including the resulting psychological impact (*A constant set of ethical dilemmas* and *What am I doing here?*).

**Table 2.** Themes derived from thematic analysis.

Perceived impact of the benefits system on participants' work			
		Role perceptions in relation to the benefits system	
<i>Salt in the wound</i>	<i>Trapped in a sick role</i>	<i>A constant set of ethical dilemmas</i>	<i>What am I doing here?</i>

**“Salt in the wound”**: an additional burden for clients and clinical psychologists.

The focus of this theme is the additional psychological burden felt by participants' clients who claimed benefits and the corresponding effects on participants' practice. Most participants described problems with the practices of the benefits system, in relation to their clients. For example, repeated eligibility assessments were experienced as punitive, invasive and inappropriate for their clients. All participants gave accounts of clients experiencing psychological distress as a result of claiming benefits. The accounts highlighted precipitated anxiety as a consequence of the assessment process and the associated threat of benefits being removed. David framed the anxieties associated with claiming PIP or ESA as a *“constant sort of, existential threat”*. Insensitive assessments and feeling mistrusted were suggested to impact clients' self-perception. The threats associated with assessments sometimes led to a worsening of clients' mental health: *“I've worked with quite a lot of people, erm, who obviously are, going for the, PIP assessment...you see them actually deteriorate, they are just, so frightened, they don't know how they're gonna manage”* (Jenny).

Several participants expressed anger and frustration about the injustice of the benefits system's processes. This included describing the additional burden experienced for people who were already disadvantaged in society and attempting to cope with psychological difficulties, particularly relating to trauma and physical health conditions. David illustrated

the unnecessary source of additional distress using the metaphor “*salt in the wound*”. Some participants described being asked to work specifically with distress that arose as a result of the benefits system’s processes. For example, Andrea described receiving referrals due to clients experiencing anxiety related to communication from the benefits system and the threats associated with this:

*I mean I've actually had a referral from somebody who was, referred, because he's got, erm, terrified of the brown envelope...every morning he won't leave the house because he sits waiting, for that postman to come and bring the brown envelope. And he was just, he's just absolutely terrified, that he's going to lose his money, when he's transferred to over to PIP...it's really shocking when I see how many of the, referrals I see, it, you know.*

Some participants attributed a large proportion of the distress that led clients to access their support to factors related to claiming benefits and views of such participants suggested that the demand on their services would be significantly reduced if issues with the benefits system and the associated threats were not present:

*I often feel like if, if all of our patients had enough financial resource, we'd probably lose about a third of our caseload because the, the stress caused by the lack of resource has such an impact on their mental health problems... (Jasmine)*

**“Trapped in a sick role”**: therapeutic work at a standstill.

This theme focuses on the impact of factors related to claiming benefits on clients’ attempts to move forward with their lives. Some participants expressed the view that the benefits system was inappropriate for their client group, which included clients experiencing physical and mental health difficulties. Participants suggested that the rigidity of assessments, and the professionals conducting these, did not adequately understand and consider issues such as fluctuating conditions and psychological difficulties. The assessments were

considered to lack flexibility and not account for uncertainty, instead seeking answers that fit into pre-determined categories. Participants described an emphasis on proving 'illness' and meeting the rigid categories of the benefits assessments. For example, Lucy suggested that *"90% of the people you're working with are dependent on, their income, being linked to them being ill. And being ill in a binary way, you know, 'I'm either ill or I'm well'"*.

These issues were described as problematic for therapeutic engagement, as participating in work that could create improvements might result in clients no longer meeting the eligibility criteria for benefits, despite not being able to work. The threats to clients' basic needs were described as overriding their psychological needs:

*...we have had people come and say, 'I understand what you're saying and I understand what I need to do, but actually, if I do that, I'm worrying about the impact that might have on my benefits, therefore, at the minute I feel too scared to, to move forward with rehabilitation, because I'm worried that they'll take all my benefits away and I'll be left with no support, and if rehab doesn't work, I'll be in more pain than I started with, with no social support'. (Sophie)*

For some clients who had previously engaged well in therapy, the importance of getting their benefits meant that they no longer had the cognitive capacity to focus on aspects of their life other than getting the money that they needed to live:

*...so we'd been doing CBT and he'd engaged kind of reasonably well, but 'round that time, he just, he couldn't cope, 'cause all he could focus on was, was he gonna have money? Was he gonna be able to, live...it was a struggle for him to focus on doing kind of ongoing work that was oriented to change. (Jenny)*

Andrea framed this as clients becoming *"trapped in a sick role, because they're terrified of, losing the benefits"*. In addition, financial restrictions were a further barrier to engagement for some clients:

*And it means you just end up...spinning your wheels, therapeutically, 'cause you can't really meaningfully help people to do any of the things that you know could be helpful, 'cause they just physically don't have the resources to be able to access them. (Tom)*

**“A constant set of ethical dilemmas”**: conflicting demands in meeting clients’ needs.

This theme captures the uncertainty and anxiety felt by participants in trying to meet the needs of their clients, which involved navigating conflicting demands. The overarching dilemma expressed by participants was wanting to support their clients but feeling concerned about the potential negative consequences of their approach. David framed this issue as “*a constant set of ethical dilemmas*”. One dilemma related to the ‘hierarchy of needs’, as having access to financial support via benefits was seen to be a fundamental basis for achieving wellbeing. In line with this, several participants questioned whether it was appropriate to continue therapy when clients’ basic financial needs were unmet.

Associated with the reported threat of losing benefits experienced by clients, participants expressed anxiety about their practice potentially impacting on their clients’ benefits. Tom described his anxiety in relation to this:

*...there's your worry as a professional... there's almost this tension when you're working with people in that situation about what, what realistically can we do that's gonna help, that isn't going to erm put you, put your benefit situation at risk...*

Another common concern expressed by participants was the fear of individualising the distress associated with claiming benefits. Several participants acknowledged the distress felt by their clients in response to the benefits system but expressed concerns about proceeding with the work that they had originally agreed to complete. The ethical implications of this were raised: “*...is it really ethical to be making people more resilient to being like, given the short straw basically, and I don't necessarily think it is*” (Claire). Zara

explained the fine line between supporting their clients and normalising what they perceived to be harmful practices: *“It’s tricky ‘cause you want people to have the skills to cope with the stresses that life chucks at them, but, I don’t want to be the person that makes a horrible system ok”*. Examples were provided to illustrate their concerns:

*‘Cause again, it’s ridiculous, how can we be working on insomnia or GAD [Generalised Anxiety Disorder] or something like that, when actually, the worries are very, very practical things about money and, you know, food and housing and all that type of thing.*  
(Laura)

There was also a concern of inadvertently causing harm by describing their clients in ways that participants perceived as incongruent with their practice. Yet this was perceived to be necessary for providing supporting evidence for benefits claims. Laura spoke about the discomfort that she felt in relation to providing supporting letters, which emphasised impairment:

*We quite often write reports to support people’s erm either applications or appeals... I struggle with writing those reports because we know that to get people what they need, we have to really emphasise how impaired they are and what they struggle with and how much they can’t do and that’s completely counter to what we do therapeutically, where we’re trying to get people to focus on what they can do and the recovery they’ve made and that type of thing. So, I do interact with the system in that way because I feel like it’s in my patients’ best interests but I, there’s also a part of me that knows that it’s, it’s not truly in people’s interests to read about themselves in that way.*

**“What am I doing here?”**: questioning one’s role and profession.

Alongside the dilemmas expressed by participants, this theme captures common experiences of uncertainty relating to their role as a clinical psychologist in the context of the

benefits system. Most participants described acting at the individual level with their clients, for example, providing emotional support and information about seeking benefits. Most also provided supporting evidence for their clients' benefits applications, which commonly involved writing letters. Participants were motivated to help but often expressed uncertainty about how best to support their clients. For example, Tom expressed:

*I think it's definitely part of my value system to want to sort of advocate however I can, I think probably why I struggle is kind of knowing how to do that in a meaningful way, in a useful way.*

Participants commonly expressed uncertainty about what was considered to be within the remit of Clinical Psychology. Some participants were uncertain of the boundary between the role of clinical psychologists and other professionals: *"I think I'm still trying to figure out very much where Psychology sits"* (Laura). Although there was some variation with the contact that participants had with the benefits system across their roles, many spoke about it being a frequent part of their work. Some described it as impossible to avoid: *"it's in your face, all the time"* (Claire). Some participants did not believe that interacting with the benefits system was part of their role but this had become their role due to the 'duty of care':

*Erm, so as a clinical psychologist, there is no part of my job description that talks about completing benefit forms for people, at all... As part of a NHS employee, that's there to support people when they're struggling, I think there's a strong argument to say it's very much any workers, any professional's role to support people when they need it.* (Stephanie)

The impact on clients, the lack of clarity regarding the participant's role and uncertainty about how to effectively support their clients had adverse consequences for participants. These included emotional consequences, judgement (of themselves and the profession) and an impact on resources. Some participants appeared to put blame on themselves when working in this context. Claire described *"a sense of guilt...that you can't*

really do much” and feeling “like I’m not doing a good enough job”. Alice expressed that she had not considered the benefits system much in her practice and that reflecting on this through taking part in the research interview was “making me feel quite terrible”. It seemed that some participants were feeling a responsibility for helping but often not knowing how. Claire described feeling frustrated and questioning her choice of career:

*When you actually see it like, every day, not like a rare situation you know it’s, it’s like what, what am I doing here? ...and I say probably once a day I should have been, should have not been a psychologist (laughing) do you know what I mean, should've been like, policy, I dunno, you know, I just think what, what are we doing? We're not, we're not contributing to meaningful change for people...*

These issues commonly resulted in many participants expressing feelings of hopelessness or powerlessness: “...it just feels quite hopeless a lot of the time I think...you want to help but it's hard to know what to do and where to point that” (Tom). Most participants described a negative psychological impact from issues raised in the interviews. Many described feelings of frustration, anger and rage:

*I think it has made me feel, very angry, very, very angry at times and in a way, it's better when I'm angry, 'cause I think the other, the other, the alternative is to feel incredibly hopeless. And actually you know, you know like Sisyphus trying to push a boulder up a mountain, in perpetuity that's kind of how it feels...alarm bells went off because you know, that's burnout, that's, that kind of, 'I can't keep doing this'... (Lucy)*

As illustrated in relation to the dilemmas described in the previous theme, worry and anxiety about the consequences of issues relating to the benefits system were common experiences shared by participants: “I'm worried that they're gonna get that [outcome of benefits assessment] through and that'll be the final straw for somebody” (Andrea). Although most participants described experiencing distress, Chris described a desensitisation at times:

*“So I can get quite irritated and angry with erm, but I guess, over time, you kind of habituate, to that”*. Zara shared concerns about her psychological distress impacting on her work with clients, which was an additional burden to manage: *“...it’s hard to kind of hold...therapy space when, as a therapist, you’re kind of really angry too”*.

A final key area of impact described by several participants was the perceived nonsensicality of using resources of clinical psychologists and mental health services to support people’s mental health, in the context of a benefits system, which was perceived as operating in conflicting ways: *“...it seems ridiculous to pump money into the NHS on one side to get people’s self-esteem up but then have this ridiculous set of demands on the other side, which is completely contradictory to what we do”* (Laura).

In response to the issues experienced by participants and their clients, many expressed the need for a professional stance in relation to the benefits system. Participants felt that more input from professional bodies and training courses was required, to equip clinical psychologists with the knowledge and confidence to work in this context, and to provide guidance on their role. Laura explained: *“I think there are some people who are very passionate and very outspoken and it’s great to learn from them but it, it would be nice to see our professional body speaking out a bit more”*. Although most participants currently engaged with some individual-level aspects of the benefits system, many believed that Clinical Psychology should influence higher-level change in the public and political sphere. They reflected on the need for a collective stance to empower Clinical Psychology to have a voice and to strengthen the possibility of change: *“...there is something about psychologists generally, sort of putting their cards on the table and having a fairly clear stance that actually, they don’t want to be complicit in a system that pathologises people for being unlucky”* (Zara).

## **Discussion**

This study aimed to explore the interaction between the benefits system and the work of clinical psychologists. Overall, participants described adverse consequences for their practice and their clients' psychological wellbeing. Issues related to claiming benefits acted as an additional burden for clients, who had already experienced significant adversity, and were seen to increase the demand for psychological support. These issues created barriers to therapeutic engagement and the provision of psychological support. Participants were faced with difficult decisions regarding how to effectively support their clients, while attempting to avoid further harm and honour their duty of care. Uncertain of their role as a clinical psychologist and with their values being challenged, many participants experienced personal adverse psychological consequences. Most participants engaged in the benefits system at an individual client level but believed that Clinical Psychology could have a useful role in higher-level change. Participants outlined barriers and facilitators to clinical psychologists having a more influential role in addressing issues faced by people who claim benefits.

Participants described adverse psychological impacts for clients who claimed benefits, which was consistent with previous literature (Barr et al., 2016; Wickham et al., 2020). It should be acknowledged that data regarding clients' experiences is based upon clinical judgement from participants in this study and cannot be assumed to accurately represent experiences of clients. Nevertheless, participants' accounts of how claiming benefits was associated with psychological distress were in keeping with qualitative studies that explored psychological outcomes for people who claimed benefits, which included anxiety caused by threats to benefits and a detrimental impact on self-perception (Cheetham et al., 2019; Clifton et al., 2013; Garthwaite, 2014; Moffatt et al., 2015; Patrick, 2016; Saffer et al., 2018; Shefer et al., 2016; de Wolfe, 2012). This suggests that the benefits system can be a source of unnecessary psychological distress for those claiming benefits and create an increased

demand on the provision of psychological support. In the context of austerity, the combination of greater demands and limited resources are likely to be creating a significant burden for clinical psychologists, particularly in areas of greater deprivation (Cummins, 2018; Higson et al., 2016; Longwill, 2015). Future research could explore the demands on clinical psychologists' time and job descriptions relating to the benefits system and further highlight the importance of addressing issues with the benefits system.

The benefits system in its current form, was described as inflexible and having an inadequate understanding of clients' difficulties, for example, psychological difficulties and fluctuating conditions. A conflict was created for clients, whereby progress towards overcoming their difficulties could be taken as evidence that they were able to work, thus preventing progress in psychological work. Participants also highlighted an incongruence between their strengths-based 'recovery' approach and clients having to repeatedly undergo problem-focussed assessments, which required clients to prove that they were sufficiently 'unwell' and participants to focus on their clients' limitations when providing evidence for benefits applications. Participants expressed a desire to move away from the narrative of 'illness' towards strength-based practice but the restrictions of the benefits system and the potential consequences of losing benefits were too threatening for clients and consequently, participants. This again highlighted the power of broader systems on the practice of individual clinical psychologists and the limits of their ability to act in line with approaches that they perceived to be more helpful for their clients. This challenged participants' perceptions of acting in line with their values and the profession's ethical principle of integrity (BPS, 2018).

An open and collaborative approach to supporting clients with accessing benefits and the consequences of claiming benefits could help to reduce the sense of value conflict. Engagement in higher-level change could also allow clinical psychologists to act in line with

their values despite threats to this in their individual client work, although currently this would be likely to sit outside of their paid employment. Higher-level approaches might include publishing data, engaging with the media and lobbying. Despite it being important to consider how Clinical Psychology can influence such issues, it would also be helpful for critical perspectives and individual clinical psychologists to acknowledge the limiting systems around them. This could perhaps reduce some of the internalisation and self-blame that participants described in wanting to be more effective for their clients.

There was a common experience of parallel processes, whereby distress and internalisation of systemic issues were felt by both parties (Sachs & Shapiro, 1976). Like their clients, issues of self-perception were pertinent to the distress experienced by participants, as they felt a responsibility in the face of issues relating to the benefits system and the threats to their integrity. This was congruent with literature, which has suggested that threats to one's identity are associated with psychological distress (Haslam et al., 2009). Similar to the experiences of clients who claimed benefits, participants expressed anxiety in relation to the potential loss of benefits, anger at the injustice, and powerlessness and hopelessness when feeling unsure of how to effectively work with the issues that arose. These issues were compounded by role ambiguity, as participants experienced increased anxiety relating to the uncertainty of the remit of their role as a clinical psychologist working in this context. The number of participants was too few and thematic analysis was not focused on making comparisons based on personal and professional characteristics. Thus, further research could highlight differences in perceived responsibility, levels of distress and emotions experienced by clinical psychologists in relation to the benefits system. Nevertheless, the psychological toll on participants was a pertinent issue in this study and requires attention to protect the wellbeing of clinical psychologists.

A survey of clinical psychologists in the UK has revealed issues of stress and burnout relating to work pressures, which this study suggests might be exacerbated by the benefits system for many clinical psychologists (Longwill, 2015). Supervision, continuing professional development and personal support were recommended, all of which are particularly important due to the underlying prevalence of psychological distress in the profession (Grice et al., 2018; Tay et al., 2018). This is also vital for the quality of care received by clients, as the level of satisfaction and wellbeing amongst NHS staff has been associated with clients' experiences of healthcare (Maben et al., 2012). Supervision is an essential part of clinical psychologists' practice and should incorporate personal and professional support (DCP, 2014). After completing the interview for this study, several participants commented on the benefit of having the space to talk about their experiences and feelings in relation to the benefits system. Due to the pressures within services, supervision might become task orientated and offer limited space to reflect on such issues but this study highlights that the value of attending to these issues in supervision should not be underestimated.

Reflective practice groups might also be beneficial in providing a non-judgemental space for clinical psychologists to share their experiences and feel validated in the context of other practitioners. The use of such support networks might reduce experiences of distress and negative impacts on self-perception. The use of relational models might be helpful for considering issues such as parallel processes and differences in reactions in this context. Cognitive Analytic Therapy (CAT) offers helpful tools to consider these areas, including the 'helper's dance' questionnaire, which supports people in helping positions to understand their responses in the context of the client they are working with, their own characteristics or experiences, and the system, model or organisation that they are embedded within (Potter, 2013; Ryle & Kerr, 2002).

Nevertheless, it is important not to be drawn into the process of individualisation when considering how to approach issues relating to the benefits system and Clinical Psychology. As highlighted by participants, change will ultimately be most powerful at higher levels (Smail, 1993). Consistent with the general survey of clinical psychologists in the UK, there was a call for stronger leadership and representation by professional bodies to support clinical psychologists to work effectively in the current climate and to promote change (Longwill, 2015). Also highlighted was the desire for psychology professional bodies to have the same strength and influence as medical professional bodies. In line with attachment theory, strong leadership and professional support could allow clinical psychologists to feel 'held' in addressing these issues in their practice (Bowlby, 1969).

Conclusions regarding how clinical psychologists generally understand and work with issues relating to the benefits system cannot be drawn from this small-scale study and a potential limitation was the possibility of a biased sample of clinical psychologists who were more aware or interested in this issue or were influenced by social desirability in their answers. There are further limitations created by the software used to analyse the data. NVivo does not allow for retrospective auditing of how themes have been developed. Examples of the process are provided in Appendices 13 and 14, but future researchers may wish to create more robust audit trails during the research process. Yet, Clinical Psychology training courses were identified as another key avenue for change, as they were seen to have the potential to increase awareness and provide the knowledge to enhance confidence in working in this context. Adequate training and support could reduce potential personal barriers to working in this context, such as, anxiety, guilt and concerns of not being seen positively by colleagues (Bemak and Chung, 2008; Lloyd & Pollard, 2019). Training other professionals could also reduce the latter issue, as practitioners would be more likely to have a shared understanding and vision for promoting wellbeing. Future research could explore areas that require

development and additional support in the profession, including managing the ethical dilemmas raised in this context. Gathering larger-scale data regarding clinical psychologists' perceived skills and confidence in this area would facilitate this understanding. It could also be helpful to evaluate the outcomes of providing further guidance and support. With professional and service-level support, clinical psychologists could be supported to include work related to the benefits system in their job plans to account for the resources that this consumes and an argument for leadership roles that work with such issues could be supported. Concluding exactly how clinical psychologists can most effectively work within this context is beyond the scope of this study and needs further consideration within the profession. Yet, participants suggested scope for input at various levels, from supporting individual clients with the practical aspects and emotional outcomes of claiming benefits to raising issues publicly and politically.

### *Conclusions*

Overall, the benefits system posed difficulties for participants in promoting psychological wellbeing in their practice. Dilemmas regarding how best to meet their clients' needs and uncertainty of their role had adverse psychological outcomes for participants. Participants highlighted the need for further support and guidance to understand their role in relation to the benefits system, and to be able to work effectively in this context. Further research can help to understand how these effects differ between clinical psychologists and how they can most effectively influence change to support psychological wellbeing, with the benefits system in mind. Nevertheless, considering the growing evidence base regarding the impact of the benefits system on psychological distress and Clinical Psychology provision, it can be argued that clinical psychologists have a duty to respond.

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Reference to a journal publication with an article number:

Van der Geer, J., Hanraads, J.A.J., Lupton, R.A., 2018. The art of writing a scientific article. *Heliyon*. 19, e00205. <https://doi.org/10.1016/j.heliyon.2018.e00205>.

Reference to a book:

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Reference to a chapter in an edited book:

Mettam, G.R., Adams, L.B., 2009. How to prepare an electronic version of your article, in: Jones, B.S., Smith, R.Z. (Eds.), *Introduction to the Electronic Age*. E-Publishing Inc., New York, pp. 281–304.

Reference to a website:

Cancer Research UK, 1975. Cancer statistics reports for the UK.

<http://www.cancerresearchuk.org/aboutcancer/statistics/cancerstatsreport/> (accessed 13

[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. <https://doi.org/10.17632/xwj98nb39r.1>.

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## Appendix 2. Critical Appraisal Skills Programme (2018) Qualitative Checklist.



CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

**How to use this appraisal tool:** Three broad issues need to be considered when appraising a qualitative study:

- ▶ Are the results of the study valid? (Section A)
- ▶ What are the results? (Section B)
- ▶ Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is “yes”, it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a “yes”, “no” or “can’t tell” to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

**About:** These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA ‘Users’ guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

**Referencing:** we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference: .....

**Section A: Are the results valid?**

1. Was there a clear statement of the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- if the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- is qualitative research the right methodology for addressing the research goal

Comments:

**Is it worth continuing?**

3. Was the research design appropriate to address the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

4. Was the recruitment strategy appropriate to the aims of the research?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
  - If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
  - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
    - If methods were modified during the study. If so, has the researcher explained how and why
  - If the form of data is clear (e.g. tape recordings, video material, notes etc.)
    - If the researcher has discussed saturation of data

Comments:

6. Has the relationship between researcher and participants been adequately considered?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider
- If there is an in-depth description of the analysis process
  - If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
  - Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
  - If sufficient data are presented to support the findings
    - To what extent contradictory data are taken into account
  - Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes	<input type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

- HINT: Consider whether
- If the findings are explicit
  - If there is adequate discussion of the evidence both for and against the researcher's arguments
  - If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
  - If the findings are discussed in relation to the original research question

Comments:

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

### Appendix 3. Quality assessment of included studies.

Study	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	Will the results help locally?
Moffatt et al. (2015) 13/20	Yes 2 Clear aim. Relevance and importance discussed.	Yes 2 Methodology is justified.	Part 1 Limited justification.	Yes 2 Recruitment strategy explained and justified.	Part 1 Data collection described but limited justification.	No 0 No discussion around researchers own biases or influence.	No 0 Ethical issues not discussed.	Part 1 Analysis described and some issues of rigour discussed.	Yes 2 Clear statement of findings and credibility attended to.	Yes 2 Implications and recommendations are highlighted.
Clifton et al. (2013) 7/20	Yes 2 Clear aim. Relevance and importance discussed.	Part 1 Qualitative methodology seems relevant but not justified.	No 0 The design was not justified.	No 0 Not described.	Part 1 Limited discussion of data collection.	No 0 No discussion around researchers own biases or influence.	Part 1 Ethical approval obtained.	No 0 Analysis was not described in the summary paper.	Part 1 Clear statement of findings but no discussion of credibility.	Part 1 Limited discussion of implications and recommendations.
Wilkinson & Ortega-Alcázar. (2019a & 2019b) 14/20	Yes 2 Clear aim. Relevance and importance discussed.	Yes 2 Methodology is justified.	Yes 2 Design justified.	Yes 2 Recruitment strategy explained and justified.	Yes 2 Information provided about data collection and justification provided.	No 0 No discussion around researchers own biases or influence.	Part 1 Limited discussion of ethical issues.	No 0 Analysis not described.	Part 1 Clear statement of findings but no discussion of credibility.	Yes 2 Implications and recommendations are highlighted.

Shefer et al. (2016) 12/20	Yes	2	Yes	2	Part	1	Part	1	Part	1	No	0	Part	1	Part	1	Part	1	Yes	2
	Clear aim. Relevance and importance discussed.		Methodology is justified.		Limited justification.		Discussion around recruitment but sampling bias not considered.		Data collection described but limited justification.		No discussion around researchers own biases or influence.		Ethical approval obtained but ethical issues not described.		Analysis and themes described. Issues of rigour not presented.		Findings discussed but limited discussion of credibility.		Implications and recommendations are highlighted.	
Cheetham et al. (2019) 16/20	Yes	2	Yes	2	Part	1	Yes	2	Yes	2	No	0	Yes	2	Part	1	Yes	2	Yes	2
	Clear aim. Relevance and importance discussed.		Methodology is justified.		Limited justification.		Recruitment strategy explained and justified.		Information provided about data collection and justification provided.		No discussion around researchers own biases or influence.		Ethical approval obtained and ethical issues described.		Analysis described and some issues of rigour discussed.		Clear statement of findings and credibility attended to.		Implications and recommendations are highlighted.	
Saffer et al. (2018) 19/20	Yes	2	Yes	2	Yes	2	Yes	2	Yes	2	Part	1	Yes	2	Yes	2	Yes	2	Yes	2
	Clear aim. Relevance and importance discussed.		Methodology is justified.		Design justified.		Recruitment strategy described and justified.		Information provided about data collection and justification provided.		The analysis was described as acknowledging the researchers' "positions, perspectives and interaction" but limited detail provided.		Ethical approval obtained and ethical issues described.		Analysis described and issues of rigour discussed.		Clear statement of findings and credibility attended to.		Implications and recommendations are highlighted.	
de Wolfe. (2012) 13/20	Yes	2	Yes	2	Yes	2	Yes	2	Part	1	Part	1	Part	1	No	0	Part	1	Part	1
	Clear aim. Relevance and importance discussed.		Methodology is justified.		Design justified.		Recruitment strategy explained and justified.		Data collection described and justified but lacking		Some consideration of the researcher's position but		Some consideration of ethical issues.		Analysis not described.		Findings discussed but limited discussion of credibility.		Limited discussion of implications and recommendations	

							clarity.	did not state how this might have biased the results.							ons.
Garthwaite . (2014) 16/20	Yes 2 Clear aim. Relevance and importance discussed.	Yes 2 Methodology is justified.	Yes 2 Design justified.	Yes 2 Recruitment strategy explained and justified..	Yes 2 Information provided about data collection and justification provided.	No 0 No discussion around researchers own biases or influence.	Yes 2 Ethical approval obtained and ethical issues described.	Part 1 Analysis and themes described. Issues of rigour not presented.	Par 1 Findings discussed but limited discussion of credibility.	Yes 2 Implications and recommendations are highlighted.					
Patrick. (2016) 10/20	Yes 2 Clear aim. Relevance and importance discussed.	Yes 2 Methodology is justified.	Yes 2 Design justified.	Part 1 Recruitment described and justified but sampling bias not considered.	Part 1 Data collection justified but limited description of the process.	No 0 No discussion around researchers own biases or influence.	No 0 Ethical issues not discussed.	No 0 Analysis not described.	Par 1 Findings discussed but limited discussion of credibility.	Par 1 Limited discussion of implications and recommendations.					
Secker et al. (2012) 16/20	Yes 2 Clear aim. Relevance and importance discussed.	Yes 2 Qualitative methodology is relevant to the aims.	Yes 2 Research design justified.	Yes 2 Recruitment strategy explained and justified.	Yes 2 Information provided about data collection and justification provided.	No 0 No discussion around researchers own biases or influence.	Part 1 Ethical approval obtained but no discussion of ethical issues.	Part 1 Analysis and themes described. Issues of rigour not presented.	Yes 2 Clear statement of findings and credibility attended to.	Yes 2 Limited discussion of implications and recommendations.					
Average score	13.6														
Total score per CASP item (Max = 20)	20	19	15	16	15	2	11	7	14	17					

**Appendix 4.** Author guidelines: *Psychology and Psychotherapy: Theory, Research and Practice*.

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As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors’ names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

## References

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For more information about APA referencing style, please refer to the [APA FAQ](#).

Reference examples follow:

### Journal article

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486. doi:[10.1176/appi.ajp.159.3.483](https://doi.org/10.1176/appi.ajp.159.3.483)

### Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

### Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from <http://www.youtube.com/watch?v=Vja83KLQXZs>

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and \*, \*\*, \*\*\* should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

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- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the [Bureau International des Poids et Mesures \(BIPM\) website](#) for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
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results, or writing a major portion of the paper. Those who so contribute are listed in the byline.” (p.18)

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All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

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*Author Guidelines updated 28<sup>th</sup> August 2019*

## Appendix 5. Ethics committee approval letter.



Central University Research Ethics Committee B

22 January 2019

Dear Dr Weatherhead

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

### Application Details

Reference: 4274  
Project Title: Exploring how the benefits system effects the work of Clinical Psychologists and what their role should be.  
Principal Investigator/Supervisor: Dr Stephen Weatherhead  
Co-Investigator(s): Miss Erika Cantrell, Dr Stephen Weatherhead  
Lead Student Investigator: -  
Department: School of Psychology  
Approval Date: 22/01/2019  
Approval Expiry Date: Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

### Conditions of approval

- All serious adverse events must be reported to the Committee ([ethics@liverpool.ac.uk](mailto:ethics@liverpool.ac.uk)) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committee B

[ethics@liverpool.ac.uk](mailto:ethics@liverpool.ac.uk)

0151 704 8290

### **Appendix - Approved Documents**

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

<b>Document Type</b>	<b>File Name</b>	<b>Date</b>	<b>Version</b>
Study Proposal/Protocol	Research Proposal (version 1- ethics)	13/11/2018	1
Advertisement	Recruitment poster (version 1)	13/11/2018	1
Evidence Of Peer Review	RRC Approval (Peer review)	13/11/2018	1
Research Tools	Demographic Details (version 1)	13/11/2018	1
Interview Schedule	Topic guide (version 1)	15/11/2018	1
Research Tools	Engagement with RD - Flowchart	16/01/2019	1
Research Tools	Distress Protocol (Version 1)	16/01/2019	1
Debriefing Material	Debrief sheet (Version 2)	16/01/2019	2
Participant Consent Form	Participant consent form (version 2)	16/01/2019	2
Participant Information Sheet	Participant information sheet (version 2)	16/01/2019	2

**Appendix 6.** Recruitment poster.



**Exploring the interface between mental health and the welfare system: the experiences of Clinical Psychologists and the role of the profession.**

*Are you a HCPC registered Clinical Psychologist working in the NHS?*

*Do you have a view on how welfare policies and the benefits system impact on the work you do?*

Our research team is hoping to build on the currently limited evidence into the interaction between **mental health and the welfare system**. This study primarily seeks to understand:

- The **impact** of the welfare system on the **work of Clinical Psychologists**.
- The views of Clinical Psychologists on **their role** in relation to the welfare system.

If you are a Clinical Psychologist and would consider participating in this study by taking part in a 1 hour research interview (face-to-face, Skype or telephone), please email Erika Cantrell (Trainee Clinical Psychologist) for more information:

**[erika.cantrell@liverpool.ac.uk](mailto:erika.cantrell@liverpool.ac.uk)**

## **Appendix 7. Participant information sheet.**



### **Exploring the interface between mental health and the welfare system: the experiences of Clinical Psychologists and the role of the profession.**

[Version 2. 08/01/19]

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

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

The aim of this study is to explore Clinical Psychologists' experiences of working at a time when the welfare/benefits system may be impacting their clients, aspects of their work and/or the services that they work in. We aim to explore impacts in such areas, how Clinical Psychologists are currently working in this context and their ideas of the role of Clinical Psychologists in relation to the welfare system.

#### **Why have I been chosen to take part?**

You have been invited to take part, as you are a HCPC registered Clinical Psychologist, working in the NHS in England. We are aiming to recruit 10-20 Clinical Psychologists in total.

#### **Do I have to take part?**

You are under no obligation to take part in the study. Your participation is entirely voluntary and you are free to withdraw your participation without explanation or incurring any disadvantage before, during or up to 2 weeks after the interview (as it might not be possible to extract your data completely from the study after this point due to anonymisation procedures).

#### **What will happen if I take part?**

If after reading this information you wish to take part in the study, please contact the primary researcher (Erika Cantrell) on the email address provided towards the end of this sheet. The researcher can then email or call you at a convenient time to arrange a suitable time and location to conduct the interview. This could be face-to-face (at the University of Liverpool, your home address or another private community venue) or via Skype or telephone, depending on your preference and location. Interviews will need to be conducted outside of work premises and your working hours, unless your line manager grants permission and informs us of procedures which we can follow to facilitate this (without requiring NHS ethical approval).

The interview with Erika will last approximately 60 minutes (maximum of 90 minutes), during which you will be asked to provide some demographic data and written or recorded verbal consent (in the case of telephone or Skype interviews). You will be asked questions to explore your experiences in line with the research aims. Interviews will be audio recorded using a Dictaphone. You are under no obligation to answer questions or share information that you do not wish to share. You will be able to take a break or terminate the interview at any point.

#### **How will my data be used?**

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The supervisor acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to [Dr Stephen Weatherhead: ste@liverpool.ac.uk ].

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Data will be collected via one-to-one interviews.
How will my data be stored?	Audio recordings will be transferred to the secure University server within 24 hours of the interview and then deleted from the Dictaphone. Demographic information and consent forms will be kept in locked storage at the University of Liverpool.
How long will my data be stored for?	Data will be deleted 10 years after the study ends.
What measures are in place to protect the security and confidentiality of my data?	The data will be securely handled and stored, and data will be anonymised in the report. Please be aware that if you opt for a Skype interview, entire security of data cannot be guaranteed due to Skype's own terms and conditions.
Will my data be anonymised?	Yes. All personal identifiable information will be removed during the transcription process. Pseudonyms will be used

	in place of participants' names.
How will my data be used?	The data will be analysed using thematic analysis and anonymously written up in a report/disseminated.
Who will have access to my data?	The primary researcher (Erika) will access the full data during data collection and analysis. The supervisors may access aspects of the interview data to check the quality of the analysis. Accredited transcribers may be used to type some of the interview transcripts.
Will my data be archived for use in other research projects in the future?	No.
How will my data be destroyed?	Paper forms will be shredded and audio recordings will be deleted from the secure University server 10 years after the completion of the study.

### **Disclosure and confidentiality**

In exceptional circumstances the researcher might need to breach the confidentiality of the participant (for example, if the participant discloses information that indicates that a person could be at risk of harm if the information is not shared). In this case, the primary researcher would seek supervision from one of the supervisors. If the team were to believe that the information needed to be shared with other parties, this would be discussed with the participant and arrangements would be made for this to take place. If the research team decided that it was necessary to share the information and the participant did not consent to do so, participant confidentiality would be overridden.

### **Expenses and / or payments**

Travel can be reimbursed to a maximum of £20.

### **Are there any risks in taking part?**

It is not anticipated that there will be any risks to taking part in the study. However, it is possible that issues discussed in the interview could be difficult or distressing. Participants are encouraged to seek support from their supervisor, GP or Samaritans (116 123) if the interview provokes distress.

### **Are there any benefits in taking part?**

It is not anticipated that there will be direct benefits to taking part in the study but it is hoped that the results will help to develop a better understanding of Clinical Psychologists experiences in the

context of the welfare system and ideas of working effectively within this. This could contribute towards changes which benefit clients, Clinical Psychologists and services in future.

### **What will happen to the results of the study?**

The results will be written up as a thesis for the Doctorate of Clinical Psychology programme. It is hoped that the results will be disseminated broadly (for example, in a peer reviewed journal, Psychology networks and presentations). Participants will have the option of receiving a summary of the results. The data will be anonymised before it is dissemination.

### **What will happen if I want to stop taking part?**

You can withdraw your participation in the study before, during or up to two weeks after the interview (due to anonymisation procedures), without explanation. The primary researcher can be contacted on the email address at the end of this sheet, if you wish to withdraw.

### **What if I am unhappy or if there is a problem?**

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Dr Stephen Weatherhead on 0151 794 5025 and he will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at [ethics@liv.ac.uk](mailto:ethics@liv.ac.uk). When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researchers involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

### **Who can I contact if I have further questions?**

Erika Cantrell (Primary researcher/interviewer)

Email: [Erika.cantrell@liverpool.ac.uk](mailto:Erika.cantrell@liverpool.ac.uk)

Address: Doctorate in Clinical Psychology

University of Liverpool

Room 2.12

Whelan Building

Brownlow Hill

Liverpool  
L69 3GB

Dr Stephen Weatherhead (Primary supervisor)

Email: Ste@liverpool.ac.uk

Telephone: 0151 794 5025

Address: Doctorate in Clinical Psychology

University of Liverpool

Whelan Building

Brownlow Hill

Liverpool

L69 3GB

Dr Hayley Higson (Secondary supervisor)

Email: Hayley.Higson@lancashirecare.nhs.uk

Telephone: 01695 684700

Older Adult Community Mental Health Team

Brookside

Aughton Street

Ormskirk

L39 2JW

**Appendix 8. Consent form.**



**Participant consent form**

**Exploring the interface between mental health and the welfare system: the experiences of  
Clinical Psychologists and the role of the profession.**

[Version 2. 08/01/19]

Research ethics approval number:

Name of researcher(s): Erika Cantrell, Dr Stephen Weatherhead & Dr Hayley Higson.

Please initial box

1. I confirm that I have read and have understood the information sheet dated 13/11/18 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that taking part in the study involves an audio recorded interview and anonymised quotations from interviews may be used during dissemination (e.g. reports, publications and presentations).
3. I understand that my participation is voluntary and that I can withdraw before or during the interview, without giving any reason and without my legal rights being affected. In addition, I understand that I am free to decline to answer any particular questions.
4. I understand that I can ask for access to the information I provide and I can request the destruction of that information if I wish at any time up to two weeks after the interview. I understand that following two weeks of the interview date, I will no longer be able to request access to or withdrawal of the information I provide.
5. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool.
6. I understand that signed consent forms and original audio recordings will be retained in locked storage at the University of Liverpool and on a secure university server (respectively) until 10 years after the completion of the study.
7. I understand that the confidentiality of the information I provide will be safeguarded and won't be released without my consent unless it is thought that there is a risk of harm to somebody, in which case confidentiality will be breached.
8. I agree to take part in the above study.

---

Participant name

---

Date

---

Signature

*For situations where the participant information sheet has been read to aloud to the participant for recorded verbal consent (in instances where a signed consent form was not able to be returned prior to telephone or Skype interviews).*

I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are freely consenting.

---

Name of person taking consent

---

Date

---

Signature

**Principal Investigator/Supervisor**

Dr Ste Weatherhead

Doctorate in Clinical Psychology

University of Liverpool

Whelan Building

Brownlow Hill

Liverpool

L69 3GB

Ste@liverpool.ac.uk

0151 794 5025

**Student Investigator**

Erika Cantrell

Doctorate in Clinical Psychology

University of Liverpool

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Erika.cantrell@liverpool.ac.uk

**Secondary Supervisor**

Dr Hayley Higson

Older Adult Community Mental Health Team

Brookside

Aughton Street

Ormskirk

L39 2JW

Hayley.Higson@lancashirecare.nhs.uk

01695 684700



## **Demographic Details**

**Age:**

**Gender:**

**Ethnicity:**

**Location of work:**

**Designation and current area of work (e.g. inpatient, primary care etc):**

**Population that you work with (e.g. adults, older adults, children):**

**Length of time in this area:**

**Length of time you have been qualified and accredited:**

**Accrediting body:**

**Do you have personal experience of accessing the welfare system (yourself or somebody close to you in your personal life)? Please circle: YES / NO / Prefer not to say**

## Appendix 10. Interview topic guide.



### Exploring the interface between mental health and the welfare system: The experiences of Clinical Psychologists and the role of the profession.

#### Interview Topic Guide

*What follows is a guide of the topics expected to be covered in the interviews, alongside example questions. The exact content of questions will be guided by participants and the data collection process.*

- **Job role**  
Overview of job (including client group, context and ways of working)
- **What interested the participant in taking part in the study?**  
Could you tell me a bit about what interested you in taking part in this research?
- **What are the participant's experiences of working in the context of the welfare system?**
  - Could you tell me what the welfare system means to you and your work? Has this changed over time or through your experiences?
  - How does working within the context of the welfare system fit with your values?
  - Do you think that the welfare system has impacted your work? (If yes, prompt to expand).
  - Has working in the context of the welfare system impacted you personally and/or professionally? (If yes, prompt to expand).
- **Role of Clinical Psychologists**
  - How do you currently interact with the welfare system in your work? How have you interacted with the welfare system in the past? Have there been any changes over time?
  - If you feel comfortable sharing personal experience of the welfare system- what, if any, personal experience do you have and has this impacted how you work within the context of the welfare system (If so, how)?
  - How do you feel about working in the context of the welfare system? Do you have a clear idea of your role? (Prompt to expand)
  - Do you have ideas of how Clinical Psychologists should interact with or navigate the welfare system in their work? How might this fit with the work of other professionals? What would support this to happen? What barriers could there be to this? Do you feel equipped with the necessary knowledge, skills and training to work in the context of the welfare system? Could there be any advantages to engaging with the welfare system?
- **Anything to add?**  
I have come to the end of what I wanted to ask you, is there anything that we have not covered that you would like to talk about?

## Appendix 11. Distress protocol.



### Distress Protocol

1. Before starting the interview, the researcher will remind the participant that should they experience distress, they can ask for a break or terminate the interview if they wish to do so.
2. If the participant reports distress or the researcher observes participant distress during the interview, the researcher will ask them how they are feeling and offer a break or termination of the interview.
3. If the person wishes to continue with the interview, ask if they are happy to continue where we left off or whether they would like to move on to the next question. Participants are aware that they do not have to answer questions if they do not wish to (included in item 3 of the consent form).
4. If they would like a break, allow them to take a break for as long as they need.
5. If they would like to discontinue the interview, offer support and enquire about the support that they have once they leave.
6. Offer the debrief sheet, containing a section on options for seeking help with distress.
7. If immediate risk emerges call 999.

## Appendix 12. Debrief sheet.



*Exploring the interface between mental health and the welfare system: the experiences of Clinical Psychologists and the role of the profession.*

### **Debrief sheet**

Thank you for taking part in this study.

#### **Further information about the study**

It is becoming increasingly recognised that social factors significantly impact mental health, which include the welfare system. Involvement with the benefits system has been linked to anxiety, shame, distrust, anger, stigma and it has been associated with suicide (e.g. Psychologists [Against Austerity](#), 2009; [Shefer et al](#), 2016). A recent study explored the impact of austerity more generally on mental health and the work of psychological therapists in the NHS, by interviewing psychological therapists (Higson, Weatherhead & Hodge, 2016). Issues of austerity were found to be a barrier to the work conducted by psychological therapists, and a sense of increased pressure and emotional strain were reported amongst therapists. This suggests that austerity in the UK may be detrimental to people's mental health and it is proving difficult for mental health professionals to work effectively within a context affected by austerity.

The present study hopes to build on the current literature. We hope that the research will increase our understanding of the relationship between the welfare system and mental health, with a particular focus on the work and experiences of Clinical Psychologists. In addition, we hope that this will contribute towards more clarity on the role of the profession related to the welfare system, so that Clinical Psychology can work effectively with this system.

**If you experience distress as a result of participation**

Due to the nature of the topic, you might have found areas covered in the interview distressing. If you are feeling distressed at the end of the interview, the researcher will be available to speak to you and provide support.

If you continue to experience distress after the interview, you can seek help in the following ways:

- Speak to your supervisor
- Speak to your GP
- Call Samaritans for 24-hour support on 116 123 ([www.samaritans.org](http://www.samaritans.org))
- Call NHS direct on 111 (24-hour)

In an emergency or crisis you can call 999 or go to the nearest A&E.

**If you would like a summary of results**

Please inform the researcher if you would like to receive a summary of results, once the research is complete: [erika.cantrell@liverpool.ac.uk](mailto:erika.cantrell@liverpool.ac.uk)

### **Appendix 13.** Data extracts from interviews

This appendix provides: 1) data extracts from two interviews, at the same point in the interview, 2) examples of data extracts from two initial codes, and 3) a table containing data extracts, alongside an initial code assigned them and the theme that they contributed towards. The table includes data extracts that appear in Part 1 and 2 of the appendix (highlighted in the same colour throughout the appendix), along with examples from other themes.

#### *1) Extracts from transcript*

##### *Participant 2 (page 8 of transcript)*

Respondent: erm, that it, there might be opportunities, and so you might share, some psychological thinking or, I dunno (19.18 unclear) but like common sense, around erm, you know, if I was, if my day centre closed down, if you hadn't given me enough money to go out and do this, and I really wanted, you know, and sometimes you're like, 'oh right, I hadn't thought about it like that', yeah, but most of the time, honestly, it feels like, psychology in this role is not, is not, I dunno like how people might see psychology, I think psychology should be more like this, but that's just the way I think but, it's, there's very few people that you just work with, and, erm, you could, do some individual work or even family work or, erm, I dunno systems work and, the financial struggles and resource restraints isn't an issue, I just, I just don't see that anywhere, it's not. So you can't really, can't get on with psychology work, whatever psychology work is, a, a lot of the time because people's social circumstances, which are impacted by (background noise) lack of resources, are so, well shit, they're just, you know, and its, its unethical to me like I often think about, you know what the ethics, what the ethical implications are of offering someone therapy about their feeling depressed, or angry, when they have every right to, and, you know, I think, the word resilience gets bandied around a lot and it really annoys me and I just think, is it really ethical

to be making people more resilient to being like, given the short straw basically, and I don't necessarily think it is, and I think what, what I personally feel is a real, sense of, absolute helplessness in, in most, settings that there's very little change, (sigh) you know, very little real, like real change that you can bring to people. Yes, you can, make them feel heard, and you can, you know, be an advocate and really try very hard to get people together, but ultimately, a lot of this, rides on some panel making decisions about, money and obviously they, you know I think this goes wider than that. I know our like, (pause) you know it's gonna be national policies, etc., etc., that impact on local, decisions. When you actually see it like, every day, not like a rare situation you know it's, it's like what, what am I doing here? Is it, is you know, and I say probably once a day I should have been, should have not been a psychologist (laughing) do you know what I mean, should've been like, policy, I dunno you know, just, I just think what, what are we doing? We're not, we're not contributing to meaningful, change for people, because of, erm, you know, for, it's not only this, so I know this is, you know, it is a huge part of it, but like, there's obviously, a lot of, discrimination, and abuse and neglect and all, all of those things that, affect people who are marginalised, like, people with learning disability and I think there's, it's horrible to say, but I feel like there's still this undertone that people aren't really human beings, they're like sub-human in some way. Erm, so they get short straw, in a lot of ways, but it's absolutely you know, that the impact of like, the welfare, their welfare is just, yeah, I can't remember what the question was now, sorry I've gone off on a, I've gone, I've gone off on a rant (laughing) but erm.

***Participant 9 (page 8 of transcript)***

Respondent: It makes it harder, erm, it's not, (pause) in the same way that if there was anything else kind of, psychologically going on, so if somebody had Post Traumatic Stress Disorder and make it harder for us to do the rehab work, having another stresser in your life,

makes it harder for you to do the rehab work because if you see somebody who, inadvertently or otherwise, you feel implies that your pain is not real, or that your health condition is in your head, that's gonna trigger all of those, beliefs that you have about other people thinking that this is made up, you're gonna feel low, and then what's your motivation to get out of bed, and actually do the, the rehab work, you know, helping to improve your mood, helping to improve your function. Erm, it, it has a, a really big impact, and it's, you know when you're working with somebody who's about to go through that process, either for the first time or again, that you're probably gonna have 4 or 5 sessions that are pretty, bumpy and rocky either on the way up to it, or just after it erm and then waiting for the decision as to what they're going to be awarded, you know that once they get that brown envelope that there's gonna be the, erm, relief and you can start to do the work again, that's, that you're trying to do, or there's gonna be a situation where you're kind of firefighting the, the distress that's caused by the system. As well as the distress that you're working with that's caused by the pain.

Interviewer: Mmm, and how do you manage that within your, role?

Respondent: (Pause) I wanna say badly, erm, but I think it, I think it, it's one of those things that we don't do so well, erm, because, I know me personally I feel quite powerless to do very much about it, the system feels very separate from the NHS system and I guess probably just as to them, the NHS feels like this kinda big monolith that they work outside of, they feel to me a bit like this kinda big 'thing' that, that we work outside of, that we can't really access erm, having worked in previous roles and having experience of having written directly to them and not getting anything back, erm, I think it's difficult to know what the procedures are, how you would access support for somebody who was struggling with that process.

Patients tell me that they struggle, to access you know, if they're gonna have an assessment, that they struggle to access reasonable modifications like, being in a building with a lift rather

than having to walk up 5 flights of stairs to get to your assessing room, erm, being able to audio or video record the, the session, and I kinda feel like it's similar for, for me as a clinician, I don't know, how to get in on that, to help people. Erm, therefore, I, I think it's a bit of a cop-out what we do in terms of, 'oh we won't get involved with that' and I understand the rationale for it, but I think it impacts so much on the people that we see, it doesn't sit comfortably, for me to, to not get involved with it. But I wouldn't know where to start.

## 2) *Example extracts from initial codes*

### **Code: Questioning one's profession and career**

Participant 2

Extract 1

When you actually see it like, every day, not like a rare situation you know it's, it's like what, what am I doing here? Is it, is you know, and I say probably once a day I should have been, should have not been a psychologist (laughing) do you know what I mean, should've been like, policy, I dunno you know, just, I just think what, what are we doing? We're not, we're not contributing to meaningful, change for people...

Extract 2

Makes me personally question what the hell I'm doing as a psychologist, and am I just (laugh) er wasting my, wasting my time really. Like, should I be putting all my energy somewhere else...

Extract 3

but you know I frequently have these thoughts about should, should I be a psychologist or not? You know, should, if you know all of these areas influence people's wellbeing then should we not be targeting something higher up to change or should we be, learn, you know people often do quite a lot of fire-fighting don't they, should we be like on the, on the ground

like, advocating for people, and using our privilege and power in that way or should we be aiming at a different level? Yeah.

### Participant 3

So I think it, and it's easy, I think it's easy then, to get, to quite quickly just think well this is all pointless isn't it? This psychology lark, I sort of said it casually to a colleague yesterday, 'oh that worked then didn't it?' and I, I just think you know, when you've got, (pause) it's just very, very difficult I think (sigh) to make changes, because as I said, the referrals we're getting in, their mental, their mental health is the last thing, and the thing is, and then they get into this argument of well, 'well we can't engage with X, Y, Z because they're so mentally unwell' and it's like, they need somewhere to live, that is safe. You cannot do trauma work, you cannot do, CBT, you know, trauma focused CBT on someone who is living somewhere where they are getting assaulted on a daily basis, or they're getting robbed, you just can't do it. Doesn't it's, it's, it, it's unethical to try and undertake that work. (Sigh) you know this is quite depressing interview (laughing)

### Participant 8

...and I think a lot of psychologists won't even see their role as they're allowed to give advice, but I really struggle without some form of advice in, what I do as in a role, because if all I'm doing is, sitting and listening and making, sort of trying to help somebody come to see, a new direction, without specifically giving people a, you know, I think, you need to contact this organisation, then, you know, what am I doing? As a psychologist am I helping somebody? You know, am I trying to make it better for them? What's the purpose of what I'm doing? To follow a therapeutic intervention, absolutely, correctly, or to help the person sat in front of me? So, I think it's a wider thing

**Code: Uncertain of how to help**

Participant 1

Extract 1

To do those types of things that we can have a pretty good guess, would help them and their wellbeing. So then, like I say, what do you do for the best there really? Do you say “Well, you know, you can’t come to therapy because you can’t engage in the things you need to get better” or do you try to be a bit more compassionate and say “This is the system in which you live- what can I do to help you within this system?”.

Extract 2

But again, it’s hard to know what does come under your role and remit, what’s you, kind of, stepping a bit too far outside that, how we can help people, you know, even suggestions on how to help people would be brilliant.

Participant 2

Extract 1

Er, I do, I do within the res-, like a service, you know the kind of internal like, within, you know, the service like, you know like I was saying like not being clear of like do we actually work this and I can find those things out, feel ok, but at a bigger level which is where I personally, and this might not be for everyone or doesn't have to be, would prefer to and see my skills as much better suited to bigger change, have no absolutely no idea. I mean I probably have some skills, I don't, I don't even know, no, I don't feel equipped, erm, to do anything bigger than those things, but that feeling, not big and like not, I feel like we, we could, like we could do more, even within our roles, you know, but I wouldn't feel equipped or haven't been trained in any way to be equipped for that sort of stuff.

## Participant 9

### Extract 1

Erm and I think, I see a lot of people who really struggle, with the benefits system. Erm, and I think it's, it's important to acknowledge that, and to, to try and make it better in some ways. I think it's hard to know what to do, when you're a psychologist working within that system, erm, but I think it's useful to, to have those conversations.

### Extract 2

Patients tell me that they struggle, to access you know, if they're gonna have an assessment, that they struggle to access reasonable modifications like, being in a building with a lift rather than having to walk up 5 flights of stairs to get to your assessing room, erm, being able to audio or video record the, the session, and I kinda feel like it's similar for, for me as a clinician, I don't know, how to get in on that, to help people. Erm, therefore, I, I think it's a bit of a cop-out what we do in terms of, 'oh we won't get involved with that' and I understand the rationale for it, but I think it impacts so much on the people that we see, it doesn't sit comfortably, for me to, to not get involved with it. But I wouldn't know where to start.

3) Data extracts with the corresponding initial code and theme

Data extract	Initial code	Theme
<p>Participant 2:</p> <p><i>When you actually see it like, every day, not like a rare situation you know it's, it's like what, what am I doing here? Is it, is you know, and I say probably once a day I should have been, should have not been a psychologist (laughing) do you know what I mean, should've been like, policy, I dunno you know, just, I just think what, what are we doing? We're not, we're not contributing to meaningful, change for people</i></p>	<p>Questioning one's profession and career</p>	<p>What am I doing here?</p>
<p>Participant 9:</p> <p><i>Patients tell me that they struggle, to access you know, if they're gonna have an assessment, that they struggle to access reasonable modifications like, being in a building with a lift rather than having to walk up 5 flights of stairs to get to your assessing room, erm, being able to audio or video record the, the session, and I kinda feel like it's similar for, for me as a clinician, I don't know, how to get in on that, to help people. Erm, therefore, I, I think it's a bit of a cop-out what we do in terms of, 'oh we won't get involved with that' and I understand the rationale for it, but I think it impacts so much on the people that we see, it doesn't sit comfortably, for me to, to not get involved with it. But I wouldn't know where to start.</i></p>	<p>Uncertain of how to help</p>	<p>What am I doing here?</p>
<p>Participant 10:</p> <p><i>You know, we've had people who erm, people are often quite scared because of their previous experience, so I suppose I</i></p>	<p>Additional burden</p>	<p>Salt in the wound</p>

<p><i>don't necessarily feel I interact hugely with the benefits system, but I guess it comes up quite a lot, in terms of, erm, the struggles that people have that they're talking about, er. As I say, it's not the sole focus now, I'm not suggesting it is, but, I think, because a lot of the people are in quite a, a vulnerable, fragile state, then it becomes, erm, its, it's another, it's kind of, major stressor for them. And, you know as you know, multiple stressors, are more likely to impact people so, it just seems like one that maybe they could, I don't know, if it was managed differently or better, then that, that might improve things a little bit.</i></p>		
<p>Participant 1:  <i>Participant: We quite often write reports to support people's erm either applications or appeals...</i>  <i>Interviewer: Mhm.</i>  <i>Participant: ...for particular things. I'll be honest and say, I struggle with writing those reports because we know that to get people what they need, we have to really emphasise how impaired they are and what they struggle with and how much they can't do and that's completely counter to what we do therapeutically, where we're trying to get people to focus on what they can do and the recovery they've made and that type of thing. So, I do interact with the system in that way because I feel like it's in my patients' best interests but I, there's also a part of me that knows that it's, it's not truly in people's interests to read about themselves in that way.</i>  <i>Interviewer: Mhm.</i>  <i>Participant: But that's the catch 22 that we're in really.</i></p>	<p>Conflicting systems</p>	<p>A constant set of ethical dilemmas</p>

#### **Appendix 14.** Extracts from the process of analysis

Initial themes and sub-themes were drafted after coding. These came under the two aims of the study, relating to *the impact of the benefits system on the work of clinical psychologists* and the *role of clinical psychologists*. The former included:

- *A problematic benefits system*. Within this were sub-themes such as:  
inappropriate/rigid, powerful/hierarchy of needs, punitive and contrasting the work of clinical psychologists.
- *Psychological impacts*: additional burden, distress, self-perception/identity, powerlessness.
- *Resources/benefits system becomes the focus*: stuck in the sick role, dilemmas, meeting the needs of the benefits system.

In relation to the second aim, the analysis initially sought to understand the role of clinical psychologists but it became apparent that most participants were uncertain of their role within the context of the benefits system.

The themes required revision to stay true to the aims of the study and the narratives of participants. For example, rather than focusing on the *'problematic benefits system'*, the data was reviewed and regrouped to focus on what this meant for the work of clinical psychologists.

An example of a new theme was **'What am I doing?'** and below are initial codes that formed this:

Name	Files	References
What am I doing		0
Boundaries of role		6
Boundary between MH and social issue		8
BS becomes the focus or priority		9
Concern of engagement leading to removal of benefits		4
Concern of withholding resources from clients		4
CP plugging the gaps		2
Duty of care (responsibility)		7
Fairness of demands on clients		4
Feeling different (CP)		1
Feeling like a hypocrite (CP)		4
Hierarchy of needs		11
Judgement from others (CP)		3
Not my role (CP)		4
Playing along with the BS		5
Powerlessness and helplessness (CP)		11
Pressure (on CPs)		3
Psychological impact (CPs)		0
Questioning one's profession and career (CP)		3
Relationship and understanding of client		1
Resources		0
Therapy or CP as collusive or harmful		5
Timing of therapy		2
Uncertain of how to help		7
Uncertainty of role		8
Uncertainty of rules (CP)		3
Values		8

Transcripts and codes were reviewed and re-reviewed, which led to codes being grouped together, separated into different themes or deleted (where it was deemed that they were irrelevant to the research aims).

Codes such as ‘feeling like a hypocrite’, ‘not my role’ and ‘powerlessness and helplessness’ were combined with data under other groups such as, ‘questioning one’s profession and career’ and ‘uncertain of how to help’ (data extracts provided in Appendix 13) to form a theme that captured how participants viewed their job and the profession as a result of the benefits system, including the psychological impact of this. The in vivo quote of **“What am I**

**doing here?”** was seen to accurately illustrate this theme, thus it was used to name the final theme.

Codes such as ‘concern of engagement leading to removal of benefits’, ‘concern of withholding resources from clients’ and ‘hierarchy of needs’ also related to the role of clinical psychologists but were more concerned with the process and dilemmas involved in working in the context of the benefits system. Codes that specifically related to this theme, which was prevalent in the data, were combined and labelled with the in vivo quote “**A constant set of ethical dilemmas**”.

**Appendix 15.** Extracts from reflexive diary.

In the beginning stages of the project, prior to refining the topic area:

“From personal and professional experiences, I have seen the psychological impact of social differences and power. I have a strong aversion to power and punitive approaches, particularly towards people who are already disempowered. I really hope that this research can be useful and contribute towards change.”

“I recognise my position being that I want people to have the view that there is a problem and we have a role in influencing this.”

During the interviewing phase:

After interview 1: “I found it hard being in researcher rather than clinical role. I was conscious of wanting to validate and give more away. I wondered if I was a bit too neutral, which could reduce the openness of participants but the feedback from the participant did not suggest that. I want to remain conscious of not asking questions in a way that could be leading.”

Interview 10: “I almost said ‘our profession’ at some points in this interview. I noticed this and changed my wording. I need to continue to remain attentive to identifying with participants in this role and to remain in the role of a neutral researcher.”

## **Appendix 16.** Researcher's position statement

I am a White female from a mixed ethnic background, having been influenced primarily by British and Armenian culture. I come from a 'working-class' background (in terms of my parents' employment and level of education) but I have been exposed to 'middle-class'/more socioeconomically privileged environments through education, employment and socially. Having personal associations with the adverse psychological impact of socioeconomic disparities and the British class system, I experience feelings of anger and injustice towards these issues. A close relative of mine also shared with me the adverse psychological consequences that they experienced relating to process of attempting to claim out-of-work benefits and being denied these. In addition, I have been working as a Trainee Clinical Psychologist in the NHS during the research process and prior to this, I have worked in several roles with people experiencing psychological difficulties. Within these roles, I have some experience of working with people who were attempting to access disability benefits due to their psychological difficulties, who were experiencing increased distress due to the stress involved in the process and the threat of losing their benefits. I have experienced the process whereby the distress that was felt by clients in relation to claiming benefits meant that they found it difficult to focus and engage with the work that we intended to do together. As such, coming into the research I felt that there may be significant issues with the benefits system and that this might be adversely impacting psychological wellbeing of people claiming or attempting to claim benefits in the UK. If this is the case, I believe that professions working to enhance psychological wellbeing should attend to this issue in their practice. However, I do not regard myself as an expert in this area and I have approached this research with openness, curiosity and a desire to learn about the experiences and perspectives of others.