

Portfolio Volume 1: Major Research Project

Learning from Compassion-Fatigue and Moral Injury within the Clinical Psychology Profession during the COVID-19 Era

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Abstract

Rationale and Aims: Recognition that the physical and mental wellbeing of healthcare workers is crucial to safe and effective healthcare is well established. There is emerging research into the impact of the pandemic on physical healthcare professionals, however knowledge related to the impact on mental health professionals, especially Clinical Psychologists, is limited. It is important we hear from Clinical Psychologists themselves as experts in their lived experiences. The current research aimed to explore the experiences of National Health Service (NHS) Clinical Psychologists who worked during the COVID-19 pandemic and their experience of moral injury and compassion-fatigue.

Methods: This study took a qualitative approach to explore the experience of NHS Clinical Psychologists who worked during the COVID-19 pandemic. Twelve Clinical Psychologists took part in semi-structured interviews to share their experiences and identify lessons learnt from the pandemic.

Analysis: Data were analysed using inductive reflexive thematic analysis, and six main themes and nine subthemes were identified from the data. Qualitative data highlighted the complex and multifaceted experiences of compassion-fatigue and moral injury reported by participants. They faced significant challenges including the loss of privacy and containment from completing therapy online at home, supporting the emotional distress of colleagues, deciding who could access psychological therapy and who needed to have therapy paused, and feeling pressurised into having the COVID-19 vaccine. These experiences highlight the need to offer more support for Clinical Psychologists within the NHS and to create a less stigmatising environment to allow Clinical Psychologists to feel comfortable discussing their own mental health needs. This needs to occur at an individual and contextual level.

Discussion: Findings of this study were discussed in relation to the wider literature. This research produced new knowledge about how Clinical Psychologists made sense of their experiences during the pandemic, including the impact on both their personal and professional lives. This novel research will be of importance in shaping policy developments and procedures at both an organisational (NHS and professional bodies) and government level. Clinical implications for this population were also considered.

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"I feel like I ended up living my values while sacrificing myself"

'Lucy', Older Adults Clinical Psychologist

Table of Contents

Abstract	1
Acknowledgements	3
Table of Contents.....	6
List of Tables and Figures	11
Chapter One: Introduction	12
1.0 Chapter Overview.....	12
1.1 Overview of Empirical Literature: Situating the Topic	12
1.1.1 The NHS and Staff Wellbeing.....	12
1.1.2 The COVID-19 pandemic.....	14
1.1.3 COVID-19 and the impact on Mental Health Professionals.....	14
1.1.4 The Stigma: Mental Health of Clinical Psychologists.....	16
1.1.5 COVID-19 guidance on wellbeing needs for Clinical Psychologists	17
1.1.6 Social and Health Inequalities	18
1.2 Positioning the Researcher.....	19
1.2.1 My Relationship to the Research Topic	20
1.2.2 Insider Perspective.....	21
1.2.3 Epistemological Position.....	22
1.3 Defining Key Terms.....	22
1.3.1 Compassion-fatigue.....	23
1.3.2 Moral Injury.....	23
1.3.3 Burnout.....	24
1.4 Theoretical Concepts.....	25
1.4.1 The Socio-Ecological Framework.....	25
1.4.2 The Job Demands-Resource Model.....	27
1.5 Conclusions from Empirical and Theoretical Literature	28
Chapter Two: Systematic Literature Review	29
2.0 Chapter Overview.....	29

2.1 Initial Scope of the Literature	29
2.2 Search Strategy	30
2.3 Included Studies	36
2.4 Quality Assessment	52
2.4.1 Quality Evaluation of the Literature	60
2.5 Synthesis of Main Findings from Literature Review	63
2.5.1 Theme 1: New Challenges	64
2.5.2 Theme 2: The Emotional Toll	67
2.5.3 Theme 3: The Role of Relationships	70
2.6 Clinical Implications	74
2.7 Evaluation and Conclusions of the Systematic Literature Review	74
2.8 Gaps in the literature	75
2.9 The Rationale for the Current Study	76
2.10 Aims of the Research and Research Questions	76
Chapter Three: Methodology	78
3.0 Chapter Overview	78
3.1 Design	78
3.1.1 Adopting a Qualitative Stance	78
3.1.2 Consideration of Alternative Methodologies	79
3.1.3 Thematic Analysis (TA)	81
3.1.4 Limitations of Thematic Analysis	82
3.1.5 Epistemological Approach	82
3.1.6 Reflexivity	83
3.1.7 Consultation with Experts by Experience	83
3.2 Participants	84
3.2.1 Recruitment	84
3.2.2 Challenges to Recruitment	87
3.2.3 Inclusion and Exclusion Criteria	88

3.2.4 Participant Demographics	89
3.3 Ethical Considerations	91
3.3.1 Ethical Approval.....	91
3.3.2 Informed Consent	92
3.3.3 Right to withdraw.....	92
3.3.4 Confidentiality and Data Protection	92
3.3.5 Thanking Participants for their Time.....	93
3.3.6 Managing Potential Distress	94
3.4 Interviews	95
3.4.1 Development of the Interview Schedule.....	96
3.4.2 The Impact of Video Interviews	96
3.4.3 Data Collection	97
3.5 Data Analysis	98
3.5.1 Phase 1: Familiarisation with the dataset.....	99
3.5.2 Phase 2: Coding	99
3.5.3 Phase 3: Generating Initial Themes.....	100
3.5.4 Phase 4: Developing and Reviewing Themes	100
3.5.5 Phase 5: Refining, Defining and Naming Themes.....	101
3.6 Methodological Rigour	101
Chapter Four: Results.....	105
4.0 Chapter Overview.....	105
4.1 Theme 1: The Calm Before The Storm	107
4.1.1 Sub-theme 1: We Know Where We Stand.....	107
4.1.2 Sub-theme 2: Psychology's Everyday Struggles.....	108
4.2 Theme 2: The Distant Thunder.....	110
4.2.1 Sub-theme 3: The Eye Of The Storm	114
4.3 Theme 3: We Are In The Same Storm, But Not The Same Boat	118
4.4 Theme 4: Weathering The Storm	121

4.4.1 Sub-theme 4: Survival Mode.....	122
4.4.2 Sub-theme 5: Psychology's A Sinking Ship.....	125
4.4.3 Sub-theme 6: Forging Ahead Through The Turbulent Sea	128
4.5 Theme 5: What About The Passengers?	130
4.6 Theme 6: Breaking Through The Clouds	133
4.6.1 Sub-theme 7: You Don't Know What You've Got Until It's Gone.....	134
4.6.2 Sub-theme 8: Every Cloud Has A Silver Lining	138
4.6.3 Sub-theme 9: Psychology Has A Lot To Learn.....	141
Chapter Five: Discussion.....	146
5.0 Chapter Overview.....	146
5.1 Revisiting the Research Questions	146
5.2 Summary of the Findings.....	147
5.2.1 What were Clinical Psychologists' experiences of compassion-fatigue during the pandemic?	147
5.2.2 What were Clinical Psychologists' experiences of moral injury during the pandemic?	148
5.3 Quality Assessment	150
5.3.1 Strengths of the Research.....	150
5.3.2 Limitations of the Research	151
5.4 Clinical Implications and Recommendations	153
5.4.1 Individual Level.....	154
5.4.2 Interpersonal Level	155
5.4.3 Institutional Level	156
5.4.4 Community Level	161
5.4.5 Policy Level.....	162
5.5 Invitations for Future Research	164
5.6 Conclusions.....	166
5.7 Dissemination	166
5.8 Final Reflections: An End, but not <i>the</i> End.....	167
References.....	168

Appendices	194
Appendix A: Mind Map of Initial Project Ideas	194
Appendix B: SLR Mapping descriptive themes onto analytical themes.....	195
Appendix C: Excerpts from IRAS Form	196
Appendix D: Email from Health Research Authority (HRA) – amendments/further information request.....	198
Appendix E: Email of amendments to the Health Research Authority (HRA) – in response to Appendix D	200
Appendix F: Ethical Approval Notification	201
Appendix G: Health Research Authority (HRA) Approval Letter	202
Appendix H: Confirmation of Capacity and Capability from NHS Trusts	205
Appendix I: Sponsorship in Full	206
Appendix J: Ethical Amendment Approval Notification.....	207
Appendix K: Recruitment Poster	209
Appendix L: Participant Information Sheet	210
Appendix M: Expression of Interest Form.....	214
Appendix N: Consent Form	215
Appendix O: Interview Schedule	217
Appendix P: Support Information	223
Appendix Q: Wellbeing boxes presented to participants on completion of their interview	224
Appendix R: Excerpts of Coded Transcript from NVivo.....	225
Appendix S: NVivo Codes Grouped Together.....	226
Appendix T: Initial Thematic Map	227
Appendix U: Final Thematic Map	229
Appendix V: Reflexive Journal Excerpts	231
Appendix W: Excerpts from Bracketing Interview	233

List of Tables and Figures

Tables

Table	Title	Page Number
1	Systematic Literature Review: Search Terms	31
2	SPIDER Tool	32
3	Literature Search Inclusion and Exclusion Criteria	33
4	Overview of Studies Included in the Systematic Literature Review	37
5	Critical Appraisal of Included Studies	53
6	Table of Themes from Thematic Synthesis	64
7	Participant Inclusion and Exclusion Criteria	88
8	Participant Demographic Information	90
9	Steps Taken to Mitigate Participant Distress	94
10	Braun and Clarke's (2022) 6-step Guide to Reflexive Thematic Analysis	98
11	Assessment of the Quality of this Research using Tracy's (2010) Eight "Big Tent" Criteria for Excellent Qualitative Research	101
12	Table of Themes from the Current Study	106
13	Summary of Clinical Implications	163

Figures

Figure	Title	Page Number
1	PRISMA Diagram	35
2	Thematic Map of Themes and Sub-Themes	106

Chapter One: Introduction

1.0 Chapter Overview

This research explored the experiences and views of National Health Service (NHS) Clinical Psychologists who worked during the COVID-19 pandemic, with particular focus on their experiences of moral injury and compassion-fatigue. There is limited knowledge related to the impact of the pandemic on mental health professionals, and especially mental health therapists. Within this chapter, I situate the research considering broader research from the COVID-19 pandemic and the impact this had on the role and experiences of mental health professionals working during this time. I will also position myself and share my relationship to this research, whilst highlighting how this research is aligned with my critical realist epistemology. Finally, an overview of the relevant background literature will be summarised, providing context to the current research, and highlighting the relevance of the topic for the profession of Clinical Psychology.

1.1 Overview of Empirical Literature: Situating the Topic

1.1.1 The NHS and Staff Wellbeing

Recognition that the physical and mental wellbeing of healthcare workers is crucial to safe and effective healthcare is well established (Hall et al., 2016). Supporting wellbeing is now considered an ethical must and an employer responsibility (Serrano-Ripoll et al., 2020), with policy documents, such as 'The NHS People Plan', highlighting the importance of staff wellbeing (NHS England, 2020). It is also essential in reducing sick leave, burnout, and staff turnover, thus safeguarding the survival of our healthcare systems (West, Dyrbye & Shanafelt, 2018; Johnson et al., 2018).

The NHS staff survey (2020) identified an increase in staff feeling unwell because of work-related stress (44% of staff), a reduction in staff reporting that they were looking forward to work, and a reduction in those who said they were often or always enthusiastic about their jobs. The survey also found that female staff, particularly nurses, were at a 24% greater risk of suicide than the national average for women.

Mental health services across the United Kingdom have suffered greatly under austerity (Reeves et al., 2013), with demands on healthcare having increased and the system struggling to cope with additional pressures. This is also the case in mental healthcare (Galante, Humphreys & Molodynski, 2019), with research highlighting increased rates of mental health problems amongst staff due to burnout, stress, depression, and anxiety which has further impacted along with pre-existing shortages among staff (Bhugra, Molodynski & Gnanapragasam, 2021). This highlights the pre-pandemic context of NHS staff's mental wellbeing, and the pre-existing difficulties that staff were reporting.

The Health and Care Professions Council (HCPC) and the British Psychological Society (BPS) have distinct processes for ensuring fitness to practice among healthcare professionals, which are crucial for maintaining staff wellbeing within the NHS. These codes of professional behaviour are designed to safeguard the public and expect clinicians to maintain standards of proficiency (e.g. Health and Care Professions Council, 2015) (Tay, Alcock & Scior, 2018). However, there is concern that these codes of practice inadvertently impact on clinicians' willingness to share, due to concerns about confidentiality and fears that their future career prospects would be impacted (Garelick, 2012; Hassan et al., 2009).

In summary, the mental health of healthcare professionals is of great importance to ensure the safe and effective running of the NHS. Despite this, research is showing that

many healthcare professionals are experiencing poor mental health outcomes from work. The fitness to practice process of the HCPC and BPS, along with NHS wellbeing initiatives, work together to ensure that healthcare professionals can perform their duties safely and effectively while maintaining their own health and wellbeing. However, there are concerns these practices impede on clinicians' willingness to share about their mental health difficulties (Garellick, 2012). Despite this, an integrated approach is crucial for sustaining high standards of care within the NHS.

1.1.2 The COVID-19 pandemic

The Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus (Glowacz, Schmits, & Kinard, 2022). The World Health Organisation (WHO) officially declared the disease a pandemic on 11th March 2020 (Cucinotta & Vanelli, 2020). As a result, governments worldwide enforced restrictive measures, such as personal measures (e.g., use of masks; hand hygiene), physical measures (e.g., social distancing; lockdowns), and movement measures which limited the movement of people locally or nationally (WHO, 2020).

1.1.3 COVID-19 and the impact on Mental Health Professionals

"Well into the third year of the COVID-19 pandemic, this report confirms that the levels of anxiety, stress and depression among health and care workers has become a 'pandemic within a pandemic'" Jim Campbell, WHO Director of Health Workforce (WHO, 2022).

There has been extensive research conducted about the mental health of the general population, however there is very limited research about the mental health of the

individuals providing mental health services (Tay, Alcock & Scior, 2018). The pandemic and the measures implemented to deal with the virus brought about unprecedented levels of stress, burnout, and a dramatic change in practice to healthcare systems across the world (Brooks et al., 2020). During the pandemic, mental healthcare professionals were placed in an exceptional situation, providing care while making far-reaching ethical and moral decisions under extreme pressures (Xiang et al., 2020). These decisions included determining how to allocate limited resources to meet the needs of service users, balance their own mental and physical wellbeing, and how to provide care to severely unwell service users with constrained or insufficient resources (Greenberg et al., 2020).

There is now an emerging body of literature looking to address this gap by looking at the experiences of mental health professionals who worked during the pandemic (Billings et al., 2021). For example, research conducted by Franza et al. (2020) found an increase of overall compassion-fatigue scores in all 102 healthcare workers studied following the pandemic; however, there was a larger increase in compassion-fatigue scores in psychiatric health workers (22% and 33%, respectively). Causes of compassion-fatigue were found to be related to increased workload and demand (Maben & Bridges, 2020), exposure to service user trauma (Nishihara, 2022), and isolation and social distancing from friends, family, and work colleagues (Brooks et al., 2020).

Moral injury among health professionals during the COVID-19 pandemic has been significant. Mantri et al. (2021) conducted a global study finding 46% of healthcare workers experienced moderate impairment in social or professional functioning related to moral injury symptoms. Additionally, Wang et al. (2022) found that moral injury symptoms were

strongly associated with increased clinician burnout, greater psychological distress, and lower levels of subjective wellbeing.

Understanding the impact of moral injury and compassion-fatigue among mental healthcare professionals is therefore crucial for developing support systems and interventions to address the long-term psychological effects of the pandemic on this workforce.

1.1.4 The Stigma: Mental Health of Clinical Psychologists

Within the limited exploration of the mental health of mental health professionals, there is even less research on the mental health of Clinical Psychologists, which is typically either dated or resulting from small-scale studies (Tay, Alcock, & Scior, 2018). A recent study by Tay, Alcock and Scior (2018) found that of the 678 Clinical Psychologists they surveyed, 62.7% described having experienced a mental health problem(s) at some point in their life, and more than half reported hesitancy to disclose these to colleagues and supervisors.

Clinical Psychologists may feel that it has been difficult to acknowledge the personal impact of the COVID-19 pandemic on them, due to the mistaken perception that psychologists should know how to cope with stress (Pope & Tabachnick, 1994), making it harder for them to ask for help. The impact for Clinical Psychologists of downplaying or ignoring signs of mental health problems, and thus evading appropriate help-seeking, is likely to intensify existing mental health difficulties, lead to the development of new mental health difficulties, impair functioning and fitness to practice, and their ability to provide quality care (APA, 2008; Health and Care Professions Council, 2015). Tay, Alcock and Scior (2018) found self-stigma, fear of a negative impact on (self-)image, and shame negatively

influenced disclosure and help-seeking amongst Clinical Psychologists. Additionally, research by Aina (2015) found that British Clinical Psychologists were more comfortable disclosing difficulties with their mental health within their own social circles, than to colleagues or employers.

It is therefore crucial that Clinical Psychologists, and the systems around them, acknowledge these challenges and recognise their potential impact. Furthermore, a change in the culture of healthcare services more generally is needed to encourage open conversations from staff about lived experience in the workplace, with the aim of reducing stigma and the associated shame (Tay, Alcock & Scior, 2018).

1.1.5 COVID-19 guidance on wellbeing needs for Clinical Psychologists

“Psychologists have made a significant contribution to the UK’s response to the COVID-19 pandemic, influencing Government policy, the media and public health messages...The pandemic has, in addition, resulted in personal and professional challenges to psychologists that may impact upon the wellbeing of our profession and on us as individuals” (BPS, 2020, p.3).

Following the start of the COVID-19 pandemic, it has been shown that many psychologists worldwide have experienced some negative impact on their mental health (Norcross & Phillips, 2020). Despite this, there has been limited research focussing directly on the experiences of NHS Clinical Psychologists working during the COVID-19 pandemic. Working as individuals in multiple systems there is an expectation that Clinical Psychologists also support the healthcare system from within, adding further pressure. The inherent

stress for Clinical Psychologists in listening to, and managing, their service users' trauma makes them more vulnerable to work-related stress and burnout (Lamb & Cogan, 2016).

In 2020, the BPS released its own guidance on the impact of COVID-19 on the wellbeing of psychologists following an identified need that, *“as psychologists, we have been very active in offering advice to other groups, but perhaps not so active in considering and addressing our own needs”* (BPS, 2020, p.1). The aim of this document was to acknowledge the impact of the pandemic on the profession, and to offer a range of resources and experiences from and to Clinical Psychologists from a variety of settings to support those working during the pandemic and improve their wellbeing.

Given the elevated work-related stress, acknowledgment of Clinical Psychology prioritising the needs of others, and increased levels of trauma Clinical Psychologists have been exposed to during the pandemic, understanding the coping strategies used by these professionals during this time of increased stress is vital for the promotion of their wellbeing and the quality of clinical practice (Keyes, Yankouskaya, & Panourgia, 2022). Furthermore, it's important to understand what was learnt by Clinical Psychologists who worked during the pandemic, to help promote ideas for future directions of clinical practice and policies.

1.1.6 Social and Health Inequalities

The economic and public health crisis created by the COVID-19 pandemic has exposed existing inequalities and created additional inequalities (Platt & Warwick, 2020). Individuals from racially minoritised groups, poorer socioeconomic backgrounds, urban and rurally deprived areas, and vulnerable groups of society (such as older adults), have been particularly affected (Mishra et al., 2021).

Individuals from the global majority were particularly hard-hit by the COVID-19 pandemic, in relation to both mortality risks and economic impacts (Platt, 2021). Whilst there remains no definitive evidence as to why this disparity exists, looking at the roles and responsibilities of care professionals from the global majority it becomes clear they are more likely to be involved in care actions and procedures on the frontline as keyworkers, and involved in direct service user care, where the risk of infection is greatest (Serrant, 2020). This is especially salient for the black African ethnic group, where nearly a third of the working-age population are employed in key worker roles, and one in five are in health and social care jobs (Platt & Warwick, 2020).

There is growing evidence highlighting the COVID-19 mortality is higher for individuals who are socioeconomically deprived, in addition to having protected characteristics such as pregnancy and disability (Mishra et al., 2021). Lockdown measures enforced by many local governments also put a strain on the society's most economically challenged groups, causing a vicious cycle exacerbating the poor health outcomes for the underprivileged members of the society (Mbunge, 2020). It is therefore important to consider how this might act as a backdrop for the experiences for Clinical Psychologists working during the pandemic.

1.2 Positioning the Researcher

All qualitative research is contextual; it occurs within a specific time and place between two or more people. Maintaining a self-reflexive position throughout qualitative research - by being transparent about the contextual interconnecting relationships between the participants and the researcher - not only improves the creditability of the findings but also deepens our understanding of the work (Dodgson, 2019). Taking a self-reflexive stance

also allows the researcher to consider how their position may impact on the outcomes of the research (Elliott et al., 1999), ensuring rigour and quality in their work (Dodgson, 2019). It is therefore important I start this report by outlining my own position in relation to the research, both from a personal and epistemological perspective. Unlike the norm in academic research, I will be writing in the first person. This is in line with the critical realist position of this study, and to demonstrate a recognition of my involvement in co-constructing this research.

1.2.1 My Relationship to the Research Topic

For the seven years before I successfully earned my place on the Doctorate in Clinical Psychology, I worked as an Assistant Psychologist (AP) in the National Health Service (NHS). During this time, I worked across several NHS Trusts, in different services, and alongside a multitude of mental health professionals, but especially Clinical Psychologists. For seven years, I developed a strong connection to the NHS and the profession of Clinical Psychology.

In March 2020, I was working as an AP in an NHS Child and Adolescent Mental Health service (CAMHS). To help me make sense of my experience, I began by drawing out a mind map of my reflections from this time, to help generate ideas for my research topic (Appendix A). Working during the pandemic, I witnessed the impact it had on the NHS as an organisation, but also Clinical Psychology as a profession. I observed the additional pressures and responsibilities placed on the Clinical Psychologists around me, and how there seemed to be little support in place for them. I was exposed to how much time and effort Clinical Psychology puts in to supporting and observing the needs of others, and yet spends very little time supporting and observing itself.

Given the recognition that the physical and mental wellbeing of healthcare workers is crucial to safe and effective healthcare (Hall et al., 2016), and given my first-hand experiences of the impact of COVID on Clinical Psychologists' wellbeing, I am hoping for this research to shine a light on Clinical Psychology and to be used as a resource for local NHS organisations, and the Clinical Psychology profession, to rethink how they support Clinical Psychologists and the work they do.

1.2.2 Insider Perspective

Insider researchers are those who share similar contexts and experiences as the group or culture being studied (Greene, 2014). Researchers operating within critical paradigms have identified the value in the knowledge that arises from lived experience (Chavez, 2015), such as the ability to create a sense of safety and build rapport, the consideration of community norms and values, and an increased depth within the interpretation of the data due to having an insider understanding of the social, political, and historical context of the participants (Ross, 2017). At the same time, insider status can also bring challenges, in particular presumptions made on the part of the researcher of a shared understanding of important concepts which could impact on the participant's meaning making (Chavez, 2015). I recognise the potential for my own bias in this research due to my closeness to the topic and have used both bracketing (Appendix W) and a reflexive diary (Appendix V) to consider how I might become aware of this and take actions to respond accordingly.

1.2.3 Epistemological Position

Epistemology is concerned with the nature of knowledge, how it is obtained, and how confident we can be about its validity (Willig, 2019). I adopted a critical realist (CR) perspective for this study, enabling me to think conceptually about the different processes which may be underlying and influencing the outcomes (Sayer, 2000). It also allows the opportunity to explore the relational and causal mechanisms at play, whilst acknowledging the wider social, political, historical, and cultural contexts (Miller & Tsang, 2011). Critical realism acknowledges the importance of both objective reality and subjective experiences in understanding the world. I will therefore also be drawing on anecdotal experience of working in NHS services during the COVID-19 era.

A critical realist perspective moves beyond the 'taken as read' by challenging the assumptions that often go unquestioned in traditional research paradigm, emphasising the importance of understanding the underlying structures and mechanisms that generate observable phenomena (Archer, 1998). Within the current project, critical realism provides a framework to enable a comprehensive exploration of both the visible impacts (such as increased workload and stress) and the underlying causes (such as institutional policies, resource availability, and societal/professional attitudes towards mental health) affecting Clinical Psychologists working during the pandemic (Fletcher, 2017).

1.3 Defining Key Terms

Having a shared understanding of key terms is important. The CR perspective argues that language mediates our interactions with the world, affecting how we communicate and share knowledge (Archer, 1998). The key terms discussed in this thesis will therefore be

summarised below to help the reader understand the lens through which I approach this research.

1.3.1 Compassion-fatigue

The traumatologist, Charles Figley, referred to compassion-fatigue as “the cost of caring,” and defined it as “the deep physical, emotional, and spiritual exhaustion that can result from working day to day in an intense caregiving environment” (Figley & Roop, 2006). Compassion-fatigue may be brought about by a stressful workplace or environment, lack of resources, or excessive hours. Compassion-fatigue has been associated with a decrease in quality care for service users, an increase in clinical errors, higher rates of anxiety and depression disorders among healthcare workers and increasing rates of stress-related leave (Mathieu, 2012).

1.3.2 Moral Injury

Greenberg et al. (2020) define moral injury as, “...*psychological distress that results from actions, or the lack of them, which violate someone’s moral or ethical code*” (p.1).

Moral injury is more likely to be experienced by individuals if there is a lack of time and preparation for the moral dilemmas they might face, and if there is inadequate organisational support. Experiences of moral injury can lead to the development of negative beliefs that threaten an individual’s perceived identity or view of the world (for example, “I’m a terrible person” and “I failed my team”), as well as the potential for feelings of guilt, shame, disgust, and anger (Williamson et al., 2021).

There are, however, limitations to defining moral injury with no one clear agreed upon definition. Instead, within the growing literature several related terms are beginning

to emerge, such as moral frustration (Litz & Kerig, 2019), moral pain (Farnsworth et al., 2017), and moral distress (Litz & Kerig, 2019). What this demonstrates is that moral injury is a complex psychological experience that requires a comprehensive array of terminology to adequately explain it (Atuel et al., 2020).

1.3.3 Burnout

Burnout refers to the emotional exhaustion, depersonalisation, and lack of personal fulfilment at work resulting from continuous exposure to occupational stressors (Rodrigues et al., 2018). The World Health Organisation (WHO) defines burnout as: *“a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed”* (WHO, 2022). As with compassion-fatigue, burnout can have serious consequences for both service users and healthcare professionals. Burnout has been shown to result in poor physical and mental health outcomes, lack of motivation, high sickness levels, and low morale in healthcare staff.

Kopacz, Ames & Koenig (2019) identified some overlap in the conceptual understanding, signs and symptoms of burnout and moral injury – highlighting the importance of clearly defining the differences in these terms. Research has shown many healthcare professionals experienced burnout during the pandemic (Sung et al., 2021; Burrowes et al., 2023), with the term burnout being seen as less stigmatising than moral injury (Kopacz, Ames, & Koenig, 2019), and may therefore be a concept more comfortably spoken to by clinicians. It is important to note burnout is not a focus of the current study. This is due to the plethora of research already carried out into burnout on healthcare staff, along with this study needing to remain focussed in keeping with the scope of a doctoral level thesis.

1.4 Theoretical Concepts

This section looks to outline relevant theoretical concepts that help to construct the current context of Clinical Psychologists' experiences of working during the COVID-19 pandemic. Applying these theoretical concepts can help in the designing of interventions and support systems that enhance the wellbeing and effectiveness of Clinical Psychologists, during the on-going challenges faced following the pandemic.

1.4.1 *The Socio-Ecological Framework*

Bronfenbrenner's (1979) socio-ecological framework, which is commonly applied within health research (Schneiders, Mackworth-Young & Cheah, 2022), suggests that human behaviours and experiences are best understood as an interaction between the individual and the wider social and environmental systems in which they live (McLaren & Hawe, 2005). In the context of NHS Clinical Psychologists working during the pandemic, this framework can be particularly useful, as it allows for the consideration of the multiple levels of influence at play, and how they interacted dynamically during COVID-19. Chemali et al. (2022) utilised this framework in their research on healthcare workers experiences during the pandemic, identifying the following levels:

1. *Individual level:* Healthcare workers' well-being, professional and personal identity, and daily work-life routine
2. *Interpersonal level:* Healthcare workers' relationships with their private and professional environment
3. *Institutional level:* Decision-making processes at work, organisation factors and availability of institutional support

4. *Community level*: Morale, norms, and public knowledge and support
5. *Policy level*: Perceived governmental response, support, and the impact of its measures on healthcare workers.

Socio-ecological frameworks therefore challenge assumptions that individuals can be viewed in isolation from their social context. Instead, the frameworks suggest that individual behaviours, experiences, and outcomes (e.g. wellbeing) are determined by interpersonal dynamics and wider systems within which the individuals are a part of (Bronfenbrenner, 1979; McLaren & Hawe, 2005). This framework also aligns with the critical realist perspective, which advocates for the idea that understanding of complex phenomena requires an understanding of the underlying mechanisms that generate observable phenomena, recognising that these mechanisms operate at different levels and can interact in complex ways (Bhaskar, 1979).

Whilst there are strengths to utilising this framework, it is not without its critiques. Research argues that the framework lacks detailed mechanisms explaining how the different levels and systems interact to influence development (Rosa & Tudge, 2013). This can, in turn, limit the framework's use in guiding detailed interventions. Rosa and Tudge (2013) also comment on the framework's reflection of Western-centric perspectives, identifying that this framework does not account for cultural variations in development and environmental interactions. Despite these limitations, this framework provides a comprehensive approach to understanding human experiences within multiple environmental contexts.

1.4.2 The Job Demands-Resource Model

The Job Demands-Resource (JD-R) model is a well-established framework in Occupational Psychology that suggests stress is a consequence of an imbalance between the individual's demands and their resource to meet these demands (Bakker & Demerouti, 2007; 2017). The model posits that every job has its own specific characteristics, which can be categorised into job demands (e.g. workload, emotional demands), and job resources (e.g. support from colleagues, autonomy, opportunities for professional development) (Van den Broeck et al., 2010). The model proposes that when demands are constantly high and not compensated by the motivational impact of resources, compassion-fatigue, poorer job satisfaction and job performance are reported as a result (Cho et al., 2020).

Within the context of the pandemic, there is an undeniable need to examine the job demands and resources that were available in health contexts to prevent the development of negative outcomes such as compassion-fatigue and moral injury (Moreno-Jiménez et al., 2021). For example, it has been shown that healthcare professionals experienced a significant increase in work-related stress factors such as witnessing service users dying and having low control (job demands), while concurrently not having access to external coping strategies such as social support or hobbies (job resources) (French, Hanna & Huckle, 2022).

In conclusion, by applying the JD-R model, teams and organisations can create a balanced work environment that not only reduces the risk of developing compassion-fatigue and burnout, but also promotes the overall wellbeing and job satisfaction of Clinical Psychologists who worked during the COVID-19 pandemic.

1.5 Conclusions from Empirical and Theoretical Literature

The presented literature highlights the vast challenges Clinical Psychologists, and other mental health professionals, faced whilst working during the COVID-19 pandemic. This includes the identified health and social inequalities, feeling unable to share their own mental health challenges, and elevated work-stress levels. It is clear from the literature that the nuance of Clinical Psychologists' experiences is often lost as research has focussed on mental healthcare workers more generally. There is a scarcity of literature focused on NHS Clinical Psychologists experience of working during the pandemic, specifically examining their experiences of moral injury and compassion-fatigue. To address this, chapter two of this study explored the existing literature on the topic.

Chapter Two: Systematic Literature Review

2.0 Chapter Overview

This chapter outlines how I systematically identified, collated, and critically examined the relevant literature with the aim of understanding more about experiences, views, and roles of mental health therapists who worked during the COVID-19 pandemic. A critical quality evaluation of the literature will follow, analysing the methodologies used and identifying any gaps in knowledge. The chapter will close with the rationale for the current research.

2.1 Initial Scope of the Literature

This systematic literature review commenced in July 2023. An initial scope, using a range of bibliographical databases (including The Cochrane Library and PROSPERO), exposed gaps in the literature related to the impact of the COVID-19 pandemic on mental health therapists, and their experiences of moral injury, burnout, and compassion-fatigue during this time. The initial scope found there was limited research into the experiences of Clinical Psychologists during this time. It was therefore felt there was not enough literature for this group to be the sole focus. Therefore, the search criteria was widened to include mental health therapists more generally. There already exists many quantitative studies assessing the psychological distress of mental health therapists during the pandemic. Synthesising qualitative research in this review would allow me to bring context, offer a human perspective and focus on the meaning and interpretations of the participants. This method also aligns with my critical realist epistemology.

This review therefore aimed to synthesise and critically evaluate the current state of knowledge relating to the experiences of mental health therapists working during the COVID-19 pandemic. Specifically, this review aimed to answer the question: *“What are the experiences and views of mental health therapists working during the COVID-19 pandemic, in relation to compassion-fatigue and moral injury?”*

2.2 Search Strategy

The literature search was carried out between July 2023 and January 2024. Multiple searches of electronic databases were conducted using ‘PubMed’, ‘Scopus’, ‘PsycArticles’, and ‘CINAHL’, as they were deemed to capture the range of publications that could potentially feed into the study aims. The decision was also made to search through Grey Literature using the electronic database ‘ETHOS’, however this did not yield any results.

Boolean operators, such as AND, and, OR (Ely & Scott, 2007) were used to help retrieve specific results and reduce the number of search results. Relevant search terms were truncated (*) to ensure the inclusion of variations on specific search terms along with the plural terms (Table 1). Terms such as ‘burnout’ and ‘vicarious trauma’ were included within the search terms to help increase the yield of results and act as a starting point for reviewing the literature in this area. These terms were not focussed on as part of the analysis, however. This was due to the large scope of literature already covering these terms, and the need for this systematic literature review to be focussed given the limited scope available.

Table 1*Systematic Literature Review: Search Terms*

Terms relating to context (Covid-19 pandemic)		Terms relating to participant group		Terms relating to psychological impact		Terms relating to psychological impact
"COVID-19" OR "Coronavirus" OR "COVID-19 Pandemic"	AND	"Clinical Psychologist*" OR "Psychological Practice" OR "Psychologist*" OR "Clinical Psychology" OR "NHS psychology" OR "Mental Health therapist"	AND	"Compassion fatigue" OR "Burnout" OR "Vicarious trauma" OR "Psychological distress"	AND	"Moral Injury" OR "Emotional Distress" OR "Moral Harm"

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) tool, developed by Cooke, Smith and Booth (2012) was used to inform and standardise the search strategy, to define key elements of the review question, and clarify inclusion/exclusion criteria (Table 2). The SPIDER tool is an alternative to the more frequently used PICO (Population, Intervention, Comparison, Outcome) tool as it modifies

the PICO components, making them better suited to searching for qualitative research papers (Cook, Smith & Booth, 2012).

Table 2

SPIDER Tool

SPIDER	
SAMPLE	Mental Health Therapists
PHENOMENON OF INTEREST	COVID-19 pandemic, experiences of moral injury and compassion-fatigue in the context of working during COVID-19
DESIGN	Interviews: can be structured or unstructured, focus groups, held over the telephone, in person or online.
EVALUATION	Views, experiences, and roles
RESEARCH TYPE	Qualitative, mixed methods

All papers were then screened for inclusion and exclusion criteria (Table 3). Only papers available in English were included within the review given the limited resources and timescale of the project. Given the paucity of research, it was decided that studies published outside of the UK would also be included. Several of the studies selected for review are therefore situated in different geographical and cultural contexts, for example Belgium (Glowacz, Schmits & Kinard, 2022) and the Philippines (Ledesma & Fernandez, 2022). The research acknowledges that this may impact experiences and outcomes for mental health therapists involved. In line with the aims of this literature review, mixed-methods papers were included, however it was agreed that only the qualitative sections of these papers would be included in the analysis to tap into the experiences and views of participants.

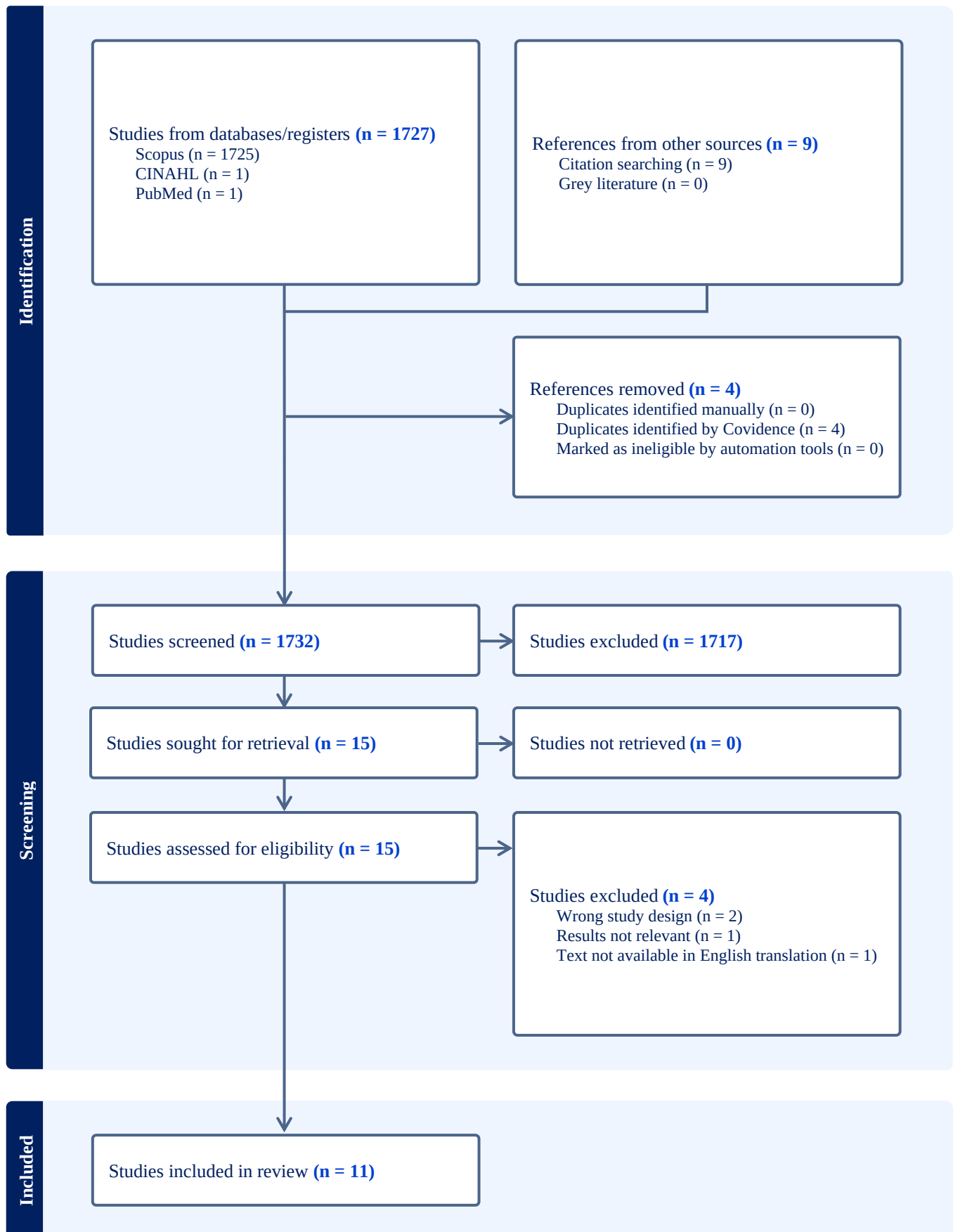
Table 3*Literature Search Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Written in English, or available in English translation	Not in English, or English translation is not available
Published after 1st March 2020	Quantitative in design
Qualitative or mixed methods studies that explore first-hand experiences, views, or the role of mental health therapists, from which data can be extracted	Heterogeneous samples from which it is not feasible to discern which participants worked specifically in mental health settings, or where it is not clear what the profession of the participants is
Studies that report any outcome that explores the impact of COVID-19 in mental health therapists	Descriptive or theoretical papers that do not evaluate or explore the experiences, views, or role of mental health therapists working during the COVID-19 pandemic
	Book chapters, conference papers, dissertations/theses, other systematic literature reviews

Search results from different databases were combined and duplicates removed using Covidence software. In total the initial literature search retrieved 1,727 papers. Additional searching of citations and references acquired another nine papers. I then screened study titles and abstracts for inclusion in the review. After initial screening, fifteen papers were selected for full text review which was completed by me, the principal supervisor, secondary supervisor, and a fellow trainee assessing for eligibility. My fellow trainee and I met to discuss any articles where it was less clear if they met the inclusion criteria and decide together if the study should be included in the review. I also utilised the

support of the principal supervisor with the decision-making process, through supervision and discussion. After full text review was completed, eleven papers were selected for data extraction and quality assessment. The review was registered on and accepted by PROSPERO on 16th February 2024 (registration number: CRD42024513466). Prospective registration of a review aims to reduce bias in the conduct and reporting of research, and to increase transparency (Pieper & Rombey, 2022).

PRISMA (Preferred Reporting Items for Systematic Reviews) guidelines (Page et al., 2021) for reporting systematic reviews were followed (Figure 1). This offers a transparent and flexible guide to reporting systematic reviews. At the time of writing, it is important to acknowledge that this research area continues to rapidly evolve, and further reviews will be needed in the coming years.

Figure 1*PRISMA Diagram*

2.3 Included Studies

The literature review identified eleven studies that met the inclusion criteria and focused on the experiences of mental health therapists working during the COVID-19 pandemic. Of these papers, seven studies utilised a qualitative methodology and four utilised mixed-methodology designs. The mixed-methodology papers included sufficient qualitative data to meet the systematic reviews inclusion criteria (McBeath, du Plock, & Bager-Charleson, 2020; Tolland & Drysdale, 2023; Glowacz, Schmits, & Kinard, 2022; Asbrand et al., 2023). Most of the identified studies were based in the UK (n=7), with the remainder based across Europe (n=3) and Asia (n=1).

Two papers looked at mental health therapists' experiences of and challenges with working from home during the pandemic (McBeath, du Plock, & Bager-Charleson, 2020; Tolland & Drysdale, 2023). Two papers looked at the experiences of Clinical Psychologists working in Learning Disability services during the pandemic (Chemerynska, Marczak, & Kucharska, 2022; Gregson, Randle-Philips, & Delaney, 2022). Six papers looked more generally at the experiences and changes to practice for mental health therapists during the pandemic (Singh et al., 2024; Glowacz, Schmits, & Kinard, 2022; Billings et al., 2021; Kreh et al., 2021; Ledesma & Fernandez, 2022; Asbrand et al., 2023). One paper focussed on what has been learnt from working during the pandemic (Cogan et al., 2022). A summary of the findings, including strengths and limitations, can be found in Table 4.

Table 4*Overview of Studies Included in the Systematic Literature Review*

Title, Author (year), and Country	Study Aim(s)	Participants/Sample Characteristics	Data Collection	Data Analysis	Summary of Findings	Strengths (+) and Limitations (-)
The challenges and experiences of psychotherapists working remotely during the coronavirus pandemic McBeath, du Plock & Bager-Charleson (2020) United Kingdom	To explore the experiences and challenges of psychotherapists who have been working remotely during the ongoing coronavirus pandemic	Purposive sampling of post-qualified psychological therapy practitioners. N = 335 Years as a therapist: - 1–4: 23% - 5–8: 18% - 9–12: 16% - 12+: 43%	Online survey including multiple response questions with respondents able to select more than one option.	Mixed methods study: - Quantitative data: descriptive statistics - Qualitative data: reflexive thematic analysis	Therapists working during the coronavirus pandemic were required to significantly adapt their ways of working and thinking to ensure that their service users could receive effective therapy. Challenges therapists faced included reconfiguring the relational and personal dynamics of the therapeutic alliance. Overall, the findings show therapists responded positively and with resilience and imagination to safeguard the well-being of their service users and themselves.	+ Strong rationale given for using mixed-methods approach + Epistemological position of research stated + Survey content derived from review of the literature, discussions with colleagues and piloted with ten psychotherapists + Large sample size - links made to the generalisability of the results to the wider profession + Limitations and implications reported - Age-range of participants not stated - No explanation given

						as to how any conflicts around themes was resolved - Main themes/categories appear to be mimic the survey questions - No suggestions for future research - Quotes not referenced, therefore not identifiable
Clinical psychologists' well-being and experiences of home working during COVID-19 Tolland & Drysdale (2023) Scotland, United Kingdom	To explore the well-being and experiences of WFH for psychology staff across a range of specialties working within one NHS Health Board in Scotland. This included an exploration of experiences of delivering therapy from home/remotely, the impact of WFH on physical and emotional well-being	Clinical Psychology staff within one health board in Scotland. N = 161 Female: N = 140 Qualified clinical psychologists: N = 130. Trainee clinical psychologists: N = 18 Assistant psychologists: N = 7 Staff in other psychology roles: N = 3 Unknown profession: N = 2	Online survey: containing a mixture of Likert-scale questions and open-ended free-text questions with additional space for further comment.	Mixed methods design: - Quantitative data: descriptive statistics recorded. - Qualitative data: analysed using thematic analysis	Clinical Psychologist's faced several challenges during the pandemic, including challenges with carrying out clinical work. They reported less collaborative working and issues with technical equipment. Higher levels of fatigue, stress and anxiety were reported compared to normal.	+ Large sample size + Survey content was informed by relevant literature and consultation with experienced clinical psychologists + Limitations and suggestions for future research stated + Psychological therapists from a range of different settings/specialities included + Some indication of implications for wider policies

	and a measure of general well-being and loneliness during the pandemic.					- Epistemological stance of research not stated - Small sample area (one health board in Scotland) therefore not representative of the wider Scottish and UK population. - Not clear if participants were compensated for their time - Limited description given for some of the sub-themes
Work-related experiences of mental health professionals during COVID-19 pandemic: a qualitative study. Singh et al. (2024) United Kingdom	To use interpretative phenomenological analysis (IPA) to explore occupational experiences of clinical psychologists, counsellors, and psychotherapists working in the NHS and private practice in the UK during COVID-19 pandemic.	Three participants were clinical psychologists, eight were counsellors, and eight were psychotherapists. N = 19 Female: N = 17 Male: N = 2 Age range: 35-68 years (M = 53.1)	Semi-structured interviews held virtually over Microsoft Teams.	Qualitative Interpretative Phenomenological Analysis (IPA)	Three superordinate themes emerged from the analysis, namely, transition from face-to-face to online therapy, novel changes and wellbeing, and uncertain professional support in uncertain times.	+ Clear rationale for using qualitative approach and IPA for data analysis given + Epistemological stance of the research stated + Inclusion and exclusion criteria of participants stated + Clearly outlined themes with good use of supportive quotes + Limitations and implications stated

						+ No conflict of interest - Interviews, transcription and data analysis completed independently by a single researcher - potential for bias. - Participants were not compensated for their time - Lack of diversity within the sample (2 males) - No mention of recommendations for future research
What are the experiences of clinical psychologists working with people with intellectual disabilities during the COVID-19 pandemic? Chemerynska, Marczak &	To understand psychologists' experiences of working with people with intellectual disabilities during the pandemic.	Purposive Sampling of Clinical Psychologists working in community services N = 11 Female: N = 10 Male: N = 1 Age range: 32-54 years (M = 41)	One-to-one semi-structured interviews, conducted virtually via Microsoft Teams.	Qualitative Interpretative phenomenological analysis (IPA)	The prolonged exposure to stress and uncertainty of working during the pandemic had a damaging effect on clinical psychologists' mental wellbeing, leading to burnout. CP's reported reduced visual cues and incomplete assessment and formulation when conducting	+ Epistemological position of the researcher stated + Clear inclusion and exclusion criteria stated + Bracketing interview conducted to identify any prior biases or preconceptions about the research topic + Clearly outlined themes and good use

Kucharska (2022) United Kingdom					psychological interventions remotely. Despite the challenges of delivering remote interventions CPs clearly found that this mode of therapy was preferable to some client groups. Findings of the current study exposed the loneliness and disconnection CPs felt because of remote working.	of quotes + Strengths and limitations clearly stated + Implications for policy and practice outlined + Suggestions made for future research + No conflicts of interest - Large percentage of the participants were female (91%), and White British (91%) - therefore lacking in diversity - Not clear what geographical location from the UK participants were from - Participants not compensated for their time
The Impact of the COVID-19 Crisis on the Practices and Mental Health of Psychologists in Belgium:	Focussing on psychologists and the impact that the pandemic has had on their mental health and	N = 187 Female = 86% Age range: 22-72 years (M = 41.6) Professional experience	Online survey - composed of forty-six questions in French with a duration of	Mixed-methods study - Quantitative data: analysed using SPSS software to perform	Qualitative analysis of free text items showed that mental health professionals were resilient and developed new frameworks and	+ Informed consent gained from all participants + Limitations stated + No conflict of interest

Between Exhaustion and Resilience Glowacz, Schmits & Kinard (2022) Belgium	practices by exploring the adaptive and innovative responses generated.	range: 1-46 years (M = 15.2)	about 20 min, including multiple choice questions, several validated scales, and eight free text items.	descriptive and inferential statistics (one-way analysis of variance) - Qualitative data: analysed using Thematic Analysis	modes for proactive interventions to reach their service users, meet the psychological and social population's needs, and maintain their relationships with the network.	+ Different data collection methods allowing for breath + Suggestions made for future research - Small geographical area covered (Wallonia and Brussels) - Sample used were from a larger study but no details given of this larger study - Psychologists recruited had a large professional experience range, and were from a large range of different services which could influence participants' experiences, sense-making and response to working during the pandemic. - Use of survey for qualitative data means some answers lack detail/richness and context
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Experiences of mental health professionals supporting front-line health and social care workers during COVID-19: qualitative study Billings et al. (2021) United Kingdom	To redress this gap by qualitatively exploring UK mental health professionals' experiences, views and needs while working to support the well-being of front line HSCWs during the COVID-19 pandemic	Snowball sampling of mental health professionals N = 28 Women: N = 23 Men: N = 5	One-to-one, semi-structured qualitative interviews held via the telephone or as online video calls	Qualitative Reflexive Thematic Analysis	Mental health professionals were motivated and driven to develop new clinical pathways, to support health and social care workers they perceived as colleagues, and many experienced professional growth. However, mental health professionals took on additional responsibilities and increased workloads, were anxious and uncertain about how best to support this workforce and tended to neglect their own health and well-being. Many were professionally isolated and were affected vicariously by the traumas and moral injuries.	+ Large sample size of 28 mental health professionals from varied professional backgrounds, career stages and settings across the UK + Co-production: semi-structured interview guide co-developed with their expert reference group + Semi-structured interview guide included for transparency + Confidentiality of data discussed + Training given to those conducting the interviews + Information relating to support services offered to participants who took part + Multiple researchers used to reduce researcher bias + Reflexivity: researchers from different backgrounds, career stages and
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						cultural groups + Training and supervision offered to researchers to support with their wellbeing whilst conducting the interviews + No conflict of interest + Some indication for future research offered - Age and ethnic group of participants not recorded - Participants were not compensated for their time - Researchers do not own positionally within the research
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Ethical and psychosocial considerations for hospital personnel in the Covid-19 crisis: Moral injury and resilience Kreh et al. (2021) Italy and Austria	To identify the subjective experience, stressors and collective coping strategies used in hospital care to relieve stress from a psychosocial perspective and manage the challenging situation of the pandemic. The objective of the study was to find out what the main stressors as well as the main stress reducing factors were during the first phase of this pandemic for healthcare workers in the hospital sector.	The data presented in this article is part of a larger study. N = 13 Psychologists = 9 Healthcare staff had to have more than 5 years of experience. Psychologists and intensive care physicians had to have more than 10 years of experience.	9 Semi-structured, expert interviews, held via telephone 1 Focus group of 4 psychologists	Qualitative Grounded Theory	Psychosocial effects on stress experience, stressors and resilience factors were identified. Moral distress and moral injury were identified as the main stressors experienced by healthcare workers. Organisational resilience plays an important part in how healthcare workers experience the crisis.	+ Questionnaire questions were revised based on the experience and role of each interviewee + Data was discussed with participants to allow for comments and correction + Clear identified themes with good use of supportive quotes + Participants taken from a larger study which has been stated - Gender of those in the focus group not made clear - Epistemological position of the researchers not stated - Age range of participants not stated - Justification for using grounded theory not made explicit - Unclear if participants were compensated for their time - No mention of limitations, or ideas for
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						future research - No mention of conflict of interest
What have we learned about what works in sustaining mental health care and support services during a pandemic? Transferable insights from the COVID-19 response within the NHS Scottish context. Cogan et al. (2022) Glasgow, United Kingdom	To understand what has been learned about what works in sustaining mental healthcare and support services during the COVID-19 response, with the aim to uncover transferable insights in preparation for the recovery phase of the pandemic and beyond.	Purposive sample of mental health workers N = 30 Female: N = 22 Male: N = 8 Age range: 23-60 years (M = 40.63) Years of experience - Range: 1-37 years (M = 14.16)	One-to-one, semi-structured, qualitative interviews, held online via Zoom.	Qualitative Inductive Thematic Analysis	This research highlighted three key lessons learned; firstly, that self-care and peer support was vital and securing it should be central to future efforts; secondly, that approaches to ensuring team cohesion and collaboration were essential and likely to be central to supporting MHWs in delivering mental healthcare and support to others; thirdly, that visible and supportive management and leadership were equally important.	+ Informed consent process explained + Example of interview questions given for transparency + Pilot interview conducted to help finalise the interview questions + Debrief sheet sent to participants after taking part in the interviews + Participants were compensated for their time + Reflexivity: lead researchers kept selective journals and held reflexive meetings to help identify pre-assumptions and reduce bias + Thematic map included to help show theme development + Limitations stated and suggestions for future research are made

						+ No conflict of interest - although funding provided by the Scottish Government - Length of interviews was relatively short (M = 44.8 minutes) - There was a wide age range of participant experience - Participants recruited from one geographical area (Scotland) - Research does not own positionally within the research - Data saturation mentioned but not how this was decided upon
Delivering Psychological Services for People with Learning Disabilities during the Covid-19 Pandemic: The Experiences of Psychologists in the UK.	To understand the experiences of psychologists delivering psychological services to people with learning disabilities during the Covid-19 pandemic. To understand the	Purposive sampling of Qualified Psychologists working in UK services for people with learning disability during the COVID-19 pandemic. N = 12 Female: N = 11 Male: N = 1	Semi-structured qualitative interviews conducted virtually over Microsoft Teams	Qualitative Thematic Analysis	Findings conclude that an emphasis on future services carefully considering potential disadvantage by over-digitisation of services is key. There is hope that future psychological services can be offered with more choice and	+ Epistemological stance of research is stated + Ethical procedure described + Table of demographics given + Participants were compensated for their time + Reflexivity: position of

Gregson, Randle-Philips & Delaney (2022) United Kingdom	impact of Covid-19 on the wellbeing of people with learning disabilities from the perspective of psychologists. To explore how these experiences may inform future practice.	Age range: 25-34: N = 4 35-44: N = 7 45-54: N = 1			flexibility. Staff wellbeing, compassionate leadership and re-establishing team connections is also essential.	researchers stated and considerations for the impact of this on the research + Thematic map included to show theme development + Recommendations, practical implications, and future research directions are discussed. + No conflicts of interest - The sample was drawn from one area of learning disability services (adult community services) and may lack generalisability - Lack of diversity within the sample - majority white British and female - Potential bias from advertising via social media and offering monetary incentive for taking part
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'If I am not well, I can't do sessions well': An analysis of the narratives of Filipino Therapists during the COVID-19 Pandemic Ledesma & Fernandez (2022) Philippines	To extend the existing body of knowledge by understanding the experiences of therapists during the COVID-19 pandemic and how they unfolded	Licensed Psychologists who had been conducting therapy during the pandemic. N = 8 Age Range: 28-35 years old	One-to-one interviews conducted online via Zoom	Qualitative Narrative Analysis	Therapists working in the pandemic suffered additional emotional distress. They needed to regain stability in their well-being before being able to become effective helpers to their service users again. As the pandemic progressed, they found new purpose and growth in their practice.	+ Ethical process described + Open narrative to allow participants to lead in the interviews + Some mention of implications of the study + Themes clearly laid out and lots of detail and description given to each with appropriate quotes - Small sample size, with small age range - Only in one geographical area (Philippines) - Participants were not compensated for their time - No mention of consent process - Does not offer limitations or areas for future research
Clinical Psychology and the COVID-19 Pandemic: A Mixed Methods Survey	To provide a European wide insight into the perceived changes to	Clinical Psychologists and Psychotherapists across Europe who are members of EACLIP.	Survey - including nine closed questions for	Thematic Analysis Qualitative arm of a	Changes to clinical practice; changes to other work activities and contexts; the	+ Large sample size + Participants recruited from a large geographical location

Among Members of the European Association of Clinical Psychology and Psychological Treatment (EACLIPT) Asbrand et al. (2023) 19 European countries: - United Kingdom - Germany - Austria - Croatia - The Netherlands - Belgium - Italy - Switzerland - Ireland - France - Lithuania - Spain - Malta - Norway - Poland - Portugal - Slovenia - Czech Republic - Bulgaria	clinical practice and research of clinical psychologists and psychotherapists, as well as the barriers and opportunities, in order to improve support to people as part of the response to the COVID-19 pandemic. The study also aims to gather information to highlight helpful ways for clinical psychologists and psychotherapists to approach, prioritise and manage their work in the context of the pandemic. Finally, it aims to provide information on how organizations and organizational bodies (such as EACLIPT) can best adapt to pandemic related changes.	N = 92 Majority of participants from the UK = 17.6%	collecting socio-demographic information, and 5 open questions to gain qualitative information Data collected between: May 2020 – September 2020	mixed methods study.	challenges and opportunities; the effect of COVID-19 measures on clinical practice.	+ Reflexivity - The first two authors kept their own reflexive journal to document logistics and methodological considerations as well as their own personal reflections + Multiple analysts reduced the risk of bias + Offers areas for future research, including reflections for government policy + Survey included as supplementary material for transparency + Good use of quotes to support qualitative results - No information given as to how consent was obtained - Lack of depth and breadth in data due to survey design - No information on how the survey was constructed or how questions were chosen - No information on
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						how any identified bias was managed or if adaptations were made - Participants were not compensated for their time
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2.4 Quality Assessment

A key stage of all systematic reviews is quality appraisal of the evidence to be synthesised (Noyes et al., 2018). A well conducted literature review needs to have credibility, integrity, and applicability (Cronin et al., 2008). Studies included in this review employed both qualitative and mixed methods designs. As only qualitative data from all studies was reviewed, a single appraisal tool was utilised to guide the assessment of the literature and make a judgement on the rigour of the research identified.

The Critical Appraisal Skills Programme (CASP) Qualitative Studies Checklist (CASP, 2018) was the chosen tool for assessing the literature for this review. The CASP tool is the most used checklist tool for quality appraisal in health and social care-related qualitative evidence syntheses (Hannes & Macaitis, 2012; Dalton et al., 2017), and is recommended by the World Health Organisation and The Cochrane Collaboration for use in qualitative evidence synthesis (Noyes et al., 2018; Hannes & Bennett, 2017). The tool has ten questions that each focus on a different methodological aspect of the qualitative study. A summary of how each paper met the CASP criteria can be found in Table 5. The overall quality of the papers and thematic synthesis of the main findings is presented in the next section.

Table 5*Critical Appraisal of Included Studies*

Critical Appraisal of Qualitative Studies Assessed using the CASP Tool											
Study and Author		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 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?	How valuable is the research?
1	The challenges and experiences of psychotherapists working remotely during the coronavirus pandemic McBeath, du Plock, & Bager-Charleson (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Highlights the challenges faced by therapists during the pandemic and the impact this had on their mental wellbeing. Also highlights the positives from working during this time.

2	Clinical psychologists' well-being and experiences of home working during COVID-19 Tolland & Drysdale (2023)	Yes	Yes	Can't Tell	Yes	Yes	No	Yes	Yes	Yes	Highlights the importance of increased access to occupational support and equipment when working from home, and for additional wellbeing resources to be offered to all staff.
3	Work-related experiences of mental health professionals during COVID-19 pandemic: a qualitative study Singh et al. (2024)	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	This study adds to the existing body of research on the impact of the pandemic on UK-based mental health professionals and it highlights the need for professionals to have additional training on offering remote therapy.
4	What are the experiences of clinical psychologists working with people with intellectual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The current study demonstrates psychologists' ability to adapt to extremely challenging circumstances,

	disabilities during the COVID-19 pandemic? Chemerynska, Marczak, & Kucharska (2022)										exposes the vulnerabilities of people with intellectual disabilities and highlights the gaps in service provision
5	The Impact of the COVID-19 Crisis on the Practices and Mental Health of Psychologists in Belgium: Between Exhaustion and Resilience Glowacz, Schmits, & Kindard (2022)	Yes	Yes	Yes	Can't Tell	Yes	No	Yes	Yes	Yes	Highlights the concerns of CPs working during the pandemic and the impact on their mental health. Offers practical guidance on supporting CPs in the future.
6	Experiences of mental health professionals supporting front-line health and social care workers during COVID-19:	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	This research highlights the urgent need to consider the mental well-being, training and support of mental health professionals who

	Qualitative study Billings et al. (2021)										are supporting front-line workers
7	Ethical and psychosocial considerations for hospital personnel in the Covid-19 crisis: Moral injury and resilience Kreh et al. (2021)	Yes	Yes	Can't Tell	Can't Tell	Yes	Can't Tell	Yes	Yes	Yes	Steering the steps of a future lesson learning process, identifying issues that due to the long timeline of the COVID-19 crisis might be of help to countries whose response will be postponed in time as well as to all those who are faced with further waves of the pandemic.
8	What have we learned about what works in sustaining mental health care and support services during a pandemic? Transferable	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	Yes	Yes	It contributes to the literature and highlights important lessons learned to help prepare for future pandemics, with transferable insights for dealing

	insights from the COVID-19 response within the NHS Scottish context Cogan et al. (2022)										with other crisis situations.
9	Delivering Psychological Services for People with Learning Disabilities during the Covid-19 Pandemic: The Experiences of Psychologists in the UK Gregson, Randle-Philips, & Delaney (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Highlights the importance of the implication of working in the pandemic with people with learning disabilities, how to adapt therapeutic interventions, and the impact on staff teams and wider implications.

10	'If I am not well, I can't do sessions well': An analysis of the narratives of Filipino Therapists during the COVID-19 Pandemic Ledesma & Fernandez (2022)	Yes	Yes	Yes	Can't Tell	Yes	No	Yes	Yes	Yes	This study highlights the importance for assessing mental health workers needs and ensuring they have the resources they need in a crisis. Also highlights the importance of individuals taking ownership of their mental health needs and taking appropriate steps in caring for oneself.
11	Clinical Psychology and the COVID-19 Pandemic: A Mixed Methods Survey Among Members of the European Association of Clinical Psychology and Psychological Treatment (EACLIPT)	Yes	Yes	Yes	Yes	Can't Tell	Can't Tell	No	Yes	Yes	The current findings emphasise the importance of including mental health issues in current policy and offers considerations on how to manage the pandemic in the longer term.

[illegible]

2.4.1 Quality Evaluation of the Literature

The CASP tool has been established to be a reasonably good measure of transparency of research practice and reporting standards, but less effective at measuring research design and conduct (Long, French & Brooks, 2020). The CASP tool is also limited in that it does not provide detailed guidance on how to interpret the data, leaving room for subjective interpretations. Despite this, it is suggested that if the first two or three questions on the tool cannot be answered with a 'yes', then the research is likely to be of poor quality (CASP, 2018). Based on this, there were two studies (Kreh et al., 2021; Tolland & Drysdale, 2022) receiving a low-quality rating. I took an inclusive approach to this review and included all studies assessed, including those with a low-quality score. This is due to the notion that quality appraisal is contingent on adequate reporting, and may only assess reporting, rather than study conduct (Carroll, Booth & Lloyd-Jones, 2012). Therefore, a lack of reporting does not necessarily constitute poor research (Aveyard, 2019) and so the low-quality scoring papers were included, but the implications of these studies were held tentatively based on the quality assessment. All remaining papers attained moderate-high quality ratings.

All included studies had clear aims, which helped to assess the appropriateness of their methodological choices. Purposive sampling within mental health community settings was the most popular sampling approach used, which was appropriate for the recruitment of homogenous participants. However, there is potential for this approach to have limited the representativeness of the findings, and therefore limited generalisability, as participants have not been selected randomly. The methodological choices made by the researchers was appropriate to the objectives in most of the studies. However, Kreh et al. (2021) employed grounded theory whilst only having a reported a sample size of n=13. Research suggests

grounded theories require sample sizes of 20-30 participants (Moser & Korstjens, 2018). Both Singh et al. (2024) and Chemerynska, Marczak and Kucharska (2022) utilised Interpretative Phenomenological Analysis (IPA; Smith & Osborn, 2003), however this may not have been the most appropriate given their sample sizes (n=19 and n=11, respectively). Considering the level of detail explored in IPA studies, sample sizes are recommended to remain relatively small, and it is advised that they do not contain more than 10 participants (Smith, Jarman & Osborn, 1999; Smith, 2011). For these studies, the use of Thematic Analysis may have been more appropriate as this is better suited for larger samples (Braun & Clarke, 2006).

Only a minority of the researchers within these studies (n=4) adequately considered, or provided sufficient detail, to be able to assess their relationship with the participant group (McBeath, du Plock & Bager-Charleson, 2020; Chemerynska, Marczak & Kucharska, 2022; Billings et al., 2021; Gregson, Randle-Philips & Delaney, 2022). Of those researchers who did critically examine their own roles, biases, and influence on the research, Chemerynska, Marczak and Kucharska (2022) acknowledged in detail how they attempted to manage this, having utilised a bracketing interview, a reflective journal, and ongoing discussions within the supervisory team. This helped to clarify the steps taken to increase the internal validity of their data collection and analysis. Billings et al. (2021) specifically commented on the range of genders and cultural groups which make up the research team, along with their own contexts to the research topic. This helped to clarify the various roles taken by members of the research team, and how they were each situated with the research topic studied. They also acknowledged the disadvantage of their closeness to the topic, however, have insufficiently commented on how they overcame this within their

research, commenting that they maintained curiosity and welcoming alternative views, but without expanding on how this was achieved. Gregson, Randle-Philips and Delaney (2022) spoke about consulting an 'outsider researcher' when shaping theme development, helping to reduce bias within their research.

Most of the studies sufficiently addressed ethical considerations such as ensuring anonymity and confidentiality of participants' data, and informed consent procedures. A few studies mentioned ethical approval from a committee, such as Ledesma and Fernandez (2021). In most of the studies included in the review, the ethical considerations did not extend to issues relating to de-briefing, risk of harm to participants, and sharing of research findings. These approaches would have been important, particularly given the sensitive nature of some of the topics discussed. Some of the studies included information on their involvement of experts by experience. For example, Billings et al. (2021) detailed how their semi-structured interview guide was drafted collaboratively with their expert reference group, which included professionals with lived experience of mental health difficulties. Utilising a lived experience lens early on in their research make the research more relevant and reflective of the specific community being studied. Asbrand et al. (2023) did not give any mention to ethical considerations or procedures within their research which could undermine the scientific integrity and credibility of their findings.

All eleven studies provided clear statements of findings linked to their research objectives. The findings were specific to their contexts but still encompassed the experiences of mental health therapists who worked during the COVID-19 pandemic. The next section will provide a thematic synthesis of the findings, holding in mind the homogeneity and heterogeneity in the narratives shared by participants.

2.5 Synthesis of Main Findings from Literature Review

The systematic review adopted a thematic synthesis approach which provides an established set of methods and techniques for the identification and development of analytic themes in primary research data (Thomas & Harden, 2008). From the initial scoping search, I found a growing number of quantitative research studies assessing the impact of COVID-19 on mental health therapists. To provide experiential context to the existing research, and to further understand these views and experiences, synthesising qualitative data for this review was deemed appropriate.

Mental healthcare services globally have faced unprecedented challenges due to the COVID-19 pandemic. However, there remains limited research looking at how well mental health therapists and their services adapted to the increased demand. Additionally, limited research exists looking at the challenges presented by the pandemic, and what could be done to improve mental healthcare for those who have suffered psychologically because of the COVID-19 pandemic (Asbrand et al., 2023). This has led to an increased interest to understand the experiences, views and roles of mental health therapists who worked during the pandemic. Synthesising qualitative research in this review would allow me to bring context, offer a human perspective and focus on the meaning and interpretations of the participants. This method also aligns with my critical realist epistemology.

After reading the included studies to immerse myself in, and understand, the data, specific findings relating to mental health therapists' experience of compassion-fatigue and moral injury were reviewed. First-order constructs represented direct quotes expressed by the research participants; second-order constructs represented the interpretation the study authors gave to the experiences of the study participants (Malpass et al., 2009). These were

then compared, and third order constructs were formed which represented my interpretation of the identified first- and second-order constructs (Britten et al., 2002). The data was then synthesised into codes. These 'free codes' were then organised into related areas to construct 'descriptive' themes, before finally being developed into three 'analytical themes' and six sub-themes (see Appendix B). The themes and sub-themes are represented in Table 6.

Table 6

Table of Themes from Thematic Synthesis

Theme	Sub-Theme
Theme 1: New challenges	1. Loss of work/life balance 2. Delivering therapy online
Theme 2: The emotional toll	3. A loss of identity 4. What sustains mental health therapists
Theme 3: The role of relationships	5. The impact on the therapeutic relationship 6. Loss of trust for management

2.5.1 Theme 1: New Challenges

In nine out of the eleven studies, a loss of work-life balance was identified as a sub-theme under the umbrella of 'new challenges' (Asbrand et al., 2023; Billings et al., 2021; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; Ledesma & Fernandez, 2022; McBeath, du Plock & Bager-Charleson, 2020; Singh et al., 2024). In all eleven of the identified studies,

'delivering therapy online' was constructed as a second sub-theme that interacted with a loss of work/life balance.

2.5.1.1 Sub-theme 1: Loss of Work/Life Balance

A loss of work/life balance was identified as a dominant theme across the literature, with nine studies highlighting the role this had on the development of therapist burnout (Asbrand et al., 2023; Billings et al., 2021; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; Ledesma & Fernandez, 2022; McBeath, du Plock & Bager-Charleson, 2020; Singh et al., 2024). Here, reference was made to the challenges mental health therapists faced in juggling their home lives and their professional boundaries. This was particularly evident for therapists who had children, where it was described as more difficult to create confidential spaces and to switch between 'parent mode' and 'therapist mode':

"At first children were still in school. And so you could kind of maintain a little bit of work life balance. But then when I've got three young boys and dogs, and [pets] and all that stuff in the background, actually maintaining that professionalism and keeping that kind of barrier, that boundary between home and work life balance became a little bit more challenging." (Chemerynska, Marczak & Kucharska, 2022, p.590)

In some cases, burnout was identified from the participants' lack of physical distance from their work, which caused the further blurring of boundaries and difficulties in managing the emotional strain of the role:

“My workspace is in my bedroom... you see your laptop sitting there and you think oh god yeah, I’ve just had that awful conversation with this client, and you know it just brings it all back.” (Gregson, Randle-Philips & Delaney, 2022, p.179)

Despite the identified challenges, one of the studies (Tolland & Dysdale, 2023) found participants enjoyed the flexibility that working from home offered, having more freedom over working hours and patterns, and no longer having to worry about long commutes to work:

“... lack of commute, more efficiency due to fewer interruptions and less travelling to meetings and improvements in work–life balance.” (Tolland & Drysdale, 2023, p.90)

This suggested that participants had a mixed response to working from home, with a majority identifying the difficulties associated with working from home, due to no longer having as much physical and emotional distance from their work.

2.5.1.2 Sub-theme 2: Delivering Therapy Online

All eleven studies shared how participants experienced moving from face-to-face interaction, to offering therapy online during the pandemic. This theme was felt to have a strong sense of compassion-fatigue, with participants identifying:

“some sense of loss of love for the role” (Gregson, Randle-Philips & Delaney, 2022, p.180).

Many of the studies highlighted the challenges to this change, including lack of stable internet connections, not knowing how to use the technology, and not having access to, and no longer being able to use, certain therapy resources:

"It's so different. There are things that I usually use, techniques in therapy that feels different when done online, and things that I cannot do online. Like ... projectives. I usually do cards to help clients." (Ledesma & Fernandez, 2022, P.528).

Other studies demonstrated how mentally demanding, and therefore draining, offering online therapy was, both for them and their service users:

"I think work is harder because I have to concentrate more." (Singh et al., 2024, p.10)

Five of the studies also highlighted the difficulties in assessing the needs and risk of their service users (Chemerynska, Marczak & Kucharska, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; Ledesma & Fernandez, 2022; Tolland & Drysdale, 2023):

"risk is difficult to assess with confidence via a remote setting". (Tolland & Drysdale, 2023, p.89)

This combination of a shift in work/life balance, finding online work more mentally draining and stressful due to the associated difficulties with assessing their service user's needs, led to many experiencing compassion-fatigue.

2.5.2 Theme 2: The Emotional Toll

All eleven studies spoke to the emotional impact the pandemic had on their participants. Themes of moral injury were identified in six of the studies (Billings et al., 2021; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; McBeath, du Plock & Bager-Charleson, 2020), for example Billings et al. (2021) found:

“mental health professionals also had to make difficult decisions about who would get their services and who would not.” (p.6).

Participants shared how hearing the trauma shared by their service users impacted them:

“stuff in there that could be vicariously traumatising” (Billings et al., 2021, P.5).

This led to the identification of two sub-themes within the studies; A loss of identity, and what sustains mental health therapists.

2.5.2.1 Sub-theme 3: A Loss of Identity

Seven of the included studies were found to describe a sense of lost identity from participants (Billings et al., 2021; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Ledesma & Fernandez, 2022; McBeath, du Plock & Bager-Charleson, 2020; Tolland & Drysdale, 2023). This included struggling to feel a:

“sense of usefulness despite frustrations” (Glowacz, Schmits & Kinard, 2022).

Studies also identified experiences of moral injury for participants, often because they wanted to do more for their service users:

“hearing the suffering of people excluded from society without being able to act.” (Glowacz, Schmits & Kinard, 2022, p.9).

“That kind of makes me think you know, I'm not doing my job right because like, you know, I don't think I'm actually able to sort of provide the service I want to provide to people” (Chemerynska, Marczak & Kucharska, 2022, p.589).

Other studies found mental health therapists described *“feelings of having ‘lost tools’”* (Gregson, Randle-Philips & Delaney, 2022, p.178) and feeling deskilled in their work, often leading to compassion-fatigue. Others reported the difficulties participants faced in acknowledging their own mental health struggles, blurring the lines between them being professionals and service users themselves:

“Okay you're anxious. Admit it that you're anxious yourself and that you kind of have to do some mental work too, like CBT on yourself, do mindfulness, do grounding techniques because you also need it” (Ledesma & Fernandez, 2022, p.529).

This sub-theme is well summarised by a quote from Ledesma and Fernandez (2022) who found:

“overall, the participants felt aimless” (p.527).

Studies described how participants struggled to find their footing during the pandemic, often feeling unhelpful or useless, and were no longer sure what their role was.

2.5.2.2 Sub-theme 4: What Sustains Mental Health Therapists

Along with the emotional strain highlighted within the studies, a majority (n=9) also identified ways in which participants were able to manage this toll and noted what they did to keep themselves going through the most difficult of times (Chemerynska, Marczak & Kucharska, 2022; Cogan et al., 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; Ledesma & Fernandez, 2022; McBeath, du Plock & Bager-Charleson, 2020; Singh et al., 2024; Tolland & Drysdale, 2023). For example:

“seeing fewer clients per day; engaging in more and different forms of exercise to ‘alleviate tension and anxiety’; and taking up different forms of social interaction”
(McBeath, du Plock & Bager-Charleson, 2020, p.401)

Other studies identified the importance of *“good support and supervision from colleagues is really important to keep going”* (Gregson, Randle-Philips & Delaney, 2022, p.185). One study, Cogan et al. (2022) divided the identified support into the ‘individual’, ‘team’ and ‘organizational’ standpoints, noting that each level of support had an impact on the improved wellbeing of participants. For example, at the individual and team levels participants identified the following:

“These problems were alleviated by engaging in ‘self-care’ (Lisa), ‘seeking support from colleagues’ (Erin) and building supportive relationships with their peers.”
(Cogan et al., 2022, p.172)

Taken together, the findings in this sub-theme identify how participants tried to take more control of their working schedule, engage in self-care practices, and increase their levels of social interaction with peers to improve their overall wellbeing. This also links to the next theme below.

2.5.3 Theme 3: The Role of Relationships

This theme identified the function of relationships for participants during the pandemic. Singh et al. (2024) found participants struggled to manage the isolation of working from home and not having regular contact with other colleagues:

“it’s a little bit harder to shake off concerns about clients uhm . . . possibly because I haven’t been able to just have a quick chat with my supervisor or with a couple of colleagues, so I think sometimes it just stays around a bit more” (p.10).

Feeling isolated and without their usual support structures led to the identification of the next two sub-themes.

2.5.3.1 Sub-theme 5: The Impact on the Therapeutic Relationship

This sub-theme was found to be the biggest contributor to participants feeling compassion-fatigue about their work:

“it is more an issue around building rapport and working with the client in a meaningful way remotely.” (Tolland & Drysdale, 2022, p.84).

Seven of the eleven studies identified a negative impact on the therapeutic relationship for participants (Asbrand et al., 2023; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Gregson, Randle-Philips & Delaney, 2022; Kreh et al., 2021; Singh et al., 2024; Tolland & Drysdale, 2023):

“Harder developing rapport and doing therapy without the same transference or cues.” (Asbrand et al., 2023, p.10)

As a result, studies found participants who offered online therapy started to burnout and lose enthusiasm for their roles, no longer feeling able to connect with their service users in the same way:

“you kind of feel more connected with them when you are face-to-face” (Gregson, Randle-Philips & Delaney, 2022, p.175).

Other studies demonstrated the potential benefits of offering therapy in a different format, with participants describing a positive impact on their relationship building, for example:

“Some of my clients are finding that giving me help with the technology is empowering” (McBeath, du Plock & Bager-Charleson, 2020, p.400).

Overall, the reviewed studies highlight the difficulties a majority of participants shared in creating and maintaining therapeutic relationships during the pandemic. No longer feeling connected to their service users led participants to experience compassion-fatigue and a loss of enjoyment for their roles.

2.5.3.2 Sub-theme 6: Loss of Trust for Management

This sub-theme relates to the reported difficulties with the guidance and change to procedures made by senior management:

“Many healthcare workers feel unsafe and experience a loss of control, as well as a loss of trust in the system, as they do not feel sufficiently protected” (Kreh et al., 2021, p.8).

This loss of trust in management was highlighted by six of the reviewed studies (Asbrand et al., 2023; Chemerynska, Marczak & Kucharska, 2022; Glowacz, Schmits & Kinard, 2022; Kreh et al., 2021; Singh et al., 2024; Tolland & Drysdale, 2023):

“Psychologists felt they were left on their own, to navigate the challenges of the COVID-19 crisis in a system ill equipped to meet the needs of its clients, often having

to fight the bureaucracy of the system.” (Chemerynska, Marczak & Kucharska, 2022, p.591).

This led to many participants expressing burnout and experiencing moral injury from having to enact new guidelines that did not always align with their own:

“they often struggled with guilt about previous vulnerable patients who had been rapidly discharged or placed on waiting lists, while they were required to prioritise staff support.” (Billings et al., 2021, p.6)

Tolland and Drysdale (2023)’s findings develop this theme further, identifying participants desire for a more compassionate approach from management:

“Instil a feeling of being actually concerned about staff rather than ‘tick box’ exercise of completing risk assessments.” (p.87).

Despite most identifying a negative reaction to management, two of the studies, including Kreh et al. (2021), reported a positive response from management during the pandemic. They found:

“clear guidance provided by the management led to more stable routines and therefore was experienced as stress relieving.” (Kreh et al., 2021, p.11).

This sub-theme highlights the role of management in the contribution of participants experiences of burnout, moral injury, and compassion-fatigue. The studies identified participants feeling uncontained and unsupported by management throughout the pandemic, with clearer guidance being needed by participants.

2.6 Clinical Implications

This review highlighted important implications for clinical practice and service delivery to better understand the psychological wellbeing of mental health therapists who worked during the COVID-19 pandemic. For example, in Gregson, Randle-Philips and Delaney (2022), recommendations are made for services to monitor the long-lasting impacts of the pandemic on staff-wellbeing and ensure timely implementation of support and wellbeing initiatives. Billings et al. (2021) argue that more research is needed on the mental health of mental health therapists, whilst Chemerynska, Marczak and Kucharska (2022) recommend that therapists have continued support and supervision in the use of digital technology to conduct remote interventions safely. Lastly, Cogan et al. (2020) highlighted the importance of services establishing visible management and leadership, whilst also implementing approaches that combat barriers related to mental health help-seeking behaviours amongst its staff. To conclude, future attempts to improve the wellbeing of mental health therapists, including Clinical Psychologists, may benefit from adopting a nuanced and considered approach.

2.7 Evaluation and Conclusions of the Systematic Literature Review

As determined in the previous section, this systematic literature review is believed to be the first of its kind exploring mental health therapists' experiences of working during COVID-19. The qualitative accounts of the therapists reviewed offered anecdotal insights into their perspectives on life during the pandemic. However, caution should be taken when interpreting the findings of some studies, due to their sample sizes being small and specific to localised populations. Several studies also lacked the use of bracketing techniques of the mention of reflectiveness practices within their research. Critically examining their own

roles and biases during the research process would have helped to strengthen their overall findings. Most of the studies provided information about their sample, including the mental health therapists' professions, however these details were often not referred back to in the context of the findings. Sufficient consideration to ethical considerations was given by most of the studies, however some failed to comment on their debriefing processes, which is vital important given the nature of the topic. Most of these studies were also conducted in the 'height' of the pandemic when the full impact was yet to be felt. This means information about the impact of the pandemic at different stages will not have been fully captured, hindering the chance for this review to fully identify mental health therapists' experiences.

2.8 Gaps in the literature

Although literature exploring the experiences of mental health therapists working during the COVID-19 pandemic is a rapidly evolving area, this review highlights the scarcity of research exploring Clinical Psychologists' experiences or working during this time. Many of the included studies combined the experiences of multiple mental health therapists, making it difficult to identify specific experiences of the different disciplines individually. Whilst some of the literature alluded to experiences of compassion-fatigue and moral injury, this was often not the main focus. Furthermore, most of the studies focussed on individuals' experiences during the heart of the pandemic, meaning opportunities to understand the changes to practice over the course of the pandemic, and beyond, have been missed. The absence of research on the experiences of Clinical Psychologists working in a UK NHS context presents a unique opportunity for this project to close the gap by exploring experiences of compassion-fatigue and moral injury in these contexts.

2.9 The Rationale for the Current Study

The experiences, views, and needs of NHS Clinical Psychologists working during the COVID-19 era have, so far, been overlooked both in the UK and globally. Many mental healthcare professionals experienced compassion-fatigue and moral injury during this time (Billings et al., 2021; Tolland & Drysdale, 2022), and yet little focus has been given to Clinical Psychologists' experiences of these. Many studies have identified mental health staffs' experiences of burnout during the pandemic (e.g. Ledesma & Fernandez, 2022; Singh et al., 2024), however this will not be a focus of this project, as the scope of this research needs to remain focused, and the aim being to research areas that have been less spotlighted. Whilst research has focussed on the experiences of mental health staff more generally during this time, there has not been a focus on the lessons that can be learnt from this period, and how this can be used to improve clinical practice going forward.

2.10 Aims of the Research and Research Questions

This research aimed to explore the experiences of compassion-fatigue and moral injury within NHS Clinical Psychologists who worked during the COVID-19 pandemic, through the following question:

What were NHS Clinical Psychologists' experiences of compassion-fatigue and moral injury during the COVID-19 pandemic, and what lessons can we learn?

Three further sub-questions were explored:

1. *What were Clinical Psychologists' experiences of compassion-fatigue during the pandemic?*

2. *What were Clinical Psychologists' experiences of moral injury during the pandemic?*
3. *What related lessons can be learnt from Clinical Psychologists' experiences of working during the pandemic?*

Chapter Three: Methodology

3.0 Chapter Overview

Within this chapter, I will provide an overview of the methodology used in this research. I will discuss the research design and the rationale for my chosen method, along with an outline of the procedure and participants' demographics. I will describe my participant and recruitment strategy and reflect on the key ethical considerations of this study. I go on to outline the involvement of consultants on the project, as well as data collection and analysis. I will close this chapter by detailing the qualitative quality assurance procedures.

3.1 Design

3.1.1 Adopting a Qualitative Stance

As the aim of this research was to explore the experience of Clinical Psychologists working in the NHS during the COVID-19 pandemic, and to appreciate *their* world from *their* perspective, a qualitative research design was deemed most appropriate for several reasons. Firstly, qualitative research is concerned with exploring human experience, allowing for consideration of the complexity of individual experience, and for greater understanding of individuals' evaluation of their own lives and experiences (Roberts & Boardman, 2014). Secondly, qualitative research is considered particularly well suited to studies in areas which are under researched and where understanding is therefore more limited (Barker et al., 2015), as was identified from the systematic literature review. Thirdly, qualitative approaches provide opportunities for theorising and generating hypotheses, which may lead to further discovery in the future.

It is possible for ethical issues to arise in all forms of research, qualitative included. I was therefore careful to consider a reflexive position throughout the research process, which included acknowledging my own power and privilege that I held as a researcher at each stage, endeavouring to be transparent around my beliefs and assumptions and regularly consider the impact these may have, with the supervision and support of the rest of my research team.

3.1.2 Consideration of Alternative Methodologies

As an alternative, this research could have utilised a quantitative design. Quantitative research aims to define a particular phenomenon by employing numerical values to data, quantifying behaviours, actions, and other variables. A quantitative research design may have been suitable for this topic area to measure, for example, the levels of anxiety and low mood experienced by Clinical Psychologists during the COVID-19 pandemic. However, this would not have met the research aims of the study, as quantitative approaches hide the 'voice' of the individual or group beneath statistics and general population trends (Roberts, 2014). This would limit my ability to make sense of contextual factors impacting an individuals' experiences.

Alternative qualitative methods, especially those privileging in-depth focus on an individuals' experience, were considered when deciding what design would best answer the research question and study aims. A brief outline of these methodologies and rationale for the final choice of Reflexive Thematic Analysis (RTA) follows.

Narrative Analysis (NA) is concerned with stories as a whole rather than separating them into themes or conceptualising them into discourses (Riessman, 2008). However, NA's

focus on how stories are told, who they are constructed for, and their purpose – rather than participants' experiences - was not considered as suitable to meet this study's aims (Burck, 2005).

Grounded Theory (GT) is a research approach in which a theory develops from the information systematically collected during the research process (Hall, Griffiths & McKenna 2013). There are no preconceived ideas about what is happening to guide the research process in grounded theory, instead the explanation (theory) is generated during the research process itself and substantiated by it (Harris, 2015). However, as my research aims were to understand and learn from participants experiences (the 'what') rather than the processes (the 'how'), GT was not considered appropriate for this study.

Participatory Action Research (PAR) conducts research *with* people, not *on* them (Heron & Reason, 2001), with the desire for research to create positive social change. PAR looks at participants having a dual role where they are participants within the research as well as collaborators, which considers service user co-production and decolonisation. Despite its benefits in empowering the voice of participants and in designing the research to meet the needs of the population, it is known for being a very time-consuming method. As such, full PAR was not possible due to the time-constraints of this thesis, and therefore was not chosen as the methodology.

Interpretive Phenomenological Analysis (IPA) involves a detailed focus on the analysis of each case, before developing themes across cases (Braun & Clarke, 2013). It was considered for the current study due to its emphasis on meaning making, which fitted well in answering the research questions for this study. However, as its focus is on the subjective experience of individuals, as opposed to the organising and summarising of consistent

patterns across groups, it was felt that TA would be a more suitable fit to answer the aims of this research.

3.1.3 Thematic Analysis (TA)

TA is a method for identifying and analysing patterns of meaning in a dataset (Braun & Clarke, 2006) and has become a widely used tool for analysing qualitative data. It illustrates which themes are important in the description of the phenomenon under study (Daly et al., 1997). TA can be conducted as 'inductive' (data-driven), or as 'deductive' (theory-driven) and pays attention to both explicit (manifest) and underlying (latent) meanings. To fit with a critical realist perspective, I chose to conduct an inductive analysis for this research, with the aim of 'giving voice', or at least partial representation, to participants experiences. Given the very particular context under which the research was conducted (COVID-19) it was also decided that inductive methods would enable the researchers to fully connect with the lived experience of participants. King (2004) argues TA is a useful method for examining the different perspectives of research participants, identifying similarities and differences, and generating unanticipated insights.

As the current study's main research aims were looking for repeated and consistent patterns of meaning amongst participants, TA was chosen over other qualitative methods (Braun & Clarke, 2006). This research took an exploratory approach, focussing on how participants experienced and understood their time working during the COVID-19 era, the impact this had on them, and what lessons we can learn from their experiences going forward. This is why a TA approach was deemed the most appropriate.

3.1.4 Limitations of Thematic Analysis

There is some confusion amongst researchers as to what TA is (Terry et al., 2017), whilst some Psychologists question whether TA is a method in its own right, or if it is a tool that underpins many different qualitative approaches (Willig, 2013). This can lead to confusion for qualitative beginners seeking clear guidance on how to approach TA, but also obscures important theoretical and conceptual differences between different TA approaches (Terry et al., 2017). Clarke and Braun (2017), however, argue TAs strengths come from there being no specific theory or epistemology underpinning the approach, thus allowing for it to be applied to a variety of research paradigms. This flexibility that TA offers, combined with its accessibility, makes it a versatile and popular choice for qualitative researchers.

A further limitation of TA is that its flexibility can lead to inconsistency and lack of coherence during the theme development phases (Holloway & Todres, 2003). To increase consistency and cohesion in the current study, I made sure to apply and make explicit my epistemological position, as well as identify any potential bias within the interpretation of the dataset.

3.1.5 Epistemological Approach

It is important that the chosen method of qualitative analysis is compatible with researchers' epistemological position (Willig, 2013). In line with my critical realist epistemological approach, it was important that I take a critical and reflexive stance to my researcher role. Qualitative research is compatible with a critical realist perspective (Maxwell, 2012). This research utilised a TA methodology which, according to Braun and

Clarke (2006), can be conducted from different epistemological standpoints (e.g. social constructionist, phenomenological, realist, etc), as the theoretical and epistemological commitments from the researcher are not indicated by TA itself, and therefore need to be chosen by the researcher. Thematic analysis adapts to include a critical realist stance suggesting that meanings participants make from their experiences are influenced by the context in which they are situated and, further, that the implications of this can be critically evaluated (Clarke & Braun, 2017).

3.1.6 Reflexivity

Reflexivity involves habitually reflecting on your assumptions, expectations, choices, and actions throughout the research process (Finlay & Gough, 2008). Due to my own experience and therefore insider perspective, I was conscious of my personal biases and the potential for these to impact the analysis of the data, development of themes, and construction of findings. To ensure I remained as transparent as possible throughout the research process, I completed a reflective research diary (Braun & Clarke, 2022) (Appendix V). I was conscious of being an insider researcher and having specific beliefs and attitudes about the NHS as a national institution. Considering this, I also took part in a bracketing interview with my research supervisor (Appendix W), to help me self-question, identify, and interrogate both my own, and my supervisors, positions, values, and practices, and how these may be influencing the knowledge generated.

3.1.7 Consultation with Experts by Experience

Consultation offers the potential to improve the quality of research at all stages (Staley, 2009). It offers opportunities for advice and feedback on the study design (Morrow

et al., 2010) and can help to inform methodological reflexivity (Treharne & Riggs, 2015). The importance of involving individuals with lived experience of the study topic is becoming increasingly recognised within research (Beames et al., 2021). Potential benefits include the researcher having a greater understanding of the researched community's needs, improved awareness into possible barriers of the research, as well as supporting the challenging of potential preconceived ideas and assumptions about the community being studied (Brett et al., 2014).

I was lucky enough to have a Clinical Psychologist who worked in the NHS during the pandemic, and offered staff support services during this time, as research consultant to the study. Consultation positively impacted the design of the research from the outset, including guidance on amending the semi-structured interview schedule, conducting a pilot interview, and supporting with ways of managing potential emotional distress.

3.2 Participants

3.2.1 Recruitment

In line with the projects aims and methodological approach (Ames et al., 2019), a purposive sampling method was adopted for identifying participants for this research. Purposive sampling is commonly used in qualitative research, where the researcher wants to gain detailed knowledge about a specific phenomenon rather than make statistical inferences, or where the population is small and specific (Obilor, 2023).

The NHS

The initial phase of recruitment consisted of advertising in, and recruiting from, two NHS Trusts. The names of these two Trusts have been anonymised to protect participants

from the risk of being identified. The Trusts chosen have large populations and cover large geographical areas, maximising the number of potential participants I could reach and allowing for a range and breadth of individual experiences. This would also allow the research to feed into workforce development, especially local needs, and solutions, within the region in which my Clinical Psychology training is commissioned.

Approval was needed from the NHS Research Ethics Committee (see Section 3.3.1). I then engaged with community clinical teams and psychology teams across the Trusts to introduce the study, explain the objectives, procedures, and potential benefit to taking part. Information was shared in the form of the recruitment poster¹ (Appendix K) and Participant Information Sheet (PIS) (Appendix L), along with details of how to directly contact the researcher.

Those who made contact showing an initial interest to take part, were sent an expression of interest form (Appendix M) to complete and return to me via email. Following this, they were offered any additional information requested about the study and given a chance to ask any further questions or share any concerns they may have, before consenting to take part. Part of these initial conversations included a shared understanding of the key terms and definitions being observed (as described in the PIS) and, for some, a conversation as to whether they felt their experience matched these definitions. In one case, a potential participant chose not to take part following these discussions, explaining they did not feel their experience met the study criteria, and feeling they were therefore

¹ Following feedback from the Research Degrees Board, the title of the overall project was changed after recruitment was completed. Therefore, all recruitment material contains the project's original title.

unable to offer enough depth and discussion to meet the research aims. Given the profession of the participants being recruited, many already had a clear understanding of the study's key terms and definitions, being familiar with them from their own study and work. This supported the recruitment process and ensured everyone who consented to take part clearly identified with having experienced moral injury and/or compassion fatigue during the COVID-19 pandemic.

If written consent (via email) was given to participate in the study, a consent form (Appendix N) was then sent via email to be signed by participants and then returned via email.

Recruitment via this method was initially very slow, with minimal participant interest. To help increase recruitment via the Trusts, I also attended NHS team meetings to share information about the research project, answer any questions, and further increase recruitment. During recruitment, both my external research supervisor and consultant worked within the two recruiting Trusts and so were able to support with recruitment internally by sharing the details of the research in psychology meetings across the Trusts. This recruitment strategy yielded eight participants.

Social Media

Following the initial difficulties in recruiting via the two NHS Trusts, an ethical amendment was made (see section 3.3.1) for a second phase of recruitment which involved expanding the recruitment strategy to include the use of social media. Social media was chosen as it allows for user connection and communication, knowledge sharing, discussion,

and collaboration with communities for professional networking (Dhar et al., 2018; Imran et al., 2019).

Two platforms were chosen: 'Instagram' and 'X' (formerly known as Twitter) due to their wide reach. Research accounts were created for the sole purpose of recruitment. Study information in the form of the recruitment poster was made available across both social media platforms, which included details of how to directly contact the researcher. A range of organisations (such as the British Psychological Society [BPS] and the Psychological Professions Network [PPN]) and NHS Clinical Psychologists were also contacted to advertise the study and share information to potential participants. My research team also supported with recruitment by circulating research materials and putting me in contact with potential participants. The most views obtained on a single social media post were 2,700 which was achieved on the platform 'X' following a re-share of my post by the BPS. This recruitment strategy yielded four participants.

3.2.2 Challenges to Recruitment

Despite this comprehensive strategy, recruitment remained challenging. Considering with my research team as to why this might be, we contemplated the nature of the topic itself, and the fact that we are not yet 'out of' the pandemic. When discussing my research in team meetings and in passing conversations, I heard people say how they had 'not had the time' to reflect on their experience of the pandemic, encouraging the question, *is now the right time for people to be talking about their experiences?* Add to this the request for people to share their experiences of moral injury and/or compassion-fatigue, I considered if the pandemic and its impact felt all too raw for people to be able to start sharing their experiences, or if they even had the time to.

Linking to previous research related to internalised stigma (see section 1.3.4), we also considered whether Clinical Psychologists were reluctant to come forward for fear of a perceived negative impact on their self-image (Tay, Alcock & Scior, 2018). My research team and I also considered the possible conflicting views individuals may have about being recruited via their employing Trust. This could leave people concerned about sharing views relating to a complicated experience with said organisation, therefore leaving people hesitant to take part.

3.2.3 Inclusion and Exclusion Criteria

The inclusion criteria aimed to provide homogeneity without being too restrictive (see Table 7). Given the limited existing research in this area, I wanted to ensure voice was given to as wide a range of experiences as was possible.

Table 7

Participant Inclusion and Exclusion Criteria

	Criteria	Further Comments
Inclusion Criteria	1. Qualified Clinical Psychologists;	Aged 18 years and older
	2. Who were employed by the NHS in a service facing role/front line;	In a community setting – this was included as it was identified (from discussions within the NHS during the pandemic) that the experience of Clinical Psychologist's working in non-community or inpatient settings would have had a vastly different experience to those in community settings, which may have made it more challenging to identify common themes across interviews.
	3. Who worked during the COVID-19 pandemic	From February 2020 – December 2021. This time frame was chosen to ensure that those taking part had enough experience to talk in an in-

		depth perspective whilst also being realistic about the pace at which people may move roles.
	4. An ability to understand spoken and written English	Communication required to work in the NHS would be sufficient for this research
Exclusion Criteria	1. Unqualified or Trainee Clinical Psychologists	It was felt anyone unqualified or currently in training would have very different experiences to those already qualified, for example in the level of responsibility, or the expectations placed on them.
	2. Individuals who did not work in the NHS for the whole of the key time period	
	3. Individuals who were on extended sick leave during the key time period	

3.2.4 Participant Demographics

In total, twelve qualified NHS Clinical Psychologists were recruited, consistent with the recommended sample size of 12 to 15 participants (Willig & Stainton-Rogers, 2017) for sufficiently rich data analysis (Crouch & McKenzie, 2006). Of the twelve participants who took part in the research, eleven were female. Participants were aged between 33-55 years of age. Participants worked across a range of services and NHS bandings ranged from 8a-8c. Pseudonyms and additional demographics collected are presented in Table 8.

Table 8*Participant Demographic Information*

Pseudonym	Age range	Gender	Ethnicity	Length of time working as a qualified Clinical Psychologist (in years)	Length of time working for the NHS (in years)	NHS Banding	Directorate
Alice	40-45	Female	White British	10+	10+	8c	CAMHS
Myra	40-45	Female	British Indian	10+	10+	8c	Working Age Adults
Priya	40-45	Female	British Indian	5-10	10+	8b	Learning Disabilities
Lucy	40-45	Female	White British	10+	10+	8a	Older Adults
Kate	35-40	Female	White British	5-10	10+	8b	Working Age Adult - Perinatal
Rekha	35-40	Female	British Mauritian	2-5	10+	8a	CAMHS and Older Adults
Phoebe	30-35	Female	White British	5-10	5-10	8a	Older Adults
Craig	35-40	Male	White British	10+	10+	8b	Working Age Adults
Joy	40-45	Female	White British	5-10	10+	8b	Older Adults
Gemma	35-40	Female	White British	5-10	10+	8a	CAMHS
Clare	40-45	Female	White British	10+	10+	8b	CAMHS – Paediatric
Miriam	50-55	Female	Mediterranean	10+	10+	8c	Working Age Adults

3.3 Ethical Considerations

3.3.1 Ethical Approval

As part of the recruitment took place through two NHS Trusts, with NHS staff as participants, ethical approval was required from the NHS Health Research Authority (HRA). Following submission for HRA ethical approval (Appendix C), I received requests for nine amendments/reviews of the information provided on my application (Appendix D). Following amendments being made (Appendix E), NHS HRA ethical approval was granted on the 14th of August 2023; IRAS project ID: 330857 (HRA reference: 23/HRA/3112; Appendix G). As the ethics approval request was for NHS staff, and not service users, NHS Research Ethics Committee (REC) review was not required for this research.

Following this, I sought research registration for my research from the two Trusts Research and Development (R&D) Departments. As interviews took place virtually, there was no need for me to attend any Trust sites. I therefore requested R&D approval for both Trusts to have the status of 'Participant Identification Centre' (PIC) – organisations that identify potential research participants for a research study (Appendix H).

Finally, I requested full sponsorship from the University of Hertfordshire Health and Human Science Ethics Committee (protocol number: LMS/PGR/UH/05333; Appendix F & I). Participants were provided with the ethics protocol number on the participant information sheet along with details of who to contact with concerns about the research.

As reported in section 3.2.2, recruitment from the NHS Trusts was initially slower than I had hoped. It was therefore agreed with my research team for an ethical amendment

to be made, seeking permission to recruit participants via social media. The approval of this ethical amendment was granted on 16th October 2023 (Appendix J).

3.3.2 Informed Consent

Potential participants were emailed an expression of interest form (Appendix M) along with a copy of the PIS (Appendix L), which outlined the aims and rationale for the study, what was involved in taking part, and information on how their information would be used and stored. Participants who returned a completed copy of the expression of interest form were then given the chance to ask any questions or share concerns before deciding if they would like to take part. Those who were happy to proceed after making an informed decision, were then asked to sign and return the consent form (Appendix N). Participants were asked to give verbal consent before taking part in the interviews, and after the interviews were completed. All completed consent forms were password protected and stored securely, separate from the participants interview data, which is in line with the University of Hertfordshire's ethical guidelines.

3.3.3 Right to withdraw

Before interviews commenced, participants were reminded of what taking part would involve and that they had the right to withdraw their interview and data, without giving a reason. It was made clear that they could withdraw this information up until the analysis process had begun, this was to ensure there was enough data for analysis.

3.3.4 Confidentiality and Data Protection

The procedure for ensuring confidentiality and its limits were outlined to participants both verbally and in writing. All interviews were conducted with just one

researcher and participant being present. The interviews were conducted virtually, and all were video, and audio recorded using Microsoft Teams software. In line with the Data Protection Act (2018), all recorded data, as well as anonymised transcripts and demographic data, were downloaded and stored onto the General Data Protection Regulation (GDPR) compliant University of Hertfordshire One Drive which was accessible only by the research team. No personal information such as participant's contact information was kept by the researcher. All participants were given pseudonyms, ensuring no data was personally identifiable. To ensure transparency, all participants were informed that the findings would be written up and form part of my dissertation, which would include anonymised interview transcripts and quotes. Participants were also made aware of possible routes for dissemination of the research, such as future publications, and how their anonymity would be upheld.

3.3.5 Thanking Participants for their Time

All participants were provided with a 'wellbeing box' (Appendix Q) to thank them for their time and participation in the research. These were funded out of the allocated research budget for this study and the content was hand-picked by the research team. Conscious effort was made to choose a thank you for participants that was meaningful, thoughtful, and in keeping with the theme of the research itself. The decision to offer wellbeing boxes was supported by conversation with my consultant and what she felt participants would like to receive.

Participants were not made aware of this until the end of their interview, nor were the boxes advertised as part of the recruitment process. The reason for this was to minimise the potential risk of undue inducement (Vinay & Bauer, 2022).

3.3.6 Managing Potential Distress

Due to the sensitive nature of the topics likely to be discussed, it was ethically critical to provide as flexible and comfortable an interview experience as possible and reduce any distress that may arise through discussion of traumatic or stressful events. Careful consideration was given to ensure this was achieved and several steps were taken to try to mitigate this as detailed in Table 9 below.

Table 9

Steps Taken to Mitigate Participant Distress

Number	Steps Taken
1	I made sure to check in with all participants at all stages of the project, to see if they had any questions or concerns that I could answer or that meant additional support would be needed.
2	Prior to each interview, participants were reminded of the potentially emotive nature of the questions and reminded that they can end the interview, or skip a question, at any time, without giving a reason. They were also encouraged to only share as much detail as felt comfortable for them.
3	During the interviews, I regularly checked in participants to check in about their level of distress. Following feedback from my consultant during the pilot interview, it was agreed this would be done after each main section of the interview. At the end of each interview, I spent time engaging participants in more 'general conversation' in order to support them to re-focus their attention to the present, rather than remaining in their distressing past experiences. This was to support participants to feel calmer and more grounded at the end of the interview, before it was concluded.
4	It was anticipated that individuals may wish to seek out further emotional support following the interview. Therefore, after each interview was completed, participants were provided with a support information sheet (Appendix P) which was sent to them via email. This provided further information and details of where they could access support, should they feel they needed to.

Time was also spent considering the potential for participants to be worried about the impact any comments they make could have for the NHS Trust in which they were working. Due to the current cost of living crisis, I was aware participants may also have worries about being seen negatively in their role and the impact this may have on their employment. To manage this, participants were recruited from more than one NHS Trust (to help with anonymity), additional information was provided on the debrief sheet relating to whistleblowing, and all participants were encouraged to speak directly to their organisation about any concerns they may have.

Finally, there is an increasing recognition of the need for emotional safety of the researcher, particularly trainee researchers in qualitative research (Bowtell et al., 2013). As such, importance was placed on allowing the time and space to reflect on any potential impact for my own wellbeing throughout the research process. This was sustained through regular supervision with my research team, peer supervision with my cohort, the use of a self-reflective journal (Appendix V), and utilising self-care strategies (such as going for regular walks and gaining some fresh air).

3.4 Interviews

Interviews aimed to study the qualitative experience that Clinical Psychologists had of their time working during the COVID-19 pandemic. Semi-structured interviews provide a balance between structure and flexibility, making them well suited for thematic analysis by allowing the researcher to explore participant thoughts, feelings, and beliefs about a particular topic and facilitating in-depth exploration of personal and sometimes sensitive issues (DeJonckheere & Vaughn, 2019).

3.4.1 Development of the Interview Schedule

The semi-structured interview schedule (see Appendix O) was developed based on a review of the literature, and in consultation with my research team. Whilst the interview schedule was organised around four main timepoints of the pandemic (e.g. pre-pandemic, first 6 months of the pandemic, 6months-2 years into the pandemic, post-pandemic), aiming to support participants to orientate themselves to any particular circumstances which may have been meaningful to them, the conversation during the interviews moved through the interview schedule in a non-linear and flexible manner (Smith et al., 2009). Included within the interview schedule were additional prompts and follow-up questions, aimed at eliciting further information and depth from the interviews. Prompt questions asking about experiences of burnout were included in the interview schedule, as this is a term more frequently used and can be seen as less stigmatising within conversation. Following the pilot interview, it was felt inviting burnout into the conversation was an inroad to some more challenging conversations. At the end of the interview, participants were invited to add any additional information to the discussion, that had not already been captured.

3.4.2 The Impact of Video Interviews

I was conscious to consider the impact of conducting the interviews online. Video interviews are considered to be most like face-to-face interviews and only slightly inferior to face-to-face interviews (Krouwel, Jolly & Greenfield, 2019). Offering interviews via video offered several benefits to the current study. It allowed for an expansion of the study population as participants were able to take part regardless of where they lived. I was still able to interpret facial expressions, elements of body language and, to some extent, other non-verbal cues (Saarijärvi & Bratt, 2021). Completing the interviews via video also added

an additional layer of privacy, as I was not required to sign in with a reception team at the participants place of work.

However, I was mindful of the potential limitations of video over face-to-face interviews. For the interviews to be successful, both parties needed to have a reliable internet connection, a high-quality camera, and microphone. Virtual interviews also called into question an additional element to confidentiality, with there being a potential risk of an uninvited person being present in the room during the interview without my knowledge. This was especially important to consider given the sensitive nature of the topics being discussed (Saarijärvi & Bratt, 2021). To manage this, all participants were asked to confirm they had found a confidential space at the start of the interviews, and were asked to let me know if, at any point, someone else entered the room.

3.4.3 Data Collection

Data collection took place between September 2023 and January 2024. Interviews were carried out virtually using Microsoft Teams (Version 1.7.00.3856). Prior to each interview, participants were sent a COVID-19 timeline to support with their recalling of memories during the interview. Interviews lasted between 65 and 100 minutes (mean = 80 minutes). The final participant also contributed additional information in writing following the interview. It was agreed with the research team that this information would also be included at the end of the interview transcript, but clearly separated to ensure transparency. All interviews were conducted by me (a white, female, trainee clinical psychologist) as the solo researcher, and one participant.

3.5 Data Analysis

To ensure a robust analysis took place, data was analysed using Braun and Clarke's (2022) guidelines for conducting Reflexive TA. This uses a six-phase process (Table 10) which acts as a tool to systematically explore, interpret, and report a pattern-based analysis from the dataset (Braun & Clarke, 2022). Data was qualitative in nature and viewed from a critical realist epistemology; that is, the data was viewed as representations of the Clinical Psychologist's reality from which I (as the researcher) integrated key themes (Kuhn & Westwell, 2012). The guidelines for this approach, how it was followed and its application to this project is outlined below.

Table 10

Braun and Clarke's (2022) 6-step Guide to Reflexive Thematic Analysis

Phase	Examples of Procedure for Each Step
1. Familiarising yourself with the dataset	This phase involves reading and re-reading the data, to become immersed and intimately familiar with its content, and making notes on your initial analytic observations and insights, both in relation to each individual data item (e.g. an interview transcript) and in relation to the entire dataset.
2. Coding	This phase involves generating succinct labels (codes!) that capture and evoke important features of the data that might be relevant to addressing the research question. It involves coding the entire dataset, with two or more rounds of coding, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.
3. Generating initial themes	This phase involves examining the codes and collated data to begin to develop significant broader patterns of meaning (potential themes). It then involves collating data relevant to each candidate theme, so that you can work with the data and review the viability of each candidate theme.
4. Developing and	This phase involves checking the candidate themes against the coded data and the entire dataset, to determine that they tell a convincing story of the data, and one that addresses the research question. In this

reviewing themes	phase, themes are further developed, which sometimes involves them being split, combined, or discarded. In our TA approach, themes are defined as pattern of shared meaning underpinned by a central concept or idea.
5. Refining, defining and naming themes	This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme, determining the 'story' of each. It also involves deciding on an informative name for each theme.
6. Writing up	This final phase involves weaving together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature.

3.5.1 Phase 1: Familiarisation with the dataset

As advised by Braun and Clarke (2022), I began the immersion process by familiarising myself with the dataset, which allowed me to capture the essence of what I believed was shared. I did this by re-reading all written transcripts, listening back to both the interviews audio and re-watching the videos. In line with reflexive TA, it was at this stage that I started to critically engage with the data by asking myself questions such as, *"How does the person make sense of what they are discussing?"*, *"How would I feel if I was in this situation?"* and *"what kind of world is revealed through their account?"* (Braun & Clarke, 2022). To support both processes, I recorded my thoughts relating to the dataset in my reflective diary, in attempt to bracket my own assumptions from what was being said by participants.

3.5.2 Phase 2: Coding

All transcripts were read line-by-line and segments of the text were tagged with a label (code) where potentially relevant meaning to my research question was identified (Braun & Clarke, 2022). Any segments capturing multiple meanings were coded more than

once to separate out the diversity of meanings from the data (Appendix R). To support with this process, coding was completed using the computer software, NVivo (version 14.23.2), to help keep structure and organisation to the codes (Appendix S). In line with a reflexive TA approach, open coding was used; whereby there were no pre-set codes, instead codes evolved, were developed, and modified during the coding process (Maguire & Delahunt, 2017). One randomly selected transcript was partially coded together with my supervisor, to support further reflective questioning and discussions as to what segments were being coded and why.

3.5.3 Phase 3: Generating Initial Themes

Once I had coded all the transcripts, the initial stages of theme development were undertaken. Data codes were reviewed to explore areas where there was some similarity of meaning, before clustering together connected codes into tentative or *candidate* themes (Braun & Clarke, 2022). I then created a thematic map (Appendix T) as a visual representation of potential themes, and relationships between themes. By the end of this stage the thematic map still required refining, however following the 'data-driven' and 'inductive' process of this study, this was to be expected as I wanted to ensure I was avoiding being influenced by existing literature.

3.5.4 Phase 4: Developing and Reviewing Themes

The next stage of analysis focussed on developing the richness of my themes. This stage was recursive, whereby I was continuously going back into my data, reviewing codes, and reviewing candidate themes, whilst also holding my research question in mind. I shared my initial thematic map with my research team and engaged in a reflective conversation

which assisted the development of theme conceptualisation, focus and scope, in line with a reflexive TA approach. Once I felt confident in my identified themes, I went back to the entire dataset to complete a thorough and open engagement to ensure I was not misrepresenting the data. A second, refined, thematic map was then developed (Appendix U).

3.5.5 Phase 5: Refining, Defining and Naming Themes

The final phase of analysis involved further development of themes and refinement of my analysis, including writing theme definitions (Braun & Clarke, 2022). Finalised themes were named with careful attention to avoid one-word theme names, as is advised in reflexive TA (Braun & Clarke, 2022).

3.6 Methodological Rigour

Tracy's (2010) Eight "Big Tent" Criteria for Excellent Qualitative Research is commonly cited within TA research to assess the quality of qualitative research. It was therefore deemed appropriate to use this tool to assess the quality and rigour of this study (see Table 11).

Table 11

Assessment of the quality of this research using Tracy's (2010) Eight "Big Tent" Criteria for Excellent Qualitative Research

Criteria for quality	Various means, practices, and methods through which to achieve	Application to current research
Worthy topic	The topic of the research is: • Relevant • Timely • Significant	This research is highly relevant, timely and significant given the recent occurrence of the COVID-19 pandemic and the lack of research into this area – as highlighted by

	• Interesting	the literature review. This research is interesting as it identifies views that are different from common sense assumptions and practices, making it interesting for those inside and outside of academia and the NHS, specifically organisations who employ Clinical Psychologists.
Rich rigor	The study uses sufficient, abundant, appropriate, and complex: • Theoretical constructs • Data and time in the field • Sample(s) • Context(s) • Data collection and analysis processes	This research uses sufficient data. Recruitment was stopped at 12 participants as it was agreed by the research team that no significantly new views were being shared. Braun and Clarke (2013) recommend 6-10 participants for qualitative data using interviews as being an acceptable number for collecting rich data. Although, it is possible that if more participants had been recruited, further themes could have emerged. Rigor was also achieved through the variety of participants selected to ensure a reasonable level of homogeneity. Rigor was also shown through the systematic analysis informed by Braun and Clarke's (2022) guidance.
Sincerity	The study is characterized by: • Self-reflexivity about subjective values, biases, and inclinations of the researcher(s) • Transparency about the methods and challenges	Self-reflexivity has been shown throughout the research process, including the use of a reflective journal. I have considered my own biases and positioning at all stages of the research process. Transparency has been achieved by clearly outlining the methods and challenges of this research. This is further supported by comprehensive examples within the appendices.
Credibility	The research is marked by: • Thick description, concrete detail, explication of tacit	Within this research I have provided abundant and concrete detail at each stage of the research process. I also utilised consultation from my

	(nontextual) knowledge, and showing rather than telling • Triangulation or crystallization • Multivocality • Member reflections	research team to help develop the research at each stage and reduce bias. I have clearly outlined how the interview schedule was developed and the interviews contained rich detail about participants experiences. Thoroughness of the research was also reflected in the writing of the Results chapter, where quotes from the transcripts were included to support the described themes and thicken the description.
Resonance	The research influences, affects, or moves particular readers or a variety of audiences through: • Aesthetic, evocative representation • Naturalistic generalizations • Transferable findings	Due to the nature of the topics discussed, this research can be described as highly emotive and is likely to promote empathy in those who read it. I believe this research will resonate with individuals from various populations and contexts, especially those who provide mental health support. The research has transferable findings, especially for Clinical Psychology forums and organisations. It has limited extrapolation to other areas given the specific experiences of participants.
Significant contribution	The research provides a significant contribution: • Conceptually/theoretically • Practically • Morally • Methodologically • Heuristically	Due to the data-driven, inductive approach taken by this research, it has limited theoretical and conceptual contributions. However, it does have the potential to offer significant contributions practically, morally, and heuristically, as it extends knowledge, improves practice, and gives voice to the experiences of Clinical Psychologists who worked during the COVID-19 era. These insights can help to support and inform the future of clinical practice both for the Clinical

		Psychology profession, but also those they support.
Ethical	The research considers: • Procedural ethics (such as human subjects) • Situational and culturally specific ethics • Relational ethics • Exiting ethics (leaving the scene and sharing the research)	Full ethical procedures and processes are described in detail. This includes the potential for emotional distress experienced by participants, and how this was managed. Relational ethics were reflected on using my reflective journal, bracketing interview, and discussions with my consultant.
Meaningful coherence	The study: • Achieves what it purports to be about • Uses methods and procedures that fit its stated goals • Meaningfully interconnects literature, research questions/foci, findings, and interpretations with each other	All elements of this research reflect the study aims and answer the research questions posed. The methodological approach and procedures used fit with the aims of the study and the epistemological stance of the researcher. The research also includes implications and suggestions for future research.

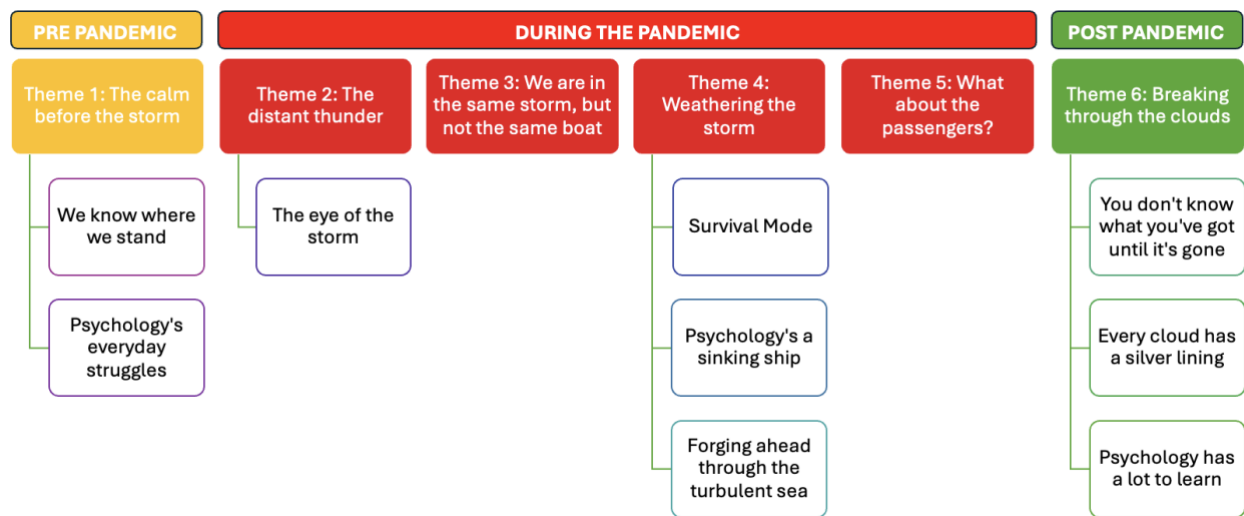
Chapter Four: Results

4.0 Chapter Overview

This chapter presents the findings of the analytic process described in the previous chapter. Data was analysed thematically, and six main themes and nine subthemes were identified as shown in the thematic map (Figure 2) and table of themes (Table 12) below. This chapter will provide an understanding of each theme, using direct quotations from participants to support the interpretations made, and to ensure the focus remains on the lived experiences of the participants.

I acknowledge other researchers may generate alternative themes to those that I have presented (Snelgrove, 2014). The presented themes represent my interpretation of the meaning that participants gave to their experiences and are based on my own views, perspectives, and interpretations of the world. This understanding is also in line with the critical realist epistemology of this research.

Connecting to the language used within the NHS, and by participants, to describe the COVID-19 pandemic, the themes for this study focus on the different stages of the pandemic in the form of an evolving storm. In line with the aims of this research, more time will be spent focussing on the themes identified 'during' and 'post' the pandemic. 'Pre' the pandemic has been explored, and acknowledged, as the context of experiences before the pandemic felt important to include, to support the understanding of how things changed for the participants over the course of the pandemic.

Figure 2*Thematic Map of Themes and Sub-Themes***Table 12***Table of Themes from the Current Study*

Stage of the Pandemic	Theme	Sub-theme
Pre	Theme 1: The calm before the storm	1. We know where we stand 2. Psychology's everyday struggles
During	Theme 2: The distant thunder	3. The eye of the storm
	Theme 3: We are in the same storm, but not the same boat	
	Theme 4: Weathering the storm	4. Survival mode 5. Psychology's a sinking ship 6. Forging ahead through the turbulent sea
	Theme 5: What about the passengers	
Post	Theme 6: Breaking through the clouds	7. Every cloud has a silver lining 8. Psychology has a lot to learn 9. You don't know what you've got until it's gone

A note on symbols:

(...) indicates words have been omitted from the quote

[] indicates words that have been added to improve clarity of meaning

4.1 Theme 1: The Calm Before The Storm

This theme explored participants' contexts and factors that influenced their experiences of working as an NHS Clinical Psychologist before the COVID-19 pandemic. '*We know where we stand*' explores the predictability and familiarity of life before the pandemic. '*Psychology's everyday struggles*' captures the practical, social, and organisational determinants which were perceived as challenges to working as a Clinical Psychologist pre-pandemic. Although participants identified challenges throughout this theme, they did not speak as strongly in terms of compassion-fatigue and moral injury.

4.1.1 Sub-theme 1: We Know Where We Stand

Within this sub-theme participants shared what their role as a Clinical Psychologist was like prior to the pandemic. Many participants spoke about their enjoyment for the job and feeling valued and mattering within their teams, feeling that psychology had a place within the MDT and was a respected and well utilised part of the team:

... I think that's because I thought I was good at my job. I had positive outcomes with therapy cases. I had a good relationship with my peers ... I think I was well liked and repeatedly would be the person that people came to for advice for support within my team. (Myra)

Participants also discussed how they managed their time pre-pandemic, including feeling as though they had a good work-life balance describing being able to complete their work in a manageable timeframe. Participants also shared feeling the work was predictable and familiar, which helped them to manage with in their roles:

But I didn't bring work home, so it was literally when I finished work, I finished work ... it was the core hours were set that it was just really predictable. (Myra)

In summary, this sub-theme captures the pre-pandemic context of working as a Clinical Psychologist within the NHS. It highlights how Clinical Psychology had a role and a place within teams, that there was a familiar nature to the work on offer, the job was enjoyable, and that participants felt able to manage their time well.

4.1.2 Sub-theme 2: Psychology's Everyday Struggles

This sub-theme captured participants' description of challenges to working as a Clinical Psychologist in the NHS, before the COVID-19 pandemic. Many reported difficulties managing long waiting lists for psychological support, fearing that Clinical Psychology was not doing 'enough', or not being helpful. Others, including Kate and Joy, shared the added pressure from the rest of the MDT and an expectation that Clinical Psychology could 'fix' things for service users:

Umm, there was a high demand for psychology ... but a a sense of kind of it never being able to ... offer enough, or meet the need. So there was quite a lot of ... needing to manage colleagues expectations as well around what psychology could offer ... (Kate)

... working with with risk and with working with people that are really, really struggling and not necessarily always being able to find the ways that can help them as, kind of, is a hard part of the job as well. (Joy)

This external pressure was further compounded by some participants describing an additional internal pressure they felt about their role, describing how they were not doing enough, and that they 'should' be doing better:

... But then also thinking to myself, ohh I'm I'm qualified, I should, I should know and I should be able to kind of do these things. (Phoebe)

Despite earlier discussions about psychology 'having its place', others described a sense of psychology needing to be multiple things to different members of the team at different times. As a result, it was indicated that psychology can be put in difficult positions within the team and sometimes be seen as 'separate' to the rest of the MDT, leading some to feel isolated within their service:

I guess that as a psychologist that puts you in a bit of a position in a team sometimes that they would look to me to to try and help ... I would urrm do ... staff training around burnout ... to get a bit of awareness about what might actually be going on for each other [within the team]. So I I kind of saw myself in a role of, in the team and part of the dynamics, but worse, it's slightly outside of the team and trying to help them function a bit better. (Clare)

Along with the emotional toll of the role, participants shared more practical difficulties including travelling across large geographical distances and struggling to find room space for sessions. In contrast to earlier discussions, for some this made the work-life

balance more challenging. It was also acknowledged that some teams often had vacant psychology posts, which further limited psychology's available resources:

I think the travel was very difficult at times ... like going in [to] different bases, making sure that you'd sort of booked a room, making sure that you could use one of the hot desking, urrm where to park ... So that was quite tricky. I'm I guess the other bits were that we had like a number of vacancies as well for psychologists. (Craig)

Overall, this sub-theme spotlights what perceived challenges existed before the pandemic for participants, including the practical difficulties as well as highlighting both an internal and external pressure placed on psychology to 'get things right' and be multiple things to multiple people.

4.2 Theme 2: The Distant Thunder

This theme explores participants' perceptions of how the NHS and their individual management/leadership teams responded to the pandemic. *'The Eye Of The Storm'* captures experiences of the vaccine roll out and the difficulties faced in navigating opposing views. This sub-theme also introduces the participants' experience of health inequalities and racial discrimination.

'The Distant Thunder' identifies participants experience of managerial decision-making during the pandemic. It was noted during the analysis that perceptions of managerial and organisational decision-making were impacted based on the NHS banding of the participants – those in higher banding positions may have been more involved in decision making processes, and therefore had a different perspective on the way systems

were being organised. To support with this sense-making for the reader, the banding of participants will be included next to quotes for this theme only.

In the initial phases of the pandemic, a few participants described a dismissive nature from management as to the severity of the situation, causing mixed feelings amongst teams:

... the teams I was working with, the managers there were not convinced that this was going to last, and they thought it was a making a mountain out of a mole hill.
(Lucy, Band 8a)

This initial confusion continued as the pandemic unfolded, with participants expressing a lack of consistency from management as to what was going on. This was accompanied by participants' uncertainty about how decisions were being made and expressing a 'top-down' approach to decision-making during this time. Feelings of unfairness and worry that only certain voices were being privileged were shared amongst participants, which led some to develop a loss of confidence in management:

Urrm yeah, it didn't feel fair ... and it felt like nobody had a voice, really. It was very.
Umm, very like a dictatorship ... There's no negotiation ... This is what this is what you're gonna do now. It just felt very strange and like we had no control ... It felt really horrible. (Clare, Band 8b)

And that I did lose some confidence there because I was thinking whose making these decisions and it's clearly not very well thought out. If people's voices are not being heard. (Rekha, Band 8a)

In contrast, a few participants, such as Miriam, shared feeling there was collaboration between managers and staff and acknowledged this was a difficult situation for everyone to navigate:

...we had the senior leadership meetings which were, they were collaborative. I wouldn't say they weren't collaborative, but I felt that, everybody's in the same boat, really, and everybody's struggling a bit with this... (Miriam, Band 8c)

Despite the mixed perception as to who was making the decisions, across all the interviews was a shared feeling of uncertainty from decisions and policies being implemented with little notice or time to fully prepare:

And you know, you'd expect planned changes very few times would you implement a change and then the decisions turned around again and that's that's basically what we were getting (Myra, Band 8c)

Participants also described experiencing moral injury from being forced to implement rules and procedures they were not in always in full agreement with:

And even though it was kind of what what the service was requesting you do, that was sometimes a a bit of a discrepancy with with my own values, I suppose. Yeah. So I think there were probably times when I felt like I couldn't completely align to my values. (Phoebe, Band 8a)

Phoebe, along with others interviewed, explored this further – sharing concerns that managerial decisions were centred heavily around prioritising the assessment of risk. Themes also emerged around the focus being more on changes to procedure than focusing on the needs of the individual:

And I think sometimes it did feel difficult relaying that kind of decisions to certain clients to say ohh, actually we're going to see you in three weeks' time rather than next week because somebody's come in the service who's got a different, you know that more urgent kind of level of risk. And I think that was, that's sometimes felt like you weren't being compassionate. (Phoebe, Band 8a)

I know senior managers will be like, oh, we've got this wonderful COVID RAG [red, amber, green] rating system, and which I think it's the worst thing in the world. (Alice, Band 8c)

Alongside this, a small number of participants identified the limited amount of priority given to the changes in procedures and rules in relation to staff wellbeing, as expressed by Joy:

But actually those other things are also really important and we didn't get as much guidance about can we do, you know, can we eat lunch together again now ... (Joy, Band 8b)

As a result, the combined lack of guidance, single narrative, and focus on prioritising risk left most participants feeling disillusioned with management and the NHS as an organisation. There was a shared sense among participants that management, and beyond, did not understand the impact their decision-making was having on psychological staff, leading to a loss of trust in the system, and a loss of meaningful connection towards the NHS, as highlighted by Lucy and Alice:

... getting really unhelpful or patronising responses either nationally from politicians or or even locally from other clinicians or my manager, you know, a real lack of

thinking about what people are going through and ... the toll that will have on ... the helpers of the world. (Lucy, Band 8a)

I suppose where the compassion goes is that ... and I think this is what happened in the NHS 'cause, you're like ... I mean, I didn't leave, but I I know that's why lots of people were leaving because you're like, I don't dislike my patients, but I can't, I just can't do the job in this environment anymore. Like it's, it's just not sustainable. (Alice, Band 8c)

As the pandemic progressed, participants also identified the difficulties in navigating management's plan for psychology within services and how this was continually changing, causing further stress, frustration, and burnout for many:

Like there wasn't like it was just like we didn't need it. We just just didn't need it. Like we've had enough. And it it sort of felt like the systems were not really appreciating what that experience was like for people (Alice, Band 8c).

Overall, this theme illustrates the multifaceted complexities participants experienced from managerial decisions imposed upon services. Participants indicated feeling burnout and experiencing compassion-fatigue from the lack of clear guidance and suffered moral injury from having to carry out other people's decisions, that most report they did not agree with.

4.2.1 Sub-theme 3: The Eye Of The Storm

I just thought, you know, if you stand back and you think, what does it mean to be told that you need to put this into your body without your consent? (Rekha)

Linked to the response from management about how services were being run, this sub-theme focuses on the decision-making of the COVID-19 vaccine roll out, and the racial discrimination that accompanied. This theme was found to contain the strongest sense of participants experiencing moral injury among participants.

Most participants shared how management would use coercive tactics to enforce NHS staff to take up the COVID-19 vaccine. This included a blanket rule that anyone who did not have the vaccine would risk losing their job:

... But you're you're being told quite actively that you're, your job for your clinical responsibility is kind of met ... [based] on this decision that you make ... it does feel, it did feel quite forceful, felt quite scary. (Rekha)

I mean, it was really stressful, really upsetting ... because it wasn't just the prospect of losing this job. It was the prospect that I may never be able to work in the NHS again ... not even knowing ... that HCPC ... they're gonna decide that ... you can't be registered unless you're vaccinated. (Gemma)

This further increased the earlier identified sense that management and the government did not get what was happening for staff, were not supporting staff, and further adding to participants' loss of trust and faith in the NHS:

I'm feeling really angry at the Government, like who the hell came up with this. This is totally ridiculous. You're really not thinking about the people who are going to suffer from this. It's just you need to have the vaccine and that's it. (Priya)

One participant, Gemma, spoke about the response she received when she tried to push back against having the vaccine; feeling ostracised and shamed for having a different view to the organisation:

I was kind of wanting to do that [research the vaccine] before I made a decision and I was like, really kind of verbally attacked for, you know, daring to question ... the integrity of our institutions ... it really like just felt ... like only one narrative is allowed. And if you ask anything that suggests you're not fully ... all in with that one way of seeing things, then you're like a terrible person. (Gemma)

In contrast, some participants shared a very different view of the vaccine rollout. For some, the vaccine was a welcome relief as it provided a level of safety they had not yet felt during the pandemic, as described by Clare:

I couldn't have been more grateful for [the] vaccine. I cried when I had my vaccine ... I am still emotional talking about it ... I just felt so grateful to be able to have a vaccine because I've been so anxious about getting it and in a setting where I was much higher risk to get it ... I didn't pay any attention to whether people were being pressured ... just was very grateful to be able to have it. (Clare)

Whilst there was a pressure for participants to take up the vaccine, there was also pressure from management for participants to encourage service users to have the vaccine. In some cases, this included calling up service users to understand what the possible barriers may be and gently encouraging them to have the vaccine - something that did not sit comfortably with participants, as Kate describes:

Patients who kind of didn't want to be vaccinated, and sometimes there was this ... sort of pressure maybe to be really advising them that they should do that, and I remember that sitting not so comfortably with me, of not really feeling that that was my place to kind of do that. (Kate)

Discussions also highlighted the pressure put on participants to discuss the vaccine rollout with their supervisees. Themes emerged of discomfort and moral injury, especially knowing these decisions could lead to someone losing their job:

So we did have to in supervision, ask people if they weren't having, if they weren't having it, see if they would talk to you about why not. (Joy)

I didn't know what to do ... you know you're in that position where you're asked to do something that you don't agree with. Urrm in terms of ultimately, that means someone's contract is terminated. (Craig)

Underpinning several of the discussions surrounding the vaccine, was the racial discrimination experienced by participants. Individuals who identified as being from the global majority highlighted the targeting and insensitive nature of certain NHS Trusts in how they approached different ethnic groups about the vaccine:

I actually remember making a complaint on one of the emails because it's been sent to what looked like from the list ... every single person of colour in the Trust ... basically saying you need to have a vaccine, there's a lot of misinformation out there, basically almost implying that we were stupid for not having the vaccine and that we were listening to information that wasn't reliable. (Priya)

The pressure and worry felt by many of the participants around having the vaccine was compounded when the government announced a change in direction on their decision to mandate the vaccine for NHS staff. This caused huge anger and the strongest sense of moral injury from participants, some of whom had agreed to the vaccine against their wishes:

... they did a complete 180 and said, oh no it's not mandatory now and feeling really, really pissed off about that. Like, you made me do this and I didn't want to. (Priya)

Yeah, I I I'm still quite angry that there was a real pressure to do that and I I absolutely would not have had it if I felt I could have kept my job and I'm annoyed it's it's more actually anger at myself really that I went along with it ... (Phoebe)

To summarise, this sub-theme demonstrated the moral injury felt by participants as a result of the government and NHS's guidelines on the vaccine rollout. Participants described the conversations being had with different ethnic groups and the racial discrimination and segregation this caused. Participants shared making decisions against their values and beliefs for fear of losing their job and the anger and frustration felt when the decision was revoked.

4.3 Theme 3: We Are In The Same Storm, But Not The Same Boat

This theme highlights the changes to the role of Clinical Psychologists during the pandemic, and how participants navigated this. In particular, it looks at the isolation of psychology from the rest of the MDT.

As the pandemic unfolded, participants spoke to the changes they witnessed for psychology within their teams. For some, they noticed a separation from psychology and the rest of the MDT, describing psychology as being an 'outsider', as shared by Miriam:

I think we were seen as a bit precious and not so important ... there's other people doing their sort of life saving stuff and ... the hero type stuff. And our psychologists were seen as sitting at home ... doing all the easy things which I think is often how psychology can tend to be seen by MDTs ... (Miriam)

Craig described how the pandemic set psychology back within his team, re-creating a historical divide that he had previously tried hard to dissolve:

... and it just feel like we're going back to the psychologist is special and different and we should have limited contact with the team and these targets we need to achieve and ... feeling quite frustrated ... like it was going back to that again. (Craig)

Along with the change of perception within teams, participants shared new pressures to 'step up' into leadership positions and act as role models for the rest of their teams. For some this required them to push aside their own feelings about the situation to support those around them:

... but I think psychologists there was also a pressure to be role models and uphold kind of the new policies and sort of help disseminate some of that information about, you know, clinical decisions, what we're doing in this circumstance ... (Phoebe)

As a result of participants feeling more isolated from the team and under pressure to make themselves as useful as possible in the changing circumstances, participants detailed the impact this had for them as the months progressed. They described the burnout of

needing to be many things to many people, whilst also maintaining compassion for those they were working with. Others shared questioning their ability to do their job successfully, as Kate shares:

... I was also put in this position of ... I guess needing to have the answers need to contain a lot of other people and, urrm yeah, that probably further contributed maybe to a feeling that I wasn't doing a very good job (Kate)

Others told of how they no longer enjoyed their role and questioned whether it was something they wished to continue with:

I began to hate my job and I wanted to retire. I really began to think, you know, if I could just be furloughed, I was quite envious of all these people that were furloughed at one point. (Miriam)

A few participants shared their struggles to understand what psychology's role was compared to other team members during the pandemic, and whether or not they were offering a useful service to others:

I think I probably went through a lot of, not crises, but really thinking about our role as psychology, and again, ... I'm thinking about where do we fit in that [the clapping]? ... And we were told, you know, repeated[ly] by managers that you are offering a vital service. You're still important. (Priya)

Participants also identified feeling isolated from the world around them and the frustration caused from comparing themselves to others:

I felt at complete odds to everybody I knew. Everybody else who was at home ... sharing ... how many TV series they've got through. And I was like, yeah, I haven't done any of that ... I felt really isolated ... yet I was the one that was around people.

(Clare)

... like on the news, they'd often say ... in this time when we've all got so much more time in our hands ... I'd say I just think to myself, oh, fuck off ... some of us are just working harder than ever. And it's not fair. (Miriam)

Overall, participants shared the noticeable shift in how psychology was seen and utilised within their services. This came with additional expectations and pressures for Clinical Psychologists who were asked to take on new and challenging roles. This often left participants feeling distanced from their colleagues, and the outside world, and no longer understanding where psychology fits within services.

4.4 Theme 4: Weathering The Storm

This theme encapsulates the overall impact for participants of living and working during the pandemic. *'Survival mode'* captures the emotional toll the pandemic took on participants as it progressed. *'Psychology's a sinking ship'* summaries the participants' feeling of losing their identity, both as individuals and as Clinical Psychologists. *'Forging ahead through the turbulent sea'* identifies the ways in which participants attempted to overcome these difficulties and improve their wellbeing.

4.4.1 Sub-theme 4: Survival Mode

This sub-theme highlights the 'breaking point' some reached whilst working during the pandemic. There are strong links to compassion-fatigue and moral injury throughout, alongside the balance of managing home and work life.

But it's about the joy, you know, like, you lose the joy like you just get in that survival mode ... (Alice)

There was a general theme across all participants of a struggle to manage boundaries and have a work-life balance when working from home:

... working from home, I found that quite challenging in terms of work life balance because I would quite easily stay on my laptop ... and then realise the time ... oh my God, it's 7:00 o'clock ... and not having that break and being kind of sat in my house working and then being sat in my house, you know, existing ... (Phoebe)

So initially ... it was good, but then as time went on, that worked sort of piled up and it was really difficult to have that natural boundary. (Craig)

For those who had children, the difficulty in maintaining a confidential space was a common issue. It also highlighted the challenge of being a work from home parent and the impact this had on participants view of their parenting identity:

I mean talking to people about child abuse whilst my kids are trying to come into the door. That was just awful. (Lucy)

I generally had a feeling throughout the whole of the pandemic that I wasn't doing my job as a mother very well and I wasn't doing my job as [a psychologist] very well

like because they just meshed so much and suddenly the boundaries and things weren't there. (Joy)

This lack of separation between work and home life was shared by a majority of participants, leading to a consistent experience of burnout:

... I was just really closed down ... I just wasn't talking as much as I used to. I wasn't really doing very much apart from work and sitting with the kids, you know, it became like a treadmill of work, kids, work, kids with some sleep and some food, and that was about it, really. (Lucy)

For others, the shift to working from home and offering therapy online meant they started to notice a loss of compassion and job satisfaction as the pandemic progressed:

And does it affect my work with client[s]? I mean I suppose the honest answer is it probably did affect my attitude towards clients ... because I couldn't have the proper connection with them that I would normally have. (Miriam)

I think I struggled to feel connected to my work in general ... even now, I I still just don't get this same, reward that I umm used to have from my work. (Kate)

Kate, who sadly suffered a suicide on her caseload whilst working in the pandemic, details how the emotions of this became entangled with her home life:

I guess the nature of our work ... is like the emotional stuff ... It all felt in my home and so I'd already kind of been struggling with that of like how to create some separation and then after this happened [the suicide] it it. Basically, my home was ...

all wrapped up in her story because it had all had happened in a way kind of there.

(Kate)

Themes also emerged around the physical risk of COVID and how participants struggled to balance keeping themselves, and those around them, safe:

... I had to keep backing away and I'd say sorry, mum, I can't hug you. I'm not allowed. And and then I'd worry that I'm also being a bit selfish because I'm going to work and maybe I'm not protecting her as much as I could. (Miriam)

It left me feeling worried. To the point where I'd come home and my children's natural instinct would be to hug me and I couldn't do that. I had to stop them and literally [go and] strip off. (Myra)

Alongside this fear, others spoke to the physical impact the stress, burnout, and compassion-fatigue had on their own bodies:

I suffer from migraines and am I basically was getting sick all the time and so I was having to take a lot of time off work. And yeah, very ill, basically. Umm, so I think a lot of my stress was emerging kind of in quite a physical way for me. (Kate)

So. Yeah. So the I think physically my body was a bit done, which probably I, well, I suppose that was a function of the stress ... (Alice)

In summary, this sub-theme speaks to the emotional distress experienced by participants caused by their change in working environments. Participants struggled maintaining boundaries, ensuring confidentiality, and feeling adequate in managing their

personal and familiar relationships, all of which caused feelings of burnout, and compassion-fatigue.

4.4.2 Sub-theme 5: Psychology's A Sinking Ship

This sub-theme captures the impact of the pandemic on the identity of participants, both as Clinical Psychologists and outside of this. Included within this is a sense of the profession of psychology itself being part of the problem.

Participants, such as Joy, Miriam, and Lucy, spoke to a loss of identity during the pandemic. They shared struggling to manage boundaries, no longer feeling helpful in their roles, and how this negatively impacted on their ability to live in line with their values:

But it definitely made me lose confidence in myself. Uh, yeah, I definitely questioned my capabilities as a psychologist much more during COVID than I ever had before.
(Joy)

The clients ... didn't seem to be particularly appreciative of the way that we were just calling them and checking in on them and it you began to feel like [I] wasn't really doing it, wasn't really being a psychologist. (Miriam)

I am I really, really did feel very, very burnt-out and and also umm a sense that I can't stop. I know that I'm not. You know I'm. I'm. I'm losing my compassion to a degree. I'm feeling like I can't do this anymore... I felt like I wasn't able to be the the psychologist, the person, that I want to be anymore ... (Lucy)

Lucy, who noted a particularly strong loss of identity during the pandemic, further expanded on her feelings, sharing the following poignant quote:

So I feel like I ended up living my values while sacrificing myself. (Lucy)

Lucy's striking quote demonstrates the impossible nature some experienced to support others and work in line with their values simultaneously. Others expanded on this, sharing their continued pressure to do more:

... That was constantly the biggest struggle for me, I think throughout was, yeah, not feeling like I was doing enough. (Joy)

Alongside this internal pressure, a common theme emerged of participants relegating their own emotional needs to prioritise others. This stemmed partly from participants themselves, but also from external sources, such as the system around them. This was a major cause of burnout and compassion-fatigue for many participants:

what I tried to do was stay consistent with those values to the point where I damaged my own health, ... my own mental health ... because I spent so much time focusing on other people ... and maintain ... for instance, teamworking, making sure the team were OK was I felt like was part of my role. (Lucy)

So I think because I was feeling so much anxiety as well, but I felt like I had to sort of hide that and not say that because I was trying to contain anxiety in the system around me. (Clare)

It was also recognised by participants that the profession of Clinical Psychology played a part in their struggle to prioritise their own needs:

It's like, well, maybe actually I'm the one that's burned out, this telling other people what burnout is, it's actually that it's happening to me. And so it's a part of it is ... the

profession perhaps not always being very helpful in or making me feel that I was exempt from having this experience happened to me ... I think I did some for some reason think that it didn't apply to me. (Kate)

... it also loses that idea of ... psychologists are human beings as well. We're we're trained in certain things like other disciplines ... that doesn't make us any less ... susceptible to experiencing stress and difficulties and being able to express how we're feeling ... so ... I think that role model element can come with a bit of an added pressure. (Phoebe)

This reflection on the Clinical Psychology profession carried across several of the themes identified, with participants sharing a sense that psychology should be able to 'fix itself' and how the system perpetuates the idea that it is not ok for Clinical Psychologists to struggle too, as expressed by Kate:

... that really was amplified for me after I had the sort of post traumatic reaction after the suicide. Again, like feeling so ashamed, really, that I couldn't cope with this event that happened. Even though kind of rationally I understood that if that my colleague had been through something similar, I wouldn't feel this way. But nevertheless. There's something within the system that for me really makes it feel not OK for us to struggle ... (Kate)

In summary, this sub-theme looks at the impact the COVID-19 pandemic had on participants' identities. It demonstrates the level to which compassion-fatigue, burnout, and moral injury were experienced by many participants and how the profession itself impacted on individuals' perceived ability to engage in self-care or to seek help.

4.4.3 Sub-theme 6: Forging Ahead Through The Turbulent Sea

With participants notably struggling during the pandemic, this sub-theme focuses on the strategies and support participants experienced which helped them to cope during the most challenging moments of the pandemic.

For others, coping during the pandemic involved learning to quickly adapt to new situations. Participants reflected a sense that this was something Clinical Psychologists are good at, and how the rapidly changing environment invited them to lean on their creative and problem-solving skills:

... and I I am very much like a problem solver in the sense that I try to kind of think about solutions to situations that I'm in. And so I kind of go well, I'll learn. I might not be great at it at the beginning, but I'll get there. Just go with it. And you know what? It was quite exciting. (Myra)

And I suppose, well [the team manager] says I am good in a crisis like, I'm quite good at ... just take this day by day, this is what we're doing with, like, we're not going to get caught up in the worry. We do this. We've got a plan. We stick to the plan. We keep going. (Alice)

Phoebe detailed how for her, supervision was where she found her strongest support network:

Yeah, I think my own, my own supervision. So my one to one supervision was really, really helpful. (Phoebe)

Whilst others shared the ability to remain connected to other colleagues was something they really valued, along with having a shared sense of everyone in the team coming together to one another, and our service users:

Yeah, I think it was being creative. I think that's what I appreciated. The ability not only for myself but other people around me to be creative in ways to connect. (Myra)

... it might be dropping off a prescription to someone or doing a welfare check, and at the start I felt like everyone was like .. of course we're gonna do that. You know what, everyone sort of looking in and things together. (Craig)

For some, strength came from outside of the NHS; with family, and within their community, helping them to reconnect with the values that are most important to them:

... when it's Eid in our community will come together we will have like a plate of food and cakes and stuff and Eid sort of fell within that that lockdown period and we ended up just doing it and on mums driveway then we all sat there on her driveway ... it was just so different but I I feel really pleased that we were able to be so creative and still find a way to come together even when we were being asked not to. (Rehka)

For others, the change in their therapeutic work bought a new perspective on the role of Clinical Psychology and what it can offer others during a pandemic, allowing participants to feel validated and useful in their role once more, as Rehka details:

... but actually begin recognising that every interaction that [I] was having could have the capacity for being therapeutic or becoming an intervention in its own right. That felt really validating, ... and that really then came back to being present, being kind

and empathetic towards people and remembering ... that's what really mattered.

(Rehka)

To summarise, this sub-theme highlights the ways in which participants coped within their roles during the pandemic; whether this was through coming together with others, learning new skills, reconnecting with their values, or by recognising the positive impact they were having for those around them.

4.5 Theme 5: What About The Passengers?

This theme looks at the perceived impact of the pandemic on service users, from participants' perspectives. The impact of the pandemic for service users was not an aim of the current research and so was not directly reflected in the interview questions asked. What this theme identifies is what participants felt about, and how they responded to, their relationship to service users during the pandemic.

Commonly, participants described feeling as though the best interest and needs of service users were not being prioritised by services, leading to feelings of anxiety and moral injury for some participants:

... But it was it felt coming risk led rather than needs led and and that didn't fit quite well, because actually that was a time when a lot of young people, you know, we know how this generation of kids were so affected by COVID. (Rekha)

... like we weren't spending time getting to know them, getting to formulate, getting to understand their problems. It was more like, Oh well, you know, checking in how you're doing. And are you safe and does everything all right. And then if you keep

doing that week after week, it becomes a bit. Almost like anxious about talking to them because I don't feel like I have much to contribute. (Miriam)

Discussions also highlighted the need for psychology to shift focus from therapeutic work to more practical interventions to meet the current needs of service users:

You know, let's make sure that people are working with. Have they got food? You know, have they got warmth? Have they got? What are the very, you know, the very core things that we need? (Lucy)

Others, including Rekha and Clare, detail the increase in their own anxiety levels at not having a clear sense of the situation for their service users, and whether or not they were really safe:

... what's happening after this appointment? Are they OK? I remember sort of having a lot more text conversations with young people and ... a lot more checking in and. You know if there is the risk of self-harm or or suicide it can be quite live for somebody young people always working with at the time. So ... making sure that they had risk management plans in place. And I just noticed my own kind of anxiety just really peaking because of the concerns around their safety. (Rekha)

... we were just trying to reassure the patients that were ringing in because they didn't know what to do ... and we didn't really know what to say. None of us really knew how it [COVID] would affect them, so we all felt really scared ourselves and scared for our patients. (Clare)

The use of PPE was a main contributor impacting on the therapeutic alliance between participants and their service users. Many detailed how unsettling the wearing of

face masks, gloves, and gowns could be for service users, especially those with additional needs:

... on the other side of our service users is what's the impact on them of seeing someone rock up in a mask, gloves and a gown. And, you know, a lot of work that we've done is to kind of break down that power between kind of professionals and service users ... we don't wear uniforms and things like that. We, you know, want to meet people where they are. And you've got someone coming into your home wearing this ... What's the experience like for them? (Priya)

... [I had] a therapy appointment with somebody who I've been seeing for a long time before COVID for trauma and having to turn up in clinic to her appointment with an apron and gloves and a mask and goggles and a visor. And just thinking, what the hell is going on? You know ... and taking her temperature ... I think that was the end of our therapeutic relationship. I think she just couldn't tolerate that. (Lucy)

In addition to the difficulties in navigating the therapeutic implications for service users, participants shared their frustrations at how service users were being perceived in other contexts, such as within the media:

I remember feeling really angry about the way older people were being perceived and treated and talked about in the media and that that became more of a conversation in in the therapy conversations. (Lucy)

Alongside side this perceived stigma, other participants also noted the social injustice, marginalisation, and health inequalities that the pandemic highlighted for some service users:

Umm, one family might have one ... laptop between them and you might need people to be [on] separate laptops and be in separate rooms cause crowded all around one laptop is quite tricky ... It wasn't fair this sort of family could only afford one laptop. You know that they should be discriminated against and not offered sort of family work ... that was really tricky. (Craig)

... So yeah, I think that led to some sense of burnout or compassion-fatigue. I don't know how I describe that, but just just feeling very, yeah, very overwhelmed with being very aware of lots of inequality and lots of difficulties that people were having. (Phoebe)

I think there's something about that a lot of the people that we were talking to were telling us that they felt even more neglected than normal, even more marginalized than normal, even more unseen, but also slightly victimised. You know, we're trying to protect older people and that's why we can't go out and then feeling afraid of going out because you know, they're not supposed to be going out. Yeah. So it kind of doubled down on some of those stereotypes. (Lucy)

In conclusion, this sub-theme touches on the impact of the pandemic for service users, from the perspective of participants. It was highlighted that the use of PPE impacted on the therapeutic relationship and how the pandemic spotlighted certain inequalities and social injustices for those who use our services.

4.6 Theme 6: Breaking Through The Clouds

This final theme focusses on the participants' perception of life 'after' the pandemic. The period referenced in this theme is identified by services resuming to 'business as usual',

where restrictions were lifted, and no further national lockdowns were enforced. *'You don't know that you've got until it's gone'* highlights the loss shared by participants from life before the pandemic. *'Every cloud has a silver lining'* focusses on participants' perceived benefits to life post the pandemic. Finally, *'Psychology has a lot to learn'* looks at the learning points participants had from their time working in the pandemic, as well as their hopes for the future of the profession of Clinical Psychology.

4.6.1 Sub-theme 7: You Don't Know What You've Got Until It's Gone

This subtheme looks at the aftermath of the pandemic for participants. Throughout the pandemic, participants shared feeling a loss of connection to and within their teams. As systems returned to normal, some participants reflected on how this loss of connection remained:

It's quite sad, actually I don't think the team never felt the same again because so many things are more remote. Umm. So in terms of things like team meetings, supervision. So I don't think that team ethos came back that we had sort of prior to to COVID ... and that's led to some conflicts as well. (Craig)

This feeling was echoed by other participants who shared a change in the team dynamics leading to a culture of people being less present:

And I also think that meetings, although people like to put in meetings, the meetings are less productive because when you're in the meeting, you can see that someone is also doing their emails ... (Alice)

I definitely think looking at other people before and after the pandemic, it's just like people barely come in. I really feel like what are people doing like I do think everyone became a bit more lax. (Gemma)

Others touched upon the change to working patterns and how hybrid working allows for more meetings to be carried out than before the pandemic, which can cause additional burnout:

You know that my diary, if you look at my diary, it's horrendous because there's just happening all over time and sometimes you know it's it's overlapping meetings having to leave one meeting early and join another meeting late that's you know ... can feel really overwhelmed. We can feel I call it when we're using zoom I zoomed out just completely like I can't look at a screen now I can't do this virtual working. (Priya)

And to the extent where, yeah, even now I'd probably say in some ways it's worse now than it was pre-pandemic just because of the amount of things people can book in, in your diary and compared to before ... that potentially can lead to more people experiencing burnout because some of those natural boundaries aren't in place. (Craig)

Gemma added to this feeling of burnout, adding the pandemic has left her feeling, at times, less compassionate towards her work:

It's not I don't care at all. I do care like about the young people I'm working with, but I feel like I've given up a bit. I don't have the same level of energy and commitment to kind of go above and beyond that I did before ... I guess I mean what I was saying

about being more checked out, I'm probably umm, more I'm probably, abit less, urrm, compassionate. (Gemma)

Another concern shared by some participants was the reduction in funding for NHS staff support services set up during the pandemic, feeling that staff are no longer seen as a priority by the organisation:

Other things that I have sadly already see leave, which I think is very unfortunate, was there was some increased staff support like brought into a lot of the hospitals and that has now been taken away in some areas ... and I think that's really unfortunate because I I wish that that increased staff support had stayed. (Kate)

Joy, who used staff support services herself, shared her sadness for the reduction in funding, having found the service to be useful for her:

It was really helpful ... sadly now and they [are] taking funding away. So it's just in the process of being disbanded. But it yeah, it was a really great service. (Joy)

Along with the changes more broadly brought about by the pandemic, participants reflected more specifically on the impact COVID-19 has had for the profession of Clinical Psychology:

Other impacts on our profession, I mean, apart from minor, well, they're not minor, but I guess it feels like it's really changed the way in which we work, right? You know, I would never. Yeah, I, I don't. Almost all psychology now happens online and, I think I have very mixed feelings about what that means for our profession, to be honest. Umm, I think in some ways it's good. But I, I think we don't know yet. (Kate)

Time was also spent looking at the impact for the NHS as an organisation following the effects of the pandemic, with sharing a loss of commitment to the NHS:

It's definitely made me a lot less like. Uh, what would the word be like before a kind of like commitment to the NHS? Like I've lost that, umm. And I know people who quit, several people who quit over this and are working privately, like and the the the NHS has lost people because of it. (Gemma)

... choosing where I want to put my energy of kind of fighting for things ... I think sometimes that can make ... me feel a bit sad or just like not so happy with the organisation ... You know, when we have, you know, young psychologists coming through the service and because they want, they have a hope and I want them to have hope too. And yet I think I feel sometimes in conflict with the reality sometimes of how things are and what ... that's like, and so I I think I think some of that has been has been affected ... for me, yeah. (Kate)

Finally, within this sub-theme there was an ongoing sense shared by all participants that time was still needed to fully process what has happened to us all during the pandemic, and this was not something teams had prioritised:

But you know, as a result, I don't often feel like we've really thought about what we have held on to what changed for us, and what we've taken away. So I really welcomed the space to think about that ...[because] something really massive happened in 2020 and it feels like actually, we've not really processed that as an organisation. (Rekha)

... but it just feels like we've been through such a surreal storm. But I think there was a there's a phrase that regarding the pandemic that was floated about quite a bit, that we're in the same storm but not on the same boat. That everybody had their own journey. And some. We'll have the boats and would remain safely on the boat, but I think that just summed it up that I think I was able to just sit with my own journey and it's been nice to reflect. It's been nice to stop and think about it. (Myra)

In conclusion, this sub-theme looks at the aftereffects of the pandemic for participants. It demonstrates the long-lasting felt effects of burnout and compassion-fatigue, as well as a sense of MDT's not feeling the same again.

4.6.2 Sub-theme 8: Every Cloud Has A Silver Lining

This sub-theme looks at what participants valued from their time working in the pandemic and the changes they would like to see stay in place going forward. For some, the additional time spent at home with family was something they really appreciated:

I feel that I was very lucky. I was. I also feel, as I say, I feel very privileged about that I was able to spend time quality time with my family, my network, my system of four. (Myra)

Whilst previous themes identified a frustration and disappointment that staff support services were being closed, others shared a different experience:

What we talked about with the staff support line, they've now actually made that a service in the Trust. It obviously started off as the COVID-19 staff support line, but it has now become more of a generic general staff support line where you know it's actually been commissioned as a service where I think is really great. Again thinking

about the welfare of the workforce, not just our services users and our, urrm families, actually, people who work for the Trust. So I think that's been a really good thing.

(Priya)

Rekha, along with others, shared feeling the mental health of staff has been put more in the spotlight within the NHS because of the pandemic:

People, like my supervisor, she often calls the NHS the sick system and that it's impossible sometimes to try and stay well within that. And I really like that metaphor, and it really has shone a spotlight on the fact that burnout, exists. Compassion-fatigue, exists and people are leaving, and that people are going elsewhere to do things that make them happy and make them feel more fulfilled in their role. Therefore, what's happening here that's not meeting their needs? I think the fact that there is more more of a a, urrm yeah spotlight on thinking about what what helps people feel fulfilled in their role and thinking about wellbeing. (Rekha)

Reflections were also made on the benefit of more flexible and hybrid working patterns, including having more choice in the way participants can work:

Yeah, whatever needs you might have flexible working can really help us [as a] service, it can really help a team because it the people, you know, the people really feel valued then and they feel, you know, you respect my work life balance instead of saying, you know, nine to five is the only way to work. (Lucy)

In addition to having more freedom, participants shared the new opportunities that have been made available following the pandemic:

Lectures and stuff, but I think there's more free stuff like that about. So I think that's another thing about making things more available. I think communication has become easier. (Miriam)

Urrm, I don't know why we weren't. Yeah, and having been able to kind of have a webinars and we had a webinar at one point with people in Australia, I mean that was phenomenal because they've been using Neuro Psych remotely for years because of the geography that they have. And I think that being able to link with people in that way was wonderful. (Lucy)

So now the fact that we can just have a teams meeting with a care coordinator who was working, you know, 30 minutes away rather than arranging a time when we can both get somewhere, it's massively better. (Joy)

Finally within this sub-theme, participants shared the perceived benefits for service users resulting from the pandemic:

I think we can we can offer therapy in a way that suits the service user, and I think we're, you know ... really able to to be more accessible by adapting what we do to make it possible for service users to access, which maybe they wouldn't have done before. (Miriam)

... and I think from a kind of service user point of view having more choice in terms of you know do they want to see someone virtually or telephonically or face to face or having more of those kind of options I think is helpful and perhaps than people had before the pandemic. (Phoebe)

In summary, this sub-theme identifies the changes that were most valued by participants from the pandemic. Participants highlighted the enjoyment for having more flexibility in how they work, being able to offer more choice to service users, as well as being able to connect with colleagues more easily all around the world.

4.6.3 Sub-theme 9: Psychology Has A Lot To Learn

This final sub-theme highlights participants learnings, hopes, and takeaway messages for the future of the Clinical Psychology profession, because of the COVID-19 pandemic. For some, they shared feeling disconnected from the Clinical Psychology profession, feeling the system could have done more to offer support during the pandemic, as Gemma details:

I didn't really leave me with hopes cause it more left me with. Like I said, this kind of sense of depressing like, Clinical psychology didn't do anything good during this. It's not like I was like, ohh great clinical psychology's got my back like it, you know, it changed [the vaccine mandate] at the last minute for other reasons and clinical psychology along with everyone else has gone along with that now ... If anything, it's it's probably, uh, shattered some of my hopes about Clinical Psychology's ability to stand up against like what I see as injustice. (Gemma)

This worry for the future of Clinical Psychology was echoed by others, including Lucy:

I do feel quite worried ... about the future of psychology in the sense that I see lots of psychologists going into private practice. Lots of psychologists, having experienced, you know, real concerns during COVID and that being the straw that breaks the camel's back. (Lucy)

For others, there was a sense of Clinical Psychologists being able to show their resilience and come through at a time of immense struggle:

... and so I guess the sense of like we can survive this and the ... professional point of view that we can do it while still being person-centred and thoughtful, we just do it in a different way, but we can still do it holding those things in mind, we don't have to like close all our caseloads and you know things like that. (Priya)

So I think looking back, I think the fact that I felt quite, I feel proud that I was able to lean in towards that uncertainty and and step into courage... (Rekha)

It was also noted that Clinical Psychology doctoral places increased during the pandemic, and it was reflected on how important this will be for the profession going forward:

Umm well, I think the one of the coolest thing is that the profession has grown is growing. So, like training, availability opportunities and stuff have really grown. (Rekha)

Myra shared how she felt psychology was 'put on the map' more during COVID and how this is something she would like to see continue going forward:

To continue to have a voice, and to be able to contribute in shaping services, in being able to evolve. And be respected because I think that we were kind of on the B team, the C teams for a lot of decisions, we were not part of the initial processes, but I think people are, have noticed ... the impact of psychological services and the impact of psychological support. I think Clinical Psychology has ... moved through a lot of waves in this time. (Myra)

Craig further builds on this reflection, adding how he feels Clinical Psychology was able to show it can be different things in different situations and adapt when needed to:

Things that I did and other members of the team were doing where you said that prior to the pandemic, it would have been like, I don't know, Ohh a Psychologist, you know, wouldn't do that, you know, drop off a prescription or something that's not in their job role or, you know, or psychiatrists volunteering to to do something on the ward or something. I don't know. We definitely wouldn't do it. People did and people did it quite willingly as well. (Craig)

A major reflection shared by most participants was a sense that the profession of Clinical Psychology needs to be better at promoting kindness towards itself:

... recognising the humanity of the people that are doing the work and. Could we do better in, umm, I guess yeah, acknowledging our own needs and how umm. How we might think about that in the services that we work in? Umm Yeah. And about not just being the ones that are providing the help and support that, but sometimes you might need to be the recipients of it as well. (Kate)

Just being able to sort of check in with yourself and what my thinking, what my feeling. What? What's my response? What's my urge? Umm, maybe things like that might be something for the future of Clinical Psychology to be a bit better at. (Phoebe)

Additionally, it was shared by some that they felt Clinical Psychology continued to be seen as 'different' to the rest of the MDT and how they hoped this is something that could change going forward:

... and maybe a sense of I don't know, that psychologists, you know, struggled during the pandemic like everyone else did. And maybe there's that sort of getting rid of the barriers between, you know, sort of how psychology might be viewed. So yeah, I think more maybe to put psychology on a more equal footing with other professions.

(Craig)

Along with the profession of Clinical Psychologists, throughout discussions, some participants shared their own hopes for the future and being better at engaging in self-care practices:

I I've learned that I need to look after myself a hell of a lot better than I did. I think I suppose that's but a lot of that is through having long COVID and realising I need to slow down, that I'm somebody that is really quick, normally at doing things and I've I literally have to make myself do things in slow motion sometimes. So I've realised I need to listen to myself when I talk to other people about self-care and do it myself.

(Lucy)

Additional hopes for the future of Clinical Psychology were shared by participants, including a larger focus on supporting social injustices and health inequalities:

... The Black Lives Matter movement essentially, and the impact that that has had on the psychology profession and mental health services in general, is something I've started to witness and that did occur kind of during this period ... because there was also inequalities in relation to its sort of deaths from COVID. And so maybe that is fair to say that I hope that that time is actually drawn attention within the psychology

profession around the need to attend to inequalities in mental healthcare, but also in our work force and some of those things. (Kate)

I think there needs to be a strong voice ... from psychology and that would be my hope that there are more kind of leadership and higher up roles within organisations, yeah. (Clare)

To conclude, this final sub-theme identified participants' take away messages and learning points from their time working in the pandemic. Participants shared their frustration at Clinical Psychology for not doing more and hopes for Clinical Psychology to take better care of and be kinder to itself. Reflections were made about the additional work Clinical Psychology needs to do to advocate for others and, overall, Clinical Psychology showed it can survive a global pandemic and come out the other side.

Chapter Five: Discussion

5.0 Chapter Overview

This chapter summarises the key findings concerning the research aims and objectives and in relation to existing literature. I will also discuss the strengths and limitations of the current study, along with suggestions for future research and recommendations for clinical practice. This chapter will conclude with discussions for dissemination as well as final reflections.

5.1 Revisiting the Research Questions

This research explored the experiences of NHS Clinical Psychologists who worked during the COVID-19 pandemic. It also looked at what lessons can be learnt from participants' experiences, and how this can inform clinical practice going forward. The main research question was *'What were NHS Clinical Psychologists' experiences of compassion-fatigue and moral injury during the COVID-19 pandemic, and what lessons can we learn?'* Three sub-questions were also explored:

1. *What were Clinical Psychologists' experiences of compassion-fatigue during the pandemic?*
2. *What were Clinical Psychologists' experiences of moral injury during the pandemic?*
3. *What related lessons can be learnt from Clinical Psychologists' experiences of working during the pandemic?*

5.2 Summary of the Findings

From the interviews conducted, six main themes were identified; *'The Calm Before The Storm'*, *'The Distant Thunder'*, *'We Are In The Same Storm, But Not The Same Boat'*, *'Weathering The Storm'*, *'What About The Passengers?'*, and *'Breaking Through The Clouds'*. In line with Bronfenbrenner's socio-ecological model, this research identified many interactions between personal (individual), team (micro-), organisational (meso-), and socio-political (exo- and macro-) factors, which reinforce the idea put forward by Devakumar et al. (2020) that *"the strength of a health system is inseparable from broader social systems that surround it"* (p. 1194). The themes and subthemes will now be summarised in relation to the research questions and situated within existing theory and literature.

5.2.1 What were Clinical Psychologists' experiences of compassion-fatigue during the pandemic?

Overall, compassion-fatigue was found across all themes, but was particularly prevalent in the 'during the pandemic' phase for participants. Compassion-fatigue was most closely linked to changes in clinical practice and offering therapy online. Participants shared how this impacted their ability to feel connected to service users, as well as limiting their ability to separate their work life from their home life. In line with the Job Demands-Resource model (Bakker & Demerouti, 2007; 2017), which proposes high work demands contribute to stress, this study found that the constantly high demands caused by COVID-19, and participants not being compensated by the motivational impact of resources, led to the development of compassion-fatigue and poorer job satisfaction. The level of compassion-fatigue experienced did not appear to be associated with participant's banding. The findings of this research correspond with studies in the systematic literature review highlighting the

difficulty in developing rapport with service users (Singh et al., 2024), the negative impact on the therapeutic relationship from the use of PPE (Kreh et al., 2021), and the difficulties with assessing risk with confidence via a remote setting (Tolland & Drysdale, 2023; Billings et al., 2021).

Compassion-fatigue was also shared in relation to Clinical Psychologists in the current study feeling isolated and alone, both within their teams, and as a profession. Participants shared feeling unable to acknowledge their own feelings, relegating their own emotional needs for the support of others.

What this research also highlighted, was a sense of compassion-fatigue towards working for the NHS, which several participants experienced. For example, in the 'post-pandemic' phase, participants shared their disappointment at staff support services being scaled back or shutdown altogether, feeling unsupported and as though the mental health needs of staff were not a priority by the organisation. This echoes the research of Tolland and Drysdale (2023) who described participants wanting a more compassionate approach from their employers. This loss of compassion for the NHS also links to participants' experiences of moral injury, which will be discussed further in the next section.

5.2.2 What were Clinical Psychologists' experiences of moral injury during the pandemic?

In conclusion, moral injury was only expressed by participants in the current study in the 'during the pandemic' and 'post pandemic' phases. The theme most strongly connected to moral injury was 'The Eye of the Storm' and discussions relating to the vaccine mandate. Here, participants shared their disillusion for their Trust, the NHS, and at times, their

professional body (e.g. the BPS) for not doing more to support their decisions. Some of the participants described feeling forced into having the vaccine due to fears of losing their jobs, and the anger and disbelief they felt when the decision to mandate the vaccine was overturned. As discussed in the previous section, this created a loss of trust in the NHS and caused a handful of participants to question their future within the organisation.

Alongside this, participants expressed moral injury from no longer working in accordance with their values. For example, participants shared their struggles with managing waiting lists (e.g. needing to decide who should and should not receive care) and having to pause therapy with service users, and the negative impact this had on their mental wellbeing. This corresponds with findings of previous research where participants did not feel able to offer the service they would like to service users (Chemerynska, Marczak & Kucharska, 2022). It also supports previous research that highlighted how the COVID-19 pandemic has exposed existing inequalities and created additional inequalities (Platt & Warwick, 2020).

Unlike with compassion-fatigue, the experiences of moral injury appeared to be impacted by banding when in relation to the implementation of managerial decisions. This research found that those in higher banding roles were less likely to experience moral injury in relation to this, due to having been more likely to either have been involved in the decision-making process or have a better understanding of how the decisions had been made. This level of understanding therefore lessened the extent to which some participants' experienced moral injury.

5.3 Quality Assessment

This research is believed to be the first of its kind, adding empirical value to the limited understanding of the experiences of moral injury and compassion-fatigue felt by Clinical Psychologists during the COVID-19 pandemic. This study also increases understanding of the factors that help and hinder Clinical Psychologists within the NHS, offering clinical implications and recommendations. When interpreting the findings of this research, some specific strengths and limitations are important to keep in mind, these will be discussed below.

5.3.1 Strengths of the Research

By qualitatively exploring Clinical Psychologists', within a UK NHS Context, experiences of the COVID-19 pandemic in relation to compassion-fatigue and moral injury, this research adds a new layer to the existing literature. Through inductive reflexive thematic analysis, I was able to collect in-depth nuanced data.

This study recruited Clinical Psychologists from a range of geographical locations, working across multiple mental health services, with a wide range of clinical experience and from different ethnic backgrounds. This increases the representation of this research and allows for wider generalisability of the findings.

In the academic ideal, qualitative research is undertaken by researchers who poses sociocultural understanding of the study context (McMahon & Winch, 2018). *"Holding membership in a group does not denote complete sameness within that group. Likewise, not being a member of a group does not denote complete difference. It seems paradoxical, then, that we would endorse binary alternatives that unduly narrow the range of understanding*

and experience" (Dwyer & Buckle, 2009, p.60). I saw myself as an 'insider-outsider' researcher during this process which added many benefits to this research project. In part, I came to the study with knowledge of the community being investigated. I had been an NHS Assistant Psychologist, working alongside Clinical Psychologists during the COVID-19 pandemic, in one of the Trusts I recruited from. However, I was conscious of the difference in my experiences to my participants, and wanted to ensure this was acknowledged and highlighted at all stages. This included checking in with participants as to their meaning behind our discussions, ensuring to avoid any misinterpretations.

During the interviews I observed that participants appeared relaxed and comfortable during our conversations, evidenced by their ability to share deep and sometimes painful memories with me. Time was spent checking in with participants throughout interviews, to ensure they felt able to stop if needed. Participants shared at the end of the interviews to have enjoyed our discussion and to have appreciated the space made for them to start reflecting on their pandemic journey.

5.3.2 Limitations of the Research

A limitation of this research is the way in which the systematic literature review was conducted. Despite the use of inclusion and exclusion criteria to narrow-down my initial search results, final numbers remained large ($n = 1732$) with many of these papers being found to be unrelated to the topic of interest and therefore removed ($n = 1717$). This is likely due to me being a novice researcher (Riaz et al., 2010). In the future, I would aim to seek additional guidance from more experienced researchers to review search terms to appropriately narrow down the literature.

Whilst this study had a good demographic and geographical spread, it is worth noting that recruited participants were mostly employed by the same two NHS Trusts, which limits the exploration of experiences geographically. With each NHS Trust applying different procedures and policies for its staff, the experience of Clinical Psychologists in other parts of the UK may be described very differently. Despite this, the current research does support the importance of local research for local implementation, and will speak to the wider experiences of Clinical Psychologists working in the NHS.

Of the twelve participants who took part in this research, only one was male (n=8%). Whilst this is a small sample, it is not remarkably different from the overall representation of males within the profession, with recent HCPC statistics showing only 17% of Clinical Psychologists in the UK are Male (HCPC, 2023). Despite this, including more male participants could have strengthened the generalisability of the study findings, as well as offer a different perspective into the experiences faced by Clinical Psychologists during this time.

In addition, the study only includes experiences of Clinical Psychologists, and therefore offers understanding of one side of this multileveled system. The voices of managers, team leaders, and supervisors working in related services was absent from this study, despite their involvement featuring heavily in Clinical Psychologists' experiences. It is therefore recommended that future research explores these additional stories.

Previous research highlights the high levels of burnout experienced by mental health professionals during the pandemic, however the scope of this project did not allow for the inclusion of this. Whilst it has been acknowledged in participants' quotes, it was not a direct

focus within this research, which may limit the wider understanding of Clinical Psychologists' experiences.

Whilst I have mentioned above the benefits of being an 'insider-outsider' researcher in this project, this also comes with its limitations. Research has shown the potential that greater familiarity with research subjects can have on compromising the researcher's objectivity, therefore increasing the risk of them making assumptions based on prior knowledge and experience (DeLyser, 2001). My critical realist framework for this project provided protection from this objectivity, as I have remained transparent about the subjectivity of my interpretations throughout the research process. I also utilised a varied group of peers to debrief with (including completing a bracketing interview), and share the findings of, the research to remain critical of the interpretations I made (Lincoln & Guba, 1985).

5.4 Clinical Implications and Recommendations

The final research question asked, *"What related lessons can be learnt from Clinical Psychologists' experiences of working during the pandemic?"* Participants within this research shared their hopes for the future of Clinical Psychology, both within the NHS and for the profession as a whole, as captured in the sixth theme: *'Breaking Through The Clouds'*.

The results of this research have shown that addressing moral injury and compassion-fatigue among NHS Clinical Psychologists requires multi-level interventions. By applying the socio-ecological framework (Bronfenbrenner, 1979), we can better understand the complex, multi-layered influences on NHS Clinical Psychologists during the COVID-19 pandemic and develop comprehensive strategies to support their wellbeing and

professional integrity. The key recommendations from this research will now be outlined with actionable clinical implications offered using the socio-ecological framework for guidance. An overview of the clinical recommendations can be found in Table 13.

5.4.1 Individual Level

At the individual level, Clinical Psychologists' experiences related to their wellbeing, professional, and personal identity, as well as daily work-life balance.

Put Your Own Life Jacket on First

A recurring theme within this research was of Clinical Psychologists putting other's needs before their own, which was felt by participants to relate to their experiences of compassion-fatigue and burnout. During the pandemic, the Division of Clinical Psychology within the BPS issued guidance on 'Staying safe and well: Steps to prepare and self-care' (Rao, 2020), highlighting the importance of Clinical Psychologists taking care of their own wellbeing. Going forward, Clinical Psychologists would benefit from regularly assessing their own emotional, psychological, and spiritual wellbeing. It's important they make personal and professional self-care a priority to avoid burnout and allow them the capacity to support others. This finding aligns with previous research stating it is ethically and professionally essential to engage in self-care whilst working in mental health (Grise-Owens et al., 2018; Shepherd & Newell, 2020).

Whilst it is important for Clinical Psychologists to take some ownership over their own mental-health, caution should be taken in organisations suggesting that individuals hold full responsibility for this. This will be discussed further in the following sections.

Lead by Example

There is an ethical imperative for Clinical Psychologists themselves to advocate for a culture change within NHS services, encouraging a culture where self-care and wellbeing promotion are celebrated (Paiva-Salisbury & Schwanz, 2022). Clinical Psychologists, who are often in leadership roles within their services, need to more openly challenge unspoken beliefs that 'experts' should be immune to experiencing distress (Tay, Alcock & Scior, 2018). Ultimately, offering interventions that support the wellbeing of mental health professionals is likely to have a positive impact on the quality of care received by the service users they support.

5.4.2 Interpersonal Level

This level relates to the change in perception that Clinical Psychologists' had of their relationships (both in their private and professional environments) during the pandemic, and how these changes in relationships impacted them.

Cultivating Connection and Community

This research has indicated that a sense of belonging among Clinical Psychologists is crucial for their wellbeing and professional effectiveness. Research has highlighted that a supportive environment, where staff feel valued and connected, can significantly enhance their job satisfaction and mental health, mitigate burnout, and improve overall workplace morale (Weir, 2024). For the participants of this study, the pandemic consumed both their personal and professional lives, leaving them isolated and burnt-out. Many spoke about a desire to feel useful and seen as belonging within their teams. In line with the findings from Vaughn et al. (2023), participants in this study shared the benefit they noticed from having colleagues who understood the nature of psychology, that they could talk with and share

aspects of their working day, and who understood the demands that were being placed on them. Policies restricting these interactions were reported as having a negative effect on participants and added to their feelings of isolation.

At an interpersonal level, it is therefore important to create a positive work environment with ongoing encouragement of supportive team working, particularly given that the work of Clinical Psychologists comes with emotional distress. In addition, interpersonal support from friends and family should be facilitated in a crisis, wherever possible, ensuring policies around this are reviewed as soon as possible (Chemali et al., 2022).

5.4.3 Institutional Level

This level presents Clinical Psychologists' perceptions of decision-making processes in the work setting and availability of institutional support. This section is further divided into the 'the NHS' and 'professional bodies'.

The NHS: Offering Opportunities for Repair

The findings of this study showed that many participants experienced moral injury during their time working in the pandemic. Many reflected on how their feelings did not feel acknowledged at the time and that they were left to 'get on with it'. As the pandemic eased, participants shared a sense that the difficulties they faced had been forgotten and a space to talk about and acknowledge these was lost. This led to a loss of trust in the organisation for many. This research has therefore highlighted the importance of opening space for Clinical Psychologists to share their stories during and beyond such crises. The invitation from these findings is for NHS management, and those who were responsible for decision

making during the pandemic, to create reflective and supportive spaces for Clinical Psychologists to come together and discuss their concerns openly.

Emotional responses need to be validated and normalised even during a crisis (Bennett et al., 2020). Williamson et al. (2023) suggests that where a betrayal event has occurred seemingly “in house”, setting up of reflective practice sessions, such as Schwartz rounds (Flanagan et al., 2020), may be effective to mitigate the development of moral injury. Schwartz rounds allow for views to be expressed and solutions to be co-produced (Williamson et al., 2023) which would support with staff feeling heard and involved in decisions that ultimately impact on their practice – something that was highlighted as a major cause of moral injury within the current study. This may also help to rebuild the trust that many participants felt they lost for management, and the NHS, during the pandemic.

The NHS: Staff Wellbeing Services

It was noted in the findings of this research that many NHS staff support services set up during COVID-19 had now lost their funding and were being shut down. Research has shown that work environments that foster appreciation of their clinicians, and promote self-care practices, can decrease the risk of staff experiences of burnout and compassion-fatigue (Clark et al., 2022). Participants described the arrival of staff support services to be a welcome acknowledgment of their need for additional psychological support. With these being removed, participants were left feeling their difficulties no longer mattered and management were not prioritising staff wellbeing.

Research has shown that leader and managers of healthcare systems acknowledge a burnt-out workforce negatively impacts service user and organisational outcomes (Taylor et

al., 2018). It is therefore vital that staff wellbeing remains on the agenda for NHS Trusts, ensuring staff feel safe and supported, and offering relevant evidence-based interventions at all levels of the organisation (Lown et al., 2019).

The NHS: Understanding the Role of the Clinical Psychologist

Hofmeyer, Taylor and Kennedy (2020) argue that managers and team leaders wanting to create empathic teams need to understand the needs of staff and tackle work-related stress, promote engagement, and encourage a compassionate culture. In empathic cultures, it is felt that self-care will become a more accessible choice for staff (Hofmeyer, Taylor & Kennedy, 2020). Participants from the current study shared their frustration when changes were made to policies and procedures within their service without their knowledge or with little to no input from them. This was particularly apparent in participants' concerns with the quality of care for their service users resulting from physical health and current level of risk taking the main priority, and increased reliance on availability of technology for face-to-face contact. There was also a shared sense of psychology being seen as 'less important' by services, further leading to feelings of compassion-fatigue and burnout amongst participants.

Policymakers, where possible, need to understand the roles and responsibilities of Clinical Psychologists in service user care, and consult with them, when formulating policies. In doing so, they will prevent against the development of moral injury from Clinical Psychologists being enforced to enact changes that they do not feel align with their morals and roles within the team.

Professional Bodies: Changing the Discourse Within the Profession

One of the major contributors to the experience of compassion-fatigue for participants in the current study, was the unspoken expectation that Clinical Psychologists should be unaffected by difficult life experiences (Davidson & Patel, 2009). Holding this view caused participants to question their own ability to do their job, experience further burnout, and for some caused them to start questioning if the NHS, or even this profession generally, was for them. This perspective is supported by Skorina (1982), who argued that psychology has developed an atmosphere of invulnerability, creating high expectations for individuals' self-efficacy and implies the experience of personal difficulties indicates incompetence.

Many participants identified hopes for the profession of Clinical Psychology to reflect inwards and consider how it supports members to look after themselves. A study by Tay, Alcock and Scior (2018) found that Clinical Psychologists surveyed who did not disclose mental health difficulties to anyone, showed higher levels of self-stigma and quoted a fear of being judged negatively, having negative impacts on their career and self-image, and feelings of shame as reasons for not disclosing. This demonstrates that the perceived stigma for Clinical Psychologists to openly share their own mental health difficulties pre-dates the pandemic. The current study highlighted how the pandemic further exacerbated these worries, at a time when mental health difficulties within staff was at an all-time high.

The BPS' strategic framework reports: *"We will promote and advocate for diversity and inclusion within the discipline and profession of psychology and work to eradicate discriminatory practice"* (BPS, 2021). The latest guidance from the HCPC, which comes into effect on 1st September 2024, includes an update (within section 6.3) stating, *"You must take responsibility for assessing whether changes to your physical and/or mental health will detrimentally impact your ability to practise safely and effectively."* (HCPC, 2023). The noted

absence of dialogue from professional bodies reported in the current study could be argued to inhibit the profession from cultivating an environment of safety so that Clinical Psychologists feel able to bring concerns to supervisors and senior managers (Gelso & Hayes, 2007), instead putting the responsibility more prominently with the individual. The profession of Clinical Psychology, and its professional bodies, need to do more to promote open discussion amongst its members and develop a more inclusive workplace. This need is well recognised with new companies, such as 'in2gr8mentalhealth', having been set up to support the de-stigmatisation of mental health practitioners with lived experiences of mental health (in2gr8mentalhealth, 2021).

Professional Bodies: For the Profession to Be More Vocal

As discussed, an area that connected very strongly with the experience of moral injury for participants within this research came from the vaccine mandate. Throughout our conversations, participants shared feeling disappointed at Clinical Psychology professional bodies' lack of response and protection for its members in relation to the vaccine. In its 2021-2022 strategic framework, the BPS reported: *"We are committed to empowering our members to create a paradigm shift by eradicating institutional racism and systemic bias towards marginalised groups, from the top down within our organisation"* (BPS, 2021). Despite this, participants reported feeling unsupported by their professional bodies at a time when they needed advocating for.

Whilst this study showed a desire for professional bodies to be more vocal on this topic, it's important to acknowledge the complexity of the vaccine mandate. Healthcare professionals and organisations (such as the NHS) have a duty of care to protect service users from known and anticipated harms of infection (Olick, Shaw & Yang, 2021). This

obligation to protect rests on ethical values for example, putting service users first and promoting their wellbeing (Galanakis et al., 2013). More vaccines, also means fewer sick days and therefore less staff shortages (Maltezou et al., 2021). Whilst healthcare professionals working in these organisations are therefore committed to upholding these ethical values too, they also have the fundamental right of autonomy to make an informed decision about their own health, including refusing unwanted medical interventions (Olick, Shaw & Yang, 2021). Galanakis et al. (2013) summarise this need for balance within their research and suggest, *“it is preferable for higher uptake rates to be achieved through consensus rather than coercion, as coercive policies would bear the cost of conflict and mistrust, devalue HealthCare Workers and thus alienate important allies and have long-term detrimental effects”* (p.7).

5.4.4 Community Level

This level entails how morale and norms, as well as public knowledge relate to Clinical Psychologists' experiences in the pandemic. Whilst the perception of public knowledge is outside of the scope of this review, there are implications and recommendations that are worth noting.

Infodemic Management

The Oxford English Dictionary (2023) defines 'Infodemic' as, *“A proliferation of diverse, often unsubstantiated information relating to a crisis, controversy, or event, which disseminates rapidly and uncontrollably through news, online, and social media, and is regarded as intensifying public speculation or anxiety”*. Participants of this research identified their struggles with the portrayal of mental health services across the media

during the pandemic, describing vulnerable groups as being negatively represented and stigmatised against. Therefore, at a community level, consideration could be given for more robust regulation of social media companies by impartial, non-corporate, global regulators to prevent the spreading of fake news and splitting content (Vadivel et al., 2021).

5.4.5 Policy Level

This level captures Clinical Psychologists' perceptions of governmental responses and the impact governmental measures had on their professional and private lives.

Equality of Esteem Between Physical and Mental Health

The decisions that can be made by services, and therefore their ability to develop empathic healthcare organisations, is directly impacted by the level of funding provided by governments (Hofmeyer, Taylor & Kennedy, 2020). Throughout interviews, participants shared their concerns around mental health of staff and service-users taking a backseat during the pandemic, leading to moral injury for those who were advised to stop offering therapy. Historically, funding for mental health services has been insufficient to population needs, leading to the government's commitment to parity of esteem between physical and mental health (Gilburt & Mallorie, 2024). Although mental health funding is increasing, mental health services are now facing demands that were not anticipated during the development of the NHS Long Term Plan, including the impact of the COVID-19 pandemic (Gilburt & Mallorie, 2024). Going forward, the government need to re-evaluate their plans for mental health funding, considering these additional demands.

Tailored and Timely Policies

Moral injury was experienced by participants from the additional administrative tasks that imposed government rules created, causing participants to compromise on the quality of care they were able to offer (Sizoo et al., 2020). Enforced national lockdowns and restricted travel made it harder for participants to get to work or see their families (Maraqa, Nazzal & Zink, 2021). Research has found that healthcare workers who worked in the pandemic identified wanting clear and consistent governmental crisis communication (Feeley et al., 2021) and tailored pandemic crisis management policies that consider both the needs of different staff and the different settings in which they work (Fang et al., 2021; Halcomb et al., 2020). This was echoed by the responses from participants in this study, who described feeling like they were often being held to rules that were designed for in-patient settings.

Table 13

Summary of Clinical Implications

Level of Influence	Invitations for change
Individual Level	Clinical Psychologists would benefit from regularly assessing their own emotional, psychological, and spiritual wellbeing. It's also important they make personal and professional self-care a priority. However this should not be taken in isolation from the additional levels. For Clinical Psychologists to lead by example and initiate a culture change within services that mental health professionals have mental health too.
Interpersonal Level	For the cultivation of connection through team building and the creation of more face-to-face opportunities for staff to come together.
Institutional Level	NHS organisations need to create safe spaces where experiences of Clinical Psychologists working during the pandemic can be shared, heard, and responded to.

	NHS organisations to offer ongoing staff wellbeing support and to ensure this reaches all levels of the organisation. For professional bodies of Clinical Psychology to foster a change in culture and support the open discussion, and normalisation of, Clinical Psychologists own mental health and wellbeing needs. For professional bodies to be more publicly vocal about issues that affect individuals within its society.
Community Level	To consider more robust regulation of social media guidelines for responsible media reporting.
Policy Level	For governments to review its financial plans for increasing funding for mental healthcare, taking into account the increased demands following the COVID-19 pandemic. For governments to have clear and consistent governmental crisis communication and tailored pandemic crisis management policies that consider different healthcare settings and mental healthcare worker's needs.

5.5 Invitations for Future Research

This research explored the experiences of twelve Clinical Psychologists who worked during the pandemic, however, there remain many more unshared stories. This research invites future studies to further explore the experiences of Clinical Psychologists who were redeployed during the pandemic or those who were based within inpatient settings. Clinical Psychologists below Band 8 were not included in this research, however the experience of those who were either finishing doctoral training, or who were newly qualified, may offer additional experiences and opportunities for learning for the profession.

This research primarily focussed on the experience of Clinical Psychologists from the South of England. Future research may benefit from considering the impact for Clinical Psychologists from a broader spectrum of NHS Trusts, and wider geographical locations, to

compare differing experiences and how these were impacted by national, and senior management guidance.

Given the experiences of internalised stigma shared by participants in the current study, further research would benefit from exploring the systemic practice of internalised stigma within the NHS and the Clinical Psychology profession further, as this is likely to promote better psychological outcomes for staff and help retain workforce (Clarkson et al., 2023).

It has been stated that the numbers of male Clinical Psychologists in the UK are *“insufficient to meet future or existing workforce demands for diversity within the National Health Service (NHS)”* (BPS, 2004, p.5). As highlighted in the limitations section, the current study only recruited one male participant. Currently, very little research has been conducted focussing on male Clinical Psychologists' perspectives alone. During a time where many healthcare professionals, including Clinical Psychologists, are leaving the NHS, future research would benefit from exploring the experiences of other genders further, to better understand their experiences and needs.

Finally, this research, along with other studies, looked mainly at the immediate impact of the pandemic on Clinical Psychologists. Research from previous major epidemics has identified that the psychological effects and impact on wellbeing for healthcare staff can have much longer-term effects (Maunder et al., 2004). Considering the severity and protracted timeline of the pandemic, the post-pandemic effect of COVID-19 might exceed those observed within the current study. This was identified by several participants who shared feeling that they were still making sense of their experiences and adjusting to new

ways of working. Therefore, it is necessary for future research to examine the longer-term effects on wellbeing for NHS Clinical Psychologists after the pandemic.

5.6 Conclusions

The COVID-19 pandemic and the procedures implemented to deal with the virus, disrupted the social and professional lives of people around the world, and had major implications for mental health (Brooks et al., 2020). Despite this, little research has been carried out into the consequences on those offering mental health support, and in particular Clinical Psychologists, during the pandemic.

The aim of this study was to explore NHS Clinical Psychologists' experience of moral injury and compassion-fatigue whilst working during the COVID-19 pandemic. This study also aimed to understand what can be learnt from these experiences and the associated clinical implications. Capturing these experiences provided an understanding of moral injury and compassion-fatigue experienced by NHS Clinical Psychologists and the negative implications this had for their own mental wellbeing. The findings of this research highlight several implications for individuals, healthcare systems, and professional bodies at all levels, to change service culture and promote openness about mental health professionals also experiencing mental health difficulties.

5.7 Dissemination

Having, I believe, to have met the research aims of this study and gained an understanding of the experiences of moral injury and compassion-fatigue felt by Clinical Psychologists during the pandemic, the next step is to contribute to change at multiple

levels and disseminate the findings. This will enable me to ensure the learnings from this research do not end with this study.

I plan to explore opportunities to publish the findings of this research to relevant professional publications and academic journals (these may include the Clinical Psychology Forum and Journal of Healthcare Leadership), and within and across NHS Trusts. Findings will also be disseminated with those participants who requested access to the results when they agreed to take part in the study.

5.8 Final Reflections: An End, but not *the* End

Throughout discussions with participants, it became clear that the full impact of what happened during the pandemic is still emerging. It is not without irony that half-way through completing the interviews for this research, I tested positive for COVID-19 for the second time, a stark reminder that COVID-19 has not left us. Throughout this process, from my literature review to my interviews, to my own experience of the virus, I have been left with a strong sense of longing for this not to be seen as the end, and for the voices and experiences of my participants to have meaning beyond this research. This research has demonstrated that a lot of work remains, in all levels of the system, to improve our mental healthcare system, to improve the wellbeing of Clinical Psychologists, and therefore ultimately improve the services we are offering to our service users. I hope this research has confronted societal discourses about who Clinical Psychologists are and what they experience because, as Phoebe explains:

“...you know, psychologists are human beings as well.” (Phoebe)

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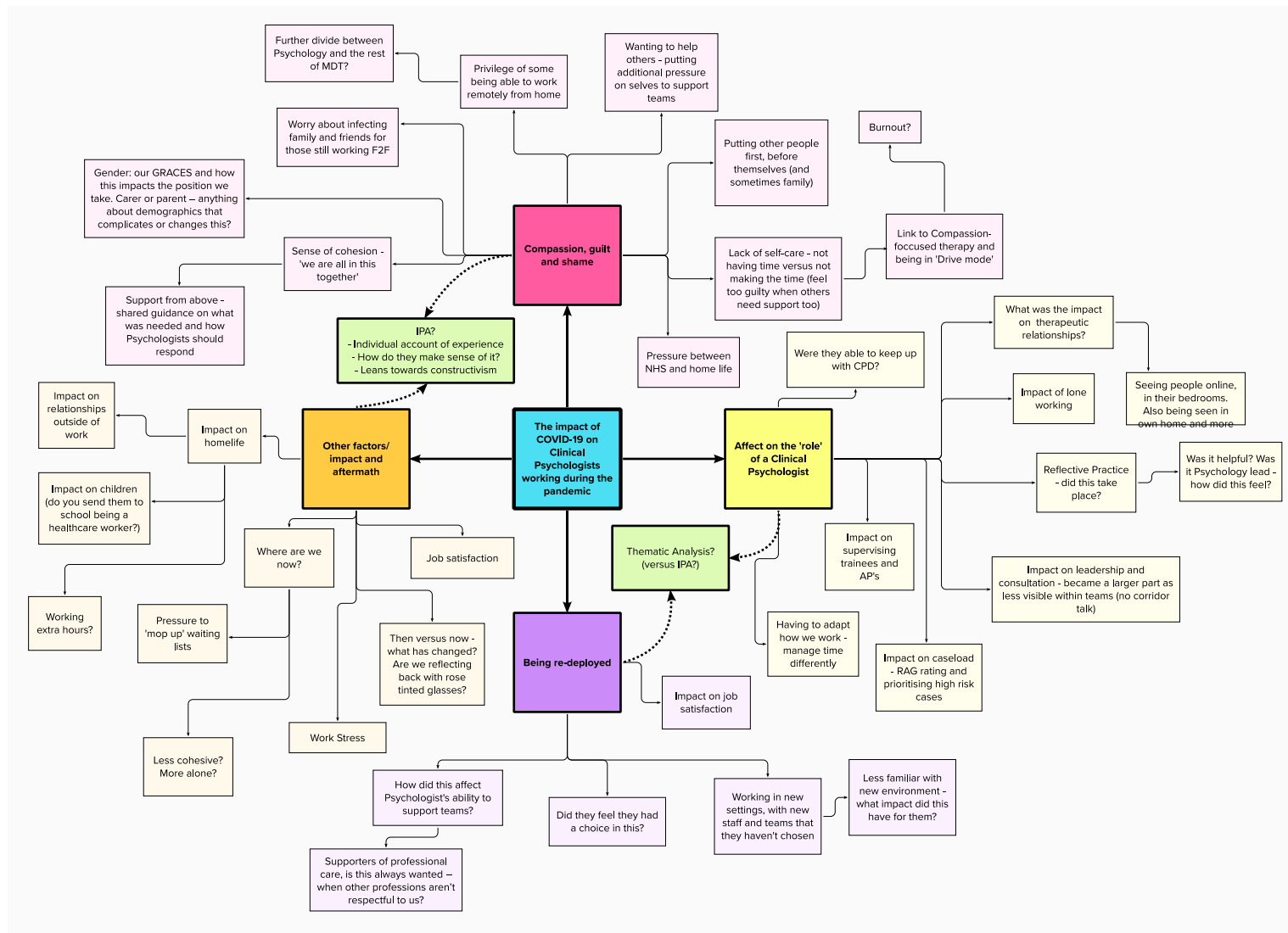
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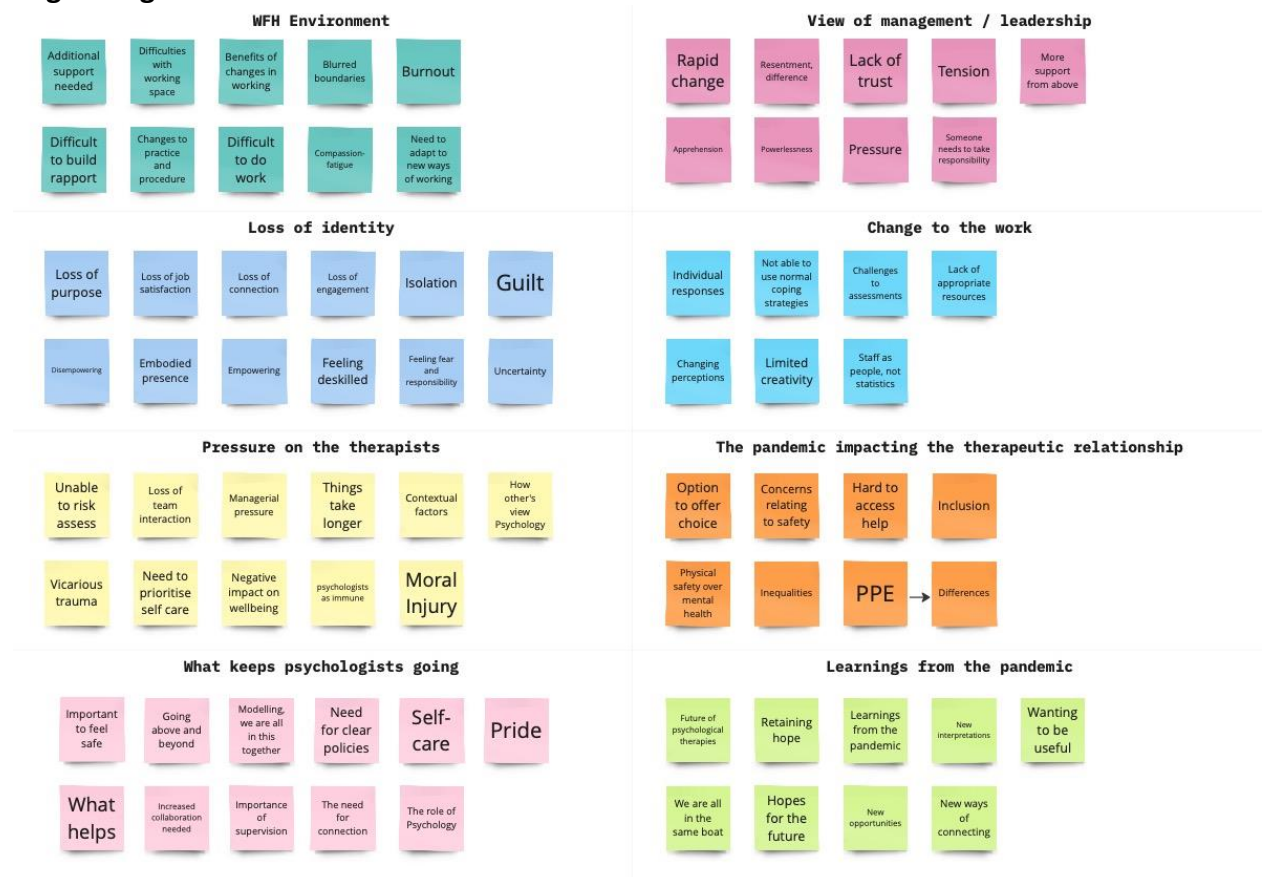
Appendices

Appendix A: Mind Map of Initial Project Ideas



Appendix B: SLR Mapping descriptive themes onto analytical themes

Organising Codes:



Descriptive Themes:

- Working from home environment
- Emotions / Moral Injury
- The pandemic impacting the therapeutic relationship
- Loss of Identity
- Change to the work
- Pressure on the therapists
- What keeps therapists going

Analytical Themes: Colour code matching to descriptive themes

Main Theme	Sub-Theme
New challenges	• Loss of work/life balance • Delivering therapy online
The emotional toll	• A loss of identity • What sustains mental health therapists
The role of relationships	• The impact on the therapeutic relationship • Loss of trust for management

Appendix C: Excerpts from IRAS Form**A6-1. Summary of the study.**

Following the start of the COVID-19 pandemic, it has been shown that nearly every psychologist worldwide is experiencing some negative impact on their mental health (Norcross & Phillips, 2020). Working as individuals in multiple systems there is an expectation that clinical psychologists also support the healthcare system from within, adding further pressure. The inherent stress for Clinical Psychologists in managing their patients' trauma renders them more vulnerable to work stress and burnout (Lamb & Cogan, 2016). Psychologists may feel that it has been difficult to acknowledge the personal impact of the COVID-19 pandemic on them, due to the erroneous perception that psychologists should know how to cope with stress (Pope & Tabachnick, 1994), making it harder to ask for help. Despite this, there has not been any research focussing directly on the experiences of Clinical Psychologists working during the pandemic.

A6-2. Summary of main issues.

Before completing the individual interviews, an information sheet will be shared, and participants will be asked to give informed consent. All data received will be anonymised (pseudonyms will be used) to ensure staff confidentiality and the right to withdraw will be detailed. Interviews will be recorded directly using Microsoft Teams software, and will then be immediately moved onto the GDPR compliant University of Hertfordshire One Drive which will be accessed by the investigative team only.

Due to the sensitive nature of the topics likely to come out, it will be ethically critical to provide as flexible and comfortable interview experience as possible and reduce any distress that may arise through discussion of traumatic or stressful events. This will be achieved by regularly checking-in with the participants at all stages of the project, prior to each interview participants will be reminded of the potentially emotive nature of the questions and reminded that they can end the interview or skip a question at any time, and by providing a debrief sheet of further information and details of where they can access support, should they need to.

There is also the potential for participants to be worried about the impact any comments they make will have on their NHS Trust. Due to the current cost of living crisis, participants may also have worries about being seen negatively in their role and the impact this may have on their employment. To manage this, participants will be recruited from more than one Trust (to help with anonymity), information will be provided on the debrief sheet relating to whistleblowing, and all participants will be encouraged to speak directly to their organisation about any concerns they may have.

A24. What is the potential for benefit to research participants?

The information we gather from the study will help us understand more about the experiences of Clinical Psychologists during the COVID-19 era. Talking about their experience with someone who is impartial may be helpful in making meaning from the experience. Also, those who take part will be contributing to a growing area of research, which may have implications for Clinical Psychologists in the future, and thus may offer some psychological benefits.

A26. What are the potential risks for the researchers themselves?

Possible psychological distress from the stories being shared in the individual interviews. There will be the opportunity for the researcher to debrief after each interview with the research team, as and when required.

A38. How will you ensure the confidentiality of personal data?

Data will be held confidentially, with access restricted to the research team. After the research is completed, anonymised interview transcripts will be stored and interview recordings will be destroyed. Signed consent forms will also be destroyed at this stage. The final study report will be written in a way that is confidential, with data anonymised and pseudonyms used. The results of the research will be written up in a report as part of the lead researcher's Doctorate in Clinical Psychology. This may contain anonymised quotes from the interview. The research will be written up for submission to peer-reviewed academic journals and conferences, so that other health professionals can learn from the research.

Appendix D: Email from Health Research Authority (HRA) – amendments/further information request

From: approvals@hra.nhs.uk noreply@harp.org.uk
Subject: IRAS 330857. Request for information
Date: 4 August 2023 at 12:44
To: e.karwatzki@herts.ac.uk, s.hollingsworth2@herts.ac.uk
Cc: research-sponsorship@herts.ac.uk



You don't often get email from noreply@harp.org.uk. [Learn why this is important](#)

Dear Dr Karwatzki ,

Thank you for submitting the above application for review.

This review is comprised of an Assessment to check compliance with the UK Study-wide governance criteria, as well as relevant additional nation specific areas of review, details of which can be found [here](#).

I have now undertaken an assessment of your application. Please would you answer the following queries by 04 September 2023.

- You have said that an email will be sent to NHS organisations acting as PICs. Will a gatekeeper then disseminate this information to all relevant participants, for example, the Head of Clinical Psychology will be contact via publicly available information will then send the relevant email to all qualified Clinical Psychologists?
- Please add a clear definition of the end of study to the protocol.
- Please take out references to NHS ethics being required in the protocol. You can refer to HRA & HCRW Approval being sought instead.
- Please ensure references to the DPA 1998 are updated in the Expression of Interest form.
- The information in the '**What are my choices about how my information is used?**' provides contradictory information at present. It details that participants will not be able to change the data sponsor holds, but then gives them the choice to remove their data. Please consider amending this to the fact that sponsor will keep information about participants that they already have.
- Please review the information at [Transparency wording for all sponsors - Health Research Authority \(hra.nhs.uk\)](#), focusing on the final 3 paragraphs. I note that most information is already present in the PIS but please do add in any information that is missing. This may also help with wording for the query noted above.
- Although I believe this to be the case, please can you confirm that only the research team will transcribe recordings.
- Please can you confirm that the emails being used to transfer personal data are sufficiently secure?
- Please add a version and date to the study poster.

Resubmission guidance

Please submit the requested documents electronically through IRAS following the guidance available [here](#).

Please provide your responses to the requests for further information detailed above by return email.

To enable your application to progress without delay we encourage you to provide your responses as soon as possible within the timeframes specified. Please do not hesitate to contact us if you have any questions or if you would like to request additional time to respond.

Kind regards,

Natalie

Natalie Wilson
Approvals Manager
Health Research Authority

T. 02071048138

E. approvals@hra.nhs.uk

W. www.hra.nhs.uk

Sign up to receive our newsletter [HRA Latest](#).

Appendix E: Email of amendments to the Health Research Authority (HRA) – in response to Appendix D

From: Emma Karwatzki e.karwatzki@herts.ac.uk
Subject: IRAS 330857. Request for information
Date: 7 August 2023 at 11:20
To: approvals@hra.nhs.uk
Cc: Sarah Hollingsworth [Student-LMS] s.hollingsworth2@herts.ac.uk

EK

Dear Natalie,

Thank you for your email, and for responding so quickly to our application. We have made the requested changes and uploaded any amended documents to the IRAS application form, electronically. Please let us know if you have any issues viewing these.

In response to your questions, please see our answers written below in red:

- You have said that an email will be sent to NHS organisations acting as PICs. Will a gatekeeper then disseminate this information to all relevant participants, for example, the Head of Clinical Psychology will be contact via publicly available information will then send the relevant email to all qualified Clinical Psychologists? - **I would expect that the Psychology Leadership within each organisation would be involved in contacting potential participants.**
- Please add a clear definition of the end of study to the protocol - **Amended**
- Please take out references to NHS ethics being required in the protocol. You can refer to HRA & HCRW Approval being sought instead - **Amended**
- Please ensure references to the DPA 1998 are updated in the Expression of Interest form - **Amended**
- The information in the **'What are my choices about how my information is used?'** provides contradictory information at present. It details that participants will not be able to change the data sponsor holds, but then gives them the choice to remove their data. Please consider amending this to the fact that sponsor will keep information about participants that they already have - **Amended**
- Please review the information at [Transparency wording for all sponsors - Health Research Authority \(hra.nhs.uk\)](https://www.hra.nhs.uk/transparency-wording-for-all-sponsors), focusing on the final 3 paragraphs. I note that most information is already present in the PIS but please do add in any information that is missing. This may also help with wording for the query noted above - **Amended**
- Although I believe this to be the case, please can you confirm that only the research team will transcribe recordings - **Yes, only the research team will transcribe recordings.**
- Please can you confirm that the emails being used to transfer personal data are sufficiently secure? - **Yes they will be, either via exchange file or I will be set up with an email account via each trust for research purposes.**
- Please add a version and date to the study poster - **Amended**

If you require anything else from us at this stage, please let us know.

Best wishes.

Emma

Dr Emma Karwatzki AFBPsS FHEA
Programme Director, Doctorate in Clinical Psychology
Room 1F423, Health Research Building
School of Life & Medical Sciences
University of Hertfordshire

Appendix F: Ethical Approval Notification**HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA****ETHICS APPROVAL NOTIFICATION**

TO Sarah Hollingsworth
CC Dr Emma Karwatzki
FROM Dr Rosemary Godbold, Health, Science, Engineering & Technology ECDA Vice Chair
DATE 07/062023

Protocol number: **LMS/PGR/UH/05333**

Title of study: Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?

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

Dr Jeanette Fuller (East London NHS Foundation Trust)

General conditions of approval:

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

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

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

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

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

Validity:

This approval is valid:

From: 07/06/2023

To: 30/04/2024

Appendix G: Health Research Authority (HRA) Approval Letter

Dr Emma Karwatzki
 School of Life and Medical Sciences
 University of Hertfordshire
 AL10 9AB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

14 August 2023

Dear Dr Karwatzki

**HRA and Health and Care
 Research Wales (HCRW)
 Approval Letter**

Study title:	Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn
IRAS project ID:	330857
Protocol number:	LMS/PGR/UH/05333
HRA reference:	23/HRA/3112
Sponsor	University of Hertfordshire

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, [in line with the instructions provided in the “Information to support study set up” section towards the end of this letter.](#)

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The ["After HRA Approval – guidance for sponsors and investigators"](#) document on the HRA website gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- ☐ Registration of Research
- ☐ Notifying amendments
- ☐ Notifying the end of the study

The [HRA website](#) also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **330857**. Please quote this on all correspondence.

Yours sincerely,

Natalie Wilson
Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: Ms Leire Caselles Vallejo, Sponsor contact

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Contract/Study Agreement template [mNC_PIC_Agreement(Sponsor-PIC)_v1-0_Sept2021 - ELFT]		
Copies of materials calling attention of potential participants to the research [Research invitation poster]	1.0	04 August 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor Insurance]		02 August 2022
Interview schedules or topic guides for participants [Semi-structured interview schedule]	2.0	28 July 2023
IRAS Application Form [IRAS_Form_14082023]		14 August 2023
Letter from sponsor [Sponsorship agreement]		21 July 2023
Other [Expression of interest form]	2.0	04 August 2023
Other [Resources for support]	1.0	28 July 2023
Other [Email to unsuccessful participants]	1.0	28 July 2023
Other [University Ethics approval application form]	2.0	23 April 2023
Other [University Ethical Approval Letter]	1.0	07 June 2023
Participant consent form [Consent Form]	1.0	28 July 2023
Participant information sheet (PIS) [Participant Information Sheet]	3.0	04 August 2023
Research protocol or project proposal [Protocol]	3.0	07 August 2023
Summary CV for Chief Investigator (CI) [CI CV]		01 January 2023
Summary CV for student [Student CV]		28 July 2023

IRAS project ID	330857
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Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Activities at NHS organisations will involve PIC activity only, including the identification of potential participants, as well as the provision of study posters, PIS documentation and Expression of Interest form.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed. Due to the nature of the activities involved, organisations will be expected to provide that confirmation to the sponsor: □ Within 35 days of receipt of the local information pack. □ After HRA/HCRW Approval has been issued. If the organisation is not able to formally confirm capacity and capability within this timeframe, they must inform the sponsor of this and provide a justification. If the sponsor is not satisfied with the justification, then the sponsor may escalate to the National	The sponsor has provided the appropriate model commercial PIC agreement that it intends to use as a subcontract between participating organisations and NHS organisations acting as their Participant Identification Centres (PICs).	Sponsor is providing funding to PICs.	The Chief Investigator will be responsible for all study activities performed at PICs.	Where an external individual is conducting only research activities that are limited to access to staff, or staff data (in either identifiable or anonymised form), or anonymised patient data then a Letter of Access is required only if these activities will take place in NHS facilities. This should be issued on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed) Where these activities will not take place in NHS facilities then no

Appendix H: Confirmation of Capacity and Capability from NHS Trusts

From: [REDACTED]
Sent: 31 August 2023 16:29
To: Sarah Hollingsworth [Student-LMS] <s.hollingsworth2@herts.ac.uk>
Cc: [REDACTED]; Emma Karwatzki <e.karwatzki@herts.ac.uk>
Subject: Confirmation of [REDACTED] involvement as a PIC for IRAS 330857: Clinical Psychologists experience of the COVID-19 pandemic

Dear Sarah,

Re. IRAS 330857: Clinical Psychologists experience of the COVID-19 pandemic

I am writing to confirm that [REDACTED] will be a Participant Identification Centre for this study, as per the fully executed PIC agreement attached.

As a PIC Site, [REDACTED] will inform potential participants about the study until December 2023. [REDACTED] is not a research site and is not responsible for study recruitment and delivery.

Best wishes,

[REDACTED]

From: [REDACTED]
Sent: 26 September 2023 10:23
To: Emma Karwatzki <e.karwatzki@herts.ac.uk>; FULLER, Jeannette (EAST LONDON NHS FOUNDATION TRUST) <jeannette.fuller@nhs.net>
Cc: [REDACTED] Sarah Hollingsworth [Student-LMS] <s.hollingsworth2@herts.ac.uk>
Subject: IRAS 330857 - [REDACTED] Confirmation of Capacity and Capability

Dear Dr Karwatzki & Dr Fuller,

Study Title: Clinical Psychologist's Experience of the COVID-19 Pandemic

IRAS Ref: 330857
Initial HRA Approval: 14/08/2023
Protocol Version: Version 3, 04/08/2023
Relevant Amendments: N/A
Attached: Fully Executed mNC PIC agreement

We are pleased to confirm capacity and capability at [REDACTED] for the above referenced study. Please find attached the fully executed mNC PIC agreement.

The study end date stated for site is 31/01/2024 we will close the study record one month after this date if we have not received communication from yourself or the sponsor regarding study extension beyond this date.

Please notify R&D of any amendments, research-related incidents or changes to the study end date by emailing [REDACTED]

Kind regards,

[REDACTED]

Appendix I: Sponsorship in Full

John M Senior
BSc MSc DSc PGCE CEng FIET FRSA FHEA
Professor of Communication Networks
Pro Vice-Chancellor (Research and Enterprise)

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Dr Emma Karwatzki
Sarah Hollingsworth
Psychology, Sports and Geography
School of Life and Medical Sciences

5 September 2023

Dear Emma and Sarah

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:

RESEARCH STUDY TITLE:

Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn

NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Emma Karwatzki

NAME OF INVESTIGATOR (Student): Sarah Hollingsworth

UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGR/UH/05333

HEALTH RESEARCH AUTHORITY REFERENCE: 330857

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements.

Permission to seek changes as outlined above should be requested from myself before submission and notification to the Health Research Authority (HRA) or University of Hertfordshire Ethics Committee with Delegated Authority (ECDA) as relevant, and I must also be notified of the outcome. It is essential that evidence of any further relevant external permissions is provided as they are received. Copies of annual reports and the end of study report as submitted to the HRA also need to be provided. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J M Senior'.

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)



University of Hertfordshire Higher Education Corporation is an exempt charity

Appendix J: Ethical Amendment Approval Notification

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA
ETHICS APPROVAL NOTIFICATION

TO	Sarah Hollingsworth
CC	Dr Emma Karwatzki
FROM	Dr Rosemary Godbold, Health, Science, Engineering and Technology ECDA Vice-Chair
DATE	16/10/2023

Protocol number: aLMS/PGR/UH/05333(1)

Title of study: Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn

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

Dr Jeanette Fuller (East London NHS Foundation Trust)

Modification:

All modifications as listed in the EC2

General conditions of approval:

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

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

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

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

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

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

Validity:

This approval is valid:

From: 16/10/2023

To: 30/04/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.

Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit a further EC2 request.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A or as detailed in the EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.

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

Appendix K: Recruitment Poster



University of Hertfordshire **UH**

Research Opportunity

Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?

WHAT IS INVOLVED? ✕

If you decide to participate, you will take part in an informal interview over Microsoft Teams. This interview will last between 45-90 minutes.

You will be asked questions about your time at work during the COVID-19 era, your experiences of compassion-fatigue, whether you have had any experiences of 'moral injury', and the lessons you feel you have learnt during this time.

WHY PARTICIPATE? ✕

The information we gather from the study will help us understand more about the experiences of Clinical Psychologists during the COVID-19 era.

By taking part you will be contributing to a growing area of research, which we hope will have implications for Clinical Psychologists in the future.

WHO CAN TAKE PART? ✕

- Adults aged 18 and over;
- Who worked as a qualified Clinical Psychologist within a community NHS setting;
- During the COVID-19 era;
- And who have experienced work-related stress or 'burnout', and/or compassion fatigue

DO I HAVE TO TAKE PART? ✕

It is completely up to you whether or not you decide to take part in this study.

Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason.

For more information, questions, or to take part, please email me at:

s.hollingsworth2@herts.ac.uk

THIS STUDY HAS BEEN APPROVED BY THE HEALTH, SCIENCE, ENGINEERING & TECHNOLOGY ECDA
PROTOCOL NUMBER: LMS/PGR/UH/05333

Appendix L: Participant Information Sheet

PIS v3.0

IRAS Ref: 330857

Date: 04/08/2023

**PARTICIPANT INFORMATION SHEET****Title of study**

Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?

Introduction

I am a Trainee Clinical Psychologist at the University of Hertfordshire. I would like to invite you to participate in this project which forms part of my doctorate research. Before you decide whether you would like to take part, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please take your time to decide whether you wish to take part.

Thank you for reading this information sheet.

What is the purpose of this study?

This study aims to redress the current gap in the literature, by qualitatively exploring Clinical Psychologist experiences of working in the NHS during the COVID-19 pandemic. This study, conducted by a Trainee Clinical Psychologist at the University of Hertfordshire UK, will investigate Clinical Psychologist experiences of compassion-fatigue and burnout. The study also aims to explore what can be learnt from working during the COVID-19 era, in the hope of identifying constructive learning points that can be taken forward by NHS providers.

'Compassion-fatigue' is a term that describes the physical, emotional, and psychological impact of helping others — often through experiences of stress or trauma. Compassion fatigue may be brought about by a stressful workplace or environment, lack of resources, or excessive hours. 'Moral injury' is a term given to the distress that can result from an action (or lack of action) that violates an individual's 'moral code'.

Why have I been invited to take part?

We are inviting qualified, NHS employed, Clinical Psychologists who worked clinically over the period of February 2020 to December 2021, and self-identify as having experienced work-related stress or compassion-fatigue during this time.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw from the interview at any time point, including during the interview and up to 14 days after the interview. You do not need to give a reason for withdrawing.

What will happen to me if I take part?

If you are interested in taking part, you will be given this information sheet to keep and be asked to sign a consent form. Please read through both forms carefully and ask the research team any questions you might have.

PIS v3.0

IRAS Ref: 330857

Date: 04/08/2023

If you decide to take part, you will organise a time with Sarah Hollingsworth (Trainee Clinical Psychologist) to have an informal interview over Microsoft Teams (videoconferencing software). This interview will last between 45-90 minutes and will take place at a location that is convenient for you, however we suggest you find somewhere that is private. You will be asked questions about your time at work during the COVID-19 era, your experiences of 'burnout' or stress, whether you have had any experiences of 'moral injury', and the lessons you feel you have learnt during this time.

What are the possible disadvantages or risks of taking part?

There are no known risks to taking part in this study. However, as part of the study we will discuss potentially emotive topics such as workplace stress and actions in the workplace that you may consider to be against your 'moral code'. While these conversations will be conducted sensitively, it is possible that the discussions may cause distress. You can decline to answer any question at any time and choose to withdraw from the interview should you wish to. You will be reminded that you should only talk about the experiences that feel you feel willing to talk about, and in a way that feels manageable for you. If you feel that it would be helpful to access support following the conversation, we can provide details of where and how this support can be accessed. Your name and personally identifiable information will not be used to help protect your anonymity (see below for further details).

What are the possible benefits of taking part?

The information we gather from the study will help us understand more about the experiences of Clinical Psychologists during the COVID-19 era. Talking about your experience with someone who is impartial may be helpful in making meaning from the experience. Also, contributing to a growing area of research, which may have implications for Clinical Psychologists in the future, may offer some psychological benefits.

How will my personal data be stored / used in the future?

We will need to use information from you this research project. This information will include your:

- ☐ Full name
- ☐ Age
- ☐ Gender
- ☐ Contact details (including location of work)
- ☐ NHS Banding

The research team will use this information to do the research to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will be anonymised.

The data you provide during this study will be kept confidential and anonymous in accordance with the 2018 UK Data Protection Act. Any data gathered as part of this study will only be published in an anonymised form, so responses cannot be traced back to individual participants.

Access to your data will be restricted to the research team. After the research is completed, anonymised interview transcripts will be stored and interview recordings will be destroyed. Signed consent forms will also be destroyed at this stage. The final study report will be written in a way that is confidential. The results of the research will be written up in a report as part of Sarah's Doctorate in Clinical

PIS v3.0

IRAS Ref: 330857

Date: 04/08/2023

Psychology. This may contain anonymised quotes from the interview. The research will be written up for submission to peer-reviewed academic journals and conferences, so that other health professionals can learn from the research.

Microsoft Teams Videoconferencing Software

You can take part in an interview using Microsoft Teams without creating an account. You will be sent a link to the meeting via email – this link will not be shared with anyone other than you and Sarah Hollingsworth. Clicking on the link will allow you to join on the web using either Microsoft Edge or Google Chrome. Interviews will be recorded directly using Microsoft Teams software, and will then be immediately moved onto an encrypted, password-protected USB stick. For full details of Microsoft Team's privacy and security settings, please visit: <https://learn.microsoft.com/en-us/microsoftteams/security-compliance-overview>.

What are my choices about how my information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you. If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

Where can I find out more about how my information is used?

- ☐ at <https://www.hra.nhs.uk/information-about-patients/>
- ☐ by contacting the University of Hertfordshire's Data Protection Team on: dataprotection@herts.ac.uk
- ☐ by sending an email to Sarah at: s.hollingsworth2@herts.ac.uk

Who has reviewed this study?

The University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee with Delegated Authority.

The UH protocol number is: LMS/PGR/UH/05333

What happens after the interview?

Following the interview, you will have no further involvement in the study. Following the end of the project, a summary of the findings will be documented and made available to those who took part, if you would like.

What happens if I agree to take part but then later change my mind?

Should you change your mind about participating in the study, you are able to withdraw your data up to 14 days after your interview. You can withdraw for any reason, and you do not have to give a reason as to why you would like to withdraw. Withdrawal from the study would have no impact on your job role.

Who is in the research team?

Name	Role	Email
Sarah Hollingsworth	Lead researcher for the project, Trainee Clinical Psychologist,	s.hollingsworth2@herts.ac.uk

PIS v3.0

IRAS Ref: 330857

Date: 04/08/2023

	University of Hertfordshire	
Dr Emma Karwatzki	Clinical Psychologist and Programme Director (Doctorate in Clinical Psychology), University of Hertfordshire	e.karwatzki@herts.ac.uk
Dr Jeannette Fuller	Principal Clinical Psychologist and secondary supervisor East London Foundation Trust	jeannette.fuller@nhs.net

What do I do if I am interested in taking part?

If you have any questions, or would like more information, you can email Sarah directly. Alternatively, if you would prefer, you can email to arrange a time to talk with her over the phone.

If you decide you would like to take part, please email Sarah who will send you a copy of this Information sheet along with an expression of interest form.

Please note, there is no guarantee that all those who apply to take part will be interviewed.

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

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

Thank you very much for reading this information sheet and for considering taking part in this study.

Appendix M: Expression of Interest Form

Expression of Interest v2.0

IRAS Ref: 320837



Date: 01/01/2023

EXPRESSION OF INTEREST FORM

Title of study: Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?

Thank you for considering taking part in this research. Please complete this form after you have read the Participant Information Sheet.

As more than the required number of participants may register their interest to take part, it may be that not everyone who expresses an interest can take part in the research. We want to make sure we include Clinical Psychologists from a range of backgrounds and different directorates. We hope that this will contribute to the literature and may inform better recommendations for Clinical Psychologists in the future.

PLEASE COMPLETE THE SECTIONS IN BLUE BELOW

Full Name	
Age	
Gender	
How would you describe your ethnic background?	
Length of time you have worked as a qualified Clinical Psychologist (in years and/or months)	
Length of the time you have worked for the NHS (in years and/or months)?	
NHS Banding (e.g. 7 / 8a / 8b, etc.)	
Directorate (e.g. CAMHS, Working Age Adults, Older Adults)	
Location of work within the Trust (e.g. [redacted] etc).	
Any other information you think is important for us to know?	

If you would like to take part, and you have read the Participant Information Sheet, please email this completed form to Sarah: s.hollingsworth2@herts.ac.uk

What happens to this information?

Regardless of whether you are chosen to take part in this study, the above information you have provided will be kept **strictly confidential** in accordance with the Data Protection Act 2018. Electronic documents will be password protected and stored on an encrypted memory stick that will only be accessible by Sarah. If you are selected to take part in the research, you will be assigned a pseudonym so that you cannot be identified.

Thank you for your time.

Appendix N: Consent Form**CONSENT FORM FOR PARTICIPANTS**

Title of study: Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?

Thank you for considering taking part in this research. Please complete this form after you have read the Participant Information Sheet.

By initialling each box, you are consenting to this element of the study. It will be assumed that any un-initialled boxes mean that you DO NOT consent to that part of the study, and you may be deemed ineligible for the study.

PLEASE COMPLETE THE SECTIONS IN BLUE BELOW

	Statement	Please initial each box
1.	I confirm that I have read and understood the Participant Information Sheet for the above study. I have had the opportunity to consider the information and asked questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I can withdraw at any time, without having to provide reason, and that my job role and legal rights will not be affected. I also understand that I can withdraw up to 14 days after the interview.	
3.	I understand that my interview will be video and audio recorded.	
4.	I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.	
5.	I understand that when a report is written and published about the study, quotes/sentences from my interview may be used, but all identifying information will be removed or changed. I give permission for publication of these anonymised quotes.	

6.	I understand that information I provide could be used in various anonymised outputs, including journal publications and conference presentations.	
7.	I agree to take part in the above study.	
8.	<i>Optional:</i> I would like to receive a copy of the study results after the research is completed, and consent to my contact details being stored until this time*	

SIGNATURES

PARTICIPANT:	Name:
	Date:
	Signature:
LEAD RESEARCHER:	Name:
	Date:
	Signature:

*If you would like to receive a copy of the research results, please leave an email address below:

Appendix O: Interview Schedule

Semi-Structured Interview Schedule

Introduction:

Hello, my name is Sarah Hollingsworth. I am a third year Trainee Clinical Psychologist doing my Clinical Psychology training at the University of Hertfordshire. Before we get started, I will give you a bit of information about the study and what to expect. There will also be the opportunity to ask any questions before we begin.

*I am aiming to find out more about the experiences of Clinical Psychologists who have been working during the COVID-19 era. I am interested in hearing about your experience of working in the NHS during COVID-19. I will ask you to tell me **your** story; there are no rights of wrongs, I would just like to hear your story in **your own words**.*

Speaking about your experiences is potentially going to bring up some emotive topics. I would like to remind you that you can skip a question or end the interview at any time, without giving a reason.

Can you confirm that you have read the Participant Information Sheet and signed the Participant Consent Form? Do you have any questions in relation to either of these?

Do you have any other questions before we go ahead with the interview?

Do you consent to me recording this interview (video and audio recording)? (If yes) – I am starting the recording now.

Interview Questions and Prompts			
Interview Section	Main Questions	Prompt questions	Questions to consider throughout

Section 1: Context: Work before COVID-19	1. <i>Could you tell me a bit about what your job was like before COVID-19?</i> 2. <i>Were there any aspects of your role that led you to feel uncomfortable or distressed?</i>		<i>Equality and Diversity – how were those more disadvantaged affected?</i>
Section 2: Setting the Scene: The initial impact of COVID-19 Time period: March 2020 – July 2020	1. <i>Can you tell me what it was like for you during the initial stages of the pandemic?</i> 2. <i>What changes did you notice at this time?</i> - <i>What was the impact for you?</i> - <i>What did this do internally for you?</i> - <i>What did you do (or not do) as a result?</i> 3. <i>Did you view yourself in any different way during this time? Do you feel others viewed you differently at all?</i> a. <i>If so, in what way?</i> 4. <i>Were there any aspects of your role at this time that led you to feel uncomfortable or distressed?</i> a. <i>If so, in what way?</i> 5. <i>Were there any additional contextual factors (personal or professional) which impacted you at work at this time?</i> 6. <i>Looking back now, what do you most appreciate about your early responses to the pandemic?</i>	1. For example: • Were you asked to work from home? • Face mask wearing • Gatherings of more than 2 people in public to be stopped • (June 2020) meeting outside in groups of 6 • Key worker's children to go to school 3. Where there any changes in how CP was utilised within the service at this time? 4. Who was making the decisions? Who was able to decide who received service input, and who didn't? How did your job/role as a CP change because of the COVID-19 pandemic? For	<i>How did it feel (inside your body)?</i> <i>What was the impact?</i> <i>What early conflicts or challenges did you experience?</i> <i>Conflicts, challenges, dilemmas</i>

		example, were you given extra responsibilities/ tasks? Was there an impact for you, with your work/life balance?	
Section 3: In the thick of it	1. <i>What values are important to you in your practice as a Clinical Psychologist?</i> 2. <i>During the COVID-19 pandemic, were there times when you had not been consistent with your values?</i> 3. <i>By offering to participate in this research, it would suggest that there has been some element of distress or conflict in relation to your work – this may be described as ‘burnout out’ or ‘compassion fatigue’, during the pandemic.</i> <i>What were the main contributing factors during the COVID-19 era for your personal and professional roles and responsibilities that contributed to you feeling this way?</i> 4. <i>What did you notice, or not notice, was going on for you at this time?</i> 5. <i>How was it to keep boundaries during this time?</i> a. <i>What did you do with these emotions?</i> 6. <i>What did you notice in the way you felt:</i>	Values examples: resilience, compassion, creativity, understanding, empathy, honesty, truth, and belief in the impact of your work Media: What was it like with the regular clapping? Did you feel this was for you too? 3. ‘Compassion-fatigue’ is a term that describes the physical, emotional, and psychological impact of helping others — often through experiences of stress or trauma. Compassion fatigue may be brought about by a stressful workplace or environment, lack of resources, or excessive hours. ‘Moral injury’ is a term given to the distress that can result from an action (or lack of action) that violates an individual’s ‘moral code’.	

	a. <i>within yourself,</i> b. <i>interacted with others,</i> c. <i>or the way in which you approached your work?</i>	How was it for you with the vaccine roll out? 6. Did you notice any feelings of: guilt, shame, anger, detachment? <i>Restrictions:</i> • <i>WFH/working online</i> • <i>What was the impact of shared experiences (professional and person)</i> • <i>Removal of resources (covid-19 risk)</i> • <i>Restrictions on clinical practice (carer's joining sessions etc)</i> • <i>Enforcing covid-19 guidelines in clinical practice</i>	
Section 4: The 'new normal' – looking back	1. <i>As restrictions were relaxed, and services resumed to 'business as usual', what were the benefits to this?</i> ○ <i>What impact, if any, did this have for you?</i> 2. <i>As restrictions were relaxed, and services resumed to 'business as usual', what were the challenges to this?</i>		

	○ <i>What impact, if any, did this have for you?</i>		
Section 5: What lessons can we learn?	1. <i>Looking back now, what has been the biggest ‘take away’ message from your time working in the pandemic?</i> 2. <i>What changes to practices or procedures, which came about during the pandemic, would you like to see continue in the NHS?</i> 3. <i>What are your hopes for the future of CP as a result of the COVID-19 era?</i> 4. <i>What meaningful opportunities, if any, came about through the COVID-19 era which were unexpected?</i>	<i>What changes would support to reduce feelings of compassion-fatigue and burnout?</i>	
Section 6: Wrapping up	1. How has it felt talking today? 2. Has there been anything during our conversation that has <i>surprised</i> you? 3. Is there anything that you feel you want to follow-up on because of this conversation? 4. Do you have anything else, not already covered, that you would like to add?	3. Be kinder to yourself Speak to others/manager Access support etc	

Concluding the Interview:

Thank you for speaking to me today and for participating in this research, it will help me to understand the experiences of NHS Clinical Psychologists at this time and therefore how we can provide better support for people.

We have covered some potentially emotional topics today and I would like to encourage you to look after yourself as needed as a result, in whatever way feels most helpful to you. In relation to this I will email you over a list of resources that I am sending to everyone that has participated in the research; it has some links to places where you can find some more information or wellbeing support.

I would like to say thank you for sharing your experiences and giving your time today, and I will be sending you a wellbeing pack as a sign of my appreciation for all you have done, and continue to do, as an NHS Clinical Psychologist.

Do you have any questions for me?

Before we end, please can I confirm that you still consent to take part in this research, and for me to use the information you have provided in the interview today? Thank you for taking the time to speak with me today.

List of Resources for Further Support

‘Compassion-fatigue and moral injury within the Clinical Psychology profession during the COVID-19 era – what lessons can we learn?’

We understand that retelling accounts of working during the COVID-19 era may have been distressing for you. We hope that some of the resources below will be helpful, should you find yourself needing some extra support.

The professional code of conduct and ethical approval for this study means that Sarah Hollingsworth cannot personally support individuals beyond the remit of the study. Therefore, we have created this debrief sheet with a list of contact details for further support.

- **GP or local Psychological Therapy Services:** for advice if you are feeling anxious, low in mood, or are affected by other emotional difficulties since working through the COVID-19 pandemic.
- **National NHS Helpline:** you can call this service on 0300 131 7000.
- **NHS Support via text messaging:** This service is available to all NHS colleagues who have had a tough day, who are feeling worried or overwhelmed, or who have a lot on their mind and need to talk it through. You can access support by texting **FRONTLINE** to **85258** for support 24/7.
- **Project5:** This service offers NHS staff access to free one-to-one support sessions with either accredited clinical psychologists, mental health experts or coaches, via an online booking system:
<https://www.project5.org/>
- **Protect:** Protect is a charity that provides free, legal, and confidential whistleblowing advice to people who are concerned about wrongdoing at

Please note: This debrief sheet should not be considered equivalent to consultation with a professional – please do seek support should you feel you need it.

This study has been approved by the Health, Science, Engineering & Technology

ECDA. Protocol Number: LMS/PGR/UH/05333

Appendix Q: Wellbeing boxes presented to participants on completion of their interview

Appendix R: Excerpts of Coded Transcript from NVivo

I think at some point and I'm trying to remember when at some point we started to go in and do face to face appointments with all the whole, you know, stuff on. I remember doing an assessment, urrm a therapy appointment with somebody who I've been seeing for a long time before COVID for trauma and having to turn up in clinic to her appointment with an apron and gloves and a mask and goggles and a visor. And just thinking, what the hell is going on? You know, this is just and taking her temperature and stuff like this and that. I think that was the end of our therapeutic relationship. I think she just couldn't tolerate that. So, but I can't remember when that was. I think there was a big debate, there was lots of debates about when should we be in seeing people and when not, and some of that was about older people because if lots of people don't want to be seen or the, you know, we're only having phone appointments, is this safe? Is this the right way of working and different places have different? Kind of ways of managing this. So of the three clinics that I was working in, one of them was completely shut the whole of COVID we couldn't get any clinics at all, even when everything was open again, they were shut. One was kind of accepting kind of not, and the other one, which is the one where they were all expected to be in the office almost the whole time of COVID. They were very much, you know, we've got a one way system, we've got plans, we've got one person in each office come and see people face to face. Urm so I felt again quite confused about all these different - there was no consistency at all and I didn't feel like there was consistency between services either. You know, older adult, adult, whatever by one of the things that I was thinking about what you were talking was the assumptions that were being made about older people because of COVID and the way older people were being seen or not seen. Umm, so I've always one of the things that's always been a part of my job is around age discrimination and helping people to understand about, you know, older people are just people who have got older. And yet there are also some specialist things about working with older people and it. Yeah, that was another thing that when you were talking about moral injury, I think that, you know, hearing about people going from hospitals into care homes was, and and trying to explain to people why that wasn't a good idea. And I had a colleague who was working in the General Hospital and saying, oh, yeah, you know, we're just saying and I was thinking what on my God, why can't you understand? I understand you need beds, but at the same time sending somebody into a into a care home, and she and I just didn't speak at one point because of that, it was just she couldn't understand. Her consultant thought it was fine and that was the national guidance sent people into care homes.

Interviewer:

Yes.

CODE STRIPES

- POST - Conflict between values and keeping your job
- DURING - Exploring new opportunities for service delivery
- DURING - Expectations of NHS workers
- DURING - Needing to choose between mental health and identity as a psychologist
- DURING - Management don't get it
- DURING - WFH environment
- DURING - Relegating own emotional needs
- POST - Making myself the priority
- POST - Feeling valued - mattering
- DURING - The toll of holding other people's emotions
- DURING - Conflict between work and parenting roles
- DURING - Psychology treated separately from the MDT
- DURING - Stereotyping and marginalisation of service users
- DURING - Physical health is the priority
- DURING - Conflict between values and professional relationships

Coding Density

of guidance on how to do it, like sit up straight, look directly at the camera the whole time, and it was like you've got to make sure you've got good eye contact and things. This just does not feel natural at all it just felt, doing that for an hour was just, I can't do that. Yeah, so I had to sort of change my approach, and because I'm naturally more sort of an introvert, there is something about I will often look away more than maybe someone who is more sort of extroverted, urrm, and I was very self-conscious of that on a video call, because I didn't want it to come across as though I wasn't interested in what someone was saying. Urrm whereas I don't know when it's face to face with someone in a room, I felt as though I could convey, you know, that I am really interested in what you are saying. Urrm, I might look down to take notes, I might look away slightly or I might look up if I'm thinking or down, all of those sorts of things. But when it was on video, I was really self-conscious to begin with that I didn't want to do any of that because I was thinking, they don't know what I'm writing if I'm doing notes, or if I'm looking away they might think I am distracted, or not interesting, whereas in person I wouldn't have any of those things.

Interviewer:

Yeah.

█:

I don't know what that was. Again, maybe it was possibly wanting to do, probably wanting to do a really good job wanting this to go really well. And so I was like, oh, you know, it's been really difficult for people to do it online. So we gotta make sure I'm, you know, looking at their camera the whole time, making sure that I'm doing a really, really sort of good sort of job here. And I was almost too self-conscious and I think I was coming across as really all forward and in the maybe that maybe too intense for people as well because looking sort of directly at them the whole time. Umm. So yeah, so bit quite quickly, I was like, I've just got to do more natural here. I can't go with this this approach and this isn't helping anyone, so.

Interviewer:

Sure. Thank you. Thank you for, for sharing them, for, for your honesty around it. And I think you you possibly already answered this, but were there any aspects of your role at this time in the early stages that we're leading you to feel uncomfortable or distressed in any way?

CODE STRIPES

- POST - The team are not the same
- DURING - Learning to adapt Psychological interventions
- DURING - The team are no longer the same
- DURING - Being forced to impose someone else's decision
- DURING - The impact of COVID on our identity
- DURING - The vaccine or your job
- PRE - Demands of the role
- DURING - Expectations of Psychology
- DURING - Psychology as part of the problem
- DURING - Restrictions and physical barrier to therapeutic relationships
- DURING - Psychology treated separately from the MDT
- DURING - Top-down command
- DURING - Conflict between values and professional relationships

Coding Density

Appendix S: NVivo Codes Grouped Together

- ☐ DURING - Being seen
- ☐ DURING - Challenge of making choices for other people
- ☐ DURING - Challenges of managing different views
- ☐ DURING - Choice in how we work
- ☐ DURING - Conflict between values and professional relations
- ☐ DURING - Conflict between work and parenting roles
- ☐ DURING - Conflict between work and personal life
- ☐ DURING - Conflict in managing views about the NHS
- ☐ DURING - Despite the context, I can cope
- ☐ DURING - Difference of opinion between Psychology and medicine
- ☐ DURING - Different impact on parenting
- ☐ DURING - Ensuring basic needs are met
- ☐ DURING - Everyone's making the decisions
- ☐ DURING - Expectations of NHS workers
- ☐ DURING - Expectations of Psychology
- ☐ DURING - Exploring new opportunities for service delivery
- ☒ DURING - Fear of being a risk to others
- ☐ DURING - Feeling valued - mattering
- ☐ DURING - Gender expectations during the pandemic
- ☐ DURING - How psychology survives
- ☐ DURING - Identity as a team player
- ☐ DURING - Identity of being helpful and playing a function
- ☐ DURING - Inequalities of staff support options
- ☐ DURING - Internal pressure of psychology
- ☐ DURING - Isolation
- ☐ DURING - It's not all bad
- ☐ DURING - Juggling work hours
- ☐ DURING - Lack of a coherent voice from below
- ☐ DURING - Lack of guidance
- ☐ DURING - Learning to adapt Psychological interventions
- ☐ DURING - Life in perspective
- ☐ DURING - Loss of identity
- ☐ DURING - Loss of job satisfaction
- ☐ DURING - Loss of safety

[Files\Interviews\](#)

1 reference coded, 0.80% coverage

Reference 1: 0.80% coverage

And yeah, I just was so anxious about having to go into work and be around people and, you know, so it's still different in hindsight, doesn't it? Because we we learn so much later about who it would affect and how serious it would be. But at the time, we didn't know that it would be mostly sort of older people or people of different ethnicities or people with underlying health conditions like we we all thought we were at risk and it felt really scary and horrible.

[Files\Interviews\](#)

1 reference coded, 0.29% coverage

Reference 1: 0.29% coverage

she would always come and want to hug me. And I had to keep backing away and I'd say sorry, mum, I can't hug you. I'm not allowed. And then I'd worry that I'm also being a bit selfish because I'm going to work and maybe I'm not protecting her as much as I could

[Files\Interviews\](#)

2 references coded, 1.15% coverage

Reference 1: 0.38% coverage

I was the one like needing to juggle home life and wondering if I was going out, am I going to bring something back home? So it was just very, I think that that when it started was very difficult, it was surreal.

Reference 2: 0.77% coverage

It left me feeling worried. To the point where I'd come home and my children's natural instinct would be to hug me and I couldn't do that. I had to stop them and literally strip off and like that, I'd as soon as I enter into the house, my husband would make sure that the kids weren't in the room. I'd strip off and literally go, um, go to the shower bag everything up and there were just things like that that we

- ☐ POST - A change in th...
- ☐ POST - A disconnection...
- ☐ POST - A disconnection...
- ☐ POST - A shift in persp...
- ☒ POST - Blurred bound...
- ☐ POST - Choice in how...
- ☐ POST - Conflict betwe...
- ☐ POST - Conflict in guid...
- ☐ POST - COVID has put...
- ☐ POST - Embrace the u...
- ☐ POST - Everyone work...
- ☐ POST - Feeling valued...
- ☐ POST - Lack of guidan...
- ☐ POST - Loss of motiva...
- ☐ POST - Lower toleranc...
- ☐ POST - Making myself...
- ☐ POST - Need time to p...
- ☐ POST - Others are less...
- ☐ POST - Psychology be...
- ☐ POST - Psychology ha...
- ☐ POST - Psychology is...
- ☐ POST - Psychology is r...
- ☐ POST - Psychology ta...
- ☐ POST - Reconnecting...
- ☐ POST - Spending mor...
- ☐ POST - Staff no longer...
- ☐ POST - Sticking to wh...
- ☐ POST - The final straw
- ☐ POST - The team are n...

[Files\Interviews\](#)

1 reference coded, 0.30% coverage

Reference 1: 0.30% coverage

And I suppose working from home is probably slightly less stressful than being in the office so. Urrm. But there is a risk that for some people it means that they'll push themselves to work when they should be off sick.

[Files\Interviews\](#)

1 reference coded, 0.47% coverage

Reference 1: 0.47% coverage

So now weekends on a Sunday I have this heavy feeling hanging over me or you know, this is my that my home space is my workspace and it gets a bit confused and I feel as though I ought to be working even when I'm not. I always had a bit of that. Anyway. I wouldn't say that's new, but it's more so because the physical space is now become associated with work. I'm now sitting at my dining room table, but it's also my workspace.

[Files\Interviews\](#)

2 references coded, 0.64% coverage

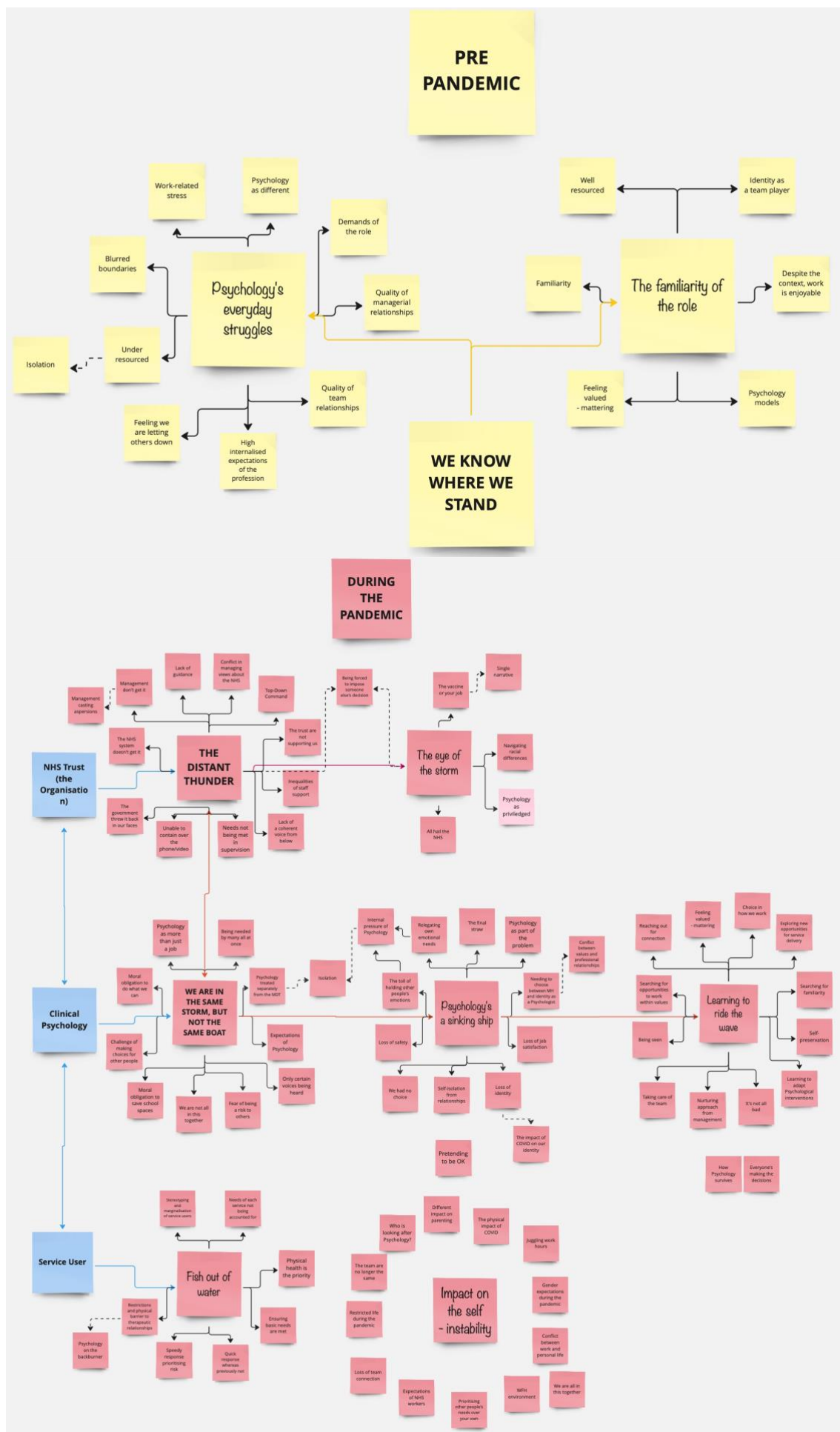
Reference 1: 0.34% coverage

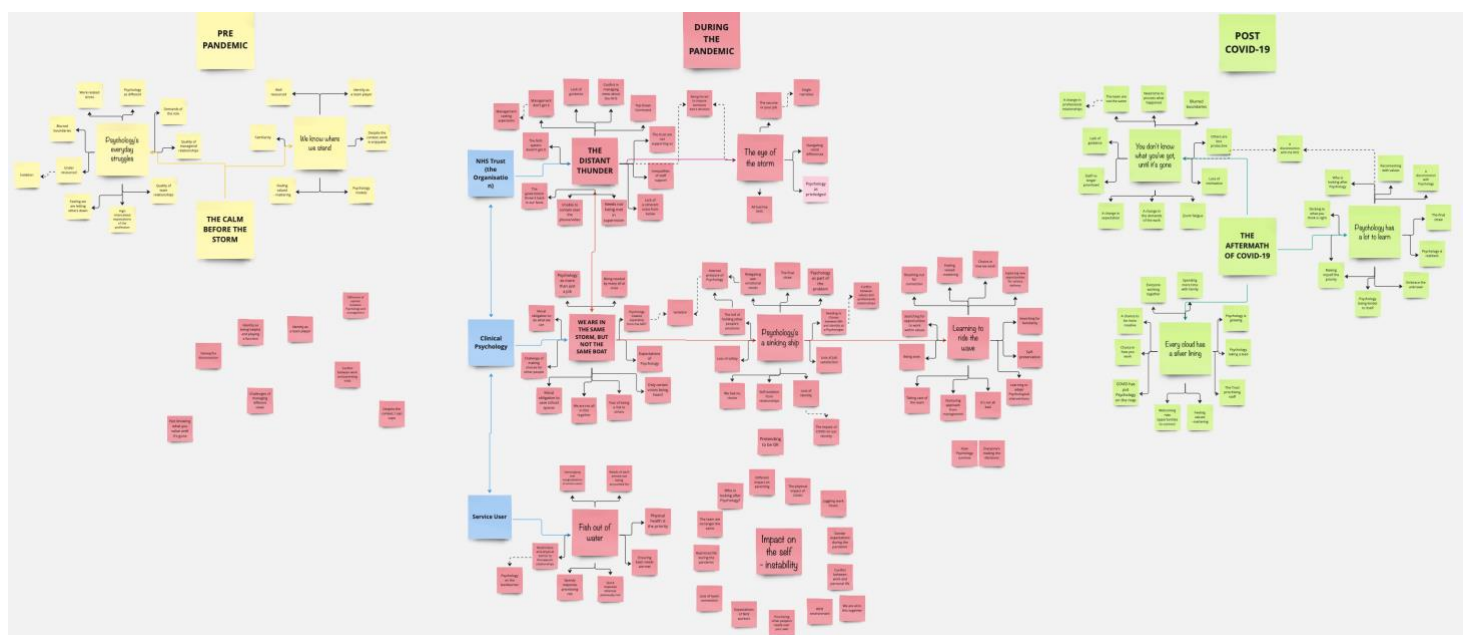
that ability to work flexibly and to avoid traffic rush hour I think can really help. But my big caveat with that is that that potentially can lead to more people experiencing burnout because some of those natural boundaries aren't in place.

Reference 2: 0.30% coverage

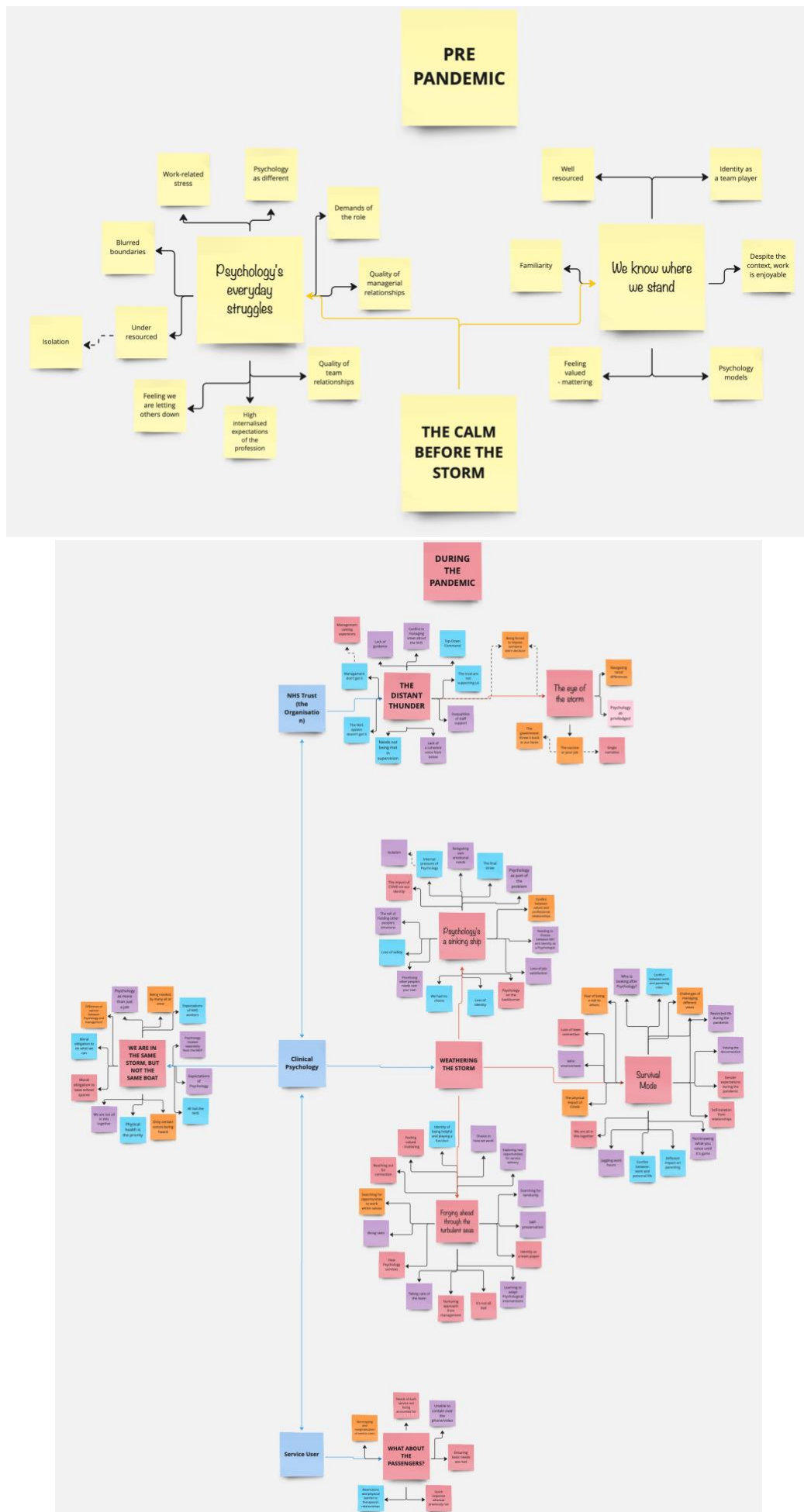
So I think the dangers and risk of overwork are very high. But on the other hand, if

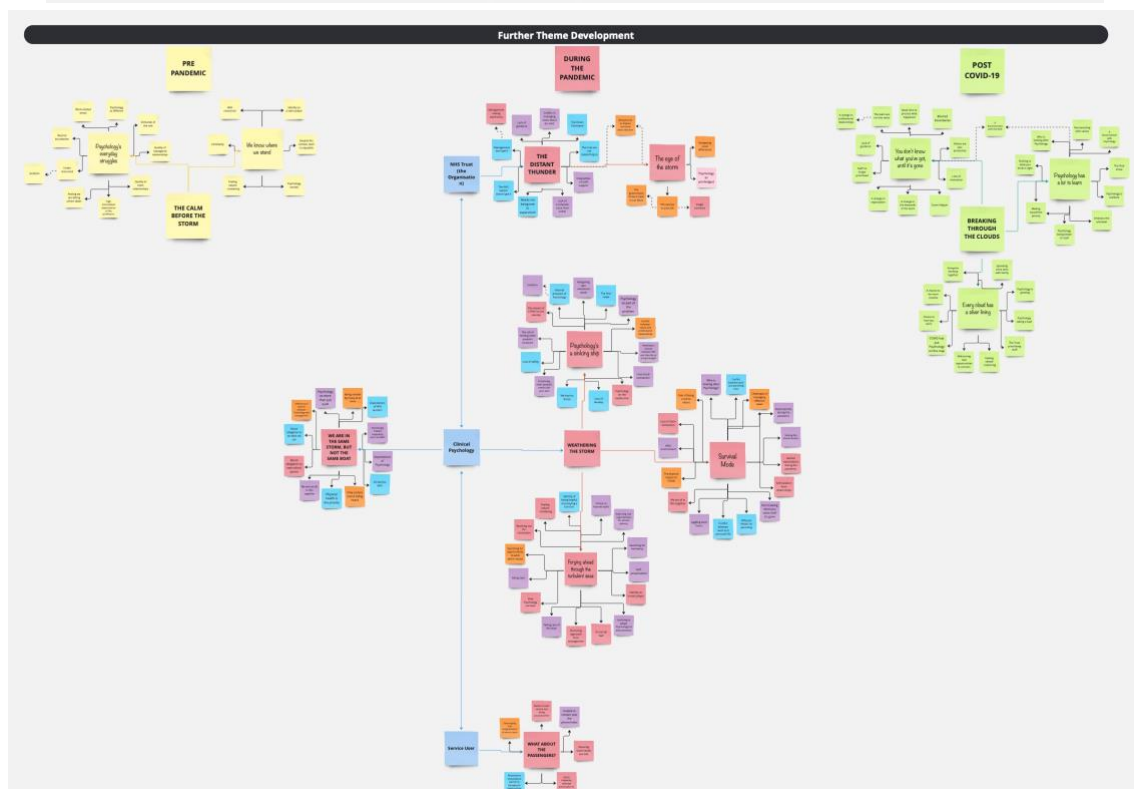
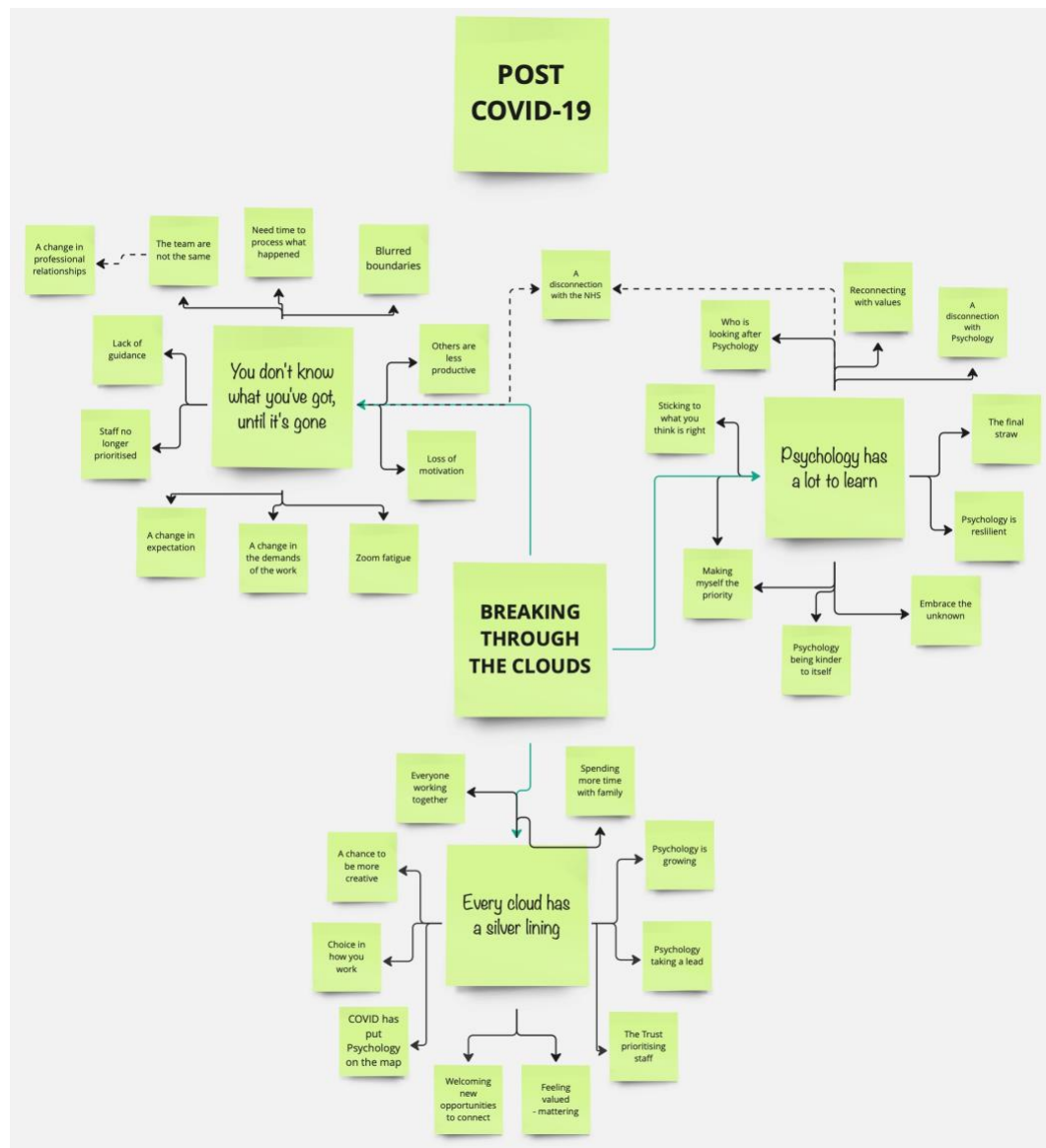
Appendix T: Initial Thematic Map





Appendix U: Final Thematic Map





Appendix V: Reflexive Journal Excerpts**12/05/2023 – Following an Advanced Thematic Analysis Methods Workshop**

Questions to consider:

1. The assumptions (if any) you hold that might shape our observations or meaning-making – have my own experiences of working during this time and with CP's – might bias or shape my own view of what it was like. Interested in CP's and how they often support to others but are less likely to support themselves. Do I have my own questions that I want answered?

2. Your values and life experiences and how these might shape how you make sense of the data – believe everyone should have a voice. That work should be shared equally.

A reminder to myself that different things will likely arise at different times. My mood and day will affect this too – as well as the people I am interviewing. Need to check-in constantly throughout, both with myself and others. I am meeting soon with my supervisor to think about own experiences of working during the pandemic and how this could influence my research.

02/10/2023 – Reflections following pilot interview

Felt that went well. Was good to have a chance to practice and see how my interview questions flowed. Need to consider offering a timeline to participants or adding dates/times into the interview questions to help participants situate themselves to the timepoint being discussed – as this was more tricky during the pilot. Good feedback from my consultant about the way the questions were phrased – conscious of being sensitive to the nature of the topics being discussed.

21/11/2023 - Reflections following first four interviews

Finding interview to be more difficult and emotionally draining than anticipated. Finding myself in a really difficult position because some of the people that I interview were in the Trust that I was in during COVID. So I maybe had more affiliation with some of those interviews because I had more of an understanding of the context, or I could remember certain things that they were sharing. And it really took me back to what my response was at the time or how I felt about what was going on. And I've always seen myself as very pro NHS. I think I will always defend the NHS. I don't dispute it has its flaws, but I think it's one thing I see as quite a privilege that we have, and I've always felt quite proud to be a part of the NHS and I won't deny that there were parts that I heard in that interview that really rocked that view. And that did make it more difficult to feel as defensive as the NHS and how it responded. And being very careful to take quite a neutral response within those interviews that it wasn't my place to give an opinion - that wasn't what I was there to do. Need to be mindful of this going forward in future interviews and reflect more on my own opinions and thoughts towards the NHS.

28/03/2024 – Following supervision with research supervisor to the project

Halfway through my coding now. Feels surreal to be at this point – felt like I may never get here. Conscious that coding is feeling more challenging than I had expected. What is a code? How many codes is too many? All things I am considering as I go through. Reminding myself to expand my view beyond my own experience and really focus in on what each participant is telling me. At this point I am conscious some of my codes may be more like themes and will need reviewing and further refinement when all codes are completed.

Appendix W: Excerpts from Bracketing Interview

Excerpt 1:

Research supervisor:

There's also something about hearing you talk that I don't know. There's it's like that, that flip in a way, to perhaps as an assistant or as a trainee, that you might notice the power you don't have ... I guess it just makes me wonder what that felt like for you to then feel as though if you've gone from being quite protected previously and obviously that will have shifted over time because that'll be will have been difficult placements were and things where you won't have been that well protected, but how that feels to be put in a on a bit of a pedestal. Maybe or to be put in quite a powerful position. And when when you hold privilege or power that that's quite daunting, can be quite daunting.

Researcher:

There were. It was an uncommon in fact, I think I'm struggling to find anyone in my head that didn't really. I think everyone shared that this was really the first time they'd opened up or had the space to really consider their own perspective on what had happened. And, you know, people were essentially sharing their trauma stories. And I think being a part of that journey where people are first exploring that and trying to make sense of it and understand that it was very difficult to sit in just a researcher position.

Excerpt 2:

Research supervisor:

Given it rocked to you quite a bit, the kind of things that people were saying, how did you keep yourself open in the research? Because there's always that risk, isn't there, that if you hear things that you don't want to hear that you might close yourself off to it or kind of, yeah, compartmentalise or make an interpretation or an assumption that fits perhaps with your pre-existing frame or idea of how things should or could be. So I wonder how you feel that you kept yourself open to that because it sounds like you did. But even if it was like, oh, OK, this wasn't quite what I was expecting that you maintained an open stance and I wondered how you did that and what you noticed to yourself doing in order to keep that going?

Researcher:

I think like I said, having the semi structured interview was helpful because I think I knew I had my questions and they would that almost kind of brought me back to my focus. That

reminded me while I was there. I had it on the screen next to me and I kept kind of looking over to it and I had prompt questions that kind of I guess, sort of covered some of those angles, so I guess brought it back to the research wherever I could. I don't know that there was. There was much else that I did. I just remember noticing it in the moment and really concentrating on. I would make a note of something and that was almost like my way of like removing it that I'd be like, right? I've parked that there because then I'll I'll think about that afterwards. So I'd make a note about like, I don't know, uncomfortable or something, and then that would be my way of like parking it. So I was like, I want to focus on what you're saying, not what I'm thinking. So I'll kind of make a note of it and then I'll, I'll come back to that in my own time to reflect on.

Research supervisor:

Keep that going then through analysis so based on the conversation we've had today and what you found, you needed to do through the interviews to keep yourself focused on what your participants were saying.

Excerpt 3:

Research supervisor:

There's almost like, what would the less persuasive experiences, or something like how are they heard? And I think that's the important thing. Then when you're going through your analysis is kind of thinking, OK, what the headlines, what are the things shouting out to me almost bracketing those, putting those to one side and what are some of the other stories coming through here or what are the more tentative stories or slightly less persuasive ones? So how can I listen to those two?

Researcher:

Yeah. Yes, I like that idea. Yeah. I guess I'm almost thinking of it. Almost like a trauma timeline, exactly as you said that you are sort of noting down what what happened, what were those main points? And then yeah, coming back and thinking about what what goes in the gaps, what were the bits that haven't been kind of noticed or spoken to? Yeah, I like that idea.
