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ORIGINAL ARTICLE

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# Occupational stress, coping and wellbeing among registered psychologists working with people with intellectual disabilities during the COVID-19 pandemic in the United Kingdom

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**ABSTRACT**

**Objectives:** To characterise the changes at work experienced by psychologists working with people with intellectual disabilities during the pandemic and whether these changes, stressors and aspects of working life were associated with mental wellbeing and occupational stress.

**Methods:** Ninety-seven psychologists completed an online survey. Free text comments were analysed using thematic analysis and triangulated with our quantitative findings.

**Results:** Occupational stress, learning new roles, demands at home, and changes due to COVID-19 were associated with poorer mental wellbeing, while uncertainty about the role, a shortage of personal protective equipment, and poorer mental wellbeing were associated with occupational stress. Two main themes emerged during the thematic analysis: being human and being an employee, and triangulation revealed agreement.

**Conclusions:** The wellbeing and occupational stress of psychologists working with people with intellectual disabilities have been affected during the pandemic. It is of note that almost a quarter of our sample reported having been redeployed.

**KEYWORDS**

COVID-19; SARS-CoV-2; mental health; psychologist; intellectual disabilities; neurodevelopmental disabilities; learning disabilities

Concerns have been raised about the impact of coronavirus disease 2019 (COVID-19) upon people with intellectual disabilities globally, and this has led some to develop specialist guidance for the care and treatment of people with intellectual disabilities who develop COVID-19 (Alexander et al., 2020). This includes an important role for psychologists in helping to mitigate any impact upon mental health and challenging behaviour, coping with illness and death, and working with those supporting people with intellectual disabilities, including paid and unpaid carers (Alexander et al., 2020). Within the United Kingdom, psychologists are an integral part of many specialist teams providing care to people with intellectual disabilities. This includes providing diagnostic assessments, further assessment relating to challenging behaviour and mental health, along with the delivery of a variety of interventions while working within a multidisciplinary team. Interventions can include a variety of psychological therapies (e.g., cognitive and behavioural psychotherapies, systemic therapy, functional analysis, the development of positive behaviour support) within multiple contexts (e.g., community and hospital settings) and often involves working with families and carers.

During the pandemic, there have been several attempts to characterise the health and coping of carers of people with intellectual disabilities, including both those who are paid and those who are unpaid. Willner and colleagues (Rose et al., 2020; Willner et al., 2020) reported that family carers of both children and adults with intellectual disabilities had increased difficulties relative to carers of children without intellectual disabilities during the pandemic, while Embregts et al. (2021) reported that paid direct support staff for adults with intellectual disabilities were afraid of contracting SARS-CoV-2 and infecting others, including their own families, with further fears about a lack of appropriate personal protective equipment (PPE), and subsequent

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effects upon their mental health. Within a rapid review of the literature about the impact of an infection outbreak upon longer-term care staff, Embregts et al. (2020) reported that care staff experienced a variety of emotional responses and considered stopping work in response to an infection outbreak.

There have now been numerous studies and opinion pieces about the likely impact of the COVID-19 pandemic upon the mental health of both patients (Troyer et al., 2020) and the staff who care for them (Rathod et al., 2020), as well as the public (Xiong et al., 2020). For example, Rathod et al. (2020) reported that healthcare professionals appear to have higher rates of anxiety and depression, as well as alcohol use, with an associated increase in seeking mental health support during the pandemic, relative to non-healthcare professionals; they also noted that healthcare professionals described feeling more isolated, even though they had greater contact with friends and family, while they also used more coping strategies. As with the general population, a substantial proportion is likely to experience symptoms of anxiety, stress, depression and trauma that will require treatment during and beyond the pandemic (Rossi et al., 2020; Torales et al., 2020; Xiong et al., 2020).

Considering the vulnerabilities of people with intellectual disabilities and the role that psychologists have with respect to the provision of psychological interventions to address mental health problems and challenging behaviours among this population, we conducted an online cross-sectional survey about changes at work, stressors and working life, mental wellbeing and occupational stress, among psychologists working with people with intellectual disabilities. The aim of this project was twofold: (a) to characterise the changes at work encountered by psychologists working with people with intellectual disabilities, and (b) to examine whether these changes, stressors, and aspects of working life were associated with mental wellbeing and occupational stress during the pandemic.

## Method

### Participants

Participants were eligible to take part in this study if they were a Health and Care Professions Council Registered Practitioner Psychologist living in the United Kingdom of Great Britain and Northern Ireland (UK) and working to provide support to people with intellectual disabilities in the National Health Service (NHS). The Health and Care Professions Council is the national regulator for practicing psychologists in the United Kingdom, and the NHS is the publicly funded healthcare system in the United Kingdom. One hundred and seventeen individuals began the questionnaire and 20 discontinued at various stages: one person withdrew after reading the participant information sheet, two indicated they were ineligible to take part, four indicated that they were eligible to take part but did not provide consent to proceed, and thirteen discontinued the survey after giving consent. Ninety-seven participants (80% female; 82% white; 49%≤40 years of age) completed the survey. The majority were spread across England (80%), with 11% from Scotland, 3% from Wales, and 3% from Northern Ireland (Table 1).

**Table 1.** Participant characteristics ($N = 97$).

| | % ($n$ =) |
|---|---|
| Sex | |
| Male | 19.6 (19) |
| Female | 80.4 (78) |
| Age (Years) | |
| 21–30 | 8.2 (8) |
| 31–40 | 41.2 (40) |
| 41–50 | 28.9 (28) |
| 51–60 | 19.6 (19) |
| 61–70 | 2.1 (2) |
| Geographical Region | |
| Scotland | 13.4 (13) |
| Wales | 3.1 (3) |
| Northern Ireland | 3.1 (3) |
| Greater London | 12.4 (12) |
| South East | 14.4 (14) |
| South West | 3.1 (3) |
| West Midlands | 13.4 (13) |
| North East | 7.2 (7) |
| Yorkshire and Humber | 6.2 (6) |
| East Midlands | 12.4 (12) |
| East Anglia | 11.3 (11) |
| Ethnicity | |
| Indian | 1.1 (1) |
| Other Asian | 2.1 (2) |
| Black | 1.1 (1) |
| White | 82.5 (80) |
| White Irish | 5.2 (5) |
| White Other | 4.1 (4) |
| Other | 3.1 (3) |
| No response | 1.0 (1) |

### Design and procedure

This study was an online cross-sectional survey of registered psychologists working with people with intellectual disabilities in the UK during the initial lockdown associated with the COVID-19 pandemic. Ethical approval for this study was given by the Research Ethics Committee of the College of Human and Health Sciences at Swansea University, UK.

The study was made available online, using Qualtrics$^{XM}$ Version 05062020, on 10 May 2020, remaining open for 1-month, closing on 10 June 2020. The survey was advertised within a Facebook group specifically for psychologists working with people with intellectual

disabilities, as well as being circulated to relevant listservs for psychologists working with people with intellectual disabilities. No personally identifiable data were collected from participants.

### Measures

*Changes at work*. The research team developed a list of changes, and participants were asked to indicate whether any had occurred in response to the COVID-19 pandemic. This list of changes was developed collaboratively by the research team based upon both their clinical and research experience. Each was discussed until consensus among the team about the inclusion of items, and their wording was achieved. These include items related to redeployment, using technology, using PPE, and homeworking. Participants were also provided with free text boxes and invited to tell us about any other changes that had occurred at work.

*Stressors and working life*. Participants were asked to rate how troublesome a group of potential stressors had been during the COVID-19 pandemic on a scale of 0–100. These included juggling demands at home, challenges of learning a new role at work, practical difficulties, equipment limitations, COVID-19 illness or another illness, uncertainty about current work role, social isolation, or concerns about clients. They were also asked to consider whether there had been a change within their working life on several constructs rated on a 3-point scale (less, the same, or more). These constructs were busyness, effectiveness, job satisfaction, and worries about the health of themselves, family, and the wellbeing of clients. Participants were also provided with free text boxes to tell us about other stressors, and what they were doing to help cope during the pandemic.

*Mental wellbeing*. The Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007) is a 14-item questionnaire that aims to assess mental wellbeing using a 5-point Likert scale, where lower scores suggest poorer mental health, which has been standardised for use with the general population. Participants were asked to answer these questions with reference to the previous 2 weeks.

*Occupational stress*. The United Kingdom Health and Safety Executive Management Standards Indicator Tool (Kerr et al., 2009) is a validated measure of workplace stress and was used to assess six likely stressor domains related to work, including demands, control, support, relationships, role, and organisational change (Cousins et al., 2004). Each area is scored in the positive direction (e.g., the demands and role domains were reversed such that higher scores mean either fewer problematic demands or clear expectations about work-related roles) such that higher scores reflect more positive working conditions. A total average domain score was calculated and reported. All questions were anchored with reference to the period beginning 23 March 2020 when the lockdown was implemented within the UK.

### Data analysis

To condense data into fewer variables for our analysis and to reduce potential collinearity, principal components analysis with quartimin rotation, as correlations between components were expected, was used to examine the structure of the 15 items about *stressors and working life* due to the pandemic after transforming all items to the same scale (0–100). Two items, busyness and uncertainty about work, were removed, and the analysis was re-run because they did not load sufficiently onto any single component; however, these two items were included in later analyses. The Kaiser–Meyer–Olkin measure of sampling adequacy was .55, and Bartlett's test of sphericity was significant, $x^2(78) = 216.51$, $p < .001$. Five components were retained and explained 63% of the variance-based upon an eigenvalue >1 and inflexion point within the scree plot. These items, their labelled components, and the structure and pattern matrix are shown in Appendix Table 1 and were used within our subsequent analyses. For the components labelled worries about health, worries about clients, and work effectiveness and satisfaction, there was noted skew, and the data did not approximate a normal distribution. This was also the case for the individual item, busyness.

Considering the aims of this study, first, to characterise the changes at work encountered by psychologists working with people with intellectual disabilities, frequencies of the various changes at work were examined and described, and where data were available, comparisons were made to datasets collected prior to the pandemic using *t*-tests. Second, to examine the association between mental wellbeing and occupational stress during the pandemic, we conducted two forward stepwise regressions as the relationship between occupational stress and mental wellbeing is likely bidirectional. For both regressions, residuals were inspected and approximated a normal distribution, and examination of the variance inflation factor indicated that collinearity was not problematic, $VIF \leq 1.2$. An *a priori* power analysis indicated that a sample size of 55 was required to ensure that our study was adequately powered assuming a medium effect size.

Thematic analysis (Braun & Clarke, 2006) was used to analyse the information provided by respondents within the free text boxes in response to questions about what participants were doing to cope themselves,

any further concerns they had at work, and what other stressors they found troublesome during the pandemic. The description of each stage of thematic analysis is presented in Appendix Table 2. Two authors, who are experienced qualitative researchers, were involved in the thematic analysis; the initial coding was completed by MM, and these codes were independently checked by CC. These two authors worked collaboratively to finalise the initial codes and combine them into subthemes and main themes. An illustration of our analysis is found within the Appendix Tables 3–5.

Methodological, data, and investigator triangulation were completed using the integration of both quantitative and qualitative data (Noble & Heale, 2019; Richards et al., 2019). Methodological triangulation was completed by taking the quantitative data and differentiating the findings into seventeen key findings, which were compared to the qualitative data by coding the relationship between them as silence (present only in one set of data), dissonance (conflicting findings in data), partial agreement (data partially supporting each other) and agreement (data fully supporting each other) (Tonkin-Crine et al., 2015). Considering data triangulation, we made use of the actual text and the number of agreements, disagreements, or silence when triangulating findings. Investigator triangulation involved the use of more than one person when completing the thematic analysis, and all authors were involved in this process, which included two experienced qualitative researchers and two experienced quantitative researchers.

## Results

### Redeployment and changes at work

Twenty-three (24%) psychologists reported being redeployed because of the pandemic. Eighteen (19%) were working in a different psychology role, while five were no longer working in a psychology role. Ten (10%) continued to work with people with intellectual disabilities while redeployed, while 13 were no longer working with this population (Table 2). Considering some of the additional changes at work, 82 (85%) psychologists reported an increased focus upon using telephone calls, while 70 (72%) reported an increased focus upon using video conferencing with people with intellectual disabilities and their families. Eighty (82%) reported working from home, and five (5%) reported experiencing a shortage of PPE within the workplace. Participants most frequently endorsed experiencing worries about their own health and the health of their family, as well as worries about clients and general busyness within work (Table 2).

**Table 2.** Descriptive statistics ($N = 97$).

| Item | % ($n$ =) |
|---|---|
| Redeployment (psychology role and *not* working with people with intellectual disabilities) | 11.3 (11) |
| Redeployment (psychology role and still working with people with intellectual disabilities) | 7.2 (7) |
| Redeployment (non-psychology role and *not* working with people with intellectual disabilities) | 2.1 (2) |
| Redeployment (non-psychology role and still working with people with intellectual disabilities) | 3.1 (3) |
| Increased focus upon phone sessions with people with intellectual disabilities and their families | 84.5 (82) |
| Increased focus upon video sessions with people with intellectual disabilities and their families | 72.2 (70) |
| Working from home currently or previously | 82.5 (80) |
| Shortage of personal protective equipment | 5.2 (5) |
| Scale | $M$ = ($SD$) |
| Warwick–Edinburgh Mental Wellbeing Scale | 45.47 (7.29) |
| Management Standards Indicator Tool | |
| Demands | 3.15 (0.72) |
| Control | 3.81 (0.89) |
| Manager Support | 3.62 (0.90) |
| Peer Support | 3.91 (0.70) |
| Relationships | 4.13 (0.64) |
| Role | 3.55 (0.67) |
| Organisational Change | 3.07 (0.85) |
| Total | 3.61 (0.54) |
| Stressors and Changes at Work | |
| Changes due to COVID-19 | 43.36 (17.03) |
| Worries about Health | 87.29 (15.36) |
| Work Effectiveness and Satisfaction | 50.00 (17.34) |
| Worries about Clients | 80.93 (13.93) |
| Challenges and Demands | 47.13 (22.08) |
| Busyness | 84.54 (22.60) |
| Uncertainty at Work | 39.13 (26.46) |

### Stress and mental wellbeing

Psychologists working with people with intellectual disabilities had significantly lower wellbeing scores relative to the general population when compared to WEMWBS standardisation data collected before the pandemic ($M$ = 51.61, $SD = 8.71$, $N = 7020$), $t(7115) = -6.14$, $p < .001$. However, the wellbeing scores of psychologists were not significantly different from data collected about British university students, ($M = 45.00$, $SD = 9.00$, $N = 214$), $t(309) < 1$, $p = .65$ (Savage et al., 2020), the general public, ($M = 45.89$, $SD = 9.08$, $N = 137$), $t(232) < 1$, $p = .71$ (Mead et al., 2020), or British school teachers (Allen et al., 2020), during the pandemic. Considering occupational stress, a comparison to British data collected before the pandemic ($N = 26{,}382$; Edwards et al., 2008) revealed that the current participants scored higher on demands, $t(26{,}477) = 21.43$, $p < .001$, control, $t(26477) = 11.84$, $p < .001$, manager support, $t(26477) = 7.48$, $p < .001$, relationships, $t(26477) = 9.19$, $p < .001$, 3.55, organisational change, $t(26477) = 2.81$, $p < .001$, and on total score, $t(26477) = 24.09$, $p < .001$, suggesting that psychologists experienced more positive working conditions during the pandemic than a large sample of working adults prior to the pandemic. However, they scored significantly lower than a large sample of the British workforce

surveyed before the pandemic on role, which included staff working within 15 different NHS Trusts and hospitals, $t(26477) = -49.00$, $p < .001$, suggesting that they had experienced a lack of clarity about expectations, duties and responsibilities at work during the pandemic. Increasing difficulties with role (indicated by lower scores) were associated with having experienced more changes due to COVID-19, $r(97) = -.21$, $p = .02$, more challenges and demands, $r(97) = -.24$, $p = .01$, having more worries about clients, $r(97) = -.18$, $p = .04$, and experiencing less work effectiveness and satisfaction, $r(97) = .35$, $p < .001$. In short, fewer difficulties with role (higher scores) were associated with higher scores on work effectiveness and satisfaction.

Examining which variables predicted mental wellbeing during the pandemic revealed a significant regression model, $F(4, 92) = 7.43$, $p < .001$, explaining 21% of the variance (Table 3). Higher levels of occupational stress, $p = .01$, challenges associated with learning a new work role and juggling demands at home, $p = .02$, and changes due to COVID-19 (e.g., changes to the usual way of coping, social isolation at work, practical difficulties with technology, illness due to COVID-19), $p = .01$, were associated with poorer mental wellbeing. Unexpectedly, worries about clients were associated with increased wellbeing, $p = .01$. Examining which variables predicted greater occupational stress during the pandemic also revealed a significant regression model, $F(3, 93) = 5.46$, $p = .02$, explaining 19% of the variance (Table 3). Uncertainty about current work role was associated with increasing occupational stress, $p = .01$, as was a shortage of personal protective equipment, $p = .02$, and poorer mental wellbeing, $p = .01$ (Table 3).

## Thematic analysis

Ninety-three (95%) out of 97 participants provided free text comments. Further investigation into these comments using thematic analysis led to the emergence of two main themes, each with three subthemes. Main themes, and subthemes are shown in Table 4. The minimum number of words written by respondents was one, and the maximum was 60.

**Table 3.** Mental wellbeing or occupational stress was predicted within two separate forward stepwise linear regressions using each of the categories of changes at work, the five components of stressors and working life, and either mental wellbeing or occupational stress.

| | Mental wellbeing | | | | |
|---|---|---|---|---|---|
| Predictor variable | *B* | *SE B* | *β* | *t* | *[95% CI]* |
| Block 1 | | | | | |
| Constant | 30.36 | 4.81 | | 6.31 | [20.80, 39.91]* |
| Occupational Stress | 4.19 | 1.12 | .31 | 3.18 | [1.57, 6.81]* |
| Block 2 | | | | | |
| Constant | 35.23 | 5.05 | | 6.98 | [25.20, 45.25]* |
| Occupational Stress | 3.45 | 1.13 | .26 | 2.63 | [0.84, 6.06]* |
| Challenges and Demands | −0.08 | 0.03 | −.24 | −2.56 | [−0.14, −0.02]* |
| Block 3 | | | | | |
| Constant | 40.41 | 5.56 | | 7.27 | [29.38, 51.45]* |
| Occupational Stress | 3.33 | 1.29 | .25 | 2.58 | [0.76, 5.90]* |
| Challenges and Demands | −0.07 | 0.03 | −.21 | −2.16 | [−0.13, −0.01]* |
| Changes due to COVID-19 | −0.09 | 0.04 | −.20 | −2.08 | [−0.17, −0.004]* |
| Block 4 | | | | | |
| Constant | 31.10 | 6.55 | | 4.75 | [18.08, 44.11]* |
| Occupational Stress | 3.51 | 1.26 | .26 | 2.78 | [1.00, 6.01]* |
| Challenges and Demands | −0.08 | 0.03 | −.23 | −2.45 | [−0.14, −−0.01]* |
| Changes due to COVID-19 | −0.11 | 0.04 | −.26 | −2.68 | [−0.20, −0.03]* |
| Worries about Clients | 0.13 | 0.05 | .24 | 2.51 | [0.03, 0.22]* |
| | | | $F(4, 92) = 7.43$, $p < .001$; *Adj* $R^2 = .21$ | | |
| | | | Occupational stress | | |
| Block 1 | | | | | |
| Constant | 3.86 | 0.09 | | 41.54 | [3.68, 4.05]* |
| Uncertainty about Current Work Role | −0.01 | 0.002 | −.32 | −3.29 | [−0.01, −0.003]* |
| Block 2 | | | | | |
| Constant | 2.97 | 0.35 | | 8.43 | [2.27, 3.66]* |
| Uncertainty about Current Work Role | −0.01 | 0.002 | −.27 | −2.77 | [−0.01, −0.002]* |
| Mental Wellbeing | 0.012 | 0.01 | .25 | 2.64 | [0.01, 0.03]* |
| Block 3 | | | | | |
| Constant | 3.03 | 0.35 | | 8.78 | [2.34, 3.71]* |
| Uncertainty about Current Work Role | −0.01 | 0.002 | −.27 | −2.83 | [−0.01, −0.002]* |
| Mental Wellbeing | 0.02 | 0.01 | .25 | 2.61 | [0.004, 0.03]* |
| PPE Shortage | −0.43 | 0.18 | −.22 | −2.34 | [−0.78, −0.06]* |
| | | | $F(3, 93) = 5.46$, $p = .02$; *Adj* $R^2 = .19$ | | |

*$p < .05$.

**Table 4.** Main themes with subthemes.

| Main theme | Subtheme |
|---|---|
| Being human | Using own skills |
| | Adapting modus operandi |
| | Companionship versus solitude |
| Being an employee | Colleagues |
| | Coping with work-related changes |
| | Unpredictability |

### *Being human*

The main theme of Being Human described the individual strategies participants used to cope during the pandemic. It included three subthemes, *Using own skills*, *Adapting modus operandi*, and *Companionship versus solitude*.

**Using own skills.** Participants stated that they tried to use different therapeutic skills on themselves, which helped them carry on with their lives during the COVID-19 related lockdown. Some of these included "watching […] catastrophic thinking," "using compassion focussed techniques on [themselves]," "trying to be kinder about the fact that [they] can't always give 100%" as well as "trying not to be too hard on myself and compare myself to others, especially in terms of lockdown productivity." Some participants started to "use mindfulness techniques" or "mindfulness practice daily," "focussing on grateful awareness of what [they] have in [their] life." Others turned to have "predictability" by "keeping structure and routine where possible."

**Adapting Modus Operandi.** Participants attempted to "simplify aspects of [their] home and work life, to try and make things easier" and to ensure "[their] basic needs are getting met." Some participants indicated they changed their eating practices by "less wasting of food," "having to be more creative with ingredients," "trying … baking," and "cooking fresh and healthy food." One participant had "bought a nutribullet" while others voiced "eating better," "eating well," or eating "healthy food." However, for some participants the change to eating practices meant turning to "chocolate and biscuits" and "drinking alcohol."

Further, some participants introduced the physical activity to their daily routines by "exercising," "walking" or going "for a long walk every day with the dog," "doing yoga," "running," or "trying to get up and move around." Some participants also attempted to "keep busy" by "decluttering the house," "trying to do nice things at home, for example, […] gardening, home improvements/ DIY" or "watching trashy TV."

Participants found it "harder to ensure work-life balance" and in an attempt to do so they set "clear boundaries between work time and family time," ensured "not working late at night," were "strict on working hours and breaks" or tried to "stick to contracted hours." In addition, they were also "taking back the time if [they] do have to work longer one day," "taking regular breaks," "taking weekends completely off" and ensuring they take "annual leave so can switch off."

**Companionship versus Solitude.** Some participants said that staying "connected to friends and family as much as possible," whether remotely or by phone contact "through zoom, Facetime … phone and video calls" or "seeing family via social distancing" helped them to cope during the pandemic. Attending "social events on zoom," "sharing funny videos and jokes" and participating in "family quizzes" online was also perceived as helpful. Other participants highlighted they enjoyed "more family time" as it allowed them to spend "time with … " and "connect with [their] children."

Participants described engaging in activities they could do on their own as important, such as "reading," "arts and crafts" including "sewing projects and sketching," "enjoying the quiet" or just "doing things [they] enjoy."

### *Being an employee*

The main theme of Being an Employee described the changes implemented to participants' working routines or their work activities either by themselves or their employer and which were helpful in minimising the stress related to COVID-19. It also depicted the stressors participants faced during what felt like an unprecedented period and constant change. It includes three subthemes, *Colleagues*, *Coping with work-related changes,* and *Unpredictability*.

**Colleagues**. Participants found their colleagues a source of both informal and formal support during the lockdown due to COVID-19. In terms of the former this was felt through "ad hoc chats … ," "frequent catch ups with colleagues," "regular phone check-ins … ," "talking to trusted friends or colleagues" or even setting up " … a virtual coffee break for my team to get back some of our social contact in work" and having "remote lunch with team." The latter appeared to be used for "phoning colleagues for debrief when needed," "more frequent peer support,""regular team meetings," "morning check ins and updates with my team" and even connecting " … with other psychologist leads from neighbouring

trusts" as well as "supporting staff in our team and the wider trust."

**Coping with work-related changes**. Participants highlighted a number of changes to their usual ways of working, which allowed them to keep abreast of workload duties activities when working from home also meant looking after their children. For some, these included changing " … work hours so to start early when kids are asleep and no emails coming in" or "working longer hours but having more breaks to enable home schooling and supporting other family members," as well as having "more flexibility with time." Others started "prioritising tasks," focusing "on a day at a time" and "on what [they] do achieve each day, rather than what [they] don't".

The COVID-19 related lockdown appeared to have also altered participants' nature of work. This included having "COVID related crisis input only," "raising risks up through trust," or "completing risk assessments … " as well as "trying to keep in touch with clients even if [clinical] work has paused." Some participants highlighted "accessing extra supervision" or having "increased supervision sessions with line manager" and "being open at work re. how I'm feeling" as useful strategies to manage their feelings.

***Unpredictability***. Participants highlighted a number of issues they faced both in personal and professional lives that were a source of heightened state of arousal and stress. Changes to daily routines during COVID-19 related lockdown meant that some participants experienced "social isolation due to living alone." Some participants felt that despite governmental advice to work from home where possible, they were "being pressured to work within COVID environment" and felt "pressure from managers to come into offices to be visible." Others found "working out new ways of working in line with restrictions," "getting to grips with the new technology," and "online/phone/computer working … draining."

Participants found it "difficult to maintain boundaries between work and home" because they needed to manage "information about work traumatic and distressing incidents coming into [their] home" as well as to cope with "sudden transitions from being in work mode to being a parent." They highlighted "hearing [their] children upset/fighting when […] working has reduced [their] concentration."

Additionally, some participants raised their concerns about "understaffing," "increased responsibilities at work," needing to respond to "multiple managerial demands with short time frames" and "constant changes to the guidelines" as well as "constant changing of goal posts and action cards." Some participants felt that "poor communication" and "mixed messages" led to "confusion and uncertainty."

Participants also felt the "policies do not consider individual needs of patients" and that they needed to tackle "more barriers than faced by our colleagues in general adult mental health" as "for [their] client group … [they needed to deal with] things not considered by upper management such as being able to use the technology, having access to a Smart device, or even having good WIFI." Some participants also found it "much more difficult than usual to conduct meaningful therapeutic work due to not being able to see clients/carers in person" and were concerned not only "about the impact that the withdrawal of their usual supports e.g., outreach support cancelled, colleges and day services close had on [their] clients and their carers/families" but also about "meeting future waiting list demands."

## *Triangulation*

Our quantitative findings were grouped into four key categories: (a) redeployment, (b) changes, (c) mental wellbeing, and (d) occupational stress and change of role. The results following triangulation of the key quantitative findings and qualitative data are shown in Table 5.

Consistent with our quantitative findings about redeployment, respondents indicated that redeployment was an issue for them and were worried about possible redeployment, even if this had not happened. However, there was silence with regards to being redeployed away from working with people, although concerns about this happening were noted. There was also silence about redeployment away from a psychology role.

Considering changes due to COVID-19, there was an agreement regarding increased worries about health and clients, increased busyness, and the use of telephones and video conferencing with clients. There was partial agreement about working at home and a shortage of PPE. We found agreement that wellbeing had been affected due to the pandemic, but silence about this being similar to other groups. There was agreement that there was a relationship between an increasing number of COVID-19 related changes and mental wellbeing, as well as the relationship between occupational stress and mental wellbeing and *vice versa*. There was also agreement that learning a new work role while juggling demands at home was associated with poorer mental wellbeing, and partial agreement suggesting

**Table 5.** Results from the triangulation of quantitative and qualitative data. Comparisons were made with each key finding from the quantitative analysis and the qualitative data. The relationship was coded as (a) silence, (b) dissonance, (c) partial agreement or (d) agreement.

| | Quantitative finding | Qualitative data summary | Relationship |
|---|---|---|---|
| Redeployment | A quarter of psychologists had been redeployed into a different role. | Seven instances where redeployment, including some mention of redeployment of colleagues, or worries about potential redeployment were discussed. | Partial Agreement |
| | Thirteen psychologists were no longer working with people with intellectual disabilities. | Two instances where a discussion about redeployment to a service not working with people with intellectual disabilities was reported, but this had not actually happened. No further instances. | Silence |
| | Five psychologists were no longer working in psychology. | – | Silence |
| | A lot of psychologists were worried about their health, the health of their family, and clients. | Two instances of worries about family members at risk, one of clients at risk, one about unwell colleagues and one about own health. One instance of discussion of feeling guilt about not service offered to clients and impact upon family. | Agreement |
| Changes | Psychologists reported being very busy at work. | Five instances where participants reported increasing busyness, increase in meetings, demands, focus upon targets. | Agreement |
| | Most were working at home. | One instance where increased home working was discussed, two of working both from home and at hospital base and one instance where no changes to work location occurred. | Partial Agreement |
| | Many now had to use telephone calls or video conferencing with their clients more frequently. | Five instances where using online videoconferences or telephone calls were discussed, including uncertainty about skills using technology, or problems with technology. | Agreement |
| | Five had a shortage of PPE | One instance where lack of PPE was discussed. | Partial Agreement |
| Mental Wellbeing | Wellbeing was lower than before the pandemic | Four instances where either reduced confidence, feeling helpless, feeling as if they are not keeping up, impact upon mental health was discussed. | Agreement |
| | Wellbeing was similar what other groups had experienced during the pandemic. | – | Silence |
| | Encountering an increased number of changes due to COVID-19 (changes to the usual way of coping, problems with equipment, social isolation at work, illness due to COVID-19 or other illness, practical difficulties like technology not working) was associated with poorer mental wellbeing. | Seven instances where either questioning skills and ability due to changes, problems with technology not working, trying to cope with changes, change in demands, change to nature of work, lack of boundaries associated with changes to work, and juggling work and home responsibilities and impact upon mental health were discussed. | Agreement |
| | Feeling more occupational stress predicted poorer mental wellbeing; poorer mental wellbeing predicted more occupational stress. | Five instances where lack of clarity about roles and responsibilities, changes to work demands, focus upon just getting things done, change to role, and increased guilt because of changes were discussed. Four instances where either effectiveness changed, reported pressure to work in environment where risk of COVID is higher, impact upon confidence, reporting too much to do and not keeping up, or difficulties with transitions between work and home life were noted. | Agreement |
| | The challenge of learning a new work role while juggling demands at home was associated with poorer mental wellbeing. | Six instances where either difficulties with using technology led to impact upon confidence and skill mastery, feeling helpless, problems with working psychologically with clients from home, difficulties with looking after children while working, feeling guilt while juggling home and working life, or managing transitions while working at home were discussed. | Agreement |
| | More reported worry about clients was associated with higher mental wellbeing. | Three instances where concerns were expressed about increased difficulties for people with intellectual disabilities relative to other service users, wider strategic changes within organisation have not prioritised needs of people with intellectual disabilities, or experience of guilt for not doing enough to support clients. No instances where such was associated with higher mental wellbeing. | Partial Agreement |
| Occupational stress and change of role | Overall, occupational stress was not high and was lower than other groups pre-pandemic. | – | Silence |
| | Psychologists were confused about their role. Role confusion was associated with experiencing more changes due to COVID-19, more challenges and demands, experiencing less work satisfaction, feeling less effective at work, and worrying about clients more. | Six instances where confusion about roles and responsibilities, increase in demands, change to nature of work, concern that expertise is not being well used, guilt about not supporting clients enough, unclear expectations, confusion or uncertainty were discussed. | Agreement |
| | Uncertainty about work role was associated with more occupational stress. | Four instances where uncertainty or confusion about role, lack of clarity about role, changes to role, or unclear expectations was discussed. | Agreement |
| | Participants who had reported a shortage of PPE in the NHS had higher occupational stress. | One instance where worry about having to engage in face-to-face sessions with shortage of PPE. | Agreement |

that psychologists were worrying about clients more, but not that this was associated with improved mental wellbeing. Finally, we found agreement that psychologists were confused about their role and there was evidence that uncertainty or a shortage of PPE was associated with occupational stress, but silence about occupational stress being lower than other groups before the pandemic.

## Discussion

Our findings indicated that a quarter of NHS employed psychologists working with people with intellectual disabilities who responded to our survey were redeployed following the implementation of the national lockdown within the UK, and of those redeployed, the majority were no longer working with people with intellectual disabilities. Considering the substantial needs of people with intellectual disabilities, and the challenges of recruiting staff to work within this specialist area, redeployment of psychologists away from working with this population is of serious concern. Further, five registered psychologists who responded to our survey were redeployed to a non-psychology role. The redeployment of a highly skilled group of mental health professionals into non-psychology roles is counter-indicated considering the marked mental health needs of the general population during the pandemic (Rossi et al., 2020; Torales et al., 2020; Xiong et al., 2020).

The psychologists who responded to this survey were experiencing poorer mental wellbeing, like other groups during the pandemic (Allen et al., 2020; Mead et al., 2020; Savage et al., 2020). However, levels of occupational stress among psychologists appeared lower than other professional groups before the pandemic, which includes samples of NHS staff (Edwards et al., 2008), although they experienced increased difficulties with understanding their role, including clarity about their duties and responsibilities, expectations, and how their work fits with the wider NHS. This was associated with changes that had been implemented because of COVID-19, increased challenges and demands, as well as more worrying about clients, and poorer work effectiveness and satisfaction. It is unsurprising that psychologists who previously had been working directly with people with intellectual disabilities experienced increasing difficulties with understanding their role during lockdown, considering the changes and challenges that had been caused by the measures implemented to attempt to control the pandemic, leading to substantial changes to routine working practices.

We also found that the wellbeing of psychologists during the pandemic was associated with increasing occupational stress, including learning a new work role while attempting to juggle home demands, and changes to the usual ways of coping, social isolation at work, and practical difficulties such as technology and equipment difficulties. However, worries about clients were associated with greater mental wellbeing, which appears counterintuitive. We speculate that in the case of the unprecedented challenge of COVID-19, this specific worry may be used as a coping strategy that leads to the suppression of other negative thoughts. There is some evidence that worry may have beneficial effects among those who are not pathological worriers (Ottaviani et al., 2014).

The psychologists who responded to our survey articulated making use of therapeutic interventions on themselves to help cope during lockdown, while trying to ensure they looked after themselves by eating well, exercising, and maintained boundaries between their home and professional life. However, difficulties maintaining these boundaries were noted by some. They also reported actively using technology to engage with family and friends or making use of strategies to minimise risk during social contact.

Considering work, psychologists communicated that they actively sought out contact with work colleagues using technology and phone calls and had to make changes to accommodate managing their home lives together with their working lives. Some described responding only to crisis, and tending to check in with clients rather than doing work in a similar manner to what would have happened before the pandemic and associated lockdown. At the same time, others disclosed that they felt under pressure to come to work regardless and attempted to figure out how to work within the context of the restrictions that were introduced, including getting to grips with using technology. They reported difficulties maintaining boundaries while working at home, as they had to deal with client information that was distressing within their home while they were also providing care to children. They communicated information that was consistent with their questionnaire reports that they had experienced a lack of clarity about work expectations, duties, and responsibilities. They also communicated concerns that people with intellectual disabilities may have additional difficulties with changes to service provision, including making use of technology to access clinical services within the context of the withdrawal of other supports such as education and social care support, and this group are likely to require additional support to make effective use of technology. When our key quantitative findings and our qualitative data were triangulated, general support for the majority of our findings was found.

There are some noted strengths and weaknesses to our study. First, completing an online cross-sectional survey allowed us to rapidly ascertain the views and experiences of psychologists who work with people with intellectual disabilities, while on the other hand, it is difficult for us to confirm that our sample is representative of all psychologists working with people with intellectual disabilities in the NHS within the United Kingdom. Second, it is the case that while we are unable to conclude there is any causal relationship between the variables investigated within our survey, which is a weakness, our questionnaires were anchored to the period of time when the restrictions were implemented, and where possible, we compared our data to data collected prior to the pandemic or during the pandemic using different samples. Further, our thematic analysis of free text allowed for a richer exploration of what was happening for psychologists, and the findings are consistent with the quantitative data generated from our survey as supported by triangulation. We did not collect data about whether participants were working within community or inpatient psychiatric settings, nor did we collect data to allow for the identification of NHS Trusts. The nature and degree of changes encountered due to the pandemic may have disproportionately affected staff working within community settings relative to inpatient psychiatric settings, but unfortunately, this could not be described.

Our findings indicated that changes implemented during the pandemic had a general negative impact upon psychologists working with people with intellectual disabilities. However, there are some specific findings that have implications for practice. Considering the needs of people with intellectual disabilities during the pandemic and considering the skillset of psychologists in intellectual disability services, it was surprising that NHS Trusts redeployed psychologists away from working with people with intellectual disabilities or within non-psychology roles. Further, the changes introduced because of the pandemic, increasing challenges and demands within both work and home, were associated with poorer mental wellbeing and increased role confusion about how to continue to work with people with intellectual disabilities. Going forward, greater clarity is needed around policies for continuing to engage people with intellectual disabilities when face-to-face contact is not possible. Related to this, our findings suggested that there were concerns about whether people with intellectual disabilities were able to make use of technology effectively to allow for continued therapeutic work. Our qualitative data indicated that some respondents were concerned that people within intellectual disabilities were being left behind as the use of technology was increasingly used, and their specific needs were not being considered effectively. Specifically, some commented that people with intellectual disabilities must overcome further barriers relative to other service users without disabilities, and these challenges were not prioritised. This appears to be an area that requires further investigation, as additional support and adaptations may be required to enable the successful use of technology with this population. Going forward and moving away from the pandemic, the use of such strategies, if appropriately adapted to meet the needs of people with intellectual disabilities, may prove to have advantages.

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## Disclosure statement

No potential conflict of interest was reported by the author(s).

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