Healthcare Professionals at Work

by

Malcolm Clayton

A thesis submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology

Coventry University, Faculty of Health and Life Sciences

University of Warwick, Department of Psychology

April 2021

Contents

List of Tables Page

List of Figures Page

List of Appendices

List of Abbreviations

ACT	Acceptance and Commitment Therapy
BPS	British Psychological Society
CP	Clinical Psychologist
HCW	Healthcare workers
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
PC	Palliative Care
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation and Research type

Acknowledgements

Firstly, my gratitude and thanks goes to the participants I met during my research. Their generosity and openness in sharing their experiences has been inspiring and I am truly thankful for their contributions, without which there would be no thesis.

I would also like to say thank you to Dr Lesley Harrison for her support in the early stages of development of my empirical paper. Our discussions helped keep me on the right path. I would like to say a special thank you to Dr Magda Marczak. From the very start of my clinical psychology journey, and all through this thesis project, your support has been unwavering. It has been an absolute privilege to have been guided by such a dedicated and encouraging supervisor.

To my cohort, for always being there when I needed to catch up, seek support, or be distracted. I would not have made it through this without each and every one of you. I hope we continue to share our clinical psychology journeys, wherever we all end up.

To my New Zealand family, thank you for all your encouragement and support. Mum, your phone calls, messages, and emails have been a constant source of positivity from the other side of the world. I hope we can celebrate together soon. To Paul and Linda, you have helped me in so many ways, thank you for everything.

Finally, to Izzy, Ellie and Hannah. Izzy and Ellie, thanks for all the love and hugs you give me each day, I finally have more time to play. Hannah, this all started with your faith and confidence in me, and words cannot express how much I love you.

Declaration

This thesis was conducted under the academic supervision of Dr Magda Marczak (Chartered Psychologist, Coventry University). Dr Lesley Harrison (Clinical Psychologist, Coventry University) contributed to the thesis planning and in preparation of the interview schedule. All contents of this thesis are my own work, except where it contains work based on collaborative research, in which case the nature and extent of the authors' individual contribution shall be indicated. The literature review was written in preparation for submission to Palliative and Supportive Care, while the empirical paper was written for submission to the Journal of Clinical Psychology. This thesis has not been submitted for any other degree or to any other institution.

Summary

Chapter one is a systematic literature review of qualitative studies investigating palliative care (PC) nurses’ experiences of stress, anxiety and burnout. Literature searches identified 18 studies for inclusion and thematic synthesis identified three main themes: *When work becomes personal*, *The burden on mind and body*, and *Finding meaning and connection*. Nurses’ experiences of stress, anxiety, and burnout are experienced on an emotional and physical level, influenced by organisational and individual factors. Clinical policy and practice implications, as well as future research recommendations, are discussed.

Chapter two is an empirical study exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients. Ten clinical psychologists were interviewed, and interpretative phenomenological analysis resulted in three superordinate themes: *Re-affirming professional identity*, *Navigating change and uncertainty*, and *“Can I go back to my day job?”*. Participants described how their professional identities were impacted, their experiences of navigating uncertainty at home and work, and their difficulties in balancing the demands of their personal and professional lives.

Chapter three is a reflective paper describing the researchers’ experience of undertaking doctoral research. This chapter explores the themes *Learning to trust myself* and *Balancing the different parts of me*, and uses concepts and related ideas from Acceptance and Commitment Therapy (ACT).

Total overall word count 19,627 (excluding abstracts, tables, figures, references, and appendices)

Chapter I: Literature Review

Palliative Care Nurses' Experiences of Stress, Anxiety, and Burnout: A Thematic Synthesis

This chapter was written in preparation for submission to Palliative and Supportive Care. Appendix A provides details of the author guidelines for this journal.

Overall word count 7,737 (excluding abstract, tables, figures, and references)

Abstract

Aim: This systematic literature review aimed to critically appraise empirical evidence investigating palliative care (PC) nurses' experiences of stress, anxiety, and burnout.

Method: Six databases (PsycINFO, MEDLINE, Scopus, CINAHL, PubMed, and Web of Science) were searched covering literature within psychology, medicine and healthcare, and social sciences. Eighteen studies satisfied the review's inclusion criteria and were considered relevant to the review aims.

Findings: Thematic synthesis (Thomas & Harden, 2008) identified three main themes: *When work becomes personal*, *The burden on mind and body*, and *Finding meaning and connection*. The findings suggested that stress, anxiety, and burnout are deeply personal feelings experienced by nurses both on an emotional and physical level. Additionally, PC nurses' experiences can differ in meaning and strength depending on their relationships with patients, patients' families, and colleagues.

Conclusion: Having a greater understanding of the factors that contribute to PC nurses' experiences may help in PC nurses' core training and continuing professional education, as well as the provision of effective supervision and staff support.

Keywords: Stress; Anxiety; Burnout; Palliative Care; Nurses

Introduction

People with advanced life-threatening illnesses, and their families, should expect good palliative care (PC) when dealing with physical symptoms such as pain, breathlessness, nausea, increasing fatigue, anxiety, depression, social, and spiritual difficulties. Management of these issues requires effective and collaborative, multidisciplinary working whether the person is at home, in hospital, or elsewhere (National Institute for Heath and Care Excellence [NICE], 2017).

PC work involves absorption of negative emotional responses, breaking bad news, challenges to personal beliefs, coping with inability to cure, immersion in emotional clashes, poorly defined roles, recurrent exposure to death, working in an area of uncertainty, patient suffering, and secondary trauma (Breen et al., 2014; Rokach, 2005; White et al., 2004). Healthcare professionals in PC settings can face a range of challenging situations while emotional demands on staff can lead to poor psychological well-being (Hill et al., 2016; Martins Pereira et al., 2012).

Stress is a universal experience that affects all human beings. It is a constellation of physiological, cognitive, emotional, and behavioural reactions as a person is confronted with perceived threats and challenges (Beng et al., 2005). Furthermore, chronic occupational stressors have been linked to an increased risk for anxiety and mood disorders (Beehr & McGrath, 1992; Schneiderman et al., 2005). The *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) describes anxiety as prominent tension, worry, and feelings of apprehension about everyday events and problems, including autonomic arousal symptoms such as accelerated heart rate, sweating, trembling/shaking, and dry mouth (World Health Organisation [WHO], 2018).

Burnout is a psychological syndrome characterized by energy depletion, increased mental distance from one's work (shown through cynicism or negativism), and reduced professional efficacy (WHO, 2018). Whilst the first research investigating the concept of burnout took place over 40 years ago, over the last 10 years burnout has become more recognised as a significant psychosocial problem among healthcare professionals linked to unsuccessfully managed chronic stress in the workplace (Maslach & Jackson, 1984; Raudenská et al., 2020).

Several studies have shown that healthcare professionals have a higher risk than other professionals of developing emotional distress related to job stress, such as burnout and anxiety (Embriaco et al., 2007; Escribà-Agüir et al., 2006; Lim et al., 2010; Maslach & Jackson, 1981; McVicar, 2003; Thomsen et al., 1999; Weinberg & Creed, 2000) and an increased risk of suicide and substance abuse (Akvardar et al., 2004; Davidson et al., 2018; Pompili et al., 2006). This has also been shown of those working in PC (Dijxhoorn et al., 2020; Gómez-Urquiza et al., 2020; Powell et al., 2020). For example, exposure to prolonged death, to the death of patients to whom nurses feel close to, to the death of young patients, and to the death of patients with an incurable disease is associated with increased stress and emotional exhaustion (Redinbaugh et al., 2001).

Conversely, some research indicates that levels of burnout may be lower in PC settings. Payne (2001) identified low levels of burnout in 89 palliative care nurses from nine hospitals, while Martins Pereira et al. (2012) in their mixed-methods study showed burnout levels in PC do not seem to be higher than in other contexts. Whilst studies have investigated the psychological well-being of healthcare professionals, both working in PC and more generally, there is still the need to undertake further research to better understand PC staff' experiences of stress and burnout (Gama et al., 2014; Harding et al., 2012; Hill et al., 2016; Jaiswal et al., 2014).

Previous Reviews

Four systematic literature reviews have been conducted to date synthesising available literature in the area of PC. Martins Pereira et al.'s (2011) review included 15 studies published between 1999 and 2009 and exploring burnout in PC staff. Their findings suggested that burnout levels in PC do not seem to be higher than in other health contexts. However, a limitation of this review is that most of the studies included were not from PC settings, and half were from staff working in oncology services. Similarly, Parola et al.'s (2017a) review of the prevalence of burnout in PC professionals included eight cross-sectional studies with a variety of healthcare professionals such as nurses, physicians and social workers. Hill et al.'s (2016) review included nine quantitative studies investigating psychosocial interventions to improve the well-being of staff who work in palliative care settings. They found no meaningful conclusions could be drawn about effective interventions for staff due to the poor quality of the research, furthermore their study was undertaken with a range of participants (paid or voluntary) with no restrictions to any one profession (Hill et al., 2016). Finally, Zanatta et al.'s (2020) review of six quantitative studies on resilience in healthcare professionals providing PC to adults, found resilience moderates and facilitates nurses adaptation to death anxiety, traumatic experiences, stress and burnout. Zanatta et al.'s review (2020) proposed a theoretical model of resilience experience and suggested that further research was required to validate their findings.

There have been several recent systematic reviews undertaken in related areas. Dijxhoorn et al. (2020) investigated interventions for burnout in healthcare professionals providing PC in various settings. Their meta-analysis of 59 studies found a wide range of burnout in various healthcare settings with lower rates in specialist services. They also highlighted that a greater understanding of burnout amongst healthcare professionals in PC was needed (Dijxhoorn et al., 2020).

Nurses spend more time with patients and families than any other health professional in PC and are the most common professionals working in teams (Schroeder & Lorenz, 2018). Lagentu et al. (2017) undertook a systematic literature review of burnout in PC nursing, however, their review only included four quantitative studies. Lastly, Powell et al.'s (2020) systematic literature review of eight qualitative and mixed methods studies focused on the resilience in inpatient PC nurses. They suggested that research on developing a greater understanding of PC nursing staff experiences of stress and burnout from a qualitative perspective is missing (Powell et al., 2020).

Rationale and Aim

To date most research on stress, anxiety, and burnout in PC has been with patients and families. Moreover, much of the research that has been undertaken with healthcare professionals has focused on psychological interventions, developing resilience, or the prevalence of common mental health issues. Where systematic reviews have been undertaken into nurses' experiences in PC, these have mainly been done in home care settings (Sekse et al., 2018). As such, this systematic literature review will address the question: "What are palliative care nurses' experiences of stress, anxiety, and burnout?".

Methodology

Literature Search

Ethical approval was obtained from Coventry University Ethical Committee (Appendix B). The review was also registered on the systematic review protocols in international prospective register (PROSPERO; ID number CRD42020221645). Registration on PROSPERO has been shown to help reduce selective reporting of outcomes and benefit users of health evidence (Sideri et al., 2018; Page et al., 2018).

Searches for studies that have investigated PC nurses’ experiences of stress, anxiety, and burnout were undertaken in December 2020. The databases used included PsycINFO, MEDLINE, Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Web of Science, covering literature within psychology, medicine and healthcare, and social sciences.

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation and Research type) tool was used to identify studies for inclusion in the review (Carroll et al., 2013). The SPIDER tool provides an organising framework by which to list search terms and main concepts (Methley et al., 2014). It has been found to demonstrate high specificity when used to search for qualitative and mixed-methods research (Cooke et al., 2012; Methley et al., 2014). The main concept terms, and synonyms, were searched for within titles, abstracts, keywords, and the main text of studies to increase the probability of identifying relevant research. The truncation operator “*” was also employed to avoid relevant search results being excluded due to minor word differences. An overview of search terms is presented in Table 1.

Table 1

Key Search Terms

SPIDER	Main concept	Synonyms	Location
Sample	Nurses	"nurs*", “healthcare professional", "health personnel", "staff"	Title Abstract Keywords Main text
Phenomenon of Interest	Working in palliative care	“palliative care", "terminal care", "end of life"	Title Abstract Keywords Main text
	Stress and anxiety	“stress”, “anxiety”, “burnout”, “vicarious trauma”, “compassion”, “burnout”, “anticipatory grief”	Title Abstract Keywords Main text
Design		“questionnaire”, “survey”, “interview”, “focus group”, “case study”, “observational study”	Title Abstract Keywords Main text
Evaluation	Experiences	“perception*”, “coping”	Title Abstract Keywords Main text
Research Type	Qualitative research	“qualitative”, “mixed methods”	Title Abstract Keywords Main text

A Boolean search strategy was used, and each search performed using the following search terms: ("nurs*" or “healthcare professional" or "health personnel" or "staff") AND ("palliative care" or "terminal care" or "end of life") AND (“stress” or “anxiety” or “burnout” or “vicarious trauma” or “compassion burnout” or “anticipatory grief") AND (“questionnaire” or “survey” or “interview” or “focus group” or “case study” or “observational study”) AND (“perception*” or “coping”) AND (“qualitative” or “mixed methods”).

Inclusion and Exclusion Criteria

An overview of the inclusion and exclusion criteria is presented in Table 2.

Table 2

Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Language	English	Any other language
Participants	Nurses working in palliative care (PC) setting	Other healthcare professionals, unqualified nurses, patients, families, carers
Experience	Focus on stress, anxiety, or burnout	Focus on any other mental health condition
Methodology	Qualitative research, or mixed-methods studies where qualitative data is extractable	Quantitative only, mixed-methods where qualitative data could not be extracted
Time period	Any time period	N/A

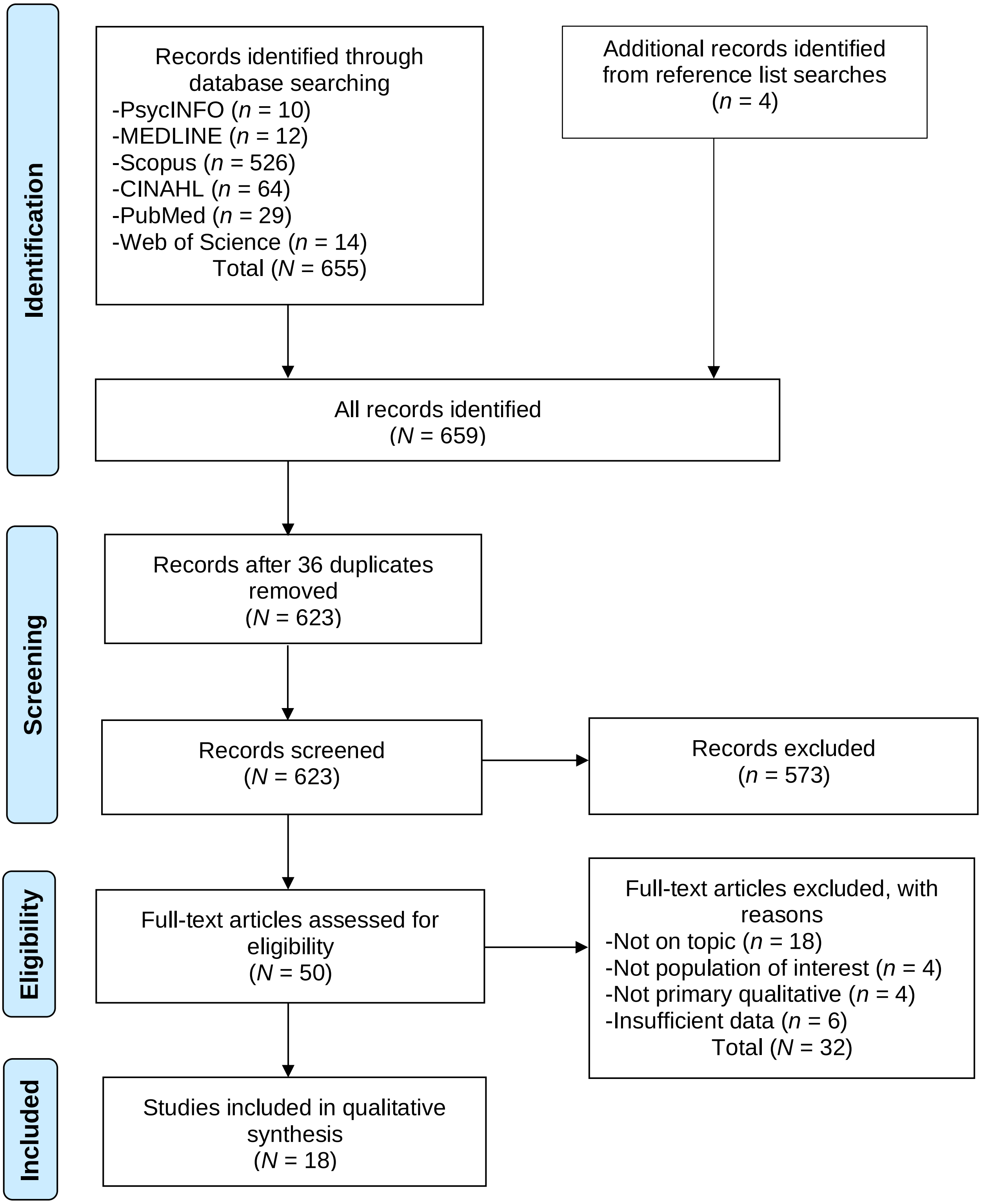
Studies were included if they were published in the English language. Participants were all nurses working in PC settings and studies were included if they focused on the experience of stress, anxiety, or burnout. Also included were qualitative research, or mixed-methods studies where qualitative data was extractable. No limits were placed on study sample size, recruitment method or date of publication. Initial screening of study titles and abstracts against inclusion and exclusion criteria was completed by both the lead researcher and a second member of the research team. Relevant studies were retained, and the full-text of each study was then screened independently by both the primary researcher and a second member of the research team. Any difference of inclusion or exclusion decision were managed by a moderating discussion focusing on the aims of this literature review. For example, comparing studies in PC is challenging due to a lack of an agreed definition of what PC is and when it should be offered (Bausewein & Higginson, 2012; McNamara et al., 2006; Radbruch et al., 2020). Subsequently, it was decided that all studies with settings described as providing PC would be included.

Classification of Studies

Study selection was recorded on a Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) flow diagram (Moher et al., 2009; Figure 1).

Figure 1

PRISMA Flow Diagram (Adapted from Moher et al., 2009)



A total of 655 articles were identified following database searches. Four additional studies were identified after reference checking. After eliminating 36 duplicates, the remaining 623 article titles and abstracts were screened excluding a further 573 articles. The full texts of the remaining 50 articles were reviewed and 32 articles not meeting inclusion criteria were excluded (Figure 1). The final result was 18 studies eligible for inclusion in the review.

Quality Assessment

The critical appraisal and quality assessment of primary research are key stages in systematic review and evidence synthesis, however quality assessment of primary qualitative research remains a contested area (Carroll & Booth, 2015; Garside, 2014; Thomas & Harden, 2008). It has been suggested that quality frameworks should be constructed to reflect the methods used and the discipline within which the research was conducted (Greenhalgh et al., 2005).

The Critical Appraisal Skills Programme (CASP) Qualitative Checklist (CASP, 2018) was used to assess study quality as it is the most commonly used tool for quality appraisal in health-related qualitative evidence syntheses (Long et al., 2020) (Appendix C). The checklist consists of 10 questions to appraise quality of qualitative research. In order to enhance reliability, a second member of the research team conducted independent quality assessment checks on all included studies using the same framework. Following independent quality assessment, three areas were identified for further critical discussion (Q 6. Researcher-participant relationships, Q 7. Ethical issues, and Q 8. Data analysis) and quality rating scores were discussed (Appendix D).

Inter-rater reliability was assessed using Cohen's kappa (*κ*). The overall kappa score was .877, suggesting very good inter-rater reliability (Altman, 1999). Individual paper scores ranged from .615 to 1.00 (Table 3 in Appendix E).

Characteristics of the Literature

The author(s), date of publication, country, aim(s), sampling method, sampling characteristics, data collection, data analysis, and main findings were extracted from the original articles. A detailed description of the characteristics of studies included in this review can be found in Appendix F. A summary of the characteristics of the literature is presented in Table 3.

Table 3

Characteristics of the Literature

Author(s), Date, Country **Quality Rating (QR)** **Inter-rater Reliability (Kappa)**	**Aim(s)**	**Sampling Method**	**Sample Characteristics**	**Data Collection** **Data Analysis**	**Main Findings with Themes**
Badger, 2005, USA QR 80% Kappa *K* = 1.00	To describe Medical Intensive Care Unit (MICU) nurses' coping behaviours	Purposive sampling from a medical intensive care unit	*N* = 24 nurses *n* = 19 female (79%) *n* = 5 male (21%) *N* = 24 identified as white (100%) Aged 24 to 57 years (*M* = 38.7) Nursing experience ranged from one to 35 years (*M* = 13.37) MICU	Data Collection Focus group interviews, informal conversations, and selective participant observation Data Analysis Three phases of analysis described: data reduction, data display, and conclusion drawing (Miles & Huberman, 1994)	Three coping strategies were identified: 1. *Cognitive* – putting up with it, visualizing, learning from experience, reminiscing, and putting things into perspective 2. *Affective* – laughter, externalizing feelings, and emotionally compartmentalizing 3. *Behavioural* – retreating, avoiding, and distancing behaviours Difficulties were primarily seen as the result of conflicts with families and physicians Providing futile care, the perception of 'torturing' the patient, and conflict with families caused the greatest distress to staff

			experience ranged from one month to 35 years (M = 9.44)		
Bailey et al., 2011, UK QR 70% Kappa K = 1.00	To explore how emergency nurses manage the emotional impact of death and dying in emergency work	Purposive sampling from a hospital emergency department	N = 10 No other demographic information provided	Data Collection Unstructured observations of practice and semi structured interviews Data Analysis Thematic Analysis	Emergency nurses develop expertise in end-of-life care giving by progressing through stages of development. Three stages/themes were identified: 1. *Investment of the self in the nurse–patient relationship* – Nurses could see the value in investing the therapeutic self into the relationship but were also concerned about boundaries between professional and personal relationships with patients. *2.* *Management of emotional labour* – Nurses were concerned about the emotional impact of caring for patients near the end of life and their relatives. Some develop distancing behaviours to protect them from grief; however, this can be more stressful over a prolonged period of time. 3. *Development of emotional intelligence* – Self-awareness is central for nurses to develop emotional intelligence. It allows them to reflect on past experiences, core values and identify strengths and weaknesses in their practice

					Barriers that prevent the transition to expertise contribute to occupational stress and can lead to burnout and withdrawal from practice.
Becker et al., 2017, USA QR 90% Kappa *K* = .615	To identify perceptions of nurses regarding their actions to provide quality end of life care for dying patients, their definitions of dying well, and their symptoms of distress and actions they took for relief	Purposive sampling from medical-oncology, surgical, progressive, and intensive care nursing units	*N* = 49 nurses *n* = 42 female (86%) *n* = 7 male (14%) All registered nurses who had worked in an acute care environment for at least 12 months	Data Collection Semi-structured questionnaires Data Analysis Grounded Theory	Three main concepts/themes describing the nurses' definition of dying well: *1. Emotional and spiritual support for the patient and family* *2. Patient and family control* *3. Promotion of a peaceful environment* Eight categories of nursing actions to promote dying well were identified, which included: 1. Communication with disciplinary team/nursing staff 2. Provision of optimal physical care 3. Demonstration of caring and compassion 4. Supporting dignity in death for patient/family 5. Education of patient/family to support dying well 6. Emotional support for patient/family, advocacy for dying well *7.* Fostering a peaceful environment Symptoms of distress among nurses, and actions for relief were also indicated by participants. This included: Sadness, anxiety, crying, feeling helpless, physical symptoms (sleeplessness, headache,

					heart racing, nausea), fatigue, guilt, bewilderment, betrayal, and anger.
Chong & Abdullah, 2017, Malaysia QR 85% Kappa $K = 1.00$	To explore the experience of community palliative care nurses providing home care to children	Purposive sampling from clinical services in greater Kuala Lumpur	$N = 16$ (all female) Aged 24 to 62 years ($M = 29.5$) Nursing experience ranged from one to 25 years ($M = 5$) Palliative care experience ranged from one to 18 years ($M = 2.5$)	Data Collection Semi-structured interviews Data Analysis Thematic Analysis	Two categories were identified: 1. Challenges with four themes: • *Communication* – Conversations with children were challenging, as their thought processes and actions seem less logical than adults and they were found to be more emotional. All nurses acknowledged their inadequate communication skills. • *Training and knowledge* – They felt challenged when parents wanted information about complications of the medical illness and prognosis. Clinical examination and doses of medication were also different from adults. The majority welcomed further training to improve their knowledge and skills. • *Personal suffering* – Providing care to children and their families was found to be a very emotive experience, compounded if they were mothers or had close relatives of the same age. Seeing a young child die was tough on them spiritually and being present with grieving parents and extended families overwhelmed

					some nurses. Parents with seemingly unrealistic expectations also challenged them in providing care for their child. • *Systemic* – Busy workloads made it difficult to juggle home visits and to deal with paediatric procedural emergencies. 2. Coping with three themes: • *Intrapersonal* – Nurses coped by being mentally focused and emotionally prepared, maintaining professional boundaries with compassion. Nurses felt the learning experience from each family enhanced their confidence and resilience. • *Interpersonal* – Colleagues are a source of emotional support and guidance. Sharing with close family members was also an important way to cope. • *Systemic* – Nurses valued teamwork, while reflective sharing and debriefing sessions in a safe work environment was useful.
Gélinas et al., 2012, Canada QR 80%	To describe stressors experienced by nurses in providing end-of-life palliative	Purposive sampling from nurses working in ICU	*N* = 42 *n* = 40 female (95%) *n* = 2 male (5%)	Data Collection Focus groups Data Analysis Content Analysis	Three categories of stressors were found: *organizational*, *professional*, and *emotional*. 1. *Organizational* stressors included a lack of a palliative care approach, interprofessional difficulty, lack of

Kappa *K* = 1.00	care (EoL/PC) in intensive care units (ICUs)		Mean age 35.4 years ICU experience ranged from 6.6 to 14.1 years	(Miles & Huberman, 1994)	continuity in life-support and treatment plans, and conflicting demands. 1. *Professional* stressors included lack of PC competencies and difficulty communicating with families and collaborating with the medical team. 2. *Emotional* stressors were described as value conflicts, lack of emotional support, and dealing with patient and family suffering.
Harris, 2013, USA QR 90% Kappa *K* = 1.00	To understand nurses coping process and adequacy of workplace coping resources	Purposive sampling from nurses working in hospices	*N* = 19 *n* = 18 female (95%) *n* = 1 male (5%) *n* = 16 (84%) were white women, ranging in age from 45 to 54 years Average nursing experience was over 10 years, however most participants had five years or less experience in hospice care	Data Collection Focus groups Data Analysis Content Analysis	Three major themes were identified: 1. *Social support* – The most helpful and most frequently used coping mechanism was talking with and/or venting to others. In particular, they relied most heavily on their co-workers in times of stress. Although sharing with spouses or significant others was cited, many believed that their colleagues were the best outlet because they could speak freely about the situation. 2. *Humour* – All participants spoke of the importance of laughing and believed that humour helped to take their minds off distressing thoughts or stressful situations. It was not uncommon for them to use it in their practice for those very same reasons. 3. *Prayer/meditation* – Taking time for meditation or reflection seemed to be discussed interchangeably with the

					concept of prayer. A majority perceived prayer and/or spirituality to be an essential part of their coping process.
Johansson & Lindahl, 2012, Sweden QR 90% Kappa $K = 1.00$	To describe the meanings of nurses' experiences of caring for palliative care patients on general wards in hospitals	Purposive sampling from acute surgical and medical care settings in two hospitals	$N = 8$ (All female) Nursing experience ranged from three to 32 years None of the nurses had any special education in palliative care	Data Collection Semi-structured interviews Data Analysis Thematic Analysis	Seven themes were identified: 1. *Being grateful to be able to share in the end of another's life* – Constantly working towards the goal of achieving the best care for patient and loved ones. 2. *Being touched by physical and existential meaning* – Experiencing a feeling of discomfort over the rapid changes to the patients' bodies. 3. *To exist in place and space* – A desire to have a separate unit for palliative care and *"'long for a special and sheltered place'"* (p. 2038) with the resources to satisfy the needs of the patients and their family. 4. *To give and receive energy* – Working with terminally ill patients costs the nurses much energy, however, caring for the terminally ill and their families means getting a lot back in return. 5. *Being open in relation to patients and colleagues* – Availability and closeness are prerequisites for being able to see and get to know the patients and families to meet and deliver care to them

					6. *Being in embodied knowledge* – The need is not always for new external knowledge but knowledge of oneself as a person and how to use one's lived knowledge. 7. *Time that does not exist* – Being unabl keep up with the work as they would lik evokes feelings of stress and dissatisfaction.
Jordan et al., 2014, South Africa QR 95% Kappa $K = 1.00$	To explore and describe the experiences of nurses with regard to end-of-life issues in the intensive care unit	Purposive sampling from an intensive care unit of a private health-care institution	$N = 9$ (All female) All permanently employed. All with experience of end-of-life issues in the intensive care unit	Data Collection Semi-structured interviews Data Analysis Thematic Analysis	Four major themes were identified: 1. *Conflicting emotions* – Nurse's experience conflicting emotions and inability to function as a patient's advocate when faced with withdrawal of life-sustaining treatment. 2. *Family relations* – A supportive relationship with family members was formed when caring for end-of-life patients and the need for support and family involvement was evident. 3. *Multidisciplinary team relations* – A need for more effective team collaboration was expressed . 4. *Supportive strategies when dealing with end-of-life issues* – Supportive strategies, for instance debriefing, use of a counsellor, education, were recognised.
Källström Karlsson et al., 2008,	To discern the nurses' thoughts,	Purposive sampling from an	$N = 5$	Data Collection	Three descriptive claims were identified in 1993:

Sweden QR 85% Kappa *K* = .630	feelings, and attitudes towards death and dying	inpatient hospice ward based at a university hospital.	No other demographic information provided	Semi-structured interviews (In 1993 and 2004) Data Analysis Interpretive descriptive method	1. *Deeper insight* – Realisation that death would come to them 2. *Changed values* – Life today is here and now 3. *Not thinking of death* – Creating a barrier against death in leisure time Four descriptive claims were identified in 2004: 1. *Adapted to death* – Being in close proximity to death 2. *Integrated values* – In-depth living in the here and now 3. *Not thinking of death* – Maintaining a barrier against death in leisure time 4. *Feelings of confidence* – Feeling confident about changes in themselves
Kaup et al., 2016, Sweden QR 90% Kappa *K* = 1.00	To highlight nurses' experiences of caring for patients in palliative care at midlife and describe their coping strategies	Purposive sampling from specialized palliative home care teams	*N* = 14 (All female) Aged 42 to 60 years Palliative experience ranged from one to 25 years	Data Collection Semi-structured interviews Data Analysis Systematic text condensation (STC) and abductive analysis	Three main themes were identified: 1. *Significance* – Experiences of significance included feeling admiration for the patients, becoming invigorated by their encounters with their patients, and getting confirmation that they did well. 2. *Stress related to the profession* – Participants described how they were affected by external influences such as meetings with patients and their families. Psychological stress, and stress-related symptoms including exhaustion, headaches, dizziness, and stomach pains.

					3. *Coping strategies* – Their own family was an important source of new energy outside the job, and many of the informants described that they had very active lives with friends and with physical training. Participants stressed the importance of having a smooth-running team and having support on an organizational level through the head nurse.
McCloskey & Taggart, 2010, UK QR 75% Kappa *K* = 1.00	To explore the experience of occupational stress from the perspective of nurses contributing to the palliative care of children	Purposeful sampling from three children's PC services	*N* = 18 No demographic information provided	Data Collection Focus groups Data Analysis Thematic content analysis (Newell & Burnard, 2006)	Four core themes were identified: *work demands; relationships, maintaining control, and support and roles*. Of particular note were stressors associated with the sub-themes of relationships, emotional demands and ethical conflicts. 1. *Demands* – This theme is based upon workload, work patterns and the work environment. 2. *Relationships* – The dominant discourse within this theme related to relationships between the nurse and the child and/or family. *3. Maintaining control* – Nurses from across the three settings identified maintaining control as a stressor. The HNs recounted the unpredictable nature of their working day, the juggling of competing demands, the need to re-prioritize their caseload and lone working as stressful consequences of their role

					4. Support and roles – Two clear sub-themes emerged, managerial support and role ambiguity.
McNamara et al., 1995, Australia QR 60% Kappa *K* = 1.00	To demonstrate how hospice nurses perceive stress in their work environment and cope with caring for dying patients	Purposeful sampling from in-patient and community-based hospice services	*N* = 22 *n* = 20 female (91%) *n* = 2 male (9%) Aged 25 and 62 years PC experience ranged from six months to 11 years	Data Collection Interviews and participant observation Data Analysis	Five sources of stress were identified: *1. Societal values and reaction* – Hospice nurses agree that dying and death are still subjects that most people would rather not discuss. *2. Organisation of the work environment* – Many of the difficulties and stresses that hospice nurses experience in their care of those who are dying relate to the structural conditions of their work. 3. *Exchanges between nurses and the patients and their families* – Positive experiences between patients, their families, and nurses validates nurses' sense of self-worth and values. *4. Exchanges between nurses and their families, friends and colleagues* – Nurse's personal networks developed between family, friends and colleagues feature most strongly as both a source of stress and support for hospice nurses. *5. Personally facing death* – Hospice health professionals must deal with the realities of death and dying within the context of their daily activities. Inevitably these contacts with the dying trigger personal responses

					Many of the stresses encountered by hospice nurses relate to the sensitive nature of their work. Not only are their patient’s frail, ill and frightened, the patient's families and friends are themselves vulnerable, unwillingly thrust into the act of final parting and entering the grieving process even before the death of a loved one.
Reid, 2013, UK QR 85% Kappa K = 1.00	To highlight challenges perceived by nurses when delivering palliative care to children and young people (CYP) in the home	Purposive sampling from community nursing teams	N = 10 (No gender details provided) Nursing experience ranged from 15 to 42 years (M = 29.5) Four had palliative care qualifications, and four had children’s experience	Data Collection Semi-structured interviews Data Analysis Content analysis and thematic analysis	Four interrelated and overlapping themes were identified, illustrating the complexity of delivering palliative care to CYP. 1. *Emotional preparedness* – Most described being underprepared to deal with the emotional impact of the death of a CYP. Rather than the younger participants or those with least experience, it appeared to be those without a child nursing qualification who struggled to reconcile themselves with the concept of child death. 2. *Navigating the ‘professional road’* – Many reported difficulties with discharge planning, late introduction and inclusion of families, and multi-agency input confusing their own perceptions of their roles, boundaries, and responsibilities. 3. *Becoming part of the family* – Over half of the participants found working in balance with the extended family, parents, and the CYP unusual. All

					described some challenges in maintaining professional boundaries, with some portraying themselves as a ‘pseudo-member’ of the family. 4. *It’s everybody’s business* – Small teams meant the ability to rest and relinquish practical and emotional responsibilities were limited. While working in small communities also meant there were risks of prejudging the family, potential breaches of confidentiality, lack of nursing anonymity, and the pressure of being a supportive pillar for the entire community.
Rose & Glass, 2009, Australia QR 90% Kappa *K* = .706	To explore nurses’ experiences of providing PC with a focus on emotional well-being and its relationship to professional practice	Purposive sampling from community nursing teams	*N* = 15 (All female) No other demographic information provided	Data Collection Semi-structured interviews and reflective journaling Data Analysis Hierarchical content data analysis (Patton, 1990)	Two main themes and four subthemes were identified. *Feeling balanced* was used to depict nurses’ experiences of well-being whilst the theme *Out of balance* captured the complexity of feeling emotionally unwell: 1. *Feeling balanced* – Balance was intrinsically linked to their well-being and their emotional, physical and spiritual health. It included four subthemes of: Being self-aware, Coping, Feeling spiritually enriched, and Settling boundaries. 2. *Feeling out of balance* – This theme discussed interconnectedness between their emotional, physical and spiritual selves to describe feeling out of balance. Physical tension, distress

					sadness, restlessness and irritability were reported. Mind racing, sleeplessness and worrying caused ongoing effects leaving some nurses depleted of energy.
Seed & Walton, 2012, USA QR 95% Kappa *K* = 1.00	To gain understanding of the challenges faced by nurses and to explore how they cope with these challenges	Purposive sampling from four hospices	*N* = 12 *n* = 11 female (92%) *n* = 1 male (8%) No other demographic information provided	Data Collection Semi-structured interviews Data Analysis Grounded Theory	The core category was *Caring for Self* with two supporting categories: *Facing the Challenges* and *Implementing Ways of Coping*. *Caring for Self* included spirituality, social support, hobbies, having fun outside work, building relationships, and keeping work and home life separate. It also involved nurturing the physical, spiritual, social, and psychological self. Participants talked of healthy self-care practices such as yoga and meditation and the ability to self-soothe and relieve stress, as well as identifying self-care deficits. *Facing the Challenges*: All participants expressed difficulty in managing their time effectively. Being drawn into family dynamics and setting boundaries were a challenge for most participants. Many participants stated that setting boundaries is nearly impossible but being aware of stepping over boundaries and knowing when to step back are necessary to prevent burnout and excessive emotional grief.

					Implementing Ways of Coping: Being able to ask team members for help is integral in dealing with burnout and a healthy team, who cares for self, is more able to cope with stress and burnout. Maintaining therapeutic relationship and having formal closure processes after death occurs are vital. If missing, guilt and the additional stress can be a burden. Finally, finding a balance between the multifaceted workplace challenges and personal life stressors was crucial to their own health and well-being.
Tunnah et al., 2012, UK QR 95% Kappa *K* = 1.00	To explore the feelings and experiences of hospice at home nurses when providing palliative nursing care for patients in the community	Purposive	*N* = 7 (all female) No other demographic information provided	Data Collection Semi-structured interviews Data Analysis Grounded Theory	Four categories were identified: 1. *Job satisfaction* – Identified as an important determinant of nurses' stress levels. 2. *Stressors* – Included conflict with colleagues from outside the team and difficulty communicating with GPs and district nurses as sources of stress. 3. *Coping strategies* – Nurses identified the need to 'switch off after work. Their strategies included walking and exercise, television, music and craft. 4. *Support* – Nurses identified support from colleagues as being important for their coping.

Wilkes et al., 1998, Australia QR 80% Kappa *K* = .756	To describe nurses' personal constructs of stress	Purposive sampling from community nursing teams	*N* = 21 (all female) No other demographic information provided	Data Collection Open-ended questionnaire and semi-structured interviews. Data Analysis Not explicitly stated[1]	Four themes were identified: 1. *Lack of control, lack of time* – Nurses found it particularly stressful when relationships with families were strained leading to conflict in care. Time was too short due to workload and lead to overload on nurses. 2. *Inadequacy/overload* – Some nurses felt useless and overloaded. Stress was generated for the nurses by the expectations of many stakeholders including themselves. 3. *Inability to cope* – Some nurses felt unable to cope. Coping strategies included talking and sharing experiences with another nurse, with the bereavement counsellor, with the palliative care team or reflecting on their experience alone. 4. *Lack of knowledge* – Some nurses felt they had lack of knowledge to give proper answers. An overwhelming expectation that caused a number of nurses' stress was the demands of family or client to go beyond what the nurses considered the boundaries of their role, for example to be a counsellor when nurses felt it was beyond their skill.

---

[1] Data was coded, categorised and themes identified

Yang & Mcilfatrick, 2001, Taiwan QR 80% Kappa $K = 1.00$	To explore the experiences of intensive care nurses caring for patients who are dying.	Purposive sampling within ICUs	$N = 10$ (No gender details provided) Aged 22 to 32 years. ICU nursing experience ranged from 2 to 12 years.	Data Collection Semi-structured interviews Data Analysis Colaizzi's Descriptive Phenomenological Analysis (Collaizzi, 1978)	Analysis identified 13 main themes, categorized into three groups: *Nurses' attitudes*, *Stressors* and *Coping strategies*. 1. *Nurses' attitudes* – The most common feelings that emerged from the data analysis were those of fear and guilt. This sense of fear and guilt was coupled with a sense of powerlessness and frustration relating both to nurses' inability to alter the ultimate outcome for patients or take away the family's grief. 2. *Stressors* – ICU nurses have many diverse demands made on them, which they reported as being stressful. Four themes were identified: the relationship between physician and nurse, family's emotional reactions, concealing illness or prognosis from patients, and do not resuscitate orders. 3. *Coping Strategies* – ICU nurses are often confronted with stressful situations and they must learn to cope and manage stresses in order to function effectively in the ICU setting. Providing good nursing care and religion and beliefs were highlighted in this study.

Analytic Review Strategy

Thematic synthesis was used to develop descriptive and analytical themes that extend the primary research studies to generate new interpretations (Thomas & Harden, 2008). This approach enabled an enhanced comprehension of the experience of stress, anxiety, and burnout than each individual study permits individually. Thematic synthesis involves three stages of analysis (Table 4; screenshots and examples from each stage can be found in Appendix G, H, and I respectively). In order to undertake the synthesis and ensure rigour in analysis, NVivo 1.4 was used at each stage (Alhojailan, 2012; Houghton et al., 2017; Thomas & Harden, 2008). During Stage two, visual mapping was also used to support theme development.

Table 4

Thematic Synthesis Stages (as adapted from Thomas & Harden 2008)

Stage	Description
1	Line-by-line coding of the findings of primary studies. Each study is coded to facilitate the *translation* of concepts from one study to another. This builds up a ‘bank’ of codes and also generates new codes.
2	The organisation of these 'free codes' into related areas to construct or 'descriptive' themes.
3	The development of 'analytical' themes.

Results

This thematic synthesis addressed the question: “What are PC nurses’ experiences of stress, anxiety and burnout?”. Thematic synthesis identified three main themes: **When work becomes personal**, **The burden on mind and body**, and **Finding meaning and connection**. An overview of themes and subthemes is provided in Table 5. Additional quotes are provided in Appendix J.

Table 5

Main Themes and Subthemes

Main theme	Subthemes
When work becomes personal	-
The burden on mind and body	Emotional impact Physical impact
Finding meaning and connection	Feeling fulfilled Connection with others

A summary of each paper’s contribution to each main theme and subtheme is shown in Table 6.

Table 6

Summary of Paper Contribution to Each Theme

Studies	When work becomes personal	The burden on mind and body		Finding meaning and connection	
		Emotional impact	Physical impact	Feeling fulfilled	Connection with others
Badger, 2005	✓	✓			✓
Bailey et al., 2011	✓	✓			✓
Becker et al., 2017	✓		✓		
Chong & Abdullah, 2017	✓	✓	✓	✓	✓
Gélinas et al., 2012	✓	✓		✓	✓
Harris, 2013		✓		✓	✓
Johansson & Lindahl, 2012	✓	✓		✓	
Jordan et al., 2014	✓	✓			✓
Källström Karlsson et al., 2008		✓		✓	✓
Kaup et al., 2016	✓	✓	✓	✓	✓
McCloskey & Taggart, 2010	✓	✓	✓		✓
McNamara et al., 1995	✓	✓	✓		✓
Reid, 2013	✓	✓		✓	✓
Rose & Glass, 2009		✓	✓	✓	
Seed & Walton, 2012	✓	✓		✓	✓
Tunnah et al., 2012		✓		✓	✓
Wilkes et al., 1998	✓	✓	✓		✓
Yang & Mcilfatrick, 2001	✓	✓		✓	

When work becomes personal

The main theme **When work becomes personal** describes how PC nurses' experiences of stress, anxiety, and burnout were linked with the personal impact of their work. Nurses in all studies apart from four (Harris, 2013; Källström Karlsson et al., 2008; Rose & Glass, 2009;Tunnah et al., 2012) stated their relationships with a patient's family could be personally challenging and a source of stress. PC nurses "*found it particularly stressful when relationships [within the family] were strained"* (Wilkes et al.,1998, p.17) and/or when they were expected *"to be the mediator"* (Seed & Walton, 2012, p.5):

> *"The relation in South Australia did not talk to the one in Queensland but they all came to the home and made things hard for every-one"*
>
> (Wilkes et al., 1998, p.17)

In addition, nurses also found it stressful when family members were experiencing difficult and distressing emotions, such as the lack of understanding, or denial, of a patient's palliative medical status:

> *"'Some families could not accept that the patient's condition had deteriorated rapidly, and that he or she would die soon. They denied or fought this situation. I felt stressed dealing with their emotional reactions.'"*
>
> (Yang & Mcilfatrick, 2001, p. 439)

Some nurses saw dealing with a families' or patient's denial of illness prognosis as the most challenging task:

> *"Often, central to the impact of the family on the nurses' stress was the family or client's denial of the illness prognosis. 'Denial and dealing with these families is the most challenging of all problems. You can cope with all other complications."*
>
> (Wilkes et al., 1998, p. 17)

Caring for PC patients requires specialist knowledge and skills to balance the needs of patients and families. Nurses are often the first and main contact for many families. For some, it was a feeling of being under pressure from families for answers that led to their work being experienced as more stressful, *"'… a lot of relatives involved in the families … all looking to you for an answer … it is more stressful.'"* (Reid, 2013, p. 543). Nurses also reported that "*families get very needy, and they start needing [the nurse] for every little part from getting [their] father up to poop, to everything that's going on in their personal life*." (Seed & Walton, 2012, p. E5).

Having good professional relationships with a patients' family were seen as important to providing good quality care. However, where nurses had built up a good rapport with families, this was also seen to contribute to increasing stress in some situations:

> *"…nurses often spoke of the stress caused by the family being 'too nice' or of the inability of the nurse to 'get away' when rapport had been built up by coming into the home so frequently"*
>
> (Wilkes et al., 1998, p.17)

In order to cope with pressure from families, some nurses had developed strategies that allow them to focus on the needs of their patient. Some learnt to "*close the door, get [the family] out of the room, out of [their] personal space"* (Badger, 2005, p 67). For others this meant not allowing themselves to get too close to the patient and thus needing to *"restrict [themselves] in the relationship"* (Johansson & Lindahl, 2012, p. 2,037) to be able to continue to deliver professional support.

The burden on mind and body

The main theme **The burden on mind and body** describes how nurses found their work to be both emotionally and physically difficult. Two subthemes are discussed, *Emotional impact* and *Physical impact.*

Emotional impact

All but one study (Becker et al., 2017) reported the emotional impact that PC work had on nurses. A range of factors were seen to increase the emotional impact that nurses felt, such as having close relationships with patients and their families, the complexity of PC clinical care, and how PC work connected with their personal values.

> *"The majority of the participants expressed mixed emotions of sadness, grief and anger when caring for patients who presented with end-of-life issues. One participant explained it as follows: 'Guilt, anger... helplessness, because... you want to fix it, but you can't. That's kind of sadness obviously...extreme sadness..."*
>
> (Jordan et al., 2014, p. 78)

Rose and Glass (2009, p.188) highlighted nurses felt *“out of balance”* as a result of an inability to provide the kind of care they wished to give and the need to maintain high professional and personal standards. This for some led to them feeling *“stressed, restless, angry. Not content, not happy not all the things that you wish you were. Very short tempered…”* and for others to making *“rash decisions that [they] wouldn’t do”*, putting themselves *“in the firing line”* and even behaving *“like [they are] a victim.”* (Rose and Glass, 2009, p. 189-190).

While the emotional impact could lead to feelings of sadness, grief, and anger, positive emotional experiences were also reported which could be protective against stress:

> *“The nurses experienced satisfaction in their involvement with the patients. The feeling of being needed, appreciated, and confirmed through the caring activities in which they engaged with patients resulted in great satisfaction. The nurses sympathized with the patients and their families and shared in their grief and their pleasure. The care was no longer considered emotionally stressful…”*
>
> (Källström Karlsson et al., 2008, p. 230)

In nine of the 18 studies, nurses specifically discussed the impact that patients’ deaths had on them (Bailey et al., 2011; Chong & Abdullah, 2017; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; McCloskey & Taggart, 2010; McNamara et al., 1995; Seed & Walton, 2012; Tunnah et al., 2012). Nurses found it particularly difficult when patients died suddenly and unexpectedly (Källström

Karlsson et al., 2008), however it was also recognised that *"…personally facing death was an issue that could not be ignored, but that [they] did get used to the idea of death".* (McNamara et al., 1995, p. 233).

Some nurses reported certain patient groups to be more challenging to work with, such as children (Chong & Abdullah, 2017) or mid-life patients (Kaup et al., 2016; McNamara et al., 1995), while others talked about the impact of having close relationships with patients and their families (Bailey et al., 201). Annette reflected how a patient's death had affected her:

> *"I think it is more the emotional side of what happens. You just think [about the loss of life] and because the family told me so much personal stuff [information], you just feel for them so much. You are putting yourself in their shoes so much that it makes you emotional. It was just so rotten."*
>
> (Bailey et al., 2011, p. 3,367)

Nurses formed close bonds with their patients and reported finding it particularly difficult when *"many patients died within a short period or if death came quickly and unexpectedly"* (Källström Karlsson et al., 2008, p. 230). In addition, for some nurses, the patient group was identified as presenting them with personal challenges:

> *"Providing care to children and their families was found to be a very emotive experience for nurses and it was compounded if they are mothers or have close relatives of the same age. Seeing a young child die was tough on them*

> *spiritually and being present with grieving parents and extended families overwhelmed some nurses."*
>
> (Chong & Abdullah, 2017, p. 128)

Two studies also reflected on some of the protective factors against burnout. Seed and Walton (2012, p. E6) identified the *"importance of closure…. being able to be there for the death and see death in that moment"* was seen as *"optimal"*, while Källström Karlsson et al. (2008, p. 227) highlighted that *"being present at the moment of death and taking care of the bodies seemed to result in less anxiety about [the nurses'] own death."*

Twelve of the 18 studies (Badger, 2005; Bailey et al., 2011; Gélinas et al., 2012; Harris, 2013; Johansson & Lindahl, 2012; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Tunnah et al., 2012; Yang & Mcilfatrick, 2001) discussed nurses' feelings of helplessness when working in complex care systems, within strict medical hierarchies, and when caring for patients who are not expected to recover from their condition:

> *"Putting up with it referred to the belief that "in essence it's coming [death] so it's just a matter of time. It's just eight or it's twelve hours knowing in the end it's not going to make a bit of difference [what we do].""*
>
> (Badger, 2005, p. 66)

Jordan et al. (2014, p. 78) found that nurses *"expressed feelings of helplessness when unable to do more for their patients" and when they engaged in "futile or unnecessary care… when dealing with end-of-life issues".*

Organisational pressures such as staff shortages (Kaup et al., 2016), system failures (Rose & Glass, 2009), and difficulties managing their time (Seed & Walton, 2012) were all mentioned as contributing to increased feelings of helplessness and stress. Stress for some nurses was also linked to a feeling that they were not working in the patients' best interests as were required to keep the diagnosis confidential for cultural reasons connected to a *"moral tension that was emerging because they felt uncomfortable with their inability to disclose prognosis"* (Yang & Mcilfatrick, 2001, p. 439).

Physical impact

Seven of the 18 studies (Becker et al., 2017; Chong & Abdullah, 2017**;** Kaup et al., 2016; McCloskey & Taggert, 2010; McNamara et al., 1995; Rose & Glass, 2009; Wilkes et al., 1998) discussed how nurses were physically impacted by their work; *"Bad deaths however, are problematic as well as physically and emotionally exhausting for those who participate in the nursing care"* (McNamara et al., 1995, p. 231). Common symptoms included physical tension, distress, sadness, restlessness and irritability, mind racing and worrying, and sleeplessness (Rose & Glass, 2009).

Physical symptoms of stress were particularly common in studies that looked at nurses working in the community (Chong & Abdullah, 2017; Kaup et al., 2016; Rose & Glass, 2009; Wilkes et al., 1998). Interestingly, some nurses reported the symptoms appeared only before or during certain patient encounters while other symptoms were more chronic and related to stress over a longer time period:

> *"…[nurses] described symptoms such as headache, dizziness, and stomach pain. Sometimes the symptoms appeared only in certain encounters; for*

> *example, stomach pain might occur on [a nurses] way to a specific patient where the participant knew it could be difficult. Other symptoms were more long lasting and were often related to stress over a longer period.”*
>
> (Kaup et al., 2016, p. 567)

Wilkes et al.’s (1998) participants reported that physical symptoms of stress and tension they experienced were a combination of work and home life stress:

> *“The stress and tension caused by relations... all these things and others not long after my own mother’s death caused a lot of stress to me...going to sleep but waking at 3am and mind racing. Falling to sleep at meetings’”*
>
> (Wilkes et al., 1998, p. 17)

Finding meaning and connection

The main theme *Finding meaning and connection* is concerned with how nurses cope with PC work. Despite the work being emotionally demanding, it was common for nurses to want to reflect on and find personal meaning in their roles rather than to distance themselves from it. Within this theme, two subthemes were identified, *Feeling fulfilled* and *Connection with others*.

Feeling fulfilled

Eleven of the 18 studies considered how nurses found meaning and reward in their work, giving them a sense of satisfaction and reward (Chong & Abdullah, 2017; Gélinas et al., 2012; Harris, 2013; Johansson & Lindahl, 2012; Källström Karlsson et al., 2008; Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Seed & Walton, 2012; Tunnah et al., 2012; Yang & Mcilfatrick, 2001). Nurses’ descriptions included their work being a privilege (Johansson, & Lindahl, 2012; Tunnah et al., 2012), being professionally rewarding and giving them a sense of satisfaction (Harris, 2013; Reid, 2013; Seed & Walton, 2012; Kaup et al., 2016; Tunnah et al., 2012).

PC nurses identified that job satisfaction came from feeling as thought they had made a difference; *"'If you can nurse someone at home and make them as comfortable as possible in their last days of life, it's a privilege to do it ... it's well worth everything you do.'"* (Tunnah et al., 2012, p. 286). Nurses acknowledged that PC work is challenging, personally and professionally, however they felt it was rewarding to deliver care during such a private, personal, and devastating time: *"It was a very privileged place to be."* (Reid, 2013, p. 544).

Some nurses described being able to deliver care to the best of their ability as providing a sense of satisfaction and gratitude:

> *"The nurses strive to achieve completeness in this unique situation. Completeness signifies a feeling that the nurses have when they have done all they can for the patients and feel satisfied with their work."*
>
> (Johansson & Lindahl, 2012, p. 2,036)

Nurses also reported gaining strength and meaning in their roles after having affirming experiences and when they felt stimulated in their work:

> *"The nurses experienced satisfaction in their involvement with the patients. The feeling of being needed, appreciated, and confirmed through the caring activities in which they engaged with patients resulted in great satisfaction."*
>
> (Källström Karlsson et al., 2008, p. 230)

Several participants mentioned their spirituality and faith as ways of coping with the stress and impact of a patient's death. These seemed to enable some nurses to find a deeper meaning in their work that connected with their sense of faith:

> *"One nurse shared that, on occasion, she is not fully aware of the stress and will find herself emotional and her spirituality will help her through. She admitted that ''it takes more of a toll than I think we know. You have to have a good spiritual base to deal with all.'"*
>
> (Harris, 2013, p. 450)

Connection with others

Fourteen of the 18 studies reported nurses sought the support of other people to cope with stress and the risk of burnout (Badger, 2005; Bailey et al., 2011; Chong & Abdullah, 2017; Gélinas et al., 2012; Harris, 2013; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; McCloskey & Taggert, 2010; McNamara et al., 1995; Reid, 2013; Seed & Walton, 2012; Tunnah et al., 2012; Wilkes et al., 1998). Team members and colleagues were a commonly reported source of support:

> *"One of their major strategies was to talk and share their experiences with others: either with another nurse, with the bereavement counsellor, with the palliative care team or reflecting on their experience*"
>
> (Wilkes et al., 1998, p. 18)

For some nurses, this connection was related to them feeling socially connected to their colleagues at work, while seeking informal support was seen as an important coping strategy. Harris (2013) found that nurses identified talking to colleagues as a key coping strategy, *“…the most helpful and most frequently used coping mechanism was talking with and/or venting to others. In particular, members of each of the focus groups reported that they relied most heavily on their coworkers in times of stress”* (p. 449). Nurses felt it was important to use informal opportunities at work to speak openly about their feelings:

> *“The nurses identified support from colleagues as being important for their coping: 'I chat with my colleague and the district nurses ... make sure we have lunch together in the office so that we can chat and you know say how we feel, so that helps”*
>
> (Tunnah et al., 2012, p. 288)

Connections with colleagues were seen not just to help with symptoms of stress, but were explicitly identified as preventing burnout. Nurses acknowledged that they relied heavily on their peers as a method of preventing burnout; *“…the burnout is definitely there with all of us to a point. We all get to that point where I just, I just can’t do it, but we bounce back real fast. We have a great team so we just work and talk among each other and help each other out.”* (Seed & Walton, 2012, p. E5).

While colleagues were most commonly mentioned, family relationships and having contact with others outside of work were also reported as protective factors against the impact of nurses’ work building up (Källström Karlsson et al., 2008; Kaup et al., 2016; McNamara et al., 1995; Tunnah et al., 2012). The concept of connection with others being a *“release”* is articulated here by a nurse working in a hospital inpatient setting:

> *“Stable and functioning family relationships were desirable so that the nurses could regain their strength during their leisure time. Spending time with children and adults outside the family or professional colleagues was understood as a shield against thoughts of death. Meeting other people who were full of life ‘‘and talking about something completely different’’ was like a release.”*
>
> (Källström Karlsson et al., 2008, p. 288)

Others talked about finding it difficult to get support from outside of work due to the lack of understanding from those who do not work in PC; *“Many nurses indicated that they thought people outside of the hospice 'system' lacked an understanding of what was involved in caring for the dying”* (McNamara et al., 1995, p. 229). Nurses reflected on how family members often did not want to hear about their work:

> *“We go through a lot during the week, not just death but huge traumas — young people — and you go home and talk to people who don’t want to hear [about] it: “Could you change [the] subject?” . . . “It’s depressing.”. “Do you have to talk about this over dinner?” . . . we see a side of life . . . that most people don’t see.”*
>
> (Gélinas et al., 2012, p. 32)

Critique of Studies

Quality assessment using the CASP resulted in scores ranging from 12 to 19, with an average score of 17. However, it is important to acknowledge that assessment of the methodological strengths and limitations of qualitative research remains contested within the qualitative research community (Garside, 2014; Noyes et al., 2019). It has been argued that using quality assessment tools too narrowly assesses the quality of methodological reporting, rather than evidence of analytic rigor, originality, or scholarly contribution to the field (Majid & Vanstone, 2018). Subsequently, the limitations of the studies need to be taken in to account in order to exert some caution when using the findings. There were three main limitations identified during the current review: sample diversity, researcher’s reflexivity, and data analysis.

All studies recruited participants using a purposive sampling approach to include participants with particular characteristics who were better able to assist with the relevant research (Etikan et al., 2016). However, three of the 18 studies had omitted reporting participants’ demographic details (Bailey et al., 2011; Källström Karlsson et al., 2008; McCloskey & Taggart, 2010). Of the remaining 15 studies, two did not include gender details (Reid, 2013; Yang & Mcilfatrick, 2001), 11 had no information regarding participants’ ages (Bailey et al., 2011; Becker et al., 2017; Johansson & Lindahl, 2012; Jordan et al., 2014; Källström Karlsson et al., 2008; McCloskey & Taggart, 2010; Reid, 2013; Rose & Glass, 2009; Seed & Walton, 2012; Tunnah et al., 2012; Wilkes et al., 1998), and only two studies reported participants’ ethnic background (Badger, 2005; Harris, 2013). A lack of reporting on gender, and a gender bias in nursing research, may contribute to knowledge gaps and a lack of research generalisability (Polit & Back, 2009). Additionally, a lack of adequate demographic information may raise questions regarding inclusion and diversity issues, and a lack of clarity impacting any generalisation of findings for clinical practice or future research (Hughes et al., 2016; Jones et al., 2020).

Reflexivity has been recognised as a crucial strategy in qualitative research (Finefter-Rosenbluh, 2017; Naples & Sachs, 2000). Only three studies discussed bias and data validation or the relationship between the researcher and participants (Becker et al., 2017; Jordan et al., 2014; Rose & Glass, 2009). The absence of reflexive discussions in the other 15 studies means it is not possible to assess any risk of bias or potential impact on the validity of findings (Lazard, 2020; Reid et al., 2018).

The suitability or rigour of data analysis approaches within the studies was also highlighted. Seven of the studies lacked enough details to assess the quality of data analysis (Bailey et al., 2011; Jordan et al., 2014; Reid, 2013; Rose & Glass, 2009; McCloskey & Taggart, 2010; McNamara et al., 1995; Wilkes et al., 1998). The lack of clarity on theoretical positions and processes undertaken during data analysis limited the ability to assess the validity of studies’ findings or recommendations (Santiago-Delefosse et al., 2016; Twining et al., 2017).

Discussion

This review addressed the question, “What are palliative care nurses’ experiences of stress, anxiety and burnout?”. Thematic synthesis was undertaken on 18 studies and three main themes were identified: **When work becomes personal, The burden on mind and body,** and **Finding meaning and connection**. Nurses found PC work to be challenging and rewarding. They experienced stress, anxiety, and burnout as a result of their work. PC work is intimate and close bonds can be formed with patients, their families, and colleagues. Nurses were required to carefully navigate these relationships, not only when things were difficult but also when they felt a close connection to patient’s families. PC nursing was described as both emotionally and physically challenging; where nurses were able to find meaning and connection with others they found this to reduce stress, anxiety, and burnout.

Summary of findings

When work becomes personal

PC nurses described how difficult relationships with a patient’s family were seen as potential sources of stress and burnout (Badger, 2005**;** Bailey et al., 2011; Becker et al., 2017; Chong & Abdullah, 2017; Gélinas et al., 2012; Johansson & Lindahl, 2012; Jordan et al., 2014; Kaup et al., 2016; McCloskey & Taggert, 2010; McNamara et al., 1995; Reid, 2013; Seed & Walton, 2012; Wilkes et al., 1998; Yang & Mcilfatrick, 2001). Conversely, some nurses with close personal relationships with families also found this to be stressful (Bailey et al., 2011; Johansson & Lindahl, 2012; Jordan et al., 2014; Reid, 2013; Seed & Walton, 2012; Wilkes et al., 1998).

Previous PC literature reviews have focused on the impact of conflict (François et al., 2017; Lichtenthal & Kissane, 2008) or burnout (Lagentu et al., 2017; Peters et al., 2012) on nurses’ stress and/or anxiety, while others have reviewed interventions aiming to improve the psychological well-being of PC staff (Gillman et al., 2015; Hill et al., 2016; Parola et al., 2017a). While the current review supports previous findings on the impact of conflict (François et al., 2017), it also highlights how close personal relationships with families contributed to nurses' experience of stress and burnout (Bailey et al., 2011; Johansson & Lindahl, 2012; Jordan et al., 2014; Reid, 2013; Seed & Walton, 2012; Wilkes et al., 1998).

This review extends our understanding of the different ways nurses can be affected by relationships with patient's families. It also highlights the importance of supporting nurses to recognise the impact of their professional relationships with patient's families in order to reduce the potential for increased stress, anxiety and burnout.

The burden on mind and body

This main theme considered how PC nurses are emotionally and physically impacted by stress, anxiety, and burnout. A range of emotional experiences were connected including: sadness, grief, anger, guilt, frustration, unhappiness, and dissatisfaction with themselves (Badger, 2005; Bailey et al., 2011; Chong & Abdullah, 2017; Gélinas et al., 2012; Johansson & Lindahl, 2012; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; McCloskey & Taggart, 2010; McNamara et al., 1995; Reid, 2013; Rose & Glass, 2009; Seed & Walton, 2012; Tunnah et al., 2012; Wilkes et al., 1998; Yang & Mcilfatrick, 2001). These findings are consistent with the existing literature (Peters et al., 2013a; Powell et al., 2020; Zanatta et al., 2020; Zheng et al., 2018), however this review also highlighted positive experiences and their function in moderating stress, anxiety, and burnout (Johansson & Lindahl, 2012; Källström Karlsson et al., 2008).

Nurses also experienced physical symptoms of stress, anxiety, and burnout. Nurses consistently reported sleep difficulties, with tension and headaches common. This impacted them in a number of ways, including at home and work, with some nurses reported not being able to concentrate, feeling agitated and unbalanced (Becker et al., 2017; Chong & Abdullah, 2017**;** Kaup et al., 2016; McCloskey & Taggert, 2010; McNamara et al., 1995; Rose & Glass, 2009**;** Wilkes et al., 1998). These findings are similar to those of Baqeas and Rayan (2018) who also found PC nurses’ sleep and physical well-being are significantly impacted by their work. Similarly, Parola et al.’s (2017b) review, looking at burnout in PC healthcare professionals, also noted the need to preserve the emotional and physical health of staff.

Similarly, while nurses’ feelings of hopelessness and difficulties have been reported in quantitative literature reviews of nurses working in PC work (Lagentu et al., 2017), feelings of helplessness were also reported in many of the current review’s studies (Badger, 2005; Bailey et al., 2011; Gélinas et al., 2012; Harris, 2013; Johansson & Lindahl, 2012; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Tunnah et al., 2012; Yang & Mcilfatrick, 2001). These feelings were related to clinical, personal, and organisational issues and contributed to nurses’ stress levels. This finding is supported by Powell at el. (2020) who’s systematic literature review also found personal factors and organisational workload pressures to be key factors in PC nurses’ stress levels.

Death anxiety has been explored in systematic literature reviews and found to be connected with fear of death, anxiety and unease (Peters et al., 2013b). Previous literature reviews have focused on what individual characteristics nurses have that contribute to their responses to death (Peters et al., 2013a; Zheng et al., 2018), or have looked more broadly at nurses working in different services providing end of life care (Griffiths, 2019; Mu et al., 2019).

Nurses in the current review described how patients' deaths affected them in deeply personal ways. This could be due to a number of factors including nurses' relationships with patients due to the patient's age (Chong & Abdullah, 2017; Reid, 2013; Yang & Mcilfatrick, 2001), cultural background (Becker et al., 2017; Reid, 2013; Tunnah et al., 2012), or when patients suddenly and unexpectedly died (Källström Karlsson et al., 2008; Yang & Mcilfatrick, 2001). These findings are supported by Malone et al.'s (2016) systematic literature review which identified that patient factors, such as age and cultural background, can impact on how nurses cope with patients' deaths, however their review was only looking at newly graduated nurses in PC.

Finding meaning and connection

Finally, nurses' feelings of fulfilment and the importance of connecting with others for support were discussed in relation to whether they experienced work to be stressful or not. Where nurses reported feeling fulfilled, a sense of satisfaction and pride in their work, they also talked about how this made the challenge of PC work worthwhile (Chong & Abdullah, 2017; Gélinas et al., 2012; Harris, 2013; Johansson & Lindahl, 2012; Källström Karlsson et al., 2008; Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Seed & Walton, 2012; Tunnah et al., 2012; Yang & Mcilfatrick, 2001). Nurses also reported finding meaning in their spiritualty and religion in six of the studies (Chong & Abdullah, 2017; Harris, 2013; Johansson & Lindahl, 2012; Reid, 2013; Rose & Glass, 2009; Seed & Walton, 2012). A recent systematic review by Sekse et al. (2018), looking at nurses' roles in PC, found that feelings of fulfilment were present when nurses felt they were able to be *“attentively present and dedicated”* (Sekse et al., p. 33).

Nurses found seeking support from family and their colleagues helped them cope (Badger, 2005; Bailey et al., 2011; Chong & Abdullah, 2017; Gélinas et al., 2012; Harris, 2013; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; McCloskey & Taggert, 2010; McNamara et al., 1995; Reid, 2013; Seed & Walton, 2012; Tunnah et al., 2012; Wilkes et al., 1998). Nurses identified that open and honest conversations about the impact of their work were important in reducing stress in the short-term and burnout in the longer-term. Spending time with others unconnected to their work was also important in helping them cope. This is consistent with other systematic reviews in PC nursing which have identified nurses’ need to express their emotional responses to others, whether with colleagues, friends, or family (Powell et al., 2020; Zanatta et al., 2020).

Strengths and Limitations

The multitude of settings and services defined as PC influenced the review’s findings. One of the challenges of undertaking research in PC is defining the parameters of which services and teams to include. Recently, PC interventions are used in a broader range of settings and earlier on with patients with life-limiting conditions (WHO, 2014). There is an acknowledgement within the literature that definitions of PC require revision and clarification (Radbruch et al., 2020; Van Mechelen et al., 2013). PC nurses work in different services, with diverse experiences, training, and staff support. Therefore, efforts to synthesise findings meant trying to find a balance in papers’ inclusion and exclusion decisions. While all participants were nurses engaged in providing PC as part of their main role, homogeneity of participants should be considered when interpreting the review’s conclusions. For example, participants were recruited from inpatient (Badger, 2005; Bailey et al., 2011; Becker et al., 2017; Chong, & Abdullah, 2017; Johansson & Lindahl, 2012; Jordan, et al., 2014; Källström Karlsson et al., 2008; Yang & Mcilfatrick, 2001), hospices (Harris, 2013; Seed & Walton, 2012) and community (Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Tunnah et al., 2012; Wiles et al., 1998) settings, and from countries with acknowledged cultural differences in attitudes to PC (Yang & Mcilfatrick, 2001).

Clinical Policy and Practice Implications

Findings from this review support and further demonstrate the complexity of feelings PC nurses have about their role, which may help both nurses and services take action to mediate against nurses' experiences of stress, anxiety, and burnout. The findings could also be helpful in expanding our understanding of how PC nurses are impacted by patients' deaths and may help to better support them in this critical aspect of their work. Two main policy and practice implications were identified within the reviewed studies: greater staff support and more relevant learning and development opportunities.

Harris (2013) highlighted that having someone to talk to would be beneficial on a particularly stressful or painful day or when nurses experienced loss. Similarly, staff support groups that were not specific to grief alone, were *"facilitated by someone outside of hospice"* and having their content kept *"confidential"* would be welcome (Harris, 2013, p. 451).

Seed and Walton (2012) suggested that nurse managers should regularly assess the stress and coping ability of their teams, to ensure nurses have/ receive unscheduled time off because of undue stress and working with difficult families.

Tunnah et al. (2012) similarly identified the need for further use of clinical supervision and reflection.

Further, staff training needs have also been highlighted as crucial to nurses having greater clarity on how to react in various care situations and how to carry out their work (Johansson & Lindahl, 2012) as well as improving the ability to identify stress and recognise their own emotional needs (Becker et al.,2017; Tunnah et al., 2012). Finally, Becker et al. (2017) suggested the need for training on effective communication with families on helpful and harmful care during the end of life.

Further Research

PC is an evolving speciality with implications for future demands on healthcare systems and PC nurses (WHO, 2014). Recent emphasis has been made on the impact that Covid-19 has had on the role of PC within a modern healthcare system (Fausto, 2020; Lancet, 2020). While there is a growing body of literature exploring nurses' experiences of working in PC, qualitative studies of PC nurses' experiences of stress, anxiety, and burnout remain an under-researched area (Powell et al., 2020; Sekse et al., 2018). Further studies could aim to gain a deeper, more nuanced, understanding of how PC nurses are affected by their work. This could be through investigating the experiences of nurses with a longer tenure working in PC, or the use of longitudinal studies to evaluate the emotional and physical impact of PC work over time. Additionally, further studies could be undertaken that help education providers and organisations better understand their role in training and staff support, for example when preparing newly qualified nurses who choose to work in PC.

When undertaking future research, consideration should be made regarding accessing diverse participant samples and reporting of appropriate and relevant participant demographics (such as age, gender, ethnicity, or race) to improve the representation of a range of views and experiences. Discussion of the relationship between researchers and participants and any conflicts, or potential bias, should also be included. Finally, research should be undertaken using appropriate research methods with clear reporting in methodological sections. Addressing these issues would improve the quality, replicability, and validity of research findings.

Conclusion

The current review explored PC nurses’ experiences of stress, anxiety, and burnout. Three main themes were identified which suggest that PC nurses experiences are complex, encompassing clinical and organisational challenges, and the personal impact their work has on them. The findings of this review highlighted that nurses’ relationships with patients, patients’ families, and colleagues, can be both a source of stress and strength. While many nurses describe their work as difficult, they also find it personally and professionally rewarding.

References

Akvardar, Y., Demiral, Y., Ergor, G., & Ergor, A. (2004). Substance use among medical students and physicians in a medical school in Turkey. *Social psychiatry and psychiatric epidemiology*, *39*(6), 502-506. https://doi.org/10.1007/s00127-004-0765-1

Alhojailan, M. I. (2012). Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences*, *1*(1), 39-47. https://westeastinstitute.com/journals/wejss/wejss-current-dec-2012/

Altman, D. G. (1999). *Practical statistics for medical research*. New York, NY: Chapman & Hall/CRC Press.

Badger, J. M. (2005). A descriptive study of coping strategies used by medical intensive care unit nurses during transitions from cure-to comfort-oriented care. *Heart & Lung*, *34*(1), 63-68. https://doi.org/10.1016/j.hrtlng.2004.08.005

Bailey, C., Murphy, R., & Porock, D. (2011). Professional tears: developing emotional intelligence around death and dying in emergency work. *Journal of clinical nursing*, *20*(23-24), 3364-3372. https://doi.org/10.1111/j.1365-2702.2011.03860.x

Baqeas, M., & Rayan, A. (2018). Improving psychological well-being and quality of life among palliative care nurses: literature review. *American Journal of Nursing Research*, *6*(3), 82-6. https://doi.org/10.12691/AJNR-6-3-1

Bausewein, C., & Higginson, I. J. (2012). Challenges in defining ‘palliative care’ for the purposes of clinical trials. *Current opinion in supportive and palliative care*, *6*(4), 471-482. https://doi.org/10.1097/SPC.0b013e32835998f5

Becker, C. A., Wright, G., & Schmit, K. (2017). Perceptions of dying well and distressing death by acute care nurses. *Applied Nursing Research*, *33*, 149-154. https://doi.org/10.1016/j.apnr.2016.11.006

Beehr, T. A., & McGrath, J. E. (1992). Social support, occupational stress and anxiety. *Anxiety, stress, and coping*, *5*(1), 7-19. https://doi.org/10.1080/10615809208250484

Beng, T. S., Chin, L. E., Guan, N. C., Yee, A., Wu, C., Pathmawathi, S., ... & Meng, C. B. C. (2015). The experiences of stress of palliative care providers in Malaysia: A thematic analysis. *American Journal of Hospice and Palliative Medicine®*, *32*(1), 15-28. https://doi.org/10.1177/1049909113503395

Breen, L. J., O'Connor, M., Hewitt, L. Y., & Lobb, E. A. (2014). The “specter” of cancer: Exploring secondary trauma for health professionals providing cancer support and counseling. *Psychological services*, *11*(1), 60. https://doi.org/10.1037/a0034451

Carroll, C., & Booth, A. (2015). Quality assessment of qualitative evidence for systematic review and synthesis: is it meaningful, and if so, how should it be performed?. *Research Synthesis Methods*, *6*(2), 149-154. https://doi.org/10.1002/jrsm.1128

Carroll, C., Booth, A., Leaviss, J., & Rick, J. (2013). “Best fit” framework synthesis: refining the method. *BMC medical research methodology*, *13*(1), 1-16. https://doi.org/10.1186/1471-2288-13-37

Chong, L., & Abdullah, A. (2017). Community palliative care nurses’ challenges and coping strategies on delivering home-based pediatric palliative care: A qualitative study. *American Journal of Hospice and Palliative Medicine*, *34*(2), 125-131. https://doi.org/10.1186/1471-2288-13-37

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative health research*, *22*(10), 1435-1443. 10.1177/1049732312452938

Critical Appraisal Skills Programme - CASP (2018). *CASP Qualitative Checklist.* https://caspuk.net/wpcontent/uploads/2018/03/CASPQualitative- Checklist-2018_fillable_form.pdf

Davidson, J., Mendis, J., Stuck, A. R., DeMichele, G., & Zisook, S. (2018). Nurse suicide: breaking the silence. *NAM Perspectives*. Retrieved November 17, 2020, from https://nam.edu/nurse-suicide-breaking-the-silence/

Dijxhoorn, A. F. Q., Brom, L., van der Linden, Y. M., Leget, C., & Raijmakers, N. J. (2020). Prevalence of burnout in healthcare professionals providing palliative care and the effect of interventions to reduce symptoms: A systematic literature review. *Palliative Medicine*, 0269216320956825. https://doi.org/10.1177/0269216320956825

Embriaco, N., Azoulay, E., Barrau, K., Kentish, N., Pochard, F., Loundou, A., & Papazian, L. (2007). High level of burnout in intensivists: prevalence and associated factors. *American Journal of Respiratory and Critical Care Medicine*, *175*(7), 686-692. https://doi.org/10.1164/rccm.200608-1184oc

Escribà-Agüir, V., Martín-Baena, D., & Pérez-Hoyos, S. (2006). Psychosocial work environment and burnout among emergency medical and nursing staff. *International Archives of Occupational and Environmental Health*, *80*(2), 127-133. https://doi.org/10.1007/s00420-006-0110-y

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4. https://doi.org/10.11648/j.ajtas.20160501.11

Fausto, J., Hirano, L., Lam, D., Mehta, A., Mills, B., Owens, D., ... & Curtis, J. R. (2020). Creating a palliative care inpatient response plan for COVID-19—the UW medicine experience. *Journal of Pain and Symptom Management*, *60*(1), e21-e26. https://doi.org/10.1016/j.jpainsymman.2020.03.025

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods*, *16*(1), 1609406917703539. https://doi.org/10.1177/1609406917703539

François, K., Lobb, E., Barclay, S., & Forbat, L. (2017). The nature of conflict in palliative care: A qualitative exploration of the experiences of staff and family members. *Patient Education and Counseling*, *100*(8), 1459-1465. https://doi.org/10.1016/j.pec.2017.02.019

Gama, G., Barbosa, F., & Vieira, M. (2014). Personal determinants of nurses' burnout in end of life care. *European Journal of Oncology Nursing*, *18*(5), 527-533. https://doi.org/10.1016/j.ejon.2014.04.005

Garside, R. (2014). Should we appraise the quality of qualitative research reports for systematic reviews, and if so, how?. *Innovation: The European Journal of Social Science Research*, *27*(1), 67-79. https://doi.org/10.1080/13511610.2013.777270

Gélinas, C., Fillion, L., Robitaille, M. A., & Truchon, M. (2012). Stressors experienced by nurses providing end-of-life palliative care in the intensive care unit. *Canadian Journal of Nursing Research Archive*, 18-39. Retrieved from https://www.researchgate.net/publication/225288054_Stressors_experienced_by_nurses_providing_end-of-life_palliative_care_in_the_intensive_care_unit

Gillman, L., Adams, J., Kovac, R., Kilcullen, A., House, A., & Doyle, C. (2015). Strategies to promote coping and resilience in oncology and palliative care nurses caring for adult patients with malignancy: a comprehensive systematic review. *JBI Evidence Synthesis*, *13*(5), 131-204. https://doi.org/10.11124/jbisrir-2015-1898

Gómez-Urquiza, J. L., Albendín-García, L., Velando-Soriano, A., Ortega-Campos, E., Ramírez-Baena, L., Membrive-Jiménez, M. J., & Suleiman-Martos, N. (2020). Burnout in Palliative Care Nurses, Prevalence and Risk Factors: A Systematic Review with Meta-Analysis. *International Journal of Environmental Research and Public Health*, *17*(20), 7672. https://doi.org/10.3390/ijerph17207672

Greenhalgh, T., G. Robert, F. MacFarlane, P. Bate, O. Kyriakidou, and R. Peacock. (2005). “Storylines of Research in Diffusion of Innovation: A Meta-Narrative Approach to Systematic Review.” *Social Science and Medicine, 61*(2): 417–430. https://doi.org/10.1016/j.socscimed.2004.12.001

Griffiths, I. (2019). What are the challenges for nurses when providing end-of-life care in intensive care units?. *British Journal of Nursing*, *28*(16), 1047-1052. https://doi.org/10.12968/bjon.2019.28.16.1047

Harding, R., List, S., Epiphaniou, E., & Jones, H. (2012). How can informal caregivers in cancer and palliative care be supported? An updated systematic literature review of interventions and their effectiveness. *Palliative Medicine*, *26*(1), 7-22. https://doi.org/10.1177/0269216311409613

Harris, L. J. (2013). Caring and coping: Exploring how nurses manage workplace stress. *Journal of Hospice & Palliative Nursing*, *15*(8), 446-454. https://doi.org/10.1097/NJH.0b013e3182a0de78

Hill, R. C., Dempster, M., Donnelly, M., & McCorry, N. K. (2016). Improving the wellbeing of staff who work in palliative care settings: a systematic review of psychosocial interventions. *Palliative Medicine*, *30*(9), 825-833. https://doi.org/10.1177/0269216316637237

Houghton, C., Murphy, K., Meehan, B., Thomas, J., Brooker, D., & Casey, D. (2017). From screening to synthesis: using nvivo to enhance transparency in qualitative evidence synthesis. *Journal of Clinical Nursing*, *26*(5-6), 873-881. https://doi.org/10.1111/jocn.13443

Hughes, J. L., Camden, A. A., & Yangchen, T. (2016). Rethinking and updating demographic questions: Guidance to improve descriptions of research samples. *Psi Chi Journal of Psychological Research*, *21*(3), 138-151. https://doi.org/10.24839/2164-8204.JN21.3.138

Jaiswal, R., Alici, Y., & Breitbart, W. (2014). A comprehensive review of palliative care in patients with cancer. *International Review of Psychiatry*, *26*(1), 87-101. https://doi.org/10.3109/09540261.2013.868788

Johansson, K., & Lindahl, B. (2012). Moving between rooms–moving between life and death: nurses’ experiences of caring for terminally ill patients in hospitals. *Journal of clinical nursing*, *21*(13-14), 2034-2043. https://doi.org/10.1111/j.1365-2702.2011.03952.x

Jones, S. H., St. Peter, C. C., & Ruckle, M. M. (2020). Reporting of demographic variables in the Journal of Applied Behavior Analysis. *Journal of applied Behavior Analysis*, *53*(3), 1304-1315. https://doi.org/10.1002/jaba.722

Jordan, P. J., Clifford, I., & Williams, M. (2014). The experiences of critical care nurses with regard to end-of-life issues in the intensive care unit. *Africa Journal of Nursing and Midwifery*, *16*(2), 71-84. https://doi.org/10.25159/2520-5293/35

Källström Karlsson, I. L. K., Ehnfors, M., & Ternestedt, B. M. (2008). Five nurses' experiences of hospice care in a long-term perspective. *Journal of hospice & palliative nursing*, *10*(4), 224-232. https://doi.org/10.25159/2520-5293/35

Kaup, J., Höög, L., & Carlsson, M. E. (2016). Care for dying patients at midlife: Experiences of nurses in specialized palliative home care. *Journal of hospice & palliative nursing*, *18*(6), 564-571. http://dx.doi.org/10.1097/NJH.0000000000000295

Lagentu, E. P., Eka, N. G. A., & Tahulending, P. (2017). Burnout in palliative care in nursing: A literature review. *UI Proceedings on Health and Medicine*, *2*. http://dx.doi.org/10.7454/uiphm.v2i0.156

Lancet, T. (2020). Palliative care and the COVID-19 pandemic. *Lancet (London, England)*, *395*(10231), 1168. https://dx.doi.org/10.1016%2FS0140-6736(20)30822-9

Lazard, L., & McAvoy, J. (2020). Doing reflexivity in psychological research: What’s the point? What’s the practice?. *Qualitative Research in Psychology*, *17*(2), 159-177. https://doi.org/10.1080/14780887.2017.1400144

Lichtenthal, W. G., & Kissane, D. W. (2008). The management of family conflict in palliative care. *Progress in Palliative Care*, *16*(1), 39–45. https://doi.org/10.1179/096992608x296914

Lim, J., Bogossian, F., & Ahern, K. (2010). Stress and coping in Australian nurses: a systematic review. *International Nursing Review*, *57*(1), 22-31. https://doi.org/10.1111/j.1466-7657.2009.00765.x

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31-42. https://doi.org/10.1177/2632084320947559

Martins Pereira, S., Fonseca, A. M., & Sofia Carvalho, A. (2011). Burnout in palliative care: A systematic review. *Nursing Ethics*, *18*(3), 317-326. https://doi.org/10.1177/0969733011398092

Martins Pereira, S., Fonseca, A. M., & Sofia Carvalho, A. (2012). Burnout in nurses working in Portuguese palliative care teams: a mixed methods study. *International Journal of Palliative Nursing*, *18*(8), 373-381. https://doi.org/10.12968/ijpn.2012.18.8.373

McCloskey, S., & Taggart, L. (2010). How much compassion have I left? An exploration of occupational stress among children's palliative care nurses. *International journal of palliative nursing*, *16*(5), 233-240. http://dx.doi.org/10.12968/ijpn.2010.16.5.48144

McNamara, B., Rosenwax, L. K., & Holman, C. A. J. (2006). A method for defining and estimating the palliative care population. *Journal of Pain and Symptom Management*, *32*(1), 5-12. https://doi.org/10.1016/j.jpainsymman.2005.12.018

McNamara, B., Waddell, C., & Colvin, M. (1995). Threats to the good death: the cultural context of stress and coping among hospice nurses. *Sociology of Health & Illness*, *17*(2), 222-241. https://doi.org/10.1111/1467-9566.ep10933398

McVicar, A. (2003). Workplace stress in nursing: a literature review. *Journal of Advanced Nursing*, *44*(6), 633-642. https://doi.org/10.1046/j.0309-2402.2003.02853.x

Majid, U., & Vanstone, M. (2018). Appraising qualitative research for evidence syntheses: a compendium of quality appraisal tools. *Qualitative Health Research*, *28*(13), 2115-2131. https://doi.org/10.1177/1049732318785358

Malone, L. D., Anderson, J., & Croxon, L. (2016). Are newly graduated nurses ready to deal with death and dying? - A literature review. *Nursing and Palliative Care*, *1*(4), 89-93. https://doi.org/10.15761/NPC.1000123

Maslach, C., & Jackson, S. E. (1984). Burnout in organizational settings. *Applied Social Psychology Annual, 5,* 133-153. Retrieved from https://www.researchgate.net/publication/232497134_Burnout_in_organization_settings

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, *2*(2), 99-113. https://doi.org/10.1002/job.4030020205

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S. (2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*(1), 1-10. https://dx.doi.org/10.1186%2Fs12913-014-0579-0

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & Prisma Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS medicine*, *6*(7), e1000097. https://doi.org/10.1136/bmj.b2535

Mu, P. F., Tseng, Y. M., Wang, C. C., Chen, Y. J., Huang, S. H., Hsu, T. F., & Florczak, K. L. (2019). Nurses' experiences in end-of-life care in the PICU: a qualitative systematic review. *Nursing Science Quarterly*, *32*(1), 12-22. https://doi.org/10.1177/0894318418807936

National Institute for Health and Care Excellence. (2017). End of life care for adults. Quality Standard [QS13]. https://www.nice.org.uk/guidance/qs13

Naples, N. A., & Sachs, C. (2000). Standpoint epistemology and the uses of self-reflection in feminist ethnography: Lessons for rural sociology. *Rural Sociology*, *65*(2), 194-214. https://doi.org/10.1111/j.1549-0831.2000.tb00025.x

Noyes, J., Booth, A., Cargo, M., Flemming, K., Harden, A., Harris, J., ... & Thomas, J. (2019). Qualitative evidence. *Cochrane Handbook for Systematic Reviews of Interventions*, 525-545. https://doi.org/10.1002/9781119536604.ch21

Page, M. J., Shamseer, L., & Tricco, A. C. (2018). Registration of systematic reviews in PROSPERO: 30,000 records and counting. *Systematic Reviews*, *7*(1), 1-9. https://doi.org/10.1186/s13643-018-0699-4

Parola, V., Coelho, A., Cardoso, D., Sandgren, A., & Apóstolo, J. (2017a). Prevalence of burnout in health professionals working in palliative care: a systematic review. *JBI Database of Systematic Reviews and Implementation Reports*, *15*(7), 1905-1933. https://doi.org/10.11124/JBISRIR-2016-003309

Parola, V., Coelho, A., Cardoso, D., Sandgren, A., & Apostolo, J. (2017b). Burnout in palliative care settings compared with other settings: A systematic review. *Journal of Hospice & Palliative Nursing*, *19*(5), 442-451. https://doi.org/10.1097/NJH.0000000000000370

Payne, N. (2001). Occupational stressors and coping as determinants of burnout in female hospice nurses. *Journal of Advanced Nursing*, *33*(3), 396-405. https://doi.org/10.1046/j.1365-2648.2001.01677.x

Peters, L., Cant, R., Sellick, K., O'Connor, M., Lee, S., Burney, S., & Karimi, L. (2012). Is work stress in palliative care nurses a cause for concern? A literature review. *International Journal of Palliative Nursing*, *18*(11), 561-567. https://doi.org/10.12968/ijpn.2012.18.11.561

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., ... & Shimoinaba, K. (2013a). Emergency and palliative care nurses' levels of anxiety about death and coping with death: A questionnaire survey. *Australasian Emergency Nursing Journal*, *16*(4), 152-159. http://dx.doi.org/10.1016/j.aenj.2013.08.001

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., ... & Shimoinaba, K. (2013b). How death anxiety impacts nurses' caring for patients at the end of life: a review of literature. *The Open Nursing Journal*, *7*, https://dx.doi.org/10.2174%2F1874434601307010014

Polit, D. F., & Beck, C. T. (2009). International gender bias in nursing research, 2005–2006: a quantitative content analysis. *International Journal of Nursing Studies*, *46*(8), 1102-1110. https://doi.org/10.1016/j.ijnurstu.2009.02.002

Pompili, M., Rinaldi, G., Lester, D., Girardi, P., Ruberto, A., & Tatarelli, R. (2006). Hopelessness and suicide risk emerge in psychiatric nurses suffering from burnout and using specific defense mechanisms. *Archives of Psychiatric Nursing*, *20*(3), 135-143. https://doi.org/10.1016/j.apnu.2005.12.002

Powell, M. J., Froggatt, K., & Giga, S. (2020). Resilience in inpatient palliative care nursing: a qualitative systematic review. *BMJ Supportive & Palliative Care*, *10*(1), 79-90. http://dx.doi.org/10.1136/bmjspcare-2018-001693

Radbruch, L., De Lima, L., Knaul, F., Wenk, R., Ali, Z., Bhatnaghar, S., ... & Pastrana, T. (2020). Redefining palliative Care—A new consensus-based definition. *Journal of Pain and Symptom Management*, *60*(4), 754-764. https://doi.org/10.1016/j.jpainsymman.2020.04.027

Raudenská, J., Steinerová, V., Javůrková, A., Urits, I., Kaye, A. D., Viswanath, O., & Varrassi, G. (2020). Occupational burnout syndrome and posttraumatic stress among healthcare professionals during the novel Coronavirus Disease 2019 (COVID-19) pandemic. *Best Practice & Research Clinical Anaesthesiology*. https://doi.org/10.1016/j.bpa.2020.07.008

Redinbaugh, E. M., Schuerger, J. M., Weiss, L. L., Brufsky, A., & Arnold, R. (2001). Health care professionals' grief: a model based on occupational style and coping. *Psycho‐Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer*, *10*(3), 187-198. https://doi.org/10.1002/pon.507

Reid, F. C. (2013). Lived experiences of adult community nurses delivering palliative care to children and young people in rural areas. *International journal of palliative nursing*, *19*(11), 541-547. https://doi.org/10.12968/ijpn.2013.19.11.541

Reid, A. M., Brown, J. M., Smith, J. M., Cope, A. C., & Jamieson, S. (2018). Ethical dilemmas and reflexivity in qualitative research. *Perspectives on Medical Education*, *7*(2), 69-75. https://doi.org/10.1007/s40037-018-0412-2

Rokach, A. (2005). Caring for those who care for the dying: Coping with the demands on palliative care workers. *Palliative & Supportive Care*, *3*(4), 325-332. https://doi.org/10.1017/s1478951505050492

Rose, J., & Glass, N. (2009). An investigation of emotional wellbeing and its relationship to contemporary nursing practice. *Collegian*, *16*(4), 185-192. https://doi.org/10.1016/j.colegn.2009.08.001

Santiago-Delefosse, M., Gavin, A., Bruchez, C., Roux, P., & Stephen, S. L. (2016). Quality of qualitative research in the health sciences: Analysis of the common criteria present in 58 assessment guidelines by expert users. *Social Science & Medicine*, *148*, 142-151. https://doi.org/10.1016/j.socscimed.2015.11.007

Schneiderman, N., Ironson, G., & Siegel, S. D. (2005). Stress and health: psychological, behavioral, and biological determinants. *Annual Review of Clinical Psychology*, *1*, 607-628. https://dx.doi.org/10.1146%2Fannurev.clinpsy.1.102803.144141

Schroeder, K., & Lorenz, K. (2018). Nursing and the future of palliative care. *Asia-Pacific Journal of Oncology Nursing*, *5*(1), 4. https://dx.doi.org/10.4103%2Fapjon.apjon_43_17

Seed, S., & Walton, J. (2012). Caring for self: The challenges of hospice nursing. *Journal of Hospice & Palliative Nursing*, *14*(7), E1-E8. https://doi.org/10.1097/NJH.0b013e31825c1485

Sideri, S., Papageorgiou, S. N., & Eliades, T. (2018). Registration in the international prospective register of systematic reviews (PROSPERO) of systematic review protocols was associated with increased review quality. *Journal of Clinical Epidemiology*, *100*, 103-110. https://doi.org/10.1016/j.jclinepi.2018.01.003

Sekse, R. J. T., Hunskår, I., & Ellingsen, S. (2018). The nurse's role in palliative care: A qualitative meta-synthesis. *Journal of Clinical Nursing*, *27*(1-2), e21e38. https://doi.org/10.1111/jocn.13912

Thomsen, S., Soares, J., Nolan, P., Dallender, J., & Arnetz, B. (1999). Feelings of professional fulfilment and exhaustion in mental health personnel: the importance of organisational and individual factors. *Psychotherapy and Psychosomatics*, *68*(3), 157-164. https://doi.org/10.1159/000012325

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45. https://doi.org/10.1186/1471-2288-8-45

Tunnah, K., Jones, A., & Johnstone, R. (2012). Stress in hospice at home nurses: a qualitative study of their experiences of their work and wellbeing. *International Journal of Palliative Nursing*, *18*(6), 283-289. https://doi.org/10.12968/ijpn.2012.18.6.283

Twining, P., Heller, R. S., Nussbaum, M., & Tsai, C. C. (2017). Some guidance on conducting and reporting qualitative studies. *Computers & Education, 106*, 1-9.
https://doi.org/10.1016/j.compedu.2016.12.002

Van Mechelen, W., Aertgeerts, B., De Ceulaer, K., Thoonsen, B., Vermandere, M., Warmenhoven, F., ... & De Lepeleire, J. (2013). Defining the palliative care patient: a systematic review. *Palliative Medicine*, *27*(3), 197-208. https://doi.org/10.1177/0269216311435268

Weinberg, A., & Creed, F. (2000). Stress and psychiatric disorder in healthcare professionals and hospital staff. *The Lancet*, *355*(9203), 533-537. https://doi.org/10.1016/S0140-6736(99)07366-3

White, K., Wilkes, L., Cooper, K., & Barbato, M. (2004). The impact of unrelieved patient suffering on palliative care nurses. *International Journal of Palliative Nursing*, *10*(9), 438-444. https://doi.org/10.12968/ijpn.2004.10.9.16049

Wilkes, L., Beale, B., Hall, E., Rees, E., Watts, B., & Denne, C. (1998). Community nurses' descriptions of stress when caring in the home. *International Journal of Palliative Nursing*, *4*(1), 14-20. https://doi.org/10.12968/ijpn.1998.4.1.9126

World Health Organization. (2014). Strengthening of palliative care as a component of integrated treatment throughout the life course. *Journal of Pain & Palliative Care Pharmacotherapy*, *28*(2), 130-134. https://doi.org/10.3109/15360288.2014.911801

World Health Organization. (2018**).** *International Classification of Diseases for Mortality and Morbidity Statistics (11th Revision)***.**
https://icd.who.int/browse11/l-m/en

Yang, M. H., & Mcilfatrick, S. (2001). Intensive care nurses' experiences of caring for dying patients: a phenomenological study. *International journal of palliative nursing*, *7*(9), 435-441. https://doi.org/10.12968/ijpn.2001.7.9.9302

Zanatta, F., Maffoni, M., & Giardini, A. (2020). Resilience in palliative healthcare professionals: a systematic review. *Supportive Care in Cancer*, *28*(3), 971-978. https://doi.org/10.1007/s00520-019-05194-1

Zheng, R., Lee, S. F., & Bloomer, M. J. (2018). How nurses cope with patient death: A systematic review and qualitative meta-synthesis. *Journal of Clinical Nursing*, *27*(1-2), e39-e49. https://doi.org/10.1111/jocn.13975

Chapter II: Empirical Paper

Exploring the Lived Experience of Clinical Psychologists Supporting Medical Staff Treating Covid-19 Patients

This chapter was written in preparation for submission to the Journal of Clinical Psychology. Appendix K provides details of the author guidelines for this journal. Overall chapter word count 7,996 (excluding abstract, tables, figures, and references).

Abstract

Background: During the Covid-19 pandemic clinical psychologists have offered formal and informal support to medical staff. This has meant the rapid redeployment for many psychologists into staff support roles, often without training, experience, or guidance. Literature shows psychologists can place large burdens on themselves when placed in demanding situations and environments, which may lead to stress and burnout. However, exposure to stressors within the workplace can also lead to positive outcomes.

Aim: This study aims to gain an understanding of clinical psychologists' experiences of supporting medical staff treating Covid-19 patients.

Method: Ten clinical psychologists were interviewed about their experiences. Interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA).

Results: IPA analysis resulted in three superordinate themes: *Re-affirming professional identity, Navigating change and uncertainty,* and *"Can I go back to my day job?".*

Conclusion: Findings highlight occupational and personal factors that impact clinical psychologists' sense of professional identity, how they experience rapid and unplanned changes in their roles, and how they attend to their self-care. There are potential benefits for those concerned with the role of clinical psychologists in healthcare systems, to consider how they plan for and respond to rapid change, and how to promote insight and self-care when responding to the personal impact of rapid and significant changes.

Keywords: Covid-19; Clinical Psychologists; Staff Support; Mental Health; NHS

Introduction

A pandemic can be defined as an infectious disease occurring worldwide, usually affecting a large number of people (Last et al., 2001). Pandemics raise medical, ethical and organisational challenges including priority setting, triaging of patients, allocation of resources, and restricting individual liberties in the interests of public health (Simonds & Sokol, 2009). The Covid-19 pandemic is likely to put healthcare staff across the world in unprecedented situations, having to make impossible decisions and work under extreme pressure (Wu et al., 2020). It is possible that, under such circumstances, healthcare workers may be unable to provide high-quality services or may even fail to practice ethical professional standards (Johnstone & Turale, 2014; Maunder et al., 2008; Ruotsalainen et al., 2014).

Exposure to significant personal and professional challenging circumstances can cause some healthcare workers to experience moral injury or mental health problems (Greenberg et al., 2020; Litz et al., 2009; Williams & Kemp, 2019). Indeed, studies have identified increased rates of Post-Traumatic Stress Disorder (PTSD) symptoms and other mental health problems in hospital staff exposed to stressors such as emergency situations, patients' deaths, and team conflicts (He et al., 2020; Schäfer et al., 2018). Wong et al. (2005) investigated the psychological impact of the Severe Acute Respiratory Syndrome (SARS) outbreak on healthcare workers in emergency departments. From 466 questionnaire responses from doctors, nurses, and healthcare assistants, they found significantly increased levels of distress, loss of control, increased vulnerability, fear for their own health and fear of the spread of the virus (Wong et al., 2005). Their findings are supported by a range of studies that have considered the negative psychological impact on organisations and individuals following the Middle East Respiratory Syndrome (MERS), SARS, and Ebola outbreaks (Brooks et al., 2018; Ji et al., 2017; Khalid et al., 2016; Maunder et al., 2008). Ji et al. (2017) highlighted that following the Ebola outbreak, medical staff showed an increased risk of a range of symptoms including obsession-compulsion, anxiety, hostility, phobic anxiety, and paranoid ideation.

Research with healthcare staff providing care during Covid-19 has already been undertaken. A recent study from Lai et al. (2020) surveyed healthcare staff working in hospitals for patients with Covid-19 in China. Between January and February 2020, Lai et al. (2020) surveyed 1,257 health care staff working across 34 hospitals. Participants experienced increased psychological burden, including symptoms of depression, anxiety, insomnia, and distress; they were identified to be especially vulnerable if they were in nursing roles, women, or frontline health care workers directly engaged in the diagnosis, treatment, and care for patients with Covid-19 (Lai et al., 2020). While maintaining staff mental health is essential to better control infectious diseases, the best approach to this during the epidemic season remains unclear (Wu et al., 2020).

Whether someone develops a psychological injury or experiences psychological growth is likely to be influenced by the way that they are supported before, during, and after a challenging incident (Greenberg et al., 2020). Psychological well-being can be influenced by personal, environmental, and work factors, with associations between changes within the workplace environment and well-being, and between work-life balance and well-being (Loretto et al., 2005). However, while some positive experiences from healthcare staff during pandemics, including Covid-19, have been reported in the literature, the overwhelming focus has been on the negative aspects of their experiences (Billings et al., 2020; Bennett et al., 2020).

Working psychologically with teams is a fundamental role for practitioner psychologists (Health and Care Professions Council [HCPC], 2015). Clinical Psychologists (CPs) have established clinical and leadership positions within healthcare teams including supporting medical teams with ‘difficult’ patients, working directly with mental health issues, providing capacity assessments, staff supervision, and leading and contributing to service development and quality improvement projects (Bonin, 2018; Donaghay-Spire et al., 2016; Palmer & Harmell, 2016; Robiner & Pertrik, 2017; Snowdon et al., 2017).

National Health Service (NHS) staff are continually being asked to do more with fewer resources (Wilkinson, 2015), with staff being put under pressure from increased work demands, among others they are expected to reach higher performance targets (Henshall et al., 2018). Furthermore, CPs working within the NHS are not immune to the effects of the same stress that others in the healthcare system are under (Tay et al., 2018). In their caring roles, psychologists can place large burdens on themselves and risk the development of stress and burnout (D’souza et al., 2011; Kaeding et al., 2017; McCormack et al., 2018). Increased stress resulting from the challenges of a prolonged response to Covid-19 has been reported amongst hospital personnel, including caregivers, support staff, administration, and emergency response teams, whilst leadership and self-care are central components of the response (Adams & Walls, 2020).

It is recognised that psychological professionals need to take care of themselves and each other physically, emotionally and psychologically as they respond to a high level of need. Supervision, time off, and self-care are all important to allow psychological professionals to continue to serve effectively (BPS, 2020a; Johnson et al., 2020a). A systematic review by Hannigan et al. (2004) found that many CPs practising in the United Kingdom (UK) experienced significant levels of psychological distress. Moreover, their review reported that organisational and professional factors may act in ways that inhibit the capacity of psychologists to seek and obtain support for stress at work (Hannigan et al., 2004). There is a paucity of research into impact of job demands on the psychological well-being of practitioner psychologists (McCormack et al., 2018), and even less specifically considering CPs (Allwood et al., 2020; Johnson et al., 2020a).

The BPS's guidance for psychological professionals during the Covid-19 pandemic highlighted supporting the well-being of staff in their organisations as important to continue during the pandemic and beyond (BPS, 2020a). To help with this, the BPS Covid19 Staff Well-being Group has recently published guidance on the psychological needs of healthcare staff as a result of the Coronavirus pandemic (BPS, 2020b). However, there remains a lack of evidence from studies carried out during or after disease outbreaks, epidemics and/ or pandemics, that helps expand our knowledge of the mental health of frontline health and social care staff (Pollock et al., 2020).

Rationale and Aim

Covid-19 is an unprecedented challenge for the NHS and CPs play a central role in the support provided to medical staff who have been impacted physically and psychologically by heavy workloads, the risk of infection, sleep deprivation, loss of colleagues, and sometimes providing care in less than adequate settings (Germine et al., 2020; Greenberg et al., 2020). Research which expands our understanding of how CPs are experiencing the provision of support for health and social care staff during a global pandemic is important. As such, this qualitative study aims to use Interpretative Phenomenological Analysis (IPA) to explore the lived experience of CPs supporting medical staff treating Covid-19 patients.

Methodology

Research Design

This study is grounded in phenomenology, a philosophical approach that is concerned with the enquiry of the conscious experience of individuals (Smith et al., 2009). Phenomenology aims to produce an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions (Chan et al., 2013; Smith et al., 2009).

IPA is a qualitative approach which aims to provide detailed examinations of personal lived experience. It is concerned with trying to understand what an individual’s unique experience is like, from the point of view of the participant. IPA employs key concepts from phenomenology, hermeneutics, and idiography. IPA is phenomenological, and draws on the work of Husserl, Heidegger, and Sartre to focus on experience and perception, intersubjectivity, and personal and social relationships (Smith et al., 2009). It is also concerned with hermeneutics, particularly *“the hermeneutic circle”* and its role in helping us understand the data by moving between the part and the whole (Smith et al., 2009 p. 27-28). Finally, IPA uses an idiographic approach to gain in-depth knowledge of the meaning of something for a particular person (Smith et al., 2009).

IPA researchers use a systematic and thorough approach to bring meaning to participants’ experiences. A detailed IPA analysis can involve asking critical questions of participants’ data to further deepen the understanding of their experiences (Smith, 1996; 2011; Smith & Osborn, 2009). This study used semi-structured interviews which offer a flexible data collection instrument and supports the research aim of collecting and analysing in detail how participants perceive and make sense of things which are happening to them (Smith et al., 2009).

Inclusion and Exclusion Criteria

Participants' inclusion and exclusion criteria are shown in Table 7.

Table 7

Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Job role	Clinical Psychologist, HCPC registered	Any other job role
Setting	Tertiary Care, in-patient, NHS, England	Primary Care or community, non-NHS settings, any other part of the UK
Patient group	Patients with confirmed or suspected Covid-19 infection	Patients without confirmed or suspected Covid-19 infection
Clinical activity	Formal support to medical staff (i.e., supervision, reflective practice, incident debrief)	Informal support

Participants were included if they were CPs working in England. Since devolution of health systems in 1999, NHS policies and structures in the four countries of the UK have diverged (Jeffrey, 2007; Walshe & Davies, 2013). This can be illustrated by examples from both clinical practice as well as in general interprofessional working policies (Beech & Verity, 2019; Hoare et al., 2015; Rout et al., 2011; Winterton et al., 2009). Consequently, to avoid participants' heterogeneity, CPs working outside of England were excluded.

Participants were included if their roles involved providing formalised support to medical staff (individuals or teams) who were involved in the care of patients being given inpatient hospital treatment for Covid-19 symptoms. This could be in the format of one to one or group supervision, facilitation of reflective practice groups, or incident debriefing. This enabled participants to reflect on and discuss their individual experiences, whilst also retaining their ability to provide access to their shared experiences (Smith et al., 2009).

Materials

A semi-structured interview schedule was developed in collaboration with academic supervisors (Appendix L). Questions and prompts were prepared in order to facilitate an open and expansive discussion, whilst allowing participants to recount their own experience (Smith et al., 2009).

Procedure

Ethics

This study was undertaken in accordance with the BPS Code of Ethics and Conduct (2018), Ethics Guidelines for Internet-mediated Research (2017), Data Protection Regulations (2018), and Code of Human Research Ethics (2014). Ethical approval was gained from Coventry University Ethics Committee (Appendix M).

Recruitment

Purposive sampling was utilised for this study. The study details were disseminated through the academic supervisors’ professional networks, including online platforms such as CP Facebook group and Twitter (Rodham & Gavin, 2006). The recruitment poster (Appendix N) was posted on the group’s page.

Interested CPs emailed the researcher and were sent a Participant Information Sheet (Appendix O) with information about the purpose of the study, benefits and risks to taking part, and what participation would involve, as well as the Informed Consent Form (Appendix P). They were given the opportunity to ask any questions about the study before returning their signed Informed Consent Forms.

All 10 interviews were undertaken online, via Microsoft Teams, between May and September 2020. This coincided with the period between the peaks of the first wave in April 2020 and second wave in November 2020. The interviews lasted between 62 and 80 minutes. Interviews were audio recorded for later transcription and analysis.

On completion of the interview, the Debrief form (Appendix Q) was emailed to provide participants with further information regarding the nature of the study, how to withdraw from the study, how to contact the research team, and sources of support. Each interview was audio recorded and transcribed verbatim by the lead researcher, during which any personal identifiable information was removed and pseudonyms were allocated to preserve participants' anonymity.

Data Collection

Participants

To make meaningful interpretations of a particular perspective using IPA, participants were drawn from a homogenous group (Smith et al., 2009, p.49-50). Based on inclusion and exclusion criteria 10 participants (6 female, 4 male) were recruited to the study. Participants were all CPs already working in hospital-based clinical health psychology services and were working at NHS band 8a or above. However, to reduce potential bias based on assumptions related to age or clinical experience, and protect participants' anonymity, the only relevant personal characteristic gathered was gender (American Psychological Association [APA], 2020). Information on gender has been gathered as there is an imbalance within the profession of clinical psychology (80% female to 20% male) which is acknowledged both within the profession and the literature (Clearing House for Postgraduate Courses in Clinical Psychology; Johnson et al., 2020b).

Analysis

Following transcription, the data was analysed using the six-step approach outlined by Smith et al. (2009; Table 8 in Appendix R).

IPA analysis using NVivo

Qualitative synthesis involves handling large volumes of data, and there needs to be an effective system for managing, collating, and synthesising data (Brunton & Thomas, 2012). Computer-based systems can be used to conduct the IPA process (Smith et al., 2009). NVivo is a Computer Assisted Qualitative Data Analysis (CAQDAS) which has features that can support a rigorous analysis consistent with IPA (Flowers et al., 2011). NVivo was used to organise data while also retaining the richness and complexity of each participant's contribution (Clabburn et al., 2019). A detailed description of how NVivo was used can be found in Appendix S, with examples of the stages shown in Appendices T to X.

Validity

To ensure data reliability, a second member of the research team undertook independent analysis on a selection of the data. The independent analyses were compared, and similarities and differences discussed. Reflective discussions took place within research supervision meetings around the data analysis and final themes.

Reflexivity

The researcher adopted an interpretivist epistemological position. Interpretivism seeks to explore the subjective nature or dynamics of the individual's experience to gain a better understanding of the issues involved (Willis, 2007; Suter, 2011). Within IPA, researchers are using their own position, knowledge, and experience to try to interpret participants’ meaning-making of their experience. (Smith et al., 2009).

The researchers’ position as a Trainee CP should be acknowledged as both a potential facilitator and barrier to the interpretation of the data. In planning and undertaking this research, steps were taken to ‘bracket’ preconceptions to ensure the analysis and interpretations were grounded in the data (Brocki & Wearden, 2006; Golsworthy & Coyle, 2001). Prior to interviews, a bracketing exercise was held with the research team to identify assumptions and preconceptions that may bias the research process. These assumptions included that participants would be supported in their roles, that the impact of supporting others would be overwhelming, and that they may not be coping at work. To aid identification of any potential bias or influence, a reflective journal was kept while interviewing, and regular reflective supervision meetings were held during the entire research process (Biggerstaff & Thompson, 2008; Vicary et al., 2017).

Results

Data analysis resulted in three superordinate themes, and six subordinate themes. A summary of themes is presented in Table 8 and discussed below with participant quotes included to support the interpretive analysis of participants' data (Smith et al., 2009). Additional quotes are provided in Appendix Y.

Table 8

Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Re-affirming professional identity	*"…We do something that's useful…"*
	Togetherness – "…we are part of this family together, a battalion together."
Navigating change and uncertainty	*"Lost at sea"*
	"…just making it up as we went along…"
"Can I go back to my day job?"	*"Feeling swamped"*
	"I don't know…when I can be off"

Theme 1

Re-affirming professional identity

This superordinate theme highlights the central role of professional identity for CPs, as they described feeling able to do something that's useful and being a part of a wider team or system.

Participants' professional identity as a CP was perceived as central to who they were as people. Their experience of being able to support staff seemed to reaffirm the significance of professional identity even more. Many participants found the sudden change of job role to provision of staff support left them questioning what it meant to them to be a psychologist. In terms of the emotional impact, there was a shared excitement to work in new clinical areas, and in new ways, they may not otherwise have been able to experience.

“…We do something that’s useful…”

For the majority of participants, staff support was a new experience which required them to adapt to new ways of working and in new environments. Many spoke about how they felt their experiences had re-affirmed what it meant to be a psychologist. For some, this affirmation was experienced alongside excitement and an appreciation of providing support to medical staff when it was needed:

> *“So it’s been quite interesting from my perspective it’s been great, to do you things I haven’t been able to do before, so it’s been exciting. The work’s being much more varied than I've had before and its really exciting meeting staff where they are in their place of work, and working with them in a kind of immediate sense.”*
>
> (Julia, lines 133-137)

Many participants identified a connection with an internal drive to feel helpful and described it as being a positive experience, *“I think there was a real drive…to feel like we were doing something which…probably was an internal drive to feel that we’ve been helpful”* (Thomas, lines 105-107). For some participants, this was related to being asked to provide advice and guidance more that they had been in the past:

> *"…I had a manager ring me up today and say "oh can I just pick your brains?", somebody who would never normally have done that, "can I just pick your brains over the phone about something?", and it was a five minute conversation, but again I was able to send them a document, and point them in the right direction, and, you know, if that doesn't work they can come back to me. And that feels much more useful. It's funny isn't it, we do want to be helpful (laughter)."*
>
> (Julia, lines 403-409)

Alice described a deepening understanding of what it meant to be a psychologist. Here, she acknowledged the usefulness and uniqueness of what CPs do. Her laughter suggests this may be in contrast to a different perception of CPs:

> "*I think that's been even…more…brought to the fore…with, with this kind of work…So, you know, how do we do something that's useful, is evidenced based, that is…'being a psychologist' and isn't something that just anyone else could do. This is real, you know, proper (laughter) clinical psychology."*
>
> (Alice, lines 617-621)

Many participants felt privileged to be able to support medical staff. This was connected to the value that was perceived in supporting staff who may not have received psychological support before. Rachel discussed how it is important to her to reflect on how she felt being present for staff when they needed it:

> *"…I support staff who aren't used to talking about their feelings, and their emotions, and…psychology can be a bit unfamiliar to some of them. Completely welcomed by others, but I found it to be such a privilege to…be there and be present, when people needed it. And that, is something that I take away from this process…which is a really, a nice thing to kind of carry with me, that it felt worth it, it felt worth it to be there."*
>
> (Rachel, lines 951-956)

Also important to participants was receiving feedback or having a sense that they had done something helpful. The sense of reward or feeling useful seemed to reaffirm the reasons for why they were CPs as expressed by Alice:

> *"So I think it's when, you know you've made a difference, I guess that's what we all want, isn't it. We go in to healthcare to make a difference, so, the rewarding bit is getting that feedback…"*
>
> (Alice, lines 668-670)

While overwhelmingly a positive experience, many of the participants also described their mixed emotions about the work undertaken and how this made them feel as psychologists. For Julia the depth and breadth of psychological work she needed to conduct filled her with *"absolute fear"* as well as *"excitement":*

> *"So all of that kind of rich vein of…psychological work and thought, and the group dynamics, there's organisational dynamics…It's been…just amazing, because you don't get that in any other circumstance, you know people tip toe*

> *around it...but it’s been on show. And actually…the fear, the absolute fear of having to work with that (laughter), but all the excitement of…what that feels like as a psychologist, that…that's…something that…certainly is around at the moment”*
>
> (Julia, lines 656-661)

Togetherness – “…we are part of this family together, a battalion together.

Feelings of connection to medical staff were prominent within participants’ experiences. For some, these experiences were described using militaristic language of being on the *“frontline”* and part of *“battalion”*. Thomas also identified that this feeling of connection with medical staff was very important to his experience, something that was not just felt, but needed to be felt:

> *“I think we felt…I think there was a need from all of us to feel like, well, we know that a lot of our colleagues in the acute hospital are…on the frontline, having a really, having a lot of difficulties…and we wanted to try and support them, but I suppose, we also, part of it…is we wanted to feel like we were doing something as well.”*
>
> (Thomas, lines 134-138)

Julia highlighted that while the military language is commonly used when describing staff efforts during pandemic, not everybody finds this appropriate. She did however feel that CPs “*are part of this family together, a battalion together”* (lines 528-529). Providing staff support was seen by some as an opportunity to work closely “*on the frontline*” of the Covid-19 response and participants described their colleagues with respect and admiration. Martin talked about having to *"earn the 'right*" to provide staff support and the importance of working alongside other staff:

> *"And for me…supporting staff, supporting colleagues is something you…earn the right to do, if you know what I mean? We, we kind of earn the right to support our colleagues…as a kind of an effect, as a benefit of, 'mucking in' really, and being on the frontline…and working with, and alongside…our our colleagues. Working with patients and the delivery of patient care."*
>
> *(*Martin, lines 90-94)

Lucy also talked about the importance of supporting medical staff seeing it as "*a part of the collective effort"* and discussed feeling responsible *"to not short-change people [who she is] I'm working with"* (lines 448-451).

For some participants, like David, following media reports on medical staff brought the motivation to help acting as "*…a 'pull of duty' and a want to kind of help and get stuck in*" (David, line 297). For Julia the possibility of remote working ruptured her sense of 'collective togetherness':

> *"…my colleagues in the hospital, who I have been serving for the last three years, they were going to have to step up and potentially lose their lives, to step up and treat this. Actually, going home and saying, "Well I can work from home, I can work remotely", it just, it was not an option."*
>
> (Julia, lines 502-505)

Additionally, participants reflected that the experience of feeling a part of the NHS, or its “battalion”, have and continued to change them in a way they did not expect:

> *“So, yes, I think it’s going to continue to change me. It’s also, hugely rewarding to know how strong we’ve been together. I don’t know how long, if that lasts or not. But, oh my god, the NHS is amazing. Truly awe inspiring. And some of the stories I’ve heard, yes they’re hard to hear and to bear, and to hold, but also incredibly inspiring. You know. Yeah. It’ll change all of us.”.*
>
> (Michelle, lines 419-423)

Theme 2

Navigating Change and Uncertainty

This theme highlights how participants experienced the process of adjustment to constantly changing situation.

“Lost at sea”

Some participants felt that decisions regarding psychologists providing staff support were being made very quickly. Some, like Lucy felt unsure about how they were able to contribute: *“Where is psychology’s role in this? Where’s my role? As the major trauma psychologist, do I have anything to do with this covid thing or not, or do I carry on as normal?”* (lines 196-198). Rapidly changing official guidance often left participants wondering how they were supposed to demonstrate leadership themselves, articulated here by Michelle:

> *“The government changes its mind every day, about what’s safe and what’s not and what is and isn’t going to happen. How can I lead, and look as if I*

> *know what I’m talking about when…how do people I work with in Leadership in the Trust look as if they know what they’re talking about? The change is horrendous.”*
>
> (Michelle, lines 286-289)

Some participants discussed how their services were stopped with little or no advanced notice. This, combined with an absence of clear guidance on what to actually do, left some of them feeling lost:

> *“…it’s actually me…sitting…there saying, kind of…trying to… make myself feel better, that I'm sitting there with very little work to do, in terms of…practical physical work to do…And I’m aware that, some of my colleagues in acute…hospital are doing so much, and it kind of felt like, well, what can I do, what, what can I do to try and support them, what can I do to, I suppose in a way, try and keep busy…”*
>
> (Thomas, lines 277-283)

While most participants attributed feeling lost to the rapidly changing situation around them, Martin expressed the feelings of uncertainty could be attributed to the lack of guidance:

> *“I do feel for a lot of my colleagues...who I think, you know, were a bit…the best way I could describe it was with a metaphor at the time…and I think the metaphor was a bit ‘lost at sea’…and that felt like…how…at the time…there wasn't really a very clear…course…that was being, kind of, steered…”.*
>
> (Martin, lines 228-231)

There was an awareness amongst participants that the pandemic was an unprecedented situation, in which "*we don't know what we're going to see…I don't have…solutions for you"* (Rachel, lines 390-392). Thus feeling unsure about how they could support staff was acknowledged as understandable, *"I guess it's…I was trying to figure out 'what does normal critical care staff support look like?' And then a pandemic hits, and you think 'nothing's normal about this'."* (Luke, lines 184-186).

While trying to constantly adjust to the rudderless official advice, some participants reflected on how they tried to portray things were under control as articulated by Alice:

> *"And I'm going, "Yes, that's fine." to everything…but oh my goodness but what…I think for me, and for my colleague, we're really struggling with the…"What is 'this'?".* (lines 410-412).

"…just making it up as we went along…"

Many participants described a sense that decisions by the government, their trust, and leadership teams were being made reactively rather than proactively, *"…just making it up as we went along…"* (Martin, lines 281-282). Some acknowledged that given the circumstances were unprecedented, stepping back and being able to reflect before taking action was important, *"…it was much more about, let's just kind of…think about this…none of us have been through this before.".* (Rachel, lines 391-392). Rachel describes this feeling of anticipation, responsibility, and an approaching uncertainty:

> *“Very quickly they wanted…us to kind of go down, “What can we do?”, “How can we support staff?”, “How can we manage”, “How are we going to cope”…”What's coming our way?”, kind of a real threat response…”Can you fix…?”, which obviously we can’t…and…we, we sit with that, but also we didn't know what was coming. So, we sit with that, and I’m kind of, “Ok, can I think of my best ideas about…how to cope, with stress and pressure?”. But I don't know what we're about to experience, and none of us do.”*
>
> (Rachel, lines 156-163)

Participants felt various emotions, ranging from feeling anxious to excited and feeling free to make new choices. Here, Martin described what it felt like:

> *“…it was quite exciting really. I mean it was quite…it was quite anxiety inducing, but it was, there was also this kind of…the real sense of being able to have this…freedom…just to kind of do something…without having to ask, or, or, or like put forward a business case. And there was this real sense of kind of ‘Wow’, you know, you could just go and seek out these opportunities…and…so I think I just sort of sent a message to them saying “I’m going to do this…”.*
>
> (Martin, lines 270-276)

Many participants talked about being comfortable with uncertainty, accepting they have no greater insight than anyone else around how to respond. For, Alice, it meant “*[getting] comfortable with the kind of, I'm going to…remain true to the* *evidence base, but…[knowing] that there isn't a…template of how to do this"* (lines 321-325).

This experience of having to navigate a totally new working environment was articulated by Michelle who talked about "*Mars*" as the planet, its *"craters*" and *"volcanos"* illustrating her feelings of uncertainty, pressure, danger, and the sense of alienness and urgency this creates:

> "…*like we've landed on Mars. And somebody has said, ok you need to get your way around this planet. You've never been here before. You need to know which routes to take to get from A to B. You need to know where the craters are, so you don't fall in. You need to know where the volcanos are, so if they erupt you don't get rained on. You need to know the climate. And you need to know it right now and you've just landed. It's impossible."*
>
> (Michelle, lines 232-237)

For those CPs who were new to providing staff support on such unprecedented scale, there was a need to remember that psychologists are used to working without answers. Lucy compared the new role of providing staff support to the experience of undertaking psychological assessment and interventions:

> *"I think sometimes when I don't feel very clear, I just have to remind myself that it's part of a psychologists' job to not have a clear picture in the first place. We readily start assessments, interventions without knowing the full picture.*

> *And I think sometimes I just need to remind myself that it’s a similar process when you do staff support.”*
>
> (Lucy, lines 537-540)

Theme 3

“Can I go back to my day job?”

“Feeling swamped”

Participants often described feeling overwhelmed with the rapid pace of change and amount of information they were faced with. Alice talked about this being a mixture of feelings, *“I veer between…feeling exhausted and just thinking “Can I go back to my day job?”, which is busy anyway, to thinking “This is amazing. I'm really excited.””* (lines 438-439).

Sarah experienced *“that sense of…being…overloaded and…everything manic and everything rushed and… yeah…That is the overwhelming…sense that [she was] left with from that time.”*(lines 904-906). Rachel connected this feeling with that of nurses facing increased workload during the “first wave” of the pandemic:

> *“[She] felt swamped probably…even then, because…the swamping was a different, from a different way. …I had a number of staff coming my way, who were… needing support…and I suppose that…in a…in a way it then…made me feel like I was getting that first wave myself.”*
>
> (Rachel, lines 188-192).

Participants talked about their responses to professional networks sending out emails, hosting webinars, and sharing resources. There was a feeling that the volume and pace of delivery was challenging. Sarah recalled *"it was panicked…[with] overload of…information to begin with"* which she found *"really, really difficult…"*. The need "*at one point ..to just shut down [her] computer and say, I cannot open my emails, because it was just constant* "(lines 68-74), suggests the cognitive and emotional impacts of this experience were profound.

David, among others, to protect his well-being felt it was important to shift from "*to start with, … wanting to try and think about and try and find out about, you know what, what are the things that are going to be good for us to be doing … [to stopping] looking at all that stuff online, just because…it, it would be too much, it would keep my mind too active, it would stress me out…" (lines 738 – 743).* Having *"the up to date advice"* was on one hand helpful to some, like Luke, who found it "*to help [him] feel ground, shifted"* but who realised it came with a price of needing to "*then…think…extra about that. And then deal with the emotional fallout"* (lines, 377 – 380).

Some participants were also parents and talked about the need to balance their responsibilities. For Rachel, managing work and home life as a parent felt like *"dealing with these millions of spinning plates …and those spinning plates included the fact, kids were taken out of school, who's getting into work, covid…we got, we all got sick, who was in, who was out, who's covering etcetera."* (lines 216-220). Sarah found conversations relating to pandemic with friends outside of work "*really suffocating",* which she coped with by avoiding online social connections:

> *"I remember turning off my, like muting all my WhatsApp conversations, because I just couldn't bear another friend saying, "Have you seen this?", or what's going…you know, I couldn't handle…any questions…any comments, I just needed…to, to just…be away from it…Yeah it was really suffocating.".*
>
> (Sarah, lines 298-304)

The interviews were often the first time that participants had spoken about their experiences and for some this brought back feelings of pressure. This was the case for Rachel:

> *"…I can feel the pressure even just talking about it now. I can still feel that, intensity, because it was really intense at the start. It felt like, everyone was emailing, unboundried…hours, people were requesting things and needed it now…So it was interesting to observe…, it was a very unique experience, I think, in my whole career."*
>
> (Rachel, lines 201-206)

"I don't know…when I can be off"

Participants also described how where staff support had been received well, they were unprepared for the demands this may place on them. For Alice, the metaphor of 'unleashing a beast' articulated this well:

> *"I think I wish I'd known…just, we were joking I think, we have unleashed a beast…and I kind of wish I'd…had a bit of a 'heads up' for that, before we, before we did. In the sense of…we've been so physical, we've worked so*

> *hard, and everybody's said "This is great.", "This is brilliant.", "We love this.", "We want more.", and it's just become this, this huge…kind of, thing that we're being asked to take forward."*
>
> (Alice, lines 641-646)

Trying to manage boundaries between work and home was a common experience for participants. For some, it was a conscious priority to have a separation between being a CP at work and being able to 'switch off' after hours. Luke felt pressure to be 'on' all the time:

> *"…I feel like "When can I be off?". And that's not me being when can I be me, and when can I not be me. It's when am I not doing the role of staff support. So, I'm always me, but yeah…I guess the intention…behind what I'm trying to do or say, when is that on and when is that off.".*
>
> (Luke, lines 170-173)

Some participants recognised that their enthusiasm of trying something different could also make it more difficult to maintain their boundaries. For Alice this felt as "*a huge opportunity, and [she has] to be quite careful that, [her] excitement doesn't then pull [her] into…working a ridiculous amount of extra hours which…that has been an issue (laughter) in the past, for a few months" (*lines 440-442). For David, it was a feeling that staff support meant he was responsible for a much larger cohort of people, from *"40, or 50 or 60, sometimes, patients on [his] caseload … to, potentially, a thousand"* (lines 874-880).

Rachel also described having enjoyed their experience of supporting staff, while also acknowledging “*it's made [her] recognise…how much [she needs] to balance…being the psychologist…with being me”* (lines 1018 -1019).

Participants recognised that CPs tend to put pressure on themselves which at times meant they were working longer hours, as Alice recalled:

> *“I have worked…a stupid amount of extra hours…I'm usually…pretty good at not working at weekends…That’s gone out the window…I’ve, you know, quite regularly done…10 hour days…at…at the hospital…Some of that is…and nobody has asked me to do that, that’s just my… you know the pressure I put on myself, and I think that's…as psychologists we tend to, to be quite, quite like that…”*
>
> (Alice, lines 536-540)

For Rachel the innate need to respond to requests from people she knew connected with her sense of wanting to help, she recognised the need to have boundaries:

> *“…it would definitely leak into my…non-working days. Because they would be, “Oh, can I just run something by you?”, little messages from people that I like, and I know, and I would, give time to…if I were in the building. So, the pressures were there, but also you have to know you’re part of…saying, “Yes” to things. And I recognise that in myself. I definitely enjoy helping people out, but, need to watch myself, and look after myself as well. I can't give too much.”*
>
> (Rachel, lines 280-285)

The negative impact of not being able to keep work- life boundaries was expressed by several participants with young children at home. Rachel described how a lack of boundary between work and home led to her feeling *“…very ‘full up’ sometimes”* which leads to her *“definitely not as patient as I would have been pre-covid with [her] kids, if they're asking … for like, 90,000 snacks “* (lines 721-726).

Discussion

This study explored the experiences of CPs supporting medical staff treating Covid-19 patients in the UK in 2020. IPA analysis resulted in three superordinate themes, **Re-affirming professional identity, Navigating change and uncertainty,** and **“Can I go back to my day job?”.**

Re-affirming professional identity

This theme highlighted that all participants experienced their professional identity as central to who they were. For some, this happened through changes to their role or working environment, while others experienced this in relation to feeling rewarded, and receiving feedback from colleagues and medical staff. While some participants had more senior positions and leadership responsibilities, self-identities linked with leadership roles did not emerge as a prominent theme within interviews. Participants described how their professional identities were impacted through working in new and varied ways, often delivering psychological support in a more responsive and immediate timeframe. Many of them found identity as a CP to be re-affirmed and appreciated how this had been fostered during their experiences supporting medical staff.

The role of CPs within the NHS includes working within multidisciplinary teams (MDTs) not only as therapists but as supervisors, consultants, and trainers, with the aim of offering services that use their specialist knowledge and skills most effectively (Christofides et al., 2012; Lavender & Paxton, 2004). The importance of professional identity was evident in the interviews. Participants came from a range of clinical backgrounds and working at different levels within the NHS, and it was common for interviewees to begin interviews by letting me know in which medical speciality they worked.

A sense of ‘doing rewarding work’ was evident, and for some this was linked to an internal drive to be helpful. For most participants, their descriptions of professional identity were grounded in their descriptions of helping others. Other participants reflected on feedback they had received and how this connected with a desire to be helpful and to have purpose. Participants also described a sense of wanting to share the experience given providing support to colleagues was seen as a privilege, and a desire to ensure staff were not *“short-changed*”. Research within heath care teams has also shown that resilience is underpinned by social support, collective experience, adaptation, and team effectiveness (Alban-Metcalfe, 2018; Iflaifel et al., 2020; Matheson et al., 2016). Despite the obvious difficulties, participants’ sense of togetherness seemed to support their determination to continue.

Feelings of togetherness and a connection to frontline medical staff were common within participants’ accounts. This was evident both where participants supported staff they already knew, and when redeployed to work in new areas. Some participants felt that this was related to the messages seen in the media and on social media and related to the language of being on the *“frontline”*.

The social identity perspective suggests that individuals can hold in and out group membership positions (Abrams & Hogg, 2010; Tajfel & Turner, 1979). Crises may also reinforce a sense of community between social groups. Indeed, the perception of a shared traumatising experience increases the perception of being “*all in the same boat*” (Drury et al., 2016; Muldoon, 2020, pp. 84–88). In times of crisis, solidarity and cohesion within groups often increase as a result of greater feelings of “*oneness*” with the group (Segal et al., 2018, p. 574).

An individuals’ occupation or profession may form part of their identity (Caza & Creary, 2016; Schein, 1978). Occupational role changes can support the development of greater self-concept, self-awareness, and self-efficacy (Leary & Tangney, 2011). This study supports the recent meta-synthesis by Billings et al. (2020) which identified cohesiveness and camaraderie as frequent themes within the literature looking at healthcare workers’ experiences of working on the frontline during COVID-19 and comparable pandemics. Participants’ shared experiences of an increased sense of togetherness and cohesion suggest that while they did not share the same identity as medical staff, they could form strong bonds with colleagues and, when under pressure, see themselves as part of the “*same family*”. The current study supports this description of crisis simulating solidarity and social cohesion.

Navigating change and uncertainty

Participants’ shared experiences of redeployment resulted in feelings of being lost. For some, these largely sudden and unexpected changes led to them feeling unclear about their new staff support roles, including how to fulfil their leadership responsibilities. However, participants shared the experience of wanting to feel helpful, stepping into new roles without clear guidance on what to do, and working over and above their normal hours. Many participants seem to compensate for uncertainty by responding rapidly to requests for help and increasing their workload. Despite this, participants recognised this was the result of an unprecedented situation facing the NHS. Some participants discussed their experience of the unknown in their work with patients, and this seemed to offer them a reference point to help them cope with uncertainty.

Healthcare systems are complex and are required to continually evolving to adapt to epidemiological, demographic and societal shifts (Figueroa et al., 2019). Covid-19 presents many challenges to healthcare systems internationally, none more so than the significant reporting among healthcare workers (HCWs) of occupational fatigue and burnout (Whelehan et al., 2021). A recent mixed-methods study of NHS workers by Gemine et al. (2021), demonstrated that Covid-related changes to workload and responsibility, alongside a perceived lack of control, contributed to levels of staff burnout.

Intolerance of uncertainty has been linked with emotional states such as stress and anxiety (Brosschot et al., 2016; Grupe & Nitschke, 2013). In ‘unsafe uncertainty’, there is a loss of believing one can influence events and feelings of being overburdened (Mason, 1993, 2015). Participants’ descriptions of coping with this uncertainty seem to be supported by theoretical concepts found within Acceptance and Commitment Therapy (ACT). Where participants were able to acknowledge the uncertainty (acceptance) and see themselves going through a difficult experience (self as context), their focus seemed to be on providing support to staff as best they could.

“Can I go back to my day job?”

This theme highlighted that supporting medical staff during the Covid-19 pandemic was for CPs cognitively and emotionally challenging. Participants described feeling overwhelmed at the pace of change and overloaded with information. It was common for participants to want to be informed, but the frequency and volume of emails, webinars, and shared resources was fatiguing. For some, the interviews were the first time they had spoken about their experiences. These feelings of being overwhelmed could also extend to contact with friends and family outside of work. To cope, participants reported restricting access to information at work and limiting discussions about Covid-19 in their personal lives.

Links have been found between workplace change and well-being and between work-life balance and well-being (Loretto et al., 2005). Participants were not immune to the effects of the same stress that others in the healthcare system reported, placing them at the risk the development of stress and burnout (D’souza et al., 2011; Kaeding et al., 2017; McCormack et al., 2018; Tay et al., 2018).

Furthermore, participants shared accounts of trying to manage boundaries between work and home. For some, this was articulated as needing a cognitive, and physical, separation between being a CP and being able to switch off. There was the recognition from several participants their enthusiasm and excitement at new opportunities also made it more difficult for them to maintain their boundaries.

Strengths and Limitations

This study used IPA to explore how CPs made sense of their experiences supporting medical staff treating Covid-19 patients. Consequently, participants were able to speak about their experiences freely during their semi-structured interviews, while reflecting and developing their thoughts and ideas (Smith et al., 2009). Accordingly, the findings provide a rich analysis and deeper understanding of participants’ experiences of professional identity, navigating change, and self-care than would not be possible using quantitative research methods.

However, it is important to recognise that qualitative research is idiographic and does not seek to offer generalised claims about groups of people (Smith et al., 2009). This study involved interviews over the summer period in 2020, with 10 CPs, all of whom were working in the NHS in England during Covid-19 pandemic. More specifically, all interviews were undertaken between May and September 2020, coinciding with the period between the peaks of the first wave in April 2020 and second wave in November 2020. Since then, a third wave of patients admitted to hospitals, and increasing vaccination rates, has meant a different experience for healthcare workers and CPs supporting them. Additionally, only limited demographic information was collected and reported. Consequently, both the ideographic nature of the study and the limited information available regarding participants, mean caution should be taken when interpreting and generalising the results.

While qualitative research can help consider and incorporate a diverse array of contextual information that is difficult to capture in quantitative research, it is not meant to offer direct insight into the wider experiences of any other person or group at any other time.

Clinical Policy and Practice Implications

The findings from this study highlight the impact on CPs of providing support to medical staff during a national health emergency. It has implications for individual psychologists, and leaders of psychological services, and how they plan for and respond to rapid changes within healthcare systems and the provision of staff support. The impact of professional identity and relationships within and between teams has been discussed, and it may be that CPs working in healthcare systems incorporate these ideas within their individual and systemic staff support work. Furthermore, it may be helpful for CPs and Psychology services to consider how their existing clinical skills and experience are transferable when there is the need to work in new clinical areas without prior training or national guidance.

There are potential benefits for those training CPs to work in the NHS, specifically when considering how to promote insight and self-care when responding to the personal impact of rapid and significant changes. Incorporating a greater and more specific focus on how CPs may be exposed to stress and pressure during clinical doctorate training, in continuing professional development, and clinical supervision, may support greater levels of self-care and lower the risk of CP burnout.

Future Research

Future research in this area could investigate how CPs' experiences have changed over the course of the pandemic in the UK. The ongoing dynamic nature of the situation means this could be by undertaking similar research, offering insight to experiences during later 'phases' of the pandemic. This may also offer an opportunity to explore experiences during the challenging 'recovery' period anticipated by some participants. Research could also be undertaken with a broader population, such as UK wide, or using mixed methodology to include online surveys or questionnaires, to capture more generalisable data.

Conclusion

During the Covid-19 pandemic, CPs have had to adapt to providing staff support, often whilst working under similar personal and professional pressures to those they have been supporting. The participants in this study described how their professional identity can be impacted, their experiences of navigating uncertainty at home and work, and their difficulty in balancing the demands of their personal and professional lives. However, their professional identity and sense of purpose was also a source of strength, connecting with their values and giving them a sense of purpose and reward.

References

Abrams, D., Hogg, M. A. (2010). Social identity and self-categorization. In Dovidio, J. F., Hewstone, M., Glick, P., Esses, E. M. (Eds.), *Handbook of Prejudice, Stereotyping, and Discrimination* (pp. 179–193). SAGE.

Adams, J. G., & Walls, R. M. (2020). Supporting the health care workforce during the COVID-19 global epidemic. *JAMA*. Published online March 12, 2020. https://doi.org/10.1001/jama.2020.3972

Alban-Metcalfe, J. (2018). Engaging Leadership-a better approach to leading a team?. *Nursing Times*, *114*(6), 21-24. https://cdn.ps.emap.com/wp-content/uploads/sites/3/2018/05/180516-Engaging-Leadership-a-better-approach-to-leading-a-team.pdf

Allwood, C. M., Geisler, M., & Buratti, S. (2020). The relationship between personality, work, and personal factors to burnout among clinical psychologists: exploring gender differences in Sweden. *Counselling Psychology Quarterly*, 1-20. https://doi.org/10.1080/09515070.2020.1768050

American Psychological Association. (2020). Publication manual of the American psychological association (7th ed.). https://doi.org/10.1037/0000165-000

Beech, C., & Verity, F. (2019). Health and social work practitioners' experiences of working with risk and older people. *Journal of Integrated Care. Advance online publication.* https://doi.org/10.1108/JICA-08-2019-0036

Bennett, P., Noble, S., Johnston, S., Jones, D., & Hunter, R. (2020). COVID-19 confessions: a qualitative exploration of healthcare workers experiences of working with COVID-19. *BMJ open*, *10*(12), e043949. http://dx.doi.org/10.1136/bmjopen-2020-043949

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, *5*(3), 214-224. https://doi.org/10.1080/14780880802314304

Billings, J., Abou Seif, N., Hegarty, S., Ondruskova, T., Soulios, E., Bloomfield, M. A., & Greene, T. (2020). What support do frontline workers want? A qualitative study of health and social care workers experiences and views of psychosocial support during the COVID-19 pandemic. *medRxiv*. https://doi.org/10.1101/2020.11.05.20226522

Bonin, L. (2018). Quality improvement in health care: the role of psychologists and psychology. *Journal of Clinical Psychology in Medical Settings*, *25*(3), 278-294. https://doi.org/10.1007/s10880-018-9542-2

British Psychological Society. (2014). *BPS Code of Human Research Ethics* (2nd ed.). https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014

British Psychological Society (2017). *Ethics Guidelines for Internet-mediated Research.* https://tinyurl.com/2x67zpjr

British Psychological Society. (2018). *BPS Code of Ethics and Conduct*. https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct

British Psychological Society. (2018). *Data Protection Regulation: Guidance for Researchers.* Leicester; BPS. https://www.bps.org.uk/news-and-policy/data-protection-regulation-guidance-researchers

British Psychological Society (BPS). (2020a). *New Guidance for Psychological Professionals During the Covid-19 Pandemic.* https://www.bps.org.uk/news-and-policy/new-guidance-psychological-professionals-during-covid-19-pandemic

British Psychological Society (BPS). (2020b). *The Psychological Needs of Healthcare Staff as a Result of the Coronavirus Pandemic.* https://www.bps.org.uk/news-and-policy/protecting-psychological-wellbeing-healthcare-staff-during-coronavirus-pandemic

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, *21*(1), 87-108. https://doi.org/10.1080/14768320500230185

Brooks, S. K., Dunn, R., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018). A systematic, thematic review of social and occupational factors associated with psychological outcomes in healthcare employees during an infectious disease outbreak. *Journal of Occupational and Environmental Medicine*, *60*(3), 248-257. https://doi.org/10.1097/JOM.0000000000001235

Brosschot, J. F., Verkuil, B., & Thayer, J. F. (2016). The default response to uncertainty and the importance of perceived safety in anxiety and stress: An evolution-theoretical perspective. *Journal of Anxiety Disorders*, *41*, 22-34. https://doi.org/10.1016/j.janxdis.2016.04.012

Brunton J & Thomas J (2012) Information management in reviews. *In An Introduction to Systematic Reviews* (Gough D, Oliver S & Thomas J eds). Sage Publications Ltd, London, UK, pp. 83–106.

Caza, B. B., & Creary, S. (2016). The construction of professional identity. In *Perspectives on Contemporary Professional Work*. Edward Elgar Publishing.

Chan, Z. C., Fung, Y. L., & Chien, W. T. (2013). Bracketing in phenomenology: Only undertaken in the data collection and analysis process. *The Qualitative Report*, *18*(30), 1-9. https://nsuworks.nova.edu/tqr/vol18/iss30/1

Christofides, S., Johnstone, L., & Musa, M. (2012). ‘Chipping in’: Clinical psychologists’ descriptions of their use of formulation in multidisciplinary team working. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(4), 424-435. https://doi.org/10.1111/j.2044-8341.2011.02041.x

Clabburn, O., Knighting, K., Jack, B. A., & O’Brien, M. R. (2019). The use of digital legacies with people affected by motor neurone disease for continuing bonds: An interpretative phenomenological analysis study. *Palliative Medicine*, *33*(7), 812-822. https://doi.org/10.1177/0269216319845805

Clearing House for Postgraduate Courses in Clinical Psychology. (n.d.). *Equal Opportunities data - 2018 Entry.* https://www.leeds.ac.uk/chpccp/equalopps2018.pdf

Donaghay-Spire, E. G., McGowan, J., Griffiths, K., & Barazzone, N. (2016). Exploring narratives of psychological input in the acute inpatient setting. *Psychology and Psychotherapy: Theory, Research and Practice*, *89*(4), 464-482. https://doi.org/10.1111/papt.12081

Drury, J., Brown, R., González, R., Miranda, D. (2016). Emergent social identity and observing social support predict social support provided by survivors in a disaster: Solidarity in the 2010 Chile earthquake. *European Journal of Social Psychology, 46*, 209–223. https://doi.org/10.1002/ejsp.2146

D'souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change*, *28*(1), 17-28. https://doi.org/10.1375/bech.28.1.17

Figueroa, C. A., Harrison, R., Chauhan, A., & Meyer, L. (2019). Priorities and challenges for health leadership and workforce management globally: a rapid review. *BMC Health Services Research*, *19*(1), 1-11. https://doi.org/10.1186/s12913-019-4080-7

Flowers, P., Davis, M. M., Larkin, M., Church, S., & Marriott, C. (2011). Understanding the impact of HIV diagnosis amongst gay men in Scotland: An interpretative phenomenological analysis. *Psychology & Health*, *26*(10), 1378-1391. https://doi.org/10.1080/08870446.2010.551213

Gemine, R., Davies, G. R., Tarrant, S., Davies, R. M., James, M., & Lewis, K. (2021). Factors associated with work-related burnout in NHS staff during COVID-19: a cross-sectional mixed methods study. *BMJ Open*, *11*(1), e042591. http://dx.doi.org/10.1136/bmjopen-2020-042591

Golsworthy, R., & Coyle, A. (2001). Practitioners' accounts of religious and spiritual dimensions in bereavement therapy. *Counselling Psychology Quarterly*, *14*(3), 183-202. https://doi.org/10.1080/09515070110037993

Greenberg, N., Docherty, M., Gnanapragasam, S., & Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ*, *368*. https://doi.org/10.1136/bmj.m1211

Grupe, D. W., & Nitschke, J. B. (2013). Uncertainty and anticipation in anxiety: an integrated neurobiological and psychological perspective. *Nature Reviews Neuroscience*, *14*(7), 488-501. https://doi.org/10.1038/nrn3524

Hannigan, B., Edwards, D., & Burnard, P. (2004). Stress and stress management in clinical psychology: Findings from a systematic review. *Journal of Mental Health*, *13*(3), 235-245. https://doi.org/10.1080/09638230410001700871

He, J. P., Liao, R., Yang, Y., Li, J. J., Weng, N. N., Luo, Y. T., ... & Zhu, Q. (2020). The Research of Mental Health Status Among Medical Personnel in China: A Cross-Sectional Study. http://dx.doi.org/10.2139/ssrn.3555260

Health and Care Professions Council. (2015). *Standards of Proficiency: Practitioner Psychologists.* https://www.hcpc-uk.org/resources/standards/standards-of-proficiency-practitioner-psychologists/

Henshall, L. E., Alexander, T., Molyneux, P., Gardiner, E., & McLellan, A. (2018). The relationship between perceived organisational threat and compassion for others: Implications for the NHS. *Clinical Psychology & Psychotherapy*, *25*(2), 231-249. https://doi.org/10.1002/cpp.2157

Hoare, D. J., Broomhead, E., Stockdale, D., & Kennedy, V. (2015). Equity and person-centeredness in provision of tinnitus services in UK National Health Service audiology departments. *European Journal for Person Centered Healthcare, 3(*3), 318-326. http://dx.doi.org/10.5750/ejpch.v3i3.984

Iflaifel, M., Lim, R. H., Ryan, K., & Crowley, C. (2020). Resilient Health Care: a systematic review of conceptualisations, study methods and factors that develop resilience. *BMC Health Services Research*, *20*, 1-21. https://doi.org/10.1186/s12913-020-05208-3

Jeffery, C. (2007). *The unfinished business of devolution: seven open questions. Public Policy and Administration, 22*(1), 92-108. https://doi.org/10.1177/0952076707071506

Ji, D., Ji, Y. J., Duan, X. Z., Li, W. G., Sun, Z. Q., Song, X. A., ... & Chen, G. F. (2017). Prevalence of psychological symptoms among Ebola survivors and healthcare workers during the 2014-2015 Ebola outbreak in Sierra Leone: a cross-sectional study. *Oncotarget*, *8*(8), 12784. https://doi.org/10.18632/oncotarget.14498

Johnson, J., Corker, C., & O'Connor, D. B. (2020a). Burnout in psychological therapists: A cross-sectional study investigating the role of supervisory relationship quality. *Clinical Psychologist*, *24*(3), 223-235. https://doi.org/10.1111/cp.12206

Johnson J., Madhill, A., Koutsopoulou, G., Brown, C., Harris, R. (2020b). Tackling Gender Imbalance in Psychology. In *Clinical Psychology Forum*. British Psychological Society. https://tinyurl.com/duez3xwp

Johnstone, M. J., & Turale, S. (2014). Nurses' experiences of ethical preparedness for public health emergencies and healthcare disasters: A systematic review of qualitative evidence. *Nursing & Health Sciences*, *16*(1), 67-77. https://doi.org/10.1111/nhs.12130

Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of Clinical Psychology*, *73*(12), 1782-1796. https://doi.org/10.1002/jclp.22485

Khalid, I., Khalid, T. J., Qabajah, M. R., Barnard, A. G., & Qushmaq, I. A. (2016). Healthcare workers emotions, perceived stressors and coping strategies during a MERS-CoV outbreak. *Clinical Medicine & Research*, *14*(1), 7-14. https://doi.org/10.3121/cmr.2016.1303

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., ... & Tan, H. (2020). Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Network Open*, *3*(3), e203976-e203976. https://doi.org/10.1001/jamanetworkopen.2020.3976

Last, J. M., Harris, S. S., Thuriaux, M. C., & Spasoff, R. A. (2001). *A dictionary of epidemiology*. International Epidemiological Association, Inc.

Lavender, A., & Paxton, R. (2004). *Estimating the applied psychology demand in adult mental health.* British Psychological Society.

Leary, M. R., & Tangney, J. P. (Eds.). (2011). *Handbook of Self and Identity*. Guilford Press.

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

Loretto, W., Popham, F., Platt, S., Pavis, S., Hardy, G., MacLeod, L., & Gibbs, J. (2005). Assessing psychological well-being: A holistic investigation of NHS employees. *International Review of Psychiatry*, *17*(5), 329-336. https://doi.org/10.1080/09540260500238371

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause (s) of burnout among applied psychologists: a systematic review. *Frontiers in Psychology*, *9*, 1897. https://doi.org/10.3389/fpsyg.2018.01897

Mason, B. (1993) Towards positions of safe uncertainty. *Human Systems, 4*, 189–200. http://www.humansystemsjournal.eu/library/volume-4-1993/volume-4-issues-3-4

Mason, B. (2015). Towards positions of safe uncertainty. *InterAction-The Journal of Solution Focus in Organisations, 7*(1), 28-43. https://doi.org/10.1111/1467-6427.12258

Matheson, C., Robertson, H. D., Elliott, A. M., Iversen, L., & Murchie, P. (2016). Resilience of primary healthcare professionals working in challenging environments: a focus group study. *British Journal of General Practice*, *66*(648), e507-e515. https://doi.org/10.3399/bjgp16X685285

Maunder, R. G., Leszcz, M., Savage, D., Adam, M. A., Peladeau, N., Romano, D., ... & Schulman, R. B. (2008). Applying the lessons of SARS to pandemic influenza. *Canadian Journal of Public Health*, *99*(6), 486-488. www.jstor.org/stable/41995158

Muldoon, O. (2020). Collective trauma. In Jetten, J., Reicher, S. D., Haslam, S. A., Cruwys, T. (Eds.), *Together apart: The psychology of COVID-19* (pp. 84–88). SAGE.

Palmer, B. W., & Harmell, A. L. (2016). Assessment of healthcare decision-making capacity. *Archives of Clinical Neuropsychology*, *31*(6), 530-540. https://doi.org/10.1093/arclin/acw051

Pollock, A., Campbell, P., Cheyne, J., Cowie, J., Davis, B., McCallum, J., ... & Maxwell, M. (2020). Interventions to support the resilience and mental health of frontline health and social care professionals during and after a disease outbreak, epidemic or pandemic: a mixed methods systematic review. *Cochrane Database of Systematic Reviews*, (11). https://doi.org/10.1002/14651858.CD013779

Robiner, W. N., & Petrik, M. L. (2017). Managing difficult patients: Roles of psychologists in the age of interdisciplinary care. *Journal of Clinical Psychology in Medical Settings*, *24*(1), 27-36. https://doi.org/10.1007/s10880-017-9490-2

Rodham, K., & Gavin, J. (2006). The ethics of using the internet to collect qualitative research data. *Research Ethics*, *2*(3), 92-97. https://doi.org/10.1177/174701610600200303

Rout, A., Ashby, S., Maslin-Prothero, S., Masterson, A., Priest, H., Beach, M., ... & Sturdy, D. (2011). A literature review of interprofessional working and intermediate care in the UK. *Journal of Clinical Nursing*, *20*(5-6), 775-783. https://doi.org/10.1111/j.1365-2702.2009.03156.x

Ruotsalainen, J. H., Verbeek, J. H., Mariné, A., & Serra, C. (2014). Preventing occupational stress in healthcare workers. *Cochrane Database of Systematic Reviews*, (11). https://doi.org/10.1002/14651858.CD002892.pub4

Schäfer, S. K., Lass-Hennemann, J., Groesdonk, H., Volk, T., Bomberg, H., Staginnus, M., ... & Michael, T. (2018). Mental health in anesthesiology and ICU staff: Sense of Coherence matters. *Frontiers in Psychiatry*, *9*, 440. https://doi.org/10.3389/fpsyt.2018.00440

Schein, E.H. (1978). *Career Dynamics: Matching Individual and Organizational Needs.* Addison-Wesley.

Segal, K., Jong, J., Halberstadt, J. (2018). The fusing power of natural disasters: An experimental study. *Self and Identity, 17*, 574–586. https://doi.org/10.1080/15298868.2018.1458645

Simonds, A. K., & Sokol, D. K. (2009). Lives on the line? Ethics and practicalities of duty of care in pandemics and disasters. *European Respiratory Journal*, *34*(2), 303-309. https://doi.org/10.1183/09031936.00041609

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using Interpretative Phenomenological Analysis in health psychology. *Psychology and Health, 11*(2), 261–271. https://doi.org/10.1080/08870449608400256

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, *5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A., & Osborn, M., (2009) Interpretative phenomenological analysis. In J. A. Smith, P. Flowers, & M., Larkin, M. (Eds.), *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage.

Smith, J.A., Flowers, P., & Larkin, M., (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* Sage.

Snowdon, D. A., Leggat, S. G., & Taylor, N. F. (2017). Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. *BMC Health Services Research*, *17*(1), 786. https://doi.org/10.1186/s12913-017-2739-5

Suter, W. N. (2011). *Introduction to educational research: A critical thinking approach*. SAGE.

Tajfel, H., & Turner, J. C. (1979). An integrative theory of inter-group conflict. In Austin, W. G., Worchel, S. (Eds.), *The Social Psychology of Inter-group Relations* (pp. 33–47). Brooks/Cole.

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

Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. *Qualitative Social Work*, *16*(4), 550-565. https://doi.org/10.1177/1473325016635244

Walshe, K., & Davies, H. T. (2013). *Health research, development and innovation in England from 1988 to 2013: from research production to knowledge mobilization.* https://doi.org/10.1177/1355819613502011

Whelehan, D. F., Algeo, N., & Brown, D. A. (2021). Leadership through crisis: fighting the fatigue pandemic in healthcare during COVID-19. *BMJ Leader*, leader-2020. http://dx.doi.org/10.1136/leader-2020-000419

Wilkinson, E. (2015). UK NHS staff: stressed, exhausted, burnt out. *The Lancet*, *385*(9971), 841-842. https://doi.org/10.1016/S0140-6736(15)60470-6

Williams, R., & Kemp, V. (2019). Caring for healthcare practitioners. *BJPsych Advances*, 1-13. https://doi.org/10.1192/bja.2019.66

Willis, J.W. (2007). *Foundations of Qualitative Research: Interpretive and Critical Approaches*. London: Sage

Winterton, J., Mitchell, L., & Boak, G. (2009). Developing competence frameworks in UK healthcare: lessons from practice. *Journal of European Industrial Training, 33*(8/9), 701-717. https://doi.org/10.1108/03090590910993580

Wong, T. W., Yau, J. K., Chan, C. L., Kwong, R. S., Ho, S. M., Lau, C. C., ... & Lit, C. H. (2005). The psychological impact of severe acute respiratory syndrome outbreak on healthcare workers in emergency departments and how they cope. *European Journal of Emergency Medicine*, *12*(1), 13-18. https://doi.org/10.1097/00063110-200502000-00005

Wu, J. T., Leung, K., & Leung, G. M. (2020). Nowcasting and forecasting the potential domestic and international spread of the 2019-nCoV outbreak originating in Wuhan, China: a modelling study. *The Lancet*, *395*(10225), 689-697. https://doi.org/10.1016/S0140-6736(20)30260-9

Chapter III: Reflective Paper

Trust and Balance: A Reflection on my Research Journey

This paper has not been prepared for submission to any journal.

Overall chapter word count 3,894 (excluding references)

Introduction

This reflective paper considers my experience of undertaking doctoral thesis research. It draws on material from the reflective journals I kept while undertaking this research, as well as my reflections leading up to and during the process of thesis writing. Using concepts and related ideas from Acceptance and Commitment Therapy (ACT) to shape and inform this paper has helped me gain a deeper understanding of how the challenge of writing this thesis has shaped me personally and professionally. Moreover, it has also helped me consider how I will continue to develop as a person and as a qualified clinical psychologist.

In line with the qualitative research that has formed the content of Chapters I and II, this chapter has themes. The first theme is *Learning to trust myself*. This theme focuses on the experiences during research that have allowed me to become more trusting of who I am as a person and as a psychologist. I will consider how the ACT principles of Acceptance, Values, and Defusion have been helpful when trying to make sense of my experiences (Hayes et al., 2006). The second theme is *Balancing the different parts of me* and highlights my experiences of trying to find balance during the research journey. Here, the ACT principles of Being Present, Self as Context, and Committed Action are used to support my reflective process (Hayes et al., 2006).

This thesis was completed between April 2020 to April 2021 during which the UK experienced the first and second waves of the Covid-19 pandemic. For me as a trainee clinical psychologist, the impact of Covid-19 on university teaching, clinical placements, and thesis research has been significant. The pandemic has influenced my choice of research topic as well as my experience of completing the thesis, both practically and personally. Therefore, a brief chronology of the thesis journey is provided before the two themes are discussed.

In March 2020, it became apparent that my original research project would not be possible. Redeployment of staff and the closure of services meant my plans to recruit patients from a local NHS outpatient service could not proceed. At the time it was impossible to escape news of Covid-19 and its impact on healthcare staff around the world, including the UK. Also, like many others in the UK, my family was personally affected by Covid-19.

Being married to a frontline NHS heath care professional meant the impact of Covid-19 on services and staff was even more apparent. I heard first-hand how hard things were for staff struggling with the pace and severity of patients' admissions and service changes. I recall feeling strongly that I wanted to be involved in the response to the crisis somehow, and, like many others in the NHS, I felt a 'pull' towards doing something. However, as a trainee clinical psychologist, I felt I was unable to help.

Over the course of a weekend, I decided to refocus my research on the experiences of clinical psychologists supporting medical teams treating Covid-19 patients. My research plans came together quickly, and, over the course of a few weeks, I received ethical approval to conduct the study. The same day I advertised my research I heard from interested clinical psychologists and two weeks later I undertook my first interview. I received emails from around England and from psychologists of varying seniority and experience. Some of my participants had provided staff support before Covid-19 while for others it was their first experience.

All the interviews were conducted between May and September 2020, coinciding with the end of the 'first wave' of Covid-19 and a period of fewer cases and hospital admissions. In preparing for interviews, I considered how my trainee status could influence the interviews. I wondered whether qualified psychologists may be less open about their own professional struggles or whether I would feel less able to explore these issues with them. This was discussed with my supervisors when planning my research and undertaking the bracketing interview. I felt it was important to acknowledge this potential influence early on in the research process and to remain mindful of this when undertaking interviews. Thankfully, many of my participants told me they found the interview a safe and supportive reflective space to discuss their experiences.

Due to face to face working restrictions the interviews were all undertaken remotely. Although I initially felt this would be a detriment to the interview experience for both myself and the participants, it allowed me to recruit participants from a variety of services around the country. Over the course of 10 interviews there were only a small number of IT problems and I feel like the online experience of interviewing was not a significant impairment to undertaking the research.

Writing the thesis occurred during the period of September 2020 to April 2021. During this time the NHS was experiencing its highest levels of Covid-19 patients and the news was dominated by the stories of patients dying and staff struggling. I found this time challenging personally as both my work and personal life felt overwhelmed by the significance of what I was witnessing. I was trying to support my children around the uncertainty of home schooling and the return to face to face teaching. In addition, my wife fell ill with Covid in January of 2021 and we were all placed in a state of home isolation for 10 days. On reflection, I feel like this contributed to a greater sense of responsibility as a researcher to complete this research and to do the participants’ experience justice in my analysis.

The final stages of this thesis have been undertaken during a time of hope. Currently Covid-19 cases are reducing, and the hospitals are not at risk of being overwhelmed. As I near the end, I am thankful that I have been able to complete this research and am hopeful about moving to the next stage of my clinical psychology journey.

Learning to trust myself

This theme focuses on how undertaking this research during has enabled me to become more trusting of myself as a person and as a psychologist. At the beginning of the research journey, I felt I should be able to complete the thesis on my own. I have learned not only was this untrue, but I am a much better, more well-rounded, researcher for being aware of and accepting the uncertainty of learning inherent to the thesis experience. The ACT principles of Acceptance, Values, and Defusion have been helpful when making sense of my experiences.

Acceptance

Acceptance within ACT involves the active and aware embrace of difficult thoughts and feelings without attempts to change their frequency or form (Hayes et al., 2006). I feel that one of the challenges for me in completing this thesis was acknowledging and accepting the stress and difficulties arising from the research process. Beginning doctorate training, I felt as an older trainee, someone who had studied while working full-time and raising a young family, I should be able to cope with any academic difficulties through good work-life boundaries and coping skills. I identified as being a ‘resilient’ person who is able to demonstrate a high capacity for hard work and steep learning curves.

During the thesis research, I found that this identity contributed to me minimising or avoiding thoughts and feelings of stress or anxiety. When I did recognise these thoughts, my reaction as a coping strategy was often to push myself harder. For example, when it became clear that I would need to refocus my research at short notice, I shifted research topics, rapidly produced new protocol and supporting documents to complete the university's ethics procedures. Although during this time I was under stress, I was able to cope by working hard.

While working hard has been largely protective as a coping strategy, I feel I have also placed additional burden on myself and, at times, have not wanted to accept difficult experiences as a valuable part of my doctorate journey. This feeling of avoidance is most prominent for me when anticipating or receiving feedback on my work. When anticipating feedback, I often fluctuate between wanting to discuss where I could make improvements and not wanting to hear it at all. This was something I noticed particularly in discussions with my supervisor around my efforts to undertake analysis for both the systematic literature review and the empirical study.

Completing this thesis has challenged me to consider the high expectations I place on myself. It has allowed me to become more open to acknowledging and accepting the feelings of uncertainty and exposure that form part of the normal experience of undertaking research and receiving feedback. I have learned to be more open to accepting the feelings of avoidance and/ or of uncertainty when receiving constructive feedback. Subsequently, I am able to notice how and when these thoughts and feelings arise, value them as an important part of my learning experience. As I continue to practice acceptance, I hope to continue to try to apply this to other parts of my academic, professional, and personal life.

Values

Values are seen within ACT as qualities of action and can be found within the important domains of person’s life such as close personal relationships, work, and family (Hayes et al., 2006). I feel that the experience of undertaking the thesis has helped me to reflect on my personal values, to connect with the research process, and to develop my identity both as a person and as a clinical psychologist. I recognise in myself the tension between my different identities and the values I associate with them.

As a trainee on clinical placements, I identify with a ‘beginner’s identity’. This means being comfortable with uncertainty, holding formulations lightly, and being open to feedback to shape and change interventions. Here, I value acceptance of myself and others, honesty, equality and mindfulness. However, while undertaking research, I have high expectations to be certain and precise about my ideas, to always work logically, and to communicate with clarity. When undertaking research, I value order, hard work, and skilfulness. Although I feel these are all positive values, as a result of holding some of these too ‘tightly’ sometimes, I have found the research experience challenging.

In the early thesis planning stages, values such as contribution, connection, and supportiveness guided me towards a research topic that I felt would be relevant and achievable. Interviewing clinical psychologists supporting medical teams has felt like a valuable way for me to use my position as a trainee clinical psychologist. It has connected with my desire to help the NHS as well as with my values giving me a sense of fulfilment that I do not think I would have had otherwise.

In the later stages of research, while undertaking analysis and writing up results, I have recognised that being inflexible with my values of order, hard work, and skilfulness, have caused me to avoid or delay certain tasks. For example, when I have felt uncertain about undertaking the analysis for both my literature review and empirical paper I have delayed starting. This was driven by a desire to get it right first time and to demonstrate a high level of competence. There have been times when holding myself to such a high standard I also placed unnecessary pressure on myself. This has led to a range of thoughts and feelings including inadequacy, self-doubt, stress and anxiety.

Following my values led me to undertake this thesis on a topic that I felt was both personally and professionally important. This sense of contribution and connection helped me set the course for my thesis research and I feel this has helped me maintain my commitment to the research. What I have learned is that valuing order, hard work, and skilfulness is not mutually exclusive to being open to feedback, which in turn helps me shape and improve my research as I learn.

Cognitive defusion

Diffusion within ACT aims to change the way a person interacts with or relates to thoughts which trigger negative emotional experiences and behaviours (Hayes et al., 2006). There have been times during the research process when I had had thoughts such as "*I'm not good at research*", "*I'm not sure I can do this well enough*", or "*I don't know how I will cope".* At times, these doubts about my research abilities helped me work harder to overcome whatever difficulties I may have been having. I feel they are connected to the values I hold in relation to my 'researcher identity', order, hard work and skilfulness, and in some ways, they have helped me to cope and become the psychologist I am today.

However, I have also spent time ruminating, avoiding research activities, and worrying excessively. Self-doubt and negative thoughts have been present throughout my entire trainee journey and have connections with feelings of imposter syndrome common within clinical psychology (Long & Hollin, 1997; Sweeney & Creaner, 2014; Tigranyan et al., 2020). This has impacted on both my experiences of research and my personal life as I am distracted, irritable, and not able to be present for my family. Although I was aware of this early on, it was not until writing my thesis that I felt like it was time to take action.

By working on developing greater awareness of my fusion to some thoughts, I have been able to practise cognitive diffusion techniques to reduce my attachment to negative thoughts. These have included simple techniques such as labelling the process of thinking, "*I'm having the thought that I'm not sure I can do this well enough*", or reflecting on the thoughts, feelings, or memories that come up for me when I am having that thought (Hayes et al., 2006). While I accept that difficult or negative thoughts may continue, I feel they no longer have the same impact as I am able to recognise them more clearly as thoughts and not facts.

I have learned that I do not need to hold myself to such high standards which only serve to place unnecessary burdens on myself. I feel that I have gained a deeper understanding of my own needs and identity as a psychologist. I feel that this has also helped me to grow as a person, to be kinder to myself, and to welcome the uncertainty, mistakes, and support that come with challenging learning experiences.

Balancing the different parts of me

This theme discusses my experiences of trying to find balance during the research journey. I found thesis research to be challenging academically and personally. At times, during the process, I struggled to maintain balance between the psychologist, the partner and parent, son, brother, and friend. The ACT principles of

Being Present, Self as Context, and Committed Action are used to support my reflective process.

Being present

ACT encourages people to be present and connected with the things that are happening around us in our day to day lives, as well as our thoughts and feelings from moment to moment (Hayes et al., 2006). The goal is to increase our awareness of these events so that we are able to respond in flexible way in line with our personal values (Hayes et al., 2006).

Undertaking this research during the pandemic, which has been so prominent in news and social media, has meant the boundaries between my academic work and my family life have been blurred. This was particularly prevalent at the beginning of the research process, which coincided with the pandemic beginning and during the early months of 2021 when the impact of Covid-19 was at its peak.

The constant pull to be up to date with the news and to feel informed has been a distraction from the events within my personal life and finding the balance between university, work, and home has been a struggle throughout the entire thesis experience. This distraction has been exacerbated by working from home, which has meant that the kitchen table became also the teaching room, clinical space, and research office. The merging of these environments has impacted on my ability to separate who I am, what I should be focused on, and when I can switch off.

In order to reduce feelings of distraction, and increase feelings of engagement with the research, I needed to practice being present in whatever I was doing. This meant switching of some notifications and setting boundaries for checking emails. I stopped watching the news as regularly and started to incorporate self-care in my work day such as exercise and mindfulness meditation.

At times I have not recognised the impact that working from home had on my family and have been distracted by my own priorities with less time for them. I began to recognise that I could not do everything simultaneously, and that trying to do so was not only impossible, but also unfair to my family. I started to make sure I spent more time each day with family, both during the week and on weekends. I also made changes to my daily and weekly routine to structure free time around my children's routines. By making space to be more present, I started to separate the different parts of my life and noticed feeling less guilty when either working or spending time with family.

The process of trying to create space and balance has helped me learn that while being informed and working hard are important to me, so is being able to attend to my own needs and that of my family. I have a stronger appreciation for the importance of being fully present when engaged with work or home life, in order to be a better psychologist, husband, and father.

Committed action

I had anticipated that completing this thesis would require me to change my behaviour in order to reach personal and academic goals set by myself, my academic tutors, and the university. However, Covid-19 brought with it even greater uncertainty and change and over the last year I have had to continually adapt to new demands and routines, juggling research, home life, teaching, and clinical placements. Feeling frustrated, stuck, and counting down the days until I finish have become a familiar feeling, requiring me to continuously reaffirm my commitment to being an active researcher engaged in the process.

ACT, with its focus on developing patterns of effective action in line with personal values, has been described as a behavioural or behaviour change therapy

(Hayes et al., 2006; Flaxman et al, 2010). By developing psychological flexibility, we are more able to take action in line with our personal values (Hayes et al., 2006).

Since starting undergraduate studies in 2014, much of my academic work has been completed in the evenings, sacrificing time with family as well as working longer days. When I began my clinical training, I relied on this routine to support me to complete the work. However, at times, the thesis research process has felt like a never-ending series of tasks, each requiring an ever-increasing degree of planning and effort.

One important aspect of completing this thesis has been the time period over which it has been completed. While having dedicated study time has been invaluable, being able to stick to a self-imposed routine, while balancing work and home life sometimes felt impossible. When the workload began to feel overwhelming, it was often stepping away and making a plan that was key to getting things done. As important as working hard was during this time knowing when I needed to step away from it to process thoughts and gain some perspective.

Maintaining a commitment to the thesis has been made easier by its connection to my personal and professional values. I feel that the public and immediate relevance of my research topic has supported my focus on achieving goals through this process. This has connected with my values of contribution, connection, and supportiveness and helped me maintain a commitment to the process and tasks involved in completing the thesis.

Self as context

It is important as a trainee clinical psychologist to develop reflective skills in order to understand our experiences from a position that allows us to step outside ourselves. This allows us to develop our self-awareness, critical thinking, and professional practice (Cooper & Wieckowski, 2017; Fisher et al., 2005). Within ACT this is known as Self As Context and is also sometimes referred to as ‘The Observing Self’ or ‘The Core You’ (Harris, 2006).

Similarly, it has been important during thesis research for me to understand my own and others’ experiences and engaging reflexively with the data in the systematic literature review and empirical paper. Qualitative researchers are required to hold different perspectives as they engage in making sense of another’s experiences and reflexivity has been recognised as a crucial strategy in qualitative research (Finefter-Rosenbluh, 2017; Naples & Sachs, 2000). In the context of the systematic literature review, my position was that of an outsider looking in. Whereas for the empirical, my position was more aligned with that of an insider, both member of a group and observer (Dwyer & Buckle, 2009).

Having explored their experiences in my empirical research, I recognise that I have identified with the clinical psychologists’ desire to be a part of the NHS response to Covid-19 and there have been similarities between their experiences and mine. I identified strongly with many of the values and motivations they described during interviews, and it would have been an easy assumption that as a trainee clinical psychologist I could understand their experiences. However, this would have made it more difficult to pay attention to and reflect on the personal meaning of their experiences. As such, I engaged in more reflective practice, using journaling, reflective peer groups, and mindfulness practices. While I found participating in reflective peer groups and mindfulness easier, I was not used to keeping reflective journals and had to work hard to ensure I captured my thoughts and feelings as I progressed through the research. On reflection, I wish I had used journaling more as a reflective practice and hope to do so as I continue learning and practicing as a qualified clinical psychologist. Overall, however, I feel that these practices have helped me to be more self-aware, and deepen my understanding and perspective of how I am thinking, feeling, and acting.

Conclusion

This thesis has been a different journey than the one I had envisioned due to the impact of Covid-19 on my academic work, clinical placements, and personal life. I have learned that I am more resilient that I thought, but that my strength comes from being open to all the cognitive, emotional, and relational challenges that come with being a clinical psychologist. It has helped me to learn to reflect on my own personal and professional values and has required me to practise acceptance, and to notice when I am not balancing work and home life. I have gained a new appreciation for being in contact with the present moment, and to acknowledge when I am focused so much on myself that I cannot see the bigger picture.

Undertaking qualitative research has challenged me to pay attention to the experiences of others and to be more conscious of when and how I can apply my skills as a psychologist. I have a greater appreciation of how important it is to me to incorporate this into my identity as a clinical psychologist.

References

Cooper, L. D., & Wieckowski, A. T. (2017). A structured approach to reflective practice training in a clinical practicum. *Training and Education in Professional Psychology*, *11*(4), 252. https://doi.org/10.1037/tep0000170

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, *8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods*, *16*(1), 1609406917703539. https://doi.org/10.1177/1609406917703539

Fisher, P., Chew, K., & Leow, Y. J. (2015). Clinical psychologists' use of reflection and reflective practice within clinical work. *Reflective Practice*, *16*(6), 731-743. https://doi.org/10.1080/14623943.2015.1095724

Flaxman, P. E., Blackledge, J. T., & Bond, F. W. (2010). *Acceptance and commitment therapy: Distinctive features*. Routledge.

Harris, R. (2006). Embracing your demons: An overview of acceptance and commitment therapy. *Psychotherapy in Australia, 12*(4). https://doi.org/10.3316/informit.545561433272993

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, *44*(1), 1-25. https://doi.org/10.1016/j.brat.2005.06.006

Long, C. G., & Hollin, C. R. (1997). The scientist–practitioner model in clinical psychology: A critique. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *4*(2), 75-83.

https://doi.org/10.1002/(SICI)1099-0879(199706)4:2<75::AID-CPP116>3.0.CO;2-E

Naples, N. A., & Sachs, C. (2000). Standpoint epistemology and the uses of self-reflection in feminist ethnography: Lessons for rural sociology. *Rural Sociology*, *65*(2), 194-214. https://doi.org/10.1111/j.1549-0831.2000.tb00025.x

Sweeney, J., & Creaner, M. (2014). What's not being said? Recollections of nondisclosure in clinical supervision while in training. *British Journal of Guidance & Counselling*, *42*(2), 211-224. https://doi.org/10.1080/03069885.2013.872223

Tigranyan, S., Byington, D. R., Liupakorn, D., Hicks, A., Lombardi, S., Mathis, M., & Rodolfa, E. (2020). Factors related to the impostor phenomenon in psychology doctoral students. *Training and Education in Professional Psychology*. https://doi.org/10.1037/tep0000321

Appendices

Appendix A – Author Guidelines (Systematic Literature Review)

Editorial Aims and Scope

Palliative & Supportive Care publishes papers on the psychiatric, psychosocial, spiritual, existential, ethical, philosophical, and humanities aspects of palliative and supportive care. Papers on psychiatric disorders and their management in the palliative care setting, including but not limited to depression, delirium, anxiety, and posttraumatic stress disorder and bereavement are invited. Evolving constructs of particular relevance to the interface of psychiatry/psychology and palliative medicine, such as demoralization, meaning, dignity, hopelessness, will to live, suffering, and developmental growth at the end of life are also a major focus of this journal. Research focusing on these issues, including epidemiology, diagnostic screening, assessment, management, and intervention drug and psychotherapy trials, are also addressed. In addition, the journal provides a forum for the study of psychosocial and sociocultural matters such as caregiver burden, health care provider burnout, counseling interventions, the impact of psychosocial factors related to pain and physical symptom control, and communication issues.

ORIGINAL ARTICLES/ORIGINAL RESEARCH ARTICLES

These articles represent well designed quantitative, qualitative or mixed methods research studies that present new information that makes a substantial contribution to the body of knowledge on the subject. Original research manuscript must contain a Title page, an Abstract (with the headings: Objectives, Methods, Results, Significance of Results – 500 word limit) and be organized into the following major sections: Introduction, Methods, Results, Discussion, Disclosures and Acknowledgments, and References (word limit 4,000 words not including references, Tables and Figures)

REVIEW

Review articles describe and evaluate previously published material in order to synthesize or describe the state of the science or suggest new approaches or ideas relevant to important topics in psychosocial palliative care. The Journal accepts both systematic and narrative reviews of high quality. Word limit: 5000 words, not including references, tables or figures. An abstract of the same format as an Original Article is required (500 word limit).

CASE REPORTS

Case reports describing a singe case or case series which describes a novel, relevant or unusual presentation of a clinical problem that is important to make the field aware of are accepted for publication. An abstract with the journal standard headings is suggested (500 word limit) case Reports have a 1500 word limit excluding references, tables and figures.

PERSONAL ESSAYS

Personal essays are creative original essays by clinicians , researchers, patients or relatives that are compelling personal experiences or insights into clinical practice or the experience of caring for patients in the supportive and palliative care setting (1500 word limit excluding references)

EDITORIALS/GUEST EDITORIALS

Scholarly opinions on scientific, clinical or policy aspects of palliative and supportive care . They can be related to papers which have appeared or currently appear in an issue of Palliative and Supportive Care.No Abstract.(1500 word limit excluding references)

LETTERS TO THE EDITOR

Letters to the editor are academically oriented letters commenting on papers appearing in Palliative and Supportive Care 500 word limit, excluding tables or figures.

POETRY

Poems related to the themes of psychosocial existential and spiritual aspects of palliative care. (750 word limit, exceptions made)

Manuscript Submission and Review

All manuscripts must be submitted through the Journal's online submission platform, ScholarOne Manuscripts. When submitting articles online, authors are required to submit a separate abstract (utilizing specific abstract headings), the full manuscript (including the elements and order described in Instructions for Authors, e.g., title page, abstract, etc.), as well as an optional cover letter. Each manuscript will normally be reviewed by at least two referees with relevant scientific experience. Authors may suggest appropriate reviewers, but final selection of referees will be made by the Editor. Reviewers are asked to evaluate manuscripts for their scientific merit and clarity of presentation.

Manuscript Preparation and Style

Manuscripts must be in English and double-spaced. Numbers should be spelled out when they occur at the beginning of a sentence; use Arabic numerals elsewhere. Abbreviations should be used sparingly and nonstandard abbreviations should be defined at their first occurrence. Metric system (SI) units should be used. Manuscripts that do not conform to the style of *Palliative & Supportive Care* will be returned without review.

MANUSCRIPT ELEMENTS AND ORDER.

Unless there are obvious and compelling reasons for variation (e.g. review articles, short communications), manuscripts should be organized as follows:

*Title page***.** This is page 1. The title should be concise, informative, and free of abbreviations, chemical formulae, technical jargon, and esoteric terms. This page should include (a) the article's full title, (b) names and affiliations of all authors, (c) the name, mailing address, email address, and telephone number of the corresponding author, (d) the address for reprint requests if different from that of the corresponding author, (e) a short title of 50 characters or less, and (f) a list of the number of manuscript pages, number of tables, and number of figures.

*Abstract and keywords page***.** This is page 2 and should include (a) the article's full title, (b) an abstract of no more than 300 words, and (c) up to 5 keywords or phrases that reflect the content and major thrust of the article. The abstract should give a succinct account of the article contents utilizing these specific abstract headings: Objectives; Methods; Results; Significance of Results.

Introduction. This section begins on page 3 and should clearly state the objective of the research in the context of previous work bearing directly on the subject. An extensive review of the literature is not usually appropriate.

*Methods***.** This section should be brief but provide sufficient information to permit others to replicate the study. Pertinent details of species, apparatus and equipment, procedures and experimental design should be described.

All experiments involving human subjects must be conducted in accordance with principles embodied in the Declaration of Helsinki (Code of Ethics of the World Medical Association). Experiments involving animal subjects must conform to the principles regarding the care and use of animals adopted by the American Physiological Society and the Society for Neuroscience. The editor may refuse papers that provide insufficient evidence of adherence to these principles.

*Results***.** The results should be presented clearly and concisely, using figures and tables to summarize or illustrate the important findings. Quantitative observations are often more effectively displayed in graphs than in tables.

*Discussion***.** The discussion should summarize the major findings and explain their significance in terms of the study's objectives and relationship to previous, relevant work. This section should present compact, clearly developed arguments rather than wide-ranging speculation or uncritical collation of earlier reports.

*Acknowledgments***.** Use a separate page to recognize the contributions of individuals and supporting institutions.

References. In the text, references should be cited as follows:
as shown by Cella and Tusky (1990)
(Bloom et al., 2000)
(Cella & Tusky, 1990; Bloom et al., 2000)

The alphabetical list of references begins a new page, and must be typed double-spaced. Each in-text citation must have a corresponding reference and vice versa. List works by different authors who are cited within the same parentheses in chronological order, beginning with the earlier work. Journal titles should not be abbreviated. Only published articles and articles in press should appear in this list. Responsibility for the accuracy of references cited lies with the authors. Brief examples:

Journal article

Cella, D.F. & Tusky, D.S. (1990). Measuring quality of life today: Methodological aspects. *Oncology*, 4 , 29–38.

Book

Tompar-Tiu, A. & Sustento-Seneriches, J. (1995). *Depression and Other Mental Health Issues: The Filipino American Experience*. San Francisco: Jossey-Bass.

Chapter in an edited book

Karnofsky, D.A. & Burchenal, J.H. (1949). The clinical evaluation of chemotherapeutic agents in cancer. In*Evaluation of Chemotherapeutic Agents in Cancer*, Macleod, C.M. (ed.), pp. 191 –205. New York: Columbia University Press.

For more than one work by the same author(s) published in the same year, use (Jones, 1986 a , 1986 b) in text and likewise in the reference section.

Tables

Tables may be submitted as Word or Excel files. Tables should be numbered consecutively with Arabic numerals. A short explanatory title and column headings should make the table intelligible without reference to the text.

Figures and Legends
Figures may be submitted as TIFF or EPS files at 300pi or higher. The number of figures should be the minimum necessary to make the essential points of the paper. Diagrams and illustrations must have a professional appearance.

Copyediting and Page Proofs
The publisher reserves the right to copyedit manuscripts to conform to the style of *Palliative & Supportive Care.* The corresponding author will receive page proofs for final proofreading. No rewriting of the final accepted manuscript is permitted at the proof stage, and substantial changes may be charged to the authors.

Author Language Services
Cambridge University Press recommends that authors have their manuscripts checked by a native English-language speaker before submission; this will ensure that submissions are judged during peer review exclusively on academic merit. We list a number of third-party services specializing in language editing and/or translation, and suggest that authors contact as appropriate. Use of any of these services is voluntary, and at the author's own expense.

Originality and Copyright
To be considered for publication in *Palliative & Supportive Care* a manuscript cannot have been published previously, nor can it be under review for publication elsewhere. Papers with multiple authors are reviewed with the assumption that all authors have approved the submitted manuscript and concur in its submission to *Palliative & Supportive Care*. An Author Publishing Agreement must be executed before an article can be published. Government authors whose articles were created in the course of their employment must so certify by using the Government Employer License to Publish. Authors are responsible for obtaining written permission from the copyright owners to reprint any previously published material included in their article.

Conflicts of Interest
Authors should include a Conflicts of Interest declaration in their manuscript. Conflicts of Interest are situations that could be perceived to exert an undue influence on an author’s presentation of their work. They may include, but are not limited to, financial, professional, contractual or personal relationships or situations. Conflicts of Interest do not necessarily mean that an author’s work has been compromised. Authors should declare any real or perceived Conflicts of Interest in order to be transparent about the context of their work. If the manuscript has multiple authors, the author submitting the manuscript must include Conflicts of Interest declarations relevant to all contributing authors.
Example wording for your Conflicts of Interest declaration is as follows: “Conflicts of Interest: Author A is employed at company B. Author C owns shares in company D, is on the Board of company E and is a member of organisation F. Author G has received grants from company H.” If no Conflicts of Interest exist, your declaration should state “Conflicts of Interest: None”.

Funding Statement
Authors must include a Funding Statement in their manuscript. Within this statement please provide details of the sources of financial support for all authors, including

grant numbers, for example: “Funding Statement: This work was supported by the Medical Research Council (grant number XXXXXXX)”. Grants held by different authors should be identified as belonging to individual authors by the authors’ initials, for example: “Funding Statement: This work was supported by the Wellcome Trust (AB, grant numbers XXXX, YYYY), (CD, grant number ZZZZ); the Natural Environment Research Council (EF, grant number FFFF); and the National Institutes of Health (AB, grant number GGGG), (EF, grant number HHHH).”
Where no specific funding has been provided for research, you should include the following statement:
“Funding Statement: This research received no specific grant from any funding agency, commercial or not-for-profit sectors.”

ORCID
Palliative & Supportive Care now requires that all corresponding authors identify themselves using their ORCID iD when submitting a manuscript to the journal. ORCID provides a unique identifier for researchers and, through integration in key research workflows such as manuscript submission and grant applications, provides the following benefits:

- Discoverability: ORCID increases the discoverability of your publications, by enabling smarter publisher systems and by helping readers to reliably find work that you’ve authored.
- Convenience: As more organisations use ORCID, providing your iD or using it to register for services will automatically link activities to your ORCID record, and will enable you to share this information with other systems and platforms you use, saving you re-keying information multiple times.
- Keeping track: Your ORCID record is a neat place to store and (if you choose) share validated information about your research activities and affiliations.

If you don’t already have an iD, you’ll need to create one if you decide to submit a manuscript to *Palliative & Supportive Care*. You can register for one directly from your user account on Scholar One or via https://ORCID.org/register. If you already have an iD, please use this when submitting, either by linking it to your Scholar One account or supplying it during submission by using the “Associate your existing ORCID ID” button.

Publishing your article as Gold Open Access
You will have the option to publish your article as Gold Open Access, enabling the final published version to be made freely available under a Creative Commons license. You might be required to pay an Article Processing Charge (APC) for Gold Open Access. You may be eligible for a waiver or discount, for example if your institution is part of a Read and Publish sales agreement with Cambridge University Press. For more information about your Open Access options, please see here. For more information about the benefits of choosing to publish Open Access, see here.

Last updated 22 January 2020

Appendix B – Certificate of Ethical Approval (Systematic Literature Review)

Palliative Care Healthcare Professionals’ Experiences of Stress, Anxiety and Burnout: A Thematic Synthesis P114776

Certificate of Ethical Approval

Applicant: Malcolm Clayton

Project Title: Palliative Care Healthcare Professionals’ Experiences of Stress, Anxiety and Burnout: A Thematic Synthesis

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Low Risk

Date of approval: 19 Nov 2020

Project Reference Number: P114776

Malcolm Clayton (D62PY) Page 1 19 Nov 2020

Appendix C – Critical Appraisal Skills Tool (CASP)

CASP
Critical Appraisal
Skills Programme

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle
Way Oxford OX2 7LG

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

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

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

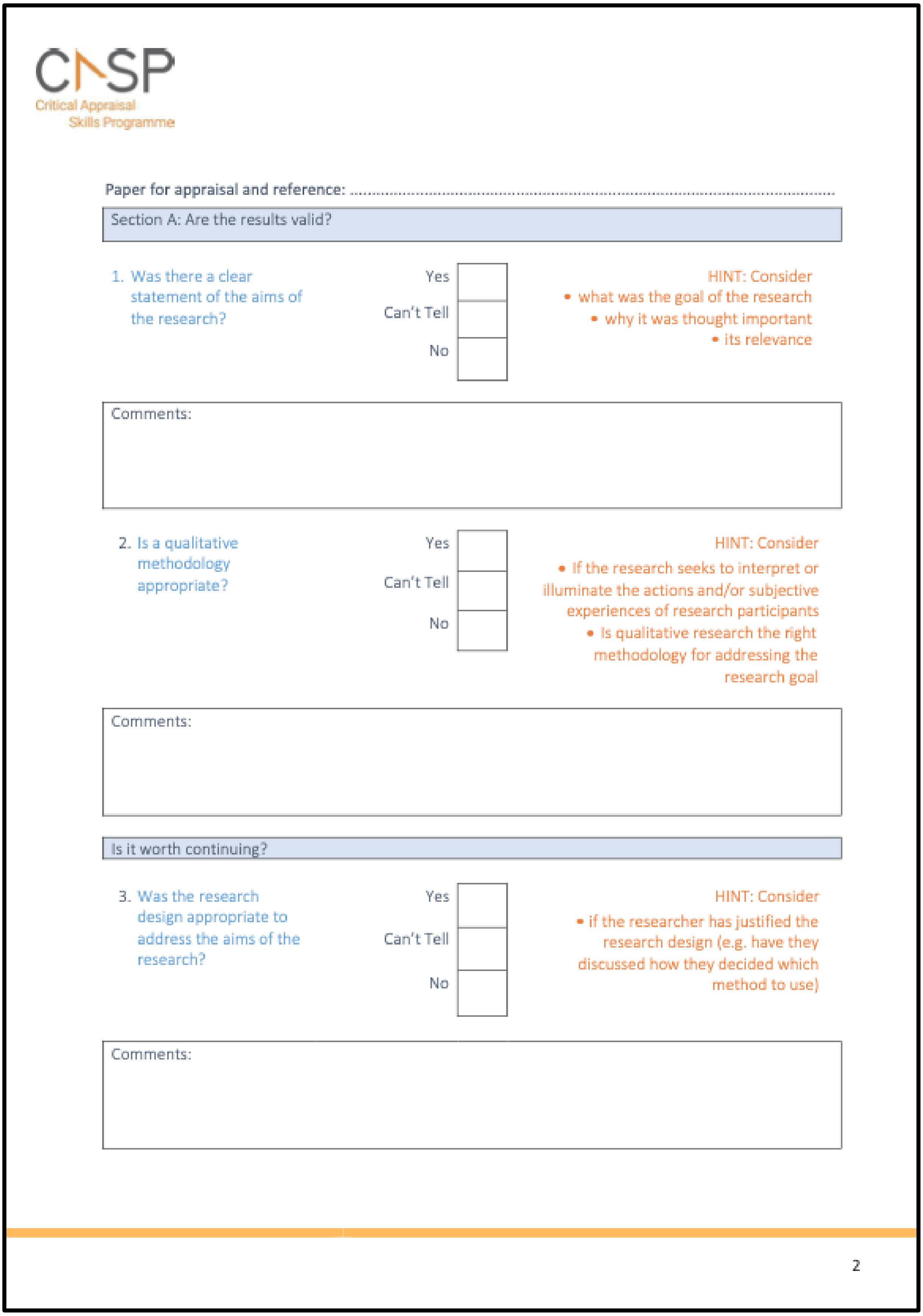
The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between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

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

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

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

Critical Appraisal Skills Programme (CASP) part of Oxford Centre for Triple Value Healthcare Ltd www.casp-uk.net



CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference: ....

Section A: Are the results valid?

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

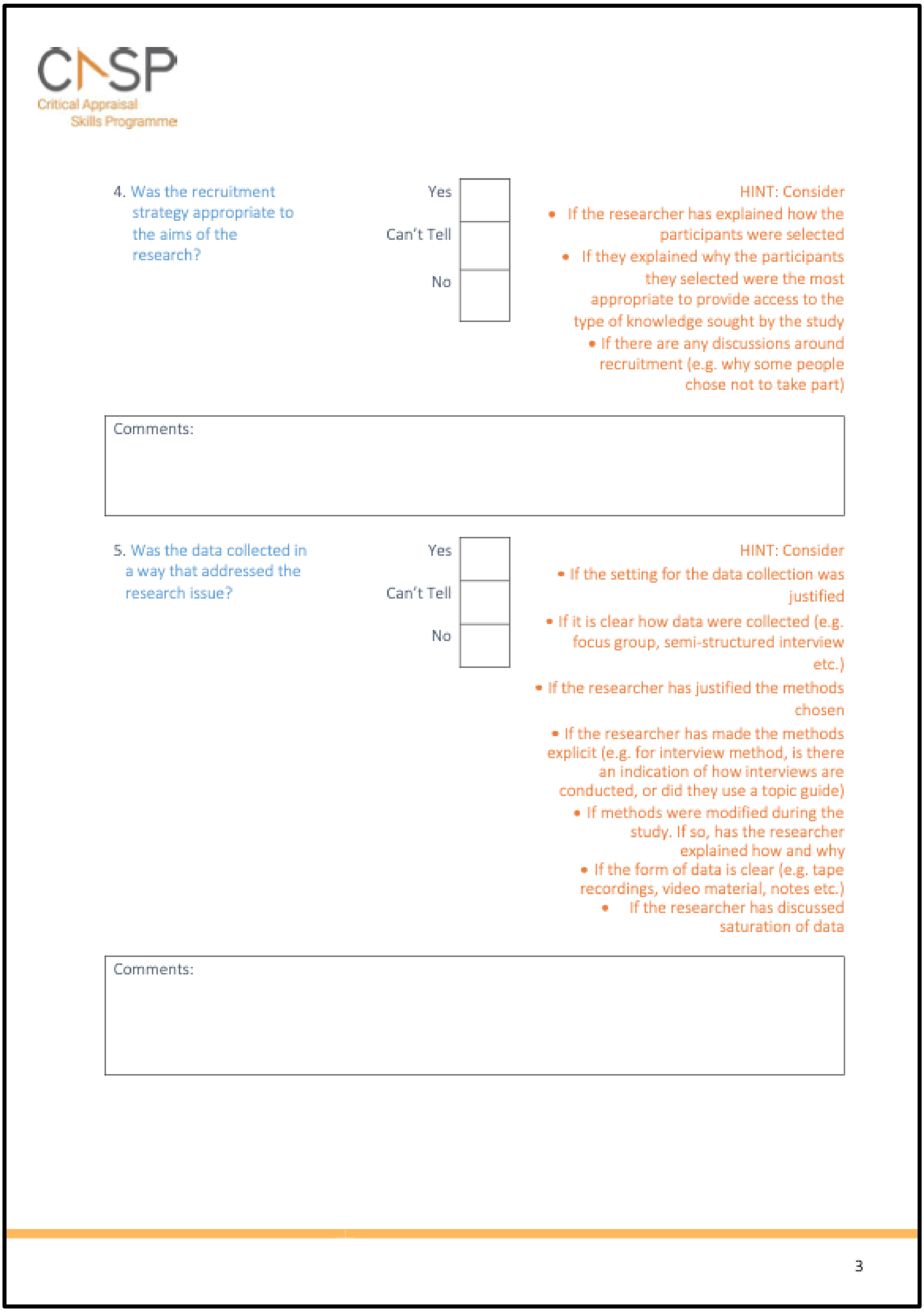
Is it worth continuing?

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:



CASP
Critical Appraisal
Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

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

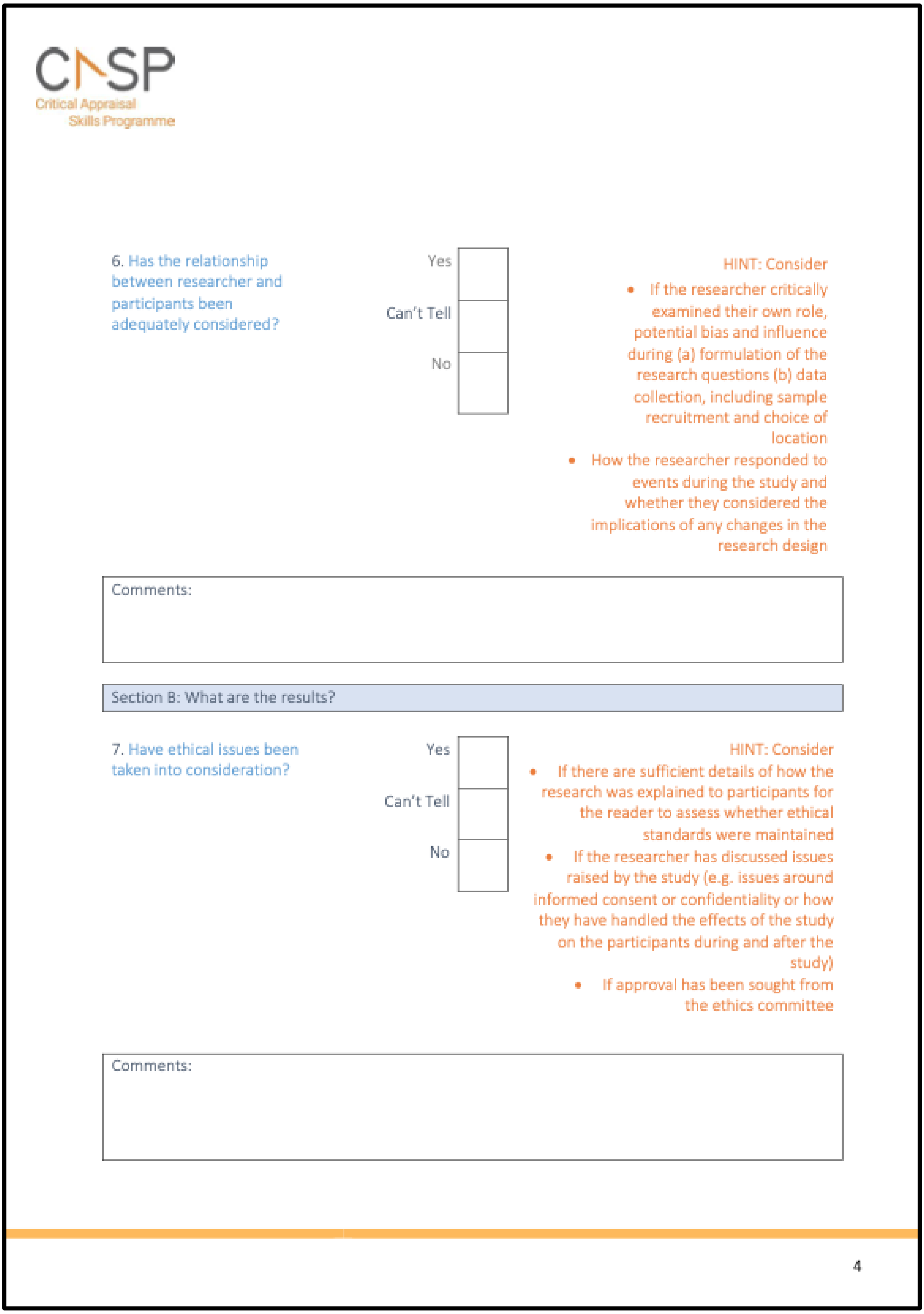
Comments:

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:



CASP
Critical Appraisal
Skills Programme

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

Yes ☐
Can't Tell ☐
No ☐

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

Comments:

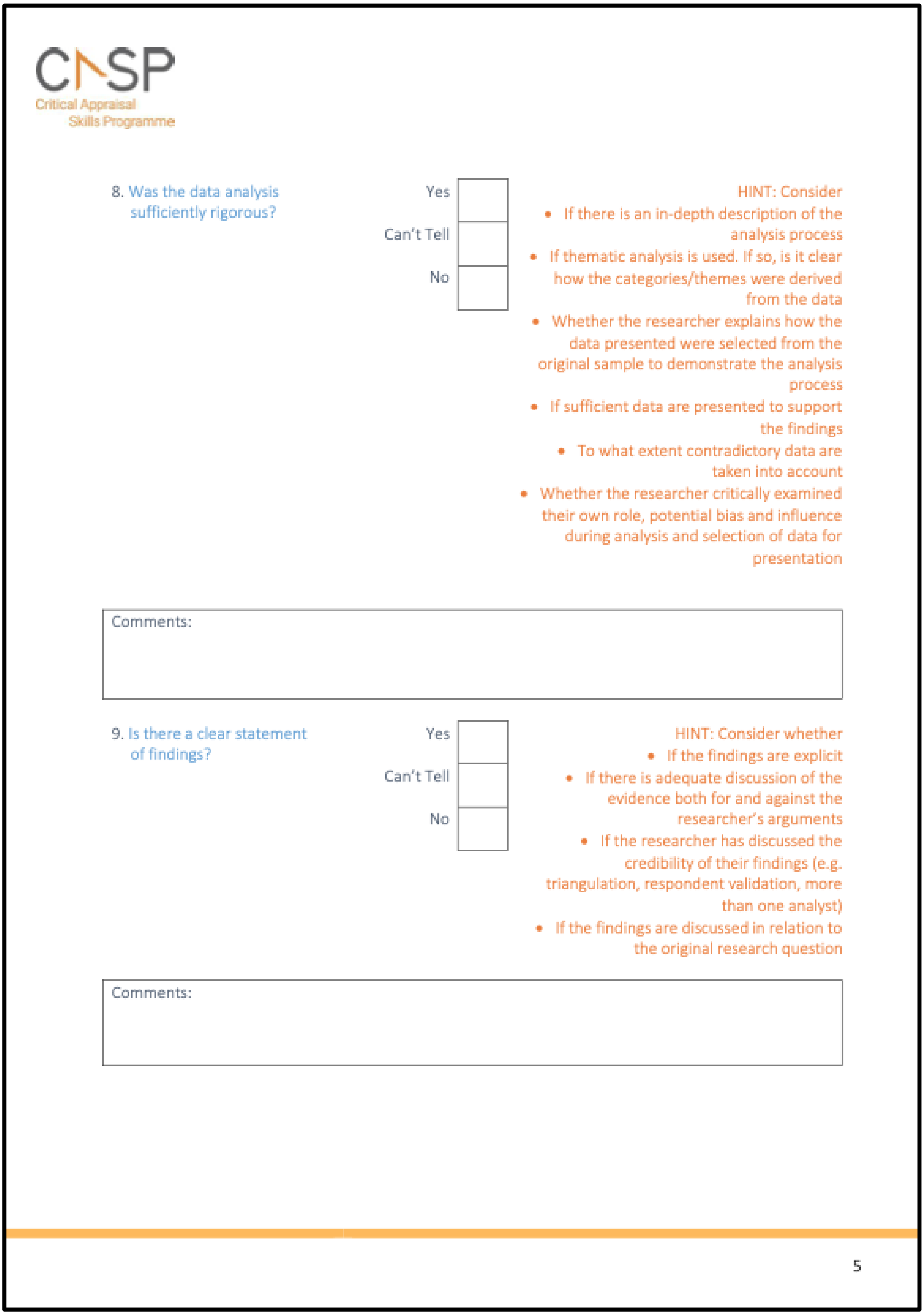
Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:



CASP
Critical Appraisal
Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

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

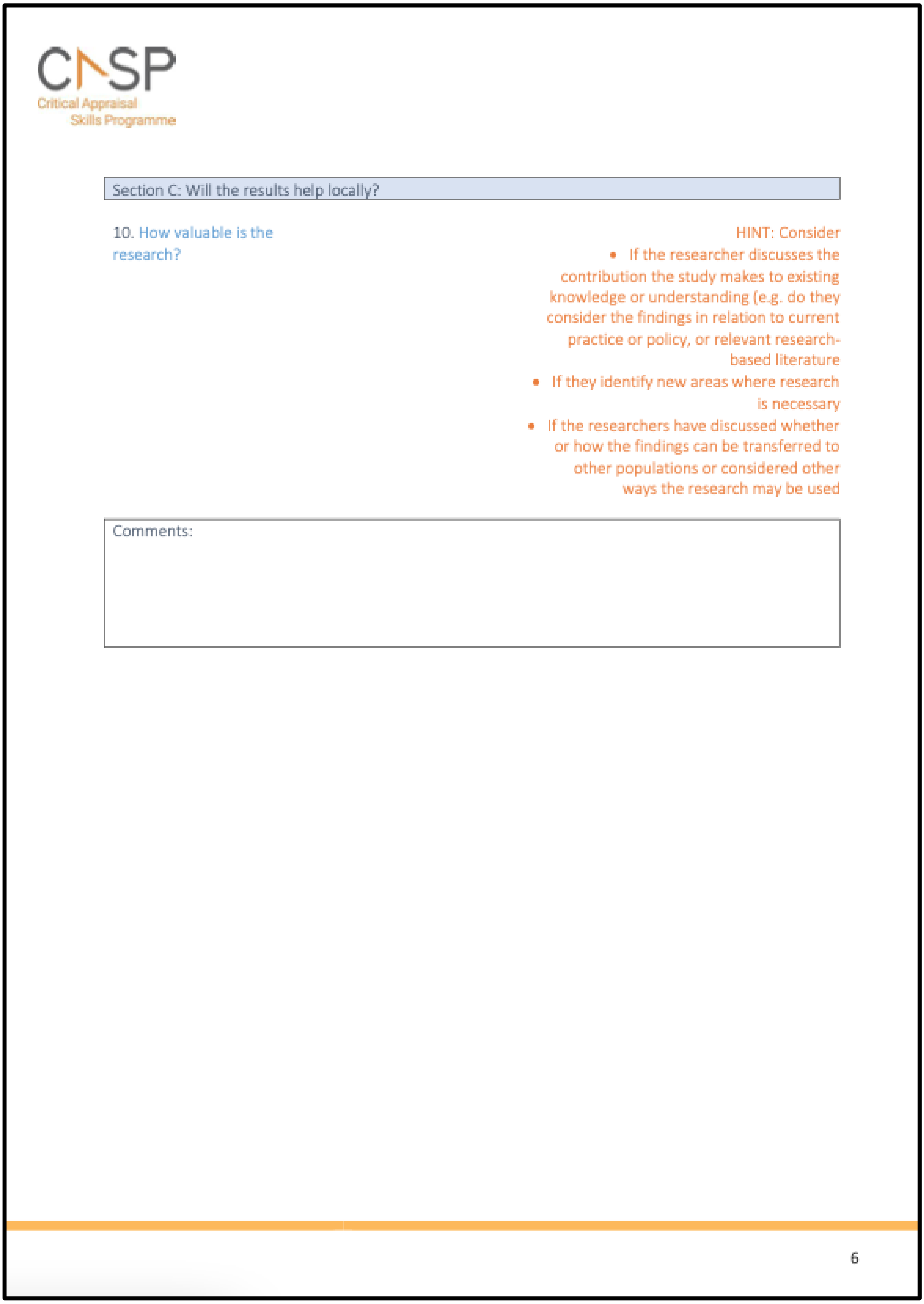
Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

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

Comments:



CASP
Critical Appraisal
Skills Programme

Section C: Will the results help locally?

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

Comments:

Appendix D – Quality Assessment Scoring

	Badger (2005)		Bailey et al. (2011)		Becker et al. (2017)		Chong & Abdullah (2017)		Gelinas et al. (2012)		Harris (2013)		Johansson & Lindahl (2012)		Jordan et al. (2014)		Källström Karlsson et al. (2008)	
Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP Questions																		
Q.1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.3	2	2	2	2	1	1	2	2	1	1	2	2	2	2	2	2	2	2
Q.4	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.5	2	2	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	2
Q.6	0	0	0	0	2	2	0	0	0	0	0	0	1	1	2	2	0	0
Q.7	1	1	2	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.8	2	2	1	1	2	2	2	2	2	2	2	2	2	2	1	1	2	2
Q.9	2	2	0	0	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.10	1	1	1	1	2	2	1	1	2	2	2	2	2	2	2	2	1	2
Total (Out of 20)	16	16	14	14	18	19	17	17	16	16	18	18	18	19	19	19	17	18
Score (%)	80	80	70	70	90	95	85	85	80	80	90	90	90	90	95	95	85	85

	Kaup et al. (2016)		McCloskey & Taggert (2010)		McNamara et al. (1995)		Reid (2013)		Rose & Glass (2009)		Seed & Walton (2012)		Tunnah et al. (2012)		Wilkes et al., (1998)		Yang & Mcilfatrick (2001)	
Rater	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
CASP Questions																		
Q.1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	1	2	2	2
Q.4	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2
Q.5	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Q.6	1	1	0	0	0	0	0	0	2	2	1	1	1	1	0	0	0	0
Q.7	2	2	2	2	0	0	2	2	2	2	2	2	2	2	2	2	1	1
Q.8	2	2	1	1	1	1	1	1	1	0	2	2	2	2	1	1	2	2
Q.9	2	2	2	2	1	1	2	2	2	2	2	2	2	2	2	2	2	2
Q.10	1	1	1	1	1	1	2	2	1	1	2	2	2	2	2	2	1	1
Total (Out of 20)	18	18	15	15	12	12	17	17	18	17	19	19	19	19	16	17	16	16
Score (%)	90	90	75	75	60	60	85	85	90	85	95	95	95	95	80	85	80	80

Appendix E – Inter-rater Reliability Coefficient (Kappa) Scoring

Study	*K* value	Significance (*p* value)
Badger, 2005	1.00	.000
Bailey et al., 2011	1.00	.000
Becker et al., 2017	.615	.035
Chong & Abdullah, 2017	1.00	.000
Gélinas et al., 2012	1.00	.000
Harris, 2013	1.00	.002
Johansson, & Lindahl, 2012	1.00	.002
Jordan et al., 2014	1.00	.002
Källström Karlsson et al., 2008	.630	.005
Kaup et al., 2016	1.00	.002
McCloskey & Taggart, 2010	1.00	.000
McNamara et al., 1995	1.00	.000
Reid, 2013	1.00	.000
Rose & Glass, 2009	.706	.003
Seed & Walton, 2012	1.00	.002
Tunnah et al., 2012	1.00	.002
Wilkes et al., 1998	.756	.001
Yang & Mcilfatrick, 2001	1.00	.000
Overall	**.877**	**.000**

Appendix F – Characteristics of the Literature

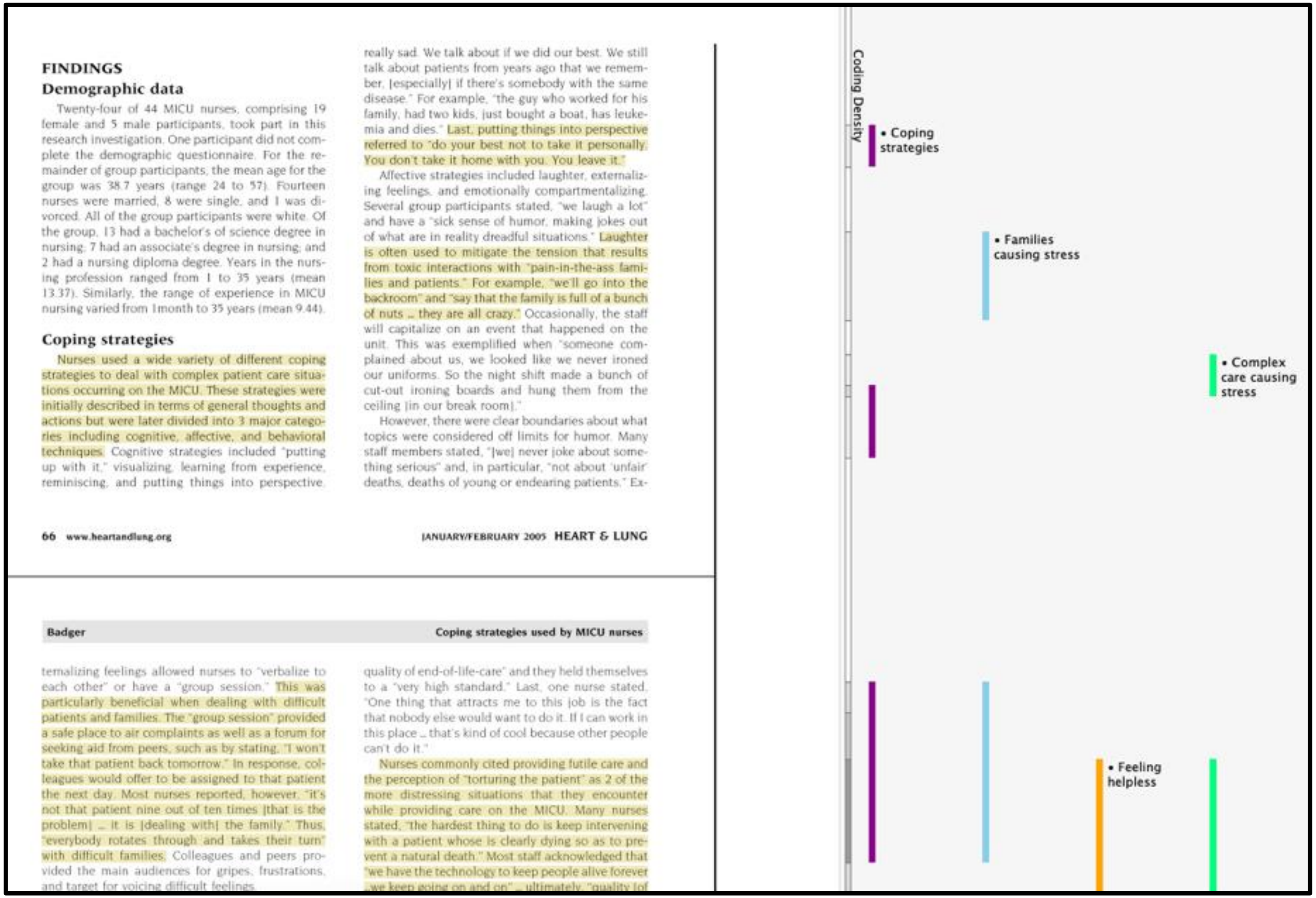
Four studies were conducted in the UK (Bailey et al., 2011; McCloskey & Taggart, 2010; Reid, 2013; Tunnah et al., 2012), and in the United States (Badger, 2005; Becker et al., 2017; Harris, 2013; Seed & Walton, 2012), three in Sweden (Johansson & Lindahl, 2012; Källström Karlsson et al., 2008; Kaup et al., 2016) and Australia (McNamara et al., 1995; Rose & Glass, 2009; Wilkes et al., 1998), one in Canada (Gélinas et al., 2012), Malaysia (Chong & Abdullah, 2017), South Africa (Jordan et al., 2014), and Taiwan (Yang & Mcilfatrick, 2001).

Studies were varied in their approaches to data collection, with focus group interviews (Gélinas et al., 2012; Harris, 2013; McCloskey & Taggart, 2010), semi structured interviews (Chong & Abdullah, 2017; Johansson & Lindahl, 2012; Jordan et al., 2014; Källström Karlsson et al., 2008; Kaup et al., 2016; Reid, 2013; Seed & Walton, 2012; Tunnah et al., 2012; Yang & Mcilfatrick, 2001), and open-ended questionnaires (Becker et al., 2017) all being used. Five studies combined qualitative data collection approaches. This included combining focus group interviews, informal conversations, and observations (Badger, 2005), observations and semi structured interviews (Bailey et al., 2011; McNamara et al., 1995), semi-structured interviews and reflective journaling (Rose & Glass, 2009), and open-ended questionnaires and semi-structured interviews (Wilkes et al., 1998).

Participants were all nurses working in services that provided PC including: hospital inpatient (Badger, 2005; Bailey et al., 2011; Becker et al., 2017; Chong & Abdullah, 2017; Gélinas et al., 2012; Johansson & Lindahl, 2012; Jordan, et al., 2014; Källström Karlsson et al., 2008; Yang & Mcilfatrick, 2001), community hospices (Harris, 2013; McNamara et al., 1995; Seed & Walton, 2012), and community/home-based PC services (Kaup et al., 2016; Reid, 2013; Rose & Glass, 2009; Tunnah et al., 2012; Wiles et al., 1998). Participants from McCloskey and Taggart (2010) came from hospital, hospice, and community teams. Seven studies reported participant ages which ranged from 22 to 62 years (Badger, 2005; Chong & Abdullah, 2017; Gélinas et al., 2012; Harris, 2013; McNamara et al., 1995; Kaup et al., 2016; Yang & Mcilfatrick, 2001).

All studies apart from five (Bailey et al., 2011; Källström Karlsson et al., 2008; McCloskey & Taggart, 2010; Reid, 2013; Yang & Mcilfatrick, 2001) reported gender, which included 240 females (93%) and 18 males (7%).

Appendix G – Stage One: Coding text



FINDINGS

Demographic data

Twenty-four of 44 MICU nurses, comprising 19 female and 5 male participants, took part in this research investigation. One participant did not complete the demographic questionnaire. For the remainder of group participants, the mean age for the group was 38.7 years (range 24 to 57). Fourteen nurses were married, 8 were single, and 1 was divorced. All of the group participants were white. Of the group, 13 had a bachelor's of science degree in nursing; 7 had an associate's degree in nursing; and 2 had a nursing diploma degree. Years in the nursing profession ranged from 1 to 35 years (mean 13.37). Similarly, the range of experience in MICU nursing varied from 1month to 35 years (mean 9.44).

Coping strategies

Nurses used a wide variety of different coping strategies to deal with complex patient care situations occurring on the MICU. These strategies were initially described in terms of general thoughts and actions but were later divided into 3 major categories including cognitive, affective, and behavioral techniques. Cognitive strategies included "putting up with it," visualizing, learning from experience, reminiscing, and putting things into perspective.

really sad. We talk about if we did our best. We still talk about patients from years ago that we remember, [especially] if there's somebody with the same disease." For example, "the guy who worked for his family, had two kids, just bought a boat, has leukemia and dies." Last, putting things into perspective referred to "do your best not to take it personally. You don't take it home with you. You leave it."

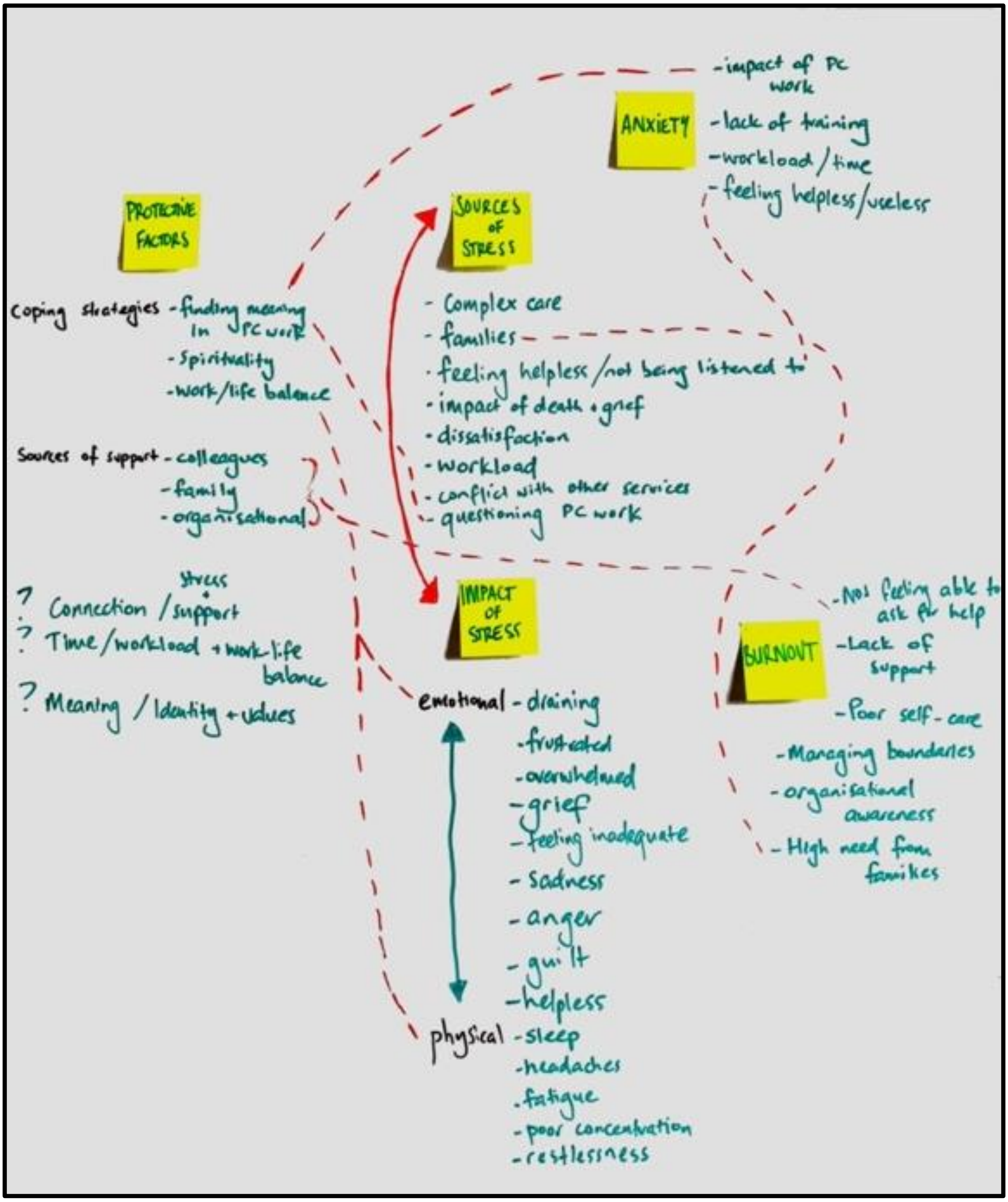
Affective strategies included laughter, externalizing feelings, and emotionally compartmentalizing. Several group participants stated, "we laugh a lot" and have a "sick sense of humor, making jokes out of what are in reality dreadful situations." Laughter is often used to mitigate the tension that results from toxic interactions with "pain-in-the-ass families and patients." For example, "we'll go into the backroom" and "say that the family is full of a bunch of nuts … they are all crazy." Occasionally, the staff will capitalize on an event that happened on the unit. This was exemplified when "someone complained about us, we looked like we never ironed our uniforms. So the night shift made a bunch of cut-out ironing boards and hung them from the ceiling [in our break room]."

However, there were clear boundaries about what topics were considered off limits for humor. Many staff members stated, "[we] never joke about something serious" and, in particular, "not about 'unfair' deaths, deaths of young or endearing patients." Externalizing feelings allowed nurses to "verbalize to each other" or have a "group session." This was particularly beneficial when dealing with difficult patients and families. The "group session" provided a safe place to air complaints as well as a forum for seeking aid from peers, such as by stating, "I won't take that patient back tomorrow." In response, colleagues would offer to be assigned to that patient the next day. Most nurses reported, however, "it's not that patient nine out of ten times [that is the problem] … it is [dealing with] the family." Thus, "everybody rotates through and takes their turn" with difficult families. Colleagues and peers provided the main audiences for gripes, frustrations, and target for voicing difficult feelings.

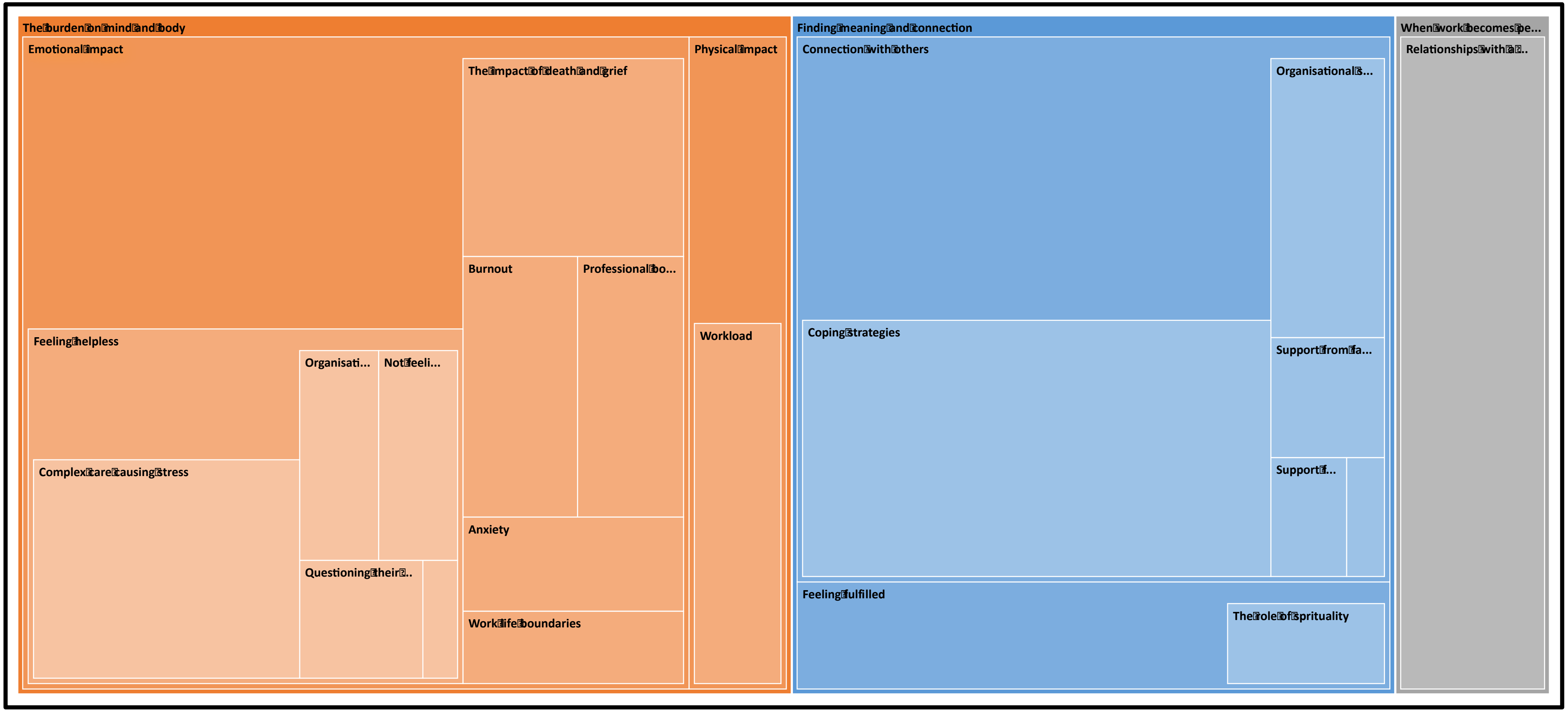
quality of end-of-life-care" and they held themselves to a "very high standard." Last, one nurse stated, "One thing that attracts me to this job is the fact that nobody else would want to do it. If I can work in this place … that's kind of cool because other people can't do it."

Nurses commonly cited providing futile care and the perception of "torturing the patient" as 2 of the more distressing situations that they encounter while providing care on the MICU. Many nurses stated, "The hardest thing to do is keep intervening with a patient whose is clearly dying so as to prevent a natural death." Most staff acknowledged that "we have the technology to keep people alive forever …we keep going on and on" … ultimately, "quality [of

Appendix H – Stage two: Developing descriptive themes



Appendix I – Stage three: The development of 'analytical' themes



Appendix J – Additional Quotes (Systematic Literature Review)

Main Theme – When work becomes personal

"Laughter is often used to mitigate the tension that results from toxic interactions with "pain-in-the-ass families and patients." For example, "we'll go into the backroom" and "say that the family is full of a bunch of nuts…they are all crazy." (Badger, 2005, p. 66)

"In addition, families may have difficulty understanding the information provided by the physician and will turn to the nurses for explanation. This situation added to the stress of having to be the bridge between the family and the physician. As a consequence of these communication difficulties, nurses sometimes received complaints from one or another of the parties. In half of the focus groups, nurses said that they found it stressful to receive critical comments from the family…" (Gélinas et al., 2012, p. 30)

"This means not allowing relations with the patients and families to become too private and requires the ability to strike a balance between closeness and distance: … So you don't get too close and personal" (Johansson & Lindahl, 2012, p. 2,037)

"The informants experienced some meetings with the patients and their families as extra demanding. They said it was difficult for them to leave them and move on. They felt exhausted. One described the feeling she had after a difficult meeting, saying that she felt as if she was going to fall into pieces. Several informants also felt that it was quite risky, as those feelings could accumulate if they did not have a chance to process them." (Kaup et al., 2016, p. 567)

Main Theme – The burden on mind and body

Subtheme – *Emotional impact*

“The nurses clearly, and sometimes tearfully, articulated the personal impact of the episode. ‘… whole emotional rollercoaster that the parents were on … you were riding that yourself ... [it was] emotionally wearying.’” (Reid, 2013, p 543)

“Three emotional stressors were addressed: value conflicts, lack of emotional support, and dealing with patient and family suffering.” (Gélinas et al., 2012, p. 31-32)

“Like Anna, Shae’s impaired emotional wellbeing also had an impact that affected others. Shae recalled: If I’m unbalanced everybody knows it. I talk about [the issue] a lot. I can’t let it go. I’m teary, I’m emotional, I’m impulsive. I say and make rash decisions that I wouldn’t do if I felt balanced which ends me up in more strife ... I put myself in the firing line sometimes unnecessarily. I don’t sleep well, I’m anxious. I’m looking for the next thing to go wrong. I come from a real negative base. I am expecting the worst instead of expecting the best..” (Rose & Glass, 2009, p. 189)

“'It's very sad really, you know when it comes to the end of their life it can hit you emotionally, but I don't take it home and think about it for hours.’” (Tunnah et al., 2012, p. 287)

“In most cases when talking of these constructs the nurses described the cause and effect of the stress on themselves. As one nurse stated: ‘It’s emotional, overload, I

find myself constantly thinking about the client, crying, having disturbed sleep'" (Wiles et al., 1998, p. 17)

"It seemed to be difficult to avoid thinking about the patients. After work, when the nurses felt that they had done everything in their power but had still been unable to relieve the patients' suffering, it was difficult to let go of their feelings. Furthermore, the nurses would dream about the patients, which was emotionally exhausting." (Källström Karlsson et al., 2008, p. 228)

"The majority of the participants expressed mixed emotions of sadness, grief and anger when caring for patients who presented with end-of-life issues. One participant explained it as follows: 'Guilt, anger... helplessness, because... you want to fix it, but you can't. That's kind of sadness obviously...extreme sadness..." (Jordan et al., 2014, p. 78)

"This sense of fear and guilt was coupled with a sense of powerlessness and frustration relating both to nurses' inability to alter the ultimate outcome for patients or take away the family's grief" (Yang & Mcilfatrick, 2001, p. 437)

Subtheme – *Physical impact*

"Physical tension, distress, sadness, restlessness and irritability were reported. Mind racing, sleeplessness and worrying caused ongoing effects leaving some nurses depleted of energy." (Rose & Glass, 2009, p. 189)

"…as identified by our study findings, over time this could be exhausting. If nurses were not supported to reach the final stage of the model, they were at risk of

developing ineffective and potentially harmful coping mechanisms that could lead to stress, ill-health and withdrawal from practice” (Bailey et al., 2011, p. 3,368)

““Sometimes I cry once I get home, from being so exhausted.”” (Gélinas et al., 2012, p. 33)

“Many nurses try this kind of nursing and leave within months, others 'burnout", but many stay despite the physical, emotional, ethical, social and spiritual problems they encounter through the course of their work.” (McNamara et al., 1995, p. 228)

“‘I do feel quite burnt out you know. How much compassion have I left? I do feel very tired. In the past year I have seriously thought about giving up nursing completely so I am obviously stressed and burnt out, and I have never done that before.’” (McCloskey & Taggart, 2010, p. 238)

Main Theme – Finding meaning and connection

Subtheme – *Feeling fulfilled*

“…caring for the terminally ill and their families means getting a lot back in return, which means experiencing affirmation and stimulation in the work. This helps the nurses to gain the strength to care and find meaning in what they do.” (Johansson & Lindahl, 2012, p. 2,038)

“Job satisfaction was identified as an important determinant of the nurses' stress levels. Several of the nurses discussed the merits of 'making a difference': 'When you've walked in and there's a crisis, the patient is in pain, family in distress, they are not coping, they are frightened. By the time you have left the home, having sorted

out the pain, the symptom control issues and you've calmed the waters ... the families are happy.'" (Tunnah et al., 2012, p. 286)

"…nurses indicated that providing comfort, respecting patient wishes and having empathy for patients and families could help balance their own emotional reactions or stress: 'I provide the optimal nursing care to the patients who are approaching death. I just want all of them to feel very comfortable and this is what I can do for them at that time… It can make me feel better when the patients die." (Yang & Mcilfatrick, 2001, p. 439)

Subtheme – *Connection with others*

"…it became clear through the discussions that most viewed the relationships with their coworkers as much more than a professional connection. For some, there was consensus that it was ''more than a family,'' whereas others agreed that the relationship was much ''more personalized and they were able to share more with one another.''" (Harris, 2013, p. 449)

*"…registered nurses found that they supported each other, which aided in their coping. They expressed that these support systems in the intensive care unit were very beneficial and helped them as illustrated by the following quote: So it's nice in this ICU, because we support each other a lot. If you've got a problem you never sit alone with a dying patient. There will be times that someone will pat your shoulder, ask how you are, or ask if they can bring you a cup of coffee or do something for you." (*Jordan et al., 2014, p. 80)

“Although the nurse's social networks may be broad and represent the totality of resources they may draw upon for support, the personal networks developed between family, friends and colleagues feature most strongly as both a source of stress and support for hospice nurses.” (McNamara et al., 1995, p. 232)

Appendix K – Journal of Clinical Psychology Author Guidelines (Empirical)

Sections

Submission and Peer Review Process
Article Types
After Acceptance

1. Submission and Peer Review Process

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at **https://mc.manuscriptcentral.com/jclp**. Please note: In Session articles are published by invitation only. Authors will receive an invitation with a custom link to ScholarOne.

For help with submissions, please contact: Swathi Kumaran at JCLPjournal@wiley.com.

For help with article preparation **Wiley Editing Services** offers expert help with English Language Editing, as well as translation, manuscript formatting, and figure preparation.

Free format submission

Journal of Clinical Psychology now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files—whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including statements relating to our ethics and integrity policies (see information on these policies below in Section 1):
- data availability statement
- funding statement
- conflict of interest disclosure
- ethics approval statement
- patient consent statement
- permission to reproduce material from other sources
- clinical trial registration

(Important: the journal operates a double-blind peer review policy. Please anonymize your manuscript and prepare a separate title page containing author details.)

- Your co-author details, including affiliation and email address.
- An ORCID ID, freely available at https://orcid.org.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Open Access

This journal is a GREEN Open Access title. See **here** for details. Submissions will be subject to an Article Processing Charge (APC) if accepted and published in the journal. For more information about APCs, and to see if you're eligible for a waiver (through your institution or because the corresponding author belongs to a waiver country) please go **here** .

Preprint policy:

Please find the Wiley preprint policy **here.**

This journal accepts articles previously published on preprint servers.

Wiley's Preprints Policy statement for subscription/hybrid open access journals:

Journal of Clinical Psychology will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

Data Sharing and Data Availability

This journal expects data sharing. Please review Wiley's policy **here**, where you will be able to see and select the availability statement that is right for your submission.

Data Citation

Please review Wiley's data citation policy **here.**

Funding

Authors should list all funding sources in the Acknowledgements section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Please see **here** and scroll down for a description of authorship criteria.

Wiley's Author Name Change Policy

In cases where authors wish to change their name following publication, Wiley will update and republish the paper and redeliver the updated metadata to indexing services. Our editorial and production teams will use discretion in recognizing that name changes may be of a sensitive and private nature for various reasons including (but not limited to) alignment with gender identity, or as a result of marriage, divorce, or religious conversion. Accordingly, to protect the author's privacy, we will not publish a correction notice to the paper, and we will not notify co-authors of the change. Authors should contact the journal's Editorial Office with their name change request.

ORCid

This journal requires ORCid. Please see Wiley's resources on ORCID **here.**

Reproduction of Copyright Material

If excerpts from copyrighted works owned by third parties are included, credit must be shown in the contribution. It is the author's responsibility to also obtain written permission for reproduction from the copyright owners. For more information visit Wiley's Copyright Terms & Conditions FAQ at **http://exchanges.wiley.com/authors/faqs---copyright-terms--conditions_301.html**

The corresponding author is responsible for obtaining written permission to reproduce the material "in print and other media" from the publisher of the original source, and for supplying Wiley with that permission upon submission.

Title Page

The title page should contain**:**

- A brief informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Acknowledgments.

Main Text File

For journals operating a double-blind peer review process, please ensure that all identifying information such as author names and affiliations, acknowledgements or explicit mentions of author institution in the text are on a separate page.

The main text file should be in word or PDF format and include:

- A short informative title containing the major key words. The title should not contain abbreviations
- The full names of the authors with institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;

- Acknowledgments;
- Abstract structured (objective(s)/methods/results/conclusion)
- Up to six keywords;
- Main body:
    1. regular section formatted as introduction, materials & methods, results, discussion, conclusion
    2. In Session (invitation only) formatted as introduction, Case Illustration (including separate sections on Presenting Problem & Client Description, Case Formulation, Course of Treatment, Outcome and Prognosis), Clinical Practices and Summary, and Selected References & Recommended Readings
- References (for In Session, please provide no more than 20 references};
- Tables (each table complete with title and footnotes);
- Figures: Figure legends must be added beneath each individual image during upload AND as a complete list in the text.

Reference Style

This journal uses APA reference style. Find more information on reference style guidelines **here**.

Figures and Supporting Information

Figures, supporting information and appendices should be supplied as separate files. **Click here** for the basic figure requirements for figures submitted with manuscripts for peer review, as well as the more detailed post-acceptance figure requirements. **Click here** for Wiley's FAQs on supporting information.

Article Types

Article Type	Description	Abstract / Structure	Other Requirements
Original Papers	reports of new research findings or conceptual analyses that make a significant contribution to knowledge	Yes, Structured	Data Availability Statement
Comprehensive Reviews	critical reviews of the literature, including systematic reviews and meta-analyses	Yes, unstructured	

Training and Professional Issues	Original research and training methods related to the education and training of professional psychologists	Yes, structured	Data Availability Statement
Case Reports (In Session – by invitation only)	original articles illustrated through case reports	Yes, unstructured	Data Availability Statement

Peer Review

This journal operates under a double-blind peer review model. You can read more about peer review model here. Papers will only be sent to review if the Editor-in-Chief determines that the paper meets the appropriate quality and relevance requirements.

In-house submissions, i.e. papers authored by Editors or Editorial Board members of the title, will be sent to Editors unaffiliated with the author or institution and monitored carefully to ensure there is no peer review bias.

Wiley's policy on the confidentiality of the review process is **available here**.

Guidelines on Publishing and Research Ethics in Journal Articles

Please review Wiley’s policies surrounding human studies, animal studies, clinical trial registration, biosecurity, and research reporting guidelines **here.**

This journal follows the core practices of the **Committee on Publication Ethics (COPE)** and handles cases of research and publication misconduct accordingly (**https://publicationethics.org/core-practices**).

This journal uses iThenticate’s CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley’s Top 10 Publishing Ethics Tips for Authors **here**. Wiley’s Publication Ethics Guidelines can be found **here**.

3. After Acceptance

Wiley Author Services

When an accepted article is received by Wiley’s production team, the corresponding author will receive an email asking them to login or register with **Wiley Author Services**. The author will be asked to sign a publication license at this point.

Cover Image Submissions

This journal accepts artwork submissions for Cover Images. This is an optional service you can use to help increase article exposure and showcase your research. For more information, including artwork guidelines, pricing, and submission details, please visit the **Journal Cover Image page.**

Author Licensing

Authors may choose to publish under the terms of the journal's standard copyright agreement, or **OnlineOpen** under the terms of a Creative Commons License.

General information regarding licensing and copyright is available **here**. To review the Creative Commons License options offered under OnlineOpen, please **click here.** *Funder Open Access*: Please click **here** for more information on Wiley's compliance with specific Funder Open Access Policies.

Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions. Please click **here** for more detailed information about self-archiving definitions and policies.

Funder Open Access: Please click **here** for more information on Wiley's compliance with specific Funder Open Access Policies.

Proofs

Authors will receive an e-mail notification with a link and instructions for accessing HTML page proofs online. Authors should also make sure that any renumbered tables, figures, or references match text citations and that figure legends correspond with text citations and actual figures. Proofs must be returned within 48 hours of recipes of the email.

Appendix L – Semi-Structured Interview Questions

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

Semi-structured interview questions

- **Could you tell me a bit about your role right now?**
  (Prompt: Has the impact of Covid-19 on staff affected you? How are your responsibilities different now? What sort of support do people seem to need?)

- **What does "supporting medical staff" mean to you?**
  (Prompt: What words come to mind, what images? How has that affected you?)

- **How does that look like in practice for you?**
  (Prompt: How was it for you at the beginning/now? How did/does that make you feel? How have you been involved in your role changing? Were you involved in decision making? How did that make you feel? How has that affected you?)

- **How have you been supported since the changes to your role?**
  (Prompt: How was it for you at the beginning/now? How did/does that make you feel? How have you been involved in your role changing? Were you involved in decision making? How did that make you feel? How has that affected you?)

- **Could you tell me a bit about how your role affects your day to day life now?**
  (Prompt: Physically, psychologically, spiritually, emotionally, financially, socially, relationships, any impact on your mental health? Symptoms of anxiety, depression, poor sleep, lack of appetite)

- **Have you been able to look after yourself?**
  (Prompt: Receiving support from supervisors, work/life balance, time off or away from online coverage?)

- **Is there anything else that I haven't asked about that you feel is important?**

Version 08/04/20

Appendix M – Certificate of Ethical Approval (Empirical)

Coventry University

Certificate of Ethical Approval

Applicant:

Malcolm Clayton

Project Title:

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

07 May 2020

Project Reference Number:

P105530

Appendix N – Research Recruitment Poster

Research participants wanted

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

I'm Malcolm Clayton, Trainee Clinical Psychologist at Coventry University. I'm looking to interview HCPC Registered Clinical Psychologists, working in the NHS in England, who are supporting medical staff treating Covid-19 patients. You will be asked to engage in an interview answering a number of questions regarding your experience. Interviews would be conducted online, or over the telephone and should last around 90 minutes. Interviews are voluntary, confidential and anonymous.

If you are interested or would like more information before making a decision, please get in touch by email clayto36@uni.coventry.ac.uk

Project supervised by:

Dr Lesley Harrison
Assistant Professor
Lesley.Harrison@coventry.ac.uk

Dr Magda Marczak
Lecturer in Clinical Psychology
Magdalena.Marczak@coventry.ac.uk

This study has been approved by Coventry University Research Ethics Committee
(Coventry University Ethics Ref: P105530)

Appendix O – Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

You are being invited to take part in research exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients. Malcolm Clayton, Trainee Clinical Psychologist at Coventry University is leading this research. Before you decide to take part it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of the study is to explore the experience of clinical psychologists supporting medical staff treating Covid-19 patients. The British Psychological Society Covid19 Staff Wellbeing Group has recently published guidance on the psychological needs of healthcare staff as a result of the Coronavirus pandemic. The area is rapidly developing, and research is needed to understand how clinical psychologists are experiencing this work. It is hoped that this study will support clinical psychologists to understand, acknowledge, and meet their own needs, as well as the needs of the staff they support.

Why have I been chosen to take part?
You are invited to participate in this study because you are a clinical psychologist, HCPC registered, working in the NHS and supporting medical staff treating Covid-19 patients.

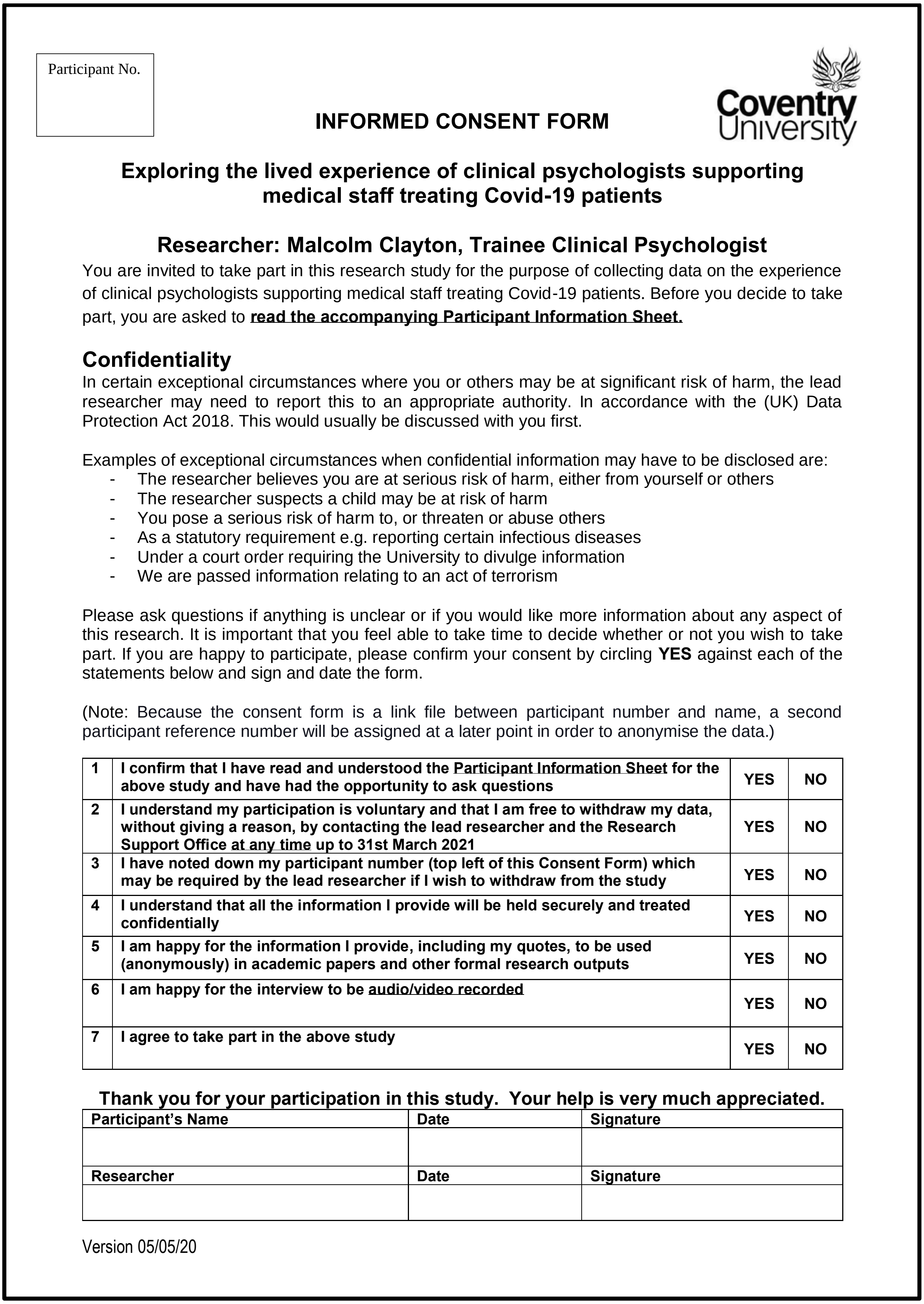
What are the benefits of taking part?
By sharing your experiences with us, you will be helping Malcolm Clayton and Coventry University to better understand the experiences of clinical psychologists supporting medical staff treating Covid-19 patients.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's Ethics Committee and NHS Ethics. There are no significant risks associated with participation. However, talking about your experiences of supporting staff who are treating Covid-19 patients may give rise to emotional distress. If you are feeling upset or concerned following your participation, you should contact your GP. There is also a list of support services on the Debrief Form.

Do I have to take part?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study at a later date. You are free to withdraw your information from the project data set at any time up to 31st March 2021, which is around one month before submission of the thesis. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (contact details are provided below). Please also contact the Research Support Office [ethics.hls@coventry.ac.uk] and provide your name and the name of the study / researcher so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?
You will be asked to engage in an interview and answer a number of questions regarding your experience of supporting medical staff treating Covid-19 patients. If it is not possible to conduct a face to face interview due to the restrictions placed by the government the interview will take place remotely, using telephone, Skype, or another secure videoconferencing application. I would like to audio/video record your responses (and will require your consent for this), so the location should be in a fairly quiet area. The interview may take up to 90 minutes to complete.

Appendix P – Informed Consent Form



Participant No.

INFORMED CONSENT FORM

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

Researcher: Malcolm Clayton, Trainee Clinical Psychologist

You are invited to take part in this research study for the purpose of collecting data on the experience of clinical psychologists supporting medical staff treating Covid-19 patients. Before you decide to take part, you are asked to **read the accompanying Participant Information Sheet.**

Confidentiality

In certain exceptional circumstances where you or others may be at significant risk of harm, the lead researcher may need to report this to an appropriate authority. In accordance with the (UK) Data Protection Act 2018. This would usually be discussed with you first.

Examples of exceptional circumstances when confidential information may have to be disclosed are:

- The researcher believes you are at serious risk of harm, either from yourself or others
- The researcher suspects a child may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- As a statutory requirement e.g. reporting certain infectious diseases
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism

Please ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take time to decide whether or not you wish to take part. If you are happy to participate, please confirm your consent by circling **YES** against each of the statements below and sign and date the form.

(Note: Because the consent form is a link file between participant number and name, a second participant reference number will be assigned at a later point in order to anonymise the data.)

1	**I confirm that I have read and understood the Participant Information Sheet for the above study and have had the opportunity to ask questions**	**YES**	**NO**
2	**I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office at any time up to 31st March 2021**	**YES**	**NO**
3	**I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study**	**YES**	**NO**
4	**I understand that all the information I provide will be held securely and treated confidentially**	**YES**	**NO**
5	**I am happy for the information I provide, including my quotes, to be used (anonymously) in academic papers and other formal research outputs**	**YES**	**NO**
6	**I am happy for the interview to be audio/video recorded**	**YES**	**NO**
7	**I agree to take part in the above study**	**YES**	**NO**

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	**Date**	**Signature**
Researcher	**Date**	**Signature**

Version 05/05/20

Appendix Q – Debrief Form

DEBRIEF FORM

Exploring the lived experience of clinical psychologists supporting medical staff treating Covid-19 patients

Thank you for taking part in this study. The purpose of the study is to explore the experience of clinical psychologists supporting medical staff treating Covid-19 patients. It is thought that clinical psychologists will be involved in supporting frontline healthcare workers in a novel, rapidly changing, and demanding clinical environment. Hence there is a need for research in this area. It is hoped that this study will support clinical psychologists, as well as the NHS, to better meet the specific needs of clinical psychologists and medical staff treating Covid-19 patients.

In writing up the study all data will be anonymised, and your individual data will not be available to anyone outside of the research team.

If you wish to withdraw your data, you can do so up to 31st March 2021. To withdraw, please contact the lead researcher (contact details are provided below). Please also contact the Research Support Office [ethics.hls@coventry.ac.uk] and provide your name and the name of the study/ researcher so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

If you would like further information about the study or would like to know more about the results, then please contact me on clayto36@uni.coventry.ac.uk. Unfortunately, I am unable to provide you with your individual results.

If taking part in this study has raised any specific concerns about your current role or clinical practice, then please contact your clinical supervisor or line manager. Alternatively, for more general support please contact:

- ☐ The British Psychological Society www.bps.org.uk
- ☐ The Association of Clinical Psychologists www.acpuk.org.uk
- ☐ The COVID Trauma Response Working Group www.traumagroup.org
- ☐ Samaritans Tel 116 123 or Email jo@samartines.org

Making a Complaint
If you are unhappy with any aspect of this research, please first contact the lead researcher, Malcolm Clayton, clayto36@uni.coventry.ac.uk. If you still have concerns and wish to make a formal complaint, please write to the research supervisors:

Dr Lesley Harrison
Assistant Professor
Coventry University
Coventry CV1 5FB
Email: Lesley.Harrison@coventry.ac.uk

Dr Magda Marczak
Lecturer in Clinical Psychology
Coventry University
Coventry CV1 5FB
Email: Magdalena.Marczak@coventry.ac.uk

Or the Associate Dean of Research, Prof Nigel Berkeley (email: ethics.hls@coventry.ac.uk) In your letter please provide information about the research study, specify the name of the researcher and detail the nature of your complaint.

Version 04/05/20

Appendix R – Stages of IPA (Smith et al., 2009)

Step	Procedure	Description
1	**Reading and re-reading**	This included listening to audio recordings whilst transcribing. Repeated reading of transcripts ensured the participant became the focus of analysis. Narratives, patterns of engagement, and meaning making through accounts and stories helped develop a ‘model’ of the overall interview. Bracketing initial reactions helped focus on the data and avoid feeling overwhelmed by initial ideas and connections.
2	**Initial noting**	This examined the semantic content and language used to identify specific ways participants understood and talked about specific issues. This produced notes and comments on transcripts and helped develop the interpretative phenomenological focus of the analysis.
3	**Developing emergent themes**	This involved mapping interrelationships, connections, and patterns between transcript notes. Themes were expressed as phrases which spoke to the psychological essence of the participants meaning making. This is part of the hermeneutic circle, where parts of the data are interpreted in relation to the whole, and the whole interpreted in relations to the parts.
4	**Searching for connections across emergent themes**	This involved mapping how themes fit together. Emergent themes were explored and incorporated, merged or discarded. An overall ‘structure’ was produced to illustrate the most important aspects of participant accounts.
5	**Moving to the next case**	Steps 1 – 4 were repeated for subsequent transcripts. Bracketing of ideas from previous transcripts was important to try to treat each transcript as important on its own terms and remain open to new themes
6	**Looking for patterns across cases**	This involved identifying connections between cases to identify superordinate and subordinate themes. This helped the analysis to move to a move theoretical level.

Appendix S – IPA analysis using NVivo

Following Step One, transcripts were uploaded to NVivo 1.4 for further analysis.

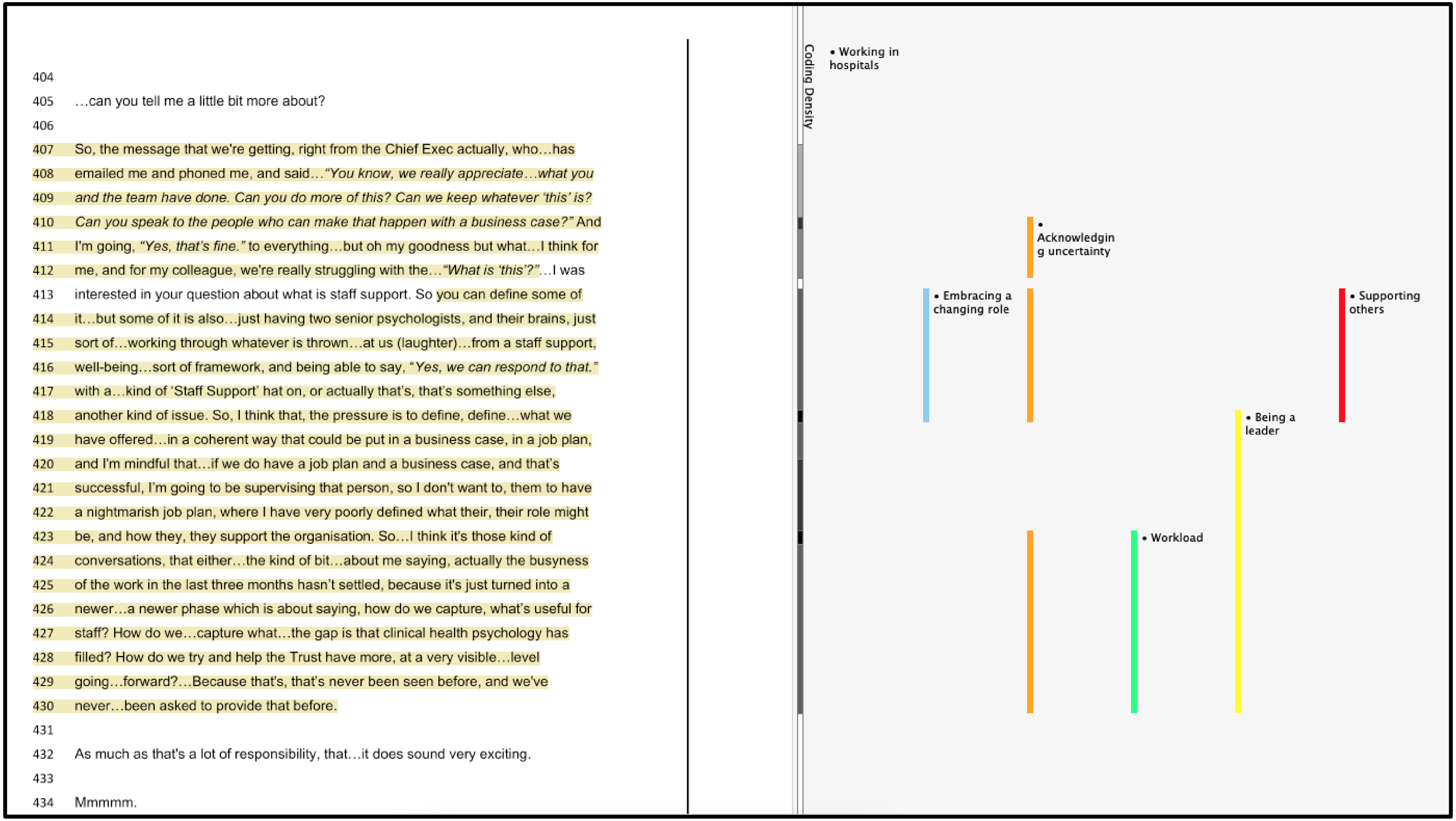
During Step Two, initial noting was undertaken using the NVivo *Coding* function (Appendix T). Here, the *Coding* function provided descriptive comments with a phenomenological focus. They described the things that were important to the participant (relationships, events, values, places, processes) and what they were like. An approach close to *"free textual analysis"* (Smith et al., 2009, p.83) was used to support a fluid process of engaging with the text. The *Annotation* function was used to record linguistic and conceptual comments. This approach ensured the analysis retained an interpretative focus.

In Step Three, emergent themes were developed by breaking up the narrative flow of the interview using the codes from Step Two. Codes were grouped together if they were similar using functions *Matrix Coding Query* (Appendix U) and *Explore Diagram* (Appendix V). The initial codes from Step Two were developed into short phrases that more closely captured and reflected the understanding gained through analysis and interpretation. This stage involved engaging in the hermeneutic circle (Smith et al., 2009, p. 28) moving *"back and forth"* through different ways of thinking about the data.

The *Explore Diagram* function enabled themes to be moved around and similar themes grouped together (Appendix V) and thus looking for connections using abstraction (Smith et al., 2009). Initial themes identified at this stage were captured and further bracketing was undertaken using a reflective journal. This ensured the idiographic approach of IPA that each transcript could be analysed on its 'own terms' .

Once Steps One through Four were completed for the first interview, the analysis moved on to the next transcript and the procedure was repeated, until all 10 transcripts were analysed. Finally, in Step Six the *Matrix Coding Query* supported looking for patterns or connections across cases using numeration (Smith et al., 2009; Appendix W) and Hierarchy chart functions (Smith et al., 2009; Appendix X).

Appendix T – Step Two: Initial noting



…can you tell me a little bit more about?

So, the message that we're getting, right from the Chief Exec actually, who…has emailed me and phoned me, and said…*"You know, we really appreciate…what you and the team have done. Can you do more of this? Can we keep whatever 'this' is? Can you speak to the people who can make that happen with a business case?"* And I'm going, *"Yes, that's fine."* to everything…but oh my goodness but what…I think for me, and for my colleague, we're really struggling with the…*"What is 'this'?"*…I was interested in your question about what is staff support. So you can define some of it…but some of it is also…just having two senior psychologists, and their brains, just sort of…working through whatever is thrown…at us (laughter)…from a staff support, well-being…sort of framework, and being able to say, *"Yes, we can respond to that."* with a…kind of 'Staff Support' hat on, or actually that's, that's something else, another kind of issue. So, I think that, the pressure is to define, define…what we have offered…in a coherent way that could be put in a business case, in a job plan, and I'm mindful that…if we do have a job plan and a business case, and that's successful, I'm going to be supervising that person, so I don't want to, them to have a nightmarish job plan, where I have very poorly defined what their, their role might be, and how they, they support the organisation. So…I think it's those kind of conversations, that either…the kind of bit…about me saying, actually the busyness of the work in the last three months hasn't settled, because it's just turned into a newer…a newer phase which is about saying, how do we capture, what's useful for staff? How do we…capture what…the gap is that clinical health psychology has filled? How do we try and help the Trust have more, at a very visible…level going…forward?…Because that's, that's never been seen before, and we've never…been asked to provide that before.

As much as that's a lot of responsibility, that…it does sound very exciting.

Mmmmm.

Appendix U – Step Three: Developing emergent themes

Matrix Coding Search Criteria

Search in: **Files and Externals**

Rows:

Files\\Interview P19 - 9 Sept 2020

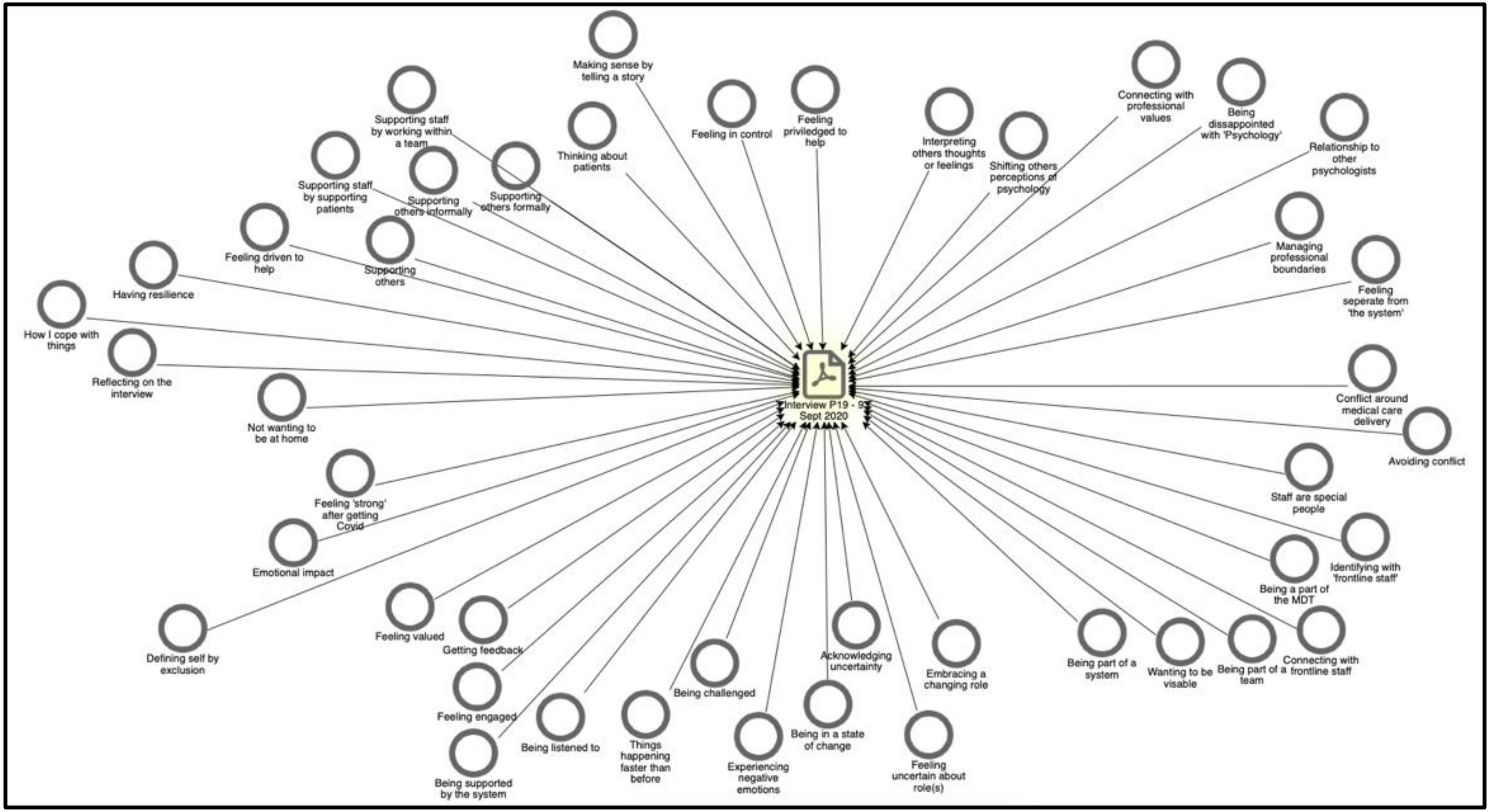
Columns:

○ Nodes\\Being human\Emotional impact\Feeling in control
○ Nodes\\Being human\Emotional impact\Feeling valued
○ Nodes\\Being human\Getting Covid\Feeling 'strong' after getting Covid
○ Nodes\\Being human\How I cope with things
○ Nodes\\Being human\How I cope with things\Having resilience
○ Nodes\\Being human\How I cope with things\Thinking about how to cope and manage
○ Nodes\\Being in a state of change
○ Nodes\\Being in a state of change\Acknowledging uncertainty
○ Nodes\\Being in a state of change\Being challenged
○ Nodes\\Being in a state of change\Embracing a changing role
○ Nodes\\Being in a state of change\Things happening faster than before

Coding Matrix

	A : Avoiding conflict	B : Being disappointed with 'Psychology'	C : Being part of a system	D : Being listened to	E : Being part of a team	F : Being a part of the MDT	G : Being supported by the system	H : Feeling separate from 'the system'	I : Feeling uncertain about role(s)	J : Connecting with frontline staff	K : Others perceptions of psychology	L : Staff are special people	M : Identifying with 'frontline staff'	Inte th
1 : Intervie...	1	13	2	3	11	8	4	13	7	10	4	8	4	

Appendix V – Steps Three and Four: Searching for connections across emergent themes



Appendix W – Step Six: Looking for patterns across cases (Part One)

- ○ Being a psychologist
  - ○ A sense of duty
  - ○ Avoiding conflict
  - ○ Being a leader
  - ○ Being dissappointed with 'Psychology'
  - ○ Connecting with professional values
  - ○ Differences between staff groups
  - ○ Feeling priviledged to help
  - ○ Following the research
  - ○ Getting feedback
  - ○ Having relevant training
  - ○ Not wanting to be at home
  - ○ Reflecting
  - ○ Relationship to other psychologists
  - ○ Supporting others
    - ○ A balancing act
    - ○ Supervising others
    - ○ Supporting others formally
    - ○ Supporting others informally
    - ○ Supporting staff by supporting patients
    - ○ Supporting staff by working within a team
    - ○ Thinking about patients
    - ○ Wanting to be visable
  - ○ Thinking about doing research
  - ○ Workload
- ○ Being human
  - ○ Being a parent
  - ○ Death of a colleague
  - ○ Emotional impact
  - ○ Getting Covid
  - ○ Having resilience
  - ○ How I cope with things
  - ○ Impact on family
  - ○ Self-care
  - ○ Struggling at home
  - ○ Thinking about how to cope and manage
  - ○ Worrying about getting sick or dying
  - ○ Worrying about the news

Unsaved Query

Matrix Coding Search Criteria

Rows:

- Files\\Interview P31 - 28 May 2020
- Files\\Interview P48 - 20 May 2020
- Files\\Interview P50 - 26 June 2020
- Files\\Interview P64 - 18 June 2020
- Files\\Interview P81 - 12 June 2020

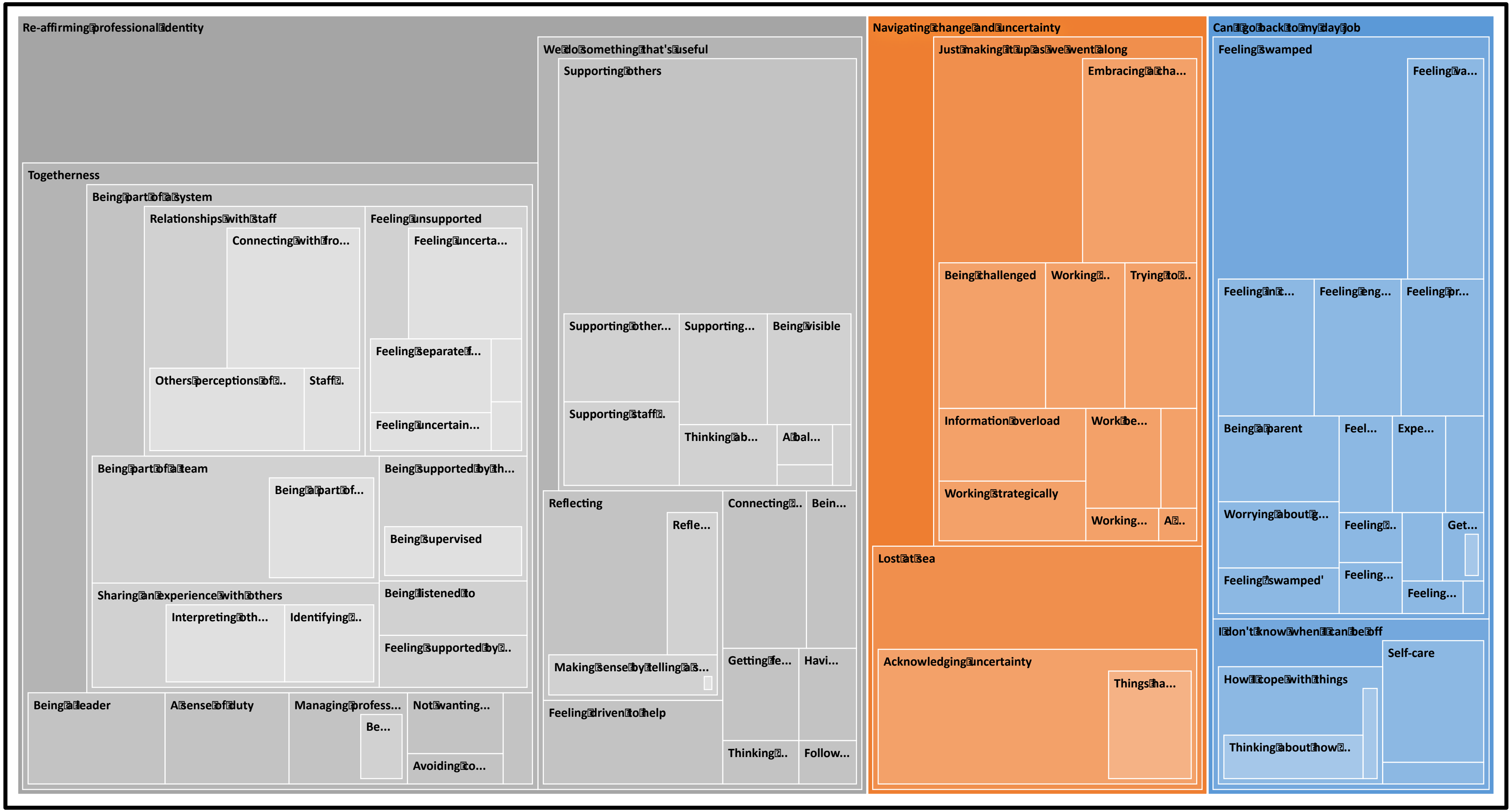
Columns:

- ○ Nodes\\Being part of a system\Relationships with staff\Others perceptions of psychology
- ○ Nodes\\Being part of a system\Relationships with staff\Staff are special people
- ○ Nodes\\Being part of a system\Sharing an experience with others
- ○ Nodes\\Being part of a system\Sharing an experience with others\Identifying with 'frontline staff'
- ○ Nodes\\Being part of a system\Sharing an experience with others\Interpreting others thoughts or feelings

Coding Matrix

	A : Being a psychologist	B : A sense of duty	C : Avoiding conflict	D : Being a leader	E : Being dissappointed with 'Psychology'	F : Connecting with professional values	G : Differences between staff groups	H : Feeling priviledged to help	I : Following the research	J : Getting feedback	K : Having relevant training	L : Not wanting to be at home	M : Reflecting	N : Making sense by telling a story	O : Having trouble remembering	P : Reflecting on the interview	Relations to ot psycholog
1 : Intervie...	0	0	1	0	13	11	0	3	0	1	0	3	0	5	0	1	1
2 : Intervi...	3	1	0	0	0	12	0	3	0	0	0	4	9	2	0	2	
3 : Intervi...	10	1	5	2	0	2	0	2	0	0	0	0	10	4	0	1	
4 : Intervi...	27	5	0	9	2	1	0	2	4	2	1	2	8	3	0	4	
5 : Intervi...	24	4	0	1	1	0	6	0	0	2	0	1	6	0	0	4	
6 : Intervi...	29	5	0	2	3	2	0	0	0	1	0	0	4	2	0	1	1
7 : Intervi...	22	1	0	1	0	0	0	0	0	0	0	1	2	0	0	2	1
8 : Intervi...	18	5	1	4	0	1	0	2	1	6	4	0	5	1	0	3	
9 : Intervi...	9	2	0	1	0	1	0	2	1	2	2	3	2	1	1	1	
10 : Intervi...	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Appendix X – Step Six: Looking for patterns across cases (Part Two)



Appendix Y – Additional Quotes (Empirical)

Superordinate Theme – Re-affirming professional identity

Subordinate Theme – *"…We do something that's useful…"*

"It doesn't matter if you're from renal, or cancer, or maybe not even in a physical health service, maybe you work in CAMHS or maybe you don't work in the hospital. Everyone gets impacted by it. So I think, now you always see a value in your role, even though at the start I didn't think, I would be any use in the first place, because I work in ICU, but, only for major trauma patients, not for respiratory patients, I know nothing about it. But then of course you realise that your skills are transferable, and psychologists are helpful even though we don't always think we're very helpful." (Lucy, lines 198-205)

"Every day I feel really incredibly lucky to be at the job where I am. I feel like it's been more positive for me. It feels like priorities have shifted, and you realise what's important and to be more grateful for what I have." (Lucy, lines 342-344)

"And that's…I think…that's something…I really noticed about being a shift in the way…I work. I think I've spoken about it with my psychology colleagues as well, I think….usually, as psychologists, we do like to take our time and…consider things." (Alice, lines 146-148)

"I think the urge was to go charging in…and I know some people have straight away put in, maybe in the acute world, the critical care wards and very much right there at the start. I'd say I wanted to take a slightly different approach, much more quietly

introduce the service and let people know the support was there. You know, they might not need it now but they need it later." (Michelle, lines 92-96)

"Because it's been awhile…and I think you get, hopefully, I suppose in a career, get quite…not comfortable but more familiar with what you're doing. So it seems more…routine, it seems more automatic and it feels much more…kind of manageable. But then that consideration of changing…and going to do something different like…professionally at work, yeah it was a little bit anxiety provoking, but at the same time quite exciting." (David, lines 279-284)

"So, I've done really interesting stuff. So, we had, we did have staff death in one of the hospitals. So I was supporting bereaved staff and the managers around that. I did the first tranche of psychoeducation. So what we thought was actually the way to get to everybody, was to have a very clear education pack that went up on the walls and all the areas. There was a little video that I did, we posted on the Trust website, and things like that. So making sure that we had psychoeducation in there. I've done mindfulness, I've done ward walks, I've done…drop-ins, group sessions, teaching, training. Whatever it was that people have felt they needed" (Julia, lines 120-128)

"I suppose it's…the covid pandemic hasn't changed, but it's maybe reminded me of some of those things. That actually…there are things that psychology can do, not that aren't just about sitting in an office…with the patients that you see. There is, you know, there are ways in which psychology can influence organisations or ways in which psychology can…influence society…as a whole." (Thomas, lines 599-603)

Subordinate Theme – *Togetherness – "…we are part of this family together, a battalion together."*

"So so I was very…keen, and very eager…not to be working from home…in that kind of role, but wanting to offer myself to redeploy, into services that were that were delivering hands on care to patients, and to try to use that as a way to provide and deliver care and support to staff…" (Martin, lines 94-98)

"So from being a very disparate group of psychologists with various pots of money in different services, the context was suddenly that we managed to kind of pull together as a team, underneath a strategy for managing staff and covid and everything else that was likely to happen." (Julia, lines 102-106)

"…my colleagues in the hospital, who I have been serving for the last three years, they were going to have to step up and potentially lose their lives, to set up and treat this. Actually, going home and saying, "Well I can work from home, I can work remotely", it just, it was not an option." (Julia, lines 502-505)

"So, I think when you've got a psychologist imbedded in a team, we quite naturally fall into…not formalised staff support, but helping teams to, to process…operational reactions towards the work that we do, and , and by default, are often the folk that the teams come to for a bit of help…when the going…gets tough…" (Alice, lines 306-310)

"I think, I've made really, really strong connections with lots of different people, nationally as well…who work in my field. And they've had similar experiences too…" (Rachel, lines 438-443)

Superordinate Theme – Navigating Change and Uncertainty

Subordinate Theme – ***“****Lost at sea”*

“…I think a lot of psychologists…got left out…got left behind from, and I think those that didn’t have the confidence to speak out, or to assert themselves, may be continued to be a bit ‘lost at sea’ with in terms of their role…” (Martin, lines 256-259)

“*Yeah, and I think even though it was really hard to remember that sometimes, in the early days, you know, it was very difficult…but……it never, it never really felt out of control, it was just…it was just uncertainty…and that's a mixture isn't it, of excitement and…and maybe a bit of…a bit of fear as well…****”*** (Sarah, lines 473-476)

“So it's a kind of unknown…But in that…position of feeling…really engaged and really valued, but also not knowing exactly what the right answer is.” (Rachel, lines 163-164)

“I can stay grounded but it took more effort to stay grounded. Because things were so changeable. So I think…that was hard, like, the busyness was there and I think a lot of uncertainty.” (Luke, lines 365-367)

“I always say to my team, you know, there’s always something, there’s always a new surprise that a group throws up, a question that you’ve never answered before, or a challenge that we've never been able to, under before, so…I think I’m…fairly comfortable with…uncertainty…So just going, kind of going along with things that can happen (laughter).” (Alice, lines 342-347)

“Yeah, gosh. Lots of change. Things were changing very quickly. Sometimes within a day, but usually every day…” (Luke, lines 358-359)

“And, and because things change so quickly, like things weren't still for one week. So…it was…you know, one night I might be thinking, “I can't do this, I can't cope with this”, but you know, 12 hours later there’d be some new advice, and something would have changed, and so it was never…Things weren't…stagnant, for long enough, for it to…for it to have a long-term effect kind of thing…” (Sarah, lines 462-467)

Subordinate Theme – “*…just making it up as went along…”*

“…So…that role, that patient facing role changed…and there was a lot of prepping with staff…and thinking about how they were going to cope and manage as well. And we were all thinking the same, how are we going to cope and manage.” (Rachel, lines 128-131)

“Much of our work…was quite easy to…change to remote working. So we were quite quick to…adopt, kind of…making a lot of our patients, and perhaps all our patients across the Trust, went to…especially psychology outpatients went telephone and video conferencing…” (Thomas, lines 418-421)

“We know we’re not going to be running our usual services…So…it, it feels like it’s…it’s grown quite organically.” (Alice, lines 67-68)

“I think sometimes when I don’t feel very clear, I just have to remind myself that it’s part of a psychologists’ job to not have a clear picture in the first place. We readily start assessments, interventions without knowing the full picture. And I think sometimes I just need to remind myself that it’s a similar process when you do staff support.” (Lucy, lines 537-540)

“And I had this kind of pent up energy like, “I wanna get stuck in”, “I wanna help”, “ I wanna see what I can do”, but to start with, you know, I was thinking, “How we gonna do it?”, “What's it gonna be like?”.” (David, lines 169-171)

Superordinate Theme – “Can I go back to my day job?”

Subordinate Theme – *“Feeling swamped”*

“And I'm sure staff were having to do that as well, with, you know, what PPE do we wear today and what do we wear tomorrow. What email actually is the up to date advice and what isn't. I think I was going through that in my own way. But it was kind of, what I put in place to help me feel ground, shifted…And I had to then…think…extra about that. And then deal with the emotional fallout, I guess. Maybe a bit more anxiety, a bit more frustration…just feeling overwhelmed.” (Luke, lines 375-380)

“I mean I think me along with lots of other people sometimes we even didn’t know what day of the week it was. If you’d had said, what’s today, I’ve had said um…and lots of people were saying that. There’s so much stuff to do.” (Michelle, lines 223-226)

“I supervise the Head Chaplain in the Trust. We were sharing a bit of a wobble, he probably won’t want me saying this (laughter). And I said, “Are you having a sense of this feeling?” And what he said back to me, which was a bit of a (gasp) moment, was “Are you feeling the pressure?” (laughter). Yes I am.” (Julia, lines 562-566)

“…it was just last week it just felt like “Oh my God, this is enormous” I felt like I was, the expression I think I used supervision was, “I'm holding the whole Trust. All 10,000 people. Including even the Chief Executive” and that just, you know, sometimes you just think (gasp).” (Julia, lines 576-579)

“I think it was…yeah…exhausting. But…there wasn’t time to be exhausted. I think it was…you had to stay ‘on’, you had to stay alert…a lot of the conversations I have with staff, and the support, were about kind of about that sympathetic nervous system really kind of, being on all of the time. And then having to work extra hard to try and switch into para…and…oh yeah exhausting, but not…but I couldn't be exhausted, if that makes sense…” (Luke, lines 400-405)

Subordinate Theme – *“I don’t know…when I can be off”*

“I guess I noticed a bit early on…probably in the stage before…we started doing the staff support, that my mind…was quite active at home, thinking about the staff support…” (David, lines 729-731)

“Somehow I found myself…I think the thing, the other thing that I've noticed is that…I've been telling a lot of, not telling, I’ve been, kind of suggesting to a lot of my colleagues and a lot of…patients that I've seen to kind of, you know, limit their use of social media…don't, you know, don't, don't be on the…BBC News app all day

long…Yet, I'm sort of, coming home, have been religiously looking at…the BBC and the Guardian every hour to get an update. Oh, what's happened here, what the, what's going on elsewhere in the world." (Thomas, lines 771-777)

"When a lot of staff were talking in the early stages about not being able to sleep, I certainly…yeah, I… said "I'm right there with you, on that", so just finding my head so full at the end of the day, just not being able to sleep, or waking up in the middle of the night, not able to get back to sleep. Weird dreams, I have those too…" (Alice, lines 540-544)

"A lot of the time I'm also having to read up and keep up to date, as well. So, it's quite schizophrenic really, it's quite split." (Michelle, lines 299-301)

"I need some separation…as me, [Name], I need that separation, now. I don't know how I'm going to get that…so that's a, a conundrum to work on…But to, for me to be the psychologist, I will need a, to give me a break from being a psychologist, for a little bit." (Rachel, lines 1,022-1,025)