Work-related Experiences of Mental Health Professionals during COVID-19 Pandemic: A Qualitative Study

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Abstract

The imposition of nation-wide lockdowns and sporadic transition to remote work produced unforeseen psychological challenges likely to impact the medium of care and workload of mental health professionals. The present study explored the lived occupational experiences of clinical psychologists, counsellors, and psychotherapists working in public health sector (also known as, the National Health Service)) and private practice in the UK during COVID-19 pandemic. Nineteen professionals (11 employed in the NHS and 8 working in independent settings) were interviewed about their professional experiences during first and second waves of the pandemic. Data were analysed using interpretative phenomenological analysis. Three main themes emerged from the analysis: (i) transition from face to face to online therapy; (ii) novel changes and wellbeing; and (iii) uncertain professional support in uncertain times. The findings suggest that lack of experience in providing online or telephonic psychotherapeutic services from home negatively impacted professionals' physical and psychological health and wellbeing. Thus, to cope with it, they availed psychological and structural support from colleagues, co-workers, clinical supervisors, managers, organisations, and professional bodies. This study adds to the existing body of research on the impact of the pandemic on UK-based mental health professionals and from an applied perspective, it highlights the need for skill-upgradation of professionals and macro-organisational changes in mental healthcare.

Keywords. Online Therapy, Remote Work, Work from Home, COVID-19 Pandemic

Lockdowns declared to reduce the transmission of SARS-CoV-2 produced a negative effect on population mental health and wellbeing (e.g., Chandola et al., 2020; O'Connor et al., 2021; Xiong et al., 2020). This is likely to impact the work of mental health professionals which is further likely to affect their occupational wellbeing. Thus, the aim of the present study was to explore the work-related experiences of mental health professionals based in the UK during COVID-19 pandemic.

Studying the experiences of mental health professionals during COVID-19 pandemic is important for two reasons. First, personal loss and life disruptions caused by the pandemic have the potential to impair population's psychological health and wellbeing (e.g., Eisma et al., 2021; Ishikawa et al., 2020) which is further likely to impact the workload of mental health professionals. Since workload remains a pertinent risk factor for poor occupational wellbeing among mental health professionals (McCormack et al., 2018; O'Connor et al., 2018; Author, 2020; Yang & Hayes, 2020) which is further likely to affect the quality of services provided to clients (Delgadillo et al., 2018), it important to explore how the pandemic has affected the practice and occupational wellbeing of mental health professionals. Second, comprehending the effect of the pandemic could generate insights for the development of capacity building programmes and support packages by organisations and professional bodies to support their personnel or members. Thus, in accordance with these reasons, clinical psychologists, counsellors, and psychotherapists in the UK were interviewed in the present study about their work-related experiences during the COVID-19 pandemic.

Prior to discussing the methodology of the current study, it is vital to review past literature on work-related factors associated with occupational wellbeing of mental health

professionals. It would aid in contextualising the findings of this study in the current scenario by providing a framework to understand how the pandemic affected or did not affect the factors associated with professional lives of mental health professionals.

Occupational Wellbeing of Mental Health Professionals

Research suggests that mental health professionals report high levels of poor occupational wellbeing such as burnout or compassion fatigue (McCormack et al., 2018; O'Connor et al., 2018; Author, 2020, 2021). Their occupational wellbeing is pivotal for mental health organisations or professional bodies to recognise because poor work-related wellbeing is associated with compromised job performance (Lemonaki et al., 2021; Liu et al., 2020), elevated rates of sickness absenteeism (Johnson et al., 2017) and reduced organisational revenue (Hassard et al., 2018). Data from February 2020 indicates that poor psychological wellbeing (specifically anxiety, stress, depression, or other psychiatric illnesses) is the largest contributory factor behind sickness absence in public health sector in England (i.e., the National Health Service; NHS Digital, 2020). According to one estimate, stress-related sickness absence and staff turnover cost the NHS £2.4 billion a year (Quality Watch, 2017, *as cited in* Ryan et al., 2019). Although a cross-occupational comparison of the cost of sickness absence could not be found in the literature, the fact that the mental health and learning disability unit of NHS, England reports the second highest rate of sickness absence following ambulatory services (NHS Digital, 2020) explicates that it is important to acknowledge and remedy the poor mental health and wellbeing of mental health professionals at work.

Research exploring the risk factors of poor occupational wellbeing suggests that the nature of the work and dynamics of the workplace (e.g., emotional demands, support from clinical supervisor, manager, and co-workers etc.) play an important role in influencing mental health professionals' wellbeing (e.g., Hammond et al., 2018; Lamb & Cogan, 2016). A recent study

on UK-based counsellors and psychotherapists suggested that dearth of career advancement opportunities, poor management of workplace bullying, perceived workload, and lack of support from management among others were associated with heightened turnover rate and turnover intention (Ryan et al., 2019). Similar findings were obtained in a recent qualitative study on eight experienced clinical psychologists in Sweden (Norrman Harling et al., 2020). The results of that study suggested that organisational and task-specific factors such as perceived quantitative and qualitative workload and lack of managerial support produced feelings of compassion fatigue in participants (Norrman Harling et al., 2020). In contrast, support provided by co-workers and provision of professional development opportunities were helpful in mitigating the risk of compassion fatigue (Norrman Harling et al., 2020).

The findings mentioned above have been replicated in research on UK-based mental health professionals working in a diverse range of interdisciplinary teams or settings within the NHS or the community at large (Bell et al., 2019; Kinman & Grant, 2020; Towey-Swift & Wittington, 2019; Westwood et al., 2017). It suggests that aspects of work that are usually beyond the remit of professionals' control are likely to contribute to their levels of perceived stress whereas, facets which provide them with a sense of assurance help in alleviating stress.

A large proportion of these studies have been either cross-sectional surveys or qualitative interview-based studies on employees i.e., those working in government hospitals, clinics, or private organisational settings. Research investigating the impact of work-setting (i.e., private, institutional, agency, or hybrid practice) on occupational wellbeing of psychologists suggests that private practice is generally associated with less work-related stress and higher work or job satisfaction (Lent & Schwartz, 2012; Rupert & Kent, 2007). A study comparing psychologists in independent practice and agency settings found that not only did the former report lower levels of burnout and higher levels of job satisfaction but also higher levels of job control and support and a smaller degree of negative client behaviour (e.g., aggressive or

threatening behaviour; Rupert & Kent, 2007). Thus, the present study included both public-sector (i.e., the National Health Service (NHS)) employees as well as independent practitioners.

In our opinion, it is important to simultaneously study the experiences of both the occupational groups for two reasons. First, given the enhanced impetus towards involving private practitioners in the provision of accredited services in government mental healthcare institutes to combat staff shortage (Callan & Fry, 2012) and high waiting period for clients (Jones, 2022), the study by exploring in-depth the experiences of both the professional groups could contribute to the literature by highlighting shared experiences or differences in their perceived psychosocial hazards and coping mechanisms. Second, the simultaneous exploration of professional experiences of both the groups has the potential to enhance our understanding of the role of the wider context in contributing to high turnover intention in mental health workforce in the NHS (Ryan et al., 2019) and burgeoning incidence of private practitioners in the UK (Golding & Moss, 2019). The NHS is a large, hierarchical organisation whose mental health employees often complain about high work-related stress, chronic shortage of funding, escalating bureaucratic requirements, and lack of autonomy (Porter, 2022; Ryan et al., 2019; Westwood et al., 2017). Whereas private practitioners generally tend to report greater latitude of decision making and fewer restrictions on practice (Golding & Moss, 2019). But challenges such as, organising one's own supervision, professional development, tax and accounts, absence of co-workers, and arranging a private pension are potent challenges for private practitioners which NHS employees are relatively safeguarded against (Golding & Moss, 2019). Thus, by exploring the challenges faced by professionals in both the settings, it is hoped that the study would be able to elucidate the complex interplay of individual, organisational, and governmental factors in influencing mental health professionals' occupational wellbeing.

Present Study

The aim of the present qualitative study was to use interpretative phenomenological analysis (IPA) to explore occupational experiences of clinical psychologists, counsellors, and psychotherapists working in the NHS and private practice in the UK during COVID-19 pandemic. The research adopted a qualitative line of inquiry because in our view, a nomothetic approach to study unexpected experiences would not have done full justice in capturing professionals' detailed, subterranean narratives (Creswell & Poth, 2018). Moreover, comprehending how professionals' lived experiences were influenced by various social actors or institutions required gaining an in-depth understanding of the context in which they operate and exist (Flick, 2007; Creswell & Creswell, 2017). Thus, qualitative methodology informed by social constructivist approach was deemed appropriate for studying the idiosyncratic, multiple realities of mental health professionals during COVID-19 pandemic.

Method

Approach

Following a review of Creswell and Creswell's (2017) description of five qualitative designs – narrative research, phenomenological research, grounded theory, ethnography, and case study – we considered phenomenology to be appropriate for the present study. Having its roots in philosophy, phenomenology is often used in psychological research to elucidate the "common meaning" individuals attribute to their lived experiences (Creswell & Poth, 2018). Its basic purpose is "to reduce individual experiences with a phenomenon to a description of the universal essence." (Creswell & Poth, 2018, p. 75) Since the present study was not mainly concerned with retelling of stories, developing a theory around social forces, or learning how a community of mental health professionals at an organisation (or even one

professional) operated during the pandemic, other approaches mentioned above were not selected. In contrast, a phenomenological approach was adopted because the aim of the current study was to explore lived occupational experiences during the pandemic. Thus, the framework provided by Smith et al. (2009) in the form of interpretative phenomenological analysis (IPA) was used.

IPA is a phenomenological approach that aims to explore personal meanings and lived experiences (Eatough & Smith, 2017; Smith & Osborn, 2015; Willig, 2013). It is phenomenological in the sense that it aims to go "*back to things themselves*" (Husserl, 1990/2001; 168 *as cited in* Smith & Osborn, 2015) i.e., describing them the way they are, or the way individuals perceive them (Smith & Osborn, 2015). Also, it is interpretative in the sense that to gain a comprehensive understanding, a researcher engages in a two-stage process known as, double-hermeneutic i.e., "[the] *participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world*" (Smith & Osborn, 2015; p. 26).

Akin to other qualitative designs, IPA is also described in terms of its ontology, epistemology, axiology, and methodology. In terms of its ontology (i.e., the nature of reality; Creswell & Poth, 2018), IPA defines reality as how participants experience it (Willig, 2013). In terms of epistemology (i.e., what kind of knowledge an approach aims to produce and how to justify its claims; Creswell & Poth, 2018; Willig, 2013), IPA considers the divulgence of private thoughts, feelings, and meanings as building blocks of knowledge (Willig, 2013). Regarding axiology (i.e., the influence of an investigator's values in research; Creswell & Poth, 2018), IPA acknowledges that a researcher's findings are influenced by their preconceived notions and biases which are recognized throughout the process and aid in positioning the findings of a study in context of researchers' interpretation of participants' accounts (Smith et al., 2009). Lastly, in terms of methodology (i.e., the process of conducting

research; Creswell & Poth, 2018), IPA studies usually involve semi-structured interviews with participants with similar experiences (Smith & Osborn, 2015).

Recruitment of Participants

A database of UK-based mental health professionals produced in collaboration with three professional bodies (namely, Division of Clinical Psychology of British Psychological Society, National Counselling Society, and the United Kingdom Council for Psychotherapy) was used to contact potential participants for the current study. It was considered appropriate because it comprised contact details of 280 professionals recruited between 5th November 2020 and 28th February 2021, the period during which the UK witnessed the second wave of COVID-19 pandemic.

To be included in this study, potential participants had to meet two inclusion criteria: (i) be a clinical psychologist, counsellor, or psychotherapist practicing either in an NHS-affiliated institution or independently in private settings and (ii) be currently working i.e., providing psychotherapeutic services to clients. Furloughed professionals and those employed full-time in private mental health organisations were not included in the sampling frame.

Fifty professionals with a minimum age of 35 years and 3 years of work experience were selected at random and invited to take part in an interview. The email invitation comprised of a participant information sheet explaining the aims and purpose of the study and a consent form for registering interest in the study. No incentives were offered to take part.

Ethical Considerations

The study received ethical approval from the institutional research ethics committee (reference number: 2020/271).

Data Collection

A semi-structured interview schedule was developed for data collection. It included three main sections: (i) rapport formation; (ii) impact of COVID-19 pandemic on personal life (e.g., any personal loss due to the pandemic), and occupation (such as, took a break from work if experienced any personal loss due to COVID-19 pandemic); and (iii) impact of the pandemic on practice and occupational wellbeing during COVID-19 pandemic (such as, experience of working from home, transitioning from face-to-face to online or telephonic therapy, support from manager, supervisor, and co-worker during the pandemic etc.). Interviews commenced on 5th March 2021 and ended on 26th May 2021. All interviews were conducted using audio meetings on Microsoft Teams. The average duration of an interview was 61 minutes (range: 38 - 73 minutes).

Socio-Demographic Characteristics of Participants

The sample comprised of 19 participants (17 women and 2 men). Three participants were clinical psychologists, 8 were counsellors, and 8 were psychotherapists. Eleven participants worked in NHS-affiliated hospitals or clinics and 8 worked in private practice. The age range was 35 - 68 years ($M = 53.1$) and the majority identified integrative approach as their preference in psychotherapeutic practice. Lastly, 8 participants reported experiencing a personal loss in the past six months: 5 due to COVID-19 and 3 due to other reasons. However, none experienced loss of an immediate family member or close friend.

Data Analysis

The analysis process delineated by Smith and Osborn (2015) was adopted by the first author, a doctoral candidate in occupational health psychology with prior experience of conducting phenomenological research and quantitative research on UK-based mental health professionals. After transcribing an interview, its transcript was read three times to get acquainted with data. Comments made at relevant points were assigned to initial codes.

Coding involved a line-by-line examination of each transcript "to identify meaningful [descriptive] units, and labelling these with a code that captures the meaning identified." (Willig, 2013, p. 189) Some comments were dropped at this stage if it was felt that they were not as important as initially perceived to be. Following this, all codes were listed, and associations were formulated among them to produce themes or clusters of codes which represented "the most salient constellations of meanings present in the data." (Joffe, 2012, p. 209) In comparison to a code, a theme is more analytical and interpretative (Willig, 2013). In this process, some codes were merged to form one theme, some were categorized under superordinate themes, and some remained independent themes. For illustration, kindly refer the following quote:

> But more than anything I've worked longer, I think because I turned that you know, I turn the computer on early in the morning and it's easy just to keep going up and keep going, so home working is great in some ways, but particularly for things like therapy or working with distressed people's needs, I, I don't want to be traumatized in my own home, you know, this is my safe space, so all the same things hold. (P3, 297-301)

The comment made for the above text was "The tendency to remain engaged in remote work for a longer period of time than face-to-face or office work could produce a negative impact on mental health by disallowing detachment or recuperation thus leading to preoccupation with clients' concerns". The code assigned to this comment was "Remote working led to an increase in the amount of work done which further led to secondary traumatic stress or vicarious trauma". The theme under which this code was included was "lack of psychological detachment" which was included under the superordinate theme "Impact on health and wellbeing".

Throughout this process, constant references were made to participant's account to ensure that codes and themes effectively encapsulated their subjective meaning. The entire process was repeated for all transcripts. Finally, similarities and distinctions across themes were noted and those that described common, lived experiences for all or the majority of participants were retained.

Findings

Three superordinate themes emerged from the analysis namely, transition from face-to-face to online therapy, novel changes and wellbeing, and uncertain professional support in uncertain times. The following sections elucidate themes included under each superordinate theme with the aid of direct quotations from interview transcripts. Each quotation is followed by a code specifying the participant and line(s) in the transcript. For example, P4 (136) refers to the fourth participant and line 136.

Transition from Face-to-Face to Online Therapy

Resistance towards technical medium

Following the declaration of the first national lockdown, all participants reported making a transition from providing psychotherapeutic services in a face-to-face setting to using an online or telephonic medium. Their lack of familiarity with these mediums contributed to reservations against adopting it in daily practice. Concerns ranging from banal ideas such as, "*it just wouldn't work very effectively*" (P15, 125) to more pertinent ones related to rapport formation, observing nonverbal behavior, client safety, and pragmatic challenges regarding online implementation of certain therapies (e.g., Eye-Movement Desensitization and Reprocessing (EMDR)) or therapeutic techniques (e.g., body-relaxation exercises) impeded a smooth transition. The reasons behind such views as suggested by P17 ("*I hadn't done any kind of training in online therapy*"; 181) and P12 ("*I had always chosen not to work online*";

172-174) were lack of training in and experience with technical modalities. Thus, the initial experience of participants was layered with stress or lack of ease (e.g., "*When I first had to start seeing clients online, I was quite worried about that, felt very anxious about that*"; P16, 90-91).

This experience was further compounded by temporary technical difficulties such as unsuitable computer applications, inefficient internet bandwidth, and unexpected termination of sessions. For instance, P2, an NHS employee stated that the online software "Attend Anywhere" provided by their employer was not suitable for providing counselling because it was "*designed really for medical consultation*" (251). Elaborating further on the experience of using it, P5 stated, "[that initially] *it was rubbish, lots of freezing of the clients or you couldn't hear them properly or couldn't connect properly or halfway through a session, it would disconnect*" (280-282). In contrast to most NHS employees, private practitioners did not report experiencing technical difficulties with online therapy.

Limitations of online therapy

Online therapy, as suggested by 15 participants reduced "*the emotional communication that happens without words*" (P2, 249-250). It inhibited observation of clients' body language below shoulders (e.g., "*you can't see the tapping nail or tapping foot*"; P9, 411) which threatened the loss of essential clinical information (e.g., signs of self-harm). Also, it didn't permit the implementation of therapeutic exercises involving physical movement. Thus, to make up for this, 13 participants reported that they resorted to asking more questions ("*I feel like I have to ask more questions because obviously I haven't got them in the room.*"; P5, 393-394) or develop innovative solutions in collaboration with clients. An example of the latter was shared by P6, where she mentioned that after demonstrating a body-related exercise over a video call, she offered to look the other way and provide verbal instructions

so that her clients could feel comfortable whilst performing those exercises. This novel finding highlights the need to adapt therapeutic interventions especially those involving physical activity or movements to the requirements of online medium. For further details, kindly refer to the discussion section.

Accessibility of online therapy

In contrast to the limitations highlighted above, 11 participants noted advantages of online or telephonic therapy as well. One of the most frequently reported merits was enhanced flexibility for clients as well as professionals. It afforded professionals more time for the core aspect of their work i.e., providing counselling or psychotherapy to clients. It didn't require them to expend efforts on miscellaneous tasks such as renting, booking, or preparing counselling rooms which further accorded them the latitude to cater more to clients' needs ("*we are able to do the first session within 48 hours of them contacting the service*"; P9, 163). From the perspective of clients, 8 participants reported that online or telephonic medium enhanced the accessibility of services for those who didn't or couldn't avail it in the past ("*those who had huge mobility problems who weren't able to come into the department*"; P7, 108-109). In addition, 9 participants reported that the privacy and comfort of seeking online therapy in personal settings facilitated self-disclosure on part of clients which further improved the pace of therapy.

> "*With my bereavement clients…while working face to face, for the client, there is some embarrassment, awkwardness sometimes, not showing emotions within a counselling environment, within a room, a physical room whereas on the telephone I found that with the clients, they have been quicker to open up so they've been quicker to go to that emotional phase, they have been quicker to be okay, to cry, to express their feelings that way whereas in the room, sometimes it can take a little longer.*" (P13, 136-141)

Such benefits led 7 NHS employees to contemplate a future inclusion of online or telephonic therapy in the wide range of services provided by them. For example, P9 opined that depending on the preferences of clients, their service "*would like to keep all the three options* [online, telephonic, and face-to-face] *available*" (392-393).

Novel Changes, Practice, and Wellbeing

Unexpected changes

The initial phase of the pandemic led to a decline in the number of clients availing mental health treatment. Twelve NHS employees reported that their organizations witnessed a significant reduction in the number of new referrals in the first few weeks following the declaration of the first national lockdown ("*we did have a real drop in referrals to begin with*"; P1, 165). It in P2's words, provided them "*a bit of breathing space*" (188) but it was a period that was particularly exacting for private practitioners. Six private practitioners reported that due to the decline in the number of clients and the shutting down of commercial centers where therapy rooms were rented, they experienced financial difficulties during the first phase of the pandemic. This is a novel finding that has implications for professional bodies of mental health professionals (for further details, kindly refer to the discussion and implications sections).

> "*when the first lockdown happened, the place where I was renting a room was closed and I had to cancel all my clients. So, from going to having a pretty full caseload to a point for about six weeks where I had no clients, it was really difficult to deal with the big lack of financial security*" (P17, 183-186).

However, after termination of the first national lockdown, the majority of NHS employees shared that their caseloads escalated to unmanageable proportions. According to P11, the waiting list for counseling at their service in the past year "*increased from 5-6 weeks to 3*

months” (292-294)**.** Five private practitioners also reported experiencing an increase in the number of clients with anxiety, stress, depression, or addiction-related issues. Such changes affected employees’ workload (“*our referrals have gone through the roof, so we are busier than ever*”; P2, 188) which further contributed to their experiences of work-related stress (“*my workload was causing me stress. I felt like I was getting behind on lots of things.*”; P4, 325-326).

Constraints on Client-Support

The restrictions imposed by lockdowns led to shutting down of avenues of change or support such as recreational centers, charities, restaurants, pubs, and health and fitness centers etc. Thirteen participants reported that it affected their practice by limiting organizations to which clients could be signposted, thereby affecting the progress or impact of the treatment and producing a sense of hampered professional efficacy. This reduced professional efficacy has the potential to foster a lack of psychological detachment from clients’ concerns as mentioned in the following subthemes and elaborated in the discussion section.

> *“I have clients who come to see me, and they want to be in a relationship. So, part of the reason why they are not in a relationship would be low self-esteem, lack of confidence. The way you would be working would be to help them gain confidence in being able to put themselves out there, to try to meet people. Well, I am not able to do that, not able to encourage a client to go the next stage of actually meeting someone because we are following the rules so that definitely was a constraint because it’s frustrating for me as a therapist and the client that we got them so far but then you stopped because you can’t go any further.”* (P8, 364-374)

"*all the work we were doing was less effective because all the things that we ask people to do, they couldn't now do so you're trying to help people out doing things, and there just isn't anything for them to do.*" (P3, 225-227)

Impact on health and wellbeing

Adaptation to the novel reality of remote work and being in the same situation as clients with regards to lockdown restrictions placed two pertinent cognitive challenges before professionals. First, to harness mental faculties to deliver counselling services using an unfamiliar medium. It added to difficulties associated with the transition ("*I think work is harder because I have to concentrate more*"; P17, 285). Second, to maintain a psychological partition from clients' experiences to prevent an obfuscation of one's own reality with that of clients. For example, "*it can be harder to separate my experience as it can be easier to over-identify with them and assume that they are experiencing the same thing as I am*" (P17, 277-278). Such challenges produced an aversive impact on participants' physical and psychological health and wellbeing.

At a physical level, 16 participants reported that working in front of a computer screen for long hours daily (e.g., "*I was easily working for 10-12 hours a day especially in the beginning*"; P9, 356) exhausted their physical energies. It increased their frequency of experiencing migraines, headaches, sleep disturbances, joint aches, and a general feeling of being tired or overwhelmed. At a psychological level, detaching from clients' emotionally laden narratives was made difficult by the restricted environment of remote work.

"*I'm sat in my living room and listening to some child abuse story…we work with people who've had horrific experiences and managing that anyway in normal life is hard but managing that while you're in your home which isn't your workplace, I think it's something that takes its toll.*" (P3, 304-314)

The restrictions imposed by lockdowns exacerbated vulnerability to vicarious trauma, as reported by 10 participants included in this study. For instance, P16 shared, "*even in the best of times, there's that possibility of vicarious trauma and then, you add on to this, layers of online counselling and not being able to go out*" (365-367). It hindered their ability to distance themselves from the context of their work and disallowed space for recuperation.

> *"You don't have that same sort of de-compression of you know, okay I am actually leaving the office, locking the door, then walking to my car and getting in the car. All these things then take you farther and farther away from the reality of your work.*" (P16, 397-400)

Feelings of professional isolation

Living up to clients' expectations whilst being present in the same situation as they contributed to feelings of perceived neglect ("*I was going through it as well…I think that clients would come into the service and they would need that support but actually sometimes I needed that support as well*"; P1, 260-262). Such feelings could have been consolidated by perceived professional isolation i.e., feeling lonely and unsupported by one's co-workers or colleagues. Lockdowns inhibited the cathartic process of informal, in-person conversations to take place thereby, adding to levels of secondary traumatic stress. The incapacity to divulge one's work-related feelings with those who could understand it and perhaps even relate to it fostered rumination over clients' distress and posed a risk to psychological wellbeing as reported by 7 participants.

> "*it's a little bit harder to shake off concerns about clients uhm…possibly because I haven't been able to just have a quick chat with my supervisor or with a couple of colleagues, so I think sometimes it just stays around a bit more. I've noticed for instance, from here and there at different times dreaming about clients more often than*

I normally would so to suggest that they are occupying my unconscious a bit more than they normally would." (P15, 265-270)

Although the provision of having an online meeting was available, 4 participants suggested that in comparison to the immediacy of workplace settings where conversations could be easily arranged, online substitutes appeared more formal and distant.

"*I would have to book a time to kind of speak to them. I couldn't just stick my ear around the door and see if they were free and just have a chat so like my conversations with them were a bit delayed, they were a bit more like formal*" (P4, 446-448)

Work-Home Interaction

Participants' remote work experiences were contingent upon their personal circumstances (e.g., having a family or young children) and structural resources (e.g., the availability of discrete working space). These factors being inextricably linked to one another added to pragmatic constraints regarding managing work whilst being in a limited space with others. An example of this was shared by a private practitioner who faced practical difficulties in finding space to attend an online training programme at home due to dearth of space:

"*if my husband is asleep then I can't use upstairs. If my son is home schooling, I can't use downstairs, so it has been quite challenging. I did one training session in a cupboard, a big cupboard but it was confidential, and it took our WiFi connection. I sat on the floor with a cushion and was wedged in there for about four hours.*" (P19, 326-330)

In contrast to this, three participants with separate home offices reported better work-life balance. For instance,

“*we are lucky enough that we live in a house where we have separation so in moments like talking to you, I am in my home office. She is in our second bedroom upstairs which we have made an office space for her. If we didn’t have that space, things would be different.*” (P13, 172-175)

This novel finding highlights the role of structural inequalities and has implications for mental health organizations in terms of allowing varied working designs. For more details, refer to the discussion section.

Remote work in the case of 5 participants liberated up time otherwise spent on travelling or miscellaneous tasks (such as preparing the counselling room for in-person sessions), which allowed more time for non-work-related interests.“*I have not got any commute so that’s really good because if I have got a full lunch hour, I will probably take that, and I might take the dog for a walk, or I might sit outside and read a book for a bit or I might prepare my vegetables. So actually, I feel like for the first time in a long time, I have got the balance of work and life pretty nailed.*” (P1, 318-321)

Uncertain Professional Support in Uncertain Times

Structural and Psychological Support

Although difficulties pertaining to online therapy and remote work adversely affected professional practice and wellbeing, to cope with it, all participants reported receiving some kind of support from professional bodies, clinical supervisors, managers, co-workers, and/or organizations. Structural and psychological aid provided by professional bodies mainly related to technical and clinical facets of online therapy. Training programmes offered free of cost in some cases allowed professionals to update their skills and stay abreast with needs of time. “*I have taken advantage of some free webinars on working online at the beginning and more recently on more clinical aspects*” (P7, 373). Regarding relationship with clinical

supervisors, whilst majority of participants reported an unaltered stream of support, 3 participants described how supervisors offered essential psychological support when required ("*she was actually the one who said 'you need to have some therapy love'*"; P1, 446-447). It facilitated adjustment to the novel reality of remote work which further consolidated relations with them ("*come to use her more often to explore different ways of working and different emotions so yeah, I have probably used her more in last 12 months*"; P12, 404-405).

With respect to support provided by individual managers, perceiving a sense of understanding and empathy for constraints faced allowed temporary respite. NHS managers in 8 cases encouraged employees to prioritize self-care and seek counselling if required ("*my manager made the referral to the counsellor*"; P9, 225). Also, their efforts to develop a virtual collegial environment reinforced the idea of community and collective experience (e.g., "*our manager set up meetings that were like a drop in…we have all felt as a service that we were in it together*", P1, 425-426).

Six NHS employees mentioned receiving social support from their co-workers as well. Having a sense of mutual experience and being exposed to similar vulnerabilities deepened pre-existing relations (e.g., "*saw a different side to them that I wouldn't have seen before*"; P8, 317). The divulgence of insecurities and perceived challenges strengthened the bonds of collegial support ("*I think we have become more* [close] *now*"; P9, 496) which provided vital psychological support ("*it just helped me survive something quite difficult*"; P8, 351).

Feelings of organizational neglect

In contrast to the unambiguity of support provided by the sources mentioned above, the support provided by organizations was equivocal. Organizational support appeared to be context-specific and layered with hierarchies. Whilst 4 NHS organizations provided training for online therapy and structural support in the form of newsletters, bulletins, and

counselling, largely participants' experiences with senior management were unpleasant. Twelve NHS employees perceived a lack of support from higher levels of management, which produced fervent feelings of discontent (e.g., "*they are useless*"; P8, 374). They described a schism between the actual reality of the pandemic and the perceived reality of apex management in terms of acknowledging the situation and making necessary amendments to adapt to it. "*The management were quite punishing, I would say. They kept saying to people it's business as usual*" (P6, 302-303). It harbored feelings of neglect ("*I think there's been a real lack of attention paid to us by those above*"; P3, 384) and disappointment ("*there's just been top-down criticism or diktats and no guidance…I'm quite annoyed with some of that*"; P3, 384-385).

Discussion

The aim of the present qualitative study was to explore occupational experiences of mental health professionals during COVID-19 pandemic. Nineteen clinical psychologists, counsellors, and psychotherapists – 11 employed in the NHS and 8 working in independent practice – were interviewed. Interviews analysed using interpretative phenomenological analysis (IPA) produced three main themes namely, transition from face to face to online therapy, novel changes, practice and wellbeing, and uncertain professional support in uncertain times.

Analysis of participants' accounts suggested that the major challenge posed by the pandemic entailed the sporadic transition from face-to-face to online or telephonic therapy. Coupled with lack of preparation at an organizational level and previous training in or experience with the medium, participants reported being confronted with a challenge not encountered before in their professional practice. The number of clients seeking treatment declined, leading to financial constraints and the requirement to efficiently adapt to the novel medium in a short

span of time added to the difficulties faced. Some of the difficulties associated with the new way of working included technical glitches or network problems, the inability to observe clients' nonverbal behavior, and the requirement to develop innovative ways to implement therapeutic exercises involving physical movement. The latter is a novel finding as previous research has focused more on the impact of the pandemic on professionals' psychological health and wellbeing (e.g., Aafjes-van Doorn, et al., 2021; Webster, 2021; Aughterson et al., 2021) and not much attention has been paid to the effect produced by the pandemic on therapeutic practice of mental health professionals. In the present study, participants reported developing innovative solutions to deliver services involving physical movements (e.g., offering instructions over a video call and then looking the other way to conduct a breathing or muscle relaxation exercise). This highlights the need to customize or adapt therapeutic interventions involving physical movements to idiosyncrasies of online therapy. As online therapy restricts the field of visual display in contrast to face-to-face or in-person therapy, it poses additional challenges before professionals to instruct clients whilst carrying out certain exercises. Since online therapy is gradually becoming popular (Connolly et al., 2020; Rowen et al., 2021) and several therapeutic approaches or techniques involve physical movement or activities (e.g., Jacobson's (1938) progressive muscle relaxation, Mitchell's (1977) method of physiological relaxation, art-based therapies etc.), it is topical to develop training programmes for mental health professionals in delivering therapeutic exercises involving physical movement or activities via an online medium.

Recent research on the impact of the pandemic on psychologists suggests that the initial phase presented unexpected challenges which required mobilization of social resources to be coped with (Aafjes-van Doorn et al., 2021, Aafjes-van Doorn et al., 2020; Békés & Aafjes-van Doorn, 2020; Blodrini et al., 2020; Machluf et al., 2021; Mancinelli et al., 2021; McBeath et al., 2020; Probst et al., 2020; Probst et al., 2020; Webster, 2021). In the present research as

well, participants reported availing peer support from co-workers or colleagues, social support from family members and friends, and structural and psychological support from managers and professional bodies to get acquainted with demands of providing online or telephonic therapy from home.

A comparison of the two occupational groups included in the present study (NHS-employed and private practitioners) revealed that whilst the transition was exacting for both, the challenges faced by NHS employees pertained mainly to structural clarity such as how and when to transition whereas those encountered by private practitioners related to work security. The shutting down of commercial centers where therapy rooms were hired combined with a reduction in the number of clients in initial weeks presented financial burdens for private practitioners that NHS employees were inoculated against. Whilst previous research suggests that private practitioners generally experience greater autonomy, work satisfaction, and less burnout than employees (Ackerley et al., 1988; Rupert & Kent, 2007), the sudden lack of work security had the potential to threaten their psychological safety and posed a risk to their occupational wellbeing. This is a novel finding that previous research has not highlighted. It is important to focus on the financial stress experienced by private practitioners during the COVID-19 pandemic because lack of financial security has the potential to impair psychological health and wellbeing (Annink et al., 2016; Netemeyer et al., 2018), which could further have negative consequences for the quality of treatment provided to client. This lack of financial stability especially in crisis situations provides an impetus to professional bodies for the development of financial-planning programmes for mental health professionals (for further details, kindly refer to the Practical Implications section below). Regarding employees, the uncertainty, ambiguity, and lack of direction from top management created additional barriers forestalling an efficient transition. Although a sense of urgency such as the one presented in this case facilitates the motion of change, heightened resistance could set in in the absence of

support and clarity from management (Kotter, 1996). In the present study, psychological difficulties faced by participants at the outset (such as anxiety or dislike) could be considered an offshoot of the lack of adequate provisions made by senior management such as training for providing online therapy.

However, with time participants became comfortable with the technical medium and recognized its merits, such as enhanced accessibility for and greater self-disclosure on part of clients. These findings have been replicated in previous research as well (Kotera et al., 2021; McBeath et al., 2020; Poletti et al., 2021; Webster, 2021). Nevertheless, it is important to acknowledge that variations were observed in participants' work from home experiences; those with discrete spaces at home and smaller or supportive families generally reported better work-life balance than those without such facilities or resources. This trend was observed even in a recent longitudinal panel study on employees working from home due to the pandemic (Allen et al., 2020). The present study is the first to the best of our knowledge to highlight the role of structural inequalities such as, lack of distinct working space at home in contributing to professionals' remote work experiences. This is an important finding because after the pandemic remote work is becoming popular in varied occupational sectors including counseling and psychotherapy (Chen et al., 2020), but it is imperative to acknowledge that employees' experiences with remote work might vary with respect to structural resources available at their disposal. For mental health organizations, this finding suggests that they should accord a certain degree of flexibility to their employees in selecting their working locations.

Remote work in the present study was found to produce a negative impact on professionals' physical and psychological health and wellbeing. The requirement to work for prolonged hours in front of a computer screen or on a mobile phone led to physical health impairments such as, headaches, migraines, muscle and joint aches, and visual fatigue. It could be, as suggested by

recent research, attributable to the escalated number of hours spent working due to enmeshment of boundaries between personal and professional lives (Maurer, 2020). Remote work or working from home might have led to an obfuscation of physical and psychological boundaries between work and non-work contexts thereby inhibiting necessary detachment from work and leading to longer duration of work. It also had the potential to produce pertinent consequences for physical health and wellbeing especially during the initial phase of the pandemic.

In addition, the requirement to listen to clients' concerns in professional isolation whilst being in the same situation as them and the restriction of not being able to direct them to otherwise available avenues of support fostered contemplation over their issues leading to secondary or vicarious trauma and hampered professional efficacy. In some instances, psychosomatic symptoms of stress such as sleeping difficulties due to stress caused by lack of psychological detachment from clients' concerns were also observed. This finding is in alignment with findings of a recent longitudinal study that suggested that reduced professional efficacy or heightened professional self-doubt regarding providing therapeutic services during the pandemic was related to vicarious trauma in mental health professionals (Aafjes-van Doorn, et al., 2021). The present study elaborated the association between constraints on client-support and vicarious or secondary trauma in professionals and its subsequent impact on professional efficacy. Not being able to direct clients to avenues of support reinforced rumination over their issues, which further led to vicarious or secondary trauma. It is important for mental health professionals to psychologically detach from their clients' concerns to prevent a cross-over of psychological ailments. Participants in the present study reported experiencing the trauma of their clients in their domestic settings due to difficulties with psychological detachment. A similar experience was described in grave detail by the founding father of Logotherapy, Viktor Frankl in his classic memoir, *Man's Search for Meaning* (Frankl, 2004). Frankl (2004) whilst elucidating his experience of treating prisoners with psychiatric

illnesses in a concentration camp in Auschwitz stated: "*To attempt a methodical presentation of the subject is very difficult, as psychology requires a certain psychological detachment. But does a man who makes his observations while he himself is a prisoner possess the necessary detachment?*" (Frankl 2004, p. 20). The present study suggested that mental health professionals might not possess the necessary objective detachment when placed under the same circumstances as their clients.

The pandemic implied a two-pronged source of stress for mental health professionals: being expected to maintain an empathetic and objective stance whilst helping others cope with trauma that they were subjected to themselves. Although academic literature on "*wounded healer*" discusses the curative power of being in the same situation as clients (e.g., Banton, 2020; Remen et al., 1985 *as cited in* Gladding, 2014), majority of participants in the present study reported feeling neglected because of a perceived lack of addressal of their feelings produced by a shared experience with clients. Thus, to mitigate its impact and continue providing beneficial services, they sought support from varied professional sources.

Structural and psychological support provided by clinical supervisors, co-workers, colleagues, managers, organizations, and professional bodies were generally appraised as beneficial in coping with demands of online therapy and remote work. The support provided by professional bodies and individual organizations in the form of online training programmes, webinars, bulletins, and newsletters helped participants to update their professional skills and adjust to the novel reality of remote work. Regarding other sources, participants reported that although they were physically distant from their co-workers, colleagues, managers, or supervisors, being in the same situation as they enhanced their interpersonal communication which further strengthened professional relationships. The latter finding can be interpreted using theories of group behavior in social psychology. Based on the theory of social comparison (Festinger, 1954), participants' interactions with their professional networks might

have provided essential cues to help them discern their relative positions and gain emotional and cognitive clarity (Baron & Branscombe, 2014). Also, it might have helped them effectively adapt to their situation by creating a sense of community which fosters the feeling that *we are in this together*. Similar findings were reported by a recent qualitative study on NHS-based health and social care professionals that suggested that a sense of team unity was created during the pandemic while working for a common cause (Aughterson et al., 2021). According to the social identity approach to health (Haslam et al., 2019), collegial support in the midst of a crisis has the potential to positively influence individuals' health and wellbeing (e.g., Bowe et al., 2021). This explains why participants who reported perceiving a sense of communal support at work generally coped better than those without it.

However, it is important to recognize that the benevolent role played by professional relations during the pandemic could have been influenced by their depth prior to the pandemic. According to a recent UK-based longitudinal study, degree of community identification and perceived community support prior to the pandemic predicted giving and receiving emotional support during the first wave of the pandemic (Stevenson et al., 2021). Thus, social relations that were perceived to be strong before the pandemic were likely to become stronger during the pandemic. Although in the current study, participants were not explicitly asked about their professional relations before the pandemic, 6 participants indicated that a sense of community existed at their workplaces even before the pandemic and collective experiences during the pandemic consolidated that sense.

Lastly, a finding specific to NHS employees that merits a brief discussion is the lack of perceived support from top management. Twelve participants reported that unanticipated changes and lack of preparation led to the establishment of a structure wherein their voices were not heard, and they felt neglected and disappointed. Some participants even suggested the formation of a command-and-control structure that didn't permit alternate or opposing views

to exist. This finding is similar to Webster's (2021) anecdotal account in which they stated that the NHS senior management started using military terms like "deployed" and "mobilized" to manage employees which produced feelings of anger and frustration. Also, in Aughterson et al.'s (2021) qualitative study on health and social care professionals, employees reported feeling frustrated because of a lack of perceived support from management. Although it is important to contrast employees' views with that of managers', studies exploring their experiences during the pandemic do not yet exist in academic literature.

Limitations

Following Yardley's (2015) criteria for appraising the validity of qualitative research, the limitations of this study are mentioned below:

(i) Online data collection: To abide by social distancing guidelines, online audio interviews were conducted. Whilst considered similar to face-to-face modality, online interviews are criticized for their limited scope to build rapport and acquire in-depth information from interviewees (Davies et al., 2020; Krouwel et al., 2019). Similar to the findings of this study, online interviews inhibited the observation of behavioral cues and nonverbal communication such as eye movements or facial expressions. Although, these expressions would not have been transcribed had the interviews been conducted face to face, their absence might have affected the rapport with participants and understanding of their narratives which might have affected the analysis and findings of this research.

(ii) Subjectivity in interpretation of data: Unlike previous research (e.g., Aughterson et al., 2021; Norrman Harling et al., 2020), interviews, transcription, and data analysis in the present study were all carried out independently by a single researcher. This might have introduced potential sources of bias. Although attempts were made to reduce subjectivity prior to conducting interviews, conscious or unconscious biases or conduct of the researcher

might have affected the information gathered in interviews and its interpretation. To reduce the impact of individual biases, frequent discussions about interpreting participants' accounts were held with co-authors.

(iii) Familiarity with pre-pandemic literature: To prevent an a priori understanding, research exploring the impact of COVID-19 pandemic on mental health professionals was not reviewed until the completion of data analysis. It allowed original findings to emerge, but awareness of pre-pandemic research could have resulted in confirmation bias that might have affected the interpretation of data.

Implications

Scientific Implications

The findings of this study contribute to extant literature on the impact of COVID-19 pandemic on professional practice and occupational wellbeing of mental health professionals (e.g., Aafjes-van et al., 2021, Aafjes-van et al., 2020; Békés & Aafjes-van, 2020; Boldrini et al., 2020; Machluf et al., 2021; Mancinelli et al., 2021; McBeath et al., 2020; Probst et al., 2020; Probst et al., 2020; Webster, 2021). It provides qualitative evidence that explains the context of professionals' experiences and wellbeing and facilitates the interpretation of quantitative findings by providing an interpretative framework (Békés & Aafjes-van, 2020). Unlike previous research that distinctly addressed specific components of the impact of pandemic such as teletherapy (e.g., Pierce et al., 2021) or physical and psychological impact (e.g., Kotera et al., 2021; Mancinelli et al., 2021; Probst et al., 2020), the present research presents a comprehensive perspective. For instance, it explains how remote work and shared experiences with clients fostered work-life imbalance and secondary or vicarious trauma for which social support was sought from family members, colleagues, and clinical supervisors. In addition, it investigated the role played by managers and professional bodies in shaping

employees' experiences. Limited research till date (e.g., Aughterson et al., 2021; Geller, 2020; Langdon et al., 2021) have explored this perspective. The findings of the present study endeavored to fill that gap in literature. Moreover, it is one of the few studies that have explored the experiences of UK-based mental health professionals during COVID-19 pandemic. (e.g., Aughterson et al., 2021; Kotera et al., 2021; McBeath et al., 2020; Webster, 2021). Most of the studies till date are from the US (Aafjes-van et al., 2021; Aafjes-van, 2020; Lin et al., 2021; McKee et al., 2021; Pierce et al., 2021). Therefore, this study contributes to that limited body of research.

Lastly, the study explored occupational experiences of both employees as well as private practitioners during the COVID-19 pandemic. Research till date has focused more on experiences of employees and relatively little attention has been paid to occupational wellbeing of independent practitioners (e.g., Jurcik et al., 2021). By simultaneously exploring their experiences, this study indicates a difference related to work security in both the occupational groups, which provides a novel perspective to research on work setting and occupational wellbeing of mental health professionals. To the best of our knowledge, the present study is the first to identify this difference. It suggests a need for financial planning training programmes as crises periods (such as the pandemic or current cost-of-living crises in the UK) could have financial ramifications for mental health professionals working independently.

Practical Implications

Similar to previous research (Aafjes-van et al., 2021; Aafjes-van et al., 2020; Békés & Aafjes-van, 2020; Machluf et al., 2021; McBeath et al., 2020; Pierce et al., 2021), participants in the present study reported lack of experience with and training in delivering counselling or psychotherapeutic services using an online or telephonic medium. It highlights the need for

training programmes in online or telephonic counselling. Professionals need to be trained not only in relational aspects of online or telephonic therapy but also in technical aspects such as, using encrypted videoconferencing services or setting webcam at an adequate angle to facilitate eye contact and interaction (Aafjes-van et al., 2021; Aafjes-van et al., 2020; Benoit & Kramer, 2021; Grondin et al., 2021; Jurcik et al., 2021). It might be prudent to inculcate training on online or telephonic therapy in educational programmes of trainee mental health professionals (Aafjes-van et al., 2021; Connolly et al., 2020; Rowen et al., 2021).

In addition, the study highlights the need for the NHS to make substantial changes in mental healthcare services. Employees working in the NHS appeared disappointed in and neglected by the system, which could result in turnover if not attended to in time. Pre-pandemic research also points out the role of problems in the NHS mental healthcare (such as, incompetent management, lack of adequate funding, and feeling disrespected and disvalued among others) in contributing to turnover rate and intention among employees (Ryan et al., 2019). The present study suggests that the unexpected nature of the pandemic could have exacerbated those problems. Therefore, it is vital for healthcare authorities to make necessary amendments (e.g., take employees' voice into cognizance to enhance trust in the organization and provide coaching-based supervision training to managers because the support provided by them could help in ameliorating employees' experience) to prevent undesirable consequences such as, a fatigued workforce or heightened turnover rate. Finally, the experiences of professionals detailed in this study could be used for developing contingency plans in case of a public health emergency in future.

Conclusion

The study explored the impact of COVID-19 pandemic on the professional practice and occupational wellbeing of clinical psychologists, counsellors, and psychotherapists working

in public healthcare sector and independent settings in the UK. The findings of this study suggest that the pandemic posed several unforeseen challenges that affected the practice and wellbeing of mental health professionals. Two of the most pertinent challenges included transition from face to face to online or telephonic therapy and adjusting to the peculiarities of remote work. Participants' unfamiliarity with online or telephonic mediums and remote work negatively impacted psychological health and wellbeing. Therefore, they availed support from professional networks which provided psychological support to cope with perceived difficulties and structural aid to adjust to the novel ways of working. This study contributes to the body of research on the impact of COVID-19 pandemic on mental health professionals and highlights the need for training programmes in online and telephonic therapy.

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