Understanding how the COVID-19 lockdown practice adaptations were experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis

Menara Islam

A thesis submitted in partial fulfilment of the requirements of the University of East London for the degree of Professional Doctorate in Counselling Psychology

January 2024

Abstract

Research on counselling psychologists adapting their working practices during a health crisis is rare. Informed by existing literature on past and present epidemics and pandemics, the aim of this qualitative research was therefore to provide a novel perspective on the experiences of counselling psychologists adapting their practice from home during government-imposed lockdowns amid the COVID-19 pandemic. Interpretative phenomenological analysis was employed to analyse data obtained from six counselling psychologists who described their experiences during individual, one-to-one semi-structured interviews conducted online via Microsoft Teams. The analysis identified four Group Experiential Themes (GETs): 'intense emotional reaction', 'newness', 'the experience of multiple losses', and 'gains'.

The first GET indicates that participants experienced intense emotional challenges linked to the unprecedented nature of the pandemic, the shift to remote work, and the merging of home and work domains. The second GET captures the experiences of counselling psychologists who felt unprepared and encountered challenges in transitioning to remote work from home such as setting up appropriate home offices, navigating online therapy platforms and coping with technological limitations. Additionally, they underwent shifts in the quality and nature of the therapeutic relationship. These challenges engendered concerns about professionalism, confidentiality and work-life balance, causing the participants significant distress. In addition, they sometimes resulted in burnout and difficulties in maintaining professional and personal boundaries.

The third GET encapsulates the multiple losses experienced by counselling psychologists whilst navigating COVID-19 practice adaptations: the loss of social connections and increased isolation, the absence of traditional in-person therapy delivery, the intermittent loss of psychological intervention, and the shift in the expert role in the therapeutic relationship. The

latter engendered self-doubt and insecurities among counselling psychologists, causing them to experience high levels of distress.

The fourth GET reflects not only participants' experience of a positive transformation through COVID-19 lockdown practice adaptation, but also their discovery of positive aspects of online working as time progressed. For instance, counselling psychologists valued the acquisition of new skills which helped them embrace and accept remote work, especially the hybrid therapy delivery model which offered advantages such as effectiveness, flexibility, efficiency and accessibility. All participants demonstrated adaptability and embraced new working norms whilst prioritising self-care, self-compassion and self-awareness. They displayed resilience and experienced post-traumatic growth. This journey led to personal and professional development, fostering a sense of professional empowerment among the participants which, in turn, cultivated a greater appreciation for remote work.

At an organisational level, to provide relevant support and learn from individual experiences, I have proposed recommendations for supervisors and managers to assist counselling psychologists in managing their emotional challenges during remote work, delivering therapy amidst technology issues, and maintaining online boundaries, confidentiality, and risk management. Additionally, psychology regulatory bodies and training providers should offer training to both existing and new counselling psychologists in effective online therapy delivery to prepare them for hybrid work settings and potential future health crises that may necessitate adapting their practice. To inform guidelines, one suggestion I have made is to research how counselling psychologists experienced growth during their adaptation to remote practice during the COVID-19 pandemic. This involves exploring factors, both personal and professional, that contribute to their post-traumatic growth.

Acknowledgements

I want to extend my thanks to the six participants who took part in my study. Your openness in sharing personal stories is truly appreciated. This research would not have been possible without your willingness to engage in profound and thoughtful conversations with me. I feel privileged to have had the opportunity to incorporate these narratives more extensively into my research.

I want to express my sincere thanks to Dr Martin Willis, my research supervisor, for being a constant source of support throughout this research journey. Your guidance and constructive feedback were instrumental in successfully completing this study. Your constant presence is genuinely appreciated, and I extend my deepest thanks for the invaluable contributions you made to my research. To Professor Rachel Tribe, my second research supervisor, I appreciate your support during this research process and for sharing relevant research articles with me. Thank you; it was highly valued.

Thanks to my friends at the University of East London for their support and intellectual inspiration during this process.

My heartfelt thanks go out to my children, family, and friends for the love and encouragement. This accomplishment would not have been achievable without each one of you.

Contents

Abbreviations

BPS	British Psychological Society
CBT	Cognitive-behavioural therapy
CoP	Counselling Psychologist
CP	Clinical Psychologist
COVID-19	CoronaVirus Disease 19
GET	Group Experiential Theme
HCPC	Health and Care Professions Council
HCW	Healthcare Workers
IPA	Interpretative Phenomenological Analysis
MERS-CoV	Middle East Respiratory Syndrome
NA	Narrative Analysis
NHS	National Health Service
PET	Personal Experiential Theme
SARS	Severe Acute Respiratory Syndrome
SARS-CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
UEL	University of East London
WHO	World Health Organisation

Chapter One

Introduction

Chapter overview

This introductory chapter provides the context for my doctoral research which focused on how therapeutic practices adapted during the COVID-19 pandemic. Specifically, my aim was to examine the experiences of counselling psychologists (CoPs) shifting to remote practice from their homes during lockdown. Throughout this chapter, I discuss various elements such as my personal context, my positioning regarding remote methods, situating them within the existing literature and how counselling psychologists traditionally work. Finally, I present an overview of remote practices in psychological therapy prior to the pandemic.

How counselling psychologists traditionally work

Counselling psychology is a distinct and relatively recent profession, having experienced noticeable growth and development over the past three decades (Jones, Nielsen & Nicholas, 2016). Cooper (2009) described counselling psychology as 'ethics in action'. At a micro level, CoPs embrace and integrate a humanistic and relational value system into their practice with the aim of understanding human experiences in their immediate context, as well as in their cultural, spiritual and social contexts. The key focus is on reducing individual psychological distress, with various therapeutic techniques and interventions utilised to support clients in understanding their subjective experiences, empowering them to make positive changes and undergo personal growth (The British Psychological Society, 2019; Woolfe et al., 2010). At a macro level, CoPs commit themselves to playing an active role in advocating social justice, equality and standing up against oppression – principles rooted in humanistic and existential values (Gupta, 2022; Woolfe et al., 2010).

Furthermore, they place a tremendous emphasis on collaboration – a key aspect of psychological practice that extends beyond individual therapy sessions. Recognising the centrality of relationships and the intersubjective nature of therapeutic processes, they concurrently hold multiple perspectives. CoPs thus strive to form an inclusive, collaborative therapeutic relationship which serves as a vehicle through which psychological problems are understood and alleviated (Cooper, 2009; The British Psychological Society, 2019). Through an examination of multiple counselling psychology texts, Cooper (2009, p. 120) identified six key defining principles of counselling psychology: 'prioritisation of the client's subjective and intersubjective experiences over the therapist's objective observations, focus on fostering growth and potential actualisation rather than solely treating pathology, orients towards empowering clients, commits to a democratic, non-hierarchical client-therapist relationship, appreciates each client as a unique being rather than a mere instance of universal laws, and understand the client as socially and relationally embedded, recognising potential experiences of discrimination and prejudice rather than solely focusing on intrapsychic aspects'. Thus, when I refer to counselling psychologists as working in a 'nuanced way', it denotes their unique approach which embodies these foundational principles and values.

The use of remote mediums to deliver therapy prior to the COVID-19 pandemic

Before the onset of the COVID-19 pandemic, therapists in the field of psychology had already established a presence in delivering remote online therapy. Richards and Viganó (2013, p.1) encapsulated the nature of online counselling by defining it as the 'delivery of therapeutic interventions in cyberspace where the communication between a trained professional counsellor and client is facilitated using computer-mediated communication'. At that time, there were two types of online counselling: synchronous which included real-time methods such as videoconferencing, and asynchronous such as email communication. The key difference between them was the timing of communication, with synchronous offering instant

responses and asynchronous having a time lag. Synchronous methods included chat/instant messaging, audio and webcam, whilst asynchronous methods included email, forums and SMS.

Such counselling involved the use of a computer and a video camera, and was described using a variety of terms, including videoconferencing, webcam counselling, real-time video counselling, telemedicine and telehealth (Backhaus et al., 2012). For the purposes of this chapter, it is referred to as the video medium. According to Berger (2017), videoconferencing resembles in-person therapy because it allows for two-way communication between clients and therapists through visual and audio interaction (Shandley et al., 2011).

Research has demonstrated that online therapy can be effective, often comparable to or even surpassing in-person therapy settings (Barak et al., 2008; Richards & Viganó, 2013). For instance, Day and Schneider (2002) compared in-person, telephone and video medium counselling, and found that therapeutic relationships could be established effectively across all methods, with no significant differences in outcomes. However, the methodological rigour of their study was limited by conducting sessions solely in a clinic, and thus did not reflect typical videoconference settings.

Several case studies have illustrated the effectiveness of online counselling, with some demonstrating positive results (Cowain, 2001; Manchanda & McLaren, 1998). However, these typically centred on cognitive behavioural therapy (CBT), potentially limiting their applicability to other therapeutic modalities. Although case study research lacks external validity, Flyvbjerg (2006) highlighted its value in providing detailed insights into individual cases. Notably, Simpson (2009) reported effective online therapy across various therapeutic modalities, suggesting that video medium delivery was effective regardless of the approach.

The effectiveness of online counselling suggests that successful therapeutic relationships can be established in remote settings. Given the significant focus on such efficacy, researchers have

deemed it important to explore whether the therapeutic relationship influences the outcome of online therapy. To that end, Yuen et al. (2013) conducted a study exploring the relationship between the therapeutic alliance and therapy outcomes for social anxiety using acceptance-based behavioural therapy via videoconferencing. However, the results revealed no significant correlation between the therapeutic alliance and therapy outcomes. Reviews conducted by Cavanagh and Millings (2013) similarly suggested that therapy outcomes in online settings may have been less reliant on the therapeutic relationship. One method that has been employed to study the therapeutic relationship involved comparing the online therapeutic alliance with in-person experiences. Such research indicated that the online alliance could be similar, different, or even stronger than the alliance experienced in-person (Richards & Viganó, 2012). Similar studies reported positive ratings by clients for the online medium (Preschl et al., 2011; Wagner et al., 2012). However, research also suggests that the therapeutic alliance is perceived as stronger when using synchronous methods such as video delivery, compared with in-person settings (Berger, 2017), implying that both mediums could be effective.

Despite the wealth of research supporting the efficacy of online therapy in nurturing strong therapeutic relationships with clients, psychologists have rated the alliance as less effective. For instance, Rees and Stone (2005) investigated psychologists' attitudes towards video therapy delivery by asking them to assess the therapeutic alliance in sessions conducted either in-person or via video. Their results revealed that psychologists consistently rated in-person sessions as establishing a stronger therapeutic alliance. Their concerns were rooted in factors that could potentially impede the therapeutic alliance, including technological disruptions and perceived challenges in accurately conveying warmth, empathy and sensitivity. Suler (2000) elaborated further on concerns regarding the inability of online therapy delivery to effectively cultivate genuine human interaction. Additionally, environmental factors such as screen size,

lighting and distorted eye contact have been identified as potentially influencing the digital experience (Jerome & Zaylor, 2000).

In summary, prior to the COVID-19 pandemic, psychologists widely embraced remote online therapy, employing both synchronous and asynchronous methods. Whilst research supports its effectiveness, concerns persist regarding its ability to facilitate genuine human interaction. Despite several studies finding no significant difference between the therapeutic alliance between online and in-person sessions, psychologists still rated the latter more highly. The challenges they identified include managing technological disruptions and effectively conveying warmth and empathy.

COVID-19 pandemic

The COVID-19 pandemic posed a major threat to global public health, disrupting people's daily lives and routines in an unprecedented manner. Initial reports emerging from the Hubei province of China described the novel virus as SARS-COV-2.[1] In January 2020, the World Health Organization[2] classified the outbreak of the disease as a global pandemic known as COVID-19. Following its onset, individuals had to make substantive adjustments to their personal and professional lives. The catalyst for this can be attributed to government responses to rising virus transmission rates and death tolls, whereby countries made the challenging decision to implement border closures and announced nationwide lockdowns in an effort to contain the virus (Xiang et al., 2020).

To mitigate the spread of COVID-19, the United Kingdom (UK) Government implemented its first nationwide lockdown on 23 March 2020 (Institute for Government, 2021), based on data indicating that intensive care units within the National Health Service (NHS) were

[1] This strain of coronavirus is known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
[2] The World Health Organization (WHO) informed the world about the COVID-19 virus on 30 January 2020 and declared it a pandemic on 11 March 2020.

overstretched. This took the form of a governmental mandate instructing the public to stay indoors, permitting exceptions solely for essential activities such as purchasing food and medicine or taking one form of daily exercise (Jarvis et al., 2020). Although these harsh measures were designed to safeguard individuals and communities at large, the psychological effects were profound. The abrupt implementation of social restrictions isolated people from those outside of their household, disrupted their daily routines, induced financial strain and had an unquestionable impact on both their personal and professional lives.

Personal Context

In the interpretative phenomenological analysis (IPA) methodology I employed for this study, there is no strict requirement for bracketing personal experiences. This is because it is valuable to acknowledge how our prior experiences may shape our perspectives on certain phenomena and our approach to studying them.

When the first COVID-19 lockdown was mandated in the UK, I was impacted by the fact that, as a counselling psychologist in training, in-person activities such as clinical work on placement and lectures came to a halt. Overnight, I received instructions to leave my clinical placement and academic settings and begin transitioning to remote work from home, which was an intensely emotional experience for me. As someone in the early stages of my training and without any prior experience in conducting therapy sessions over the phone or via video mediums, I was unsure of what that actually entailed. Fortunately, I had access to a laptop and service database. However, in terms of what I was required to do and how to set up my practice from home, clarity and direction were absent, resulting in an extremely stressful experience of practice adaptation.

Then came the next challenge – my home was not adequately set up for home working as I did not have an office. Consequently, working from my bedroom was the only option, given that I

shared a home with family members, including children. This set-up blurred the lines between my private and professional life, making it challenging to establish boundaries for myself. As a result, I often found myself working late into the evening and even at weekends due to the ease of access to work, leading to a blurring of boundaries between my professional and personal life.

Moreover, ensuring client confidentiality and privacy proved challenging, especially within the home environment, where the risk of others overhearing therapy content and breaching confidentiality was heightened. Similarly, clients encountered difficulties in finding a private and secure space within their household to receive their therapy sessions.

Furthermore, at the time, I grappled with the deeply ingrained belief that 'good quality' clinical work and a robust 'therapeutic alliance' could only be established through in-person interactions, with the client physically present in a clinical setting. These uncertainties, compounded by the isolation experienced as a result of remote practice, completely disconnected me from my colleagues, peers and social support network and intensified my self-doubt and anxiety as to whether I would be providing 'good enough' therapy to my clients. Overall, as I reflected on my personal experience during the initial transitional phase of adaptation, I found myself operating from a place of fight or flight, underscoring the intense emotional toll of navigating these unprecedented circumstances.

During the initial phase of the first lockdown, I began to wonder if my colleagues were encountering the same level of difficulty in adapting to the changes in practice, and how they were handling it. Feeling overwhelmed, I envisioned them coping more effectively, which discouraged me from reaching out for support due to the fear of being judged as a 'bad therapist'. The mandated pandemic lockdown practice adaptation felt distinct from existing remote work because there was no choice or control over the situation. Given my own

experiences, I sought to understand the experience of other CoPs who switched their working practice to their homes.

Contextualisation of the literature review

In the early stages of the COVID-19 pandemic, the literature predominantly consisted of quantitative studies that examined the mental well-being of healthcare workers (HCWs). Later, a number of qualitative studies on practice adaptation among HCWs emerged, revealing themes such as emotional, cognitive, practical and professional impacts. I utilised this literature due to the limited availability of literature specifically addressing psychologists (Embregts et al., 2020; Liu et al., 2020; McGlinchey et al., 2021).

In addition, the literature review focused on several studies that explored how psychologists adapted their practice within intellectual disabilities services. In these studies, the researchers performed a thematic analysis which uncover themes related to practice adaptation and well-being (Embregts et al., 2022; Gregson et al., 2022). However, the researchers also acknowledged the limitations of this approach in fully capturing the depth of participants' experiences, thus leading me to use IPA in my study.

Finally, the review examined studies that explored the experiences of clinical psychologists (CPs) and applied psychologists, emphasising the importance of assessing the impact of remote working on the quality of therapists' practice. For instance, Chemerynska et al. (2022) conducted research in order to understand the experiences of CPs working with clients with intellectual disabilities, utilising IPA for data analysis. Their findings suggest that psychologists demonstrated the capability to adapt to challenging circumstances. Similarly, Morgan et al. (2022) used IPA to evaluate the impact of remote working on the quality of therapists' practice. They proposed that adjusting working methods could enhance the benefits of remote work and address potential challenges. The review concluded by highlighting the

scarcity of phenomenological studies examining psychologists' experiences during a health crisis, especially within the realm of counselling psychology, which represents a notable gap in research.

Overall, the literature review provided a comprehensive overview of existing research, whilst identifying gaps and the need for further exploration of psychologists' experiences during the COVID-19 pandemic, particularly within the context of practice adaptation and the unique challenges faced by counselling psychologists.

In this paper, the terms 'psychology professional', 'therapist', 'counsellor', 'clinician' and 'psychotherapist' are used interchangeably to reflect the diverse terminology found within the global psychology profession, as evidenced by the literature review. These terms collectively refer to professionals who use psychological therapy to treat clients and support their mental well-being.

Definitions:

Coronavirus (COVID-19) – an infectious disease caused by the SARS-CoV-2 virus (World Health Organization, 2023)

Pandemic – a novel infection that has rapidly proliferated worldwide and caused a high incidence of morbidity and mortality (Doherty, 2013, p. 42)

Lockdown – a government order for citizens to stay at home and only go out for essentials, with police imposing fines on those who fail to comply; while lockdown measures were imposed in the United Kingdom from March 2020 to December 2021 (Buchholz, 2020, p. 1; Institute for Government, 2021).

In-person therapy – traditionally, 'face-to-face therapy' referred to the therapist and client meeting in person for sessions. However, with technological advancements, online video

platforms have come to resemble face-to-face interactions more closely (Berger, 2017). This is because online counselling via videoconference technology has been considered to mirror face-to-face counselling, primarily due to the visibility of the upper body. This resemblance is further enhanced by the interactive two-way communication between the client and therapist (Shandley et al., 2011). Additionally, Tudor et al. (2021) have noted similarities between 'face-to-face in-person' and 'face-to-face online' sessions. Given its prevalence in psychological research, the term 'in-person' is now favoured and will be used in my writing.

Counselling Psychology – according to the British Psychological Society (2005, p. 1), 'Counselling psychology has developed as a branch of professional psychological practice strongly influenced by human science research as well as the principal psychotherapeutic traditions. Counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology. It continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship.'

Chapter summary

In this thesis, my aim was to explore the experience of CoPs engaging in practice adaptation from home during the initial COVID-19 lockdown. Within the introduction, I highlighted the significance of this inquiry within my personal context, as I encountered this adaptation process alongside others. Additionally, I discussed the dynamic nature of CoP practice and the diverse array of research in this field.

Chapter Two

Literature Review

Introduction

This chapter presents a comprehensive literature review conducted prior to commencing the study. The intention was to critically appraise current literature on the adaptation of working practices in response to the government imposed national COVID-19 lockdown measures, specifically among psychologists. This enhanced my understanding of current issues and what is already known about this area of research. In this chapter, I present a clear overview of the COVID-19 pandemic, as well as other health crises, given that COVID-19 research is still emerging. In so doing, I discuss the gaps emerging from the literature, acknowledge the limitations of the literature review, provide the rationale for this study, state the research aims and formulate the research questions in accordance with the most suitable methodological approach. Lastly, I further contextualise the importance of exploring this research topic within the area of counselling.

Literature review search strategy

The journal articles examined as reference material for this research were accessed using search engines such as PsycINFO, Academic Search Complete, Google Scholar, PubMed, Scopus, and Science Direct. Additionally, I read books to increase the scholarly depth of the references and gather further information. I employed the following keywords for the searches: Epidemic OR Pandemic OR Quarantine, Quarantine and Lockdown, Psychologist AND Health disaster, Natural disaster AND Psychotherapy, Natural Disaster AND Psychologist, and Psychologist AND COVID-19. In addition, I searched the university library to obtain electronic articles whilst simultaneously using those accessible at the British Library. The selection of literature from these different outlets was then used to write this chapter.

Overview of restrictive measures imposed during the COVID-19 lockdown

In the UK, the COVID-19 lockdown phase is now behind us and we are presently in the post-lockdown phase. However, it remains in the wider community, maintaining a restrained presence without causing mass fatalities. During the initial national lockdown, people were required to adhere to various government mandated restrictions which included a requirement for individuals to remain in their homes, a prohibition on the mixing of households, and the closure of non-essential shops, hospitality and leisure industries (Institute for Government, 2021; Sherrington, 2022). During the second lockdown,[3] educational establishments such as schools and universities remained open for in-person learning; however, throughout the first and third lockdowns,[4] institutions implemented remote online learning - for younger school children, which required parental supervision (Barber et al., 2022; Institute for Government, 2021). This situation further complicated the lives of those who found themselves managing their work whilst simultaneously fulfilling their duties as parents, caring for their children and supervising their online classes. The multitude of changes prompted by the COVID-19 lockdown profoundly affected all aspects of individuals' lives, most notably by integrating all personal and professional activities within the home setting.

Impact of COVID-19 lockdown on individuals

The extensive impact of COVID-19 lockdowns on individuals' lives created myriad challenges and disruptions across various aspects of daily life, interrupting the everyday rhythm people once enjoyed. A plethora of research suggests that individuals living through the COVID-19 lockdowns were prone to mental and physical health difficulties due to factors such as social isolation, bereavement and financial insecurity (Sibley et al., 2020). Qiu et al. (2020) contributed further insights, suggesting the COVID-19 pandemic had the potential to leave

[3] The second national lockdown was implemented on 5 November 2020 for four weeks.
[4] The third national lockdown was implemented on 4 January 2021.

deep psychological scars on individuals due to the uncertainty and unpredictability of the future, lack of knowledge about the disease, the need for distancing and isolation, its rapid transmission and the significant threat it posed to life, all of which challenged the fundamental coping mechanisms employed by individuals (Horesh & Brown, 2020; Qiu et al., 2020; Wang et al., 2021).

Exacerbating an already difficult situation, the pandemic led to the extraordinary circumstance of a massive loss of lives. In the UK, there have been 197,010 COVID-19-related deaths and 23 million infections with COVID-19 (UK Government, 2020, 2023). This has given rise to a complicated recovery process and a difficult grieving experience for individuals (Cooper & Williams, 2020; Simon et al., 2020). Moreover, the lockdown restrictions imposed during the initial phase of the pandemic prevented individuals from being present with their loved ones at the time of their passing. This led to emotions of guilt, anxiety, sadness, anger, changes in sleep or appetite and a diminished interest in activities (Bonanno & Kaltman, 2001; Stroebe et al., 2007). To further amplify the situation, additional restrictions were imposed on the possibility of physically gathering to mourn with family members and friends (Wallace et al., 2020), while restrictive caps were placed on the number of people permitted to join funeral ceremonies. This unprecedented absence of traditional rituals – arguably disrupting the grieving process (Burrell & Selman, 2022) – without attending a funeral to mark the transition to the irreversibility of death, give meaning to the loss, and receive social and emotional support meant that individuals were not able to process what had happened (Simon et al., 2020). The COVID-19 death rate thus had a profound impact on the entire UK population, whether individuals experienced the loss of a loved one first-hand or learnt about others' losses as a secondary experience. This occurrence extended beyond personal lives, permeating into people's professional lives and their work.

The impact of COVID-19 on individuals can be conceptualised in two ways: the effect on individuals personally and its effect on their professional practice. I believe these aspects are interconnected rather than mutually exclusive, and the way in which people practise is inseparable from their personal lives. In particular, when individuals are suddenly mandated to work from home without transitional space, this can create challenges in effectively establishing physical and psychological boundaries between one's personal and professional life. Because the global pandemic was an experience that was universally shared, it can be assumed that it impacted everyone, irrespective of their career specialisation. This transition leads to the subsequent section which focuses on the in-person delivery of psychotherapy.

In-person delivery of psychotherapy

A widely shared view within the field of psychotherapy is that in-person delivery facilitates the implementation of respect, openness, empathic understanding, and congruence within the therapeutic relationship (Rogers, 1951). Additionally, research indicates that clients have a strong preference for in-person therapy delivery (Day & Schneider, 2002; Renn et al., 2019; Wong et al., 2018). Traditionally, the training of psychologists leans towards in-person therapy delivery as the superior medium and is favoured by most psychotherapists. Furthermore, this approach was endorsed by Freud, who described in-person therapy as conducive to a friendly atmosphere within which successful therapeutic change is believed to occur (Freud, 1953).

Hart (2018) highlighted the importance and value of non-verbal communication in continuous clinical assessment and psychological formulation. Her findings suggest that the majority of communication occurs non-verbally, with 55% involving emotions and attitudes being conveyed through facial expressions, 7% via vocal expression, and 38% through the tone of speech. This may be why psychologists favour in-person therapy as the preferred medium for delivering therapy. During the COVID-19 lockdowns, the British Psychological Society (BPS)

published guidance on how to switch psychological therapies to digital platforms or telephone (BPS, 2020) as a way of preventing virus transmission. This meant psychologists had to shift their practice to remote telephone and video platforms from home. This was viewed as a huge loss by psychologists who value working in-person, particularly CoPs, who work in nuanced and unique ways and engage in practices that operate on the periphery of the medical model. The subsequent section explores in more detail this shift in working practice.

Adaptation to remote telephone and online therapy

As the UK entered the initial COVID-19 lockdown, psychologists experienced an abrupt shift to remote work, a change for which they had minimal or no prior preparation (Cameron, 2020; Chemerynska et al., 2022; Morgan et al., 2022; Serrão et al., 2022). Studies indicate that remote telephone and online therapy were a potentially safe and efficacious alternative to in-person therapy during the pandemic (Swartz, 2020; Wind et al., 2020). Prior to the lockdown, an extensive body of literature already existed on working over the internet, as well as the effectiveness of telephone, online, and in-person therapies, particularly regarding the quality of the working alliance (Day & Schneider, 2002; Richardson et al., 2009; Simpson & Reid, 2014). However, such research predominantly focused on person-centred or cognitive behavioural therapy modalities, raising concerns about potential limitations in terms of inclusivity. Recognising the importance of a diverse range of therapeutic approaches is crucial for a more comprehensive understanding of the subject. Therapeutic modalities, whilst sharing certain traits, diverge somewhat in their theoretical frameworks, techniques and approaches. Although all strive to enhance mental well-being, each modality offers distinct perspectives on psychological issues and their resolution. For instance, CBT seeks to address negative thought patterns and behaviour through collaborative, present-focused interventions (Beck, 1995). Conversely, person-centred therapy emphasises the importance of core conditions such as empathy, congruence, and unconditional positive regard during sessions to facilitate effective

therapy. (Rogers, 1946). Psychodynamic therapy, by contrast, delves into unconscious processes and past experiences (Abrahams & Rohleder, 2021). These differences in theory and practice render each therapeutic modality unique and tailored to address specific client needs and preferences. Moreover, the shift from in-person to remote practice varies with each therapist, as it is influenced by their training and specialist background, as well as their subjective experience of the event.

Research conducted before the pandemic suggests that remote psychotherapy is effective for treating diverse diagnostic groups such as those with social anxiety disorder and posttraumatic stress reactions (Carlbring et al., 2018; Knaevelsrud & Maercker, 2007), and facilitates the formation of a strong therapeutic alliance in remote settings (Castro et al., 2020; Norwood et al., 2018; Simpson & Reid, 2014). During the pandemic, therapists across various modalities, especially those inexperienced with remote delivery, had to adapt their practices to suit remote mediums at short notice, and in a manner tailored to their specific frameworks. This presented a new obstacle for therapists (Kazantzis & Dobson, 2022; Waller et al., 2020). Given the specialisation of psychologists in diverse modalities, the strength of the therapeutic alliance, whether conducted online or in-person, profoundly shapes therapeutic outcomes (Castro et al., 2020). Hence, understanding their unique experiences during this period is imperative.

During the initial phase, several psychologists were reluctant to embrace online work, despite research indicating that internet-based CBT effectively treated and managed various psychiatric disorders, including depression, generalised anxiety disorder, social anxiety, panic disorders, phobias, adjustment disorder, bipolar disorder and obsessive-compulsive disorder (Kumar et al., 2017; Morgan et al., 2017). This may be because earlier research drew on the experiences of psychologists who voluntarily opted to practise online, freely embracing this new expansion of their work as it became accessible. Consequently, it does not accurately reflect the prevailing viewpoint among psychology professionals compelled to switch their

practice to remote online work during the pandemic. Nevertheless, the body of literature related to involuntary remote practice adaptation from home during the COVID-19 lockdown is growing rapidly. During this period, psychologists were urged to tackle the challenges of the COVID-19 crisis whilst remaining mindful of the ethical standards outlined by professional bodies (British Psychological Society, 2021; Chenneville & Schwartz-Mette, 2020).

In one notable review, Poletti et al. (2021) examined the findings from 18 empirical studies which delivered psychotherapy through synchronous web technology and reported that online therapy demonstrated substantial equivalence to in-person therapy in its effectiveness for treating common mental health disorders (Poletti et al., 2021). For instance, it was efficacious in treating anxiety, depression and post-traumatic symptoms (Catarino et al., 2018; Egede et al., 2015; Wierwille et al., 2016). Moreover, those clients who received online therapy treatment reported levels of perceived quality of life, satisfaction and treatment credibility similar to those involved in in-person therapy (Egede et al., 2015). In another study, Sammons et al. (2020) conducted research at two different points during the COVID-19 pandemic; initially, during the remote practice adaptation phase, and then six months later. They observed an increase in psychologists' comfort with using online therapy delivery over time, probably influenced by their growing familiarity with the technology and increasing acceptance and ease of its use.

However, despite evidence supporting the effectiveness of remote online work, there also appear to be widespread negative attitudes towards this approach. For instance, research suggests psychologists perceive online therapy as less effective than in-person therapy (Gordon et al., 2015; Schulze et al., 2019). This could be attributed to concerns about privacy, confidentiality, and security issues, psychologists' competence and requirements for special training, communication issues related to technology, and the dearth of research in this area (Stoll et al., 2020; Titzler et al., 2018; Topooco et al., 2017). Furthermore, there has been a

noted reluctance among clients, especially those with prior experience in in-person therapy, to embrace online therapy (Apolinário-Hagen et al., 2017; Hantsoo et al., 2017). Nevertheless, other studies have found that once psychologists start delivering therapy online, this apprehension usually decreases (Sucala et al., 2013). A major concern psychologists had regarding online therapy concerned their ability to build a strong therapeutic relationship in a remote setting (Connolly et al., 2020; Roesler, 2017). However, other studies found that psychologists were able to maintain emotional connectedness with clients - such professionals felt that whilst remote work is different, it can still be effective, even if not perceived as equivalent to in-person work (Aafjes-van Doorn et al., 2021). Moreover, Futkowska et al. (2017) found that therapists working with adolescents and adults typically exhibit a more optimistic view of online therapy, despite recognising some concerns regarding the potential risks and technological challenges associated with this platform. This may be attributed to the fact that therapists understand that these age groups frequently utilise media across various social, educational and professional settings, potentially rendering online therapy a more acceptable alternative environment for such treatment (Rutkowska et al., 2023).

Recent research indicates that because adapting to COVID-19 lockdown practices was an involuntary process, psychologists may have experienced a sense of loss and anxiety related to the shift away from in-person therapy delivery, expressing multiple concerns about building therapeutic relationships with clients and their professional competence for remote work during the earlier phase of the adaptation (Giordano et al., 2022; Pierce et al., 2021). Nevertheless, the literature indicates that with time, a large number of psychologists came to embrace and appreciate the effectiveness of online therapy (Aafjes-van Doorn et al., 2021; Daplyn, 2022; Embregts et al., 2022).

In summary, research conducted before and during the pandemic has demonstrated that the effectiveness of remote online methods in treating psychiatric conditions is comparable to that

of in-person therapy. It also highlighted the importance of understanding psychologists' unique experiences, regardless of their modalities. Despite this, psychologists frequently held negative attitudes toward this approach, as they felt they were unable to build a strong therapeutic alliance with clients online, despite evidence suggesting otherwise. However, with time, they were able to accept and embrace remote mediums. I will now explore how clients experienced remote practice adaptation.

Client experiences of remote therapy during the pandemic

According to Benzel and Graneist (2023), clients adapting to remote therapy during the COVID-19 pandemic lockdown found themselves responsible for creating a safe therapeutic space within their own homes, often needing to negotiate this space with family members. Consequently, concerns about confidentiality arose due to the possibility of others overhearing sessions. Clients also encountered technological difficulties with the intrusion of the 'digital third' into the virtual therapy room (Benzel & Graneist, 2023; Trub & Magaldi, 2017). Additionally, the absence of physical bodily communication, such as greetings and handshakes, was noted as a significant change in remote sessions. This lack of a physical dimension may have been perceived as compromising the security and reliability of the therapeutic alliance. Clients experienced conflicting emotions regarding potential therapist judgments due to their room being displayed on the video camera. However, they also expressed moments of happiness and appreciation for the opportunity to share their personal space (Benzel & Graneist, 2023). In addition, clients experienced a sense of loss without the 'transitional space' of travelling to and from therapy. This physical movement allows for reflection on the session and a change of scenery, which are important for distancing oneself from burdensome topics and feelings. Despite these challenges, Serhal et al. (2020) assessed how satisfied patients were with telepsychiatry in four areas: access and timeliness, appropriateness, effectiveness, and safety. Their findings suggested that both safety and access, as well as timeliness, emerged as

statistically significant predictors of satisfaction (Serhal et al., 2020). Von Below et al. (2023) found that clients experienced remote psychotherapy delivery as 'good enough' for COVID-19 lockdown practice adjustment; however, their preference was for in-person sessions (von Below et al., 2023). I will now explore how the adaptation of practices affected the home environments of professionals.

The impact of switching professional practice to the home environment

The initial COVID-19 national lockdown required individuals to remain within their homes, potentially resulting in solitary conditions or cohabitation with other family members, including partners, children and extended family. In the UK, an unprecedented 46.6% of the working population worked from home using online platforms, with 86.0% doing so as a result of the pandemic (Cameron, 2020). Given that only a small number of individuals had prior experience of remote online work before the pandemic, the sudden nature of the lockdown meant individuals were not adequately prepared for the distinctive challenges of switching from their office to their home environment. Literature from the early phase of the COVID-19 lockdown indicated that employees experienced difficulties in managing the balance between their professional and personal lives, resulting in dissatisfaction in both domains.

According to boundary theory, individuals establish and maintain psychological, physical and behavioural boundaries around various life roles, such as those related to work and home, as part of their organisational framework. Having the ability to maintain such boundaries allows the individual to opt for the role most suited for a given situation (Ashforth et al., 2000). They also have the capacity to transition between different roles throughout the course of a day. Furthermore, although roles are typically bound to a specific physical and temporal context, such as being at work during designated hours, individuals also have the capacity to adopt roles that extend beyond their immediate physical location.

Boundary theory posits a continuum of segmentation to integration – where employees keep their professional and personal roles separate with little overlap – to integration where roles cross over and share similar identities (Ashforth et al., 2000). The practice adaptation from home that occurred during the COVID-19 lockdowns undoubtedly blurred the distinction between the two-domain role for individual employees by removing the physical separation of these spaces, resulting in more permeable role boundaries (Allen et al., 2021). This, in turn, increased the likelihood of transitioning between roles throughout the day. For instance, receiving a personal telephone call during work hours violated the work boundary, whilst receiving a work-related telephone call beyond work hours violated the home boundary. Previous literature reveals that such violations of boundary can lead to an individual becoming dissatisfied with their investment in professional or personal domains (Hunter et al., 2019).

Furthermore, greater integration of boundaries can create conflicts between roles. In such cases, the home role and responsibilities may encroach on the work role or the work role may disrupt the home role, especially when working beyond normal hours (Delanoeije et al., 2019). Sullivan and Lewis (2001) affirmed this finding, reporting that employees believed the easy accessibility and proximity of work and home compelled them to work in the evening. From a beneficial standpoint, employees had greater personal freedom and flexibility to structure their day as they wished, with the added advantage of being able to conveniently attend to domestic responsibilities. However, their perception of this situation may have varied depending on whether they had a preference for segmented or integrated boundaries (Delanoeije et al., 2019; Kreiner, 2006). For individuals working from home, there is evidence to suggest a risk of home responsibilities disrupting work duties. This indicates a conflict between roles, where transitioning to the home role during the workday utilises resources originally allocated for work-related tasks (Delanoeije et al., 2019). Moreover, the absence of a transitional space between work and home, coupled with the absence of a commute to work, may have made the

transition between work and home roles particularly challenging, as the latter commonly occurs during the commute (Sullivan & Lewis, 2001).

In summary, boundary theory provides insights into how an individual's boundaries may have been influenced by working remotely from home during COVID-19 lockdowns and illuminates the challenges remote workers may have faced in multitasking various roles during the workday. Beyond this, it is worth noting that not having access to a physical workspace in the form of an office may have substantially impacted the experience of those working from home. This leads to an exploration of the effect of COVID-19 remote home practice adaptation on professionals' personal lives.

The impact of remote online home practice on personal life

The adaptation that occurred during the initial phase of COVID-19 lockdown measures required individuals to transition to a home-based work model, compelling them to strategically allocate a work area within their personal living spaces. This adjustment became especially challenging due to the widespread scarcity of extra space within households in which to establish a dedicated and confidential home office (Wethal et al., 2022). The closure of childcare, schools, and educational facilities presented additional challenges to maintaining a balance between professional and personal life. This exerted a particularly notable and disproportionate impact on women, who assumed household chores, prepared more meals due to restaurant closures and skilfully balanced caring responsibilities with home-schooling their children within the context of a home-as-office setting (Rudolph et al., 2021). Moreover, COVID-19 pandemic remote workers with young children found themselves having to work with an additional layer of background noise, adding complexities to their home practice adaptation (Rudolph et al., 2021).

In the literature, a drawback identified for individuals working from home was the extended periods of isolation from colleagues and the absence of a regular social support system, which adversely impacted their well-being (Bentley et al., 2016). Ellis et al.'s (2020) research findings align with the observation that the COVID-19 lockdown subjected individuals working from home to social isolation, leading to increased levels of loneliness that potentially impacted their well-being. This correlated with a reduction in job satisfaction and performance, along with an increase in stress levels (Bentley et al., 2016; Toscano & Zappalà, 2020). Bentley et al.'s (2016) findings emphasised the importance of organisational support for remote workers in enhancing the alignment between themselves and their environment, ultimately ensuring positive outcomes for home-based work. Furthermore, the job-control and support model posits that social support serves as a protective shield, mitigating the impact of the demands of work on overall well-being (Van der Doef & Maes, 1999).

Before the COVID-19 pandemic, research on remote work generally categorised it as either beneficial or harmful (Koslowski et al., 2019). However, it was primarily based on participants occasionally and inconsistently working from home. Consequently, this body of research did not fully comprehend the intricacies of working from home in the novel context of a health crisis (Lamers et al., 2017). Psychologists work to create a secure space for clients, nurturing containment whilst valuing their work within confidential boundaries with minimal disruption. Consequently, exploring the experiences of psychologists in adapting to these changes in remote home practice is bound to provide valuable insights, especially CoPs who work with a set of professional values and in a nuanced manner.

Burnout

The concept of burnout was first coined by psychologist Freudenberger (1974) who characterised it as a process of physical and emotional exhaustion, fatigue, detachment and self-doubt experienced by individuals in caring professions. A steady growth in empirical

evidence indicates that occupational health gained heightened relevance in the context of the COVID-19 pandemic, with the significant negative impact of burnout extending to individuals' personal and professional lives. This led the WHO to define burnout as a phenomenon specific to the occupational setting (Edú-Valsania et al., 2022). Specifically, the WHO (2019) defined it as '…a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed' (P.1). The earliest quantitative studies on the occupational stress experienced by psychologists focused on the work setting and revealed that this engendered a higher level of stress than working privately (Ackerley et al., 1988; Hellman & Morrison, 1987; Raquepaw & Miller, 1989). Subsequently, Vredenburgh et al. (1999) reported similar findings among CoPs.

Research also reveals that psychologists are vulnerable to experiencing burnout due to their frequent exposure to emotive narratives of distress. Several quantitative systematic reviews identified both risk and protective factors linked to therapist burnout (McCormack et al., 2018). For instance, Simionato and Simpson (2019) and Pakenham and Stafford-Brown (2012) explored the prevalence of personal risk factors associated with burnout and found that the most commonly reported factors were age and duration of work experience. Other studies reported similar findings, enhancing the reliability and validity of such research (McCormack et al., 2018; Pakenham & Stafford-Brown, 2012; Simpson et al., 2019).

A cross-sectional study by Crescenzo et al. (2022) investigated the prevalence and predictors of burnout syndrome (BOS) among Italian psychologists. It also explored the differences between emotional exhaustion, depersonalisation and personal accomplishment based on voluntary or non-voluntary work. The findings revealed no statistically significant variations between the two groups. Additionally, psychologists who volunteered from Italian regions most affected by COVID-19 during the first wave exhibited heightened levels across all dimensions of BOS (Crescenzo et al., 2022). Furthermore, Serrao et al. (2022) reported a high

level of burnout in both the personal and professional domains of Portuguese psychologists during the initial phase of COVID-19 lockdowns. In addition, their data suggested that those with children younger than 12 years present at home during lockdown experienced higher levels of stress. The researchers made several recommendations to manage burnout such as emotion management strategies, self-care and mindfulness interventions.

Enduring the COVID-19 pandemic undeniably affected psychologists, and was potentially worsened by the transition to remote work which might have contributed to their experience of burnout. Furthermore, their difficulties might have been intensified by the expected consequences of listening to clients' distress in psychology sessions. Further research will enhance our understanding of the experiences of psychologists, especially CoPs working during the pandemic. The following section proceeds to consider the potentially highly distressing experiences and traumas psychologists were exposed to during the remote home practice adaptation.

Trauma and highly distressing experiences of practice adaptation

The definition of trauma varies across fields and contexts, encompassing a range of experiences. Beyond merely describing trauma, it also shapes individuals' understanding of themselves, relationships, events, and the world around them (Holton & Snodgrass, 2023). According to the American Psychiatric Association (2022), trauma is defined as 'an emotional response to a terrible event such as an accident, rape, or natural disaster', an experience which entails 'actual or threatened death, serious injury, or sexual violence', which are acknowledged as constituting real trauma (American Psychiatric Association, 2022). Another clinically useful definition, found in Webster's dictionary, describes trauma as 'an emotional shock that creates substantial and lasting damage to the psychological development of the individual, generally leading to neurosis; something that severely jars the mind or emotions' (Webster, 1995, p. 1173). Allen (2001) noted that this definition aligns closely with psychotherapy perspectives,

suggesting that trauma is not merely an event, but also a response to it, signifying a lasting adverse reaction to the experience. In academic literature, the terms ‘stress’ and ‘distress’ are frequently used interchangeably. Within the context of this study, distress is defined as a negative, physical and psychological reaction to prolonged environmental and internal conditions, placing a strain on a person's adaptive capabilities (Williams & Huber, 1986).

The COVID-19 pandemic impacted every aspect of human life, including employment, social interactions and finances, resulting in heightened levels of distress and exacerbating mental health issues for individuals and clients (Ren et al., 2020; Wang et al., 2020). Existing literature indicates that up to 80% of psychologists experience a high level of distress from life events and personal challenges at some point during their career (Strohm Kitchener & Anderson, 2011). Moreover, research indicates that a multitude of factors made the adaptation to COVID-19 lockdown practices highly distressing for therapists. The accumulation of these challenges resulted in a certain level of trauma in the midst of a deadly pandemic, where therapists faced the challenge of moving their practice to home environments after abrupt government-mandated lockdowns. The lack of preparedness and guidance served as the initial and profoundly distressing experience for therapists, despite the prevalence of remote work which was still relatively new for many (Flannery et al., 2023; Shklarski et al., 2021; von Below et al., 2023). The transition from conducting therapy in person to delivering it remotely posed a significant source of stress for a large number of therapists. Research reveals that numerous clinicians experienced ‘techno stress’ or ‘Zoom fatigue’ (Wiederhold, 2020) from prolonged use of video platforms such as Zoom, resulting in exhaustion from extensive screen time. Interpreting clients’ body language became challenging, prompting therapists to rely more on observing facial expressions. This increased level of attentiveness further elevated the draining nature of client engagement (Flannery et al., 2023; Shklarski et al., 2021). The COVID-19 lockdown also exacerbated therapists’ distress due to social isolation from their social network

and colleagues, coupled with feelings of loneliness (Hwang et al., 2020; Kluzowicz & Kluzowicz, 2021).

Moreover, working from home meant there was no clear distinction between personal and professional lives. Therapists often found themselves multitasking, doing household chores during work hours, and working or thinking about their clients' traumatic stories during personal time. This blurred boundary between home and work led to therapists experiencing high levels of distress (Baker et al., 2024; Flannery et al., 2023). Several additional factors potentially heightened this such as a lack of space at home for conducting remote therapy sessions for both therapists and clients. Distractions such as the presence of family members, children and pets further exacerbated these challenges, disrupting the therapeutic process and necessitating clarification whilst impacting emotional expression. Even therapists familiar with online therapy encountered significant emotional strain when establishing new boundaries, such as clients refraining from eating during sessions and protecting their own family members from exposure to clients' traumatic experiences in order to maintain client privacy. Understandably, the transition to online practice increased the workload for individuals and had repercussions for the well-being of both therapists and their clients (Baker et al., 2024; McBeath et al., 2020; Shklarski et al., 2021). Moreover, Litam and Balkin (2021) suggested that during the initial phase of the COVID-19 pandemic, physicians experienced a slight rise in trauma levels.

According to the literature, personal distress and vulnerabilities among psychology professionals such as experiencing intense emotions can cultivate empathy towards client issues (Smith & Moss, 2009; Zerubavel & Wright, 2012). However, conducting therapy whilst enduring ongoing personal distress could undermine therapist effectiveness, thereby raising ethical concerns. For instance, prolonged distress may result in professional impairment, manifesting as personal challenges that could compromise the effectiveness of therapy services

or even harm clients (Smith & Moss, 2009). Practitioners who are impaired and distressed might demonstrate inconsistency and incompleteness in their therapeutic delivery (O'Connor, 2001). Therefore, it is essential to understand the impact of distress and trauma on psychologists, as professionals have an ethical responsibility to avoid causing harm, work towards benefiting others and strive for professional excellence (Health Care Professions Council, 2015; Oates et al., 2021).

In summary, the pandemic required therapists to transition to remote therapy, leading to increased levels of stress, distress, and trauma as they adapted to technology, blurred boundaries between work and personal life, and distractions at home. Although therapists continued to empathise with clients, their personal and work-related distress may have impeded the effectiveness of therapy delivery. However, navigating through such high-level distress and trauma can also facilitate positive psychological changes, fostering post-traumatic growth (PTG), an aspect explored in the following section.

Post-traumatic growth

Tedeschi and Calhoun (1996) extensively discuss the negative physiological effects of trauma; yet despite this, some individuals undergo positive transformations as a result. These transformations encompass three overarching themes: personal strengths, interpersonal connections, and a newfound appreciation for life which includes openness to new opportunities and spiritual changes. Building upon this, the concept of PTG developed by Tedeschi and Calhoun (1995) provides valuable insights into the phase of growth and development following trauma. Tedeschi et al. (2018, p. 3) defined PTG as 'positive psychological changes experienced as a result of the struggle with trauma or highly challenging situations'. The COVID-19 pandemic and the adjustment to remote practice posed considerable challenges for therapists. It is conceivable that PTG arising from stressful events such as the pandemic could aid in enhancing individuals' overall adaptation to practice changes. This is

because personal growth can emerge as a consequence of experiencing trauma (Cui et al., 2021). According to Tedeschi and Calhoun (1996), overcoming trauma can cultivate a renewed sense of self-reliance and competence, leading to perceived positive changes within oneself and enhancing confidence in facing future challenges.

Furthermore, traumatic experiences may prompt individuals to reassess their interpersonal relationships, acknowledging their vulnerability and sometimes overlooked importance. Lastly, going through trauma could foster a deeper appreciation for life overall, marking a third dimension of posttraumatic growth (Tedeschi & Calhoun, 1995). Aafjes-van Doorn et al. (2022) examined how therapists responded to the challenges of vicarious traumatisation and transitioning to online therapy during the COVID-19 pandemic, exploring their experiences of resilience and post-traumatic growth. Tracking 185 psychotherapists across four stages of the pandemic, the findings revealed that therapists reported resilience during the early phases of COVID-19. Those who experienced higher levels of trauma and were more at ease with online therapy during the pandemic tended to undergo greater PTG (Aafjes-van Doorn et al., 2022). Furthermore, Jiang et al. (2023) reported that social support indirectly influences post-traumatic growth through resilience, cognitive reappraisal and the cascading effects of psychological resilience and cognitive reappraisal.

The experience of healthcare professionals working during a health crisis

To the best of my knowledge, literature exploring psychologists' experiences in adapting their working practices during the COVID-19 lockdown is limited and there is no literature available on CoPs. Nevertheless, the body of research on the COVID-19 pandemic is steadily growing due to the novelty of the virus. The dearth of research led me to utilise studies on past outbreaks such as Middle-East respiratory syndrome (MERS-CoV), severe acute respiratory syndrome (SARS), and Ebola, as well as more recent epidemics and pandemics. These studies focused on the experiences of applied psychology professions and allied healthcare professionals

(nurses and doctors). The findings from several such studies indicate that changes in work practices resulting from the COVID-19 pandemic negatively impacted the mental health of healthcare workers (HCW), leading to increased levels of anxiety, depression, insomnia, occupational stress (e.g. redeployment, lack of resources, poor organisational support), and somatic and stress symptoms in participants. Young single females from low socio-economic backgrounds were disproportionately affected (Li et al., 2020; Pappa et al., 2020; Rossi et al., 2020; Xiaoming et al., 2020). Further investigation revealed that a large number of HCWs suffered from non-clinically significant exhaustion and chronic pain (Robinson et al., 2015; Teng et al., 2020). Liu et al. (2020) also found that senior male paediatric medical doctors in China exhibited higher symptoms of anxiety, depression and stress. Persistent indicators suggest that poor mental well-being not only impacts individuals on a personal level, but also at a professional level (Brooks et al., 2018; Sage et al., 2018). These findings suggest that the psychological impact observed in HCWs working under adapted practices during a health crisis may also extend to professionals such as CoPs who had to adapt their practice during the COVID-19 lockdowns.

Cabarkapa et al. (2020) conducted a systematic review with the aim of investigating the psychological impact on HCWs facing epidemics or pandemics. The results incorporated comparable clinical conditions (Pappa et al., 2020; Rossi et al., 2020) and revealed that HCWs faced an elevated risk of experiencing trauma and encountering stigmatisation. Although drawing similar conclusions contributes to the reliability and validity of these reviews, it is important to note that these studies predominantly analysed some of the same set of papers, militating against any overemphasis on the findings. Nevertheless, the isolation and fear of uncertainty of contracting the virus experienced by HCWs lay at the forefront of the psychological challenge (Cabarkapa et al., 2020).

Notably, research conducted at the initial phase of the COVID-19 outbreak among HCWs generated analogous outcomes; for example, demographic and occupational factors were found to be significantly linked with negative mental health outcomes. Furthermore, a systematic review by Brooks et al. (2018) identified social and occupational factors affecting the psychological well-being of HCWs during the SARS crisis. Their findings revealed that the psychological impact of SARS on HCWs was linked to occupational roles, level of training and preparedness, exposure to high-risk work environments, experiences with quarantine, role-related stressors, perceived risk, the availability of social support, social isolation, and the influence of SARS on their personal or professional lives. These factors can serve as indicators of the impact exerted on psychologists adapting their working practice to remote online from home during COVID-19 national lockdowns. The analysis of existing literature also revealed that the majority of studies exploring the experiences of HCWs during health crises utilised quantitative methods, including systematic reviews, cross-sectional studies and meta-analyses, employing tools such as surveys and questionnaires.

The focus, however, now turns to the limited qualitative research available on HCWs as this offers a more nuanced and flexible approach which allows for an in-depth exploration of the complex health crisis, capturing insights from participants rooted in the rich context of their experiences of a given phenomenon. For instance, Embregts et al. (2020) studied the experience and needs of direct support staff during the initial days of COVID-19 lockdowns in the Netherlands. The findings indicated that participants encountered emotional, cognitive, practical and professional impacts (Embregts et al., 2020). Similar outcomes were reported in two other qualitative studies, one conducted by Liu et al. (2020) in China and the other by McGlinchey et al. (2021) in the UK. These reported challenges in newly adapted practices, the psychological impact on individual care providers, and the resilience and fortitude demonstrated by such professionals whilst working in the face of danger, despite disparities in

the healthcare systems of both countries. However, alongside their evident strengths, these studies also had a number of limitations. For instance, conducting interviews over the phone meant that the absence of non-verbal cues impeded the ability of the interviewer to build a good rapport with interviewees. In addition, both studies were interdisciplinary and involved multiple professionals; consequently, individual differences between professionals were not identified.

It could be argued that the findings appeared to be similar because both studies were conducted during the early phase of the COVID-19 lockdown. However, a retrospective qualitative study conducted five years after the Ebola epidemic (Locsin et al., 2009) to capture the experiences of nurses caring for patients dying from the virus in Uganda exhibited commonality with these findings. Thus, it can be inferred that CoPs adapting their practice remotely from home may have undergone similar psychological challenges, as observed in the studies by Liu et al. (2020) and McGlinchey et al. (2021). I will now consider literature on the experience of remote practice adaptation by psychologists.

The experience of practice adaptation by psychologists during a health crisis

Qualitative research aimed at phenomenologically understanding psychologists' experiences of adapting their working practices during a health crisis has generally been limited. Moreover, there is a significant lack of research specifically addressing the first-hand experiences of CoPs. In the initial phase of the COVID-19 pandemic, a qualitative study conducted by Embregts et al. (2020) explored the experiences of psychologists working with intellectual disabilities. The thematic analysis performed by the researchers unveiled three themes: working from home, adapting to the new reality, and advising and coaching support staff. This particular study highlighted the challenges faced by psychologists working remotely from home and striving to support service users at a service base. In another study, Gregson et al. (2022) explored psychologists' experiences in UK intellectual disabilities services during the third lockdown,

focusing on service delivery and its impact on the psychological well-being of people with learning disabilities (PWLD). Three superordinate themes were identified: delivering psychological well-being, the well-being of PWLDs, and learning and future practice. The first theme captured adaptations to practice and the impact on participants' personal and professional lives. This involved evaluating the accessibility and acceptability of the new ways of working, the questioning of their professional identity due to changes in roles and values within the profession, and acknowledging the loss of a team connection with colleagues, especially given the absence of informal interactions. At a personal level, participants highlighted their shared experience of living with the virus and the challenges of separating private life from professional responsibilities such as managing childcare whilst working from home. The second theme, the well-being of PWLDs, highlighted the resilience of PWLDs and the inequality they faced. The third theme, focusing on learning and future practice, underscored the importance of reducing discrimination and enhancing inclusivity (Gregson et al., 2022). In a subsequent study, Geraldina et al. (2023) explored the challenges faced by psychologists in Indonesia in adapting their working practices online. The researchers identified six key challenges in delivering mental health services online: namely, engagement difficulties, distractions, boundary maintenance, confidentiality concerns, efficacy assessment, and understanding attitudes towards online sessions.

Furthermore, during the third lockdown, Chemerynska et al. (2022) explored the experiences of clinical psychologists (CPs) working with individuals with intellectual disabilities. The analysis identified two overarching themes. The first of these, 'Survive or Thrive', highlighted the emotional intensity and challenges faced by CPs as they adapted their practices. The blending of work and home boundaries proved to be a hindrance, gradually encroaching on their personal lives and complicating their ability to navigate challenges. Nevertheless, despite these difficulties, some psychologists thrived, demonstrating adaptability and even uncovering

unexpected benefits arising from the sudden onset of the pandemic. The second theme highlighted CPs' perception of their patients as neglected and overlooked within society. The findings revealed how adept CPs were in adapting to exceptionally challenging situations (Chemerynska et al., 2022). Daplyn's (2021) research focused on the experiences of transactional analysis therapists who worked through the COVID-19 pandemic. The study asked them about their experiences before, during, and after the UK lockdown, the aim being to understand how their feelings and work changed at different stages of the pandemic. Three main themes emerged from the analysis: Physical Safety Concerns and Evoked Feelings, which relate to the personal impact of the pandemic on therapists; and Preparedness, Changed Relationship with Clients, and Professional Empowerment, which relate to both the gains and losses associated with the professional impact. Aligning with the research questions, the findings were structured along a timeline of the pandemic. What sets this research apart is its focus on understanding therapists' experiences by exploring their thoughts and feelings across three pivotal phases: the period preceding the first official UK lockdown, the shift to online work following the lockdown announcement, and the evolving sentiments of therapists as the pandemic unfolded.

In another qualitative study, Morgan et al. (2022) explored the experiences of therapists who delivered remote psychotherapy during the COVID-19 pandemic as part of breast cancer services. The data were collected between the second and third lockdown period, which meant that participants encountered periods of both easing and subsequent tightening of COVID-19 lockdown restrictions. Three themes emerged from the data analysis. The first was 'Coping with COVID: from crisis to a new way of working'. This theme captured participants' experiences of upheaval due to the pandemic and the impact on their personal and professional lives. It also illuminated how they navigated through the initial shock of the transition and devised strategies to deliver optimal services despite challenging circumstances. As

participants adjusted, they began envisioning the potential characteristics of a new normal. The second theme, 'Remote working real therapy?: adjusting to novel barriers in therapeutic practice' centred around the challenges therapists encountered during practice adaptation from their normal way of working to a novel way of remote working from their homes. This shift posed a challenge to their professional identities, reshaping their understanding of how they, as therapists, should deliver therapy. It elucidated how confidence in their abilities and the techniques they had traditionally relied upon were impacted. Participants' reactions to this challenge differed, as a lack of prior experience or professional guidance meant they relied on their personal values and resourcefulness. The third theme was 'Making connections through technology: the impact of technology on the therapeutic dynamic'. Here, participants identified that establishing a personal connection with their clients was a key aspect of delivering high-quality therapeutic works. They detailed the profound effect of integrating technology on this connection and emphasised how its impact on the therapeutic dynamic fundamentally altered their therapy experience. The researchers concluded that consideration should be given to the impact of remote working on therapists and the quality of their practice. They argued that adjustments to ways of working could help to enhance the benefits of remote working whilst minimising potential issues (Morgan et al., 2022).

Morgan et al.'s (2022) study contributes crucial insights to the body of COVID-19 research, pertaining specifically to the adaptation of practices during the later lockdowns. The emphasis lay on qualitatively exploring the lived experiences of therapists, focusing on their professional identity and how they extended this to remote online platforms. For this study, interviews with clinical psychologists, Macmillan psychologists, psychotherapists and a counsellor were conducted. Their professional identities revealed slight nuances, with each profession incorporating distinct training, methodologies and therapeutic modalities within its specific professional framework. Participants' levels of experience ranged from newly qualified to

highly experienced with extensive years of practice. Moreover, variations emerged regarding their length of service and the levels of seniority they held within the field. All these factors probably affected the experience of remote practice adaptation for these participants. Furthermore, the participants had experience with a specific physical health condition (breast cancer); thus, the researchers recommended that future research be conducted to explore different client groups working with different modalities.

Discussion and conclusion

To conclude, a review of the literature surrounding CoPs' experience of COVID-19 lockdown practice adaptation from home revealed that the body of research on pandemics is steadily growing due to the novelty of the virus. The dearth of literature, specifically on CoPs, necessitated the utilisation of research on applied psychology professions and allied health professionals during both current and past epidemics and pandemics. The existing literature on HCWs indicates that an adaptation in working practice during an epidemic or pandemic can adversely affect the mental health of workers, resulting in elevated levels of anxiety, depression, insomnia, occupational stress, somatic, trauma and stress symptoms among participants (Li et al., 2020; Pappa et al., 2020; Rossi et al., 2020; Wu et al., 2009; Xiaoming et al., 2020). Furthermore, those in senior positions encountered heightened levels of anxiety (Liu et al, 2020). Moreover, Brooks et al. (2018) found that the psychological well-being of HCWs working in a health crisis was associated with various factors such as their job roles, training level, preparedness, exposure to high-risk environments, quarantine experiences, role-related stressors, perceived risk, availability of social support, social isolation and the impact of SARS on their personal and professional lives.

The analysis of existing literature also revealed that most of the earlier COVID-19 pandemic research was quantitative, centred around the exploration of experience, the impact on HCWs, enhancing mental well-being and the improvement of support provided to staff. It

predominantly subscribed to a positivist ontology which assumes that experience is an objective reality that can be discovered through empirical testing (Li et al., 2020; Liu et al., 2020; Pappa et al., 2020; Rossi et al., 2020). The positivist paradigm in which this is situated conceptualises the relationship between the researcher and participant as dualist and objective, which may be construed as a reductionistic approach to research within the discipline of counselling psychology (Langarizadeh et al., 2017; Ponterotto, 2005). Whilst CoPs broadly operate within the NHS setting, they employ clinical approaches and evidence-based knowledge utilised in the medical model. This understanding provides an incomplete overview rather than full and comprehensive insights into the perception of HCWs, yet CoPs also strive to understand the subjective experiences of participants (Murphy, 2017). Therefore, a recognition exists that qualitative research will offer a more comprehensive and profound insight into the lived experiences and meaning making of individual participants (Smith et al., 2022). This is in line with the hermeneutic phenomenological approach employed in this study to explore the experience of CoPs adapting to their new practice from home due to COVID-19 pandemic lockdown restrictive measures, a detailed discussion of which can be found in the methodology chapter.

The literature review highlighted several qualitive studies conducted on HCWs during the early phase of the pandemic. For instance, Embregts et al. (2020) found that adapted practice during COVID-19 lockdowns in the Netherlands impacted staff emotionally, cognitively, practically and professionally. Liu et al. (2020) examined the experience of HCWs during the COVID-19 pandemic in China. Both studies used thematic analysis to analyse their data. A UK-based study conducted by McGlinchey et al. (2021) generated similar outcomes, including challenges faced during the newly adapted practice, the psychological impact on care providers and the resilience demonstrated by HCWs when working with danger. The researchers broadened the scope of their study to explore the experience of a wider range of HCWs by including

paramedics, nurses, mental health and social care workers in their sample. This study was therefore highly inclusive, encompassing a diverse group of professionals. However, capturing interprofessional differences within such a varied sample group could pose a challenge.

Notably, the body of qualitative literature exploring psychologists' experience of practice adaptation from home during COVID-19 is steadily growing. Embregts et al. (2022) and Gregson et al. (2022) both investigated the experiences of psychologists working with individuals with intellectual disabilities during the initial phase of the COVID-19 lockdown in the Netherlands and the UK, respectively. Both used thematic analysis to analyse the data, based on which Embregts et al. (2022) identified three themes: (1) working from home; (2) adapting to the new reality; and (3) advising and coaching support staff. However, these themes were extremely vague and initial practice adaption involved the experience of intense negative emotions such as guilt and anxiety and dealing with clients' challenging behaviour due to restrictive lockdown measures. A notable limitation of the study was that data were collected using audio recordings, which prevented the researchers from asking follow-up questions to expand on certain topics, perhaps accounting for the vagueness of the themes. In the study conducted by Gregson et al. (2022), three themes were identified: (1) delivering psychological service; (2) well-being of PWLDs; and (3) learning and future practice. The first theme captured important data about the practice adaptation of psychologists and the multitude of newness they experienced, as well as multiple losses (team, social connections, professional identity, etc). Both CPs and CoPs participated in this study. Because these studies employed thematic analysis, the emphasis was on identifying patterns and exploring surface-level content. By contrast, I wished to delve more deeply into the richness of participants' experiences. Therefore, I felt IPA would be more appropriate for the purpose of my research.

Chemerynska et al.'s (2022) research aimed to understand the experience of CPs working with an intellectual disabilities client group, using IPA to analyse the data. The findings suggested

that psychologists have the ability to adapt to extremely challenging circumstances. Similarly, Daplyn (2021) examined how transactional analysis therapists adapted during COVID-19, capturing their experiences before, during, and after the UK lockdown. Three main themes emerged: personal impacts such as safety concerns, and professional shifts including changes in client relationships and empowerment, analysed across different stages of the pandemic. In so doing, they provided insights into therapists' evolving experiences and emotions throughout the crisis. Applying the same method of data analysis to a sample of applied psychologists, counsellors and psychotherapists, Morgan et al. (2022) highlighted the importance of assessing the impact of remote working on therapists and the quality of their practice. The researchers suggested that adjustments to ways of working can help to optimise the benefits of remote work whilst mitigating potential challenges.

Furthermore, despite advancement in research on the experience of HCWs working during the COVID-19 pandemic, few studies have phenomenologically explored the experiences of psychologists adapting their working practice during a health crisis. There also appears to be a notable scarcity of research specifically examining the first-hand experiences of CoPs. This represents an important gap in the research with respect to the lived experiences and emic perspective of CoPs adapting to their practice during the COVID-19 lockdowns.

Research rationale

The implementation of COVID-19 lockdown remote practice adaptation presented a multitude of challenges for applied psychology professionals, as evidenced in the literature, inducing extreme levels of distress and trauma as they modified the delivery of therapy using remote online mediums. This impact was experienced in multifaceted ways in both their professional and personal lives as the segmented boundaries of each domain started to dissolve and integrate, as outlined by boundary theory. Psychologists entered unfamiliar territories by adopting a mode of working they had not initially endorsed. As someone who highly

appreciates the importance of uniqueness and subjectivity of individuals, the principles upheld by CoPs are of particular importance to me. However, the literature review highlighted a significant gap with respect to the voices of CoPs. In alignment with the values of my profession and my epistemological stance, I believe it is essential to understand the individual and their experience in context. Therefore, the purpose of my study was to conduct a more extensive exploration, encompassing the perspectives of CoPs and providing them with the opportunity to openly share their in-depth experiences. Furthermore, a pluralistic approach to clinical practice is central to the identity of CoPs (Murphy, 2017); therefore, it is important to develop an understanding of their idiosyncratic experiences in adapting their practices during lockdown. My research was designed to make a beneficial contribution to the field of counselling psychology by adding to existing knowledge on the practice adaptation of CoPs during the COVID-19 pandemic. I anticipate that the findings will enhance individual resilience by facilitating quick adjustments by CoPs, not only in their professional lives, but also in their personal lives in response to unexpected life adversities or adaptations made necessary by emergency health crises. This underscores the notion that cultivating positive outcomes can be feasible, even in the aftermath of highly challenging events.

Research aims

The aim of this research was to explore CoPs' experience of practice adaptation from home during government-imposed lockdowns amid the COVID-19 pandemic. It employed data collection methods that facilitated an exploration of the lived experiences of CoPs, taking into account ontological and epistemological positions that acknowledge participants' relatedness to the world. Consequently, the emphasis lay on contextualising their experiences within the intersubjective process of meaning-making between the researcher and the participant.

Research question

1. What is the lived experience of counselling psychologists adapting their working practices in response to the government imposed national COVID-19 lockdown measures in the UK?

Chapter Three

Methodology

Chapter Overview

This chapter outlines the methodology I employed to address the research question presented in the previous chapter. I begin with an examination of the research question, the aims of the research, and their underlying assumptions. Following this, I present my rationale for adopting a qualitative research methodology, specifically interpretative phenomenological analysis. Within this context, an in-depth description is provided of my philosophical position, comprising an examination of both my epistemological and ontological stance. I then present a comprehensive overview of the data collection process, detailing the criteria for participant selection and describing in depth the analytical process and procedure. The chapter also includes a reflexive section, an important component of the qualitative methodological process and concludes with a discussion of the ethical considerations of the research.

This chapter is written in the first person, reflecting my personal epistemological standpoint. Specifically, I embraced an interpretative phenomenological position, highlighting my active involvement and thorough immersion in the research process.

Rationale for Using IPA

The aim of this study was to gain a deeper understanding of the lived experiences of CoPs who had to adapt their working practices during the national COVID-19 lockdowns in the UK. My principal objective was to gain a thorough understanding of the lived experiences of individual CoPs in an effort to understand the phenomenon itself rather than focusing on any specific laws or processes governing their reported experiences. To the best of my knowledge, no other studies have addressed the experiences of CoPs engaged in practice adaptations during the recent or any past epidemic/pandemic. Given this gap, it appeared appropriate to choose a

methodology that could examine this phenomenon through a lens focused on lived experiences. This research therefore utilised an exploratory and qualitative stance to capture the complexities and nuances present in data on the lived experiences of CoPs engaged in practice adaptation during COVID-19 lockdowns.

Motivated by my role as a scientist-practitioner, my choice of epistemological position was guided by the type of research I was seeking to produce and my desire to explore my personal perspectives on the nature of reality and subjectivity. Morrow (2007) suggested that aligning the choice of paradigm and method with practice is essential, particularly in the field of counselling psychology. Therefore, during the early stages of formulating this project, two approaches, narrative analysis (NA) and phenomenology, were considered before ultimately selecting IPA as the qualitative framework that best fits and addresses my research question (Willig, 2012).

I initially explored the option of using NA because of its emphasis on language in exploring human experiences. As a researcher, this would involve examining how CoPs narrated their practice adaptation experiences through meaningful stories and to 'impose order on the flow of experience' in order to derive meaning from events and actions in their lives and weave their experiences into a cohesive narrative (Willig, 2012, p. 430). However, I recognised some tension between my interpretative phenomenological stance, which is underpinned by a critical realist (ontology) and NA's social constructionist orientation. The latter suggests that whilst the construction of meaning is not entirely separate from social contexts, it maintains that subjective reality is not shaped or influenced by broader social and material structures. Additionally, the primary focus of NA appears to be on the social aspects of storytelling, specifically the delivery narrative, rather than on the individual lived experience of a particular phenomenon. I decided that utilising a phenomenological approach would be the most suitable method for focusing on the subjective meaning of the experiences of CoPs adapting to changes

in their working practices during the COVID-19 pandemic. Moreover, phenomenology has the potential to provide rich, thorough, and comprehensive descriptions of the explored phenomenon (Pietkiewicz & Smith, 2014).

Ontological and Epistemological Considerations

Ponterotto (2005) referred to the philosophical roots underpinning the quest for knowledge. He argued that a philosophical and conceptual framework can provide a guide that the researcher adapts with regard to methodology and the research process. Ponterotto emphasised that ontology is a division of philosophy and corresponds with the theory of the nature of reality, whilst epistemology is concerned with the study of how knowledge is acquired (Willig, 2013). From the outset of the research process, it is considered essential to identify the researcher's own epistemological position. Such a position is 'characterised by a set of assumptions about knowledge and knowing' (Willig, 2012, p. 5) which can be identified through philosophical reflection. Identifying one's personal epistemological position from the beginning of the research guides the analytical process of the enquiry and supports the evaluation process.

My epistemological stance is interpretative phenomenological, through which I seek to understand the reality experienced by participants and their relatedness to the world by exploring their unique personal accounts and experiences through the process of intersubjective meaning-making, rather than a process of discovery (Larkin & Thompson, 2012). I acknowledge that, as a researcher, it is not possible for me to have direct excess to an individual's experiences; hence, it is imperative to actively participate in a reflective and relational process of understanding and making sense of others' meaning-making about the world.

My ontological assumptions about the nature of reality and the essence of being human are that each individual is acknowledged as a unique entity, constructing their own distinct worlds.

From an ontological standpoint, I recognise that there is a real phenomenon to explore with regard to each research participant, one that exists independently of my perception and is solely observable and experiential through my individual standpoint, perspective, and interpretation (Maxwell, 2012). This aligns with my critical realist position which seeks to uncover the underlying levels of reality that might not be immediately observable, but nonetheless impact an individual (Bhaskar, 1975). The phenomenological view is that what appears to be the same may be experienced differently by individuals; for example, diagnosis or loss, implying 'there are potentially many (experiential) worlds as there are individuals' (Willig, 2012, p. 18). As an integrative psychologist, this aligns with my own perspective in which I prioritise the individuality and subjective experience of a person over adopting a standardised approach.

Overview of IPA and Rationale for Choosing this Methodology

I chose IPA as the method that was most suitable for addressing my research question. IPA, a qualitative method grounded in health psychology, is extensively employed in psychological research, particularly in the field of counselling psychology (Larkin et al., 2006). As articulated by Smith et al. (2009), IPA aims to explore how individuals make sense of their own lived experiences, primarily by considering the influence of their social, political, and cultural contexts, as well as the meanings they attribute to them. It is also an inductive method, focusing on perception and experiences to facilitate the emergence of data from the analysis, as opposed to establishing the veracity of conclusions based solely on the truth of statements (Larkin & Thompson, 2012).

IPA aligns with the counselling psychology discipline which, rooted in humanistic values, places a strong emphasis on subjective and intersubjective experiences. Counselling psychology acknowledges individuals as unique beings situated within relational and social contexts (Cooper, 2009). Furthermore, it prioritises the importance of meaning-making over a perspective centred on psychopathology (Milton, Craven & Coyle, 2010).

Theoretical Foundations of IPA

This method is guided by three philosophical principles: phenomenology, which involves delving into unique lived human experiences; idiography, encompassing a comprehensive examination of the individual; and hermeneutics, which focuses on the theory of interpretation (Smith et al., 1995).

Phenomenology

IPA originates from phenomenology, a philosophical approach introduced by Husserl (1970) that is concerned with the study of human experience (Husserl, 1970; Larkin & Thompson, 2012; Smith et al., 2022). Husserl was interested in discovering how individuals could accurately understand their own experiences of a specific phenomenon as they unfolded through consciousness. This understanding, pursued with depth and rigour, would enable them to identify the essential qualities of that particular experience. If accomplished, this would 'transcend the particular circumstances of their appearance and might then illuminate a given experience for others too' (Smith et al., 2022, p. 8). Husserl critiqued the view of psychology as a 'science' and the application of natural science methods to human issues, emphasising the neglect of context. He proposed a new science of being through phenomenology, one that strives to understand the subjective experiences of research participants (Laverty, 2003; Willig, 2012). The purpose is to understand experiences as they are disclosed, without becoming overly concerned with the accuracy of their representation or the causes underpinning psychological events. The researcher immerses themselves in these experiences, entering the subjective world of participants by interpreting how they make sense of such experiences (Willig, 2012). The initial phase of phenomenology, rooted in a transcendental stance based on Husserl's ideas, aims to uncover the essence of conscious experience. This encompasses the experiential content prior to thoughts, meaning-making, and interpretation. The process requires bracketing pre-existing knowledge and experience to eliminate preconceived assumptions about the

world, allowing for a clearer understanding of the core essence of the phenomena (Langdridge, 2007).

The next phase of phenomenology was articulated by Heidegger, Merleau-Ponty, and Sartre, who shifted away from the transcendental stance and embraced an existential and hermeneutic positioning, acknowledging that a reduction to an essential core of a phenomenon was not achievable because observations are inherently grounded in the lived world. More specifically, Heidegger questioned the possibility of attaining knowledge without adopting an interpretative perspective, emphasising its inseparable connection to individuals, relationships, culture, and language. Being-in-the-world is always perspectival, temporal, and in relation to something (Smith et al., 2009). Merleau-Ponty (1962) suggested that individuals who exist as bodies in a world of other bodies gain a sense of themselves and their surroundings through their unique embodied perspectives and shared experiences with others, thus highlighting the crucial role of intersubjectivity and relatedness. Sartre's (2003) existential phenomenology delves into the nature of existence, viewing the self as an ongoing project of continual self-becoming, signifying a perception that our existence in the world is constantly evolving. Consequently, the process of meaning-making unfolds concurrently for both the researcher and the participant through the dual hermeneutics of an empathetic understanding of the participant's viewpoint, alongside questioning aspects of their narratives of which they may not be fully aware (Smith et al., 2009).

In addition to phenomenology, IPA's second major philosophical underpinning describes the theory of interpretation which has roots in hermeneutics (Smith et al., 2009).

Hermeneutics

Hermeneutics is a process in which the researcher actively engages in intimate interpretative procedures, aiding the comprehension of a phenomenon as it develops and consistently

interpreting what emerges throughout the analysis (Heidegger, 1962; Smith, 2022). This is undertaken whilst being mindful of their own prior experiences, assumptions, and preconceptions. Because it is not possible to fully understand the meanings participants construct about their experiences, the researcher's own perspectives become essential for making sense of and interpreting their personal worlds (Smith & Osborn, 2003). Within IPA, the process of interpretative analysis involves researchers striving to make sense of participants trying to make sense of their interpretations, which constitutes the double hermeneutic process (Smith et al., 2022).

Smith et al. (2009) referred to the 'hermeneutic circle' which postulates two types of process: first, between part and whole, and second, between the researcher and participant. The authors explained the dynamic relationship between the part and the whole as entailing a cyclical process of repetitive engagement with the aim of understanding the part, which is a single word, extract, or episode, by seeking the whole, which could be a sentence, the entire text, or their whole life. Simultaneously, it also seeks to understand the whole by looking at the part. Additionally, the analytical process in IPA acknowledges the importance of interpretation and recognises that bracketing is not something that can be fully achieved, thus IPA analysis will always be subjected to the influence of the researcher.

Idiography

The third major theoretical influence on IPA is idiography, an approach concerned with particulars rather than general laws of human behaviour obtained by averaging individual variation. It aims to understand an individual case, offering a nuanced, in-depth study of particular lived experiences before advancing to the examination of similarities and differences across cases. Thus, allowing for the personal accounts and patterns of meaning for participants has the capacity to reflect shared experience with an idiosyncratic flow (Smith & Eatough, 2007; Willig, 2013).

Research Method

For the remainder of this chapter, I outline the steps taken to collect data from participants that would effectively give voice to their experiences through a suitably phenomenological and interpretative account of their stories. I also offer my reflections on the conceptual and practical challenges I encountered, with the aim of providing a transparent account of my research journey during the execution of the study design, as well as in the collection and analysis of data (Tuffour, 2017).

Sampling Method

I utilised purposive sampling, a method commonly employed in IPA research (Smith et al., 2009), to select my participants. The key criterion for participant selection was their suitability to provide insights into the phenomena being studied. Consequently, to meet this condition, I defined the inclusion criteria, stipulating that participants needed to be CoPs who had experience of adapting their working practices during government-imposed COVID-19 national lockdowns in the UK. When using IPA, the aim is to recruit a fairly homogenous sample for whom the research question will be meaningful (Smith et al., 2009). CoPs typically work predominantly in-person within the NHS setting and in private practice. This makes them particularly interesting to study when exploring how working practices have adapted in response to the challenges posed by the COVID-19 pandemic.

According to Pietkiewicz and Smith (2014), the level of homogeneity within a purposively selective sample depends on two key factors: interpretative concerns and pragmatic considerations. Pragmatic considerations encompass how easy or challenging it is to reach out to potential participants and the extent to which the phenomenon being studied is uncommon or widespread. Additionally, the subject matter itself can shape the boundaries of the relevant sample (Pietkiewicz & Smith, 2014; Smith et al., 2022).

In my study, several factors played a role, including a pragmatic decision regarding the timing of sample recruitment during the easing of the COVID-19 third lockdown. The topic of my study, focusing on CoPs and their experience adapting to COVID-19 lockdown practices, was relatively new in research. Consequently, participant availability was limited at the time of the interviews due to them readjusting to in-person work at their service base. This scarcity directly influenced the selection of my participants.

To address this challenge, I adapted a pragmatic approach and decided to explore the experiences of CoPs who were two years post-qualification. However, since my research question focuses on experience, it was crucial to ensure a robust study by including CoPs with varying degrees of experience across different therapeutic modalities, contexts, roles, and levels of risk in clinical work.

In future studies, researchers can be more selective about the factors considered for homogeneity and prioritise the dimensions of the experience deemed most significant. Additionally, they can explore other dimensions of the experience that warrant further investigation.

Inclusion/Exclusion Criteria

All participants had at least two years of post-registration experience as CoP and changed their work practice so that it was conducted from home during all three government-mandated COVID-19 national lockdowns in the UK (March 2020, November 2020, and January 2021). Thus, anyone with less than two years post-registration and those who had not changed their working practice during lockdown were excluded from this study. The rationale for the former recognises themes in the existing literature such as anxiety which might emerge, but could be linked to the challenges of being newly qualified rather than the specific experience of adapting to work and a health crisis (Avieli et al., 2016). The latter aimed to enhance homogeneity and

tap into the experience of those CoPs who underwent practice adaptation across all three COVID-19 lockdowns in the UK. Participants with at least two years of post-qualification experience were engaged in either private practice, the NHS, or both. I therefore verified whether participants met the eligibility criteria for participation. Additionally, I confirmed their registration with professional bodies, namely the British Psychological Society (BPS) and the Health & Care Professions Council (HCPC).

Recruitment Strategy

To ensure a purposively selected sample, I contacted the British Psychological Society's Division of Counselling Psychology so that I could promote the study via their online newsletter. I provided my contact details and the advertisement for my study, along with ethical approval and the participant information sheet that outlined the purpose of the research (Appendix 5). Both the study advertisement (Appendix 3) and participant information sheet (Appendix 2) included my contact details, allowing participants to get in contact me if they wanted additional information. Recruitment also occurred through social media (specifically, Facebook counselling psychology forums) and professional networks. Colleagues in the profession volunteered to share my advertisement with their private contact lists of CoPs, resulting in interested individuals seeking to participate in the study. I sent the participant information sheet to these parties and offered to participate in telephone calls if they required any further explanation of the research.

Interview Procedure

I received seven responses from CoPs who were suitably qualified and met the necessary criteria for participation. I communicated with all prospective participants who expressed an interest via email then mobile channels. Subsequently, I disseminated the recruitment advertisement and asked them to respond if they wanted to participate. All participants were then interviewed online through Microsoft Teams.

One interview was a pilot; the data from this participant were not included in the data analysis, as this was a trial process conducted to resolve any issues. No modifications were required to the interview schedule based on the feedback from the pilot interview. Nevertheless, the latter served as a helpful learning experience for me as a researcher, providing valuable insights into the set-up of online interviews and enabling me to adapt to the role of a researcher.

All interviews were conducted between May 2022 and June 2022, in accordance with Smith's (2009) guidelines for phenomenological research. Single semi-structured interviews each lasting approximately 40 to 60 minutes were conducted with six participants who had adapted their working practices. I intentionally kept participants' demographic information to a minimum so that they could not be identified from such information or when considered together with their words during the interviews. The interview questions were open-ended and non-directive, with a specific focus on discussions around their understanding and experience of practice adaptation during COVID-19 lockdowns (Appendix 6). Of the six participants involved, two described their gender as male and four as female.

Each participant demonstrated attentiveness during the interview and shared their accounts, recounting their experiences, thoughts, and feelings about adapting their working practices during lockdowns - the central focus of this research. This idiographic focus helped enlighten the complex cognitive and emotional process these CoPs faced in adapting their working practice from home, whilst simultaneously adjusting and managing their personal lives. Hence, the benefit of the targeted sample lay in its ability to focus on this specific group - CoPs - who shared their experiences of adapting their work practices during lockdowns.

Table 1 - Introducing the participants demographic information

Participants (CoPs)	Gender	Age Range	Years Worked as Therapist	Number of clients seen in typical week	Number of people living in household during lockdowns	Remote lockdown adaptation of private / NHS practice	Job Role
James	M	55 - 60	4	16	3	NHS Practice	CoP
Sarah	F	50 - 55	16	15	4	Both	Management/ Senior CoP
Adam	M	40 - 50	4	25	3	Both	CoP
Shanti	F	40 - 45	11	10	4	NHS Practice	CoP
Helen	F	50 - 55	14	10	2	Both	Senior CoP
Eva	F	40 - 45	19	6	3	NHS Practice	Management/ Senior CoP

Data Collection

The desired method for qualitative data collection is that of semi-structured interviews (Reid et al., 2005). This method is considered to allow the fluidity required to gain access to novel facets of experience (Smith et al., 2009). According to Rapley (2001), researchers using IPA do not view interviews as an impartial and unbiased method for collecting data. The researcher seeks to work with the participant collaboratively and flexibly, identifying and interpreting the relevant meanings that are utilised to make sense of the particular phenomenon (Reid et al., 2005, p. 4). During the interview, the researcher fosters a rapport with the participant, providing a conducive environment for the expression of their beliefs and ideas through thorough discussion. Interactionally, both the participant and the researcher play active roles in the research process (Smith et al., 2009, p. 52). CoPs work with certain values and in a way that is client centred, being inclusive and adaptive to their needs. However, my epistemological stance

required me to elicit each participant's unique experience of practice adaptation during COVID-19 lockdowns and gain an understanding of how they make sense of these experiences.

Confidentiality

Participants were informed of the study's commitment to confidentiality and ensuring their privacy through the anonymisation of their data. Pseudonyms were assigned to participants to safeguard confidentiality and audio recordings were kept on a password-protected laptop device and in their verbatim form.

Data Analysis

This section provides an overview of the analytical process undertaken following the data collection stage. I conducted data analysis using IPA and, as a novice with respect to using this method and qualitative research, closely adhered to the seven recommended steps of the analytical process (Smith et al., 2022). I provide an outline below of how I engaged in the process of analysis, offering both a description and reflexive observations.

Step One: Reading and re-reading

As suggested by Smith et al. (2022), I began this stage by immersing myself in the original data. This involved reading and re-reading the transcripts in order to fully engage in the experiential worlds of the participants. I read each transcript whilst listening to the video recording of the interview, taking into consideration the tone of voice, volume, facial expressions, and silences. This allowed me to reconnect with each participant by recalling details related to their interviews (Pietkiewicz & Smith, 2014). For example, when the participants expressed joy or sadness, this helped me during the analysis stage. I also noted my own role as an interviewer, how I managed to handle the semi-structured format, the open-ending process of following the participant's sense-making, whilst always ensuring I remained focused on the key questions pertaining to my study and the phenomenon being investigated.

Step Two: Exploratory noting

During this stage of analysis, I presented the data in a table format with two columns. In the first column, the original transcript was presented. In the second column, labelled 'exploratory noting', I engaged in an exploratory-level analysis of participants' use of linguistic content, their descriptions of their experiences, and conceptual comments. I maintained an open mind throughout, documenting any noteworthy findings in the transcript (Smith et al., 2022).

Step Three: Constructing experiential statements

At this stage of the research, the emphasis was on reducing the volume of detail by diverting the focus away from the transcript and relying on the insights gathered through exploratory notes (Appendix 9). This aided in consolidating meaning and allowed me to preserve both complexity and depth as I progressed to the development of 'experiential statements', considering key factors such as their frequency in the data, the richness of the text, and their capacity to elucidate what appeared to be significant aspects of participants' experiences. Themes were expressed as phrases, preserving psychological meaning and establishing a connection between the participant's original words and thoughts and my own interpretations (Smith et al., 2022).

Step Four: Searching for connections across experiential statements

At this stage of analysis, after identifying all the experiential statements in each participant's account using a manual cut-out method and placing them randomly on a large horizontal table, I rearranged them until connections were identified, enabling me to ensure they were appropriately grouped (Appendix 12). This was conducted in line with Smith et al.'s (2022) method for identifying connections and patterns among experiential statements, including abstraction, subsumption, polarisation, and contextualisation. Furthermore, this exploration involved assessing whether certain statements could be merged into other experiential

statements or whether they should be excluded. The decision was influenced, to some extent, by the broader research question and its scope. Following this, the aim was to choose an overarching statement name that captured the salient aspects of participants' experiences, effectively representing the entire data set (Smith et al., 2022). During this stage, I created a Microsoft Word document to assist me in organising the experiential statements.

Step Five: Naming, consolidating, and organising the personal experiential themes

At this stage in the clustering process, experiential statements that shared a connection were grouped together into larger clusters named Personal Experience Themes (PETs). After organising the experiential statements in a meaningful manner, this arrangement formed the basis for creating a table that encapsulates all the identified themes, referred to as the PET Table.

Step Six: Continuing the individual analysis of other cases

At this stage, steps one to five of the analytical process were repeated for each participant's account. I approached each individual case independently, aligning with IPA's idiographic commitment, viewing each as a distinct universe of inquiry and allowing for the emergence of new analytical entities with each case (Smith et al., 2022).

Step Seven: Working with personal experiential themes to develop group experiential themes across cases

The final step involved exploring patterns of similarity and differences across the PETs, leading to the creation of a set of Group Experimental Themes (GETs) (Appendix 10, 11). The primary objective was not to establish a 'group norm', but through cross-case analysis to emphasise both the shared and unique features of the experiences among the contributing participants. Finally, I created a Microsoft Word table of Group Experiential Themes.

Ethics

I obtained ethical approval for this study from the University of East London Ethics Committee (Appendix 1). To achieve this, I abided by the key principles of ethical research provided by the British Psychological Society Code of Practice for Research Ethics and Conduct (2021) and the University of East London (UEL) Code of Practice for Research Ethics (2020). These standards prioritise the protection of participants' rights, ensuring the preservation of their privacy, dignity, and overall well-being. Additionally, the Code of Human Research Ethics (BPS, 2021) outlines standards for psychologists to follow when conducting research with UEL. Furthermore, I considered the guidelines for working with participants amid the COVID-19 pandemic, remaining cognisant of the potential additional stressors that participants might have encountered during this challenging period (BPS, 2021).

I familiarised myself with the practices involved in conducting qualitative research and sought advice from my research supervisor to ensure that this study met the required quality standards and adhered to the guidelines set by UEL. In conducting the research, I sought to uphold an understanding of, and guide the approach in accordance with, the aspects covered by the ethical approval. Participants were given an information sheet containing details and the rationale for the study, outlining what was expected of them, along with information on how their data would be utilised and anonymised. It also included information on their option to withdraw from the study, along with contact information for both the researcher and supervisor (Appendix 2). Every participant was sent an email consent form (Appendix 4), their signature on which would confirm that they had read the information sheet associated with the research study. It also indicated that they had been adequately informed of the nature and objectives of the research. Furthermore, participants were given the opportunity to ask questions, ensuring their comprehension of the proposed study and the procedures in which they would be involved.

In line with BPS (2021) guidelines, I ensured that I maximised benefits and minimised harm throughout the research. I understood that some participants, particularly those who had experienced bereavement or loss during COVID-19, might have been triggered by traumatic personal memories. Given the sensitive nature of the research topic, harm to participants during the interviews was minimised by clearly communicating that they could withdraw from the study if they felt uncomfortable discussing their experiences. Moreover, breaks were readily offered during the interviews if needed by the participants.

In my role as a qualitative researcher, I was careful not to cultivate any connections with the participants. Throughout this journey, I adhered to the ethical guidelines set forth by the BPS (2021) and HCPC (2016).

Debriefing

Debriefing was provided for participants at the end of each interview in order to assess any potential distress arising from the interview. I provided participants with a list of organisations to support them, if need be, including resources for bereavement support (Appendix 7). Finally, I informed participants that they had the option to withdraw from the study two weeks after the interview.

Enriching Research Quality

Yardley (2000) proposed four essential criteria for assessing the quality and validity of qualitative research, focusing on four key dimensions rooted in the phenomenological domain to ensure the rigour of the study (Finlay, 2011). In my research, these criteria were used as a framework to maintain good quality research.

This aided in addressing the ongoing challenge of ensuring that my research reflected my interpretative phenomenological positioning and aligned with the philosophical commitments

of IPA methodology (Willig, 2013). In the subsequent discussion, I briefly explore each criterion and elaborate on how I met these during the course of my research.

Sensitivity to Context

Yardley (2000) described sensitivity to context as a fundamental attribute crucial for conducting a good qualitative research study. This was demonstrated through the social-cultural context of the participant, sensitivity to the data, drawing upon relevant theoretical and empirical literature surrounding the topic of exploration, and by considering and addressing pertinent ethical issues that may have arisen during the research.

Commitment and Rigour

Yardley (2000) emphasised that demonstrating 'commitment' entails sustained engagement with the topic, acquiring expertise and proficiency in the methods used, and immersing oneself in the data. In conjunction with this, 'rigour' is demonstrated by conducting extensive data collection and comprehensive analysis. In the course of my research, I established commitment and rigour through continuous engagement with the focus of the study. I demonstrated rigour by intentionally collecting data through the purposeful selection of participants who were pertinent to the inquiry. I remained attentive to participants throughout the process of data collection and analysis. Furthermore, I systematically followed the IPA analytical procedure (Smith et al., 2022) to ensure that I maintained a sufficient idiographic focus in the research. This involved treating the lived experiences of each participant as unique narratives. Specifically, I viewed each participant's account as a unique entity, meticulously analysing every transcript to precisely capture their individual experiences.

Transparency and Coherence

In alignment with Yardley's (2000) suggestion, transparency and coherence in both the research process and the write-up are achieved by providing a clear explanation of each stage such as

methodological and recruitment procedures. To enhance transparency, I explore reflexivity, a topic addressed in both the methodology and discussion sections.

Impact and Importance

Yardley (2000) asserted that good-quality research findings need to have the potential to generate a substantial impact, whether at a practical or theoretical level. She stressed the importance of qualitative research in influencing communities, policymakers, and practitioners. This is achieved by utilising empirical material to offer an innovative perspective and introduce new avenues for understanding a topic. In doing this, I believe that my study broadens the understanding of the experiences and feelings of CoPs in changing their working practices during a pandemic lockdown. Currently, there is a scarcity of research highlighting the experiences of CoPs in this area.

Reflexivity

Reflexivity serves as a key strategy employed for quality control in qualitative research. It constitutes a crucial aspect of the research process, commonly understood as a continuous need for internal and critical evaluation of the researcher's role in a study, coupled with the acknowledgment that their standpoint has the potential to affect the outcome (Berger, 2015). The goal of reflexivity in qualitative research is to monitor and mitigate these influences, thereby improving the accuracy of the research and enhancing the credibility of the findings by acknowledging and addressing the researcher's involvement (Berger, 2015). Therefore, as per Finlay (2002), it is imperative for the researcher to continually examine the effects of their professional and personal factors on the entire research process, from data collection through to data analysis. According to Frank (1997), the goal is not to eradicate 'bias' to achieve greater 'neutrality', but to utilise it as a focal point for gaining more profound insights without distancing oneself (p. 89).

As a CoP trainee, reflexivity has become an important component of my training, integral to my process of understanding and interpreting my assumptions, bias, and personal thoughts. Thus, reflexivity has developed into a vital feature of my research process. In the context of interpretative phenomenology, the researcher's understanding of participants' thoughts is influenced by their own way of thinking, assumptions, and conceptions, thereby enhancing the richness of participants' narratives. This approach aligns with the notion that participants' accounts should not be 'reduced' but are essential for the researcher's interpretation. Additionally, the researcher adds their personal perspective to the reflexive results of the research (Willig, 2013).

The importance of including both personal and methodological reflexivity in every qualitative research process to uphold research credibility was highlighted by Finlay (1998).

Methodological Reflexivity

I recognise that my clinical experience played a role in shaping my preference for this analytical approach, influencing my decision to choose IPA. My person-centred approach to work aligns with IPA theory - emphasising the subjectivity of human experience - and consequently, my clinical stance, which involves understanding experiences through this concept and thus influenced my decision to explore my chosen topic in a similar manner. Furthermore, at the core of counselling psychology lies the therapeutic relationship, operating within professional values and working with 'transference' and 'countertransference' - a process whereby the therapist examines their emotional response to the client's behaviour in order to enhance their understanding of the client. The shift from traditional in-person therapy delivery to remote format may have further influenced my decision to focus on practice adaptation during COVID-19 lockdowns. This is in line with McLeod's (2001) view that there is a likeness between therapy process and qualitative research.

Furthermore, during the analysis stage, I encountered challenges in condensing participant quotes, as I felt concerned about failing to fully capture their perspectives. Over time and with experience, I had to remind myself of the research question I aimed to address. This approach helped me maintain focus on the transcript sections that most effectively supported my goal. However, I had an overwhelming compulsion to include as much detail as possible, which posed a problem, not only during the analysis stage, but also when writing up my analysis chapter. A considerable portion of my time was dedicated to reading and re-reading the quotes multiple times, and the process of overwriting, followed by attempts to condense or delete content, which proved incredibly frustrating at times. The way I made sense of this difficulty was that I wanted to represent my participants' narratives by remaining close to their voice and meaning whilst making interpretations, not just 'at face value', but also beyond by striving to understand the meaning of experience in a manner that involved 'stepping outside of the literal account and reflecting upon its status as an account and its wider social, cultural, and psychological meaning' (Willig, 2013, p. 73). As a researcher, I understood that my interpretations would inevitably be shaped by my own subjectivity, highlighting the significance of the double hermeneutic process in IPA. Additionally, the goal of this research surpassed the mere identification of themes; in line with the ethos of an IPA study, I sought to interpret participants' experiences and extract meaning.

Nevertheless, the process of data analysis became a source of frustration and uncertainty, stemming from the repetitive examination of the data and the multitude of potential interpretations. As suggested by Willig and Stainton-Rogers (2017), I maintained a reflective journal to record the evolution of my thoughts, ideas, and any shifts that occurred throughout the research process. Additionally, I sought personal therapy and supervision in order to express and explore the source of these frustrations. As a CoP researcher, I worked to maintain an open and inquisitive stance toward participants' experiences, immersing myself in their

accounts. Before delving into the data analysis stage, I found it helpful to talk with my research supervisor about my assumptions and bias in order to heighten my awareness and understanding, preventing any unintentional influence on my interactions with participants.

Personal Reflexivity

As a qualitative researcher, it is important for me to reflect on and consider how my personal assumptions, beliefs, interests, bias, experiences, wider aims in life and social identities have affected and may have shaped the research. I recall the emergence of COVID-19 when I was a first-year trainee, only a few months into my counselling psychology training. During that time, I was already striving to orient myself to both the training programme and my placement. The onset of the pandemic lockdowns prevented me from going to my usual base for lectures and clinical work, requiring me to make essential changes in how I managed my practice and study. This transition was marked by elevated levels of anxiety and uncertainty on multiple fronts, as dealing with the unfamiliar territory of remote clinical work and the absence of a designated office space at home intensified my feelings of anxiety and uncertainty about both the future and my professional practice. This period of adaptation entirely disrupted every facet of my personal and professional life, unsettling everything that had once been familiar to me.

Initially I felt unsure of how to translate key counselling skills to remote platforms where I had to look onscreen to maintain eye contact and build a genuine therapeutic alliance with clients using technology. Engaging with the novelty of remote practice and its emotional consequences played a significant role in shaping my identity as a trainee CoP. A crucial element of a CoP's work and identity involves working with the 'process' which encompasses the dynamics of the therapeutic relationship (BPS, 2019). It frequently entails engaging with unspoken aspects influencing the therapeutic work. Fuelled with numerous uncertainties, I resorted to research, but faced challenges in locating pertinent studies on how CoPs adapt their practice to work with 'process' within the therapeutic setting. I questioned whether other CoPs faced similar

challenges whilst adapting their professional practices, sparking my curiosity and igniting my interest in understanding their experiences during the COVID-19 pandemic.

My personal experience as a CoP trainee living through the pandemic and adapting my working practices from home positioned me as an 'insider' in this research study. Consequently, my roles as both a clinician and a researcher were intertwined and challenging. Therefore, throughout the interview process, I made a conscious effort to remain as neutral as possible, being mindful of my reactions whilst fostering an empathic rapport with the participants. In accordance with Radley's (1999) viewpoint, I prioritised the importance of the relationship between the interviewer and the interviewee. In doing so, I emphasised that interviewees were the experts and that my role was to attentively listen to their insights.

Additionally, I acknowledge that my experiences of remote practice, as an Asian woman, may differ significantly from the experiences of other people's experiences. Navigating practice adaptation within an extended family setting raised complex challenges for me. Whilst the presence of family members, particularly younger ones, made the COVID-19 lockdowns more manageable, it also gave rise to issues related to space and noise. Despite these challenges, I deeply value this distinctive experience for its impact on shaping my future professional practices.

Chapter Summary

This chapter provided a thorough overview of my chosen research methodology, elucidated the positioning adopted for this study and outlined the various stages that constituted the data analysis process. I also described the process of data collection and IPA analysis. Finally, I explained that the epistemological stance of this study was interpretative phenomenological, and provided a rationale for this choice (Yardley, 2000, 2017).

Chapter Four

Analysis

Chapter overview

This chapter presents a rich and nuanced analysis of the lived experience of CoPs adapting their working practice in response to the COVID-19 government-imposed lockdown measures in the UK. Consistent with the IPA approach, as the researcher, my primary emphasis was on examining excerpts from transcripts and elaborating on my thorough analytical insights into the content (Smith et al., 2022). Due to the extensive amount of data meticulously analysed both on an individual basis and across all participants, it is not feasible in this chapter to encompass every facet of the participants' narratives. Nevertheless, it organises themes in a manner that follows a path through the areas that most effectively shed light on the research question. The analysis is organised into four GETs, three comprising four Subthemes and one consisting of two subthemes representing various aspects and reflecting both common experiences and an idiosyncratic tenor.

It is crucial to emphasise that during both the interview stage and the subsequent analysis, the research process involved the co-construction of meaning and sense-making between the researcher and participant. This process was firmly rooted in the principles of the hermeneutic circle (Smith et al., 2022).

Through this approach, my role as the researcher involved a fluid, cyclical, and dynamic interpretative engagement. This iterative process allowed me to select and prioritise themes and excerpts based on subjective choice. Furthermore, it is important to acknowledge that another researcher might have chosen a different set of themes and excerpts from this data set. Nevertheless, such variability is inherent in the subjective nature of the research (Smith et al., 2009).

During the interviews, the specific order in which participants shared their experiences of COVID-19 lockdown practice adaptation appeared most appropriate for encapsulating their narratives. They spoke of their initial shock at having to engage in lockdown practice adaptation, encountering a multitude of new aspects, whilst practising from home, experiencing the impact of losses and finally developing an acceptance and appreciation for the new mode of therapy delivery.

Every GET presented in this chapter starts with a representative overview across participants, with the subthemes contained within each, providing an idiographic focus through individual extracts that offers a more detailed unique and nuanced facet of the CoPs' experience of lockdown practice adaption.

The four main GETs, and fourteen Subthemes identified are as follows:

GET one: Intense emotional reaction to sudden COVID-19 lockdown practice adaptation

Subthemes:

1. The experience of intense emotions and uncertainty about practice adaptation
2. 'Deserted streets felt apocalyptic'

GET two: Newness of COVID-19 lockdown practice adaption

Subthemes:

1. Multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas
2. Embracing and adjusting to new remote practice adaption and working with new mediums – 'Absurdity of the new world we live in'
3. Newness of confidentiality and managing risk – 'Counselling somebody in the middle of a shopping mall'
4. Newness of working with technology and the impact of internet disruption on therapy

GET three: The experience of multiple losses during COVID-19 lockdown practice adaptation

Subthemes:

1. Personal and professional – Loss of support systems and social connection with others
2. Loss of in-person therapy delivery – 'Unheard of and not the done thing'
3. Loss of therapeutic interventions – doing support work
4. Loss of expert position in the therapeutic relationship

GET four: Gains – embracing new way of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation

Subthemes:

1. Home practice adaption – learning new skills and an opportunity to develop as a therapist to deliver therapy using different mediums
2. Acceptance and embracing hybrid therapy delivery
3. Acceptance of new norms emerging from lockdown practice adaptation
4. Practice adaptation – importance of self-care, self-acceptance, self-compassion, self-connection, and self-awareness

GET one: Intense emotional reaction to sudden COVID-19 lockdown practice adaptation

The first GET focuses on participants describing the rollercoaster of emotions they experienced as they entered COVID-19 lockdown and had to adapt their practice to accommodate lockdown measures from their homes. This resulted in participants experiencing emotional dysregulation, feeling disoriented and confused due to the challenge of navigating through the unfamiliar terrain of remote practice.

Subtheme one: The experience of intense emotions and uncertainty about practice adaptation

This theme from the data set captures the intense emotions participants experienced during the initial stage of COVID-19 practice adaptation from home. The participants were taken by

surprise due to the sudden impact of the virus; they were entirely unprepared for its severity, extensive reach, swift transmission, and the significant number of fatalities that occurred. The necessity for all participants to adjust their personal and professional lives due to the pandemic led to them feeling overwhelmed and stressed. Five participants made direct, and one participant indirect, statements explicating the experience of intense emotions during practice adaptation. The following excerpt from Shanti encapsulates the essence of the intense emotional reaction from CoPs:

> *"On the 23rd of the March… when we were told to sort of pack up and go home. It came as a real shock… I didn't really know what that meant."* (Shanti, p. 3)

Here, Shanti points to her experience of shock and state of confusion at being asked to pack up and leave the office building. For her, therapy delivery had always been from her work base; therefore, she experienced ambiguity about the implications of being sent home and was unsure about the continuity of her work. James conveyed a similar view:

> *"Initial lockdown was… very jarring and a bit of a shock and it just felt very bizarre and…like many people, I've found it very disorientating, you know. I think it was the most, it was the most severe lockdown."* (James, p.3)

The intensity of emotions experienced during unexpected and unforeseen COVID-19 lockdown practice adaptation is reflected in the use of words such as 'jarring', 'shock', and 'bizarre' to describe the striking unfamiliar situation James found himself in. Whilst expressing his experiences, his voice was noted to be trembling, indicating this had been an intensely emotional and stressful time for him. He had to repeat 'most' twice to emphasise the severity of the first lockdown. Helen concurred with him in this regard:

> *"Sadness, anxiety… I must have been slightly traumatised. So yeah, couldn't watch the news anymore because I was just crying a lot. And umm feeling on edge… yeah, anxious*

and sort of worried a lot of the time. Umm yeah, sort of easily sort of sparked to anxiety a lot of the time (smiling).” (Helen, p. 3)

This extract describes the profound emotional distress and grief experienced by Helen, which left her deeply distressed. The amalgamation of managing the COVID-19 virus, its related anxieties and adjusting to work modifications heightened her difficulties. Helen’s statement illustrates her cognitive, emotional, and behavioural reaction to this transition. She opted for an avoidance strategy, refraining from watching the news as a defense mechanism to manage the situation during that period. Whilst speaking of difficult emotions, she was observed to be smiling, perhaps wanting to show that she was in control and managed things well. This inconsistency was further elaborated by Sarah:

“I’m just kind of distancing myself from this experience, to be honest, and yeah, so it’s kind of become to be quite distant. But I it was generally it was awful when I when I really think of it, it was awful… there are moments when we kind of think, oh, is it true? Has it really happened? Did it really happen to us, and we survived… such a thing? Never thought of going through… looking back, I think… I kept going… I kept I kept going, and I had pretty normal life.” (Sarah, p.3)

Here, Sarah used rhetorical language by posing numerous questions to herself, showcasing her astonishment and disbelief regarding the COVID-19 lockdown and the adjustments made to her practice, highlighting the sheer incredulity of the situation. She made contradictory statements, describing her experience of lockdown practice adaptation as ‘awful’ whilst simultaneously having a ‘pretty normal life’. This may have been a coping mechanism for her as she mentioned trying to distance herself from the earlier, more difficult practice adaptation experiences. Repeated questioning regarding the surprise of living through the lockdown and

surviving appears to reflect her existential anxiety that she survived the pandemic, which to her seemed unfathomable.

In summary, adapting to working from home during the COVID-19 pandemic was an intense emotional experience for CoPs. This led to the next subtheme: environmental factors, such as deserted streets, further exacerbating their feelings of hopelessness.

Subtheme two: 'Deserted streets felt apocalyptic'

This theme encapsulates the participants' state of mind and the extent of their fear of the COVID-19 virus. The description of deserted streets feeling apocalyptic reflects their profoundly intense emotional experiences and a feeling of being unable to see a way out of this grave situation. Three participants described indirectly seeing deserted (usually busy) locations during lockdown as a cataclysmic experience evoking fear of something bad happening to them - three directly referred to the abandoned locations as an apocalyptic, catastrophic, and surreal experience. For example, James stated:

> *"It felt quite shocking at the time… walking up the High Street here where I live a few days later, to go food shopping and finding the streets utterly deserted. I mean, I live in central London, so it was, you know, emotionally it had a big impact because it it did feel very apocalyptic at the time."* (James, p. 4)

In this extract, James describes the emotional impact he felt during the initial lockdown by reflecting metaphorically that it seemed as if it was the end of the world, using the word 'apocalyptic'. This metaphor gives a sense that he was noticing the impact of lockdown around him both at work and in his locality and was perhaps not able to see a way out of these draconian measures. James's use of a vivid metaphor to illustrate this process seemed to reflect the experiences of other participants. Therefore, it seemed fitting to adopt it as the label for this theme. Eva echoed this further:

> *"I could actually drive into central London… I was driving him in which all just seemed a bit surreal because the roads were empty, you didn't see anyone. It's just very surreal. It's like being the only people in London. It was really weird."* (Eva, p. 4)

Eva's repetition of the word 'surreal' emphasises the unsettling circumstances she encountered, resulting in a state of continual hyper-awareness among many of the participants. Being the 'only people in London' highlights the social disconnection she felt from the people outside of her household. At a personal level, participants experienced existential anxiety, stress, and uncertainty, reflecting the collective experiences of the broader population.

In summary, the shared element binding the two previously discussed Subthemes is a period at the onset of the COVID-19 lockdown during which participants underwent diverse experiences of intense emotional upheaval. The rationale for choosing this GET and the subthemes is rooted in the unanimous description provided by all participants of experiencing intense emotional responses during the initial adaptation to remote work amid the COVID-19 pandemic. Given the aim of my research, which is to explore the lived experiences of CoPs, it felt imperative to capture these profound emotional reactions. Arising from the unprecedented nature of the virus, lockdown measures, and the shift to remote work, these emotions became intricately intertwined and inseparable from home and work domains. Furthermore, the subtheme 'Deserted streets felt apocalyptic' shed light on a sense of hopelessness regarding the newly adapted remote work, as well as participants' struggle to envision a future beyond the pandemic. Therefore, it was essential to capture these sentiments as they reflected the profound impact of the crisis on individuals' perceptions and experiences.

GET two: Newness of COVID-19 lockdown practice adaption

The second GET describes participants' experiences of abruptly finding themselves plunged into a confusing state of uncertainty during lockdown, as they grappled with the sudden need

for practice adaptation from home without clear guidelines, leaving them feeling disoriented and unsure of how to navigate this new reality. None of the participants had prior experience conducting clinical work remotely, making it an entirely unfamiliar and novel experience. Helen and Eva, however, had some prior experience of conducting online supervision using online platforms. This theme describes the multiple forms of newness participants encountered whilst adapting their practice from home.

Subtheme one: Multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas

All participants described struggling to create a suitable workspace within their homes. Shanti was unable to envisage the thought of working from home, the idea felt unfathomable and inconceivable to her as a psychologist, as in-person interaction was viewed by her as the superior and familiar medium of therapy delivery. Adam described work permeating every corner of his home and dominating his living space.

> *"…my allocated workspace…it's the living room and previously was my bedroom…I didn't have an office; I transformed my house environment into an office... It was so absurd that it was so strange, but I just thought that there's not much more I can do really… I felt a bit bad restricting my family's space."* (Adam, p. 12)

Adam's use of words such as 'absurd' and 'strange' points to the novel and unique situation he found himself in with regard to his professional life encroaching on his personal life. The extract illustrates Adam subtly indicating a loss of personal control whilst adapting to remote work from home. Additionally, from the tone of his voice, I sensed his guilt at restricting his family's movements. Furthermore, both Sarah and Shanti worked out of their bedrooms to accommodate their practice from home.

Participants James, Helen and Shanti had to restructure part of their home to make a confidential office space for themselves. Whilst recounting their experiences, I observed that the participants alternated between laughter and frequent frowns as they described the actions they took to adjust their practices, possibly aiming to reconcile the emotional dissonance that arose by minimising the seriousness of the situation:

> *"Little cupboard under the stairs… it doesn't have any windows."* (James, p. 14)

> *"We don't have an office space at home, but we've created one now in our bedroom… So that was a big adaptation… a bit weird to be working from your bedroom.*" (Shanti, p. 18)

James chuckled in disbelief as he shared the story of transforming the windowless understairs cupboard into his office. The laughter seemed to be his way of coping with distress, perhaps reflecting the creativity and resilience he found in adapting his workspace.

In the initial phase of adjusting to remote work amid chaos, participants utilised digital screen backgrounds to conceal their real-life mayhem from clients whilst working from any available private space in their homes. Sarah, Adam and Eva directly mentioned this, whilst other participants indirectly expressed the same:

> *"So, the main thing was the background was decent so, so that no one couldn't see… the other things.'* (Sarah, p. 17)

Sarah emphasised that her top priority was to shield her clients from the chaos in her life. She achieved this by employing a professional digital screen background to establish a sense of containment for them, but appeared to be without containment herself. Eva managed to create a sense of containment for her clients by using a brick-patterned shower curtain to visually divide her workspace, simulating a wall for those viewing her digital screen, all whilst working

from her garden shed. The lack of a distinct division between personal and professional life caused difficulties for all participants, as described by Shanti:

> *'Mean there is sort of issues around separating home life and work life. Being able to feel professional while sitting in your bedroom… over time, I've been quite successful at being able to do that, partly because I can see the benefits from working from home; so, I was motivated to make it work.'* (Shanti, p. 18)

In this excerpt, Shanti expresses the blurring of dual-domain roles that occurred due to the absence of physical separation between home and workspaces, resulting in more permeable role boundaries. As indicated by Allen et al. (2021), this led to her inability to feel professional when providing therapy from her bedroom.

James used compartmentalisation as a coping mechanism to mentally segregate his personal and professional domain roles, given the impossibility of physical separation due to lockdown restrictions. His use of the phrase 'broken down' suggests that his home lacked complete tranquillity, being divided into distinct areas for both work and personal aspects. This choice of words could also indicate a sense of loss, reflecting the challenge of establishing a unified and relaxing environment:

> *'Compartmentalisation of work and home… had to be broken down… having a discipline to put my work aside when I was finished work.'* (James, p. 15)

In summary, participants detailed how remote work extended into their personal lives and spaces, lacking a dedicated home office. They shared strategies for maintaining a clear boundary between work and personal life, both physically and mentally. This led to the next subtheme, exploring how CoPs adjusted their remote practices to accommodate working with remote mediums.

Subtheme two: Embracing and adjusting to new remote practice adaption and working with new mediums – 'Absurdity of the new world we live in'

This theme highlights key elements of participants' experience in adapting their professional practice during COVID-19 lockdown. They had to use remote online mediums such as phones and video platforms to deliver therapeutic interventions. Although some participants had prior experience in offering informal therapeutic conversations over the phone, they lacked any experience in conducting clinical work online. Such novelty and unfamiliarity made it challenging for them to accept that the standard of therapy they were delivering was effective. Apart from Eva, all the participants reported poor execution of adaption at an organisational level, causing them anxiety and uncertainty, as stated by Adam:

> *"…they were anxieties…there was also a lot of curiosity because…it wasn't me; it was everyone. So, we were all in the same boat and that really helped…there was…solidarity between colleagues and with patients as well…the patients were extremely understanding and willing to try. So, I think there was anxiety, but also some curiosity about this challenge."* (Adam, p. 6)

Despite the noted disconnect among higher management, Adam found the collective experience of changes during COVID-19 lockdown with his colleagues, and the understanding and accommodating nature of his clients, to be helpful. He highlighted this using terms such as 'same boat' and 'solidarity', emphasising the notion of not feeling alone, even when experiencing anxiety about the upcoming challenges. Adam's use of words such as 'curiosity' and 'willing' indicates his open-mindedness and positive attitude towards embracing these new mediums of therapy delivery. During the interview, I noticed that his voice exuded an enthusiastic tone, indicating a feeling of hope and resilience for the future. By contrast, James viewed the new method of therapy delivery as absurd:

> *"It's kind of an absurdity of this new world that we find ourselves in."* (James, p. 16)

This excerpt captures James's overall outlook and emotional reaction to the changes he made in adapting his work to a home environment. Referencing 'new world' and 'an absurdity' might indicate his belief that the changes appeared unfamiliar and permanent and did not align with his values, primarily because he strongly advocates the traditional in-person psychotherapy delivery. This excerpt depicts participants' sentiments so accurately that it has been employed as a sub-theme heading. All the experienced CoPs felt a sense of inadequacy due to the changes they encountered, leading them to catastrophise and anticipate the potential failure of the newly adapted practice, as observed in the following excerpts by Sarah and Adam:

> *"… there's a practical level. But of course, it's how you work as a… therapist, that's that was another challenge. How to… adapt to… seeing people online?"* (Sarah, p. 6)

> *"I was a bit sceptical or anxious about them...it is not gonna work."* (Adam, p. 6)

In these excerpts, participants reveal cognitive bias through the use of terms such as 'sceptical' and 'not gonna work', suggesting a tendency to catastrophise the potential failure of their newly adapted practices. Sarah, a senior CoP, voiced apprehension about working remotely using different mediums, highlighting the necessity to relearn how to function as a therapist and expressing a perceived loss of skills. This apprehension may be linked to a lack of confidence in conducting therapy sessions through remote and online platforms. Such sentiments may have stemmed from an unfamiliarity with technical aspects, uncertainties about effectively engaging with clients remotely, or concerns about adapting therapeutic techniques to an online environment.

Half of the participants found the use of remote phone mediums for therapy delivery to be beneficial, whereas others encountered difficulties for various reasons. James shared his challenging experience with using the phone medium for therapy:

> *"I was suddenly sort of gone from face-to-face working to ringing a faceless voice, really in a void which umm I did find very, very hard. It was stressful for me… all of a sudden… I had far less information, if you like, about the person in front of me than I would normally have… There was no… non-verbal communication to look at."* (James, p. 6)

Here, James describes phone therapy as a 'faceless voice', referring to the absent body, and the use of the phrase 'in a void' metaphorically refers to a psychological state of finding himself in limbo where there is a sense of being lost or not having a specific path or guidance. James stresses that utilising this method resulted in a notable decrease in non-verbal cues from the client, creating challenges, as well as stress. Adam assessed the advantages and disadvantages of providing therapy over the phone:

> *"…there's a lot that you can pick up from the person or the person picks up from you, with the phone being non-verbal, it's very excluded. Well, it's almost absent apart, you know, from the tone of voice. So, it's very distant. I think the patients, but also my myself as a therapist, it was very easy to disengage. I mean, it was sometimes I found myself lying on the sofa whilst on the phone… and my own attention was a bit compromised. I think both me and the patients, there was an issue about being present there emotionally..."* (Adam, p. 9)

In this excerpt, Adam concurs that the phone could be limiting in terms of picking up non-verbal cues. However, he also mentions that he was able to gather substantial information by paying attention to the tone of the voice during phone interactions. Adam's depiction of the medium as 'distant' may imply a perceived physical separation between the therapist and the client, coupled with an emotional disconnect. This distancing could potentially have served as a coping mechanism during this stressful period, acting as a means of self-protection. When

Adam discussed working with compromised boundaries such as working whilst resting on the sofa, he chuckled, displaying a resemblance to a child caught engaging in an activity they were not supposed to do. Conversely, Helen mentioned her ability to be fully engaged and focused when communicating over the phone:

> *"Real intimacy that can be created with telephone sessions, which is really, really nice actually… I tend to sort of really sort of crouch over the phone and you're really listening really, really hard, like extra hard to like, watch someone saying and how they're saying that they they there's a real sort of connection that can be created with telephone sessions and effective work definitely can be done."* (Helen, p. 9)

In this passage, Helen conveys her ability to cultivate 'real' and authentic 'intimacy' over the phone, indicating that emotional closeness, understanding, and a strong connection can be effectively developed and nurtured even without being physically present with the other person. Eva concurred that good therapeutic work can be accomplished over the phone.

Five participants were introduced to video therapy a couple of months into the lockdown, whilst Eva began using it immediately after the lockdown commenced. Shanti discussed her anxiety about using the video medium for delivering therapy:

> *"The idea of video work just seemed really alien, that hadn't even been mentioned at that point."* (Shanti, p. 4)

In the above excerpt, Shanti metaphorically employs the term 'alien' to characterise an unfamiliar and uncertain situation. The choice of this word implies Shanti's firm commitment to exclusively favouring in-person therapy, showcasing her inflexible position against adopting an alternative approach. Eva spoke of her experience of video therapy delivery and being 'camera shy' and suddenly finding herself 'performing on camera' for hours, which she found to be a 'weird' experience. She spoke further of her experience of delivering video therapy:

> *"I ran a few webinars for people… all the patients… like 50 people in a meeting, but they all have their cameras off, and it really did look, I was talking to myself because there was nothing to talk to."* (Eva, p. 7)

From this excerpt, it is clear that Eva conducted a webinar for an unseen audience. The absence of visible participants, with all cameras remaining off, transformed the webinar experience into a scenario resembling speaking to oneself and performing for an empty space. This unique situation posed a distinct challenge for a CoP who values relational interaction. The intricate aspect of engaging with what feels like an empty space and delivering a presentation without the usual visual cues added an additional layer of complexity to the process of adapting to new practices. Eva's laughter as she described the incident conveyed her reaction, indicating a blend of surprise and disbelief regarding the situation she encountered during the webinar. Sarah felt she had to adapt how she displayed her emotions on video:

> *"My emotional reaction would be more obvious, so the client can read me better."* (Sarah, p. 8)

Sarah adapted to remote online platforms by heightening her emotional expressions on camera to aid client understanding. However, this adjustment resulted in a loss of nuance in comprehension, prompting Sarah to compensate by increasing verbal communication in her sessions. During online therapy sessions, she experienced discomfort with therapeutic silence, which she attributed to the transition to digital platforms. Initially, Helen perceived the remote online work experience as artificial. However, as time progressed, she witnessed an improvement in the overall experience.

In summary, some participants embraced the telephone medium, while others felt a sense of disconnect and disengagement due to the loss of non-verbal cues. Initially, the video platform

was not as readily embraced, but over time, participants became more accepting of it. This leads to the next subtheme: the novelty of confidentiality and managing risk.

Subtheme three: Newness of confidentiality and managing risk – 'Counselling somebody in the middle of a shopping mall'

This theme delves into the unique process of setting boundaries, managing risk and maintaining confidentiality for both practitioners and clients during the transition to remote online work from home. Participants highlighted the difficulties arising from the novelty of the medium, compounded by both their and their clients' inability to access confidential spaces for conducting and receiving therapy. Sarah gave an example of her experience of working with new blurred boundaries:

> *"I worked more… and I gave more than I used to because it feels almost… what's the problem, to stay one hour longer when I'm at home?"* (Sarah, p. 19)

In adjusting her practice, Sarah implemented more flexible professional boundaries, extending her working hours beyond the usual due to an increase in workload. She justified this decision, potentially viewing it as a way to contribute more to the service and to her clients. As a CoP grounded in values such as empathy and compassion, she went the extra mile for her clients. Later, she noted that employing this approach to modify her work routine resulted in substantial physical, emotional, and psychological exhaustion, which noticeably affected her enthusiasm and motivation for engaging in various activities. Eva faced a similar challenge adjusting to new professional boundaries. Additionally, the participants noted that their clients encountered difficulties in maintaining boundaries and faced challenges in finding a private, confidential space at home for their psychology sessions.

> *"Client who… was living at home, but part of the problem was a systemic issue with the family…first session one of her sibling's walks… past the screen."* (James, p. 8)

> *"One person had therapy when she was walking in the park because she didn't have privacy at home. Uh so it became… challenging."* (Sarah, p. 6)

These excerpts detail the difficulties participants faced in upholding confidentiality during online therapy sessions with clients. They dealt with disruptions such as family members entering the room or individuals walking outdoors during therapy. Sarah's description of the situation as 'challenging' signifies the struggle to maintain therapeutic boundaries and establish a secure space for clients. This challenge was intensified by the limited availability of private space in their homes during the COVID-19 lockdowns. This elevated the barriers, introducing a sense of novelty due to the unique circumstances of the pandemic. The therapeutic framework, reliant on building a relationship within a secure space, meant that it was difficult for participants to provide containment for clients in the absence of such a space. Consequently, participants experienced a sense of inadequacy. James conveyed a comparable perspective:

> *"Sometimes it feels as like counselling somebody in the middle of a shopping mall… doesn't feel right.'* (James, p. 17)

Here, James uses a simile, drawing a comparison between counselling and being in a shopping mall to highlight the challenges associated with delivering therapy in the absence of a private and confidential space. This comparison suggests that the challenges and distractions in a non-private therapy setting mirror the bustling and public atmosphere of a shopping mall. All participants faced the same issues concerning privacy. Adam spoke about his experience of setting online boundaries for groups:

> *"…remember with groups having to rethink about the ground rules relevant to the online format… about not eating whilst…they're doing the group not having obviously other people in the room…the privacy of where people were…I had not only to know the IT side of it, but also to adapt the clinical setting because I think there was always*

a risk of people having the session who were having breakfast. So, the boundaries would get very, very blurred." (Adam, p. 10)

In this excerpt, Adam describes the challenges he faced whilst managing online group sessions and the need to formulate specific ground rules designed for the dynamics of online group interactions. Adam twice reiterated the intensity by using the adverb 'very' alongside 'blurred', emphasising the extreme difficulty of managing confidentiality in the adapted online format. As he recounted his experiences, he appeared overwhelmed and even out of breath, particularly when detailing the myriad tasks he had to navigate during the group session to enforce the rules. All participants, both individually and collectively as a team, experienced anxiety when managing client risks remotely from their homes, as explained by Shanti:

"… we were offering sort of limited interventions because we… didn't think we could manage the risk, the process issues through of this client going through video therapy." (Shanti, p. 23)

In this excerpt, Shanti reveals a leaning towards offering brief interventions rather than opting for regular therapeutic sessions. Her preference stems from her apprehension about managing the unfamiliar risks and addressing various process issues within the online and remote mediums. She views online therapy as riskier and considers it a secondary choice. Sarah also related her personal of experience of managing a risk situation remotely:

"I had someone banging her head on the wall… which was very stressful. Yeah. I think … this kind of risk issue… was very difficult to… deal with on the phone because it's if you have a patient in the room, it's much more you can do." (Sarah, p. 13)

In this excerpt, Sarah expressed her difficulties by pairing the word 'very' with 'stress' and 'difficult' to emphasise the level of distress she experienced during this remote encounter whilst working with a client in which she was unable to manage a risky situation. She clarified

that this could be attributed to the physical distance between her and the client, suggesting that she felt powerless to control and handle the risk whilst working from home.

In summary, this theme encapsulates the challenge participants faced in upholding confidentiality and handling risks online, causing significant stress. This leads to the next subtheme of adapting to technology assistance for therapy delivery and navigating disruptions caused by the internet.

Subtheme four: Newness of working with technology and the impact of internet disruption on therapy

In this theme, all participants spoke of the newness of delivering therapy using technology and the difficulties they encountered in adapting their practice from home. All participants, except Eva, initially had difficulties in accessing equipment and tools to enable them to perform work tasks under new lockdown measures. Sarah shared her experience of being disadvantaged in providing psychological support to clients due to her restricted access to technology:

> *"So initially I was… using my own phone… we didn't have laptops to be able to do much."* (Sarah, p. 4)

Similarly, Adam and Shanti experienced a delay of a few months before gaining access to technology. By contrast, Helen obtained access swiftly without significant delays, whereas Eva already had the necessary technology and equipment in place. All participants discussed the challenge of clients lacking access to technology, creating a dilemma as they worked remotely from home:

> *"Clients who…didn't have the technology or couldn't work the video therapy, then they were in a position of disadvantage…clients who needed face-to-face and we couldn't give them."* (Shanti, p. 17)

> *"Lots of our clients didn't want to use laptops, so… we have to move to phones."* (Sarah, p. 4)

In these excerpts, Sarah and Shanti highlight the presence of digital poverty within their client group, expressing concern that individuals faced disadvantages because they either lacked access to technology or were unable to use it for therapy. Shanti earlier mentioned feeling as though she was not performing her job properly in view of these challenges. The COVID-19 lockdown measures, paradoxically, exacerbated the gap in spite of CoPs holding professional values geared towards diminishing poverty and disparity. These measures hindered their ability to operate in alignment with these professional values. Helen highlights practical elements of her experience using the new mediums to deliver therapy:

> *"The very practical thing of um that little picture of yourself… you're looking at a client, how do you make eye contact with a client? Because actually, if I'm gonna make eye contact, someone I have to look at the screen and the little camera, which means that I'm not actually looking at them. And then you're distracted by that picture of yourself… how do you look… what do you look at to build a relationship that actually feels genuine?"* (Helen, p. 11)

Here, Helen articulates her apprehension towards adopting technology for therapy, disclosing a lack of confidence in pivotal elements such as sustaining eye contact and determining the appropriate focal point on the camera whilst delivering therapeutic sessions to clients. This underscores the unparalleled and pioneering nature of this transition, thereby contributing to this participant's perception of inadequacy and inexperience in the realm of online therapy. Helen explains how being distracted by her own screen image led her to shift away from client-centred work towards self-monitoring, significantly impacting the effectiveness of her efforts. In the midst of pervasive uncertainty, Helen articulated her endeavour to establish relationships

that felt genuinely authentic, implying a perception that online connections may not embody this sense of authenticity, making them a secondary choice. Sarah expanded on her preoccupation with facial expressions in the video:

> *"I saw my face twitching, a very strange grimace and it was frozen on the screen, and I was very aware of my… patients were seeing this this horrible grimace. So… we had to work with this…It was yeah, frustrating and anxiety provoking."* (Sarah, p. 8)

In this excerpt, Sarah recounts detecting involuntary 'twitching' and an unappealing 'grimace' on her face in the video during a therapy session with clients. This heightened her self-awareness and preoccupation with concerns about clients' perceptions of her, causing her to feel anxious and frustrated. This experience engendered dissatisfaction in her professional role, particularly given the client-centric nature of traditional in-person therapy. The inability to replicate an equivalent standard of service in the online setting intensified her discontentment. Eva delineates the practical challenges she experienced with the use of technology:

> *"CBT type session, not having materials, not being able to share the pen, harder to figure out how to co-create a diagram, co -create some kind of a document. My IT skills weren't quite up to figuring out how to draw thing on the screen."* (Eva, p. 8)

In this extract, Eva highlights the constraints she faced when delivering CBT through an online platform. She notes that technology posed a barrier to her collaborative co-creation of therapeutic work, and her limited technological skills, combined with the novelty of the practice, impeded her ability as a therapist to customise the work to address the specific needs of the client. Sarah explained the negative effects of remote work adaptation using technology and her experience of technology failing:

> *"… negative effects are short lasting… there's a feeling that you want to smash the laptop, for example, or curse and swear at the internet."* (Sarah, p. 9)

Here, Sarah conveys her initial and powerful emotional reaction to adapting to a new technological practice, suggesting a strong inclination to physically release frustration such as feeling the urge to smash her laptop or expressing it verbally by cursing and swearing at the internet. This may be associated with her perception of losing control over the therapeutic space, given that CoPs typically hold the space and boundaries for clients. Furthermore, she seemed to unintentionally resist the technological adaptation, as evidenced by her emotional expressions. Helen shared her first-hand experience of dealing with interruptions caused by internet interference in her recently adjusted professional practice:

> *"The internet or your laptop isn't working quite great… sound goes in and out or there's a pause, that really did feel quite intrusive in the beginning. Umm and having to say to people, can you repeat?... That felt really, really difficult."* (Helen, p. 12)

In this excerpt, Helen elaborates on her experience of dealing with technological disruptions, described as 'intrusions' during therapy. These disturbances created an environment reminiscent of a third party in the therapeutic setting. The added challenge of having to ask clients to repeat themselves significantly hindered the therapeutic process, impeding her capacity to cultivate an authentic therapeutic relationship and contributing to her feelings of inadequacy.

In summary, the GET 'Newness' encapsulates participants' efforts to navigate the challenges of transitioning to remote work amid the COVID-19 lockdown. Establishing suitable homework environments presented hurdles, including the absence of dedicated office spaces, the need to restructure living spaces, and the use of digital backgrounds to maintain professionalism. Participants encountered unfamiliarity with remote online mediums for therapy delivery, resulting in anxiety due to a lack of clear organisational guidelines. Challenges in maintaining confidentiality and professional boundaries arose such as extended

working hours contributing to burnout and the complexities of conducting therapy sessions in shared home spaces. Adapting to technology proved challenging, encompassing issues such as accessing equipment, addressing the digital divide among clients and adjusting therapeutic techniques for online settings, all of which were compounded by technological limitations and disruptions.

GET three: The experience of multiple losses during COVID-19 lockdown practice adaptation

The third GET explores the multiple losses CoPs experienced during COVID-19 practice adaption. The first subtheme, 'Personal and professional - Loss of support systems and social connection with others' provides an insight into the experience of the abrupt loss of support systems and social connection in their lives. The second subtheme, 'Loss of in-person therapy delivery' delves deeper into the experience of not being able to see clients in person and ways in which they managed that. The third subtheme, 'Loss of therapeutic interventions to providing support' taps into the experience of participants providing support instead of clinical therapeutic work, and the fourth subtheme, 'Loss of expert position in the therapeutic relationship' addresses the experience of participants feeling vulnerable at times during remote practice and expressing uncertainty about the situation to clients.

Subtheme one: Personal and professional – Loss of support systems and social connection with others

This theme encapsulates the deprivation of participants' social and support networks amid the COVID-19 lockdown, coinciding with the transition of their professional practices to their homes. Each participant had, at a minimum, one other person in their household, a fact for which they expressed profound gratitude. They acknowledged that enduring the lockdown without the presence of others in their household would have posed significant emotional

challenges. Furthermore, they believed that individuals who were alone during this period were grappling with heightened difficulties. Helen describes her experience of a loss of professional support from her senior management:

> *"Management… it felt like the sort of level above me was not quite there with the NHS role and that felt a little bit scary."* (Helen, p. 16)

In this extract, Helen, who holds a management position, describes her experience of not having higher level management support during the initial days of COVID-19 lockdown practice adaption, which felt 'scary' for her. She expresses feeling emotionally dysregulated without those in a position of power containing her. This sense of managerial absence was a collective experience among all participants at the commencement of the COVID-19 lockdown. James also spoke of a loss of social connections with colleagues:

> *"Felt very isolating and disconnected… those kinds of social connections where you chat to colleagues… you find out who's who; I never met my team."* (James, p. 18)

Here, James articulates a profound sense of isolation and disconnection from his team. In his new role, he lacked the opportunity to acquaint himself with colleagues through informal interactions, intensifying his feelings of loneliness. Despite being a member of a team, he discerned a distinct solitude whilst working independently. Shanti directly referred to challenges in both her professional and personal life:

> *"Life shutdown for my whole family. So, we didn't have any childcare support any school… it was really… trying to find a balance between family life and work life… as a parent is expected to do things as well, like home schooling…it just felt like I was trying to do about 10 different roles at the same time… I think initially…people were trying to get their head around it all."* (Shanti, p. 12)

Shanti delineates a ‘life shutdown’, suggesting that she might have been operating in autopilot mode, not fully engaged in living. This occurred as her support systems collapsed, leaving her vulnerable whilst concurrently managing multiple roles. The entire experience was an emotionally intense time for her, a shock to her system that required some time for her to comprehend and adapt to the challenges it presented. She expressed a deep feeling of isolation from her team, making earnest attempts to ‘survive’ and navigate the intricate challenges presented by the COVID-19 pandemic and the necessity to adjust her professional practices. Sarah echoed this feeling, clarifying her experience of professional isolation and emphasising the crucial need to ‘survive’ the pandemic. She highlighted that this situation was not just an abstract challenge but a real life-and-death scenario where both aspects intricately influenced each other. Adam expressed missing socialising with colleagues on many aspects and feeling disconnected from the wider team:

> *“…there was some sense of boredom about not being physically in touch with people…”* (Adam, p. 16

Adam points towards feeling the emotion of ‘boredom’, perhaps indicating his desire for physical connection and social interaction with others:

> *“I think because this was such a global thing, I remember reconnecting with people…friends I hadn't spoken with long time…in Italy…we had more time to ourselves…to be in the house, so I in one way reconnected with people a lot.* (Adam, p. 16)

Adam described the loss of his immediate social network, but highlighted the acquisition of a global network. He speaks of utilising the opportunity to rekindle relationships with long-lost friends from Italy through online connections. Overall, he spent two months working under strict lockdown measures before returning to his base for a specific job that required interaction

with colleagues. Helen proposed that CoPs bear the responsibility of seeking support for themselves and providing support to others:

> *"I feel our job as a psychologist is quite solitary actually. So, you, it's up to us to kind of make use of the supervision and… sort of checking in with colleagues and that continued for me um because I have kind of good relationships with my colleagues. So that, I was able to sustain that."* (Helen, p. 16)

In this excerpt, Helen characterises her profession as inherently 'solitary', seemingly acknowledging and accepting this aspect as intrinsic to her job. She highlights the importance of social connections and suggests that all participants should actively seek supervision whilst maintaining consistent connections with colleagues to alleviate this solitude. It is worth noting that Helen faced additional challenges, having lost loved ones to COVID-19 and experiencing a loss of contact with family members, depriving them of the opportunity to grieve together, thus she was at risk of isolation. Eva conveyed a limited inclination for social connections both in her personal and professional life, expressing contentment with working alone from home.

In summary, this subtheme captures how participants experienced loss of social connections, particularly with colleagues working remotely from home during lockdown, leading to a sense of isolation. This leads to the next subtheme: the loss of in-person therapy delivery.

Subtheme two: Loss of in-person therapy delivery – 'Unheard of and not the done thing'

In this theme, all six participants revealed their preference for in-person clinical work or remote work online. Shanti expressed her leaning towards in-person work:

> *"Providing video therapy… personally, it felt quite unheard of and not the done thing."* (Shanti, p. 25)

> *"…felt like, uh, I wasn't doing my job… not being able to see face-to-face clients and… provide therapy."* (Shanti, p. 6)

In the above excerpts, Shanti articulates her profound conviction that employing video for therapeutic delivery constitutes an unconventional approach among psychologists, a sentiment unequivocally not aligned with her own professional inclinations. She felt that, in her role as a psychologist, she fell short unless she offered in-person therapy, underscoring her belief in the superiority of in-person therapy as a delivery method. My selection of this assertion as the title for the theme is emblematic of the overarching conviction held by all participants.

Sarah outlined the reasons underpinning her inclination towards in-person practice:

> *"Started seeing them face-to-face… 2021… Some people who are more dysregulated were finding more difficult to to access because… being on the phone in the car wasn't very helpful with with very powerful emotions…"* (Sarah, p. 16)

In this extract, Sarah emphasises that utilising in-person therapy as a delivery medium offers a more accessible framework for therapy, providing containment, a conducive environment and emotional regulation that facilitates the safe expression of emotions. James and Sarah concurred that the in-person medium affords CoPs greater control over the facilitation of the environment and ensures confidentiality. Helen alluded to the fact that the preference of clients is for in-person therapy:

> *"A few… were saying they would have preferred face-to-face, but they were OK that this was an option for them."* (Helen, p. 5)

This situation illustrates that in Helen's professional experience, her clients opted for remote therapy as a compromise, although their initial preference was for in-person sessions. Helen further explains her experience of remote practice adaption:

> *"Just felt like it was ticking the boxes and good enough to kind of keep services going but it would be so much better face-to-face. I think that was in the back of my mind at the beginning as well. Umm, which I think makes you almost work that little bit extra harder to to feel like… you are being helpful to people, but that felt a bit of a challenge."* (Helen, p. 6)

In the above excerpt, Helen clearly aligns her viewpoint with her clients, expressing a preference for in-person therapy over remote online delivery. She acknowledged that during the COVID-19 lockdown period, it served as a 'good enough' solution, but not as a general preference. Helen conveyed her experience of having to exert additional effort to feel genuinely helpful to clients – a challenge she found demanding.

In summary, this theme highlights the participants' preference for in-person therapy and their perception that online mediums demanded more effort from them. This leads to the subtheme: Loss of therapeutic intervention.

Subtheme three: Loss of therapeutic interventions – doing support work

All participants, excluding Eva, underwent an initial phase of adapting their therapeutic practices. This involved a temporary shift, transforming the therapeutic space into a supportive one that was primarily centred around making phone calls and conducting check-ins with clients. An example of this was given by Shanti:

> *"It went from providing kind of weekly telephone contact to clients... more like support…as opposed to therapy… we thought it'd be a short-term time frame."* (Shanti, p. 7)

Here, Shanti describes her feelings of experiencing a loss in therapeutic interventions, supplanted by telephone support work. Initially hopeful for a brief interim, the prolonged

continuation of this altered approach left her disheartened. Whilst narrating her encounter with this novel intervention, her subdued tone, restrained expressions and muted laughter during discourse all conveyed a profound sense of disappointment and discouragement stemming from the absence of familiar therapeutic interventions. Sarah encountered a similar experience:

> *"Therapy… became…more supportive stance, in those initial kind of weeks at least, until we adopted, till we can get some kind of sense that we can work psychotherapeutically."* (Sarah, p. 7)

In this extract, Sarah expresses the necessity to grasp the nuances of online psychotherapeutic work. This statement, coming from a senior CoP with years of experience implies a potential sense of disorientation and perceived inadequacy. Despite her extensive years of experience, this acknowledgment signals a lack of confidence in delivering therapy through remote online mediums. In a similar vein, Helen expressed her view that therapy turned into well-being checks and case management work for CoPs. Shanti then spoke of her guilt:

> *"Guilty in a way that that I couldn't see clients anymore sort of mid treatment."* (Shanti, p. 6)

Here, Shanti articulates her feelings of guilt at leaving her clients during the middle of their therapy sessions, highlighting the sense of powerlessness that she experienced due to the situation being beyond her control. Adam emphasised the lack of power and control over how he worked, expressing the overwhelming pressure he felt to proceed with the job, as 'the job sustained my family'.

In Summary, in the initial phase of transitioning to remote practice, therapeutic interventions were substituted with brief interventions and case management tasks, prompting feelings of guilt among participants. This leads to the next subtheme: Loss of expert position in the therapeutic relationship.

Subtheme four: Loss of expert position in the therapeutic relationship

This theme explores how participants navigated the experience of giving up a role infused with expertise, requiring a shift towards depending on clients for technological aid. It entails the disclosure of vulnerability, wherein the individual was compelled to express uncertainty and admit a lack of knowledge to their clients. This theme also encapsulated the loss of professional identity within the therapist-client dynamic in the newly adapted remote practice setting. In the following excerpt, Sarah describes feeling out of depth during therapy:

> *"I had a client who was a software consultant and with him there was always the biggest problem and I felt, oh my God, I'm so much out of my depth."* (Sarah, p. 13)

Sarah's use of expressions such as 'oh my God' and 'out of my depth' underscore the shift in the expert position to her client, intensifying stress and nervousness on her part. It is plausible that Sarah, in her endeavour to uphold professional credibility, experienced substantial pressure and anxiety, potentially stemming from concerns about appearing less knowledgeable than her expert client within the dynamics of their professional relationship:

> *"I said, that's OK… I'll use your help because that's what you know how to do. So initially I I felt very, very insecure using the medium, I felt on the kind of the, the, the one who just doesn't know how to use it. So, the balance but it was very, very shifted to that kind of I wasn't all the sudden I wasn't, I didn't have expertise; I wasn't an expert at all."* (Sarah, p. 14)

In this extract, Sarah openly expresses self-doubt, acknowledging her own limitations whilst admiring the client's extensive knowledge and understanding. This manifestation can be interpreted as a form of self-deprecation. Sarah's insecurity stemmed from her perception that the client possessed superior expertise, resulting in a shift in the balance of knowledge and proficiency away from her. The repetition of the phrases 'I didn't have expertise' and 'I wasn't

an expert at all' emphasises the significant loss of her previously held position of expertise. This concern, perhaps driven by the fear that her client might perceive her as inadequate, could have impacted their therapeutic relationship and engagement. James, Adam and Shanti indirectly alluded to the loss of expert position whereas Helen and Eva did not mention this at all:

> *"I'm laughing at this now, but it was extremely stressful (laughs)." (Sarah, p. 17)*

Sarah responded by laughing in disbelief - a defense mechanism to help her process the situation. Shanti added:

> *"As a psychologist, it was always face-to-face work, you're in clinic… I was very attached to going into work and seeing clients face-to-face… the idea of doing any of that from home felt quite alien."* (Shanti, p. 4)

Shanti thus articulated her conception of her expertise as a psychologist derived from working in an office and conducting in-person sessions, which offered a sense of safety and containment. However, the transition to remote practice prompted by the lockdown resulted in a substantial loss for her, as the familiar sense of safety and containment became unavailable. The term 'alien' suggests that Shanti's transition from an expert position was characterised by navigating uncertainty and adapting through trial and error in the process of practice adjustment.

In summary, this GET theme highlights the multifaceted losses experienced by CoPs during the unprecedented transition to remote online practice from home. It elucidates the emotional and professional complexities inherent in this transformative process. Participants faced an abrupt loss of personal and professional support systems, as well as connections with others, leading to heightened feelings of isolation. The unanimous preference for in-person therapy over remote methods underscored their view of remote approaches being unconventional and

inconsistent with their professional preferences. During the earlier phase of adaptation, therapeutic interventions transformed into support work for CoPs. This marked a shift from an expert position to vulnerability, especially in navigating technological challenges, fostering self-doubt and insecurity. These changes significantly impacted the dynamics of the therapeutic relationship.

GET four: Gains – embracing new way of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation

This theme encapsulates a pivotal moment of positive transformation in participants' lives as they acquired new skills, progressed professionally as therapists, and wholeheartedly embraced the continual process of practice adaptation. This critical juncture not only ushered in transformative changes, but also opened doors to novel opportunities.

Subtheme one: Home practice adaption – learning new skills and an opportunity to develop as a therapist to deliver therapy using different mediums

In this theme, participants gain an understanding and gratitude for the novel skills and knowledge they acquired through their COVID-19 lockdown practice adaptation. They recognise that this newfound appreciation expanded their potential to employ a diverse array of mediums to deliver therapy. The following is an instance where Eva altered her perspective and stance regarding the provision of remote online therapy:

> *"Prior to the pandemic, the idea of remote working…was really looked down on by a lot of senior people in my team and the wider psychodynamic psychotherapeutic community, the idea this wouldn't work. You can't have a relationship unless you're literally in the same room with somebody. So, it was just like it was an unchallenged sort of solid idea that very soon dissolved into well, actually there's an awful lot you can do… I'm sure that I'd paid lip service to that idea prior to lockdown myself. But we*

> *very quickly kind of discovered that there is an awful lot that can be done… It's a willingness on both sides, on the sides of the patient and also on the side of the therapist and the system to kind of say, well, how could we make this work?"* (Eva, p. 20)

This excerpt delineates the resistance observed among senior personnel and within the psychotherapeutic community regarding the delivery of therapy through remote mediums, with the prevailing sentiment favouring the in-person medium as superior. Eva, a senior member within the psychodynamic community, made the choice to refer to herself in the third person, potentially aiming to establish a differentiation between her views on remote work before and after the onset of COVID-19. This contrast became more evident when she chuckled whilst acknowledging her earlier superficial endorsement of an idea, stating, 'I'd paid lip service'. This suggests that she may have experienced a sense of embarrassment that her previous stance was not in support of remote online work. Eva used the term 'awful' figuratively, emphasising that her experience with remote online practice adaptation was extremely positive and effective. Sarah agreed with her stance:

> *"In a way I'm pleased we developed this way. That we kind of can offer people more options now and also it doesn't have to be just one way. Yes, a part of me is quite pleased that we can move on with time."* (Sarah, p. 9)

> *"I learned something new, I found I can do something new and… this was quite satisfying."* (Sarah, p. 9)

In these excerpts, Sarah expresses her appreciation for the opportunity to acquire skills in utilising various remote therapy delivery mediums, offering clients a range of options through which to receive therapy. She reflects on the evolution of the psychological community during the COVID-19 lockdowns, emphasising the embrace of technology commonly used in the contemporary world. This integration not only enhanced the convenience of connecting with

individuals, but also significantly increased the accessibility of psychological services. Sarah expressed her contentment with this positive shift, relishing the newfound ability to learn something new. Enthusiasm radiated through her voice and facial expressions as she discussed these developments. All the participants directly communicated their gratitude for technological advancements that contributed to the enhancement of therapeutic delivery using multiple mediums. Eva felt the COVID-19 lockdown aided her professional development:

> *"So, it was learning how to apply some of the digital aids and having to learn a little bit more than really, I would ever probably have ever developed in my life possibly otherwise."* (Eva, p. 8)

Eva describes her gain as learning new digital aid skills, enhancing her capability to provide Cognitive Behavioural Therapy to clients online and ensuring they did not miss out on quality therapy. She believed that these skills, crucial for professional growth, would not have been cultivated without the impact of the COVID-19 lockdown. Shanti effectively encapsulates this view:

> *"Not restricted to a certain way of working because we're psychologists…we focus a lot on interpersonal communication and skills and relation. There's lots of process and relational aspects to our work, I think umm you feel there's only way, there's only one way that you can work, I think, which is face-to-face in a room."* (Shanti, p. 24)

This excerpt illuminates a shift in Shanti's perspective on the efficacy of psychological work solely within in-person sessions, as indicated by her choice of words such as 'not restricted', signalling an openness to working with alternative mediums for therapy. At a specific juncture during the lockdowns, her unwavering belief in the superiority of traditional, in-person psychological interventions experienced a transformation. This change motivated her to actively acquire the skills and knowledge necessary for conducting therapy online. This

adjustment not only provided Shanti with flexible working arrangements, but also proved beneficial to her clients, offering them greater choice in receiving therapy through multiple mediums.

> *"Lot of… younger people, this is normal for them. They're they're quite happy to uh, you know, speak to people online and um the convenience so that people don't have to travel, and…I think there's really really big benefits to that, that people can actually make time for seeing someone... There's also… some people that are… socially anxious… they never would have come to services to meet you if we were open. So, the fact that we could offer this thing was a really, really great thing actually, really helpful for us to be able to support people in their homes in safety, and it was convenient for them and um they were able to engage with something without actually having the anxiety of having to travel to see someone."* (Helen, p. 8)

In this lengthy extract, Helen argues that the provision of online therapy has broadened the accessibility of psychology, benefiting two specific demographics in particular: the younger generation and individuals grappling with social anxiety. In adapting her practice, Helen observed that the younger demographic, characterised by their adeptness with technology, seamlessly incorporate digital tools into their daily lives, viewing online therapy as a normative mode. This group exhibited greater receptivity and enthusiasm for virtual therapeutic sessions, demonstrating an inherent inclination towards technological assimilation. Similarly, for individuals contending with social anxiety, online therapy offers a valuable avenue to access therapeutic interventions that might otherwise be challenging to obtain. Helen emphasised the significance of this medium, noting that it provides an opportunity for such individuals to engage in therapy they would typically find daunting. Her reiterated use of terms such as 'really', 'benefits', and 'great' underscores her emphasis on the positive outcomes and advantages associated with online therapy. This repetition serves to highlight her satisfaction

in facilitating access to therapy for clients who previously faced barriers in engaging with therapeutic services.

In summary, this subtheme encapsulates the participants' appreciation for learning new skills and the opportunity to evolve as therapists by delivering therapy through various mediums. This leads to the next subtheme: acceptance and embracing of hybrid therapy delivery.

Subtheme two: Acceptance and embracing hybrid therapy delivery

This theme represents a stage where the participants accepted and embraced the new hybrid practice approach, granting them the benefits of both domains: the in-person clinical work favoured by the majority of CoPs combined with the utilisation of online platforms for a well-balanced combination. During the third lockdown, all participants fully embraced, accepted and welcomed this hybrid approach to working:

> *"COVID and the situation… as a new way of working emerged." (Shanti, p. 2)*

Here, Shanti describes the shift from the pre-COVID-19 work approach to embracing and accepting the new hybrid model, highlighting the reinstatement of elements that are familiar and comforting to her:

> *"Made me feel a lot more contained with myself …. seeing the patient there and that… restored a lot of what had been lost in the previous."* (James, p. 9)

As indicated above, the return to in-person clinical work provided James with a sense of professional ease and familiarity, restoring equilibrium in his professional pursuits. Sarah described her hybrid practice weekly schedule:

> *"I see all my patients face-to-face on one day. I'm doing private practice once a week face-to-face. I see few people online but mainly face-to-face, and the rest of the work can be done… I find it much more relaxing and more productive."* (Sarah, p. 10)

Sarah repeatedly emphasised in-person therapy, her face beaming with contentment as she continued to smile. This suggested that she had indeed reached a satisfying balance with the hybrid practice, wholeheartedly embracing and accepting it. She believed that this hybrid approach enhanced the efficiency and productivity of her work. Shanti emphasised the flexibility facilitated by hybrid practice:

> *"Main benefit… flexibility that is it's given me umm, in terms of um juggling home life and work life… now we're at a place where we can take the parts of it that will work for the long-term."* (Shanti, p. 14)

> *"When you can get to a place where it can equally pay payoff, then it becomes like a strength to your practice."* (Shanti, p. 16)

In these excerpts, Shanti expresses gratitude for the flexibility provided by hybrid practice, facilitating a harmonious blend of her personal and professional life. She explicitly states her desire to retain the successful elements derived from the COVID-19 practice adaptation for long-term use. Furthermore, her use of the term 'payoff' suggests she is strategically positioned to take advantage of the benefits of practice adaptation, aiming to enhance and fortify her professional practice. Sarah consistently stressed that hybrid working contributes to a favourable balance between work and personal life:

> *"… benefit is that I'm working from home… all the meetings are online and I I'm doing a lot of things which require me just using computer and which which is of course very positive for me because I don't have to commute…Office is often very crowded, I don't have to fight about rooms, about space. So, yes for me it's more positive than negative."* (Sarah, p. 10)

In the extract above, Sarah delineates the primary advantages of hybrid practice as conducting all her meetings online and expressing gratitude for the time saved by eliminating the commute.

Her use of the word ‘fight’ indicates a chronic shortage of clinical space in which to see clients at her service, thus making hybrid practice more favourable for her. Adam and Eva articulated an identical sentiment about the effectiveness of home practice, with Adam further adding:

> *“I remember when…I started coming once a week, to the hospital, then within secondary care I remember feeling quite happy of having that bits…to socialise…I realise I like that more than what I realised…”* (Adam, p. 14)

Here, Adam shares his experience of hybrid practice, emphasising that the resumption of in-person social interactions with colleagues were moments that brought him joy, referred to as ‘that bits’. His repetition of ‘I realise’ underscores the emergence of a previously suppressed emotion, specifically joy, during the COVID-19 lockdown. Shanti noted the willingness of clients to engage in online work.

> *“When assessing clients… some clients actually opt-in for video therapy… there's just so much more flexibility, you're not restricted to a room, times.”* (Shanti, p. 14)

Shanti thus highlights the benefits clients gain from a variety of therapy delivery options, allowing them to choose the medium that aligns with their preferences. Describing in-person therapy as ‘restricted’ for those favouring a different medium, Shanti suggests that the hybrid approach grants her the desired freedom and flexibility. She perceives this as mutually advantageous for both clients and therapists. Eva was in favour of continuing hybrid working due to the physical health benefits.

> *“Fact I was sort of saying this is good, keep it going, my knees are so much better.”* (Eva, p. 11)

In summary, this subtheme reflects participants’ embrace and acceptance of hybrid working practices. They found they could maintain the most beneficial elements of both remote and in-

person approaches, providing enhanced flexibility for clinicians and their client groups. This leads to the next subtheme: acceptance of new norms.

Subtheme three: Acceptance of new norms emerging from lockdown practice adaptation

This theme captures participants' acceptance of a new, different way of working that emerged due to adjustments made during the COVID-19 lockdown. Adam described his perspective on the change:

> *"I think we as human we adapt very much quicker than what we think... After some time, it became much more the norm, so I felt comfortable, but…the first month they were hard to adapt."* (Adam, p. 9)

In this excerpt, Adam expresses his astonishment at how quickly and effectively he adapted to the new practice from home, surpassing his initial expectations. Over time, this adapted approach became his new norm, a change he accepted and embraced. Adam's positive outlook may be attributed to experiencing a short lockdown period, after which he seamlessly shifted to a hybrid work model within a few months. All participants acknowledged that, following a period of disruption, they embraced a new and accepted way of working.

> *"I was open to from a clinical point of, I was really open to adapt my practice online and I was pleasantly surprised how possible that was actually in most cases." (Adam, p. 4)*

Here, Adam explains that openness, for him, served as a prerequisite to accepting the new remote online model of working. He stresses this by emphasising the words 'really open', indicating that being receptive to change played a key role in his adoption and embracement of the new model of working which became the norm. Eva affirmed this statement:

> *"it's about keeping a curious mind and keeping an open attitude towards what's possible and what's doable and what can work or what can you try? What can you experiment with?" (Eva, p. 20)*

In this excerpt, Eva highlights the importance of maintaining an 'open attitude', nurturing a 'curious mind' and continuously experimenting with methods that resonate with her. These factors played a pivotal role in her acceptance of the new adaptation and in wholeheartedly embracing the transition to remote online practices. Helen mentioned that she felt comfortable requesting clients to repeat themselves over time without worrying about appearing inattentive. Adam compared both in-person and online practice:

> *"I would say…especially for counselling psychologists and that…from a technical point of view that the online format is not worst or better, it's different…the sources of information that you get about the person, it's not the same as face-to-face, but there are differences. So, you pick-up on different things."* (Adam, p. 18)

In this excerpt, Adam, as a CoP, describes how he found acceptance of the new working model by recognising that online clinical work is as effective as in-person interactions. He emphasises the term 'different' multiple times and stresses 'not better or worse' to highlight the equal significance of both approaches. For Helen, overcoming perfectionism helped in accepting the new norm:

> *"Reminding yourself of like actually there's there's valuable things that we can do that are maybe not in a perfect piece of work, but actually in a connection or relationship or something or validation and all of those kind of key counselling kind of stuff."* (Helen, p. 20)

Helen's alleviation of self-doubt regarding her performance and anxiety about delivering a flawless online therapeutic intervention to a satisfactory standard proved advantageous. She

recognises that prioritising relationship-building and applying essential counselling skills significantly contributed to her acceptance of this specific new way of working:

> *"Whether you feel like you've done a good enough job afterwards, maybe that reduced a little bit… because there was a lot of people really grateful that… they were able to connect to someone online. So, you definitely did get some sort of sense of achievement and that you were doing a a worthwhile bit of therapy."* (Helen, p. 14)

Helen's confidence and self-assurance were enhanced as she received feedback from clients expressing gratitude for having access to a therapist. This reassurance confirmed her positive impact on her clients and helped her embrace this emerging norm.

In summary, this subtheme encapsulates the acceptance of a new norm emerging from practice adaptation among participants, leading to a sense of achievement. This leads to the last subtheme caring and nurturing oneself.

Subtheme four: Practice adaptation – importance of self-care, self-acceptance, self-compassion, self-connection, and self-awareness

This theme captures the latter stage of lockdown practice adaptation where participants were able to nurture themselves through self-care, embrace and accept the new way of working, be kind and compassionate to themselves, build a strong relationship with their own identity through self-connection and gain a deeper understanding of themselves through self-awareness. Sarah acknowledged her shared experiences with others:

> *"… it's important to be human, and… being in the same boat as other people, as our clients because… we are not any different, we are also affected by everything and this needs to be acknowledged. We are not above any calamities, we are very much affected and… to be able to kind of get help from each other, get support."* (Sarah, p. 23)

In this excerpt, Sarah emphasises the importance for CoPs of being 'human', almost as if she now feels safe to let her guard down to reveal her vulnerabilities and acknowledge that she is not infallible or shielded from the dangers or the negative consequences associated with the COVID-19 virus. In the early days of the COVID-19 lockdown, Sarah fully immersed herself in her work, suppressing numerous emotions and eventually succumbed to burnout. This was the default position of James, Adam, Shanti, and Helen. Given their heightened sense of empathy, commitment to assisting their clients, and determination to offer comprehensive care, CoPs may have willingly shouldered additional responsibilities, even if these extended beyond their typical job descriptions.

James learnt that monitoring and minimising self-criticism, whilst concurrently increasing self-compassion, was beneficial in mitigating the negative impact of adapting to lockdown practices:

> *"Just to do your best, really and to not be… self-critical… show yourself some compassion." (James, p. 22)*

James felt that self-compassion during COVID-19 was paramount. Adam reiterated the importance of kindness and compassion, whilst also emphasising the significance of recognising and accepting one's own limitations:

> *"…it's been good to have some time to slow down, to reflect, to pick up all the interests, old hobbies…"* (Adam, p. 3)

For Adam, COVID-19 lockdown practice adaptation provided an opportunity for life to slow down, presenting an invaluable opportunity for deep self-reflection and introspection, and offering a precious moment to revive past passions and interests. Eva shared a similar view:

> *"You needed to be centred as a therapist, you need to be grounded, you need to be kind of, you know, you need to be in that place so that you can be able to support others."* (Eva, p. 21)

Eva asserted throughout the interview that CoPs should maintain a sense of being 'centred' and 'grounded' and prioritise kindness towards themselves. When speaking about her experience of adapting to COVID-19 lockdown practice, she consistently exhibited a serene and composed demeanour, reflecting her emotional and mental stability and focus. She clearly found it crucial to convey this aspect, especially considering her senior role within her organisation. Helen encapsulated her experience of change as follows:

> *"Whole experience has has changed me… I did change my my work pattern… I think it's, the whole experience has changed, how I feel about work and what I want to prioritise. So, for example within the [public] sector… you get pulled into different kind of roles… it kind of reminded me of what I do feel passionate about… most fulfilled about is actually the therapy. So, and just kind of working out what's important to me and what I want to get out of my work. Uh really, I think I've learnt that over the last two years and not worrying so much about what I should be doing in my career or what other people are doing and really tapping into what is right for me. So… I'm kind of grateful for the last two years as well, to sort of really trust myself again and what I, what is right for me and taking things slow, slower, and not feeling any guilt about that, prioritising my well-being… Not saying yes to things, you know, that I don't really want to do. All of those kinds of things I think have really emerged and and strengthened and that's a good thing, I think."* (Helen, pp. 20-21)

In this excerpt, Helen places significant emphasis on the term 'change', highlighting the COVID-19 lockdowns as a pivotal time in which she underwent a substantial transformation

in her perspective and aspirations. She explained that her actions and choices became more ego-syntonic, enhancing her connection with her own thoughts, emotions, and needs. This resulted in an increased sense of self-awareness and inner alignment, leading to both personal and professional growth and providing her with a greater sense of clarity and purpose. When she mentioned being 'pulled', referring to managerial roles and responsibilities, it seemed that she had lacked control and autonomy over her professional choices before the lockdown. Helen also employs the terms 'passionate' and 'fulfilled' to express her deep affection for therapy and her desire to continue her career in this field. Her life choices were profoundly influenced by a combination of experiencing loss and adapting to COVID-19 practices. This not only helped her overcome a competitive streak but also taught her to trust herself in making the professional decisions she desires. Helen encapsulates her experience by stating that she developed the capacity to overcome the guilt associated with saying 'no' to others. The entire journey heightened her self-awareness, self-compassion, and proficiency in managing her emotions.

In summary, this cluster of themes reveals a positive transformation among participants throughout the COVID-19 lockdown practice adaptation, encapsulated in four overarching themes. Initially, participants valued the acquisition of new skills and opportunities for professional development through home practice adaptation. Subsequently, they embraced a hybrid therapy delivery model, seamlessly integrating in-person and online practices to improve their flexibility and efficiency. Thirdly, participants demonstrated adaptability and openness to transformative changes, acknowledging and accepting new norms in their working methods. Finally, in the later stages of practice adaptation, there was a notable emphasis on the significance of self-care, self-acceptance, self-compassion, self-connection, and self-awareness.

In summary, four GETs emerged from the data analysis. The first GET, ‘Intense emotional reaction’, highlights participants’ experiences of profound emotional upheaval at the onset of the COVID-19 lockdown practice adaptation from home. The second GET, ‘Newness’, encapsulates participants’ efforts to navigate the challenges of transitioning to remote work during the COVID-19 lockdown. They faced obstacles such as establishing suitable home workspaces, grappling with unfamiliar online therapy mediums, and addressing technological challenges. Additionally, they encountered challenges in maintaining confidentiality and professional boundaries with clients in the newly adapted online therapeutic environment, managing extended working hours, and adapting therapeutic techniques for online settings amidst technological constraints and interruptions. The third GET, ‘Multiple losses’, explores the losses experienced by participants during the COVID-19 practice adjustment. This includes the sudden loss of support systems and social connections, the challenges of transitioning from in-person to remote therapy delivery from home, the shift from clinical therapy to providing support, and the vulnerability felt by participants in their expert role within therapeutic relationships during remote practice. On occasion, participants felt embarrassed when they had to ask clients for help with technological difficulties. This also highlighted a loss of their expert position within the therapeutic relationship. Despite these challenges, the fourth GET highlights ‘Gains’, a positive transformation experienced by participants during the COVID-19 lockdown. This entailed valuing the acquisition of skills to deliver therapy across multiple mediums, thereby enhancing therapy accessibility for all clients and fostering professional growth. Participants also adopted hybrid therapy delivery models, demonstrating their adaptability to new norms, and placed a priority on self-care and self-awareness.

Chapter Five

Discussion

Chapter Overview

The initial section of this chapter summarises and discusses the major findings of this study in relation to the existing body of research, and highlights their broader significance for the practice of counselling psychology. Given the richness of the findings, a more in-depth exploration is provided of novel aspects, the aim of which is to contribute the unique perspectives of participants to this research topic. Following this, I discuss the clinical implications of the study and offer suggestions for future research.

Research Aims and Summary of Results

The aim of the current study was to explore the experiences of counselling psychologists (CoPs) adapting their professional practice to working from home during the government-imposed COVID-19 lockdowns. The participants' narratives illuminated the myriad challenges faced by CoPs as they transformed their practice and grappled with the difficulties of working remotely whilst upholding their professional values. This aspect was consistently evident in their narratives. Four GETs emerged from the data analysis: ‘intense emotional reaction to sudden COVID-19 lockdown practice adaptation’, ‘newness of lockdown practice adaption, the experience of multiple losses during COVID-19 lockdown practice adaptation’, and ‘gains – embracing a new way of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation’. The first two GETs centre around the initial reaction to the COVID-19 pandemic, lockdown and adaptations in work environments, which elicited a fearful, intense and uncertain emotional response directed both towards the virus itself and the novelty of the new reality. The third GET captures the multifaceted losses experienced by CoPs in their personal and professional domains due to the intrusion of the pandemic. This encompasses the loss of what was once familiar to them such

as a physical office base, in-person therapy delivery, home space as a place for relaxation, and psychological interventions. The fourth and final GET, 'gains', encompasses growth, learning and personal and professional development. CoPs were observed to value this newfound learning experience and succeeded in providing therapy via these innovative remote and online mediums, which they viewed as an avenue for both personal and professional development. This GET is marked by the acceptance of this novel working approach, leading to an increase in self-care practices and a reduction in self-criticism.

Understanding the Themes in the Context of Existing Literature

This section discusses the primary findings that emerged in relation to the existing body of literature. Additionally, it examines novel findings that broaden current inquiries concerning the experiences of CoPs adapting their working practices during the COVID-19 pandemic lockdown. The four GETs derived from participants' conceptualisation of their experiences exhibit interconnectedness, rendering certain aspects inseparable. Participants' narratives resist straightforward compartmentalisation, demonstrating an inherent crossover across GETs. Despite the non-linearity of the process, it nevertheless appears to encompass elements universal for all participants. The four GETs are described further in the following sections. At this juncture, it is crucial to emphasise that this discussion chapter presents my subjective interpretation rather than a generalisable explanation. The insights are derived from the analysis of participants' experiences, aligning with the idiographic approach of interpretative phenomenological analysis where the researcher's focus remains on the particular rather than universal experiences (Smith et al., 1995).

GET One: Intense emotional reaction to sudden COVID-19 lockdown practice adaptation

In this GET, the intense emotional reaction to the pandemic among participants is divided into two subthemes: 'the experience of intense emotions and uncertainty about practice adaptation'

and ‘deserted streets felt apocalyptic’. In the early stage of the first COVID-19 lockdown, all participants described feeling overwhelmed with intense emotions as they adjusted their working practices from home in the face of the sudden onset of a deadly pandemic and its associated restrictions. They elaborated on these in the first subtheme, ‘the experience of intense emotions and uncertainty about practice adaptation’. All participants described practice adaptation as a protracted journey through intensely distressing experiences, emphasising a clear inclination towards emotions such as ‘shock’, ‘anxiety’, and ‘uncertainty’, coupled with ‘disorientation’. The findings from this theme are consistent with both quantitative (Gordon et al., 2015; Pappa et al., 2020; Qiu et al., 2020) and qualitative research (Chemerynska et al., 2022; Daplyn, 2022; Embregts et al., 2022) conducted on practice adaptation during the COVID-19 pandemic, which examined the emotional impact of such adaptation on clinicians. For instance, in the current study, Helen described feeling on the ‘edge’, preoccupied with ‘worry’ and ‘sadness’, and feeling ‘traumatised’. She found herself crying a lot of the time due to the loss of close family members and the inability to grieve with others – a phenomenon documented in similar research (Bonanno & Kaltman, 2001; Cooper & Williams, 2020; Simon et al., 2020). This indicates that practice adaptation was multifaceted and had a profound emotional impact on CoPs at multiple levels as they lived through the pandemic, deeply affecting them emotionally as they collectively navigated the challenges arising from the situation.

To holistically understand participants’ experience of practice adaptation from home, it felt important to capture what was going on around them in their environment during lockdown, as practice cannot be separated from other aspects of their lives. Therefore, the second subtheme, ‘deserted streets felt apocalyptic’, captured participants’ experiences of intense emotional upheaval, fear and the profound disruption of daily life and the sense of an uncertain, bleak future. For instance, James described the physical environment around him as ‘apocalyptic’

and Eva similarly described the situation as ‘surreal’, ‘weird’ and feeling like she was the ‘only person in London’, depicting the abrupt halt of normal activities and highlighting the pandemic’s significant impact on society. Participants’ portrayals evoke feelings of isolation and vulnerability, emphasising the stark contrast between the lively pre-pandemic world and the quiet, empty reality brought about by health crises and changes in work practices. This finding reflects a similar outcome to that identified by Morgan et al. (2022) whose participants characterised the early days of the COVID-19 response as chaotic and frantic, reflecting the widespread panic they felt, akin to that in a natural disaster. In a similar vein, Chemerynska et al. (2022) highlighted the emotional toll inflicted by the stress and uncertainties of practice adaptation during the pandemic on CoPs and their well-being. This finding aligns with the experiences of support staff. For instance, Embregts et al. (2020) identified an ‘emotional impact’ theme along with the subtheme ‘overwhelmed with emotions’, reporting that support staff faced rapidly changing emotions such as fear of infection, frustration, disappointment and a strong sense of responsibility towards those they serve.

In summary, this GET encapsulates participants’ varied and intense emotional struggles. These emotions were closely tied to the unprecedented nature of the virus, lockdown measures and the transition to remote work, blurring the distinction between home and work life. Moreover, it reveals the sense of despair felt regarding the adaptation to remote work and participants’ difficulty in envisioning life after the pandemic. Hence, it was essential to capture these feelings as they highlighted the significant impact of the crisis on the outlooks and experiences of CoPs.

GET Two: Newness of lockdown practice adaption

The novel nature of both the COVID-19 pandemic and remote working practices not only heightened the intense emotional struggles experienced by participants; they also encountered a multitude of practical challenges in adjusting to new mediums through which to deliver

remote therapy from their homes as part of their adapted practice. In their study, Embregts et al. (2020) reported that the theme of 'practical impact' on staff was commonly noted during practice adaptation amid the pandemic. Even though some therapists were already working online and had embraced it, it was a new experience for the participants in this study. The following four subthemes capture some of the experiences and struggles involved in CoPs' practice adaptation: the 'multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas', the task of 'embracing and adjusting to new remote practice adaptation and working with new mediums - "absurdity of the new world we live in"'; the novelty of 'newness of confidentiality and managing risk – "counselling somebody in the middle of a shopping mall"', and the 'newness of working with technology and the impact of internet disruption on therapy'.

The first subtheme, 'multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas', describes the intrusion of home practice adaptation into participants' personal lives. It highlights the ways in which this blurring of boundaries between personal and professional domains impacted their daily functioning in numerous ways. All participants detailed the challenges they faced in setting up a private workspace at home with family members, especially when young children were around. They described utilising any space they were able to access such as the bedroom, living room, understairs cupboard and garden storage shed. CoPs prioritised shielding their clients from all the lockdown chaos in their lives and accomplished this by utilising a professional digital screen background to instil a sense of containment for their clients, even whilst appearing to lack containment themselves. For example, Shanti expressed her difficulty in 'being able to feel professional while sitting in the bedroom to work', leading to 'issues around separating home life and work life', which impacted her ability to focus and be present during therapy sessions. All participants described encountering comparable difficulties with boundary

separation, aligning with the findings of Kerman et al. (2022) who identified a domain-specific connection between boundary violations and satisfaction with domain investment. It was observed that daily interruptions influenced satisfaction in both work and home domains. This finding echo that of Spreitzer et al. (2017) who found that increased goal obstruction and negative affect were associated with extensive use of flexible work arrangements.

Furthermore, participants faced concurrent hurdles; for instance, they were disturbed by noise coming from family members and children in the household whilst working. However, there was also a risk of family members overhearing the session, potentially breaching confidentiality. Consequently, some participants had to ask their families to limit their movement during working hours, leading to the feelings of 'guilt', as described by Adam. These findings align with previous research indicating that higher integration of boundaries causes conflicts between roles, with home duties interfering with work and work disrupting home life, especially when work extends beyond regular hours (Delanoeije et al., 2019). Several researchers have found that the easy accessibility to and proximity of work make boundaries more permeable, increasing the likelihood of transitioning between roles throughout the day and violating domain-specific boundaries (Allen et al., 2021; Sullivan & Lewis, 2001). This leads to dissatisfaction among individuals with an investment in professional or personal domains (Hunter et al., 2019). The benefits of being able to access home practice for personal freedom and flexibility, noted in previous research, were not observed in the current study at this stage of adaptation (Delanoeije et al., 2019; Kreiner, 2006). Supporting the evidence presented in previous research, James actively engaged in boundary work to navigate and regulate the overlaps and collisions that arose from the amalgamation of various elements (Ashforth et al., 2000; Sullivan & Lewis, 2001; Wethal et al., 2022). He achieved this by compartmentalising work and home and disciplining himself to set work aside when he had completed his tasks for the day. At this stage of adaptation, all participants had

accepted that their homes had become their workplace and that the boundaries between their home and work roles had become blurred.

Simultaneously, participants were tasked with adapting to remote mediums through which to deliver therapy. This was a novel experience for all CoPs, as none had any previous experience providing remote clinical work. In the second subtheme, James expressed his emotional reaction to the change in therapy delivery medium as entering a 'new world', labelling it as 'absurd'. This suggested that he found the changes unfamiliar and permanent, conflicting with his values as he strongly favoured traditional, in-person psychotherapy delivery. This sentiment is accentuated by a cognitive bias among all participants that reveals a propensity to catastrophise potential failures in their adapted practices during the earlier days of the pandemic. Half of them thought that the phone medium was not as effective for therapy delivery; for instance, Adam characterised it as 'distant' and 'disengaging', compromising both his and his clients' attention and emotional presence during sessions. James concurred, describing telephone therapy as 'ringing a faceless voice' in a 'void', thereby implying that delivering therapy through voices alone is challenging and stressful due to the absence of visual cues, making it difficult to communicate empathy and to establish a genuine relationship with clients. These findings are consistent with previous research which indicated that therapists felt inadequately skilled when confronted by the challenges of remote working, particularly due to the diminished interpersonal cues (Knott et al., 2020; McBeath et al., 2020).

The remainder of the participants found value in the telephone medium; for example, Hannah described experiencing the 'real intimacy' that can be created with telephone sessions. In the absence of visual cues, she felt that other senses were heightened, and she relied particularly on hearing to discern the tone of a person's voice, leading to the creation of a 'real connection' with the client and engagement in some effective therapeutic work. This is in line with Coughtrey and Pistrang's (2018) findings which highlighted the effectiveness of telephone

therapy interventions in reducing symptoms of depression and anxiety, leading to high levels of satisfaction being reported upon completion of the treatment (Bee et al., 2010). In remote therapy, talking on the phone is analogous to conversing with someone out of sight, aligning with our evolutionary adaptation. The absence of visual cues minimises expectations with respect to facial expressions and body language, facilitating a more focused mental engagement and reducing disorientation.

A noteworthy finding from the current study is that the majority of participants did not feel comfortable using video platforms during the initial phase of practice adaptation, despite the availability of visual cues. Shanti described delivering therapy via video as 'alien', indicating her unfamiliarity with this medium. Eva, who described herself as 'camera shy', viewed this medium more as a 'performance' than a means of therapy delivery. This perspective might arise from the fact that when clients had their cameras switched off, it seemed to Eva that she was talking to herself. Sarah felt this medium resulted in the loss of nuance and emotions on which one picks up during in-person sessions; thus, she felt she had to compensate by increasing verbal communication and reducing therapeutic silence in her sessions. Over time, Adam's confidence grew and he recognised the value of video work, ultimately leading him to embrace it. There is a plethora of research from both before and after COVID-19, indicating that online therapy is effective for treating various diagnostic groups such as those with social anxiety disorder and post-traumatic stress reactions (Carlbring et al., 2018; Knaevelsrud & Maercker, 2007). Additionally, studies demonstrate that a strong therapeutic alliance can be formed in remote settings (Castro et al., 2020; Norwood et al., 2018; Simpson & Reid, 2014). However, the findings from this subtheme indicate that CoPs were reluctant to engage in online video therapy, which is consistent with previous studies (Apolinário-Hagen et al., 2017; Hantsoo et al., 2017). Other studies suggest that this apprehension gradually decreases once online therapy begins (Sucala et al., 2013).

The initial challenges faced by CoPs in establishing emotional connections with clients through remote online platforms can be better understood through the lens of construal level theory (CLT), a social psychological theory that assists in elucidating fundamental aspects of the remote therapy experience which may be beyond conscious awareness. According to CLT, various forms of psychological distance such as spatial or temporal separation are interconnected, representing different ways in which the subject of interest is distanced from the central reference point of the self. To bridge psychological distance, individuals employ mental abstraction; the greater the distance of an object, the more it adopts an abstract quality, creating a separation from direct, personal experience (Trope & Liberman, 2010). This theory provides insight into why participants struggled to establish emotional connections with clients who were physically distant. The psychological distance arising from being in separate rooms demands mental abstraction on the part of the client, affecting various aspects of the relationship, including the challenge of feeling emotionally connected in the present moment. The shared aim of participants and therapists inherently conflicts with the mental abstraction needed to connect with a client who is physically distant and, consequently, psychologically distant. Morgan et al. (2022) also found that therapists faced difficulties in embracing remote therapy delivery mediums.

In the third subtheme, titled ‘newness of confidentiality and managing risk: “counselling somebody in the middle of a shopping mall”’, participants delved into the unique process of establishing boundaries, managing risks and maintaining confidentiality both for themselves and their clients in the newly adapted remote online work setting from home. All participants found that, due to the pandemic lockdown restrictions, their clients faced challenges in accessing a private and confidential space for their therapy sessions because of system issues. For example, James encountered clients’ family members walking in during sessions, whilst Sarah noted that her clients walked outdoors or sat in their cars, indicating the difficulty of

finding a protected space for therapy. This could have impeded the therapeutic process and inhibited clients' readiness to express emotions in a public setting. This significantly affected CoPs, as they found themselves lacking control over the therapeutic environment and framework, leading to dissatisfaction with the service they were providing. James described his experience of delivering remote and online therapy as 'counselling somebody in the middle of a shopping mall'. This comparison suggests that the challenges involved in establishing therapeutic boundaries and the interruptions in a non-private therapy setting are similar to the noisy and public atmosphere of a shopping mall. This finding is consistent with other research findings suggesting that therapists experienced the therapeutic safe space as being influenced by external distractions and disruptions in their newly adapted practice. Research reveals that clients became distracted when showing their therapist items on video, diverting themselves from the therapeutic focus (Geraldina et al., 2023; Kotera et al., 2021). These disruptions, although present in in-person therapy, were more unpredictable and more difficult to manage (Brenes et al., 2011; James et al., 2022). Consequently, the changes in boundaries enabled clients to exhibit behaviour not typically observed in formal therapy. However, Simpson and Reid (2014) highlighted the fact that remote therapy, despite boundary challenges, offers new opportunities, notably by enhancing client accessibility.

Furthermore, all participants felt ill-prepared to handle risk concerns whilst working remotely. Sarah faced a challenging situation where she found it difficult to manage a risky scenario over the phone, particularly when the client was self-harming, causing her significant distress. She related her sense of powerlessness in intervening because of the physical 'distance' between herself and the client, which she believed heightened the risk over the phone due to the perceived separation. This emphasises the sense of powerlessness in handling risks whilst working remotely. This is supported by research revealing that psychologists experienced

uncertainty in dealing with specific ethical issues, maintaining therapeutic boundaries, confidentiality, and managing risks (Geraldina et al., 2023; Singh & Sagar, 2022).

Research suggests that a strong therapeutic relationship is established within a framework of practical and symbolic boundaries that encapsulates both the therapeutic space and the therapy process (Bass, 2007). A reliable, consistent and therapeutic environment signifies the quality of care that CoPs provide, allowing the client to internalise the therapist as a 'good enough' figure, thereby fostering trust in the therapeutic process (Winnicott, 1965). Any disruption to this dynamic negatively impacts CoPs' ability to do a 'good enough' job, as clients may be reluctant to open up about intimate issues or express difficult emotions in a public space. Under the new remotely adapted circumstances, CoPs were under added pressure to learn ways of navigating the new practice environment and reframing new boundaries of therapy.

In the fourth subtheme, 'newness of working with technology and the impact of internet disruption on therapy', the majority of participants initially lacked access to the technology and equipment required for conducting therapy online. Similarly, some clients did not have access to technology or were unable to use it, preventing them from accessing therapy. Shanti believed that as clinicians 'they were in a position of disadvantage' and she felt she was not maintaining her professional values, which were aimed at reducing poverty and inequality (Cooper, 2009). Consequently, she perceived that she was not fulfilling her job responsibilities adequately.

All participants encountered struggles when switching their practice to an online medium. Among the practical problems they faced was uncertainty as to how to use technology to foster a genuine therapeutic relationship with clients. Participants were hyper-focused on themselves on camera. For instance, Sarah mentioned that she saw her 'face twitching, a very strange grimace, and it was frozen on the screen', which she found 'frustrating', 'anxiety-provoking' and 'embarrassing' as the clients were looking at this image. She thus described an initial and

powerful emotional response to adapting to a new technological practice, expressing a strong desire to physically release frustration such as the urge to 'smash the laptop' or express it verbally by 'cursing and swearing at the internet'. Helen described technological disruptions as 'intrusions' in therapy, likening them to having a third person in the therapy room. She found this experience 'really difficult', obstructing the therapeutic process and limiting her ability to nurture an authentic therapeutic relationship, compounding her feelings of inadequacy. This finding is in line with earlier studies which demonstrated that, although online therapy is beneficial for enhancing access and uptake (Morgan et al., 2019), technological disruptions and blurred professional boundaries may undermine its emotional impact, adversely affecting the therapeutic relationship and containment (Békés et al., 2021; Embregts et al., 2022; Kotera et al., 2021). Consequently, this hinders the capacity of both therapists and clients to fully engage in the therapy experience (Morgan et al., 2019).

Initially, all participants found themselves in a situation where they had to learn independently how to provide therapy, resulting in a phase of confusion, anxiety and uncertainty. This was exacerbated by a sense of being unsupported and without clear guidance from their workplace or superiors. Additionally, CoPs had to navigate the challenges of delivering therapy online, mastering the use of technology and coping with limited resources.

In summary, this GET encapsulates the challenges faced by CoPs as they adjusted their practices to work remotely from home during the COVID-19 lockdown. Such challenges included setting up suitable home offices, navigating unfamiliar online therapy platforms and coping with technological limitations. These obstacles raised concerns about professionalism, confidentiality and maintaining a work-life balance, highlighting the complexities of remote therapy delivery. Such factors caused participants to experience a high level of distress.

GET Three: The experience of multiple losses during COVID-19 lockdown practice adaptation

Participants described experiencing multiple losses during COVID-19 practice adaptation from home, which this GET captures through four subthemes: 'personal and professional - loss of support systems and social connections', 'loss of in-person therapy delivery – "unheard of and not the done thing"', 'loss of therapeutic interventions: doing support work', and 'loss of expert position in the therapeutic relationship.'

The first subtheme captures participants' loss of personal and professional support systems. All participants had at least one person in their household with whom they were in lockdown, and all described the absence of senior-level management during the initial phase of practice adaptation; as Helen described, they were 'not quite there' which 'felt a little bit scary'. James felt 'very isolated and disconnected' from his colleagues and missed informal 'social connections where you chat to colleagues' as he had started a new job during the first COVID-19 lockdown and did not meet his team. This was observed in Singh and Sagar's (2022) research which found that lockdowns impeded informal, in-person conversations, leading to professional isolation and loneliness. This increased the levels of distress felt by therapists. Adam describes his experience of 'boredom' resulting from not being 'physically in touch with people'. However, during this time, he globally reconnected with old friends, feeling that he had more time and space to do so. The above findings were echoed in research by Morgan et al. (2022) and McBeath et al. (2020), who observed that physical isolation from the workplace and colleagues emotionally affected therapists, causing feelings of loss and sadness due to the disruption. Furthermore, Ellis et al.'s (2020) research indicates that remote working during the COVID-19 lockdowns led to increased loneliness, affecting individuals' well-being. Moreover, in the current study, Shanti not only felt professionally isolated from colleagues, but also experienced the collapse of her support systems due to lockdown restrictions, including the

closure of schools and childcare. Consequently, she felt overwhelmed managing multiple roles simultaneously, a phenomenon also observed in the study conducted by Rudolph et al. (2021).

In the second subtheme, all participants articulated a sense of loss associated with the shift from in-person clinical work to remote online practice. Shanti, in particular, described her experience with video therapy as 'unheard of and not the done thing'. Not working in her preferred medium made her feel like she was not fulfilling the requirements of her job, leading to feelings of anxiety and inadequacy regarding her work. Although Kotera et al.'s (2021) research suggests some therapists and clients had a 'positive experience of online therapy' during the COVID-19 lockdown, this was not observed in the current study. Despite research evidence supporting the effectiveness of remote online work, there is widespread negative sentiment towards this approach among psychologists who view online therapy as less effective than in-person therapy (Gordon et al., 2015; Morgan et al., 2022; Schulze et al., 2019). As Helen described, remote online work 'felt like it was ticking the boxes and good enough to kind of keep services going, but it would be so much better face-to-face'. She described working 'extra hard' to compensate for the loss of in-person therapy delivery and making herself 'helpful to people' which she found to be 'a bit of a challenge'.

In the third subtheme, 'loss of therapeutic interventions: doing support work' all participants except Eva described how practice adaptation resulted in a loss of psychological interventions, which changed to a 'well-being check' and weekly 'case management' contact with clients for a couple of months. As described by Sarah, 'till we can get some kind of sense that we can work psychotherapeutically', participants initially lacked the confidence that they could effectively deliver remote online therapy. This was a significant change to the way CoPs usually worked. Shanti felt 'guilty' that she had no option but to abandon her clients 'mid-treatment' during the COVID-19 lockdown, as therapeutic interventions were no longer feasible. As far as I am aware, no other research has previously captured this theme

In a therapy relationship, psychologists typically hold the position of an expert. This means they possess specialised knowledge, skills and experience in psychology, which they use to support their clients by offering insights, evaluations, strategies and interventions to help them navigate mental health challenges and achieve their therapeutic goals (British Psychological Society, 2017). In the fourth subtheme, 'loss of expert position in the therapeutic relationship', the participants described how implementation of the COVID-19 lockdowns presented an unforeseen challenge, leading them to re-evaluate their identities and experience a sense of departure from their accustomed spheres of comfort. For instance, Sarah described feeling out of her depth and 'very insecure using the medium', feeling like the 'one who just doesn't know how to use it' when she had to resolve a technological problem. It appeared that she was undergoing a genuine identity crisis, experiencing the loss of her position as the expert in the therapeutic relationship. Sarah felt that 'the balance' had 'shifted' and that she no longer had the 'expertise' to manage difficulties encountered in virtual therapy space, instead having to make herself vulnerable by asking the client for help. This, she explained, 'was extremely stressful'. This finding aligns with that of a study conducted by Gregson et al. (2022) where participants reported feeling unable to deliver a 'good enough' service remotely, leading to internal conflict, dissatisfaction with their work, and a sense of misalignment with their professional values. Furthermore, Morgan et al. (2022) found that remote work negatively impacted job satisfaction among therapists, but they pragmatically addressed this by focusing on their duty and flexibility, finding comfort in their roles by helping others. However, in Titzler et al.'s (2018) study, therapists stated they had ample expertise and skills in remote working and did not experience any conflict regarding their professional identity.

In summary, this theme illuminates the multiple losses CoPs faced when transitioning abruptly to remote online practice from home. It highlights the emotional and professional challenges of this shift, including the sudden loss of support systems and connections which heightened

feelings of isolation. Participants strongly preferred in-person therapy, viewing remote methods as unconventional and not in line with their professional preferences. Initially, therapeutic interventions shifted to supporting CoPs who found themselves transitioning from a position of expertise to vulnerability. This change, especially in navigating technological obstacles, triggered self-doubt and insecurity, significantly impacting the dynamics of therapeutic relationships and causing intense distress for CoPs regarding their practice.

GET Four: Gains – embracing a new way of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation

This GET encapsulates the growth and development CoPs derived from the adaptation to remote online practices during the COVID-19 pandemic. It comprises four subthemes: 'home practice adaption - learning new skills and an opportunity to develop as a therapist to deliver therapy using different mediums', 'acceptance and embracing of hybrid therapy delivery', 'acceptance of new norms emerging from lockdown practice adaptation', and 'practice adaptation – importance of self-care, self-acceptance, self-compassion, self-connection and self-awareness'.

Initially, all participants collectively resisted remote work. However, as the adaptation to practice progressed, a shift began to occur within CoPs as they recognised its inherent value, leading to a more receptive attitude, as described in the first subtheme. For instance, Eva defined a moment when her 'unchallenged solid idea' - that remote work was 'really looked down on' by 'senior people' and the 'psychotherapeutic community' in her team, including herself - made her believe that a nurturing therapeutic relationship was only possible through in-person therapy. Despite this, she described these limiting ideas as having 'dissolved' during lockdown and she 'discovered that there is an awful lot that can be done' working in remote practice, given that both therapist and clients are willing to make changes. Notably, research

indicates that before the pandemic, training programmes and professional bodies generally discouraged online therapy, still considering in-person therapy to be superior (Drego, 1983). Sarah further added that she was 'pleased' with the new development and that she could 'offer people more options' regarding mediums for therapy delivery. She was incredibly surprised to find that she was able to learn new ways of working. This development was 'satisfying' for her as she felt that staying up to date with technological advancements was important and had been achieved. This sentiment was echoed by all participants, who felt they acquired new technical knowledge and were able to make therapy accessible. For example, Helen explained that the availability of online therapy broadened accessibility and extended the reach of psychology to her socially anxious clients, who otherwise would not have had the opportunity to engage in therapy using in-person mediums. This finding aligns with research indicating that the adaptation to remote work during the COVID-19 lockdowns provided psychologists with the skills to deliver therapy using various mediums, thereby improving accessibility and acceptability (Gregson et al., 2022). Furthermore, Morgan et al. (2022) found that transitioning to online practices during the pandemic equipped psychologists with new competencies in remote therapy, a discovery supported by Daplyn (2022). This will improve access to services for the younger generation who are raised with technology as an integral part of their daily lives and social connections. Indeed, they are actively seeking services that meet their preferences and reflect their worldview - findings that echo those of earlier studies (Simpson & Reid, 2014).

Hybrid practice, arising from the adaptation to lockdown measures, involves a blend of home and office-based work. The second subtheme, 'acceptance and embracing of hybrid therapy delivery', captures the fact that this was welcomed by the majority of participants. Shanti explained that 'now we're at a place where we can take the parts of it that will work for the long term', emphasising that when aspects of this hybrid approach contribute, it becomes a

‘strength for one’s practice’ as it provides the ‘flexibility’ to manage personal and professional domains. In line with this finding, Békés et al. (2021) found that therapists accepted and embraced hybrid practice. In accordance with self-determination theory (SDT) (Patrick & Williams, 2012), hybrid working practices fulfilled the three innate psychological needs of CoPs: autonomy, competence, and relatedness. The need for autonomy was realised as lockdown restrictions were lifted, providing CoPs with the choice to decide whether to work from home, the office, or adopt a hybrid approach. Through adapting their practice during the COVID-19 lockdown, all participants felt they had gained competence and confidence in online work. For example, Sarah embraced the hybrid approach as ‘flexible,’ ‘relaxing’ and ‘more productive’, and experienced it as ‘more positive than negative’. Most participants expressed the view that incorporating some in-person elements into their practice satisfied their desire for social interaction with colleagues, which brought happiness to Adam. According to Hayes (2023), hybrid work diminished social isolation and introduced a social aspect to otherwise solitary routines. Individuals require daily interactions to feel validated, competent and, most importantly, to experience a sense of belonging within the organisation. In this way, all basic needs were met, fostering personal growth and development, alongside the embracing of the new norm - hybrid working. Furthermore, Mellentin et al. (2021) found that a hybrid therapy delivery intervention for alcohol use disorder resulted in higher treatment compliance and better treatment outcomes due to the increased flexibility of the treatment schedule. Erbe et al. (2017) assert that hybrid therapy is a feasible and effective approach for treating common mental health disorders. It is noteworthy that all CoPs in this study reinstated some in-person clinical practice as soon as it was feasible, indicating a return to the prior state, which is consistent with research suggesting that therapists reverted to some in-person therapy delivery when possible (Sokół-Szawłowska & Mierzejewski, 2023).

The third subtheme captures CoPs' 'acceptance of new norms that emerged from lockdown practice adaptation'. According to SDT, even when specific needs are compromised following a traumatic event, individuals actively seek to restore themselves to a state of well-being (Patrick & Williams, 2012). All participants accepted their 'new norms' of practice adaptation. For instance, Adam explained that 'as humans, we adapt much quicker than we think... after some time, it became much more of a norm', illustrating that adjusting to lockdown practices prompted individuals to reconsider their perspective. Such an adaptation involves dealing with problems, learning from the environment and adjusting one's own mindset, transitioning from a less flexible mindset and uncovering untapped potential which hitherto had gone unnoticed (Taha et al., 2022). It is worth noting that Adam's positive attitude may have been influenced by experiencing a brief lockdown period and smoothly transitioning to a hybrid work model within a few months. He appeared to be receptive to change, which played a key role in his adoption and embrace of the new working model. Similarly, after adapting to remote work, all other participants embraced the changes, as was also observed in James et al.'s (2022) research. Transitioning from in-person to remote practice required therapists to manage various adjustments, including boundaries in therapy, work-home balance, changes in therapy settings and understanding the impact of remote work boundaries. Despite the increased stress associated with remote therapy delivery, therapists accepted this new approach and maintained the working alliance and therapeutic boundaries during remote sessions, a departure from their usual experiences with in-person sessions.

Helen's ability to overcome self-doubt and anxiety regarding her online therapeutic intervention proved advantageous. She attributed her success to prioritising relationship-building and implementing essential counselling skills. This enabled her to deliver a satisfactory standard of care whilst adapting to this new way of working. Helen's confidence grew as clients expressed gratitude for her therapeutic support online, affirming her positive

impact and helping her adjust to this new norm. Such findings align with those of other studies showing that both therapists and clients accepted online psychological therapy and wished to continue after the lockdown (Pierce et al., 2021; Sammons et al., 2020). However, although Ramsetty and Adams (2020) created online clinics for economically disadvantaged clients during the pandemic, a lack of digital access required ongoing in-person services, highlighting ethnic and socioeconomic disparities.

This positive shift, where all participants accepted and embraced the adapted practice, can be explained by post-traumatic growth theory which proposes that individuals can experience personal development and positive transformation following highly challenging experiences or traumatic events. Amid the COVID-19 pandemic and the abrupt need to adapt their practices, therapists faced various challenges in both their personal and professional lives due to lockdown restrictions. These involved transitioning their practice to remote settings from home, balancing work and home life, adapting to remote online platforms for therapy delivery, and adjusting therapy boundaries, confidentiality and client risk management online. Additionally, they had to navigate various losses, including the loss of social connections and the familiar in-person therapy environment. Moreover, they briefly substituted therapeutic intervention with supportive work. The challenges of adapting their practices, listening to the traumatic experiences of clients and dealing with the fear and stress of navigating a deadly pandemic had a profound impact on CoPs. This led to health concerns, economic hardships and disruptions to daily life. Additionally, it uncovered various vulnerabilities, whilst also showcasing the remarkable resilience of those who continued to provide therapy in their adapted practice. Resilience refers to the capacity to 'bounce back' from difficult situations and gradually return to normal. Post-traumatic growth takes this a step further, as it refers to instances where individuals not only recover, but become even stronger and better after facing adversity, as stated by Tedeschi et al. (2018); hence, personal development can arise as a result

of encountering distress or trauma. Research suggests that alongside the negative consequences of the COVID-19 pandemic, it also prompted post-traumatic growth in certain individuals (Chen et al., 2021; Cui et al., 2021; Prieto-Ursúa & Jódar, 2020). In line with Tedeschi and Calhoun's (1996) findings, this study found that the challenging experience of living through a traumatic pandemic and adapting practices fostered a renewed sense of self-reliance and competence. This led to positive personal changes and increased CoPs' confidence in facing future challenges.

After navigating the initial stages of adapting to remote practices, all participants experienced positive shifts in self-perception, interpersonal relationships and their philosophy of life. This resulted in heightened 'self-awareness', 'self-confidence', 'self-acceptance', 'self-compassion', 'self-connection' and 'self-care', engendering a more open attitude towards others, a deeper appreciation of life and the exploration of new possibilities in their personal and profession lives. For example, Adam strongly appreciated having some 'time to slow down, to reflect, to pick up all the interests, old hobbies'. This finding mirrors those of Wise et al. (2012), suggesting that psychologists should prioritise flourishing over surviving, with a focus on intentional and reciprocal self-care. This highlights the need to integrate self-care seamlessly into daily routines rather than adding it as an extra task to existing personal and professional duties.

Helen described her transformation in detail, explaining that she learnt to say 'no' to others without feeling 'guilty' and began 'trusting' herself and her decisions. She believes that this experience 'strengthened' her both as an individual and as a CoP. Similar findings have been observed among frontline nurses where post-traumatic growth moderated the negative impact of traumatic work-related experiences on life satisfaction (Dell'Osso et al., 2022; Rodríguez-Rey et al., 2019; Tedeschi & Calhoun, 1996). Similarly, research conducted by Li et al. (2024) found that medical staff during the COVID-19 pandemic experienced moderate post-traumatic

growth, particularly with regard to relationships, life philosophy and personal competence. Trauma exposure, sociodemographic, psychological traits, coping mechanisms and social support were identified as key influencing factors. Despite facing vicarious traumatisation and struggling with online therapy during the pandemic, therapists, as noted by Aafjes-van Doorn et al. (2021), exhibited resilience over the first 12 weeks, as evidenced by a decrease in professional self-doubt. Nevertheless, for most therapists, the level of vicarious trauma experienced was not severe enough to lead to post-traumatic growth.

In summary, this GET captures CoPs' acceptance of remote work and their recognition of its benefits, particularly the hybrid model. They demonstrated resilience and personal growth, adapting to new norms and experiencing positive shifts in self-perception and interpersonal relationships, all of which fostered a deeper appreciation of life and a more open attitude towards others. Despite the challenges, they exhibited resilience and post-traumatic growth, highlighting the importance of coping mechanisms and social support in overcoming adversity.

Implications for Practice

Whilst some themes identified in this study align with existing ideas in psychological literature, the findings also illuminate the unique idiosyncratic experiences of participants adapting their practice during COVID-19 lockdowns, rendering generalisation unfeasible. Nonetheless, the potential for transferability can still be discussed. It is crucial to recognise that the possibility of another pandemic similar to COVID-19 occurring remains. Should this happen, the implementation of lockdowns and other safety measures might become necessary once again. The knowledge and lessons acquired from the COVID-19 pandemic, as well as from this study, will be essential for the effective management of similar practice adaptation situations.

The findings from the initial stages of practice adaptation suggest that CoPs experienced intense emotions from the outset of the pandemic, exacerbated by the government mandated

adjustment of their practices to remote settings from their homes. Participants described feeling isolated and experiencing uncertainty as a result of having to navigate this significant adaptation in the absence of any organisational support or guidelines directing them on the steps to follow. Because both psychologists and clients were confronted with the shared experience of living through the pandemic, therapists naturally brought aspects of their personal lives into their professional practice. This integration affected their emotional reserves and their ability to empathise with patients experiencing psychological distress (Nissen-Lie et al., 2013). Therefore, it is imperative for therapists to safeguard their own mental and emotional health before engaging in therapy sessions. One approach is for employers in organisational settings to offer regular individual or group supervision, or other protected spaces, in which to process these emotions and provide practical and emotional support. In a private setting, CoPs may wish to access supervision and personal therapy if they find themselves becoming overwhelmed with emotion.

Additionally, as the practice transitioned to participants' homes, it blurred the boundaries between their personal and professional domains - an amalgamation leading to a multitude of difficulties. For example, finding a private and confidential area to conduct therapy sessions was challenging because their homes were not designed with an office space, leading to a shortage of suitable areas. Participants also found that work intruded on their personal time because of the convenience and accessibility of working from home. Therefore, it would be beneficial to establish boundaries that separate work from home life in the absence of a transitional space. Participants suggested that symbolically compartmentalising work and home by ending work at a set time and transitioning into personal space helped them maintain this balance, alongside maintaining strict boundaries if they felt both domains were overlapping. Employers offering training to clinicians on how to achieve this would

significantly benefit those who are newly transitioning to remote work in their regular practice, as well as in potential future health crises.

Furthermore, during the COVID-19 lockdowns, CoPs working from home described using common areas such as the living room and bedrooms to conduct therapy sessions. However, they expressed anxiety about family members overhearing confidential client information. Negotiating with family members to designate a specific area in the home as an office space could alleviate this concern. Additionally, this appeared to mirror a parallel process, as the study revealed that clients also encountered difficulties in accessing a private, confidential space for their therapy sessions due to systemic issues. This lack of privacy affected the ability of CoPs to deliver effective therapy, as interruptions from others entering the virtual space disrupted the therapeutic process. Furthermore, clients resorted to walking outdoors or sitting in their cars during sessions due to space constraints, hindering their ability to express their true emotions in public settings. In the future, with remote work becoming more common in clinical practice, it will be advantageous to pre-emptively discuss with clients the necessity of securing a private space before their therapy sessions, particularly for those who opt for remote or online therapy. Therapists in the current study considered establishing a clear therapeutic contract from the outset to manage changes in the formality of therapy. Knapp and Slatterty (2004) highlight the importance of boundaries in therapeutic relationships, thereby differentiating them from other types of relationships.

Moreover, CoPs encountered considerable difficulties in adapting to practice, particularly in transitioning from in-person therapy delivery to remote online therapy using technology. Because the participants in this study had no prior experience of conducting clinical work remotely, this represented a completely novel experience for them. They encountered practical challenges in the adapted practice such as accessing technology. Moreover, upon gaining access, they struggled to determine where to direct their attention on the screen to establish a

genuine therapeutic alliance with clients. Some CoPs found themselves distracted by their own frozen images on their laptop screens, whilst interruptions such as internet disconnections or freezes during critical disclosures made by clients felt intrusive, prompting therapists to ask clients to repeat themselves. CoPs disclosed that this evoked strong emotions, most notably frustration arising from their inability to hold the space and effectively manage the therapeutic environment, as they are traditionally accustomed to doing in an in-person setting. For CoPs to confidently embrace remote online work, it is crucial for them to adapt their humanistic and relational value system to the virtual space, ensuring they can effectively understand and engage with human experiences in various contexts. Offering training could help them not only to address practical challenges such as working with technological difficulties, but also to learn how to build genuine therapeutic relationships online and utilise therapeutic silence effectively. This may benefit all CoPs, especially those in training, by preparing them for future health crises and ensuring a smooth adaptation of their practice.

This research found that CoPs who adapted their working practices experienced high levels of distress and trauma. Initially, participants struggled to differentiate between their professional and personal spheres whilst working from their private homes. This blending of boundaries along with other challenges ultimately contributed to increased fatigue, stress and burnout, as highlighted by Stoll et al. (2020). Participants emphasised the struggle of adjusting to new mediums alongside the fears and challenges of enduring a deadly pandemic lockdown. Simultaneously supporting clients grappling with trauma and other complex issues often leads to psychological distress and burnout among clinicians, as evidenced in a number of studies (Aafjes-van Doorn et al., 2021; Barton, 2020). CoPs lamented the fact that these challenges led to physical symptoms and a loss of skills and confidence in their roles as helpers within the newly adapted practice, hindering their ability to empathise with and build connections with their clients, as noted by Aafjes-van Doorn et al. (2021). Therapists struggled with switching

between their professional role and personal identity, adding to their stress and burnout. Although self-care has been shown to effectively prevent distress and enable therapists to manage the demands of the job (Figley, 2002), some struggled with prioritising their own self-care, often placing the needs of others over their own due to internal conflicts, whereby they viewed self-care as selfish (Barton, 2020). These findings were also observed in the current study. After experiencing distress, extreme burnout and trauma, CoPs began to pay attention to self-care and self-kindness, which significantly assisted them in centring themselves and focusing on their well-being. Therefore, employers supporting clinicians in integrating self-care into their practice will inevitably assist them in coping not only with daily personal and work-related high-level distress, but also with stress and traumatic experiences arising from potential future health emergencies.

Furthermore, many participants felt isolated and alone whilst working from home during the lockdown. With not only their professional, but also personal support networks diminishing, they grappled with the multitude of challenges associated with adapting their practice. CoPs highlighted the significance of missing the support and informal conversations with their colleagues. Therefore, it might be beneficial for employers to create online platforms for mutual interaction to mitigate loneliness, which can adversely affect work (Groarke et al., 2020). Additionally, participants experienced reduced confidence in handling online risks compared with in-person interactions, attributing this to the physical distance separating them.

Nevertheless, participants expressed a desire to maintain the benefits of adapting to remote practice beyond the crisis response measures. They found the flexibility of hybrid practice especially appealing, offering them increased freedom in scheduling clients, particularly as the pressure on room space reduced. Hybrid therapy emerged as the preferred option for therapists, resulting in improved client engagement and accessibility, as noted in several previous studies (James et al., 2022; McBeath et al., 2020). This preference occurred for two primary reasons:

firstly, participants felt that remote working enhanced their productivity and efficiency, and secondly, onsite work fulfilled their need for social connection, both of which had a positive impact on their evolved practice. Consequently, participants expressed a desire to continue some aspects of online therapy delivery, citing the success of flexible and remote working during the COVID-19 pandemic, as revealed in an NHS staff survey (NHS, 2022). This aligns with the NHS's Long-Term Plan (NHS, 2019) which emphasises innovation and workforce support, particularly through practices that enhance staff well-being. The majority of participants felt that adjusting to COVID-19 practices liberated them from their previously constrained views on remote online therapy - a change they deeply appreciated and embraced. They expressed a desire to maintain an open-minded approach towards future practice changes.

At an organisational level, this research will help supervisors and managers support CoPs in effectively handling various challenges, including managing their own intense emotions, addressing technological difficulties and adapting to new environments and frameworks.

The acceptance of remote practice during COVID-19 lockdowns is now permanent, indicating a significant shift in acknowledging that technology will be integral to ongoing therapeutic practice. At a higher level, it would be beneficial for trusted bodies - both the HCPC, the statutory regulator for Practitioner Psychologists in the UK, and the BPS - to offer therapist training programmes focusing on conducting therapy online and utilising online platforms for delivery. Additionally, integrating training in the use of future technologies and the capacity to adapt to their evolving forms should form an integral part of these courses. Psychologists require easily accessible and accurate information to rapidly expand their knowledge in areas that are likely to be impacted during future global crises. This will equip newly trained and qualified CoPs with the essential skills to quickly adapt their practice.

Personal Reflexivity

In qualitative research, it is widely acknowledged that researchers themselves actively shape the research process. Consequently, an essential criterion for evaluating the quality of such studies is reflexivity, recognising the researchers' influence on the research (Willig, 2012). This encourages researchers to reflect on how their past experiences, perceptions of the research topic and subjective feelings and thoughts during the process of conducting research are shaped by the research and its findings (Engward & Goldspink, 2020; Willig, 2012). This enhances the rigour and credibility of the research. In interpretative-phenomenological studies, researchers practice reflexivity by intentionally setting aside their usual methods of understanding a phenomenon, a practice referred to as 'bracketing' (Smith et al., 2009; Zahavi, 2019). This intentional approach allows for a deeper insight into the lived experience and perceptions of participants, whilst also acknowledging and incorporating these elements to enrich overall understanding (Smith et al., 2009; Willig, 2012). In terms of my own personal reflexivity, my lived experience of the COVID-19 pandemic and the lockdown remote working practice adaption played a significantly role in shaping my overall interest in this field. It also influenced the design of the research, the formulation of interview questions, and the process of listening to and interpreting the data.

Participants' experiences of the COVID-19 pandemic and the lockdown practice adaption resonated strongly within me. I distinctly recall personally undergoing periods of adapting to the crisis, experiencing loss, adjusting my practice, and undergoing growth and development throughout the lockdowns. The accounts and sentiments of the participants, including their experiences of intense emotions, loss, and grief also resonated with me. The profound loss of a valued peer to COVID-19 affected me deeply, at times more intensely than others. When Helen shared her experience of losing her father and uncle, she described being struck by grief and overwhelmed by sadness. This was a poignant experience for me, tapping into my own

sense of anger and frustration at a time when I was unable to get in touch with my peer, leading to the situation reaching a point where communication ceased. I lacked updates on her condition from the hospital until the eventual disclosure of her passing. The memory of being unable to say goodbye to her due to lockdown restriction measures, coupled with the thought that she passed away alone, filled me with intense feelings of guilt and sadness. Both Helen and I carried these emotional burdens whilst adapting our practices, impacting both our personal and professional lives, as well as our levels of motivation. Helen shared that she only functioned for work and her clients, and after her workday, she 'collapsed in bed', incapable of engaging in anything else. I was deeply moved by the narratives shared by my participants and their openness in disclosing their COVID-19 practice adaptation journeys. Their experiences were so relatable that they deeply affected me, exerting a significant impact on both my role as a researcher and as a trainee CoP. This profound connection became entangled with my research and clinical journey and, at times, proved difficult to separate.

Finlay (2009) outlines a universal experience marked by uncertainty and confusion, entailing a state of being lost within complex ambiguity. The oscillation between roles and their duality gave rise to dilemmas that required my attention and I needed to reflect on this. As time passed, I developed the ability to remain in the role of a researcher whilst navigating the challenges of stepping away from my position as a trainee CoP. The research process can be demanding, especially when dealing with the relational aspects of the study and striving to separate ourselves from the participants. This is consistent with therapeutic work, where we assess our reactions to clients' narratives and reflect on the dynamics of the therapeutic relationship.

From my experience engaging with the literature on adapting health crisis practices, I discovered that minimal attention had been paid to psychologists' perspectives and that the perspectives of CoPs were often disregarded and, to the best of my knowledge remained unexplored. This was extremely frustrating for me, which further influenced my focus on this

topic. I acknowledge that my personal experiences may have contributed to my thoughts and emotions, inevitably influencing the literature selected for the review, my interpretation of findings, and the process of developing themes. Throughout this process, I wanted to ensure CoPs' voices regarding their COVID-19 pandemic practice adaptation experiences would not only be heard, but also be accurately depicted. The trust that participants placed in me was strengthened by my status as a trainee in the CoP. Faced with the scarcity of research during the initial phase, they recognised the value of my research for our professional community. This, in turn, may have facilitated a more open and uncensored sharing of insights into the most challenging aspects of their experience in adapting to the COVID-19 pandemic practices.

Strengths and Limitations of this Study

This section discusses both the strengths and limitations of this research. In terms of limitation, there are a number of areas where this study could be improved; for instance, there was no distinction made among participants regarding the timing of entering lockdown. Not all participants commenced lockdown when the prime minister announced the initial lockdown in the UK on 23 March 2020, ordering people to 'stay at home'. Although one participant adapted their one-day private practice from home immediately, she was travelling to her work base four days a week to set up her service. When that was up and running, she started doing hybrid work; therefore, her experiences were different from the others who spent lockdowns solely at home. Furthermore, two other participants returned to work early, with one mandated to return within two months of the lockdown and the other opting for an optional early return to a hybrid practice. The remainder of the participants entered the first lockdown together and exited with an evolved hybrid practice during the third lockdown. It would have been beneficial to consider this distinction in their experiences during the participant recruitment process. However, according to Smith, Flowers, and Larkin (2009), complete homogeneity is rarely attainable. Nonetheless, participants were recruited during the period when they were emerging from the

third lockdown, a time when they were contemplating the option of returning to the work base. Consequently, the added pressures meant that a restricted number of CoPs were accessible for recruitment in this study. Introducing this distinction during the recruitment process would have had adverse effects, further limiting the already constrained participant pool. At the point of participant recruitment, there did not seem to be any need to limit my sample in this way to achieve homogeneity of data, so I opted not to implement any distinction. As suggested by Pietkiewicz and Smith (2014), the participants were selected purposively with the aim of identifying individuals for whom the research problem holds relevance and personal significance. Therefore, the existing sample held the capacity to contribute significantly to the field.

Participants shared how their remote practice and therapy, influenced by various factors, evolved throughout lockdowns. Therefore, it is reasonable to expect that this evolution will persist as their personal and social context undergoes further changes. The single-interview design employed in this study may not capture the full extent and scope of longitudinal changes. An alternate multiple interview research design may potentially provide additional insights into this aspect. Because this was an IPA study, the aim was not to generalise findings, but rather to explore the profound experiences and meaning-making processes of the CoPs involved. Consistent with an IPA approach, conducting a single interview with six participants allowed for the exploration and analysis of rich data.

This study also possessed multiple strengths, with one notable aspect being its contribution to addressing a gap in the current literature. The majority of the literature available on the experience of practice adaptation during health crises is focused on medical professions, specifically HCW, and is quantitative in nature. There is limited qualitative research exploring the experience of allied psychology professionals, psychoanalysts, and counsellors, but to the best of my knowledge, CoPs' experience of practice adaptation has not been addressed.

Therefore, it is essential to provide a space for CoPs' voices to be expressed and heard, not only by the wider psychotherapeutic community, but also by other CoPs less inclined towards practice changes, instilling in them the assurance that aligning with their professional values and nuances is not only achievable, but also welcomed and appreciated by their client group.

Recommendations for Future Research

The research findings indicate that CoPs experienced high level of distress whilst adapting to COVID-19 practices from their homes. This situation may foster post-traumatic growth, characterised by positive psychological changes arising from challenging or traumatic experiences. There is ample research investigating psychologists' experiences during the initial phase of practice adaptation. However, insufficient attention has been given to the stage when psychologists accept and embrace the new medium of therapy delivery. Conducting additional qualitative and mixed methods research would be beneficial for exploring the experiences of CoPs in terms of growth, specifically with regard to examining the contributory factors such as personal and professional aspects, which facilitated and cultivated post-traumatic growth during their adaptation to COVID-19 practices. This approach would aid in developing a more nuanced understanding of this phenomenon.

Additionally, given that all participants in this study reported positive experiences with the emergence of a hybrid working model whilst adapting to lockdown practices, it may be beneficial to utilise qualitative methods to delve more deeply into this specific experience. By doing so, we can uncover what aspects of this blended delivery method were so readily embraced and accepted. The findings will inform CoPs newly entering the profession about what to expect and how to embrace hybrid therapy. Additionally, it is essential to explore the perspectives of those who did not find the changes beneficial. This is crucial for capturing diverse experiences and presenting a well-rounded perspective on the outcomes of practice adaptation among CoPs during a health crisis.

Finally, participants felt that the amalgamation of multiple factors during practice adaptation had a negative impact on them, causing distress, fatigue and even trauma. However, they all noticed that when they introduced self-care elements such as regular walks, practising mindfulness and other relaxation techniques, they were able to centre themselves. A qualitative research study on CoPs' experiences of COVID-19 practice adaptation and self-care would provide valuable insights for psychologists anticipating future health crises.

Conclusion

This research has offered an in-depth and unique process for understanding and making sense of the experiences of CoPs adapting their practice during the COVID-19 pandemic. Four GETs were identified: 'intense emotional reaction to sudden COVID-19 lockdown practice adaptation', 'newness of lockdown practice adaptation', 'the experience of multiple losses during COVID-19 lockdown practice adaptation', and 'gains - embracing new ways of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation'. CoPs found themselves pleasantly surprised at their capacity to acquire and embrace a new way of delivering therapy using different mediums. This self-discovery ultimately led to the welcome innovation and adoption of a hybrid therapy delivery model, acknowledged for its effectiveness, efficiency and accessibility. In this chapter, my intention was to illustrate how the findings of this study could make a valuable contribution to the field of counselling psychology and the broader psychotherapeutic community. This is especially pertinent for new CoPs who are required to work from home as part of the evolved practice or to adapt their practices in response to a future health emergency or crises. My goal was to create a platform for CoPs to express their narratives, whilst also incorporating the qualitative perspective of CoPs engaged in COVID-19 pandemic remote practice adaptations - a dimension notably absent in the current literature. Finally, the overarching aim of this study was to address this gap in the existing literature and offer additional insights into the challenges

associated with practice adaptation in both personal and professional domains. This contribution enriches current scholarly understanding of this topic.

References

Aafjes-van Doorn, K., Békés, V., & Prout, T. A. (2021). Grappling with our therapeutic relationship and professional self-doubt during COVID-19: Will we use video therapy again? *Counselling Psychology Quarterly*, *34*(3–4), 473–484. https://doi.org/10.1080/09515070.2020.1773404

Abrahams, D., & Rohleder, P. (2021). *A clinical guide to psychodynamic psychotherapy* (1st ed.). Routledge.

Ackerley, G. D., Burnell, J., Holder, D. C., & Kurdek, L. A. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, *19*(6), 624–631. https://doi.org/10.1037/0735-7028.19.6.624

Allen, J. (2001). *Traumatic relationships and serious mental disorders*. John Wiley.

Allen, T. D., Merlo, K., Lawrence, R. C., Slutsky, J., & Gray, C. E. (2021). Boundary management and work-nonwork balance while working from home. *Applied Psychology*, *70*(1), 60–84. https://doi.org/10.1111/apps.12300

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th DSM-V-TR).

Apolinário-Hagen, J., Vehreschild, V., & Alkoudmani, R. M. (2017). Current views and perspectives on e-mental health: An exploratory survey study for understanding public attitudes toward internet-based psychotherapy in Germany. *JMIR Mental Health*, *4*(1), e8. https://doi.org/10.2196/mental.6375

Ashforth, B. E., Kreiner, G. E., & Fugate, M. (2000). All in a day's work: Boundaries and micro role transitions. *The Academy of Management Review*, *25*(3), 472. https://doi.org/10.2307/259305

Avieli, H., Ben-David, S., & Levy, I. (2016). Predicting professional quality of life among professional and volunteer caregivers. *Psychological Trauma: Theory, Research, Practice, and Policy*, *8*(1), 80–87. https://doi.org/10.1037/tra0000066

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. *Psychological Services*, *9*(2), 111–131. https://doi.org/10.1037/a0027924

Baker, C. N., Oshrin, S., Petrovic, L., Swanberg, S., & Nastasi, B. (2024). Transitioning to telehealth during COVID-19: Challenges and opportunities for trauma-focused school psychology. *Training and Education in Professional Psychology*. https://doi.org/10.1037/tep0000477

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*(2–4), 109–160. https://doi.org/10.1080/15228830802094429

Barber, S., Brown, J., & Ferguson, D. (2022, July 14). *Coronavirus: The lockdown laws*. House of Common Library. https://commonslibrary.parliament.uk/research-briefings/cbp-8875/

Barton, H. (2020). An exploration of the experiences that counsellors have of taking care of their own mental, emotional and spiritual well-being. *Counselling and Psychotherapy Research*, *20*(3), 516–524. https://doi.org/10.1002/capr.12280

Bass, A. (2007). When the frame doesn't fit the picture. *Psychoanalytic Dialogues*, *17*(1), 1–27. https://doi.org/10.1080/10481880701301022

Beck, J. S. (1995). *Cognitive Behavior Therapy: Basics and beyond* (1st ed.). Guilford Press.

Bee, P. E., Lovell, K., Lidbetter, N., Easton, K., & Gask, L. (2010). You can't get anything perfect: "User perspectives on the delivery of cognitive behavioural therapy by telephone." *Social Science & Medicine*, *71*(7), 1308–1315. https://doi.org/10.1016/j.socscimed.2010.06.031

Békés, V., Aafjes-van Doorn, K., Luo, X., Prout, T. A., & Hoffman, L. (2021). Psychotherapists' challenges with online therapy during COVID-19: Concerns about connectedness predict therapists' negative view of online therapy and its perceived efficacy over time. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.705699

Békés, V., Aafjes-van Doorn, K., Zilcha-Mano, S., Prout, T., & Hoffman, L. (2021). Psychotherapists' acceptance of telepsychotherapy during the COVID-19 pandemic: A machine learning approach. *Clinical Psychology & Psychotherapy*, *28*(6), 1403–1415. https://doi.org/10.1002/cpp.2682

Bentley, T. A., Teo, S. T. T., McLeod, L., Tan, F., Bosua, R., & Gloet, M. (2016). The role of organisational support in teleworker wellbeing: A socio-technical systems approach. *Applied Ergonomics*, *52*, 207–215. https://doi.org/10.1016/j.apergo.2015.07.019

Benzel, S., & Graneist, A. (2023). "Bye, click, and gone"—A qualitative study about the experiences of psychotherapists and adolescent patients on remote treatment during the COVID-19 pandemic. *Psychoanalytic Psychology*, *40*(3), 190–198. https://doi.org/10.1037/pap0000427

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Berger, T. (2017). The therapeutic alliance in internet interventions: A narrative review and suggestions for future research. *Psychotherapy Research*, *27*(5), 511–524. https://doi.org/10.1080/10503307.2015.1119908

Bhaskar. (1975). *A Realist Theory of Science*. Routledge.

Bonanno, G. A., & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review*, *21*(5), 705–734. https://doi.org/10.1016/S0272-7358(00)00062-3

BPS. (2020). *Adaptations to psychological practice: Interim guidance during Covid-19 pandemic*. Britisth Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Adaptations%20to%20psychological%20practice%20-%20interim%20guidance%20during%20Covid-19.pdf

BPS. (2021). *Guidance for psychological professionals during the Covid-19 pandemic*. The Britisth Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Guidance%20for%20psychological%20professionals%20during%20Covid-19.pdf

Brenes, G. A., Ingram, C. W., & Danhauer, S. C. (2011). Benefits and challenges of conducting psychotherapy by telephone. *Professional Psychology: Research and Practice*, *42*(6), 543–549. https://doi.org/10.1037/a0026135

British Psychological Society. (2005). *Division of Counselling Psychology Professional Practice Guidelines: Cover*. British Psychological Society. https://doi.org/10.53841/bpsrep.2005.rep75

British Psychological Society. (2017). How psychologists work. In *practice guidelines*. British Psychological Society. https://doi.org/10.53841/bpsrep.2017.inf115.3

British Psychological Society. (2021a). *BPS Code of Human Research Ethics*. https://www.bps.org.uk/guideline/bps-code-human-research-ethics

British Psychological Society. (2021b). *Code of Ethics and Conduct*. British Psychological Society. https://doi.org/10.53841/bpsrep.2021.inf94

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 & Environmental Medicine*, *60*(3), 248–257. https://doi.org/10.1097/JOM.0000000000001235

Buchholz, K. (2020, April 23). *Infographic: What share of the world population is already on COVID-19 lockdown?*. Statista Infographics. https://www.statista.com/chart/21240/enforced-covid-19-lockdowns-by-people-affected-per-country/

Burrell, A., & Selman, L. E. (2022). How do funeral practices impact bereaved relatives' mental health, grief and bereavement? A mixed methods review with implications for COVID-19. *OMEGA - Journal of Death and Dying*, *85*(2), 345–383. https://doi.org/10.1177/0030222820941296

Cabarkapa, S., Nadjidai, S. E., Murgier, J., & Ng, C. H. (2020). The psychological impact of COVID-19 and other viral epidemics on frontline healthcare workers and ways to address it: A rapid systematic review. *Brain, Behavior, & Immunity - Health*, *8*, 100144. https://doi.org/10.1016/j.bbih.2020.100144

Cameron, A. (2020, August 7). *Coronavirus and homeworking in the UK: April 2020*. Office For National Statistics.

Carlbring, P., Andersson, G., Cuijpers, P., Riper, H., & Hedman-Lagerlöf, E. (2018). Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: An updated systematic review and meta-analysis. *Cognitive Behaviour Therapy*, *47*(1), 1–18. https://doi.org/10.1080/16506073.2017.1401115

Castro, A., Gili, M., Ricci-Cabello, I., Roca, M., Gilbody, S., Perez-Ara, M. Á., Seguí, A., & McMillan, D. (2020). Effectiveness and adherence of telephone-administered psychotherapy

for depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, *260*, 514–526. https://doi.org/10.1016/j.jad.2019.09.023

Catarino, A., Bateup, S., Tablan, V., Innes, K., Freer, S., Richards, A., Stott, R., Hollon, S. D., Chamberlain, S. R., Hayes, A., & Blackwell, A. D. (2018). Demographic and clinical predictors of response to internet-enabled cognitive–behavioural therapy for depression and anxiety. *BJPsych Open*, *4*(5), 411–418. https://doi.org/10.1192/bjo.2018.57

Cavanagh, K., & Millings, A. (2013). Interpersonal computing: The role of the therapeutic relationship in e-mental health. *Journal of Contemporary Psychotherapy*, *43*(4), 197–206. https://doi.org/10.1007/s10879-013-9242-z

Chemerynska, N., Marczak, M., & Kucharska, J. (2022). What are the experiences of clinical psychologists working with people with intellectual disabilities during the COVID-19 pandemic? *Journal of Applied Research in Intellectual Disabilities*, *35*(2), 587–595. https://doi.org/10.1111/jar.12971

Chen, R., Sun, C., Chen, J., Jen, H., Kang, X. L., Kao, C., & Chou, K. (2021). A large-scale survey on trauma, burnout, and posttraumatic growth among nurses during the COVID-19 pandemic. *International Journal of Mental Health Nursing*, *30*(1), 102–116. https://doi.org/10.1111/inm.12796

Chenneville, T., & Schwartz-Mette, R. (2020). Ethical considerations for psychologists in the time of COVID-19. *American Psychologist*, *75*(5), 644–654. https://doi.org/10.1037/amp0000661

Connolly, S. L., Miller, C. J., Lindsay, J. A., & Bauer, M. S. (2020). A systematic review of providers' attitudes toward telemental health via videoconferencing. *Clinical Psychology: Science and Practice*, *27*(2). https://doi.org/10.1111/cpsp.12311

Cooper, L. A., & Williams, D. R. (2020). Excess deaths from COVID-19, community bereavement, and restorative justice for communities of color. *JAMA*, *324*(15), 1491. https://doi.org/10.1001/jama.2020.19567

Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, *24*(3–4), 119–129. https://doi.org/10.53841/bpscpr.2009.24.3-4.119

Coughtrey, A. E., & Pistrang, N. (2018). The effectiveness of telephone-delivered psychological therapies for depression and anxiety: A systematic review. *Journal of Telemedicine and Telecare*, *24*(2), 65–74. https://doi.org/10.1177/1357633X16686547

Cowain, T. (2001). Cognitive–behavioural therapy via videoconferencing to a rural area. *Australian & New Zealand Journal of Psychiatry*, *35*(1), 62–64. https://doi.org/10.1046/j.1440-1614.2001.00853.x

Crescenzo, P., Chirico, F., Ferrari, G., Szarpak, L., Nucera, G., Marciano, R., Tarchi, L., Denicolo, D., Maiorino, A., Batra, K., & Sharma, M. (2022). Prevalence and predictors of burnout syndrome among Italian psychologists following the first wave of the COVID-19 pandemic: A cross-sectional study. *Journal of Health and Social Sciences*, *6*(4), 509–526.

Cui, P. pan, Wang, P. pan, Wang, K., Ping, Z., Wang, P., & Chen, C. (2021). Post-traumatic growth and influencing factors among frontline nurses fighting against COVID-19. *Occupational and Environmental Medicine*, *78*(2), 129–135. https://doi.org/10.1136/oemed-2020-106540

Daplyn, C. (2022). Interpretative phenomenological analysis of therapists' experience of working through the COVID-19 global emergency using transactional analysis. *International Journal of Transactional Analysis Research & Practice*, *13*(1), 11–27. https://doi.org/10.29044/v13i1p11

Day, S. X., & Schneider, P. L. (2002). Psychotherapy using distance technology: A comparison of face-to-face, video, and audio treatment. *Journal of Counseling Psychology*, *49*(4), 499–503. https://doi.org/10.1037/0022-0167.49.4.499

Delanoeije, J., Verbruggen, M., & Germeys, L. (2019). Boundary role transitions: A day-to-day approach to explain the effects of home-based telework on work-to-home conflict and home-to-work conflict. *Human Relations*, *72*(12), 1843–1868. https://doi.org/10.1177/0018726718823071

Dell'Osso, L., Lorenzi, P., Nardi, B., Carmassi, C., & Carpita, B. (2022). Post traumatic growth (PTG) in the frame of traumatic experiences. *Clinical Neuropsychiatry*, *19*(6), 390–393. https://doi.org/10.36131/cnfioritieditore20220606

Doherty, P. C. (2013). *Pandemics: What everyone needs to know*. Oxford University Press.

Drego, P. (1983). The cultural parent. *Transactional Analysis Journal*, *13*(4), 224–227. https://doi.org/10.1177/036215378301300404

Edú-Valsania, S., Laguía, A., & Moriano, J. A. (2022). Burnout: A review of theory and measurement. *International Journal of Environmental Research and Public Health*, *19*(3), 1780. https://doi.org/10.3390/ijerph19031780

Egede, L. E., Acierno, R., Knapp, R. G., Lejuez, C., Hernandez-Tejada, M., Payne, E. H., & Frueh, B. C. (2015). Psychotherapy for depression in older veterans via telemedicine: A randomised, open-label, non-inferiority trial. *The Lancet Psychiatry*, *2*(8), 693–701. https://doi.org/10.1016/S2215-0366(15)00122-4

Ellis, W. E., Dumas, T. M., & Forbes, L. M. (2020). Physically isolated but socially connected: Psychological adjustment and stress among adolescents during the initial COVID-19 crisis. *Canadian Journal of Behavioural Science / Revue Canadienne Des Sciences Du Comportement*, *52*(3), 177–187. https://doi.org/10.1037/cbs0000215

Embregts, P. J. C. M., Tournier, T., & Frielink, N. (2020). Experiences and needs of direct support staff working with people with intellectual disabilities during the COVID-19 pandemic: A thematic analysis. *Journal of Applied Research in Intellectual Disabilities*, *34*(2), 480–490. https://doi.org/10.1111/jar.12812

Embregts, P. J. C. M., Tournier, T., & Frielink, N. (2022). The experiences of psychologists working with people with intellectual disabilities during the COVID-19 crisis. *Journal of Applied Research in Intellectual Disabilities*, *35*(1), 295–298. https://doi.org/10.1111/jar.12916

Engward, H., & Goldspink, S. (2020). Lodgers in the house: Living with the data in interpretive phenomenological analysis research. *Reflective Practice*, *21*(1), 41–53. https://doi.org/10.1080/14623943.2019.1708305

Erbe, D., Eichert, H.-C., Riper, H., & Ebert, D. D. (2017). Blending face-to-face and internet-based interventions for the treatment of mental disorders in adults: Systematic review. *Journal of Medical Internet Research*, *19*(9), e306. https://doi.org/10.2196/jmir.6588

Finlay, L. (1998). Reflexivity: An essential component for all research? *British Journal of Occupational Therapy*, *61*(10), 453–456. https://doi.org/10.1177/030802269806101005

Finlay, L. (2002). “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, *12*(4), 531–545. https://doi.org/10.1177/104973202129120052

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, *3*(1). https://doi.org/10.29173/pandpr19818

Finlay, L. (2011). *Phenomenology for therapists*. Wiley. https://doi.org/10.1002/9781119975144

Flannery, E., Peters, K., Murphy, G., Halcomb, E., & Ramjan, L. M. (2023). Bringing trauma home: Reflections on interviewing survivors of trauma while working from home. *International Journal of Qualitative Methods*, *22*, 160940692311754. https://doi.org/10.1177/16094069231175445

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219–245. https://doi.org/10.1177/1077800405284363

Frank, G. (1997). Is there life after categories? Reflexivity in qualitative research. *The Occupational Therapy Journal of Research*, *17*(2), 84–98. https://doi.org/10.1177/153944929701700203

Freud, S. (1953). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. *The Hogarth Press*, *12*, 123–144.

Geraldina, A. M., Suen, M.-W., & Suanrueang, P. (2023). Online mental health services during COVID-19 pandemic in Indonesia: Challenges from psychologist perspective. *PLOS ONE*, *18*(6), e0285490. https://doi.org/10.1371/journal.pone.0285490

Giordano, C., Ambrosiano, I., Graffeo, M. T., Di Caro, A., & Gullo, S. (2022). The transition to online psychotherapy during the pandemic: A qualitative study on patients’ perspectives. *Research in Psychotherapy: Psychopathology, Process and Outcome*. https://doi.org/10.4081/ripppo.2022.638

Gordon, R. M., Wang, X., & Tune, J. (2015). Comparing psychodynamic teaching, supervision, and psychotherapy over videoconferencing technology with Chinese students. *Psychodynamic Psychiatry*, *43*(4), 585–599. https://doi.org/10.1521/pdps.2015.43.4.585

GOV.UK. (2020, May 25). *Public Health England*. https://www.gov.uk/government/organisations/public-health-england

GOV.UK. (2023, November 30). *Coronavirus (COVID-19) in the UK.* https://coronavirus.data.gov.uk/

Gregson, N., Randle-Phillips, C., & Delaney, C. (2022). Delivering psychological services for people with learning disabilities during the Covid-19 Pandemic: The experiences of psychologists in the UK. *Journal of Mental Health Research in Intellectual Disabilities*, *15*(2), 168–196. https://doi.org/10.1080/19315864.2022.2047844

Groarke, J. M., Berry, E., Graham-Wisener, L., McKenna-Plumley, P. E., McGlinchey, E., & Armour, C. (2020). Loneliness in the UK during the COVID-19 pandemic: Cross-sectional results from the COVID-19 psychological wellbeing study. *PloS One*, *15*(9), e0239698. https://doi.org/10.1371/journal.pone.0239698

Gupta, N. (2022). Truth, freedom, love, hope, and power: An existential rights paradigm for anti-oppressive psychological praxis. *The Humanistic Psychologist*, *50*(3), 460–475. https://doi.org/10.1037/hum0000274

Hantsoo, L., Podcasy, J., Sammel, M., Epperson, C. N., & Kim, D. R. (2017). Pregnancy and the acceptability of computer-based versus traditional mental health treatments. *Journal of Women's Health*, *26*(10), 1106–1113. https://doi.org/10.1089/jwh.2016.6255

Hart, S. (2018). *Brain, attachment, personality*. Routledge. https://doi.org/10.4324/9780429472541

Hayes, N. (2023). The social psychological implications of our hybrid future. *British Psychological Society*.

Health & Care Professions Council. (2016). *Standards of conduct, performance and ethics*. https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-conduct-performance-and-ethics.pdf

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

Heidegger, M. (1962). *Being and time*. Blackwell Publishing.

Hellman, J. D., & Morrison, T. L. (1987). Practice setting and type of caseload as factors in psychotherapist stress. *Psychotherapy*, *24*, 427–433.

Holton, M. J., & Snodgrass, J. L. (2023). A theoretical and theological reframing of trauma. *Pastoral Psychology*, *72*(3), 337–351. https://doi.org/10.1007/s11089-023-01063-1

Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call to close critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(4), 331–335. https://doi.org/10.1037/tra0000592

Hunter, E. M., Clark, M. A., & Carlson, D. S. (2019). Violating work-family boundaries: Reactions to interruptions at work and home. *Journal of Management*, *45*(3), 1284–1308. https://doi.org/10.1177/0149206317702221

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy.Transl*. Northwestern University Press.

Hwang, T.-J., Rabheru, K., Peisah, C., Reichman, W., & Ikeda, M. (2020). Loneliness and social isolation during the COVID-19 pandemic. *International Psychogeriatrics*, *32*(10), 1217–1220. https://doi.org/10.1017/S1041610220000988

Institute for Government. (2021). *Timeline of UK government coronavirus lockdowns and restrictions*. Institute of Government . https://www.instituteforgovernment.org.uk/data-visualisation/timeline-coronavirus-lockdowns

James, G., Schröder, T., & De Boos, D. (2022). Changing to remote psychological therapy during COVID-19: Psychological therapists' experience of the working alliance, therapeutic boundaries and work involvement. *Psychology and Psychotherapy: Theory, Research and Practice*, *95*(4), 970–989. https://doi.org/10.1111/papt.12413

Jarvis, C. I., Van Zandvoort, K., Gimma, A., Prem, K., Klepac, P., Rubin, G. J., & Edmunds, W. J. (2020). Quantifying the impact of physical distance measures on the transmission of COVID-19 in the UK. *BMC Medicine*, *18*(1), 124. https://doi.org/10.1186/s12916-020-01597-8

Jerome, L. W., & Zaylor, C. (2000). Cyberspace: Creating a therapeutic environment for telehealth applications. *Professional Psychology: Research and Practice*, *31*(5), 478–483. https://doi.org/10.1037/0735-7028.31.5.478

Jiang, Y., Qiao, T., Zhang, Y., Wu, Y., & Gong, Y. (2023). Social support and vicarious posttraumatic growth among psychological hotline counselors during COVID-19: the role of resilience and cognitive reappraisal. *Health Psychology and Behavioral Medicine*, *11*(1). https://doi.org/10.1080/21642850.2023.2274550

Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly*, *29*(2), 206–215. https://doi.org/10.1080/09515070.2015.1127210

Kazantzis, N., & Dobson, K. S. (2022). Therapeutic relationships in cognitive behavioral therapy: Theory and recent research. *Psychotherapy Research*, *32*(8), 969–971. https://doi.org/10.1080/10503307.2022.2124047

Kerman, K., Korunka, C., & Tement, S. (2022). Work and home boundary violations during the COVID-19 pandemic: The role of segmentation preferences and unfinished tasks. *Applied Psychology*, *71*(3), 784–806. https://doi.org/10.1111/apps.12335

Kluzowicz, J., & Kluzowicz, M. (2021). Psychotherapy during social isolation caused by COVID-19 – therapists' and clients' perspectives. *Psychoterapia*, *196*(1), 5–31. https://doi.org/10.12740/PT/134717

Knaevelsrud, C., & Maercker, A. (2007). Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: A randomized controlled clinical trial. *BMC Psychiatry*, *7*(1), 13. https://doi.org/10.1186/1471-244X-7-13

Knapp, S., & Slattery, J. M. (2004). Professional boundaries in nontraditional settings. *Professional Psychology: Research and Practice*, *35*(5), 553–558. https://doi.org/10.1037/0735-7028.35.5.553

Knott, V., Habota, T., & Mallan, K. (2020). Attitudes of Australian psychologists towards the delivery of therapy via video conferencing technology. *Australian Psychologist*, *55*(6), 606–617. https://doi.org/10.1111/ap.12464

Koslowski, N. C., Linehan, C., & Tietze, S. (2019). When is a bed not a bed? Exploring the interplay of the material and virtual in negotiating home-work boundaries. *Culture and Organization*, *25*(3), 159–177. https://doi.org/10.1080/14759551.2017.1349128

Kotera, Y., Kaluzeviciute, G., Lloyd, C., Edwards, A.-M., & Ozaki, A. (2021). Qualitative investigation into therapists' experiences of online therapy: Implications for working clients. *International Journal of Environmental Research and Public Health*, *18*(19), 10295. https://doi.org/10.3390/ijerph181910295

Kreiner, G. E. (2006). Consequences of work-home segmentation or integration: A person-environment fit perspective. *Journal of Organizational Behavior*, *27*(4), 485–507. https://doi.org/10.1002/job.386

Kumar, V., Sattar, Y., Bseiso, A., Khan, S., & Rutkofsky, I. H. (2017). The effectiveness of internet-based cognitive behavioral therapy in treatment of psychiatric disorders. *Cureus*. https://doi.org/10.7759/cureus.1626

Lamers, M., van der Duim, R., & Spaargaren, G. (2017). The relevance of practice theories for tourism research. *Annals of Tourism Research*, *62*, 54–63. https://doi.org/10.1016/j.annals.2016.12.002

Langarizadeh, M., Tabatabaei, M., Tavakol, K., Naghipour, M., & Moghbeli, F. (2017). Telemental health care, an effective alternative to conventional mental care: A systematic review. *Acta Informatica Medica*, *25*(4), 240. https://doi.org/10.5455/aim.2017.25.240-246

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method* (1st ed.). Pearson Education Canada.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In *Qualitative Research Methods in Mental Health and Psychotherapy* (pp. 99–116). Wiley. https://doi.org/10.1002/9781119973249.ch8

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120. https://doi.org/10.1191/1478088706qp062oa

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3), 21–35. https://doi.org/10.1177/160940690300200303

Li, G., Miao, J., Wang, H., Xu, S., Sun, W., Fan, Y., Zhang, C., Zhu, S., Zhu, Z., & Wang, W. (2020). Psychological impact on women health workers involved in COVID-19 outbreak in Wuhan: a cross-sectional study. *Journal of Neurology, Neurosurgery & Psychiatry*, *91*(8), 895–897. https://doi.org/10.1136/jnnp-2020-323134

Litam, S. D. A., & Balkin, R. S. (2021). Moral injury in health-care workers during COVID-19 pandemic. *Traumatology*, *27*(1), 14–19. https://doi.org/10.1037/trm0000290

Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., Xia, L., Liu, Z., Yang, J., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: A qualitative study. *The Lancet Global Health*, *8*(6), e790–e798. https://doi.org/10.1016/S2214-109X(20)30204-7

Liu, Y., Wang, L., Chen, L., Zhang, X., Bao, L., & Shi, Y. (2020). Mental health status of paediatric medical workers in China during the COVID-19 outbreak. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.00702

Locsin, , Rozzano C., Kongsuwan, , Waraporn, & Nambozi, , Grace. (2009). Ugandan nurses' experience of caring for persons dying from Ebola hemorrhagic fever. *International Journal of Human Caring*, *13*(4), 26–32. https://doi.org/10.20467/1091-5710.13.4.26

Manchanda, M., & Mclaren, P. (1998). Cognitive behaviour therapy via interactive video. *Journal of Telemedicine and Telecare*, *4*(1_suppl), 53–55. https://doi.org/10.1258/1357633981931452

Maxwell, J. A. (2012). *A realist approach for qualitative research*. SAGE Publications.

McBeath, A. G., du Plock, S., & Bager-Charleson, S. (2020). The challenges and experiences of psychotherapists working remotely during the coronavirus* pandemic. *Counselling and Psychotherapy Research*, *20*(3), 394–405. https://doi.org/10.1002/capr.12326

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*. https://doi.org/10.3389/fpsyg.2018.01897

McGlinchey, E., Hitch, C., Butter, S., McCaughey, L., Berry, E., & Armour, C. (2021). Understanding the lived experiences of healthcare professionals during the COVID-19 pandemic: An interpretative phenomenological analysis. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.1904700

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy*. Sage.

Mellentin, A. I., Behrendt, S., Bilberg, R., Blankers, M., Folker, M. P., Tarp, K., Uffelmann, J., & Nielsen, A. S. (2021). BLEND-A: Blending internet treatment into conventional face-to-face treatment for alcohol use disorder - a study protocol. *BMC Psychiatry*, *21*(1), 131. https://doi.org/10.1186/s12888-021-03122-4

Merleau-Ponty, M. (1962). *Phenomenology of perception*. Routledge.

Milton, M., Craven, M., & Coyle, A. (2010). Understanding human distress: Moving beyond the concept of "psychopathology". In *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues* (M. Milton, pp. 57–72). Wiley-Blackwell.

Morgan, A., Davies, C., Olabi, Y., Hope-Stone, L., Cherry, M. G., & Fisher, P. (2022). Therapists' experiences of remote working during the COVID-19 pandemic. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.966021

Morgan, C., Knowles, G., & Hutchinson, G. (2019). Migration, ethnicity and psychoses: Evidence, models and future directions. *World Psychiatry*, *18*(3), 247–258. https://doi.org/10.1002/wps.20655

Morgan, C., Mason, E., Newby, J. M., Mahoney, A. E. J., Hobbs, M. J., McAloon, J., & Andrews, G. (2017). The effectiveness of unguided internet cognitive behavioural therapy for mixed anxiety and depression. *Internet Interventions*, *10*, 47–53. https://doi.org/10.1016/j.invent.2017.10.003

Morrow, S. L. (2007). Qualitative research in counseling psychology. *The Counseling Psychologist*, *35*(2), 209–235. https://doi.org/10.1177/0011000006286990

Murphy, D. (2017). *Counselling psychology: A textbook for study and practice*. John Wiley & Sons.

NHS. (2019). *The NHS long term plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS. (2022). *NHS staff survey 2021: National results briefing*. https://www.nhsstaffsurveys.com/static/8c6442c8d92624a830e6656baf633c3f/NHS-Staff-Survey-2022-National-briefing.pdf

Nissen-Lie, H. A., Havik, O. E., Høglend, P. A., Monsen, J. T., & Rønnestad, M. H. (2013). The contribution of the quality of therapists' personal lives to the development of the working alliance. *Journal of Counseling Psychology*, *60*(4), 483–495. https://doi.org/10.1037/a0033643

Norwood, C., Moghaddam, N. G., Malins, S., & Sabin-Farrell, R. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical Psychology & Psychotherapy*, *25*(6), 797–808. https://doi.org/10.1002/cpp.2315

Oates, J., Carpenter, D., Fisher, M., Goodson, S., Hannah, B., Kwiatkowski, R., Prutton, K., Reeves, D., & Wainwright, T. (2021). *BPS Code of Human Research Ethics*. British Psychological Society. https://doi.org/10.53841/bpsrep.2021.inf180

O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research and Practice*, *32*(4), 345–350. https://doi.org/10.1037/0735-7028.32.4.345

Pakenham, K. I., & Stafford-brown, J. (2012). Stress in clinical psychology trainees: Current research status and future directions. *Australian Psychologist*, *47*(3), 147–155. https://doi.org/10.1111/j.1742-9544.2012.00070.x

Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., & Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: A systematic review and meta-analysis. *Brain, Behavior, and Immunity*, *88*, 901–907. https://doi.org/10.1016/j.bbi.2020.05.026

Patrick, H., & Williams, G. C. (2012). Self-determination theory: Its application to health behavior and complementarity with motivational interviewing. *International Journal of Behavioral Nutrition and Physical Activity*, *9*(1), 18. https://doi.org/10.1186/1479-5868-9-18

Pierce, B. S., Perrin, P. B., Tyler, C. M., McKee, G. B., & Watson, J. D. (2021). The COVID-19 telepsychology revolution: A national study of pandemic-based changes in U.S. mental health care delivery. *American Psychologist*, *76*(1), 14–25. https://doi.org/10.1037/amp0000722

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1). https://doi.org/10.14691/CPPJ.20.1.7

Poletti, B., Tagini, S., Brugnera, A., Parolin, L., Pievani, L., Ferrucci, R., Compare, A., & Silani, V. (2021). Telepsychotherapy: A leaflet for psychotherapists in the age of COVID-19. A review of the evidence. *Counselling Psychology Quarterly*, *34*(3–4), 352–367. https://doi.org/10.1080/09515070.2020.1769557

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126–136. https://doi.org/10.1037/0022-0167.52.2.126

Preschl, B., Maercker, A., & Wagner, B. (2011). The working alliance in a randomized controlled trial comparing online with face-to-face cognitive-behavioral therapy for depression. *BMC Psychiatry*, *11*(1), 189. https://doi.org/10.1186/1471-244X-11-189

Prieto-Ursúa, M., & Jódar, R. (2020). Finding meaning in hell. The role of meaning, religiosity and spirituality in posttraumatic growth during the coronavirus crisis in Spain. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.567836

Qiu, J., Shen, B., Zhao, M., Wang, Z., Xie, B., & Xu, Y. (2020). A nationwide survey of psychological distress among Chinese people in the COVID-19 epidemic: Implications and policy recommendations. *General Psychiatry*, *33*(2), e100213. https://doi.org/10.1136/gpsych-2020-100213

Radley, A. (1999). Social realms and the quality of illness experience. In M. Murray & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and Methods*. Sage.

Ramsetty, A., & Adams, C. (2020). Impact of the digital divide in the age of COVID-19. *Journal of the American Medical Informatics Association*, *27*(7), 1147–1148. https://doi.org/10.1093/jamia/ocaa078

Rapley, T. J. (2001). The artfulness of open-ended interviewing: Some considerations on analysing interviews. *Qualitative Research*, *1*(3), 303–323. https://doi.org/10.1177/146879410100100303

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice*, *20*(1), 32–36. https://doi.org/10.1037/0735-7028.20.1.32

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology: Research and Practice*, *36*(6), 649–653. https://doi.org/10.1037/0735-7028.36.6.649

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18*(1), 20–23.

Ren, Z., Zhou, Y., & Liu, Y. (2020). The psychological burden experienced by Chinese citizens during the COVID-19 outbreak: Prevalence and determinants. *BMC Public Health*, *20*(1), 1617. https://doi.org/10.1186/s12889-020-09723-0

Renn, B. N., Hoeft, T. J., Lee, H. S., Bauer, A. M., & Areán, P. A. (2019). Preference for in-person psychotherapy versus digital psychotherapy options for depression: Survey of adults in the U.S. *Npj Digital Medicine*, *2*(1), 6. https://doi.org/10.1038/s41746-019-0077-1

Richards, D., & Viganó, N. (2012). Online counseling. In *Encyclopedia of Cyber Behavior* (1st ed., pp. 699–713). IGI Global.

Richards, D., & Viganó, N. (2013). Online counseling: A narrative and critical review of the literature. *Journal of Clinical Psychology*, *69*(9), 994–1011. https://doi.org/10.1002/jclp.21974

Richardson, L. K., Frueh, B. C., Grubaugh, A. L., Egede, L., & Elhai, J. D. (2009). Current directions in videoconferencing tele-mental health research. *Clinical Psychology: Science and Practice*, *16*(3), 323–338. https://doi.org/10.1111/j.1468-2850.2009.01170.x

Robinson, R. L., Stephenson, J. J., Dennehy, E. B., Grabner, M., Faries, D., Palli, S. R., & Swindle, R. W. (2015). The importance of unresolved fatigue in depression: Costs and comorbidities. *Psychosomatics*, *56*(3), 274–285. https://doi.org/10.1016/j.psym.2014.08.003

Rodríguez-Rey, R., Palacios, A., Alonso-Tapia, J., Pérez, E., Álvarez, E., Coca, A., Mencía, S., Marcos, A., Mayordomo-Colunga, J., Fernández, F., Gómez, F., Cruz, J., Ramos, V., & Olmedilla, M. (2019). Are pediatric critical personnel satisfied with their lives? Prediction of satisfaction with life from burnout, posttraumatic stress, and posttraumatic growth, and comparison with noncritical pediatric staff. *Pediatric Critical Care Medicine*, *20*(3), e160–e169. https://doi.org/10.1097/PCC.0000000000001861

Roesler, C. (2017). Tele-analysis: The use of media technology in psychotherapy and its impact on the therapeutic relationship. *Journal of Analytical Psychology*, *62*(3), 372–394. https://doi.org/10.1111/1468-5922.12317

Rogers, C. R. (1946). Significant aspects of client-centered therapy. *American Psychologist*, *1*(10), 415–422. https://doi.org/10.1037/h0060866

Rogers, C. R. (1951). *Client-centred therapy*. Constable.

Rossi, R., Socci, V., Pacitti, F., Di Lorenzo, G., Di Marco, A., Siracusano, A., & Rossi, A. (2020). Mental health outcomes among frontline and second-line health care workers during the coronavirus disease 2019 (COVID-19) pandemic in Italy. *JAMA Network Open*, *3*(5), e2010185. https://doi.org/10.1001/jamanetworkopen.2020.10185

Rudolph, C. W., Allan, B., Clark, M., Hertel, G., Hirschi, A., Kunze, F., Shockley, K., Shoss, M., Sonnentag, S., & Zacher, H. (2021). Pandemics: Implications for research and practice in industrial and organizational psychology. *Industrial and Organizational Psychology*, *14*(1–2), 1–35. https://doi.org/10.1017/iop.2020.48

Rutkowska, E., Furmańska, J., Lane, H., Marques, C. C., Martins, M. J., Sahar, N. U., Meixner, J., Tullio, V., Argo, A., & Bermeo Barros, D. M. (2023). Determinants of psychotherapists' attitudes to online psychotherapy. *Frontiers in Psychiatry*, *14*, 1196907. https://doi.org/10.3389/fpsyt.2023.1196907

Sage, C. A. M., Brooks, S. K., & Greenberg, N. (2018). Factors associated with type II trauma in occupational groups working with traumatised children: A systematic review. *Journal of Mental Health*, *27*(5), 457–467. https://doi.org/10.1080/09638237.2017.1370630

Sammons, M. T., VandenBos, G. R., Martin, J. N., & Elchert, D. M. (2020). Psychological practice at six months of COVID-19: A follow-up to the first national survey of psychologists during the pandemic. *Journal of Health Service Psychology*, *46*(4), 145–154. https://doi.org/10.1007/s42843-020-00024-z

Sartre, J.-P. (2003). *Being and nothingness: A phenomenological essay on Ontology*. Simon & Schuster.

Schulze, N., Reuter, S. C., Kuchler, I., Reinke, B., Hinkelmann, L., Stöckigt, S., Siemoneit, H., & Tonn, P. (2019). Differences in attitudes toward online interventions in psychiatry and psychotherapy between health care professionals and nonprofessionals: A survey. *Telemedicine and E-Health*, *25*(10), 926–932. https://doi.org/10.1089/tmj.2018.0225

Serrão, C., Rodrigues, A. R., Teixeira, A., Castro, L., & Duarte, I. (2022a). The impact of teleworking in psychologists during COVID-19: Burnout, depression, anxiety, and stress. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.984691

Serrão, C., Rodrigues, A. R., Teixeira, A., Castro, L., & Duarte, I. (2022b). The impact of teleworking in psychologists during COVID-19: Burnout, depression, anxiety, and stress. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.984691

Shandley, K., Klein, B., Kyrios, M., Austin, D., Ciechomski, L., & Murray, G. (2011a). Training postgraduate psychology students to deliver psychological services online. *Australian Psychologist*, *46*(2), 120–125. https://doi.org/10.1111/j.1742-9544.2011.00034.x

Shandley, K., Klein, B., Kyrios, M., Austin, D., Ciechomski, L., & Murray, G. (2011b). Training postgraduate psychology students to deliver psychological services online. *Australian Psychologist*, *46*(2), 120–125. https://doi.org/10.1111/j.1742-9544.2011.00034.x

Sherrington, A. (2022). *2 years of COVID-19 on GOV.UK*. GOV.UK. https://gds.blog.gov.uk/2022/07/25/2-years-of-covid-19-on-gov-uk/

Shklarski, L., Abrams, A., & Bakst, E. (2021). Navigating changes in the physical and psychological spaces of psychotherapists during Covid-19: When home becomes the office. *Practice Innovations*, *6*(1), 55–66. https://doi.org/10.1037/pri0000138

Sibley, C. G., Greaves, L. M., Satherley, N., Wilson, M. S., Overall, N. C., Lee, C. H. J., Milojev, P., Bulbulia, J., Osborne, D., Milfont, T. L., Houkamau, C. A., Duck, I. M., Vickers-Jones, R., & Barlow, F. K. (2020). Effects of the COVID-19 pandemic and nationwide lockdown on trust, attitudes toward government, and well-being. *American Psychologist*, *75*(5), 618–630. https://doi.org/10.1037/amp0000662

Simon, N. M., Saxe, G. N., & Marmar, C. R. (2020). Mental health disorders related to COVID-19–related deaths. *JAMA*, *324*(15), 1493. https://doi.org/10.1001/jama.2020.19632

Simpson, S. (2009). Psychotherapy via videoconferencing: A review. *British Journal of Guidance & Counselling*, *37*(3), 271–286. https://doi.org/10.1080/03069880902957007

Simpson, S. G., & Reid, C. L. (2014). Therapeutic alliance in videoconferencing psychotherapy: A review. *Australian Journal of Rural Health*, *22*(6), 280–299. https://doi.org/10.1111/ajr.12149

Simpson, S., Simionato, G., Smout, M., van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2019). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. *Clinical Psychology & Psychotherapy*, *26*(1), 35–46. https://doi.org/10.1002/cpp.2328

Singh, S., & Sagar, R. (2022). Online psychotherapy during the COVID-19 pandemic: The good, the bad, and the ugly. *Indian Journal of Psychological Medicine*, *44*(2), 177–180. https://doi.org/10.1177/02537176211070427

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In *analysing qualitative data in psychology* (pp. 35–50). SAGE Publications, Ltd. https://doi.org/10.4135/9781446207536.d10

Smith, J. A., Flower, P., & Larkin, M. (2022). *Interpretative phenomenological analysis theory, method and research* (Second). Sage Publication Ltd.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage Publications Ltd.

Smith, J. A., Harre, R., & Langenhove, L. V. (1995). *Rethinking methods in psychology (1st ed.)*. SAGE Publications Ltd.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In *qualitative psychology: A practical guide to research methods* (pp. 51–80). Sage Publications, Inc.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science and Practice*, *16*(1), 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

Sokół-Szawłowska, M., & Mierzejewski, P. (2023). Warunki pracy i reakcje psychologów podczas pięciu fal pandemii COVID-19 w Polsce. Badanie prospektywne. *Psychiatria*, *20*(2), 65–72. https://doi.org/10.5603/PSYCH.a2023.0009

Spreitzer, G. M., Cameron, L., & Garrett, L. (2017). Alternative work arrangements: Two images of the new world of work. *Annual Review of Organizational Psychology and Organizational Behavior*, *4*(1), 473–499. https://doi.org/10.1146/annurev-orgpsych-032516-113332

Stoll, J., Müller, J. A., & Trachsel, M. (2020). Ethical issues in online psychotherapy: A narrative review. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00993

Stroebe, M., Schut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *The Lancet*, *370*(9603), 1960–1973. https://doi.org/10.1016/S0140-6736(07)61816-9

Strohm Kitchener, K., & Anderson, S. K. (2011). *Foundations of ethical practice, research, and teaching in psychology and counseling* (2nd ed.). Routledge/Taylor & Francis Group.

Sucala, M., Schnur, J. B., Brackman, E. H., Constantino, M. J., & Montgomery, G. H. (2013). Clinicians' attitudes toward therapeutic alliance in e-therapy. *The Journal of General Psychology*, *140*(4), 282–293. https://doi.org/10.1080/00221309.2013.830590

Suler, J. R. (2000). Psychotherapy in cyberspace: A 5-dimensional model of online and computer-mediated psychotherapy. *CyberPsychology & Behavior*, *3*(2), 151–159. https://doi.org/10.1089/109493100315996

Sullivan, C., & Lewis, S. (2001). Home-based telework, gender, and the synchronization of work and family: Perspectives of teleworkers and their co-residents. *Gender, Work & Organization*, *8*(2), 123–145. https://doi.org/10.1111/1468-0432.00125

Swartz, H. A. (2020). The role of psychotherapy during the COVID-19 pandemic. *American Journal of Psychotherapy*, *73*(2), 41–42. https://doi.org/10.1176/appi.psychotherapy.20200015

Taha, A. A., Zhang, Z., Driessnack, M., Huntzicker, J. J., Eisen, A. M., Bernstein, J., Chen, A., Chandra, R. A., Drake, K., Fung, A., Ladkany, R., LaVigne, B., Nardos, R., Sayama, C., Tereshchenko, L. G., Wilson, B., & Steckler, N. A. (2022). Emerging frontline leaders' voices in response to COVID-19 crisis. *Nursing Research*, *71*(2), 104–110. https://doi.org/10.1097/NNR.0000000000000571

Tedeschi, R., & Calhoun, L. (1995). *Trauma & transformation: Growing in the aftermath of suffering*. SAGE Publications, Inc. https://doi.org/10.4135/9781483326931

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*(3), 455–471. https://doi.org/10.1002/jts.2490090305

Tedeschi, R. G., Shakespeare-Finch, J., Taku, K., & Calhoun, L. G. (2018). *Posttraumatic growth: Theory, research, and applications*. Routledge.

Teng, Z., Wei, Z., Qiu, Y., Tan, Y., Chen, J., Tang, H., Wu, H., Wu, R., & Huang, J. (2020). Psychological status and fatigue of frontline staff two months after the COVID-19 pandemic outbreak in China: A cross-sectional study. *Journal of Affective Disorders*, *275*, 247–252. https://doi.org/10.1016/j.jad.2020.06.032

The British Psychological Society. (2019). *Standards for the accreditation of Doctoral programmes in counselling psychology*. BPS. https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Counselling%20Accreditation%20Handbook%202019.pdf

Titzler, I., Saruhanjan, K., Berking, M., Riper, H., & Ebert, D. D. (2018). Barriers and facilitators for the implementation of blended psychotherapy for depression: A qualitative pilot study of therapists' perspective. *Internet Interventions*, *12*, 150–164. https://doi.org/10.1016/j.invent.2018.01.002

Topooco, N., Riper, H., Araya, R., Berking, M., Brunn, M., Chevreul, K., Cieslak, R., Ebert, D. D., Etchmendy, E., Herrero, R., Kleiboer, A., Krieger, T., García-Palacios, A., Cerga-Pashoja, A., Smoktunowicz, E., Urech, A., Vis, C., & Andersson, G. (2017). Attitudes towards digital treatment for depression: A European stakeholder survey. *Internet Interventions*, *8*, 1–9. https://doi.org/10.1016/j.invent.2017.01.001

Toscano, F., & Zappalà, S. (2020). Social isolation and stress as predictors of productivity perception and remote work satisfaction during the COVID-19 pandemic: The role of concern about the virus in a moderated double mediation. *Sustainability*, *12*(23), 9804. https://doi.org/10.3390/su12239804

Trope, Y., & Liberman, N. (2010). Construal-level theory of psychological distance. *Psychological Review*, *117*(2), 440–463. https://doi.org/10.1037/a0018963

Trub, L., & Magaldi, D. (2017). Left to Our Own Devices. *Psychoanalytic Perspectives*, *14*(2), 219–236. https://doi.org/10.1080/1551806X.2017.1304118

Tudor, K., & Murphy, D. (2021). Online therapies and the person-centered approach. *Person-Centered & Experiential Psychotherapies*, *20*(4), 283–285. https://doi.org/10.1080/14779757.2021.2000139

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications*, *02*(04). https://doi.org/10.4172/2472-1654.100093

University of East London. (2020). *Code of Practice for Research Ethics*. https://research.uel.ac.uk/file/5c405149b25b0f9d82b5cc6eb5645986208c763898dad77658ca4d9becdca2e7/184862/Code%20of%20Practice%20for%20Research%20Ethics%202020%20%282%29.pdf?s=a54d3bd77a234ed5a91cdf7b0e74864489f0c89e41d1319cae275c9585d1f4f4

University of East London. (2020). *Code of Practice for Research*. https://research.uel.ac.uk/file/b319bc2a019fc4e02e92b53eb9c43b839062dd2f0a3e1d7ca941c2a1138f1c17/309679/Code%20of%20Practice%20for%20Research%202020_21%20%28w%29.pdf?s=0a67f743348a6a3bb61492dbbbad4f365d1538bc95befcbf28a4aac747f369e4

Van der Doef, M., & Maes, S. (1999). The job demand-control (-support) model and psychological well-being: A review of 20 years of empirical research. *Work & Stress*, *13*(2), 87–114. https://doi.org/10.1080/026783799296084

von Below, C., Bergsten, J., Midbris, T., Philips, B., & Werbart, A. (2023). It turned into something else: Patients' long-term experiences of transitions to or from telepsychotherapy during the COVID-19 pandemic. *Frontiers in Psychology*, *14*. https://doi.org/10.3389/fpsyg.2023.1142233

Vredenburgh, L. D., Carlozzi, A. F., & Stein, L. B. (1999). Burnout in counseling psychologists: Type of practice setting and pertinent demographics. *Counselling Psychology Quarterly*, *12*(3), 293–302. https://doi.org/10.1080/09515079908254099

Wagner, B., Brand, J., Schulz, W., & Knaevelsrud, C. (2012). Online working alliance predicts treatment outcome for posttraumatic stress symptoms in Arab war-traumatized patients. *Depression and Anxiety*, *29*(7), 646–651. https://doi.org/10.1002/da.21962

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: Considerations for palliative care providers. *Journal of Pain and Symptom Management*, *60*(1), e70–e76. https://doi.org/10.1016/j.jpainsymman.2020.04.012

Waller, G., Pugh, M., Mulkens, S., Moore, E., Mountford, V. A., Carter, J., Wicksteed, A., Maharaj, A., Wade, T. D., Wisniewski, L., Farrell, N. R., Raykos, B., Jorgensen, S., Evans, J., Thomas, J. J., Osenk, I., Paddock, C., Bohrer, B., Anderson, K., … Smit, V. (2020). Cognitive-behavioral therapy in the time of coronavirus: Clinician tips for working with eating disorders via telehealth when face-to-face meetings are not possible. *International Journal of Eating Disorders*, *53*(7), 1132–1141. https://doi.org/10.1002/eat.23289

Webster. (1995). *Webster's new college dictionary* (2nd ed.). Houghton Mifflin.

Wethal, U., Ellsworth-Krebs, K., Hansen, A., Changede, S., & Spaargaren, G. (2022). Reworking boundaries in the home-as-office: Boundary traffic during COVID-19 lockdown and the future of working from home. *Sustainability: Science, Practice and Policy*, *18*(1), 325–343. https://doi.org/10.1080/15487733.2022.2063097

Wiederhold, B. K. (2020). Connecting through technology during the coronavirus disease 2019 pandemic: Avoiding "Zoom Fatigue." *Cyberpsychology, Behavior, and Social Networking*, *23*(7), 437–438. https://doi.org/10.1089/cyber.2020.29188.bkw

Wierwille, J. L., Pukay-Martin, N. D., Chard, K. M., & Klump, M. C. (2016). Effectiveness of PTSD telehealth treatment in a VA clinical sample. *Psychological Services*, *13*(4), 373–379. https://doi.org/10.1037/ser0000106

Williams, J. C., & Huber, G. P. (1986). *Human behavior in organizations*. South-Western Publishing.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In *APA handbook of research methods in psychology, Vol 1: Foundations, planning, measures, and psychometrics.* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Willig, C. (2013). *Introducing qualitative research in psychology third edition*. University Press.

Willig, C., & Stainton-Rogers, W. (2017). *The SAGE Handbook of Qualitative Research in Psychology* (2nd ed.). Sage Publication.

Wind, T. R., Rijkeboer, M., Andersson, G., & Riper, H. (2020). The COVID-19 pandemic: The 'black swan' for mental health care and a turning point for e-health. *Internet Interventions*, *20*, 100317. https://doi.org/10.1016/j.invent.2020.100317

Winnicott, D. W. (1965). The maturational process and the facilitating environment: Studies in the Theory of Emotional Development. *The International Psycho-Analytical Library*, *64*, 1–276. http://doctorabedin.org/wp-content/uploads/2015/07/Donald-Winnicott-The-Maturational-Process-and-the-Facilitating-Environment-1965.pdf

Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, *43*(5), 487–494. https://doi.org/10.1037/a0029446

Wong, K. P., Bonn, G., Tam, C. L., & Wong, C. P. (2018). Preferences for online and/or face-to-face counseling among university students in Malaysia. *Frontiers in Psychology*, *9*. https://doi.org/10.3389/fpsyg.2018.00064

Woolfe, R., Strawbridge, S., Douglas, B., & Dryden, W. (2010). *The Handbook of Counselling Psychology* (3rd ed.). Sage Publications.

World Health Organization. (2019, May 28). *Burn-out an "occupational phenomenon": International Classification of Diseases*. World Health Organization.

https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

World Health Organization. (2023). *Coronavirus disease (COVID-19) Pandemic*. https://www.who.int/health-topics/coronavirus#tab=tab_1

Wu, P., Fang, Y., Guan, Z., Fan, B., Kong, J., Yao, Z., Liu, X., Fuller, C. J., Susser, E., Lu, J., & Hoven, C. W. (2009). The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception, and altruistic acceptance of risk. *The Canadian Journal of Psychiatry*, *54*(5), 302–311. https://doi.org/10.1177/070674370905400504

Xiang, Y.-T., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. H. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *The Lancet Psychiatry*, *7*(3), 228–229. https://doi.org/10.1016/S2215-0366(20)30046-8

Xiaoming, X., Ming, A., Su, H., Wo, W., Jianmei, C., Qi, Z., Hua, H., Xuemei, L., Lixia, W., Jun, C., Lei, S., Zhen, L., Lian, D., Jing, L., Handan, Y., Haitang, Q., Xiaoting, H., Xiaorong, C., Ran, C., … Li, K. (2020). The psychological status of 8817 hospital workers during COVID-19 Epidemic: A cross-sectional study in Chongqing. *Journal of Affective Disorders*, *276*, 555–561. https://doi.org/10.1016/j.jad.2020.07.092

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, *12*(3), 295–296. https://doi.org/10.1080/17439760.2016.1262624

Yuen, E. K., Herbert, J. D., Forman, E. M., Goetter, E. M., Juarascio, A. S., Rabin, S., Goodwin, C., & Bouchard, S. (2013). Acceptance based behavior therapy for social anxiety disorder through videoconferencing. *Journal of Anxiety Disorders*, *27*(4), 389–397. https://doi.org/10.1016/j.janxdis.2013.03.002

Zahavi, D. (2019). *Phenomenology: The basics*. Routledge.

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482–491. https://doi.org/10.1037/a0027824

APPENDIX 1: Ethics Approval UEL

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in **orange**

Details	
Reviewer:	**Lucy Poxon**
Supervisor:	**Martin Willis**
Student:	**Menara Islam**
Course:	**Prof Doc in Counselling Psychology**
Title of proposed study:	**Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis**

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of

	this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED - MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

Minor amendments

Please clearly detail the amendments the student is required to make

1. We are no longer able to add Samaritans to UEL participant information letters, therefore please remove Samaritans from your participant letter and debrief letter.

2. Name of assessor on the Risk Assessment form should be student's name with Supervisor's signature in a separate box.

3. You refer to "Lockdowns 1-3" in the Ethics form, but "Lockdown" in your interview schedule. Your participant will need to be clear what period you want them to focus on – be consistent throughout.

4. The interview questions need some refining to avoid the repetition and overlap that is evident currently.

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**D**r Lucy Poxon

Date:	**04/04/2022**
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee	
RESEARCHER PLEASE NOTE For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place. For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.	

Confirmation of minor amendments (Student to complete)	
I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	**Menara Islam**
Student number:	**U1927975**
Date:	**08/04/2022**
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX 2: Participant Information Sheet

Version: 2

Date: 03/03/2022

PARTICIPANT INFORMATION SHEET

Title of research: Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis

Contact person: Menara Islam

Email: U1927975@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Please feel free to speak with others about the study (friends, family, etc.) before making your decision. If you have any questions, please do not hesitate to contact me via email.

Who am I?

My name is Menara Islam, and I am currently studying for a Professional Doctorate in Counselling Psychology at the University of East London's School of Psychology (UEL). As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into the lived experiences of counselling psychologists adapting their working practice due to the government-imposed COVID-19 lockdown measures in the UK, with the hope that they will be able to access support and assistance for themselves. Counselling psychologists needing to adapt their working practice in the setting of future health crises, will benefit from these research findings. Additionally, service providers can utilise the findings to support their workforce. Furthermore, these research findings will provide an insight into how the practice of counselling psychologists may evolve in the years following the COVID-19 pandemic.

Why have I been invited to take part?

To address the aims of this study, I am inviting counselling psychologists to take part in my research. If you are a counselling psychologist who is two years post-qualification with experience of working during all three COVID-19 national lockdowns in the UK, you are eligible to take part in the study. It is entirely up to you whether you take part or not as participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to give an individual account of the adaptations you made to your working practice in response to the government-imposed COVID-19 lockdown measures in the UK.

You will be interviewed individually for approximately 60 minutes on MS Teams. During this time, you will be invited to offer detailed account of both positive and negative aspects of your experience regarding adapting your practice from home during the COVID-19 lockdowns. The interview will be informal and will be audio recorded using Teams platform.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without an explanation and without consequences. If you would like to withdraw from the interview, you can do so by emailing the researcher. Should you decide to withdraw, your data will not be used as part of the research.

You can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within a period of 2 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

Due to the sensitive nature of the research topic, you may experience distress associated with recalling your experiences living through the COVID-19 lockdown. You can contact the helplines below for further support:

1. Mind, the mental health charity in Newham
   mind.org.uk
   Granta House, 15-19 Broadway, London E15 4BQ. Phone: 020 8519 21220,
   email: info@mithn.org.uk
2. Cruse Bereavement Support Helpline 0808 808 1677. Can follow via social media Facebook, Instagram and Twitter and use the chat option on the website.
   https://www.cruse.org.uk/
3. Sudden Bereavement Help 0800 2600 400
   https://sudden.org/covid-research/sudden-bereavement-charter/
4. The Loss Foundation- bereavement support for loss to cancer or COVID-19.
   https://thelossfoundation.org/. Phone: 0300 200 4112,
   email: hello@thelossfoundation.org

How will the information I provide be kept secure and confidential?

Confidentiality and anonymity will be ensured by referring to participants by pseudonym in the transcript. The real names and identifying references will be omitted from the transcripts, and only the main researcher will have access to the names and identities of the participants, which will be kept separately from all the transcripts. The transcripts and signed consent forms will be stored in a locked and secure cabinet. The audio recordings will be stored on a password protected laptop and kept within the home of the researcher. The audio recordings and transcripts will be read by myself. After the data is analysed my supervisors and examiners will have access to sections from the anonymised transcriptions of the interviews.

From the anonymised interview data, selective quotes will be anonymised to support the analysis. You hold the right to withdraw from the study at any time without any disadvantages to yourself and without any obligation to give any reasons within the first 2 weeks following the interview. If you wish to withdraw after the period of 2 weeks, the researcher reserves the right to use your data anonymously in the write-up of the study and in any further analysis that may be conducted.

After the completion of the study, all audio recordings will be deleted, and the anonymised transcripts will be kept securely for a maximum of 5 years after the interview takes place, in line with the University of East London Research Data Management Policy (2019), in the event that is possible to publish the findings.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see the following website:

www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository Registry of Open Access Repositories (ROAR). Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles and blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally. Any personally identifying information will either be removed or replaced with pseudonyms.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Martin Willis for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Menara Islam

Email: U1927975@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Martin Willis

School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: M.Willis@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

APPENDIX 3: Participant Advertisement

PARTICIANTS NEEDED FOR RESEARCH ON

Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom

Are you a qualified counselling psychologist, two years post qualified, with experience of working from home remotely during all three COVID-19 national lockdowns in the UK (March 2020, Nov 2020, and Jan 2021)?

If so, would you like the opportunity to talk about your experience of your working practice adaptation during lockdowns?

In order to participate, you will need to attend one interview where we will meet online via Microsoft Teams for approximately 60 minutes. You will be asked about your experience of adapting your working practice during COVID-19 lockdowns. All interviews are confidential, and your participation will be anonymous.

For more information about this study, or take part, please contact Menara Islam at: U1927975@uel.ac.uk

Research supervisor Dr Martin Willis, School of Psychology.

Email: M.Willis@uel.ac.uk

APPENDIX 4: Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of research: Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis

Contact person: Menara Islam

Email: U1927975@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 20/02/2022 for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have two weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Teams recording facilities.	
I understand that my personal information and data, including audio recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name:

……

Participant's Signature

……

Researcher's Name: MENARA ISLAM

……

Researcher's Signature

……

Date

……

APPENDIX 5: Recruitment Advertisement Email

Dear [redacted]

I will be very grateful if you could place the below advert on the next Division of Counselling Psychology newsletter.

I am Menara Islam, and I am a final-year student on Professional Doctorate in Counselling Psychology training with University of East London. As part of the requirement for the Doctorate I am conducting a study to gain deeper understanding of the lived experience of counselling psychologists adapting their working practice in response to the government-imposed national COVID-19 lockdown measures in the UK. This study aims to conduct approximately 60 minutes semi structured interview via Microsoft Teams and the participants will be asked about their experience of adapting their working practice during COVID-19 lockdowns.

I am looking for:

- Two years or more post qualified counselling psychologists
- someone with experience of working from home remotely during all three COVID-19 national lockdowns in the UK (March 2020, Nov 2020, and Jan 2021).

Participation is voluntary and you are welcome to ask any questions you might have about the study. If you are interested in participating in the study, please contact me. Taking part is your decision and you are free to change your mind at any time, without giving a reason and without any negative consequences.

The study has been given ethical approval by the University of East London Ethics Committee and is being supervised by Dr Martin Willis. The supervisor can be contacted via email: M.Willis@uel.ac.uk. For more information about this study, or take part, please contact Menara Islam at: U1927975@uel.ac.uk.

Kind regards,

Menara Islam

Trainee Counselling Psychologist

APPENDIX 6: Interview Schedule

Start by introducing the interview, frame confidentiality, recording, right to withdraw and explain the structure of the interview.

- ✓ Questions

Move to some **warming questions to build rapport:**

Demographics:

- Age:
- Ethnicity:
- Relationship status:

Scene setting

- How long have you been qualified as a counselling psychologist?
- What sector do you work in?
- How many clients to you see on average a month?
- Did you spend the COVID-19 lockdowns 1-3 (1st lockdown, March- June 2020; 2nd lockdown, Nov – Dec 2020, and 3rd lockdown, Jan- Mar 2021) in the UK alone or with others?

Narrowing the focus

1. Can you please tell me a bit about your overall experience of COVID-19 lockdowns?
2. What were the main feelings that you were experiencing at the time?
3. Did COVID-19 lockdowns affect your working practice? If so, how
    - Prompt: How did it affect you personally?

- Prompt: How did it affect you professionally?

4. What was your experience of adapting your working practice during COVID-19 lockdowns?
    - Prompt: What were the adaptations you made to your practice?
    - Prompt: Can you please describe how you felt about these adaptations?
    - Prompt: Did it affect you in any way? If so, how did it affect you?
    - Prompt: What were the impacts on yourself? If any
    - Prompt: What were the impacts on your practice? If any
    - Prompt: Do you recall any challenges you faced?
    - Prompt: If so, can you please tell me a little about it?
    - Prompt: Do you recall any benefits of this adaptation?
    - Prompt: If so, can you please tell me a little about it?
5. During lockdown, which remote working medium did you use for work (online video conferencing or telephone)?
6. What were your experiences of adaptation to this medium of working?
    - Prompt: In what ways did you accommodate your practice from home?
    - Prompt: Did you experience any technological problems? If so, what were they?
    - Prompt: How did it impact your work?
    - Prompt: What were the impacts on yourself and work? If any.

7. Were your experiences of working during COVID-19 lockdowns any different from your experience of working pre-COVID-19? If so, how
    - Prompt: How did you feel working alone?
    - Prompt: How did you feel working away from your colleagues?

8. What source of support did you draw on?

9. Reflecting on your personal experience of practice adaptation during the pandemic, what advice will you give to future counselling psychologists if they find themselves in a similar situation?
    - Prompt: Future health crisis, emergencies, epidemics, or pandemics.

Ending

10. Any other thoughts, feelings, or reflections that you would like to share that I haven't asked about?

- ✓ Many thanks for your time
- ✓ Give debrief form

- I will prompt throughout the interview:
    - I will ask for examples – Could you please give me an example?
    - I will ask for more information - Could you please tell me a little more about that?
    - I will ask about idiosyncratic meaning- What does _____mean to you?

APPENDIX 7: Debrief Letter

PARTICIPANT DEBRIEF SHEET

Title of research: Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis

Thank you for taking the time to participate in this research. The aim of this study is to gain a deeper understanding of the lived experiences of counselling psychologists who have had to adapt their working practice during the national COVID-19 lockdowns in the UK. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the participant information sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository Registry of Open Access Repositories. Findings will also be disseminated to a range of audiences (academics, clinicians, the public etc.) through journal articles, conference presentations, talks, magazine articles and blogs. In all material produced, your identity will remain anonymous, in that it will not be possible to identify you personally. Any personally identifying information will either be removed or replaced by pseudonyms.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Martin Willis for a maximum of 3 years, following which all data will be deleted.

What if I have been adversely affected by taking part?

It is not expected that you will be adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation or the effects following participation may have been distressing, or uncomfortable in some way. If you have been affected in any of these ways, you may find the following resources/services helpful in relation to obtaining information and support:

1. Mind, the mental health charity in Newham
   mind.org.uk
   Granta House, 15-19 Broadway, London E15 4BQ. Phone: 020 8519 21220,
   email: info@mithn.org.uk

2. Cruse Bereavement Support Helpline 0808 808 1677. Can follow via social media Facebook, Instagram and Twitter and use the chat option on the website.
   https://www.cruse.org.uk/

3. Sudden Bereavement Helpline 0800 2600 400
   https://sudden.org/covid-research/sudden-bereavement-charter/

4. The Loss Foundation- bereavement support for loss to cancer or COVID-19.
   https://thelossfoundation.org/. Phone: 0300 200 4112,
   email: hello@thelossfoundation.org

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Menara Islam

Email: U1927975@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Martin Willis. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: M.Willis@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

APPENDIX 8: Ethics - Title change application approval

University of East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents	
A copy of the approval of your initial ethics application.	**YES** ☒

Details	
Name of applicant:	**Menara Islam**
Programme of study:	**Prof Doc in Counselling Psychology**

Title of research:	**Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis**
Name of supervisor:	**Dr Martin Willis**

Proposed title change	
Briefly outline the nature of your proposed title change in the boxes below	
Old title:	Understanding how the COVID-19 lockdown has been experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis
New title:	Understanding how the COVID-19 lockdown practice adaptations were experienced by Counselling Psychologists in the United Kingdom: An Interpretative Phenomenological Analysis
Rationale:	The research explores experience of counselling psychologists' 'Practice adaptations', therefore it was important to include it in the title of the thesis. Also, it was one of the recommended viva amendments by examiners.

Confirmation		
Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature	
Student: (Typed name to act as signature)	**Menara Islam**
Date:	**07/06/2024**

Reviewer's decision		
Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested in the viva.**	

Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**
Date:	**14/05/2024**

APPENDIX 9: Example interview transcript

Exploratory notes	Interview for participant 1 James	Experiential statement
	1. **How did you lock, how did COVID-19 lockdowns**	
	2. **affect your working**	
	3. **practice? If so, sorry, did COVID-19 lockdown affect**	
	4. **your working practice?**	
	5. **If so, how?**	
	6. **J:** Yes, a profoundly affected my working practice. So	
	7. basically, I was finishing off, as I say, one job and I was	C-19 lockdown - huge impact on work practice Transitioning from one job to job
	8. coming to the very end, so there's last two weeks, I was	
	9. sent home until the stay home and to work from home. But	
Profoundly affected working practice	10. I had never worked with a patient remotely before and I've	New experience of remote working Unfamiliar therapy delivery platforms
	11. never even heard of Teams or, you know any of the other	
Changed jobs.	12. sort of platform. To be able to do this. So, it was it it	A time of confusion / disorientation
L1 - First time working remote working - Unfamiliar with video platforms: Team Zoom etc – disorientating. Remote option - phone option -was only means for me and client to finish/ end work	13. would it really, it was very, very disorientating. And umm	
	14. basically I've finished my I finished my client work in	No choice of therapy delivery means- Remote delivery only choice Both clients and therapist restricted choice
	15. that job on the phone because I didn't have any other	
	16. means to do it. And neither did my neither did my my	
	17. clients or patients. Uhm and so you know that job kind of	
	18. came to an end with a bit of a splatter. I had a month or so	
	19. off between jobs. Then when I began the new job, this	Abrupt ending of employment – no planning/ closure
	20. made a huge, profound difference because, the the the the	
	21. venue of the new job, it was an older adult service. Umm	
	22. on the venue of that job, the, the, the, the, the clinic was	New beginning with new team – alone and isolated
Commencing new job – older adult's service	23. shut, it had been completely shut down and no patient	
	24. were being seen face to face, yeah, face to face at all…and	
	25. they were not being seen face- to-face in their homes, nor	Part of the team but alone
	26. face to face in this clinic. And so, the only option I had	
	27. was to ring people. And because of the nature of the the	
	28. age range, most people	- Phone therapy delivery – only option

APPENDIX 10: Theme Recurrence Table

A table illustrating the frequency of occurrence for both GET and subthemes.

Themes	P1	P2	P3	P4	P5	P6
GET One: Intense emotional reaction to sudden COVID-19 lockdown practice adaptation						
Subtheme One: The experience of intense emotions and uncertainty about practice adaptation	✓	✓	✓	✓	✓	✓
Subtheme Two: Deserted streets felt apocalyptic	✓	✓				✓
GET Two: Newness of COVID-19 lockdown practice adaption						
Subtheme One: Multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas	✓	✓	✓	✓	✓	✓
Subtheme Two: Embracing and adjusting to new remote practice adaptation and working with new mediums – 'Absurdity of the new world we live in'	✓	✓	✓	✓	✓	✓
Subtheme Three: Newness of confidentiality and managing risk: 'Counselling somebody in the middle of a shopping mall'	✓	✓	✓	✓	✓	✓
Subtheme Four: Newness of working with technology and the impact of internet disruption on therapy	✓	✓	✓	✓	✓	✓
GET Three: The experience of multiple losses during COVID-19 lockdown practice adaptation						
Subtheme One: Personal and professional - Loss of support systems and social connection with others	✓	✓	✓	✓	✓	
Subtheme Two: Loss of in-person therapy delivery - 'Unheard of and not the done thing'						
Subtheme Three:	✓	✓	✓	✓	✓	

Loss of therapeutic interventions: doing support work						
Subtheme Four: Loss of expert position in the therapeutic relationship	✓	✓	✓	✓		
GET Four: Gains – embracing new way of working using different mediums to deliver therapy and self-development opportunities during lockdown practice adaptation						
Subtheme One: Home practice adaption – learning new skills and an opportunity to develop as a therapist to deliver therapy using different mediums	✓	✓	✓	✓	✓	✓
Subtheme Two: Acceptance and embracing of hybrid therapy delivery	✓	✓	✓	✓	✓	✓
Subtheme Three: Acceptance of new norms emerged from lockdown practice adaptation	✓	✓	✓	✓	✓	✓
Subtheme Four: Practice adaptation- importance of self-care, self-acceptance, self-compassion, self-connection, and self-awareness	✓	✓	✓	✓	✓	✓

APPENDIX 11: GET Two - Newness of lockdown practice adaption

Subthemes	Evidence from transcripts	Participants
One: Multiple challenges of establishing a dedicated home workspace and effectively separating it from personal living areas	*'Little cupboard under the stairs… it doesn't have any windows.'* (James, P. 14) *'Starting a new job… not leaving the cupboard under the stair… anxiety.'* (James, P.19) *'Home space and a relaxing space… become a workspace.'* (James, P. 15)	**James**
	'My private practice, well, it was initially it was in the bedroom because the house was full, so everyone was in the house because kids don't go to school. Yes, that very quickly… it took me a while to buy myself an armchair, proper chair. But I think it was the next year. So, it was really rubbish kind of sitting wherever…' (Sarah, P. 17)	**Sarah**
	'There was a lot of re-juggling, negotiating with members of my family… it was a combination of being more open with clients, that this is a new way of working, but also shielding them from a lot, there was a lot of confusion and chaos going on in the background… crazy outside.' (Shanti, P. 11) *'Mean there is sort of issues around separating home life and work life. Being able to feel professional while sitting in your bedroom… over time, I've been quite successful at being able to do that, partly because I can see the benefits from working from home; so, I was motivated to make it work.'* (Shanti, P. 18)	**Shanti**
	'…my son…was in lockdown. It was very difficult…he was smaller than now. To think about the space…about him making noise, that also my personal boundaries…respecting the confidentiality of the clients. Again, as I said, we as humans, I think we adapt quickly (laughed), so, my family adapted quickly.' (Adam, P. 11) *'It was so absurd that it was so strange, but I just thought that there's not much more I can do really.'* (Adam, P. 12) '*I felt a bit bad restricting my family's space.'* (Adam, P. 12)	**Adam**
	'I live in a small flat… I'm not the only one that lives here. So, I had to do a bit of sort of restructuring of the flat to find a safe place for myself, and what	**Helen**

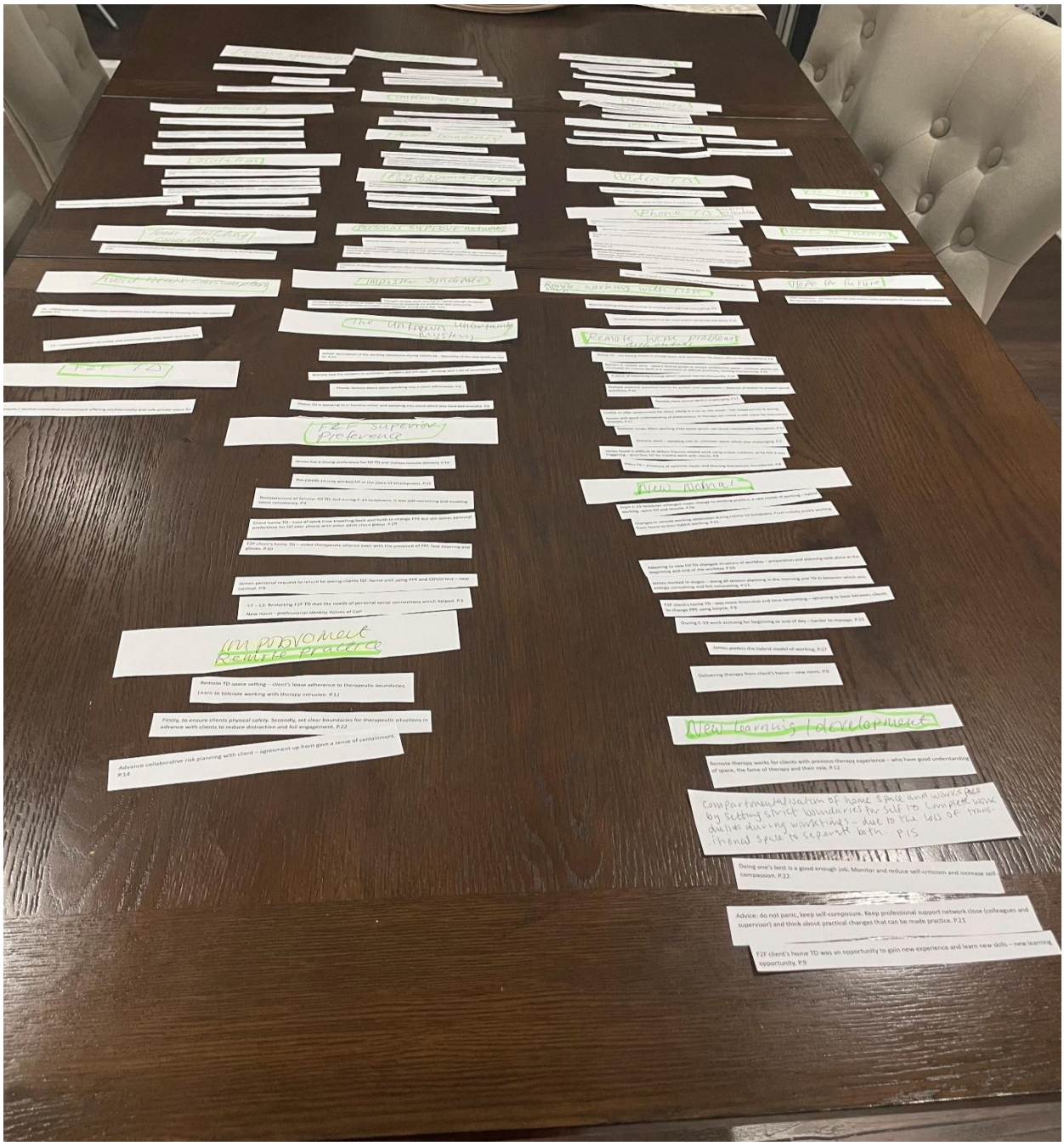
	that would look like and confidential space considering as someone else who lives here, so that was a challenge.' (Helen, P. 6)	
	*'I was working in the living room and people have to walk through the living room to get from the front room door to the back of the house. So, you're in that kind of situation where you're trying not to let people see that you're following people and people can see your eyes… patients… could see probably from what I was looking at that somebody was there…which is not ideal, but there wasn't any other alternative.' (*Eva, P. 5)	**Eva**
Two: Embracing and adjusting to new remote practice adaptation and working with new mediums – 'Absurdity of the new world we live in'	*'…there's a lot that you can pick up from the person or the person picks up from you, with the phone being nonverbal, it's very excluded. Well, it's almost absent apart, you know, from the tone of voice. So, it's very distant. I think the patients, but also my myself as a therapist, it was very easy to disengage. I mean, it was sometimes I found myself lying on the sofa whilst on the phone… and my own attention was a bit compromised. I think both me and the patients there was an issue about being present their emotionally...'* (Adam, P. 6)	**Adam**
	'The idea of video work just seemed really alien that hadn't even been mentioned at that point.' (Shanti, P. 6)	**Shanti**
	'I was suddenly sort of gone from face to face working to ringing a faceless voice, really in a void which umm I did find very, very hard. It was stressful for me… all of a sudden… I had far less information, if you like, about the person in front of me than I would normally have… There was no… nonverbal communication to look at.' (James, P. 6)	**James**
	'Real intimacy that can be created with telephone sessions, which is really, really nice actually… I tend to sort of really sort of crouch over the phone and you're really listening really, really hard, like extra hard to like, watch someone saying and how they're saying that they they there's a real sort of connection that can be created with telephone sessions and effective work definitely can be done.' (Helen, P. 9)	**Helen**

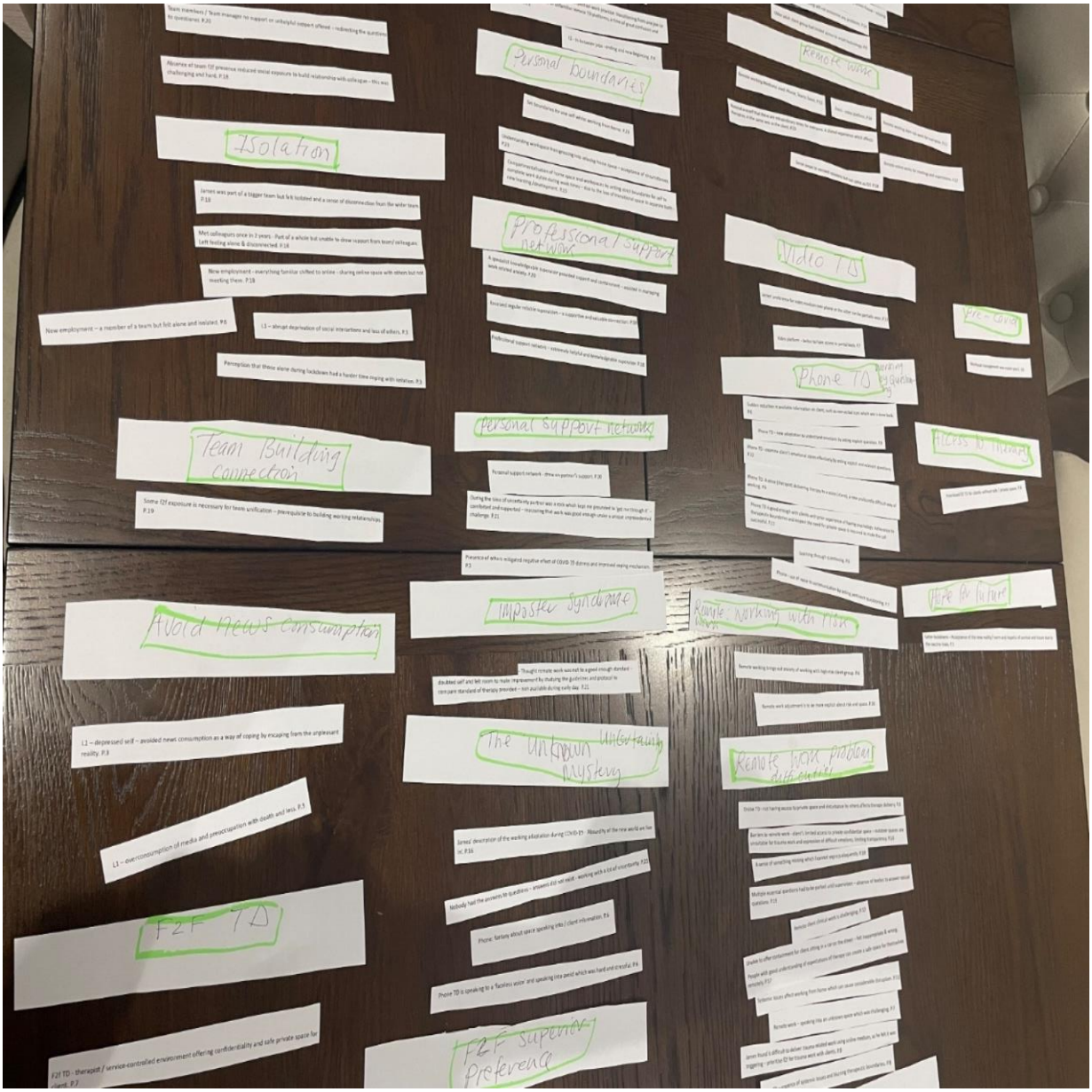
	'I ran a few webinars for people… all the patients… like 50 people in a meeting, but they all have their cameras off, and it really did look, I was talking to myself because there was nothing to talk to.' (Eva, P. 7)	**Eva**
	'My emotional reaction would be more obvious, so the client can read me better.' (Sarah, P. 8)	**Sarah**
Three: Newness of confidentiality and managing risk: 'Counselling somebody in the middle of a shopping mall'	*'Client who… was living at home, but part of the problem was a systemic issue with the family…first session one of her sibling's walks… past the screen.'* (James, P. 8). *'Sometimes it feels as like counselling somebody in the middle of a shopping mall… doesn't feel right.'* (James, P. 17)	**James**
	'One person who had therapy when she was walking in the park because she didn't have privacy at home. Uh so it became… challenging.' (Sarah, P. 6)	**Sarah**
	'remember with groups having to rethink about the ground rules relevant to the online format… about not eating whilst…they're doing the group not having obviously other people in the room…the privacy of where people were…I had not only to know the IT side of it, but also to adapt the clinical setting because I think there was always a risk of people having the session was having breakfast. So, the boundaries would get very, very blurred.' (Adam, P. 10)	**Adam**
	'I had someone banging her head on the wall… which was very stressful. Yeah. I think … this kind of risk issue… were very difficult to… deal with on the phone because it's if you have a patience in the room, it's much more you can do.' (Sarah, P. 13)	**Sarah**
	'… it's so easy to just stay in front of your computer and work an extra hour and get your admin done. Umm yeah, possibly, that's one of the disadvantages.' (Eva, P. 17)	**Eva**
	'… we were offering sort of limited interventions because we… didn't think we could manage the risk, the process issues through of this client going through	**Shanti**

	video therapy.' (Shanti, P. 23). *'There was anxiety… because we were still holding these clients and holding the risk, they carried but unable to provide treatment.'* (Shanti, P. 6)	
Four: Newness of working with technology and the impact of internet disruption on therapy	*'So initially I was… using my own phone… we didn't have laptops to be able to do much*.' (Sarah, P. 4). *'Lots of our clients didn't want to use laptops, so… we have to move to phones.'* (Sarah, P. 4) *'I saw my face twitching, a very strange grim and it was frozen on the screen, and I was very aware of my… patients were seeing this this horrible grimmer. So… we had to work with this…It was yeah, frustrating and anxiety provoking.'* (Sarah, P. 8)	**Sarah**
	'Clients who…didn't have the technology or couldn't work the video therapy, then they were in a position of disadvantage…clients who needed face-to-face and we couldn't give them.' (Shanti, P. 17)	**Shanti**
	'The very practical thing of um that little picture of yourself… you're looking at a client, how do you make eye contact with a client? Because actually, if I'm gonna make eye contact, someone I have to look at the screen and the little camera, which means that I'm not actually looking at them. And then you're distracted by that picture of yourself… how do you look… what do you look at to build a relationship that actually feels genuine?' (Helen, P. 11)	**Helen**
	'CBT type session, not having materials, not being able to share the pen, harder to figure out how to co-create a diagram, co -create some kind of a document. My IT skills weren't quite up to figuring out how to draw thing on the screen.' (Eva, P. 8)	**Eva**
	'The Internet or your laptop isn't working quite great… sound goes in and out or there's a pause, that really did feel quite intrusive in the beginning. Umm and having to say to people, can you repeat?... That felt really, really difficult.' (Helen, P. 12)	**Helen**

APPENDIX 12: Data Analysis Pictures

Analysing connections between participant experiential themes (PETS) (P1 James and P2 Sarah).




Isolation
Personal boundaries
Remote work
Professional support network
Video TD
Phone TD
Team Building connection
Personal support network
Access to therapist
Avoid news consumption
Impostor Syndrome
Remote working with risk
Hope for future
The Unknown Uncertainty Mystery
Remote work problem
F2F TD
F2F Supervisor preference

Analysing connections between group experiential themes (GETS)