Vulnerability and uncertainty in the therapeutic work: Therapy through the lens of the therapist

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Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (DPsych)

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December 2021

TABLE OF CONTENTS

List of tables and figures……...…...8

Acknowledgments……...…...9

Declaration……...…10

Preface……...…11

SECTION A: DOCTORAL RESEARCH……...……16

Abstract……...……..17

Chapter 1: Introduction and Literature Review……...……...18

1. Introduction……..…...18
2. Literature review……...……..20
    2.1. Covid-19……...…...21
    2.1.1. Impact of Covid-19 on mental health……...…….21
    2.1.2. Therapy during Covid-19……...……..23
    2.1.3. A shared traumatic reality……...……..26
    2.2. Remote therapy……..…...30
    2.2.1. Experiences of providing remote therapy……..……32
    2.2.2. Working from home……..…….35
    2.3. Bereavement……..……38
3. Summary……..……41
4. Rationale for the present study……...…..43
5. Study aims and relevance to Counselling Psychology……..……..44

Chapter 2: Methodology……..……47

1. Overview……...……47
2. Rationale for the methodology……...47
    2.1. Research question……..48

2.2. Ontological approach……49

2.3. Epistemological approach……50

2.3.1. Epoché……51

2.3.2. Interpretation……..……...51

2.3.3. The researcher……..……52

3. Qualitative design……..…53

4. Interpretative phenomenological analysis (IPA)……..…55

4.1. Rationale for IPA……....…56

5. Method…….…..……..58

5.1. Recruitment……..…….58

5.2. Semi-structured interviews……...60

5.2.1. Round 1: Narration focused interviews……..……..….61

5.2.2. Round 2: Visually focused interviews……...……..62

5.2.3. Procedure for data collection……...……65

6. Transcribing……...…..….66

7. Data analysis……..….67

8. Ethical considerations……....71

9. Reflexivity……...……..……..74

9.1. Epistemological reflexivity……..…..74

9.2. Personal reflexivity……..……..77

Chapter 3: Findings…….……..….80

1. Overview…….……...…..…80

2. Master theme 1: Adapting to a new intervention: Experiences of challenge and opportunity ……..……....…81

2.1. Working with uncertainty: “To be like an explorer”……...……82

2.2. An opportunity to help during Covid-19: “Wow, here's something I can actually do to help!”…….……88

2.3. Responsibility for the intervention: “We can’t let the service down”……..……90
2.4. Summary……...……..…..93
3. Master theme 2: The shared reality of Covid-19: Novelty and familiarity towards a brief intervention…….……..94
3.1. A fast-paced intervention: “You’re really sort of like running a race”……..…….…..94
3.2. Boundary and connection in the shared reality of Covid-19: “It was quite hard to not think about the client”…….……...……99
3.3. A familiar way of working “It was a sense almost of coming home”…….……104
3.4. Summary……...……107
4. Master theme 3: Being human: Experiences of vulnerability in a time of isolation……..……...…….....108
4.1. To witness distress: “As a human being to listen to somebody else’s suffering”…….……..……108
4.2. Safety through connection: “You’re not out there on your own”……..……..…….111
4.3. Summary……..……..…116
5. Summary of findings……...……...117
Chapter 4: Discussion……...……119
1. Overview……...…...119
2. Findings and the literature……...….120
2.1. Master theme 1: Adapting to a new intervention: Experiences of challenge and opportunity.…….…..120
2.2. Master theme 2: The shared reality of Covid-19: Novelty and familiarity towards a brief intervention…….…….....128

2.3. Master theme 3: Being human: Experiences of vulnerability in a time of isolation……..……..134

3. Critical discussion……..……...141

3.1. Limitations……..……...141

3.2. Strengths……..…….142

4. Reflexivity……..….144

5. Implications for practice and relevance to Counselling Psychology…….....145

6. Future research…….....149

7. Conclusion…….....150

References……..……152

Appendices……..……...166

Appendix A: Recruitment advert……..…….167

Appendix B: Participant information sheet……..….168

Appendix C: Interview schedule 1……..…….171

Appendix D: Consent form 1……...…...172

Appendix E: Interview schedules 2……..….173

Appendix F: Consent form 2……...……175

Appendix G: Debrief form……..….177

Appendix H: Initial ethical approval from……..178

City University of London Ethics Committee……...…….178

Appendix I: Amended ethics application……...……189

Appendix J: Amended ethics application 2……...……191

Appendix K: Sample of individual participant transcript analysis……..…...193

Appendix L: Sample of Emergent Themes and Associated Quotes……...….195

Appendix M: Clustering Themes for an Individual Case……...….197

SECTION B: COMBINED CASE STUDY AND PROCESS REPORT……..….198

1. Part 1: Introduction……..……...199

1.1. The patient……..…...199

1.2. Rationale……..……..199

1.3. Theoretical framework……..…...199

2. Part 2: Patient study……..…….202

2.1. Assessment……..…….202

2.2. Rationale for psychodynamic therapy……..….204

2.3. Formulation……..……..204

2.4. Interventions……...……206

2.5. Key content in therapy……...…...207

2.5.1. Connecting with affect……..…...207

2.5.2. Relationships……..…...209

2.5.3. Difficulties in the transference……...……..210

2.6. Supervision…….212

2.7. Outcome and ending…….212

3. Part 3: Process report……..……..215

3.1. Overview……..……..215

3.2. Transcript and commentary……..……..216

4. Part 4: Discussion……..…...227

References……...….229

SECTION C: PUBLISHABLE PAPER…….....234

Abstract……..…235

1. Introduction……..…...236

2. Methods……..….239

2.1. Research questions…….....239

2.2. Methodology……...…239

2.3. Participants……..…..241

2.4. Procedure……...…….241

2.5. Data collection……...…242

2.6. Data analysis……..…...242

3. Findings..……...……..243

3.1. Exploring and developing a psychological response to loss from Covid-19……...…….243

3.1.1. Making sense of a developing intervention……...…244

3.1.2. Lack of control vs action in the context of the Covid-19 pandemic...…245

3.1.3. Responsibility for the intervention……...……246

3.2. A different type of support.……...….247

3.2.1. A fast-paced intervention……..247

3.2.2. Managing the therapeutic relationship……...……248

3.2.3. A familiar way of working…..……...….250

3.3. An emotionally charged experience……...…251

3.3.1. Witnessing distress……...……252

3.3.2. An exciting experience……...……..253

3.3.3. Importance of support and connection……..…...254

4. Discussion……...…255

4.1. Study limitations……...….258

5. Conclusion……...…259

References……...…….260

LIST OF TABLES AND FIGURES

Figure 1: Master Themes and Subthemes……81

Figure 2: Jack Drawing 1……..…..86

Figure 3: Jack Drawing 3……...……..91

Figure 4: Sarah Drawing 2……..……101

Figure 5: Sarah Drawing 1……..…....106

Figure 6: Jack Drawing 2……..…..110

Figure 7: Sarah Drawing 3……..……113

ACKNOWLEDGMENTS

I wish to thank my four participants for sharing their time by taking part in this research. Thank you for your openness, warmth, and trust in sharing your experiences with me. I hope that you will find this research to adequately represent your experiences of providing a new, early, and brief intervention during Covid-19.

I would also like to thank my supervisors, Professor Carla Willig and Dr Nollaig Frost. The support, feedback, and ideas you offered were invaluable, and I am very grateful for your responsiveness and for making yourselves available when I had queries, as well as for your optimism at times of doubts.

Thank you to Bryan and to my family, particularly my parents and my sister, for being there in my ups and downs, for their love, support, and constant encouragements throughout my training. This doctorate would not have been possible without you.

I also wish to thank my classmates with whom I have shared these challenging and enriching years of training, as well as the course lecturers and tutors.

DECLARATION

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PREFACE

The preface will introduce the doctoral thesis portfolio which is made of three sections: a qualitative doctoral research project, a publishable article and a case study which includes a process report. The first part of the portfolio will include a doctoral research project which involves a qualitative exploration of counsellors' lived experiences of providing a new, early, and brief intervention in the context of the Covid-19 pandemic. The second part of the portfolio will be a case study and process report in which I discuss my work with a 69-year-old man who self-referred for bereavement therapy following his wife's death. The final part will include a publishable article which will include a publishable version of the doctoral research.

Section A: Doctoral Research

The first section of the portfolio presents a doctoral research project looking at the experience of counsellors in offering a new intervention during the Covid-19 pandemic. This intervention was bereavement-focused and tailored to individuals having lost a loved one from Covid-19. This intervention's specificity was that it involved three sessions provided over the telephone to individuals very recently bereaved. Four participants, two males and two females, between the ages of 59 and 70, agreed to take part. Participants were interviewed on two occasions, once under a semi-structured interview agenda, and a second time using visual methods whereby participants were prompted to draw their experiences of the work which were then discussed. Accounts were analysed using Interpretative Phenomenological Analysis (IPA), from which three master themes and eight subthemes emerged. The findings highlight counsellors' experience of not knowing and uncertainty, as well as meaningfulness as counsellors appeared to be driven by a wish to be of help to others impacted by the Covid-19 pandemic. The context of Covid-19 seems to have shaped the experience of boundary and connection in the therapeutic work, and increased experiences of isolation and vulnerability.

In turn, connection to peers and self-care were highlighted as sources of safety and containment. The study hopes to inform Counselling Psychologists of themes that may arise when providing new interventions, or when providing unfamiliar interventions, particularly in the context of Covid-19.

My research journey involved several changes, either in topic or in research focus. I was initially interested in exploring the impact of body therapy as an adjunct treatment to psychological therapy for trauma. I found myself having to change topics when the pandemic began, as body therapies stopped being offered for an indefinite period, in turn jeopardizing recruitment. At the time, I was on placement at a bereavement charity, in which discussions were had on the impact of Covid-19 onto bereavement needs and bereavement experiences. I was informed of the intention to develop a new bereavement intervention specifically for people bereaved from Covid-19 and wished to take part in this in some way, here through research. This intervention was new in that it involved providing three sessions over the telephone to individuals who were recently bereaved. My focus at that stage was to explore the impact of this new, early, and brief intervention, and I began developing research projects whereby clients would be interviewed about their experiences of the intervention and the therapists about their perception of the intervention. This idea too was halted as funding for this new, early, and brief intervention was stopped temporarily, and at that time, it was uncertain whether funding would resume. I had hesitations around recruiting clients from an ethical viewpoint, as it would entail interviewing individuals who would have been very freshly bereaved and therefore coping with the associated practical and emotional challenges of grief. The funding's interruption added another layer of concern around being able to recruit enough participants in a contained and timely fashion. I therefore considered alternative research questions while maintaining a focus on the new intervention and I felt curious about the therapists' experiences in providing a new, early, and brief intervention in a time of crisis. I was practicing myself as trainee Counselling Psychologist and had to adapt to changes in practice such as working from home and providing therapy remotely, being isolated from peers

and colleagues, supporting clients through this unusual time while simultaneously adapting myself to the impact of the pandemic on my personal life. As a result, I was interested in how other counsellors experienced providing a very different, early, and brief intervention, particularly when considering the context within which they were doing this. In exploring the literature, it became apparent that there was scope for this research topic to provide an original contribution to the field of Counselling Psychology. Exploring counsellors' experiences of providing a new, early, and brief intervention during Covid-19 therefore appeared to be an original and potentially valuable research project, as well as feasible, and as such this was the final agreed focus for my doctoral research.

Section B: Case Study

The second section includes a case study describing my therapeutic work with a male client who referred himself to the bereavement charity I was on placement with. The client initially referred himself following his wife's death to explore the past unprocessed death of his sister in his childhood which he felt had recently re-emerged following his wife's passing. He wished the work to provide a reflective space to explore and make sense of his past losses. As the work unfolded, the focus shifted to exploring and working on the more recent loss of his wife in the context of past unprocessed grief. My work was guided by a relational psychodynamic theoretical framework which focuses on the relationships we form to self and others, viewed as source of psychological distress and vehicle of change. The case study includes a process report in which a ten-minute segment of my third session with this client is transcribed and discussed in the context of the overall therapeutic work. Both the case study and process report focus on the parallel conscious (e.g., interpretation) and unconscious (e.g., transference, countertransference) processes of psychodynamic work, including my experience of the transference, projective identification and the countertransference. The interaction between the conscious and unconscious work and associated challenges are also discussed.

Section C: Publishable Article

The final section also presents the doctoral research but under the format of a publishable article. The format and length of this article were based on the publishing guidelines of the journal of Counselling and Psychotherapy Research.

These three sections connect to each other in two different ways. One common thread amongst the different sections is that all three share a common focus which is the lens of the therapist, in the research by looking at counsellors' lived experiences of providing a new, early, and brief intervention during a pandemic, and in the case study because as the therapist, I recount my experience and perspective on a piece of bereavement therapy offered. That is, the subjective perspective of the therapist is explored throughout the portfolio, although in the case study the therapist is myself and in the research the therapist are counsellors that have agreed to take part in my research. The portfolio therefore looks at the therapeutic work from the therapist's viewpoint, although different perspectives are explored because the work provided and the therapists whose viewpoint are looked at differed between the case study and the research.

Retrospectively, I find that the three sections also connect under the theme of vulnerability. Within the article and the doctoral thesis, the literature review emphasises the potential challenges that therapists may encounter while working in the context of the pandemic which has led to a variety of changes such as working from home and offering online therapies. Similarly, the findings highlight therapists' experiences of vulnerability for example, around witnessing clients' raw distress, from the uncertainties and changes associated with an unprecedented pandemic and in also having to adapt to a very different type of therapeutic intervention. Finally, within the case study, an important aspect of the work discussed revolves around my experience of vulnerability through the transference and countertransference, and,

more specifically, my experience of vulnerability as a therapist whose own personal human vulnerabilities interact with the client's in the process of relational work. Vulnerability was also a recurrent experience throughout my training, which I experienced in the process of learning new skills, of being evaluated academically and clinically and of engaging in personal therapy. From both my personal experiences and my research participants' shared experiences, I increasingly feel that vulnerability is a challenging yet enriching position where the potential for growth and change occurs.

SECTION A: DOCTORAL RESEARCH

Exploring counsellors' experiences of providing a new, early, and brief psychological intervention during the Covid-19 pandemic

Abstract

Despite changes in practice and a reported rise in new bereavement interventions during Covid-19, the topic of therapists' experiences of providing new interventions during Covid-19 is under-researched. This qualitative study aims to explore counsellors' experiences of providing a new, three-session long intervention provided to individuals sooner than usual after bereavement, during Covid-19. Two sets of individual interviews incorporating visual methods were carried out seven months apart with four counsellors. Accounts were analysed using Interpretative Phenomenological Analysis. Accounts highlight experiences of uncertainty around procedures, roles and aims for this new intervention, particularly around the work's brevity. Increased vulnerability, hopelessness and loneliness amongst therapists were also highlighted in the context of working from home, in isolation from colleagues, and with highly distressed clients. Changes in boundaries were discussed in the context of Covid-19 being a reality shared with clients, as the clinical work became a reminder of counsellors' personal experiences around Covid-19 and vice versa. These challenges appear to have been countered by the experience of meaningfulness and excitement towards providing an intervention aimed at helping others impacted by Covid-19. Self-care and connection to counsellors providing this new intervention were also associated with safety and containment. These findings can inform Counselling Psychologists in their roles as practitioners, managers, consultants, trainers and supervisors of the potential challenges and support needs when providing new or unfamiliar interventions. Counselling Psychology strives for continuous development, and as such it would be expected that new interventions will be developed, and that Counselling Psychologists will be learning new therapeutic approaches, as part of their training or professional development. By gaining awareness of therapists' experiences of delivering new interventions, these findings can inform Counselling Psychologists in supporting themselves and/or others when providing new or unfamiliar interventions, particularly in the context of shared traumatic realities such as pandemics, natural disasters, or war.

Chapter 1: Introduction and Literature Review

1. Introduction

This chapter will introduce a research project examining the experiences of therapists in providing a new intervention during the Covid-19 pandemic. This intervention was developed and provided by a bereavement charity and aimed at providing bereavement support to individuals who had recently lost a loved one from Covid-19. The intervention entailed three telephone sessions provided over the span of two weeks and was tailored to individuals whose loss had resulted from Covid-19, and whose loss had occurred sometimes under six months ago, at times only a few weeks ago. The aim of this intervention was to provide psychoeducation on bereavement, to offer a containing and supportive space to discuss thoughts and feelings associated with the loss, and, as appropriate, to provide tools to cope with the thoughts and feelings experienced. The rationale behind the intervention was that the circumstances of the pandemic and the circumstances of a Covid-related loss such as increased isolation, decreased social support, or the inability to be with the loved one while they passed away, would increase the complexity of bereavement experiences and reactions. As a result, the intervention was developed with the consideration that psychological interventions for bereavement earlier in the process were increasingly important. Whereas the charity had previously provided bereavement therapy to people at least six months post-loss, this intervention differed from the therapy usually offered in the following ways: it involved a total of three sessions rather than 10 to 12 sessions, it was provided over the telephone, and as said above, it was offered under six months post-loss rather than later, as had been done previously. A small number of experienced bereavement counsellors within the charity were selected to provide this new intervention in the context of Covid-19. I was myself on placement at this service but not involved in providing this new intervention. This research project aimed

at exploring these counsellors' experiences in delivering that new, early, and brief intervention in the context of the pandemic.

As said in the preface, an early research aim was to explore the impact of this intervention, by enquiring about clients' experiences and therapists' perceptions of the intervention. Practical and ethical considerations led me to re-tailor my research question around this new, early, and brief intervention. In part through reading the literature on therapists' experiences of working during Covid-19, my research question shifted to wanting to know what it was like for the counsellors to be providing a new, early, and brief intervention during the pandemic. My initial literature review therefore focused on the field of bereavement, while my subsequent literature review no longer aimed at looking at what the research suggested was helpful or not within bereavement interventions, but instead looked at research which provided insight into psychologists', counsellors, therapists, and psychotherapists' experiences of providing therapy as well as in providing new interventions during the Covid-19 pandemic. My wish to explore what it was like to provide this new, early, and brief intervention during Covid-19 was underpinned by my personal experiences of practicing during the pandemic and adapting to life during Covid-19.

Firstly, the literature will be reviewed and gaps in the literature and suggestions for future research will be explored. My literature review covers research which could give me an insight into what it might be like for therapists to be practicing during these times. I specifically looked at research on therapists' experiences of working during Covid-19 and working remotely. I aimed to contextualise the new, early, and brief intervention which was bereavement-focused by also briefly looking at some literature around therapists' experiences of providing bereavement interventions during Covid-19. Secondly, this chapter will outline the rationale for this study, as well as aims and relevance to the field of Counselling Psychology.

2. Literature review

Database searched were PsychINFO, City University Library, Google Scholar and Senate House Library which provided broad and sufficient access to past research. The reference lists of articles were also explored to yield further research. The following key words were used to guide the search: bereavement, grief, counselling, therapy, grief therapy, bereavement therapy, pandemic, Covid-19, remote therapy, lockdown, experiences, therapists, psychotherapists, counsellors, psychologists, novel/new interventions, shared traumatic reality, the Severe Acute Respiratory Syndrome (SARS), the Ebola Virus Disease (EVD), teletherapy and online therapy. These words were selected because they represented themes, such as teletherapy, that seemed relevant to gain insight into what it may be like to remotely provide a new intervention during Covid-19. Only studies written in English were included. Quantitative, qualitative studies, reviews and articles were included. Literature from 2019 was considered when exploring research around Covid-19, while literature from 2014 onwards and 2002 onwards was included when looking at the research around the EVD and SARS respectively. No date criteria were used for exploring the literature on experiences of providing bereavement therapy, as it quickly became apparent that there was very little research on the topic. The research topic touched on a variety of themes including working from home, teletherapy, new interventions, Covid-19, and as such, the literature outlined below includes studies or articles on relevant themes which could provide an insight into what it might be like for a practitioner to be offering a new intervention during Covid-19. Some topics yielded much more literature than others. For example, there was less literature on the mental health of practitioners during the pandemic, than on experiences of providing teletherapy, or on experiences of providing therapy during a shared traumatic reality. Similarly, no literature was found which explored therapists' experiences of providing a new intervention, either during the pandemic, or before, and very little literature was found on practitioners' experiences of new or changing bereavement work during the pandemic. A such, certain sections differ in length on the basis of the amount of existing literature on the topic.

2.1. Covid-19

The Coronavirus-19 has been the source of a pandemic starting in 2019 named Covid-19 (World Health Organisation [WHO], 2020). Symptoms commonly involved in Covid-19 include dry cough, tiredness, fever, loss of taste or smell while additional, less common symptoms include aches, headaches, sore throat, diarrhoea, skin rash and loss of colour in toes and fingers (WHO, 2020). However, asymptomatic cases also occur (WHO, 2020). According to the WHO (2020), about one individual out of five with Covid-19 develops significant breathing difficulties. It is believed that contamination occurs via droplets from the nose and mouth, with a timeframe of one to fourteen days between contamination and symptom onset (WHO, 2020). The absence of current treatment for Covid-19 and its rapid spread across the globe has led to a worldwide pandemic to be declared, with everyday life being impacted (WHO, 2020). At the time of writing in August 2021, 216 943 564 cases of Covid-19 have been confirmed, with a total of 4 511 731 deaths worldwide (Worldometer, 2021).

2.1.1. Impact of Covid-19 on mental Health

Policies put in place to minimise the spread of Covid-19 have strongly affected daily life, altering access to healthcare, professional and family life, with increases in unemployment while school and work have continued remotely from home (Klaiber, Wen, DeLongis, & Sin, 2020). Policies around confinement, social distancing, lockdown, travel bans, and border closures have also impacted people's work, social and family lives (Newby, O'Moore, Tang, Christensen, & Faasse, 2020). Given these important changes, the psychological impact of the measures put in place has been explored. Studies exploring the impact of Covid-19 in China, the impact of previous pandemics, and the literature on the impact of confinement measures during Covid-19 converge in finding increased depression and anxiety symptoms, specifically health anxiety, as well as increased loneliness (Duncan, Avery, Seto, & Tsang, 2020; Newby et al., 2020; Tull et al., 2020). Lack of physical activity is another negative

consequence from Covid-related confinement, which was found to be associated with increased stress and anxiety (Duncan et al., 2020). Current studies on the topic have important limitations due to the speed at which they have been carried out given the novelty of the situation and the urge to comprehend its impact. Most have recruited participants online, minimising control over confounding variables, inclusion and exclusion criteria (Newby et al., 2020; Tull et al., 2020). For example, most participants in Newby et al.'s (2020) study reported a history of mental health difficulties, arguably increasing the likelihood of being negatively impacted by the confinement policies under Covid-19. Perhaps the effect size would be weaker or non-significant with participants without pre-existing mental health difficulties. Research designs may also be limited, for example in Tull et al.'s (2020) study which explored the impact of confinement policies on mental health, in which the data was not compared with pre-confinement scores and confinement at the time of the study had been of only five days. Therefore, while these studies give us an insight into the psychological difficulties that may result from Covid-19-related policies, there is much yet to be explored.

Other studies have also enquired about the wellbeing of mental health professionals during the Covid-19 pandemic. One quantitative study explored therapists' experiences of resilience during the pandemic and found that rates of vicarious trauma and professional self-doubt were higher compared to data collected pre-pandemic (Aafjes-van Doorn, Békés, Luo, Prout, & Hoffman, 2021). However, they also found that levels of reported vicarious trauma and professional self-doubt decreased over time while resilience and post-traumatic growth increased (Aaafjes-van Doorn et al., 2021). The strength of this study was that measures were taken longitudinally, at different points throughout the pandemic. This suggested that the pandemic experiences of therapists initially may have been difficult, but also that practitioners may be adapting well over time. The majority of participants in this study were female and it would be interesting to see if different findings would emerge if this study was replicated with male participants. Similarly, a survey indicated reduced wellbeing scores and decreased work quality as reported by CAMHS practitioners (Bentham, Driver, & Stark, 2021). The data was

collected only 6 weeks after the first Covid-19 lockdown in the UK, and perhaps the survey results reflected the stresses of adapting to this new situation. It would have been interesting to have data captured longitudinally to see whether wellbeing would improve over time, as in Aafjes-van Doorn et al.'s (2021) study. Additionally, Bentham et al. (2021) recruited within a CAHMS team which focuses on supporting families and children, an area which may have been particularly impacted by the lockdown restrictions. Perhaps a study looking at the wellbeing of practitioners in another NHS primary service, say, which focuses on anxiety and depression in adults, would have found different levels of wellbeing and work quality. Both studies suggest that the pandemic may entail some challenging experiences which may in turn affect practitioners' wellbeing, but the extent of the impact on therapists' experiences remains unclear. It is therefore difficult to evaluate how practitioners are currently coping and how the quality of psychological support may be impacted.

2.1.2. Therapy during Covid-19

Social distancing policies have also led to significant changes in the delivery of psychological therapies which have switched from face-to-face to remote provision, using videoconferencing platforms, telephone, or web. While the literature suggests that remote therapy yields approximately similar outcomes as face-to-face therapy, it remains that this change in practice requires various considerations around confidentiality, security, safeguarding, the therapeutic relationship and communication (British Psychological Society [BPS], 2020; Martin, Millán, & Campbell, 2020; Richards, & Viganó, 2013). The BPS (2020) advises practitioners to consider the security of any platform used for sessions, clients' access to adequate internet and tools, as well as to a confidential and quiet space for their sessions. Guidance was also published around anticipating and responding to technical problems which may arise during appointments (BPS, 2020). Finally, it is argued that safeguarding concerns may increase, particularly around domestic violence and in the context of increased financial and housing strains (BPS, 2020). Reflecting on the therapeutic relationship in remote therapies, Roesler

(2017) emphasised the loss of eye contact, and of some, if not all, non-verbal communications. Aspects of power dynamics are also altered: the therapist is no longer in control of the space in which the client has his/her sessions, while the client may feel more control over the therapy, where to have it, and the possibility of exiting with the click of a button (Roesler, 2017; Scharff, 2013). While these changes may not significantly affect outcome, it feels important to acknowledge the differences in remote therapy which in turn may affect clients' and therapists' experiences of therapy (Richard, & Viganó, 2013; Roesler, 2017). Reflecting on her personal experience of the pandemic as a family therapist in Hong-Kong, Lee (2020) highlights the experience of uncertainty during Covid-19 and emphasises how people might react or experience the uncertainty of the pandemic differently based on their culture. This article does not provide empirical insight of how therapists have experienced uncertainty during the pandemic but does highlight how little we know in this respect, given how therapists' different cultures, life circumstances and past experiences will influence one's Covid-related experiences. Some studies have also indicated changes in therapists' subjective experiences during the pandemic. Humer et al. (2020) distributed an online survey in which therapists in Austria rated the importance of certain areas of life before the pandemic and during the pandemic, as well as meaning in life. While meaning in life was unchanged before or during the pandemic, therapists rated mental health and physical health as more important now compared to pre-pandemic and work was rated as less important (Humer et al., 2020). Relationships with others and hobbies were rated similarly before and during the pandemic. The decrease in rated importance of work during the pandemic compared to before was greatest for older therapists but no gender difference was identified (Humer et al., 2020). This study gives an indication that subjective perceptions may have shifted during Covid-19 and one could speculate that the findings could suggest that therapists' experiences including at work may be different during the pandemic. Arguably, this study also increases the uncertainty around how it is for therapists to be practicing in these times, as it does not tell us how participants actually experienced work or other life areas. Another limitation is that ratings of importance pre-pandemic were retrospective and therefore prone to recollection bias. Humer

et al.'s (2020) study recruited therapists in Austria and perhaps replicating the study in a different country might yield different findings, as meaning making and values are arguably influenced by socio-cultural factors. Probst, Humer, Stippl, and Pieh (2020) also distributed an online survey to Austrian therapists to capture levels of stress, work-related concerns and fears of Covid-19. Their analysis suggested that overall, stress levels were higher for therapists during Covid-19 compared to overall stress levels in a comparative population pre-pandemic. However, they found that work-related factors such as the format of therapy (remote or face-to-face), previous experiences of remote therapy and the number of clients seen every week had no effect on stress levels, which in turn suggests that the increased stress during the pandemic may not be related to work experiences, but perhaps to other areas of life (Probst et al., 2020). Similarly, they found that stress levels were higher for practitioners who relied on private practice for income compared to those that did not, which again suggests that, perhaps, stress may not stem from the experience of the clinical work during the pandemic per se, but by other factors such as financial security (Probst et al., 2020). Additionally, the difference in stress levels was significant but with only a small effect size (Probst et al., 2020). This could suggest that the pandemic's impact on therapists' experiences may not be as severe as what some of the literature on Covid-19 may suggest. This study recruited participants in the early days of the pandemic, and it would be interesting for this study to be replicated at a later stage in the pandemic, or for a longitudinal study to be carried out, to get a sense of how stress may evolve or stay the same over time. Again, because this study was quantitative and void of open questions, it does not specify what the experiences of the therapists were during the pandemic. In the future, qualitative studies could provide more in-depth information about therapists' pandemic-related experiences. Overall, the majority of studies carried out during Covid-19 have mainly been surveys indicating how aspects of therapists' experiences, such as stress or meaning-making, may have changed during Covid-19. The strength of these quantitative studies is that they may be more generalisable than qualitative designs, but their limitation is that they do not give us in-depth insight into what it is like for therapists to be practicing during the pandemic. Having looked at

the literature on therapists' experiences during previous pandemics such as the 2002 SARS or the Ebola Virus Disease (EVD), it is striking that the research looking at the experiences of healthcare professionals during these times was solely focused on physical health professionals rather than mental health professionals. Consequently, there is little insight into what the experiences of therapists may be like in this current pandemic.

2.1.3. A shared traumatic reality

The concept of a shared traumatic reality has been highlighted when considering the impact of the pandemic on therapists' work (Baum, 2010; Catrone, 2021). The expression 'shared traumatic reality' (STR) refers to situations in which both therapist and client are experiencing the same distressing event at the same time. Baum (2010) suggested that, despite the lack of formal conceptualisation of shared trauma, STRs are characterised by the presence of a current event which is community-wide, which has the potential to traumatise a significant amount of people within that community and in which therapists are exposed to the event both directly, at a personal level, and indirectly, through their clinical work. Examples of events leading to STRs which have been explored in the literature include 9/11 and storm Katrina. For therapists practicing during those times, difficulties may emerge from having to work with client material which may be similar to material the therapist is personally currently processing, in turn enhancing the experience of countertransference in sessions (Baum, 2010). One potential impact of a STR may be that boundaries become blurry within the therapeutic work. The therapists' personal difficulties may taint the professional work while the clinical material may become similar to difficulties in the therapist's personal life. Sessions are likely to take place in a different setting (e.g., online) and the therapist might have to adapt to new responsibilities, roles or focus for the work based on clients' needs (Baum, 2010).

Eidelson, D'Alessio and Eidelson (2003) sent a survey containing both closed and open questions about the impact of 9/11 on psychologists in New York. The survey indicated a

mixture of positive and negative impacts, including increased work-related stress, feeling unprepared and helpless around the levels of distress reported by clients, work-related changes (e.g., shift in therapeutic focus or increased demands), blurred boundaries, feelings of burnout, but also meaningfulness, purpose, and increased connection to both clients and loved ones (Eidelson et al., 2003). Psychologists appeared to associate the increased stress to the parallel process whereby they were processing their own shock and trauma while simultaneously attending to clients' increased distress and needs (Eidelson et al., 2003). The increased feelings of purpose within the work appeared to be about taking part or being of use in "the healing of the nation at a time of great need" (Eidelson et al., 2003, pp. 147). Overall, participants reported that 9/11 had significantly impacted, positively and negatively, both their professional and personal lives. This study had low response rates and perhaps the profile and experiences of the psychologists who responded to the survey may be different from those of psychologists who chose not to respond to the survey. A strength of the study was that it provided insight into the impact of a STR on psychologists' professional and personal lives rather than just their therapeutic work. Future studies could also further enquire about the interaction between their personal and professional experiences and how one impacts the other. A similar mix of positive and negative experiences and changes post-9/11 were reported by Bauwens and Tosone (2010) who also distributed surveys to therapists to capture the long-term impact of the terrorist attack. Again, changes to practice were reported years later, including altered boundaries, increased feelings of anxiety, vulnerability, but also increased connection with clients and heightened emphasis on maintaining self-care (Bauwens, & Tosone, 2010). This study provides further insight into clinicians' experiences of working during STRs but is also limited as only two open questions were included, which does not enable data saturation. Participants were not obliged to answer the open questions, and again, it can be wondered whether therapists who answered the open questions perhaps had different experiences from those that chose not to answer the open-ended questions.

Some studies have also explored mental health practitioners' experiences of working in war-related STRs. For instance, Cohen, Roer-Strier, Menachem, Fingher-Amitai and Israeli (2015) used mixed methods to explore therapists' experiences of offering psychological support to traumatised children after the second Lebanon war. As in the studies above, participants reported a mix of positive and negative experiences associated with the STR. The positive experiences were similarly around increased connection and empathy as well as increased commitment, empowerment, healing and work satisfaction as clinicians were able to help children affected by similar experiences (Cohen et al., 2015). Again, difficulties experienced pertained to feeling increased anxiety, overwhelm and hopelessness in reaction to children's material, overlap between client material and their own difficulties, and blurred boundaries whereby therapists reported thinking and feeling concerned about their clients between sessions (Cohen et al., 2015). Support including supervision, training, from peers, friends, family or personal therapy, as well as self-care were highlighted as helpful while working in the context of a STR (Cohen et al., 2015). Similar experiences appear to emerge despite differences between studies, such as the type of STR looked at or the differences in methods, for instance between Cohen et al.'s (2015) emphasis on qualitative methods and analysis and Eidelson et al.'s (2003) and Bauwens and Tosone's (2010) focus on quantitative designs. More recently, similar accounts were again identified in a qualitative study exploring displaced Syrian mental health professionals' experiences of supporting clients displaced (Hamid, Scior, & Williams, 2020). Again, increased empathy, connection but also increased reminders of personal difficulties, burnout and vicarious trauma as well as fulfilment from being able to help others in similar situations were highlighted (Hamid et al., 2020). As in Cohen et al.'s (2015), participants also emphasised the value of self-care, social and professional support (Hamid et al., 2020). Reflecting on practitioners' shared experiences of working after the STR of the storm Katrina, Boulanger (2013) also highlighted altered boundaries and difficulties in supporting clients on material similar to the therapists' ongoing personal difficulties. Boulanger's (2013) article does not provide an in-depth exploration of clinical work experiences post-storm Katrina and one can wonder whether STRs would be experienced

similarly or differently when the event is man-made, such as 9/11, or when it is not man-made, such as with natural disasters or the Covid-19 pandemic.

Overall, all the mentioned studies relied on self-reports and therefore it can be wondered whether objective measures would reflect the shared subjective experiences. For instance, increased empathy and connection with clients have been repeatedly reported and future studies could try to observe whether these experiences are similar to clients' and if they are captured by quantitative measures of the therapeutic relationship. Regardless of the nature of the STR, it appears that similar positive and negative experiences are reported across the literature. The current Covid-19 pandemic could arguably be considered a STR as it has brought about anxieties around health, illness, death, uncertainty, increased isolation, concerns around financial security and adaptations to day-to-day life, which may be common to both client and therapist (BPS, 2020; Catrone, 2021; McBride, Joseph, Schmitt, & Holtz, 2020). Nuttman-Shwartz and Shaul (2021) have distributed a survey to therapists and social workers to enquire about their perception of the pandemic as a STR. Results suggested that Covid-19 is experienced as an STR in which work, financial security and health are mostly impacted. In fact, there was a positive relationship between participants' reported levels of shared health and financial or work-related concerns and the perception of the pandemic being a STR while shared concerns between therapists and clients around family difficulties were unrelated to perceiving the pandemic as a STR (Nuttman-Shwartz, & Shaul, 2021). Furthermore, older or more experienced therapists were less likely to rate the situation as a STR, which suggests that the amount of experience may alter the experience or responses to situations such as Covid-19 (Nuttman-Shwartz, & Shaul, 2021). Participants were Israeli practitioners, and for this reason, these findings may not reflect perceptions of mental health practitioners in other countries and cultures. This study indicates that STR may be an important aspect of mental health practitioners' experiences during the pandemic, but it does not tell us what it might be like for therapists to be practicing in these times. It seems that there

is no current qualitative study looking at therapists' experiences of practicing under the STR of Covid-19.

2.2. Remote therapy

While I tend to refer to 'remote' therapy to describe therapy carried out over telephone or using videoconference platforms such as Zoom, previous literature on the topic referred to this medium as online therapy or teletherapy and I will use those terms interchangeably. The literature has highlighted that teletherapy and face-to-face therapy provide similar outcomes and similar levels of therapeutic alliance (Norwood, Moghaddam, Malins, & Sabin-Farrell, 2018; Simpson, Richardson, Pietrabissa, Castelnuovo, & Reid, 2021). Regardless, pre-pandemic, this medium has had limited uptake potentially due to concerns about the use of technology, access to private spaces and to the necessary technology, confidentiality, loss of control over the therapeutic space, risk management and the quality of the therapeutic relationship (Simpson et al., 2021). In fact, a survey completed by independent practitioners having shifted to remote therapy during the pandemic indicated that up to 46.80% had never used teletherapy previously, while 42.36% of those that had reported using it had used it less than a quarter of their time (Phillips, Thompson, Edelman, & Ruiz, 2021). Some studies have indicated that concerns about the quality of the therapeutic relationship was a principal obstacle for the uptake of remote therapy (Perry, Gold, & Shearer, 2020; Rees, & Stone, 2005). Rees and Stone (2005) carried out a study looking at clinicians' beliefs towards online therapy by asking therapists to rate the therapeutic relationship for either a taped face-to-face session or remote session. Despite both tapes reportedly being identical, alliance in teletherapy sessions was rated as weaker compared to face-to-face sessions, suggesting that practitioners may hold negative assumptions towards remote therapy. Given that this study took place some time ago, perhaps the technology available for teletherapy may not have been of the same quality as it is today nor as widespread, in turn influencing therapists' perceptions of teletherapy. Now that remote therapy has been widely used as a result of the

pandemic, it would be interesting to see whether therapists still hold a similar bias towards remote therapy. In fact, since the start of the pandemic, it seems that the literature on the therapists' experiences and views on remote therapy has expanded. Studies on clinicians' experiences of working online seem to offer diverging information from the views and concerns reported towards teletherapy (Fletcher-Tomenious, & Vossler, 2009). In fact, in a qualitative enquiry about therapists' experience of trust in online therapy, analysis suggested that participants felt that clients' trust developed quicker online compared to face-to-face, perhaps because of the safety of not being in the same space, potentially not being seen and not seeing the therapist and increased control over the therapeutic space (Fletcher-Tomenious, & Vossler, 2009). Additionally, participants reported that difficulties encountered around the therapeutic relationship were similar to those experienced in face-to-face work (Fletcher-Tomenious, & Vossler, 2009). Similarly, a mixed study enquiring about therapists' experiences of remote therapy suggested that the main difficulties encountered in online work revolved around the technology rather than the therapeutic alliance (McBeath, Plock, & Bager-Charleson, 2020). It appears that two studies, one pre-pandemic and the other post-pandemic both indicate a discrepancy between therapists' views or expectations about remote work and their actual experience of this. To note, participants in Fletcher-Tomenious and Vossler's (2009) study had a minimum of one year experience of remote therapy, while McBeath et al. (2020) did not report how much experience participants had with working remotely at the time of recruitment. It can be wondered whether similar experiences of teletherapy would be reported with practitioners who would have just begun working remotely and whether these experiences would evolve over time. Some authors suggest that perhaps the lack of teaching on teletherapy within training courses may explain the low uptake (Rees, & Stone, 2005; Simpson et al., 2021). Perry et al. (2020) distributed a survey aimed at capturing barriers to the use of remote therapy and responses indicated that one of the biggest self-reported barriers was the absence of training while the researchers noted that participants identifying as users of teletherapy were more likely to have received relevant training compared to non-users. However, they noted that an important number of participants trained for teletherapy

did not use it, suggesting that other themes may be associated with the low use of this medium (Perry et al., 2020).

2.2.1. Experiences of providing remote therapy

Given the lack of popularity of remote therapy pre-pandemic, one can wonder how therapists have experienced having to quickly shift to this medium. A majority of the research on mental health practitioners' experiences during the pandemic appears to be focused on therapists' experiences of offering therapy remotely. While the literature seems to indicate that the therapeutic relationship may not be of particular concern in remote work, studies have identified different sources of difficulty inherent to this way of working. Some advantages and difficulties have been identified by qualitative studies exploring clients' and practitioners' perspectives on remote therapy (Rortvedt, & Jacobs, 2019; Sanchez et al., 2019). Advantages reported include increased flexibility, accessibility, and no travel costs (Rortvedt, & Jacobs, 2019; Sanchez et al., 2019). Mentioned disadvantages and challenges included logistics, technology-based problems, privacy and loss of face-to-face contact including access to body language, boundary management and clients' access to a quiet and private space for sessions (Békés, Aafjes-van Doorn, Prout, & Hoffman, 2020; Rortvedt, & Jacobs, 2019; Sanchez et al., 2019). McBeath et al., (2020) carried out a mixed methods study exploring therapists' experiences of working remotely during the pandemic. The survey indicated that a majority of participants felt that remote work was "somewhat challenging" (McBeath et al., 2020, pp. 398). Reported difficulties included the absence of interpersonal cues, technological difficulties, risk management and screen fatigue (McBeath et al., 2020). Similarly, in another qualitative study looking at students' experiences of learning how to deliver therapy online, participants emphasised the felt lack of control over clients' environments in sessions, and how this creates concerns regarding risk and distress management (Springer, Bischoff, Kohel, Taylor, & Farero, 2020). Technological difficulties were also mentioned, although participants shared that these were more troublesome when

they had limited experience of remote therapy (Springer et al., 2020). Lack of control over the therapeutic space such as over background noises was also mentioned in another study (Smith, & Gillon, 2021). Having training and clear protocols and/or guidelines was also emphasised as important in different qualitative studies (McBeath et al., 2020; Smith, & Gillon, 2021; Springer et al., 2020). In response to some of the challenges that can arise in teletherapy, the use of guidelines, focusing on the benefits and purposes of online therapy, not working alone but as part of a team and taking more time to prepare for a session were elements that were mentioned as helpful (Smith, & Gillon, 2021; Springer et al., 2020). Because Springer et al. (2020) recruited students who chose to learn about remote therapy rather than being obliged to in the context of the pandemic like in other studies, it could be argued that the experiences highlighted might not extend to therapists who had to start offering teletherapy. On the other hand, it appears that other studies, in which therapists had to, rather than chose to shift to remote therapy, have found similar experiences (McBeath et al., 2020; Smith, & Gillon, 2021). Perhaps a commonality amongst participants' circumstances across these studies is that most seemed to be in the process of learning, whether as students, or as a result of having to become acquainted to offering therapy differently, and this in turn may partially account for the similarity in reported experiences. It could be interesting to explore differences and similarities between the experiences of therapists who are experienced in teletherapy and those that have recently begun.

In McBeath et al.'s (2020) study, analysis suggested that the experience of working remotely during the pandemic was more positive than what might have been anticipated by participants. Opportunity was communicated, for learning about oneself as a therapist and for positive changes within the therapeutic work (e.g., more balanced power dynamics, clients opening up more quickly) (McBeath et al., 2020). Similarly, Smith and Gillon (2021) described participants' experiences of skill development as a result of online work, such as increased self-reflection and increased attention to client's context, tone of voice and modulations. The advantages of online therapy such as clients holding more control and power in the therapeutic space were

also discussed (Smith, & Gillon, 2021). Shklarski, Abrams and Bakst's (2021) mixed method study reported similar experiences around remote work during Covid-19. In this study, participants reported experiencing some challenges around adapting to working from home, making needed changes around admin procedures to fit with remote working, getting information about the safety of different remote platforms and deciding which platform was most ethical to use for the purposes of therapy (Shklarski et al., 2021). Participants also reported finding that their experience of offering remote therapy felt different to face-to-face therapy. Similar to other studies, participants reported missing client's body language in the therapeutic work and had experienced concerns about their clients' access to a confidential space in which to have therapy while also having to manage background noises in their own homes from partners, children or pets (Shklarski et al., 2021). They also reported feeling more distance in the therapeutic relationship with clients they had only had remote therapy sessions with and suggested that they would return to face-to-face therapy if they had the opportunity. However, participants also shared that they had easily become acquainted and comfortable with teletherapy and that the benefits of remote therapy outweighed the difficulties (Shklarski et al., 2021). Participants' experiences of increased distance in the therapeutic relationship with clients they had only worked with remotely seems to contradict other findings that difficulties characteristic of teletherapy were not about the therapeutic relationship (Fletcher-Tomenious, & Vossler, 2009; McBeath et al., 2020). Looking at the different studies, an apparent difference was that in Shklarski et al.'s (2021) study, the interview schedule included a question which explicitly asked about differences experienced in the therapeutic relationship when working remotely compared to face-to-face, while McBeath et al.'s (2020) study did not ask about the experience of the therapeutic relationship within their interview schedule. Perhaps the interview question on the therapeutic relationship in Shklarski et al.'s (2021) study prompted participants to reflect on their experience of distance with solely remote clients. Additionally, only 7% of participants in McBeath et al.'s (2020) study reported working with new clients and therefore, perhaps the experiences of the therapeutic relationship with new clients were not as prominent in participants' overall experience of remote work.

In a study by MacMullin, Jerry and Cook (2020), participants reported confidence in working remotely with technology, that this confidence grew as experiences of offering teletherapy increased and that the initial confidence in remote work was associated with past experiences of working on helplines. Similarly to other studies, the main difficulties reported were around technological difficulties (e.g., unstable internet) but participants reported having been able to respond to those adequately (MacMullin et al., 2020). Participants in this study were all in their 30s and perhaps their experience of confidence with using technology from the beginning may be associated with the increased exposure to technology in this generation, and perhaps different experiences would be reported by older therapists. Some common experiences are reported across studies but also differences, highlighting the subjectivity of clinicians' experiences around work during the pandemic which arguably suggests that further research may be warranted. Overall, it seems that studies on experiences of remote therapy have based their surveys or interview agendas on previous literature, which arguably may bias future studies whereby enquiry might remain focused on themes identified previously and undermine the likelihood of new material to emerge.

2.2.2. Working from home

Another aspect of therapeutic work during Covid-19 was to adapt to working from home, as teletherapies pre-pandemic would have not necessarily been carried out from the practitioner's home, whereas at this time, therapists are asked to offer online therapy from their own homes which may affect the experience of providing teletherapy. In addition to adapting to online therapy, practitioners have had to adapt to living in a pandemic which has included working from home, social isolation, and concerns towards their loved ones' and their own health, in turn impacting practitioners' experiences (Patterson, Edwards, Griffith, & Wright, 2021).

One common challenge identified in the literature has been the blurring of boundaries between the workspace and the personal space when working from home (Liberati et al., 2021; McBeath et al., 2020; Phillips et al., 2021). Liberati et al.'s (2021) analysis indicated that participants found it difficult to separate themselves from work and noted that they worked longer hours since working from home. Increased isolation was also described as informal contact with colleagues became more difficult while working remotely (Liberati et al., 2021). In Phillips et al.'s (2021) study looking at the experience of independent therapists, participants communicated increased isolation from loved ones in the context of social distancing policies but did not mention isolation from colleagues. Given that private practitioners tend to work more individually than in community settings, it may be that isolation from colleagues may not have been as keenly felt as the isolation from loved ones, which can suggest that for those in community settings such as the NHS, a double isolation from both colleagues and loved ones may be experienced.

Another difficulty mentioned in qualitative studies was around adapting to evolving service policies and procedures made to respond to the guidelines and needs during the pandemic (Liberati et al., 2021; Patterson et al., 2021). In Liberati et al.'s (2021) exploration of NHS practitioners' experience of remote work during the pandemic, analysis also highlighted participants' experiences of frustration and of moral dilemmas for not being able to provide the quality of care that they felt would be required and feelings of "letting service-users down" (Liberati et al., 2021, pp. 7). Perhaps this experience was enhanced by the context of working in secondary care in which clients' needs may be greater than in other primary care settings. Nonetheless, a similar experience of not offering the best quality of care under the circumstances was described in Patterson et al.'s (2021) study enquiring about the experience of family therapists and physicians around the Covid-19 transition. An overall sense of concern for the wellbeing and mental health of clients and of the wider community as well as a wish to support others in the pandemic was also communicated in the literature (Bentham et al., 2021; Phillips et al., 2021). The importance of connection, for example through team meetings, of

receiving professional support or other forms of support while working remotely during the pandemic was also highlighted (Bentham et al., 2021; Patterson et al., 2021; Phillips et al., 2021).

Overall, these qualitative studies mainly seem to gather information on the impact of the pandemic upon therapists' work, but no detailed information is given about the impact on the clinicians' personal wellbeing or experiences, perhaps because the focus of enquiry was on their experience of adapting to remote work. It could be interesting for future research to explore the impact on clinicians' wellbeing and how this in turn may affect their clinical work. Furthermore, a commonality across studies such as Liberati et al.'s (2021), Bentham et al.'s (2021) and Phillips et al.'s (2021) is that recruitment occurred in the early days of the pandemic, specifically around the time of the first confinement in spring/summer of 2020. The literature generally seems to lack longitudinal studies which could explore therapists' experiences of working during the pandemic over time. Many studies such as Liberati et al.'s (2021) and Bentham et al.'s (2021) also recruited not only therapists but other mental health practitioners, therefore providing a general picture of the experiences of mental health practitioners but not necessarily therapists per se. Given that roles, responsibilities, and Covid-related changes to practice may differ amongst professionals such as psychiatrists, psychologists, social workers and mental health nurses, it could be relevant to have studies which explore the experiences of specific professionals separately.

Generally, it appears that the transition from face-to-face to remote work has been experienced positively by practitioners and clients, despite the challenges entailed (Békés, & Aafjes-van Doorn, 2020; Békés et al., 2020). Some of the literature on Covid-19 provides a worrisome picture of what it might be like for therapists to practice during the pandemic, however, other studies suggest that experiences during the pandemic may not be as negative as one might assume (Békés, & Aafjes-van Doorn, 2020; Békés et al., 2020; Duncan et al., 2020; Humer et al., 2020; Newby et al., 2020; Probst et al., 2020; Tull et al., 2020). Further

qualitative studies on mental health practitioners' experiences during the pandemic are needed to see whether reported experiences are consistent with what quantitative studies are indicating. In fact, within at least three studies looking at the experiences of working remotely, therapists have reported that their experience of teletherapy had been more positive than what was expected (Humer, Stippl, Pieh, Pryss, & Probst, 2020; MacMullin et al., 2020; Shklarksi et al., 2021).

2.3. Bereavement

The focus of this study is on the experience of providing a new intervention during the Covid-19 pandemic, rather than on bereavement work. However, a brief overview of bereavement work will be provided, for the purpose of contextualising the new intervention looked at here, which was bereavement focused. The fact that the new intervention was a bereavement intervention is also representative of increased and changing bereavement needs during the pandemic, which has led authors to recommend developing and implementing new bereavement interventions (Carr, Boerner, & Moorman, 2020; Laranjeira et al., 2022).

Grief is defined as "the pain and suffering experienced after a loss" (Humphrey, & Zimpfer, 2008, pp. 3). Grief can be experienced as a result of a variety of losses, including job loss, loss of identity and loss of a relationship (Humphrey, & Zimpfer, 2008). Meanwhile, bereavement was defined as "the reaction to the loss of a close relationship" (Humphrey, & Zimpfer, 2008, pp.3). Therapy focused on supporting bereaved individuals will be referred to as bereavement therapy. Pre-pandemic, psychological interventions for all forms of bereavement typically involved around eight to twelve sessions and were offered at least six months post-loss, as per research indications that therapeutic outcomes were better from interventions provided further from the time since the loss (Jordan, & Neimeyer, 2003).

Since the beginning of the pandemic, the literature has highlighted how bereavement needs might significantly change as a result of Covid-19. Lack of social support, suddenness of loss and additional losses, such as loss of financial security, job, of social connections and activities, are elements which have been suggested to potentially contribute to prolonged, complex bereavement (Bertuccio, & Runion, 2020; Morris, Moment, & Thomas, 2020; Zhai, & Du, 2020). In turn, bereavement support needs are thought to be affected (Bertuccio, & Runion, 2020; Morris et al., 2020; Zhai, & Du, 2020). This raises the question of what the experiences of working in a context of changing needs and practice, during the pandemic, might entail. Two studies were identified which provide some insight into the potential experiences of practitioners involved in providing different, new forms of bereavement care during Covid-19. Menichetti, Borghi, Cao di San Marco, Fossati, and Vegni (2021) explored the experiences of families who received a follow-up phone call up to 72h after the loss of a loved one from Covid-19, as well as practitioners' perceptions of the intervention. Because the study was not focused on exploring the therapists' experiences of carrying out the phone call, the study provides limited insight into the experiences of providing the intervention. However, it does give some indication of what it might be like to be providing a new intervention to support bereaved individuals from Covid-19. For instance, the study highlighted practitioners' experiences of adapting to changes in role, procedure, process and aims in the context of a very different type of intervention which differed from the typically offered bereavement therapy (Menichetti Delor et al., 2021). The aspect of the work which was reportedly experienced as both the most challenging and fulfilling was connecting with family members' feelings, as this seems to have been viewed as both an opportunity to connect but also experienced as emotionally heavy (Menichetti Delor et al., 2021). One participant likened the experience of connecting with clients' experiences to being "all on the same boat in this dramatic and new experience (Menichetti Delor et al., 2021, pp. 507). A study by Pearce et al. (2021) was also identified as providing some insight into what it might be like for bereavement practitioners to be adapting to changes in bereavement care during Covid-19. An online survey capturing experiences of working with bereavement during the pandemic

was distributed to bereavement practitioners such as bereavement counsellors, but also palliative nurses, doctors and chaplains. Responses reflected experiences of adapting to pandemic-related changes such as increased waiting lists and earlier bereavement interventions, as well as experiences of adapting to the lack of face-to-face contact or of having to wear protective equipment which was reportedly experienced as uncomfortable and made communication more difficult (Pearce et al., 2021). The study suggested that practitioners were emotionally impacted by the increased needs for bereavement support during the pandemic in combination with their personal Covid-19-related emotional difficulties, stressors and experiences of loss (Pearce et al., 2021). When asked about suggestions for future bereavement services, participants highlighted the need for, and importance of training (Pearce et al., 2021). The study provides some brief insight into the experiences of providing bereavement care during the pandemic but, arguably, the use of one-to-one interviews or focus groups could provide a more in-depth understanding of practitioners' experiences. The study also included a variety of bereavement professionals, and not just psychological therapists and it is unclear which experiences were reported by which professionals. Perhaps different experiences would be reflected if a similar study recruited therapists only.

A recently published literature review by Laranjeira et al. (2022) explored the existing research on new bereavement interventions put in place during the pandemic to support those having lost a loved one from Covid-19. Interventions reported varied but included remote interventions, brief, one-time or four-session long interventions, and interventions provided under six months post-loss (Laranjeira et al., 2022). The focus of these studies however has been on the content or outcome of these interventions, and none of the studies reported in the review have aimed to enquired about practitioners' experiences of providing a new intervention during Covid-19. Similarly, when exploring the literature for this research project, no research was found to explore experiences associated with providing new interventions developed to respond to Covid-19 bereavement needs. Laranjeira et al.'s (2022) review indicates that, across the world, new interventions tailored to Covid-19 have been

implemented. Within this context of change and adaptation where new interventions are implemented, it seems increasingly relevant to explore what it is like for practitioners to be providing a new, unfamiliar, brief, and early intervention, particularly during Covid-19. The present study aimed at examining experiences associated with providing a new, early, and brief intervention in the UK during Covid-19. As mentioned earlier in this chapter, this new intervention differed from typically offered bereavement interventions, in that it involves three sessions provided over two weeks, over the phone, and before six months post-loss.

3. Summary

The above literature review looked at research which could provide insight into therapists' experiences of providing a new, time-limited, and remote intervention during the Covid-19 pandemic, shortly after the bereavement. The main areas covered included research on the impact of Covid-19 on practitioners' experiences and wellbeing, experiences associated with remote therapy prior to, and during the pandemic, practitioners' experiences of practicing in STRs and research on therapists' experiences around changing bereavement work during the pandemic.

The literature around practitioners' experiences during Covid-19 suggests that practitioners may be experiencing increased anxiety, isolation, uncertainty, decreased wellbeing and increased professional self-doubt (Aafjes-van Doorn et al., 2021; Duncan et al., 2020; Newby et al., 2020; Tull et al., 2020). Significant changes in practice have also been highlighted, such as offering therapy remotely, and from one's home rather than in an allocated therapy room. The majority of studies on Covid-related experiences were quantitative and provided limited insight into practitioners' experiences of providing therapy during Covid-19. Looking at past pandemics, no research was identified that could provide an indication as to how therapists might be experiencing work during Covid-19.

Another important change in the therapeutic work during Covid-19 was the shift from face-to-face therapy to teletherapy. Overall, the literature indicates that the transition has been experienced positively, albeit some challenges around the use of technology, the absence of physical cues, access to confidential spaces and the challenges of offering therapy from one's own home (MacMullin et al., 2020; McBeath et al., 2020; Smith, & Gillon, 2021; Shklarski et al., 2021). The literature around the experiences of working as a therapist during Covid-19 appears to have mainly enquired about the experience of offering teletherapy rather than asking broadly what it is currently like to be practicing as a therapist. There is also an overall lack of longitudinal studies which could inform us of how experiences might evolve over time, particularly as practitioners might adapt to the context of Covid-19 and the majority of studies have recruited participants in the early days of the pandemic, at which point it could be expected that higher levels of difficulties and distress might be experienced.

Because both therapists and clients are having to cope simultaneously with the challenges of the pandemic, the concept of STR has been highlighted in the Covid-19 literature. Research suggests that STRs can lead to both significant positive and negative experiences including helplessness, anxiety, burnout but also meaningfulness, satisfaction and increased sense of connection and empathy (Bauwens, & Tosone, 2010; Cohen et al., 2015; Eidelson et al., 2003; Hamid et al., 2020). Despite some indications that Covid-19 may involve a STR between clients and therapists, there was no identified research on practitioners' experiences of STR during the pandemic (Nuttman-Shwartz, & Shaul, 2021). Finally, the literature on practitioners' experiences of providing new bereavement interventions during the pandemic was looked at, and found to be surprisingly scarce, while the existing literature on new, tailored bereavement interventions during Covid-19 have focused on examining the content and outcome of such interventions rather than experiences of providing a new, different, early, brief intervention (Laranjeira et al., 2022).

Given the challenges and changes brought about by the pandemic and as new interventions are implemented to respond to changing needs, it is important to enquire about therapists' experiences of working during Covid-19, and, specifically, to enquire about the experiences associated with providing new, early, and brief interventions in the context of the Covid-19 pandemic (Bell, Crabtree, Hall, & Sandage, 2021; O'Connor et al., 2020). For these reasons, the present study aimed to explore counsellors' experiences of providing a new, early, and brief intervention during Covid-19. My understanding prior to interviewing participants was that offering this intervention during the pandemic might involve various challenges such as adapting to a very different type of therapeutic work, working from one's home and working with highly distressed clients while personally coping with the challenges of the pandemic. I was therefore curious to know how the counsellors providing this intervention experienced the work.

4. Rationale for the present study

This study aimed to examine counsellors' experiences of providing a new, early, and brief intervention during the Covid-19 pandemic. The literature and ethical guidelines highlight the importance of therapists' emotional wellbeing and experiences for quality therapeutic work (Dattilio, 2015; Guy, Poelstra, & Stark, 1989; Pakenham, & Stafford-Brown, 2012). New interventions are put in place to respond to Covid-19-related needs, and it seems relevant to explore how practitioners are experiencing providing these new, early, and brief interventions during the pandemic. Insight into therapists' experiences could inform Counselling Psychologists in the implementation of adequate training, professional support, supervision, as well as within the remits of other tasks such as consultancy, service management and development. For example, when implementing Covid-19-tailored new, early, and brief interventions or new interventions broadly, the study could help Counselling Psychologists in the above roles to be aware of relevant themes and needs that could arise, particularly in the context of community-wide crisis. In fact, there have been calls for research around the

pandemic, such as qualitative enquiries of pandemic-related experiences (Bell et al., 2021; O'Connor et al., 2020). As new, early, and brief interventions are reported, it feels particularly relevant to enquire about therapists' experiences of providing a new, early and brief intervention, in the context of the pandemic. Given the lack of studies exploring practitioners' experiences of providing new interventions during Covid-19, a qualitative study appeared to be appropriate in enabling an open exploration of the topic (Barker, Pistrang, & Elliott, 2016; Morrow, 2007). Qualitative methods are also appropriate means to enquiring about subjective experiences (Barker et al., 2016). The current literature around practitioners' experiences of working during Covid-19 or in previous pandemics has mainly focused on other healthcare professionals such as doctors and nurses, rather than psychological therapists, in majority includes surveys rather than in-depth interviews, or has focused mainly on the experiences of teletherapy. Consequently, the study aimed to explore the following research question:

How do counsellors experience providing a new, early and brief intervention during Covid-19?

5. Study aims and relevance to Counselling Psychology

The current pandemic has arguably led to an unprecedented mental health crisis, in which anxiety, depression, loneliness, and loss may be increasingly experienced (Bertuccio, & Runion, 2020; Duncan et al., 2020; Eisma, Boelen, & Lenferink, 2020; Newby et al., 2020; Singer, Spiegel, & Papa, 2020; Tull et al., 2020). Counselling Psychology is currently having to adapt to increased and changing needs as a result of Covid-19, which involve developing guidelines around working remotely, working from home, while different, new interventions have been reported, for example around bereavement care (BPS, 2020; Menichetti Delor et al., 2021; Pearce et al., 2021). No studies looking at experiences of providing new interventions during Covid-19 were found, and, to my knowledge, there are no existing studies that have qualitatively explored, through one-to-one interviews, therapists' experiences of providing a new, early and three session-long intervention in the context of the pandemic. The

BPS (2020) has encouraged research projects contributing to our ability to respond to Covid-19-related psychological needs, consistent with Counselling Psychology's ethos of continually growing knowledge around best practice (McLeod, 2015).

The study therefore aims to gain insight into counsellors' experiences of providing a new, early, and brief intervention in the context of Covid-19. Exploring practitioners' experience of offering a new intervention is argued to be of interest for the development and maintenance of future interventions, as it could inform training and support needs to put in place when providing new, unfamiliar interventions, particularly in times of crisis, such as natural disasters, future pandemics, or war. Indeed, Counselling Psychology strives for continuous development, and as such it would be expected that, regardless of the pandemic, new interventions will be developed, and that Counselling Psychologists will be learning new therapeutic approaches, as part of their training or professional development. The roles held by Counselling Psychologists are varied and include training, supervisory, consultant and management positions, which can involve providing feedback and support, inviting colleagues or/and supervisees to reflect on their practice and engage with reflexivity, as well as providing input and shaping decisions around service development and clinical governance (Henton, & Kasket, 2018; Nicholas, 2018). Roles held by Counselling Psychologists in management positions also include ensuring adequate training, supervision, quality of service, addressing difficulties within the team and ensuring that staff feels confident with their role (Gale, 2016). These duties require an awareness of, and attention to fellow Counselling Psychologists' potential experiences and needs, particularly when partaking in new, unfamiliar psychological interventions and when practicing in difficult contexts such as Covid-19, war, or natural disasters (Gale, 2016). As such, examining counsellors' experiences of providing a new, early, brief intervention during the Covid-19 pandemic could inform Counselling Psychologists holding management, training, consultancy, or/and supervisory positions of some of the themes that can arise for practitioners when providing new interventions and in the context of

crisis. In turn, this awareness could help shape management, training, consultant and/or supervisory considerations for Counselling Psychologists.

Chapter 2: Methodology

1. Overview

As indicated previously, this project involves a qualitative study, aimed at exploring counsellors' experiences of providing a new, early, brief intervention during Covid-19. Two sets of one-to-one, semi-structured interviews were carried out with four participants. In the second round of interviews, participants were invited to draw aspects of their experience, and the drawings served as a platform to further discuss their experiences of providing a new, early, and brief intervention. Interpretative Phenomenological Analysis (IPA) was used to analyse participants' accounts.

In this chapter, the chosen methodology, epistemological and ontological positions for this research project will be outlined. Procedures around recruitment, data collection and analysis will also be described and discussed. The aim of this chapter is to voice the rationale behind the decisions made for this research project. Reflexivity, which involves exploring the dynamic between the researcher and the research project, and how one influences the other, is particularly central to qualitative research (Finlay & Gough, 2003). As such, reflexivity will also be explored. Designing this research project indeed stemmed from both personal views, reflections, wishes, and academic considerations around producing quality research (Ponterotto, & Grieger, 2017).

2. Rationale for the methodology

Methodology can be described as "a general approach to studying research topics" (Willig, 2013, pp. 8). One's methodology will therefore involve one's theoretical approach to knowledge and research. Decisions around the methods used and the type of analysis

selected stem from one's methodological orientation (Willig, 2013). Methodological position can be uncovered via the following questions:

"What kind of knowledge do I aim to create?"
"What are the assumptions that I make about the (…) world(s) which I study?"
How do I view the role and the relationship of the researcher in regard to the research? (Willig, 2013, pp. 15).

Answers to the above questions will depend on the researcher's ontological and epistemological positions which will be described below (Willig, 2013).

2.1. **Research Question**

As outlined in the Preface, this research project underwent several changes in both topics and method and my initial interest was around evaluating a piece of therapy work, either through a mixed or qualitative design. For instance, my initial project was around looking at the combined use of body therapies and talking therapies as treatment for trauma. Once the pandemic began and my first project was jeopardised, I turned towards the new, early, and brief intervention I was informed was being provided by the charity I was on placement with. Again, my initial curiosity was around the impact of this intervention on clients. I began developing a research project whereby clients having received this early, brief bereavement intervention would be interviewed on their experience of the work while counsellors would be interviewed via a focus group to explore their perspectives on the work. For both practical and ethical reasons, I chose not to interview clients. In parallel, the questions I wished to explore increasingly pertained to therapists' experiences of providing a very different and new intervention, provided over a short time, over the telephone in the context of a worldwide pandemic. The wish to examine this research question was reinforced as I explored the literature and realised that there were few studies which could suggest what counsellors'

experiences might be like around providing a new, early, brief intervention during Covid-19. Research-informed practice is core to the ethos and training of Counselling Psychology and exploring counsellors' experiences of providing a new intervention during a time of crisis can inform the work of Counselling Psychologists around clinical governance, supervision provision, training, and clinical team management (Kasket, 2012).

The research question is the following: How do counsellors experience providing a new, early, and brief intervention during Covid-19?

2.2. **Ontological approach**

Ontology refers to one's position towards reality and influences the object and means of enquiry (Langdridge & Hagger-Johnson, 2013; Ponterotto, 2005). Two main ontological stances are realist and relativist. Realism argues for the existence of an objective, common reality, in which reality is assumed to exist outside of people's perception (Crotty, 1998; Derksen, 2010). Meanwhile, relativism views reality as constructed and influenced by socio-cultural variables (Derksen, 2010). This paradigm postulates that one's perceived reality is moulded by beliefs and experiences and therefore differs from one individual to the next (Willig, & Stainton Rogers, 2017). Within this project, I assumed the position of ontological realism, which assumes that reality contains a dimension independent of our thoughts or perceptions, outside of our control (e.g., Covid-19 or physical pain) (Ponterotto, 2005). Similarly, the phenomenon looked at here, a new, early, brief intervention is a reality independent of my, or my participants' interpretations or perceptions of it. Furthermore, I argue that the current context of the pandemic, social isolation and associated deaths is another reality independent of one's perceptions. My choice of a qualitative exploration of this intervention partly stems for a wish to capture and acknowledge the current social context of the pandemic while I felt a quantitative exploration would neglect this (Galbraith, 2018). Willig (2016) has argued that qualitative research is not incompatible with a realist ontology as

realism does not preclude another subjective dimension of reality, one that is dependent on ones' experiences or perceptions.

2.3. **Epistemological approach**

Epistemology queries about "the nature of knowledge", what research can capture and how (Willig, 2019, pp. 187). I adopted a relativist epistemological position here, which assumes that the relationship between what is out there and our perceptions of this is mediated by our interpretations, themselves fed by our experiences, assumptions, and socio-cultural backgrounds (Ponterotto, 2005). As a result, I also took a phenomenological position to my enquiry, whereby my focus was on participants' experiences of a phenomenon rather than on the phenomenon itself (Willig, 2013). As such, I argue that the reality of the new intervention is independent of anyone's subjective interpretation of it but also that each individual counsellor is likely to have a unique experience of providing the intervention, on the basis of socio-cultural background, past experiences and so on. My decision to focus on lived experiences and my aim for this study, which was to enquire about the experience of providing a new, early, brief intervention during the Covid-19 pandemic, were based on my relativist and phenomenological epistemological positions. That is, I wished to enquire about a phenomenon (a new, Covid-tailored intervention) which I argued was independent of peoples' subjective perceptions. However, as per my epistemological relativism, I argued that individuals interpret and make sense of phenomena and that this subjective interpretation will shape one's experiences and behaviour. The question therefore guiding my enquiry was 'what was it like for this participant to provide this new, early and three-session long intervention?'. As such, the focus of the study was on the experience of providing a new intervention during Covid-19, but it was not my intention to assess the usefulness of such an intervention (Willig, 2013).

2.3.1. Epoché

An important component of phenomenological enquiry is the attitude of bracketing one's theoretical knowledge, personal views, beliefs, all of which could bias how participants' experiences are understood and apprehended (Wertz, 2005). In phenomenological research, this attitude is referred to as *epoché* (Hays, & Wood, 2011; Wertz, 2005). Bracketing is to be practiced throughout the research process and involves an active process of identifying assumptions and positions, in order to avoid having these inform study-related decisions (Fischer, 2009). Bracketing can be likened to "mindfulness" as it privileges self-awareness (Fischer, 2009, pp. 584). Specifically, Fischer (2009) recommends disclosing motivations, goals and perspectives surrounding the study. There are disagreements amongst phenomenologists around whether epoché is fully reachable (Langdridge, & Hagger-Johnson, 2013). In this regard, I adopted a hermeneutic phenomenological position, whereby I appreciated that, as the researcher, my personal experiences, motivations, wishes, and biases would inevitably influence the shaping of this study and of the analysis, despite my efforts to engage in bracketing (Langdridge, & Hagger-Johnson, 2013). I therefore aimed to be open and transparent throughout the study about my held assumptions and attitudes and how these might affect my understanding of participants' experiences. My reflections on my personal impact upon this project will be further outlined in the reflexivity section.

2.3.2. Interpretation

There are different types of enquiry within the phenomenological position (Willig, 2013). One is descriptive, in which data is described as it is (Willig, 2013; Willig, & Stainton Rogers, 2017). Another is interpretative, in which the researcher not only seeks to describe, but also to understand, to make sense of the participant's experience by attending to the data beyond face value (Willig, & Stainton Rogers, 2017). The interpretative position takes into account socio-cultural context and theory when considering participants' experience, with the

assumption that no analysis is devoid of some interpretation (Willig, 2013). Interpretative phenomenology aims to offer an “amplification of meaning”, “an exploration and clarification of the many strands of meaning which constitute the phenomenon of interest” (Willig, & Stainton Rogers, 2017, pp. 15). As per my epistemological assumption that individuals make sense of events, and that this making sense is a subjective, dynamic concept shaped by individual factors such as gender, culture, age, ethnicity, and socio-economical background, I felt that an interpretative position was meaningful.

Within interpretative phenomenology, two modes of interpretation can be employed (Willig, 2013). One is suspicious interpretation, in which theory guides interpretation (Willig, 2013). Another is empathic interpretation which maintains the interpretation to the realm of reported experiences (Willig, 2013). Ricoeur (1996) (as cited in Willig, 2013) suggested that neither stances should be taken on individually. Similarly, a middle ground was postulated for this study, in which the influencing role of assumptions and theories are acknowledged while a focus on the experience and epoché is maintained to ensure that my interpretation of the data is not overly guided by external factors and that it remains grounded within participants’ accounts (Willig, 2013). My process of bracketing my own assumptions and positions will be examined later in this chapter when discussing reflexivity.

2.3.3. The researcher

The phenomenological position implies some interaction between the researcher and the research project. While participants’ experiences are influenced by a variety of factors, so my experience of the study and of the participants’ experiences are shaped by my own assumptions and individual factors. It results that I somewhat influenced the study, through my assumption-driven interpretations, while the study also influenced me, my beliefs and assumptions (Langdridge, & Hagger-Johnson, 2013; Willig, 2013). This acknowledgment calls for ethical considerations around my role as researcher within the research project

(Haverkamp, 2005). This puts in question the representativeness of the findings, whether they reflect the participant or the researcher most and it is recommended that qualitative researchers should aim to form interpretations based on a plurality of perspectives, to minimise "biased subjectivity" (Haverkamp, 2005, pp. 147; Willig, 2013). Many other considerations are to be explored later in this chapter, around the relationship between researcher and research project, and researcher and participants, while some include power dynamics, and the integration of the trainee Counselling Psychologist's approach to that of the qualitative researcher (Haverkamp, 2005; Teo, 2011; Willig, 2013).

3. Qualitative design

As mentioned above, a qualitative design was adopted, involving a focus on peoples' worldviews (Morrow, 2007; Yardley, 2000). Philosophical underpinnings include plurality of perspectives as full objectivity is perceived as unreachable (Barker et al., 2016; Morrow, 2007; Yardley, 2000). From a phenomenological position, it was important that the study's design enabled an idiographic exploration of the subjective experience of providing a new, early, and short intervention during Covid-19 (Morrow, 2007). In this regard, qualitative designs were considered most suitable. Unlike quantitative approaches, qualitative studies follow hypothesis-free, open-ended enquiries, ensuring that a much wider spectrum of experiences and responses may be captured, without restraining or simplifying participants' experiences (Barker et al., 2016; Willig, & Stainton Rogers, 2017). Given the novelty of the pandemic, of the intervention, and the lack of studies on practitioners' experiences of providing new, early brief interventions during Covid-19 overall, an open exploration of the topic, in which participants could voice their experience of the phenomenon, felt most appropriate. In fact, qualitative designs are prominent in Counselling Psychology research, fit with the profession's ethos, and have contributed to knowledge around therapeutic work and best practice (Ponterotto, Park-Taylor, & Chen, 2017). Another motivation for this choice of design is that qualitative studies are arguably easier to read and to understand for non-expert readers

(Ponterotto et al., 2017). I wanted this study to offer information for professionals, but also to be accessible to any lay reader.

Yardley (2000) suggests four main quality criteria fitting with the philosophy of qualitative methods. These criteria were used as a guide to ensure the quality of this research. Firstly, the context surrounding the topic, such as the literature, diverse theories and perspectives should be considered (Yardley, 2000). In response to this criterion, a thorough exploration of the literature relevant to getting a sense of therapists' experiences of providing new, early, brief interventions during Covid-19 was carried out. Participant's context was also taken into consideration, by checking-in with them how they felt about having the interviews over zoom, their access to a quiet and confidential space with adequate internet connection, but also by considering the context of myself as researcher also volunteering at the same charity and how this could affect participants' experiences of participating in the study. Secondly, Yardley (2000) postulates "commitment and rigour" (pp. 219), referring to the researcher's engagement in all aspects of the research, including in-depth data collection and analysis (Leung, 2015; Yardley, 2000). I made sure to have an adequate understanding of the processes, and potential errors involved in carrying out interviews, transcription and analysis, by engaging with readings and discussing questions or uncertainties in supervision. All interviews were analysed using the same analytical steps. In line with my phenomenological approach, I aimed to remain curious and empathetic towards the data throughout (Yardley, 2000). A fit between method, design, analytic tool used, epistemological, and ontological positions, as well as rationale for method-related decisions are also suggested (Leung, 2015; Yardley, 2000). Clear descriptions of procedures, data collection and analysis are recommended to ensure transparency (Leung, 2015; Yardley, 2000). These criteria were considered when developing this project and when writing this chapter, in which I aimed to clearly describe the steps undertaken for this study, and to voice my rationale for my methodology-related decisions, as well as how these aligned with my epistemological and ontological positions. Finally, reflexivity should also be thoroughly explored, as well as the

relevance of the study (Leung, 2015; Yardley, 2000). Reflexivity was emphasised throughout and involved making written or/and mental notes, as well as discussions with my supervisor and peers. The study's relevance to the field of Counselling Psychology was considered at different points of the project, particularly when defining a research question which could contribute to the existing research, and when examining the findings in light of previous studies and theories.

4. Interpretative Phenomenological Analysis (IPA)

IPA is one type of phenomenological enquiry (Eatough, & Smith, 2017). IPA's aim is to gain insight into participants' experiences of a phenomenon, which are assumed to be mediated by one's thoughts and beliefs (Willig, 2013). An idiographic approach is therefore applied here, whereby individual participants' accounts are analysed individually before patterns are identified between participants' accounts (Langdridge, & Hagger-Johnson, 2013). IPA's focus remains on the experience of a phenomenon, not on the phenomenon itself (Eatough, & Smith, 2017). As such, in this study, IPA was adopted to uncover how providing the intervention was experienced by the counsellors individually, while also looking at patterns, commonalities and differences between counsellors' experiences.

IPA is characterised by hermeneutics, defined by Grondin (1994, pp. 20) (as cited in Willig, & Stainton Rogers, 2017) as the process of "making meaning intelligible". IPA involves two different levels of analysis. A first level is based on empathetic hermeneutic whereby the researcher aims to describe participants' accounts of their experiences (Eatough, & Smith, 2017; Miller, Chan, & Farmer, 2018). The second level is referred to as suspicious hermeneutic and involves exploring the meaning(s) attached to participants' experiences, considering the context such as socio-cultural and psychological dynamics in a hope to find hidden meaning which may not be apparent at face value (Eatough, & Smith, 2017; Miller et al., 2018). IPA therefore involves both an empathetic, data-driven, bottom-up, and a

suspicious, theory-driven, top-down phenomenological enquiry of participants' accounts (Eatough, & Smith, 2017). Furthermore, a double hermeneutic engagement also involves a back-and-forth movement between a part and the whole (Eatough, & Smith, 2017). For example, in this study, a sentence was considered in relation to the words it contained, and a word was considered in relation to its sentence. Similarly, one aspect of a participant's experience was considered within the wider reported experience, while the overall experience was also observed in relation to specific aspects. The incorporation of these different approaches to analysis aim to produce various interpretations of the data, to explore all avenues of understanding participants' experiences (Eatough, & Smith, 2017).

4.1. **Rationale for IPA**

My decision for adopting IPA in this project stemmed from my epistemological and ontological positions, as well as my study's aims and focus on lived experiences. As per my ontological and epistemological standpoints, I held the assumption that one's experience of reality is subjective and shaped by socio-cultural dynamics (Willig, 2013). Given how context can affect how one makes sense of a phenomenon, interpretation was argued to be inevitable, as I additionally assumed that it is impossible to fully detach oneself from socio-cultural influences (Willig, 2013). As such, IPA appeared to be an appropriate analytical method, given that it is embedded in the presumption that individuals make sense of their experiences, that this process of sense-making is influenced by context, and that attending to interpretation when examining participants' narratives can provide further information about the experience of a phenomenon (Lopez, & Willis, 2004). This focus on interpretation guided my choice of analysis from amongst other phenomenologically oriented methods, such as thematic analysis (TA). TA was considered as it suited a phenomenological enquiry (Harper, & Thomspon, 2012). TA is recommended to explore experiences, such as the experience of psychological interventions (Harper, & Thomspon, 2012). I hesitated between TA and IPA because I felt both enabled an interpretivist enquiry but concluded that IPA would enable a stronger focus on

interpretation. Considering the context of participants' experiences through a focus on interpretation felt particularly relevant, given the potential impact of the pandemic upon individuals', everyday lives, assumptions and beliefs. Similarly, my epistemological and ontological positions underpinned my decision to engage in interpretative phenomenological inquiry, and not descriptive phenomenological inquiry. Descriptive phenomenological methods focus on individuals' narratives of their experience while interpretive methods focus on the interpretation of individuals' narratives with the aim of exploring how "the lifeworld inhabited (…) contribute to commonalities and differences" in experience (Lopez, & Willis, 2004, pp. 279). I therefore felt that interpretive methods fit better with my epistemological standpoint which emphasises interpretation and my wish to consider the interaction between context and participants' experiences.

Further considerations were explored to choose amongst the different interpretative phenomenological methods. For instance, existential-hermeneutic phenomenological enquiry was considered. Similar to IPA in its approach to interpretation and epoché, this method is embedded within existential philosophy and said to be best for exploring existential topics such as joy, pain, death, loss, life (Harper, & Thompson, 2012). However, unlike IPA, existential-hermeneutic phenomenology does not entail a 'generalisation' of findings, an exploration of the essence common to all participants' experiences (Harper, & Thomson, 2012). Uncovering commonalities was important in my choice of method, as I wished to get a sense of recurrent themes within the individual experiences of the intervention. Finally, as the study focuses on the participants' experience of providing a new, early, brief intervention, an existential enquiry was judged not to be the most appropriate, meanwhile confirming my choice of IPA as analytic method.

Aside from phenomenological methods, grounded theory was considered to explore the topic of counsellors' experiences of providing a new, early, and brief intervention during Covid-19. Grounded theory focuses on developing theoretical explanations of experiences and

processes (Charmaz, & Henwood, 2017; Tweed, & Charmaz, 2012). This method has been adopted in Counselling Psychology research and theoretical explanations elicited by grounded theory have been found to inform policy making and clinical practice (Charmaz, & Henwood, 2017; Tweed, & Charmaz, 2012). However, when developing my research focus and research question, I chose to focus on counsellors' individual lived experiences of providing a new intervention during Covid-19, rather than aim to develop theoretical explanations for the reported experiences. I wanted to focus the enquiry on gaining insight into the complexity of counsellors' lived experiences, or in other words, on answering the question "what" rather than "why". Grounded theory could be adopted for future research which might further explore experiences around providing new psychological interventions. Indeed, the study's findings which will be described in the following chapter elicited questions and curiosity around explanations and theories which could help understand participants' experiences.

5. Method

5.1. Recruitment

I was on placement at a charity offering bereavement counselling which agreed for me to carry out this research project on their newly developed, early, brief bereavement intervention, by interviewing counsellors providing the intervention. I emailed the study's advert to counsellors providing the new intervention. Within this advert, counsellors were informed of the research topic, and my contact details were provided for those interested in taking part or wanting to learn more about the study (see Appendix A). Once participants contacted me and notified me of their interest in taking part in the study, an information sheet was sent via email, detailing what the study would entail and providing information regarding confidentiality (see Appendix B). A link to the study's consent form was also sent (Appendix D). Participants were able to read this and provide consent electronically via Qualtrics. Within the consent form, participants were also asked to provide age, gender and ethnicity which was collected to know which

context was associated with the experiences described as I argue that these characteristics can influence how events are experienced and interpreted. When completed, a copy of the participants' completed consent form was emailed to the participants. Once consent was given and a time and date were agreed upon, a Zoom invitation was sent to participants. At that point, I had not decided whether to have a second interview. This depended on the number of participants recruited as I wanted sufficient data to ensure a rich analysis. Within the information sheet, as well as when speaking with participants, I informed them about a potential second interview and asked if they would be happy to be contacted in the future regarding this. Further information regarding the content and process of the second interview was included in a later email to participants inviting them to take part in a second interview. Participants who agreed to be interviewed again were also sent a link to a second consent form, in which they were asked consent for including their drawing within the thesis (see Appendix F).

One criterion for participating in the study was being a counsellor at this bereavement charity and being involved in providing the new, early, brief Covid-19 bereavement intervention. Additional inclusion criteria included: being eighteen or over and speaking fluent English. The language criterion ensured understanding during interviews, as I needed participants to be able to express themselves effectively to enable a reliable IPA (Braun & Clarke, 2006). The age criterion stemmed from an ethical standpoint, to facilitate ethical applications, although it was not expected that the service would have underaged counsellors. There were no exclusion criteria.

Four participants were recruited. I had initially aimed to recruit between four to eight participants, which is typically recommended for this type of method (Wertz 2005). However, this intervention had been recently put in place at a small scale and only a few counsellors were involved. As a result, I chose to add a second interview to ensure sufficient data, with a focus on IPA's idiographic enquiry (Starks, & Brown Trinidad, 2017). Participants included two

males and two females, aged between 59 and 70. Ethnicities included White British, Asian and mixed African and Asian Caribbean. One of the participants did not respond to the email invitation to take part in the second interview, therefore only three of the initial participants took part in the second round of interviews.

5.2. **Semi-structured interviews**

Data was collected using one-to-one, Zoom, semi-structured interviews. This method aims to capture the richness and variability of participants experiences which fits with my epistemological assumption that peoples' experiences of a similar event will be uniquely shaped by their own background and therefore my wish to focus on exploring counsellors' meaning making of providing a new, early, brief intervention during Covid-19 (Barker et al., 2016; Ponterotto, 2005). Semi-structured interview is a method of interviewing involving pre-conceived interview questions with some flexibility for participant-led exploration in-between questions (Langdridge & Hagger-Johnson, 2013). As such, the questions serve as guidance for the interviewer rather than fixed guidelines. I chose this method as it offered some flexibility to explore the topic and some focus based on the interview schedule. Preparing questions in advance ensured that they were open-ended, non-directive, non-judgmental, using simple, and intelligible language, which are important factors to build safety and rapport with participants (Langdridge & Hagger-Johnson, 2013). Additionally, a one-to-one space can help establish confidentiality and safety for participants to open up. One-to-one interviews also provide the space for an in-depth and uninterrupted exploration of a participant's experience, which would help explore participants' individual experiences, as per IPA (Langdridge & Hagger-Johnson, 2013). Additionally, participants were all part of the same organisation and supervision group. As such, I felt that having a one-to-one discussion would optimise safety around sharing views or experiences which might differ from their colleagues. As I wished to minimize intrusiveness upon participants, other methods such as diaries, were also excluded. Finally, this method was selected because I felt it enabled the following: rapport and reciprocity

between researcher and participant, as well as a dialogue supporting participants to examine their experiences (Galletta & Cross, 2013). Once I knew that four counsellors involved in the intervention would take part in the research, I hesitated between expanding recruitment to other services or adding a second interview with each participant to ensure sufficient data. Based on IPA's idiographic focus, I decided to have two rounds of one-to-one interviews with each participant, prioritising in-depth exploration of each counsellor's experience. Visual methods, specifically drawing, were adopted in the second set of interviews, as will be further outlined below.

5.2.1. Round 1: Narration focused interviews

The first round of interview took place in October 2020 and involved a 'classic' one-to-one exploration of participants' experiences with questions to support the conversation while maintaining opportunity for participants to direct the conversation. Galletta and Cross (2013) suggest that questions should remain topic-related, moving from open-ended, to more focused questions, reflecting an increasingly detailed exploration of participants' experiences. As such, initial questions enquired about the participants' overall feelings towards the intervention before and while engaged in providing the work. I then focused more on specific aspects of the intervention such as their experience of working remotely. My interview agenda was based on previous studies and thesis portfolios which had adopted an IPA qualitative study to explore the experience of a therapeutic intervention (see Appendix C). One aspect I struggled with in this process was to remain neutral in my choice of words. I realised that my instinctual choice of words informed me of my biased assumption that counsellors might have struggled with the intervention's structure. Once I became conscious of this, I paid particular attention to go through questions several times and ensure that my wording was as neutral as possible.

Additionally, through engaging with the interviews, I realised that some questions asked, around the content of the work and clients' thoughts/views towards the work's outcome were

not relevant to my research question which was phenomenologically focused rather than evaluative of the intervention. In hindsight, I think these questions stemmed from an additional wish to know about the intervention's effectiveness, rather than driven by my research enquiry. Overall, I found that I did not need to rely heavily on the interview agenda as participants expanded on their experiences. I would at times prompt them to elaborate further, for example by asking "Could you say more about that?". The interview ended once I felt I had no more questions to ask, and participants felt that they didn't have anything further to share.

5.2.2. Round 2: Visually focused interviews

The second interviews were carried out approximately seven months later, in April 2021. As mentioned previously, funding was temporarily halted a few weeks before the first round of interviews. I chose to allow a gap between both interviews for two reasons. One was that I wanted the second interviews to take place some time after funding resumed. This was to ensure that participants' experiences of providing the intervention would be as rich and recent as possible, to avoid potential recollection bias. The second reason was that I wished to have individualised interview schedules for the second interviews, for the purpose of idiographic enquiry. As such, I took the time to transcribe and analyse the first round of interviews, to identify master themes and subthemes for each participant, upon which I developed the second interview schedules.

The purpose of the second round of interviews was to deepen the exploration of participants' experiences. I wished to have a space in which previous themes could be explored further and unexplored themes could potentially emerge. I decided to adopt visual methods for the second interviews as I felt that the use of drawings could enable a different expression of participants' experiences, which could perhaps be more difficult to share with language only (Bartoli, 2020). Given that participants had already engaged in one interview, adopting a different interview approach, a different modality of expression felt appropriate to further

explore participants' experiences, to enable a rich, varied, and multi-layered understanding of their experiences (Bartoli, 2020). There is an increased use of visual methods within qualitative studies, including the combined use of visual methods alongside IPA (Bartoli, 2020; Shinebourne, & Smith, 2011). Visual methods have been suggested to enable a "deeper understanding of human experience", where the use of the visual provides a platform upon which participants can voice their experience, enabling them not only to talk of their experience but also to show their experience (Bartoli, 2020, pp. 1012; Shinebourne, & Smith, 2011). Similarly, one held assumption here was that drawing would evoke "visual metaphors to depict internal realities" (Literat, 2013, pp. 88). The communicative power of images is also translated in Lynn and Lea's (2005) expression "one picture is worth ten thousand words" (pp. 216).

Visual methods can be used in a variety of ways (Silver, & Willig, 2021). Here, I wished to invite participants to draw aspects of their experiences, and then to discuss these drawings with the participants, to invite them to interpret and make sense of what they depicted. My choice of having drawings interpreted by participants rather than analysing them myself directly stemmed from a frequent criticism of visual methods that its analysis is more prone to the researcher's subjectivity, assumption and biases (Literat, 2013; Lynn, & Lea, 2005). Similarly, it has been recommended to adopt visual methods alongside participants' verbal accounts to avoid such biases (Bartoli, 2020; Shinebourne, & Smith, 2011). While I appreciated that subjectivity could not be avoided, I aimed to minimise the risk of over-interpretation or misinterpretation by having drawings interpreted by the participants and then analysing their interpretation myself using IPA. The purpose of drawing was therefore to prompt participants' reflection, discussion and expression of their experience (Reavey, & Johnson, 2017). One reason for choosing drawing over other visual methods was practical: given the context of the pandemic and remote interviews, drawing was easy to organise and not costly. Another was based on my familiarity in working with drawing and painting to get insight into the other's experience, through a placement as play therapist with children. Finally,

the use of drawing in qualitative research has been reported and associated with participants' experience of agency and engagement within the interview process (Bartoli, 2020).

Given that the interviews took place over Zoom, the whiteboard function was used, which enables participants and researchers to share a board on which participants can draw. One of the participants shared that he was not comfortable with drawing but happy with any other visual form. I explored with him and my supervisor other methods that may be comfortable, and which could elicit further exploration of the participant's experiences while minimising bias. We finally agreed on using a set of symbols on the Zoom whiteboard and asked the participant to choose the symbol which best represented his experience and then to justify his choice (see Appendix E, P2 Interview Agenda). I also offered the participant to alternatively describe a landscape which would best represent his experience.

For the purpose of deepening the idiographic enquiry, I set up individual interview agendas for each participant, on the basis of what emerged in the first interview (see Appendix E). For instance, main themes that emerged in the first interviews were around feelings, the therapeutic relationship and support. These themes were evoked in interview questions such as: "Could you draw your experience when considering the feelings that emerged around the work?", or "Could you draw your experience when thinking about the therapeutic relationship?". Agendas did not contain more than four questions, as I wanted to give enough time for participants to draw and discuss with me their drawings. Overall, the second interview agenda covered the following: feelings around the work, experience of the therapeutic relationship, experience of support, clients' needs and experiences of the work's format.

The structure of these interviews followed Gillies et al.'s (2005) recommendations (as cited in Reavey, & Johnson, 2017): 1. Use of questions as prompts, 2. Participants painted or chose a symbol/described a landscape, 3. Paintings or symbol/landscape were discussed and

interpreted by participants. I also encouraged participants to further interpret and discuss their drawings through comments or questions about the choice of colour, patterns or shapes.

5.2.3. Procedure for data collection

Given the circumstances and recommended social distancing during the pandemic, interviews took place remotely using Zoom. Benefits of remote interaction include increased accessibility whereby participants did not have to commute to take part to the study (Rortvedt, & Jacobs, 2019; Sanchez et al., 2019). It also yielded several considerations around technical issues (e.g., Internet connection, participant's ease at using Zoom) and around participants' access to a quiet and private space in which they would feel comfortable sharing their experience (Békés et al., 2020).

To begin the one-to-one interviews, participants were asked if they were in a space in which they felt comfortable proceeding with the interview. Participants were reminded of the focus of the interview, its expected duration and that they would be emailed a debrief form at the end of the interview. Participants were then invited to share any thoughts or queries regarding the interview or the study. I informed participants about putting both a separate recording device and the Zoom recorder on. At the end of the interview, I notified participants about turning off the recorder. They were then invited to reflect on their experience of the interview, and check-in how they felt. Following the interview, I saved the recording in a password-protected file. The debrief form was sent to participants via email in which I invited them to contact me if they had any questions or wished to discuss the study further (see Appendix G). Interview length varied between forty minutes to one hour and a half depending on participants' availabilities and depending on the amount of material to be explored.

The process was the same for the second round of interviews. The main difference was that I invited participants to draw their experiences rather than to narrate them. I informed

participants that they had about three minutes to either draw their experience or chose a symbol best representing their experience, and three drawings/symbols emerged from each participant. The procedure followed this sequence: I invited participants to think about an aspect of providing the intervention (e.g., the therapeutic relationship) and to draw their experience of this; participants were given approximatively three minutes to draw; I invited participants to talk me through their drawing; when needed, I prompted the conversation by asking them to explain their choice of shapes, patterns or colours used; once participants felt they had fully explained their drawing, I would invite them to think about the next topic, and so on. Once a drawing had been fully explained and it was agreed to move-on to the next question, I asked participants permission to screenshot the drawing. Lyon (2020) highlights the importance of considering how participants may experience the process of drawing, as well as their feelings around ownership of the drawings and use of the drawings within the research. As such, at the end of the interviews, I invited participants to reflect on their experience of drawing. Finally, I asked participants if they wished for me to send them their drawings by email.

6. Transcribing

Prior to analysing the data, interviews were transcribed. A 'naturalistic' approach was adopted, whereby interviews were transcribed verbatim, including non-verbal communications such as voluntary and involuntary sounds, pauses and hesitations (Nascimento, & Steinbruch, 2019; Oliver, Serovich, & Mason, 2005). Transcription is an important step in the analysis of the data and can be prone to misinterpretations or misrepresentations, in turn setting the scene for the quality and representativeness of the subsequent analysis (Easton, McComish, & Greenberg, 2000). I chose this approach to transcription rather than a denaturalised approach whereby content only would be transcribed, as I wished the transcription to be as objective and unbiased as possible (Oliver et al., 2005). My aim for this project was to get a sense of participants' experiences and I felt that *how* they spoke of their experiences, and not just *what*

they said, was important in capturing their experiences. As such, I tried to depict their speech in both form and content as accurately as possible, making sure to keep any grammatical mistake or mispronunciation in. To note, interpretation is part and parcel of this form of transcription, and my decisions around what constituted a pause or not was subjective and prone to bias (Nascimento, & Steinbruch, 2019; Oliver et al., 2005). I tried to minimise this by establishing what constituted a pause on the basis of the general pace of the individual participant's speech. I also tried to engage reflexively in this process, reflecting on how my own rhythm of speech, and French linguistic background might influence my transcription (Shelton, & Flint, 2019).

7. Data analysis

As per IPA's double hermeneutics, the analysis entailed a movement between a descriptive enquiry and an interpretative one (Eatough, & Smith, 2017). Specifically, I aimed to both describe what the phenomenon in question was like according to participants' accounts and enquire about the meanings attached to participants experiences, making sense of participants' own sense making of their experiences (Larkin, Watts, & Clifton, 2006; Miller et al., 2018). This process also involved a movement between the parts and the whole whereby words, sentences, extracts of participants' accounts were considered within the wider interview and the wider interview explored in relation to specific extracts (Miller et al., 2018). The above entailed attending to the content, what participants said at face value, language used and finally exploring the meaning behind participants' interpretations of their experiences, by considering the wider context. This double hermeneutic was adopted throughout the different steps of analysis. Additionally, each interview was analysed individually before any comparison with other accounts was made. The research topic and research question were kept in mind throughout to maintain the analysis focused on the research question.

Willig (2013) offers a description of the different stages of analysis in IPA. The first step involves several readings of the transcript, enabling the development of reflections and observations. Secondly, themes, which are patterns of meaning, are identified, which should be grounded within the participant's subjective experience. Quotes which illustrate the themes are selected. The third stage involves organising themes hierarchically into clusters. Themes representing similar meaning are joined into master themes under which relevant subthemes are clustered. Willig (2013) recommends that themes should evoke both an empathetic, and interpretative approach to the data. Once the above steps are carried out for each participant, themes identified for each participant can be compared and master themes, common to all participant's experiences, can be distinguished (Willig, 2013). Finally, master themes can be further considered in the context of the literature, models and theories. Epoché should be carried out throughout the different steps, although no specific guidance is given (Willig, 2013). These steps were followed for analysing participants' narratives. Overall, I engaged with epoché mainly through active reflexivity through diary writing, in which my thoughts, feelings and reactions towards aspects of the research were noted and their impact upon analysis was considered.

The first step recommended for IPA is to become acquainted with the data by reading the transcript several times and making notes of preliminary observations and reflections (Willig, 2013). This process began while transcribing the interviews, at which point I paid particular attention to participants' tone of voice, pace and rhythm of their speech, pauses and hesitations. Appreciating the role I played in the interviews, data collection and analysis is also crucial within IPA (Larkin et al., 2006; Willig, 2013). I therefore used this step to further reflect on my responses in the interviews, and how these might in turn affect participants' responses. For instance, I noticed that my responses were very hesitant in all interviews, as I felt anxious not to influence the interviewee and to remain neutral through my choice of words. Nonetheless, I noticed that, particularly in my first few interviews, I struggled to separate my therapeutic skills from that of an interviewer.

I proceeded to coding the data, making notes in the margin around content and process (see Appendix K). I also assigned colour codes to topics (e.g., emotions). Comments made included:

Descriptive comments summarising participants' narratives.

Linguistic comments, including use of pronouns, words or verbs used, verb conjugation, metaphors and images mentioned. Pace such as pauses, hesitations, sighs, and tone of voice were also noted.

Decontextualization where words and expressions were considered within and outside the context of the full interview.

Conceptual comments around recurring topics, their interconnection and what they evoked about the participant's experience. I ensured to remain text-bound throughout my reflections and meaning-making of the participants' experiences and checked whether an interpretation was evidenced in the text.

Engaging reflexively, I noticed that elements that I observed first fit most with my initial assumptions of participants' experiences. By contrast, I realised I was less observant of elements which I didn't expect. Reflecting on my meaning-making of words or expressions when out of context also informed me about my own assumptions. I also considered the impact of my pre-existing relationship with the organisation and the participants (McCormack, & Joseph, 2018). Being on placement at the service, I was aware that participants may have concerns about the interview content being shared with colleagues which I held in mind and some participants voiced that concern or expressed hesitations as to what to share or not in the course of the interview. I tried to alleviate any discomfort by going through participants'

questions and concerns, and by clarifying anonymity. Nonetheless, I appreciated that this dynamic could impede participants' comfort in sharing certain aspects of their experience.

Patterns of meaning began to emerge which I aimed to organise as themes and subthemes within each interview individually. These themes resulted from this combination of descriptive and interpretive understanding of the data. Emergent themes were colour-coded as patterns were identified. As suggested by Smith, Flowers and Larkin (2009), I aimed to keep the themes grounded within the participant's narrative.

Once I had identified emergent themes, I looked at connections between them. I began by attending to the frequency with which themes were evoked by participants (Smith et al., 2009). I drew a table with each theme within an interview and noted the number of times I encountered a theme, by looking at the number of quotes identified for each (see Appendix L). I also looked at the commonalities and differences between themes and the relationship between a theme and the overall narrative (Smith et al., 2009). Themes which evoked a similar meaning were combined under one master theme under which relevant subthemes were clustered (see Appendix M). Once this was carried out with each interview individually, I drew a table of all themes amongst all interviews, again examining their relationship with one another. I clustered themes into superordinate themes and subthemes according to their relevance and representativeness of participants' experiences.

The above steps were carried out to analyse data from the first and second round of interviews. Once I had organised a table of themes and subthemes from the first interviews and a separate one for the second interviews, I proceeded to further organise and cluster themes in order to combine the findings of both rounds of interviews.

8. Ethical considerations

City University's and the British Psychological Society's (BPS) ethical guidelines for carrying out research were considered when developing this research project. An ethics application was submitted and granted approval prior to recruitment and data collection (see Appendix H). Two amendments were made to the ethics form, at different times, which were submitted and approved prior to recruitment. Both pertained to a change in the study's focus and associated procedures, for example, changing from using focus groups to one-to-one interviews (see Appendix I and Appendix J).

Firstly, the BPS highlights the importance of informed consent (BPS, 2021). Prior to the interviews, relevant information was shared with participants through the study advert, information sheet and consent form. Potential adverse effects from participation in the study, such as emotional distress, was included in the information sheet and discussed with participants (Brinkmann, & Kvale, 2017). Participants were told, both by email and/or telephone and within the information sheet, that their willingness to participate or not would not impact their work at the charity.

Secondly, I considered means to protect participants' anonymity (BPS, 2021). Completed consent forms and interview transcriptions were password protected. Similarly, interview recordings were transferred to a laptop and password protected. Names and identifiable information were removed from the transcriptions and replaced by pseudonyms. Additional identifiable information was also withheld for anonymity purposes, such as the name of the bereavement charity or the names of helplines participants shared having worked for (Saunders, Kitzinger, & Kitzinger, 2015). Within the consent form, participants were asked if I could use certain quotes or drawings within the thesis to which all participants consented. I ensured that quotes and drawings present in the analysis chapter did not contain any identifiable information (Brinkmann, & Kvale, 2017). The consent form also enquired whether

participants would like to be informed of the research findings, to which all responded that they would. Findings were summarised and sent via email to participants. Participants were also invited to contact me if they wished to discuss the results further.

Because a small number of participants was recruited within the same charity, another consideration around anonymity was that participants could potentially identify each other when looking at the study's findings, even after anonymisation (Saunders et al., 2015). In response to this, I invited participants to express questions or concerns around how data would be anonymised, who would access the data and around the limits of confidentiality in this project. I also aimed to invite participants to discuss any concern or hesitation about the interview process or content, or about the research, before starting the interviews. I also invited participants to let me know if they wanted me to stop recording at any point during the interview, if there was anything they were uncomfortable about or if there was material which they didn't want to include within the analysis, which they might not want to be identified as saying. There was one occasion where a participant asked to interrupt the recording as she was referring to a piece of work with a client and was not certain what to say or not to protect the client's anonymity and confidentiality. In this instance, I stopped recording, discussed the participant's concern, and resumed the recording once she was comfortable to do so.

Finally, the BPS postulates "maximising benefits and minimising harm" (BPS, 2021, pp. 9). Various aspects of the study were considered in light of their impact on participants, such as choice of words, type of method and interview schedule (Langdridge & Hagger-Johnson, 2013; Morrow, Castañeda-Sound, & Abrams, 2012). Potential harm and benefits were communicated within the information sheet. No particular potential harm was expected in this study, although there is always a risk of participants experiencing distress during the interview (Brinkmann, & Kvale, 2017). Participants were therefore debriefed at the end of the interviews and a debrief form including helplines was sent after the interview in which I invited participants to speak to myself or provided helplines if they experienced any study-related distress.

Highlighting participants' autonomy in the study process, respect through the language used, and displaying genuine interest in participants' experiences were important aspects to rapport-building and in promoting a positive experience for participants.

Particular consideration was required around power dynamics as I was recruiting counsellors who were colleagues at the charity I was myself volunteering at. Specifically, the impact of this dual relationship on participants' confidence in consenting or refusing to participate was reflected upon (BPS, 2021). The BPS (2021) advises to reflect on how consent is sought and how this influences participants' liberty to participate or not. In this study, I sent participants the research flyer via email in which participants were invited to contact the researcher if interested. This email simply contained the research flyer and purposely did not address any participant directly to minimise any felt pressure to respond or engage. To mitigate the risk of participants consenting to participate as a result of my relationship to the service, the information sheet and consent form included a statement explaining that their decision to participate or not would not impact their work within the charity. Regardless, I appreciated that the dual relationship could influence participants' engagement with the study. As such, at the start of each interview, I invited participants to express any concerns or hesitations that they may have about the study, I clarified that this study was part of my doctoral studies and independent of the charity, and that only my research supervisor and myself had access to the data. I also attended to any signs which could suggest lack of assent, such as non-verbal communications of discomfort or hesitation, as suggested by the BPS' code of human research ethics (2021).

A final ethical consideration pertained to the use of visual methods. Mountian et al. (2021) postulate transparency around the use of visual methods within the research, for example around data analysis or around the inclusion of participants' reflections on their drawings. At the beginning of the second interviews, I clarified with participants that I would be analysing their explanations of their drawings rather than their drawings, and as such, that only their

understanding and perspective of their drawings would be considered. A second recommendation is to ask participants whether they provide or deny consent for the researcher to include the drawings within the thesis (Mountian et al., 2021). The consent form for the second interview included a question asking for consent to include their drawings. To protect participants' anonymity, I ensured that drawings included did not contain any identifiable information. Finally, I invited participants to reflect on how they felt about the use of drawing, during and at the end of each interview (Mountian et al., 2021). One participant shared prior to the interview that he felt uncomfortable with drawing, and we discussed other options, such as the use of symbols, which felt comfortable for him.

9. Reflexivity

Reflexivity is the exploration of the dynamic between the researcher and the research project, and how one influences the other (Finlay & Gough, 2003). Specifically, different levels of reflexivity exist. One is personal reflexivity, focused on the researcher's values, culture, identity, and experiences, and another is epistemological reflexivity, focused on epistemology, interpretations and analysis (Willig, 2013). These will be discussed below.

9.1. Epistemological reflexivity

I was drawn to this particular intervention because it was new and different to ones previously offered, in that it was provided much earlier than usual and three-session long. I was curious about both its impact and about the experience of working in this way, of adapting to a different way of working during the pandemic. As I immersed myself in the literature, my interest in the qualitative experiences of those involved in this work gradually increased. The literature evoked for me a significant amount of unknown and uncertainty around what clinicians' experiences of providing a very different type of intervention during the pandemic might be like. As a result, this 'not knowing' elicited feelings around my

experience of ‘learning on the job’ throughout my training. This focus on counsellors’ experiences of providing this new, early, and brief intervention during Covid-19 strengthened in the process of developing and carrying out this project. In hindsight, I noticed that my additional wish to know whether the intervention was helpful shaped this research, particularly when designing the first interview agenda, in which I included a question which pertained more to what counsellors thought of the intervention, than how they experienced the intervention.

In turn, my internal approach to the project influenced its unfolding. My initial assumption was that it must be very difficult and stressful to work in such a short term with clients recently bereaved, and I realised through the interviews and analysis that I expected to hear difficult experiences. To my surprise, reported experiences were more varied than that and involved positive experiences. I had to regularly remind myself that my expectation came from a frame of thinking about how *I* would respond if I had to work in that way, rather than how it might be for someone else. As such, carrying out interviews felt somewhat challenging because I felt I had to attend as much to the participants’ narratives as to my own internal processes and responses. My anxiety around being a ‘neutral’ interviewer was present throughout my interviews and I still wonder how differently the interaction may have been if that anxiety had not been so prevalent. For instance, I was hesitant in my choice of words when responding to participants and I feel that perhaps at times I connected better with participants when they related feelings or experiences similar to what I assumed they would have had (Fitzpatrick, & Olson, 2015). My awareness of my assumptions and bias towards information which met my expectations was particularly salient during the process of transcription and analysis, as I paid attention to each of my and participants’ responses. Again, I noticed that elements that I first noticed were similar to my assumptions of how I would respond to the work while elements that were different were only noticed later.

I also noticed that my expectations were much lessened when having the second round of interviews. Engaging in visual methods somehow enabled me to take a much more open-minded position in which I mainly felt curious to see which drawings would emerge and what they meant. This time around, a challenge was to bracket the themes from the first round of interviews in order to keep the space open for any material, similar or different, to emerge. I engaged with this by actively avoiding making mental interpretation of the drawings, by simply noticing 'facts' such as colours used, patterns or shapes. I also found that having a second interview enabled a deeper understanding of participants' experiences, where themes previously identified were explored further but also where additional themes, such as around responsibility, emerged. Specifically, the use of drawings, being able to *see* aspects of participants' experiences, helped me foster more detailed and focused discussions on participants' experiences, in turn benefitting analysis by having a richer, more detailed understanding of participants' experiences.

Overall, having a gap between the two rounds of interviews during which I transcribed and analysed the first interviews was particularly helpful. This gap enabled me to gain an awareness of my assumptions and to bracket these for the following interviews, in turns benefitting the quality of analysis. My research project had evolved several times in a relatively brief time, from a focus on the impact of body therapies for trauma, to exploring the impact of a new, early, and brief bereavement intervention, to finally an exploration of counsellors' experiences of providing a new intervention. As I began developing and undertaking the present project on counsellors' experiences of a new, early, brief intervention, remains of an earlier wish to explore the impact of the intervention transpired in research decisions, particularly in the early stages of this research project, such as when developing the interview agenda. Having a gap between interviews was therefore beneficial in that I gradually immersed myself into a different research approach and focus. As such, by the time of the second part of my research (the second interviews and analysis), I was better embedded within my new research focus and aims, whereby my analysis was then

guided by the question ‘what is it like for participants’ rather than ‘how useful or impactful was that intervention’ which was present when developing the project.

9.2. **Personal reflexivity**

As I engaged with this project, reflected on the design, formed interview questions, and carried out the interviews and analysis, I aimed to notice and question my instinctual responses or reactions, as I wished to bracket my assumptions as much as possible, but also consider how my identity, personal experiences and values impacted the project regardless (Finlay & Gough, 2003; Guillemin & Gillam, 2004). Looking back to my choice of research focus and approach to enquiry, it is undeniable that the study could have taken many other shapes and forms with another researcher. For instance, I think my choice of focusing on counsellors’ experiences rather than service-users’ partly stemmed from practical reasons, but also from my personal experience of burnout during my training, and consequent sensitivity to the impact of the therapeutic work onto therapists’ wellbeing. Indeed, an ongoing theme for me throughout was around the emotional impact of working as a therapist and of hearing and being with clients’ distress. Other aspects of the work, such as the feelings of ‘not knowing’ or incompetence that can sometimes arise for a therapist were also themes that I was immersed in. These topics resonated with the new intervention in the context of Covid in that a new, therefore uncertain therapeutic approach was being developed in a wider context of not knowing and change. Another researcher with a different relationship to the profession and to the therapeutic work might have had a very different reaction to this intervention, perhaps less focused on the emotional challenges.

My identity as a trainee Counselling Psychologist also played a role in the dynamic between myself and my participants. On one hand, I felt that there was a commonality between participants and myself in as much as we shared a similar profession and within the same

organisation. On the other, I realised how much younger and inexperienced I was compared to my participants, and this felt discrepancy provoked a certain shyness and fear of being disapproved of by my participants. This manifested in hesitations throughout the interviews, a fear of saying the wrong word or of not conveying understanding, which I think conflicted with my researcher aim of minimising my influence over the data collection. As a result, I sometimes found myself paraphrasing participants in a wish to convey empathy when this could influence participants' narratives (Wetherell, 2005). Overall, my use of therapeutic skills such as active listening played a role in the interview dynamic, hopefully in conveying listening and empathy to participants, in turn encouraging them to reflect and share their experiences.

Additionally, as participants were colleagues at the charity I was myself volunteering at, I felt that there was comfort and trust between some participants and myself prior to the initial interviews. Some participants I had not met before. On one hand, I think having this pre-existing relationship perhaps helped them to feel comfortable to open up in the interviews. However, my being in the organisation may have also contributed to anxieties around power dynamics and confidentiality, perhaps making it more difficult for participants to comfortably decline participating in the research or making it more difficult to share some of the difficult aspects of their experience (Russo & Thompson, 2012). It may be that experiences shared could have differed if I had been completely independent from the charity. Similarly, recruiting a small number of participants known to each other within the same charity increased the risk of being identified by peers at the charity. This may have also influenced the experiences reported, as participants may have filtered their narrative to what they felt comfortable being identified by their peers as saying. In turn, when analysing, I felt the weight of wanting to accurately voice their experiences. It was important for me that if they were to read the results, that they would feel respected and represented. Consequently, I stayed very close to the language used when analysing and avoided interpretations which I could not adequately back up in the transcript. One advantage of

that anxiety perhaps was an increased attention to the quality of my analysis. However, I may have also limited my interpretations out of this concern.

Chapter 3: Findings

1. Overview

The analytical steps described in the previous chapter yielded three master themes: Adapting to a new intervention: experiences of challenge and opportunity, The shared reality of Covid-19: Novelty and familiarity towards a brief intervention and Being human: experiences of vulnerability in a time of isolation. A table displaying the master themes and subthemes can be found below (Figure 1). These master themes represent prevalent experiences shared by participants towards giving a new, early, brief intervention during Covid-19. These master themes and related subthemes will be explored in this chapter. Overall, aspects of the work which were highlighted as new included working over a very brief time (three sessions), working with clients who were very recently bereaved and working during Covid-19. Experiences of change and not knowing were conveyed and associated at times with adventure-like feelings of excitement, and at times with discomfort. Providing a new intervention in the context of the pandemic was associated with altered boundaries between the workspace and personal space, as well as increased isolation and vulnerability. Within this context, connection with the other counsellors providing the new intervention appeared to be increasingly needed as a source of safety and containment.

These themes emerged from my analysis of both the first and second interviews of each participant. I found that participants' narratives in their second interviews at times confirmed themes identified in their first interview and at other times supplemented or refined my understanding of their experiences. Participants' drawings will be included in this chapter. As discussed previously, the findings described below stem from my analysis of participants' interpretations of their drawings and not my own analysis of their drawings.

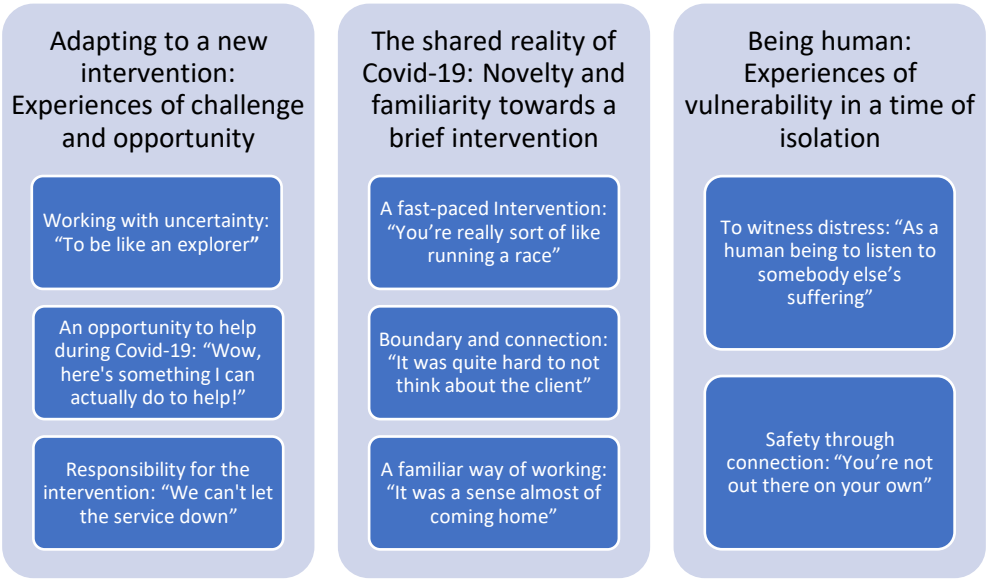

Figure 1: Master Themes and Subthemes

My analysis is a subjective interpretation and other researchers and perhaps the participants themselves would have presented different findings (Larkin et al., 2006). As I aimed to remain text-bound to be close to participants' experiences, associated quotes will be presented with each theme (Larkin et al., 2006). Some quotes will have been shortened in which case this will be indicated by […]. While doing so could alter meaning I aimed to maintain the essence of what participants were sharing. Non-verbal communication was noted in brackets. Hesitations were captured with "…" and words which were emphasised by participants were written in capital letters. Lastly, identifiable information including names have been changed for confidentiality purposes. Participants will be referred to as Jack, Dany, John and Sarah.

2. Master theme 1: Adapting to a new intervention: Experiences of challenge and opportunity

All participants evoked a process of exploring and adapting to this new intervention. As such, participants frequently referred to not knowing as an important aspect of their experience.

Specifically, the in-session work, such as the therapeutic process and out-of-session work, such as the admin and paperwork involved aspects which were not known or in formation. I noticed an overall movement from not knowing to knowing between the first and second interviews, as over time participants reported having a clearer sense of the intervention's aims and expectations and how to adapt their therapeutic work to this particular format. Within this context of being part of a new intervention, excitement, enthusiasm, nervosity and discomfort were expressed, and one participant communicated a feeling of responsibility towards clients and the service. Other participants referred to the context of adapting to a new intervention while they were themselves adapting to being in a world-wide pandemic.

2.1. Working with uncertainty: "To be like an explorer"

Most participants described an experience of becoming acquainted with a new intervention. The idea of something unknown is evoked in the interviews, as the nature and aims of the therapeutic work are explored. John reported:

"[…] everything was so unplanned and unformed at that stage. Um… that… I didn't know what the procedure was going to be. […] I'm being asked to do something new. So I don't even know if I can do it at that point. Um... and... I guess, yes, it did feel, it feel really experimental […]" (John: Interview 1, 18-30)

The breadth of what is not yet known is highlighted by the use of "everything". Similarly, "I don't even know" highlights uncertainty and unknown around the intervention, described as new, "experimental" as it was being developed to respond to the pandemic, which itself was new.

Similarly, in his second interview, John communicated his experience of doing something new:

"I was having to sort of be... like an explorer going to a part of the earth that's never been... discovered, you know it was- that's the way it felt." (John: Interview 2, 21)

"Like an explorer" conveys the idea of an adventure, which could imply excitement and adrenaline. This metaphor emphasises the unknown, as unchartered territories are explored. The verb 'discover' further suggests novelty and unknown as it indicates that what is explored was not found or uncovered before.

John further conveyed excitement or energy towards the uncertainties of providing a new, early, and time-limited intervention:

"Well, it was exciting! At the same time, I was... I was a bit nervous. Just because everything was so unplanned and unformed at that stage. […] It did make me nervous. […] the sort of nervous, where... um... it gives me energy and motivation." (John: Interview 1, 18-25)

"At the same time" suggests that John was experiencing a variety of feelings, from excitement to nervousness. John explains that his nervousness was associated with not knowing mentioned above. He goes on clarifying that this nervousness gave him "energy and motivation", that it wasn't depleting or negatively experienced. He later indicated that his excitement was about the opportunity to help others. It seems that "energy and motivation" stemmed from the challenges of working with the uncertainty of the new.

Exploration was also mentioned by Jack who expressed questioning and sense-making in relation to the intervention:

"None of us [counsellors] *was really prepared for it. […] there was a sense of exploration […]. So she* [the supervisor] *was exploring… just as... we were and not entirely sure, are we supposed just to hold? Are we supposed to just provide befriending or comforting? Can you really do counselling in three sessions?" (Jack: Interview 1, 417-430)*

Jack highlights the shared experience with colleagues, mentioning, "none of us" and the repeated use of "we" while referring to uncertainty. His process of making sense seems to include reflections around the therapeutic aims and the nature of the new intervention which is indicated by the questions. These questions suggest that Jack's experience involved a process of adapting his way of working to the needs and frame of this particular, new intervention.

Similarly to John, Jack communicated eagerness and enthusiasm towards providing the intervention, particularly around the fact that the intervention was new and therefore involved uncertainty or not knowing:

"I felt excited. […] But there is an energy to feeling... 'I need to achieve this and I need to achieve it on time'. […] And it was really exciting and thrilling […]. I love the unknown. I love learning. […] And for me, there's an excitement of discovery and of being comfortable being uncomfortable. What do we do here? I haven't a clue. […] And… that was exciting." (Jack: Interview 1, 128-458)

His enthusiasm is apparent in the repetition of "I love" associated with not knowing and to learning. Jack appears to express excitement for the challenges of providing a very different intervention. "I need to achieve this on time" echoes a requirement, a necessity. Out of context, "I haven't a clue" could evoke a challenging situation, but here this is associated with excitement. In fact, excitement is referred to three times within this extract, as well as "thrilling"

which communicates high energy. Overall, one could argue that this extract describes an experience similar to an adrenaline rush, which appears to have been provoked by not knowing and the challenges that the new intervention entails. This could suggest that providing this intervention was a challenging experience but that the challenge was meaningful and energising.

Dany also described an experience of making sense of a different, early, brief intervention, by defining the intervention's purpose and her role as counsellor:

"There were all kinds of discussions going on there about […] what we'll be offering. Was it counselling, was it support group, a support network. It was really just a holding space. I think that's what we established that it was just a holding space" (Dany: Interview 1, 42-43)

"all kinds of discussions" evokes a significant amount of exploration around the new intervention, which Dany specifies is about the nature of the work. The repetition of the question "was it?" evokes again a process of making sense, of defining the work. Dany finally concludes that "holding", containment was an agreed upon focus, aim for the new intervention.

The process of making sense of and getting acquainted to was not only mentioned around the nature of the work but also around the admin or procedures surrounding the new intervention. Jack reported:

"From an admin point of view. Like, do they [the clients] *want Zoom or do they want telephone? […] Um... so, all of that stuff at the beginning is a bit of a kerfuffle. Not getting used to each other but getting used to how we're going to do this." (Jack: Interview 2, 84-89)*

The question reflects a process of figuring out how the work will practically be carried out. “all of that stuff” suggests quantity, that there was a significant amount of details around admin that needed to be explored and clarified. “kerfuffle” suggests commotion, fighting which could indicate that this process may have been difficult.

He later added, referring to his drawing (Figure 2):

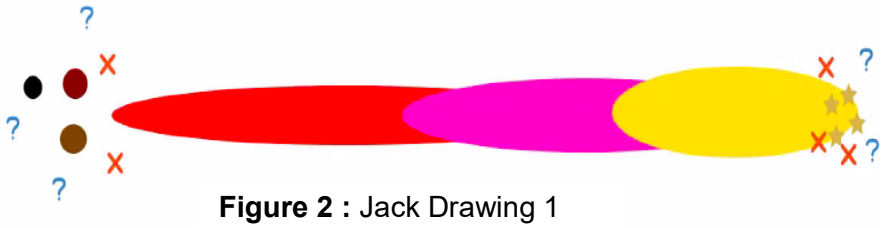

Figure 2 : Jack Drawing 1

“I mean the dark blobs or the question mark could be 'I think I've got the wrong email address here?'. […] So there was-there was just messy bits front and back.” (Jack: Interview 2: 146-152)

Again, a question is expressed which suggests uncertainty around practical aspects. “messy bits” again echo with “kerfuffle”, further communicating a feeling of disorder. However, “bits” indicates that the experienced mess was in small fragments or portions rather than representative of the overall experience of providing the new intervention. Finally, “front and back” suggests that these doubts or difficulties were surrounding the work rather than in the therapeutic work, as Jack separated the in-session work with clients, represented by the three coloured spheres, from the out-of-session procedures. This separation could indicate a dual process of adaptation: adaptation to the in-session therapeutic work, and to the surrounding administrative tasks and procedures.

Some participants appeared to link knowing and being familiar with to feeling grounded. As Jack reflected on the extent that was unknown and undefined, he commented:

"But, we were all kind of finding our feet together." (Jack: Interview 1, 432)

The phrase "finding our feet together" conveys a sense of shared "exploration", of investigating or uncovering something that is unclear and unknown. This expression also evokes a process of grounding and stabilising oneself within the new intervention, as their roles, aims as counsellor, the protocol, procedure, and nature of the work are explored.

Similarly, John reported:

[…] "In general, I feel much more NOW, like... I can feel the ground under my feet, I know what I'm doing it- from session to session." (John: Interview 2, 114-120)

In this second interview, John emphasises the shift since the time of the first interview, from getting acquainted with the work to feeling that he is familiarised with providing a very brief telephone intervention to individuals shortly bereaved. The "ground", which he "now" feels, which he is in contact with, could symbolise safety, stability which appears to have been found in the process of moving from not knowing to knowing.

Similarly, Jack suggests a link between having a ground to stand on and knowing, as he voices questions regarding his work:

"I can't operate happily in a vacuum without somebody looking at my work and either saying Jack that was rubbish, we need to talk or, um, that looks like a good job. So those are the question marks at the end. I'm kind of... it's a bit like the cartoon characters on the edge of the cliff, they're running running running running running and suddenly they realize they're on the edge of a cliff." (Jack: Interview 2, 167-168)

Here, Jack is talking about his experience of not having feedback on his work in providing the new, early and brief intervention and his wish that he had this. A “vacuum” indicates emptiness and aloneness associated with the lack of feedback. The need for feedback is reinforced by the verb “operate” which suggests that feedback is required to function within the counselling role. The cliff metaphor describes the image of someone running over emptiness, without a ground onto which to run, and this lack of ground appears to be linked to not knowing how good the work was.

Jack also commented:

“You know, it'd be nice to know, was it successful, wasn't it successful?” (Jack: Interview 2, 380)

Here, Jack shares his questions around the outcome of the new intervention and his wish to have an answer to those questions. Despite his overall experience and confidence in working in this format as explored later in this chapter, there seems to remain a feeling of uncertainty, a “vacuum” of information which impacted his experience of providing this new, early, brief intervention. While uncertainty around how to provide a very different intervention was associated with adventure-like excitement, uncertainty around how this new intervention impacted clients seems to have been experienced as difficult, an obstacle from being able to “operate happily”.

2.2. An opportunity to help during Covid-19: “Wow, here's something I can actually do to help!”

For some participants, their experience of providing this new intervention, developed to support people having lost a loved-one from Covid-19, was shaped by the pandemic, which brought about a loss of control in various ways. For example, John reported:

"[…] because we were in this situation of lockdown... […] everything had suddenly become very quiet and, and very still. […] And I guess there may be underneath it, there was a feeling that I wanted some, I wanted to be able to do something about it. And suddenly I was presented with an opportunity... to… to help people. […] Wow, here's something I can actually do to help!" (John: Interview 1, 34-43)

Here John describes working from home rather than at the service as a result of the pandemic, described as "quiet" and "still", evoking a lack of movement. "everything" and "all the time" indicate that the stillness is constant and in all aspects of life. Within this, he mentions a wish to take action, to respond to the situation by helping others. "Wow" and "opportunity" both evoke a positive response and positive feelings towards the new intervention which appears to offer the possibility to meet his need to take action within this context.

Similarly, Dany reported:

"[…] my immediate response was, yes, of course, I'll help because that's what we do in... That's my job. That's, I wanted to be... of help and I also particularly I wanted to be of help in this time or at that time, you know... it felt so... urgent to be doing something, um... of… of value." (Dany: Interview 1, 38-39).

Dany's wish to support others is emphasised by the repetition of "I wanted to be of help", as well as her response "immediate" and "of course" which indicate no hesitation in her decision to get involved in providing a new intervention tailored to Covid-19 related bereavements. Although Dany initially associates wanting to help to her identity as counsellor "that's my job", she then adds that this wish was specific to the context of the pandemic, in which she felt an urgency in responding.

Dany also evokes shared feelings of lack of control in the pandemic:

"And I think that's generally in the kind of field at the moment, isn't it, this, you know, the lack of control. […] So much less of, of control of anything." (Dany: Interview 1, 195-196)

"so much less of" highlights Dany's feeling that feeling of control has significantly decreased, while "anything" indicates that this loss of control applies to many areas of life. "Generally" and the use of "we", as well as "you know", seem to be an invitation to connect to the participant's narrative, echoing that this experience is shared and not individual to Dany.

2.3. Responsibility for the intervention: "We can't let the service down"

Jack conveyed a feeling of responsibility towards this new, early, and brief intervention, around making sure that the intervention had a positive impact on clients. For example, he reported:

"It's our job to... help the person, to relieve the suffering, relieve the pain, help them to see... that there are more options than they thought they were." (Jack: Interview 1, 49-50)

Here, Jack seems to be talking about his role as counsellor, as a professional providing emotional support. "help" and "relieve" are repeated twice, and both indicate a form of impact, the former meaning being of support and the latter meaning alleviating and soothing. "job" indicates duty or responsibility, in this case around helping clients with their emotional pain.

Similarly, Jack reported the following in his second interview:

Figure 3 : Jack Drawing 3

"I consider it part of my job... (Pause) Not really to bring light to them [the clients], *but... to, to help them to see that there is light." (Jack, Interview 2, 338-341)*

Referring to the drawing above (Figure 3), Jack reflects on his therapeutic role. He refers to putting the light forward or supporting clients to see some light, which arguably represents hope. Similarly, he later added:

"I'm the person sitting with the mouse... to do the drawings." (Jack: Interview 2, 349)

Here Jack positions himself outside of the drawing itself, behind the scenes, while the client is represented on the drawing. "to do the drawings" indicates a directive role, whereby Jack gives shape to the work, and as such, holds some responsibility for the outcome of the drawing or the work.

Jack also expressed feeling responsible for ensuring that this new, early, brief intervention would be helpful or have good outcomes:

"There was almost a sense of responsibility for, we can't let the service down. […] I think there was… responsibility on our shoulders for making sure this works." (Jack: Interview 1, 659-664)

The pronouns "we", "our" are used here when talking about feelings of responsibility, indicating that this experience was not only Jack's but perhaps shared by other counsellors involved in providing this new intervention. The weight of this responsibility is suggested by the expression "on our shoulders" which depicts a weight being carried. Similarly, "we can't"

communicates the idea of no alternative, no other choice but to make sure that the intervention "works". A sense of duty is evoked here, not only towards clients as has been the case in the above extracts, but here towards the organisation in which the counsellors were embedded.

The sense of responsibility towards the new intervention appears to have been accentuated by the intervention's brevity:

"[…] I need to achieve this and I need to achieve it on time. It is really important because there was no possibility to extend the three sessions. And therefore, it meant you have to do your job properly within three sessions. And… In a business-like way." (Jack: Interview 1, 130-133)

"time" is mentioned here as a factor which appears to increase the challenges in meeting his felt duty as counsellor. The repetition of "achieving" indeed suggests a double challenge, one of meeting his aims for the work and another in achieving those in the timeframe. This sense of duty is further emphasised by "really important", "no possibility" and "you have to" which highlights importance and the absence of other alternatives. Finally, "in a business-like way" could communicate a need to maintain a professional level of work despite the difficulties encountered such as the limited time allocated.

Similarly in his second interview, Jack appears to contrast his responsibilities in the work with the allocated sessions:

"And... we... need to... get used to each other, get to know each other. But we've only got three sessions so... I need to do it respectfully, I need to do it... not aggressively. Um... I need to do it, not in a hurried way. But I need to bring a certain energy..." (Jack: Interview 2, 51-55)

Here, Jack describes the early stages of providing the early, brief intervention which involves building a relationship with the client. The pronoun “we” is used as he speaks of the importance of establishing this therapeutic relationship in the allocated time. “But” suggests an opposition which in turn highlights the timeframe as an obstacle to the aim of establishing rapport. Within this tension, Jack repeats the verb “need” which communicates a necessity, paired with the pronoun “I”, which suggests that the weight of these duties rests on him. Overall, this extract suggests some of the difficulties that may have been experienced when providing this new and very brief intervention, of working with “a certain energy”, a certain pace, without rushing.

2.4. Summary

Overall, is seems that participants commonly experienced a process of making sense and getting acquainted with a new intervention that is brief and time constrained. Specifically, the nature of the work, how to work in three sessions over the telephone with recently bereaved individuals, the work’s aims, the counsellors’ roles and the procedures and protocols around the work were aspects which participants mentioned. Not knowing and the sense of having little time available appear to have been linked to a sense of discomfort and agitation whether that was anxiety, adrenaline or excitement. Meanwhile, knowing appears to have been associated with being grounded which suggests calm and confidence. Another aspect which appeared to be important to some participants was the context of being in a pandemic with associated changes to day-to-day life and uncertainty regarding the future, within which the intervention was viewed as an opportunity to be of help. Responsibility towards the outcome of a new intervention was also communicated, and it appears that this feeling was accentuated in the context of working over a very brief time.

3. Master theme 2: The shared reality of Covid-19: Novelty and familiarity towards a brief intervention

All participants emphasised how different this intervention was to the usual therapy previously provided at the service. One common difference which participants mentioned was the intervention's timeframe, of having to adapt to work in three sessions, as well as the rapid pace at which the intervention was delivered. Speed and urgency also related to being in the context of the pandemic in which a rapid response to the pandemic, through the rapid implementation of a different intervention was felt to be needed. Another theme mentioned by participants was the therapeutic relationship, forming and closing the relationship in a short amount of time, having sessions remotely and managing boundaries within the shared context of the pandemic. Despite these differences, participants who had prior experience of working on helplines shared a feeling of familiarity and confidence towards the intervention.

3.1. A fast-paced intervention: "You're really sort of like running a race"

Participants highlighted that the pace of the intervention was much quicker than the counselling typically provided. John evoked a feeling of urgency from this pace:

"[…] It-it was very immediate, so instead of hav- being allocated a client and then thinking about it, accepting them and it taking a few weeks until you start working with them, suddenly you're presented with a client and... you need to start working with them tomorrow. […] You feel like you're really sort of like running a race with it." (John: Interview 1, 114-120)

John emphasises the little time between allocation and the start of therapy by comparing the usual bereavement work to the intervention, a "few weeks" versus "immediate", "tomorrow"

which indicate no time or much less time. The imagery “like running a race” conveys urgency, the need to go quickly.

Similarly, Sarah reported:

“Non Covid-related clients […] there’ll be a gap between that assessment and when they see, um… a counsellor and that could be six to eight months. […] Whereas these clients they came through a system where they will be seeing their counsellor, um… within days […] It was almost like emergency medicine” (Sarah: Interview 1,145-149)

Again, “months” are compared to “days”, highlighting a different pace in this intervention. The expression “emergency medicine” evokes an urgent need, perhaps an accentuated need for providing quick care and support in the context of Covid-19, during which the number of deaths increased quickly. Urgency also appears to relate to the experience of providing the intervention shortly after individuals became bereaved, of accelerating the process between loss and access to bereavement support.

Referring to the pace of the work, John also evoked a rush and absence of time:

“[…] I was in reaction mode if you like. Yeah, I mean, you know, I really didn't, I didn't have time to sort of really think of what I was hoping for out of it.” (John: Interview 1, 137-140)

The expression “in reaction mode” highlights the fast pace of the work as John expresses the absence of time for thinking, for processing, indicating that it was a time of action, of responding to the situation of Covid-19. Within the interview, it also appears to relate to the fast pace with which the intervention was put in place, whereby there was little time to make sense of the intervention or form any expectations towards the intervention before starting to

provide it. The expression “reaction mode” could also be understood as describing a response to the quick unfolding of the pandemic, related infection rates, deaths, and social isolation policies. Within this context, it seems that counsellors felt that there was little time to think or make sense of the reality of the pandemic and instead felt an urge to respond quickly by supporting individuals bereaved from Covid-19.

This urgency is indeed also conveyed above, under master theme 1, subtheme 2, as participants reflected on their experience of opportunity to help by providing the intervention:

“*[…]* everything had suddenly become very quiet and, and very still.” (John: Interview 1, 38)

“And suddenly I was presented with an opportunity... to… to help people.” (John: Interview 1, 40-41)

“*[…]* it felt so... urgent to be doing something, um... of… of value” (Dany: Interview 1, 38-39).

The words “suddenly” and “urgent” suggest that as the pandemic came about rapidly, that similarly, supporting individuals bereaved from Covid-19 during the pandemic was experienced as pressing. It seems that urgency and suddenness were experienced within the wider context of the pandemic, and in turn, were experienced when providing a very rapid, brief intervention which they felt was needed.

Reflecting on the experience of working over three sessions in this new intervention, Jack expressed confidence and determination towards working over a shorter time:

“[…] you need to do something to make an impact on this person's life and mental health. Um... without the luxury of saying, well, I've got 10 weeks or I've got 12 weeks. […] I think

my attitude with the three, it's very much, okay, let's get down to business. […] But I know that we don't have time to lose." (Jack: Interview 1, 32-105)

The use of "luxury" presents time as a source of comfort. Time is also conveyed here as something that felt precious, important in this work: John's expressions "let's get down to business" and "don't have time to lose" both indicate that time was limited and not to be wasted in this new intervention.

Jack also reflected:

"I think it's important that clients feel… a sense of possibility, not a sense of 'Oh, it's going to take such a long time', um… 'three weeks isn't going to scratch the surface'. Of course it can." (Jack: Interview 1, 67-71)

The contrast between "Possibility", "Of course it can" and the reported doubts clients may hold highlights the opportunities that three sessions can offer. Time, as in the 10, 12 weeks of therapy typically offered which Jack refers to in the previous extract, therefore seems to be a luxury but one that is not necessary to be of help.

In contrast, John appeared to have had a different response towards the brevity of the new intervention:

"When you realize that, 'Ew, I've got two weeks, three sessions'. […] What I found I had to do was really work with myself, not to get caught up in the urgency of it." (John: Interview 1, 145)

The sound “Ew” here seemed to communicate uneasiness, evoking some discomfort around having to work within that timeframe, while “work with myself” indicates some need to adapt, that it is not immediately comfortable. Not “getting caught up” suggests a risk of getting trapped by the urgency, which highlights the initial discomfort with working in three sessions.

While time was evoked in terms of number of sessions in his first interview, in his second interview, John spoke of time as a subjective experience which depended on the therapeutic process with clients. For instance, he reported:

“[…] With some clients you- even three sessions can actually feel like a lifetime, because they- they can be in a very stuck place. […] some people, it might feel very slow and sort of like you're wading through mud. Um... Whereas with other people you're-you're sort of like walking down a, a, a proper road and that sort of thing.” (John: Interview 2, 47-83)

“lifetime” here suggests a long time and is associated with being “stuck” which indicates an inability to move. Similarly, he links “slow” with “wading through mud” which conveys discomfort at moving. This difficulty of movement is contrasted with “walking down (…) a proper road” which suggests movement, ease and effortlessness. Overall, “they”, “other people” and the image of the mud or road either impeding or enabling movement indicate that the subjective experience of time is shaped by external factors independent of the therapist, that time is experienced as fast or slow based on the movement experienced within the therapeutic work. The shift from referring to time as being very short or limited, to time being referred to as sometimes a “lifetime” could indicate increased familiarity and confidence with this pace of work.

3.2. Boundary and connection in the shared reality of Covid-19: "It was quite hard to not think about the client"

Participants reflected on the therapeutic relationship in the context of the new intervention's brevity. Changes in boundaries were also mentioned as a result of working remotely and in the context of Covid-19. Dany reported difficulty in maintaining the boundary between her personal space and the work:

"I think also, working at home, you know we're work- we're all working in our home space. […] And it's stepping over the threshold into my living space. And it's quite hard then to leave that stuff... behind. It's, it's, in fact is impossible because we are also lives, we're still in, in, living with Covid, and at that time, it was... it was... you know there were many deaths every day. Um... It's, it was quite hard to not think about the client. […] Really, really difficult to, um… to kind of bracket off." (Dany: Interview 1, 100-107)

Dany offers a depiction of a boundary being broken, and "it", the work, walking beyond that "threshold", a limit between the workspace and the "living space". As a consequence, Dany seems to have struggled to detach herself from the work which was provided to support those who had lost a loved one from Covid-19. This difficulty is highlighted by the word "impossible", "quite hard" and "really, really difficult". This difficulty is associated with constant reminders of the work as a result of "living with Covid" and hearing about the "many deaths". "Everyday" emphasises the prevalence of such reminders. "many deaths" also suggests that the threshold breached does not only pertain to the clinical work because of working from home, but perhaps also to death becoming a constant presence, both through the bereavement intervention, and because "we're still […] living with Covid" which involved "many deaths everyday". Perhaps the increased difficulty with boundaries in the clinical work was therefore both about working from one's home, but also a result of death becoming a common theme within the work but

also in Dany's personal life whereby she was also exposed to the threat of death and loss from Covid-19. Consequently, it seems that personal experiences of the pandemic became reminders of the clinical work while the clinical work may have been reminders of the pandemic in Dany's personal life. As a result, home, which once may have been a separate and safe space, may have no longer been experienced as shelter because exposed to the clinical work which echoed the threats of living during the pandemic.

John also spoke of the shared context between client and counsellor in this intervention:

"[…] with most clients they would want to have a conversation about, 'oh, so how are you coping with it?' […] And maybe I need to... also be thinking much more consciously about how flexible I can be with things like... like boundaries of information, um... You know... can I talk about... what it's like just to go out of the house at the moment." (John: Interview 1, 322-332).

John mentions "most clients", highlighting the prevalence and challenges of clients' questions around his experiences of the pandemic, resulting from counsellor and client being in the shared context of Covid-19. This extract suggests that being in the shared context of Covid-19 impacted the experience of boundaries when providing the intervention, here around navigating self-disclosure with clients. John indeed appears to have undergone a process of reflection around the boundaries, self-disclosure, and adapting those to the current circumstances, reflected by the questions he asked himself.

When reflecting on what it felt like to have clients ask about his experience of the pandemic, John reported:

"I just, all, all I did was, was basically, well, what I usually do. (Laughing). […] the way I dealt with it was just thinking, 'ok, I have to be aware of this'." (John: Interview 1, 326-329)

"usually" indicates that John's experience of being confronted with issues of self-disclosure in the context of this new intervention was similar to any other experience of self-disclosure in other interventions, pre-pandemic. The use of "just", "all", "basically" also communicates ease and confidence in responding to clients' questions. John laughs in this extract, which perhaps could indicate a certain discomfort despite the ease suggested here.

Connection was also explored when discussing the relationship between therapist and client in the new, early, brief intervention. Reflecting on her drawing below (Figure 4), Sarah commented:

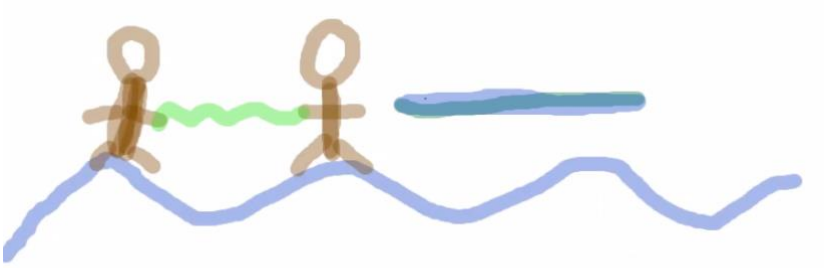

Figure 4: Sarah Drawing 2

"We're on two different places, but we're trying to get to a level playing field or a level ground, um, which offers safety and maybe a foundation to go from, rather than be on the, you know, sort of the waves […]." (Sarah: Interview 2, 124-126)

The repetition of "we" communicates a unity between Sarah and her clients, as she describes the therapeutic process of providing a sense of "safety" for clients, in moving from the unstable, threatening "waves" to a stable and reliable "level ground".

"[…] I wanted to symbolise there is a distance, initially, and um, but there's a connection." (Sarah: Interview 2, 168-169)

"[…] and also accepting that there was a link between us, and that link said 'I'm ready for you. I'm able to, um, support you […]." (Sarah: Interview 2, 147-142)

"[…] by recognising and offering them, um, a commonality that we're ALL in this together, that it's not just you, um, but not taking away their power, but actually saying, 'I'm here for you too, and the service is here, and that we're a- we're in this together'". (Sarah: Interview 2: 158-160)

Similarly, in the above extracts, Sarah evokes connection between herself and clients, indicated by the words "connection", "commonality" and the repetition of "link" and of "together". Sarah also repeats the verb "here" which communicates presence. There seems to be a dual connection experienced by Sarah in the work. One seems to be a connection via the therapeutic relationship, as indicated by the initial distance described, which could be understood as the initial encounter between client and therapist, at which point a relationship has not been yet formed. Within the context of the pandemic, a second source or type of connection appears to have been experienced around being in the shared context of Covid-19 which connects client and therapist. This is indicated by the expression "we are ALL in this together" in which "all" is emphasised, highlighting the shared reality of Covid-19. Connection here seems to have a healing function, particularly in times of distress and instability.

John similarly reflected on emotional connection within the new, early, brief intervention:

"I do think that I have to... put my heart and my emotions into the work. […] So I really think that I have to listen, both with my brain and my heart to, to what's being said." (John: Interview 2, 138-146)

The repetition of “heart” and the word “emotions” suggests vulnerability and personal commitment in working with clients. John seems to be evoking a dual process of being with, of connecting with clients, using both his “brain”, which perhaps symbolises the objective, professional, perhaps more detached aspect of the work and his “heart” which could symbolise the personal, emotional involvement of the self in the work. Within the interview, he explains that this emotional connection was particularly important when providing this new intervention because clients who were seen very soon after their loss presented with very painful and raw material. This could indicate that for John, forming a connection with clients in this new intervention required further emotional presence because of the rawness of the grief when working with someone very recently bereaved rather than at least six months post-loss as was previously the case.

He also commented:

“One of the things that that actually I wasn't expecting when we started doing this was... How quickly some clients and it is only some, but how quickly with some clients, you can get very deep into, into a relationship of trust. […] it's a very short period for someone to actually just say no, I'm gonna trust you completely and pour their hearts out to you”. (John: Interview 2, 190-194)

John refers to his experience of building a strong therapeutic relationship within this new intervention, and his surprise in doing so in “a very short period”. He indicates that these relationships are characterised by “trust” which is repeated, suggesting confidence and safety. The expressions “very deep” and “pour their hearts out to you” reinforces the trust and strength of the relationship. Both client and therapist seem to bring vulnerability and emotion to the therapeutic encounter in this new intervention. His surprise at the speed at which the therapeutic relationship was formed could be indicative that John may have previously experienced that more time was needed to form a connection. This would therefore suggest

that, for John, the experience of providing this new, very brief intervention entailed forming a deep connection with clients very rapidly, perhaps more rapidly than usual.

3.3. A familiar way of working: "It was a sense almost of coming home"

Despite the differences of the new intervention, some also evoked familiarity in working over the phone, and short-term. This was reported by participants who had previous work experiences that they felt prepared them for this intervention's format. For instance, Jack explained:

"[…] for me, it was a sense almost of coming home. Because I've done [x helpline] for quite a lot of years. And… you just don't get a second chance. So… this was very much like that."

(Jack: Interview 1, 34-37)

"coming home" strongly conveys familiarity and comfort which Jack associates to previous experiences. He likens his helpline experience to this new intervention, highlighting the limited time: "you don't get a second chance", which suggests the need to make use of the time allocated. It seems that Jack was familiar with working in such a short timeframe, with the associated pressures and challenges that can result. This can be suggested by the contrast between "coming home" which conveys confidence and pleasure and "you don't get a second chance" which emphasises urgency and the risk of not being able to use this time usefully. Here, it seems to indicate that there may have been something meaningful or energising about working in a way that is not easy and that contains its set of challenges. He later added:

"It's almost like coming full circle at the service to what I really enjoy doing and feel I'm best at doing." (Jack: Interview 1, 618)

“Full circle” here can be interpreted as a cycle being completed, coming back to the starting point, to a way of working very similar to how he worked at an earlier time. “enjoy” and “best” indicate ease, confidence and pleasure from that way of working.

Similarly, Sarah reported:

“[…] it was almost a natural progression, […] um... it was normal progressing from what I, what I’d do” (Sarah: Interview 1, 25-27)

Sarah employs “natural” and “normal”, both indicating familiarity. A “natural progression” conveys that her experience of adapting to the new intervention was unforced, it was not difficult, that it was a smooth continuation from her previous work.

She later added:

“Because I’ve got the five years previous experience of intensity that you do get on that first call, I was actually prepared for it”. (Sarah: Interview 1, 92)

Referring back to her experience of working on helplines, Sarah expressed a sense of preparation, readiness, of having the tools to take part in this brief and early intervention.

She similarly spoke of feeling prepared and motivated to offer this new intervention in her second interview, as she reflected on her drawing (Figure 5):

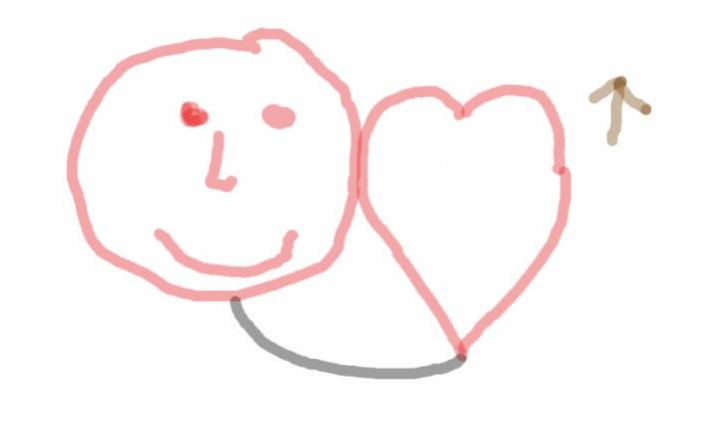

Figure 5: Sarah Drawing 1

"[…] I felt, um… that the-the-the early intervention was something that I was well practiced in, and I knew about it, I'd experienced it, um… as a counsellor, and, um… practitioner. So I was happy to, um… continue the work, and I suppose, really, it connects me, um… something that I was, um… very well versed in and I'd been trying to introduce it to the service […]." (Sarah: Interview 2, 38-42)

The use of the verbs "practiced", "knew", "experienced" and "versed" all suggest knowledge, readiness and confidence which, as said above, is linked to her previous experiences. "So" links Sarah's happiness to her past experiences, to her readiness to partake in the work, which emphasises the connection between her familiarity with this type of work, her confidence and her enjoyment of the work.

Referring to her drawing (Figure 5 above), Sarah further conveyed enjoyment, excitement, and confidence towards providing a very brief telephone intervention, a format that she was "well practiced in":

"So, I was quite pleased, I was very happy, I love my work, and, to me it was an upward move, both in terms of… um… providing the service, being part of the, um… process and the journey, and really this is my personal experience, so, the line, the curved line, just connected, um… my love of the work that I was doing, and, I suppose that's my face being happy, and the arrow it's upward and forward, yeah?" (Sarah: Interview 2, 43-48)

Being able to work in this way appears to be linked to positive feelings such as happiness, as indicated by the intensification of emotions, from “quite pleased” to “very happy”. She also speaks of feeling connected, of what seems to be a connection between feeling happy and being able to do the job she loves. Finally, she speaks of moving “upwards” and “forwards” when referring to the new intervention, suggesting improvement, progress, in turn highlighting Sarah’s experience of belonging and confidence towards this intervention. However, she comments that this experience may not be shared by others and highlights that this is her “personal experience”.

3.4. Summary

Overall, participants explored how different this way of working felt from the previous therapy offered. A sense of urgency, of having no time to lose was identified in the context of providing a very brief intervention but also within the quick unfolding of Covid-19. Similarly, participants explored the therapeutic relationship within the context of a new intervention which was very brief and provided very soon after clients’ loss, in the context of working from home and of being in the shared context of Covid-19. Specifically, broken boundaries seemed to have been experienced whereby the threat of death became prominent within counsellors’ personal spaces and daily lives, and as the clinical work and the reality of living during Covid-19 echoed each other. Emotional connection also appears to have been experienced as deep and fast-developing within the work and this seems to have been associated with the shared reality of Covid-19 but also to working with very raw emotions of recently bereaved clients. Despite these new challenges around boundaries and connection, this work felt familiar to some due to previous experiences of working over the phone and short-term. Ease and confidence were indeed expressed towards working over the phone, over a very brief time and with clients presenting with strong and raw emotions. Nonetheless, providing this new intervention was associated with a set of new, previously unencountered challenges around working in the

shared context of Covid-19 with changes to boundaries between client and therapist, between work and personal life.

4. Master theme 3: Being human: Experiences of vulnerability in a time of isolation

A difference in the new intervention was that clients were seen at times days after having lost a loved one from Covid-19. Participants reflected on their experience of witnessing clients' distress. Some participants described difficult feelings around witnessing their clients' pain, particularly in the context of working from home, while others reported confidence and meaningfulness from providing a needed intervention in times of crisis. Finally, participants reflected on the importance of receiving support themselves and feeling connected with one another.

4.1. To witness distress: "As a human being to listen to somebody else's suffering"

Dany and Sarah reflected on the distress clients brought to sessions in this early intervention in which clients were recently bereaved. As mentioned above, Dany reported struggling with maintaining a boundary between the client material and her personal space. This is revisited here, as she mentions the clients' helplessness, in terms of her own:

"[…] the helplessness. I think that came up a lot, for, I think, all of the clients. […] I think sometimes helplessness on my part also, I know most... Um... Most of the clients talked about their helplessness, but mine was... I couldn't help them I, you know." (Dany: Interview 1, 194-301)

Dany refers to the clients' helplessness but then highlights the strength of her own helplessness which she experienced when witnessing clients' pain. This is highlighted by "but

mine was…", "I couldn't help them" which convey powerlessness, witnessing suffering but feeling unable to do anything about it.

Dany also evokes her experience of holding clients' distress from home:

"[…] but actually at home it's really difficult. And when... you know you've got your family around it's... not able to say anything." (Dany: Interview 1, 102-103)

This suggests that the context of working from home intensified her experience. She mentions the presence of family members but "not able to say anything", which evokes a sense of loneliness, of having to keep the client material to herself. Perhaps, this loneliness, not being able "to say anything" stemmed in part from being isolated from colleagues while working remotely. "And" arguably connects "it's really difficult" to "you've got your family around", suggesting that being around family while providing the work contributed to the challenges of providing this new intervention from home. Dany may have experienced keeping the material to herself because of confidentiality but it may have also stemmed from a wish to protect her family, her personal space discussed earlier, from the intervention which highlighted or echoed the threat of loss and death during Covid-19.

Similarly, Sarah evoked helplessness when witnessing clients' emotions when she reported:

"[…] without exception, without exception Johanna, the first session was so distressing. […] as a human being to listen to somebody else's suffering. It did impact me. It made me feel that, um… it was outside of my skill level" (Sarah: Interview 1, 73-93)

The repetition of "without exception" and the use of "so" before distressing highlight the intensity of emotions encountered in the work. "outside my skill level" evokes her

helplessness, powerlessness in the face of clients emotions. She describes her experience "as a human being", and not as a counsellor, highlighting vulnerability. In this extract, Sarah mentions my name, which perhaps was an invitation to connect to her experience, or perhaps was a way to call my attention to the level of distress, to the level of emotions experienced when supporting clients who were very recently bereaved.

Reflecting on his second drawing (Figure 6), Jack expressed his confidence in being with clients' pain which he associated with having had some positive feedback from previous clients:

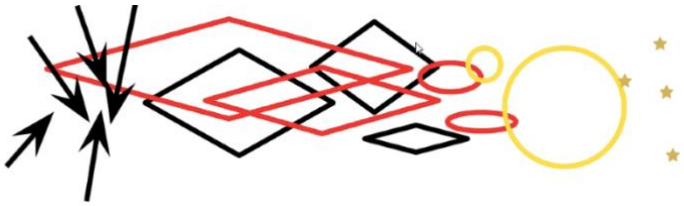

Figure 6: Jack Drawing 2

"[…] Yeah I think I know what I'm doing here. Every- every person is going to be totally different, of course. But... my attitude is still 'it's gonna be okay'. […] Being able to hold all of this and move it towards what I know […]." (Jack: Interview 2, 262-272)

Reflecting on working with clients' distress, Jack evokes confidence through his use of "I know" which suggests certainty and familiarity. Similarly, the verb tense in "it's gonna be okay" indicates confidence about the future, perhaps about the clients' future or about the upcoming therapeutic work. "All of this" here refers to the rectangular shapes which Jack explained symbolise the clients' pain when in their first session. He communicates being able to "hold", to contain clients' feelings with the help of what he knows. In the interview, it seems that what is known stems from having had previous clients who have provided positive feedback about elements of this early, brief intervention which were helpful. This knowledge seems to have

given Jack the confidence to contain and be with future clients' emotions when providing this new intervention.

In his second interview, John reflected on his experience of witnessing high levels of distress when providing the new early, brief intervention. He seemed to communicate excitement and inspiration:

"I'm actually fine with it. Um, it's, because, it's, it's, I mean that's what- yes it's painful but it's also very stimulating. […] There's something about it that feels so important and so... VITAL and ALIVE. And... I think that's what I respond to." (John: Interview 2, 158-162)

The words "stimulating" and "alive" both suggest energy, motivation while "important" and "vital" communicate a necessity. It seems that the work, supporting people who are distressed, and particularly supporting people impacted by Covid-19, although "painful", was experienced as meaningful and important and therefore source of energy, excitement and motivation. As was suggested earlier, it may be that the meaningfulness of the work provided here related to the context of being in a worldwide pandemic within which providing the intervention was viewed as a way of taking action by helping others impacted by Covid-19. The energy of being part of something significant seems to have countered the potential difficulties in witnessing other people's distress.

4.2. Safety through connection: "You're not out there on your own"

Most participants reflected on the importance of receiving support from different sources while providing this new intervention. One source of support mentioned was group supervision. John reported:

"[…] supervision sessions, just for the people, just for the counsellors doing the early intervention work. That, that really did help because suddenly... […] You're actually with people who know what it's like to be in the situation you're all in. […] So the difference it made was […] that I would end up thinking something new about it, 'Oh, maybe I could do that with this client'" (John: Interview 1, 243-265)

John highlights that being with other counsellors similarly involved in providing the new intervention was particularly helpful, emphasised by "really did". He specifies that having a space with individuals who were also providing the same new intervention from home during Covid-19, who therefore had a shared understanding, a common experience, was helpful and supportive. This also reinforces the idea that providing this new intervention during Covid-19 may have felt very different from providing the usual bereavement counselling, and therefore required a supportive space specifically for those providing the new intervention. "People who know" evokes a sense of community. The use of "people", rather than, say, 'counsellors', arguably echoes human connection which appears to have been needed, specifically with people who knew what it was like to provide the intervention, who shared this experience. John adds that the space enabled him to think about the work and to form different ideas, perhaps because this space enabled counsellors to share their experiences of providing this new intervention and to share ways to manage these.

Similarly, Sarah reported:

"[…] without supervision, this work would have been, I think, near impossible. Because we formed a really strong group... and the supervisor was there to guide, listen, teach, um... respond. And it was a place to bring any of our fears any, of, anything that might have impacted us […]." (Sarah: Interview 1, 247-248)

The importance of supervision to Sarah is evoked by “near impossible”, suggesting that providing the new, early, brief intervention would not be possible without this support. Like John, she evokes the value of a “group”, a sense of community, of connection, emphasised by “really strong”. The list of verbs “guide, listen…”, as well as the use of “any” and “anything”, conveys the scope of support received in group supervision. “Fears” indicates that this was also a space for emotional support, where Sarah felt she could take difficult emotions. The verb “guide” suggests that guidance, information, advice may have been another form of support experienced through supervision, particularly when providing a new intervention which entailed uncertainty and not knowing.

In her second interview, Sarah further spoke of the value of connection through supervision. Reflecting on her third drawing (Figure 7), she commented:

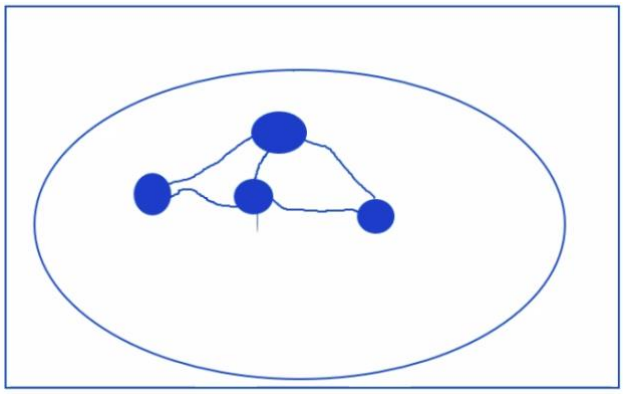

Figure 7: Sarah Drawing 3

“[…] you’re not out there on your own, trying to do something, there is a structure around you and th- that structure keeps you safe (Pause) as a therapist, yeah. And as a human being. And as a… you know (laughing), as an individual.”

(Sarah: Interview 2, 478-480)

Here, Sarah reflected on her experience of support while providing the new intervention. She explained that the outer rectangle represented the service and the wide sphere represented supervision while the smaller spheres symbolised the supervisor and her peers, each connected by the lines. Sarah speaks of a “structure” which here may be either or both the rectangle (the service) and the sphere (supervision) which contains and keeps her safe. This idea of safety can suggest that there is a potential danger within the work. She also suggests that the service and supervision do not only offer containment, but also connection and

protection from isolation or from being “out there on your own”. Again, as above, it is specifically connection with the other counsellors and with the service who are involved in providing the new intervention, who know what it is like, who can understand, that is highlighted as necessary and supportive. She also mentions different levels of self within the work, that of “therapist” which suggests the professional, of “human being” and finally “as an individual”, which both convey vulnerability, and as a result highlight the need for connection and protection.

She further commented:

“[…] Being a human being, you know, some things that would’ve impacted on us, um… it was very important to have a space to talk about, um… what might have impacted, um… and-and sharing our experiences as well. And know- knowing that we had a safe confidential space to do that in was very important for me.” (Sarah: Interview 2, 374-378)

Again, Sarah evokes vulnerability here with “human being” and the repetition of “impacted” which highlight vulnerability, in turn reinforcing the importance of receiving adequate support when providing this intervention. Indeed, safety is mentioned here again and paired with the word “important” which further highlights the need for support and protection. It may be that the increased vulnerability and need for support here were related to working in the context of the pandemic, of working from home, with blurred boundaries between the personal and work space. Increased isolation from peers may have also meant less opportunity to safely process the experience of providing this intervention. In this context, having a supervision group only for the counsellors providing the new intervention appears to have been viewed as a “safe confidential space” in which the experiences of providing the intervention could be discussed and processed together.

Sarah further highlighted the importance of feeling connected and connection as a source of support while providing this intervention:

"But the basis of it was a connectivity, um… to… to her [the supervisor] *and to one another* [counsellors]. *Um… I felt it was really needed, that network, was very, um… essential… or important to my work." (Sarah: Interview 2: 349-351)*

Prior to this segment, Sarah explains that supervision was helpful to think clinically and share ideas, but then emphasises that the most important aspect, "the basis" of supervision was feeling connected and not alone. The value of that sense of connection and of community is emphasised by "needed", "essential" and "important" which convey necessity, suggesting that the provision of the new, early, brief intervention could not have been carried out without this structure.

Meanwhile, Dany reflected on the importance of self-care in addition to supervision and how she maintained and adapted self-care practices to the new intervention and current context:

"[…] I do think a lot about self-care now, particularly as, as we work from home, we're working remotely. And although we all have supervision, which is really valuable. We are still very much, you know... in our own spaces with our client material. […] It's very much... been a focus of mine, since I suppose since the pandemic. But really, since I started, well, or after I started working with Covid clients." (Dany: Interview 1, 134-140)

Dany highlights the need for self-care in the context of the pandemic and remote working, "but", "really" then indicates that this need for self-care further increased once having started providing the new intervention. She briefly mentions the support of supervision but seems to indicate that this was not enough in the context of Covid-19, when working from home, "in our

own spaces". The physical isolation evoked by "our own" followed by "client material" suggests a sense of loneliness, of holding emotional material alone at home.

4.3. Summary

Overall, participants reflected on their experience of working with distressed, very recently bereaved clients, in the context of Covid-19, as well as on the importance of support and connections via group supervision and self-care. One theme that stood out was around witnessing clients' pain within the work. This was associated with helplessness and loneliness in the context of working from home, in the shared context of Covid-19 and associated blurred boundaries. Difficulties around witnessing clients' distress also appears to have stemmed from client and counsellor sharing the same context of the pandemic, whereby the clinical work would remind of the threats of Covid-19 onto one's personal life. Having had previous experiences and positive feedback from clients seemed to provide confidence in holding and being with clients' pain. The meaningfulness associated with providing the new intervention seems to have also been a source of motivation and resilience towards the challenges of the work. Support was also emphasised as necessary. Most participants spoke of supervision as a space to connect with individuals who shared similar experiences, that could relate and understand what it was like to provide the new intervention. The supervisory space appears to have offered counsellors a space to discuss, reflect and process, and therefore provided protection from potential feelings of loneliness and isolation while providing the new intervention. Self-care was also mentioned as increasingly required in addition to supervision, as the context of working remotely within a pandemic appears to have heightened the emotional challenges that therapeutic work can have for therapists.

5. Summary of findings

Across the themes identified, I observed that participants spoke of the self in terms of the human being self rather than the professional counsellor self, which, as a result, emphasised the challenges, the vulnerability, and the emotions experienced while providing a new, early, and brief intervention. A shared human experience was conveyed at a wider societal level, in which counsellors and clients both were adapting to a worldwide pandemic, to social isolation and to remote work. It was also conveyed at a professional or peer level, as participants adapted and learnt to offer this new intervention together with their colleagues. Shared humanity was also conveyed when participants explored the in-session work, as what was emphasised was the pain and distress clients were in when they began the work, the therapists' experiences of witnessing and staying with these intense feelings and their experiences of the therapeutic relationship.

Within a context of change and uncertainty, togetherness and connection were mentioned and appeared to be linked to safety and containment. I also felt that a need for connection with their colleagues and peers was communicated, specifically with colleagues who were also providing the new intervention, perhaps because working from home and working on a new intervention in the context of Covid-19 increased potential feelings of isolation and vulnerability.

I also observed a tension between knowing and not knowing, in that not knowing was at times associated with excitement and motivation and at other times a source of discomfort or difficulty. Having previous experiences seemed important for counsellors to have a positive experience of providing the new intervention, to feel confident and grounded. On the other hand, the novelty and uncertainty, for some, were associated with energy and excitement as there seemed to be something energising about the challenges of working in a new way, and in providing an intervention that felt meaningful in the context of Covid-19. A sense of

adventure was conveyed as I analysed the interviews, with its associated excitement and challenges. Overall, it seems that all participants were driven by a wish to be of help to others in unsettled times.

Specifically, some of the prominent experiences of providing this new intervention included: uncertainty around providing a new intervention, which was associated with excitement and discomfort; meaningfulness around providing an intervention supporting others impacted by Covid-19; a sense of urgency both around responding to the impact of the pandemic and because of the brief nature of the work; broken boundaries from working from home and from having a shared reality with clients in which the clinical material and counsellors' personal experiences of the pandemic echoed each other; witnessing particularly heightened distress given that the intervention was provided soon after the loss; and the need for group supervision, for connection with other counsellors providing the new intervention, for a safe and containing space with others who shared similar experiences.

Chapter 4 : Discussion

1. Overview

The previous chapter (Chapter 3) used IPA to explore counsellors' lived experiences of providing a new, brief, and early intervention during Covid-19. Analysis suggested that uncertainty around the intervention's procedures and around counsellors' roles and aims was a prominent experience of providing this intervention, particularly around the fast pace and early nature of the work, and this was associated with adventure-like excitement and nervosity. Importantly, analysis suggested that the experience of providing this new intervention was shaped by the context of Covid-19. Providing a new intervention tailored to pandemic-related needs was associated with experiences of meaningfulness, a sense of responsibility and urgency in providing support to others impacted by Covid-19, and this seems to have provided counsellors energy and resilience towards the challenges of the work. Within the context of Covid-19, increased vulnerability was also communicated as boundaries changed, whereby the clinical work echoed counsellors' reality of living with Covid-19, while the context of the pandemic became a constant reminder of the clinical work. Within the challenges of providing a new intervention in the context of Covid-19, counsellors expressed the need for connection with colleagues who were also delivering this new intervention. Similarly, connection was discussed in the therapeutic relationship, as counsellors experienced therapeutic relationships being built very rapidly. Connection here appears to have stemmed both from the counsellors-client relationship but also from having a common reality of living with Covid-19, with the uncertainties, changes, and threats that it entailed.

To the author's knowledge, this is the first piece of research which explored counsellors' lived experiences of providing a new intervention during Covid-19. The findings particularly highlight the impact of working in the context of a traumatic reality shared with clients. While this

concept has been explored in different contexts such as war, shared traumatic reality (STR) has not been looked at, or highlighted in current research on therapists' experiences of work during the pandemic. Counselling Psychologists hold important leadership roles including management, training, consultancy, and supervisory positions. As such, the above findings could inform such Counselling Psychologists of themes that may arise for practitioners they manage, supervise, train, in the context of working during the pandemic, future pandemics or other community-wide crises such as natural disasters, and when providing new interventions. The field of Counselling Psychology strives for continuous development, and as such it would be expected that new interventions will be developed, and that Counselling Psychologists will be learning new therapeutic approaches, as part of their training or professional development. Awareness of experiences associated with providing new interventions is therefore warranted for ensuring quality, safe and supportive delivery of new or unfamiliar interventions.

This chapter will begin by discussing the master themes identified in the context of the literature review explored earlier (see Chapter 1). Similarities, differences or gaps between this study's findings and the literature will be looked at. Finally, the study's strengths and limitations will be discussed and implications for practice, and for the field of Counselling Psychology will be explored.

2. Findings and the literature

2.1. Master theme 1: Adapting to a new intervention: Experiences of challenge and opportunity

The experience of providing a new intervention entailed feelings of uncertainty and not knowing as participants had to adapt to different aims and procedures. This uncertainty was associated with experiences of challenge, excitement and to a sense of adventure around doing something different. Energy and motivation towards providing this new intervention was

also expressed around doing something which felt needed and therefore meaningful in the context of Covid-19. In fact, times where participants expressed discomfort or difficulty around uncertainty was either when that uncertainty pertained to the out-of-session, practical elements of providing the work, or when it pertained to how the work impacted clients, or in other words, when the intervention's helpfulness was undermined by either practical procedures or by uncertainties around outcome. Responsibility towards ensuring that the intervention was successful was also expressed, and this seems to have been enhanced by the intervention being new and very brief.

This study was interested in exploring counsellors' lived experiences of providing a new, early, and brief intervention during Covid-19. Findings suggested that adapting to a new, early, and brief intervention has included a process of reflecting on and redefining aims and purposes of the work and therapists' roles, a process which was experienced as challenging, uncertain, anxiety-provoking, exciting and energising. Similarly, Menichetti Delor et al.'s (2021) study indicated that psychologists involved in a different intervention which involved follow-up phone call to families who had recently lost a loved one from Covid-19 underwent a process of adapting their roles and aims to that specific intervention, to the context and time since the loss. Change and adaptation have also been hinted at by other studies on practitioners' experiences of working during the pandemic, including around adapting to working remotely rather than face-to-face, as suggested in Reilly et al.'s (2020) survey. Other surveys distributed during Covid-19 have also reported practitioners' experiences of changes in service procedures, in treatment or interventions offered and roles and expectations have been reported as undefined during the pandemic (BPS, 2020; Liberati et al., 2021). It seems that the pandemic has involved change for practitioners broadly, as they have adapted to the changing needs, whether or not they were involved in new interventions. A main gap in the literature identified was that those studies were mainly using surveys, limiting an in-depth exploration of practitioners' experiences, while Menichetti Delor et al.'s (2021) study did not enquire about psychologists' experiences but perceptions of the work. The present study's

use of IPA offered a deeper enquiry into participants' lived experiences of uncertainty, change and adaptation. A finding from this study which was not suggested by previous research is that uncertainty here appears to have been experienced as something both exciting and challenging, particularly in the context of Covid-19 in which this intervention was viewed by the therapists as meaningful because it was an opportunity to help others impacted by the pandemic. Uncertainty from providing a new intervention therefore seemed to have been experienced as exciting when it was around the in-session work, around helping others impacted by Covid-19, but experienced as anxiety-provoking when around the out-of-session practicalities or around not knowing what the impact of the work was.

The literature suggested a mixed picture of what it might be like for practitioners to be working during the Covid-19 pandemic, with some research indicating that practitioners may be experiencing difficulties while others suggested that the transition may be going well. For instance, surveys carried out during the pandemic have suggested that therapists have been experiencing increased stress, feeling overwhelmed, vicarious trauma, professional self-doubt as well as decreased wellbeing and self-reported quality of work (Aafjes-van Doorn et al., 2021; Bentham et al., 2021; BPS, 2020; Probst et al., 2020). In contrast, in this study, participants did not seem to be significantly negatively impacted by their experience of not knowing or of role or procedure ambiguity which was part of the process of adapting and getting acquainted to a new way of working. Previous studies have recruited in the early days of the pandemic and perhaps difficult or negative experiences reflected the stressors of the early stages of Covid-19. In this study, participants were interviewed in October 2020 and April 2021, some time after the first lockdown. Perhaps different experiences would have been captured if participants had been interviewed in the very early days of providing the intervention. Probst et al.'s (2020) study suggested that stressors experienced by practitioners are not necessarily related to the experiences of the therapeutic work during Covid-19 nor to the experiences of remote therapy, but to other aspects of participants' lives, such as concerns around the safety of loved ones or financial concerns. If indeed stressors during Covid-19 for

therapists revolve mostly around personal experiences rather than professional ones, then perhaps experiences in this study did not reflect the difficulties reported in other quantitative studies, as the enquiry was around work-related experiences, rather than personal life experiences. Similarly, qualitative studies enquiring about therapists' experiences of working remotely or/and working during the pandemic have also indicated challenges, such as tiredness, increased anxiety, uncertainty, adapting the admin tasks to remote working, increased isolation, technological difficulties and lack of interpersonal cues (Eppler, 2021; MacMullin et al., 2020; McBeath et al., 2020; Shklarski et al., 2021). These different qualitative studies also reported positive experiences that appeared to counteract the difficulties, such as opportunity and gratitude for being able to use technology to continue offering therapy during the pandemic and increased compassion and trust in oneself (Eppler, 2021; McBeath et al., 2020). It was also reported that the experience of working during the pandemic and/or remotely had been more positive than expected, and that difficulties encountered, such as technological difficulty, were relatively easily overcome or responded to (Eppler, 2021; MacMullin et al., 2020; McBeath et al., 2020; Shklarski et al., 2021). In this study, participants similarly appeared to have an overall positive experience of meaningfulness, adventure, challenge, and connection within the work despite the challenges encountered.

The analysis also suggested that participants' lived experiences of uncertainty and not knowing were gradually replaced, at least partially, with familiarity and knowledge by the time of the second interview, which could suggest that participants had adapted to the new intervention. The literature on practitioners' experiences during the pandemic lacks longitudinal studies, and it is therefore difficult to compare this finding with other studies. One longitudinal study was identified, which found that therapists' levels of vicarious-trauma and professional self-doubt decreased while levels of post-traumatic growth and acceptance of remote therapy increased during the time of the study, indicating that therapists have been able to adapt to new ways of working relatively quickly despite the challenges that may be involved in working in an unfamiliar way and within a context of uncertainty (Aafjes-van Doorn

et al., 2021). Further longitudinal studies would be needed to see whether a similar trend is observed with other samples. The finding that counsellors adapted to the differences of this new intervention, whereby unfamiliarity was replaced by some familiarity, was observed because interviews were carried out twice with a gap of several months between each.

As mentioned above, one finding in this study which was not suggested in previous research was that knowing was associated with confidence and safety, while not knowing was experienced as challenging or/and energising by some participants. An important aspect of participants' experiences was indeed not knowing or uncertainty when providing a new intervention in which expected outcomes, required protocols and steps or processes within the therapeutic work needed to be redefined. Not knowing was sometimes associated with a challenge or obstacle which could impede on the therapist's work and to a sense of anxiety. Meanwhile, knowing or the later acquired familiarity with the work seems to have been associated with security and stability. At other times, not knowing seemed to be associated with excitement and energy. Perhaps, the previously explored literature did not suggest experiences of excitement and/or challenges, or safety associated with uncertainty because the literature was either using surveys rather than in-depth one-to-one interviews, or the literature was focused on the experiences of working remotely rather than the experience of working during the pandemic broadly. This study looked at counsellors' experiences of providing a new intervention and perhaps that is why uncertainty was such an important aspect of their experiences. The literature previously discussed did not specifically look at experiences of providing new interventions and this may be another reason that this association between uncertainty, excitement, challenge and safety was not highlighted previously.

The job of therapist itself entails working with not knowing, with uncertainty and ambiguity (DeRoma, Martin, & Kessler, 2003; Hillen, Gutheil, Strout, Smets, & Han, 2017; Levitt, & Jacques, 2005; Rober, 2002). In fact, staying with a stance of not knowing and curiosity is

suggested to therapists as part of the process of attending to clients' material (Larner, 2000). Perhaps, the uncertainties of the intervention were counterbalanced by participants' familiarity with working with uncertainty. Nonetheless, the literature indicates that uncertainty and ambiguity generally tend to be avoided and can have a negative impact such as anxiety, stress, vulnerability and reduced decision-making (Anderson, Carleton, Diefenbach, & Han, 2019; Curley, Yates, & Abrams, 1986; Hillen et al., 2017). The general finding that uncertainty and unknown is anxiety-provoking and avoided would be consistent with the findings in the present study that knowing was at times associated with safety and not knowing was associated with challenges.

The literature around uncertainty tolerance (UT), which is the tendency to feel comfortable or not when in uncertain, ambiguous or unclear situations, suggests that there are individual differences in how one responds to uncertain situations, or in other words, situations which involve a lack of information or lack of familiarity (Jach, & Smillie, 2019). The definition of uncertainty varies but uncertainty is typically described as involving a situation where something is unknown or uncertain or where there is a lack of information and where there is awareness of that lack of knowing (Anderson et al., 2019). Individuals with low UT have been found to be more likely to experience stress and anxiety (Anderson et al., 2019). Meanwhile, higher UT or ambiguity tolerance, an arguably overlapping concept, has been associated with higher job satisfaction compared to individuals with lower ambiguity tolerance and UT has been associated with higher levels of creativity, tolerance and risk-taking (Anderson et al., 2019; Wittenberg, & Norcross, 2001). Hillen et al. (2017) reviewed the literature on uncertainty and UT and identified some common responses and feelings associated with uncertainty. The authors reported that some will seek uncertainty, others will try to reduce the uncertainty while some will focus on other aspects of the situation to direct their attention away from what is uncertain (Hillen et al., 2017). Additionally, feelings identified in response to uncertain situations included enjoyment, curiosity, denial, self-doubt, confusion, catastrophising, discomfort, stress, and anxiety (Hillen et al., 2017). Overall, there seems to be more identified

negative responses to uncertainty than positive ones, perhaps because individuals are prone to biases in thinking more about potential negative consequences than positive ones, as from an evolutionary perspective, failing to attend to a negative outcome may have a much higher cost than not attending to a positive outcome (Anderson et al., 2019). Models have suggested that how one appraises an uncertain situation (e.g., is the situation viewed as an opportunity or a threat) will affect one's emotional and behavioural responses to uncertainty and that this appraisal will be dependent on personality traits, context, socio-cultural variables, goals, control, and coping abilities (Anderson et al., 2019; Hillen et al., 2017). Such models would suggest that participants responded to or experienced uncertainty within the work differently on the basis of individual differences around UT and on how uncertainty in the work was appraised, to the extent of threat or benefits perceived in the context. In fact, uncertainty appears to have been anxiety-provoking when associated with doubts around the intervention's outcome and associated with excitement when around the opportunity to help others impacted by Covid-19.

There is also evidence suggesting that uncertainty may heighten emotions experienced (Bar-Anan, Wilson, & Gilbert, 2009). To test out the uncertainty intensification hypothesis proposing that "uncertainty makes unpleasant events more unpleasant (…) but also makes pleasant events more pleasant", participants were shown a pleasant or unpleasant movie scene and subsequently asked to repeat sentences evoking either certainty or uncertainty around the movie (Bar-Anan et al., 2009, pp. 123). Higher emotional ratings were found in the uncertainty conditions, whereby those in the pleasant group reported higher levels of happiness while those in the unpleasant group reported higher levels of sadness compared to participants in the certainty condition. Curiosity was identified as a potential mediator of this effect, whereby participants in the uncertainty condition also reported higher levels of curiosity and engagement towards the clips. Here, both uncertainty and emotions (happiness versus sadness) were manipulated for the purpose of the research, which is arguably very different from non-manipulated situations of affect and uncertainty, as was the case for participants in

my study. However, one can wonder whether the feelings participants may have initially held for the new intervention, or their work generally, may have been accentuated by the uncertainties of this particular intervention. Therefore, perhaps one's excitement or energy in response to the uncertainties of the work may be an intensification of feelings towards the therapeutic intervention in the first place. Anderson et al. (2019) highlight that it remains unclear what mediates how people respond to uncertainty.

This study's enquiry into counsellors' lived experiences of providing a new, early, and brief intervention during Covid-19 also found that participants' experience of adapting to this new intervention appears to have been shaped by the wider context of living and adapting to life in a worldwide pandemic. One impact of the pandemic which was mentioned was the perceived loss of control. Within this context, the intervention seemed to have been received as an opportunity to regain some control by supporting others impacted by Covid-19. Similarly, surveys on therapists' pandemic-related experiences highlighted a wish to be of help in the context of Covid-19 and meaning and purpose from focusing on helping others during the pandemic (Bentham et al, 2021; BPS, 2020). The literature on practitioners' experiences of working during STRs have also reported positive experiences associated with being able to support others, including increased positive feelings, and work satisfaction (Cohen et al., 2015; Eidelson et al., 2003; Hamid et al., 2020). It seems that despite the different types of STRs explored in the literature, such as 9/11 by Eidelson et al. (2003), the second Lebanon war by Cohen et al. (2015) or the conflicts in Syria by Hamid et al. (2020) a common wish to take action by helping others in the shared context has been reported. Meaning making, defined as "how individuals construe, understand, and make sense of life events", has been associated with coping in difficult situations such as the Covid-19 pandemic (Frankl, 1985; Gaj, & Castiglioni, 2020; Park, 2010; Yang et al., 2021, pp. 2). In this study and in previous studies, being of help to others in STRs, such as Covid-19, seems to have brought about an experience of meaningfulness. In this particular study, the context of Covid-19 and of providing a new intervention tailored to respond to Covid-19 needs seems to have also been associated

with the experience of taking action and therefore regaining some of the control participants felt they lost as a result of the pandemic.

2.2. Master theme 2: The shared reality of Covid-19: Novelty and familiarity towards a brief intervention

Participants reflected on how different this new, early, and brief intervention was to the work previously offered at the service. One particular difference which was highlighted was the speed and brevity of the work, as participants emphasised how much less time was involved in the new intervention, and how much quicker the work unfolded. Again, adaptation was evoked here as participants seemed to evoke a process of getting used to working in a much shorter amount of time or at a much quicker pace. The therapeutic relationship was another aspect of the work which was emphasised. Boundaries between counsellors' personal and work life as well as boundaries between counsellors and their clients were mentioned as changed as a result of both working from home and from the shared reality of the pandemic.

When reflecting on their experience of the new intervention, participants focused on the brevity of the intervention which contrasted with the usual number of sessions previously offered. Urgency was conveyed, associated with the intervention's brevity, but also to the fast pace at which the intervention developed and was put in place, in echo of the context of a fast-unfolding pandemic. In this context, participants communicated a feeling that an intervention tailored to Covid-related needs was urgently needed. For participants who had previous experience of working on helplines, the lived experience of working over a short time involved confidence while for other participants, it appears to have involved discomfort, at least initially, as they were not familiar with working within this timeframe. Meanwhile, the literature on therapists' experiences of working during Covid-19 seems to have mainly emphasised the experience of working remotely (Bentham et al., 2021; BPS, 2020; Liberati et al., 2021; Reilly et al., 2020; Shklarski et al., 2021). This may be because practitioners recruited in these

studies were providing the same interventions as previously, whereas in this study, counsellors' experiences of providing a new intervention were explored, and the amount of sessions offered was one of the characteristics of this new intervention. Looking at the literature on brief interventions, it seems that there are no studies exploring practitioners' experiences of providing therapy over a short time equivalent to that particular intervention. Laranjeira et al. (2022) identified studies on new, brief interventions similar to the new intervention looked at here, but these focused on the outcomes and content of these brief interventions rather than the experience of providing a very brief piece of work.

Another finding was that participants experienced boundaries as thinner within this intervention, as a result of being in the common context of the pandemic with clients and of working from home. This finding is consistent with the literature around therapists' experiences of work in the pandemic, which also reported experienced changes in boundary (BPS, 2021; Liberati et al., 2021; McBeath et al., 2020; Phillips et al., 2021). Previous studies have reported boundary change with regards to work and personal spaces becoming the same while working from home (Liberati et al., 2021; McBeath et al., 2020; Phillips et al., 2021). Similarly, in this study, the lived experience of working with altered boundaries entailed difficulties in separating work life and personal life, in leaving the clinical material behind, which in turn was experienced as heavier to hold. The fact that the experience of boundaries becoming thinner or blurrier has been reported in different studies, with different methodologies and different participant populations, highlights that change in boundaries may be a significant experience for mental health practitioners during the Covid-19 pandemic. Perhaps future professional support and training could consider this phenomenon and support clinicians to manage and cope with boundary changes when working from home.

An additional finding in this study which has not been mentioned in previous research on Covid-19, was that boundary change was also discussed in terms of sharing a common traumatic event with clients. The present findings would be in line with the concept of STR

suggesting that stressful events which are simultaneously experienced by both therapist and client may lead to blurring of boundaries whereby personal experiences taint the therapeutic work while client material may become reminders of personal difficulties or stressors (Baum, 2010; Leifman, 2021). Similarly, this study's findings suggested that counsellors' lived experiences of providing the new intervention involved having daily reminders of client material while the clinical material in turn reminded or echoed threats of loss from Covid-19 in counsellors' personal lives. In turn, the clinical material seems to have become heavier to bear because it was more difficult to leave behind. The lived experience of providing a new, early, and brief intervention during Covid-19 also entailed self-awareness and reflection around self-disclosure, whether to disclose in a particular situation or not, in response to clients' increased enquiries about counsellors' Covid-19 experiences. However, the process of reflecting and deciding whether to disclose or not seems to have been experienced as similar to reflecting on self-disclosure before Covid-19. In an article reflecting on practitioners' reported experiences of work following the hurricane Katrina, Boulanger (2013) related therapists' reflections around self-disclosure and hesitations in disclosing how they were faring when their clients enquired. Although Boulanger's (2013) article does not constitute empirical research, it does resonate with this study's findings around increased reflections on self-disclosure and whether to self-disclose in the context of a STR. Similarly, in Cohen et al.'s (2015) study on therapists providing therapy following the second Lebanon war, participants reported that clinical material at times reminded them of their own war-related experiences including unprocessed material. Participants in Hamid et al.'s (2020) study on Syrian practitioners supporting displaced Syrian clients also reported that client material at times reminded them of personal stressors. Likewise, in Eidelson et al.'s (2003) study on psychologists' experiences after 9/11, participants reported that one source of stress was managing the parallel process of processing their own shock and trauma while supporting clients on similar issues or topics. All three studies covered experiences of STRs in which the event was human caused. Nonetheless, the experiences reported align with those found in this current study, in which the event (Covid-19) is alike to a natural disaster rather than a human-caused event. The

present findings suggest that changes in boundary from working remotely and from home may not be the only challenges for therapists practicing during the pandemic. Simultaneously sharing common, potentially traumatic, or at least significant experiences with clients seems to be another source of difficulty or challenge around managing the boundary between one's personal and professional life.

Within the therapeutic relationship, participants also emphasised the importance of connection between therapist and client, as well as their experience of a strong and fast developing connection with clients. This was in the context of a very brief intervention, of the shared reality of Covid-19 which connected counsellor and client, but also in the context of providing an intervention very early after clients were bereaved, in which emotions were strong and raw. For instance, connection was associated with safety and healing in the therapeutic work. Overall, it appears that participants experienced a fast-developing connection with clients in the work. In this intervention provided in the context of Covid-19, it seems that counsellors' experience of connection with clients was twofold: one was about the therapeutic relationship which develops through the work, another seems to have been around simultaneously being in a shared reality of the pandemic, of being connected by this shared experience. Connection is a theme which was recurrently observed in the STR literature and in studies on practitioners' experiences of working within a STR, in which participants have reported feeling increased connection and empathy towards clients in the context of a STR (Bauwens, & Tosone, 2010; Cohen et al., 2015; Dekel, & Baum, 2010; Eidelson et al., 2003; Hamid et al., 2020; Shklarski et al., 2021). Perhaps having a shared experience contributes to clinicians' experiences of connection in the therapeutic relationship. Perhaps sharing a similar experience *simultaneously* may even more so contribute to connection and empathy in the therapeutic relationship, as found in the present study and as reported in Shklarski et al. (2021). It could be interesting for future studies to enquire about clients' perceptions of the therapeutic relationship while being in the shared context of the Covid-19 pandemic.

Lived experiences of the therapeutic relationship included surprise that a safe therapeutic relationship built in such a short time, as experienced by the extent to which clients opened up. This would be consistent with the literature on remote therapy suggesting that the therapeutic relationship is of equivalent quality compared to face-to-face work (Norwood et al., 2018; Simpson et al., 2021). However, studies have looked at interventions which would include more than three sessions and therefore do not provide information about the formation of therapeutic relationships over a very short time. Qualitative studies have reported that therapists experienced their clients opening up quicker when working remotely compared to face-to-face (Eppler, 2021; Fletcher-Tomenious, & Vossler, 2009). Perhaps, clients in this study and others have felt able to open up quickly because of the increased control in remote sessions (e.g., being able to exit the session in one click) and because, at least with telephone therapy as is the case for this new intervention, the client cannot see the therapist's expressions and cannot be seen himself/herself, which perhaps may feel safer or less exposing (Fletcher-Tomenious, & Vossler, 2009). In the context of the new intervention, it may also be that clients knew that there were only three sessions and therefore they could have felt it was important to make use of every session as much as possible. On the other hand, participants in other studies have reported experiencing more difficulties in connecting with clients while providing sessions remotely (Bentham et al., 2021; Shklarski et al., 2021). In Bentham et al.'s (2021) study on CAMHS practitioners' work experiences during the pandemic, participants reported finding it more difficult to connect with clients over the telephone. This would be counter to the present findings that counsellors felt they could connect well and develop a strong relationship quickly with clients in a telephone-based intervention. However, in this study, participants had only provided this specific intervention over the phone, and perhaps if they had previously given it face-to-face, they might have shared a different experience, while CAMHS practitioners' experiences of the therapeutic relationship over telephone sessions might have been shaped by their previous experience of face-to-face work. Additionally, it may be expected that CAMHS clinicians would be working with children and families, and perhaps working with this client group remotely may be different

from working with adults. Nonetheless, participants' in Shklarski et al.'s (2021) study similarly reflected that they experienced more difficulty in establishing a therapeutic relationship with clients they had never seen face-to-face previously. Given that these studies, including the present one, are qualitative, it is unclear which criteria were used by different participants in different studies to self-assess their experience of the therapeutic relationship. Perhaps this could account for the variability in reported experiences. Importantly, the experience of connection reported in the present study pertained to the shared context of Covid-19, of a brief intervention and an intervention provided very shortly after loss whereas other studies discussed here seem to have looked at connection in the context of remote work compared to in-person work.

Some participants who had previous experiences of working on helplines, entailing working over the course of one phone call, expressed familiarity towards the new, early, and brief intervention and conveyed the sense that their previous work experience of helplines prepared them for the format of the intervention. It seems that having previous experience of working in a very short time over the phone was associated with participants' lived experience of feeling prepared to provide a new, brief, and early intervention and to adapt relatively easily. The value and importance of past experience has also been mentioned in previous qualitative studies. For instance, in Cohen et al.'s (2015) study, participants emphasised training and experience as important sources of support for their work. Similarly, in MacMullin et al.'s (2020) study, participants associated their confidence in providing teletherapy with previous experiences of working on helplines. These studies did not provide further insight into how having previous experiences affects clinicians' experiences of their clinical work whereas one finding of this study is that having relevant past experiences seems to have been supportive because it fostered confidence and knowledge around how to work in this format and timeframe. In light of these findings, perhaps providing relevant training and ensuring that practitioners build or have had relevant clinical experiences may be important considerations when providing new interventions. Findings also suggested that experience was associated

with a sense of pleasure, enjoyment or happiness around working in a familiar format. However, two studies exploring experiences of teletherapy during Covid-19, one quantitative and the other qualitative, suggested that stress levels and frustrations around the use of technology were similar regardless of the amount of experience in teletherapy pre-Covid-19 (Eppler, 2021; Probst et al., 2020). Arguably, stress and technology-related difficulties are different concepts from confidence and familiarity, and therefore it may be that having prior experience is helpful in some ways such as feeling confident, but not in others, such as levels of work-related stress experienced.

2.3. Master theme 3: Being human: Experiences of vulnerability in a time of isolation

Participants reflected on the experience of witnessing clients' distress in the context of providing a new intervention offered very soon after clients became bereaved. Some counsellors reported experiencing helplessness and vulnerability when facing clients' high levels of distress. The difficulty around witnessing clients' pain seems to have been enhanced by the context of working from home, isolated from colleagues, as well as in the context of a shared reality in which clients' distress echoed the risk of loss during Covid-19, in which the personal space was no longer a safe separate space. Helplessness and overwhelm from clients' material were also reportedly experienced by practitioners providing therapy in the context of STRs, across different socio-cultural backgrounds (Cohen et al., 2015; Dekel, & Baum, 2010; Eidelson et al., 2003). A common finding between these studies on STRs and the present study on providing a new intervention during Covid-19 is that the clinical material became a reminder of the therapists' own experiences of the shared traumatic reality, diminishing the therapists' ability to separate from the clinical work and in turn increasing the challenges of sitting with clients' distress (Cohen et al., 2015; Dekel, & Baum, 2010; Eidelson et al., 2003). These experiences were not reported by previous studies on clinicians' experiences of practicing during the pandemic, perhaps because most studies on Covid-19 focused on the experience of teletherapy, and/or perhaps because most studies during the

pandemic looked at experiences of usually offered therapeutic interventions, rather than new interventions. Similarly, studies on new bereavement interventions have focused on content and outcome rather than exploring therapists' experiences of providing the work (Laranjeira et al., 2022). In Menichetti Delor et al.'s (2021) study on psychologists' perceptions of a new intervention entailing a follow-up call to families having recently lost a loved one from Covid-19, clinicians reported that being a "mirror", reflecting back family members' emotions was the most challenging aspect of the intervention because it felt emotionally difficult to be with families' intense painful emotions (pp. 506). Similarly, for some participants in this study, staying with clients' emotions was challenging and evoked strong emotional reactions in themselves. Another commonality between the literature on STR and in Menichetti Delor's (2021) study was that the interventions were provided to clients who were in crisis or had experienced a potentially traumatic event and therefore it could be expected that clients in these studies, just like in the present one, might bring higher levels of distress.

For one participant, the experience of witnessing clients' distress was enhanced by the context of working from home, as well as by the context of Covid-19 which seems to have brought about a feeling of isolation and increased the difficulty in separating oneself from the clinical work. Likewise, increased isolation has also been reported in studies exploring clinicians' experiences of practicing during the Covid-19 pandemic, which could suggest that this participant's experience of isolation was shared amongst mental health professionals (BPS, 2020; Eppler, 2021; Liberati et al., 2021; McBeath et al., 2020). For instance, in McBeath et al.'s (2020) study, isolation was reported as the third most common reason for finding remote work challenging. Previous studies, however, did not indicate what impact the increased isolation had on practitioners, whereas in the present study, findings suggest that isolation from colleagues in the context of Covid-19 made it more difficult or emotionally challenging to witness clients' distress. Future studies could further explore the impact of pandemic-related experiences, such as increased isolation and shared context onto practitioners' clinical work.

Other participants' lived experiences entailed confidence, motivation, and meaningfulness towards witnessing clients' distress. It seems that having had positive feedback from previous clients fostered the confidence that they could provide the work and support clients. The analysis also suggested that in the context of Covid-19, the new intervention was viewed as an important, needed support for individuals impacted by the pandemic, and therefore felt meaningful. It seems that the meaningfulness of the new intervention counteracted the difficulties of the work, including difficulties around witnessing high levels of distress.

Similarly, the literature on practitioners' experiences of therapy during STRs suggests that the meaningfulness, fulfilment, and satisfaction experienced from supporting others in a shared context counteracted the difficulties of the clinical work (Cohen et al., 2015; Eidelson et al., 2003; Hamid et al., 2020). In a study by McMahon and Hevey (2017), surveys were distributed to Irish psychologists to capture factors associated with clinical confidence. Past and ongoing training, amount of clinical experience and supervision were reported as the main elements which participants reported built their confidence (McMahon, & Hevey, 2017). Participants' perception of the quality of their training was a greater predictor of confidence than the amount of training received, and similarly, perception of the quality of supervision was a greater predictor of confidence than the amount of supervision received (McMahon, & Hevey, 2017). Alike this study, participants also reported that receiving positive feedback from clients helped build their confidence in their clinical work. In a similar vein, Bischoff, Barton, Thober and Hawley (2002) explored, in one-to-one interviews, student therapists' experiences associated with developing confidence in their first year of clinical practice. As in McMahon and Hevey's (2017) study, previous experiences of providing therapy and supervision were mentioned as the most important elements which helped develop confidence. Specifically, supervisors' acknowledgments of what participants were doing well and gaining insight through supervisors' clinical experiences and knowledge were thought to promote confidence (Bischoff et al., 2002). Contact with peers, including through peer supervision was also highlighted as helpful, as it reportedly normalised students' experiences (Bischoff et al., 2002). These studies

provide useful insight into elements which could help promote clinicians' experiences of confidence in clinical practice. The studies would indicate that focusing on providing quality supervision and training and fostering peer support would be recommended when organising the provision of therapeutic interventions, particularly when the intervention is new.

Finally, the study's exploration of counsellors' lived experiences of providing a new intervention during Covid-19 suggested that being supported, for instance by supervision, and feeling connected to colleagues involved in providing the new intervention, was important to offer a space in which the counsellors could share and reflect on their experiences, to receive ideas and guidance. Similarly, practitioners in studies exploring work experiences during the Covid-19 pandemic and during STRs have highlighted the importance of feeling connected to colleagues, friends and family, and the importance of supervision (Bentham et al., 2021; BPS, 2020; Cohen et al., 2015; Dekel, & Baum, 2010; Hamid et al., 2020; Phillips et al., 2021; Shklarski et al., 2021). Specifically, just like in this study, supervision and peer support have been reported as particularly helpful and participants discussed the importance of professional support from supervision and peer support from their colleagues (Cohen et al., 2015; Dekel, & Baum, 2010; Hamid et al., 2020; Shklarski et al., 2021). In Bentham et al.'s (2021) study, CAMHS practitioners reported that team meetings, supervision and connection with colleagues felt more important since the beginning of the pandemic. A commonality amongst these studies is that they explored clinicians' work experiences within a challenging context, whether that context was the pandemic and its resulting isolation and adaptation to teletherapy, or the context of a STR, in which personal experiences and clinical material may echo each other. This could indicate that offering appropriate clinical supervision and fostering peer support and connection amongst colleagues may be needed and emphasised in psychological services, specifically when clinicians are having to cope with challenges such as adapting to new interventions or/and procedures, or with increased isolation and stressors such as during the pandemic. In this study, participants indicated that connection and supervision were helpful to learn how to provide the intervention and to reflect on their clinical

work, but more importantly, they seemed to emphasise the role of supervision and connection as sources of emotional support and safety to cope with the challenges of the work. Connection in this study was specifically discussed towards colleagues similarly involved in the new intervention, which could suggest the importance of ensuring that the supervisory space provided be made of individuals providing the same type of intervention, who may in turn have similar experiences to share and support each other with.

Similarly, previous research suggests that social connection is positively associated with wellbeing and coping in times of stress (Smallen, 2021; Szkody, Stearns, Stanhope, & McKinney, 2021). For instance, Szkody et al. (2021) found that, in a sample of university students, reported social support was positively correlated with wellbeing and negatively associated with lower anxiety and depression scores. Similarly, Nitschke et al. (2021) examined the relationship between social connection and levels of stress during Covid-19 and found that connection was negatively associated with stress, fatigue, and pandemic-related worries. Authors argued that, perhaps, having social connections supports coping because they increase the likelihood of receiving support, including practical or emotional support (Nitschke et al., 2021). These findings do not inform us of the experiences associated with social support or connection, but they nonetheless highlight the relevance of social connection in times of stress such as during the pandemic. Tuason, Güss, and Boyd (2021) not only found correlations between wellbeing and social connection but suggested that loneliness predicted levels of wellbeing during Covid-19. In Smallen's (2021) study, participants reported that connection enabled affirmation, normalisation of their experiences, decreased difficult emotions and increased positive emotions. This finding seems to emphasise emotional support as a main experience around social connection. Similarly, in the present study, the role of connection in offering containment and emotional support was emphasised, both in supervision, and in the therapeutic work with clients.

The literature also suggests that individuals have been seeking more connection and have been more prosocial during the pandemic (Luchetti et al., 2020; Smallen, 2021; Zaki, 2020). The Meaning Making Model (MMM) argues that "when the coherence of one's meaning framework is threatened, a person tends to seek to affirm comprehensibility of meaning in their life by focusing on domains which can be made coherent" (Smallen, 2021, pp. 2889). Arguably, perhaps the uncertainty brought about by the pandemic, in turn threatening one's meaning framework, may lead individuals to focus on the meaningfulness of other life areas, such as social connections, or, in Smallen's (2021) words, "social connections may function to reinforce a person's sense of self in situations that threaten their meaning framework" (pp. 2888). For instance, in Smallen's (2021) study, participants reported experiencing increased meaningfulness around their social connections. The sample in the study consisted of psychology students in universities in the United States, and as such, it can be wondered whether a different group of participants, say working professionals, or samples from another culture, would have yielded similar findings. Nonetheless, there seems to be a converging finding that connection may be of relevance at times of crisis such as during the Covid-19 pandemic.

In this study, connection was emphasised in the context of group supervision, which seems to have provided participants with a space in which to reflect and form ideas around the clinical work, but also to share affect around the work and connect with colleagues involved in providing the same intervention under the same circumstances. Looking at the literature, it appears that group supervision is associated with positive experiences overall, and that connection with peers is one of the aspects of group supervision which is recurrently mentioned as a positive aspect of this supervision format (Mastoras, & Andrews, 2011; Tan, 2019; Valentino, LeBlanc, & Sellers, 2016). Mastoras and Andrews (2011) carried out a review of the literature on therapists' experiences of group supervision. They emphasised the finding that receiving and providing peer feedback in group supervision fostered feelings of confidence and validation and were reported as helpful because peers offered multiple

perspectives and ideas on clinical material (Mastorals, & Andrews, 2011). They also highlighted that the experience of safety in the group, whereby therapists can feel safe to express ideas or difficulties, including feelings to the supervision group, and ultimately the experience of group cohesion, were important in enabling helpful and positive experiences in group supervision (Mastorals, & Andrews, 2011). Similar experiences of connection, support and validation were also reported by school counsellors who received group supervision in Singapore (2019). The fact that similar experiences were reported across cultures suggests that group supervision may be a beneficial supervision format, which can help foster connection and support to counsellors. This might be a relevant consideration, when thinking about the importance of feeling connected for the counsellors in this study, and potentially for professionals overall when providing a new intervention or during the Covid-19 pandemic.

In addition, self-care was reported as increasingly important to cope with the clinical material in the context of the pandemic and in the context of working from home. Clinicians in previous studies on therapy during the pandemic or during a STR have also reflected on the importance of self-care (Cohen et al., 2015; Hamid et al., 2020; McBeath et al., 2020; Phillips et al., 2021; Shklarski et al., 2021). The fact that self-care, supervision and connection have been reported in a variety of different studies and different contexts, pre-pandemic, in the context of STRs, and during the pandemic, highlights the importance of providing adequate support to clinicians, particularly in challenging circumstances. Inferences between this study and previous research is limited by the fact that there have been no studies identified which qualitatively explored, as was done here, the experiences of counsellors in providing a new, early and brief intervention during Covid-19. Further research on providing new interventions during Covid-19 would be warranted to examine whether similar or different experiences are reported.

3. Critical discussion

3.1. Limitations

As any research project, this study contains its set of limitations which will be discussed. IPA entails capturing experiences including cognitions, emotions and embodied experiences, although Finlay (2011) suggests that a common mistake in researchers new to IPA is to fail to capture the embodied experience, focusing mainly, instead, on cognitions and meaning making. In hindsight, I wonder if this study could have included further emphasis on participants' embodied experiences. For instance, one of the emergent themes was around the importance of connection, in a context of physical separation whereby therapy was provided remotely, and social distancing policies were in place. Having carried out interviews remotely may have also contributed to decreased attention to embodiment. Perhaps, future studies on similar topics could further emphasise participants' embodied experiences.

The study used purposive sampling, whereby all counsellors providing the new intervention at a bereavement counselling service, were invited to take part in the study. By recruiting within one service only, it may be that the potential variability of experiences reported were reduced. Additionally, the ages of the counsellors recruited ranged between 59 and 70 years old. Again, it may be that this commonality amongst participants may have limited the variabilities in reported experiences explored in this study. Perhaps younger counsellors or/and less experienced counsellors might have reported different experiences. On the other hand, there was some variability in genders and ethnicities represented in the participants recruited, as two participants were male and two were female, and two of the participants described their ethnic backgrounds as Caucasian while one described as Asian/Mixed African and the other as Asian Caribbean.

Given that participants recruited were volunteering at the charity I was on placement with, there was a pre-existing relationship between two of the counsellors and myself, and a pre-existing relationship between the service and myself. It is possible that my relationship with the service could have affected the content of experiences shared with me at interviews (Russo & Thompson, 2012). Indeed, had I been uninvolved with the service, perhaps participants would have reported different experiences or felt more comfortable sharing difficulties experienced. Overall, I felt that participants were transparent and did share difficult experiences, although some also expressed at times hesitations about what could be shared. I tried to minimise the impact of my pre-existing relationship by explaining that the research project was independent from the bereavement service and by discussing confidentiality and concerns.

3.2. Strengths

The literature review suggested that qualitative studies using one-to-one interviews to explore therapists' experiences of working during the pandemic were lacking, and/or mainly focused on experiences of teletherapy. In this study, however, the use of one-to-one interviews arguably provided an in-depth exploration of counsellors' experiences of providing a new, early, and brief intervention during the Covid-19 pandemic. Ponterotto et al. (2017) suggest that qualitative designs allow the observation of the complexity, layers, or nuances of experiences. Compared to open-ended questions in surveys, which have been often used in the Covid-19 literature, one-to-one interviews also enable rapport between researcher and participants, and offer the opportunity for the researcher to prompt participants to expand further, when needed (Galletta & Cross, 2013). Additionally, the incorporation of visual methods in the present study is thought to have contributed to an in-depth exploration which conveyed layers of time and space in participants' experiences (E.g., in Figure 2, 6 and 4 of the Analysis Chapter) (Reavey, 2021).

Previous studies around Covid-19 or previous pandemics such as SARS or Ebola have mainly focused on healthcare professionals such as doctors or nurses, rather than psychological therapists. Meanwhile, the studies that looked at mental health practitioners' experiences recruited a range of professionals, including mental health nurses and psychiatrists, despite the variability in responsibilities amongst these different roles. This study therefore also contributes to the literature on practitioners' pandemic-related experiences as it provides an exploration focused on the experiences of therapists only. Findings presented here therefore reflect experiences associated with the specific role and context of counsellor.

Additionally, studies carried out around Covid-19, such as Bentham et al.'s (2021), Liberati et al.'s (2021) and Phillip et al.'s (2021), have mostly been carried out in the early days of the pandemic and have not explored therapists' experiences longitudinally. This study carried out a first round of interviews, in October 2020, and a second round approximatively seven months later, in April 2021. This gap between the first and second interviews permitted to observe how experiences evolved over the course of the pandemic, and indeed, findings suggested greater familiarity and overall adaptation by the time of the second interviews, compared to the first interviews.

A further gap identified in the literature was a significant lack of studies exploring therapists' experiences of providing new interventions during Covid-19, despite suggestions in the literature that new interventions tailored to the needs of the pandemic may be warranted and put in place (Laranjeira et al., 2022). Consequently, it is believed that this study is the first to qualitatively explore and provide insight into counsellors' experiences of providing a new, early, and brief intervention during Covid-19.

4. Reflexivity

The findings of the study differed from my initial assumptions and expectations of what it might be like to be providing a very different, brief, and early intervention during the Covid-19 pandemic. Indeed, when I was first informed about this new intervention, my initial thoughts were that it must be challenging emotionally to be working with acutely distressed clients over such a short term. When I imagined what it might be like to be providing this intervention, I imagined experiences of anxiety and difficulties. However, findings revealed that, although challenges were indeed present, counsellors' overall experiences were positive, and involved enthusiasm, excitement and meaningfulness. As a result of my bias towards expecting difficulties in providing this type of intervention during a pandemic, themes such as 'safety through connection' or 'to witness distress' became apparent quicker, while I took more time to notice experiences of excitement and meaningfulness as the association between uncertainty, challenges and excitement felt quite distant from my personal experiences of uncertainty. In turn, I feel that these findings have opened my mindset towards challenges within the clinical work, moving from a position of fearing and being wary of difficulties, to appreciating the opportunities for meaningfulness and purpose within challenging work.

The use of visual methods in the second set of interviews was particularly helpful in allowing me to bracket my expectations and notice the positive experiences of providing the intervention. Perhaps the drawings provided me with a mediation between participants' narratives and my assumptions. It is also possible that by the time of the second interviews, I had become more acquainted with IPA, as I had already interviewed, transcribed, and analysed the first set of interviews, and had become aware of the biases and assumptions that had shaped the process of interviewing and analysing. Therefore, it may be that by the time of the second interview, I was much more aware of my biases, and therefore more able to bracket them off during the second round of interviews and analysis.

5. Implications for practice and relevance to Counselling Psychology

Counselling Psychologists hold varied roles, including that of therapist, manager, supervisor, training provider and consultant, which may involve providing feedback and support, supporting reflective practice, and shaping decisions around service development (Henton, & Kasket, 2018). The above findings can inform Counselling Psychologists at both a practitioner-level around their clinical roles, but also at a service-level, around service development and clinical governance. The findings indeed suggest several implications for practice for Counselling Psychologists, for services implementing interventions during the pandemic and services generally who may implement new interventions, or who may support clinicians including counsellors and Counselling Psychologists to provide an intervention which may be new or may feel new. The above findings may also be relevant to Counselling Psychologists who may be learning a particular approach for the first time, or trainee Counselling Psychologists who, as part of their learning, may similarly experience uncertainty, not knowing, having to adapt and make sense of one's roles and aims. Specifically, the study can inform Counselling Psychologists of the potential challenges when providing a new or unfamiliar intervention, particularly in a shared traumatic reality, as well as potential sources of support.

Indeed, the study hopes to provide Counselling Psychologists an awareness of the challenges that can emerge when working remotely, and when adapting to a different form of therapy, such as increased isolation, vulnerability, uncertainties, and difficulty in separating work from the personal space. With this awareness, at a practitioner level, Counselling Psychologists could ensure, when working remotely or providing an unfamiliar piece of work: to take part in peer supervision with colleagues who may similarly be practicing remotely or learning about the same unfamiliar intervention; to put in place ways to help separate their personal life from their work life, for example by allocating a specific space to provide online therapies, ideally outside of one's home; to reflect on one's experience of boundaries in the work and discussing

this in supervision or with colleagues. In sessions with clients, Counselling Psychologists could be mindful of experiences of excitement, uncertainty, anxiety, that could emerge when providing a new intervention, and experiences of boundaries in the context of a shared traumatic reality. Being mindful of these potential experiences could help Counselling Psychologists monitor the impact of their experiences on the quality of the therapeutic work.

The study can also inform Counselling Psychologists of ways to cope or counter the above-mentioned challenges of practicing in challenging circumstances, such as when providing a new, unfamiliar intervention, when working from home or in the context of a STR. For instance, meaningfulness and likening for the intervention's approach and format were associated with confidence, enjoyment, and resilience towards the challenges of the work, and this could also suggest Counselling Psychologists, in training and qualified, that practicing in a way which may feel meaningful and in line with one's preferences may be beneficial for fostering resilience and wellbeing in the profession. Similarly, the literature on practitioners' experiences of practicing in challenging contexts such as STRs indicates that the meaning associated with the clinical work appears to provide support to cope with the challenges of providing therapy in a difficult context (Bentham et al, 2021; BPS, 2020; Cohen et al., 2015; Eidelson et al., 2003; Hamid et al., 2020). Perhaps, this calls for further emphasis for Counselling Psychologists holding roles of supervisors, team managers or consultants to consider how to foster therapists' meaning making and purpose towards the clinical work. For example, as supervisors, Counselling Psychologists could invite supervisees to discuss and explore their preferences, sources of enjoyment and meaningfulness in their roles, as well as their identity as practitioners. As team manager or consultant, this could involve fostering a culture within the service where supervisors and managers enable the space for learning about employees'/trainees' preferences, identities and values and taking these into account to tailor duties and responsibilities accordingly where possible. In practice, this could entail initiating conversations in one-to-one meetings around aspects of the role which are most and least enjoyable, and hopes, wishes, preferences moving forward.

This study also highlights connection as particularly important for counsellors, when working in challenging circumstances, such as during the pandemic, during a STR overall or/and when providing an unfamiliar or new intervention (Bentham et al., 2021; BPS, 2020; Cohen et al., 2015; Dekel, & Baum, 2010; Hamid et al., 2020; Phillips et al., 2021; Shklarski et al., 2021). Findings suggest that feelings of connection were fostered by group supervision, in which counsellors felt able to share their thoughts and feelings around the therapeutic work. At a service level, Counselling Psychologists who hold the roles of team manager or consultant could ensure that peer support groups or group supervision be put in place. It cannot be assumed, however, that having group supervision or peer supervision will enable experiences of connection, as this will depend on group cohesion which will shape feelings of safety in the group, willingness to participate and engage with others, and experiences of anxiety around how one might be perceived or responded to by peers (Enyedy et al., 2003; Mastoras, & Andrews, 2011; Tan, 2019). It may therefore be recommended to regularly review therapists' experiences of their supervision or support provided, to ensure that supervision provided fosters as much as possible connection or/and support. As supervisor or team manager, it might therefore mean checking how group supervision is being experienced, perhaps by checking in with group members individually. Ensuring that clinicians are experiencing support and/or connection from group or/and peer supervision may be particularly important in times when therapists may be vulnerable, for example when learning to provide an unfamiliar intervention. Specifically, the study suggests that group supervision was helpful because it was a space in which difficulties, experiences of providing the work could be shared. Counselling Psychologists supervising groups could therefore aim to foster conversations around experiences of providing the therapeutic work. This could involve asking the group questions such as "I wonder how you are finding…".

Having previous experiences or receiving adequate training was also highlighted as helpful in this study and in the literature (Cohen et al., 2015; McMullin et al., 2020). In this study, having

relevant past work experiences was associated with experiences of familiarity and confidence towards the clinical work, despite the challenges of adapting to a new intervention during the pandemic. At a service-level, it would therefore be recommended for Counselling Psychologists in leadership roles to offer relevant training, or to tailor training provided to those themes. For example, trainings could be offered around providing teletherapy and working from home. If future similar early and brief interventions were implemented, training could also be provided around working over a very short time such as three sessions. Counsellors reported a process of re-evaluating their role, processes and aims for the intervention, as well as reflecting about changes in boundaries. Trainings could also explore changes in practice when working remotely, and when working in the context of a STR. For instance, trainings could incorporate themes around changes in boundaries and boundary management, such as self-disclosure, boundary between home and work and working in the context of a shared reality with clients. Receiving feedback from clients was also mentioned in this study and in previous research as helpful to develop confidence (McMahon, & Hevey, 2017). Again, Counselling Psychologists holding roles of team leads, consultants, managers or supervisors could ensure that client feedback is collected and shared with therapists after the client is discharged, for the purpose of learning and for the development of therapists' confidence. For example, client feedback could be anonymised and emailed to the practitioner, with the opportunity to be discussed with supervisor or team lead on a regular basis, for instance every two months.

Finally, since Covid-19, the use of teletherapy and remote working has significantly increased and it may be that moving forward, Counselling Psychologists and training bodies need to consider the impact on boundary management, isolation and self-care when providing therapy from one's home. In practice, this may entail inviting colleagues, supervisees, trainees to reflect on their experience of boundary when working from home and to think about ways to manage this as needed. For example, supervisors could invite supervisees to reflect on their experience of working from home in supervision. Training courses and service managers

could also offer training or workshops around providing therapy remotely, in which issues such as boundary management could be discussed.

6. Future research

This study was a first exploration of counsellors' experiences of providing a new, early, brief intervention during Covid-19. Further research could be carried out around new interventions developed in response to pandemic-related needs. Given the lack of previous research on the experiences of providing a new intervention during Covid-19, I chose to maintain the research question open rather than focused on any specific aspect of the work (e.g., working over the phone), to enable any aspects of counsellors' experience to be mentioned or, on the contrary, not mentioned, and in turn to see which aspects came to the fore of participants' experiences. However, future studies exploring experiences of new interventions developed in response to Covid-19 could further narrow the enquiry on a specific area, such as the STR or working with people very recently bereaved rather than six months post-loss as is usually offered. Experiences of working over a very brief time could also be explored in more depth.

This study focused on counsellors' experiences of providing a new, early and brief intervention during Covid-19, with the aim that the insight gathered could inform Counselling Psychologists in their roles at both practitioner and service level, by raising awareness of themes that may arise for themselves as practitioners, or to colleagues within their team, supervisees or trainees when providing a new intervention, or when delivering an unfamiliar intervention, particularly in, but not exclusive to the context of Covid-19. Indeed, the study's findings around the experience of providing an intervention during a STR could extend to other contexts of shared realities. This could include future pandemics, natural disasters, economic, political crises, or war.

One finding was that being in the shared reality of the pandemic impacted counsellors' experiences of boundaries in the therapeutic work, and these findings resonated with past research on practitioners' experiences of providing therapy in the context of STRs. No studies were found which explored the concept of STR in the context of the Covid-19 pandemic. Perhaps future research could look at therapists' and clients' experiences of STR within the context of Covid-19 and explore how these might in turn affect the clinical work. Again, this could further inform practice in the event of future STRs.

Finally, the present findings indicated that having relevant past work experiences was helpful and associated with feelings of confidence and familiarity towards the new, early, brief intervention. Perhaps future research could investigate the role of training and past experiences on experiences of providing new, unfamiliar types of therapy, and specifically explore the ways in which having professional experience may shape clinical experiences.

7. Conclusion

The present study aimed to explore counsellors' lived experiences of providing a new, early, brief intervention during Covid-19. This intervention was a bereavement intervention developed to support individuals having lost a loved one from Covid-19, and entailed three telephone sessions, provided shortly after the loss. Four counsellors were recruited and IPA was adopted to analyse the data collected through one-to-one interviews. The study found that counsellors' lived experiences entailed questioning and uncertainty at least in the early days, associated with feelings of excitement, energy, but also nervousness. The context of Covid-19 appears to have shaped counsellors' experiences of providing the new intervention. Meaningfulness and energy were expressed towards providing an intervention developed to support others impacted by Covid-19, in a context of loss of control. Changes in boundaries were expressed, both because of working from home, but also because of the pandemic becoming a common theme between the clinical work and counsellors' lives, whereby

personal experiences became reminders of the work and the work reminders of personal experiences or potential risk of loss during the pandemic. As a result, lived experiences included increased isolation and vulnerability, but also strong connection to clients connected by both the therapeutic relationship and by the shared context. Meaningfulness and being able to rely on the knowledge and skills acquired from previous experiences seem to have helped counter the challenges of working with highly distressed clients over a very short time. Finally, within this experience of isolation and vulnerability, connection to peers similarly involved in providing the new intervention and self-care were highlighted as source of containment and safety. It is hoped that these findings can inform Counselling Psychologists within their different roles in supporting themselves and others around providing new, unfamiliar work, around working from home, and around practicing in the context of STRs, such as future pandemics, natural disasters, or war.

References

Aafjes-van Doorn, K., Békés, V., Luo, X., Prout, T. A., & Hoffman, L. (2021). Therapists' resilience and posttraumatic growth during the COVID-19 pandemic. *Psychological trauma: theory, research, practice, and policy.* Advance online publication. http://dx.doi.org/10.1037/tra0001097

Anderson, E. C., Carleton, R. N., Diefenbach, M., & Han, P. K. J. (2019). The relationship between uncertainty and affect. *Frontiers in Psychology, 10*, 2504-2504.

Bar-Anan, Y., Wilson, T. D., & Gilbert, D. T. (2009). The feeling of uncertainty intensifies affective reactions. *Emotion, 9*(1), 123-127.

Barker, C., Pistrang, N., & Elliott, R. (2016). *Research methods in clinical psychology: An introduction for students and practitioners* (Third ed.). Malden, MA: John Wiley and Sons, Inc.

Bartoli, A. (2020). Every picture tells a story: Combining interpretative phenomenological analysis with visual research. *Qualitative Social Work, 19*(5-6), 1007-1021.

Baum, N. (2010). Shared traumatic reality in communal disasters: Toward a conceptualization. *Psychotherapy: Theory, Research, Practice, Training, 47*(2), 249–259.

Bauwens, J., & Tosone, C. (2010). Professional posttraumatic growth after a shared traumatic experience: Manhattan clinicians' perspectives on post-9/11 practice. *Journal of Loss & Trauma, 15*(6), 498-517.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Békés, V., & Aafjes-van Doorn, K. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration, 30*(2), 238-247.

Békés, V., Aafjes–van Doorn, K., Prout, T. A., & Hoffman, L. (2020). Stretching the analytic

frame: Analytic therapists' experiences with remote therapy during COVID-19. *Journal of the American Psychoanalytic Association, 68*(3), 437-446.

Bell, C. A., Crabtree, S. A., Hall, E. L., & Sandage, S. J. (2021) Research in counselling and psychotherapy Post-Covid-19. *Counselling and Psychotherapy Research, 21*(1), 3-7.

Bentham, C., Driver, K., & Stark, D. (2021). Wellbeing of CAMHS staff and changes in working practices during the COVID-19 pandemic. *Journal of Child and Adolescent Psychiatric Nursing, 34*(3), 225-235.

Bertuccio, R. F., & Runion, M. C. (2020). Considering grief in mental health outcomes of COVID-19. *Psychological Trauma*, *12*(1), 87-89.

Bischoff, R. J., Barton, M., Thober, J., & Hawley, R. (2002). Events and experiences impacting the development of clinical self-confidence: A study of the first year of client contact. *Journal of Marital and Family Therapy, 28*(3), 371-382.

Boulanger, G. (2013). Fearful symmetry: Shared trauma in New Orleans after hurricane Katrina. *Psychoanalytic Dialogues, 23*(1), 31-44.

Brinkmann, S., & Kvale, S. (2017). Ethics in qualitative psychological research. In, Willig, C., & Stainton Rogers, W. (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 193-211). London; Thousand Oaks, CA;: SAGE Publications.

British Psychological Society (2020). Adaptations to psychological practice: Interim guidance during Covid-19 pandemic. Retrieved from 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

British Psychological Society (2020). Effective therapy via video: Top tips. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Effective%20therapy%20via%20video%20-%20top%20tips.pdf

British Psychological Society (2020). Taking trauma related work home: Advice for reducing the likelihood of secondary trauma. Retrieved from

https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Taking%20trauma%20related%20work%20home%20-%20advice%20for%20reducing%20the%20likelihood%20of%20secondary%20trauma.pdf

British Psychological Society (2020). The impact of Covid-19 on the wellbeing of psychologists. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20%20Files/Impact%20of%20Covid-19%20on%20the%20Wellbeing%20of%20Psychologists.pdf

British Psychological Society (2021). BPS code of human research ethics. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf

Carr, D., Boerner, K., & Moorman, S. (2020). Bereavement in the time of Coronavirus: Unprecedented challenges demand novel interventions. *Journal of Aging & Social Policy, 32*(4-5), 425-431.

Catrone, C. (2021). The impact of the COVID-19 pandemic on the relational world of the patient-clinician dyad: Obstacles and opportunities. In Tosone C. (Ed.), *Shared trauma, shared resilience during a pandemic: Social work in the time of COVID-19* (pp. 167-178). New York, NY: Springer International Publishing.

Charmaz, C., & Henwood, K. (2017). Grounded theory methods for qualitative psychology. In, Willig, C., & Stainton Rogers, W. (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 193-211). London; Thousand Oaks, CA;: SAGE Publications.

Cohen, E., Roer-Strier, D., Menachem, M., Fingher-Amitai, S., & Israeli, N. (2015). “Common-fate”: Therapists’ benefits and perils in conducting child therapy following the shared traumatic reality of war. *Clinical Social Work Journal, 43*(1), 77-88.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Thousand Oaks, CA; London;: SAGE.

Curley, S. P., Yates, J. F., & Abrams, R. A. (1986). Psychological sources of ambiguity avoidance. *Organizational Behavior and Human Decision Processes, 38*(2), 230-256.

Dattilio, F. M. (2015). The self-care of psychologists and mental health professionals: A review and practitioner guide. *Australian Psychologist, 50*(6), 393-399.

DeRoma, V. M., Martin, K. M., & Kessler, M. L. (2003). The relationship between tolerance for ambiguity and need for course structure. *Journal of Instructional Psychology, 30*(2), 104.

Dekel, R., & Baum, N. (2010). Intervention in a shared traumatic reality: A new challenge for social workers. *The British Journal of Social Work, 40*(6), 1927-1944.

Duncan, G. E., Avery, A. R., Seto, E., & Tsang, S. (2020). Perceived change in physical activity levels and mental health during COVID-19: Findings among adult twin pairs. *PloS One,15(*8), 1-11.

Derksen, M. (2010). Realism, relativism, and evolutionary psychology. *Theory & Psychology, 20*(4), 467-487.

Dunphy, R., & Schniering , C. A. (2009). The experience of counselling the bereaved. *The Humanistic Psychologist, 37*, 353-369.

Easton, K. L., McComish, J. F., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research, 10*(5), 703-707.

Eatough, V., & Smith, J. A. (2017). Interpretative Phenomenological Analysis. In, Willig, C., & Stainton Rogers, W. (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 193-211). London; Thousand Oaks, CA;: SAGE Publications.

Eidelson, R. J., D'Alessio, G. R., & Eidelson, J. I. (2003). The impact of September 11 on psychologists. *Professional Psychology, Research and Practice, 34*(2), 144-150.

Eisma, M. C., Boelen, P. A., & Lenferink, L. I. M. (2020). Prolonged grief disorder following the coronavirus (COVID-19) pandemic. *Psychiatry Research, 288*, 113031-113031.

Enyedy, K. C., Arcinue, F., Puri, N. N., Carter, J. W., Goodyear, R. K., & Getzelman, M. A.

(2003). Hindering phenomena in group supervision: Implications for practice. *Professional Psychology, Research and Practice, 34*(3), 312-317.

Eppler, C. (2021). Systemic teletherapists' meaningful experiences during the first months of the coronavirus pandemic. *Journal of Marital and Family Therapy, 47*(2), 244-258.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. Chichester: Wiley-Blackwell.

Finlay, L., & Gough, B. (2013). *Reflexivity: A practical guide for researchers in health and social sciences*. Malden, MA: Blackwell Science.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4-5), 583-590.

Fitzpatrick, P., & Olson, R. E. (2015). A rough road map to reflexivity in qualitative research into emotions. *Emotion Review, 7*(1), 49-54.

Fletcher-Tomenious, L., & Vossler, A. (2009). Trust in online therapeutic relationships: The therapist's experience. *Counselling Psychology Review, 24*(2), 24–34.

Frankl, V. E. (1985). *Man's search for meaning.* New York, NY: Washington Square Press.

Gaj, N., & Castiglioni, M. (2020). Fostering the reconstruction of meaning among the general population during the COVID-19 pandemic. *Frontiers in Psychology, 11*, 1-13.

Galbraith, V. (2018). *Counselling psychology.* London: Routledge, Taylor & Francis Group.

Gale, N. (2016). Leading and managing. In, Douglas B., Woolfe R., Strawbridge S., Kasket E., & Galbraith V. (Eds.), *The handbook of Counselling Psychology*, (pp. 567-582). London: SAGE publications.

Galletta, A., & Cross, W. E. (2013). *Mastering the semi-structured interview and beyond: From research design to analysis and publication.* New York: New York University Press.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and “Ethically important moments” in research. *Qualitative Inquiry, 10*(2), 261-280.

Guy, J. D., Poelstra, P. L., & Stark, M. J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology, Research and Practice, 20*(1), 48-50.

Hamid, A., Scior, K., & Williams, Amanda C de C. (2020). Qualitative accounts from Syrian mental health professionals: Shared realities in the context of conflict and forced displacement. *BMJ Open, 10*(5), 34291-34299.

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counselling Psychology, 52*(2), 146-155.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* Chichester: Wiley-Blackwell.

Hays, D. G., & Wood, C. (2011). Infusing qualitative traditions in counselling research designs. *Journal of Counselling and Development, 89*(3), 288-295.

Henton, I., & Kasket, E. (2018). Research in Counselling Psychology. In, Galbraith, V. (Ed.), *Counselling Psychology* (pp. 183-198). London: Routledge, Taylor & Francis Group.

Hillen, M. A., Gutheil, C. M., Strout, T. D., Smets, E. M. A., & Han, P. K. J. (2017). Tolerance of uncertainty: Conceptual analysis, integrative model, and implications for healthcare. *Social Science & Medicine, 180*, 62-75.

Humer, E., Schimböck, W., Kisler, I., Schadenhofer, P., Pieh, C., & Probst, T. (2020). How the COVID-19 pandemic changes the subjective perception of meaning related to different areas of life in Austrian psychotherapists and patients. *International Journal of Environmental Research and Public Health, 17*(22), 8600-8612.

Humer, E., Stippl, P., Pieh, C., Pryss, R., & Probst, T. (2020). Experiences of psychotherapists with remote psychotherapy during the COVID-19 pandemic: Cross-sectional web-based survey study. *Journal of Medical Internet Research, 22*(11), 20246-20258.

Humphrey, G. M., & Zimpfer, D. G. (2008). *Counselling for grief and bereavement* (2nd ed.). London; Los Angeles, Calif;: SAGE.

Jach, H. K., & Smillie, L. D. (2019). To fear or fly to the unknown: Tolerance for ambiguity and big five personality traits. *Journal of Research in Personality, 79*, 67-78.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counselling work? *Death Studies, 27*(9), 765-786.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review, 27*(2), 64-73.

Klaiber, P., Wen, J. H., DeLongis, A., & Sin, N. L. (2020). The ups and downs of daily life during COVID-19: Age differences in affect, stress, and positive events. *The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 76*(2), *30*-37.

Langdridge, D., & Hagger-Johnson, G. (2013). *Introduction to research methods and data analysis in psychology* (3rd ed.). Harlow, England: Pearson.

Laranjeira, C., Moura, D., Salci, M. A., Carreira, L., Covre, E., Jaques, A., … Querido, A. (2022). A scoping review of interventions for family bereavement care during the Covid-19 pandemic. *Behavioral Sciences, 12*(5), 155-169.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102-120.

Larner, G. (2000). Towards a common ground in psychoanalysis and family therapy: On knowing not to know. *Journal of Family Therapy, 22*(1), 61-82.

Lee, W. (2020). The musings of a family therapist in Asia when COVID-19 struck. *Family Process, 59*(3), 1018-1023.

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of family medicine and primary care, 4*(3), 324-327.

Levitt, D. H., & Jacques, J. D. (2005). Promoting tolerance for ambiguity in counsellor training

programs. *The Journal of Humanistic Counselling, Education and Development, 44*(1), 46-54.

Liberati, E., Richards, N., Willars, J., Scott, D., Boydell, N., Parker, J., … Jones, P. B. (2021). A qualitative study of experience of NHS mental healthcare workers during the Covid-19 pandemic. *BMC Psychiatry, 21*, 250-262.

Literat, I. (2013). “A pencil for your thoughts”: Participatory drawing as a visual research method with children and youth. *International Journal of Qualitative Methods, 12*(1), 84-98.

Lopez, K. A., & Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research, 14(*5), 726–735.

Luchetti, M., Lee, J. H., Aschwanden, D., Sesker, A., Strickhouser, J. E., Terracciano, A., & Sutin, A. R. (2020). The trajectory of loneliness in response to COVID-19. *The American Psychologist, 75*(7), 897-908.

Lynn, N., & Lea, S. J. (2005). Through the looking glass: Considering the challenges visual methodologies raise for qualitative research. *Qualitative Research in Psychology, 2*(3), 213-225.

Lyon, P. (2020). Using drawing in visual research: Materialising the invisible. In, Pauwels, L., & Mannay, D. (Eds.), *The SAGE handbook of visual research methods* (pp. 297-308). London: SAGE Publications.

MacMullin, K., Jerry, P., & Cook, K. (2020). Psychotherapist experiences with telepsychotherapy: Pre COVID-19 lessons for a post COVID-19 world. *Journal of Psychotherapy Integration, 30*(2), 248-264.

Martin, J. N., Millán, F., & Campbell, L. F. (2020). Telepsychology practice: Primer and first steps. *Practice Innovations*, *5*(2), 114-127.

Mastoras, S. M., & Andrews, J. J. W. (2011). The supervisee experience of group supervision: Implications for research and practice. *Training and Education in Professional Psychology, 5*(2), 102-111.

McBeath, A. G., 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.

McBride, H. L., Joseph, A. J., Schmitt, P. G., & Holtz, B. M. (2020). Clinical recommendations for psychotherapists working during the coronavirus (COVID-19) pandemic through the lens of AEDP (accelerated experiential dynamic psychotherapy). *Counselling Psychology Quarterly,* 1-21.

McCormack, L., & Joseph, S. (2018). *PHENOMENA: A 9-step guide to avoiding pitfalls when doing interpretative phenomenological analysis (IPA)--IPA and the "lived" experience of complex trauma.* London: SAGE Publications Ltd.

McMahon, A., & Hevey, D. (2017). “It has taken me a long time to get to this point of quiet confidence”: What contributes to therapeutic confidence for clinical psychologists? *Clinical Psychologist, 21*(3), 195-205.

Menichetti Delor, J. P., Borghi, L., Cao di San Marco, E., Fossati, I., & Vegni, E. (2021). Phone follow up to families of COVID-19 patients who died at the hospital: Families' grief reactions and clinical psychologists' roles. *International Journal of Psychology, 56*(4), 498-511.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counsellor Education and Supervision, 57*(4), 240-254.

Morris, S. E., Moment, A., & Thomas, J. D. (2020). Caring for bereaved family members during the COVID-19 pandemic: Before and after the death of a patient. *Journal of Pain and Symptom Management, 60*(2), 70-74.

Morrow, S. L. (2007). Qualitative research in counselling psychology: Conceptual foundations. *The Counselling Psychologist, 35*(2), 209-235.

Morrow, S. L., Castañeda-Sound, C. L., & Abrams, E. M. (2012). Counselling psychology research methods: Qualitative approaches. Washington, DC;: American Psychological Association.

Mountian, I., Lawthom, R., Kellock, A., Duggan, K., Sixsmith, J., Kagan, C., … Purcell, C. (2021). On utilising a visual methodology. In, Reavey, P. (Ed.), *A handbook of visual methods in psychology* (pp. 572-587). London: Routledge, Taylor & Francis Group.

Nascimento, L. d. S., & Steinbruch, F. K. (2019). “The interviews were transcribed”, but how? reflections on management research. *RAUSP Management Journal, 54*(4), 413-429.

Newby, J. M., O’Moore, K., Tang, S., Christensen, H., & Faasse, K. (2020). Acute mental health responses during the COVID-19 pandemic in Australia. *PloS One, 15*(7), 1-21.

Nicholas, H. (2018). Professional developments in Counselling Psychology. In, Galbraith, V. (Ed.), *Counselling Psychology* (pp. 201-2016). London: Routledge, Taylor & Francis Group.

Nitschke, J. P., Forbes, P. A. G., Ali, N., Cutler, J., Apps, M. A. J., Lockwood, P. L., & Lamm, C. (2021). Resilience during uncertainty? Greater social connectedness during COVID-19 lockdown is associated with reduced distress and fatigue. *British Journal of Health Psychology, 26*(2), 553-569.

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 and Psychotherapy, 25*(6), 797-808.

Nuttman-Shwartz, O., & Shaul, K. (2021). Online Therapy in a Shared Reality: The Novel Coronavirus as a Test Case. *Traumatology.* Advance online publication.

O'Connor, D. B., Aggleton, J. P., Chakrabarti, B., Cooper, C. L., Creswell, C., Dunsmuir, S., … Armitage, C. J. (2020). Research priorities for the COVID-19 pandemic and beyond: A call to action for psychological science. *The British Journal of Psychology, 111*(4), 603-629.

Oliver, D. G., Serovich, J. M., & Mason, T. L. (2005). Constraints and opportunities with interview transcription: Towards reflection in qualitative research. *Social Forces, 84*(2), 1273-1289.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*(2), 257-301.

Patterson, J. E., Edwards, T. M., Griffith, J. L., & Wright, S. (2021). Moral distress of medical family therapists and their physician colleagues during the transition to COVID-19. *Journal of Marital and Family Therapy, 47*(2), 289-303.

Pearce, C., Honey, J. R., Lovick, R., Zapiain Creamer, N., Henry, C., Langford, A., Stobert, M., & Barclay, S. (2021). 'A silent epidemic of grief': A survey of bereavement care provision in the UK and Ireland during the COVID-19 pandemic. *BMJ Open, 11*(3), 46872-46882.

Perry, K., Gold, S., & Shearer, E. M. (2020). Identifying and addressing mental health providers' perceived barriers to clinical video telehealth utilization. *Journal of Clinical Psychology, 76*(6), 1125-1134.

Phillips, L. A., Thompson, T. J., Edelman, S. A., & Ruiz, T. U. (2021). Independent Mental Health providers' experience in the initial months of the Covid-19 Pandemic. *Practice Innovations*. Advance online publication. http://dx.doi.org/10.1037/pri0000153

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52*(2), 126-136.

Ponterotto, J. G., & Grieger, I. (2007). Effectively communicating qualitative research. *The Counselling Psychologist, 35*(3), 404-430.

Ponterotto, J. G., Park-Taylor, J., & Chen, E. C. (2017). Qualitative research in counselling and psychotherapy: History, methods, ethics and impact. In, Willig, C., & Stainton Rogers, W. (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 496-515). London; Thousand Oaks, CA;: SAGE Publications.

Probst, T., Humer, E., Stippl, P., & Pieh, C. (2020). Being a psychotherapist in times of the

novel coronavirus disease: Stress-level, job anxiety, and fear of coronavirus disease infection in more than 1,500 psychotherapists in Austria. *Frontiers in Psychology, 11*, 559100-559108.

Reavey, P. (2021). The return to experience: psychology and the visual. In Reavey, P. (Ed.), *A handbook of visual methods in psychology: Using and interpreting images in qualitative research* (pp. 20-38). London: Routledge, Taylor & Francis Group.

Reavey, P., & Johnson, K. (2017). Visual Approaches: Using and Interpreting Images. In, Willig, C., & Stainton Rogers, W. (Eds.), *The Sage handbook of qualitative research in psychology* (pp.354-373). London; Thousand Oaks, CA;: SAGE Publications.

Rees, C. S., & Stone, S. (2005). Therapeutic alliance in face-to-face versus videoconferenced psychotherapy. *Professional Psychology, Research and Practice, 36*(6), 649-653.

Reilly, S. E., Zane, K. L., McCuddy, W. T., Soulliard, Z. A., Scarisbrick, D. M., Miller, L. E., & Mahoney III, J. J. (2020). Mental health practitioners' immediate practical response during the COVID-19 pandemic: Observational questionnaire study. *JMIR Mental Health, 7*(10), 1-18.

Richards, D., & Viganó, N. (2013). Online counselling: A narrative and critical review of the literature. *Journal of Clinical Psychology, 69*(9), 994-1011.

Rober, P. (2002). Constructive hypothesizing, dialogic understanding and the therapist's inner conversation: Some ideas about knowing and not knowing in the family therapy session. *Journal of Marital and Family Therapy, 28*(4), 467-478.

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.

Rortvedt, D., & Jacobs, K. (2019). Perspectives on the use of a telehealth service-delivery model as a component of school-based occupational therapy practice: Designing a user-experience. *Work, 62*(1), 125-131.

Russo, K., & Thompson, A. (2012). Ethical dilemmas for clinical psychologists in conducting

qualitative research. *Qualitative Research in Psychology, 9*(1), 32-46.

Sanchez, S., Jindani, F., Shi, J., van der Maas, M., Hagopian, S., Murray, R., & Turner, N. (2019). Acceptability of internet-based interventions for problem gambling: A qualitative study of focus groups with clients and clinicians. *BMC Medical Informatics and Decision Making, 19*(1), 1-10.

Saunders, B., Kitzinger, J., & Kitzinger, C. (2015). Anonymising interview data: Challenges and compromise in practice. *Qualitative Research: QR*, 15(5), 616-632.

Scharff, J. S. (2013). Technology-assisted psychoanalysis. *Journal of the American Psychoanalytic Association, 61*(3), 491-510.

Shinebourne, P., & Smith, J. A. (2011;). 'It is just habitual': An interpretative phenomenological analysis of the experience of long-term recovery from addiction. *International Journal of Mental Health and Addiction, 9*(3), 282-295.

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.

Simpson, S., Richardson, L., Pietrabissa, G., Castelnuovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical Psychology and Psychotherapy, 28*(2), 409-421.

Singer, J., Spiegel, J. A., & Papa, A. (2020). Preloss grief in family members of COVID-19 patients: Recommendations for clinicians and researchers. *Psychological Trauma*, *12*(1), 90-93.

Smallen, D. (2021). Experiences of meaningful connection in the first weeks of the COVID-19 pandemic. *Journal of Social and Personal Relationships, 38*(10), 2886-2905.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London; Los Angeles;: SAGE.

Smith, J., & Gillon, E. (2021). Therapists' experiences of providing online counselling: A qualitative study. *Counselling and Psychotherapy Research, 21*(3), 545-554.

Springer, P., Bischoff, R. J., Kohel, K., Taylor, N. C., & Farero, A. (2020). Collaborative care at a distance: Student therapists' experiences of learning and delivering relationally focused telemental health. *Journal of Marital and Family Therapy, 46*(2), 201–217.

Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380.

Szkody, E., Stearns, M., Stanhope, L., & McKinney, C. (2021). Stress-buffering role of social support during COVID-19. *Family Process, 60*(3), 1002-1015.

Tan, S. Y. (2019). Clinical group supervision experiences of Singapore school counsellors. *British Journal of Guidance & Counselling, 47*(4), 432-445.

Teo, T. (2011). Empirical race psychology and the hermeneutics of epistemological violence. *Human Studies, 34*(3), 237-255.

Tuason, M. T., Güss, C. D., & Boyd, L. (2021). Thriving during COVID-19: Predictors of psychological well-being and ways of coping. *PloS One, 16*(3), 1-19.

Tull, M. T., Edmonds, K. A., Scamaldo, K. M., Richmond, J. R., Rose, J. P., & Gratz, K. L. (2020). Psychological outcomes associated with stay-at-home orders and the perceived impact of COVID-19 on daily life. *Psychiatry Research, 289*, 113098-113118.

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. In Harper, D., & Thompson, A. R. (Eds), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 131-146). Chichester: Wiley-Blackwell.

Valentino, A. L., LeBlanc, L. A., & Sellers, T. P. (2016). The benefits of group supervision and a recommended structure for implementation. *Behavior Analysis in Practice, 9*(4), 320-328.

Wertz, F. J. (2005). Phenomenological research methods for counselling psychology. *Journal of Counselling Psychology, 52*(2), 167-177.

Wetherell, M. (2005). Unconscious conflict or everyday accountability? *British Journal of Social Psychology, 44*(2), 169-173.

Willig, C. (2013). *Introducing qualitative research in psychology*. Maidenhead: Open University Press.

Willig, C. (2019). Ontological and epistemological reflexivity: A core skill for therapists. *Counselling and Psychotherapy Research, 19*(3), 186-194.

Willig, C., & Stainton Rogers, W. (2017). The SAGE handbook of qualitative research in psychology (Second ed.). London; Thousand Oaks, CA;: SAGE Publications.

Wittenberg, K. J., & Norcross, J. C. (2001). Practitioner perfectionism: Relationship to ambiguity tolerance and work satisfaction. *Journal of Clinical Psychology, 57*(12), 1543-1550.

Worldometer. (2021). Coronavirus death toll. Retrieved from https://www.worldometers.info/coronavirus/coronavirus-death-toll/

World Health Organization. (2020). Q&A on coronaviruses (Covid-19). Retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronruses

Yang, Z., Ji, L., Yang, Y., Wang, Y., Zhu, L., & Cai, H. (2021). Meaning making helps cope with COVID-19: A longitudinal study. *Personality and Individual Differences, 174,* 1-6.

Yardley, L. (2000). Dilemmas in qualitative research. *Psychology and Health, 15*(2), 215-228.

Zaki, J. (2020). Catastrophe compassion: Understanding and extending prosociality under crisis. *Trends in Cognitive Sciences, 24*(8), 587-589.

Zhai, Y., & Du, X. (2020). Loss and grief amidst COVID-19: A path to adaptation and resilience. *Brain, Behavior, and Immunity, 87*, 80-81.

Appendices

Appendix A: Recruitment Advert

As part of a research study looking at the support offered to the recently bereaved, we want to hear from counsellors who are happy to talk about their experiences of providing early bereavement support for clients bereaved during Covid-19, and would be prepared to take part in a confidential, zoom focus group.

This research is designed to shape best practice.

If you are interested in participating in the study, or would like more information, please contact

Johanna Salkin (Researcher)

[redacted]

This study has been reviewed and received ethics clearance through the Psychology Research Ethics Committee, City University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee [redacted]

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at [redacted]

Appendix B: Participant Information Sheet

Title of study: Grief during Covid-19: Exploring an early bereavement support intervention
We would like to invite you to take part in our research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take the time to read the information below. Do not hesitate to ask to ask us questions if anything is unclear or if you would like to have more information.

What is the purpose of the study?
This study is carried out as part of a Professional Doctorate in Counselling Psychology at City University London. The study is expected to be completed in 2021-2022. The aim of the study is to explore counsellors' experience and perceptions of providing a support bereavement intervention for losses during Covid-19. The objective of the study is to explore the current support services put in place during Covid-19.

Why have I been invited?
Counsellors having provided the bereavement support intervention [redacted] will be invited to take part in the study.

Do I have to take part?
Participation is voluntary. You can choose not to participate in part or all of the project. You can also withdraw at any stage of the project without being penalised or disadvantaged in any way.
If you decide to take part, you are still free to withdraw from the study without giving a reason and at any time before the data is analysed in December 2020.

What will happen if I take part?
You will be asked to engage in a one-to-one interview over Zoom. The interview should last around one hour and will involve a discussion on your experience and perceptions of providing the bereavement Covid-19 support intervention. The session will be audio-recorded using a password-protected recorder. Your personal information (such as name) will be anonymised and the recorder will be kept in a locked file cabinet. You could potentially be asked to engage in a second one-to-one interview at a later time, to further the conversation around your experience of providing the bereavement intervention.

What are the possible disadvantages or risks of taking part?
Discomfort or anxiety from answering the questions could potentially happen although it is not anticipated. You are encouraged to talk about any emotional upset with the researcher who will be interviewing or/and to contact the research supervisor.

What are the possible benefits of taking part?
The study could hopefully help develop the support offered to clients experiencing grief during the Covid-19 pandemic. The study could provide you with the opportunity to talk about your experience of providing support for grief during Covid-19.

What should I do if I want to take part?

You will be asked to complete an electronic consent form.

Data privacy statement
City University of London is the sponsor and data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task. Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study as necessary. If you wish to receive the results of the study, your contact details will also be kept for this purpose. The only people at City who will have access to your contact details will be the researcher and the research supervisor. City will keep your contact details about you from this study until the end of the study, after which contact information will be destroyed. The interview data will be safely kept for ten years before being destroyed.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

Will my taking part in the study be kept confidential?
The researcher and research supervisor only will have access to the data before it is anonymised. Personal information will be anonymised. The recorder containing the recording of the interview will be stored in a locked file cabinet. The transcription of the session will be stored in an encrypted, password-protected laptop. Electronic data (interview data) will be deleted after ten years.

What will happen with the results?
The results will be used in the thesis for the Professional Doctorate in Counselling Psychology. The results could potentially contribute to an article which could be published in a research journal. The data and any identifiable information will remain anonymous. Your name will not appear anywhere in the thesis or journal articles.
If you wish to be informed about the results, you can request to have the researcher contact you to share the results once the study is finished. If you request this, you will be asked to consent to the researcher retaining your contact details and data for this purpose.

What will happen when the research study stops?
Data will be stored securely and destroyed after ten years. Identifiable information (name, age, email address) will be destroyed at the end of study.

Who has reviewed the study?
This study has been approved by City, University of London Psychology Research Ethics Committee.

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone [redacted]. You can then ask to speak to the Secretary to Senate Research

Ethics Committee and inform them that the name of the project is: Grief during Covid-19: Exploring a early bereavement support intervention.
You can also write to the Secretary at:
[redacted]

Insurance
City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Further information and contact details

Johanna Salkin
[redacted]

Thank you for taking the time to read this information sheet.

Appendix C: Interview Schedule 1

- How do you feel about taking part in this research?

- What were your initial thoughts/feelings about providing that kind of support? Specifically, did you have any specific hopes or concerns regarding this intervention?

- I would be interested in hearing a little about what the sessions entailed.
    - Was there anything that you would have liked to be different?
    - Was there anything that you found particularly helpful or unhelpful in the work?

- What was your experience of providing these sessions remotely compared to face-to-face?

- Would you like to say a little about your experience of providing this support?
    - Is there anything that you would have ideally liked to be different about this support?
    - Do you feel that this support has impacted the difficulties clients initially contacted the service for?

- Is there anything that you would want to share with counsellors who would want to provide this type of support?

- Is there anything else that you would like to add regarding your experience of providing this intervention?

Appendix D: Consent Form 1

Q1.
Please read through the information below which is also present in the information sheet. If you have any queries or concerns regarding these, please feel free to contact the researcher. If you are happy to go ahead with the study, please select 'I consent'.

I confirm that I have read and understood the participant information dated 08/10/2020 (version 3) for the above study. I have had the opportunity to consider the information and ask questions.

I understand that this will involve taking part in a one-to-one interview over Zoom in which I will be talking about my experience of providing an early bereavement support intervention during Covid-19.

I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged. I understand that I will be able to withdraw my data up to the time the interview will be transcribed, in December 2020.

I understand that information I provide is confidential and that no identifiable information will be disclosed in any reports or to any other party.

I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR). I understand that data will be anonymised and kept safely for a period of 10 years. Personal information (e.g., name, age, email) will be destroyed at the end of the study for confidentiality purposes.

I confirm that I am 18 or above and that I agree to take part in the above study.

- (●) I consent
- ( ) I do not consent, I do not wish to participate

Q5. I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.

- (●) Yes
- ( ) No

Q9. I am happy for the researcher to use direct quotes from the interview when writing up the research. The quote will be anonymised whereby the researcher will ensure that no identifiable information is contained within the quote.

- (●) I consent
- ( ) I do not consent

Q4. **Please provide the following information:**

Age:

[redacted]

Q5. Gender I identify with:

Q6. Ethnicity:

[redacted]

Appendix E: Interview Schedules 2

P1 – Interview Agenda

Could you draw your experience when considering:

1. the feelings that emerged around the work? (around content/process of sessions)
2. When thinking about the therapeutic relationship? (how it was for you to work with emotions brought by clients)
3. Your experience of support throughout this developing piece of work?
4. A sense of responsibility towards the work was evoked in our previous conversation, would you be able to explore this experience further through drawing?

Is there anything else that we haven't explored that you would like to represent or mention in some way?

P2 – Interview Agenda

From the above symbols, could you pick one (alternatively, could you describe a landscape) which best represents:

1. your experience when considering the various feelings that emerged around the work and how you managed these?
    a. Around the content/process of sessions
    b. Around structure of intervention (pace, time-limited)
2. When thinking about the therapeutic relationship?
3. When considering your experience of the clients' needs (what they wished/needed from the work)

Is there anything else that we haven't explored that you would like to represent or mention in some way?

P3 – Interview Agenda

Could you draw your experience when considering:

1. the feelings that emerged around the work? (around content/process of sessions) + around the intensity of the work.

2. When thinking about your experience of the intervention's format? (working over the phone, the pace)

3. When thinking about the therapeutic relationship?

4. Around your experience of support throughout that work?

Is there anything else that we haven't explored that you would like to represent or mention in some way?

Appendix F: Consent Form 2

Please read through the information below. If you have any queries or concerns regarding these, please feel free to contact the researcher. If you are happy to go ahead with the study, please select 'I consent'.

I confirm that I have read and understood the participant information form dated 08/10/2020 (version 3) for the above study. I have had the opportunity to consider the information and ask questions.

I understand that this will involve taking part in a one-to-one interview over Zoom in which I will be talking about my experience of providing an early bereavement support intervention during Covid-19. I understand that I will be invited to explore my experience of providing this intervention via drawing/imagery.

I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged. I understand that I will be able to withdraw my data up to the time the interview will be transcribed, in July 2021.

I understand that information I provide is confidential and that no identifiable information will be disclosed in any reports or to any other party.

I understand that this information will be used only for the purpose(s) explained in the participant information sheet and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR). I understand that data will be anonymised and kept safely for a period of 10 years. Personal information (e.g., name, age, email) will be destroyed at the end of the study for confidentiality purposes.

I confirm that I am 18 or above and that I agree to take part in the above study.

I consent

I do not consent, I do not wish to participate

I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.

Yes

No

I am happy for the researcher to use direct quotes from the interview when writing up the research. The quote will be anonymised whereby the researcher will ensure that no identifiable information is contained within the quote.

I consent

I do not consent

I am happy for the researcher to include my drawings in writing up the research. Only drawings which do not have any identifiable information would be included.

I consent

I do not consent

Appendix G: Debrief Form

CITY UNIVERSITY LONDON

Participant Debrief Form

Title of Study: Grief during Covid-19: Exploring an early bereavement support intervention

Thank you for taking part in this study. Now that it's finished, we would like to tell you a little more about it.

The research aimed at exploring counsellors' experiences of providing an early bereavement support intervention during Covid-19. Due to Covid-19, psychological needs have grown, particularly around the experience of grief during the pandemic, when social distancing measures are in place. Service like [redacted] have developed interventions aimed at supporting people grieving in these exceptionally difficult circumstances. We wished to enquire what counsellors' experience was of this, as little research currently exists on the topic. Knowing what it is like to work under a particular context could help inform the development of such interventions.

If the research has raised any concerns or distress, you may contact:

The researcher: [redacted] Your GP
Samaritans: 116 123 or jo@samaritans.org

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following email address:

Johanna Salkin

[redacted]

Ethics approval code: ETH1920-1676

Appendix H: Initial Ethical Approval from City University of London Ethics Committee

Ethics ETH1920-1676: Johanna Salkin (Low risk)

Ethics application

26 May 2020
Johanna Salkin
[redacted]
Exploring the effects of combining aromatherapy massages to trauma- focused therapy: A mixed methods design.
School of Arts and Social Sciences
Psychology

Risks

R1) Does the project have funding?

No

R2) Does the project involve human participants?

Yes

R3) Will the researcher be located outside of the UK during the conduct of the research?

No

R4) Will any part of the project be carried out under the auspices of an external organisation, involve collaboration between institutions, or involve data collection at an external organisation?
Yes

R5) Does your project involve access to, or use of, material that could be classified as security sensitive?
No

R6) Does the project involve the use of live animals?

No

R7) Does the project involve the use of animal tissue?

No

R8) Does the project involve accessing obscene materials?

No

R9) Does the project involve access to confidential business data (e.g. commercially sensitive data, trade secrets, minutes of internal meetings)?
No

R10) Does the project involve access to personal data (e.g. personnel or student records) not in the public domain?
No

R11) Does the project involve deviation from standard or routine clinical practice, outside of current guidelines?
No

R12) Will the project involve the potential for adverse impact on employment, social or financial standing?
No

R13) Will the project involve the potential for psychological distress, anxiety, humiliation or pain greater than that of normal life for the participant?
No

R15) Will the project involve research into illegal or criminal activity where there is a risk that the researcher will be placed in physical danger or in legal jeopardy?
No

R16) Will the project specifically recruit individuals who may be involved in illegal or criminal activity?
No

R17) Will the project involve engaging individuals who may be involved in terrorism, radicalisation, extremism or violent activity and other activity that falls within the Counter- Terrorism and Security Act (2015)?
No

Applicant & research team

T1) Principal Applicant Name
Johanna Salkin

T2) Co-Applicant(s) at City Name
[redacted]

T3) External Co-Applicant(s)

T4) Supervisor(s)

[redacted]

T5) Do any of the investigators have direct personal involvement in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest? No

T6) Will any of the investigators receive any personal benefits or incentives, including payment above normal salary, from undertaking the research or from the results of the research above those normally associated with scholarly activity?
No

T7) List anyone else involved in the project.

Project details

P1) Project title

Grief during Covid-19: Exploring counsellors' and service-users' experience of a remote early bereavement support intervention.

P1.1) Short project title

Early bereavement support interventions during Covid-19

P2) Provide a lay summary of the background and aims of the research, including the research questions (max 400 words).
Bereavement is described as "the reaction to the loss of a close relationship" (Humphrey, & Zimpfer, 2008, pp. 3). Bereavement is associated with emotional and cognitive difficulties, changes in behaviour physical symptoms, increased vulnerability to mental health difficulties including increased risk of suicide (Stroebe et al., 2015). Complicated grief (CG) relates to prolonged grief, involving longing, affect such as anger, guilt, cognitive symptoms such as intrusive thoughts or images related to the deceased or his/her death and strong responses to reminders (Stroebe et al., 2015). The following factors have been identified as increasing the likelihood of CG: sudden death, being a carer for the deceased, nature of the relationship with the deceased, social support, external factors, past experiences of loss, already existing mental health difficulties (Stroebe et al., 2015).

It has been argued that the Covid-19 pandemic and its impact on situational factors surrounding the loss of a loved one (separation, not being able to say goodbye, being in ICU), increase the likelihood of CG (Gesi et al., 2020). Indeed, studies looking at the relationship between the nature of the death and CG identified that when a stay in ICU is involved, not being present during the death and lack of communication between the loved ones and the hospital staff are factors associated with CG. These findings highlight the need for developing appropriate psychological responses to the increased bereavement needs that will arise during Covid-19 (Gesi et al., 2020).

Studies exploring the impact of providing early bereavement interventions to individuals having lost someone to suicide found that both face-to-face and remote interventions decreased the risk of suicide and symptoms (Gehrmann et al., 2020).

The above literature indicates a need to explore early interventions developed to support individuals bereaved due to, during Covid-19.

Early support bereavement interventions developed during Covid-19 remain new and unexplored, particularly as they are provided remotely. Carrying out research exploring such intervention could

provide necessary information to evaluate its use. This study aims to explore clients' and counsellors' experiences and perceptions of a remote, early bereavement support

intervention. This study could provide preliminary insight on clients' and counsellors' feelings, thoughts about the support developed to respond to the increased bereavement needs during Covid-19. In turn, this could inform services on the appropriateness of such intervention.

The research question is the following: How do service-users and counsellors experience and perceive an early, remote bereavement support intervention during Covid-19?

P4) Provide a summary and brief explanation of the research design, method, and data analysis.
Research design:

A qualitative study would be adopted, looking at the experience and perceptions of both counsellors and clients providing/receiving early bereavement support interventions for losses due to Covid-19. The focus of the study will be on their experience of the intervention rather than their experience on grief. That is because participants will have been very recently bereaved, and it was judged too early to have a thorough exploration with them of their experience of loss under Covid-19. A qualitative design was thought to be more adequate, as quantitative methods were judged potentially too cognitively burdensome for individuals having lost someone less than 6 months ago. Additionally, qualitative methods fit with the researcher's relativist position.

Method:

A focus group comprised of the counsellors providing this intervention would be carried out. Clients having received this intervention would be interviewed using a one-to-one, semi-structured interview. Both would be asked about their experience of receiving/providing such intervention. A focus group was judged to potentially yield richer insight from counsellors. One-to-one interviews were thought to be more suitable for clients, given the sensitive nature of the topic. Interviews might provide a safe, comfortable space for participants to reflect on their experiences. The focus group would take place via zoom. The semi-structured interviews would take place either over the telephone, or over zoom, depending on the participant's preference.

Early Bereavement Intervention:

The intervention involves a 3 session-long, psychological support, in which clients are able to talk about their current experience, receive some psychoeducation around bereavement. Clients receiving this service are individuals having lost someone from Covid-19 less than six months ago.[redacted]

Data analysis:

Data would be analysed using IPA, as this method is thought to fit with the researcher's relativist, phenomenological position, and with the aim of exploring participants' experiences of an intervention, in the current sociological context of Covid-19.

P4.1) If relevant, please upload your research protocol.

P5) What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?
Ensuring participants' autonomy: The research flyer will be included at the feedback form

which participants are asked to complete at the end of the three sessions. Therefore, participants will have the freedom to contact me if they are interested in taking part. The information sheet and consent form will include clear statements around the participants' rights to drop out of the research. Transparency in all written and oral communications with participants will be ensured so they will be able to make informed decisions.

Confidentiality: As researcher, independent of the organisation, participants' anonymity will be protected, including from the service providing the support intervention. Participants' contact information, consent forms, will be kept securely in a password-protected, encrypted laptop, and will be destroyed at the end of the study. After data collection, participants will be anonymised, whereby names will be replaced by numbers. No one apart from the researcher and research supervisor will have access to the data before anonymisation. Any potential hard copies will be stored in a locked cabinet in City University's counselling psychology research clinic.

Participant protection: To limit any risk of harmed caused to participants, the following would be done:

- Informing participants about the subject of the study and what participation would entail, in the consent form and information sheet.

- A Pre-interview screening phone call, enabling participants to get further acquainted with the study, and talk about any concern they may have regarding the study.

- The content of the interview questions focuses on participants' experience of receiving/providing an early bereavement support intervention. By focusing on the intervention itself instead of the bereavement, it is thought to minimise the risk of causing participants distress.

- Adequate resources will be included in the debrief form, in the event that participants would be emotional from the interview.

Another potential issue may be that counsellors taking part in the focus group may feel concerned about openly sharing their views and experience of the intervention, as other counsellors within the organisation would be present. Information sheets and consent forms will include asking participants to maintain the content of the focus group confidential, whereby they will not disclose what is said by other counsellors.

Additionally, counsellors may feel uncomfortable talking about their client work, perhaps for confidentiality. At the beginning of the focus group, participants will be asked to protect their client's anonymity if they wish to speak of specific work carried out (eg, to use a pseudonym, not to give any identifiable information).

Participants will also be told to feel free to say as much or as little as they wish, to avoid any pressure they may feel around answering questions.

P6) Project start date

The start date will be the date of approval.

P7) Anticipated project end date

29 Sept 2021

P8) Where will the research take place?

The study will take place remotely, either via zoom or telephone. This is to respect social distancing measures applied for the pandemic.

P10) Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee?
No

External organisations

E1) Provide details of the external organisation/institution involved with this project.

[redacted]

E2) If applicable, has permission to conduct research in, at or through another institution or organisation been obtained?
Yes

E2.1) Provide details and attach the correspondence.

Human participants: information and participation

The options for the following question are one or more of:
'Under 18'; 'Adults at risk'; 'Individuals aged 16 and over potentially without the capacity to consent'; 'None of the above'.

H1) Will persons from any of the following groups be participating in the project?

None of the above

H2) How many participants will be recruited?

15

H3) Explain how the sample size has been determined.

[redacted]

10 clients would be ideally recruited for one-to-one interviews. This leaves space for participants who may drop out of the study.

Overall, the literature suggests a sample size of 6-8 participants for qualitative interviews.

H4) What is the age group of the participants? Lower Upper
18

H5) Please specify inclusion and exclusion criteria.

Exclusion criteria for clients: Under 18 years old (for safeguarding/ethical reasons), who are at risk to self or others (to minimise potential harm to participants), not speaking fluent English (to ensure reliable analysis of the client's narrative + quality communication during the interview)

Inclusion criteria for clients: Above 18, having completed the 3 sessions of the early bereavement intervention, no identified risk to self or others, speaking fluent English.

Inclusion criteria for counsellors: Being a counsellor[redacted] over 18, providing the early Covid- 19 bereavement support intervention, speaking fluent English.

H6) What are the potential risks and burdens for research participants and how will you minimise them?
The potential risk for research participant would be that thinking about the topic of the interview could be emotionally difficult. All clients having undergone this intervention will have been risk assessed prior to being allocated to the intervention. Additionally, risk will be explored in the screening telephone call, to ensure that clients taking part in the study are not under safeguarding risks.

Furthermore, risk will be minimised by paying close attention to the language used throughout the study.

Debrief forms will be provided at the end of the interviews in which participants will be encouraged to contact the researcher, research supervisor or any of the provided helplines if they were to experience any distress related to the research. This will be communicated by the researcher at the end of the interviews and via the debrief forms sent to participants following the interviews.

Finally, participants will be invited to take breaks during the interview process if they wish.

Regarding the counsellors taking part in the focus groups, a potential risk could be that discussing their experience and perspective of this intervention with their colleagues within the organisation may feel uncomfortable, that they fear any repercussions from what they may want to share. This will be minimised by including a line asking participants to keep what is discussed in the focus group confidential, not to disclose any of the content. Additionally, group discussions in which different perspectives and experiences are shared can always create some tension between participants. Perhaps some guidance at the beginning of the focus group, around remaining respectful of everyone's input, not to interrupt someone speaking, could be mentioned. If any of the focus group participant appears to be emotionally distressed or uncomfortable, the researcher will privately message the participant via zoom, offering to check-in at the end of the focus group. Emotional support, risk assessment,wil be carried out based on the participant's needs, as assessed by the researcher.

Counsellors may also feel uneasy about talking about their client work. Participants will be asked to ensure service-users' anonymity if they wish to talk about specific client work (using pseudonyms, avoiding identifiable information). Overall, participants will be invited to share as much or as little as they wish, to minimise any pressure they may experience around answering any of the questions.

H7) Will you specifically recruit pregnant women, women in labour, or women who have had a recent stillbirth or miscarriage (within the last 12 months)?
No

H8) Will you directly recruit any staff and/or students at City?

None of the above

H8.1) If you intend to contact staff/students directly for recruitment purpose, please upload a letter of approval from the respective School(s)/Department(s).

H9) How are participants to be identified, approached and recruited, and by whom?

All clients having received this Covid-19 intervention will be sent a feedback form to complete at their final session. The research will be advertised at the end of this form. Participants interested in taking part will be invited to contact the researcher with the contact details provided on the form. Ideally, it would have been preferable to leave flyers in the service premises. Unfortunately, due to Covid-19, all clinical work is carried out remotely, and this way was felt to be the most suitable given the current circumstances.

[redacted] counsellors, an email with the study's advert with the researcher's contact details will be sent to counsellors providing this intervention. Again, this was felt to be the best means of advertising the study given the circumstances.

If participants contact the researcher and wish to take part in the study, an information sheet will be sent via email and a screening phone call will take place, in which the researcher will ensure that participants fit the inclusion criteria, and to provide more information about the research.

Following this, a consent form would be sent via a Qualtrics link, enabling participants to provide consent electronically.

Once participants would have formally consented to taking part in the study, a time/date for the focus group/interview would be agreed upon with the participant(s). Finally, a debrief form will be sent via email to the counsellors at the end of the support group. This debrief form is the same as the one sent to clients.

H10) Please upload your participant information sheets and consent form, or if they are online (e.g. on Qualtrics) paste the link below.
H11) If appropriate, please upload a copy of the advertisement, including recruitment emails, flyers or letter.

H12) Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained.
The main researcher will be obtaining participants' consent. Prior to a screening phone call, participants will be sent an information sheet via email. After the screening phone call, if participants are still interested in taking part and if they meet the inclusion criteria, a link to a Qualtrics consent form will be sent by email to participants. Participants will be able to provide consent electronically, by ticking either 'I consent' or 'I do not consent'. Qualtrics enables participants to download a pdf version of their consent. The researcher will also ensure to upload a copy of their Qualtrics consent, to send to them via email. The time between sending out the information sheet and the consent form will vary, depending on the speed at which participants respond to the email and the participants', researcher's availabilities for the screening phone call, and availabilities/preferences for a date and time for the interview/focus group. A minimum of 24h is expected between the time the information sheet is sent and the time of the focus group or interview.

H13) Are there any pressures that may make it difficult for participants to refuse to take part in the project?
No

H14) Is any part of the research being conducted with participants outside the UK?

No

Human participants: method

The options for the following question are one or more of:
'Invasive procedures (for example medical or surgical)'; 'Intrusive procedures (for example psychological or social)'; 'Potentially harmful procedures of any kind'; 'Drugs, placebos, or other substances administered to participants'; 'None of the above'.

M1) Will any of the following methods be involved in the project:

None of the above

M2) Does the project involve any deceptive research practices?

No

M3) Is there a possibility for over-research of participants?

No

M4) Please upload copies of any questionnaires, topic guides for interviews or focus groups, or equivalent research materials.
M5) Will participants be provided with the findings or outcomes of the project?
Yes

M5.1) Explain how this information will be provided.

The consent form will include a statement asking participants if they would like to be informed of the study's findings. In qualtrics, participants will be able to tick 'Yes' or 'no' to the question: 'I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose.'

For participants who ticked yes, their email address will be retained, and at the end of the project (once data has been analysed and the thesis has been drafted), a summary of the findings will be sent to them via email.

M6) If the research is intended to benefit the participants, third parties or the local community, please give details.
short-term benefits include: The opportunity for participants to talk about their experience of receiving this intervention/ or of providing this intervention

Long term benefits include working towards developing bereavement interventions to meet the increasing bereavement needs through Covid-19, understanding the challenges of these interventions. Considering that this type of intervention has been newly developed/put in place to

respond to the complex bereavement needs during Covid-19, studies investigating both clients' and counsellors' experiences, perspectives on these seem paramount.

M7) Are you offering any incentives for participating?

No

M8) Does the research involve clinical trial or clinical intervention testing that does not require Health Research Authority or MHRA approval?
No

M9) Will the project involve the collection of human tissue or other biological samples that does not fall under the Human Tissue Act (2004) that does not require Health Research Authority Research Ethics Service approval?
No

M10) Will the project involve potentially sensitive topics, such as participants' sexual behaviour, their legal or political behaviour, their experience of violence?
No

M11) Will the project involve activities that may lead to 'labelling' either by the researcher (e.g. categorisation) or by the participant (e.g. 'I'm stupid', 'I'm not normal')?
No

Data

D1) Indicate which of the following you will be using to collect your data.

Interviews
Focus groups
Audio/digital recording interviewees or events

D2) How will the the privacy of the participants be protected?

Anonymised sample or data

D3) Will the research involve use of direct quotes?

Yes

D5) Where/how do you intend to store your data?

Data to be kept in a locked filing cabinet
Password protected computer files
Storage on encrypted device (e.g. laptop, hard drive, USB Storage at City

D6) Will personal data collected be shared with other organisations?

No

D7) Will the data be accessed by people other than the named researcher, supervisors or examiners?
No

D8) Is the data intended or required (e.g. by funding body) to be published for reuse or to be shared as part of longitudinal research or a different/wider research project now or in the future?
No

D10) How long are you intending to keep the research data generated by the study?

Data will be kept for a period of 10 years, based on institutional guidelines, after which time, it will be destroyed.

D11) How long will personal data be stored or accessed after the study has ended?

If participants do not wish to be informed of the study's findings, personal data will be stored until the interview/focus group has been transcribed.

For participants wanting to be informed of the study's findings, personal information will be destroyed immediately at the end of the research project (expected to be in September 2021).

D12) How are you intending to destroy the personal data after this period?

Personal data will be in an electronic format in an encrypted, password-protected laptop and laptop folder. The information will be deleted from laptop, including laptop bin.

Any potential hard copies (eg, interview transcription), will be shredded before being binned.

Health & safety

HS1) Are there any health and safety risks to the researchers over and above that of their normal working life?
No

HS3) Are there hazards associated with undertaking this project where a formal risk assessment would be required?
No

Appendix I: Amended Ethics Application

Ethics ETH2021-0383: Miss Johanna Salkin (Low risk)

Ethics application

Amendments

08 Oct 2020 08 Oct 2020 12 Oct 2020

Miss Johanna Salkin [redacted]
Doctoral Researcher Academic Staff

[redacted]
Grief during Covid-19: Exploring counsellors' and service-users' experience of a remote early bereavement support intervention. School of Arts and Social Sciences
Psychology
Approved

SA1) Types of modification/s

Change the design and/or methodology of the project, including changing or adding a new research method and/or research instrument
Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

SA2) Details of modification

Instead of having a focus group, counsellors' experience of the intervention would be explored via a one hour, one-to-one semi-structured interviews.

Potentially, a second interview with each participant would take place, although this would be confirmed at a later stage.

Information sheet would be amended to reflect the above changes.

SA3) Justify why the amendment is needed

Following discussion with a research tutor, a semi-structured interview was thought to be most appropriate for an IPA analysis.

As the intervention is no longer being funded, the chances of recruiting clients for interviews is significantly reduced. Therefore having one-to-one interviews with counsellors would enable richer data, in the event of low recruitment of clients. Additionally, a potential second interview with counsellors could further enrich the data collected, by exploring further counsellors' experiences.

SA4) Other information

SA5) Please upload all relevant documentation with highlighted changes Project amendments

P1) Project title

Grief during Covid-19: Exploring counsellors' and service-users' experience of a remote early bereavement support intervention.

P2) Principal Applicant Name
Miss Johanna Salkin

P3) Co-Applicant(s) at City Name
[redacted]

P4) External Co-Applicant(s)

P5) Supervisor(s)

[redacted]

Appendix J: Amended Ethics Application 2

Ethics ETH2021-1463: Miss Johanna Salkin (Low risk)

Ethics application

Amendments

10 Mar 2021 10 Mar 2021 11 Mar 2021

Miss Johanna Salkin Prof Carla Willig [redacted]
Doctoral Researcher Academic Staff

Prof Carla Willig
Grief during Covid-19: Exploring counsellors' experience of providing a remote early bereavement support intervention.
School of Arts and Social Sciences
Psychology
Approved

SA1) Types of modification/s

Change or add supervisors involved in the project
Change project documentation such as protocol, information sheets, consent forms, questionnaires, recruitment materials (please upload the relevant files with highlighted changes)

SA2) Details of modification

Research supervisor is now Dr Carla Willig.

The research will only explore counsellors' experiences of providing the early Covid bereavement intervention and not both counsellors' and clients' experience as was initially planned.

The first amendment referred to potentially having a second round of one-to-one interviews with participants, which participants were informed about in the information sheet. This was also mentioned at the first interviews, and participants reported being happy to engage in further interview. This amendment would be to provide further information about the second round of one-to- one interviews, including consent form and interview agendas.

The same participants are to be invited via email to take part in a second interview, in which their experience of providing an early Covid bereavement intervention will be further explored, using drawing/visual methods. Participants will be asked to represent their experiences through drawing.

One participant reported being uncomfortable with drawing but happy to use imagery in other forms. As such the interview agenda was modified appropriately for this participant. This participant will be invited to pick from a selection of symbols and to describe visualised landscapes best representing his experience.

The use of visual methods will be used to elicit further exploration and conversation around participants' experiences. The conversation elicited by the visual methods will be analysed using IPA.

Individual interview agendas were developed for each participant, on the basis of themes present in their first interview.

SA3) Justify why the amendment is needed

The bereavement organisation had to stop providing this early covid bereavement intervention due to lack of funding. As such, recruitment of clients was interrupted and I chose to focus the research on counsellors' experiences only for practical reasons.

Given the small number of counsellors offering this intervention, and the small number having agreed to take part in the research (4), I decided to add a second round of interviews to ensure richness of the data.

SA4) Other information

SA5) Please upload all relevant documentation with highlighted changes Project amendments

P1) Project title

Grief during Covid-19: Exploring counsellors' experience of providing a remote early bereavement support intervention.

P2) Principal Applicant Name
Miss Johanna Salkin

P3) Co-Applicant(s) at City Name
Prof Carla Willig

P4) External Co-Applicant(s) Name
N/A

Title of post

Affiliation

N/A

Provide details of the researcher's insurance cover.

P5) Supervisor(s)

Prof Carla Willig

Appendix K: Sample of Individual Participant Transcript Analysis

Participant's Pseudonym: John	
Original Transcript	Comments
13 00:01:20.340 --> 00:01:21.810 [redacted]	[redacted]

[redacted] 21 00:02:22.860 --> 00:02:28.440	

Appendix L: Sample of Emergent Themes and Associated Quotes

A developing intervention	"(…) everything was so unplanned and unformed" (l. 18) "I didn't know what the procedure was going to be." (l. 20) "I mean, obviously, it had never been done before (…)" l. 31 "So just thinking about 'ok, what can I offer'?" (l. 70) "So obviously, you're not going to have all of the infrastructure there already, you, you're going to have to set it up as you go along." (l. 93)
Unfamiliarity of working in the midst of a pandemic	"(…) because we've never been in the situation of a worldwide pandemic before." (l. 31) "It hadn't been that last that long since we've gone into lockdown, since we've switched over to working remotely. So... I was still getting used to working that way... the clients were still getting used to working in that way." (l. 109-110)
Past experiences as supportive	"So just, I started thinking about that and realizing 'Oh, actually, I do have s-skills already in this area.'" (l. 82) "And I can combine them with my experience of being with clients who... maybe only needed someone to listen." (l. 83) " (…) I did have the experience of working on a helpline. Which really did support me. Um… because I found that I very quickly remembered what that was like." (l. 208-210)
Action and lack of control within the Covid-19 pandemic	"(…) because we were in this situation of lockdown… and… that was a very strange situation for me personally to be in." (l. 34-35)

	"Everything had suddenly become very quiet, and very still. (…) Suddenly I was at home all the time" (l. 38) "(…) I was presented with an opportunity... to… to help people." (l. 41) "(… here's something I can actually do to help!" (l. 43)

Appendix M: Clustering Themes for an Individual Case

A different type of therapeutic work

Time as condensed

Working with distress associated to Covid-19: offering practical and psychological support
- Importance of support

A natural progression

A positive experience

A different experience from colleagues'

SECTION B: COMBINED CASE STUDY AND PROCESS REPORT

Attending to the unconscious in bereavement work: When a parallel process emerges between therapist and patient

This content has been removed for data protection reasons

SECTION C: PUBLISHABLE PAPER

"Wow, here's something I can actually do to help!": Exploring counsellors' experiences of providing a bereavement intervention during Covid-19

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