The experience of ICU nurses working on the frontline during the COVID-19 pandemic

Rossana Basile

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

August 2022

ABSTRACT

The impact that COVID-19 is having on the worldwide population has been made clear by the emerging literature on the ongoing COVID-19 pandemic, which links it to a broader idea of collective trauma. However, its implications on the healthcare system are particularly significant, considering that the National Health System was already in decline before the pandemic due to persistent underfunding and, as a result, a shortage of staff. Literature on previous pandemics and more recent literature on the COVID-19 outbreak have both drawn attention to the considerable hardships that pandemics impose on frontline workers. Questions about the experience of ICU nurses working on the frontline during the COVID-19 outbreak arise in light of this multi-layered context. This question is being investigated in the current study adopting a hermeneutic phenomenological approach in order to explore participants' relationships to the world and their lived experiences related to this specific phenomenon. Semi-structured interviews were conducted with six senior registered nurses who worked on the frontline as ICU nurses from the start of the pandemic in March 2020 to July 2020. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Four Group Experiential Themes have emerged from the data: ""SURREAL" INSIDE AND OUTSIDE HOSPITALS", "DOING (VERSUS BEING): THE ADAPTATION TO THE COVID REALITY", "BYSTANDER: DISAPPOINTMENT WITH THE GOVERNMENT AND THE PUBLIC" and "EMOTIONAL DETACHMENT AS COPING SRATEGY". As per the methodological underpinning, emphasis has been placed on reflexive awareness. The study seeks to contribute to a new perspective on the topic, integrating literature from Counselling Psychology, Social Justice, and the Power-Threat Meaning Framework (Johnstone & Boyle, 2020).

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF TABLES

ABBREVIATIONS

2019-nCoV	Novel Coronavirus
CCUs	Critical Care Units
CoP	Counselling Psychology
COVID-19	CoronaVirus Disease 19
ERs	Emergency Rooms
FAO	Food and Agriculture Organization of the United Nations
GET	Group Experiential Theme
GT	Grounded Theory
HDUs	High Dependency Units
ICU	Intensive Care Units
IPA	Interpretative Phenomenological Analysis
ITUs	Intensive Therapy Units
MERS - CoV	Middle East Respiratory Syndrome Coronavirus
NHS	National Health Service
NQNs	Newly Qualify Nurses
OIE	World Organization for Animal Health
PET	Personal Experiential Theme
PPE	Personal Protective Equipment
PSTD	Post-Traumatic Stress Disorders
SARS	Severe Acute Respiratory Syndrome
SARS- CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
WHO	World Health Organisation

ACKNOWLEDGEMENTS

I am incredibly thankful to my participants who agreed to be interviewed for this study. You have bravely shared your experience with me, and I am honoured to have met you and to reveal your stories within my research.

I wish to express my sincere thanks to my supervisors, Dr Lucy Poxon and Dr Martin Willis, for your constant guidance, constructive criticism of my writings, and availability during this process. Also, thank you, Dr Lucy Poxon, for igniting my interest and enthusiasm for my research along this journey.

For sharing and containing both joy and sorrow during those years, my group of colleagues on the Professional Doctorate of Counselling Psychology Programme deserve my utmost gratitude.

I am proud of myself for accomplishing this goal and feel extremely fortunate for the love and support from my loved ones.

DEDICATION

"To see a World in a Grain of Sand
And a Heaven in a Wild Flower
Hold Infinity in the palm of your hand
And Eternity in an hour"
William Blake, 1968

To Leah

CHAPTER ONE

INTRODUCTION

The COVID-19 pandemic has greatly alarmed the public due to the numerous reports of mortality rates, hospital pressure, and rising infection rates across the globe. The United Kingdom has been one of Europe's most affected countries, with unprecedented demand imposed on the healthcare workforce (Vindrola-Padros et al., 2020). Frontline workers were particularly at risk for transmission, sickness, and mortality, and this has had a detrimental effect on their psychological health (Newman et al., 2021). This is consistent with prior pandemic study findings and current research on the COVID-19 pandemic, which emphasise the need to focus on frontline workers as being more susceptible to being influenced by the pandemic's aftereffects. Despite this fact, there appears to be little research on intensive care unit (ICU) nurses in particular. This study seeks to explore the experiences of Italian ICU nurses working on the frontline of the COVID-19 pandemic. Since I was interested in exploring human experience on its own terms rather than in accordance with a predefined category (Smith et al., 2022), I was driven to employ a hermeneutic phenomenological approach. Six participants participated in a qualitative study using semi-structured interviews, which were then analysed using Interpretative Phenomenological Analysis (IPA). Participants are of Italian nationality, working in London as senior registered nurses in NHS Trusts. The study's purpose is to provide a forum where audiences inside and beyond the Counselling Psychology (CoP) community can learn about the experiences of ICU nurses working during the COVID-19 outbreak. It contributes to a novel perspective on the experience of working during the COVID-19 pandemic, informed by existing literature on past and present pandemics, including material from the nursing profession, the fields of Counselling Psychology, Social Psychology, and Social Justice.

This research seeks to be anchored in a set of principles and ethics unique to the CoP profession, based on humanistic values (Joseph, 2008; Orlans & Van Scoyoc, 2009; Walsh & Frankland, 2009; Woolfe & Dryden, 1996). These include but are not limited to an emphasis on clients' subjective and intersubjective experiences; a shift toward empowerment, encouraging growth through individual's resources and potential; a concern on a non-hierarchical client-therapist relationship; and, last but not least, a recognition of the client as a unique human being who is socially and relationally entrenched (Cooper, 2009). Additionally, counselling psychology "pays particular attention to the meanings, beliefs, context and processes that are constructed both within and between people and which affect the psychological well-being of the person" (Orlans & Van Scoyoc, 2009, p.18). This viewpoint is aligned with the aims of this study as well as the methodological and epistemological foundations chosen, which encourage a specific understanding of the phenomenon (this is covered in more detail in the section on the clinical contribution in the discussion chapter). This is consistent with the statement included in the Professional Practice Guidelines for Counselling Psychology (BPS, 2020, p. 1), "counselling psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology". My personal perspective and background in the research have been significant since they have influenced what has been included and how narratives have been interpreted. This is described in greater depth in the methodology chapter.

The following sections will provide an overview of the disease, its symptoms, and its consequences, as well as a review of the socio-political context, policies, and setting for this research, all in accordance with the CoP principles and the epistemological and methodological underpinning selected for this study.

Before moving on to the next sections, it seems necessary for this research to define terms. The terms "critical care" and "intensive care" are used interchangeably due to the lack of standardisation in critical care nomenclature (Faculty of Intensive Care Medicine and Intensive Care Society, 2022) (For more details, check section 2.3.1.). The virus is called SARS-CoV-2, and the disease it causes is termed Corona Virus Disease 2019, abbreviated as COVID-19. The World Health Organization (WHO) selected the name following the World Organization for Animal Health (OIE) and the Food and Agriculture Organization of the United Nations (FAO) guidelines to find a name that was pronounceable and that did not refer to any geographical location, animal, person, or group of people to prevent stigmatisation (WHO, 2022a).

1.1. COVID-19

The WHO has designated the ongoing COVID-19 pandemic an international public health emergency (Teng et al., 2020). On December 31st, 2019, the Wuhan Municipal Health Commission in Wuhan City, Hubei Province, China, reported a cluster of 27 pneumonia cases of unknown origin, including seven severe cases, all linked to Wuhan's Huanan Seafood Wholesale Market (European Centre for Disease Prevention and Control, ECDC, 2022). The SARS-related coronavirus (CoV) and the recently discovered coronavirus (2019-nCoV) were quickly linked (ECDC, 2022). In February 2020, the WHO disclosed the new virus's name. Due to its resemblance to the coronavirus that caused the 2013 Severe Acute Respiratory Syndrome (SARS) pandemic, it was named Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Teng et al., 2020). The COVID-19 pandemic started slowly but advanced swiftly, and little was known about its exact initial occurrence, with reports going back to November 2020 and others linking it to December of that year, as well as its mode of transmission, incubation time, medication, and vaccination (Allam et al., 2020).

The first known fatality occurred on January 9, 2020, in a 61-year-old patient with serious underlying medical issues who had reportedly visited Wuhan's Huanan Seafood Wholesale market while the virus continued to spread in Wuhan and other parts of China (Ravelo & Jerving, 2020). Numerous preventative measures were attempted due to the virus's original ambiguity over its cause, transmission, and treatment, many of which have proven ineffective as more information about the virus has become known. For instance, the WHO first recommended that masks only be worn by health professionals or patients in hospitals, but as it was established that human-to-human transmission was a possibility, it became essential that masks should be worn by everyone (Allam et al., 2020). After human-to-human transmission spread outside of China, the WHO declared the SARS-CoV-2 outbreak a Public Health Emergency of International Concern on January 30, 2020, after more than 80,000 confirmed cases were reported globally (Cucinotta & Vanelli, 2020).

The ongoing COVID-19 is an infectious disease that affects people in diverse ways, according to the most recent WHO information (WHO, 2022a). Fever, cough, trouble breathing, nausea, diarrhoea, headache, and loss of taste and smell are just some of the symptoms associated with COVID-19 as a respiratory infection (Centers for Disease Control and Prevention (CDC), 2022). Most persons experience mild to moderate symptoms and are able to recover without the need for specific treatment. However, some people, particularly those with underlying medical concerns, can become severely unwell requiring admission to hospital. At the time of writing, it has been determined that anyone, at any age, can become infected, seriously or fatally ill. Since its first human transmission, handwashing and sanitiser were introduced due to the risk of transmission by physical contact/touch. Social distance limitations and the use of fitted masks have been implemented worldwide to prevent airborne transmission, while vaccination recommendations and local guidelines have been introduced (WHO, 2020a).

The SARS-CoV-2 virus has been discovered in three variations thus far, each with a separate lineage and additional mutations (ECDC, 2022). These variants had an impact on the epidemiological situation due to their transmissibility, severity, and immunity, and coexisted with other de-escalated variants that had either stopped circulating or had no impact on the epidemiological situation due to their long-term circulation (ECDC, 2022). As new versions emerge, Public Health and Social Measures (PHSM) continue to be changed (WHO, 2020b). Nonetheless, contemporary SARS-CoV-2 virus strains are thought to cause mild to moderate illness in otherwise healthy people (WHO, 2020b).

1.2. How effectively were various countries in preventing the spread of COVID-19?

To date, it has been known that certain countries reacted differently to the COVID-19 pandemic and were able to contain the virus's spread in their populations during the first wave, which lasted from February to July 2020, reducing the number of cases and fatalities. Since January 2020 to April 2020, countries including Australasia, East/Southeast Asia, most East/Central European, Scandinavian, many African, most Middle East-North African, and some South American countries have taken the pandemic danger more seriously, and have developed testing capacity, isolation, and quarantining procedures (Tang et al., 2022).

After witnessing what was happening in China, the people of East/Southeast Asia responded with compliance and cooperation, realising that sacrificing their independence in exchange for public health measures would have helped the greater good and prevented the virus from spreading (Tang et al., 2022). This is in contrast to most Western European, North American, and South American countries where government and public health messages were ambiguous, conflicting and often played down the threat posed by the virus (Brooks, 2020; Lewis, 2021;

Asmelash, 2021). Trust in the healthcare system and the government was a predictor of limiting the virus's transmission during the first wave in several countries, as citizens were more compliant with social distancing restrictions (Tang et al., 2022). Western countries exaggerated their pre-existing influenza pandemic strategies and healthcare system's capabilities to deal with the new respiratory virus (Bamford, 2020). In the United Kingdom, British exceptionalism contributed to the notion that the SARS-CoV-2 virus would have little impact on the nation, prompting the government to dismiss the East/Southeast Asian country experience (Tang et al., 2022; Horton, 2020; Hunter, 2020). Since the current study was conducted in London, in the next paragraph, I describe in more detail the severity of the COVID-19 pandemic in England.

1.3. The severity of the COVID-19 pandemic in England

The epidemic had a devastating impact on the United Kingdom, particularly England. In the UK, wearing a fitted mask was required by law at the start of the pandemic. Although the government still endorses this requirement as of the time this document was written, it is no longer enforced by law. In the UK, WHO (2022b) has received reports of 23,213,017 confirmed cases of COVID-19, 182,727 fatalities, and 150,195,878 vaccination doses administered as of the time of writing. The first wave of the pandemic in England occurred between March and July 2020 (Armour, 2020). According to an article published by Tang et al. (2022), the government squandered time debating whether the virus transmission was ultimately airborne, whether masks were effective, and the appropriate level of personal protective equipment (PPE) for health care professionals (Nyashanu et al., 2020). The COVID-19 pandemic strategy was delayed as a result of this scepticism, and the subsequent chaotic and disorganised reaction allowed COVID-19 to flourish and fatalities to rise (Tang et al., 2022).

1.4. The policy of the UK government

The COVID-19 pandemic fluctuated according to changes in governmental regulations especially in relation to lockdown measures and local alerts. Three nationwide lockdowns were announced on the 23rd of March 2020, the 5th of November 2020, and the 6th of January 2021, in conjunction with the vaccination programme rolling out from the 8th of December 2020, immediately following the approval of the Pfizer-BioNTech COVID-19 vaccine, and the Oxford-AstraZeneca vaccine later the same month (Institute for Government, 2022). While the government still advocates vaccines and wearing a face covering in crowded or enclosed spaces as of the time of writing, lockdown restrictions were lifted by July 2021 (Gov.UK, 2022).

The COVID-19 pandemic generated near-unprecedented policy adjustments in favour of government participation, at a pace and scale that seemed impossible until 2020 (Cairney, 2021). Many have criticised the UK's reaction as weak and delayed, accusing politicians of playing the blame game rather than making wise decisions (Gaskell et la., 2020; Boin et al., 2020; Oliver, 2020). These criticisms focused on the UK's scepticism towards existing evidence on the virus, even after the devastating effects of the COVID-19 disease in China in January 2020 and Italy in February 2020. The UK's response was delayed compared to other countries in terms of testing to limit the spread and/or implementing prevention measures such as closing businesses, schools, social events, and regulating social behaviour to prevent infections through human interactions and in public spaces/transports (Henley, 2020; Boin et al., 2020). Critics pointed to problems with PPE, testing capacity, and a test-trace-and-isolate system, all of which contributed to increases in transmission and mortality rates (Gaskell et al., 2020). Others argue that the UK government adopted a mitigation strategy, which focused on decreasing COVID-19 infection rates and impacts until the population acquired "herd immunity" (Cairney, 2021, p. 91) rather than implementing immediate suppressive measures

until the development of a vaccine (Sridhar, 2020; Cairney, 2021). Insufficient PPE in hospitals and the transfer of persons from hospitals to care homes without testing were found to be the most important causes of high fatality rates (Cairney, 2021; Campbell et al., 2020; Burn-Murdoch & Giles, 2020; Scally et al., 2020). The government response to the COVID-19 pandemic further eroded trust in the UK that was already low after Brexit and the subsequent General Election in late 2019 (Davies et al., 2021). While levels of trust did increase after the first lockdown was implemented in March 2020, this quickly fell again after Dominic Cummings (then Prime Minister's chief adviser) disregarded governmental lockdown rules (Davies et al., 2021). This led to further distrust and reduced compliance with lockdown measures (Stewart, 2020).

The next section explores the role of health care workers, notably nurses who worked on the frontline during the COVID-19 pandemic and explains why they have been prioritised in this study.

1.5. The National Health System

The COVID-19 epidemic struck at a particularly inconvenient moment for the NHS, as funding began to dwindle in 2010/2011, and since then, it has been argued that financial restrictions have harmed patient care owing to staffing cuts and upgraded clinical equipment (Robertson et al., 2017). The shortage of financing also happened at a time when the demand for care has risen (Lafond et al., 2016), owing to technical advancements and broader cultural shifts that have emphasised individual rights and more consumer-focused services (Greengross et al., 1997). This has resulted in higher levels of stress and an increase in sick leave among nursing staff (Robertson et al., 2017).

The successful operation of the UK public healthcare system necessitated assistance from trained personnel from other EU countries and England has 63,650 European nationals among its 1.2 million NHS employees (Baker, 2021). Following the EU referendum, the number of EU and other non-EU nationals employed by the NHS decreased (Dalingwater, 2019). Such elevated concentrations of departure for both groups of workers are concerning given that, following Brexit, it would be more difficult to fill the gap by recruiting from other European Union countries (NHS Digital, 2018). Despite former Chancellor of the Exchequer Nigel Lawson's depiction of the NHS as "the closest thing English people have to a religion" (Dalingwater, 2019, p. 4), many employees have decided to resign owing to its decline in recent years. The biggest reason for NHS professionals leaving their profession, according to a survey (Ellis, 2018), was to seek a better work-life balance, followed by a lack of prospects and inadequate compensation or benefits. According to the Organisation for Economic Co-operation and Development (OECD, 2015), the UK has the second highest number of foreign workers in the health sector after the US, with Indian workers being the most common nationality, followed by Filipino, Irish, Polish, Portuguese, and Spanish (NHS Digital statistics, 2018). However, there is concern that strict immigration restrictions may make it harder to recruit EU workers once they are subjected to the same requirements as other immigrants.

Prior to the 2016 Brexit referendum, the NHS was already having trouble retaining employees; in fact, since 2010, nursing has grown at a slower rate than other categories of staff in England's hospitals (Dalingwater, 2019). Nurses' personnel increased by 6.2% between November 2010 and November 2019, compared to a 20.6% increase in hospital doctors and an 18.4% increase in scientific, therapeutic, and technical employees (Macdonald & Baker, 2020). Nurse recruitment was falling far short of what was needed, despite employers' efforts to acquire more personnel in the wake of Sir Robert Francis' cautions about patient safety, following a scandal

of unacceptable care in the Mid Staffordshire NHS Foundation Trust (Royal College of Nursing, 2015). In the same period, the decision to cut back on training as well as the government rule to reduce the demand for migration labour by deporting non-EU nurses earning less than £35K a year did not help the situation (Royal College of Nursing, 2015). In a different report carried out in 2018/2019, the Care Quality Commission (CQC) highlighted how the quality and quantity of available care decreased because of people's inability to access appropriate services, as well as staff cuts, and/or staff missing the necessary competencies, a lack of training and clinical support, and less staff with care experience (CQC, 2019). In addition, 40% of respondents of an NHS staff survey reported feeling unwell because of work-related stress within a 12-month period (West, 2020).

The shortage of nurses has caused a spike in the recruitment of newly qualified nurses (NQNs). Nevertheless, if the environment is not supportive of the individual, the initial motivation to join the trust may be quickly replaced by irritation and dissatisfaction, leading to stress and, if not addressed, burnout (Spinetta et al., 2000). Extensive research on the experience of shifting from student to employee in the ward environment highlighted major stressors such as physiological disruptions, including insomnia and weight loss (O'Shea & Kelly, 2007) and work-related burnout (Rudman & Gustavsson, 2007). NQNs were taken aback by the level of expertise required to care for critically sick patients and felt overwhelmed by the anxiety (King & Clark, 2002). The increasing rate of burnout among NQNs has been attributed to the survival of the fittest concept (McKee & Ashton, 2004), which suggests that burnout typically happens within the first five years of a nurse's career, during which time a nurse may opt to leave the profession, and the remaining nurses are the ones who have survived.

In conclusion, economic restrictions associated with health care reform had impeded health care professionals' ability to provide high-quality care in accordance with their standards since before the COVID-19 outbreak (Maslach, 2003; Laschinger & Montgomery, 2014). This has contributed to a higher turnover in the nursing profession (Maslach, 2003). Given what has been discussed thus far, the COVID-19 outbreak occurred at a particularly vulnerable time for nurses and the NHS. Since the focus of this research is to explore the experiences of ICU nurses on the frontline during the COVID-19 pandemic, I now review the literature on the aftermath of previous pandemics before moving on to the developing research on the COVID-19 outbreak.

Section 2.7., instead, concentrates on protective factors and resilience in health care workers.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

In this chapter I present a critical review of the experiences of ICU nurses working on the frontline during the COVID-19 epidemic. It will outline studies that have indicated significantly more challenging COVID-19 implications among various population groups, particularly health care frontline employees, providing justification for the focus on ICU nurses. The research data from prior pandemics and current emerging findings, as well as research on protective factors for frontline workers, will be reviewed, eliciting consideration on whether the COVID-19 pandemic has affected individuals and communities as a collective trauma. The chapter will conclude with a review of the questions addressed in this study as well as its relevance with the CoP practices, after emphasising the theoretical framework and the importance of qualitative studies during the COVID-19 pandemic.

2.2. Search Strategy

I reviewed articles indexed in the electronic database EBSCO until July 2022. The search terms combined with the Boolean operator were COVID-19, SARS-CoV-2, pandemics, coronavirus, ICU nurses, frontline workers, mental health, trauma, counselling psychology, social justice, Power-Threat Meaning Framework.

2.3. Why nurses in Intensive Care Units?

2.3.1. Intensive Care Units

According to the Office for National Statistics (2022), more than 90% of all patients admitted to critical care between February 2020 and December 2021 in England were patients for whom COVID-19 was the primary reason for admission. Towards the end of December 2021, during the period when Omicron replaced Delta as the dominant variant, this trend started to change. The number of patients admitted to critical care due to COVID-19 dropped from 761 in January 2022 to 87 in June 2022.

Intensive care units (ICUs) are specialised hospital wards that treat severely ill or surgical patients who require close monitoring and advanced equipment (NHS, 2022). Critical care units (CCUs) and intensive therapy units (ITUs) are other names for ICUs. One or two patients are typically cared for by one ICU nurse and are connected to equipment through tubes, wires, and cables (NHS, 2022). The typical shift for ICU nurses is twelve hours (NHS, 2022). The Nursing and Midwifery Council registers all nurses in the UK. A specialised nursing degree is not required for direct admission to ICU. Many would, however, have had a placement in an intensive or high dependency units (HDUs) or given a preceptorship time to gain experience in the department (Scottish Nursing Guild, 2021). Preceptorship is a period of structured transition to help new practitioners progress from students to independent professionals (NHS Employers, 2022).

This thesis is concerned with the experience of ICU nurses on the frontline during the COVID-19 pandemic, so I discuss below some of the ethical issues and challenges that have been recognised in the nursing literature prior to the outbreak.

2.3.2. Stress and strains implicit in the nursing profession

Before delving into the literature on ethical challenges in the nursing profession, I discuss the notion of care and stress that are intricately intertwined at the profession's core and from which ethical conflicts in the workplace develop. Care is regarded as an important component of the nurse-patient relationship, with practice grounded in the ethical principles of beneficence and non-maleficence, which imply a concern for people's well-being while abstaining from behaving in a way that may cause harm (Beauchamp & Childress, 2022). Despite the fact that various studies (e.g. Von Essen & Sjoden, 1991; Von Essen & Sjoden, 1993; Higgs, 1998) among nurses and patients ranked honest and clear information and expert clinical care as the most important care behaviours, other studies concluded that discussions about bad news should be prevented since they can cause distress (Sprigler, 1997), depression (Andrews, 1996; Downs, 1999), pain (Reeder, 1988), and endanger hope in patients (Begley & Blackwood, 2000; Vegni et al, 2001; Flaming, 2000). According to some research, this communication control is chosen to minimize harm and promote well-being among patients (Tuckett, 2005). Controlling communication, however, is against the principles of beneficence and non-maleficence; it eventually gives the medical staff control over patients' rights, limiting the growth of a relationship built on trust and loyalty (Wolf & Hughes, 2008).

Nurses in critical care units care for trauma and surgical patients, who frequently arrive postoperatively, wired, and tubed to the ventilators on which they rely. It should be noted that the continual noise generated by the beeping and sounds of these machines compounds the strain of their task (Baker, 1993; Kam et al., 1994). Nurses are expected to offer ongoing monitoring for these patients' overall care, and they are regularly asked to operate with limited resources, such as understaffing, insufficient, or malfunctioning equipment, and a lack of management assistance, all of which add stress and burden to their workload (Flynn & Bruce,

1993). Being exposed to critically sick patients, communicating with, and attending to worried family and relatives, as well as recording every action performed, is emotionally and physically taxing, as Hudak et al. (1998) reported. Extended life spans, increased technology, the public's unrealistic expectations of medical care, significantly larger cultural and religious diversity, greater emphasis on patient rights, shifts in healthcare financing, and limited resources are all contributing to an increase in ethical conflicts (Morris & Dracup, 2008; Schlairet, 2009).

To gain a better understanding of the experiences of ICU nurses on the frontline during the COVID-19 epidemic, I discuss the moral problems that nurses have been facing on a regular basis prior to the outbreak.

2.3.3. Moral problems faced by nurses

According to findings from a review of the literature (Georges & Grypdonck, 2014), nurses, despite their commitment to care and patients, fail to recognise the moral dimensions of the problems they face, which often result from factors beyond their control, leaving them feeling insecure and powerless. These pressures can be linked to organisational demands and expectations versus individual needs, understaffing, and an excessive workload with limited resources (Sullivan & Decker, 1997), all of which have an impact on nurses' moral behaviour. Ethical conflicts may emerge in the workplace when nurses' values clash with their perceptions of how patients are cared for and treated (Gaudine et al., 2011). As several studies have shown (Dierckx de Casterlé et al., 1996; Benner, 1991; Valente et al., 1998; O'Connor, 1996), nurses have limited control and involvement in treatment decisions when caring for dying patients, which may drive them to behave against their own values. Nurses may separate themselves from their patients once they realise they have no control over the situation, therefore moral dilemmas are no longer a problem (van der Arend & Remmers-van den Hurk, 1995). These

findings are consistent with studies on the nursing profession in ethical issues, which show that nurses are unsure about their specific role and when their obligations cease (Lawrence & Farr, 1982; Swider et al., 1985).

According to a report from the Harvard Medical Practice Study (Leape et al., 1991), more than 70% of mistakes resulting in adverse events were ascribed to carelessness, and more than 90% were deemed preventable. These errors, which may or may not harm patients, reflect a variety of systemic difficulties, such as a culture that is not focused on safety and the prevalence of unfavourable working circumstances for nurses (Reason, 1990; Wolf & Huges, 2008), all of which contribute to further ethical conflicts. Due to a lack of autonomy and authority, nurses may be unwilling to express moral concerns for fear of being judged as unprofessional by their colleagues (Hart et al., 1998; Wilkes et al., 1993). As a result, they are torn between the urge to act in support of patients' well-being and want to be appreciated by their colleagues (Udén et al., 1992; Sundin-Huard et al., 1999).

2.3.3.1. Moral Distress

Moral distress was coined by Jameton (1984) to describe how institutional policies and procedures might compel nurses to perform actions they know are ethically wrong (McCarthy, 2013). Since then, a range of explanations of moral distress has been established, as well as a range of empirical tools for identifying the origins of moral distress and measuring its impact on nurses and other health professionals (McCarthy & Gastmans, 2014). Liaschenko's study (1995) related moral distress to the idea of the nurse as "artificial personhood" since "the work of nursing is embedded in complex institutions and networks of power, in which nurses must

act on decisions made by others" (Liaschenko, 1995, p. 187), whereas Begley and Piggott's (2012) study distinguished between moral distress and moral stress and extended these experiences to family and patients who had to make tough ethical choices. In a qualitative study, Varcoe et al. (2012) discovered a variety of systemic factors that contribute to moral distress, including workload/overload, lack of competence in self and others, witnessing tragedies, and moral compromise. These studies focused on nurses' experiences with moral distress and the impact on their patients, revealing that moral distress is a relational concept anchored in the environment of work and the power dynamics in which nurses make decisions. Staff shortages (Corley et al., 2005; Ohnishi et al., 2010), low-quality care and unrealistic hope provided to patients and families were found to be the main findings in various research reviews (Schluter et al., 2008). The interconnection between the experience of moral distress and work context is a key finding from these studies. As a result, moral distress should be considered as a connection between people and organisations rather than just a personal or an institutional problem.

Research on moral distress has been criticised in a variety of ways, and one of the main criticisms is that there is no widely agreed definition of the concept of moral distress (Willis, 2015). Additionally, the wording of the Moral Distress Scale (MDS), which has been used in many studies (e.g., Elpern et al., 2005), can only be understood in context (Willis, 2015). Repenshek (2009) suggested that moral distress occurred because of nurses' discomfort with moral subjectivity, seeing as a lack of clarity with their ethical obligations rather than their inability to act on moral decisions. On the other hand, this study seeks to provide a deeper understanding of the complexity of the experience of ICU nurses working during the COVID-19 epidemic by avoiding reductive categorization. This is covered in more detail in the section on the clinical contribution in the discussion chapter.

2.3.3.2. Moral Injury

Although the term moral injury originated in the context of military personnel, it has only recently been used in the healthcare field as it is becoming increasingly recognised as a challenge for health care providers. According to the British Medical Association (2021), moral injury occurs when long-term moral distress causes reduced function or long-term psychological suffering. Moral injury can result in feelings of deep remorse and humiliation, as well as feelings of betrayal, rage, and moral disorientation. Since the COVID-19 epidemic, there has been an increased focus on moral injury; nevertheless, to date the overall prevalence of moral injury is unclear, and no study has looked at the relationship between moral injury and its association among health care workers (Amsalem et al., 2021). Nurses in all specialities and settings are routinely called upon to make or witness morally difficult patient care decisions, and the COVID-19 epidemic has heightened the risk of moral injury for nurses (Williams et al., 2020; Greenberg et al., 2021). During the peak of the epidemic, many health care workers had to make life-or-death choices concerning COVID-19 patients who were very ill (Tracy et a., 2020). Triage decisions, the use of ventilators, prioritising who is treated for disease (Tracy et al., 2020) as well as a lack of PPE, and non-pharmaceutical therapies (Kreh et al., 2021) are among them. As a result, COVID-19 exposed health care workers to situations that might possibly contradict their moral values, resulting in moral injury. However, all these publications on moral injury among health care workers during the COVID-19 pandemic have been purely commentary or theoretical, with no adequate assessment of moral injury levels or consequences (Amsalem et al., 2021). As a result, the research limitations on moral injury make no additional contributions to the current investigation. This is in line with the study's efforts to avoid categorising ICU nurses' experiences of working during the COVID-19 pandemic.

2.3.3.3. Burnout

Burnout is defined “as the feelings of exhaustion, professional cynicism or reduced professional ability resulting from chronic workplace stress” (British Medical Association, 2021, p. 4). Although it is frequently associated with moral distress and moral injury, burnout is distinct from the other terms in that it does not always include a moral component (British Medical Association, 2021). With burnout, “the emphasis has been on the process of psychological erosion, and the psychological and social outcomes of this chronic exposure, rather than just the physical ones” (Maslach, 2006, p. 39). As a result of burnout, an employee may choose to leave their job or stay but work inefficiently (Sullivan & Decker, 1997). Indeed, as Brooker and Nicol (2003) pointed out, burnout has contributed to a large number of nurses leaving not only ICUs, but also the profession of nursing, since it often arises from causes beyond the individual's control. Maslach (1999, 2006) clarifies burnout as a state that develops from a protracted mismatch between an individual and their workplace. In particular, Maslach emphasised "the individual's relational transactions in the workplace" (2006, p. 39), as example of this, King et al. (2006) further suggested that it might be linked to several factors in the workplace, including a scarcity of staff, insufficient time, and excessive workloads. Subsequent burnout models differ from Maslach's in that they do not consider burnout to be solely a work-related syndrome, and as a process rather than a state (Ekstedt, 2005; Shirom, 2003).

In a European nursing study, stress and burnout were shown to have a strong correlation with an interest in leaving the profession and burnout was substantially higher among UK nurses (42%) than the European average (28%) (Heinen et al., 2012). Nurses are subjected to high physical and emotional demands due to extended shifts and overtime, leaving them exhausted

and unable to cope well with stress (Geiger-Brown et al., 2004; Page, 2004). Additionally, because of an ageing population and higher levels of co-morbidity, nursing care has become more demanding. This, along with a nursing shortage, has led to an uneven distribution of nursing workload across different levels of care within the patient population (Vahey et al., 2004; Tai et al., 1998; Hemingway & Smith, 1999; Strachota et al., 2003). The results of these studies do not clearly define the nursing speciality and refer to the general population of nurses, whereas the current study intends to focus on ICU nurses.

2.4. Literature on past pandemics

The current COVID-19 epidemic has resulted in significant and widespread fatalities as well as a variety of stresses affecting the worldwide population, such as financial hardship, bereavement, compromised individual feelings of safety, and alienation from social support networks (Norris et al., 2020). This worldwide catastrophe has added to the stressful working circumstances and lack of equipment that frontline workers have been forced to endure (Hoernke et al., 2021). Many frontline workers are suffering from clinically significant exhaustion, depression, chronic pain, sleep problems, and anxiety (Robinson et al., 2015; Teng et al., 2020). A growing body of literature has explored the impact of trauma at a group level on various occupations including emergency services, military personnel, and health care professionals (Serrano-Ripoll et al., 2020; Mobbs & Bonanno, 2018; Brooks et al., 2020). Section 2.6. (Do the effects of the COVID-19 pandemic represent a collective trauma?) discuss this in more detail. Poor mental wellbeing has been shown to have lasting consequences not just on a personal level but also on productivity at work and on colleagues (Sage et al., 2018; Brooks et al., 2018).

A systematic review (Carmassi et al., 2020) of studies of previous coronavirus outbreaks within the last decade, such as Coronavirus syndrome (SARS-CoV) and the Middle East Respiratory Coronavirus Syndrome (MERS-CoV), with the majority of studies conducted in China, Canada, and South Korea, found that frontline workers are particularly exposed to developing PTSD symptoms due to the extreme working conditions imposed by pandemics, such as caring for traumatized people, managing critical medical situations, witnessing death and trauma, unstable sleeping pattern due to work shifts (Cieslak et al., 2014; Berger et al., 2012; Garbern et al., 2016; Hegg-Deloye et al., 2013). Furthermore, nurses working in the ITU generally reported even higher rates of PTSD, burnout syndrome, anxiety, depression, decrease in attention, and fatigue, than other nursing specialities (Mealer et al., 2009; Karanikola et al., 2015; Machado et al., 2018). While the review was primarily based on cross-sectional studies of stress related to the coronavirus outbreaks of SARS and MERS-CoV infections by using self-report measures, these studies also included mixed populations with a focus on hospital or healthcare workers, either as a sub-sample or as the only sample.

The existing literature on short-lived past pandemics has drawn attention to population groups including children, women, people from lower socioeconomic backgrounds, and frontline workers (Tang et al., 2014; Brooks et al., 2020). Research on hospital staff has found that 17.3% of hospital workers developed significant mental health issues during the Severe Acute Respiratory Syndrome (SARS) outbreak (Lu et al., 2006) and scored highly on depressive symptoms (Liu et al., 2012) and PTSD (Wu et al., 2009) even years after the quarantine period. Staff who had to quarantine due to SARS were more inclined to report exhaustion, irritability, insomnia, lack of concentration, poor job performance, high level of stress, anxiety, depression, PTSD, and thoughts of resigning (Bai et al., 2004; Lee et al., 2007). Frontline staff also reported mental health difficulties when assisting in other emergencies (Borho et al, 2019).

2.5. Recent research evidence on health care frontline professionals

At the time of writing, there is a dearth of qualitative research in the emerging literature on the COVID-19 pandemic, and the majority of publications on health care workers appear to be strictly theoretical, detailing the potential consequences of the COVID-19 pandemic for frontline personnel based on previous pandemic findings. Furthermore, only a few qualitative studies have focused on the experiences of health care workers working during the COVID-19 pandemic (Tan et al., 2020; Sy et al., 2020) and the experiences of frontline ICU nurses in the UK during the COVID-19 outbreak appear to be a grey area that this study seeks to address.

The NHS and social care sectors have borne the brunt of the effects of COVID-19 (Billings et al., 2021). The virus's rapid growth put a strain on the profession's core values, including care, compassion, competence, communication, courage, and commitment, since personnel were compelled to keep a safe distance from patients while assessing the degree of care offered (Snow et al., 2020). According to the findings of a quantitative study (Platt & Warwick, 2020), frontline health care workers' distress grew after the government failed to stockpile PPE due to rising costs. This led to a lack of trust in the government, particularly among Pakistani, Black African, and Black Caribbean ethnic groups, who are over-represented among key workers, and thus predominantly impacted, compared to those of other ethnic groups (Platt & Warwick, 2020). This evidence is consistent with the findings of a rapid qualitative appraisal study on the perceptions of PPE among healthcare workers (Hoernke et al., 2021). This study emphasised the various challenges to providing care that arises from inadequate PPE provision, unclear instructions, and a lack of training on its use (Hoernke et al., 2021; Vindrola-Padros et al., 2020). Its results revealed limitations in the representation of participants from a variety of professional backgrounds as well as representation of Black, Asian, and other minorities, and

limited access to data sources due to time constraints. However, the findings of this study appeared to be supported by quantitative studies that demonstrated how a lack of access to PPE was a critical contributor to increased death rates among Black, Asian, and minority ethnic health care workers (Moorthy & Sankar, 2020; Nguyen et al., 2020).

Early quantitative research on COVID-19 pandemic on frontline health care personnel working in ICUs in the UK found higher rates of depression, anxiety, PTSD, suicide ideation and thoughts of self-harm (Greenberg et al., 2021; Greene et al., 2021). A recent qualitative study (Newman et al., 2021) on health care workers in the UK sought to understand how working during the pandemic has affected their psychological wellbeing and what solutions can be implemented to help them cope with the resulting psychological difficulties. By using qualitative content analysis (Elo & Kyngäs, 2008), the study identified three themes: 1. despair and insecurity: feeling overburdened while attempting to protect everyone, 2. behavioural and psychological effects: affecting well-being and functioning and 3. coping and employer support: receiving the appropriate care (Newman et al., 2021). This study has provided an in-depth understanding of the strain placed on NHS employees to fulfil their civic, personal, and professional responsibilities to ensure everyone's safety, which had detrimental psychological and behavioural repercussions. However, given the nature of the survey questions, it showed limitations: since the survey link circulated on social media, it precluded the opportunity for in-depth responses, challenging queries, or request clarification. These findings were corroborated and strengthened by evidence from a qualitative study (Montgomery et al., 2021) on frontline staff working in critical care during the first wave of the COVID-19 pandemic in the UK. The sociological concept of community of fate proposed by Baehr (2005) was used to interpret the data. The term described a pattern of transient social cohesion acquired by a group of individuals going through a similar crisis (Baehr, 2005). This study clarified the importance

of considering the social and organisational factors at play in addition to an individualised understanding of staff well-being (Montgomery et al., 2021). In fact, the findings indicated that strong teamwork, camaraderie, pride, and fulfilment helped to lessen the stress and isolation of working in critical care during the COVID-19 pandemic. This study, as opposed to the majority of studies that concentrated on individualised mental health outcomes, seemed to offer a sociological analysis of critical care work during the first wave of the COVID-19 pandemic in the UK (Montgomery et al., 2021). However, it generalised the diverse groups and roles of healthcare professionals working in critical care by using a sample largely comprised of medical and nursing personnel. Instead, this research seeks to thoroughly unveil the lived experience of ICU nurses, during the COVID-19 pandemic.

The findings from earlier pandemics and the newly developing research on the present pandemic have raised concerns whether the COVID-19 epidemic's aftermath constitutes a collective trauma. More information on this topic is provided in the section that follows.

2.6. Do the effects of the COVID-19 pandemic represent a collective trauma?

Hirschberger (2018) defines collective trauma as “a cataclysmic event that shatters the basic fabric of society. Aside from the horrific loss of life, collective trauma is also a crisis of meaning” (Hirschberger, 2018, p. 1). The COVID-19 pandemic has resulted in social, cultural, and economic disasters, as well as collective trauma on a personal and global scale (Stanley et al., 2021). Trauma is a complicated reaction to a stressful event that exceeds an individual's capacity to cope (Masiero et al., 2020). The amount to which we are permitted to talk about traumatic events is typically socially determined, with many of them being swept under the carpet (Taylor, 2020). Trauma adaptations such as denial, dehumanisation, detachment, and splitting can be communicated on an individual as well as a social level (Taylor, 2020). When

a traumatic event is not elaborated, it is eventually connected with behavioural and psychological changes like issues with emotional regulation and maladapted defence mechanisms, e.g., dissociation (Masiero et al., 2020; Weathers & Keane, 2007; DSM-IV-TR, 2022). Many stressors, such as health-related dangers for themselves and loved ones, worry about loved ones, grief for the death of loved ones, the social impact of lockdown, social distancing and isolation, job losses, constant exposure to stress through the media, and a lack of habitual instruments to manage emotions, have prompted questions about whether the COVID-19 pandemic should be regarded as a collective trauma (Stanley et al., 2021; Masiero et al., 2020; Lassri & Desatnik, 2020). As a result, there has been an emphasis in emerging research on the COVID-19 pandemic on the protective factors and coping strategies employed by health care professionals, which I explain in the following paragraph.

2.7. Protective factors and resilience in health care workers

As previously noted, and similar to the findings of prior pandemic-related studies, there is accumulating evidence that the psychological health of health care workers is deteriorating, with widespread rates of anxiety, burnout, depression, PTSD, and psychological distress (Chew et al., 2020; Shechter et al., 2020). These findings have indicated a present need to enhance the mental health of health care workers exposed to the COVID-19 since the beginning of the pandemic. Local communities of mental health professionals have acknowledged this problem by providing free counselling and support to frontline staff coping with the pandemic (NHS, 2020), as well as advice on psychological support to frontline staff during this unprecedented time (BPS, 2020).

A cross-sectional study (Labrague & De los Santos, 2020) discovered a high level of resilience among frontline health care personnel and hospital nurses, as well as a significant capacity to

recover from adversity and return to a healthy state (Luceo-Moreno et al., 2020), which appeared to be associated with a decreased prevalence of anxiety related to the pandemic. This is in line with previous research showing that health care workers are emotionally resilient as a result of their training and experience dealing with death and disease (Brooks et al., 2020). However, there was already a higher rate of stress, burnout, depression, drug and alcohol addiction, and suicide among all categories of health staff prior to the COVID-19 pandemic (Carrieri et al., 2018). A systematic review of studies (Labrague, 2021), which comprised primarily quantitative research indicated coping behaviours such as communication with family, friends, and colleagues that were utilised to assist health care professionals in dealing with the impact of the COVID-19 outbreak on their mental health. Reduced levels of traumatic stress (Blanco-Donoso et al., 2021) and emotional distress (Chew et al., 2020) were connected to good management and supervision, as well as support from co-workers, peers, friends, and family (Dong et al., 2020). However, this review lacks consideration for the in-depth lived experience of frontline ICU nurses working during the COVID-19 pandemic.

A qualitative study was carried out by Billings et al. (2021) to learn more about the experiences and perceptions of frontline health and social care workers regarding psychosocial support during the COVID-19 pandemic. While some individuals perceived psychological treatment to be well-marketed and easily accessible, others encountered ambiguous communication since they did not know how to access it or that it was only offered during business hours. This study found stigma associated with seeking psychological care, particularly in terms of how others would have perceived them as individuals and in their professional roles. As a result, some study participants had opted for an individual session outside of their organisation over the informal and reflective team sessions led by a psychologist as they were uncomfortable speaking in front of their colleagues and mistrusted their organisation (Billings, 2021). This

study identified several limitations, including a lack of diversity in the sample, which might have revealed additional needs and preferences from frontline health and social care workers from different settings, ethnicities, and age groups.

2.8. Discussion and Conclusion

This literature review provides an overview pertinent to the current study. Attention has been drawn to research investigating the effects of previous pandemics as well as the COVID-19 pandemic and the psychological support provided to frontline workers to date. Brooks et al. (2020) reviewed the evidence on the psychological impact of quarantine during earlier outbreaks, including SARS, the 2009 and 2010 H1N1 influenza pandemic, Middle East respiratory syndrome, Ebola, equine influenza, to explore its probable effects on mental health and psychological wellbeing. They found that only a limited number of studies employed qualitative methods. For instance, Robertson et al. (2004) used grounded theory principles to analyse the data and develop an explanatory framework to examine the psychosocial effects of quarantining due to SARS exposure on healthcare workers.

Because this research study is interested in interpretative phenomenology, the ultimate purpose of this review is to ICU nurses' lived experience of working during the ongoing COVID-19 pandemic. This is placed within a Power Threat Meaning Framework (PTMF, Johnstone & Boyle, 2018), which permits considerations embedded within a broader critique of medicalized understandings of distress that pathologize emotions and other responses while rejecting the contextual impact and links to social injustices that are manifested at the individual, familial, and societal levels (Morgan et al., 2022). This seems especially pertinent in the context of ongoing research on the COVID-19 pandemic, given that the majority of studies are primarily grounded on quantitative research and that the dearth of qualitative findings suggests a pressing

need to identify and assess the empirical basis of the psychological impact of pandemics. The usage of qualitative research methodologies has increased dramatically during the last five years (Elliot et al., 1999). This has occurred in a variety of disciplines and countries as the necessity to comprehend and depict people's experiences and behaviours as they meet, interact with, and live through circumstances has become increasingly relevant (Elliot et al., 1999; Rennie, 2004; Levitt, 2015). Qualitative research is especially useful for gaining an in-depth understanding of people's lived experiences and meaning-making (Smith et al., 2022). This is consistent with the hermeneutic phenomenological approach adopted in this study to explore the experiences of ICU nurses working during the COVID-19 pandemic, which is discussed in detail in the methodology chapter.

The findings of qualitative studies, such as those by Newman et al. (2021), on health workers in the UK, suggested feelings of hopelessness and despair at the prospect of contracting COVID-19 or spreading it to loved ones and patients, as well as a fear of going to work out of concern that they might endanger patients through mistakes or because they would be asked to perform tasks that they did not feel comfortable performing. A large number of employees showed behavioural changes, including less sleep, bad diet, increased irritability or hostility, lack of tolerance, tearfulness, self-harm, and avoiding going to work. Lack of PPE, redeployment to sectors outside of expertise and rapidly shifting guidance were major sources of conflict with employers. These findings were consistent with Harris et al. (2021) study on frontline doctors, which highlighted risks such as inadequate PPE, staff and patient noncompliance with hospital safety measures, and delayed vaccinations. In the participant's narratives, there were complaints about bad leadership decisions, PPE purchasing, and the perception that the government had not acted in the frontline workers' best interests.

The phenomenological dimension of newly developing studies on the COVID-19 pandemic provided a detailed and highly emotional picture of the most challenging facets of working as frontline workers, with issues such as high workloads, the government's management of the pandemic, and inadequate PPE being most generally noted. As evidenced by the developing literature on the COVID-19 pandemic and findings on prior pandemics, frontline workers need special attention during the current COVID-19 outbreak. Nevertheless, what has been published thus far has comprised a general sample of health care professionals, emphasising a scarcity of qualitative investigations. Furthermore, many qualitative studies lacked clarity regarding participant recruitment strategies, data collection and analysis methods, ethical concerns, and consideration of the researcher-participant relationship (Billings et al., 2021). Despite advancements in research on the experiences of health care personnel on the frontline during the COVID-19 outbreak, there has been little research on nurses working in ICUs in the UK to date. The current study intends to fill this gap by uncovering the lived experience of ICU nurses working on the frontline during the COVID-19 pandemic. The following section discusses the significance of performing qualitative research during the COVID-19 pandemic, which will be further expanded in the methodology chapter.

2.9. Research Questions

Amongst the up-to-date studies and systemic reviews, the quantitative-epidemiological data has contributed to speculation on the causes of the disease and how it spreads (Teti et al., 2020), but only a limited number of qualitative studies have concentrated on the experience of health care providers working during the COVID-19 pandemic (Tan et al., 2020; Sy et al., 2020). The findings of previous reviews (Johnson & Vindrola-Padros, 2017; Crawford et al., 2016) about qualitative studies on disease outbreaks (i.e., flu, Ebola Virus Disease (EVD), malaria) demonstrated how these have contributed to different discoveries. People’s lived experience of

the emergency and the way individuals and community made sense of it have ameliorated interventions and aimed to reduce the negative impact of the pandemic (Teti et al., 2020). Building on these findings, Teti and colleagues (2020) emphasised how qualitative studies have deeply enriched the knowledge of social, political and cultural aspects of an epidemic. For instance, individuals tend to rely on their perception of preventive measures due to scepticism towards the government, demonstrating how complex psychological, social, and cultural determinants may influence compliance with precautionary measures (Tulloch & Ripoll, 2020). Qualitative methods provide an in-depth understanding of phenomena that complement the findings offered by quantitative methods (Palinkas, 2014). By focusing on the "how" rather than the "what", qualitative research helps to provide a variety of perspectives on the COVID-19 pandemic as it evolves (Palinkas, 2014; Teti et al., 2020). Furthermore, this research methods fit well within the debate on how to improve policy and practices that address the needs, concerns and priorities of health care providers and patients (Chafe, 2017).

While adopting a social justice perspective, the current study seeks to contribute to CoP practice by recognising how societal circumstances, as well as society's pluralistic nature, affect individual mental health fitness and advocating a way of working that empowers individuals (BPS, 2020). In particular, the COVID-19 pandemic has probably prompted unresolved traumas and losses that have become entangled with current events due to a fear of a silent, deadly virus (Stubley, 2022). According to the tenets of CoP, people form their worldviews as a result of the influences and experiences they encounter throughout their lives (Van Deurzen-Smith, 1990) and because of their relational nature (Milton, 2010). An individual's experience of suffering is conceptualised via a CoP lens as an adaptation to a context as opposed to a pathologizing behaviour. This awareness enables the recognition of individual’s inner world and the co-construction of their meaning, facilitating comprehension and growth (Orlans &

Scoyoc, 2009), enhancing a person's ability to reflect on their own thoughts, feelings, and behaviour (Bateman et al., n.d.). According to what has been presented thus far and in light of the cumulative and ongoing trauma that ICU nurses were exposed to, the current study recommends providing this group additional care in clinical practice based on fostering a trauma-informed approach. This is covered in greater detail in the clinical contribution section of the discussion chapter.

Additionally, this study aims to address a gap in the grey literature by interviewing ICU nurses about their experiences of working on the frontline during the COVID-19 outbreak. The findings of the research conducted to date emphasise the importance of concentrating on the meanings of the individual's subjective experience of the present epidemic. This contribution would be essential as we take stock of the impact of the COVID-19 pandemic, which appears to be ascribed to a broader discussion about collective trauma. Nonetheless, since the researcher was also affected by the COVID-19 pandemic, self-reflexivity was especially relevant while co-constructing participants' lived experiences. As a result, an IPA methodology, further explored in the following chapter, has been recommended for this study, as it respects participants' sense-making about their relationship with the world (Smith et al., 2022), in order to answer the overarching research question:

What is the experience of ICU nurses working during the COVID-19 pandemic?

by considering the following research questions:

1. What were the effects of working during the COVID-19 pandemic on their mental and physical health?
2. How did ICU nurses cope during the COVID-19 outbreak?

CHAPTER 3

METHODOLOGY

3.1. Introduction

The purpose of this chapter is to identify and describe the methodology utilised to address the research question given in the previous chapter. It accomplishes this by first establishing the research paradigm and exploring the research question for its underlying assumptions, and then outlining the rationale for selecting the Interpretative Phenomenological Analysis research methodology (IPA).

The research design framework is also described, including participant sampling and recruiting, data collection, data analysis and ethical considerations. Finally, the quality of this research study is carefully considered. Personal reflexivity, which is offered in Italic throughout this chapter, would further strengthen transparency and coherence in accordance with the epistemological stance. This chapter has been written in the first person since interpretative work necessitates the researcher to immerse in the data according to the epistemological position – hermeneutic phenomenological.

3.2. Research paradigm and research question underlying assumptions

Prior to embarking on this research project, I reflected on several philosophical assumptions. Questions about paradigms are critical at the start of a research study since paradigms comprise a "fundamental belief system based on ontological, epistemological, and methodological assumptions" (Guba & Lincoln, 1994, p. 107). In response to the question of the nature and origins of any knowledge, various perspectives have been offered (Willig, 2012). Guba and Lincoln (1994) distinguished four research paradigms, which Ponterotto (2005) eventually embraced. The current distinction will be used for the purposes of this research. This

classification highlights four study paradigms namely positivism, post-positivism, constructivism–interpretivism, critical–ideological. These are discussed below.

The positivism approach has long dominated science, including psychology, and is linked to quantitative research (Morrow, 2005). The hypothetico–deductive method is used to describe phenomena relating to a theory or model, presuming an objective external reality that the investigator can study (Guba & Lincoln, 1994). Post-positivism derives from positivism and emphasises the cause-and-effect relationship of phenomena (Lincoln & Guba, 2000). Whereas post-positivists acknowledge an objective reality that can only be apprehended and measured imperfectly, an ontological position known as critical realism; positivists accept one objective, apprehendable and measurable reality, a position known as naïve realism (Ponterotto, 2005; Lincoln & Guba, 2000).

The constructivism-interpretivism takes a relativism approach, recognising the existence of multiple realities, rather than a single true reality. Nonetheless, the researcher and the participant co-create the meaning and lived experience of the phenomenon being studied (Ponterotto, 2005), which must be understood in the context of social and cultural variables (Morrow, 2005). Given the importance of authenticity and trustworthiness in the research process, reflexivity allows the researcher to be more conscious of how their own experiences and understanding of the world influence the research process (Morrow, 2005).

Finally, the critical-ideological paradigm accepts that reality is assumed to be apprehendable although shaped over time by political, social, cultural, gender, and ethnic values. According to Ponterotto (2005), critical theorists concentrate on realities that are mediated by socially and historically constituted power relations, with the researcher's values inevitably influencing the inquiry (Guba & Lincoln, 1994).

The constructivism-interpretivism paradigm was found to be more congruent with the research question since it adds an interpretative dimension to the possible meanings of participants' accounts of the social phenomena with which they interact (Rehman & Alharthi, 2016). Nevertheless, before discussing the research paradigm in the context of the current study, it is necessary to note that this research seeks to answer the question:

What is the experience of ICU nurses working during the COVID-19 pandemic?

As a result, the research aims to comprehend ICU nurses' subjective experiences in relation to the COVID-19 outbreak. This research question is based on three assumptions about the type of knowledge the researcher is attempting to produce: 1. People assign meaning to events, which shapes their experience of them; 2. COVID-19 has impacted people all over the world and may cause a variety of symptoms; 3. The meanings people attribute to events are the result of social interactions (Willig, 2013), hence the researcher can infer participants' meanings from their narrative. Therefore, the research question is framed on phenomenological grounds, as outlined in the following section.

The ontological underlying assumptions assert the existence of a reality independent of our understanding of it. However, that reality is always historically, socially, and culturally placed, and it can be interpreted through one's own subjectivity (McLachlan & Garcia, 2015). As a researcher, I assume that participants' meanings of working during the COVID-19 pandemic are co-constructed in a social context that includes both the participant and me. In considering the philosophical assumptions that ground the knowledge that I intend to produce, and due to the nature of the research enquiry, the Interpretative Phenomenological Analysis (IPA), within the qualitative research method, appears to be the best option.

3.3. Epistemological considerations

Epistemology is defined as “the branch of philosophy that studies the nature of knowledge and the process by which knowledge is acquired and validated” (Gall et al., 2003, p. 13).

Willig (2012) maps out three epistemological positions within qualitative research, which stem from the relationship between the researcher and the knowledge the research intends to generate, i.e., realist, phenomenological and social constructionist knowledge.

Phenomenology was chosen above the realist and social constructionist approaches since the current study does not attempt to apply scientific methods to social phenomena and is not concerned with the social construction of knowledge through the use of language (Willig, 2012). However, there are two main phenomenological approaches in psychology: descriptive and interpretative, which encompass a wide range of data collection and methods of analysis. Descriptive phenomenological psychologists are interested in describing rather than explaining phenomena (Langdridge, 2007). It necessitates the researcher to adopt a phenomenological mindset in which they set aside all prior knowledge of the phenomenon under investigation (Willig, 2013) and "return to things themselves" (Langdridge, 2007, p. 86). The theoretical underpinnings of descriptive phenomenology are based on Husserlian philosophy, which aims to transform the dichotomy between subjects and objects into a correlation between what is experienced (noema) and how it is experienced (noesis) (Husserl, 1970). Therefore, how things of experience are present in consciousness awareness through directing our attention (Langdridge, 2007). Instead, interpretative phenomenology is rooted in hermeneutics, stating that all descriptions are a form of interpretation, and that understanding cannot occur without some underlying assumptions about the meaning of what we are trying to comprehend (Willig, 2013). Language, for instance, is an interpretative process that captures the lived experience (Van Manen, 1990). The insights gained from interpretative phenomenology research are

mostly the result of the researcher's interaction with the data (Willig, 2013). The section "3.4.1. IPA's theoretical underpinnings" would provide further insight into the interpretative phenomenology.

The current study utilised a qualitative method of enquiry to capture the experience of ICU nurses working during the COVID-19 pandemic. The impact of the COVID-19 epidemic has been the focus of limited but expanding research (Bhaskar et al., 2020). According to the present literature, the majority of study taken on nurses during the previous and current pandemics was primarily grounded on quantitative methods, which employ quantification to describe and evaluate aspects of social reality (Gall et al., 2003). Nonetheless, there is renewed interest in the qualitative approach. This is aligned with Counselling Psychology's (CoP) emphasis on methodological variety, which stresses the subjectivity and complexity of experiences (Heppner et al., 2000).

My epistemological stance for this research, as per its hermeneutic phenomenological nature, is consistent with CoP's theoretical core values, which emphasise the importance of subjective experience, a heterogeneous approach to knowing that reflects human diversity and the therapeutic relationship (Hage, 2003). My interest is to unveil various aspects of the COVID-19 pandemic's impact on the work of nurses, as well as the emotional texture of their complex experience. These aims align with phenomenological research, which focuses on capturing the texture and quality of the lived experience rather than what causes the social and psychological event to occur (Willig, 2013). Even though reality is constructed by the research participant (Ponterotto, 2005), its meaning is hidden and must be revealed through deep reflection within the context of a dialogue between researcher and participant (Sciarra, 1999).

To avoid influencing the research process, I employed a methodology that allows for reflexivity by exploring all layers of data interpretation. This is evidenced by the inclusion of additional self-reflexive sections, which will be identified in this text by their Italicization.

3.4. Research Methodology – Interpretative Phenomenological Analysis

IPA is the employed methodology in this research study. IPA is concerned with exploring and comprehending the participants' perspectives on the phenomenon under investigation as they interact and live through this experience (Smith et al., 1999; Elliot et al., 1999). It aspires to represent the quality and richness of individual experience, as do other, more descriptive phenomenological approaches to data analysis (Willig, 2013). However, this approach also recognises that such knowledge is never immediately available to the researcher (Willig, 2013). In this aspect, IPA is phenomenological as it concentrates on the participant's subjective perspective of a phenomenon, in conjunction with the researcher's reflective and dynamic process of interpretation (Smith et al., 2022).

In light of the foregoing considerations, as well as the aim of this research, which is to explore participants' experiences and meanings of working during this exceptional historical period, it was determined that IPA would be a suitable methodology to accomplish this task.

3.4.1. IPA's theoretical underpinnings

The following section will describe the theoretical underpinning of IPA: phenomenology, hermeneutics, and idiography (Smith et al., 2022). This specification serves the purpose of helping the reader become familiarised with the theoretical commitment and epistemological stance that lies at the heart of this research as dictated by the chosen methodology.

3.4.2. Phenomenology

Phenomenology is a philosophical approach to the study of experience (Smith et al., 2022). While Husserl (1970) proposes that the phenomenological method is descriptive, based on the intuition of the given (Smith et al., 2022) and advocates for a complete suspension of one's belief to return "to the things themselves" (Smith et al., 2022, p. 8), interpretative phenomenology regards description and interpretation as intrinsically tied. The latter is rooted in Heidegger's (1962) philosophy, which stresses the idea that human beings are thrown into a pre-existing world of objects, relationships, language and culture, and by engaging with this, they make sense of it as per their relational nature (Smith et al., 2022).

According to Heidegger (1962), a person is a Dasein, which he used to refer to the essential nature of the human being, although it literally corresponds to "Being there" and is more widely understood and translated in English as "Being-in-the-world" (Spinelli, 1989, p. 108). Dasein's greatest accomplishment is that it substitutes the Cartesian dualism (e.g., subject/object, mind/body) with people as Being-in-the-world with things and with others (Willig & Stainton-Rogers, 2017). Heidegger acknowledges Dasein's intrinsically social element, as we are inextricably social beings, constantly in relation to the other, always Being-with (Mitsein) (Langdridge, 2007). Therefore, our experiences are always in relation to something, connected inter-subjectively and to be interpreted by others (Smith et al., 2009; Smith & Osborn, 2007). This aligns with how the IPA considers people and the worlds they live in as socially, historically, and culturally interconnected.

By recognising the gap between individual subjectivity and that of the researcher, IPA as a methodology emphasises the significance of reflexivity on the researcher's part. In line with this, the exploration of meaning and sense-making of the participant's world is affected by the

interpretative activity undertaken by the researcher (Smith & Osborn, 2007). Since one is not always cognizant of one's own preconceptions in advance, reflexive analysis attempts to capture some of the relationships through which subject and object influence and constitute one another (Finlay, 2002). Reflexivity is about "finding strategies to question our own attitudes, theories-in-use, values, assumptions, prejudices and habitual actions; to understand our complex roles in relation to others. It develops responsible and ethical actions, such as becoming aware of how much our ways of being are culturally determined; other peoples have very different expectations and norms" (Bolton & Delderfield, 2018, p. 10).

Heidegger's phenomenological discoveries articulated the case for hermeneutic phenomenology (discussed in greater depth in the following section) by pointing out that access to the Dasein is through interpretation. He was especially interested in finding how a phenomenon appears and how the researcher contributes to enabling and explaining its appearance (Smith et., 2022). Heidegger (1962) asserted that while a researcher's preconceptions may precede interactions with new things, understanding may occur the other way around, from things to preconceptions. His ideas have clarified bracketing as a cyclical process linked to reflexivity practice (Smith et., 2022).

3.4.3. Hermeneutics

Hermeneutics is the "art and science of interpretation" (Ezzy, 2002, p. 24), which is a process to investigate the experience of a phenomenon. Hermeneutics began as a framework for interpreting biblical texts (Smith et al., 2022). Gadamer (1989) and, in particular, Ricoeur (1981) expanded on Heidegger's (1967) theories in the domains of method and interpretation of hermeneutic phenomenological research. Gadamer emphasises that all knowledge is historically and culturally situated (Langdridge, 2017). According to Gadamer (1989), the

relationship between researcher and participant, or reader and text, is a continuous discourse, and so interpretation is a collaborative activity. When the interpreter opens to a question, all previous experience or understanding of the question is instantly transcended by the influence of the new experience; engaging in dialogue with a text, whether written or lived experience, contributes to constant expansion (Gadamer, 1989).

Ricoeur (1981) established the link between hermeneutics and phenomenology. Ricoeur (1973) underlined that text demonstrates "a fundamental characteristic of the historicity of human experience" (p. 130). He emphasised that in the case of speech, persons involved in the conversation are present with (in the psychosocial context of the debate) and to each other (conscious of the nonverbal aspects of the dialogue) (Tan et al., 2009). When discourse is done through writing as opposed to speaking, the meaning etched by the text prevails over the meaning intended by the author (Langdridge, 2017).

By converting this to data interpretation, the researcher becomes dependent on the text, from which they have become distant, even though they conducted the interviews themselves. Each participant tries to convey their own particular experience and prior knowledge, which they get to know more during the study (Tan et al., 2009). Parallel to this, the researcher becomes someone new as a result of "appropriating" (Ricoeur, 1981, p. 158) this experience and the new world of possibilities that appeared through the interaction with the world of text (Tan et al., 2009). The hermeneutic arc, as defined by Ricoeur (1981), is the movement between the particular parts of the text and a broad perspective throughout the interpretation process. Ricoeur distinguishes between two different ways of understanding meaning. The hermeneutics of empathy interprets the meaning of the text in its own terms. In contrast, the hermeneutic of suspicion delves beneath the surface of a text in search of hidden meaning (Langdridge, 2017).

IPA research includes both views. It attempts to understand from participants' point of view while also looking at them from a different perspective and wondering about what they are saying, becoming more dependent on the interpretive work of the researcher (Smith et al., 2022). When considering IPA, it is important to note that a double-hermeneutic (Smith & Osborn, 2003) is applied, as the final outcome would be an account of how the researcher makes sense of how the participant has made sense of what happened to them (Smith et al., 2009). Therefore, the analysis is a dynamic and dialectic process of descriptions and engagement with the transcripts (Finlay, 2009), where the researcher is "scientifically removed from, open to and aware of, while also interacting with research participants in the midst of their own experiencing" (Finlay, 2008, p. 3). By its very nature, this methodology implies analysis as a co-construction between participant and researcher. In this context, reflexivity has been a significant process of continuous reflection upon the interpretation of my own experience and the given phenomenon, in the active search for meaning in the participant's account (Smith et al., 2022). For further details, please refer to the reflexivity sections penned in Italics throughout the document and the reflexivity paragraph in the discussion chapter.

3.4.4. Idiography

As opposed to the nomothetic approach, which adopts generalisations of human behaviours (Willig, 2013), IPA depends on an idiographic approach as interested in an in-depth, case-by-case exploration. In doing so, IPA research gives profound attention to the sociocultural context of particular people whence data are generated (Reid, 2005). Its idiographic lens has been preserved by the recommendations of a small sample size, which facilitates a detailed examination of each participant (Smith & Osborn, 2007).

3.5. Selecting a method

As part of the rationale for selecting IPA, various qualitative methods were compared. As a result of comparing these different methods, various versions of the Grounded Theory approach were found to be very similar to IPA (Willig, 2013). In order to conduct a rigorous qualitative study, the relationship between IPA and Grounded Theory has been considered in the debate of selecting the appropriate methodology that fits with the belief about the nature of reality (Mills et al., 2006).

Grounded Theory is a qualitative methodological approach that was first introduced by Glaser and Strauss (1967) with the goal of developing new theories and hypotheses inductively from many observations (Glaser, 1992); hence, theories are grounded in the data. Grounded Theory, like IPA, accords significance to line-by-line analysis. However, this is done to guarantee that analysis is correctly grounded and that higher categories, which subsequently become theoretical formulations, develop from the data instead of being forced upon it (Willig, 2013). In contrast to phenomenology, Grounded Theory aims to incorporate all data sources that might aid in the construction of a theory; participants are also theoretically chosen (Chun Tie et al., 2019).

Later, Charmaz (2006) argued for a more interpretive and constructivist approach to Grounded Theory. He acknowledged the existence of multiple realities and the complexity of beliefs and behaviours without underestimating the role of the researcher in the process, who chooses the categories, inquiries about the data, and advances personal beliefs and experiences (Creswell, 2013). Studies that accept this methodology, however, are interested in social interactions and processes by inquiring about what happens and how individuals interact (Sbaraini et al., 2011).

Grounded Theory was not regarded as the best option since this research project is interested in the experiences of ICU nurses who worked on the frontline during the COVID-19 pandemic, focusing on the individual's subjective meaning-making rather than identifying categories and conclusively developing theory.

3.6. Research Design Framework

The qualitative design has been chosen in line with the paradigm from which the research inquiry stems, its object of interest and consequently the research methodology adopted (Sparkes & Smith, 2009). Six participants were engaged in one-to-one semi-structured interviews conducted remotely via Microsoft Teams. Smith et al. (2022) recommend a sample size of between four and eight interviews for Professional Doctorates in the UK, particularly in research that uses IPA as the qualitative method of analysis since it allows for in-depth exploration of convergences and divergences between participants' accounts. The following paragraph will provide a thorough explanation of the context in which participants for this study were recruited.

3.6.1. Context

The participants in this study worked at COVID-19 critical care units in a variety of London hospitals. ITUs had to redeploy staff members and volunteer healthcare workers due to a staff shortfall that the NHS had been grappling with even before the epidemic hit (Montgomery et al., 2021). The COVID-19 pandemic struck at an inopportune time for the NHS, as it was still recovering from decades of underfunding, which had harmed healthcare workers and, as a result, the care offered to patients. Furthermore, the COVID-19 epidemic coincided with the fallout from Brexit, which rocked an already weak system by leading to the exodus of European medical and nursing staff (Rolewicz & Palmer, 2019).

Migrants constitute an important element of the healthcare workforce (Alderwick & Allen, 2019). According to the House of Commons Statistics (Baker, 2021), London has the highest percentage of NHS workers with a nationality other than British, at 27%. In England's hospital and community health facilities, 5.6% of all nurses are EU nationals. Nurses are the only category of employees whose number of EU nationals has declined since the referendum from 7.4% to 5.6% (Baker, 2021). According to data, migrants use fewer services than UK-born citizens since they may find it more difficult to access services due to language problems or ambiguity regarding eligibility (Alderwick & Allen, 2019).

It is crucial to emphasize how this data may have influenced the choice to concentrate on Italian nurses, given the discussion about Brexit regulations at the time of recruiting participants. I was, therefore, inspired by a desire to give a particular group of people a platform to discuss their personal lived experiences during the COVID-19 outbreak. Being Italian made it easier to develop a connection and sense of empathy with participants and acquire more in-depth information, especially when exploring such a sensitive phenomenon (Lester, 1999).

3.6.2. Participants

3.6.2.1. Inclusion and exclusion criteria

In line with previous pandemic literature and emerging research on the COVID-19 outbreak, ICU nurses bore the brunt of the pandemic's aftermath, and even many years later, reported higher rates of PTSD, burnout syndrome, anxiety, depression, attention deficits, and fatigue than other nursing specialities (Azoulay et al., 2020; Mealer et al., 2009; Karanikola et al., 2015; Machado et al., 2018). For this reason, ICU nurses working with COVID-19 patients in temporary COVID units and/or intensive care units were chosen as opposed to other nursing

specialities. All participants have worked in London since the initial phase of the COVID-19 outbreak from March 2020 to July 2020. To prevent any risks of harm, interviews were arranged a year after that timeframe. Participants being under the care of a psychiatrist were also excluded as ongoing distress could be exacerbated by the interview.

Although the sample was selected purposively as suggested by Pietkiewicz and Smith (2012), participants revealed differences in terms of length of nursing experience within the intensive care unit. The degree of this variation has not compromised the homogeneity between participants. This is consistent with the idiographic approach of IPA, which requires a relatively homogeneous and small sample to fully understand, on a case-by-case basis, participants' experiences of the phenomenon while still detecting convergences within that sample (Smith et al., 2022).

The eligibility criteria of the sample included participants working as a nurse in England and over eighteen years of age. Similarities were not required in terms of gender, age, ethnicity, or place of work. This was to ensure a certain variability amongst participants. Using the snowballing technique, participants have been recruited through personal contact. This enabled the researcher to find six participants reasonably quickly. Through the snowballing technique and because of my network, the most interest was from Italian nurses. As a result, being Italian served as an additional criterion for inclusion that contributed to a homogeneous sample. As the research was conducted in England, fluent English was also an inclusion criterion, considering this being a requirement of participants working within the NHS, holding clinical responsibilities, and communicating with staff and patients. Due to concerns around complexities and nuances in the expression of the experience, participants have had the opportunity to convey further information during the debriefing space in their own language.

Although the decision to concentrate on Italian participants was made during the recruitment stage, I noticed how this choice impacted the research process and interviews. The fact that I am Italian made it easier for participants to decide to partake in the research. This factor increased participants' feelings of connectivity and familiarity that strengthened their desire to participate in the study since they trusted its process and purpose more and to engage in an in-depth exchange of sensitive data. This is consistent with research findings on the relationships between decision-making, trust, and social interactions (Stanley et al., 2011; Fershtman & Gneezy, 2001).

Belonging to the same ex-pats group has enabled me to pick implicit meanings within communication, which are often engrained in a socio-cultural group. According to Gadamer (1989), every understanding involves interpretation, and all interpretation entails pre-understanding (i.e., the understanding that the researcher has and brings to the research). As a result, the reflexive practice has been given greater emphasis in order to become aware of my preconceptions while getting closer to the part encountered with each participant, in accordance with the IPA's double hermeneutic. Reflexivity is considered further in the discussion chapter.

3.6.2.2. Participant Information

This research involved six participants, two males and four females, aged between 30 and 34 years old. Four participants were ICU senior nurses, the other two recently joined an ICU team after working in a different nursing role at a senior level. One was invited to work as an ICU nurse due to staff shortages exacerbated by the pandemic.

TABLE 1 - Participant demographic information, pseudonyms, age, and expertise level

Participant Pseudonym	Age	Ethnicity	Gender	Level of expertise
Marilena	30	Italian	F	Senior ICU nurse
Giovanni	34	Italian	M	Worked as ICU nurse, although senior nurse in a different speciality
Luca	33	Italian	M	Senior ICU nurse
Giorgia	32	Italian	F	Senior ICU nurse
Rebecca	30	Italian	F	Senior ward nurse, joined ICU team later during the pandemic
Alessandra	33	Italian	F	Senior ICU nurse

3.6.3. Interview Schedule

Semi-structured interviews facilitate a discussion between researcher and participant and consequently allow the researcher to explore in-depth specific responses or topics that arise using probes and prompts (Smith & Osborn, 2007). The Interview Schedule (Appendix 5) assisted the researcher to think beforehand about what the interview could have covered. By following the funnelling technique (Smith & Osborn, 2007), the set of identified questions suggested a sequence from general aspects to more specific and sensitive issues since participants might feel more at ease in responding to certain questions and with the researcher's presence during the interview instead of the beginning (Shinebourne, 2011).

The choice of the wording for the questions was pivotal as the researcher aimed to leave questions as open as possible to avoid leading participants' responses. The first interview was created as an interview pilot, intended to adjust questions, practicalities, or obstacles which

could have compromised participants' capacity to talk freely (Willig, 2007). However, this was treated as additional data and included as one of the six interviews, as no issues emerged during this initial interview.

3.6.4. Interview Procedure

The interviews were recorded and transcribed verbatim and lasted for approximately one hour. Following the interview, a debriefing space was offered to address any challenges encountered during the interviews, and for participants to leave the space with the same mindset as they entered it (McLeod, 2015). The debriefing space made it possible to clarify any meanings in order to concentrate on a thorough examination of participants' experiences and understanding of the phenomenon being investigated (Smith et al., 2022).

The interviews were conducted in English, with the opportunity for clarification in their native language during the debriefing space, in order to produce a verbatim transcript in English for research and publication purposes. This ensured that participants' meanings were not lost in translation, avoiding clarification questions post-interview, and enhanced the researcher's interpretation of their meanings in accordance with IPA' s tenets.

According to the research findings of Dodds and Hess (2021), the virtual modality in this study had no impact on the interaction between the researcher and participants. In fact, it helped plan and time the interviews, already hampered by the exhausting working hours and various night shifts as per their role as ICU nurses. Before and after each interview, it was valuable to reflect upon the experience of the interview to bracket any thoughts, feelings, and assumptions about the participants' accounts as recommended when conducting qualitative research with an IPA

methodology (Willig, 2008). A reflexive diary accompanied this journey and informed the writing up of the analysis chapter.

3.6.5. Data Analysis

The analysis of this research was guided by the updated IPA procedural steps highlighted by Smith et al. (2022). As they argue, the IPA analysis is characterised by different strategies that allow a motion from the participant's point of view to the broader psychological aspect of the individual's meaning-making in that specific context (Smith et al., 2022).

At the start of the analysis, I transcribed the interviews verbatim. I then immersed myself in the data, reading and re-reading the written transcripts and delving deeply into the first case in accordance with the IPA's dedication to idiographic accuracy (Smith et al., 2022). I wrote down some first comments and observations using a line-by-line analysis in the right-hand margin. Guided by Smith et al. (2022), I attempted to concentrate on three aspects: descriptive, linguistic, and conceptual. Descriptive and linguistic notes were more focused on what participants intended to convey and the words and metaphors they used to describe the experience, whereas exploratory notes were more conceptual and entailed questioning meanings on a psychological and interpretive level. Following that, I created a summary of what was significant in the various notes and constructed experiential statements in each transcript. The purpose of this phase was to capture the understanding of the participant's unique experience.

The following phase was to look for connections in each experiential statement. By writing the experiential statements on a board and assigning different colours to them, I was able to gain a visual understanding of them and look for potential connections. Experiential statements were

clustered utilising various strategies, including polarization, narrative, and functional (Smith et al., 2022). The related quotation and page/line numbers in the transcripts were also recorded. For each participant, the patterning generated Personal Experiential Themes (PETs). At this point, I reflected on the notes I kept in the research diary, which mirrored my thoughts and sentiments before and after each interview. I continued this process for each of the six participants. Following this, I searched for patterns of similarity and difference among the PETs and developed a set of Group Experiential Themes (GETs). The GETs table illustrates the convergence of participants' experiences (Appendix 9).

The supervisory team assisted in determining the essence of each GET and made sure PETs logically matched their corresponding GETs throughout the analysis process. They helped me delve deeper while keeping an interpretive focus. The conclusive stage of the analysis continued in the writing up of the research, with themes presented in a thorough, systematic, and compelling narrative (Smith et al., 2022). As per the double-hermeneutic circle, this stage transmitted the researcher's interpretation (hermeneutic 2) of the participant's interpretation (hermeneutic 1) of their own lived experience (Smith et al., 2022).

3.7. Ethical Considerations

3.7.1. Ethical Approval

This study was subjected to rigorous ethical oversight and the approval of the School of Psychology Research Ethics Sub-committee of the University of East London. The Ethical Approval notification can be found in Appendix 1. As NHS staff were recruited as research participants due to their professional role, an Independent NHS Research Ethics Committee Review was not required (Health Research Authority, 2020).

3.7.2. Managing risks

The ethical analysis around the research question, research process, and potential findings has been pivotal under these difficult circumstances of the COVID-19 pandemic and enabled me to pose a few ethical questions. The British Psychological Society (BPS) Ethics Best Guidance on Conducting Research with Human Participants during COVID-19 pandemic (BPS, 2020), guided the ethical decisions of this research, alongside the Code of Human Research Ethics (BPS, 2021) and the Code of Ethics and Conduct (BPS, 2018). These documents stress the importance of adhering to four primary ethical principles when conducting research during this time, respectively, respect for the autonomy, privacy and dignity of individuals and communities, scientific integrity, social responsibility, maximising benefit and minimising harm (BPS, 2020).

This research was designed and conducted in a way to minimise any potential risks to the psychological wellbeing and personal values of the participants. As a result, several strategies were incorporated during data collection: a. Screening Interview and Distress Protocol (Appendix 4) to determine whether there were any reasons for participants to withdraw from the interview and consequently research; b. Continuous monitoring of participant's emotional response; c. Offering frequent breaks to wind down; d. Debriefing at the end of the interview to discuss any difficult emotions that emerged; e. Providing information about available psychological organizations, offering therapy also in the Italian language (Appendix 6) (Draucker et al., 2009). These and other actions to reduce harm are discussed below.

3.7.3. Informed Consent

Participants were approached by email and given a Participant Invitation Letter (Appendix 2), which included all information about the study and asked to sign a Consent Form (Appendix

3) to participate in the research interview and request further clarification about the research before the interviews. This allowed them to understand the nature of their involvement in the research and participate by informed decision, with respect to the key principles of competence, responsibility and integrity delineated by the BPS Code of Ethics and Conduct (BPS, 2018) and UEL Code of Practice for Research Ethics (UEL, 2013). Participants were reminded at the interview stage about the role and purpose of the research, their right to withdraw up to three weeks after the interview and to request breaks at any moment due to the sensitivity of the topic. No participants withdrew their consent during or after interviews and none were paused due to distress.

3.7.4. Confidentiality

To ensure confidentiality all interview recordings, and transcriptions were anonymised, coded, and stored securely according to the Data Protection Act (1998, 2018). The audio files and transcription documents were password-protected. The research team was granted access to the transcripts after participants' details were altered and anonymised. Every effort was made to protect participants' identities. Confidentiality was assured through data anonymity by assigning a pseudonym to each participant's recording and transcript; participants were informed about it.

3.8. Quality in IPA

Broad guidelines for evaluating qualitative research are available (Elliott et al., 1999; Yardley, 2000). However, there were no specific quality criteria for IPA. Nizza, Farr, and Smith (2021) expanded on the specific criteria that distinguish high-quality IPA research, identifying four quality indicators, as outlined below.

The analysis should present an engaging and coherent story by creating a narrative that develops within the analytical interaction between the interpreted participant extracts, in accordance with the first indicator "Constructing a compelling, unfolding narrative". The narrative is then advanced as each theme contributes to key points of focus in the story. The second indicator "Developing a vigorous experiential and/or existential account" suggests that a good IPA typically results in a situation in which participants are encouraged to reflect on what has occurred in order to make sense of its meaning, frequently interacting with degrees of experiential or existential significance (Smith et al., 2022). According to the third indicator of quality, "Close analytic reading of participants' words" the interpretations of excerpts reveal the data's deeper meaning and how participants made sense of their experiences as per the idiographic depth. Lastly, the "Attending to convergence and divergence" indicator alludes to a balance between participant individuality and commonality. IPA studies demonstrate how participants share higher-order qualities without losing sight of people's distinctive idiosyncratic characteristics (Smith et al., 2022). The quality of this study is further explored in the discussion chapter. However, Appendix 7 provides additional clarification of the quality of this study according to the guidelines of Yardley (2000) and Elliot et al. (1999).

3.9. Conclusion

This qualitative research study employed a hermeneutic phenomenological epistemological approach, which reflects ontological underlying assumptions that fall under a relativism position of knowing. Participants were selected to maintain a purposive and homogeneous sample by meeting the inclusion criteria for the semi-structured interviews. Each interview transcript was analysed in accordance with the six-step procedure set out by Smith et al. (2022). To assure the quality of this qualitative research, Nizza, Farr and Smith's (2021) principles were followed at every level, ensuring that it adhered to the IPA methodology's central tenets.

In Chapter 3, the analysis is presented, and in Chapter 4, the clinical implications and limitations of the analysis are addressed.

CHAPTER FOUR

ANALYSIS

4.1. Introduction

This chapter discusses four Group Experiential Themes (GETs) that were identified through interpretative phenomenological analysis of semi-structured interviews with six participants. These themes would bring a thorough insight into the ICU nurses' experiences working on the frontline during the COVID-19 pandemic.

The 4 main GETs, and 12 Personal Experiential Themes (PETs) identified are as follows:

1. "SURREAL" INSIDE AND OUTSIDE HOSPITALS
    a. Hypervigilance
    b. Fear of contamination
    c. Living a catastrophe, live in front of your eyes

2. DOING (VERSUS BEING): THE ADAPTATION TO THE COVID-19 REALITY
    a. Newness
    b. Support available and accessed
    c. Growth and resilience

3. BYSTANDER: DISAPPOINTMENT WITH THE GOVERNMENT AND THE PUBLIC
    a. Let down
    b. Facing scepticism

c. Shared guilt

4. EMOTIONAL DETACHMENT AS COPING STRATEGY

a. Secrecy

b. Loss

c. Dehumanisation

Despite the fact that all participants shared experiences connected to the GETs, not all of them could relate to every PETs.

4.2. Presentation of the Group Experiential Themes

The phenomenon that this research study wants to analyse, as discussed in previous chapters, is the experience of ICU nurses serving on the frontline during the COVID-19 pandemic. Participants echoed the "surreal" extent and rapidity of the COVID-19 pandemic's overwhelming effects the first GET. The second GET offers a closer look at participants' everyday lives during the COVID-19 pandemic, the adaptation to the new reality on a personal and professional level, and the various layers of factors that needed to be considered on a daily basis. The third GET provides insight into life outside of the hospital, in the public sphere, including family, friends, the government, and society at large, with their contributions and responses to frontline ICU nurses and, more broadly, to the COVID-19 pandemic, and how their actions affected nurses' daily lives, which were characterised by high levels of anxiety and in autopilot mode. The last GET appears to have been largely influenced by more profound emotions that were not understood to anyone outside of the hospital walls where a true tragedy was occurring.

Each GET is critical to comprehending the overall experience of ICU nurses serving on the frontline during the COVID-19 pandemic. This particular sequence and the way the other themes are expanded upon to reveal additional significance convey the story of ICU nurses working during the COVID-19 outbreak. The themes of "DOING (VERSUS BEING): THE ADAPTATION TO THE COVID-19 REALITY" and "BYSTANDER: DISAPPOINTMENT WITH THE GOVERNMENT AND THE PUBLIC" seem to convey what happened to them, while the connection between ""SURREAL" INSIDE AND OUTSIDE HOSPITALS" and "EMOTIONAL DETACHMENT AS COPING STRATEGY" provides a better understanding of their underlying feelings. This split appears to reflect a clash between the empirical reality of the COVID-19 epidemic and the underlying psychological world of emotions, which the majority of participants were unable to attend to, let alone process. They are described below in more detail.

4.3. "SURREAL" INSIDE AND OUTSIDE HOSPITALS

This cluster of related PETs concentrates on how the COVID-19 epidemic abruptly affected the participants, who were entirely unprepared for the intensity of the virus, its global impact, rapid transmission, and the sheer quantity of fatalities. The strain of having to work in the ensuing "catastrophe" was significant, not least because it was impossible to take a break from it, portraying a "surreal" scenario that led to a state of constant hypervigilance in many participants. ICU nurses had to learn about the virus through experience, therefore, their anxiety response to the situation lessened as they came to see themselves as more knowledgeable and experienced, even though new variants continued to emerge as of the time of writing this document.

4.3.1. Hypervigilance

Hypervigilance is defined as "a state of abnormally heightened alertness, particularly to threatening or potentially dangerous stimuli" (American Psychological Association, n.d.). The following excerpt from Giovanni appears to capture the essence of continuous alertness as the threat of the COVID-19 would have been everywhere:

> "it was this doom sensation of trying to do everything right in terms of like, you know, protection, prevention of cross infection and things, that is felt like oh no, you touched your nose or like, you did not wash your hands 15 times yeah, this idea, that the danger is everywhere basically" (Giovanni, pp. 34-35, lines 382-386)

All of the participants had in common that the COVID-19 epidemic in their workplace translated to a constant state of hyperarousal to cope with the demands of an increasing number of critically ill patients who deteriorated in the space of a few hours. In the line that follows, Marilena describes how the COVID-19 pandemic seemed to have taken over her life to the point where she was unable to distinguish between her job and personal life due to the incessant demands it placed on her and the constant threat it posed:

> "when COVID hit our unit, COVID was 24 hour, I will wake up in the morning, listen to the news and they were talking about COVID, I will go to the station to go to work and they were talking about COVID in the station, about people wearing the mask, I will go to work and it was COVID at work, it was 24 hours COVID" (Marilena, pp. 8-9, lines 95 – 100)

The data further revealed the impression that the COVID-19 threat was increasingly prevalent and seemed relevant to the hypervigilance PET by unveiling how much alertness was needed to sustain it throughout long shifts in response to the demands of the job and continuing life risks. While four senior ICU nurses were accustomed to working 12-hour shifts while maintaining a high level of concentration and hyperarousal, two participants, Giovanni and Rebecca, had a different experience with this since they were both working as nurses in a different speciality where the focus did not need to be sustained for such a long time:

> "you have such an amount of energy to use in this 12 hours and I felt I was running short in there because I was not prepared to be like focused 12 hours nonstop compared to the work that I was doing before, in which there was more like time for high intensity and then like slow down and then again high intensity, instead in there I felt like it was always, always like top, top, top, concentration, stress and everything" (Giovanni, pp. 36-37, lines 347-353)

By repeating the word "top," Giovanni in particular, emphasises the expectations and difficulties of maintaining concentration for such a long time, as well as the stress accumulated as a result. Rebecca, who was relatively new to the ITUs, similarly reflects on her own challenges around the volume of tasks to accomplish while looking after COVID-19 patients for only two hours and soon after realising the need for a break.

Other participants, like Giorgia and Marilena, found it difficult to fall asleep at the thought of returning to the same environment the following day:

> "sometimes it was difficult to sleep because a bit of anxiety of thinking oh I am going back there tomorrow again" (Giorgia, p. 24, lines 271 - 273)

While Giorgia expresses her worry at the prospect of going to work, Marilena captures in the following excerpt the overwhelming sense of doom of her routine following the 12-hour shifts, which is also accompanied by the commute home and this hypervigilance state that appeared difficult to silence once home as would feed rumination thinking about going into the same predicament the next day:

> "basically you finish a shift, it is 12 hours, you need to take a shower before going home, worst case scenario you got home by half past 10 at night, your next shift starts at 8:00 o'clock in the morning, and I have got an hour of travel to go to work, so for me was also overwhelming to go home, it was so late and I was already thinking I need to go home and back to work tomorrow, I will not have time to sleep, the more I was thinking about it, the more I could not sleep" (Marilena, p. 25, lines 285 – 292)

In addition to working nonstop for 12 hours, all participants appeared to be motivated by a desire to support their colleagues, which affected their decisions to request brief breaks during the shift, often working an additional shift rather than taking the day off, and remaining around after their shift finished to provide additional support:

> "I always worked at least 45 minutes to an hour and half, extra on top of my paid shift just to catch up on things and to prevent my colleagues from having to go through the things that were not done during the day so you have this pressure and psychological stress during the shift, you have it towards the end where you want to make sure that everything is done but at the same time you are so tired that you really want to go home" (Luca, p. 22, lines 251-257)

While Luca embodies this sense of being unable to escape from this alert state, motivated by a duty to want to assist colleagues and ensure everything has been completed correctly despite the urge to go home, Marilena reveals her strategy of beginning to smoke as a frantic attempt to leave the building to enjoy a genuine break:

> "it was again a kind of a way out, as in when you manage to have a break, you did not want to spend your break in that building, it was not a break, because even in the staff room where you have a break, you could still hear the monitor alarming, you can still hear the emergency alarm going off, when the emergency alarm goes off, it means that there is someone that really needs a hand in a bay or in a side room COVID, and it really needs a hand from outside and you know that the other nurses cannot go to help because they are really busy with their patients, and it probably would end up being you on break running from the emergency buzzer to give them a hand" (Marilena, pp. 30-31, lines 348 – 359)

Marilena clearly exemplifies how difficult it was to take a break in the building where the adrenaline in her body just seems to constantly flow from all the alarms of the machines and everyone in need of aid at any time, forcing her to end her break and "run" to help. The word "run" perfectly captures the urgency of an endless crisis.

4.3.2. Fear of contamination

Nurses were concerned for both their own safety and the safety of their patients due to the virus's rapid transmission. However, the overwhelming uncertainty and insufficient knowledge around the virus, how to prevent it, its symptoms, and treatment intensified a reasonable fear

of becoming contaminated and spreading the disease to others, placing oneself in potentially hazardous situations as a result.

The following passages really captured the struggle of trying to protect people without knowing at the time the level of threat posed by the SARS-CoV-2 virus:

> “having to consider what you are wearing, try to minimize as much as possible your personal equipment, we used to have like pens, you could have like stethoscopes and this sort of things, even your underwear, we start considering whether we should have kept the underwear on or not, because obviously you are not sure if you are contaminating your own underwear when you remove your scrubs” (Luca, pp. 9-10, lines 103-109)

> “we were scared, I remember we were really scared because uhm we did not really know the virus itself, we did not really know, ok am I going to get in and am I going to be fine afterwards?! so it was bad” (Rebecca, p. 17 – lines 185– 188)

The uncertainty surrounding the virus, as Rebecca emphasises with the word "scared”, caused dread and tension at the prospect of catching it and putting themselves and others in danger.

People in the community, however, appeared to identify the nurses as a threat due to the nature of their profession and the fact that they could be more exposed to the virus. This was a significant experience that seemed to emerge from Giovanni and Luca's accounts, with Luca specifically emphasising how difficult an ICU nurse's life has been outside of the hospital, in this case with landlords asking them to vacate their shared rental home:

> "I went to Italy, and I felt a little bit like how to say, I was like a zombie, spreading the disease, there was something weird" (Giovanni, p. 16, lines 178 – 180)

> "it was not unusual for nurses to be, not assaulted, but treated differently by their neighbours, because obviously they were like "oh you are, you could spread the virus so we do not want you in our house, we do not want you in the flat, I heard stories of landlords asking health care professionals to leave the place where they were renting because they were threatening, not threatening sorry but they were putting in danger others housemates" (Luca, p. 40, lines 464 – 470)

Some participants, including Alessandra, Giovanni and Marilena, recognised that it was safer for them to be apart from their family in terms of possibly infecting them. This came with its own set of difficulties, including not being able to use the emotional support of having your family nearby to take care of you, particularly during a period of great hardship:

> "when the social life is zero at least having your family near is definitely a good thing to have and no because they were quite scared, like uh you know if I was working in such a setting I would be scared that myself because my parents are bit older so, they were on the dangerous range of age" (Giovanni, p. 25, lines 278-282)

Nevertheless, due to the nature of their profession and the various protective measures implemented in the different countries, other participants' accounts more accurately capture their concern for their families as well as their families' anxiety for them:

> "I remember that at the beginning England was not doing enough, the government was not doing enough here, so my family was worried for me saying like, because they know, of course I am a nurse and I am more exposed to that, so they were worried and at the same time hearing them being worried made me worried as well because I was like maybe I am underestimating the situation" (Rebecca, p. 29, lines 323 - 329)

> "it was difficult to ask them to stay home without making them too much worried about me, because I am their little girl at the end of the day, for them I am not a senior nurse in intensive care" (Marilena, p. 28, lines 331- 334)

Marilena's excerpt was particularly moving since it perfectly captures the stress she experienced as she tried to warn her parents about COVID-19 without making them worry about her. This illustrates her internal struggle over attending to the needs of her patients before her own. By reminding her that she is ultimately only a "little girl", not an ICU nurse, her parents' concern for her manages to bring the tension back into balance.

4.3.3. Living a catastrophe, live in front of your eyes

Giovanni fiercely described what it was like for him to work on the frontline during the COVID-19 outbreak, painting a vision of a catastrophe unfolding in front of his eyes every day, which inspired this PET:

> "it was kind of living a catastrophe, live in front of your eyes every day" (Giovanni, pp. 10-11, lines 115-116)

This metaphor eloquently but brutally conveys the challenges ICU nurses have been confronting; Rebecca used the word “surreal" which would make her and her colleagues frightened:

> “we were really scared because we were like this looks surreal to us” (Rebecca, p. 19, lines 214-215)

The extraordinary choice of the words "catastrophe" and "surreal" conveys the otherworldliness element of the COVID-19 pandemic scenario, which made it exceedingly difficult to believe as reality. These metaphors also portrayed the rapidity with which the virus spread and the impact it had on hospitals, endangering nurses' capacity to provide patient care in accordance with their standards and values. Participants were put in a position where they had no power to change things and lost control over their profession, the care they provided, and the lives of their patients, all while being forced to labour under such difficult conditions for such a long time.

The SARS-CoV-2 virus, according to all of the participants, significantly affected their workloads, and the possibility of continuing in the face of another surge was terrifying for four of them:

> “we were seeing lots of people out of the blue coming to the hospital, not having a clue of what was going to happen, then through the first surge it got a bit worse and then with the second surge it was like when it was very bad, and it has been difficult thinking to go back to normal but at the same time is difficult thinking of continuing in the view of another surge, uhm it is scaring both way” (Giorgia, p. 6, lines 61 – 67)

According to the preceding excerpt from Giorgia's account, participants' experiences differed slightly in terms of which COVID-19 outbreak waves affected them the most. The first wave was significantly more difficult for Luca, Rebecca, Alessandra, and Giovanni due to the novelty of the virus and its ambiguity regarding severity, treatment, way of working, and when it would end. In particular, Giovanni captures the devastating impact of the COVID-19 on ICU nurses and patients during the first wave as they tried to figure out how to manage it:

> "during the first pandemic, it was very hard because they were not expecting it, they were not prepared for it, so they had to improvised, adapt, find creative resources and solutions, so they did not have for example the wide set of equipment needed, like for example the PPE, the protective equipment, this impacted shifts because we could not take breaks, if not like the necessary breaks basically, that means that you ended up in a 12 and half hours shift to be and work four or five days in a row and it is a hard job, it is very hard on physical, mental and stress level and it is a technical job because like, rarely you will find people that are in a good health condition like most of them were like with serious, serious issues, even those that were there only for the COVID itself, with not much of past medical history, I could see them very, very much struggling at breathing, they had to wear this high flow masks the whole time, this to mention that it was very challenging" (Giovanni, pp. 9-10, lines 100-115)

However, there is a sense from the participants' accounts that the COVID-19 threat was always present since every new COVID patient would trigger memories of the beginning, as encapsulated by Giorgia in the following passage in her use of the word "scare" and “bringing back memories”:

> "in this moment that we are in between that we do not know if we are going towards the third surge when you go to work and you have one admission with COVID you are like ok, ok, we are there again, it is going to get worse again, we have to go through again, it might be worse again, uhm and that is scary and obviously is bringing back memories" (Giorgia, p. 11, lines 117 – 122)

4.3.4. Group Experiential Theme 1 - Summary

These three PETs, which frame the GET "SURREAL", show how the COVID-19 outbreak, with its abrupt shifts in participants' workloads, portrayed a scenario far from reality that had a severe impact on both patients and ICU nurses. From their point of view, the COVID-19 pandemic is undoubtedly perceived as a threat given that the recollection of working at the beginning of the epidemic would arouse feelings of fear and anxiety. The experience of this catastrophe playing out in front of their eyes is not something they can readily or easily forget. The final GET, which portrays the participants' survival response, goes further in addressing the psychological effects of this tension between the care that could be offered and the load of the COVID-19 pandemic on the healthcare system, while the following theme would bring additional meaning to what happened to them.

4.4. DOING (VERSUS BEING): THE ADAPTATION TO THE COVID-19 REALITY

The influence of the COVID-19 pandemic on participants' workload and the conflicts it caused saturate this GET as participants manoeuvred "Doing" imposed by the COVID-19 epidemic with "Being" present to oneself. These PETs, in particular, illustrated the tension between "DOING"— working mechanically to provide care and satisfy the demands of seriously ill patients—and "BEING"—allowing themselves to halt and experience the present moment,

tuning into their feelings and needs, that could not be immediately responded to. The PET "Newness" provide more specifics regarding their work on the frontline, while the last two PETs "Support available and accessed" and "Growth and resilience" concentrated more on elements that would aid in their thinking and the processing of their experiences.

4.4.1. Newness

The challenge of adjusting to the novelties of the COVID-19 world started with considering the psychical workspace as captured by the following passage of Luca. Their job appears to have needed to adjust to a new working environment that the virus imposed on intensive care units and hospitals in general, starting with thinking about the unit space, where to work, to the actual care offered:

> "we ended up working in different rooms, we ended up working in theatre, we ended up working on recovery, just to give you an idea, if you are not familiar with the ERs, so these are places where you have part of the equipment, but not all of it, so you might have to build your own environment, so you might have a monitor that you might use in ICU, but you might have pumps borrowed from a different unit and they might not have the same shape, they might have different buttons, they might have different set ups, and every small change might compromise the care that you are giving" (Luca, pp. 38-39, lines 441 – 450)

The way Luca takes the time to delve into the specifics of an emergency room's equipment captures the challenge of having to recreate the working environment from scratch, especially in a time of emergency, and the pressure of having to consider every little aspect since it might affect the calibre of the care provided. Giovanni also explains how three hospital floors were transformed into proper wards. He expresses incredulity at how quickly these empty spaces

were converted into wards, emphasising the pressure and urgency for COVID areas, given the high number of people requiring hospitalisation. Giorgia addresses this aspect as well, as she describes how nurses were overburdened by a huge number of admissions relative to staff availability, necessitating an abrupt adjustment in nurse-patient ratios from 1:1 to 1:6:

> “before Covid, doing one to one meant having a holistic view of the patients going from A to Z, taking care of them completely so family, patient, mental health of the patient, and all the physiology of the patient, during COVID, obviously having one to six meant to just look superficially, uh, just what there were the priority and sometimes not being even able to cover all the priority because of the stretch on the nurse ratio, uhm and that was a challenge” (Giorgia, p. 8, lines 83 – 90)

Georgia expresses in her report the hardship of not being able to deliver the expected standard of care, changing from a "holistic" to a "superficial" perspective on the treatment of patients. Similar to the below passages of Rebecca and Giovanni, it conveys a sense of being compelled to adjust to a changing working environment where the definition of care delivered had to be constantly revised to match the demands and resources at hand, with a high degree of alertness and without realising an end:

> "I cannot focus only on one patient, I have to think about what is it the priority in this case?! because I have three patients, what is the priority like what is the thing that is going to save my patients’ life" (Rebecca, pp.10-11, lines 114 - 117)

> "it was a sensation that you have to feel to understand this trap thing like not seeing an exit, it was kind uhm…a choking you know like this fucked up scene what a hell am I going to do now?" (Giovanni, p. 32, lines 352 – 355)

The above extract of Giovanni conveys through vivid metaphors the powerlessness and hopelessness of being caught in a detrimental circumstance for oneself with no escape and no one to turn to for help. His choice of words "trap", "choking", "fucked up", "hell" effectively conveys his despair as well as the struggle that the COVID-19 outbreak imposed on nurses who had to respond to their duty of care.

> "we would be with the PPE for 12 hours straight with no breaks, and that was very tiring…so you were getting to a point sometimes that you did not care, you just wanted to get out of the PPE no matter what, so you were leaving the patients' safety behind and obviously it is not what I have been trained for" (Giorgia, pp. 9-10, lines 100-105)

Prior to the excerpt above, Giorgia describes her experience of wearing PPE for 12 hours straight as claustrophobic and how PPE made it much more challenging to prioritize patients' safety before their own. However, it appears that even merely considering her needs would be inconsistent with the nursing profession's duty of care. In the following passage, Marilena embodies how wearing PPE makes her feel disconnected from the outside world and isolated:

> "it was warm, it was isolating, as soon as you put all the gear of the PPE on, you are isolated from the rest of the world, that is not, you feel alone, you are in the room but

> you cannot see properly, you cannot hear properly, the only thing you know there are many alarms and everything in your hand" (Marilena, p. 17, 197 – 202)

Using PPE evoked the same claustrophobic feelings as being stuck in these circumstances, bearing the burden alone, and not having anyone to turn to for assistance since everyone is in the same predicament.

The PET "Newness" adds additional meaning to the "DOING" aspect that emerges from the data. The PET unveil being trapped in the COVID-19 scenario and forced to work mechanically to satisfy their duty of care and the demands imposed by the COVID-19 pandemic. I now concentrate on the resources available for adopting a "BEING" approach, such as attending to their own needs and feelings, which were ultimately challenging to address.

4.4.2. Support available and accessed

Although all participants were able to enlist the support of their partners, families, friends, and flatmates, the main source of immediate support seemed to be their team of colleagues since they were enduring the same challenges:

> "I think the biggest support that I received personally was given by my own colleagues, close colleagues, people that are my age and those that became my friends over the past few years, while I was working there uhm, so yeah, we were talking about holidays, we were talking about music, you might talk about plans for the after COVID" (Luca, pp. 30-31, lines 351 – 356)

> "the main thing was like the possibility to stay a bit more at work with my colleagues just to have a laugh or just to have a bit of interaction with someone else, they knew what I was going through, because we were all going through the same" (Giorgia, p. 19, lines 208 – 211)

Giorgia and Luca both appear to cherish the time spent with their colleagues discussing topics other than the COVID-19 pandemic and their patients. Giorgia seems to attach to the time off with their colleagues a deeper significance that has to do with sharing a common understanding and needs with them as they go through the same experience.

In the passage that follows, Marilena additionally portrays in a touching manner a sense of feeling disconnected from the others within the society since they were unable to fully understand what they had gone through and could only find solace among their colleagues by referring to them as "family":

> "we really are a family and COVID got us really close, because (silence) it was us and then it was the rest of the world, the no-COVID, the no-mask, people that would not believe in COVID, people that would believe in COVID, and then it was us in the middle of it, especially us nurses" (Marilena, p. 21, lines 241 – 245)

Giovanni was the only one to express how the relationship with his colleagues was negatively impacted by the stress they endured at work:

> "this is something that I did not like, and it made me feel a bit sour, it was a very specific emergency and stressful situation for everyone, and it was some arguing with some

> colleagues that I felt it was completely needless because it was stressful for everyone" (Giovanni, p. 20, 220 – 224)

Lockdown restrictions prevented participants from engaging in any distractions outside of their work. Two participants, Luca and Alessandra, considered exercising, albeit it was harder for them when the lockdown precluded it. However, Luca appears to be attempting to maximise his time off in the following extract:

> "I was making the most of my days off, I was trying to not think about anything, not using too much my laptop or phone, music, sunbathing in summer and going out for runs" (Luca, p. 50, lines 582 – 585)

While Rebecca acknowledges being too exhausted to engage in physical activities, Marilena reveals in the later passage how caring for a pet helps her avoid thinking about work, which encapsulates the challenge of looking after oneself in such extreme circumstances:

> "I got a lockdown pet, and it helped a lot, my life went from this to that (movement of the hand to show a big improvement) because it is my focus now when I am off and I am at home, I got a cat to look after, so it is taking my mind off everything else" (Marilena, p. 34, lines 393 – 397)

In the next passages, Giovanni conveys how valuable relaxation exercises and yoga have been for managing stress. Rebecca also emphasises this, while Giorgia advises that they be offered to nurses in the future:

> "basically they do this well-being session in which there is a psychologist coming at work say first thing in the morning so they come at 8:00 o'clock and then like first 45 minutes we do session of for example like experiencing techniques of relaxation, posture relaxation, yoga, little things you know like I feel this was very good for coping with stress" (Giovanni, p. 48, lines 485 – 490)

In terms of psychological support, Giovanni and Marilena, in the following passages describe how their organisation offered text message services to check their wellbeing or for support with sleeping difficulties, as well as meditation apps:

> "there have been quite a lot of different initiatives that have been going on during the period, there was like our well-being team being involved, trying to catch up with people on how they were feeling, they have some kind of messaging, texting service, to which you can write, I received several messages like how are you feeling today? thumbs up, thumbs down, things like that" (Giovanni, p. 23, lines 255 – 261)

The phrase "catch up with people" suggests some scepticism regarding the usefulness of those applications that appear to serve the purpose of monitoring people rather than truly supporting them, as he would later in the interview emphasize with the phrase "keep track of everyone" (Giovanni, p. 45, line 447). This sentiment seems to be also preserved in Marilena's following passage:

> "they would give us these websites, these free apps to help you sleep or to help you meditate, as I said I did not find it really helpful, I found it like a joke, to be honest, but

> it is no one fault, I mean it was busy for us it was busy for the big heads in the hospital" (Marilena, p.41, lines 481 – 485)

Furthermore, Marilena's use of the word "joke" captures her disappointment and underlying anger towards the "big heads". Instead, in the following excerpt, Luca reinforces that his colleagues are his primary source of support. Later in the interview, he says that he was curious to sit in on one of these open sessions with a psychologist to better understand the purpose of these sessions, despite the fact that he was only there to listen:

> "obviously psychologist was always happy to have us on a one-to-one conversations but then again, I personally always preferred having small chats with my colleagues and friends while on the job to have like small break sessions" (Luca, p. 33, lines 388 – 392)

The majority of the participants, like Luca, did not request this support, and just two of them, Alessandra and Rebecca, were motivated to begin individual therapy with a psychologist they sought out on their own, as Alessandra describes in the following excerpt:

> "sometimes we cannot really do everything by ourselves, well, I admire people that have been able to do by themselves and there are people weak as well and luckily asking help to a psychologist or expert that can help you to read and interpret the life differently or with other eyes, it has been, for me it has been helpful" (Alessandra, pp. 46, lines 453 – 458)

By using the word "weak," Alessandra appears to be placing herself toward the notion that therapy is just for the "weak". Marilena also conveys expectations from therapy, as evidenced by the difficulty of explaining things to a therapist, which seemed to be remedied with colleagues as they were going through the same experience. Instead, the following extract vividly portrays the stress that appears to have prevented Giorgia from seeking help - the speed at which the virus evolved discouraged them from pausing to consider how they were feeling:

> “things were going so fast, so slow because we could not see the end but at the same times, day by day was so fast that, you did not really have time to realize that there was anxiety, there was burnout, there were other things going on so even if there was loads of support provided and you were able to ask for it, I do not think we were actually in the position or in the moment where we needed it” (Giorgia, pp. 29-30, lines 329 – 335)

Rebecca, however, reveals another facet of the experience of seeking psychological support, which made me wonder if it mirrored what was going on inwardly for certain participants:

> “some people do not ask for help and they think just I can cope with that, I can do that because I am strong, I do not need, I do not need anyone because they see like the asking help as a weakness, but it is actually not, it is actually a way to love yourself and being humble as well because you are recognizing that you have limits as everyone has” (Rebecca, pp. 33-34, lines 376- 381)

As I realised the load they had to carry, which was palpable from their narrative, I was surprised by how vehemently defended they were in seeking psychological treatment. It made me wonder whether there were any other assumptions about therapy or if other societal or

cultural factors discouraged them from seeking psychological support. It is also intriguing to notice how this decision was at odds with their involvement in a psychological study. Luca did not seem eager to talk about himself in any detail; instead, he spent the majority of his narrative carefully describing the way of working before and after the pandemic so that I would fully grasp the changes that the COVID-19 reality brought about, placing the emotional strain on his colleagues. This appeared to be consistent with his other remarks about not using any psychological support, but only attending a few times out of curiosity about what was talked about, which made me wonder if there was something about emotions that needed to be hidden away and could not be expressed along with any psychological support. When we discussed how his friend questioned him about his work and the COVID-19 reality in the hospital, the tone of the conversation shifted, becoming less formal and more personal. Luca was more frank in his depiction of his experience, his disappointment at reading those messages, and his struggles to tolerate those in the community who disputed COVID-19 and spread untrue information about it.

4.4.3. Growth and resilience

Attempts to make sense of their experiences are recounted by focusing on positive elements during the semi-structured interviews, which appeared to be provoked by my questions. In the subsequent extract, Giovanni draws on his own resilience to convey a sense of having survived a "catastrophe" and to prompt reflection on the relationship between the COVID-19 pandemic and trauma, encapsulated by the word “survival”:

> “I feel empowered like I feel I can deal with an insane amount of stress and, anxiety, the way I did, so I know that if something happens again, I am going to be somewhat prepared, I will know what to expect in the way I am going to feel and what to do maybe

> to make it better or different, yeah, I feel like a little bit a survival now you know, like, we survived this global catastrophe somewhat united, it is good, it is feels good because I feel like that in the difficult situation you find that you are stronger than you believe" (Giovanni, pp. 39-40, lines 379 – 387)

Alessandra and Luca observe their progress from a professional rather than an individual perspective:

> "I know I can look after very sick patients and maybe at the same time as well" (Alessandra, p. 34, lines 317 – 318)

> "it taught me a lot about remaining calm and be able to, you know, take on challenges and critical situations without actually losing sight of what the priorities, what needs to be done in a timely manner" (Luca, p. 18, lines 204 – 207)

Additionally, it appears that participants were reflecting on their experiences while they shared them with me. As the following passages capture, few of them seem aware of how their burnout transformed into an existential crisis regarding their lives and personalities:

> "I strongly, strongly believe that anyone has started to doubt and to ask questions about what they want in life, what they really want in life so, I mean I always try to see the bright side of the situations because at the end I find myself better than one year and a half ago, even if it was stressful and really painful going through all that but being stressed, being anxious, feeling anxious drove me and let me to ask for help and when I asked for help, I realized that I had to change certain things and certain attitudes as

> well, so I think the way I cope with problems now it is different compared to, compared to like how I used to cope with problems" (Rebecca, pp. 54-55, lines 622 – 631)

> "I am learning to put myself first and see what I want, what really makes me happy first, what make me feel, you know good in tough situations, so I am basically doing whatever makes me feel happy and yeah, because in this kind of situation you need to learn how to live with yourself" (Alessandra, p. 36, lines 339 – 343)

Near the end of the interview, Marilena and Giorgia became more compassionate as they realised how tough it had been for their mental health to work during the COVID-19 pandemic, what they would have done differently, and what they might require now:

> "we never had time to think so yeah, probably I would have thought about myself a bit more, going back, looking back, especially when I started having those intrusive thoughts, that is when I probably had to ask for help" (Marilena, pp. 45-46, lines 529 – 533)

> "support wise, it should be more for the future, instead for the actual moment because as I said, everything was going so fast that even if they were offering other kind of support, I do not know if I would have taken it uhm, I think like support should be like more delivered now or in the future just to get over it than in the actual moment" (Giorgia, pp. 37-38, 424-428)

4.4.4. Group Experiential Theme 2 - Summary

These PETs are interconnected as they succinctly express the tension between having to provide care for patients at the expense of their own wellbeing as well as physical safety due to a lack of time to reflect and process their emotions. Their severe burnout and the support they were able to get were in stark contrast to having to carry on working on autopilot and being trapped in the COVID-19 scenario, which did not appear to stop at any point. Two individuals recognised the value of seeking psychological support. However, other participants chose not to use it even though they knew it was accessible within their organisation. This choice appeared to have been influenced by a variety of elements, such as a propensity to interact with colleagues who shared similar experiences. It appears that being questioned for this study caused them to think about their previous experiences and that by reflecting, they were able to identify some positive aspects of dealing with a global epidemic. Few participants spoke of the existential concerns about their interrelationships, futures, and careers that the COVID-19 pandemic sparked.

4.5. BYSTANDER: DISAPPOINTMENT WITH THE GOVERNMENT AND THE PUBLIC

The Good Samaritan Parable, in which Jesus described a man being attacked and how no one interfered until the Samaritan did, served as the source of inspiration for this overarching theme. The parable eventually sought to convey a different message, although having a connection to the idea of a bystander, who is someone who witnesses something happening but refrains from taking part in it (Cambridge Dictionary, n.d.). This cluster of interrelated PETs covers how the general public influenced the participants' experiences of working during the COVID-19 outbreak. The burden on nurses and their workloads were increased by government decisions about preventive measures, the distribution of PPE, and public scepticism surrounding the COVID-19 outbreak. This fostered a profound sense of guilt in the ICU nurses,

who were making life-or-death decisions with limited knowledge about the SARS-CoV-2 virus and how to treat it, particularly at the early stages of the pandemic.

4.5.1. Let down

The unpredictability of the government's decision-making created a state of panic and destabilisation among participants working on the frontline during the outbreak.

> "they were planning to give a salary increment to the NHS workers, I do not know if you heard about the story and how it ended up, but basically, they were supposed to do it at the beginning of the year, this year, and it was supposed to be like something between 5% and 10% and then again, it did not happen, and it is not going to happen probably until next year, and it is going to be 1%, my God! that is bollocks because I felt like a kind of betrayed on this point of view, because, I know the government supported a lot of people, like, loads, millions really of people in terms of like, working shielding, activities that were paid to be closed, people were working at home, I kind of felt like me as a nurse and the other colleagues were doing like the hardest job possible" (Giovanni, pp. 42- 43, lines 412 – 425)

With words such as "bollocks", " betrayed", and "hardest job", the preceding excerpt from Giovanni conveys a feeling of tremendous indignation at the disdain exhibited by the government. Similarly, Rebecca expresses a sense of abandonment and subsequent sentiments of frustration:

> "the government did not really help us on this, on their side, to be honest, that is what I felt and what my colleagues felt as well so, there was frustration because we worked

> really hard every day, every day we go to work, we do not stop, I see nurses running around, they literally do not stop and we felt a bit like, I do not know abandon from who it is supposed to take care about us basically" (Rebecca, p. 18, lines 198 - 204)

These sentiments were reinforced by the government's decision to stop providing PPE, which eventually led her to experience several panic episodes and to then refuse to go to work:

> "afterwards like from a day to another, they [government] decided to take off the aprons, not the aprons, the gowns, basically, because I think, I believe that the main reason was that we did not have PPEs around the hospital so there was a big shortage of PPEs" (Rebecca, p. 48, lines 547 – 550)

Both preceding passages reflected a similar underlying rage, which is expressed vividly in the following excerpt, in this case, also directed at the media for calling nurses "heroes". The idea of a negligent government made me think of an absent mother ignoring the infant's cry since she does not know how to handle it:

> "let's, be clear, nobody signed up for this when you sign up to be a nurse, you do not sign up for this, calling us heroes, I never liked, when people called us heroes because we were just doing our job" (Marilena, pp. 36-37, lines 423 – 426)

Given that the participants are Italian, the following excerpts perfectly capture the dissonance brought about by the contrasting preventive measures and ways of working implemented in both countries. Rebecca, in particular, conveys further dissonance between her family's

concerns, since the COVID-19 pandemic struck Italy a month earlier, and the government announcements in England to remove PPE:

> "I think Italy did a little bit better with COVID" (Marilena, pp. 27-28, lines 316 – 317)

> "my family was worried about me and I was worried about them, so hearing them worried and saying, they keep saying like are you sure you want to go to work and you have to be careful because you are really exposed to that and when I told them, how the government decided, the Health Organization decided that it was fine to work just with a surgical mask, they were really upset because they were like you are putting yourself in danger, just speak up, talk to them because it is not possible that you work in this city in these conditions, so that was stressful as well, because I knew that was the right thing to do" (Rebecca, p. 45, lines 511 – 520)

The above excerpt from Rebecca emphasises how the disparity between the countries translated into heightened anxiety and powerlessness, further aggravated by a lack of support from an informed government.

Two participants, Rebecca and Luca, embody a movement of people – some relocating to be nearer to family, others leaving their country – that was notably pronounced during the COVID-19 pandemic. Particularly in Alessandra, this exodus sparked existential questions about her life and her interpersonal interactions:

> "most of my colleagues like me, come from other countries, who from Portugal, Spain, Italy, anyway, most of them have left, I do not know, maybe because of sick of all of

> that, because also these friends before were not thinking to go home they were ok here, people that were thinking to buy a house here and stay here, they left, I do not know, maybe scared because they missed the family more than how they were missing before, I do not know because scared of I do not know that this COVID could interfere with their projects" (Alessandra, p. 38, lines 358 – 366)

> "I was at the time living with two other flatmates, there were other people, but some of them left, they went back to their houses" (Luca, p. 24, 280 – 281)

Rebecca outlines in the subsequent passage how she requested sick leave after experiencing panic attacks as a result of the government's decision to remove protective equipment and how challenging it was to be believed by her GP:

> "I actually had problems with the GP because they did not want to give me a sick note at first because they said ah there are loads of people that they are in your situation I cannot do this and I was like I am sorry I am a nurse and I cannot go back to work, so my GP was not really helpful at the beginning" (Rebecca, p. 51, 582 – 587)

The extract above emphasizes how the public response to the COVID-19 pandemic exacerbated the storms of dread and unpreparedness that swamped ICU nurses' work during the COVID-19 outbreak.

I was personally influenced by the COVID-19 pandemic, while I researched participants' work experiences on the frontline during the epidemic. In particular, I observed that my apprehension of the virus subsided after contracting it at the very beginning of the pandemic's

UK outbreak. This increased my understanding of Luca, who went through a similar situation and found it harder to express how the pandemic affected him during the interview. Additionally, as an Italian, I was constantly updated on the impact of the epidemic in Italy and the strategies put in place to manage its spread. As a result, I realised that I shared the participants' opinions about how the UK government should have responded more proactively and firmly, and I could relate to their indignation displayed, particularly by Marilena, Giovanni, Giorgia, and Rebecca, having lost a colleague because of COVID-19. I admired Marilena for exposing her vulnerabilities and genuine challenges to me; she appeared to value the opportunity to get it all out and open the box that she needed to keep hidden for a year.

4.5.2. Facing scepticism

> "I had a lot of discussions with my friends, in a great way and just uhm I am going to say constructive way, I am talking about all fake news that they were going on the TV, lots of anti-vaxxers in this case now but at the beginning, people were thinking that the virus was a hoax, that the people were not actually dying, people asked me to see bodies dying in the hospital, just because they were healthy and they were not thinking that the virus was actually true, still surprises me up to these days, having someone asking me to see someone who is dying in the hospital just because they do not think they are actually sick, uhm so yeah as I was saying with my friend, lots of them were asking, saying are this things really true, are you really working so much? Are you really going crazy at work? like having so many patients? And I was yes, that is why I have not had a day off in like 7 days or that is why I am doing extra shifts every now and then, that is why I cannot text you so much, but none of them, although there were, some of them were a bit sceptical, they were like, oh, it cannot be true, I mean, it is impossible, it

> never happened, and every day I was trying to explain them" (Luca, pp. 55-56, lines 637 – 655)

I chose the above excerpt to introduce this PET as it accurately captures the experience of ICU nurses who must endure such intolerable working conditions while also facing outside friends' scepticism as they were asking them to send pictures of the body. It is vital to note that the word "explain" accurately captures Luca's incredible patience in maintaining his composure in the face of this terrible circumstance and his mental clarity to deal with these unpleasant demands and utterances. This was more apparent in Luca, whereas Giorgia and Marilena's portrayals show anger:

> "so on the first surge, we were receiving a lot of cards, a lot of food, a lot of gifts in the unit, which was like brightening our day because obviously it was that small thing that was nice and we felt very appreciated as well as the clapping, then with the second surge, obviously people were tired so we felt much less appreciated and now people look like they are upset with us like if we are the one bringing COVID, like we are the one making… like lots of people are in denial and they think that COVID does not exist and they kind of uhm, how can I say, that they are actually saying that we are making that up" (Giorgia, pp. 14, lines 149- 158)

The above passage from Giorgia perfectly captures how the community's attitude has transformed since the start of the pandemic, going from an initial display of solidarity to eventually shifting the blame for their frustration to the ICU nurses and being in "denial" of the continuance of the SARS-CoV-2 virus:

> "it was nice the first time the claps and then it was just too much, because at the end of the day, now we are, COVID is not, I do not think that the community realizes that COVID is still happening, even if there is not a big wave outside within the walls of the hospital, COVID is still happening is still hitting hard not only in intensive care cause let's be clear if the intensive care is busy then the rest of the hospital is busy, if intensive care does not have a bed for a patient, it means that the patient has to stay in A&E, in the emergency department and if the emergency department is busy, all the ambulances at the hospital are still busy, which means that on the community, if you break your leg, there will not be an ambulance to help you. So, the community does not understand, it really angers me when I see people still not wearing a mask on the streets, saying that it is too hot, how about me? I wear a mask for 12 hours when it is 40 degrees, it is still very hot, you can wear a mask for 10 minutes while you are taking the underground" (Marilena, p. 40, 461 – 477)

The emotion expressed in the Marilena excerpt is primarily indignation toward individuals who disregarded safety procedures. Her portrayal almost seems to be an attempt to shift the immense burden she had been carrying up until that moment to the community while also trying to exonerate herself of any moral obligation and hold everyone to the same standard of accountability.

Hearing the strong scepticism about the job strain for ICU nurses as well as the aftermath of the COVID-19 pandemic from friends and strangers completely shocked and horrified me. These actions make me more receptive to Marilena and Giorgia's feelings of rage than to Lucas's patience, although I really admired his composure and patience in educating his friends about COVID-19. At that point, I saw myself becoming protective of him and holding

back on saying that I believed these requests were cruel. I thought the demand for seeing pictures of people dying was excessive and displayed a great deal of ignorance, coming from a cynical and egotistical society.

4.5.3. Shared guilt

Throughout the participants' interviews, guilt as a result of feelings of shame and regret for having done something wrong is quite palpable. The tremendous ambiguity surrounding the virus conflicted with the legal obligation of care that all nurses have to their patients, leading to mistakes and internal tensions:

> "you have caused it, and you know, like you say, wow, what I have done? It is like, I killed the patient, in other words it is that…of course, you are not alone, because at the end there are other nurses around, uhm, I mean, and also is like 24 hours over 24 hours jobs, so you finish the shift, there is another nurse, and if, for example, the other nurse does not realize about the mistake and continue to, you know to make this mistake at the end, it is not only your fault, it is like the team fault because it was other people's distraction as well" (Alessandra, pp. 44-45, lines 431-439)

The preceding excerpt read like a type of confession of misdeeds; although the incident described by Alessandra about nurses' mistakes with a medication dosage had little to do with her personally, she witnessed it as the pandemic catastrophe began and swiftly got worse.

I was completely overwhelmed by Alessandra's bravery in exposing this reality. I came to understand how this revelation did link with anger within me that I was not aware of at the time. I later realised that the reason this comment struck a chord with me and moved me deep

inside was because I had actually lost a beloved colleague to COVID-19. However, I could see how her story swiftly moved me to a place of understanding and compassion.

Guilt was felt for being unable to help colleagues by taking time off or needing to take sick leave. The following excerpt reflects Rebecca's struggles with going back to work, involving her use of the words "anxious" and "hyperventilate," as well as her decision to go back to work anyhow to help her colleagues. It does highlight the contradiction between how they feel and what they ultimately do:

> "I cried every day for one week (giggle) I was crying everyday uhm, I was feeling like I am not supported enough, I do not want, I felt really every time, every time that in my mind came up, the image of me going back to work, I started to hyperventilate (giggle) and feeling really, really anxious, so I was like I am not ready to go back to work, I do not even want to see that hospital now so I felt really sorry after two weeks, I went back just because I want to help my colleagues, that was the main thing that led me to go back to work" (Rebecca, p. 53, lines 601-608)

> "during the surges there was loads of pressure for us to do a bit more of extra shifts, which they were paying a bit more so you were taking them, we were going to work a bit more, and in the other hand, it is not that you are home doing much and at the same time again you are scared to go to work by at the same time you feel guilty if you do not go to work to help, so then we ended up going to work a bit more so I would say we were probably working 50 hours per week" (Giorgia, p. 28, lines 311 – 319)

The above sections exhibit a sense of shared accountability among participants, as they feel obligated to help their colleagues out of a sense of moral obligation as a result of sharing the same dire situation. This is true despite experiencing anxiety when contemplating going back to work, being afraid of the workplace, or understanding the value of taking time off for the safety of patients, as Luca explained during the interview.

Giorgia also emphasises how she felt she was failing the redeployed and junior staff as a senior ICU nurse. Later in the interview, she describes feeling worthless since she did not have time to demonstrate how to do things while overseeing complex patients.

4.5.4. Group Experiential Theme 3 - Summary

These PETs are related since they provided more specific details regarding the research question. They offered a more in-depth perspective on how the government and public sphere impacted their experience, worsening a shared sense of guilt that seemed to follow ICU nurses in their daily work, given the urgency of the crisis as well as the early lack of knowledge of the SARS-CoV-2 virus. The ultimate GET would concentrate on the ICU nurses' survival strategy of detachment.

4.6. EMOTIONAL DETACHMENT AS COPING STRATEGY

This last cluster of PETs is nested within the previous GETs since it embodies an instinctual survival mechanism brought on by a work that has grown to be perceived as threatening. It comes as a result of being forced to continue working despite the gravity of the situation and seeing a significant amount of people dying suddenly, including patients and colleagues, which served as a sobering reminder that everyone's safety was compromised. Patients are severely

dehumanised in these challenging situations, but so are ICU nurses who have to hide their psychological needs in order to fulfil their moral obligation.

4.6.1. Secrecy

The separation between the participants' microworld and the outside world is captured by the "Secrecy" PET. As previously indicated, the lack of understanding from the government and people in the community created a gap in which ICU nurses appeared to have been left to bear the burden of the COVID-19 outbreak on their own.

In the extract that follows, Marilena conveys a conflict between wanting to talk about her experience and being afraid of engaging in "juicy gossip," a phrase that she seems to use to portray a public denial and shift of blame onto the ICU nurses by the general public. These dynamics intensify a sense of detachment from the COVID-19 catastrophe that ICU nurses experienced as an adaptive survival response. She also depicts how difficult it is to get back to normal life and how strange it is to communicate with people as if she was abducted and held secluded from reality for too long:

> "I do not like talking about it, just because it is some juicy gossip and they need to know what is happening behind the wall so I would not talking about it to brag so, I always felt like I am holding a secret with them, especially…now being outside and spending a night out with my friends, I feel like I still need to readjust to normal, I feel like I am back on speaking a language that I have not spoken for years, I do not know if it makes sense, sometimes I need to oh a normal person would say this, so I will say this, or a normal person will act like this, so I will act like this, so I still kind of in the back of my

> mind thinking what I am doing, instead of just being myself" (Marilena, pp. 42-43, lines 494 – 505)

The dissonance of the situation is heightened by another feature that seems to emerge from the data. The desire to protect redeployed staff from the harshness of the situation as being responsible for them intensified this sense of secrecy that needed to be maintained also with them. Luca's excerpt shows a protective instinct towards volunteers as he would explain before this passage how he had to select what to ask them to avoid exposing them to disturbing tasks:

> "it is probably affecting you a little bit less compared to a student that is already coming there to help you, is a volunteer, and on top of that you put them in a situation where they have to stand with someone who is crying, grieving and you know it is just not nice for them" (Luca, p. 80, lines 936 – 940)

Marilena, instead, more effectively conveys the difficulty of having to hide and lie about her feelings as well as their working realities since their "figure of support". Her extract vividly depicts the dual reality of her inner world and the need to maintain a façade and look as though everything is under control in the outside world:

> "they did not know what to do and they were here to help and you have to look after them and explain that everything is fine, that being scared it is fine, that not having time to do things it is fine…uhm…it was difficult cause you are stressed yourself, you are angry yourself, you scared yourself, you want to cry yourself, you are not allowed to do so, at least not in front of everyone because if you are, if you that you are the senior

> one and you are the figure of support, if you breakdown then, who is going to support the others?!" (Marilena, pp. 38-39, lines 440 – 449)

The following passage from Alessandra has an aura of secrecy surrounding it since it illustrates the dreadful consequences of giving patients the incorrect dosage of medication given the novelty of the virus. Mistakes typically need to be kept secret and cannot be disclosed to the public:

> "we really did not know how to balance sometimes medication with the patient conditions and sometimes because we tired, because of distractions, because we were fed up, we forgot to check the levels and in the meantime, the damage maybe was already done" (Alessandra, pp. 14-15, lines 160 – 164)

While Alessandra reveals a distressing but genuine truth about what was happening at the start of the epidemic, surrounding the SARS-CoV-2 virus and the entire COVID-19 scenario, Rebecca highlights the value of sharing one's experience. She expresses a subtle desire for her experience to be shared and used as a lesson rather than kept secret. This is done in an effort to enhance the care provided as a reflection of better healthcare professionals' well-being.

The PET "Secrecy" provides additional meaning to the considerable distance between ICU nurses and the general public, who, according to participants' account, seemed unconcerned about the COVID-19 hardship on ICU nurses. This exacerbated the detachment response required by ICU nurses while striving to satisfy the demands of the COVID-19 outbreak.

4.6.2. Loss

This PET effectively captures the distress brought on by having to observe such a significant number of individuals passing away due to COVID-19, which proved to be distressing also for ICU nurses, who are accustomed to witnessing death as part of their nursing profession. As a result, ICU nurses developed a detachment response to sustain their attention on their duties since the increased demands would prevent them from being able to process their feelings.

> "I remember when there was the first wave and so all this COVID things was new, a lot of people were dying so a lot of death, but there were lots of admissions at the same time, so very tough situation emotionally" (Alessandra, p. 5-6, lines 56 – 60)

> "I mean, as a nurse you are I mean, it is not nice to say, but you are used to, or I mean you see things (giggle) and you see people that might not make it and they might pass away, so in that case, it made me realize how severe was the situation, basically because in my in my experience in my ward was really, really rare to find patients that when palliative, or, yeah, they might pass away" (Rebecca, p. 41, lines 467 – 472)

While Alessandra acknowledges that having to observe people dying while handling admissions encapsulates a challenge in processing emotions, Rebecca pauses more on the fact that people were passing away, which was unusual in her previous work, although, as she highlights, the expectation is for nurses to "be used to" this. Later on in the interview, she expresses how unsettling it was to learn that, despite their age group, colleagues were also suffering from COVID-19 and ultimately dying:

> "we had actually a young person, it was like 23 years old, we actually do not know if it was COVID at the end, we do not know but we remember that, it was in the other ward connected to mine anyway and they was working all night long basically and they was not feeling very well but they did not wanting to go home because they were short of staff but basically when they got home, they went to sleep and the mum found in bed after a cardiac arrest, again, maybe it was not COVID we do not know, the main thing was that, it was the first surge so we did not know what the consequences were of what this virus could be, so we got really, really scared and we kept hearing from other wards, maybe, colleagues, between 50s and 60s getting COVID and dying for it" (Rebecca, pp. 42-43, lines 483 – 494)

Learning that colleagues were passing away due to COVID-19, as Rebecca describes in the extract above, raised their awareness of the life-threat circumstances they were exposed to, which appeared adaptively suppressed on a regular basis. For this reason, the PET "Loss" was included in the GET "Detachment." Similarly, Alessandra appears to have realised the viral threat, as encapsulated by the sentence "we are all involved" in the following passage:

> "we talk about variants and they start to affect also young people, and they said, ok, things are changing now, so we are all involved even healthy people, people that have never had problems in terms of food, or, you know, hypertension they were affected so… it was really bad" (Alessandra, pp.16-17, lines 182 – 186)

Another aspect was the stress of having to deal with a grieving family. There is a sense in Lucas's excerpt that having to support the bereaved family was adding to their duties both physically and emotionally:

> "we had many deaths, and many how can I say, we have to face lots of relatives, something that I did not mention was the fact that there were few occasions where we were in a room with a grieving family, when you have to tell them your loved one is alive but at the same time we are kind of at the upper limit of the care that we can provide and they have to understand that within like few minutes things might go bad and this person might not survive, so we had lots of situations where you are just there, drained with your energy, literally you have no energy left, you have million thoughts in your head, you have so many things to do and yet you do not want to leave because you are standing next to this person and you have been looking after for maybe the past few days and the family is there and they know that you both know that this person is about to die" (Luca, pp. 78-79, lines 915 – 928)

According to the above passage, the realisation that you have been caring for someone "for the past few days" who is about to pass away encapsulates the emotional awareness of the relational nature of nurse-patient that ICU nurses struggled to attend to since the mourning family required to be comforted.

4.6.3. Dehumanisation

In relation to the previous PET, this one elaborates on how the demands of the COVID-19 pandemic forced a deprioritisation of the care given, creating a situation where ICU nurses were also deprived. The COVID-19 outbreak increased the burden on the workload of ICU nurses, forcing them to rethink their way of working to the point of prioritising tasks that would have kept the patient alive, as Luca conveys:

> "you know the target was not to get them well, at some point the target was keep them alive" (Luca, pp. 47-48, lines 552 - 553)

Marilena emphasises the difficulty of dealing with the ire of the family of sick patients after she was unable to update them due to the overwhelming workload that forced her to be "rude on the phone" rather than showing empathy and comforting distraught relatives.

> "it was difficult dealing with families at the beginning when COVID was not a thing yet when everybody thought that COVID was just a bad flu, it was difficult dealing with family, they were really angry at you because you did not answer the phone calls cause you did not have time to answer the phone calls because their 40 years old husband was really sick and they were not allowed to come in and see them, because your daughter, your sister, your mom is really sick and you are not allowed to come and see them because you are so busy that you are rude on the phone" (Marilena, p. 39, lines 449 – 458)

> "with COVID patients I saw as well you actually do not get the chance to do everything you are supposed to do, and you would love to do because you know that there is a patient that can be I do not know your brother, your mother, your sister, whoever, so, since we are human beings and we get sick as well, I guess they suffered a lot shortage of staff" (Rebecca, p. 10, lines 108 - 113)

The excerpt above clearly depicts that Rebecca regards the patients not just as patients but also as human beings, and the same is true for the nurses. This seems to collide with the great dilemma of not being able to provide the standard of care that is expected of them due to the

urgency of the entire situation. Additionally, it is likely that patients end up being a form of surrogate for the family that they struggle to see as being separated from their own family due to the lockdown. This was present in Alessandra and Marilena's accounts as well.

Giorgia reveals how she would find it easy to dwell on whether to prioritise herself or the patients due to the overwhelming conditions of working with PPE. She would later in the interview directly recognise how the patients get dehumanised by the circumstances and medications:

> "I do not know if I will be able to go to another surge because the workload and the burnout is massive. I think like we lost a bit of compassion towards the patient because we got in ITU, we got used to have them deeply sedated so you start not seeing the person as a person anymore at some point, uhm that is a bit scary" (Giorgia, p. 7, lines 71 – 76)

In the section that follows, Giovanni evokes similar sentiments, indicating a sense of contradiction between how one was feeling and the nature of their profession – taking care of others – as well as the effort to remain positive in the face of stress and negativity:

> "it was difficult to keep yourself motivated and proactive and like you know supportive, you are supposed to be kind, respectful and like pleasant to the patient and to the colleagues and everything, but obviously this is not easy in such situations, so the management, I would say the management of the particular situation and stress management was probably the hardest thing in general for everyone like adapting to the negativity, the increased amount of work to be done, stress to be coped physically

> and mentally, yes this, this is the thing that I felt most" (Giovanni, p. 35, lines 389 - 397)

Marilena walked me through her daily hardships and tremendous hurdles. She portrays the stresses of the COVID-19 pandemic on ICU nurses, reaching the point of not seeing any escape from it since it did not seem to end at any moment. She would experience intrusive thoughts of hurting herself, such as jumping in front of a moving car so that she would have a legitimate justification for not having to go to work:

> "I remember having some intrusive thoughts, sometimes, I remember going to work crossing the street, thinking maybe if a car run over me, at least it is over, I am really, I talk about it very easily because as I said, I have got really supportive friends and partner so I have talked to them already, I remember these intrusive thoughts happening a lot, like you know, maybe I will not die, but at least if I got a broken leg, I do not have to go to work, that is me not being able to take a break from work because you feel like" (Marilena, p. 23, lines 262 – 269)

Within the next excerpt, Marilena depicts the severity of what it felt like to work in such a threatening situation by evoking powerful imagery of struggles that resemble PTSD symptoms, such as flashbacks, dissociation, and social withdrawal. The passage perfectly embodies her experience that was communicated through a body that appeared to be in danger, worn out, and operating on autopilot, split from the mind:

> "the things happening during the shift will come back to me as in flashbacks at night, I remember even not being able to have a shower because I was in the shower and then

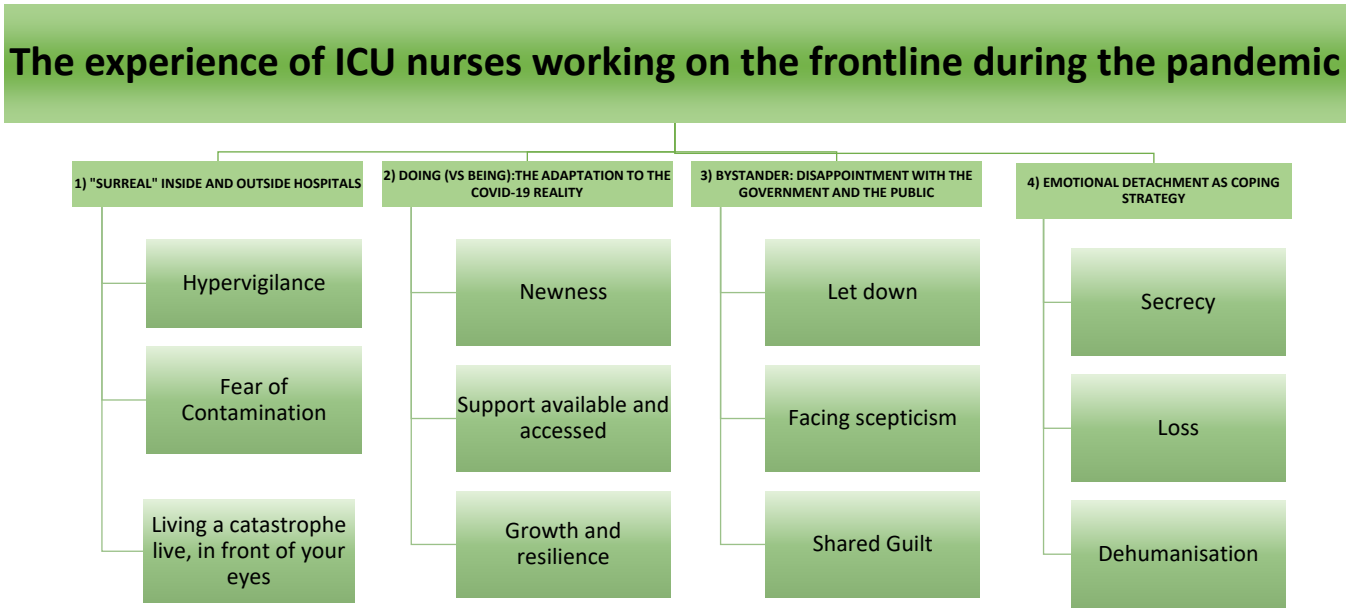
> the only thing I know, I spent an hour in the shower only thinking about work, I was not even washing myself, I was just there staring at the emptiness, I was not able to watch movies anymore, I will just isolate myself from everything, I will just find myself all of a sudden realizing that I was just flying with my thoughts, and I was not there, present in the moment" (Marilena, pp. 25-26, lines 293 – 301)

Hearing her story left me feeling extremely overwhelmed. She exposed herself to such a great extent that I appreciated it since it indicated that our relationship felt like a safe space. The more she explained to me what she had gone through, the more I realised how important it was to keep on wearing my researcher hat and resist the urge to don the clinician one. Because of how much self-neglect she seemed to have borne, it has been difficult for me to listen to her narrative, I frequently caught myself holding back from encouraging her to start therapy or making a clinical comment.

4.6.4. Group Experiential Theme 4 - Summary

This fourth and final cluster of PET represents the effort to prevent emotional suffering and pain brought on by the pressure that the COVID-19 pandemic has placed on the healthcare system. The first PET describes how participants almost had to compartmentalise all of their feelings and experiences from working during the COVID-19 outbreak of how poorly understood they would be by outsiders. According to some accounts, their reality had to be kept secret even from volunteers who offered to help within the COVID-19 units. This is owing to the obligations placed on them as senior ICU nurses. The PET "Loss" indicates an additional burden required to be faced, whilst the last theme concerns a poor balance between care offered to patients and care provided to themselves, resulting in a severe sense of neglect.

4.7.Schematic Summary



1. The surreal consequences of the COVID-19 pandemic played out inside and outside of hospitals, causing a constant state of hypervigilance that was made worse by the demands the virus placed on ICU nurses as well as a great dread of getting the virus and jeopardising patients and loved ones. Hospitals portrayed a daily catastrophe with memories of the first surge triggered for any new patient that tested positive for COVID-19 as the pandemic subsided.
2. The working adaptations to the COVID-19 novelty crisis resulted in ongoing autopilot work and struggle to access support as well as reflect on their own feelings and experiences. The interview process seemed to have increased reflection on growth and resilience.
3. The public's and the government's response of turning a blind eye to the enormous obligations of ICU nurses during the pandemic resulted in feelings of disappointment owing to inadequate government decisions to protect their safety, public scepticism

regarding the deadly effects of COVID-19, and the burden of the virus's responsibility on ICU nurses, which intensified intense guilt due to a lack of adequate quality care.

4. The emotional detachment of ICU nurses was caused by a lack of understanding by the community and government, which led them to keep the experience of working on the frontline during the COVID-19 epidemic within themselves, as well as experiencing an unusually large quantity of death and a severe level of dehumanisation on ICU nurses, due to having to prioritise patient safety before their own as per their duty of care.

Three primary concepts have been extrapolated from the four GETs identified based on the above summary, including DISSONANCE, which emphasises an ongoing internal conflict between predominantly work demands and care provided, ABSENT RESCUER, which reinforces the impact of government and the public on their work on the frontline during the pandemic, and, finally, DISCONNECT, which is related to participants' survival response to the pandemic by disconnecting from their feelings, from other people, and from their vulnerability. The following chapter will go deeper into these concepts.

CHAPTER FIVE

DISCUSSION

5.1. Introduction

In this chapter, I will provide the findings of this study within the context of the research literature outlined in chapter one. Nonetheless, this discussion would reflect on additional studies not included in the literature review, with the hope that the interviews and analysis would contribute to the discipline of Counselling Psychology (CoP) research and clinical practice as well as to the wider field. Prior to conducting semi-structured interviews with six participants, an Interview Schedule (Appendix 5) was designed with the aim of addressing: 1. How the COVID-19 pandemic has impacted the work of ICU nurses? 2. What were the effects of working during the COVID-19 pandemic on mental and physical health? 3. What helped ICU nurses in coping? 4. What has been the main challenge? 5. What has been the support provided? As a researcher, I have explored the experience of ICU nurses working on the frontline during the COVID-19 pandemic. However, I realised how my personal experience, including how I quickly caught the virus and lost a colleague to COVID-19, has impacted the analytical process. The paragraph on reflexivity, in section 5.4. offers more clarification.

Much of the content of the identified themes would provide a unique perspective into the experience of ICU nurses working during the COVID-19 outbreak, based on considering the multi-layers of the meaning of distress by anchoring the conversations in the larger societal context from which these stories emerge. This study seeks to further draw parallels with the meaning-based threat response, which is a functional response within the context of trauma, in line with the Power-Threat Meaning Framework (PTMF), outlined by Johnson and Boyle (2020), to be discussed later in this chapter. This is owing to the magnitude of participants' emotional responses to the COVID-19 pandemic and their relevance to trauma. This study

intends to raise awareness of the meaning of distress as survival adaptations to adversity and adopt a more trauma-informed language in accordance with the values of CoP discipline. The chapter will conclude with suggestions for other study directions.

5.2. Discussion of the themes in the context of the research literature

The sections that follow examine how participants conceptualised their experience of working on the frontline during the COVID-19 pandemic within the four GETs that were determined for this study, as well as how they incorporated and expanded upon the existing literature. I present three core concepts that I extrapolated from the GETs, which can be grouped under the headings of "Dissonance", "Absent Rescuer", and "Disconnect", rather than repeating the analysis' pertinent points and going over each theme again. The findings reveal the dissonance within their nursing profession: the COVID-19 pandemic's emergency has pressured ICU nurses to perform their duty of care without the possibility of processing their emotions; the absence of a leader-government who, rather than acting as a rescuer, fits the definition of a bystander; and the ultimate disconnected response to manage their hyperarousal continuous state as a survival adaptation to a scenario that did not seem to stop at a certain point. These three core concepts appear to frame ICU nurses' experiences working during the COVID-19 pandemic within the context of a traumatic event.

5.2.1. Dissonance

As Giovanni captures in the word "catastrophe", participants in the interviews expressed a sensation of being unprepared for the COVID-19 epidemic, which struck them like a tornado that lingered in one place for too long. The impact of this unforeseen circumstance was especially relevant since the findings from this study show how ICU nurses were forced to swiftly adjust to the realities of the COVID-19 pandemic as well as a large number of

admissions. They started from scratch by thinking about isolating the space so that COVID-19 patients would not have contaminated the regular patients, creating the ITUs in other areas such as theatres, and thinking about how to fulfil their duty of care without exposing themselves and others at risk.

The PETs of "Newness", "Hypervigilance", "Living a catastrophe, live in front of your eyes", and "Fear of contamination" brought this experience to light. Most participants described how quickly they adjusted to the COVID-19 emergency's immediacy. However, in between waves, they appeared to realise how the demands would just keep growing and impose a tremendous emotional strain. The results of this study appear to be consistent with recent qualitative research on the COVID-19 pandemic (Newman et al., 2021; Montgomery et al., 2021; Hoernke et al., 2021; Billings et al., 2021; Vindrola-Padros et al., 2020), which indicated the high level of responsibility required to care for critically ill patients and redeployed untrained ICU staff as well as the challenge of providing care, while wearing PPE. These aspects created additional and emotional demands and internal conflicts in a situation where ICU nurses were unable to take any days off or breaks due to patients-nurse ratios and the concerns of leaving patients and untrained staff unattended. ICU nurses' stress was further compounded by the lack of time off to engage in social activities outside of work due to lockdown procedures and limited social interactions (Billings et al., 2021; Harris et al., 2021).

Another finding from the participants' interviews was a persistent state of dissonance brought on by the COVID-19 reality demands, which forced them to operate on autopilot. It was acknowledged that their actions were putting them at risk of burnout and excessive stress levels, which contradicted their commitment to caring. Similar internal conflicts would emerge as a result of the government's failure to provide a safe workplace in the wake of the COVID-19 outbreak. The theory of dissonance was first proposed by Festinger (1957) to explain the

experience of having two conflicting cognitions or a misalignment between behaviour and beliefs. The psychological distress caused by a cognitive discrepancy motivates behaviour change or belief change (Festinger, 1957). Cognitive dissonance appeared to be very significant to ICU nurses given that they were required to act in ways that were inconsistent with their beliefs and conceptions of patient care. For instance, choosing which aspect of the patient's care should be prioritised considering the enormous demands on care and staff shortage led to it.

The considerations on cognitive dissonance may be relevant to the decisions made by ICU nurses who have been expected to perform their duty of care under demanding conditions that jeopardised the calibre of the care provided and their professional nursing ambitions. For instance, they had been considering factors like predicted outcomes (prognosis), health state, patient age, and patient will when determining which patients to treat first in light of the COVID-19 pandemic and the high volume of admissions relative to staff available (Simm et al., 2022; Dos Santos et al., 2020; Mazza et al., 2020; Royal College of Physicians, 2020). In line with experiments in the dissonance research context, it appears rather reasonable that ICU nurses had to look out for positive aspects of having to work in these extreme situations to minimise cognitive dissonance (Brehm, 1956), such as having enhanced their professional abilities, capacity to handle a large amount of stress, and, a correspondingly remarkable level of resilience, in accordance with the findings of this study such as the “Growth and resilience” PET. The "Dehumanisation" PET appears to be a reaction to the dissonance experienced.

Dissonance can result from people acting in ways that are at odds with their moral principles and values (Loughnan et al., 2010). Accordingly, the COVID-19 pandemic may have contributed to moral distress among many personnel of the UK healthcare profession.

However, the concept of moral distress has been discussed in the international nursing literature even before the current epidemic (McCarthy & Deady, 2008; Corley et al., 2005). The evidence on the phenomenon of moral distress supports the research findings of this study, which revealed that ICU nurses regularly had to make decisions on a large number of patients and redeploy personnel. Yet they felt pressured to act in ways that were inconsistent with their moral principles and adaptive integrity, which caused a significant dissonance. However, the phenomenon of moral distress has drawn a variety of criticisms, foremost among them being the lack of a widely accepted clear definition of moral distress (Willis, 2015). As a result, this evidence together with the current limited study on the COVID-19 pandemic and moral distress, cannot be generalised. The decision of not incorporating moral distress within this study is also consistent with the aim of this research, which is to investigate ICU nurses' experiences of working during the COVID-19 pandemic without tying them to any predetermined category.

Cognitive dissonance increases physiological activation and sympathetic nervous system activity, which produces a measurable level of discomfort (Croyle & Cooper, 1983; Losch & Cacioppo, 1990) - more information on which is provided in the section “Disconnect”. According to a study (Muschalik et al., 2020), mindfulness acceptance helps people deal with dissonance since it reduces their desire to take action. Mindfulness is described as “the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p. 145). This result appears consistent with the findings of this study as a few participants found breathing exercises, mindfulness, and yoga practice beneficial when introduced before their working shift.

5.2.2. Absent Rescuer

The findings of this study demonstrate a common sentiment of being let down by both the government and the public, who appeared to shift the burden of responsibility for the COVID-19 outbreak onto ICU nurses. For instance, Rebecca as well as other participants, clearly pictured the frustration of the contradiction between ICU nurses "running around, they literally do no stop" as well as risking their lives and a lack of concern from the government. Without effective leadership to maintain coherence over the preventive measures and remind people what they should do, participants were exposed to the threat of danger and death for a prolonged period of time.

The "bystander effect" (Darley & Latané, 1968), a concept from social psychology that describes people's propensity to remain inactive in high-danger circumstances due to the presence of other bystanders, can be used to interpret the findings of this study regarding the public response to ICU nurses working during the COVID-19 epidemic (Latané & Nida, 1981). Bystander passivity is affected by three psychological processes (Latené & Darley, 1970): the sensation of having less responsibility in the presence of other bystanders (diffusion of responsibility), the fear of being judged by the public if aiding (evaluation apprehension); and the acceptance of other people's overt reactions, leading to the perception that there is no emergency since no one is helping (pluralistic ignorance). Distress is posited to be an individual's immediate response to an emergency that triggers the fight-freeze-flight-fawn-flop system and prevents behaviour that would otherwise be beneficial, resulting instead in avoidance and freezing (Graziano & Habashi, 2015). These processes appeared to explain some of this study's findings which included a public that became sceptical about the COVID-19 pandemic, stopped expressing solidarity with and support for ICU nurses, and suffered significant psychological distress as a result of the fear of the disease, which eventually led to

the freeze response and resentment shifted to ICU nurses (Harris et al., 2021). The devastating effects of the COVID-19 pandemic on the healthcare system and the government's inability to make an informed decision to defuse the emergency, as evidenced by the decision to remove PPE during a high peak of contamination risk for ICU nurses (McKee, 2020), revealed a severe lack in the government's capacity for leadership, sparking pluralistic ignorance.

These accounts of the detrimental effects of extreme stress linked to extended exposure to life-threatening situations, which are encapsulated by the PETs “Let down”, “Facing scepticism”, “Shared guilt”, “Secrecy”, and “Loss”, are characteristics of traumatic experiences and are consistent with studies' findings on COVID-19 and past pandemics, which indicated a considerable prevalence of PTSD symptoms in ICU nurses (Greenberg et al., 2021; Greene et al., 2021; Mealer et al., 2009; Karanikola et al., 2015; Machado et al., 2018). People in times of crisis frequently turn to leaders and authority figures whom they regard as having more control over a dangerous and unpredictable world (Kets de Vries et al., 2004; Kay et al., 2008), like a child would seek parental proximity. According to the emerging literature on the COVID-19 epidemic (e.g., Harris et al., 2021; Aughterson et al., 2021), the surreal events that occurred within the hospitals coincided with the government's poor leadership decisions not to impose stricter regulations and acquire additional PPE. Being unable to be understood and feeling abandoned to battle the COVID-19 outbreak alone caused ICU nurses to feel profoundly alienated from the outside world, although this also fostered a sense of camaraderie among their colleagues (Billings et al., 2021). Due to the public and government's denial, as Marilena reveals, it appears that the COVID-19 pandemic experience for ICU nurses felt like they were keeping a secret.

The relationship between trauma and secrecy is deeply entrenched in society, reinforcing the idea that discussing certain traumatic topics in public is inappropriate, hard to bear, and would only lead to generational denial. When thinking about trauma and secrecy, child incest at the far end of the trauma spectrum comes to mind. It is important to stress that I do not intend to compare the severity of the two traumatic experiences but rather their element of secrecy. The majority of incest survivors fear the incest secrecy's disclosure as they believe they have no other options and that doing so will result in tragedy (Herman, 2000). Since the offender does not acknowledge responsibility for their actions, the survivors frequently feel responsible for the situation and guilty about it (Stubley & Young, 2022). These dynamics, applied to the experience of ICU nurses working during the COVID-19 outbreak, clarify how bias and public ignorance caused ICU nurses to keep their incredible experience a secret, almost as if its disclosure would result in a societal catastrophe due to the perceived emotional charge attached to it.

The difficulty of disclosure resulted in a significant sense of responsibility that could not be shared and, as a result, a sense of guilt over every decision that had to be made regarding patient care and obligations involving redeployed staff. This also seemed to be motivated by a desire to avoid being misunderstood or engage in "juicy gossip" with her friends, as Marilena encapsulates: an expectation from people that echoed a government that seemed uninterested in ICU nurses. Nonetheless, these sentiments caused ICU nurses to become more united amongst their colleagues, as they would feel less alone within their team and more like a family as a result of going through the same experience. This was particularly depicted in the accounts of Marilena and Rebecca.

Maternal absence, once again in relation to incest survivors, is a recurring theme in the clinical literature. In particular, mothers are frequently observed to be incapable of maternal love or to be emotionally unavailable (Herman, 2000), which causes them to fail in their role of the rescuer, protect the child, and put an end to the situation. The government absence and public scepticism appeared to contribute to further pressure on ICU nurses' shoulders as well as spiralling guilt feelings brought on by a negative focus on a particular behaviour (Lewis, 1971), which in this case was the quality of care provided to patients. Similar to this, it seems from these data that the rescuers' indifference, in this case, the public and the government, undermined the ICU nurses' enthusiasm and motivation for their work by raising concerns about their nursing profession and whether this new adaptation would have been their new way of working.

5.2.3. Disconnect

In a setting of extreme emergency, like the COVID-19 pandemic, it is difficult for ICU nurses to provide the high standards of care expected and uphold the four bioethical principles of beneficence, non-maleficence, autonomy, and social justice (Beauchamp & Childress, 1994) considering the significant neglect and hardship. This is further compounded by a lack of leadership on the part of the government and public scepticism, as explained in the previous section. Participants' accounts suggested that ICU nurses emotionally disconnected as an adaptive response to satisfy the demands of the COVID-19 pandemic and the enormous pressure they found themselves under. The PET "Dehumanisation", "Support available and accessed", "Hypervigilance" and "Living a catastrophe, live in front of your eye" notably captured this response.

According to the latest neuropsychological discoveries (see Siegel, 1999; LeDoux, 2002; Ogden et al., 2006; Porges, 1994; Van der Kolk, 1996) within the field of trauma, excessive stress, abuse, neglect, war, disasters, and political upheaval can undermine the neurophysiological pathways that underlie people's capacities for connection, self-regulation, compassion, and cooperation (Gerbarg et al., 2019). As a result, when the environment is considered dangerous or life-threatening, the individual's response moves outside the window of optimal arousal to the hyper- or hypo- arousal extremes (Siegel, 1999). Working on the frontline during the COVID-19 epidemic elicited survival reactions in ICU nurses that fell outside of the window of tolerance, with participants alternately indicating hyper- and hypo-arousal states. Alessandra, for instance vividly conveyed her fear at remembering the beginning of the COVID-19 outbreak, while Rebecca recalled her experience with panic attacks. Marilena, disclosed thoughts of self-harm, night-time flashbacks, numbness, social withdrawal, and dissociation. Howell (2011) defines dissociation as "the separation of realms of experience that would normally be connected" (p. 35). It is a component of the hypoarousal freeze (Stubley & Young, 2022), and in the context of the COVID-19 pandemic, it appeared that Marilena employed it adaptively to protect herself from overwhelming, helpless anxiety that seemed to have been precipitated by working during the COVID-19 catastrophe. Furthermore, as the Polyvagal Theory (Porges, 1994) suggests, social interactions elicit emotional and self-regulating features. During the COVID-19 epidemic, ICU nurses experienced reduced social interactions due to lockdown restrictions, which made it harder for them to regulate their overwhelming emotions. According to research evidence and the results of this study, breathing techniques provide an efficient and easily accessible voluntary behaviour that modulates the sympatho-vagal balance, which supports prosocial functions, such as compassion and empathy (Gerbarg & Brown, 2016).

5.3. Clinical contribution

Despite some of the themes that emerged from this study illuminating pre-existing ideas from the psychological literature, it shed light on the participants' experiences of working during the COVID-19 pandemic. These findings represent an invitation from the participants to raise public awareness of the ICU nurses' experiences working during the COVID-19 pandemic, particularly in the current climate where COVID-19 does not appear to dominate newspapers headlines anymore, and people are attempting to return to the idea of a pre-pandemic-normal life by downplaying its effects and refusing to discuss it. The results of this study suggest that society frequently reacts to traumatic events by turning a blind eye, as though the emotional cost would be too tremendous to bear. This social reaction encourages the idea of unspeakable secrecy, which places the blame on the individuals who actually endured the experience. In this instance, it was the ICU nurses who were left to bear the responsibility and resulting guilt associated with their care decision-making within the context of the COVID-19 pandemic and deal with its aftermath on their own. The public's scepticism further separates the population and perpetuates misconceptions about how the COVID-19 pandemic has affected individuals in general but especially ICU nurses.

This study seeks to adopt a perspective that goes beyond diagnosis and the categorization of lived experiences through the use of the most up-to-date diagnostic categories defined by the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-V-TR, American Psychiatric Association, 2022). For instance, studies have shown that relaxation techniques, such as the progressive muscular relaxation of Jacobson (1938), the mindfulness-based stress reduction techniques, and the relaxation techniques outlined by Benson et al. (1974), lower stress, anxiety, and depression while also enhancing patients' and healthcare professionals' quality of life (Kabat-Zinn, 1990; Botha et al., 2015; Carver & O'Malley, 2015; Greenlee et

al., 2017; Tsitsi et al., 2017; Harorani et al., 2019). However, several studies have highlighted how healthcare personnel may be unable or unwilling to participate in psychological activities during times of crisis (Chen et al., 2020). This appears to support this study's findings, indicating that even though initiatives such as yoga practice, training in relaxation techniques, and psychological aspects of patient management (Chen et al., 2020) might be helpful, the best course of action during the COVID-19 pandemic is still unclear (Chen et al., 2020; Kang et al., 2020; Xiang et al., 2020). It is worth noting that before advocating these techniques to care leaders and incorporating them into the healthcare workforce agenda, it is critical to be fully informed about the adverse effects of these techniques, as it is not within the scope of this study to address this issue.

This research does not partner with any grandiose ambition to prescribe clinical treatment or to grant narrative authority to specific individuals' issues or illnesses. The methodology choice mirrors this purpose by offering insight into aspects of lived experience and perspectives sometimes neglected in epidemiological and clinical research since it enables to focus not only on what but also on how the phenomenon is experienced and lived subjectively (Teti et al., 2020). In doing so, it upholds the humanistic foundations of the CoP discipline, as well as its social-contextual, developmental perspective and emphasis on the client-psychologist relationship. CoPs strive to construct the meaningful reality of clients by being reflective practitioners rather than trying to fit them into a theoretical model (Wilkinson, 2004). Context is more significant than pathology as they are more interested in knowing how change occurs or what should be changed than whether a change has occurred (Goldfried & Eubanks-Carter, 2004). This study adopts a social justice position in keeping with CoP by interpreting the experiences of ICU nurses who worked on the frontline during the COVID-19 pandemic as an adaptive reaction to an oppressive and unfair circumstance (Tribe & Bell, 2018). It intends to

validate ICU nurses' stories by employing a Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2020), with the ultimate objectives of educating and empowering individuals, communities, and organisations.

The PTMF is a comprehensive framework that recognises how each person's perspective of the world as well as their behaviour is purposeful and meaningful and incorporates various cultural experiences and expressions of distress. However, meaning is discovered and created (Shotter, 1993) within a larger discourse and ideological presumptions about the world (Morgan et al., 2022). As a result, the purpose and the significance of the threat response appear to be intertwined within the cultural context and frequently follow "patterns of embodied, meaning-based threat responses to the functioning of power" (Johnstone & Boyle, 2018, p. 9). As Johnstone (2020) pointed out, the COVID-19 epidemic has provided an opportunity to question an organisational mode of thinking that tends to categorise people's experiences of distress or deliver instructions to individuals on how to use apps and rate their mental health as a form of support. In the aftermath of collective trauma, society's lifestyle, values, and identity are called into question (Herman, 1992), and the COVID-19 pandemic has exposed a flaw in the system, which is too concerned with placing feelings into boxes of categorized diagnosis. For instance, it is currently recognized that spending the entire day washing hands and cleaning door handles is not a sign of OCD but rather the behaviour of a diligent citizen (Johnstone, 2020). Similar to that, this study hopes to make a small contribution to questioning the dominant medical narrative by providing a platform for ICU nurses to express their meaning of working on the frontline during the COVID-19 pandemic and by encouraging individuals to stay in touch with their emotions. Additionally, the results of this study raise concerns about how the NHS system, while paying too much attention to offering ICU nurses a standardised level of support, is neglecting the importance of basic human connections and attention. On the other hand, this

standard of care appeared to have been demanded by this study's participants for their own patients, although it could not be maintained owing to the COVID-19 pandemic's aftereffects. Furthermore, human bonds appear to be particularly relevant in contrast to the COVID-19 lockdown procedures, where social interactions have been restricted and controlled.

Within the context of therapeutic practice, this research highlights the importance of interpersonal relationships and interactions, which may frequently be overlooked by clinicians who are excessively preoccupied with using a variety of techniques and approaches to support clients (Deangelis, 2019; Hill, 2005). This may cause distance in their relationship and lead clinicians lose interest in building a secure relationship with their clients as well as attuning to their needs (Deangelis, 2019). This is especially true in the current climate, as NHS Trusts are struggling to meet rising therapeutic demand while also dealing with staff shortages and persistent underfunding (Rolewicz, 2021). As a result, clinicians may prioritise some therapeutic goals over others and possibly ignore their patients' psychic pace due to the pressure of offering time-limited therapy. Additionally, this study increases awareness of individuals coming together and helping one another, particularly when they have collectively experienced the same traumatic event since this reduces loneliness and fosters compassion for oneself and others (Gerbarg et al., 2019). When considering the themes identified in this study, curricular development and training may seek to put more emphasis on human interactions and support.

The implications for clinical practice that this study aims to suggest are anchored in the fundamental ethics and politics that underpin the counselling psychology profession, as well as in a wish to respect and validate the other, and particularly this specific group of ICU nurses, in their entirety as unique subjective experiences, comprehending them in terms of the social, organisational, and cultural limitations that they may have encountered and that the COVID-

19 pandemic may have made worse (Cooper, 2009). In particular, interventions may have a trauma-informed focus on establishing compassionate human interactions, delivering physical and emotional safety and comfort, and assistance in articulating needs and concerns, offering positive coping strategies and acknowledging efforts and strengths in an empowering way (Stubley, 2020). According to what emerged from participants' phenomenological accounts, support in mentalising their experience may be advised as appropriate in accordance with a mentalised-based therapy conducted individually or in a group setting. This is in light of the difficulty in reflecting on their own experience while the pandemic affected their work. In mentalization-based therapy, mentalizing is placed at the core of the therapeutic process to give clients the opportunity to examine their thoughts and feelings about themselves and others, how these affect their behaviour, and how distortions lead to maladaptive actions despite being intended to manage irrational feelings (Bateman et al., n.d.). According to the COVID-19 pandemic's emotional, physical, and psychological burden on ICU nurses, clinical interventions may concentrate on helping individuals "to re-establish mentalizing when it is lost and maintain mentalizing when it's present" (Bateman et al., n.d., p. 5) so they can be able to manage their emotions stemming from their work and self-regulate.

5.4. Reflexivity

Reflexivity resides in Heidegger's (1967) "Dasein," as in "Being-there," being present in our experience, in how we connect to the world, and in the meanings, we ascribe to it. Since data exists in the researcher's thinking, IPA reflexivity is not a choice but a completely integrated aspect of the research process. The hermeneutic phenomenological IPA foundations recognise the interplay between what happened in the past, what is happening right now, and what might be in the researcher's way of thinking (Engward & Goldspink, 2020). This adds rigour and credibility (Yardley, 2017). Being involved in other people's stories and dealing with their

words about their lived experiences and my own words and experience (Engward & Goldspink, 2020) has proven to be quite difficult due to the intense emotions that both participants and I encountered.

Participants' accounts and feelings reverberated within me, at times stronger than others, as having lost a dear colleague due to COVID-19. I occasionally tapped into my own anger about how the situation with my colleague deteriorated to the point where we stopped hearing from her and were unable to get hospital updates on her condition until we learned that she had passed. Alessandra's explanation of nurses' errors prompted me to revisit this difficult emotional territory. I did, however, realise how grateful I was for her putting her faith in me to tell me about her experience in its entirety, as well as how compassionate I was toward the terrible hardships that nurses had to endure while attempting to satisfy the demands of the COVID-19 pandemic by exposing their own lives to danger and suffering extreme burnout.

According to Smith, Flowers, and Larkin (2009), "successful analyses require the systemic application of ideas and methodical rigour; but they also require imagination, playfulness, and a combination of reflective, critical, and conceptual thinking" (p. 40). It was very challenging to encourage critical and conceptual thinking without assuming a clinical role. For instance, I became rather concerned when Marilena admitted having had suicidal thoughts and dissociative experiences. I vividly remember feeling relieved for having asked the three screening questions at the start of the interview, which confirmed that there were no risks of harm to herself or others. However, I noticed hesitating to ask exploratory questions as I worried that by recalling her experience, I would have subjected her to severe distress and caused her to dissociate.

The interviews successfully achieved the goal of encouraging participants to freely communicate their own lived experience through the questions presented in the Interview Schedule. However, I realised that as time went on, I grew more at ease interviewing people and that I began to elaborate more, and it seemed more challenging to conduct the new interviews with a clean slate without having the output of the old interviews taint the new ones. Despite the initial challenge in arranging interviews due to the demanding work schedule and night shifts, I was able to identify participants' strong motivation to participate in my research study. This would be clarified in the debriefing space as motivated by the opportunity to share their bare and raw experience with the public, hoping to educate and enlighten them about what ICU nurses have gone through and dispelling all preconceptions, biases, and prejudices. I understood that this great expectation was a result of deeper feelings of letdown and underappreciation for the extraordinary role they played throughout this "surreal" period. This unintentional responsibility that was given to me has left me under tremendous pressure to treat these priceless accounts with the respect and care that they merit. I think that the fact that the participants were as Italians as me, strengthened their trust in my position as well as my research purpose and may have allowed for a little degree of uncensored insight into the most challenging facets of working on the frontline during the COVID-19 pandemic.

Additionally, as Smith and Osborn (2015) explained with their definition of the double hermeneutic, there is a focus on the researcher's sensemaking of the participants' understanding of their world. This process is shaped in the interactions between the researcher and participants, in a movement that flows from the descriptive to the interpretative, from the specific to the shared. As a result, through journaling and, particularly, supervisions, I realised the need to be more attentive to the participants' accounts and sentiments, allowing me to

identify the trigger moments when awareness shifts and interpretation happens (Engward & Goldspink, 2020).

5.5. Strengths and Limitations

The strengths and limitations of this study will be discussed in this section. To do so, it is necessary to return to the study's quality by examining the four quality indicators established by Nizza, Farr, and Smith (2021). According to the first indicator, the findings are presented as telling a tale; under each sub-theme, each quote makes a point for the narrative, which progresses as more quotes are presented and new perspectives are offered. The narrative has created coherence among themes and enhanced the hermeneutic cycle, with each theme tied to the entire story, in line with the IPA analytic process (Smith, 2007). The findings offer a level of depth and insight that frequently transitions from an experiential level of significance to an existential meaning, in keeping with the second criterion of quality. This improves IPA's quality by introducing fresh meanings and posing existential dilemmas (Smith, 2019). As per the third indicator's recommendation, excerpts are closely and analytically presented to offer their idiographic depth and add transparency to my interpretation. This reflects the hermeneutic process, which involves switching back and forth between the meaning of the language in the excerpts and the wider transcript (Smith, 2007). The presentation of participants' convergence and divergence has benefited from cross-referencing themes within participants' accounts. According to the final indicator, the purpose of this study was to maintain a balance between what made each participant's experience similar and what made it distinctive (Smith, 2011).

Additionally, this study focused on a limited sample since it had no intention of offering generalisations to a larger population or situations. Any conclusions are therefore specific to this sample. The sample was purposive and homogenous (Smith & Osborn, 2007), providing a

thorough understanding of this narrowly defined group of Italian ICU nurses. Further studies may want to conduct comparable research frameworks to examine the parallels and discrepancies between ICU nurses' experiences working during COVID-19 across other ethnic groups.

While carefully examining the inclusion and exclusion criteria, the SARS-CoV-2 virus' fast mutation, new symptoms linked to it and its transmission, as well as government announcements regarding lockdown measures, have all had an impact on the interviews, even if they happened rather quickly one after the other. How much these contextual variations impacted the interviews is impossible to determine. For instance, Alessandra, who was last to be interviewed, seemed to place a greater emphasis on social and existential aspects than Luca and Giorgia did in their interviews, which were conducted before the lockdown measures were lifted.

Another IPA's limitations lie in the use of language used to capture the subjective experience of the participants. As Willig notes, a transcript "tells us more about the ways in which an individual talks about a particular experience within a particular context, than about the experience itself" (Willig, 2008, p. 67). This renders the access to the experience more closely related to a reflection of the researcher-participant interaction during the interview.

5.6. Suggestions for future research

Considering the study's findings, which suggested the use of mindfulness meditation for stress reduction and trauma-informed work, I believe it would be intriguing to conduct a qualitative study with ICU nurses who worked on the frontline during the COVID-19 pandemic after completing a time-limited course in mindfulness-based stress reduction. This, along with

trauma psychoeducation, would be beneficial in examining the impact of these experiences on their wellbeing. The intention is to advance research on effective interventions to use in the case of a future pandemic or emergency. To ensure that study's findings may be used to inform changes in policy and practises, it would be vital to establish collaborations with stakeholders early in the process of designing the studies to understand their evidence needs and timeframes (Vindrola-Padros et al., 2020).

It would also be advantageous to consider any additional quantitative or qualitative methodologies that speak to different facets of the experiences of ICU nurses who worked during the COVID-19 pandemic and/or other sample groups. One of these aspects could be how the lockdown and decreased social interaction have affected ICU nurses' work and the extent to which this has increased physical and mental strain. Given the impact that time had on interviews due to a constantly changing virus and preventive measures, further research may consider conducting this research study in a different time frame, such as five years after the acute phase of the COVID-19 pandemic.

5.7. Conclusion

This study's findings indicate how the experiences of ICU nurses working on the frontline during the COVID-19 pandemic are inscribed within the terrain of trauma. Being obliged to behave against their beliefs about providing care resulted in a survival adaptative reaction of disconnecting emotionally, especially in a context with inadequate leadership. This study seeks to give voice to a population's narrative that has been ignored in the literature, which emphasises the value of human relationships and goes beyond the categorisation of individual experiences of distress.

The analysis process was the product of a combination of phenomenological and hermeneutic understanding. According to Smith et al. (2022), when listening to the participant account, I was aware of my preconceptions and intended for them not to alter the data. However, I soon realised that bracketing was not viable, so I embraced them transparently and reflexively. Attending my reflexivity practice helped me become more aware of my own position within the research process, which increased my knowledge of the dynamics of preconceptions within the hermeneutic cycle of the research process (Smith et al., 2022).

REFERENCES

Alderwick, H. & Allen, L. (2019). *Immigration and the NHS: the evidence.* The Health Foundation. https://www.health.org.uk/news-and-comment/blogs/immigration-and-the-nhs-the-evidence

Allam, M., Cai, S., Ganesh, S., Venkatesan, M., Doodhwala, S., Song, Z., Hu, T., Kumar, A., Heit, J., Study Group, C. N., & Coskun, A. F. (2020). COVID-19 Diagnostics, Tools, and Prevention. *Diagnostics*, *10*(6), 409. https://doi.org/10.3390/diagnostics10060409

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-V-TR)* (5th ed.). American Psychiatric Association.

Amsalem, D., Lazarov, A., Markowitz, J. C., Naiman, A., Smith, T. E., Dixon, L. B., & Neria, Y. (2021). Psychiatric symptoms and moral injury among US healthcare workers in the COVID-19 era. *BMC Psychiatry*, *21*(1). https://doi.org/10.1186/s12888-021-03565-9

Andrews, L. (1996). Telling patients the truth. *Nursing New Zealand; 8:* 22-4. PMID: 8945290.

Anyan, F. (2013). The Influence of Power Shifts in Data Collection and Analysis Stages; A Focus on Qualitative Research Interview. *The Qualitative Report*, *18*(18), 1-9. https://doi.org/10.46743/2160-3715/2013.1525

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (DSM-5-TR). https://doi.org/10.1176/appi.books.9780890425787

American Psychological Association (APA), n.d. *Hypervigilance*. Dictionary of Psychology. https://dictionary.apa.org/hypervigilance

Armour, C., McGlinchey, E., Butter, S., McAloney-Kocaman, K., & McPherson, K. E. (2020). The COVID-19 Psychological Wellbeing Study: Understanding the Longitudinal

Psychosocial Impact of the COVID-19 Pandemic in the UK; a Methodological Overview Paper. *Journal of Psychopathology and Behavioral Assessment*, *43*(1), 174–190. https://doi.org/10.1007/s10862-020-09841-4

Asmelash, L. (2021). *The surgeon general wants Americans to stop buying face masks*. Cable News Network (CNN). https://edition.cnn.com/2020/02/29/health/face-masks-coronavirus-surgeon-general-trnd/index.html

Aughterson, H., McKinlay, A. R., Fancourt, D., & Burton, A. (2021). Psychosocial impact on frontline health and social care professionals in the UK during the COVID-19 pandemic: a qualitative interview study. *BMJ Open*, *11*(2), e047353. https://doi.org/10.1136/bmjopen-2020-047353

Azoulay, E., de Waele, J., Ferrer, R., Staudinger, T., Borkowska, M., Povoa, P., Iliopoulou, K., Artigas, A., Schaller, S. J., Hari, M. S., Pellegrini, M., Darmon, M., Kesecioglu, J., & Cecconi, M. (2020). Symptoms of burnout in intensive care unit specialists facing the COVID-19 outbreak. *Annals of Intensive Care*, *10*(1). https://doi.org/10.1186/s13613-020-00722-3

Baehr, P. (2005). Social extremity, communities of fate, and the sociology of SARS. *European Journal of Sociology*, *46*(2), 179–211. https://doi.org/10.1017/s000397560500007x

Baker, C. (2021). *NHS staff from overseas: statistics Research Briefing*. House of Commons Library, UK Parliament. https://commonslibrary.parliament.uk/research-briefings/cbp-7783/

Baker, C. F. (1993). Annoyance to ICU noise. *Critical Care Nursing Quarterly*, *16*(2), 83–90. https://doi.org/10.1097/00002727-199308000-00009

Bai, Y., Lin, C.-C., Lin, C.-Y., Chen, J.-Y., Chue, C.-M., & Chou, P. (2004). Survey of stress reactions among health care workers involved with the SARS outbreak. *Psychiatric Services*, *55*(9), 1055–1057. https://doi.org/10.1176/appi.ps.55.9.1055

Bamford, C. (2020). *The original Sars virus disappeared – here's why coronavirus won't do the same*. The Conversation. https://theconversation.com/the-original-sars-virus-disappeared-heres-why-coronavirus-wont-do-the-same-138177

Bateman, A. W., Bales, D., & Hutsebaut, J. (n.d.). A Quality Manual for MBT. https://www.annafreud.org/media/15224/a-quality-manual-for-mbt-ed-jan-2022.pdf

Beauchamp, T. L., & Childress, J. F. (1994). *Principles of biomedical ethics*. Oxford University Press.

Beauchamp, T. L., & Childress, J. F. (2022). *Principles of Biomedical Ethics 8th Edition*. Oxford University Press.

Begley, A., & Blackwood, B. (2000). Truth-telling versus hope: A dilemma in practice. *International Journal of Nursing Practice*, *6*(1), 26–31. https://doi.org/10.1046/j.1440-172x.2000.00178.x

Begley, A., & Piggott, S. (2012). Exploring moral distress in potential sibling stem cell donors. *Nursing Ethics*, *20*(2), 178–188. https://doi.org/10.1177/0969733012452682

Benner, P. (1991). The role of experience, narrative, and community in skilled ethical comportment. *Advances in Nursing Science*, *14*(2), 1–21. https://doi.org/10.1097/00012272-199112000-00003

Benson, H., Beary, J. F., & Carol, M. P. (1974). The Relaxation Response. *Psychiatry*, *37*(1), 37–46. https://doi.org/10.1080/00332747.1974.11023785

Berger, W., Coutinho, E. S. F., Figueira, I., Marques-Portella, C., Luz, M. P., Neylan, T. C., Marmar, C. R., & Mendlowicz, M. V. (2012). Rescuers at risk: a systematic review and meta-regression analysis of the worldwide current prevalence and correlates of PTSD in rescue workers. *Social Psychiatry and Psychiatric Epidemiology*, *47*(6), 1001–1011. https://doi.org/10.1007/s00127-011-0408-2

Bhaskar, S., Rastogi, A., Menon, K. V., Kunheri, B., Balakrishnan, S. and Howick, J.

(2020). Call for Action to Address Equity and Justice Divide During COVID-19. *Frontiers Psychiatry,* 11:559905. doi: 10.3389/fpsyt.2020.559905

Billings, J., Ching, B. C. F., Gkofa, V., Greene, T., & Bloomfield, M. (2021). Experiences of frontline healthcare workers and their views about support during COVID-19 and previous pandemics: a systematic review and qualitative meta-synthesis. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06917-z

Blanco-Donoso, L. M., Moreno-Jiménez, J., Amutio, A., Gallego-Alberto, L., Moreno-Jiménez, B., & Garrosa, E. (2020). Stressors, Job Resources, Fear of Contagion, and Secondary Traumatic Stress Among Nursing Home Workers in Face of the COVID-19: The Case of Spain. *Journal of Applied Gerontology*, *40*(3), 244–256. https://doi.org/10.1177/0733464820964153

Blake, W., & Baskin, L. (1968). *Auguries of innocence*. Printed anew for Grossman Publishers

Boin, A., Lodge, M., & Luesink, M. (2020). Learning from the COVID-19 crisis: an initial analysis of national responses. *Policy Design and Practice*, *3*(3), 189–204. https://doi.org/10.1080/25741292.2020.1823670

Bolton, G., & Delderfield, R. (2018). *Reflective practice: writing and professional development*, 5th Ed, p. 10. SAGE Publications Ltd.

Borho, A., Georgiadou, E., Grimm, T., Morawa, E., Silbermann, A., Nißlbeck, W., & Erim, Y. (2019). Professional and Volunteer Refugee Aid Workers–Depressive Symptoms and Their Predictors, Experienced Traumatic Events, PTSD, Burdens, Engagement Motivators and Support Needs. *International Journal of Environmental Research and Public Health*, *16*(22), 4542. https://doi.org/10.3390/ijerph1622454

Botha, C., Farmer, A. D., Nilsson, M., Brock, C., Gavrila, A. D., Drewes, A. M., Knowles, C. H., & Aziz, Q. (2015). Preliminary report: modulation of parasympathetic nervous system tone influences oesophageal pain hypersensitivity. *Gut*, *64*(4), 611–617. https://doi.org/10.1136/gutjnl-2013-306698

Brehm, J. W. (1956). Postdecision changes in the desirability of alternatives. *The Journal of Abnormal and Social Psychology, 52*(3), 384–389. https://doi.org/10.1037/h0041006

British Medical Association (2021). *Moral distress and moral injury – recognising and tackling it for UK doctors.* https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf

British Psychological Society (2020). Division of counselling psychology: professional practice guidelines, page 1. BPS

Brooker, C., & Nicol, M. (2003). *Nursing Adults: The Practice of Caring* (1st ed.). Mosby Ltd.

Brooks, S., Amlôt, R., Rubin, G. J., & Greenberg, N. (2018). Psychological resilience and post-traumatic growth in disaster-exposed organisations: overview of the literature. *BMJ Military Health*, *166*(1), 52–56. https://doi.org/10.1136/jramc-2017-000876

Brooks, S. K., Webster, R. K., Smith, L. E., Woodland, L., Wessely, S., Greenberg, N., & Rubin, G. J. (2020). The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. *The Lancet*, *395*(10227), 912–920. https://doi.org/10.1016/S01406736(20)30460-8

Burn-Murdoch, J., & Giles, C. (2020). *UK suffers second-highest death rate from coronavirus.* Financial Times. https://www.ft.com/content/6b4c784e-c259-4ca4-9a82-648ffde71bf0

Cairney, P. (2021). The UK Government's COVID-19 Policy: What Does "Guided by the Science" Mean in Practice? *Frontiers in Political Science*, *3*. https://doi.org/10.3389/fpos.2021.624068

Cambridge Dictionary,

n.d. *Bystander.* https://dictionary.cambridge.org/dictionary/english/bystander

Campbell, D., Perraudin, F., Davis, N., & Weaver, M. (2020). *Calls for inquiry as UK reports highest Covid-19 death toll in Europe*. The Guardian. https://www.theguardian.com/world/2020/may/05/uk-coronavirus-death-toll-rises-above-32000-to-highest-in-europe

Care Quality Commission (CQC), (2019). *Annual report and accounts 2018/19*. https://www.cqc.org.uk/sites/default/files/20190812_annualreport201819.pdf

Carmassi, C., Foghi, C., Dell'Oste, V., Cordone, A., Bertelloni, C. A., Bui, E., & Dell'Osso, L. (2020). PTSD symptoms in healthcare workers facing the three coronavirus outbreaks: What can we expect after the COVID-19 pandemic. *Psychiatry Research*, *292*, 113312. https://doi.org/10.1016/j.psychres.2020.113312

Carrieri, D., Briscoe, S., Jackson, M., Mattick, K., Papoutsi, C., Pearson, M., & Wong, G. (2018). 'Care Under Pressure': a realist review of interventions to tackle doctors' mental ill-health and its impacts on the clinical workforce and patient care. *BMJ Open*, *8*(2), e021273. https://doi.org/10.1136/bmjopen-2017-021273

Carver, M. L., & O'Malley, M. (2015). Progressive muscle relaxation to decrease anxiety in clinical simulations. *Teaching and Learning in Nursing*, *10*(2), 57–62. https://doi.org/10.1016/j.teln.2015.01.002

Centers for Disease Control and Prevention (CDC). (2022). *Symptoms of COVID-19*. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

Chafe, R. (2017). The value of qualitative description in health services and policy research. *Healthcare and Policy, 12*, 12–18.

Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* Sage Publications.

Chen, N., Zhou, M., Dong, X., Qu, J., Gong, F., Han, Y., Qiu, Y., Wang, J., Liu, Y., Wei, Y., Xia, J., Yu, T., Zhang, X., & Zhang, L. (2020). Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: a descriptive study. *The Lancet*, *395*(10223), 507–513. https://doi.org/10.1016/s0140-6736(20)30211-7

Chew, Q. H., Chia, F. L. A., Ng, W. K., Lee, W. C. I., Tan, P. L. L., Wong, C. S., Puah, S. H., Shelat, V. G., Seah, E. J. D., Huey, C. W. T., Phua, E. J., & Sim, K. (2020). Perceived Stress, Stigma, Traumatic Stress Levels and Coping Responses amongst Residents in Training across Multiple Specialties during COVID-19 Pandemic—A Longitudinal Study. *International Journal of Environmental Research and Public Health*, *17*(18), 6572. https://doi.org/10.3390/ijerph17186572

Chun Tie, Y., Birks, M., & Francis, K. (2019). Grounded theory research: A design framework for novice researchers. *SAGE Open Medicine*, *7*, 205031211882292. https://doi.org/10.1177/2050312118822927

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2014). A meta-analysis of the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services*, *11*(1), 75–86. https://doi.org/10.1037/a0033798

Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3&4), 119-129.

Corley, M. C., Minick, P., Elswick, R. K., & Jacobs, M. (2005). Nurse Moral Distress and Ethical Work Environment. *Nursing Ethics*, *12*(4), 381–390. https://doi.org/10.1191/0969733005ne809oa

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J., & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment:

results of a national survey. *British Journal of Psychiatry*, *208*(3), 260–265. https://doi.org/10.1192/bjp.bp.114.162628

Creswell, J.W. (2013). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* 4th Edition, SAGE Publications, Inc.

Croyle, R. T., & Cooper, J. (1983). Dissonance arousal: Physiological evidence. *Journal of Personality and Social Psychology, 45*(4), 782–791. https://doi.org/10.1037/0022-3514.45.4.782

Cucinotta, D., & Vanelli M. (2020). WHO Declares COVID-19 a Pandemic. *Acta Biomed.; 91*(1):157-160. doi: 10.23750/abm.v91i1.9397

Dalingwater, L. (2019). NHS staffing shortages and the Brexit effect. *Observatoire de La Société Britannique*, *24*, 67–86. https://doi.org/10.4000/osb.3216

Darley, J. M., & Latane, B. (1968). Bystander intervention in emergencies: Diffusion of responsibility. *Journal of Personality and Social Psychology, 8*(4, Pt.1), 377–383. https://doi.org/10.1037/h0025589

Data Protection Act, 2018. *Data Protection Act 2018.* https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Davies, B., Lalot, F., Peitz, L., Heering, M. S., Ozkececi, H., Babaian, J., Davies Hayon, K., Broadwood, J., & Abrams, D. (2021). Changes in political trust in Britain during the COVID-19 pandemic in 2020: integrated public opinion evidence and implications. *Humanities and Social Sciences Communications*, *8*(1). https://doi.org/10.1057/s41599-021-00850-6

DeAngelis, T. (2019). Better relationships with patients lead to better outcomes. A good relationship is essential to helping the client connect with, remain in and get the most from therapy. *American Psychological Association, Vol. 50*, No. 10, 38.

de Casterlé, B. D., Janssen, P. J., & Grypdonck, M. (1996). The Relationship between Education and Ethical Behavior of Nursing Students. *Western Journal of Nursing Research*, *18*(3), 330–350. https://doi.org/10.1177/019394599601800308

Dodds, S., & Hess, A.C. (2021). Adapting research methodology during COVID-19: lessons for transformative service research. *Journal of Service Management*, Vol. 32 No. 2, pp. 203-217. https://doi.org/10.1108/JOSM-05-2020-0153

Dong, Z. Q., Ma, J., Hao, Y. N., Shen, X. L., Liu, F., Gao, Y., & Zhang, L. (2020). The social psychological impact of the COVID-19 pandemic on medical staff in China: A cross-sectional study. *European Psychiatry*, *63*(1). https://doi.org/10.1192/j.eurpsy.2020.59

dos Santos, M. J., Martins, M. S., Santana, F. L. P., Furtado, M. C. S. P. C., Miname, F. C. B. R., Pimentel, R. R. D. S., Brito, G. N., Schneider, P., dos Santos, E. S., & da Silva, L. H. (2020). COVID-19: instruments for the allocation of mechanical ventilators—a narrative review. *Critical Care*, *24*(1). https://doi.org/10.1186/s13054-020-03298-3

Downs, M. (1999). How to tell? Disclosing a diagnosis of dementia. *Generations; 23*: 30–34.

Draucker, C. B., Martsolf, D. S., & Poole, C. (2009). Developing Distress Protocols for Research on Sensitive Topics. *Archives of Psychiatric Nursing*, *23*(5), 343–350. https://doi.org/10.1016/j.apnu.2008.10.008

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215–229. https://doi.org/10.1348/014466599162782

Ekstedt, M. (2005). *Burnout and sleep*. Thesis. Department of Public Health Sciences, Division of Psychosocial Factors and Health. Karolinska Institutet. https://openarchive.ki.se/xmlui/bitstream/handle/10616/39068/thesis.pdf?sequence=1&isAllowed=y

Ellis, R., (2018). Data: Why NHS Workers Quit. *Unison*.

https://www.unison.org.uk/news/ps-data/2018/06/data-nhs-workers-quit/

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Elpern, E. H., Covert, B., & Kleinpell, R. (2005). Moral Distress of Staff Nurses in a Medical Intensive Care Unit. *American Journal of Critical Care*, *14*(6), 523–530. https://doi.org/10.4037/ajcc2005.14.6.523

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

European Centre for Disease Prevention and Control (ECDC), (2022). *Rapid Risk Assessment: Cluster of pneumonia cases caused by a novel coronavirus, Wuhan, China, 2020*. Https://Www.Ecdc.Europa.Eu/En/Publications-Data/Rapid-Risk-Assessment-Cluster-Pneumonia-Cases-Caused-Novel-Coronavirus-Wuhan

Ezzy, D. (2002). *Qualitative analysis, practice and innovation*. P. 24. Routledge.

Faculty of Intensive Care Medicine and Intensive Care Society, (2022). *Guidelines for the provision of intensive care services*. http://www.ficm.ac.uk/standardssafetyguidelinesstandards/guidelines-for-the-provision-of-intensive-care-services

Fershtman, C., & Gneezy, U. (2001). Discrimination in a Segmented Society: An Experimental Approach. *The Quarterly Journal of Economics*, *116*(1), 351–377. https://doi.org/10.1162/003355301556338

Festinger, L. (1957). *A theory of cognitive dissonance.* Stanford University Press

Flaming, D. (2000). Improve Care and Comfort: Use the Label "Dying." *Journal of Palliative Care*, *16*(2), 30–36. https://doi.org/10.1177/082585970001600206

Flynn, J. M., & Bruce, N. P. (1993). *Introduction to Critical Care Skills* (1st ed.). Mosby.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*(2), 209–230. https://doi.org/10.1177/146879410200200205

Finlay, L. (2008). A dance between the reduction and reflexivity: explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology*, *39*(1), p. 3 https://link.gale.com/apps/doc/A181539465/AONE?u=anon~fc2a4f5d&sid=googleScholar&xid=03787f49

Finlay, L. (2009). Debating Phenomenological Research Methods. *Phenomenology & Practice*, *3*(1). https://doi.org/10.29173/pandpr19818

Gadamer, H. G., (1989). *Truth and Method*. Crossroad.

Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: An introduction (7th ed.).* Allyn & Bacon.

Garbern, S. C., Ebbeling, L. G., & Bartels, S. A. (2016). A Systematic Review of Health Outcomes Among Disaster and Humanitarian Responders. *Prehospital and Disaster Medicine*, *31*(6), 635–642. https://doi.org/10.1017/s1049023x16000832

Gaskell, J., Stoker, G., Jennings, W., & Devine, D. (2020). Covid-19 and the Blunders of our Governments: Long-run System Failings Aggravated by Political Choices. *The Political Quarterly*, *91*(3), 523–533. https://doi.org/10.1111/1467-923x.12894

Gaudine, A., LeFort, S. M., Lamb, M., & Thorne, L. (2011). Clinical ethical conflicts of nurses and physicians. *Nursing Ethics*, *18*(1), 9–19. https://doi.org/10.1177/0969733010385532

Geiger-Brown, J., Trinkoff, A. M., Nielsen, K., Lirtmunlikaporn, S., Brady, B., &

Vasquez, E. I. (2004). Nurses' perception of their work environment, health, and well-being: a qualitative perspective. *AAOHN journal: official journal of the American Association of Occupational Health Nurses*, *52*(1), 16–22.

Georges, J. J., & Grypdonck, M. (2002). Moral Problems Experienced by Nurses when Caring for Terminally Ill People: a literature review. *Nursing Ethics*, *9*(2), 155–178. https://doi.org/10.1191/0969733002ne495oa

Gerbarg, P. L., & Brown, R. P. (2016). Breathing practices for mental health and aging. In H. Lavretsky, M. Sajatovic, & C. Reynolds III (Eds.), *Complementary and integrative therapies for mental health and aging* (pp. 239–255). Oxford University Press.

Gerbarg, P. L., Brown, R. P., Streeter, C., Katzman, M., & Vermani, M. (2019). Breath Practices for Survivor and Caregiver Stress, Depression, and Post- traumatic Stress Disorder: Connection, Co-regulation, Compassion. *OBM Integrative and Complementary Medicine, 4* (3). https://doi.org/10.21926/obm.icm.1903045

Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. AldineTransaction Publishing Company.

Glaser, B. (1992). *Basics of Grounded Theory Analysis*. Sociology Press.

GOV.UK. (2022). *England returns to Plan A as regulations on face coverings and COVID Passes change today*. https://www.gov.uk/government/news/england-returns-to-plan-a-as-regulations-on-face-coverings-and-covid-passes-change-today

Goldfried, M. R., & Eubanks-Carter, C. (2004). On the Need for a New Psychotherapy Research Paradigm: Comment on Westen, Novotny, and Thompson-Brenner (2004). *Psychological Bulletin, 130*(4), 669–673. https://doi.org/10.1037/0033-2909.130.4.669

Graziano, W. G., & Habashi, M. M. (2015). Searching for the prosocial personality. In D. A.

Schroeder & W. G. Graziano (Eds.), *The Oxford handbook of prosocial behavior* (pp. 231–255). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195399813.013.017

Green, B. (2017). Use of the Hippocratic or other professional oaths in UK medical schools in 2017: practice, perception of benefit and principlism. *BMC Research Notes*, *10*(1). https://doi.org/10.1186/s13104-017-3114-7

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

Greenberg, N., Weston, D., Hall, C., Caulfield, T., Williamson, V., & Fong, K. (2021). Mental health of staff working in intensive care during Covid-19. *Occupational Medicine*, *71*(2), 62–67. https://doi.org/10.1093/occmed/kqaa220

Greengross, P., Grant, K., & Collini, E. (1999). *Helpdesk Report: The History and Development of the UK National Health Service 1948 - 1999*. Health Systems Resource Centre. https://assets.publishing.service.gov.uk/media/57a08d91e5274a31e000192c/The-history-and-development-of-the-UK-NHS.pdf

Greene, T., Harju-Seppänen, J., Adeniji, M., Steel, C., Grey, N., Brewin, C. R., Bloomfield, M. A., & Billings, J. (2021). Predictors and rates of PTSD, depression and anxiety in UK frontline health and social care workers during COVID-19. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.1882781

Greenlee, H., DuPont-Reyes, M. J., Balneaves, L. G., Carlson, L. E., Cohen, M. R., Deng, G., Johnson, J. A., Mumber, M., Seely, D., Zick, S. M., Boyce, L. M., & Tripathy, D. (2017). Clinical practice guidelines on the evidence-based use of integrative therapies

during and after breast cancer treatment. *CA: A Cancer Journal for Clinicians*, *67*(3), 194–232. https://doi.org/10.3322/caac.21397

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications, Inc.

Hage, S. M. (2003). Reaffirming the Unique Identity of Counseling Psychology: Opting for the "Road Less Traveled By". *The Counseling Psychologist, Vol. 31*, No. 5, 555-563 DOI: 10.1177/0011000003256434

Harorani, M., Noruzi Zamenjani, M., Golitaleb, M., Davodabady, F., Zahedi, S., Jadidi, A., & Rezaei, M. (2019). Effects of relaxation on self-esteem of patients with cancer: a randomized clinical trial. *Supportive Care in Cancer*, *28*(1), 405–411. https://doi.org/10.1007/s00520-019-05025-3

Harris, S., Jenkinson, E., Carlton, E., Roberts, T., & Daniels, J. (2021). "It's Been Ugly": A Large-Scale Qualitative Study into the Difficulties Frontline Doctors Faced across Two Waves of the COVID-19 Pandemic. *International Journal of Environmental Research and Public Health*, *18*(24), 13067. https://doi.org/10.3390/ijerph182413067

Hart, G., Yates, P., Clinton, M., & Windsor, C. (1998). Mediating conflict and control: practice challenges for nurses working in palliative care. *International Journal of Nursing Studies*, *35*(5), 252–258. https://doi.org/10.1016/s0020-7489(98)00037-6

Health Research Authority (HRA), (2020). *Does my project require review by a Research Ethics Committee?* http://www.hra-decisiontools.org.uk/ethics/docs/Algorithm%20-%20Does%20my%20project%20require%20REC%20review%20v2.0%2020200304.pdf

Hegg-Deloye, S., Brassard, P., Jauvin, N., Prairie, J., Larouche, D., Poirier, P., Tremblay, A., & Corbeil, P. (2013). Current state of knowledge of post-traumatic stress, sleeping

problems, obesity and cardiovascular disease in paramedics. *Emergency Medicine Journal*, *31*(3), 242–247. https://doi.org/10.1136/emermed-2012-201672

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

Heidegger, M. (1967). *Being and time*. Basil Blackwell.

Heinen, M. M., van Achterberg, T., Schwendimann, R., Zander, B., Matthews, A., Kózka, M., Ensio, A., Sjetne, I. S., Casbas, T. M., Ball, J., & Schoonhoven, L. (2013). Nurses' intention to leave their profession: A cross sectional observational study in 10 European countries. *International Journal of Nursing Studies*, *50*(2), 174–184. https://doi.org/10.1016/j.ijnurstu.2012.09.019

Hemingway, M. A., & Smith, C. S. (1999). Organizational climate and occupational stressors as predictors of withdrawal behaviours and injuries in nurses. *Journal of Occupational and Organizational Psychology*, *72*(3), 285–299. https://doi.org/10.1348/096317999166680

Henley, J. (2020). *'Complacent' UK draws global criticism for Covid-19 response*. The Guardian. https://www.theguardian.com/world/2020/may/06/complacent-uk-draws-global-criticism-for-covid-19-response-boris-johnson

Heppner, P. P., Leong, F. T. L., & Chiao, H. (2008). A growing internationalization of counseling psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 68–85). John Wiley & Sons, Inc.

Herman, J. L. (1992). *Trauma and recovery.* Basic Books/Hachette Book Group

Herman, J. L. (2000). *Father-Daughter Incest (with a new Afterword)*. Harvard University Press.

Higgs R. (1998). On telling patients the truth. *Proceedings of the 11th National Bioethics Conference*; 29–30 March 1993, Christian Centre for Bioethics; 35–44.

Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic

relationship: Inextricably intertwined in the therapy process. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 431–442. https://doi.org/10.1037/0033-3204.42.4.431

Hirschberger, G. (2018). Collective trauma and the social construction of meaning. *Frontiers in Psychology, 9*(1441), 1–14. https://doi.org/10.3389/fpsyg.2018.01441

Horton, R. (2020). Offline: COVID-19 and the NHS—"a national scandal." *The Lancet*, *395*(10229), 1022. https://doi.org/10.1016/s0140-6736(20)30727-3

Hoernke, K., Djellouli, N., Andrews, L., Lewis-Jackson, S., Manby, L., Martin, S., Vanderslott, S., & Vindrola-Padros, C. (2021). Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal. *BMJ Open*, *11*(1), e046199. https://doi.org/10.1136/bmjopen-2020-046199

Howell, E. F. (2011). *Understanding and Treating Dissociative Identity Disorder: A Relational Approach (Relational Perspectives Book Series)* (1st ed.), p. 35. Routledge.

Hudak, C., Gallo, B., & Morton, P. G. (1998). *Critical care nursing: A holistic approach*. Lippincott.

Hunter, D. J. (2020). Covid-19 and the Stiff Upper Lip — The Pandemic Response in the United Kingdom. *New England Journal of Medicine*, *382*(16), e31. https://doi.org/10.1056/nejmp2005755

Husserl, E. (1970). *The crisis of european sciences and transcendental phenomenology.* Northwestern University Press.

Institute for Government. (2022). *Coronavirus vaccine rollout*. https://www.instituteforgovernment.org.uk/explainers/coronavirus-vaccine-rollout

Jacobson, E. (1938). *Progressive Relaxation*, *(2nd ed.).* Univ. Chicago Press.

Jameton, A. (1984). *Nursing Practice: The Ethical Issues (Prentice-Hall series in the philosophy of medicine)* (1st ed.). Pearson College Div.

Johnson, G. A., & Vindrola-Padros, C. (2017). Rapid qualitative research methods during complex health emergencies: A systematic review of the literature. *Social Science & Medicine*, *189*, 63–75. https://doi.org/10.1016/j.socscimed.2017.07.029

Johnstone, L. (2020). Does COVID-19 pose a challenge to the diagnoses of anxiety and depression? A psychologist's view. *BJPsych Bulletin*, *45*(5), 278–281. https://doi.org/10.1192/bjb.2020.101

Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System. *Journal of Humanistic Psychology*, 002216781879328. https://doi.org/10.1177/0022167818793289

Johnstone, L. & Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Overview*, p. 9. The British Psychological Society.

Joseph, S. (2008). Psychotherapy's inescapable assumptions about human nature. *Counselling Psychology Review, 23*(1), 34–40.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness*. Delacorte.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156, p. 145. https://doi.org/10.1093/clipsy.bpg016

Kam, P. C. A., Kam, A. C., & Thompson, J. F. (1994). Noise pollution in the anaesthetic and intensive care environment. *Anaesthesia*, *49*(11), 982–986. https://doi.org/10.1111/j.1365-2044.1994.tb04319.x

Kang, L., Ma, S., Chen, M., Yang, J., Wang, Y., Li, R., Yao, L., Bai, H., Cai, Z., Xiang Yang, B., Hu, S., Zhang, K., Wang, G., Ma, C., & Liu, Z. (2020). Impact on mental health and perceptions of psychological care among medical and nursing staff in Wuhan during the 2019 novel coronavirus disease outbreak: A cross-sectional study. *Brain, Behavior, and Immunity*, *87*, 11–17. https://doi.org/10.1016/j.bbi.2020.03.028

Karanikola, M., Giannakopoulou, M., Mpouzika, M., Kaite, C. P., Tsiaousis, G. Z., & Papathanassoglou, E. D. E. (2015). Dysfunctional psychological responses among Intensive Care Unit nurses: a systematic review of the literature. *Revista Da Escola de Enfermagem Da USP*, *49*(5), 847–857. https://doi.org/10.1590/s0080-623420150000500020

Kay, A. C., Gaucher, D., Napier, J. L., Callan, M. J., & Laurin, K. (2008). God and the government: Testing a compensatory control mechanism for the support of external systems. *Journal of Personality and Social Psychology*, *95*(1), 18–35. https://doi.org/10.1037/0022-3514.95.1.18

Kets De Vries, M. F., Vrignaud, P., & Florent-Treacy, E. (2004). The Global Leadership Life Inventory: development and psychometric properties of a 360-degree feedback instrument. *The International Journal of Human Resource Management*, *15*(3), 475–492. https://doi.org/10.1080/0958519042000181214

King, L. A., & McInerney, P. A. (2006). Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. *Curationis*, *29*(4), 70–81.

King, L., & Clark, J. M. (2002). Intuition and the development of expertise in surgical ward and intensive care nurses. *Journal of Advanced Nursing*, *37*(4), 322–329. https://doi.org/10.1046/j.1365-2648.2002.02105.x

Kissler, S. M., Tedijanto, C., Goldstein, E., Grad, Y. H., & Lipsitch, M. (2020). Projecting the transmission dynamics of SARS-CoV-2 through the postpandemic period. *Science*, *368*(6493), 860–868. https://doi.org/10.1126/science.abb5793

Kreh, A., Brancaleoni, R., Magalini, S. C., Chieffo, D. P. R., Flad, B., Ellebrecht, N., & Juen, B. (2021). Ethical and psychosocial considerations for hospital personnel in the Covid-19 crisis: Moral injury and resilience. *PLOS ONE*, *16*(4), e0249609. https://doi.org/10.1371/journal.pone.0249609

Labrague, L. J. (2021). Psychological resilience, coping behaviours and social support among health care workers during the COVID-19 pandemic: A systematic review of quantitative studies. *Journal of Nursing Management*, *29*(7), 1893–1905. https://doi.org/10.1111/jonm.13336

Lafond, S., Charlesworth, A., Roberts, A. (2016). *A perfect storm: an impossible climate for NHS providers' finances? An analysis of NHS finances and factors associated with financial performance.* Health Foundation. www.health.org.uk/publication/perfect-storm-impossibleclimate-nhs-providers%E2%80%99-finances

Langdridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method.* Pearson Education.

Langdridge, D. (2017). Phenomenology. In B. Gough (Ed.), *The Palgrave handbook of critical social psychology* (pp. 165–183). Palgrave Macmillan/Springer Nature. https://doi.org/10.1057/978-1-137-51018-1_9

Lasagna, L. (1964). *Hippocratic Oath—Modern Version*. http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html

Laschinger, H., & Montgomery, A. J. (2014). Burnout and HealthCare – Editorial. *Burnout Research*, *1*(2), 57–58. https://doi.org/10.1016/j.burn.2014.08.002

Lassri, D., & Desatnik, A. (2020). Losing and regaining reflective functioning in the times of COVID-19: Clinical risks and opportunities from a mentalizing approach. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S38–S40. https://doi.org/10.1037/tra0000760

Latané, B., & Nida, S. (1981). Ten years of research on group size and helping. *Psychological Bulletin, 89*(2), 308–324. https://doi.org/10.1037/0033-2909.89.2.308

Latané, B., & Darley, J. M. (1970). *The Unresponsive Bystander: Why Doesn't He Help?* Prentice Hall.

Lawrence, J. A., & Farr, E. H. (1982). "The nurse should consider." Critical care ethical issues. *Journal of Advanced Nursing*, *7*(3), 223–229. https://doi.org/10.1111/j.1365-2648.1982.tb00234.x

Leape, L. L., Brennan, T. A., Laird, N., Lawthers, A. G., Localio, A. R., Barnes, B. A., Hebert, L., Newhouse, J. P., Weiler, P. C., & Hiatt, H. (1991). The Nature of Adverse Events in Hospitalized Patients. *New England Journal of Medicine*, *324*(6), 377–384. https://doi.org/10.1056/nejm199102073240605

LeDoux, J. (2003). The Emotional Brain, Fear, and the Amygdala. *Cellular and Molecular Neurobiology*, *23*(4/5), 727–738. https://doi.org/10.1023/a:1025048802629

Lester, S. (1999). *An Introduction to Phenomenological Research*. Taunton: Stan Lester Developments. http://www.sld.demon.co.uk/resmethy.pd

Levitt, H. M. (2015). Qualitative psychotherapy research: The journey so far and future directions. *Psychotherapy*, *52*(1), 31–37. https://doi.org/10.1037/a0037076

Lee, A. M., Wong, J. G. W. S., McAlonan, G. M., Cheung, V., Cheung, C., Sham, P. C., Chu, C., Wong, P. C., Tsang, K. W. T., & Chua, S. E. (2007). Stress and Psychological Distress Among SARS Survivors 1 Year After the Outbreak. *The Canadian Journal of Psychiatry, 52:*233-240. https://doi.org/10.1177/070674370705200405

Lewis, D. (2021). COVID-19 rarely spreads through surfaces. So why are we still deep cleaning? *Nature*, *590*(7844), 26–28. https://doi.org/10.1038/d41586-021-00251-4

Lewis, H. B. (1971). *Shame and guilt in neurosis*. International Universities Press.

Liaschenko, J. (1995). Artificial Personhood: Nursing Ethics in a Medical World. *Nursing Ethics*, *2*(3), 185–196. https://doi.org/10.1177/096973309500200302

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 1065-1122), Sage Publications.

Liu, X., Kakade, M., Fuller, C. J., Fan, B., Fang, Y., Kong, J., Guan, Z., & Wu, P. (2012). Depression after exposure to stressful events: Lessons learned from the severe acute respiratory syndrome epidemic. *Comprehensive Psychiatry*, *53*(1), 15–23. https://doi.org/10.1016/ j.comppsych.2011.02.003

Losch, M. E., & Cacioppo, J. T. (1990). Cognitive dissonance may enhance sympathetic tonus, but attitudes are changed to reduce negative affect rather than arousal. *Journal of Experimental Social Psychology, 26*(4), 289–304. https://doi.org/10.1016/0022-1031(90)90040-S

Loughnan, S., Haslam, N., Murnane, T., Vaes, J., Reynolds, C., & Suitner, C. (2010). Objectification leads to depersonalization: The denial of mind and moral concern to objectified others. *European Journal of Social Psychology*, n/a. https://doi.org/10.1002/ejsp.755

Lu, Y.-C., Shu, B.-C., Chang, Y.-Y., & Lung, F.-W. (2006). The mental health of hospital workers dealing with severe acute respiratory syndrome. *Psychotherapy and Psychosomatics*, *75*(6), 370–375. https://doi.org/10.1159/000095443

Luceño-Moreno, L., Talavera-Velasco, B., García-Albuerne, Y., & Martín-García, J. (2020). Symptoms of Posttraumatic Stress, Anxiety, Depression, Levels of Resilience and

Burnout in Spanish Health Personnel during the COVID-19 Pandemic. *International Journal of Environmental Research and Public Health*, *17*(15), 5514. https://doi.org/10.3390/ijerph17155514

Machado, D. A., Figueiredo, N. M. A. D., Velasques, L. D. S., Bento, C. A. D. M., Machado, W. C. A., & Vianna, L. A. M. (2018). Cognitive changes in nurses working in intensive care units. *Revista Brasileira de Enfermagem*, *71*(1), 73–79. https://doi.org/10.1590/0034-7167-2016-0513

Macdonald, M. & Baker, C. (2020). Nursing workforce shortage in England. *House of Commons Library.* Debate Pack. Number CDP-2020/0037 https://researchbriefings.files.parliament.uk/documents/CDP-2020-0037/CDP-2020-0037.pdf

Mazza, M. G., de Lorenzo, R., Conte, C., Poletti, S., Vai, B., Bollettini, I., Melloni, E. M. T., Furlan, R., Ciceri, F., Rovere-Querini, P., & Benedetti, F. (2020). Anxiety and depression in COVID-19 survivors: Role of inflammatory and clinical predictors. *Brain, Behavior, and Immunity*, *89*, 594–600. https://doi.org/10.1016/j.bbi.2020.07.03

McCarthy, J., & Deady, R. (2008). Moral Distress Reconsidered. *Nursing Ethics*, *15*(2), 254–262. https://doi.org/10.1177/0969733007086023

McKee MG, Ashton K. (2004). Stresses of daily life. In R. Lang, D. D. Hensrud, (eds). Clinical Preventive Medicine. 3rd ed., *AMA Press*; 81-91.

Masiero, M., Mazzocco, K., Harnois, C., Cropley, M., & Pravettoni, G. (2020). From Individual To Social Trauma: Sources Of Everyday Trauma In Italy, The US And UK During The Covid-19 Pandemic. *Journal of Trauma & Dissociation*, *21*(5), 513–519. https://doi.org/10.1080/15299732.2020.1787296

Maslach, C. (1999). Chapter 12 - Progress in Understanding Teacher Burnout.

Understanding and Preventing Teacher Burnout. A Sourcebook of International Research and Practice, pp. 211 – 222 https://doi.org/10.1017/cbo9780511527784.014

Maslach, C. (2003). Job Burnout. *Current Directions in Psychological Science*, *12*(5), 189–192. https://doi.org/10.1111/1467-8721.01258

Maslach, C. (2006). Understanding Job Burnout. In Rossi, A. M., Perrewé, P. L., & Sauter, S. L. *Stress and Quality of Working Life: Current Perspectives in Occupational Health*. Information Age Publishing.

Masterson, G. M., & Batchelor, A. (2022). *Guidelines for the Provision of Intensive Care Services.* The Faculty of Intensive Care Medicine. Https://Ficm.Ac.Uk/Standardssafetyguidelinesstandards/Guidelines-for-the-Provision-of-Intensive-Care-Services

McCarthy, J. (2013). Nursing Ethics and Moral Distress: the story so far (Guest Editorial). *Nursing Ethics Special Issue on Moral Distress (Curated). Journal Volume Edited*. https://journals.sagepub.com/pb-assets/cmscontent/NEJ/NEJ-suppl-Moral-distress-1471876829607.pdf

McCarthy, J., & Gastmans, C. (2014). Moral distress. *Nursing Ethics*, *22*(1), 131–152. https://doi.org/10.1177/0969733014557139

McKee, M. (2020). England's PPE procurement failures must never happen again. *BMJ*, m2858. https://doi.org/10.1136/bmj.m2858

McLachlan, C. J., & Garcia, R. J. (2015). Philosophy in practice? Doctoral struggles with ontology and subjectivity in qualitative interviewing. *Management Learning*, *46*(2), 195–210. https://doi.org/10.1177/1350507615574634

McLeod, J. (2015). *Doing Research in Counselling and Psychotherapy* (Third ed.). SAGE Publications Ltd.

Mealer, M., Burnham, E. L., Goode, C. J., Rothbaum, B., & Moss, M. (2009). The prevalence and impact of post traumatic stress disorder and burnout syndrome in nurses. *Depression and Anxiety*, *26*(12), 1118–1126. https://doi.org/10.1002/da.20631

Mills, J., Bonner, A., & Francis, K. (2006). Adopting a constructivist approach to grounded theory: Implications for research design. *International Journal of Nursing Practice*, *12*(1), 8–13. https://doi.org/10.1111/j.1440-172x.2006.00543.x

Milton, M. (Ed.). (2010). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues.* Wiley-Blackwell. https://doi.org/10.1002/9780470667279

Mobbs, M. C., & Bonanno, G. A. (2018). Beyond war and PTSD: The crucial role of transition stress in the lives of military veterans. *Clinical Psychology Review*, *59*, 137–144. https://doi.org/10.1016/j.cpr.2017.11.007

Montgomery, C. M., Humphreys, S., McCulloch, C., Docherty, A. B., Sturdy, S., & Pattison, N. (2021). Critical care work during COVID-19: a qualitative study of staff experiences in the UK. *BMJ Open*, *11*(5), e048124. https://doi.org/10.1136/bmjopen-2020-048124

Morgan, G., Barnwell, G., Johnstone, L., Shukla, K., & Mitchell, A. (2022). The Power Threat Meaning Framework and the Climate and Ecological Crises. *Psychology in Society. 63*, 83-109.

Morris, P. E., & Dracup, K. (2008). Time for a tool to measure moral distress. *American Journal of Critical Care, 17*(5), 398–401

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250–260. https://doi.org/10.1037/0022-0167.52.2.250

Moorthy, A., & Sankar, T. K. (2020). Emerging public health challenge in UK: perception and belief on increased COVID19 death among BAME healthcare workers. *Journal of Public Health*, *42*(3), 486–492. https://doi.org/10.1093/pubmed/fdaa096

Muschalik, C., Crutzen, R., Elfeddali, I., & de Vries, H. (2020). Mindfulness is not associated with dissonant attitudes but enhances the ability to cope with them. *BMC Psychology*, *8*(1). https://doi.org/10.1186/s40359-020-0377-x

National Health System (NHS). (2022). *Intensive care*. https://www.nhs.uk/conditions/intensive-care/

Newman, K. L., Jeve, Y., & Majumder, P. (2021). Experiences and emotional strain of NHS frontline workers during the peak of the COVID-19 pandemic. *International Journal of Social Psychiatry*, *68*(4), 783–790. https://doi.org/10.1177/00207640211006153

NHS Digital, (2018). *NHS Hospital & Community Health Service (HCHS) workforce statistics.* https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics.

NHS Employers. (2022). *Preceptorships for newly qualified staff*. https://www.nhsemployers.org/articles/preceptorships-newly-qualified-staff

NHS England, (2020). *NHS strengthens mental health support for staff*. https://www.england.nhs.uk/2020/10/strengthening-mental-health-support-for-staff/

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, *18*(3), 369–386. https://doi.org/10.1080/14780887.2020.1854404

Norris, J., Layard, R., & Cornaglia, F. (2020). How is coronavirus affecting the mental health of adolescents? *Economics Observatory*. https://www.economicsobservatory.com/how-coronavirus-affecting-mental-health-adolescents

Nguyen, L. H., Drew, D. A., Graham, M. S., Joshi, A. D., Guo, C. G., Ma, W., Mehta, R. S., Warner, E. T., Sikavi, D. R., Lo, C. H., Kwon, S., Song, M., Mucci, L. A., Stampfer, M. J., Willett, W. C., Eliassen, A. H., Hart, J. E., Chavarro, J. E., Rich-Edwards, J. W., Davies, R., Capdevila, J., Lee, A. K., Lochlainn, M. N., Varsavsky, T., Sudre, C. H., Cardoso, M. J., Wolf, J., Spector, T. D., Ourselin, S., Steves, C. J., & Chan, A. T. (2020). Risk of COVID-19 among front-line health-care workers and the general community: a prospective cohort study. *The Lancet Public Health*, *5*(9), e475–e483. https://doi.org/10.1016/s2468-2667(20)30164-x

Nyashanu, M., Pfende, F., & Ekpenyong, M. (2020). Exploring the challenges faced by frontline workers in health and social care amid the COVID-19 pandemic: experiences of frontline workers in the English Midlands region, UK. *Journal of Interprofessional Care*, *34*(5), 655–661. https://doi.org/10.1080/13561820.2020.1792425

O'Connor, K. F. (1996). Ethical/moral experiences of oncology nurses. *Oncol Nurs Forum; 23*:787–94.

Office for National Statistics (ONS). (2022). *Coronavirus (COVID-19) latest insights: Hospitals*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19latestinsights/hospitals

Ogden, P., Pain, C., & Fisher, J. (2006). A Sensorimotor Approach to the Treatment of Trauma and Dissociation. *Psychiatric Clinics of North America*, *29*(1), 263–279. https://doi.org/10.1016/j.psc.2005.10.012

Ohnishi, K., Ohgushi, Y., Nakano, M., Fujii, H., Tanaka, H., Kitaoka, K., Nakahara, J., & Narita, Y. (2010). Moral distress experienced by psychiatric nurses in Japan. *Nursing Ethics*, *17*(6), 726–740. https://doi.org/10.1177/0969733010379178

Oliver, D. (2020). Let's be open and honest about covid-19 deaths in care homes. *BMJ*, m2334. https://doi.org/10.1136/bmj.m2334

Organisation for Economic Co-operation and Development (OECD), (2015). Health at a Glance. https://doi.org/10.1787/health_glance-2015-en

Orlans, V., & Scoyoc, V. S. (2009). *A Short Introduction to Counselling Psychology (Short Introductions to the Therapy Professions)* (1st ed.). SAGE Publications Ltd.

O'Shea, M., & Kelly, B. (2007). The lived experiences of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland. *Journal of Clinical Nursing*, *16*(8), 1534–1542. https://doi.org/10.1111/j.1365-2702.2006.01794.x

Page, A. (2004). *Keeping Patients Safe: Transforming the Work Environment of Nurses* (1st ed.). National Academies Press.

Palinkas, L. A. (2014). Qualitative and Mixed Methods in Mental Health Services and Implementation Research. *Journal of Clinical Child & Adolescent Psychology*, *43*(6), 851–861. https://doi.org/10.1080/15374416.2014.910791

Platt, L., & Warwick, R. (2020). *Are some ethnic groups more vulnerable to COVID-19 than others?* The Institute for Fiscal Studies. https://ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/

Pietkiewicz, I., & Smith, J. A. (2014). A Practical Guide to Using Interpretative Phenomenological Analysis in Qualitative Research Psychology. *Psychological Journal, 20*, 7-14.

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

Porges, S. W., Doussard-Roosevelt, J. A., & Maiti, A. K. (1994). Vagal Tone and the Physiological Regulation of Emotion. *Monographs of the Society for Research in Child Development*, *59*(2–3), 167–186. https://doi.org/10.1111/j.1540-5834.1994.tb01283.x

Ravelo, J. L., & Jerving, S. (2022). *COVID-19 in 2020 — a timeline of the coronavirus outbreak*. Https://Www.Devex.Com/News/Covid-19-in-2020-a-Timeline-of-the-Coronavirus-Outbreak-99634

Reason, J. (1990). The contribution of latent human failures to the breakdown of complex systems. *Philosophical Transactions of the Royal Society of London. B, Biological Sciences*, *327*(1241), 475–484. https://doi.org/10.1098/rstb.1990.0090

Reeder, J. M. (1988). Should patients always be told the truth? *AORN Journal*, *47*(5), 1306–1310. https://doi.org/10.1016/s0001-2092(07)66064-5

Rehman, A. A., & Alharthi, K. (2016). An Introduction to Research Paradigms. *International Journal of Educational Investigations. Vol.3*, No.8: 51-59. http://www.ijeionline.com/attachments/article/57/IJEI.Vol.3.No.8.05.pdf

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

Rennie, D. L. (2012). Qualitative research as methodical hermeneutics. *Psychological Methods*, *17*(3), 385–398. https://doi.org/10.1037/a0029250

Repenshek, M. (2009). Moral Distress: Inability to Act or Discomfort with Moral Subjectivity? *Nursing Ethics*, *16*(6), 734–742. https://doi.org/10.1177/0969733009342138

Ricoeur, P. (1981). *Paul Ricoeur hermeneutics and the human sciences*. Thompson, J. B., Ed. Cambridge University Press.

Ricoeur, P. (1973). The task of hermeneutics. *Philosophy Today, 17*(2/4), 112–128, p. 130. Doi:10.5840/philtoday197317232

Robertson, E., Hershenfield, K., Grace, S. L., & Stewart, D. E. (2004). The

Psychosocial Effects of Being Quarantined following Exposure to SARS: A Qualitative Study of Toronto Health Care Workers. *The Canadian Journal of Psychiatry*, *49*(6), 403–407. https://doi.org/10.1177/070674370404900612

Robertson, R., Wenzel, L., Thompson, J., & Charles, A. (2017). Understanding NHS financial pressures. How are they affecting patient care? *The King's Fund*. https://www.kingsfund.org.uk/publications/understanding-nhs-financial-pressures

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

Rolewicz, L. (2021). Taking stock: is the government meeting its commitments to increase NHS staff numbers? The Nuffield Trust. https://www.nuffieldtrust.org.uk/news-item/taking-stock-is-the-government-meeting-its-commitments-to-increase-nhs-staff-numbers

Rolewicz, L. & Palmer, B. (2019). *The NHS workforce in numbers. Facts on staffing and staff shortages in England.* The Nuffield Trust. https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers.

Royal College of Nursing (RCN), (2015). *RCN London Safe Staffing Report*. https://www.rcn.org.uk/london/about/publications/safe-staffing-report-2015

Royal College of Physicians, (2021). COVID-19 and the Workforce: The Impact of the Second Wave. https://www.rcplondon.ac.uk/projects/outputs/covid-19-and-workforce-impact-second-wave

Rudman, A., & Gustavsson, J. P. (2011). Early-career burnout among new graduate nurses: A prospective observational study of intra-individual change trajectories. *International*

Journal of Nursing Studies, *48*(3), 292–306. https://doi.org/10.1016/j.ijnurstu.2010.07.012

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

Sbaraini, A., Carter, S. M., Evans, R. W., & Blinkhorn, A. (2011). How to do a grounded theory study: a worked example of a study of dental practices. *BMC Medical Research Methodology*, *11*(1). https://doi.org/10.1186/1471-2288-11-128

Scally, G., Jacobson, B., & Abbasi, K. (2020). The UK's public health response to covid-19. *BMJ*, m1932. https://doi.org/10.1136/bmj.m1932

Schlairet, M. C. (2009). Bioethics mediation: The role and importance of nursing advocacy. *Nursing Outlook*, *57*(4), 185–193. https://doi.org/10.1016/j.outlook.2008.10.006

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' Moral Sensitivity and Hospital Ethical Climate: a Literature Review. *Nursing Ethics*, *15*(3), 304–321. https://doi.org/10.1177/0969733007088357

Sciarra, D. (1999). The role of the qualitative researcher. In M. Kopala & L. A. Suzuki (Eds.), *Using qualitative methods in psychology* (pp. 37–48). Sage Publications, Inc. https://doi.org/10.4135/9781452225487.n4

Scottish Nursing Guild. (2021). *What is an ITU nurse?* https://scottish-nursing-guild.com/blog/what-is-an-itu-nurse/

Serrano-Ripoll, M. J., Meneses-Echavez, J. F., Ricci-Cabello, I., Fraile-Navarro, D., Fiol-deRoque, M. A., Pastor-Moreno, G., Castro, A., Ruiz-Pérez, I., Zamanillo Campos, R., & Gonçalves-Bradley, D. C. (2020). Impact of viral epidemic outbreaks on mental

health of healthcare workers: a rapid systematic review and meta-analysis. *Journal of Affective Disorders*, *277*, 347–357. https://doi.org/10.1016/j.jad.2020.08.034

Shechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., Birk, J. L., Brodie, D., Cannone, D. E., Chang, B., Claassen, J., Cornelius, T., Derby, L., Dong, M., Givens, R. C., Hochman, B., Homma, S., Kronish, I. M., Lee, S. A., . . . Abdalla, M. (2020). Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. *General Hospital Psychiatry*, *66*, 1–8. https://doi.org/10.1016/j.genhosppsych.2020.06.007

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis, 22*(1), 16–31.

Shirom, A. (2003). Job-related burnout: A review. *Handbook of Occupational Health Psychology.*, 245–264. https://doi.org/10.1037/10474-012

Shotter, J. (1993). *Cultural politics of everyday life: Social constructionism, rhetoric and knowing of the third kind.* University of Toronto Press.

Siegel, D. (1999). *The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are*. Guilford Press.

Simm, K., Zameska, J., & Lubi, K. (2022). Frontline Healthcare Professionals' Views Regarding the Impact of COVID-19 on Ethical Decision-Making: A Multicentre Mixed-Methods Study from Estonia. *Healthcare*, *10*(4), 711. https://doi.org/10.3390/healthcare10040711

Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-Being*, *2*(1), 3–11. https://doi.org/10.1080/17482620601016120

Smith, J. A. (2011). 'We could be diving for pearls': the value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin, 12*, 6-15.

Smith, J. A. (2019). Participants and researchers searching for meaning: Conceptual developments for interpretative phenomenological analysis. *Qualitative Research in Psychology*, *16*(2), 166–181. https://doi.org/10.1080/14780887.2018.1540648

Smith, J. A., Flower, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. *Qualitative Research in Psychology*, *6*(4), 346–347. https://doi.org/10.1080/14780880903340091

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, Method and Research* (Second ed.). SAGE Publications Ltd.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. *Qualitative Health Psychology: Theories and Methods*, 218–240. https://doi.org/10.4135/9781446217870.n14

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

Smith, J. A., & Osborn, M. (2007). Pain as an assault on the self: An interpretative phenomenological analysis of the psychological impact of chronic benign low back pain. *Psychology & Health*, *22*(5), 517–534. https://doi.org/10.1080/14768320600941756

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British Journal of Pain*, *9*(1), 41–42. https://doi.org/10.1177/2049463714541642

Snow, S., Shields, J., & Whitecross, A. (2020). NHS voices of COVID-19. The British Academy. https://www.thebritishacademy.ac.uk/publications/covid-decade-nhs-voices-of-covid-19/

Sparkes, A. C., & Smith, B. (2009). Judging the quality of qualitative inquiry:

Criteriology and relativism in action. *Psychology of Sport and Exercise, 10*(5), 491–497. https://doi.org/10.1016/j.psychsport.2009.02.006

Spinelli, E. (1989). *The interpreted world: An introduction to phenomenological psychology.* P. 108. Sage Publications, Inc.

Spinetta, J. J., Jankovic, M., Ben Arush, M. W., Eden, T., Epelman, C., Greenberg, M. L., Gentils Martins, A., Mulhern, R. H., Oppenheim, D., & Masera, G. (2000). Guidelines for the recognition, prevention, and remediation of burnout in health care professionals participating in the care of children with cancer: report of the SIOP Working Committee on Psychosocial Issues in Pediatric Oncology. *Med Pediatr Oncol.;35*(2):122-125.

Sprigler, G. (1996). When the truth hurts. *Plastic Surgical Nursing*; *16*: 56.

Sridhar, D. (2020). *Britain must change course – and resume Covid-19 testing to protect frontline NHS staff*. The Guardian. https://www.theguardian.com/commentisfree/2020/mar/16/resume-covid-19-testing-protect-frontline-nhs-staff

Stanley, B. L., Zanin, A. C., Avalos, B. L., Tracy, S. J., & Town, S. (2021). Collective Emotion During Collective Trauma: A Metaphor Analysis of the COVID-19 Pandemic. *Qualitative Health Research*, *31*(10), 1890–1903. https://doi.org/10.1177/10497323211011589

Stanley, D. A., Sokol-Hessner, P., Banaji, M. R., & Phelps, E. A. (2011). Implicit race attitudes predict trustworthiness judgments and economic trust decisions. *Proceedings of the National Academy of Sciences*, *108*(19), 7710–7715. https://doi.org/10.1073/pnas.1014345108

Stewart, H. (2020). *Neil Ferguson: UK coronavirus adviser resigns after breaking lockdown rules*. The Guardian. https://www.theguardian.com/uk-news/2020/may/05/uk-coronavirus-adviser-prof-neil-ferguson-resigns-after-breaking-lockdown-rules

Strachota, E., Normandin, P., O???Brien, N., Clary, M., & Krukow, B. (2003). Reasons Registered Nurses Leave or Change Employment Status. *JONA: The Journal of Nursing Administration*, *33*(2), 111–117. https://doi.org/10.1097/00005110-200302000-00008

Stubley, J. (2020). *The early response to Covid 19 – a psychoanalytic and trauma perspective*. https://tavistockandportman.nhs.uk/about-us/news/stories/early-response-covid-19-psychoanalytic-and-trauma-perspective/

Stubley, J., & Young, L. (2022). Complex trauma: the Tavistock model. A review. *Journal of Mental Health*, *31*(3), 450. https://doi.org/10.1080/09638237.2022.2069728

Sullivan, E., & Decker, P. J. (1997). *Effective Leadership and Nursing Management in Nursing, with Student Video (4th Edition)* (Subsequent ed.). Addison-Wesley.

Sundin-Huard, D., & Fahy, K. (1999). Moral distress, advocacy and burnout: Theorising the relationships. *International Journal of Nursing Practice*, *5*(1), 8–13. https://doi.org/10.1046/j.1440-172x.1999.00143.x

Sy, M. P., Pineda, R. C. S., Yao, D. P. G., Guevara, C. A. L., Delos Reyes, R. C., & Castro, I. M. (2020). Shared voices of Filipino occupational therapists during the COVID-19 pandemic: reflections from an online forum. *World Federation of Occupational Therapists Bulletin*, *76*(1), 60–64. https://doi.org/10.1080/14473828.2020.1761575

Swider, S. M., McElmurry, B. J., & Yarling, R. R. (1985). Ethical decision making in a bureaucratic context by senior nursing students. *Nursing research*, *34*(2), 108–112

Tai, T. W. C., Bame, S. I., & Robinson, C. D. (1998). Review of nursing turnover research, 1977–1996. *Social Science & Medicine*, *47*(12), 1905–1924. https://doi.org/10.1016/s0277-9536(98)00333-5

Tan, B. Y., Chew, N. W., Lee, G. K., Jing, M., Goh, Y., Yeo, L. L., Zhang, K., Chin, H. K., Ahmad, A., Khan, F. A., Shanmugam, G. N., Chan, B. P., Sunny, S., Chandra, B., Ong,

J. J., Paliwal, P. R., Wong, L. Y., Sagayanathan, R., Chen, J. T., Sunny, S., Chandra, B., Ong, J. Y. J., Paliwal, P. R., Wong, L. Y. H., Sagayanathan, R., Chen, J. T., Ng, A. Y. Y., Teoh, H. L., Ho, C. S., Ho, R. C., & Sharma, V. K. (2020). Psychological Impact of the COVID-19 Pandemic on Health Care Workers in Singapore. *Annals of Internal Medicine*, *173*(4), 317–320. https://doi.org/10.7326/m20-1083

Tan, T. P., Stokes, T., & Shaw, E. J. (2009). Use of qualitative research as evidence in the clinical guideline program of the National Institute for Health and Clinical Excellence. *International Journal of Evidence-Based Healthcare*, *7*(3), 169–172. https://doi.org/10.1111/j.1744-1609.2009.00135.x

Tang, B., Liu, X., Liu, Y., Xue, C., & Zhang, L. (2014). A meta-analysis of risk factors for depression in adults and children after natural disasters. *BMC Public Health*, *14*(1). https://doi.org/10.1186/1471-2458-14-623

Tang, J. W., Caniza, M. A., Dinn, M., Dwyer, D. E., Heraud, J. M., Jennings, L. C., Kok, J., Kwok, K. O., Li, Y., Loh, T. P., Marr, L. C., Nara, E. M., Perera, N., Saito, R., Santillan-Salas, C., Sullivan, S., Warner, M., Watanabe, A., & Zaidi, S. K. (2022). An exploration of the political, social, economic and cultural factors affecting how different global regions initially reacted to the COVID-19 pandemic. *Interface Focus*, *12*(2). https://doi.org/10.1098/rsfs.2021.0079

Taylor, M. (2020). Collective trauma and the relational field. *The Humanistic Psychologist*, *48*(4), 382–388. https://doi.org/10.1037/hum0000215

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

Teti, M., Schatz, E., & Liebenberg, L. (2020). Methods in the Time of COVID-19: The Vital Role of Qualitative Inquiries. *International Journal of Qualitative Methods*, *19*, 160940692092096. https://doi.org/10.1177/1609406920920962

The British Psychological Society (BPS), (2020). *Conducting research with human participants during Covid-19.* https://www.bps.org.uk/node/1047

The British Psychological Society (BPS), 2020. *Coronavirus – Psychological perspectives.* https://www.bps.org.uk/psychologist/coronavirus-psychological-perspectives

The British Psychological Society, (2018). *Code of Ethics and Conduct.* https://www.bps.org.uk/node/1714

The British Psychological Society, (2021). *BPS Code of Human Research Ethics.* https://www.bps.org.uk/guideline/bps-code-human-research-ethics-0

Tracy, D. K., Tarn, M., Eldridge, R., Cooke, J., Calder, J. D., & Greenberg, N. (2020). What should be done to support the mental health of healthcare staff treating COVID-19 patients? *The British Journal of Psychiatry*, *217*(4), 537–539. https://doi.org/10.1192/bjp.2020.109

Tribe, R., & Bell, D. (2018). Social justice, diversity and leadership. *The European Journal of Counselling Psychology*, *6*(1), 111–125. https://doi.org/10.5964/ejcop.v6i1.145

Tsitsi, T., Charalambous, A., Papastavrou, E., & Raftopoulos, V. (2017). Effectiveness of a relaxation intervention (progressive muscle relaxation and guided imagery techniques) to reduce anxiety and improve mood of parents of hospitalized children with malignancies: A randomized controlled trial in Republic of Cyprus and Greece. *European Journal of Oncology Nursing*, *26*, 9–18. https://doi.org/10.1016/j.ejon.2016.10.007

Tuckett, A. G. (2005). The care encounter: Pondering caring, honest communication and control. *International Journal of Nursing Practice*, *11*(2), 77–84. https://doi.org/10.1111/j.1440-172x.2005.00505.x

Tulloch, O., & Ripoll, S. (2020). *Key considerations: Quarantine in the context of COVID-19*. https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/15133/SSHAP%20COVID-19%20Key%20Considerations%20Quarantine.pdf?sequence=24&isAllowed=y

Udén, G., Norberg, A., Lindseth, A., & Marhaug, V. (1992). Ethical reasoning in nurses' and physicians' stories about care episodes. *Journal of Advanced Nursing*, *17*(9), 1028–1034. https://doi.org/10.1111/j.1365-2648.1992.tb02036.x

University of East London (UEL), (2013). *Code of Practice for Postgraduate Research Degree*. Graduate School and Quality Assurance & Enhancement. https://www.uel.ac.uk/sites/default/files/5751.pdf

Vahey, D. C., Aiken, L. H., Sloane, D. M., Clarke, S. P., & Vargas, D. (2004). Nurse Burnout and Patient Satisfaction. *Medical Care*, *42*(2), II–57. https://doi.org/10.1097/01.mlr.0000109126.50398.5a

Valente, S. M., & Trainor, D. (1998). Rational Suicide Among Patients Who Are Terminally Ill. *AORN Journal*, *68*(2), 252–264. https://doi.org/10.1016/s0001-2092(06)62518-0

van der Arend, A. J., & Remmers-van Den Hurk, C. H. (1999). Moral Problems Among Dutch Nurses: a survey. *Nursing Ethics*, *6*(6), 468–482. https://doi.org/10.1177/096973309900600603

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (Eds.). (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society.* The Guilford Press.

Van Deurzen-Smith E. (1990). Existential therapy. In Dryden W. (Ed.), *Individual*

therapy: A handbook (pp. 149–74). Milton Keynes, England: Open University Press.

van Manen, M. (1990) *Researching lived experience: Human science for an action sensitive pedagogy*. State University of New York Press.

Varcoe, C., Pauly, B., Storch, J., Newton, L., & Makaroff, K. (2012). Nurses' perceptions of and responses to morally distressing situations. *Nursing Ethics*, *19*(4), 488–500. https://doi.org/10.1177/0969733011436025

Vegni, E., Zannini, L., Visioli, S., & Moja, E. (2001). Giving bad news: a GPs' narrative perspective. *Supportive Care in Cancer*, *9*(5), 390–396. https://doi.org/10.1007/s005200100236

Vindrola-Padros, C., Andrews, L., Dowrick, A., Djellouli, N., Fillmore, H., Bautista Gonzalez, E., Javadi, D., Lewis-Jackson, S., Manby, L., Mitchinson, L., Mulcahy Symmons, S., Martin, S., Regenold, N., Robinson, H., Sumray, K., Singleton, G., Syversen, A., Vanderslott, S., & Johnson, G. (2020). Perceptions and experiences of healthcare workers during the COVID-19 pandemic in the UK. *BMJ Open*, *10*(11), e040503. https://doi.org/10.1136/bmjopen-2020-040503

Vindrola-Padros, C., Chisnall, G., Cooper, S., Dowrick, A., Djellouli, N., Symmons, S. M., Martin, S., Singleton, G., Vanderslott, S., Vera, N., & Johnson, G. A. (2020). Carrying Out Rapid Qualitative Research During a Pandemic: Emerging Lessons From COVID-19. *Qualitative Health Research*, *30*(14), 2192–2204. https://doi.org/10.1177/1049732320951526

von Essen, L., & Sjödén, P. O. (1991). The importance of nurse caring behaviors as perceived by Swedish hospital patients and nursing staff. *International Journal of Nursing Studies*, *28*(3), 267–281. https://doi.org/10.1016/0020-7489(91)90020-4

von Essen, L., & Sjödén, P. O. (1993). Perceived Importance of Caring Behaviors to Swedish Psychiatric Inpatients and Staff, with Comparisons to Somatically-Ill Samples.

Research in Nursing & Health, *16*(4), 293–303. https://doi.org/10.1002/nur.4770160408

Walsh, Y., & Frankland, A. (2009). The next 10 years: Some reflections on earlier predictions for counselling psychology. *Counselling Psychology Review, 24*(1), 38–43.

Weathers, F. W., & Keane, T. M. (2007). The criterion a problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, *20*(2), 107–121. https://doi.org/10.1002/jts.20210

West, M. (2020). What does the 2019 NHS Staff Survey truly tell us about how staff needs are being met? *The King's Fund*. https://www.kingsfund.org.uk/blog/2020/02/2019-nhs-staff-survey-are-staff-needs-being-met

Wilkes, L., White, K., & Tolley, N. (1993). Euthanasia: a comparison of the lived experience of Chinese and Australian palliative care nurses. *Journal of Advanced Nursing*, *18*(1), 95–102. https://doi.org/10.1046/j.1365-2648.1993.18010095.x

Williams, R. D., Brundage, J. A., & Williams, E. B. (2020). Moral Injury in Times of COVID-19. *Journal of Health Service Psychology*, *46*(2), 65–69. https://doi.org/10.1007/s42843-020-00011-4

Willig, C. (2007). Reflections on the Use of a Phenomenological Method. *Qualitative Research in Psychology*, *4*(3), 209–225. https://doi.org/10.1080/14780880701473425

Willig, C. (2008). *Introducing Qualitative Research in Psychology* (2nd ed.). Open University Press.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 1. Foundations, planning, measures, and psychometrics* (pp. 5–21). American Psychological Association. https://doi.org/10.1037/13619-002

Willig, C. (2013). *Introducing Qualitative Research in Psychology Third Edition*. Open University Press.

Willig, C., & Rogers, S. W. (2017). *The SAGE Handbook of Qualitative Research in Psychology* (Second ed.). SAGE Publications Ltd.

Willis, M. H. E. (2015). *Moral decisions, moral distress, and the psychological health of nurses*. Thesis. https://www.researchgate.net/publication/272795333_Moral_decisions_moral_distress_and_the_psychological_health_of_nurses

Wilkinson, D. (2004) *Focus Group Research. Qualitative Research Theory, Method and Practice.* SAGE Publications.

Wolf, Z. R., & Hughes, R. G. (2008). Error Reporting and Disclosure. In R. G. Hughes (Ed.), *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Agency for Healthcare Research and Quality.

Woolfe, R., & Dryden, W. (Eds.). (1996). *Handbook of counselling psychology*. Sage Publications, Inc.

World Health Organization (WHO). (2020a). *Coronavirus disease 2019 (COVID-19) Situation Report – 38* https://apps.who.int/iris/bitstream/handle/10665/331226/nCoVsitrep27Feb2020-eng.pdf?sequence=1&isAllowed=y

World Health Organization (WHO). (2020b). *Systematic approach to monitoring and analysing public health and social measures (PHSM) in the context of the COVID-19 pandemic: underlying methodology and application of the PHSM database and PHSM Severity Index*. https://apps.who.int/iris/bitstream/handle/10665/337686/WHO-EURO-2020-1610-41361-56329-eng.pdf?sequence=2&isAllowed=y

World Health Organization (WHO). (2022a). *Naming the coronavirus disease (COVID-19) and the virus that causes it*. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it

World Health Organizations (WHO). (2022b). *WHO Health Emergency Dashboard*. https://covid19.who.int/region/euro/country/gb

Wu, P., Fang, Y., Guan, Z., Fan, B., Kong, J., Yao, Z., Liu, X., Fuller, C. J., Susser, E., Lu, J., & Hoven, C. W. (2009). The Psychological Impact of the SARS Epidemic on Hospital Employees in China: Exposure, Risk Perception, and Altruistic Acceptance of Risk. *Canadian Journal of Psy-chiatry. Revue Canadienne de Psychiatrie*, *54*(5), 302–311. doi: 10.1177/070674370905400504

Xiang, Y. T., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. H. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *The Lancet Psychiatry*, *7*(3), 228–229. https://doi.org/10.1016/s2215-0366(20)30046-8

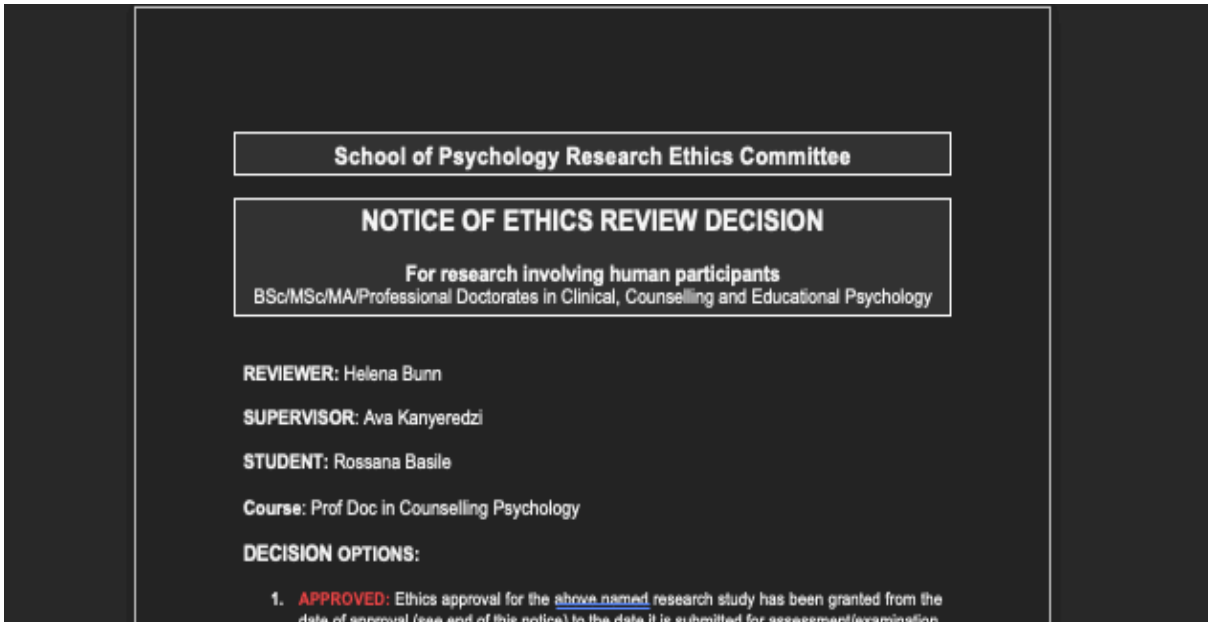
Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Yardley, A. (2008). Living Stories: The Role of the Researcher in the Narration of Life. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *9*(3). https://doi.org/10.17169/fqs-9.3.990

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

APPENDICES

APPENDIX 1 – Ethical Approval



School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Helena Bunn

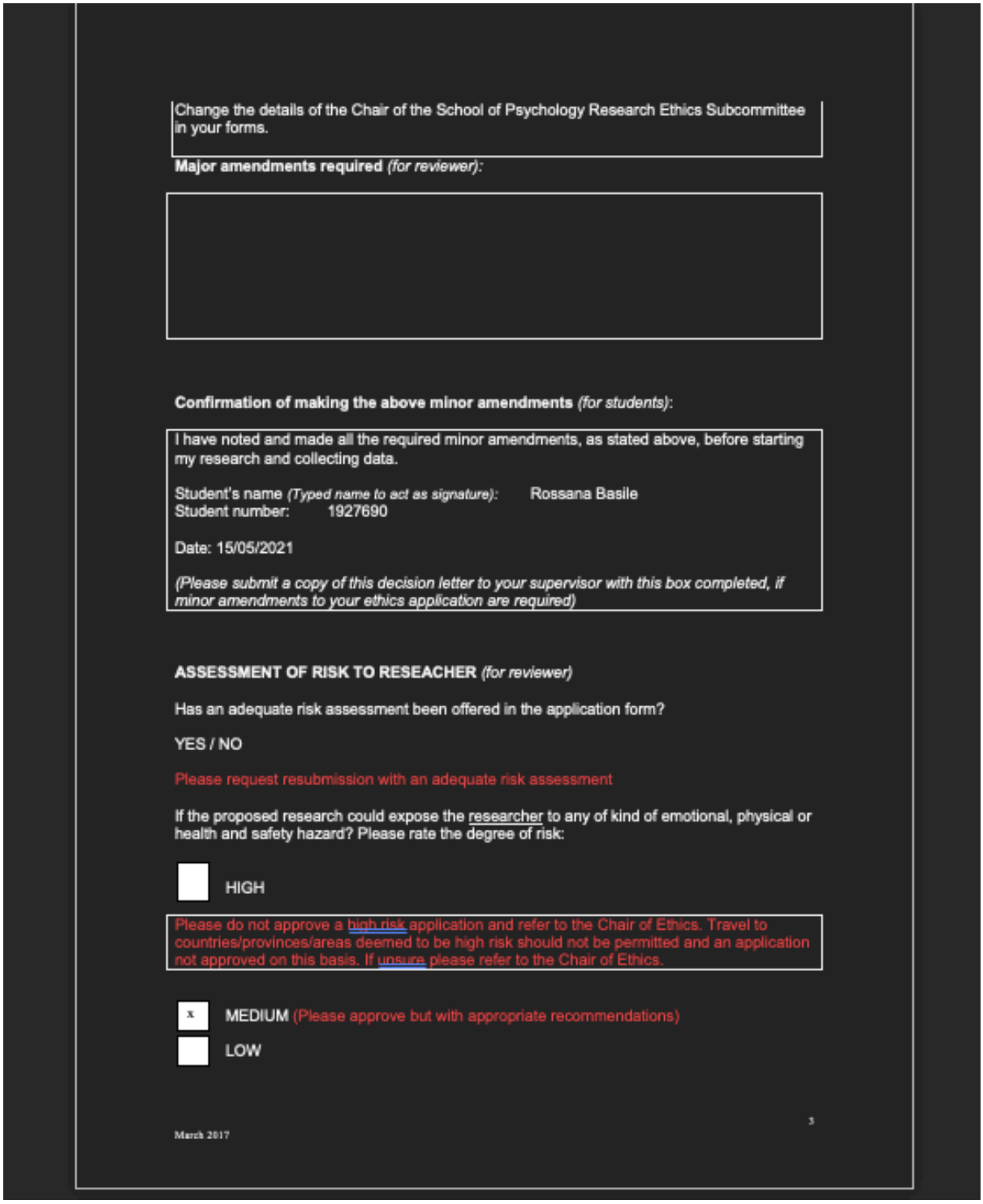
SUPERVISOR: Ava Kanyeredzi

STUDENT: Rossana Basile

Course: Prof Doc in Counselling Psychology

DECISION OPTIONS:

1. APPROVED: Ethics approval for the above named research study has been granted from the



Change the details of the Chair of the School of Psychology Research Ethics Subcommittee in your forms.

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature)*: Rossana Basile
Student number: 1927690

Date: 15/05/2021

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH

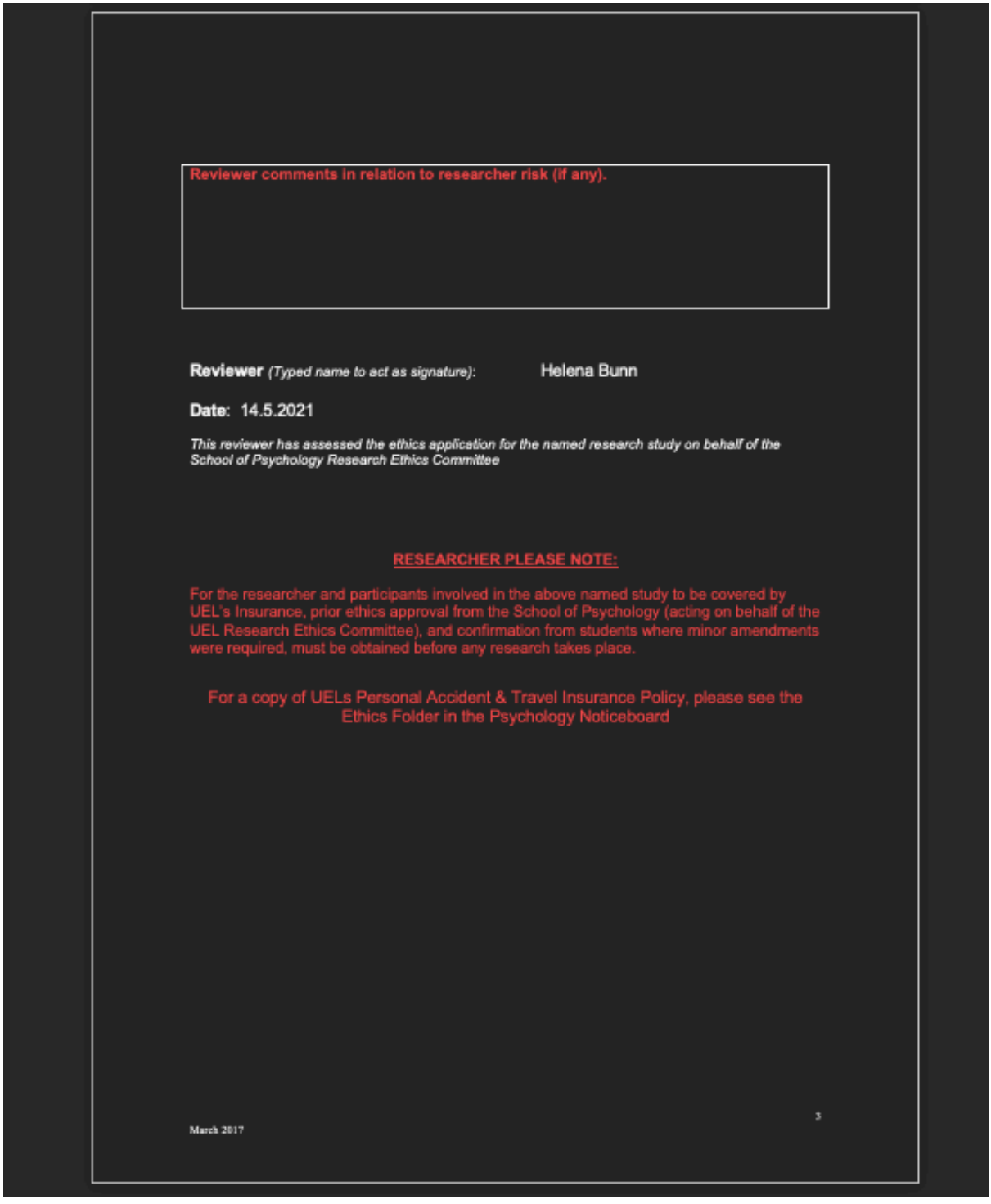
Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☒ MEDIUM (Please approve but with appropriate recommendations)

☐ LOW

March 2017

3



Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature):* Helena Bunn

Date: 14.5.2021

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

RESEARCHER PLEASE NOTE:

For the researcher and participants involved in the above named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UELs Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

3

March 2017

ETHICS REVIEW DECISION

MINOR AMENDMENTS:

The backup recording captured with an encrypted recording device will be only audio, in .mp4 format.

The interview will also be recorded with an encrypted recording device as a backup in the event that the audio recording, collected through Microsoft Teams, appears faulty and unsuccessful.

Different steps will be considered, among these will be the option of calling, with the participants' permission, the emergency contact collected during the recruitment phase. This emergency contact will be a family member or a close friend.

Chair of the School of Psychology Research Ethics Subcommittee: Dr Trishna Patel, Stratford Campus, School of Psychology, The University of East London, Stratford Campus, London, E15 4LZ (t.patel@uel.ac.uk)

Dear Rossana

Thank you for the documents. Please keep both for your thesis appendices.

You are now free to begin your data collection, well done here!

[redacted]

Please let me know.

With best wishes
Ava

Dr Ava Kanyeredzi
Senior Lecturer
Course Leader BSc Clinical and Community Psychology
School of Psychology, Water Lane, Stratford, E15 4LZ
020 8223 4461
https://www.uel.ac.uk/Staff/k/ava-kanyeredzi

Current Project: http://www.bcdaf.org.uk

University of East London
Pioneering Futures Since 1898

APPENDIX 2 – Participant Invitation Letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a Doctorate in Counselling Psychology. As part of my studies, I am conducting the research you are being invited to participate in *"The experience of ICU nurses working on the frontline during COVID-19 pandemic"*.

What is the research?

This study is being conducted to increase knowledge concerning COVID-19 pandemic. It will be exploring the experience of ICU nurses working on the frontline during this unprecedented global emergency.

My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as you meet the criteria required for the exploration of my research topic. I am looking to involve ICU nurses who have been working on the frontline in COVID-19 wards during the timeframe from March 2020 to July 2020. The research will include adult from England, all aged over 18, with no specific gender and ethnicity requirements.

Before you decide whether to participate, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way, and you will be treated with respect.

Your participation is strictly voluntary, you are quite to decide whether or not to participate and should not feel coerced.

What will your participation involve?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given a digital information sheet to keep and be asked to sign a consent form, which will gather your demographic information as well as an emergency contact in case any risk arise during or after the interview phase. Due to the sensitivity of the topic, questions may bring up emotionally charged experiences of your work, however, you will be free to pause the interview, or discontinue it if you feel this is necessary.

You will only be required to take part in a single interview, which will be last between 60 to 90 minutes approximately. The interview will be recorded and will take place remotely via Microsoft Teams in a safe and confidential space, for instance at home. You will be asked to have your camera on. The day/time will be scheduled accordingly with your commitments.

There will be asked around five separate questions such as “how the COVID-19 pandemic has impacted your work as ICU nurse?”. It will take approximately an hour to respond to all questions. The interview will unfold as an informal chat, with freedom in not responding to a particular question if you do not feel so.

Your support will allow me to complete my doctorate in Counselling Psychology as well as bring further understanding about this unprecedented time by giving significance to a particular population group.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential

For all of these purposes, there is a responsibility to maintain confidentiality and anonymity of material. Your privacy and safety will be respected at all times. All data used for this project will be kept confidential.

To ensure confidentiality, the researcher will be the only person accessing the recording. The transcripts will be anonymised, and all identifiable information will be altered or removed from the transcripts.

The interview will be recorded through Microsoft Teams, although will be also captured with an encrypted recording device as a backup, in case Microsoft Teams recording is unsuccessful. Within 12 hours from the recording being made, the recording will be transferred on the encrypted UEL OneDrive for Business and deleted from the Microsoft Teams system. The backup audio recording will be transferred on an encrypted UEL H: Drive and deleted from the recording device.

Once the recorded interviews are transcribed, they will be deleted from the university server, while the transcripts will be stored securely, and password protected. A unique identifier will be assigned to each transcript to preserve anonymity.

Consent forms and participants' details will be stored securely and password-protected on the encrypted UEL OneDrive for Business and backed up on an encrypted UEL H: Drive.

Anonymised and pseudonymised data will be stored separately (on a separate password-protected folder) from identifiable data such as consent forms or recordings.

All emails and communications with participants will be deleted after the interview.

Only anonymised data will be shared. The researcher and Supervisory Team will have access to the encrypted UEL OneDrive for Business, once data have been anonymised and pseudonymised. I will assign permission to my Supervisory Team to access the anonymised data.

Anonymised data will be shared with password-protection with examiners upon prior request.

Because the research topic can be sensitive and might bring up tough feelings, you will be asked three screening questions to determine whether is best for you to not participate. If any distress is experienced during the interview, you will be free to pause the interview and taking breaks or discontinue it if you feel this is necessary. An emergency contact will be provided and in case of emotional distress, the appointed person will be called prior to permission.

A debriefing space will be provided after the interview as well as a debriefing letter will be sent, which will include information and contact details of the suggested source of support.

What will happen to the information that you provide?

Within 12 hours from the recording being made, the recording will be transferred on the encrypted UEL OneDrive for Business and deleted from the Microsoft Teams system. The backup audio recording will be transferred on an encrypted UEL H: Drive and deleted from the recording device.

Once the recorded interviews are transcribed, they will be deleted from the university server, while the transcripts will be stored securely and password-protected on the encrypted UEL OneDrive for Business.

The audio e video file of the interviews will be deleted immediately, once data will be transcribed and anonymised. As suggested by the UEL Research Data Management Policy (2019), data will be deposited on the UEL's data repository, appraised at the end of the project and retained for five years for possible future publication. Afterwards, anonymised data will be transferred from the UEL drive to a personal hard drive. Everything will be then deleted under secure conditions from the UEL OneDrive for Business.

All documents will be sent via email with password protection. All emails and communications with participants will be deleted after the interview.

The researcher and Supervisory Team will have access to the encrypted UEL OneDrive for Business, once data have been anonymised and pseudonymised. I will assign permission to my Supervisory Team to access the anonymised data. Anonymised data will be shared with password-protection with examiners upon prior request.

You will agree and sign a consent that only anonymised data will be shared.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage or consequence. Separately, you may also request to withdraw your data even after you have participated. This request can be made within **three weeks** of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Rossana Basile email: u1927690@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact the research supervisor Dr Ava Kanyeredzi. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: a.kanyeredzi@uel.ac.uk

APPENDIX 3 – Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

'The experience of ICU nurses working on the frontline during the COVID-19 pandemic'

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study 3

weeks after the date of the interview without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's details:

Email:

Emergency contact:

The above details will be stored securely and password-protected and deleted under secure condition at the end of the project.

Model Consent Form

Interview Number:

I confirm that I have read the information sheet dated _____ for the above study and that I have been given a copy to keep. ☐

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation in the study is voluntary and that I may withdraw ☐

within three weeks of the data being collected, without providing a reason for doing so.

I understand that if I withdraw from the study, my data will not be used. ☐

I understand that I have 3 weeks from the date of the interview to withdraw my data from the study. ☐

I understand that the interview will be recorded using Microsoft Teams. ☐

I understand that my interview data will be transcribed from the recording and anonymised to protect my identity. ☐

I understand that my personal information and data, including audio recordings from the research will be securely stored and remain strictly confidential. Only the research team will have access to this information, to which I give my permission. ☐

It has been explained to me what will happen to the data once the research has been completed. ☐

I understand that short, anonymised quotes from my interview may be used in the thesis and that these will not personally identify me. ☐

I understand that the thesis will be publicly accessible in the University of East London's Institutional Repository. ☐

I understand that short, anonymised quotes from my interview may be used in material such as conference presentations, reports, articles in professional and academic journals resulting from the study and that these will not personally identify me. ☐

I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to. ☐

I agree to take part in the above study. ☐

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

ROSSANA BASILE

Researcher's Signature

……

Date: ……..…….

APPENDIX 4 – Screening and Distress Protocol

This is Ms Rossana Basile from the University of East London. Thank you for the interest in our study. Do you have any questions about the study? [if yes, answer the questions. If no, proceed.]
Could you please verify your name, email address and phone number?
Because the research topic can be sensitive and might bring up tough feelings, I am advising individuals who are experiencing a high level of stress, or emotional distress not participate at this time. It is all right if I ask you some questions to determine if there is any reason you should not participate? [If no, thank for time and interest. If yes, conduct screening interview.]

Screening Questions	**NO**	**YES**	**Follow up Questions** **If YES, ask questions**	**Participant's responses**	**Acute Emotional Distress or Safety Concern? (Y or N)**	**Imminent Danger? (Y or N)**
1. Are you experiencing a high level of stress or any emotional distress?			1. Tell me what you are experiencing 2. Is it getting in the way of you doing things you need to do (schools, work, family obligations)? 3. Is it getting in the way of you taking care of yourself? 4. Have you been in the hospital recently for this problem?			
2. Are you currently having thoughts of harming yourself?			1. Tell me what thoughts you are having 2. Do you intend to harm yourself? 3. How do you intend to harm yourself? 4. When do you intend to harm yourself? 5. Do you have the means to harm yourself?			
3. Are you currently having thoughts of harming someone else?			1. Tell me what thoughts you are having. 2. Do you intend to harm someone else? Who? 3. How do you intend to harm him/her/them? 4. When do you intend to harm him/her/them?			

			5. Do you have the means to harm him/her/them?			

Actions for screener:

1. If answer to screening questions are all NO, read the confidentially statement below and schedule an interview.

CONFIDENTIALITY STATEMENT
All the answers that you give will be kept private. This is so because this study has been given a Certificate of Confidentiality. This means anything you will tell us will not have to be given out to anyone, even if a court orders us to do so, unless you say it's okay. But under law, we must report if you tell us you are planning to cause serious harm to yourself of others.

*2. If a participant's responses reflect **acute distress or safety concerns but NOT imminent danger**, take the following actions:*

a. Do not schedule an interview
b. Recommend that the participant contact his/her General Practitioner or Mental Healthcare Provider
c. Indicate that, with the participant's permission, the researcher will call the emergency contact indicated

*3. If a participant's responses to additional screening questions reflect **imminent danger**:*
a. Indicate that, with the participant's permission, the researcher will call the emergency contact indicated
b. Provide the participant with local source of support number such as, Samaritans, Shout 85258, Crisis Team or Mind and encourage the participant to call either if he/she experiences increased distress in the hours/days following the interview

RESEARCH INTERVIEW AND DISTRESS PROTOCOL

The following protocol outlines the actions of the researcher if, during the course of the interview, a participant exhibits acute distress or safety concerns, or imminent danger to self or others.

Indications of Distress During Interview	**Follow up-questions**	**Participant Behaviours /Responses**	**Acute Emotional Distress/Safety Concern? (Y or N)**	**Imminent Danger (Y or N)**
Indicate they are experiencing a high level of stress or emotional distress, OR exhibit behaviours suggestive that the interview is too stressful such as uncontrolled crying, incoherent speech,	1. Stop the interview 2. Offer support and allow the participant time to regroup 3. Assess mental status: a. Tell me what thoughts you are having. b. Tell me what you are feeling right now. c. Do you feel are you able to go on about your day?			

indications of flashbacks, etc.	d. Do you feel safe? (If NO, ask question below) 4. Determine if the person is experiencing **acute emotional distress beyond what would be normally expected in a interview about a sensitive topic.**			
Indicate they are thinking of hurting themselves	1. Stop the interview. 2. Express concern and conduct a safety assessment: a. Tell me what thoughts you are having. b. Do you intend to harm yourself? c. How do you intend to harm yourself? d. When do you intend to harm yourself? e. Do you have the means to harm yourself? 3. Determine if the person is an **imminent danger to self**.			
Indicate if they are thinking of hurting others	1. Stop the interview. 2. Express concerns and conduct a safety assessment a. Tell me what thoughts you are having b. Do you intend to harm someone else? Who? c. How do you intend to harm him/her/them? d. When do you intend to harm him/her/them? e. Do you have the means to harm him/her/them? 3. Determine if the person is an **imminent danger to others.**			

Actions for the researcher:

1.If a participant's distress reflects an emotional response reflective of what would be expected in an interview about a sensitive topic, offer support and extend the opportunity to: (a) stop the interview, (b) regroup, (c) continue.

2. If a participant's distress reflects ***acute emotional distress or a safety concern beyond what would be expected in an interview about a sensitive topic, but NOT imminent danger****, take the following actions:*
a. Encourage the participant to contact his/her General Practitioner or Mental HealthCare Provider
b. Indicate that, with the participant's permission, the researcher will call the emergency contact indicated
c. Provide the participant with local source of support number such as, Samaritans, Shout 85258, Crisis Team or Mind and encourage the participant to call either if he/she experiences increased distress in the hours/days following the interview

3. If a participant distress reflects ***imminent danger****, take the following actions:*
a. Indicate that, with the participant's permission, the researcher will call the emergency contact indicated or 111
b. Provide the participant with local source of support number such as, Samaritans, Shout 85258, Crisis Team or Mind and encourage the participant to call either if he/she experiences increased distress in the hours/days following the interview

Adapted from Draucker et al., 2009

APPENDIX 5 – Interview Schedule

INTERVIEW SCHEDULE

Thank you for agreeing to be interviewed about your experience of working as ICU nurses in COVID-19 units.

Please answer as openly as you can, but do not feel obliged to answer any question you would rather not.

1. How the COVID-19 pandemic has impacted your work as ICU nurses?
    - What is required within your job?
    - What was your usual routine before COVID-19?
    - What this means to you?
2. What were the effects of working during the COVID-19 pandemic on your mental and physical health?
3. What supported or helped you cope?
    - How did you manage to work out or meet people with the restriction?
    - Has your relationship with family and friends been affected?
4. What has been the main challenge for you?
    - What has been for you witnessing this amount of loss?
    - What has been for you losing a colleague? Has this affected your work?
    - Do you think this event has changed the way you think about yourself or others?
5. What has been the support provided?
    - How much did you find it helpful?
    - Have you approached anyone for help?
    - What you would have found useful?

Is there anything else that you feel I should have asked, or that you would like to add concerning your experiences of working during the COVID-19 pandemic?

Thank you very much for your time and effort. It is very much appreciated.

APPENDIX 6 - Debriefing Letter

PARTICIPANT DEBRIEFING LETTER

Thank you for participating in my research study on "*The experience of ICU nurses working on the front line during COVID-19 pandemic".* The purpose of this research study is to explore the meaning and experience of ICU nurses working on the frontline within the context of COVID-19 pandemic.
This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided.

The interview will be recorded through Microsoft Teams, although will be also captured with an encrypted recording device as a backup, in case Microsoft Teams recording is unsuccessful. Within 12 hours from the recording being made, the recording will be transferred on the encrypted UEL OneDrive for Business and deleted from the Microsoft Teams system. The backup audio recording will be transferred on an encrypted UEL H: Drive and deleted from the recording device. Once the recorded interviews are transcribed, they will be deleted from the university server, while the transcripts will be stored securely and password-protected on the encrypted UEL OneDrive for Business. The password-protected Word documents of the transcripts will be saved on a separate password-protected folder on the encrypted UEL H: Drive.

All data will be backed up regularly on the encrypted UEL OneDrive for Business and on an encrypted UEL H: Drive.

Consent forms and participants' details will be stored securely and password-protected on the encrypted UEL OneDrive for Business and backed up on an encrypted UEL H: Drive.

Anonymised and pseudonymised data will be stored separately (on a separate password-protected folder) from identifiable data such as consent forms or recordings. A unique identifier will be assigned to each transcript to preserve anonymity.

All emails and communications with participants will be deleted after the interview.

The researcher and Supervisory Team will have access to the encrypted UEL OneDrive for Business, once data have been anonymised and pseudonymised. I will assign permission to my Supervisory Team to access the anonymised data. Anonymised data will be shared with password-protection with examiners upon prior request.

In line with UEL Research Data Management Policy (2019), data will be deposited on UEL's data repository and retained for five years for possible future publication such as academic journal. Afterwards, anonymised data will be deleted under secure conditions from the UEL OneDrive for Business.

You are free to withdraw from the research study at any time and at any cost during the research process and three weeks after the data collection. There is no possibility to withdraw once data analysis has begun, which will be three weeks after data collection.

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

- Shout 85258 is a free, confidential, 24/7 text-messaging support service for anyone who is struggling to cope. To start a conversation, text the word 'SHOUT' to 85258. https://giveusashout.org

- Samaritans offers 24-hours support, tailored also to frontline workers, contact number 116123 or email jo@samaritans.org. The website includes also additional psychoeducational resources https://www.mentalhealthatwork.org.uk/ourfrontline/

- Mind is a charity that provides additional psychoeducational information and psychological tools as well as a helpline and talking therapies. It might also be likely that the interview creates a space for self-introspection and reflection on starting a therapeutic journey.
  Email: info@mind.org.uk
  Infoline:0300 123 3393 website: https://www.mind.org.uk
  Text: 86463
  Post: Mind Infoline, PO Box 75225, London, E15 9FS

- NHS 111 or Crisis Team provide support to people in crisis. The Crisis Team's contact number differs depending on the living area.

- Psicologo4u provides online psychotherapy with Italian psychologists in the event the interview might create a space for reflection on starting therapy. https://psicologo4u.com

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Rossana Basile email: u1927690@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact the research supervisor Dr Ava Kanyeredzi. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: a.kanyeredzi@uel.ac.uk

APPENDIX 7 - Data Quality according to the Guidelines of Yardley (2000) and Elliot et al. (1999)

Guidelines (Yardley, 2000)	Evidence in Present Study
Sensitivity to context	This study has conducted a systemic review of the relevant literature as starting point to identify the grey area and gaps in knowledge, which informed the subsequent research question. As recommended by Yardley (2000) central to qualitative study is the socio-cultural and political context of the study. In light of the uniqueness and unprecedented event of the COVID-19 pandemic and its aftermath, the Literature Review chapter fully examines the environment in which participants have been immersed. The ontological and epistemological positions discussed in the Methodology chapter of this document have provided the reader transparency around my feelings, beliefs, and opinions. These are specifically relevant to the socio-political context of the COVID-19 pandemic and how it may have impacted the relationship between researcher-participants and shared understanding of participants' utterances. In this respect, the continuous self-reflexivity process illustrated at various stages of this document in Italics encapsulates my subjectivity and my own "lifeworld" (Husserl, 1970). As part of the sensitivity to context to demonstrate the validity of this research (Yardley, 2000), I have been mindful of the power imbalance that could interplay within the relations with participants (Anyan, 2013). Therefore, reminders of their right to stop the interviews at any time and suggesting breaks due to the sensitivity of the topic have helped participants feel comfortable in sharing their stories and contributed to an equalisation of power dynamics.
Commitment and rigour	In an effort to ensure a rigorous and committed approach to the data collection and analysis, I have constantly referred to the

	research questions and attempted to be consistent within the different elements of the research process, namely epistemology, theory, methodology and methods. Rigour has been maintained while conducting research in line with disciplinary norms and standards. For instance, the University Research Ethics Committee were rigorous in its oversight and approved the ethical considerations submitted for this study as previously outlined. The size of the sample, and the decision of focusing on Italian ICU nurses, as inclusion criteria, have provided rich materials for comprehensive analysis as they have enabled the identification of both individual and group similarities and differences. Appendix 9 – The Illustrative Representations of GETs show the reader pattern of convergence and divergence across participants. The consistent consultations with the supervisory team have provided further revisions of the analytical process, specifically around PETs: their meanings, intercorrelations and theoretical references. Rigour has been also evidenced by the process of bracketing fostered by discussions with supervisors and colleagues as well as my reflexive diary. I hope that these efforts emerged clearly in the Analysis chapter, where excerpts of the participants' voices are provided alongside my interpretation of the data.
Transparency and coherence	Yardley (2008) referred to coherence and transparency in how the stages of the research process, for instance, data collection method, analysis, interpretation of data and findings, are presented to the reader. This research stemmed from underlying theoretical assumptions, illustrated in the Literature Review. I endeavoured to be clear in the rationale for selecting IPA methodology, thereby remaining consistent with its principles and presenting this study's limitations. Furthermore, I provided a coherent narrative, in each stage of the process and

	the steps involved. I hope that each stage of this research can be grasped by the reader with clarity so as to allow reasonable judgment of the quality and validity.
Impact and importance	According to Yardley (2000, 2008), the validity of research lies in its capacity to make an impact by providing useful material that may contribute to a change. Due to the novelty of the ongoing pandemic, research around its aftermath is still at an early stage, although they have predicted long-lasting effects for up to 5 years (Kissler et al., 2020). As a result, I believe that the accounts of the participants will contribute significant knowledge to the practice of Counselling Psychologists and mental health practitioners in general, while also advocating for organisational change - clinical implications and future recommendations are outlined in the Discussion chapter.

Guidelines (Elliot, Fisher and Rennie, 1999)	Evidence in Present Study
Owning one's perspective	Since the beginning of this document, the researcher has provided both personal and epistemological positions to highlight values, biases, and perspectives that might affect the understanding of participants' accounts in line with the double-hermeneutics commitment. Additionally, reflective sections, penned in Italics throughout the document, further attempt to offer to the reader, the researcher's process of bracketing carried out to maintain the fidelity of the data. Furthermore, the theoretical framework and methodology have consistently been presented.
Situating the sample	Demographic information about the sample has been provided (Table 1): their gender, age, ethnicity, and level of working experience.
Grounding in examples	Examples have been presented in the Analysis chapter to show the suitability of analytical procedure and understanding of data.

Providing credibility checks	The supervisory team has supported the reliability checks throughout the analysis process and by reading the initial draft of this document. This provided further guarantee that the researcher was grounding PETs on the texts instead of being deceived by personal assumptions and biases (Smith et al., 2009).
Coherence	The researcher has reached an integration of meanings that led to identifying GETs. However, data have been presented within a coherent narrative while preserving similarities and differences.
Accomplishing general vs. specific research tasks	As per the idiographic underpinning of IPA, this research project aims to gather a deeper understanding of a small number of participants (Pietkiewicz & Smith, 2014) rather than extending the findings to other contexts and sample groups (Elliot et al., 1999). The Discussion chapter highlights the pertinence of the result to the group studied, refraining from generalising to other samples. The specific research tasks reflected the research questions outlined in the literature review. These were also the focus of the interview schedule and areas of interest concluded in the Discussion chapter.
Resonating with readers	The researcher strived to accurately encapsulate participants' utterances around the experience of working on the frontline during the COVID-19 pandemic in the hope that the reader may expand the understanding of their experience and capture their emotive veil.

APPENDIX 8 - Illustrative Quotes for Themes

Group Experiential Theme

Group Experiential Themes (GETs)	Personal Experiential Themes (PETs)	Evidence from Transcripts	Participants
	Hypervigilance	it was this doom sensation of trying to do everything right in terms of like, you know, protection, prevention of cross infection and things, that is felt like oh no, you touched your nose or like, you did not wash your hands 15 times yeah, this idea, that the danger is everywhere basically (pp. 34-35, lines 382-386)	Giovanni
		you have such an amount of energy to use in this 12 hours and I felt I was running short in there because I was not prepared to be like focused 12 hours nonstop compared to the work that I was doing before, in which there was more like time for high intensity and then like slow down and then again high intensity, instead in there I felt like it was always, always like top, top, top, concentration, stress and everything (pp. 36-37, lines 347-353)	Giovanni
		sometimes it was difficult to sleep because a bit of anxiety of thinking oh I am going back there tomorrow again (p. 24, lines 271 - 273)	Giorgia
		when COVID hit our unit, COVID was 24 hour, I will wake up in the morning, listen to the news and they were talking about COVID, I will go to the station to go to work and they were talking about COVID in the station, about people wearing the mask, I will go to work and it was COVID at work, it was 24 hours COVID (pp. 8-9, lines 95 – 100)	Marilena
		basically you finish a shift, it is 12 hours, you need to take a shower before going home, worst case scenario you got home by half past 10 at night, your next shift starts at 8:00 o'clock in the morning, and I have got an hour of travel to go to work, so for me was also overwhelming to go home, it was so late and I was already thinking I need to go home and back to work tomorrow, I will not have time to sleep, the more I was thinking about it, the more I could not sleep (p. 25, lines 285 – 292)	Marilena
		it was again a kind of a way out, as in when you manage to have a break, you did not want to spend your break in that building, it was not a break, because even in the staff room where you have a break, you could still hear the monitor alarming, you can still hear the emergency alarm going off, when the emergency alarm goes off, it means that there is someone that really needs a hand in a bay or in a side room COVID, and it really needs a hand from outside and you know that the other nurses cannot go to help because they are really busy with their patients, and it probably would end up being you on break running from the emergency buzzer to give them a hand (pp. 30-31, lines 348 – 359)	Marilena
		I always worked at least 45 minutes to an hour and half, extra on top of my paid shift just to catch up on things and to prevent my colleagues from having to go through the things that were not done during the day so you have this pressure and psychological stress during the shift, you have it towards the end	Luca
SURREAL		where you want to make sure that everything is done but at the same time you are so tired that you really want to go home (p. 22, lines 251-257)	
		the nights during the first wave they were really bad like we could not have any breaks or just 30 minutes of break, that is nothing, not even the time to go to the loo and drink water or whatever, and you come back home, sleeping, really tired and go back for the night (pp. 51-52, lines 516 – 520)	Alessandra
		you need to have all your eyes open and be alert about whatever is happening around you (p. 43, lines 418 – 419	Alessandra
	Fear of contamination	having to consider what you are wearing, try to minimize as much as possible your personal equipment, we used to have like pens, you could have like stethoscopes and this sort of things, even your underwear, we start considering whether we should have kept the underwear on or not, because obviously you are not sure if you are contaminating your own underwear when you remove your scrubs (pp. 9-10, lines 103-109)	Luca
		it was not unusual for nurses to be, not assaulted, but treated differently by their neighbours, because obviously they were like "oh you are, you could spread the virus so we do not want you in our house, we do not want you in the flat, I heard stories of landlords asking health care professionals to leave the place where they were renting because they were threatening, not threatening sorry but they were putting in danger others housemates (p. 40, lines 464 – 470)	Luca
		the most challenging thing was reaching my family and being afraid that I was actually… it was me bringing the virus to them uhm, I mean, I think that this is going to go on, like, even if or even though they had the vaccine, I will still be very cautious, very cautious and worried every time I was approaching them (p. 61, lines 711– 715)	Luca
		we were scared, I remember we were really scared because uhm we did not really know the virus itself, we did not really know, ok am I going to get in and am I going to be fine afterwards?! so it was bad (p. 17 – lines 185– 188)	Rebecca
		I remember that at the beginning England was not doing enough, the government was not doing enough here, so my family was worried for me saying like, because they know, of course I am a nurse and I am more exposed to that, so they were worried and at the same time hearing them being worried made me worried as well because I was like maybe I am underestimating the situation (p. 29, lines 323 - 329)	Rebecca
		I went to Italy, and I felt a little bit like how to say, I was like a zombie, spreading the disease, there was something weird (p. 16, lines 178 – 180)	Giovanni
		when the social life is zero at least having your family near is definitely a good thing to have and no because they were quite scared, like uh you know if I was working in such a setting I would be scared	Giovanni

		that myself because my parents are bit older so, they were on the dangerous range of age (p. 25, lines 278-282)	
		I mean following the rules by the letter, it was insane, it was insane, seriously, you could not do anything, you literally had to stand like that, not touching anything anywhere, yeah it was something very, very peculiar to be fair (p. 12, lines 128-131)	Giovanni
		it was difficult to ask them to stay home without making them too much worried about me, because I am their little girl at the end of the day, for them I am not a senior nurse in intensive care (p. 28, lines 331- 334)	Marilena
		I am happy they are there because they are safe there, because you know in London because it is a big city, UK is a big country, you know there are more risks that this virus can spread (pp. 24-25, lines 275-278)	Alessandra
	Living a catastrophe, live in front of your eyes	it was kind of living a catastrophe, live in front of your eyes every day (pp. 10-11, lines 115-116)	Giovanni
		during the first pandemic, it was very hard because they were not expecting it, they were not prepared for it, so they had to improvised, adapt, find creative resources and solutions, so they did not have for example the wide set of equipment needed, like for example the PPE, the protective equipment, this impacted shifts because we could not take breaks, if not like the necessary breaks basically, that means that you ended up in a 12 and half hours shift to be and work four or five days in a row and it is a hard job, it is very hard on physical, mental and stress level and it is a technical job because like, rarely you will find people that are in a good health condition like most of them were like with serious, serious issues, even those that were there only for the COVID itself, with not much of past medical history, I could see them very, very much struggling at breathing, they had to wear this high flow masks the whole time, this to mention that it was very challenging (pp. 9-10, lines 100-115)	Giovanni
		we were really scared because we were like this looks surreal to us (p. 19, lines 214-215)	Rebecca
		we were seeing lots of people out of the blue coming to the hospital, not having a clue of what was going to happen, then through the first surge it got a bit worse and then with the second surge it was like when it was very bad, and it has been difficult thinking to go back to normal but at the same time is difficult thinking of continuing in the view of another surge, uhm it is scaring both way (p. 6, lines 61 – 67)	Giorgia
		in this moment that we are in between that we do not know if we are going towards the third surge when you go to work and you have one admission with COVID you are like ok, ok, we are there again, it is going to get worse again, we have to go through again, it might be worse again, uhm and that is scary and obviously is bringing back memories (p. 11, lines 117 – 122)	Giorgia
		the memory of how the first wave was, scares us, or scare me, I mean I do not want to speak in general, but I mean for my experience, like every time or maybe the 2nd wave is coming, the 3rd wave is coming, so the memory of the first one, that was I think the worst for me, it is like makes me think Oh my God again, Oh my God again (p. 9, lines 96- 101)	Alessandra
		we are just scared by the memory so it is like PTSD, post-traumatic syndrome (p. 20, lines 230 – 232)	Alessandra
		if I go back, I would never have chosen nurses ever again, my life is signed, in ten years' time that there is another pandemic, I got experience as an ITU nurse so I will probably be redeployed (p. 37, lines 427 – 430)	Marilena

Group Experiential Theme 2

Group Experiential Themes (GETs)	Personal Experiential Themes (PETs)	Evidence from Transcripts	Participants
	Newness	we ended up working in different rooms, we ended up working in theatre, we ended up working on recovery, just to give you an idea, if you are not familiar with the ERs, so these are places where you have part of the equipment, but not all of it, so you might have to build your own environment, so you might have a monitor that you might use in ICU, but you might have pumps borrowed from a different unit and they might not have the same shape, they might have different buttons, they might have different set ups, and every small change might compromise the care that you are giving (pp. 38-39, lines 441 – 450)	Luca
		before Covid, doing one to one meant having a holistic view of the patients going from A to Z, taking care of them completely so family, patient, mental health of the patient, and all the physiology of the patient, during COVID, obviously having one to six meant to just look superficially, uh, just what there were the priority and sometimes not being even able to cover all the priority because of the stretch on the nurse ratio, uhm and that was a challenge (p. 8, lines 83 – 90)	Giorgia
		we would be with the PPE for 12 hours straight with no breaks, and that was very tiring… so you were getting to a point sometimes that you did not care, you just wanted to get out of the PPE no matter what, so you were leaving the patients' safety behind and obviously it is not what I have been trained for (pp. 9-10, lines 100-105)	Giorgia

DOING (VERSUS BEING)		I cannot focus only on one patient, I have to think about what is it the priority in this case?! because I have three patients, what is the priority like what is the thing that is going to save my patients' life (pp.10-11, lines 114 - 117)	Rebecca
		it was a sensation that you have to feel to understand this trap thing like not seeing an exit, it was kind uhm… a choking you know like this fucked up scene what a hell am I going to do now? (p. 32, lines 352 – 355)	Giovanni
		it was warm, it was isolating, as soon as you put all the gear of the PPE on, you are isolated from the rest of the world, that is not, you feel alone, you are in the room but you cannot see properly, you cannot hear properly, the only thing you know there are many alarms and everything in your hand (p. 17, 197 – 202)	Marilena
	Support available and accessed	I think the biggest support that I received personally was given by my own colleagues, close colleagues, people that are my age and those that became my friends over the past few years, while I was working there uhm, so yeah, we were talking about holidays, we were talking about music, you might talk about plans for the after COVID (pp. 30-31, lines 351 – 356)	Luca
		I was making the most of my days off, I was trying to not think about anything, not using too much my laptop or phone, music, sunbathing in summer and going out for runs (p. 50, lines 582 – 585)	Luca
		obviously psychologist was always happy to have us on a one-to-one conversations but then again, I personally always preferred having small chats with my colleagues and friends while on the job to have like small break sessions (p. 33, lines 388 – 392)	Luca
		the main thing was like the possibility to stay a bit more at work with my colleagues just to have a laugh or just to have a bit of interaction with someone else, they knew what I was going through, because we were all going through the same (p. 19, lines 208 – 211)	Giorgia
		things were going so fast, so slow because we could not see the end but at the same times, day by day was so fast that, you did not really have time to realize that there was anxiety, there was burnout, there were other things going on so even if there was loads of support provided and you were able to ask for it, I do not think we were actually in the position or in the moment where we needed it (pp. 29-30, lines 329 – 335)	Giorgia
		there could be some help that could be offer, I do not know like meditation those kinds of things that can be useful or even like relaxing time, like massages or stuff like that would be helpful (p.39, 440 – 442)	Giorgia
		the thing that I found really helpful is talking to my colleagues because when you know that you are experiencing something that you are not alone because you are not the only one that is experiencing that, maybe they feel a different way, but they are, they are living the same situation as you are, so I	Rebecca

	Support available and accessed	found that talking to my colleagues it was really helpful and, it makes you think like I am not alone" (pp. 34-35, 391– 397)	
		some people do not ask for help and they think just I can cope with that, I can do that because I am strong, I do not need, I do not need anyone because they see like the asking help as a weakness, but it is actually not, it is actually a way to love yourself and being humble as well because you are recognizing that you have limits as everyone has (pp. 33-34, lines 376- 381)	Rebecca
		I did not want to workout or I do not know, do physical activities because I did that, I was not feeling any energy, I did not have energy and strength (pp. 27-28, lines 311 – 313)	Rebecca
		during the first wave, there was someone that was doing yoga sessions free for NHS staff, they was from South England, I do not know, and they came to work where I was working previously, to give free yoga sessions to the NHS staff that was willing to experience that, and it was really helpful, I did it for two/three months and it was really helpful, the person was lovely as well (p. 37, lines 418 – 424	Rebecca
		we really are a family and COVID got us really close, because (silence) it was us and then it was the rest of the world, the no-COVID, the no-mask, people that would not believe in COVID, people that would believe in COVID, and then it was us in the middle of it, especially us nurses (p. 21, lines 241 – 245)	Marilena
		I got a lockdown pet, and it helped a lot, my life went from this to that (movement of the hand to show a big improvement) because it is my focus now when I am off and I am at home, I got a cat to look after, so it is taking my mind off everything else (p. 34, lines 393 – 397)	Marilena
		they would give us these websites, these free apps to help you sleep or to help you meditate, as I said I did not find it really helpful, I found it like a joke, to be honest, but it is no one fault, I mean it was busy for us it was busy for the big heads in the hospital (p.41, lines 481 – 485)	Marilena
		the support I received from work, as I said, was this group of people that will allow you to chat and send a message if you needed, outside the psychologists. I did not find them really helpful, not as they were not helpful, it is probably me, I found it helpful, if I have to explain how I am and I have to explain all the background and why I feel, for me it is just a waste of time, I need to speak, I do not need to explain why I feel like that so, they were really helpful for my colleagues, it is just the way I am, I found it more helpful to talk with people that already know what we were going through, I found it really therapeutic, talking with someone that was going through the same thing (pp. 34-35, lines 398 – 409)	Marilena
		this is something that I did not like, and it made me feel a bit sour, it was a very specific emergency and stressful situation for everyone, and it was some arguing with some colleagues that I felt it was completely needless because it was stressful for everyone (p. 20, 220 – 224)	Giovanni

		basically they do this well-being session in which there is a psychologist coming at work say first thing in the morning so they come at 8:00 o'clock and then like first 45 minutes we do session of for example like experiencing techniques of relaxation, posture relaxation, yoga, little things you know like I feel this was very good for coping with stress (p. 48, lines 485 – 490)	Giovanni
		there have been quite a lot of different initiatives that have been going on during the period, there was like our well-being team being involved, trying to catch up with people on how they were feeling, they have some kind of messaging, texting service, to which you can write, I received several messages like how are you feeling today? thumbs up, thumbs down, things like that (p. 23, lines 255 – 261)	Giovanni
		sometimes we cannot really do everything by ourselves, well, I admire people that have been able to do by themselves and there are people weak as well and luckily asking help to a psychologist or expert that can help you to read and interpret the life differently or with other eyes, it has been, for me it has been helpful (pp. 46, lines 453 – 458)	Alessandra
		during the first wave at least, we could go, I mean, because I do gym so at least I could go to the park and have some, you know, fresh air but during the second we were not even allowed to go to the park and you know, run and do something just to distract yourself (p. 12, lines 133 – 137)	Alessandra
		I got my psychologist, so that is been quite helpful as well, I have been trying to find other kind of distractions as well, so like I was doing sports so I do more, I play tennis, listen music, music and Netflix (p. 23, lines 261 – 264)	Alessandra
	Growth and resilience	I feel empowered like I feel I can deal with an insane amount of stress and, anxiety, the way I did, so I know that if something happens again, I am going to be somewhat prepared, I will know what to expect in the way I am going to feel and what to do maybe to make it better or different, yeah, I feel like a little bit a survival now you know, like, we survived this global catastrophe somewhat united, it is good, it is feels good because I feel like that in the difficult situation you find that you are stronger than you believe (pp. 39-40, lines 379 – 387)	Giovanni
		it taught me a lot about remaining calm and be able to, you know, take on challenges and critical situations without actually losing sight of what the priorities, what needs to be done in a timely manner (p. 18, lines 204 – 207)	Luca
		I strongly, strongly believe that anyone has started to doubt and to ask questions about what they want in life, what they really want in life so, I mean I always try to see the bright side of the situations because at the end I find myself better than one year and a half ago, even if it was stressful and really painful going through all that but being stressed, being anxious, feeling anxious drove me and let me to ask for help and when I asked for help, I realized that I had to change certain things and certain	Rebecca

		attitudes as well, so I think the way I cope with problems now it is different compared to, compared to like how I used to cope with problems (pp. 54-55, lines 622 – 631)	
		I know I can look after very sick patients and maybe at the same time as well (p. 34, lines 317 – 318	Alessandra
		I am learning to put myself first and see what I want, what really makes me happy first, what make me feel, you know good in tough situations, so I am basically doing whatever makes me feel happy and yeah, because in this kind of situation you need to learn how to live with yourself (p. 36, lines 339 – 343)	Alessandra
		before COVID, it is like now I think more about the future that it should not happen because we need to leave the present instead, but it is like the COVID, make me in crisis like project completely changed yeah, before maybe I was living the life like lightly without you know, just job, go out like without thinking much (pp. 28-29, lines 250 – 255)	Alessandra
		we never had time to think so yeah, probably I would have thought about myself a bit more, going back, looking back, especially when I started having those intrusive thoughts, that is when I probably had to ask for help (pp. 45-46, lines 529 – 533)	Marilena
		I support wise, it should be more for the future, instead for the actual moment because as I said, everything was going so fast that even if they were offering other kind of support, I do not know if I would have taken it uhm, I think like support should be like more delivered now or in the future just to get over it than in the actual moment (pp. 37-38, 424-428)	Giorgia

Group Experiential Theme 3

Group Experiential Themes (GETs)	Personal Experiential Themes (PETs)	Evidence from Transcripts	Participants
	Let down	they were planning to give a salary increment to the NHS workers, I do not know if you heard about the story and how it ended up, but basically, they were supposed to do it at the beginning of the year, this year, and it was supposed to be like something between 5% and 10% and then again, it did not happen, and it is not going to happen probably until next year, and it is going to be 1%, my God! that is bollocks because I felt like a kind of betrayed on this point of view, because, I know the government supported a lot of people, like, loads, millions really of people in terms of like, working shielding, activities that were paid to be closed, people were working at home, I kind of felt like me as a nurse and the other colleagues were doing like the hardest job possible (pp. 42- 43, lines 412 – 425)	Giovanni
		the government did not really help us on this, on their side, to be honest, that is what I felt and what my colleagues felt as well so, there was frustration because we worked really hard every day, every	Rebecca

BYSTANDER		day we go to work, we do not stop, I see nurses running around, they literally do not stop and we felt a bit like, I do not know abandon from who it is supposed to take care about us basically (p. 18, lines 198 - 204)	
		afterwards like from a day to another, they [government] decided to take off the aprons, not the aprons, the gowns, basically, because I think, I believe that the main reason was that we did not have PPEs around the hospital so there was a big shortage of PPEs (p. 48, lines 547 – 550)	Rebecca
		my family was worried about me and I was worried about them, so hearing them worried and saying, they keep saying like are you sure you want to go to work and you have to be careful because you are really exposed to that and when I told them, how the government decided, the Health Organization decided that it was fine to work just with a surgical mask, they were really upset because they were like you are putting yourself in danger, just speak up, talk to them because it is not possible that you work in this city in these conditions, so that was stressful as well, because I knew that was the right thing to do (p. 45, lines 511 – 520)	Rebecca
		I actually had problems with the GP because they did not want to give me a sick note at first because they said ah there are loads of people that they are in your situation I cannot do this and I was like I am sorry I am a nurse and I cannot go back to work, so my GP was not really helpful at the beginning" (p. 51, 582 – 587)	Rebecca
		let's, be clear, nobody signed up for this when you sign up to be a nurse, you do not sign up for this, calling us heroes, I never liked, when people called us heroes because we were just doing our job (pp. 36-37, lines 423 – 426	Marilena
		I think Italy did a little bit better with COVID (pp. 27-28, lines 316 – 317	Marilena
		most of my colleagues like me, come from other countries, who from Portugal, Spain, Italy, anyway, most of them have left, I do not know, maybe because of sick of all of that, because also these friends before were not thinking to go home they were ok here, people that were thinking to buy a house here and stay here, they left, I do not know, maybe scared because they missed the family more than how they were missing before, I do not know because scared of I do not know that this COVID could interfere with their projects (p. 38, lines 358 – 366)	Alessandra
		in ITU you always do 12 hours, it is not like in our countries where you do 8 hours, the shift is 12 hours, so maybe 12 hours is a very long day, so maybe they could have provided to reduce, but you can really do it because this means that you need to find other nurses or you need to change the kind of rotations in terms of shifts (pp. 50- 51, lines 507 – 512	Alessandra
		I was at the time living with two other flatmates, there were other people, but some of them left, they went back to their houses (p. 24, 280 – 281)	Luca

	Facing scepticism	I had a lot of discussions with my friends, in a great way and just uhm I am going to say constructive way, I am talking about all fake news that they were going on the TV, lots of anti-vaxxers in this case now but at the beginning, people were thinking that the virus was a hoax, that the people were not actually dying, people asked me to see bodies dying in the hospital, just because they were healthy and they were not thinking that the virus was actually true, still surprises me up to these days, having someone asking me to see someone who is dying in the hospital just because they do not think they are actually sick, uhm so yeah as I was saying with my friend, lots of them were asking, saying are this things really true, are you really working so much? Are you really going crazy at work? like having so many patients? And I was yes, that is why I have not had a day off in like 7 days or that is why I am doing extra shifts every now and then, that is why I cannot text you so much, but none of them, although there were, some of them were a bit sceptical, they were like, oh, it cannot be true, I mean, it is impossible, it never happened, and every day I was trying to explain them (pp. 55-56, lines 637 – 655)	Luca
		so on the first surge, we were receiving a lot of cards, a lot of food, a lot of gifts in the unit, which was like brightening our day because obviously it was that small thing that was nice and we felt very appreciated as well as the clapping, then with the second surge, obviously people were tired so we felt much less appreciated and now people look like they are upset with us like if we are the one bringing COVID, like we are the one making… like lots of people are in denial and they think that COVID does not exist and they kind of uhm, how can I say, that they are actually saying that we are making that up (pp. 14, lines 149- 158)	Giorgia
		it was nice the first time the claps and then it was just too much, because at the end of the day, now we are, COVID is not, I do not think that the community realizes that COVID is still happening, even if there is not a big wave outside within the walls of the hospital, COVID is still happening is still hitting hard not only in intensive care cause let's be clear if the intensive care is busy then the rest of the hospital is busy, if intensive care does not have a bed for a patient, it means that the patient has to stay in A&E, in the emergency department and if the emergency department is busy, all the ambulances at the hospital are still busy, which means that on the community, if you break your leg, there will not be an ambulance to help you. So, the community does not understand, it really angers me when I see people still not wearing a mask on the streets, saying that it is too hot, how about me? I wear a mask for 12 hours when it is 40 degrees, it is still very hot, you can wear a mask for 10 minutes while you are taking the underground (p. 40, 461 – 477)	Marilena
	Shared guilt	you have caused it, and you know, like you say, wow, what I have done? It is like, I killed the patient, in other words it is that… of course, you are not alone, because at the end there are other nurses around, uhm, I mean, and also is like 24 hours over 24 hours jobs, so you finish the shift, there is another nurse,	Alessandra

		and if, for example, the other nurse does not realize about the mistake and continue to, you know to make this mistake at the end, it is not only your fault, it is like the team fault because it was other people's distraction as well (pp. 44-45, lines 431-439)	
		I cried every day for one week (giggle) I was crying everyday uhm, I was feeling like I am not supported enough, I do not want, I felt really every time, every time that in my mind came up, the image of me going back to work, I started to hyperventilate (giggle) and feeling really, really anxious, so I was like I am not ready to go back to work, I do not even want to see that hospital now so I felt really sorry after two weeks, I went back just because I want to help my colleagues, that was the main thing that led me to go back to work (p. 53, lines 601-608)	Rebecca
		during the surges there was loads of pressure for us to do a bit more of extra shifts, which they were paying a bit more so you were taking them, we were going to work a bit more, and in the other hand, it is not that you are home doing much and at the same time again you are scared to go to work by at the same time you feel guilty if you do not go to work to help, so then we ended up going to work a bit more so I would say we were probably working 50 hours per week (p. 28, lines 311 – 319)	Giorgia
		I had responsibility to others, and I felt sometimes I was failing them uhm, I mean the junior nurses or the redeployed nurses (p. 26, 295 – 297)	Giorgia
		you always want to do extra shifts to help your colleagues, so instead of having you know three days off, you might take only one, maybe two (pp. 49-50, lines 576 – 578)	Luca

Group Experiential Theme 4

Group Experiential Themes (GETs)	Personal Experiential Themes (PETs)	Evidence from Transcripts	Participants
	Secrecy	I do not like talking about it, just because it is some juicy gossip and they need to know what is happening behind the wall so I would not talking about it to brag so, I always felt like I am holding a secret with them, especially… now being outside and spending a night out with my friends, I feel like I still need to readjust to normal, I feel like I am back on speaking a language that I have not spoken for years, I do not know if it makes sense, sometimes I need to oh a normal person would say this, so I will say this, or a normal person will act like this, so I will act like this, so I still kind of in the back of my mind thinking what I am doing, instead of just being myself (pp. 42-43, lines 494 – 505)	Marilena
		they did not know what to do and they were here to help and you have to look after them and explain that everything is fine, that being scared it is fine, that not having time to do things it is fine… uhm… it was difficult cause you are stressed yourself, you are angry yourself, you scared yourself, you want to	Marilena

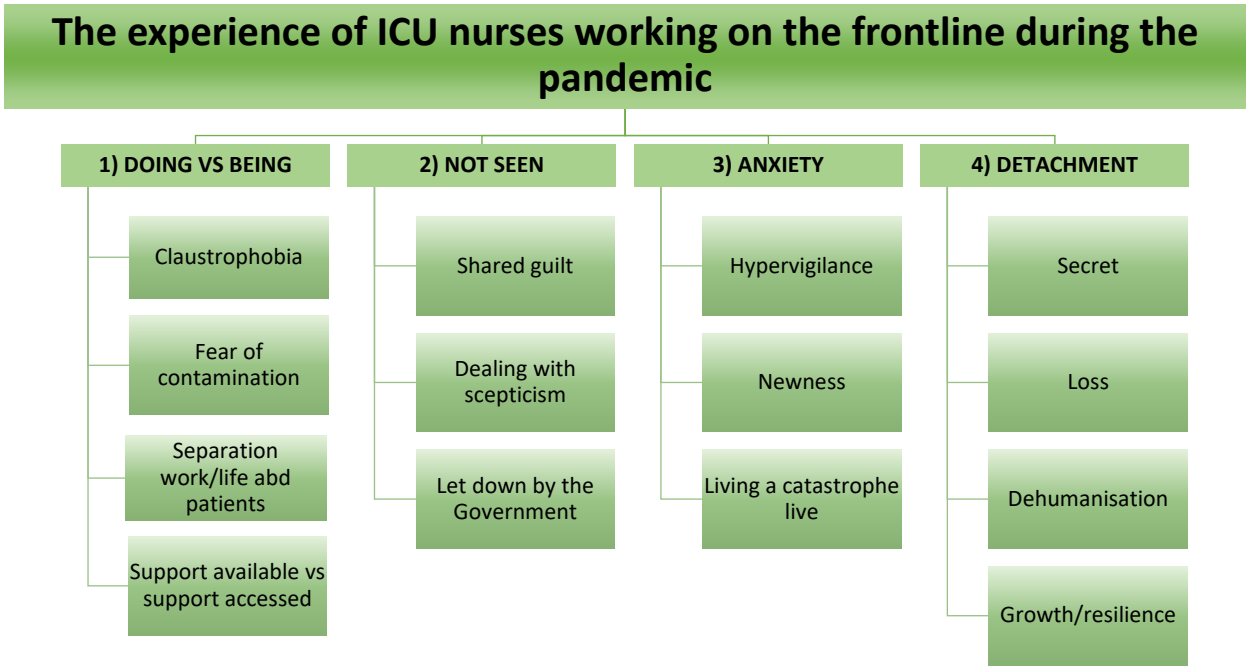
		cry yourself, you are not allowed to do so, at least not in front of everyone because if you are, if you that you are the senior one and you are the figure of support, if you breakdown then, who is going to support the others?! (pp. 38-39, lines 440 – 449)	
		it is probably affecting you a little bit less compared to a student that is already coming there to help you, is a volunteer, and on top of that you put them in a situation where they have to stand with someone who is crying, grieving and you know it is just not nice for them (p. 80, lines 936 – 940)	Luca
		we really did not know how to balance sometimes medication with the patient conditions and sometimes because we tired, because of distractions, because we were fed up, we forgot to check the levels and in the meantime, the damage maybe was already done (pp. 14-15, lines 160 – 164)	Alessandra
		the thing I would like to add is not like my experience but there is something that can be done in the future and I hope that, I mean, now we learn from not the mistakes because I mean we are, again, we are human beings, but we learn from the experiences, the past experiences, and we can do better for our patients and for the nursing and doctors self-worth because at the end of the day, nurses and doctors run the hospital, so if we do not feel good with ourselves and our job, it is going to affect the care that we give to the patient (pp.30-31, lines 345 – 352)	Rebecca
DETACHMENT	Loss	I remember when there was the first wave and so all this COVID things was new, a lot of people were dying so a lot of death, but there were lots of admissions at the same time, so very tough situation emotionally (p. 5-6, lines 56 – 60)	Alessandra
		we talk about variants and they start to affect also young people, and they said, ok, things are changing now, so we are all involved even healthy people, people that have never had problems in terms of food, or, you know, hypertension they were affected so… it was really bad (pp.16-17, lines 182 – 186)	Alessandra
		I mean, as a nurse you are I mean, it is not nice to say, but you are used to, or I mean you see things (giggle) and you see people that might not make it and they might pass away, so in that case, it made me realize how severe was the situation, basically because in my in my experience in my ward was really, really rare to find patients that when palliative, or, yeah, they might pass away (p. 41, lines 467 – 472)	Rebecca
		we had actually a young person, it was like 23 years old, we actually do not know if it was COVID at the end, we do not know but we remember that, it was in the other ward connected to mine anyway and they was working all night long basically and they was not feeling very well but they did not wanting to go home because they were short of staff but basically when they got home, they went to sleep and the mum found in bed after a cardiac arrest, again, maybe it was not COVID we do not know, the main thing was that, it was the first surge so we did not know what the consequences were of what this virus could be, so we got really, really scared and we kept hearing from other wards, maybe, colleagues, between 50s and 60s getting COVID and dying for it (pp. 42-43, lines 483 – 494)	Rebecca

		we had many deaths, and many how can I say, we have to face lots of relatives, something that I did not mention was the fact that there were few occasions where we were in a room with a grieving family, when you have to tell them your loved one is alive but at the same time we are kind of at the upper limit of the care that we can provide and they have to understand that within like few minutes things might go bad and this person might not survive, so we had lots of situations where you are just there, drained with your energy, literally you have no energy left, you have million thoughts in your head, you have so many things to do and yet you do not want to leave because you are standing next to this person and you have been looking after for maybe the past few days and the family is there and they know that you both know that this person is about to die (pp. 78-79, lines 915 – 928)	Luca
	Dehumanisation	with COVID patients I saw as well you actually do not get the chance to do everything you are supposed to do, and you would love to do because you know that there is a patient that can be I do not know your brother, your mother, your sister, whoever, so, since we are human beings and we get sick as well, I guess they suffered a lot shortage of staff (p. 10, lines 108 - 113)	Rebecca
		you know the target was not to get them well, at some point the target was keep them alive (pp. 47-48, lines 552 - 553)	Luca
		it was difficult dealing with families at the beginning when COVID was not a thing yet when everybody thought that COVID was just a bad flu, it was difficult dealing with family, they were really angry at you because you did not answer the phone calls cause you did not have time to answer the phone calls because their 40 years old husband was really sick and they were not allowed to come in and see them, because your daughter, your sister, your mom is really sick and you are not allowed to come and see them because you are so busy that you are rude on the phone (p. 39, lines 449 – 458)	Marilena
		it is not just a patient, it is life, it is family, it is everything and I had to let go to all of those little details uhm, I remember handing over the patients, the handover of the patient is when you finish a shift and you then give the handover to the next shift nurse, I remember handing over a patient and I did not remember anything about the patient, I did not know anything about them, I did not know their name from where they were, the only thing I knew is I kept them alive for today, keep them alive overnight (pp. 11-12, lines 126 – 134)	Marilena
		I remember having some intrusive thoughts, sometimes, I remember going to work crossing the street, thinking maybe if a car run over me, at least it is over, I am really, I talk about it very easily because as I said, I have got really supportive friends and partner so I have talked to them already, I remember these intrusive thoughts happening a lot, like you know, maybe I will not die, but at least if I got a broken leg, I do not have to go to work, that is me not being able to take a break from work because you feel like (p. 23, lines 262 – 269)	Marilena

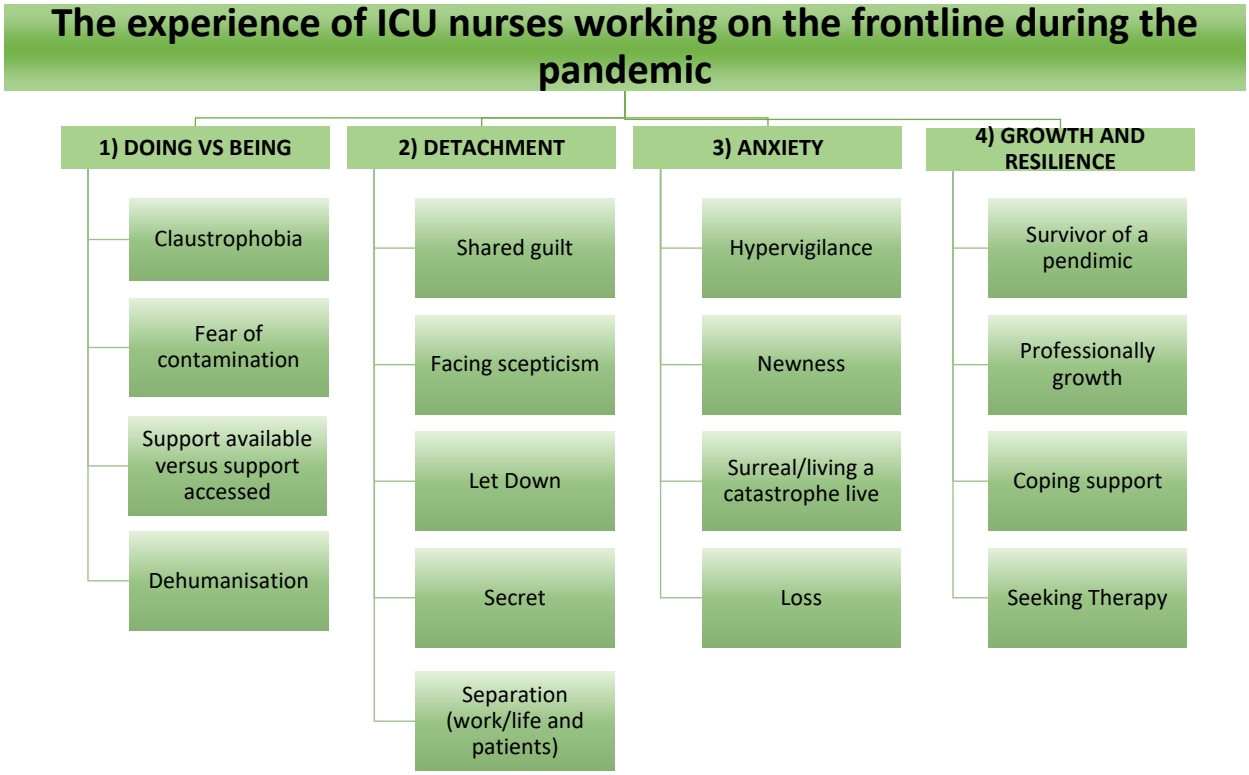
		the things happening during the shift will come back to me as in flashbacks at night, I remember even not being able to have a shower because I was in the shower and then the only thing I know, I spent an hour in the shower only thinking about work, I was not even washing myself, I was just there staring at the emptiness, I was not able to watch movies anymore, I will just isolate myself from everything, I will just find myself all of a sudden realizing that I was just flying with my thoughts, and I was not there, present in the moment (pp. 25-26, lines 293 – 301)	Marilena
		it was difficult to keep yourself motivated and proactive and like you know supportive, you are supposed to be kind, respectful and like pleasant to the patient and to the colleagues and everything, but obviously this is not easy in such situations, so the management, I would say the management of the particular situation and stress management was probably the hardest thing in general for everyone like adapting to the negativity, the increased amount of work to be done, stress to be coped physically and mentally, yes this, this is the thing that I felt most (p. 35, lines 389 - 397)	Giovanni
		I mean there is no patients that need to be treated less than another one, we have to guarantee the same treatment to everyone (p. 10, lines 106 – 108)	Alessandra
		sometimes we were really fed up of this job, there was a period like where I did not want to be a nurse, and maybe, yeah, it is like Oh my God, why I choose this job? I did not want to go to work, sometimes I did not want to look after, you know, patients (pp. 17-18, lines 194 – 198)	Alessandra
		sometimes I just did not want to eat, so I was not eating much (p. 20, lines 223- 224)	Alessandra
		I do not know if I will be able to go to another surge because the workload and the burnout is massive. I think like we lost a bit of compassion towards the patient because we got in ITU, we got used to have them deeply sedated so you start not seeing the person as a person anymore at some point, uhm that is a bit scary (p. 7, lines 71 – 76)	Giorgia
		we would be with the PPE for 12 hours straight with no breaks, and that was very tiring…so you were getting to a point sometimes that you did not care, you just wanted to get out of the PPE no matter what, so you were leaving the patients' safety behind and obviously it is no what I have been trained for (p. 9, lines 100 – 105)	Giorgia

APPENDIX 9: Visual Presentation of Themes' Discovery Process

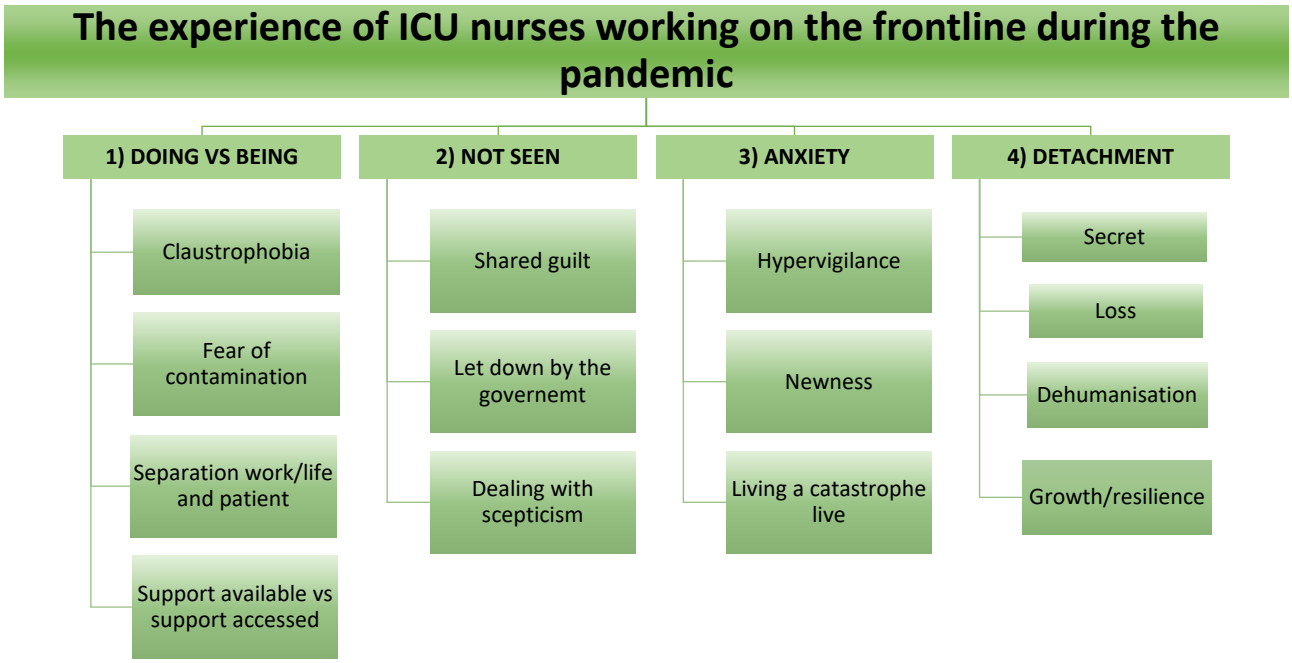
VERSION 1 - 19/05/2022



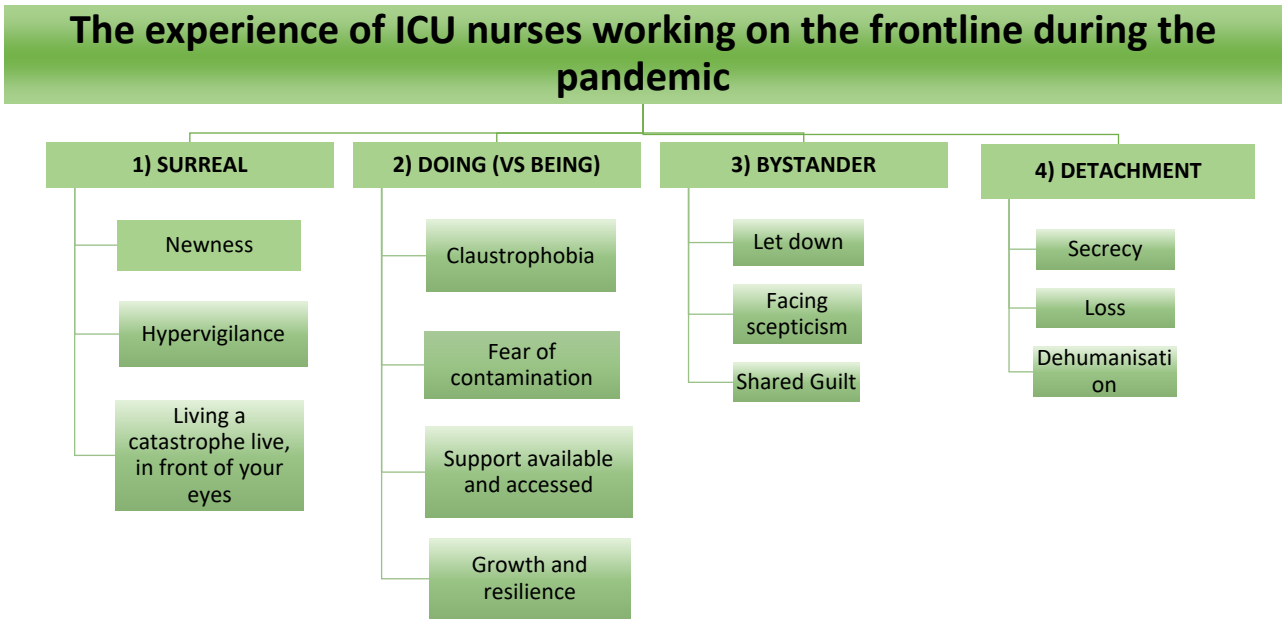
VERSION 2 - 24/05/2022



VERSION 3 - 25/05/2022



VERSION 4 – 30/05/2022



VERSION – 10/08/2022