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The impact of collective trauma on mental health psychology practitioners' wellbeing: Insights gained from Covid-19

Annita Ventouris [a,*], Agata Wezyk [b], Constantina Panourgia [b]

[a] School of Health, Medicine and Life Sciences, University of Hertfordshire, College Lane, Hatfield, AL10 9AB, UK
[b] Department of Psychology, Bournemouth University, UK Fern Barrow, Poole, BH12 5BB, UK

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ABSTRACT

Objective: This study aimed at investigating how the pandemic, a collective trauma experience, affected the mental health and wellbeing of Mental Health Psychology Practitioners (MHPPs), along with the strategies employed to maintain positive wellbeing.
Method: An exploratory, qualitative research approach was taken, and semi-structured interview data was collected from nine MHPPs and analysed thematically.
Results: Three main themes were identified, consisting of two subthemes each, ranging from experiences of vicarious traumatisation, personal vs. professional identity issues, through to the strategies participants employ to maintain their wellbeing.
Conclusion: The need for training focusing on collectively traumatic experiences was highlighted by this study's results. The development of targeted interventions and comprehensive training programmes are essential, including modules on self-care, resilience-building, and maintaining professional boundaries, as they can help this group of practitioners be less susceptible to occupational risks, resulting in better outcomes for both practitioners and their clients.

1. Introduction

The onset of the COVID-19 pandemic in early 2020 caught the world unprepared for a crisis of such magnitude. Its acute emergence, rapid escalation, and prolonged duration significantly intensified pre-existing mental health issues among the general population (Kar et al., 2021), while simultaneously generating new anxieties, increasing the prevalence of mental health problems and expectations of a mental health surge (Bäuerle et al., 2020; Shevlin et al., 2020). Numerous studies reported increased demand for mental health services and psychiatric consultations in 2020, with projections indicating longer waiting lists and ongoing strain on mental health systems in the post-pandemic period (i.e., Di Lorenzo et al., 2021; McNicholas et al., 2021; Tedja et al., 2023). These widespread psychological effects reflect what has been termed collective trauma, a phenomenon describing the shared psychological impact experienced by communities and societies during shared traumatic events (Aydin, 2017).

In situations of collective trauma, such as the COVID-19 pandemic, Mental Health Psychology Practitioners (MHPPs) play a critical role in mitigating the psychological impact on individuals and communities. In the UK, MHPPs adopted an active and multifaceted role, delivering services not only to vulnerable individuals, but also supporting local authorities, schools, social care services, and the National Health Service (NHS). Furthermore, they contributed to mass communication efforts and public health messaging (BPS, 2020a). Notably, these services were predominantly delivered through teleworking, with many MHPPs required to transition abruptly to telepsychotherapy, often without prior training or adequate preparation. Although research highlights MHPPs' adaptability and generally positive attitudes towards telepsychotherapy (e.g., Békés & Aafjes-van Doorn, 2020; Feijt et al., 2020), this transition also posed considerable challenges. Practitioners reported experiencing feelings of isolation, fatigue, professional self-doubt, and perceived deterioration in the therapeutic alliance with clients (i.e., Aafjes-Doorn et al., 2022; Lin et al., 2021). This rapid shift in practice conditions, combined with increased demands and emotional strain, underscored the occupational vulnerabilities of MHPPs—challenging the assumption of their inherent professional resilience.

Despite being perceived as resilient due to their professional expertise (Kar & Singh, 2020; Posluns & Gall, 2020), MHPPs themselves remain vulnerable to occupational risks (Laverdière et al., 2018), an

* Corresponding author.
E-mail addresses: a.ventouris@herts.ac.uk (A. Ventouris), awezyk@bournemouth.ac.uk (A. Wezyk), cpanourgia@bournemouth.ac.uk (C. Panourgia).

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issue that became particularly apparent during the COVID-19 pandemic. For instance, a survey conducted by the British Psychological Society at the onset of the pandemic, involving over 200 psychologists, highlighted both "potential risks to wellbeing as well as positive benefits" (BPS, 2020b, p. 3). While some practitioners reported positive experiences, many also described a deterioration in their own wellbeing and mental health. The psychological impact of COVID-19 was characterised by some as an "emotional rollercoaster" that, although occasionally energising and motivating, also elicited "feelings of sadness, frustration, boredom, anger, shame, and anxiety" (BPS, 2020b, p. 10).

Another study conducted during the first COVID-19 lockdown in the UK with 41 self-employed female psychologists found that, although this period presented certain positive opportunities, it also raised significant concerns. These included challenges related to childcare responsibilities, financial uncertainty, and the health and wellbeing of friends and family. Participants further reported heightened feelings of isolation, stress, anxiety, and doubts regarding their professional efficacy (Miller & Essex, 2023). These findings are consistent with results across the globe. For example, a study of 214 Canadian school psychologists found that (Ritchie et al., 2021). These findings underscore the broader psychological toll of the pandemic on mental health professionals.

The impact of COVID-19 on the wellbeing of MHPPs can be partly attributed to their dual exposure to the same adversities faced by their clients. Nuttman-Shwartz and Shaul (2021) found that therapists perceived the pandemic as a "shared traumatic reality" in terms of trauma experiences, wherein reported parallel concerns with their clients, particularly around health and financial insecurity. While providing empathetic support to individuals processing grief and trauma, MHPPs were also navigating their own experiences of collective suffering and personal loss amid the public health crisis (Captari, 2020).

Consequently, patient narratives and anxieties often resonated with therapists' own emotional strain, heightening the risk of vicarious traumatisation (Joshi & Sharma, 2020; McBride et al., 2020). This condition, defined as the emotional and cognitive disruptions therapists may experience through engagement with individuals affected by trauma (McCann & Pearlman, 1990), can manifest through a range of symptoms. These may include intrusive thoughts, evading, emotional numbing, hyperarousal, and somatisation including headaches, nausea, sleeplessness, anger, sadness, and anxiety (Iqbal, 2015). Such symptoms can have a profound effect on therapists' personal wellbeing and professional functioning (Kjellenberg et al., 2014), ultimately rendering vicarious traumatisation as a significant occupational hazard in clinical practice (Iqbal, 2015). Evidence from the early lockdown period support this, with Aafjes–van Doorn et al. (2020) reporting that two-thirds of psychotherapists experienced moderate levels of vicarious traumatisation, three-quarters reported increased exhaustion, one-third perceived a decline in professional competence, and nearly half felt less able to emotionally connect with their patients.

Furthermore, the detrimental impact of the pandemic on the wellbeing of MHPPs has been well documented internationally, with psychologists reporting symptoms of psychological distress and exacerbated levels of compassion fatigue. For example, Kercher and Gossage (2024) identified COVID-19-related stress, engagement with high-risk clients, and elevated symptoms of stress and anxiety as the most significant predictors of compassion fatigue among psychologists in New Zealand. Their study also suggested that access to informal supervision, enhanced resilience, and increased organisational support were positively associated with greater compassion satisfaction. Another study by Kercher et al. (2024) found that most psychologists in their sample experienced heightened work-related stress and increased caseload intensity during the pandemic, alongside high levels of compassion fatigue and low resilience. Notably, their findings indicated that elevated compassion fatigue was not associated with working with at-risk clients, personal support levels, or managing childcare responsibilities, but was also significantly predicted by COVID-19-related stress, psychological distress, years of professional experience, and the frequency of supervision received. Interestingly, 90 % of the participants claimed no intention of leaving this profession.

The question of how MHPPs coped, particularly in the face of sustained psychological strain intensified by the COVID-19 pandemic—such as vicarious traumatisation—naturally arises. Coping as an essential aspect of our responses to stress (Montero-Marin et al., 2014) involves cognitive and behavioural efforts to manage situations viewed as stressful (Lazarus & Folkman, 1984). While coping strategies for health-care professionals have been extensively examined in the context of the pandemic, research on MMPPs remains limited. For instance, a study of psychotherapists in Turkey identified education, supervision, personal therapy, social support, and staying informed as key coping strategies, with particular emphasis on the importance of supervision and psychotherapy in maintaining effective practice (Dilekler Aldemir et al., 2024). Similarly, a qualitative descriptive study of African American counsellors in the United States highlighted the value of social support networks, self-care practices, spiritual or religious engagement, boundary setting, and acceptance of change as essential coping mechanisms during the pandemic (Thomas, 2024). In Italy, volunteer psychologists reported that collegial support and expressions of gratitude contributed significantly to their coping processes (Rossi et al., 2021).

Evidence from the UK during the first lockdown further underscores the role of psychological self-resources in coping. MHPPs with higher levels of self-compassion were more likely to adopt approach-oriented coping strategies (i.e., directly addressing a stressful situation) and less inclined to rely on avoidance strategies (i.e., disengaging from the source of stress) (Keyes et al., 2023). Additionally, neither pre-pandemic stress nor COVID-19-related stress significantly predicted the use of approach coping among MHPPs. This was attributed to the unpredictable and uncontrollable nature of the pandemic, which may have rendered planning and problem-solving strategies less effective under such conditions of uncertainty (Panourgia et al., 2022).

A pandemic like COVID-19 is considered as a collective trauma and therefore, can be used to contextualise the experiences of MHPPs, who shared the same traumatic reality with their patients. Consequently, exploring how this collective trauma affects MHPPs' mental health, wellbeing, and coping strategies can inform the transformation of existing training programmes and relevant guidelines from professional bodies.

The remainder of this paper is structured as follows. First, we present the study's objectives, followed by a detailed account of the methodology, including the design, sampling approach, data collection procedures, and data analysis. We then outline the results, organised around three key themes: vicarious traumatisation, professional and personal identity, and coping and wellbeing maintenance. The discussion that follows situates these findings within the broader literature. Finally, we conclude with reflections on the implications of the study, practical recommendations, and an acknowledgement of its limitations.

2. Objective

Global collective traumas have significantly increased MHPPs' stress and wellbeing challenges as they face both primary and secondary trauma (Tosone et al., 2012). Despite their crucial role in such situations the impact on MHPPs' mental health often remains overlooked. This study aimed to give voice to MHPPs by examining their personal and professional lived experiences, offering valuable insights into the unique stressors they face, as well as the coping strategies they employed. Understanding their coping strategies and support needs can inform the development of tailored training and wellbeing initiatives, ultimately helping to safeguard the mental health of such practitioners and improve the quality of care they provide during widespread crises.

A qualitative, exploratory approach was used to explore MHPPs' experiences, providing insights into their perceptions, meanings, and practices. This understanding can reveal limitations and suggest improvements in training, particularly for handling collective trauma.

Therefore, the main aim of this study is to investigate the following research questions:

- RQ1: In what ways has the shared traumatic reality of COVID-19 pandemic affected the mental health and wellbeing of MHPPs?
- RQ2: What strategies and mechanisms have MHPPs employed to cope and maintain positive wellbeing during the collectively traumatic pandemic?

3. Methods

This qualitative study was designed to inform a larger-scale quantitative study, investigating the concurrent effects of pre-pandemic and COVID-19 stress on resilience in MHPPs, focusing on the mediation effects of specific individual factors. Rich interview data provided valuable insights into the lived experiences of MHPPs, helping to identify potential variables for inclusion in the subsequent quantitative phase.

3.1. Design

The study used an exploratory, inductive, qualitative approach, featuring semi-structured interviews with nine MHPPs who performed their duties during the COVID-19 pandemic in the UK. The first lockdown in the UK began on 23 March 2020, in response to rapidly rising infection rates; strict restrictions were introduced, requiring people to stay at home except for essential activities such as buying food, seeking medical care, or exercising once daily. Schools, non-essential shops, and workplaces were closed, and the country faced widespread uncertainty, isolation, and a significant shift to remote living and working.

The interviews for this study were conducted within this context, from June 2020 to November 2020. Semi-structured individual interviews were primarily chosen for their flexibility, enabling adjustments to the line of inquiry to follow up on interesting responses and elicit rich, illuminating material (Robson, 2011) and enabling the participants' voices to be heard.

3.2. Sampling

Pre-existing networks facilitated contact with MHPPs who agreed to participate in the study, using snowball sampling as defined by Vogt (1999). Nine MHPPs (two men, seven women) from urban and rural UK areas, working in private and public sectors with varying experience (3–25 years), participated. All reported increased workloads during the pandemic. Specific demographics including age, ethnicity, years of experience and sector they currently work at, can be found in Table 1.

While broader participation could have enhanced diversity, interviews ceased once data saturation was reached. The insights gained from this qualitative study informed the development of a comprehensive questionnaire for a subsequent large-scale quantitative investigation.

Table 1
Participant characteristics.

Pseudonym	Age	Ethnicity	Years of Experience	Sector (current)
Patricia	31	White	3	Private & Public
Annie	35	White	8	Private & Public
Mary	42	White	15	Public
Jane	46	Asian British	19	Private & Public
Andrianne	46	Black	14	Private
Tina	48	White	20	Private & Public
Tim	49	Black	18	Public
Carol	51	Mixed	23	Private& Public
Peter	52	White	25	Private

3.3. Procedure

The semi-structured interviews, which ranged from 45 to 75 min with an average duration of 1 h, were conducted online by all members of the research team. Each interview was recorded and subsequently transcribed. The interview questions explored the impact of the pandemic on participants' daily lives and professional roles, focusing on both stressors and coping mechanisms. Questions such as "How has your work been affected as a result of the COVID-19 restrictions?" and "Has COVID-19 affected the ways you usually deal with challenges and in what ways?" aimed to understand the emotional and practical difficulties faced. Additional questions examined how participants typically manage stress and whether their approaches to self-care and wellbeing had changed during the pandemic.

3.4. Data analysis

Thematically analysed data (Clarke & Braun, 2013) demonstrated patterns and themes across MHPPs' experiences, perceptions and practices in relation to the research questions under investigation. Three main interrelated themes were identified, consisting of two subthemes each: (1) experiences of vicarious traumatisation, (2) personal vs. professional identity, (3) coping strategies participants employ to maintain their wellbeing (see Table 2). A supporting narrative analysis is presented in the next section. In line with BPS (2018) ethical guidelines for conducting research with human participants, the identity of the subjects is protected using pseudonyms.

The study ensured validity through deep immersion in the data, with multiple readings and two rounds of coding based on Clarke and Braun's (2013) framework. Although one primary coder conducted the initial coding, regular team discussions helped ensure credibility and minimise bias. Manual coding, rather than software, allowed for close, detailed engagement with the data. Reflexivity was maintained through

Table 2
Table of themes for MHPPs' perceptions.

Thematic Category	Subtheme	Illustrative quote
Vicarious Traumatisation	Identification with the patients' fears	*She (client) was crying over her dying father, and the whole time I kept thinking of my own brother who is in the hospital, and I knew exactly how she felt (Mary)*
	Intrusive symptoms	*Sometimes I cannot stop thinking of what a client has told me, for example, losing a loved one, and I am just in bed unable to sleep and thinking what I should have said or done that I didn't (Jane)*
Professional Vs. Personal Identity	Questioning the Professional Self	*I listen to their stories, anxieties and I feel so unable to help. I don't have the resources, and the thought that some patients only rely on me is too much to bear, I mean what is my role? (Annie)*
	Personal – Professional Life Imbalance	*No boundaries, I have to work flexibly around my young children, I have to spread my hours across five days a week, so there is a bit of work there every day, so it is much harder to switch off (Tina)*
Coping & Wellbeing Maintenance	Internal Coping Mechanisms	*Working on myself … I took it as some time to think about actually what is it that I really want to do after this (Peter)*
	Peer Support	*I may feel very relieved after talking to someone, I feel less lonely and other times I may still feel very upset and worried about it, but I know there is someone else there who thinks about it too (Mary)*

reflective notes and rigour was reinforced through peer debriefing.

Each theme was developed from repeated patterns in the data, and although there were variations in how participants experienced and responded to the challenges discussed—for example, differences in coping styles, levels of emotional impact, and access to support, there were no substantial counter-examples that challenged the main thematic categories. The shared context of the pandemic, as a collective trauma, may have contributed to this alignment in experiences.

4. Results and discussion

4.1. Vicarious traumatisation

Despite varied roles and experiences, all MHPPs in this study shared significant concerns about the impact of the pandemic on their clients' lives. They also described how these experiences affected them personally and professionally, particularly as they faced the same unprecedented circumstances. These issues are captured under the theme *Vicarious Traumatisation*, with subthemes *Identification with the Patients' Fears* and *Intrusive Symptoms*.

In shared traumatic realities, MHPPs experience stress from the same disaster affecting their clients, increasing vulnerability and emotional strain (Pulido, 2007). Participants identified with fears like health risks, loneliness, and financial worries, echoing Seeley's (2008) findings post-9/11. While countertransference shaped interactions (VandenBos, 2007), participants also felt personally affected, as illustrated by Mary, who related deeply to a client's situation:

> 'He lost his job because of the pandemic; he was in dire financial straits and was my first client who told me he could no longer afford therapy. He talked about his mortgage and all financial challenges, which I could totally understand, but at the same time I was thinking "what about my own mortgage".'

Mary reflected that her patient's case made her recognise the shared impact of COVID-19 and triggered memories of her own past financial struggles, when she experienced chronic unemployment; this aligns with Finklestein et al. (2015), who found that therapists' distress is linked to prior trauma exposure when working with highly traumatised communities. Jane, a therapist, shared how prior trauma from caring for her dying mother resurfaced when working with a patient unable to visit their COVID-19-stricken mother. This experience highlighted unresolved emotional issues, causing Jane to identify with the patient's fear of loss. She reported heightened anxiety and difficulty separating her past from the client's situation, affecting her focus and ability to provide effective support:

> 'I knew how to do my job, but in this case, it was just too much, it was a trigger … there she was, a woman my age, who was going through what I went through back then and still … I felt I could not support her.'

Vicarious traumatisation, linked to reduced wellbeing and professional performance (Figley, 1995), can lead to burnout and hinder effective care. Tina, a participant, described distress from the pandemic's unpredictability and its impact on her children, making it difficult to discuss related concerns with her patients:

> 'I have always seen psychotherapy as a two-way relationship, so quite often in my practice I would disclose my own emotions when it was suitable. I felt I could not do this when discussing with patients how Covid has changed our lives and the lives of our children- it was like I had to adopt different approaches to support patients, which was not easy for me.'

Participants experienced vicarious traumatisation through intrusive symptoms such as distressing thoughts and flashbacks linked to client trauma during the pandemic. Mary, whose brother recovered from COVID-19, reported sleeplessness from identifying with grieving patients, echoing the thought, "I could have been in their position," showing disruptions in cognitive and emotional regulation (Pearlman & Saakvitne, 1995). Jane described persistent worries about loved ones' safety, while Peter expressed guilt and overprotectiveness toward his distant mother, feeling remorse for "not being there." Other MHPPs reported experiencing heightened levels of negative emotions, such as sadness, fear, and anger. According to Tina:

> 'I get furious when I think about what my patients are going through, what we are all going through … it is like I am grieving for my patients and my own life as well.'

The emotional burden of MHPPs, compounded by personal and client distress during collective trauma, can lead to emotional exhaustion and reduced wellbeing (Figley, 1995), impacting professional effectiveness, personal satisfaction, and quality of life; therefore, managing this burden is vital for both practitioner health and effective care.

4.2. Professional/personal identity

The second thematic category centres on MHPPs *Professional and Personal Identity* and relates to how they navigated the interplay between their professional duties and personal experiences during COVID-19.

The sub-theme *Questioning the Professional Self* captures MHPPs' concerns about their identity and abilities, as they balance professional responsibilities with their own emotional responses, creating tension between supporting others and managing personal wellbeing. As Annie put it:

> 'A patient told me that our sessions are so important to her that she wouldn't know what to do if it wasn't for them; she told me this at a point when I was thinking that I have run out of energy and couldn't cope anymore. I was under pressure to perform, but I kept thinking that she has me, but I cannot be there for myself'.

This conflict between caregiving and self-care can lead to guilt, burnout, and compassion fatigue among therapists (Bride et al., 2007). Many MHPPs felt overwhelmed by the added responsibility of supporting patients, especially when typical stress relief strategies, like going to the gym or traveling, were unavailable. This led to distressing thoughts about their patients' wellbeing and their own abilities, with less experienced therapists struggling most to maintain professionalism during the pandemic. As Patricia reported:

> 'I cannot help but feel inefficient in my work. And I am not just talking about the logistics like learning how to use Zoom and adjusting to online sessions … I am just not able to function as a professional when I must deal with a pandemic, home schooling, and new ways to work'.

As highlighted by Adams and Riggs (2008), MHPPs may grapple with feelings of guilt, inadequacy and self-doubt if they perceive themselves as being unable to fully meet the needs of their clients while also attending to their own needs. Moreover, MHPPs noted that limited resources and logistical constraints, like insufficient support and outdated technology for teletherapy, intensified these feelings. This aligns with Courtois and Gold's (2009) findings that inadequate support and training hinder therapists' ability to help trauma survivors, leading to frustration and self-doubt.

MHPPs highlighted struggles in balancing personal and professional life, emphasising the intertwined nature of their identities. As Tim, a counselling psychologist, put it:

> 'My workload increased overnight, I had to shift to teletherapy which I was not familiar with and had to learn so many new protocols. I just couldn't switch off, even when I was going to bed – very late in the evening because I had to catch up with the admin'.

Some MHPPs mentioned they struggled to remain focused, especially because family members, especially their children, were constantly

around and had to cater to their needs, experiencing constant interruptions to their work. Participants also mentioned that allowing clients to virtually enter their homes contributed to the blurred boundaries between work and personal life:

> 'The clients would often make comments about background noises, like my screaming toddler, they could hear her tantrums and my partner trying to calm her down … my personal life was all of a sudden exposed to my clients without my consent, really'.

The lockdown and various restrictions imposed by the pandemic was another factor that negatively contributed to the imbalance between personal and professional life, experienced by MHPPs:

> 'Where does work end and life begins when you cannot engage in any social or recreational activities? I ended up working until late, as there was literally nothing else to do, which took a toll on my own mental health, and I was exhausted'.

Participants described several challenges in maintaining a balance between their personal and professional lives due to increased workloads, shifts to teletherapy, and personal stressors stemming from the pandemic's impact, with some of them experiencing increased fatigue and even burnout. These findings align with similar studies on the experiences of mental health professionals during the pandemic; for example, Szlamka et al. (2021) found that the blurred lines between work and personal life, spending entire days in front of the computer, and the absence of social and recreational activities posed challenges to counsellors' mental health in Hungary, who struggled to organise their day and distinguish between work and recreational activities.

International research highlights that work-life balance is vital for MHPPs (Norcross & Guy, 2007; Pakenham, 2017; Posluns & Gall, 2020), but pandemic restrictions hindered hobbies, increasing fatigue. Participants relied on professional identity and positive attitudes to prevent burnout, finding meaning in their work. This aligns with Lasalvia et al. (2009) on patient exposure affecting stress and rewards, and Freedman and Tuval Mashiach (2018) on shared trauma enhancing empathy, commitment, and personal growth. Nevertheless, some MHPPs, especially the ones with more years of working experience, reported attempts to establish boundaries to separate work time from personal time, by setting time aside to engage in self-care practices; these are discussed in the next section as a main coping and wellbeing maintenance strategy employed by participants.

4.3. Coping & wellbeing maintenance

In addition to the strategies employed to achieve balance between personal and professional life during the pandemic, MHPPs discussed coping strategies and practices they engaged in to maintain their wellbeing. *Coping and Wellbeing Maintenance* is the third and final thematic category, encompassing the sub-themes *Internal Coping Mechanisms* and *Peer* Support.

As discussed, coping is a crucial component of the stress process (Montero-Marin et al., 2014), involving cognitive and behavioural approaches to manage stressful situations (Folkman & Lazarus, 1986), including approach and avoidant strategies (Carver et al., 1989). Approach coping, involving active problem-solving, is linked to better psychological outcomes and lower burnout risk (Thompson et al., 2016). Most participants in this study used approach coping strategies, emphasising self-awareness and self-reflection to manage pandemic-related changes. These strategies helped regulate emotions and balance professional and personal roles; in a participant's own words:

> 'I know who I am, I know that I've been through several things that I survived, so there is a chance that I can survive this situation too. Self-knowledge is something that helps you interrupt the worrying'.

Self-reflection and self-awareness are key to MHPPs' professional growth and ethical practice, enhancing client outcomes (Williams, 2008) and development (Skovholt & Rønnestad, 1992). Self-reflection involves observation and evaluation (Bennett-Levy et al., 2001), while self-awareness recognises the MHPP's role as a change agent (Sullivan et al., 2005). Participants in this study used these tools to evaluate interventions and adapt techniques to client needs during collective trauma. According to Tim:

> 'Self-reflection has made me realise that, although my clients and I are in this together, I need to take a step back and remove my own biases, emotions, and reactions'.

Early research links continuous self-assessment to improved clinical skills and stronger professional identity (Schön, 1983). Self-monitoring also reduces emotional exhaustion, burnout, and compassion fatigue while enhancing job satisfaction and emotional balance (Rupert & Kent, 2007; Sansó et al., 2015), even during collectively traumatic events like for example the COVID-19 pandemic.

MHPPs participating in this study also reported a variety of approach coping methods for improving their self-awareness during the pandemic, including meditation and mindfulness:

> 'Never thought that the act of being mindful would calm me down … I am going for a walk, and I pay attention to the air I breathe, the sound of the leaves on trees, the birds singing'.

Participants also explained that these strategies, along with techniques like cognitive reappraisal, that is the attempt to reinterpret a situation that evokes emotion in a manner that shifts its significance and alters its emotional effect (Lazarus & Alfert, 1964), helped them in regulating their emotions and in some cases avoid burnout. Peter mentioned:

> 'There are dangerous thoughts, but once I start thinking of alternative scenarios and put things in perspective by asking myself all the 'what if' questions … you must do this constantly and it does help with exhaustion from work, home schooling and isolation'.

Cognitive reappraisal improves wellbeing, fostering positive emotions and better interpersonal functioning (Finlay-Jones et al., 2015; Gross & John, 2003). Xu et al. (2020) found it reduced anxiety in COVID-19 isolated individuals with high stress; therefore, learning how to manage stress through reappraisal is vital for mental health in high-pressure, traumatic situations.

Awareness, reflection and emotional regulation techniques are often referred to in the literature as self-care, which is defined as engagement in behaviours that sustain and enhance one's own physical and emotional wellbeing (Myers et al., 2012). As such, it is a necessary practice among MHPPs, because it can prevent negative outcomes for both practitioners and their clients. In this study some participants cited self-care practices like exercising, new hobbies, healthy eating, and workload adjustments to manage pandemic demands. Setting boundaries helped prevent work stress from intruding on personal time. Similarly, Reilly et al. (2021) found MHPPs in the USA used strategies like distraction, family time, and exercise during COVID-19. Posluns and Gall (2020) confirmed the benefits of these strategies in their literature review on self-care's role in promoting MHPPs' wellbeing, advocating its integration into clinical training and quality assurance.

Some other participants used avoidant coping strategies, like procrastination, avoiding pandemic discussions, and disengaging from news and social media to avoid stress. Avoidant coping is linked to ineffective stress management and decreased wellbeing (Southwick et al., 2005). These participants, such as Annie, also struggled to engage in self-care due to the pandemic's circumstances:

> 'I have no time for myself; I even find it difficult to wash my hair! We are all constantly together, in a two-bedroom flat- which I am trying to work from. I have to do everything by myself and although my partner is supportive, I feel so lonely'.

According to research (Rokach & Sha'ked, 2013), insufficient self-care may cause feelings of loneliness to MHPPs, especially if they believe they are solely responsible for their clients, whereas stress may arise from their dedication to clients, organisations, and family commitments. Consequently, within the context of a collectively traumatic situation, like COVID-19, stress levels and feelings of loneliness among MHPPs may intensify.

Peer support, identified as the second sub-theme within this category, was unanimously recognised by participants as the primary factor enabling them to cope, particularly during the initial phases of the lockdown. Although they discussed the role of family and friends in navigating through the pandemic challenges, MHPPs mainly focused on their relationships with peers from their professional networks who provided opportunities for them to receive support, advice and share their experiences. According to Mary:

> 'When it gets too much, I think I am not alone in this, people in my community, who have to support others, are going through exactly what I am going through. I guess we are sort of there for each other, advising and supporting one another'.

Professional and peer support is crucial for MHPPs' self-care, reducing isolation-related burnout (Stebnicki, 2007) and psychological distress (Nelson et al., 2001). Morgan et al. (2022) found UK therapists valued reflective practice and peer support during remote work, aiding in processing experiences and mitigating isolation. Indeed, the MHPPs involved in this study highlighted how regular contact with colleagues helped to compensate for the lack of relevant training on collective trauma:

> 'We have regular Friday evening meetings with colleagues; it is a great opportunity to vent. I think we have all realised how unprepared we were for this. No courses, textbooks or previous experiences could have ever prepared us for a situation as harsh as this one'.

MHPPs noted that formal and informal supervision provided a supportive space to discuss personal and professional challenges, helping them validate their emotions and address biases and doubts about their abilities during the crisis. In Tina's words:

> 'Sometimes I feel so helpless … but then I hear something like 'you are doing the best you can', from my supervisor, and I realise that yes, indeed, I am doing the best I can!'

Research indicates that regular supervision is linked to lower stress and burnout levels among MHPPs. For example, McMahon and Patton (2018) suggest that supervision helps manage the emotional demands of therapeutic work, acting as a buffer against the negative impacts of high-stress situations. Participants in this study reported a high reliance on supervision, but also mentioned they value the flexibility to contact their supervisor any time:

> 'I now use informal supervision more often … if I feel like I need to talk. It is not supervision that is in place regularly. I am only able to do that because I guess I've learnt that through my regular supervision'.

Flexibility offered by supervisors contributes to compassion satisfaction among MHPPs (Kostouros & Kearney, 2023). Some participants highlighted that this kind of flexibility, expressed in the form of informal supervisions and 'impromptu online chats', enhanced their sense of support. In Jane's words:

> 'It was the unplanned supervisions and chats … they helped in finding meaning in my work again … it is like you can self-reflect and see how the lockdown and everything else affects you as a professional because you also get the opinion of someone you value'.

Engaging in reflective practice through informal supervisions enabled MHPPs to gain insights into their professional approaches and personal challenges, which have changed due to the nature of the collective trauma. Informal supervisions, described by participants as 'unplanned' and 'improvised,' can still offer a structured context for reflection, like formal supervisions. This can enhance self-awareness, leading to greater compassion satisfaction, as emphasised by Schön (1983).

5. Conclusions

5.1. Implications

The findings directly answer the research questions in terms of how MHPPs coped during a period of collective trauma; they underscore the need for targeted interventions and training to address the unique challenges faced by MHPPs during traumatic events like the COVID-19 pandemic. Due to the prevalence of vicarious traumatisation and blurred personal-professional boundaries, targeted interventions and comprehensive training programmes are essential, including modules on self-care, resilience-building, and maintaining professional boundaries. These could take the form of institutional policies that prioritise the wellbeing of practitioners and consider it as a professional standard and not a personal burden. Moreover, as indicated by our findings, establishing peer support networks and follow-up care programmes can provide ongoing emotional and professional support, highlighting the importance of the role of community and sense of belonging in coping and maintaining wellbeing in times of crisis.

From a research perspective, further studies might explore the long-term effects of collective trauma on MHPPs and to evaluate the efficacy of different interventions and training programmes. Longitudinal research could provide deeper insights into how these practitioners adapt over time and what specific factors contribute to their resilience or vulnerability and how their needs change over time, especially post-crises. Additionally, comparative studies across various contexts can determine if training programmes and interventions are universally effective or need to be tailored to different contexts (e.g., remote or face to face). Integrating findings from this kind of research into practical applications can enhance support systems for MHPPs, resulting in improved mental health outcomes for practitioners and clients alike.

5.2. Recommendations and limitations

Based on both existing literature and the findings of this study, recommendations can be made to enhance the wellbeing of MHPPs during collectively traumatic situations. While individual actions and coping strategies play an important role, these may create a sense of highly individualised responsibility for one's health (Crawford, 1980) adding to work-related and personal/family demands. Recent developments in employees-focused wellbeing interventions, such as the Individual, Group, Leader, Organisation, Overarching context (IGLOO) framework, underscore the importance of a multilevel approach ensuring that interventions are not solely reliant on individual coping, but also supported by structural and cultural changes across the system (Nielsen et al., 2018). Structural support can be provided by employers and professional bodies to enable MHPPs to effectively manage stressors and sustain their wellbeing in challenging circumstances. For example, clinical training should incorporate the cultivation of self-awareness, self-efficacy, and self-compassion which have been discussed by participants in this study and found to be related to improved wellbeing (Van Hoy et al., 2022). Flexible scheduling, workload adjustments, and support for remote or hybrid models, including clear guidance for users and relevant technical support to reduce barriers to online provision of therapy, can help protect work-life boundaries (Fejit et al., 2020; Watson et al., 2023). It has also been suggested to ensure greater employees' involvement in disaster planning for future crises (Kinman et al., 2020) which, given that MHPPs are both employed and self-employed, should take place at the level of both employing organisations as well as

professional bodies.

Furthermore, this study highlights the importance of collective coping and peer support among MHPPs, especially during crises. Research indicates that formal support, such as regular supervision, offers structured reflection and guidance, while informal peer support groups enable sharing experiences and emotional support (Rodríguez-Rey et al., 2020). Implementing formal peer support programmes in institutions can provide ongoing mentoring, with Posluns and Gall (2020) advocating for professional support as essential for self-care and mandatory in many mental health professions. Fostering a supportive organisational and professional culture through supervision, peer support, and time for reflection, including reflective practice groups, can help MHPPs manage the emotional demands of their work, encourage self-care, and promote shared responsibility for their wellbeing.

Although a large-scale quantitative study would allow us to make generalisations, the strength of this qualitative study lies in its ability to provide rich insights into people's perceptions and feelings, as it allowed MHPPs to discuss their own experiences of a collectively traumatic situation, at both a personal and professional level. However, one of its major limitations is related to the crisis itself. Data was collected during the first lockdown in the UK - an unprecedented situation for all, which influenced mental health on a collective level; therefore, data collected at an extraordinary single point may not accurately reflect longer-term trends. Although building this evidence base is important, follow up studies, allowing MHPPs to provide a reflective account of their own experiences and practices during and after the pandemic, might provide more accurate information.

Implementing relevant strategies is crucial for organisations, policymakers, and stakeholders to support MHPPs' wellbeing during collective crises, ensuring necessary support for both practitioners and clients. This aligns with the broader goal of building robust mental health systems capable of addressing collective trauma and widespread psychological impacts.

CRediT authorship contribution statement

Annita Ventouris: Writing – review & editing, Writing – original draft, Resources, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Agata Wezyk:** Writing – review & editing, Resources, Conceptualization. **Constantina Panourgia:** Writing – review & editing, Writing – original draft, Validation, Resources, Project administration, Data curation, Conceptualization.

Informed consent

Informed consent was obtained from all participants included in the study.

Consent to publish

The participants provided their consent for their words to be quoted in publications, reports, web pages and other research outputs without using their real name. They also agreed that their data may be used in an anonymised form by the research team to support other research projects in the future, including future publications, reports or presentations.

Ethical approval

The study was performed in line with the principles of the Declaration of Helsinki and in accordance with the BPS Ethics code of conduct. Approval was granted by the Ethics Committee of X University (ID: 32246)

Clinical trial registration

N/A.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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