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An exploration of the Lived Mental Health Experiences of psychologists working in the public sector during the COVID-19 pandemic in South Africa

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2023
University of the Witwatersrand, Johannesburg
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Harvey, Zena. (2023). An exploration of the Lived Mental Health Experiences of psychologists working in the public sector during the COVID-19 pandemic in South Africa. [Master's dissertation, University of the Witwatersrand, Johannesburg]. WIReDSpace. https://hdl.handle.net/10539/40557

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Research Report

Title:

An exploration of the Lived Mental Health Experiences of psychologists working in the public sector during the COVID-19 pandemic in South Africa.

By

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Submitted in partial fulfilment of the requirements for
the Degree of Master of Arts in Social and Psychological Research (PSYC7022)
in the Department of Psychology, School of Human and Community Development, Faculty of Humanities, at the University of the Witwatersrand, Johannesburg.

Submitted on: 26 June 2023

Abstract:

The COVID-19 pandemic severely impacted mental health in South Africa, exacerbating the existing mental healthcare treatment gap. Psychologists working at public institutions have been at the forefront of providing mental health care to the public during the crisis. However, psychologists themselves may be considered a vulnerable group at risk of developing adverse mental health outcomes, such as depression, anxiety, burnout and vicarious traumatisation due to the nature of their profession. This vulnerability may have been further amplified during the COVID-19 pandemic. The well-being of psychologists is integral to ensuring high quality patient care and to the overall management of pandemic and other disease outbreaks. There remains a significant dearth in the available literature examining the lived mental health experiences of psychologists, especially those working in the public sector. This study aims to address this pertinent gap by investigating the lived mental health experiences of ten psychologists employed in South African public institutions, amidst COVID-19 pandemic. Semi-structured interviews comprising sixteen questions were conducted with each psychologist. The following five overarching themes emerged from an Interpretive Phenomenological Analysis (IPA): 'The personal effects of COVID-19 on psychologists', 'Changes to therapy During COVID-19', 'Experiences of COVID-19 exposure in public hospitals', 'Coping Mechanisms' and 'Survivor Guilt: Privilege during the pandemic'. A discussion of the abovementioned findings highlighted the importance of addressing, prioritising and monitoring the psychological wellbeing of these public sector-psychologists, during pandemic and other disease outbreaks to increase their support structures.

Key words: COVID-19, public sector, mental health, psychologists, South Africa.

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It wasn't necessary for participants to reside in any particular province within South Africa as interviews were conducted online. The sample was collected through the use of a non-probability purposive sampling approach. Purposive sampling involves specifically selecting sample group based on particular characteristics that relate to the research area of interest (Palinkas et al., 2015; Padgett, 2004). The sample is considered a volunteer sample as the participants were invited to take part in the study and could choose whether to volunteer their participation or not. This sample is also considered a convenience sample because this study relied on who chose to respond as well as their availability and willingness to participate (Etikan et al., 2016).During the process, the clinical psychologists who were interviewed were asked if they could refer any other psychologist whom they thought may be interested

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Declaration:

I declare that this dissertation is my own original work and I did not receive any assistance in the writing of this research report. It is being submitted in partial fulfilment of the requirements for the Degree of Masters of Arts in Social and Psychological Research by coursework and Research Report in the Department of Psychology, University of the Witwatersrand, Johannesburg.

This research report has not been submitted to any other university of institution for any other degree or examination.

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Signed: 

Date: 24 June 2023

Acknowledgements:

Firstly, I would like to extend immense gratitude to my Supervisor Professor Sumaya Laher, for her unwavering patience and dedication in supporting me with the successful completion of this dissertation.

Additionally, I would like to express my deep appreciation for my parents. To my father, whose commitment to the pursuit of knowledge has been an enduring source of inspiration. His dedication to social justice has contributed to my desire to gain a deeper understanding of the complexity of our human experience. It is by unpacking the multifaceted mechanisms that shape our social fabric; that we no longer see the individual in isolation. His work has left me with a sense of responsibility to challenge the prevailing inequalities within our country, and to advocate for a more just society. Thank you for teaching me to be courageous and resilient.

And to my beloved mother, whose love for literature and highly empathetic nature helped shape my outlook on life. Thank you for listening compassionately, constantly availing yourself to me, and encouraging me to pursue my dreams fervently. You have taught me that no challenge is insurmountable, and that sometimes a mere shift in perspective, coupled with a touch of humour, can make an enormous difference.

Lastly, I remain indebted to the psychologists who generously gave of their time to partake in this study, despite the stressors placed on them by the COVID-19 pandemic. This research would not have been possible without your valuable insight and collaboration.

Chapter One: Literature review

1.1 Introduction:

The COVID-19 pandemic has had a profound impact on all facets of human life, including severely impacting mental health throughout the globe (Chutiyami et al., 2021; Gloster et al., 2020). The available literature suggests that the COVID-19 pandemic has not only contributed to a worldwide spike in rates of depression, anxiety and Posttraumatic Stress Disorder (PTSD), but has further worsened the symptomology of pre-existing mental illnesses generally (Bouza et al., 2023), thereby increasing the global burden of disease (Gebru et al., 2021; Rathod et al., 2017; Santomauro et al., 2021; Vigo et al., 2022).

COVID-19 has severely aggravated the concerning state of mental health in South Africa; a Low and Middle income Country (LMIC) that was already experiencing a public mental health crisis prior to the pandemic (Nguse & Wassenaar, 2021; Padmanabhanunni et al., 2022). South Africa's population is continually confronted with traumatic events, acts of physical violence, social unrest and the grim realities of structural inequality; it has thus been regarded as one of the most traumatised societies globally (Kaminer et al., 2018; Munishvaran & Booysen, 2022). The pandemic has had significantly harsher consequences for the more impoverished members of the population (Webb Hooper et al., 2020). This disproportionate impact further highlighted the systematic failures within South Africa. COVID-19 created even more barriers to obtaining mental healthcare services, particularly for individuals residing in remote rural areas; thereby further extending the mental health care treatment gap (Kola et al., 2021; Nguse & Wassenaar, 2021; Padmanabhanunni et al., 2022; Pillay & Barnes 2020). Research on epidemics (e.g. Ebola) in Lower and Middle income countries (LMIC's) states that epidemics, famine and natural disasters indeed increase the risk of mental health challenges. Simultaneously, countries scarce resources are often placed elsewhere during these emergencies, leaving mental health service provision underprioritized (Ornell et al., 2020; Rathod et al., 2017).

Extensive literature has confirmed that healthcare workers are a susceptible group of people who may face both immediate and long-term, psychological and occupational ramifications, whilst serving the public during pandemic or other disease outbreaks (Greenburg et al., 2020; Mahlangu et al., 2023; Temsah et al., 2020). Frontline healthcare workers like clinical psychologists, particularly those employed in public institutions, have been at the forefront of efforts to deliver quality psychological care to members of the public during the COVID-19 pandemic. In South Africa, the

population group most likely to use public mental health care facilities are those of a lower socioeconomic status (Maphumulo & Bhengu, 2019). As has been previously argued, these individuals were most severely impacted by the pandemic because of the devastation it caused to their everyday lives. Many South Africans experienced a worsening of their pre-existing poor living conditions such as: high unemployment rates, limited access to basic needs such as housing and food, as well as a lack of access to quality healthcare, which is largely provided in the private sector (Nguse & Wassenaar, 2021; Pillay & Barnes, 2020). Furthermore, it has been proposed that psychologists who work with disadvantaged populations in LMIC's under mostly fragile health care systems, are at an increased risk of developing adverse mental health outcomes (Borges, 2014; Kola et al., 2021; Rathod et al., 2017). High levels of occupational distress may negatively impact job performance and attitudes (Alrawashdeh et al., 2021; Gilboa et al., 2008; Wushe, 2019), especially for HCW's in under-resourced work-settings (Wushe, 2019).

This study seeks to explore the lived mental health experiences of a cohort of clinical psychologists who were employed in the public sector during the COVID-19 pandemic. Particularly, this study aims to provide a more in-depth understanding of the distinctive challenges and stressors faced by these psychologists during the pandemic, as well as the impact it may have had on their own physical and mental health. Because the psychologists in this study consisted of trainee clinical psychologists as well; it was of increased interest to establish if their experiences were distinctive or unique because they were still in training, compared to the fully qualified psychologists employed in the public sector during the pandemic. This study further seeks to establish how these psychologists adapted their practices in efforts to continue providing quality psychological treatment in spite of the multiple barriers imposed by COVID-19, such as: social distancing, the wearing of face masks, the prevailing fear of infection, and working in highly - pressured and under-resourced public institutions. Additionally, this study sheds light on the positive aspects of their experiences during the pandemic, such as a deep sense of reward and fulfilment derived from undergirding the public psychologically during COVID-19; as well as some accounts of posttraumatic growth.

The upcoming literature review will focus on a comprehensive overview of some of the available literature on the mental health impact of COVID-19 on mental healthcare professionals, with a particular focus on the experiences of psychologists working in the public sector. The review will begin by providing a brief indication of the broader context of the COVID-19 pandemic, first globally and then specifically in the South Africa. Thereafter, some of the available literature on the mental health impacts of COVID-19 on South African citizens will be investigated. Subsequently, the

available research on the mental health experiences of both psychologists in training as well as of fully qualified psychologists working amidst the COVID-19 pandemic in South Africa, will be explored (based in various settings but the literature search will be focus on public institutions). To conclude, the review will aim to identify gaps in the existing literature, which will also highlight the very importance of this particular research study.

1.2 The COVID-19 pandemic context in South Africa

The World Health Organization (WHO) announced the discovery of a cluster of pneumonia cases on the 31st of December 2019, in the city of Wuhan, China (She et al., 2020). COVID-19 is considered an infectious disease caused by the 'Severe Acute Respiratory Syndrome Coronavirus 2' (SARS-CoV-2) (Lai et al., 2020; Xiong et al., 2022). Since the first reported cluster, COVID-19 has spread to almost every country in the world, of which South Africa is included. The resultant spread of the coronavirus has led to a devastating global pandemic, with the number of worldwide infections at 766, 895, 075 and mortalities 6,935,889, as at the 24th of May 2023 (*WHO Coronavirus (COVID-19) Dashboard*, 2023). National lockdown restrictions were put into place by the president of South Africa, Cyril Ramaphosa, in an effort to stem the spread of rising COVID-19 infections in March 2020 for a period of 35 days (Kiewit et al., 2020). These restrictions meant that citizens were prohibited from leaving their homes, with the exception of travel for essential goods. However, frontline healthcare workers were considered an essential service and were expected to travel to work to fulfil their duties to the public. After the initial hard lockdown period that ended mid- April 2020, South Africa moved to an alert level system whereby restrictions would change, dependent on the rate of virus transmission at any particular time. These unprecedented and unfamiliar experiences of sudden restrictions on freedom of movement; social distancing and confinement, mandatory mask wearing, amongst other regulations, have impacted the citizens of South Africa in a multitude of ways. As previously mentioned, the impact was compounded by the fact that South Africa is a country that is regarded as one of the most unequal societies in the world, in terms of income distribution, as it still battles against the ramifications of Its apartheid past (*The World Bank*, 2019, Nguse & Wassenaar, 2021).

South Africans have endured periods of quarantine, social isolation, threats to daily survival and extreme uncertainty about the foreseeable future (Pillay & Barnes, 2020; Mbunge, 2020), which has had a detrimental impact on their emotional, mental and psychological well-being. These adverse impacts have been document in numerous other countries as well (Pedrosa, 2020; Bhuiyan et al., 2020; Mamun & Ullah, 2020). Furthermore, It had been disproportionately challenging for the poorer and more marginalized communities to abide by certain COVID-19 regulations such as social

distancing in crowded living conditions, and frequent hand washing, when there was limited access to running water (Pillay & Barnes, 2020; Yancy, 2020).

Additionally, lockdown restrictions led to further increases in the already high unemployment rates which were 32.5 % at the end of 2020, and are currently 32.9%, as of the first quarter of 2023 (*Statssa*, 2023). An approximation of three million South African citizens lost their jobs during the first four months of the COVID-19 lockdown (Ingle et al., 2020 as cited in Nguse & Wassenaar, 2021). Relatedly, a high level of food insecurity had been documented; an economic crisis that South Africa certainly could not afford (The World Bank, 2021; Mbunge, 2020). Arguably, those citizens affected the most were the poorest workers who were already disadvantaged even prior to the pandemic because they often relied on daily wages, grants, and income from casual jobs for their survival (Roberts et al., 2020; Yang, 2020; Kim et al., 2020; Tsamakis et al., 2021).

1.3 The Mental health of South Africans during the COVID -19 pandemic:

Indeed research indicates that financial distress is a prominent risk factor for the development and or worsening of mental disorders, as well as for acts of suicide (Pedrosa et al., 2020 as cited in Conejero et al., 2020 & Vandoros et al., 2019). This is evidenced by the suicide rates in many LMIC's that have been linked to unemployment and financial distress during the COVID-19 pandemic (Dsouza et al., 2020; Mamun & Ullah, 2020). Furthermore, the experience of home confinement for prolonged periods of time – and the frustrations thereof, may have contributed to increases in domestic violence (Pedrosa et al., 2020; Joshi & Sharma, 2020) and decreases in access to help and support (Pedrosa et al., 2020 as cited in Usher et al., 2021).

Overall, majority of the research on the psychological effects of quarantine measures have demonstrated notable increases in the probability for the development of mental illness and suicidal ideation (Kim et al., 2020**;** Chen et al., 2020; Ammerman et al., 2021; Di Fazio et al., 2022). A supposed clear - cut definition of mental illness or mental disorder is contentious, however for the purpose of this study, mental illness or disorder (these terms may be used interchangeably) will be defined as **"**a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning", as is defined by the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5). Mental illnesses or disorders may range from mild to severe, and can significantly impact an individual's quality of life, as well as their general daily functioning (Connell et al., 2012).

A comprehensive literature search was conducted to investigate the available research on the impact of the pandemic on public mental health in South Africa, in particular. A survey based study was conducted on over (n=12 000) participants by the University of Johannesburg and Human Sciences Research Council on the effect of COVID-19 on the mental health of South African's which indicated that during lockdown, thirty-three percent (33%) of adults in South Africa were depressed, forty-five percent (45%) were experiencing fearfulness, and twenty-nine percent (29%) were experiencing increased loneliness (Orkin et al., 2020). Amongst these aforementioned figures, were frontline medical personnel and counsellors that endured psychological difficulties like depression, distress, and anxiety due to the then rapidly growing confirmed COVID -19 cases and related deaths (Suh Moh & Sperandio, 2020). The previously mentioned study by Orkin et al. (2020) produced similar results to another survey based study conducted on a sample of (n=203) South Africans during the first wave of the COVID-19 pandemic by Lentoor & Maepa (2021). Findings indicated that thirty two percent (32%) of participants experienced pandemic-related feelings of sadness and anger, whilst forty percent (40%) felt distressed about financial uncertainties, and sixty one percent (61%) experienced distress and anxiety during the first wave of lockdown. Participants with pre-existing mental health concerns exhibited an amplified increase in levels of stress during the first wave of the lockdown (Lentoor & Maepa, 2021).

An additional survey based study was conducted in the Western Cape during the month of May 2020. The aim of this study was to explore the mental health of South African citizens during the period in which they were instructed to follow quarantine regulations to curb COVID-19 transmission. The purpose was to establish whether there were any correlations between COVID-related stressors and poor mental health outcomes (De Man et al., 2021). The sample comprised of eight hundred and sixty (n=860) individuals who volunteered to participate in the online survey. This sample encompassed individuals who were of a higher economic status than the general population and were also of a higher educational status (De Man et al., 2021). Structural equation modelling analysis was utilized for the purpose of establishing if and how the aspects of: 1) stressors related to COVID-19, 2) belonging to vulnerable groups and 3) sociodemographic variables, were associated to anxiety and or depression. Results indicated that forty six percent (46%) of participants met the criteria for an anxiety disorder, and forty seven percent (47%) met the criteria for a depressive disorder diagnosis. In this study, stress related to self-isolation measures set by the government, as well as recurrent anxieties about being infected by the virus were both significantly associated with an increase in symptoms of depression and or anxiety. Moreover, the presence of a pre-existing

mental disorder also highlighted a positive and significant correlation with an exacerbation of symptoms linked to anxiety and or depression (De Man et al., 2021). Interestingly, this study found that being a healthcare worker actively working during the quarantine period of the pandemic, was not associated with poorer mental health outcomes. As is quite common in South Africa, results also indicated that very few of these individuals struggling with depression and or anxiety disorders sought mental health care services during that time.

A further mixed-methods study entitled 'Evaluating the Mental Health Impact of the COVID-19 Pandemic in Urban South Africa' reported a significant positive relationship between perceived COVID-19 infection risk and depressive symptoms within a sample of (n=957) residents of Soweto Township in Johannesburg. It is notable that this relationship was stronger amongst the adults in the sample who had experienced childhood trauma in their lives (Kim et al., 2020). The majority of participants however, expressed that COVID-19 was not impacting their mental health. Only up to approximately (20%) of the sample reported that they grappled with rumination, anxiety, and fear during the COVID-19 pandemic (Kim et al., 2020). The qualitative section of the research confirmed some of these participant's experiences of financial instabilities, heightened fear of infection and persistent negative thoughts during their interviews (Kim et al., 2020 p.5). This study was conducted during the first six weeks of South Africa's lockdown.

Further, results from another survey-based study conducted during the first and second waves of COVID-19, using the National Income Dynamics-Coronavirus Rapid Mobile Survey (NIDS-CRAM) revealed that adults who had lost their employment during the pandemic had significantly higher depression scores compared to the adults who remained employed (Posel et al., 2021). It has been confirmed by some of the available research that indeed extreme psychological distress has been reported to be exacerbated by the financial strain and physical health threats posed to people due to the COVID-19 outbreak (Kamal et al., 2020; Pedrosa et al., 2020; Nguse & Wassenaar, 2021).

It is noteworthy that a limited body of research on the mental health of South Africans during the COVID-19 pandemic was available (Kim et al., 2020; Roberts et al., 2020; *SADAG*, 2020; Orkin et al., 2020; Van Niekerk & Van Gent, 2021; & Padmanabhanunni[a] & Pretorius, 2021; De Man et al., 2021; Lentoor & Maepa, 2021; Posel et al., 2021; Nguse & Wassenaar, 2021). There was a significantly larger body of research available internationally on the mental health impact of citizens in countries abroad (Bhattacharjee & Acharya, 2020; Roy et al., 2020; Ren et al., 2020; Zhao et al., 2020; Baloran, 2020; Jia et al., 2020, Keeter, 2020; Mansfield et al., 2021; Giuntella, et al., 2021; Li et al., 2021; Jia et

al., 2021; Blanchflower & Bryson, 2022). Further, it must be considered that the available studies on the mental health impact of the COVID-19 pandemic may have potentially included psychologists as well, as they were also experiencing the pandemic themselves as individuals outside of their professional capacity.

1.4 The Mental health of frontline healthcare workers during COVID-19 pandemic: International findings

Salari et al. (2020) conduced a systematic review of meta-reviews to establish the prevalence of depression, anxiety and stress amongst (n= of 22,380) frontline healthcare workers in (n= 29) of articles. Findings indicated that overall, the prevalence of stress was 45%, of anxiety 25.8% and of depression 24.3%. Similarly, a meta-review of systematic reviews was conducted by Chutiyami et al. (2021) on forty (n=40) systematic reviews, involving (n=3, 245, 786) healthcare professionals. Findings revealed that depression, anxiety and PTSD were the most prevalent global mental health concerns. Healthcare workers also reported burnout, sleep problems, Obsessive Compulsive disorders, increased fearfulness, substance abuse, somatic symptoms and thoughts of suicide. The most prominently identified risk factors were: being a frontline healthcare worker, being a nurse, being a woman, and being in a younger age group. Further, healthcare workers felt that their own individual or group therapy helped them cope. They also mentioned that support from their loved ones (inclusive of family and friends), accessibility and quality of Personal Protective Equipment (PPE) as well as increased training, were useful coping mechanisms (Chutiyami et al., 2021). This meta - review is a significant contribution to the available research.

A study was conducted on the mental health of (n= 257) administrative staff and (n= 2024) medical healthcare workers based at a provincial hospital in China. Findings indicated that the medical healthcare workers had more fearfulness and symptoms of depression and anxiety, compared to the administrative staff based at the hospital during the pandemic. Additionally, of the medical staff, those who closely with COVID-19 patients were more likely to battle anxiety and depression, as well as other mental disorders, compared to those who didn't (Lu et al., 2020). Correspondingly, the results from a rapid systematic review conducted by the Norwegian Institute of Public Health repository, based on (n= 59) studies, demonstrated that frontline healthcare workers experiences of mental health difficulties were most frequently correlated with their direct exposure to COVID-19 (Muller et al., 2020). Further correlations were based on anxieties regarding contracting the virus and transmitting it to others, as well as the female sex. Further, healthcare worker's reports of feeling supported socially, was correlated with lower instances of mental health difficulties in this

study (Muller et al., 2020). Research confirms that social support often serves a protective function to safe-guarding mental health, particularly during periods of heightened distress (Cohen & McKay, 2020; Bjørlykhaug et al., 2021).

A further study conducted in the USA investigated the prevalence of healthcare worker's mental health symptoms based to three different aspects, these were: depressive symptoms, anxiety symptoms and burnout (Firew et al., 2020). Certain risk factors for the increased prevalence of these symptoms were discussed. A previous COVID-19 infection increased the risk of developing depressive, anxiety and burnout symptoms. Further, a lack of COVID-19 testing when the healthcare workers were displaying symptoms increased their depressive symptoms. Additionally, those who lived alone were at greater risk of developing depressive symptoms. Interestingly, the participants who lived alone also had lesser risk of anxiety and burnout. However, healthcare workers who lived away from home in a temporary residence were at higher risk developing anxiety and to a lesser extent, burnout (Firew et al., 2020). Associations between living alone (increased social isolation) and poor mental health outcomes related to depression and anxiety, have been documented globally during the COVID-19 pandemic (Robb et al., 2020; O'Sullivan et al., 2021).

A qualitative study was conducted to explore the experiences of healthcare workers in Japan using a cohort of (n=24) participants. All of the healthcare workers in the study reported an increase In levels of stress and loneliness (Kotera et al., 2022). They battled with an increased workload, feelings of anxiety, uncertainties about the foreseeable future and fears about contracting the virus. These struggles experienced by healthcare workers are well documented within the literature (Stone et al., 2021; Pappa et al., 2021; Naldi et al., 2021; Miguel-Puga et al., 2021; Ulfa et al., 2022). Participants in the study by Kotera et al. (2022) also revealed that they had limited coping mechanisms to rely on due to the constraints posed by the pandemic. Many of the healthcare workers emphasised the importance of self-care as a mitigating factor, however they also acknowledged that self -care is not a large part of Japanese culture and therefore highlighted the importance of endorsing it within the health care field. An additional coping mechanism mentioned was frequent communication with their colleagues who could identify with their challenges. Particularly because their feelings of social isolation were increased due to workplace lunch conversations and social gatherings being put to a halt (Kotera et al., 2022). They included that receiving positive feedback and a sense of 'acknowledgement' for their hard work from their supervisors, managers, peers and patients helped protect their mental health. These particular aforementioned studies are based on frontline healthcare workers in general and are based

internationally. They are not focused on specifically on the lived mental health experiences of psychologists working with the public sector during COVID-19 in the South African context (Kotera et al., 2022).

1.5 The Mental health of frontline healthcare workers during COVID-19 pandemic: South Africa

A survey methods study conducted by the Human Sciences Research Council (2020) aimed at establishing how COVID-19 affected healthcare workers in South Africa. A total of (n=7 607) healthcare workers participated in the study. Fifty percent (50%) of the participants were employed in the public sector at the time of the survey (Msomi, 2020). Results indicated that there was a relatively high perception of risk of infection amongst healthcare workers; approximately three quarters of the sample concurred with this. Additionally, one in four healthcare workers felt increased concern about their risk of contracting COVID-19 due to their own co-morbidities. More than half of the respondents indicated that there was not enough PPE available to them, which increased their risk of infection and feelings of stress and anxiety regarding COVID-19 mortality (Msomi, 2020). Approximately 60% of the nurses in the same study experienced particularly high levels of stress and fears about infecting their loved ones. It is important to note that the nurses working in the public sector reported greater feelings of psychological distress compared to those working in private organisations (Msomi, 2020). The healthcare workers in general reported an inverse relationship between psychological distress and general wellbeing, when psychological distress was high, general wellbeing was low (Msomi, 2020).

Olashore et al. (2021) conducted a systematic review to establish the prevalence and condition of psychiatric disorders amongst African healthcare workers during the COVID-19 pandemic. Twelve studies (n=12) met the inclusion criteria for this review. Results indicated that depressive and anxiety disorders were most frequently reported within the available literature. This also applied to international literature in both LMIC's and high income countries (HIC's). The prevalence of anxiety disorders amongst the studies in the review by Olashore et al. (2021) ranged from 9.5% to 73.3% and that of depressive disorders ranged from 12.5% to 71.9%. The factors that reduced or mitigated symptoms associated with these two disorders were access to information on COVID-19 preventative measures, as well as availability and access to PPE**.** The review found that a few factors increased the risk of the either the onset or worsening of depression and or anxiety, these are: pre-existing chronic illnesses, a lack of social support, substance use and abuse as well as lower levels of reported resiliency in healthcare workers (Olashore et al. 2021). These results were corroborated by

research on frontline healthcare workers globally, inclusive of both LMIC's and HIC's (Chutiyami et al., 2021).

Another survey based study conducted by Lee et al. (2022) on a sample of (n= 154) healthcare workers in South Africa, conformed most of the available literature on the negative mental health impact of COVID-19 on healthcare workers. Results demonstrated that high rates of psychological distress were being experienced, at a rate 57.4% that was above the general health questionnaire cut-off values. Further, strong associations were found between perceived risk of COVID-19 infection in the public health workplace and increased psychological distress. Mitigating factors in this study (as was the case in majority of studies of this nature) were related to the presence of social support amongst colleagues within the workplace as well as having received additional pandemic specific training (Lee et al., 2022).

The purpose of the survey study conducted by Cook et al. (2021) was to investigate the mental health and coping skills of healthcare workers who were based at a South African Ophthalmic consulting practice and hospital, during COVID-19 (Lockdown level 2 and 3). The survey was conducted on two occasions, with a total sample that comprised (n=31) and (n=15) healthcare workers, respectively. Findings evidenced some experiences of psychological distress. This was inclusive of burnout and anxiety. According to the results of both of the surveys, the participants in this study also experienced a lack of social support. Mitigating factors to their adverse mental health experiences were the implementation of useful coping strategies, the presence of institutional support as well as higher levels of resiliency.

A qualitative study was conducted by Mahlangu et al. (2023) on a cohort of (n=44) South African healthcare workers who were at the frontline of the COVID-19 pandemic, working in public hospitals and or clinics. This study's findings referred to a few aspects that facilitated the development of positive coping mechanisms amongst the healthcare professionals. Interviews were conducted during the first wave of the pandemic based on the working experiences of these healthcare workers in relation to the impact on their physical and mental health, which was described in this study as overall 'wellness'. Results of this study suggested that the majority of healthcare workers experienced periods of heightened distress as well as trauma, whilst working settings that were emotionally demanding during the first wave of COVID-19. Healthcare workers reported experiencing anxiety and depression, as has been prevalent in similar research. Some of the respondents also reported: insomnia, burnout, demoralization, impaired functioning and increased

irritability. Many of the participants in the study mentioned problems with their physical health. These were: physical fatigue, headaches and other bodily pains. Some of the healthcare workers expressed that their dedication and commitment to their profession, motivated them and facilitated the development of coping mechanisms (Mahlangu et al., 2023). Indeed professional commitment and dedication has been frequently documented as both a work motivator and protector against burnout (Bernales-Turpo et al., 2022).

Psychiatric nurses

A phenomenological qualitative interview study was conducted on a sample of eighteen (n=18) highly experienced psychiatric nurses working in a psychiatric hospital in China. The findings revealed that the nurses felt severely underprepared for the pandemic and lacked the necessary knowledge pertaining to coping skills. Some of the psychiatric nurses reported feelings of inadequacy when comparing themselves to the ICU nurses working with patients. Nurses reported feeling torn between work and having to adjust to their new family roles and responsibilities (Wu et al., 2020). Nurses were battling with supporting their children with the new terrain of online schooling, for example. Additionally, these nurses reported constantly feeling anxious and worried about virus transmission between their patients and family members at home. Lastly, a theme that emerged from data was that these psychiatric nurses felt that their lives outside of work were put on hold and their personal life plans had to be postponed to an unforeseeable future (Wu et al., 2020).

These types of studies on psychiatric nurses are quite limited in available literature, both internationally and in the South African context. These are some of the few limited studies on psychiatric nursing during COVID-19 that were uncovered (Cheung et al., 2020; Ning et al., 2020; Wu et al., 2020; Zhang et al., 2021; Kameg et al., 2021; Ward-Miller et al., 2021; Napoli, 2022; Tavako et al., 2023). The study by Zhang et al. (2021) listed previously, also comprised a sample of psychiatrists as well as psychiatric nurses. Interestingly, results showed that only 28.52% of frontline psychiatric clinicians experienced depression. This study also made mention of a further study based in Japan that demonstrated depression ratings on the Centre for Epidemiologic Studies for Depression Scale (CES-D) to be between 36% and 38%, based on the gender (/sex) of these psychiatric clinicians (Zhang et al., 2021). Similar findings have been identified across various studies.

Research was conducted in Croatia by Jokić-begić et al. (2020) aimed to establish the mental health of psychiatrists, and other medical specialists (who were non-mental healthcare specialists) in the initial period of the COVID-19 pandemic, specifically the first lockdown. The sample consisted of

(n=725) physicians, of which 22% were psychiatrists responded to an online based survey focused on mental health indicators, coping behaviours and COVID-19 pandemic related worries. Results suggested that the psychiatrists in this study had less anxiety compared to the physicians who were not mental healthcare workers. Psychiatrists in this study were also more prone to utilizing substances (inclusive of sedatives) as a coping mechanism during psychological distress (Jokić-begić et al., 2020). Further, the results revealed specific risk factors for impaired mental health amongst the sample: lower levels of resiliency, younger age groups, heightened perceived risk of COVID-19 as well as a lack of flexibility should be considered (Jokić-begić et al., 2020). These findings have been corroborated by the prior discussed studies in this review.

It is notable that a larger body of literature was available on the mental health impact of COVID-19 on nurses and medical doctors on duty during the pandemic, both globally and in South Africa (Govender et al., 2020; Maben & Bridges, 2020; Nelson & Lee-Winn, 2020; Puradollah & Ghasempour, 2020; Sun et al., 2020; Galehdar et al., 2020; Sovold et al., 2021; Dawood et al., 2022). Some of these studies indicated themes of depression, anxiety, burnout, helplessness, compassion fatigue, alongside some positive experiences as well, such as those related to providing help during the pandemic and increased development of resiliency (Sun et al., 2020; Zaka et al., 2020; Shanafelt et al., 2020).

1.6 The Mental health of Trainee psychologists working in the public sector during COVID-19:

Frontline healthcare workers such as psychologists, play a pivotal role in the efforts to combat and undergird the devastating mental health consequences of pandemics and other disease outbreaks, as was the case with the onset of COVID-19 (Joshi & Sharma, 2020; Glowacz et al., 2022). For the purpose of this current study, the term 'psychologist' will refer to any psychologist registered in the category of Clinical psychology, who were employed in the public healthcare sector during the pandemic. The term will also encompass psychologists registered under the 'Intern' and 'community service' categories (as per Health Professional Council of South Africa definitions) who were completing their training and working based learning (WBL) at various public institutions amidst the COVID-19 pandemic. Whilst researchers and scientists were hard at work trying to uncover effective vaccinations for the population during the beginning phases of the pandemic, it can be argued that the mental health response countries required was largely underprioritized (Banerjee, 2020; Ornell et al., 2020). Research suggests that frontline workers such as psychologists working in hospitals and other public sectors, can themselves be considered a vulnerable and at-risk population for

developing various mental health issues such as depression, burnout and PTSD, to name a few, because of the unique nature of their work (which involves dealing closely with trauma) as well as sometimes working with marginalized populations (Shapiro et al., 2007; Glowacz et al., 2022; Munishvaran & Booysen, 2022). This may have been compounded by numerous aspects during the pandemic that are inclusive of but not limited to: an increased heavy workload, staff shortages, perceived stressors, prolonged emotional and physical exhaustion, continuous feelings of uncertainty, a perceived lack of control in their work setting, a lack of PPE, insufficient infrastructure, stigmatization from the public, as well as fears of being infected by the virus at work and passing it onto their loved ones at home (Chersich et al., 2020**;** Deng & Naslund, 2020; Rokach & Boulazreg, 2020; Tsamakis et al., 2021).

The purpose of an internship is to practically link theoretical knowledge gained during academic years with the practical competencies required to qualify as a healthcare practitioner, and specifically as a psychologist, based on the topic of this study (Bola et al., 2015; Chin et al, 2020). The period of internship is therefore crucial to the development of competent healthcare workers who possess the necessary ability and skill-set to function safely and independently. The unprecedented conditions of COVID-19 have brought up different challenges to internship sites, thereby impacting the both the type and quality of internship training received.

A national mixed- methods study conducted in Okhaloma, the USA, on the mental health impact of COVID-19 on (n=400) intern psychologists in training demonstrated that respondents experienced clinically increased levels of anxiety and depression (Schneider et al., 2021). Themes that emerged were similar to most studies on healthcare workers during COVID-19, indicating that respondents were anxious about the lack of PPE and exposing themselves to the virus at work, particularly related to seeing patients in person. Additionally, the respondents expressed a desire for working remotely, and for the ability to have access to more telehealth options (Schneider et al., 2021) probably to decrease their risk of exposure. The intern psychologists in the sample conveyed a need for greater supervisory communication and support. Furthermore, it was mentioned that they desired greater flexibility in the training programme to cater for the stressors and challenges that arose whilst working amidst a pandemic. The wellbeing of intern psychologists is vitally important to the type of mental health support they are able to provide to the public. It appeared as if the unprecedented conditions of COVID-19 seemed to have compromised the quality of training offered to these intern psychologists. Further, research has suggested that intern healthcare workers may already experience exacerbated stress partially because of the inherent power dynamics and limited

resources during their intern year [Singaram et al., 2021). It is notable that this study was conducted nationally within the USA, it could be argued that South African intern psychologists (in a LMIC) may face even more challenges in light of the state of public mental health service delivery here compared to that in HIC's.

Gardner et al. (2021) conducted a survey based study in the USA with (n=63) Training Director's, purposed on gaining insight into their perspectives of Psychology interns and Postdoctoral Fellows Training experiences during the COVID-19 pandemic. Findings revealed that training during COVID-19 impacted the interns mostly in terms of five aspects. These were: the extent, depth and type of training offered to interns during the pandemic that didn't meet all their expectations; an increase in self-reported levels of stress as well as the corresponding decrease of morale amongst interns and supervisory staff; the lack of sufficient collaboration between disciplines/departments in the hospital setting; limitations posed on assessment training that was to be done face to face as well as less organic experiences in therapeutic settings (Gardener et al., 2021). Overall, the study revealed that Training Director's perceived that the interns were exposed to both positive and negative experiences during their internship training, and that the pandemic also provided interns with the prospects of gaining access to telehealth/telepsychology services training. Some of the themes that emerged were of concern in terms of the unprecedented challenges that arose and alterations that had to be made to intern training that may have impacted the necessary exposure, skill development and competency needed for intern psychologists to begin independent practice (Gardener et al., 2021). It is important to mention that these results were indeed based on the perspectives of the training directors and that a limitation and gap is that the reader does not have access to primary data based on the actual thoughts and experiences of the intern psychologists themselves.

Iskander et al. (2021) conducted a qualitative research study based on the experiences of (n=4) paediatric psychology interns alongside their training director, during the COVID-19 pandemic. The interns mentioned challenges related to a loss of training opportunities that were afforded to previous interns not training during a pandemic, challenges associated with the unfamiliarity of providing tele-psychotherapy services, heightened feelings of stress and fear of exposure to the virus when working with patients, as well as the realities of social isolation. Interns reflected on positive experiences that arose from training during a pandemic. They mentioned the opportunity to train in and provide telehealth services, develop flexibility and practice innovation, as well as the ability to

increased support to their medical doctor colleagues as some positive experiences and skills gained during COVID-19 (Iskander et al., 2021).

Authors Lourens & Uren (2023) conducted a study to explore how South African intern psychologists developed their professional identity during the COVID-19 pandemic. The study was interview based and included a cohort of seven participants; four counselling psychologists and three clinical psychologists. Four of these participants (clinical) had been based in a public hospital setting as interns, and the remaining three psychologists (counselling) had been based in an educational environment during their internship year. Inclusion criteria at the time was that the research participants needed to have completed their internships in 2020 (in either clinical or counselling psychology). An interpretive phenomenological analysis (IPA) was conducted and the findings described the working experiences of these psychologists. Most of the participants expressed anxiety and uncertainty regarding how to work effectively during the pandemic; this was coupled with a sense of under – preparedness for the nature of work itself during pandemic-related conditions (Lourens & Uren, 2023). Generally the uncertainty (and sense of unfamiliarity) they experienced was linked to a lack of formalised training on conducting therapy online or via means of a voice call; as well as inadequate formal training on COVID-19 protocols (particularly the clinical interns in public hospital settings). In terms of conducting online therapy: participants raised ethical concerns and dilemmas regarding privacy and confidentiality, as an example. Some of the psychologists also mentioned that they were not always familiar with the technology they began using to conduct online therapy. Some of the psychologists suggested that this contributed to feelings of inadequacy and incompetence when having to transfer therapy online without the necessary skills and training. Network related issues interrupted the flow of therapy and this was noted as a challenge. Many of the psychologists made mention of needing to make quick decisions (judgement calls & improvisations) during the unpredictability of the pandemic. One psychologists reflected that the need for improvisation helped increase her confidence and self-trust (Lourens & Uren, 2023). Further concerns regarding the development of a safe therapeutic relationship was mentioned, these related mainly to: mask wearing and technology glitches during online therapy that impaired the therapeutic process. All the psychologists expressed that working during COVID-19 took a toll on their mental health, and that they all experienced burnout and severe depletion. Some of the psychologists reflected on some of the consequences of burnout: namely, a decrease in the ability to empathise with patients. Contrastingly, others experienced an inverse relationship, where deep empathy buffered their experience of burnout.

In terms of internship requirements, standards and related intern expectations, the majority of psychologists highlighted the limits that the COVID-19 context posed to hands on experiential learning (they missed out on certain aspects of work based experiential learning such as assessments and group therapy as well as community work) , as well as opportunities for 'professional development'. Specifically, these deficits in the internship year were connected to insufficient supervision (Lourens & Uren, 2023). All of the psychologists mentioned a necessary self-reliance, and development (or tapping into) of resiliency and flexibility. Importance was also placed on the social support that they found in each other, through teamwork and collaboration**.** This study is significant in that the topic and sample are quite similar to the current research study and can be used to compare and contrast experiences. There is a lack of studies available based on the experiences of trainee psychologists employed in public hospitals during COVID-19.

Further research was conducted in South Africa on (n=46) medical interns based at various public hospitals in KwaZulu-Natal. The aim of this study by Singaram et al. (2021) was to elicit the perspectives of these medical interns on their training experiences during the COVID-19 pandemic. This was done using an online survey that contained open-ended questions. A thematic analysis revealed that the interns felt that the pandemic exacerbated their perceptions of having limited working knowledge within their field as well as having insufficient experience to equip them for their work during COVID-19. Many of the interns seemed to feel under-prepared in this study. Another theme uncovered that many of the interns felt that the social isolation put a strain on access to support structures and that this worsened their stress levels. Interns also expressed fears of a lack of safety in terms of being infected by the virus at work and potentially infecting their loved ones (Singaram et al., 2021). Interns stated that the pre-existing structural problems with South Africa's public healthcare system (such as a lack of resources, infrastructure and staff shortages) were exacerbated during the pandemic and that this impacted their mental health negatively in terms of struggles with burnout. Some interns described feeling neglected by their supervisors, and expressed concerns of inadequate communication, feedback and support. Further, interns mentioned challenges faced with the power dynamics and hierarchical structures in their work environment. Overall, there was a sense that intern training and academic learning was compromised negatively during the pandemic. Interns reflected on what facilitated the development of coping skills during the pandemic, these were: social support, supportive collegial relationships amongst fellow interns, some interns also mentioned supervision. Interns added that the pandemic indeed offered opportunities for pandemic-specific training. They also reflected on the development of competencies related to 'leadership', 'collaboration' and 'advocacy' (Singaram et al., 2021). This

study was based on medical interns and not on intern psychologists. However similar findings to those on intern psychologists have been observed in the literature as evidenced in this current literature review.

However, a contextual element that must be mentioned is that some HPCSA (Health Professional Council of South Africa) internship sites in South Africa have indeed been critiqued for not always meeting the requirement criteria for successful intern training as per the set HPCSA guidelines. A survey based study conducted by Bola et al. (2015) with the aim of investigating whether these guidelines were being upheld by a few internship sites in South Africa, was conducted on a sample of (n=90) already qualified medical doctors who had completed their internships. Results of this study demonstrated that respondents strongly felt that supervision during internship needed improvement. Thirty-three percent 33% of the doctors conducted their very first interventional operation without the presence of supervision. Twenty four percent 24% of the sample experienced an event where they urgently required the help of a supervisor/ senior staff member, but that help was not made available to them. Over 50% of the sample had shifts overseen by supervisors who had less than three years of experience within that particular speciality (Bola et al., 2015). It is important to mention that COVID-19 may have worsened the state of internship training experiences, but that many of these issues i.e. regarding inadequate supervision for example, existed prior to pandemic related circumstances and can be related back to the state of South Africa's health care system.

The previously mentioned study by Singaram et al. (2021) was conducted with medical doctor interns within South Africa, and not on psychology interns. Most of the literature available was based on experiences of intern nurses (Eweida et al., 2020; Abdul Razzaque et al., 2022; Almadani et al., 2023; Xu et al., 2023) or intern medical doctors (Huded et al., 2021; Shetty et al., 2021; AbuDujain et al., 2021; Singaram et al., 2022). There was also some research available on the experiences of medical students globally during COVID-19 (Maharaj 2020; Nakhostin-Ansari et al., 2020; Lyons et al., 2020; Sharma & Bhaskar, 2020; Nolan & Owen, 2021; Collaborative, T.D, 2021; Aftab, 2021; Johns et al., 2022) as well as on undergraduate psychology students internationally (Usher et al., 2020; Sobral, 2021) and in South Africa specifically (Laher et al., 2021). Overall, there was a prominent dearth in literature specifically on trainee psychologists working in the public sector (as well as in other environments to that point) during the COVID-19 pandemic, both globally and in South Africa. The available research on this critical area of knowledge is very scarce in South Africa, as has been demonstrated by this literature review.

1.7 The Mental health of fully qualified psychologists working in the public sector during COVID-19:

A study was conducted by Cerasa et al. (2022) entitled: 'the impact of COVID-19 on psychologists' practice: An Italian experience.' utilizing an online survey study, with a sample of (n=204) psychologists, who met the inclusion criteria of: 1) having at least three years of clinical experience, 2) being employed in either in the public sector or giving psychotherapy in independent practice and 3) were part of the Register of Psychologists in Italy. Results of this study indicated that (59%) of the sample noted a rapid increase in the influx of new patients with the onset of the pandemic. It is worth mentioning that more than half of the sample with this experience of a significantly increased patient load, were working in private practice at the time. Further, 84% of the psychologists in this study mentioned that their main means of conducting therapy was online video calling platforms such as Zoom, for example. Of this group, 65% regarded online therapy as being mostly effective and successful. The psychologists were also asked to reflect on the impact of COVID-19 on their therapeutic relationships with their patients. Most of the psychologists in this study 59% believed that these relationships were not negatively impacted. The majority of psychologists reported that their mental health 56% as well as their physical health 43% was compromised during the pandemic (Cerasa et al., 2022).

Psychologists in this aforementioned study were also asked to report on the mental health of their patients during pandemic circumstances. Results revealed that there was an eruption of new clinical symptoms relating mostly to depression, anxiety and stress syndromes**.** Further, there was a reoccurrence of older symptomatology's that has seemingly been resolved or been more manageable (in remission) before the emergence of COVID-19. The resurfacing of these symptomatologies were also connected to depression, anxiety and stress disorders, which were reported to have been indirectly associated with COVID-19 at a rate of 81% (Cerasa et al., 2022). These findings have been frequently documented in the literature (Gobbi et al., 2020; De Man et al., 2021; Neelam et al., 2021; Lentoor & Maepa, 2021).

Further research was conducted on the experiences of female psychologists working in independent practice in the United Kingdom (UK) during the COVID-19 pandemic. The study was survey-based and a total of (n=41) participants were included in the final results. Data was gathered during the initial wave of COVID-19 in the UK. Based upon a thematic analysis, results revealed a few prominent themes: The first theme related to challenges and experiences of strain on the psychologists

relationships with their families (both partners and children). Further, psychologists struggled with adapting to working from home and having to renavigate their routines and blurred roles in the household. Many psychologists reported a deterioration of their mental health, particularly with increasing anxiety levels (Miller & Essex, 2023). The presence of online support networks for social connection and professional interaction seemed to have been a mitigating factor. Some psychologists contrasted the challenging experience of being confined to their home environments with their families, with the positive element of gaining the opportunity to spend more time with their families and gain a greater closeness with them. Additionally, psychologists mentioned utilizing various means of 'self-care' as a necessary coping mechanism during the pandemic (Miller & Essex, 2023).

Vicarious trauma amongst psychologists during COVID-19:

Vicarious traumatization refers to the psychological experiences of an indirect exposure to traumatic events that were experienced by another person. VT is often experienced by mental health care professionals who treat patients that have experienced trauma (Branson, 2019). Symptoms of VT can mimic those of PTSD (Ogińska-Bulik et al., 2021). The symptoms of VC are characterised as those relating to adverse changes in mood and thinking, avoidance coping mechanisms, experiences of intrusion, and changes to an individual's sense of arousal and reactiveness (Ogińska-Bulik et al., 2021).

A survey based study was conducted In the United States (USA) to measure potential experiences of vicarious trauma in a sample of three hundred and thirty-nine (n=339) psychologists seeing patients during COVID-19. Results revealed that approximately 15% of the sample experienced high levels of vicarious trauma (Aafjes-van Doorn et al., 2020), which was associated with unpleasant online therapy experiences, younger age groups and consequently, fewer years of experience in clinical practise. Approximately 63% of the sample reported moderate levels of vicarious trauma (Aafjes-van Doorn et al., 2020).

Furthermore, additional research was conducted by Aafjes-van-Doorn et al. (2022) which aimed to establish psychologists response to experiences/symptoms of vicarious traumatization, as well as the transition to conducting online therapy during the COVID-19 pandemic. This study was longitudinal as data was collected during four different periods of the pandemic. A total of (n=185) psychologists partook in the study and reported significant levels of self-doubtfulness as professionals, this was more than what they had experienced prior to COVID-19 circumstances. Self-doubtfulness was

forecast by the factors of: less years of working experience, less collaboration and alliance with colleagues, higher levels of vicarious traumatization as well as feeling resistant to the technology and process of transitioning to online therapy. Psychologists in this study also reported increased resiliency and posttraumatic growth. Psychologists who were reportedly more traumatized as well as more accepting and comfortable with online therapy also experienced a greater degree of posttraumatic growth (Aafjes-van-Doorn et al., 2021). Psychologists in this study were predominantly American, white and female.

Vicarious Trauma amongst South African Psychologists

Qualitative research was conducted previously on six South African psychologists' experiences of treating victims of trauma prior to the pandemic and uncovered that all the psychologists reported symptoms of vicarious trauma. However, all of the participants also reported vicarious posttraumatic growth which was related to: positive changes in their perspectives on life as well as their self-image, they also shared a deepened sense of social connection with others (Cheng Sui & Padmanabhanunni, 2016). This aforementioned study however was not conducted during COVID-19 circumstances and these psychologists were not only based in the public sector.

An additional South African study was uncovered by Munishvaran & Booysen (2022) which aimed to explore three clinical psychologists experiences of treating PTSD at a low-resourced public psychiatric hospital based in the Eastern Cape, South Africa. A total of six interviews were conducted on the three participants, with one week apart so that they could provide a 'reflective account' for the follow-up interview. An IPA was then conducted. The one clinical psychologist who was a white male, emphasized a deep discomfort in the therapeutic space when working with female (mostly of colour) patients who were often sexually abused by a male. Another participant mentioned feeling overwhelmingly distressed by child rape cases, as well as working with the perpetrators thereof. One participant mentioned having struggling with distrust and a loss of faith in humanity due to her experiences with working with both victims and offenders of sexual abuse (assault and rape). The participants mentioned feeling a sense of fearfulness as well as hopelessness, as they were often in contexts where they felt a sense of perceived (or real) risk and unsafety with dangerous patients (Munishvaran & Booysen, 2022). Both the female psychologists mentioned hypervigilance with themselves and their own children, as well as how their working environment impacted their parenting styles; they became more 'protective'. Psychologists mentioned the importance of social support (including professional collegial support), upholding boundaries in personal and professional

spheres, flexibility and 'acceptance' as factors that helped with coping (Munishvaran & Booysen, 2022). This study is significant in that it contributes to the topic of this current research study based on clinical psychologists experiences of working during the public sector, however it was not conducted during COVID-19 and lacks that contextual element.

Research was available both on South African (Cheng Sui & Padmanabhanunni, 2016) and International psychologists (Brockhouse et al., 2011; Bartoskova, 2017; Coleman et al., 2018; McNeillie & Rose, 2020) experiences of vicarious traumatization prior to the COVID-19 pandemic, and also during/ post pandemic settings, such as the study by Padmanabhanunni & Gqomfa (2022) whose study focused particularly on vicarious traumatization with female psychologists working with victims of sexual trauma in South Africa, but made no mention of work experiences during COVID-19. Adams et al. (2008) also conducted a significant study of vicarious traumatization with regards to psychologists in training, prior to COVID-19 events.

Burnout amongst psychologists

The continuous stressors and anxieties faced by frontline healthcare professionals have contributed to frequent accounts of burnout, as has been extensively highlighted in research (Maslach, 2003; Lee et al., 2020). Given that a substantial body of burnout literature highlights perceived stressors as one of the main predictors of burnout (Pimble, 2016; Rubino, 2009; Guthier et al., 2020), it is reasonable to assert that frontline healthcare workers (like psychologists) represent a vulnerable population at risk of burnout; particularly due to the heightened pressures experienced working amidst the COVID-19 pandemic as well as the inherent nature of their work that involves dealing with complex human emotions and traumas which could lead to vicarious distress or traumatization (Shapiro et al., 2007; Trombello et al., 2022).

While definitions of burnout vary, the general consensus is that burnout can be described as 'emotional depletion' (Norcross & VandenBos, 2018 as cited in Rokach & Boulazreg, 2020). Burnout with regards to psychologists has often been described as being associated with "exhaustion, cynicism, reduced professional efficacy, and decreased caring about one's clients" (Schutte et al., 2000 as cited in Rokach & Boulazreg, 2020 p. 3; Rupert & Morgan, 2005) as well as a sense of depersonalization (O'Connor, 2018; Pimble, 2016; Simpson et al., 2018). Experiences of burnout can have adverse effects on the level of professional treatment that psychologists are capable of providing to their patients (Joshi & Sharma, 2020; Morse et al., 2012; Baker, 2003; Trombello et al.,

2022; Volpe et al., 2014). Further concerns pertain to the development of compassion fatigue, a lack of perceived therapeutic effectiveness (Joshi & Sharma, 2020), and its associations with decreased morale and professional burnout amongst psychologists. Moreover, instances of vicarious trauma as previously mentioned, further compounds these concerns.

A larger body of literature has been dedicated to investigating experiences of burnout, amongst frontline medical healthcare workers such as doctors and nurses, amidst the COVID-19 pandemic (Barello et al., 2020; Matsuo et al., 2020; Firew et al., 2020; Ghahramani et al., 2021). However, there remains a prominent dearth in the current research concerning the mental health (i.e. burnout) of psychologists working during COVID-19 conditions, both globally and particularly within the South African landscape.

Findings from a cross -sectional research survey measuring vulnerability factors associated with burnout amongst clinical and counselling psychologists in various countries, inclusive of but not limited to Australia, New Zealand and Scotland, revealed that 47.9% of (n=443) psychologists reported moderate to high levels of emotional depletion (Simpson et al., 2018). Various occupational stressors, such as work life balance for example, were reported as a noteworthy contributor. Significant predictors of burnout amongst this sample of psychologists were connected to maladaptive coping mechanisms and 'early maladaptive schemas' (Simpson et al., 2018). Interestingly, these aforementioned predictors of burnout outweighed the predictor of job demands in this sample. This study was conducted prior to COVID-19 circumstances and further, was not based in South Africa. A systematic review of the 'The Prevalence and Cause(s) of Burnout Among Applied Psychologists' was conducted before the onset of COVID-19. Results from twenty-nine papers demonstrated that 34.48% of those papers cited emotional exhaustion as experienced by applied psychologists. Workload and work-related stressors were reported as contributing factors to instances of burnout (McCormack et al., 2018).

A study was conducted by Trombello et al. (2021) on a sample of (n=62) psychologists based at one medical centre in the Department of Psychiatry in the USA. The purpose of this study was to investigate burnout during the COVID-19 pandemic context. Of the participants, 48.4% experienced burnout. Less years of clinical experienced served as a predictor for increased severity of burnout. The psychologists degree of control over their workload and having insufficient time for paperwork both served as significant independent predictors of 'continuous' burnout. This study was conducted

on psychologists who work in an academic setting, thus their work includes research and supervisory roles in addition to their clinical practice (Trombello et al., 2021).

A further study conducted by Glowacz et al. (2022) was based on an exploration of COVID-19's impact on the mental health and practices of psychologists in based in Belgium. An online based survey was completed by (n=187) psychologists. They survey was conducted approximately one year post the onset of the pandemic. Most of the psychologists (72%) indicated that they experienced burnout to a 'medium' degree and seven percent of respondents reported a high degree of burnout. The psychologists who saw patients in person had higher levels of continuous exhaustion in this study. Interestingly, rates of anxiety and depression in this sample were not very high, with 39% reporting depressive symptoms and 36% reporting anxiety-related symptoms. Prevalence of these symptoms were also low at 17% for depression and 12% for anxiety (Glowacz et al., 2022). A few themes were uncovered upon a qualitative thematic analysis of a question in the survey regarding the psychologists experience of challenges in their working environment during COVID-19. The analysis revealed that both social distancing and mask-wearing **(**COVID-related precautionary measures) served as a barrier to communication and rapport within the therapeutic space. Another theme related to radical changes and disruptions to workloads, whether this be by a drastic increases in work load or at times the decrease or the inability to see patients for periods of time. Additionally, many psychologists mentioned feeling powerless due to many aspects such as what was referred to as the 'digital divide' whereby some patients were unable to access technology for teletherapy and when online therapy was met with challenges such as space constraints, a lack of privacy and network interruptions (Glowacz et al., 2022). Some psychologists experienced blurred boundaries between their professional obligations and personal lives (responsibilities) which they felt was challenging to navigate.

The psychologists in this study conducted by Glowacz et al. (2022) mentioned using creative means to adapt, and maintain psychological flexibility in order to continue helping patients during the pandemic; as well as relying on social connection between colleagues (who were also mental health professionals) as a means of emotional support and solidarity. Psychologists demonstrated high resiliency (Glowacz et al., 2022) and felt motivated by their sense of responsibility and commitment (ability to provide some relief) to the public during the pandemic. They also felt rewarded by positive feedback, recognition and the knowledge that they had helped patients in some way.

Brillon et al. (2021) conducted an online survey based study with the purpose of comparing the psychological distress (i.e. mental health) of (n=616) Mental Healthcare workers with (n=658) workers in the general public during the COVID-19 pandemic in Quebec. Findings indicated lower instances of clinical depression and anxiety amongst MHW's compared to the general public. The prevalence of depression among MHW's was 19% compared to 27% in the general population, and anxiety was 16% for MHW's compared to 29% for the general public. However, these levels of depression and anxiety increased amongst MHW's in areas where there were high numbers of active COVID-19 infections (Brillon et al., 2021). The prevalence of both depression and anxiety symptoms amongst MHW's was similar (the same level) to that of the general population in high COVID-19 incidence territories and simultaneously higher than that of MHW's in regions with lower numbers of COVID-19 cases. Additionally, MHW's in high incident regions reported higher levels of irritability and decreased resiliency compared to other MHW's (Brillon et al. 2021).

The American Psychological Association's (APA) 2022 COVID practitioner impact survey yielded (n=2295 respondents), of which were psychologists in the USA. Survey results indicated that demand for treatment of anxiety and depression amongst the population remained high. Namely, (65%) of psychologists in the sample mentioned an increase in the severity of their patients symptoms. Additionally, there was a reported significant increase in the demand for therapeutic care from younger age groups, individuals of colour and healthcare workers (*APA*, 2022). The workload of psychologists thus continued to increase, with many patients on the waitlist. Burnout was high amongst psychologists in this sample, with 45% reporting burnout symptoms. Many of the psychologists reported that they were unable to meet demands from their patients. The majority of psychologists utilized peer social support 60%, practices of self-care 77% and upholding their work life balance 63% as coping mechanisms (*APA*, 2022).

Research conducted by Van Hoy et al. (2022) purposed to investigate cross-cultural differences in levels of burnout amongst (n=2915) psychologists working in twelve different European countries during COVID-19. The Maslach Burnout Inventory-Human Service Survey was utilized as a measurement of indication and severity of burnout. Results suggested that individual differences amongst psychologists (an example is openness to change and self-transcendence, buffered burnout) were seemingly more influential as compared to differences based on country of residence (and heightened levels if COVID-19 related distress predicted increased levels of burnout)(Van Hoy et al. 2022). Whilst this study highlights the importance of individual differences in the experience

and severity of burnout, it must be mentioned that this study was based in Europe and a similar study conducted in LMIC's within Africa for example, may yield completely different results.

At the time of writing, no published research focussed solely on the experiences and impact of burnout amongst South African psychologists working during the COVID-19 pandemic was located. Psychologists undergo distinctive experiences that contribute to the prevalence of burnout amongst them in general (Trombello et al., 2022). Given the onset of COVID-19 circumstances, it is crucial to investigate this phenomenon. Research into this phenomenon within LMIC's like South Africa, is of increased and particular importance.

1.8 The Online therapy experiences of psychologists during COVID-19:

A survey based study was conducted by Sammons et al. (2020) with a sample of more than (n=3000) psychologists within the USA, 23% of whom were employed within hospital or clinic settings at the time. The study was conducted with the aim of establishing the impact of the COVID-19 pandemic on their clinical practices. Results demonstrated that most of the psychologists had to make an extremely rapid transition to online therapy (in this instance 'tele-therapy' referred mostly to video calling). The psychologists in this study were also asked about how they thought their patient's experienced receiving 'teletherapy'. The findings demonstrated that according to the perception of the psychologists, only 20% of the participants reported that their patients 'liked' or enjoyed the experience of teletherapy. A large proportion of psychologists felt that their patients were neutral about the experience of online therapy (Sammons et al., 2020).

The psychologists were also asked to report on their level of preparedness to conduct online therapy. Fifty eight percent 58% reported feeling prepared or 'somewhat prepared' for conducting teletherapy. Whereas, twenty percent 20% felt underprepared (Sammons et al., 2020). This research was conducted using a sample based within the USA. Studies based on experiences of teletherapy within Lower and Middle Income Countries (LMIC's) like South Africa may produce differences based on multiple factors such as patient access to technology for therapy sessions and relatedly the ability for 'uptake'. Interestingly, age did not appear to play a factor in any differences in levels of perceived preparedness amongst psychologists within this sample. A previously mentioned study conducted by Cerasa et al. (2022) based on the impact of COVID-19 Italian psychologists practice revealed that the large majority of psychologists (84.8%) had to utilize online means such as video calling to conduct therapy, and that 64.7% regarded online therapy as effective alternative to in person therapy during COVID-19 circumstances.

Additional research on psychologists experiences of providing therapy online involved a study conducted by Serrao et al. (2022) who investigated the impact of 'teleworking' during COVID-19 on a sample of (n=83) psychologists based in Portugal. The sample consisted of both psychologists who were employed and those not working for various reasons 14.5% at the time. Findings of the study revealed that psychologists who were primarily conducting online therapy demonstrated a higher degree of personal burnout compared to the group of psychologists who were not working, as well as the group that was working directly at their workplace. Teleworking was also significantly associated with high levels of stress and depression in this study (Serrao et al., 2022).

According to APA's 2022 COVID-19 Practitioner Impact survey, since the occurrence of COVID-19 58% of psychologists have moved to a 'hybrid' model whereby patients are treated both in person and online. Results indicate that the amount of psychologists reporting telehealth related challenges with their patients has significantly decreased from 84% in 2020 to 71% in 2022. Indicating that telehealth challenges are still prevalent amongst patients even those in HIC's. The most frequently mentioned telehealth related challenges were based on technical difficulties, problems with access to internet and or internet connectivity (network signal) as well as struggles with attaining privacy. Only 27% of psychologists felt that telehealth impacted the ability to connect and develop rapport. Almost all psychologists agreed that online therapy is a useful modality and that they would continue conducting therapy online post pandemic circumstances (*APA*, 2022). Additional research on psychologists experiences of online forms of therapy in international countries include (Bekes et al., 2020; Bekes et al., 2021; Mancinelli et al., 2021; Stefan et al., 2021; Messina & Loffler-Stastka, 2021; Sperandeo et al., 2021; Kotera et al., 2021; Erlandsson et al., 2022; Ahlström, et al., 2022;. Jesser et al., 2022; Aafjes-van Doorn et al., 2022; Stadler et al., 2023; von Below et al., 2023; Ivey & Denmeade, 2023). A South African study based on sixteen (n=16) psychologists uncovered that the psychologists experienced feelings of anxiety relating to the rapid transition to telepsychology, which was reportedly unfamiliar for them. Some psychologists mentioned difficulties with certain therapeutic modalities when conducting online therapy (i.e. the psychodynamic approaches). Further, they iterated that there were financial difficulties (data costs) that limited access to telepsychology for their patients, and that internet connectivity (network signal) was disruptive to the therapeutic process. Ethical concerns regarding confidentiality and privacy were also raised (Goldschmidt et al., 2021).

1.9 Conclusion:

The research aims of this study is to explore the lived mental health experiences of South African psychologists working in the public sector during the COVID-19 pandemic. This literature review has highlighted the gap in the available research on qualitative (and quantitative) studies exploring the lived mental health experiences of these psychologists during the COVID-19 pandemic, in particular to the South African context. Further research is certainly needed into this area to gauge a better understanding of psychologists supporting the public during a pandemic and other disease outbreaks, in LMIC settings.

Chapter Two: Methods

2.1 Aims:

The aim of this study is to explore the lived mental health experiences of South African psychologists working in the public sector during the COVID-19 pandemic.

2.2 Rationale:

The South African Depression and Anxiety Group (SADAG) report that one in six South Africans battle with depression, substance abuse, and difficulties with anxiety ("The shocking state of mental health in South Africa in 2019", 2021). The 2021 Mental State of the World Report published by Sapien Labs, reported that South Africa is regarded as one of the countries with the worst state of metal health. Additionally, the South African College of Applied Psychology (SACAP) stated that only around 27% of the South Africans with reported severe mental disorders receive treatment (Nguse & Wassenaar, 2021). Furthermore, there is a high chance that these statistics are under-represented due to a lack of reporting (*PsySSA*, 2019; "The shocking state of mental health in South Africa in 2019", 2021). In addition to this, South Africa is a currently a country where mental health issues are still highly stigmatized across racial and cultural groups, and this could potentially impact rates of self-reporting (Egbe et al., 2014). Further contributing factors could be related to the limitations of self-report measures in the use of surveys such as inaccurate reporting and potential social desirability bias, for example. Nevertheless, these statistics point to the already grim state of mental health in South Africa and the limited public access to professional mental health treatment due to various aspects such as a lack of government funding, inadequate mental health expenditure from governmental healthcare budgets, limited availability of trained mental health professionals and an overall major discrepancy between policy and implementation (Nguse & Wassenaar, 2021; Bain, et al., 2017; Pillay, 2019; Docrat, et al;, 2019; Govender et al., 2020; Kim et al., 2020; The shocking state of mental health in South Africa in 2019", 2021). One merely has to refer to the Life Esidimeni incident where 144 psychiatric patients died, for further evidence of the severity of the neglect of public mental health care in South Africa's health care system (Nguse & Wassenaar, 2021; Pillay, 2019).

The recent occurrence of the COVID-19 pandemic was initially predicted to, and indeed has, amplified the pre-existing mental health crisis in South Africa (Orkin et al., 2020; Naidu, 2020; Semo & Frissa, 2020; Nguse & Wassenaar, 2021). The COVID-19 pandemic has worsened mental health outcomes in a country that is rated one of the most economically unequal societies in the world according to the World Bank (*The World Bank, 2022*). South Africa is arguably still regarded a LMIC

(*The World Bank*, 2021) and is already marked by social inequality, high unemployment rates, class disparities, and gender-based violence; against the backdrop of our traumatic sociohistorical past (Wyatt et al., 2017; Pillay, 2019; Nguse & Wassenaar, 2021). Extreme psychological distress has been reported as a result of the financial strain and physical health threats posed to people due to the COVID-19 outbreak (Kamal et al., 2020; Tomita et al., 2019). The minority of people who could previously afford psychological support from private professional mental health practitioners were no longer be able to do so. This placed increased pressure on psychologists working in the public sphere during COVID-19; particularly considering that the South African public health sector is already under- resourced (Maphumulo & Bhengu, 2019; Barron & Padarath, 2017; Nguse & Wassenaar, 2021). Research on recent public health crises like Middle East Respiratory Syndrome (MERS) for example, has suggested that individuals who had mental health disorders prior to experiences of quarantine are at risk of having both the duration and severity of their mental disorders exacerbated (Kim et al., 2020). Psychologists were not only treating pre-existing mental disorders that may have worsened but are also supporting a population under severe mental health strain from the psychosocial ramifications of COVID-19 (Kontoangelos, et al., 2020; Semo & Frissa, 2020; Tsamakis et al., 2021).

Research has suggested that the efficient functioning of hospitals during pandemic or epidemic outbreaks may be compromised by the high levels of psychological distress that frontline workers endure. South Africans had to rely heavily on a stable and reliable health care system response from frontline workers, like psychologists, perhaps more than ever before. Arguably, this stability partially depends on the physical and mental health of psychologists working in the public sector (Robertson et al., 2020). It can be reasoned, that while a psychologists role is to support vulnerable groups of people, this pandemic may have increased the very vulnerability of these psychologists themselves supporting the public (Rokach & Boulazreg, 2020).

The wellbeing of psychologists is of critical importance during the COVID-19 context to ensure their availability in providing quality mental health support and relief to the citizens of South Africa (*APA,* 2014 as cited in Joshi & Sharma, 2020). Generally, the preservation of the mental health of frontline healthcare workers is critical to the overall management of infectious disease outbreaks (Chen et al., 2020; Temsah et al., 2020).

It appears that more studies based on the mental health of front-line healthcare workers working during COVID-19 internationally (Gupta & Sahoo, 2020; Vera San Juan et al., 2020; Lasalvia, et al.,

2020; Hall, 2020; Muller et al., 2020; Chutiyami et al., 2021; Kotera et al., 2022), were available – albeit this research was still limited. Further, there appears to be a significant gap in the research with regards to qualitative studies focusing particularly on psychologists' unique lived mental health experiences of treating patients in the public sector during the COVID-19 pandemic, both globally and particularly, within the distinctive South African context. This area, or phenomenon appears to be evidently under- researched. This study will be contributing to the limited body of qualitative research on the lived mental health experiences of South African psychologists working during pandemics in the public sector. It is an aim that this research will lead to increased support for these healthcare workers and greater awareness of the intricacies of psychologists' mental health experiences during the COVID-19 pandemic in the unique and distinctive South African context.

2.3 Research Questions:

What are the lived mental health experiences of psychologists working in the public sector during the COVID-19 pandemic?

2.4 Theoretical Framework:

The phenomenological theoretical framework was selected for this research study. Phenomenology is a qualitative theoretical framework that was initially developed by Edmund Husserl (Pietkiewicz & Smith, 2014; Fade, 2004) and expanded upon by Martin Heidegger (Finaly, 2011 as cited in Tuffour, 2017). The phenomenological framework is a subjective paradigm that focuses on the 'lived experiences' of individuals and how they perceive, interpret and assign meaning to their worlds (Smith & Osborn, 2007; Lester, 1999; Fade, 2004; Finlay, 2011). The aim of Phenomenology is to investigate and describe the "universal essence" (Creswell, 2006, p. 58) that comprises the thoughts, feelings and lived experiences of individuals in various contexts and especially during eventful experiences, such as the onset of the COVID-19 pandemic, as an example. Phenomenology then portrays these collective experiences as somewhat of a shared 'phenomenon' that is characterised by that *specific* group of individuals (Creswell, 2006; Lester, 1999).

Phenomenology is powerful framework in that it purposes to delve deeply into the rich inner worlds of individuals and provide insight into the intricacies and complexities of their lived human experiences. Additionally, Phenomenology can amplify the hidden voices of people and create greater awareness of their experiences, by challenging commonly predetermined ideas about social phenomena (Lester, 1999). This research study will focus on the hermeneutic style of phenomenology which recognizes both the participants *and the researcher* as an inherent,

inseparable, and invaluable part of the research production process and outcome (Finlay, 2008; Laverty, 2003; Smith, 1997). Hermeneutic phenomenology does not encourage the 'bracketing' and removal of the researchers biases and world-views entirely, but rather promulgates that they be acknowledged and made explicit in the research study (Laverty, 2003).

2.5 Research design:

This study falls part of a larger mixed- methods research study titled: 'Mental Health of South African Healthcare Workers During the COVID-19 Pandemic' (Fraser et al., 2020). This study will be based on a qualitative research design. Qualitative research relies on the usage of written and spoken words as data and assumes a subjective, interpretive paradigm (Braun & Clarke, 2006; Padgett, 2004). A qualitative research design was selected as the most suitable design for this study because it focuses on collecting rich and thick descriptions of meaning from participants based on their experiences and perceptions of their social worlds (Braun & Clarke, 2006; Hammarberg et al., 2018). Qualitative research seeks to uncover data based on participants emotions, experiences, behaviours, and the interpretations of meaning they ascribe to their behaviours within certain contexts (Braun & Clarke, 2006; Creswell & Poth, 2016). The Interpretive phenomenological research design was selected as it would be utilized to focus on the *lived* experiences of psychologists working in the public sector during COVID-19.

2.6 Participants:

The group of participants selected for this study consists of ten clinical psychologists working in the public health sector in South Africa. Overall, the sample compromised of psychologists who were either intern clinical psychologists; psychologists in the process of completing their community service year, and one fully qualified clinical psychologists with clinical experience. This broadened the range of the type of experiences these clinical psychologists would be facing whilst conducting therapy during the COVID-19 pandemic. The sample comprised specifically of eight community service clinical psychologists (of which five were female and three were male), one intern clinical psychologist who was a male, and one fully qualified clinical psychologist. The fully qualified clinical psychologist was female and had seven years of experience. All of the participants were conducting therapy with clients or patients within public hospitals, as this was the inclusion criteria for participation in this study. These psychologists mostly saw patients who were of a lower-income (impoverished) socioeconomic status.

It wasn't necessary for participants to reside in any particular province within South Africa as interviews were conducted online. The sample was collected through the use of a non-probability purposive sampling approach. Purposive sampling involves specifically selecting sample group based on particular characteristics that relate to the research area of interest (Palinkas et al., 2015; Padgett, 2004). The sample is considered a volunteer sample as the participants were invited to take part in the study and could choose whether to volunteer their participation or not. This sample is also considered a convenience sample because this study relied on who chose to respond as well as their availability and willingness to participate (Etikan et al., 2016).During the process, the clinical psychologists who were interviewed were asked if they could refer any other psychologist whom they thought may be interested in participating in this study. Therefore, a snowball sampling technique was also partially utilised in this research (Browne, 2005).

2.7 Procedure:

Initially it was decided that psychologists would be approached via emails to public hospitals and professional societies like the Psychological Society of South Africa (PsySSA) for example. However, the researcher managed to get a participant group of ten psychologists by contacting some of them directly via email and or WhatsApp. As mentioned in the sampling section, many psychologist were recruited via a snowball sampling technique which may be regarded as a 'Who do you know?' referral approach to accessing participants. It was a requirement that these psychologists speak English as a first language. It was also required that they have at least one year of experience as a psychologist working in the public sector.

As previously mentioned in the larger project, interviews were set to take approximately one hour to be conducted. The interviews were conducted in one. These interviews will took place on online platforms such as Google Meets and Teams, depending on the participants preferences. The interviews were both video and audio recorded for purpose of transcription. Participants were informed about the nature and purpose of the study beforehand. Participants were given information sheets and consent forms (for participation as well as for the audio and video recordings) to read and complete prior to being interviewed. The researcher also verbally asked for consent before beginning the interview and gave a brief overview of the purpose of the study. Only participants who had provided the researcher with informed consent were interviewed in this study. The interviews were thereafter transcribed using the audio and video recordings.

2.8 Data Collection:

The researcher conducted in depth semi- structured interviews with each of the ten psychologists working in the public sector. This format provided the researcher with the freedom and flexibility to allow for a natural flow of the conversation and ask new and interesting questions as they emerged (Adeoye-Olatunde et al., 2021). This was consistent with the interpretive phenomenological analysis (IPA) method, which values the richness and diversity of participants' lived experiences (Smith & Osborn, 2007). The actual process of an interview in general, provides the researcher with additional information from which to situate their findings (i.e. access to facial expressions, tonality, and non-verbal affect (Creswell, 2007; Hammarberg et al., 2018). These interviews took approximately 60 minutes to complete. This study is based on an interview schedule that was utilized by the researchers from the larger study at the University of the Witwatersrand titled: "Mental Health of South African Healthcare Workers during the COVID-19 Pandemic" (Fraser et al., 2020). The interview scheduled is a published schedule and consists of sixteen questions. These questions were developed from the relevant literature that was reviewed in the larger study as well as a few of the open-ended questions that were part of the questionnaire utilized in the larger project. The questions that were developed are based on an exploration of "the healthcare workers' lived experiences of, and reflections on, working during the pandemic" (Fraser et al., 2020) and focus on themes such as coping, burnout and resiliency.

2.9 Data Analysis:

Interpretive Phenomenological Analysis (IPA) was selected as the means of data analysis in this study. The overarching goal of IPA is focused on an investigation of the ways in which human beings understand and interpret their lived experiences (Pietkiewics & Smith, 2014). There are no fixed and unilateral ways to do conduct an IPA, instead the researcher is encouraged to use the available guidelines with their own flexibility and discretion (Pietkiewics & Smith, 2014; Smith & Osborn, 2007). For the purpose of this study, the IPA guidelines will be briefly summarised as a rough idea of how the researcher went about analysing the data collected. The first step in the process is for the researcher to read the transcripts or listen to the audio recordings multiple times and "immerse themselves in the data" (Pietkiewics & Smith, 2014) to deepen their familiarity with the material (Smith & Osborn, 2007). At this step, the researcher wrote down notes of their observations while re-reading or relistening to their research material (Smith & Osborn, 2007). Thereafter, the researcher worked on converting their notes into the development of initial themes. The next stage involved the researcher grouping themes together dependent on underlying connections (relationships) or similarities, giving a label to these themes and also potentially developing a list of

sub themes (Pietkiewics & Smith, 2014; Smith & Osborn, 2007). Thereafter, the research wrote up the findings in the form of a research report.

2.10 Ethical Considerations:

Internal Ethical clearance for this study was granted (**Appendix D**). The Ethical clearance number is: M200461. All considerations will be upheld by ensuring that participation is entirely voluntary. Participants were given an information sheet that clearly explained the purpose of this study as well as what will expected from them should they participate (**Appendix B**). Participants were required to give informed consent (**Appendix C**) digitally, in writing, to participate in the interviews as well as to have these interviews be audio and video recorded. It was not possible to uphold anonymity in this study as the researcher interviewed the participants face to face over a digital online platform. The confidentiality of these participants was however ensured by assigning participant numbers to them during the write up of the results and discussion sections. Moreover, only the researcher had access to the transcripts and audio recordings of the interviews conducted. These transcripts were kept safely on cloud platform like google drive, that is password protected and could only be accessed by the researcher during the report writing process. These transcripts will be kept by the researcher for potential future use. Participants were informed clearly that they are permitted to leave the study at any point in time should they wish to. They were also informed that they could refuse to answer any particular question during the interview process if they felt uncomfortable or just didn't wish to answer for their own reasons. Participants were also made aware that there are no direct risks or benefits associated with participation in this study.

It was possible that participants may have experienced distress or vulnerability during or after their interviews. As also mentioned in the larger study, a list of professionals providing tele counselling for healthcare workers, as well as their contact details, were made available to participants (**Appendix B**). The participants were informed that should they wish to access further information about the nature and or results of this research, it will be made available to them in due course. The contact details of the researcher were made available to participants on the information sheet. Additionally, participants were notified that they are welcome to contact the ethics committee should any ethical issues pertaining to the research arise.

2.11 Trustworthiness and Credibility

Credibility refers to the 'truth' or accuracy of the research conclusions in a qualitative study (Lincoln & Guba, 1985). It establishes whether the results reflect the information retrieved from the research participant's actual thoughts, and that they were not misrepresented by the researcher (Lincoln & Guba, 1985 as cited in Korstjens & Moser, 2018; Cope, 2013). The researcher upheld the standards of credibility in this study by using direct quotes from participants to highlight assertions in the results produced from the research. An audit trail was kept throughout the process, and the researcher had feedback meetings with their supervisor to highlight any potential gaps in ensuring high credibility standards (Cope, 2013). Further strategies included 'prolonged engagement, 'triangulation' and 'persistent observation' (Lincoln & Guba, 1985).

2.12 Self-Reflexivity:

Self-reflexivity in qualitative research relates to the 'positionality' of the researcher and how their views of the social world, inevitably influences and guides the research process and output (Holmes, 2020; Rowe, 2014). It is important for a researcher to engage in self- reflexivity because it can be used as a measure for gauging the rigour and the quality of the research produced (Finlay & Gough, 2008; Holmes, 2020; Subramani, 2019). My social identity is that of a 29 year old, female Intern Research Psychologist, who identifies as mixed race (i.e. half Indian, and half coloured). Based on my identification as an Intern Research Psychologist at the time of writing, I felt a sense of relatability and closeness with the participants of this study because we are in the same professional; albeit in different psychology categories. I found myself experiencing a deep-seated empathy for their lived experiences during the COVID-19 pandemic. I also experienced various changes, limitations and constraints to my own psychology internship programme at the time, due to the COVID-19 pandemic. Further, because I too identify as a psychologist working in the field of mental health in South Africa, I felt quite triggered and angered by the fact that the government's response to public mental health was largely under-prioritised during the pandemic. This brought up difficult feelings for me; I had felt that my profession is not as valued in South Africa, compared to the medical profession for example. These feelings contributed to me feeling quite protective of the participants in this study.

Overall, the intersectionality between these aforementioned aspects of my identity, as well as others, may have influenced what I 'saw' in the data and the lens through which I analysed it. I, to the best of my ability, managed this by keeping a reflexivity journal to write down my thoughts, feelings, and initial reactions to the data (i.e. the various aspects of the participant's

speech/responses) throughout the research process. I also consulted my supervisor during the research analysis process and before submission, to make sure that any potential hidden bias could be highlighted and addressed.

2.13 Conclusion:

This methods chapter has outlined and discussed the purpose of the current study and has served as a motivation for its importance in the rationale section. This type of research will possibly be contributing to a prominent gap in the available literature on the in depth qualitative experiences of psychologists who were providing therapy to patients in the South African public sector, during the COVID-19 pandemic. This chapter outlined how the participant group were recruited as well as the process of data collection and data analysis. As previously mentioned, this is a qualitative research design and data was collected using semi-structured interviews. Participants were interviewed via online means. The data was analysed using an Interpretive Phenomenological Analysis (IPA). The researcher included a section on self-reflexivity and mentioned that their identity as a mixed race, female Intern Research Psychologist may have influenced the manner in which the data was interpreted and written up. The researcher mentioned that they took measures such as a reflexivity journal and supervisor checks to ensure that they remained conscientious of their potential biases that may impact the research. The results of this study are available in the next chapter, Chapter three.

Chapter Three: Results

3.1 Introduction

This chapter presents the qualitative findings from an Interpretive Phenomenological Analysis (IPA) applied to interview transcripts from semi-structured interviews conducted with ten (10) psychologists, working in public sector hospitals during the COVID-19 pandemic in South Africa. Five overarching main themes were developed from the IPA. These themes are: 'Personal effects of COVID-19 on psychologists', 'Changes to therapy during COVID-19', 'Experiences of COVID-19 exposure in public hospitals' as well as 'Coping Mechanisms' and 'Survivor guilt'. The aforementioned main themes and their respective related sub-themes will be presented in this current results chapter. A summary of the main themes and sub-themes can be found in Table 3.1 below.

Main themes:	**Sub-themes:**
3.2 Personal mental health effects of COVID on psychologists	3.2.1 A sense of helplessness 3.2.2 Inadequate training and development opportunities during COVID-19 3.2.3 Burnout 3.2.4 Changes to Personality 3.2.5 Rewards: A sense of fulfilment
3.3 Changes to therapy during COVID-19	3.3.1 Masks as a barrier to rapport during therapy 3.3.2 Under-preparedness to work as a psychologist during COVID-19 3.3.3 Navigating Online therapy during COVID-19

	3.3.4 Therapeutic space impacted by the therapist
3.4 Experiences of COVID-19 exposure in public hospitals	3.4.1 Anxieties and fears 3.4.2 Taking safety precautions 3.4.3 Challenges related to resources 3.4.3.1 space constraints 3.4.3.2 Masks 3.4.3.3 A lack of psychologists 3.4.4 The Sporadic Nature of doing the work
3.5 Coping Mechanisms	3.5.1 Positive Coping Mechanisms 3.5.2 Negative Coping Mechanisms 3.5.3 Neither Positive or Negative: context dependent coping mechanisms
3.6 Survivor guilt	3.6 Privilege highlighted during the pandemic

3.2 Personal effects of working during COVID-19 on psychologists

This theme will describe the personal effects of working during COVID-19 on the cohort of psychologists in the form of five distinct subthemes, these are: 'A sense of helplessness', 'Inadequate training and development opportunities during COVID-19, Burnout, Changes to Personality' and 'Rewards: A sense of fulfilment'.

3.2.1 A sense of helplessness

All of the ten psychologists who were interviewed expressed that they had experienced a sense of 'helplessness' and or 'powerlessness' whilst working during the COVID-19 pandemic. This sense of helplessness was predominantly attributed to the novel and unprecedented nature of the pandemic itself; coupled with the related feelings of uncertainty with how to provide effective psychological assistance. This is demonstrated by Participant two (2) who shared: "*I can remember times where I just felt quite, experienced feelings of helplessness, you know, where you, you feel like you want to do something, but you can't, you know, it's beyond you, and I think at times COVID, panic created a kind of reminder of that"*

These sentiments were similarly expressed by Participant four (4): *"Yeah, they there is that sense of helplessness, but also feeling stuck? Like, what do I do, but the way that I sort of cope with it is to just sit with a patient and acknowledge just how helpless and how, you know, bad that the situation is. So I even acknowledge and say to the patient, this is awful. And I don't even know what to do or to say, I feel helpless. And to just sit with it, because what can you do?"*

In addition, Participant nine (9) conveyed a sense of disappointment that was associated with the helplessness she had experienced during the pandemic. She states: *" I felt disappointed, I felt disappointed that everything that I had been trained to do, I wasn't able to do and it was almost like, you know, when you when you've worked so hard to get somewhere, your eight years, 10 years, whatever you've gone through to get to where you are. And you're at the spot where now you can give back because that's what the comm serve is. And to get in there and to think I'm really not giving back. I'm really just filling holes. There is not much I can really do."* Participant nine (9) contributed an additional dimension to the theme of helplessness, which connected to feeling that she was unable to utilise her training and expertise to help patients. She shared that she did not feel that she was 'giving back' or serving her intended purpose because of pandemic-related constraints that prevented her from engaging in the work she was trained to do.

In contrast, one psychologist (participant 3) mentioned that he didn't feel that his sense of helplessness was solely attributed to the COVID-19 pandemic, but rather to the 'systemic failures' in South Africa; this was even further highlighted when working with the underprivileged population he was providing therapy to. Participant three (3) shared*: "the sense of helplessness I felt was not COVID related, interestingly enough, it was to do with the demographic and the poverty and the deprivation and trauma, loss. Yeah, just the systemic failures in general"***.** He expressed feeling a

sense of helplessness when working with patients who often live without adequate access to basic human needs such as food and housing. Further, he conveyed that his helplessness is associated with providing care to a population who is burdened by trauma and bereavement.

Participant seven (7) also expressed*: "I think that the helplessness is so out there. And it's something that we have to sit with all the time. And part of being in that particular context is realising that this is some things that you just can't fix, even outside of the pandemic on its own. There is helplessness that exists just from doing the job of a psychologist. So yeah, it kind of amplifies things, and when you suddenly have to stop doing group, you know, suddenly, like, the President makes an announcement today, and then tomorrow, you have to call the patient and you think about where they last ended. And then you have to stick to that, and there's nothing you can do about it. At that particular time, the best thing you can do is to hold them in mind, and just hope that they're going to be okay"*

Participant seven (7) above seemed to express that there is a sense of helplessness that is inherent to being a psychologist. She qualifies this by saying that this pre-existing sense of helplessness was exacerbated by the context of the pandemic; and then evidences this by referring to the COVID-19 related disruptions to group therapy with patients. She further corroborates other participants sentiments by saying "*there's nothing you can do about*". She seems to be referring to a lack of control within her occupational role during the pandemic, which renders her helpless and that her only resolution was to remain hopeful that her patients are going to be okay.

Overall, all of the psychologists in this study experienced helplessness and a perceived lack of control, whilst working amidst the pandemic. Although, some psychologists highlighted that the sense of helplessness was also a normalised part of the job of a psychologist. One psychologist in particular mentioned that their experience of helplessness was not solely related to COVID-19, but more so to the 'demographic' he worked with who experienced poverty, deprivation, trauma and bereavement because of the systematic failures in South Africa. Another psychologist shared her perspective on a sense of helplessness that arose from the loss of the opportunities to use her psychological training and skills. She the purpose of her role and felt that she was unable to do the work she was trained to do, and ***that she had hoped to do.***

3.2.2 Inadequate training and development opportunities during COVID-19

This theme was about a few of the psychologists who experienced inadequate exposure to training and practical development opportunities as a trainee psychologist (only the trainee psychologists

mentioned this) working during COVID-19 pandemic. and that this had an impact on their professional development as a psychologist.

Participant one (1) who was an intern clinical psychologist at the time said: *"that was one of the biggest challenges also with therapy and exposure to actually doing the practical work, I feel like that group, that's quite a disadvantage in terms of learning as much as possible in that one internship year, which sort of like employs quite a lot of anxiety going into community service year, because then you wondering, did you have enough exposure in terms of diagnosis groups "*. This psychologist expressed that she felt disadvantaged because she did not have adequate exposure to practical work (she made reference to group therapy/work specifically) during her internship year. This created feelings of anxiousness in her because she was doubtful about whether she was sufficiently prepared (had sufficient practical exposure) for her community service year.

Further, participant (9) who was in her community service year at the time also alluded to this phenomenon by stating that she was unable to practically implement her skills (developed through training) during many stages of the pandemic: as previously stated: "*I felt disappointed that everything that I had been trained to do, I wasn't able to do..."*

3.2.3 Burnout

This theme encompasses the participant's experiences of burnout whilst carrying out their work during the COVID-19 pandemic. Their experiences are as follows:

Participant one (1) stated: *"there will be constant instances where you experience burnout so the experience of Burnout is, like three months into the internship, and just when you reaching that constant, sort of, like, plateau, you like, Okay, I've got this, I know how this works. And then you shifting to another clinical setting as well. And then that sort of disrupts the contingency that you've got, and then you need to pick yourself up again"* and continued: *"But I guess the main thing for me was extreme exhaustion".* Here the participant mentioned burnout verbatim and referred to having experienced 'extreme exhaustion', the participant further expressed that the transition to different clinical settings was often a disruptive factor that contributed.

Participant two (2) similarly expressed: "*my challenges came in, in a form of exhaustion feeling quite exhausted. mentally physically, you know, but there was a lot of those a point where I felt quite burnt out, like I just had pushed myself beyond what I needed to do, and I guess, also the nature of the*

work that we're doing, I just found myself in a position where to do more than that a fellow staff members not well and have to chip in, you know, fill in here and there". Here the participant also acknowledges both mental and physical exhaustion, as well as burnout. She expressed that she may have potentially pushed herself beyond her capacity and used the example assuming the workload of absent staff members as evidence of this.

Participant seven (7) concurred: *"I think there is burnout that is there as well, because the load is increasing, the kind of cases you seeing are very difficult, you know, and in the context way, it's just go, go, go, go go. Like there's no time to stop and process things."* The participant also highlighted an increased work load and fast paced work demands that were continuous; and that there was insufficient time to pause to reflect which was necessary because their patient cases were challenging.

A few participants also mentioned struggling with compassion fatigue as a part of their experience of burnout. Participant eight (8) said: *"you know, it's, it's many times, I thought I was burning out because you know compassion fatigue is a real thing. And, you know, just holding space for people, when you can't really guarantee anything for them was quite difficult, it was quite challenging to just to keep people hopeful, and, you know trying to convince them to persevere was tough"* And participant seven (7) mentioned: "*Where like when you start to get a bit of compassion, compassion, fatigue, where you where you start to feel yourself much more tired"* here the participant corroborated the other psychologists similar accounts of extreme exhaustion.

3.2.4 Changes to Personality

This theme encompasses the participant's experiences of undergoing changes to their personalities in response to working during the pandemic, as well as from experiencing the pandemic in their individual capacities.

Participant one (1) stated*: "Probably it would have strengthened my core personality of being quite resilient."* She continued: *"I had to rely on the external resources. And part of that was the extent to the teamwork, and very kind of teamwork in terms of pulling together in one direction, so more open to relying on a team or external support."*

Here the participant mentions that she felt her pre-existing resiliency was enhanced and that her openness and willingness to relying on external support from others, such as team work, also increased.

Participant two (2) shared that he felt that his levels of self -awareness and capacity for self-exploration increased during his experience of the pandemic, he states as follows: *"I think that in that sense I became more self-aware to know you actually are anxious you know. There is a level of concern and fear of potentially your demise.. As I say I haven't really made sense of that but I know I started to explore myself more.. What do I, what are my fears.. What is my thinking process. what is my understanding of the world. So you know it encouraged me to learn more about myself when people point things about me that I was not really paying attention to you know or not really saw as important.. So like self-exploration, self-awareness."*

Participant ten (10) expressed: "*I think I've been much more closer to people close to me, this sense that I can reach out, I can talk to them more often than previously, I feel like those have been the long term effects on my personality. And now I find myself engaging more online. And I'm starting to sort of trying to start up social media pages on mental health and things like that."*
Here the participant (10) expressed that she felt she was able to open up and reach out to people more easily than she could before the pandemic, and that this improved her relationships. Additionally she noticed changes in her engagement with people online. It seems that the participant became more sociable and open to connecting with others.

Participant eight (8) iterated that she felt she had a greater acceptance of the uncertainties of life, which helped her developed a more adaptive personality. She expressed: "*And I think if anything, this pandemic forced me to get used to the idea that a lot of things are not in our control, and you can't plan everything, and you have to be able to adapt, and sometimes overnight, which is what we had to do, adapt more".*

Participant seven (7) appeared to share similar sentiments in this regard. She states: *"And I've learned to be a little bit more flexible than I normally would. And also, I think, you learn to let go of control way because the one thing that this year has taught us is that things can just go out of control. And, and there's not much you can do about it. in a And I think for me, it's one of the things I've always struggled with, like letting go of like the control.. So I think that's one thing that has kind of changed about my personality, like in the long term"*

Overall, most of the psychologists underwent two predominant changes: 1) an increase in

resiliency and 2) the ability to be more flexible and adaptive. Further changes included an increase in relational capacity to receive support, an improving in relationships, as well as in the ability for self-awareness and reflection (a deepening of the relationship with self).

3.2.5 Rewards: A sense of fulfilment

This theme encompasses the participant's sharing their experiences of deriving sense of fulfilment from their work with patients during the pandemic. The majority of the psychologists interviewed experienced this rewarding and gratifying sense of fulfilment.

Participant two (2) mentioned: *"Seeing psychological change. People come into the room distressed. Going through loss. You know like work, bodily functions, loss of loved ones, depression, and you see change. It's something quite rewarding to see a patient makes sense of their own experiences in the room without me even saying anything and considering of how slow the process of therapy is and the frustration and all the negative feelings and all the negative countertransference one experiences. At times you ask yourself whether you are contributing to this person's life. Coming into a hospital where there is COVID cases, they are putting themselves in places where their physical health is on the line to access help for their mental health. And at times you feel like am I giving this person something? And when you see the change for me that was something quite beneficial, that was something I felt quite encouraged by"*

Here the participant (2) expressed that he derived a sense of reward from witnessing his patient's mental health and well-being improve. He mentioned that he sometimes questioned the efficacy of his work, but that it was encouraging to know that the patient gained some value from the therapeutic process; especially considering the risks they took physical health to access mental health care services at the hospital.

Participant three (3) shared similar sentiments: *"I really enjoy feeling like, I'm a big part of a patient growing, and overcoming their struggles and having meaningful change, and, also playing a big role in their inter psychic life, to be understood, it really feels like what I do matters a lot and I love that. And I also, it's really wonderful when a patient is doing much better. And there's actually a sense of like, I'm really proud of what they've done, what they've accomplished."* Participant eight (8) concurs and mentions*: "it's really hard work, but it's really rewarding in so many different ways as well"* The participant shares that witnessing the patient's psychological growth was evidence that their work matters and is significant. This seemed to be perceived as a professional accomplishment.

Participant ten (10) also felt a sense of reward, she said: *"Well, the work itself is always rewarding, working with somebody who's going through so much pain, and then allowing you to see all of that, they're trusting you with their lives. With parts of them that they don't want any other person to see. And then seeing them grow from the pain and shift their own mindset. That has been rewarding. You know, when you see a person the first time you see them, they in a different state. And maybe when you see them for the last time, they are like, They've just grown"* she found it rewarding to witness her patients undergo psychological growth. She qualified this by stating that the work of a psychologist is 'always rewarding' and seemed to imply that it wasn't only rewarding because of pandemic circumstances.

Overall, all the psychologists experienced their patient's psychological growth as rewarding and fulfilling. It contributed to their feelings of personal accomplishment and simultaneously served as a reminder that they were making a difference in their patient's lives.

3.3 Changes to Therapy during COVID-19

The COVID-19 outbreak brought about sudden and unforeseen changes to the manner in which therapy was typically conducted by psychologists. Their experience of navigating these changes will be discussed below, according to these three subthemes: 'Masks as a barrier to rapport during therapy', 'Under-preparedness related to training', 'Navigating online therapy during COVID-19' and 'Therapeutic space impacted by the therapist'.

3.3.1 Masks as a barrier to rapport during therapy

This subtheme encompasses all of the psychologists iterating that the wearing of facial masks was a barrier to building rapport and establishing connection with their patients during the therapeutic process. Masks were perceived as 'barriers' to different degrees and intensities by the different psychologists however they all concurred that it was a hindrance during therapy.

Participant two (2) expressed: "*it kind of served at times as a barrier, you know, like in terms of connecting with, with patients, especially psychotic patients, because I mostly work in a psychiatric ward, so most of the population are quite psychotic. And I noticed that at times, it does create a barrier at times, even for them when they speak, you find that it's quite difficult to hear what they say. And sometimes I've we've had cases where patients would pull the mask down and actually to, to speak, and you can actually hear Him clearly. So it does in that sense does serve as a barrier for some patients, especially if they're quite introverted and, and quite, in a reserved type of person. So,*

you find that, when you try to engage them, they quite restricted by that wearing a mask. So it requires a bit of patience" Here the participant also includes that it was more of a barrier with specific types of patients, such a psychotic patients and also those who could be described as more introverted or reserved.

Participant 10 shared her experiences of giving therapy with face masks, she expressed: "*So as psychologists, we don't just rely on words, we also rely on facial cues and things like that, that has been the biggest challenge during COVID. Because now you can't really see your patient, they have a mask, you also have a mask. So you don't really know, the person behind the mask. You know, you just focus more on eye contact, you just find yourself staring at somebody's eyes. So it's hard, like if a person is shy and all of that. Now, they just have to maintain eye contact, because there's no other way to communicate. Because I feel like there's a lot of things that get lost, that we cannot really see somebody's face, I don't know what that does for the relationship that I have, with my patient that they can't really see me, it was so strange, because on Friday, we had like support group. And this is a patient that I've been seeing before she went to support group. And that was like the first time that I saw him, without a mask, like a completely different person must be a totally different person. So that's hard in that regard"*
Participant ten (10) appeared to concur with participant two's (2) assertion about masks being a particular barrier with shy patients or clients.

Participant three (3) also concurred that mask wearing was a barrier to connection and seemed to express that there was important information that was missed due to the wearing of face masks. He states: *"I do also think that the masks were an obstacle, I think even learning to adapt with them. I still find myself vastly preferring no masks, you're just such, like so much more richness. Like some people are super expressive with their eyes and their voice and body language. But like, sometimes the subtle stuff you can see on like the nose, and also the throats and you often just can't pick that up with a buffer. And likewise, what are they picking up for me? I certainly felt that connection was more difficult to make with a mask on."*

Participant nine (9) contributed: "*I could never get that feel like it was something authentic, that it was something that I could, you know that that relationship with the client was authentic, it was always I'm protecting myself and I'm protecting you, there was always that barrier, that's the first concern is that we, I'm protecting me, and I'm protecting you. So the client really just took a backseat"* Here it seems as if participant nine (9) is expressing that mask wearing took away from the

authenticity of a relationship between patient and therapist in a therapeutic space. She seemed to assert that this was because through acts like mask wearing there was an overall focus on protection from the virus.

3.3.2 Under-preparedness to work as a psychologist during COVID-19

This theme involves the majority of the psychologists expressing that they felt under-prepared to fulfil their roles as psychologists during the pandemic. It is noteworthy that the psychologists in this cohort comprised of a mix of Intern clinical psychologists, Community service clinical psychologists, as well as one psychologist who had more experience as a fully-qualified clinical psychologist. The theme of under-preparedness, relates to most of the psychologist who stated that they felt under-prepared and under-equipped to function effectively as a psychologist during the COVID-19 pandemic.

This is expressed by participant two (2) who stated: *"Umm…I think starting there, each and every situation that I encountered there was always a certain level of anxiety and it came down to how prepared am I to help. You know because I guess our training is done in a space where we are not taking covid into account".* Participant nine (9) also echoed this by stating: *"I don't believe we were prepared for it."* The participant expressed that the psychological training provided to them did not cater to the unique pandemic-related challenges, and she therefore felt ill- equipped to fulfil her role during COVID-19 pandemic. She mentioned that this contributed to feelings of anxiety.

Participant eight (8) also voiced that: *"It's nothing I think we were trained for I don't think COVID was anything that any of us were trained for in terms of the, you know, the, what's the word I'm looking for? The heaviness of it, you know, it's, yes, as psychologists, we deal with some really severe pathologies. And people do go through some really serious things. But no human being that I dealt with in the hospitals were prepared emotionally to deal with something like COVID."* Here the psychologists mentions that he felt unprepared for the emotional burdens of working during the pandemic.

In contrast, one psychologist, namely, participant four (4) stated that she had felt that her training did indeed prepare her for the COVID-19 pandemic. She expressed: "*I guess maybe, you know, like, them teaching us how to do trauma work". Because we, you know, you see a lot of that with the pandemic. Yeah. I think as a psychologist, we are everywhere. I mean, everything is psychological in life. There's always a centralised aspect to it. And yeah, I think I was prepared."* This participant

expressed that she felt the training had generalized aspects to it, such as trauma training, that could be applied to various contexts and situations.

One participant, namely participant one (1) questioned the whole concept of being 'prepared' for a pandemic. In her opinion, she states as follows: *"I don't think it's something that you can ever say that you were prepared for. Because it was a different context. I would have I could have done research in terms of what goes on internship. But for us, it was a new and different context. It's nothing that you can prepare yourself for. So much so that even I think that the supervising clinicians themselves could never have prepared themselves for that".* This participant was expressing that she doesn't believe it is possible to ever be prepared for a pandemic such as COVID-19, and that even her supervisors were not prepared despite their years of clinical experience.

Additionally, participant eight (8) added in another layer of under-preparedness which concerned training for conducting online therapy. She expressed that she was never exposed to training that was specifically for the purpose of conducting online therapy: *"We were never trained to do telephonic therapy in the first place or doing therapy online. And that's one of the things we just really had to kind of like jump on. Because like, that's, that's the only thing you have, if you're lucky that your patient has that. So that has been a bit of a curveball, where you're sitting in front of a screen and you're talking to a patient when in clinic, you had to see them in person, and you had to interact with them in the room and kind of figure out your countertransference and all of this stuff. So different, we were never trained for this, and I think the unique thing about the pandemic, is that we are going through it ourselves, and we are also right in the thick of it as best as well as the human being, as well. So how the training doesn't prepare you for that."*

The prevailing sentiments amongst the cohort of psychologists was that they not feel prepared to carry out their work during the COVID-19 pandemic. Except for one psychologist who felt that training has foundational aspects to it that could be adapted and applied to pandemic contexts. The subsequent subtheme will describe the participant's experiencing of conducting online therapy.

3.3.3 Navigating Online therapy during COVID-19

All of the psychologists had to use online therapy as a way to continue providing mental health care services to their patient's during the pandemic. Within this subtheme, the psychologists recount some of their reflections of and experiences with conducting online therapy.

Participant six (6) mentions: "*With COVID happening we had to become tech savvy, and we had to use platforms like zoom, which really changed things quite a bit. Because you're no longer able to refocus on the nonverbals because you're not with the person in the room. So you have to change the way you give therapy. And I think it was very difficult even for clients to really grapple with that. I think at first everyone's uncomfortable, the therapists, the client, the supervisors, not quite sure what to do either. So it was very difficult. I'd say at first"* This participant stated that he had to become familiar with video calling platforms and further expressed that conducting online therapy meant that there was an absence of non-verbal body language for him to witness. He further acknowledged that there was a shared sense of discomfort and uncertainty experienced amongst himself, his supervisors and his patients, which stemmed from the unfamiliarity of transitioning to online therapy.

Participant six (6) continues: *"And then something quite interesting started to happen because you're seeing clients, normally, they're at home for the session. And so you can kind of put up your defences, when you know, you're seeing a therapist at a specific time specific place, you can have your guard up quite high for that hour, or 50 minutes. It's much more difficult to put on that sort of I don't really want to call it a facade, but to have those defences up when you at home, and the situation is a lot more unpredictable. So it helped in that sense. I think, for all the cons that came with it. There were definitely some pluses."* This participant shared that he felt it was more difficult for the patients to maintain their emotional guards at home, particularly with the accompanying unpredictability of the pandemic. He viewed this as positive aspect of online therapy.

Participant two (2) shared his experiences with online therapy*: "So we had started doing video calling as a way to, to continue with the process.. And most of the time ,a lot of disruptions like connecting to the internet, or you find that, in terms of understanding what family therapy is about. There was also lack of understanding around what is the therapy is about so you'd find that we scheduled a meeting, right, let's say the session is going to be at two o'clock. And the family must be ready to connect, we find that when two o'clock hits, not everyone is the others are not, you know, so there's also quite a lot of disruptions with that, you know, also resources, you know, certain people would have preferred not to come to the hospital, right. And we use a video call however, data is expensive."* This participant made reference to the disruptions he encountered during online therapy sessions, these were: internet network issues and patient's limited understanding regarding the process of family therapy online. He also referred to financial resource constraints that were a further hinderance.

Participant seven (7) expressed that she felt mixed feelings regarding conducting online therapy: "*I have mixed feelings about it, it was quite an interesting experience and a big adjustment for me, because you've never had to conduct the therapy beyond a screen. And then it affects things like countertransference, and not being able to pick up on some of the body language things which are normally very useful for you in the room, because then you can use it to kind of go forward in the process and pick up on this thing. So it's very difficult in that sense, but I think I enjoyed being able to see my patients face. And she enjoyed being able to see mine and we actually had a heartfelt conversation about it about how, you know, as people we have masks and then the pandemic makes us to wear an extra mask on top of what we have and how they can affect the trust in the room because then they can't really read and my patients is like I've had to rely on your eyes, because that feels familiar"*. Here this psychologist highlighted that the experience of providing online therapy was an adjustment for her, as she had no prior experience with it. She corroborated the views of other participants' regarding the impact of the inability to witness useful body language cues. However, she also added that the ability to see her patient's face during online therapy was as a positive aspect. She contrasted this to mask-wearing as a barrier to developing trust in the relationship.

3.3.4 Therapeutic space impacted by the therapist

This theme emerged from the participant's indications that their relationship with their patients in the therapeutic space may have been impacted by their own mental health and emotional well-being during the COVID-19 pandemic.

This is evidenced by participant three (3) who expressed: *"there's no question that at some level, my patients may have unconsciously felt that when they're crying and taking their mask off, I'm not being a comforting presence in that moment, because I am angry, I am frightened. I'm not being containing. And like, while nobody said anything, you know, often their eyes were more focused on the tissue, things like that. It must have been awful"*

Here the participant (3) mentions that he didn't feel like he was being a 'comforting presence' whilst his patients were emotional. He expressed that this was the case because of his own fears and anger arising from them removing their face masks and thereby exposing him to the virus. He seemed to imply that it may have not been a good experience for the patient, even though they didn't say anything verbally. He also stated that this experience may have been unconscious for them.

He then continued: *“I was also very compassionate and gentle with. It's okay, you’re scared, this is actually not an irrational response. Just like be calm, just sit with it inside yourself. Even though, I would also be like, this is pulling me out of my therapy, like , not being here, the clients and their stuff. So most of the time I just sit with that tension thing*.” Here the participant mentioned that he felt tension during his therapy sessions with his patients because whilst he had extended compassion towards himself, and tried to normalize his emotions, he simultaneously felt that he was not very present with the patient. Participant seven (7) shared her experience: *“you start to feel yourself a bit more tired. And you start to feel more irritable when you are sitting in front of a patient*.” And then continued: “*You find yourself thinking, Oh, my God, did you honestly really end up in the hospital because of that? But you think it sometimes. And that's how you know that, I'm really tired. Now, I need to do a bit more self-care than I'm doing”* Here the participant (7) seems to express that she experiences irritability and increased exhaustion at times when with her patients, she has at times questioned the legitimacy or severity of the reasons for the patient attending therapy. She implied that she experienced a decrease in her levels of empathy. She further regarded this as a sign that she needed to intervene by practising more self-care.

Participant eight (8) concurs with the aforementioned participants and notes a similar experience: *“it's a crazy how desensitised you become when you're doing crisis management or emergency medicine all the time. And that can come into the therapy space”* The participant here mentions a state of being desensitized, and that this can influence therapy with the patient. The participant continues to note:” *I do think that people do feel guilt and you know, you wonder why you're not reacting more to something. So it's a bit of a surreal feeling. And it happens, It creeps up on you. And then in the moments as well, you kind of like, but I'm standing next to somebody that just passed away, and I'm not feeling anything that's weird, you know”* The participant shares the feelings of guilt that can arise when psychologists are desensitised.

Another participant, participant ten (10) mentions her own sense of fear that entered the therapy space: *“you don’t know if you're gonna get COVID or not, especially during the waves when at peak, that's when you become scared of your own patient.”* Participant ten (10) continues to express: *“So obviously, your work is going to be impacted in so many ways, you have to understand that you're also in a state of panic, you're also trying to survive. And also your patient is also trying to survive. Because the first thing first, is protection. Because once you feel safe, then you can explore all these other things in your life. But when you're not feeling safe, you're on a flight or fight mode. And it's*

hard to do therapy with somebody in that state, even much more harder, even when the therapist is also in that state. So there was just a lot of reminding that, don't forget that we are in a crisis, we're in a pandemic." Here the psychologist conveyed her experience of panic and of a lack of safety, similarly to her patients. She mentioned that she tried to normalised the 'obvious' impact this would have on her work, by acknowledging and reminding herself that she too was navigating the impact of the pandemic, alongside her patients.

3.4 Experiences of COVID-19 exposure in public hospitals:

3.4.1 Anxieties and fears of COVID-19 exposure

This theme encompasses the psychologists experiences of being exposed to COVID-19 whilst working in a public hospital setting. All of the psychologists expressed feelings of anxiousness regarding potentially being exposed to the virus whilst on duty. Their sentiments are outlined below:

Participant one (1) shared: *" Yeah, that was, it was quite scary at first. Cause considering the fact that I, myself had severe COVID, before I went to the clinical site, and the risk of re exposure was just always there"* Participant one expressed that her anxiety regarding exposure to the virus at work was amplified due to having already been infected with COVID-19 once before. She was anxious about reinfection.

Participant seven (7) also mentioned similar experiences of anxiety, she stated*: " So there's things that we have to think about that as a healthcare worker as well, could I be exposing my own patients as well, to COVID, as much as I'm exposed myself, so it's a really difficult time to work. And I think it's just surrounded by anxiety"* here she added that she was also anxious about potentially exposing her patient to the virus.

Participant three (3) also shared his experience, as he states*: "I think I did have a greater sense of fear going to work. I didn't want to have the sense of my health being threatened with the prospect of long COVID And like eternal brain fog, reduced lung capacity and stuff. I was not having that"* he was concerned about the effects of COVID-19 infection on his body and mind.

He continued to express: *"And before I was vaccinated, I would often feel a huge wave of, of anxiety and actually anger that I'd have to manage very quickly. Because there'd be times where patients in*

my room during a wave right in like lockdown, serious conditions, they'd like take off their masks to blow their nose, very understandable, right? We're human beings, we have emotional responses that come through, I'm thinking this is not safe for me. And my instinct is to clamp down and just, just relax, just be okay. You know, they're not doing this intentionally. This is life and human emotions, just navigate around it." Participant three (3) then shared that he didn't feel as fearful and angry once he was vaccinated: "*But once I got vaccinated, not a concern anymore. I was like, Cool. I at least have some measure of protection against this. And I am okay with this. Let me just make sure that I've got good ventilation in my room, there's good space between us as much as is possible, because the clinics don't always have great space".*

Participant eight (8) also felt at risk whilst working during the pandemic however mentioned an additional layer of fearfulness that was related to potentially exposing her family to the virus. This is evidenced in her statement: *"not only are you fearful of your own health, and, for example, going into COVID ward, you are constantly putting yourself at risk to contract the virus, and you know, you have your own family and you have people in your family that are you know, vulnerable to, or have comorbidities and you putting yourself because I think that's what we're unprepared for."* Several other participants also mentioned fears regarding potentially exposing their loved ones.

3.4.2 Taking safety precautions

In this subtheme the participants shared the various ways in which they took safety precautions whilst working in a high risk public hospital setting during the COVID-19 pandemic, and their experiences thereof. Participant two (2) shared: "*wearing a visor was quite uncomfortable. You know, wearing a mask, I think I've over time I've gotten comfortable, but I think initially wearing a mask was quite uncomfortable, especially when you have to talk in a group context and an individual or doing family therapy. Sometimes it could be a challenge."* Participant ten (10) also commented*: "And also, you're also very hyper vigilant in terms of like, contact with your patients. Sometimes you have to wear a visor or you already wearing a mask, and then you have a visor on"*

Further, participant two (2) reflected that they experienced themselves sanitizing quite frequently at the hospital, as was pointed out by one of their colleagues*: "when it came to the hospital space I would sanitize more than anyone else. That's what everyone else was telling me. At least one my colleagues, not everyone but one of my colleagues: I sanitise when I put on my mask, I make sure the surface is clean you know. So I guess it was my way of containing myself for trying to protect myself you know and not just my health. Like not just my physical health but my mental health"* Here the

participant expressed that the frequent sanitising was a way in which they could protect both their physical and mental health.

Participant seven (7) also found herself sanitizing quite often, she mentioned: *"So you develop a little bit of OCD to cope with anxiety… And what I've also noticed as well is that I will sanitise like randomly in the middle of consultation you just pick up your sanitizer, and you just sanitise your hands".* She further reflected on this: *"I think there's some compulsions stuff that's happening. You know, if I don't do this as often I'm definitely going to catch COVID. It's not on a pathological level but it kind of speaks to what's happening with my own mental health and my own anxieties about working during the time of the pandemic"*

Participant eight (8) concurred: *"When I went in there (the hospital), I cleaned the door handle, I cleaned the kettle handle, I cleaned the microwave, I clean with sanitizer. And I think there was another intern with me, we used to laugh because whoever got in first it was their job to do that. But despite whoever got in first, the other one still did it anyway, just for their own anxiety, too. But I have to admit, I was more so in the hospital than I was away from the hospital"*

3.4.3 Challenges related to resources

In this subtheme the participants shared their experiences of the challenges faced whilst working in under-resourced public institutions during the COVID-19 pandemic. These are as follows: 'Space constraints', 'Mask shortages' and a 'A lack of psychologists'.

3.4.2.1 Space constraints

Participant one (1) explained her challenges in terms of resources. In this instance, it appears her main concern related to the lack of available consulting space in the hospital to conduct therapy in a manner that was conductive and that upheld patient confidentiality. She mentions: *"And then you need to factor in things such as confidentiality, is the space even therapeutic enough, you know. But then you'll find that you need to improvise, you need to be seeing the patient, you need to sort of work out in terms of how you're going to negotiate the space. And sometimes you'll find that because of the limits of the space that you get sessions being interrupted by other clinicians who need to use possibly the room because the clinicals and sometimes you use you giving whatever maybe containment therapy or consult at the patient's bedside"* She mentioned the need to negotiate the use of space, and that sometimes therapy would be interrupted by colleagues who required the same space.

Participant six (6) also mentioned the difficulties of navigating space constraints*: "because you're sharing an office with three other interns becomes difficult in terms of if you have to see someone online. Where do the other two interns go during that time? Yeah, it was, it was very difficult. We had to get very creative."* Both participants one and six mentioned the need for creativity and improvisation with the usage of space. Several other participants also corroborated these experiences.

3.4.2.2 Mask Shortages

Participant three (3) expressed: "I *did resent the shit out of clinic management for not ensuring that we had masks and that the venues were COVID compliant. They were not, some were, but some which was just like, yeah, they don't give a shit. They really don't give a shit. So, yeah, that that was crap. The feeling like, okay, so we could actually work telephonically. But because, you know, you guys are like pinching pennies, and that's more important than our lives. You are you don't care. We have to go back. We have to go in. Yeah, that that was really aggravating*". Here the participant felt anger and resentment towards the institutions clinical management who did not ensure the sufficient availability of face masks and also did not ensure that the venues used were COVID-19 compliant.

Participant two (2) also struggled with regards to the availability of masks in particular. He shares: "*there was situations like that especially patients come to the group and I need to organise masks for them and sometimes the masks are not available. Or sometimes they are there but sometimes the person you have to get the mask for they aren't really willing to do that so It was challenging. I remember like currently I bought I my stack of masks because you will find that there are masks available but I need to go through someone to get the masks. Like here at the hospital it takes some time and I guess that speaks to the frustration that I had. Now I feel like I need to get to work, go to the manager office and get a mask then you find they also have their own schedule so when do I get a chance to get the mask right. So I ended up buying my own masks so that I don't have to call or message my head psychologist or my superior to get the mask".*
Here the participant (2) mentioned that although there were masks available at times, the administrative process involved in obtaining the masks was too challenging and therefore resorted to purchasing his own masks.

3.4.2.3 A lack of psychologists

Many of the psychologists expressed frustration that there was a lack of psychologists in their public hospital settings. The ratio between psychologists and patients waiting to be helped was extremely disproportionate. Participant three (3) succinctly expressed: *"When you only have like one psychologist working like with like, 300 patients on the waiting list, then how do you deal with that, especially if you're kind of groups during the pandemic, you need a lot more psychologists"*

Participant four (4) also mentioned*: "And then there's also a shortage of psychologist,. Yeah, many of the hospitals and it just it does not make sense. I mean, the fact that I'm in comm serve to clinical psychologist and I'm the only one at this hospital, right? At the end of this year, if they don't offer me a permanent position, there's going to be no one next year"* Here the participant (4) concurs that there is a shortage of psychologists and that she is currently the only clinical psychologist working at the public hospital she was working at during the pandemic. This was also mentioned by participant seven (7) who shared: *"We don't have enough psychologists. Like in general in the public health system, there's just not enough people for the amount of work that is out there."*

3.4.4 The Sporadic Nature of doing the work

All of the psychologists expressed dissatisfaction that changes to lockdown regulations by the government during the pandemic, negatively impacted their ability to conduct therapy and support the public consistently. The predominant interruption mentioned by all of the ten psychologists was the sporadic nature of their group work. The psychologists mentioned that whenever a staff member tested positive for COVID-19, the wards would often have to shut down and their group work would come to a halt. The theme 'The sporadic nature of the work' is therefore related to work interruptions based on changes to lockdown regulations as well as the presence of COVID-19 positive cases in the hospitals they were based at. All of the psychologists expressed that they were negatively affected by these frequent interruptions that impeded their ability fulfil their duties.

Participant two (2) states: "*so what usually happens if there's a positive case in the ward, they will close the ward and then I will not see patients for groups, which also disrupts our programme"* Participant one (1) corroborated this assertion by sharing: "*it was like, on and off, if I can say that, for example, if you were working in a ward, and then there is a Covid exposure to staff, then it means that all work needs to come to a halt".* Participant three (3) also concurred with the aforementioned, in his statement that*: "The only difference was no group work or if the there was an infection amongst the staff at a clinic the whole clinic would close down."*

3.5 Coping Mechanisms

This theme involves the psychologists exploring the various coping mechanisms they believed they had developed whilst working during the COVID-19 pandemic. This theme was divided Into three subthemes: namely 'positive' coping mechanisms, 'negative' coping mechanisms and coping mechanisms that were 'neither negative nor positive' according to the psychologists.

3.5.1 Positive Coping Mechanisms:

Participant one (1) shared her positive coping mechanisms: *"being in my own personal therapy. That was really helpful as well as in supervision and constant supervision. I mean, there's a lot of supervision that goes on in your internship year that umm whether it's groups, supervision or individual supervision, but that becomes very powerful. That kind of support system actually sort of like grows your own have therapeutic muscle. That's how you were able to gauge when you are in a therapy session that actually this is my stuff that's going on. This belongs to the patient. And this is how much containing I can do or can take. And I think when you're in the clinical space, what I found most amazing was the constant check in on everyone else's mental health from everybody else. I mean, because of these shared experiences, I know I'm going through so much anxiety because, for example, my ward has broken out into a COVID. But I work with other therapists as well, they will ask you, constantly, we hear that there's been exposure, how you feeling? Are you okay? There's just this so much constant, containing of each other's entirety as a team, which I found quite helpful."* Here the participant (1) mentions that what helped her cope during the pandemic was attending her own therapy, and the availability and utilization of consistent supervision during her internship. She also mentioned the support she had received from her colleagues who were also therapists, she found the collegial support to be very beneficial and 'containing' for her. She mentioned that everyone checked in on each other's mental health because they were sharing similar experiences during the pandemic.

Participant one (1) then went on to mention the following: *"So support became like my, go to place, it was very important to have like stable and persistent support, not only from the working environment, but also from the home and friends. I mean, the circles are the people that you keep around you. If they don't understand what you quite going through at the time, it becomes hard to maintain those relations."* Here the participant (1) notes that in addition to support from her colleagues, she also relied on support from her family as well as her friendship circles.

Participant two (2) concurred with participant one (1) as well as all of the remaining psychologists that were interviewed in this study, that personal individual therapy was a positive coping mechanism that helped them. This is evidenced by participant two's (2) utterance: *"I think it was quite helpful to, to start with individual therapy often, you know, I got to a point where I said I needed that space, because just pouring from an empty cup"*

Participant two (2) also shared similar sentiments regarding support. He mentioned: *"I definitely benefited from utilising the support available to me, supervision, peer supervision, therapy, all of these things. I think it's something that I want to keep moving forward, you know, I felt because I learned quite a lot in those in those interactions. And also learning that you're not going through this alone, other people are feeling the same way, I think that's very quiet. It normalises that experience, you don't feel like there's something wrong with you, you know? Or they're judging you, you're not coping because you didn't do things correctly, and that in itself was containing knowing that."* Here the participant seemed to express that he felt that the social support normalized the experience for him and made him feel less judged. He also expressed that he felt the support was 'containing', similar to participant one (1).

Participant three (3) shared his experience: *"The Clinics had a really lovely team. And it was just wonderful to feel held and supported together. Like not management. Collegial"* Here participant three (3) also emphasises the positive experience of collegial support as a coping mechanism.

Participant eight (8)also stated: "*Just talking to colleagues and just sharing the experience was we almost created a support network where we would sort of talk about the struggles of this and not feel so alone in the helplessness and it was also an important thing for me to know that I have my own psychologist to, you know, take care of my own mental health, a lot of self-care was necessary".* This participant highlighted the importance of self-care. [Include one more quote on self-care].

Generally, all the psychologists interviewed expressed that they found social support from their colleagues (who were also psychologists) as well as their friends and family, to very beneficial. All of the psychologists also shared that their individual therapy was a positive coping mechanism during the pandemic. Some of the psychologists mentioned that supervision was also very beneficial. As seen by participant nine (9) as an example: *"The one thing was getting my own external supervision, supervision was really, really important"*

Further positive coping mechanisms included physical fitness. Participant three (3) expressed: *"I also started exercising more regularly. Just for my health in general and also my wedding was coming up in April. So I was like, Yeah, gotta look good for those photos too. And that's been great. I've loved it. It's really helped me be like more in touch with my body. And just the a great sense of like mindfulness and confidence. I've also started like a breath work thing that I do every day. And it's, yeah, it's like a Wim Hof thing. It helps"*

Here the participant three (3) mentioned that he enjoyed exercising regularly and that it helped him cope, he also added that it helped him get more in touch with his body. He additionally expressed that breath work assisted him during the pandemic. Participant two (2) concurred with exercising being useful in his statement: *"So once I did, I started exercising, I would run. I find it quite helpful, it helped me sleep better"* Here the participant also expressed that exercising, specifically running, helped him with his sleep.
Participant nine (9) also stated that the act of running was a useful coping mechanism. This is evidenced as follows: *"So I run I run a lot. I run three times a week. So I continued with my exercise and if I could go out and like and right in the beginning or it was hard lockdown. Then I would kind of like jog up and down the driveway. And yeah, I think that was my exercise. The positive coping mechanism."*

3.5.2 Negative Coping Mechanisms:

In this subtheme, the psychologists explored coping mechanisms that they had experienced as negatively impacting them. These are coping mechanisms that they found clearly unhelpful and perhaps harmful for themselves.

Participant eight (8) mentioned: *"I'm a smoker, I can definitely tell you, I smoked a lot more"* as a coping mechanism that she regarded as 'negative'.

Participant ten (10) expressed that food became a negative coping mechanism for her: *"Because you're just eating for comfort. Most of the times, you're just eating because you have to eat and you find that if you're working in a more taxing environment, if it's taxing emotionally and physically, you find yourself eating a lot of junk food, which is not really good for your physical health. So that's what you notice a lot at barra because the very difficult environment, I mean, a lot of people eat junk food, you know, would even like pop money in to just buy like snacks. Because we need that to survive.*

Here she suggests that food provided her with comfort during challenging times and seemed to state that this was common amongst the healthcare workers at the hospital, as somewhat of a survival mechanism.

3.5.3 Neither negative or positive: context dependent coping mechanisms

In this subtheme, the participants didn't feel that the coping mechanisms fit strictly into negative or positive binaries. Instead, seemed to suggest that the coping mechanisms developed could be considered both negative and positive, but that overall, the development of these coping mechanism was not harmful. Rather, these coping mechanism seemed to be normalized by the psychologist especially considering the context of a pandemic.

Participant three (3) explains: *"I almost want to say I did game a lot. A lot. But I don't know if I'd say that it was like, necessarily unhelpful. It wasn't as beneficial as the other ones. But no, I got in touch with like a primary school friend. And you know, we talk every week and we're actually really close now. That wouldn't have happened if I weren't gaming. And I really enjoyed that. That's probably like as unhealthy as it gets"*

Here the participant expressed that he did game a lot but that he didn't view it necessarily as a negative coping mechanism because there were positive benefits that helped him. For example, he highlighted the ability to interact with his primary school friends through the gaming platform as an experience he would not have had access to without gaming often.

Participant two (2) states one of his coping mechanisms: "*listening to music, I find it quite therapeutic, but also, with that, for years I've been listening to music I think more recently, at least this year, I also found it quite unhelpful at times. Because what it does is you switch on hip hop, let's say I listen to hip hop music, I switch on the music, it plays and I focus on a song. But in that moment, you can, don't worry, because for me, I didn't reflect on how I was feeling at the time, it was more like, I was just feeling, let's say, I was feeling upset, I might have been anxious, or angry or frustrated or anxious. And then I'll just switch on the music, listen to it. So it's like, I'm not really addressing what I'm feeling, but more avoidant using music, you know, it's good to distract. But when distraction become, the way and main way of coping, and it becomes maladaptive, because it's like, you're just not aware of self. So I did feel that music was beneficial. But I also see, I saw how, at times, it was not helpful because it didn't allow me to spend time with myself ,without feeling my thoughts"*

Here the participant (2) seems to feel that listening to music could be maladaptive at times but that it was also beneficial at times as a coping mechanism during the pandemic.

Participant nine (9) mentioned that she also watched YouTube videos in excess. The videos she watched were of pimple popping. She states: "*Dr. Popper got me through it even though I watched it excessively"* She went on at a later point during the interview to explain why it helped her. Participant nine (9) explains: *" But I think that for me, my de- stressing was probably when I would get home YouTube was something that really helped me I kind of like Dr. Pimple Popper it was, I would just sit there and zone out. Obsessively maybe. I think that it was an I really I thought about it quite a lot. And it was almost like , if you think about what she does, it was almost that release for me, a metaphor of getting rid of the festering".* Here the participant reflects on why the coping mechanism was metaphorically helpful for her.

3.6 Survivor's Guilt: Privilege highlighted during the pandemic

This theme entitled 'Survivor Guilt: Privilege during the pandemic' emerged based on a few participants expressing feelings of guilt due to the fact that they did not have to go through the same type of hardships that their patients endured during the pandemic. This theme relates mostly to financial privileges that these psychologists acknowledged, in contrast to the underprivileged population they were giving therapy to.

Participant five (5) mentioned that he struggled to admit that he was impacted by the pandemic because he still had his job compared to so many who didn't. He states: *"But it was tough. It was tough. But at the same time you feel guilty to say that because we still got paid, we have jobs, we got to train. Yeah."* At a later point during the interview he continues: *"But I'm also grateful to still have that chance to be in an internship during COVID. And to especially to be paid during COVID while people were losing jobs, families very affected in all of this session. And it just breaks your heart because you're getting paid at the end of the month. But a lot of people aren't getting paid. So yeah, difficult sad as well. I must admit"*
Participant six (6) referred to the feelings he felt conceptually as a form of 'survivor *guilt'.* He explained: *"It was difficult. I think at first it was I can only liken it to a bit of survivor's guilt but sort of why I think of it that way is yes, COVID-19 affected my work. But at no point did I feel that, I could possibly be retrenched or I could stop working. I could lose my source of income. And so when you're seeing a patient, or clients who had recently lost their job, and they were really struggling and sort of the depressive symptoms and the anxiety symptoms that they But at that point makes sense because*

of a life circumstances, it becomes so difficult in therapy. Because yes, you can sort of help patients to be more robust in dealing with life challenges. But those life challenges exist every single week, they stay there"

Participant ten (10) corroborated the sentiments of the aforementioned mentioned psychologists by expressing the following experience of hers: *"when your patients don't have money to come to the hospital, when your patients don't have money to just take care of themselves, because they've lost jobs. it's been a struggle to work with that, because you're going into work during COVID. And people have lost their jobs, you know, and you have your job, you're still able to sustain yourself, but the guilt that comes with that is really hard. Because you're expecting somebody to come to therapy, who probably doesn't even have money to come to therapy, and you're able to do that you're able to continue with your life as if nothing happened. So I think for me, it was just a lot of guilt around that even now the guilt is still there, because things are just getting worse and worse, the job losses, companies changing, people working online, there's a lot of patients who can't even access any online help, because they don't have access to such things."* Here participant ten expresses her feelings of guilt regarding being employed during the pandemic whilst many of her patients had insufficient financial resources to sustain themselves and also to attend therapy at the hospital. She mentioned the privilege of being able access mental health care services whilst access to mental healthcare for her patients is limited by their financial constraints. She further mentioned that some patients are unable to access online mental health assistance.

3.7 Conclusion:

This results chapter has provided an outline and description of the themes that were generated from the interviews of ten (10) psychologist working in different hospitals within the public sector, in South Africa. The themes emerged from an interpretive Phenomenological Analysis (IPA). As previously mentioned, the identified themes are as follows: 'Personal effects of working during COVID-19 on psychologists', 'Changes to therapy during COVID-19', 'Experiences of COVID -19 exposure in public hospitals', 'Coping mechanisms and 'Survivor guilt'. The next chapter, chapter four will be provide a detailed discussion of the aforementioned findings.

Chapter Four: Discussion

4.1 Introduction

This current chapter will provide an in - depth discussion of the results presented in Chapter three. The discussion of these aforementioned findings will be presented in a chronological manner, as they were presented in the results chapter`(Chapter 3). The overall objective of chapter four is to provide the reader with a critical discussion of the findings, that is situated within psychological and social theories and explanations from prior related research, as well as the broader literature.

4.2 Personal effects of COVID on psychologists

The COVID-19 pandemic had a multifaceted impact on the daily lives and overall wellbeing (including mental, psychological, social aspects) of people globally (Pfefferbaum & North, 2020; Pedrosa, 2020). South Africa was one of the countries who were most severely affected by alarmingly high numbers of COVID-19 infections and deaths (*WHO*, 2023). South Africa's severe exposure to COVID-19 contributed to the adverse mental health outcomes seen amongst the population (Nguse & Wassenaar, 2021; De Man, 2022). Psychologists based at hospitals in the public sector were among the frontline healthcare workers who were regarded as an essential service during the pandemic. Psychologists (and trainee psychologists) have long been considered a vulnerable group of healthcare professionals because of the specific type of work they do with encompasses continuous exposure to trauma and increased emotional stressors, even prior to the pandemic (Pearlman & Saakvitne, 2013; Sui & Padmanabhanunni, 2016; Pimble, 2016; Trombello et al., 2022).

According to research, psychologists themselves have been grappling with the ramifications of not only supporting the public psychologically during a catastrophic pandemic, but also experiencing the pandemic themselves (Uphoff et al., 2021; Aafjes-van Doorn et al., 2020). They often went through similar experiences to the patients they were trying treating. However, many of the psychologists in this study acknowledged a differentiating factor: that they were in a privileged position because they remained employed and did not experience financial insecurity during the pandemic, in contrast to the patients they were treating. The theme entitled 'Personal mental health effects of COVID-19 on psychologists' encompassed the psychologists reflections of the ways in which they had been (both negatively and positively) impacted by working on the frontlines during an unprecedented pandemic, in South Africa. The subthemes that emerged under this overarching theme of the personal mental health effects on psychologists, are: 'A sense of helplessness', 'Inadequate training and development opportunities during COVID-19, 'Burnout', 'Changes to personality' 'Rewards: A sense of fulfilment' and 'Survivor's guilt: Privilege during the pandemic. These subthemes will be presented below.

4.2.1 A sense of helplessness

As previously mentioned in the results chapter, all of the psychologists who were interviewed described that they felt a sense of helplessness and or 'powerlessness' whilst working with their patients during the COVID-19 pandemic. The psychologists in this study attributed their experiences of helplessness/powerlessness to the pandemic-related conditions they were working under, the marginalized population they were treating, and an overall collective uncertainty about when the pandemic would end. Some of the psychologists expressed they felt helplessness not only because of the unfamiliarity and novelty of working during a pandemic, but also because they were more limited/constrained in the ways they could provide 'help' and conduct therapy.

One participant described it as feeling 'stuck'; and another participant said that he really wanted to help his patients amidst their suffering but he couldn't because 'it was beyond him'. These feelings of helplessness may have been amplified by the fact that the majority of the patients seen by these psychologists were from disadvantaged communities who faced the harsh realities of job losses, increased exposure to COVID-19 infection in crowded and unsanitary living conditions, and the general lack of access to basic needs (Webb Hooper et al., 2020; Nguse & Wassenaar, 2021). Glowacz et al. (2022) suggests that professional burnout is more common amongst psychologists who work with disadvantaged and impoverished communities, because of the higher degrees of distress and feelings of powerlessness that may arise when working with these populations.

A further contextualisation of their feelings of helplessness could pertain to their perceived lack of a sense of control. Research has shown that both a lack of control within ones work environment and the inability to partake in decision making can lead to negative psychological health consequences i.e. increased stress (APA, 2022.; Rupert & Morgan, 2005; Michie, 2002). To this effect, a study conducted by Trombello et al. (2021) found that inadequate control over workload increased the risk of helplessness and burnout, amongst the sample of psychologists. Kotera et al. (2022) found that health care workers in Japan felt an unsettling lack of control during the pandemic and relied on coping mechanisms (collegial communication and support, self-care, and professional acknowledgment) in an effort to combat this lack of control. Participant seven (7) from this current study referenced experiencing a lack of control over the frequently occurring pandemic-related interruptions to her group therapy treatment with patients, she said "*there's nothing you can do about*", and further that: "*this year has taught us is that things can just go out of control*".

It is evident that the COVID-19 pandemic impacted these psychologists experience of a sense of reasonable control in their occupational roles, which often rendered them feeling helpless and

powerless amidst an uncertain present and future. However, some psychologists in this study made meaning of the experiences of lack of control, and referred to positive shifts in their approach to the uncertainty that is inherent in life (i.e. shifts in life philosophies).

Another psychologist (participant 9) in this study, further expressed that there was little she could really do (i.e. referring to a lack of control) and that this realisation had been a source of great disappointment for her. An additional dimension to the theme of helplessness arose for this particular psychologist (participant 9) who expressed that she was "just filling holes". She felt that she was unable to use her knowledge and skills to make a difference and impact in people's lives, which she referred to as 'giving back'. She explained that that was supposed to be the purpose and goal of her community service year. Indeed it is commonly understood that the psychology community service year is purposed to be one in which mental health care services can be provided to socio-economically disadvantaged members of society (Swarts, 2013).

There appeared to be disappointment, frustration and a grief as a result of this opportunity being stripped away from her during the pandemic. Uncertainties and blurred lines regarding the specific duties of an individual's occupational role (i.e. work-role ambiguity), work related policies and guidelines, as well as and a lack of control over 'job design', has been shown to increase dissatisfaction at work and contribute to poorer mental health (Mental Health at Work, 2022; Alyahya et al., 2021).

It could be argued that this psychologist (participant 9) may have additionally been negatively impacted by the diminished sense of professional accomplishment and professional development afforded to her, which she expected to receive in her community service year. In contrast, South African studies conducted by Soloman (2019) and Pillay et al. (2012) revealed that the psychologists in their cohorts felt a sense of professional accomplishment and work satisfaction whilst working in hospitals, during their time. Both of their studies however were conducted prior to the COVID-19 pandemic, which may have influenced and contextualised the participant nine's (9's) experience of grief for not being able to have that same experience. Work satisfaction is regarded as a protective factor for burnout amongst healthcare professionals (Mcloughlin et al., 2022). Although it is noteworthy that mental healthcare professionals tend to report lower rates of personal accomplishment (and relatedly work satisfaction) in their early careers (Aldrees et al., 2017; Alqarni et al., 2022). Higher rates of professional accomplishment have been found to be positively associated with increasing age amongst mental healthcare professions (Hamaideh et al., 2011; Volpe et al., 2014; Melchior et al., 1997). It can be therefore be argued that trainee psychologists and those in their early careers, may have been more susceptible to the negative consequences of a lack

of professional accomplishment and work satisfaction whilst they were working in the public sector (especially with all its accompanied resource-related challenges), particularly during the COVID-19 pandemic. As previously mentioned, it has been well documented that diminished professional accomplishment is a pertinent risk factor for burnout (Maslach, 2016; Pimble, 2016; Patel et al., 2018).

One psychologist (participant 3) in this study differed from the rest in his reflection that the helplessness was not caused directly by the COVID-19 pandemic, but rather from the pre-existing systematic failures within the public health care sector (of which the mental health provision is included) in South Africa. This assertion has been corroborated by research that suggests that healthcare workers (inclusive of clinical psychologists) employed in South Africa's public sector face unique challenges and emotional stressors due to the conditions under which they work, in comparison to healthcare workers employed in the private sector. Public institutions in South Africa are characterised by a lack of resources, inadequate infrastructure, high workload, and staff shortages (Munishvaran & Booysen, 2022; Swarts, 2013). Reportedly only five percent (5%) of governmental financial investment is provisioned for mental health care facilities (Munishvaran & Booysen, 2022; South African Government, 2022). This has often been experienced as demotivating and demoralising for healthcare workers and has led to them feeling helplessness and powerlessness (De Sousa & Dela Coleta, 2015).

A psychologist (participant 7) in this study provided another dimension onto this theme of helplessness. She said: "*there is a helplessness that exists just from doing the job of a psychologist*" suggesting that it is part of the nature of the work of a psychologist, to navigate the experiences of helplessness that may arise when working with patients. This psychologist (participant 7) felt that COVID-19 exacerbated this 'inherent' helplessness. It is reasonable to suggest that these feelings of helplessness experienced by psychologists may be more prominent in LMIC's, and specifically in public institutions in these countries (Borges 2014; Rathod et al., 2017; Kola et al., 2021). Psychologists in these contexts often work with patients who live in impoverished conditions, are exposed to traumatization, and have a general lack of access to basic needs. Psychologists may question whether the therapeutic space is of real help to these patients who need hands on practical support. This factor could further contribute to psychologists questioning their therapeutic effectiveness, as was the case for the psychologists in a study by Borges (2014) who experienced helplessness and powerlessness when working with low-income clients.

4.2.2 Inadequate training and development opportunities during COVID-19

A few psychologists in this current study felt that they had inadequate exposure to training and professional development opportunities (that they needed to develop) as a trainee psychologist working during COVID-19 pandemic, and that this disadvantaged their professional development. One of the major factors that impact workplace stress and the manifestations of ill -psychological health, is the lack of opportunities for professional development and growth within an individual's role (O'Connor et al., 2018.). This distress may be further amplified during years of training and development when adequate exposure to Work - based learning (WBL) is required for the development of the core competencies needed for future practice in the professional (Lourens & Uren, 2023). Further, the lack of sufficient WBL during an internship year may negatively impact the development of professional identity (Lourens & Uren, 2023). Professional identity refers to "a conscious embodiment of the way a professional defines who they are and the way they choose to act and represent themselves" (Sonday, 2021, p. 49).

Some psychologists in this study alluded to experiences of inadequate exposure to professional development opportunities in the form of WBL during COVID-19. One psychologist (participant 1) was concerned about whether she was adequately prepared for her community service year, due to the impact that COVID-19 had on her internship year. This had contributed to feelings of anxiety and under-preparedness as a trainee psychologist. And as previously mentioned, participant (9) shared that she was unable to use her skills (and prior training) practically and effectively during her community service year; thus inadvertently concurring with the previous participants (participant 1's) sentiments about the lack of the opportunities for sufficient WBL, and thus, professional development, during the COVID-19 context. This connects to the aforementioned subtheme in that the psychologist also experienced helplessness in relation to the loss of WBL opportunities. Studies have confirmed that healthcare workers in training (i.e. medical students and interns) have been at risk of adverse mental health concerns due to interruptions to their education and training programmes; and relatedly to the loss of the opportunity for skill development during the COVID-19 pandemic (Sharma & Bhaskar, 2020; Dedeilia et al., 2020; Gardner et al., 2021). This has negative implications for the medical and psychological professional in terms of the questionable production of a competent workforce (Sharma & Bhaskar, 2020).

4.2.3 Burnout

All of the psychologists in this study either mentioned the term 'burnout' verbatim or alluded to the experience of burnout by referring to a few of its defining components during their interviews. For example, the psychologists all provided accounts of extreme 'exhaustion' whilst working in the

public sector during the pandemic. Extreme exhaustion (physical, emotional, mental) caused by an individual's working conditions has been regarded as a defining feature of professional burnout (Kirstensen et al. 2005; Demerouti & Bakker, 2007; Maslach & Jackson, 2016; Freudenberger, 1974). The high prevalence of burnout in this current study corroborates the frequent accounts of extreme exhaustion and or 'burnout' (mentioned verbatim) amongst mental healthcare professionals, like psychologists, in the literature (Volpe et al, 2014; Rupert & Morgan, 2005; Simpson et al., 2018; Pimble, 2016; McCormack et al., 2018; Joshi & Sharma, 2020; Trombello et al., 2021; Lourens & Uren, 2023). This is evidenced by a systematic review and meta-analysis conducted by O'Connor et al. (2018) which comprised (n=62) original studies (conducted between 1997 and 2017) from thirty-three (n=33) various countries on the prevalence and determinants of burnout amongst mental healthcare professionals (including psychologists, counsellors, doctors, social workers, occupational therapists and nurses) within that specific population. Findings indicated high rates of emotional exhaustion coupled with moderate rates of depersonalization and reasonable indications of professional accomplishment, amongst mental healthcare workers were established. Specifically, (40%) of participants reported professional burnout; with emotional exhaustion being the primary concern (O'Connor et al., 2018). This research was conducted prior to the context of the pandemic. The onset of the COVID-19 pandemic has undoubtedly increased the risk for burnout amongst frontline healthcare workers, like psychologists, as has been confirmed in the available research (Joshi & Sharma, 2020; Trombello et al., 2021; Glowacz et al., 2022; *APA***,** 2022; Van Hoy et al., 2022).

Some psychologists in this current study expressed that the heavy caseload (workload) and working hours contributed to their burnout. This has been consistently identified in the research as one of the main predictors of burnout amongst mental healthcare workers generally (Billings et al., 2021; Mcloughlin et al., 2022; O'Connor et al., 2018; Portoghese et al., 2014; Rupert & Morgan, 2005; Yang & Hayes, 2020). One psychologist in this current study mentioned that she felt she was pushing herself 'too hard' (participant 7) and explained that she sometimes had to carry her colleagues' workload when they were absent from work. Absenteeism amongst healthcare workers was not uncommon during the pandemic; this could have been associated with increased COVID-19 infections and periods of quarantine/ isolation (Billings et al., 2021). Further, professional burnout has also been associated with frequent absenteeism (Maslach & Leiter, 2016). Frontline healthcare workers based in hospitals globally have reported increased workload and staff shortages during the pandemic (Liu et al., 2020; Ardebili et al., 2021; Søvold et al., 2021; Billings et al., 2021). It is important to mention that even prior to pandemic related circumstances, there was a lack of qualified healthcare workers in comparison to the overall population that require healthcare

services; particularly within LMIC's like in Africa (Rispel et al., 2016). This shortage of healthcare workers has compounded their levels of work-related stress and burnout, within their work environments that are often already under-resourced (Søvold et al., 2021).

Most of the psychologists reported that the continuous and prolonged nature of the stressors and feelings of extreme exhaustion were emotionally taxing. Indeed heightened stress that is sustained over a long period of time has been associated with the development of burnout, particularly within caregiving professions (Davies et al., 2021; Maslach, 2003; O'Connor et al., 2018; Simionato & Simpson, 2018). A few psychologists mentioned they were often dealing with complex and difficult patient-cases (this is unsurprising given the public state of mental health during the onset of the pandemic, as well as the state of mental health within South Africa generally). One psychologist (participant 7) shared that there was insufficient time for them to process these difficult cases and to replenish their internal resources after being exposed to these challenging cases. This particular participant (7) was a trainee psychologist at the time and it is possible that this factor contributed to his increased need for time to process and replenish internal resources whilst still training, learning and developing his professional resources. Research suggests that both trainee and newly qualified psychologists are at increased risk of becoming too invested and enmeshed in their patients traumatic experiences (Davies et al., 2021). Further, some literature suggests that indeed intentional rumination, and 'processing' of traumatic experiences may be an important factor for the development of Post-traumatic growth. (PTG) (Feingold et al., 2022).

According to research, the high emotional demands of therapeutic work generally make psychologists vulnerable to burnout, which not only affects their wellbeing negatively but may also impact their professional effectiveness (i.e. therapeutic effectiveness), and thus may have detrimental consequences for the patient (Maslach, 2007 as cited in Simionato , & Simpson, 2018; Volpe et al., 2014; Pimble, 2016; Joshi & Sharma, 2020; Davies et al., 2021). Psychologists in training may have unique risk factors that make them even more susceptible to burnout (Rodolfa et al., 1988; Davies et al., 2021; Mcloughlin et al., 2022). As previously mentioned, some of the psychologists in this current study experienced restrictions to opportunities for professional development and growth. Research has suggested that this can further contribute to the development of burnout symptoms (O'Connor et al., 2018).

Research findings indicate that not only are trainee mental healthcare workers (i.e. psychologists in training) at increased risk of burnout, but that fully qualified psychologists with limited working experience are too at risk (Dorociak et al., 2017; Volpe et al., 2014). The aforementioned study

conducted by Dorociak et al. (2017) found that more intensive work demands were reported by psychologists who had less years of clinical experience as well as limited opportunities for additional training and professional development. In addition, they reported more negative experiences with their patients and less professional resources, compared to psychologists with more years of clinical experience. Psychologists with more working experienced also appeared to spend more time engaged in self-care practices compared to psychologists in their early career stage (Dorociak et al., 2017). This corroborates the majority of research on burnout that suggested that healthcare professionals tend to develop greater internal resources to cope (more effective and efficient coping strategies) with occupational stressors and demands as they grow older and their years of working experience increases (Mcloughlin et al., 2022; Simionato & Simpson, 2018; Trombello et al., 2022). These findings were also mentioned previously in relation to a sense of professional accomplishment.

Supervision was a prominent factor in the literature that served as one of the main mitigating/buffering factors to the development of burnout amongst trainee and early-career psychologists, in particular (Davies et al., 2021; Duggal & Rao, 2016; Hiebler-Ragger et al., 2020). Many of the psychologists in this current study indeed expressed that their experience of supervisory relationships assisted them and helped them cope with the realities of working on the frontlines during the COVID-19 pandemic. Consistent supervision is associated with increased work satisfaction, competency and feelings of confidence amongst health care professionals generally (Mcloughlin et al., 2022).

4.2.4 Changes to Personality

All of the psychologists in this study shared their accounts of positive long term changes to their personalities, that were facilitated by their experiences of working during the COVID-19 pandemic. This has often been described in the literature as Posttraumatic growth (PTG) (Tedeschi et al., 1998; Jiang et al., 2022). PTG is considered a process of psychological growth during or after periods of adversity or traumatic distress (Jiang et al., 2022). A study conducted in the USA, New York by Feingold et al. (2022) investigated both the determinants and prevalence of 'pandemic- post traumatic growth' amongst a sample of frontline healthcare workers based at a tertiary care hospital institution. Data was collected at two points in time, during the first wave of the pandemic and then again, seven months later during the second wave. Findings revealed that (77%) of HCW's experienced PTG that was 'pandemic related'**.** The most predominate aspects of the pandemic-related PTG were seen in a reported increase in increase in their 'strength' /resiliency as well as a

strengthening of their personal relationships, and more positive, appreciative philosophies on life (Feingold et al., 2022). These aforementioned findings are significant to the field of psychology since the majority of studies on PTG amongst frontline healthcare workers were conducted prior to the COVID-19 pandemic. The phenomenon of 'Pandemic-related' Posttraumatic growth requires further investigation. This current study contributes to the body of research on the experiences a *distinctive* pandemic-related PTG, amongst frontline psychologists working in the public sector during COVID-19 in South Africa**.** Similarities between the study by Feingold et al. (2022) and the results of this current study are evident.

The two most frequently mentioned personality trait changes amongst psychologists in this current study were: 1) an increase in the capacity for resiliency and 2) the ability to be more flexible and adaptive amidst change and uncertainty. Indeed, adaptability has been regarded as a key component of resiliency in the literature (Finstad et al., 2021). Resiliency thereby includes an individual's ability to adapt and maintain functionality amidst traumatic events or difficult experiences (Finstad et al., 2021; Caniëls et al., 2019). One psychologist (participant 1) in this study referred to the COVID-19 pandemic strengthening a core, pre-existing personality trait of hers, when she expressed: *"Probably it would have strengthened my core personality of being quite resilient".* Some research on healthcare workers around the world have frequently reported increases in their levels of resiliency in response to the pandemic (Finstad et al., 2021; Huffman et al., 2021; Baskin & Bartlett, 2021; Chen et al., 2021). It is well known that resiliency may decrease the severity of psychological distress, anxiety, burnout, depression and PTSD (Skovholt & Trotter-Mathison, 2014; Ojo et al., 2021; Manchia et al., 2022).

Further accounts included an increased openness to reliance on external resources such as social support (this could also be related to a growing trust of people), which improved and deepened the participant's relationships with their social networks. Research indicates that social support is a protective factor that mitigates the impact of psychological distress (Ojo et al., 2021; Mcloughlin et al., 2022). The presence of social support can facilitate the development of positive adjustment strategies, such as those related to Posttraumatic growth (PTG) (Shang et al., 2020; Jiang et al., 2022*)*, as evidenced in the findings by Feingold et al. (2022). One psychologist (participant 2) reported developing a greater self-awareness and self-exploratory nature, it is hypothesized that this could have improved and deepened the psychologists relationship with themselves, complementing the aforementioned improvement in relationships with others. Psychologists in this current study

also made reference to changes to their life philosophies. These related mostly to a relinquishing of control and greater acceptance of change.

Asmundson et al. (2021) suggest that the frequent accounts (self-reported) of PTG by healthcare workers during the COVID-19 pandemic may not always be an accurate reflection of their mental health. These accounts of positive growth may at times be illusory; in that they could be considered avoidance strategies or defensive coping mechanisms to mask their true psychological states and thereby lead to increased levels of distress (Asmundson et al., 2021). This concept was also theorised in a study by Boerner et al. (2020), and must be considered in this current study as a possibility. Especially against the backdrop of the fact that none of the psychologists in this study made direct reference to any long term negative effects of working as a psychologist in the public sector during the COVID-19 pandemic. It is possible that these psychologists did not have as much insight into the possible negative alterations to their personalities because the pandemic was still ongoing; and that the more long term negative effects of the pandemic were yet to be discovered. Further, it is possible that these psychologists did not necessarily regard their adverse mental health experiences as leading to negative long term changes to their personalities. Another possibility is that the psychologists in this study were uncomfortable sharing their reflections on this topic. Perhaps due in part to the stigma that exists even within the mental health professional, and that disclosure about one's true mental state may lead to questions regarding therapist competency; and may further result in the loss of opportunities in work environments (Tay et al., 2018; Devendorf & Victor, 2022). To conclude, it is also arguable that the possible 'illusory' reports PTG by healthcare workers may serve a positive function for them, and may not be entirely maladaptive.

4.2.5 Rewards: A sense of fulfilment

Most of the psychologists in this study concurred that they had derived various rewards from working with patients during the COVID-19 pandemic. These rewards were mostly described as a sense of 'fulfilment'. The psychologists all mentioned that witnessing their patients undergo positive psychological change felt rewarding for them. The words 'psychological change' , 'change in mindset' and 'growth' were used by these psychologists to describe their patients experiences. It is hypothesized that witnessing their patient's mental health improve, increased the psychologists confidence, sense of therapeutic effectiveness and sense of professional accomplishment (Pimble, 2016). Some psychologists mentioned that seeing their patients benefit from therapy made them feel both helpful and purposeful. It thus served as a positive affirming experience, and a reminder of their professional competency. This affirming experience was important because many of the

psychologists were at times doubtful of the helpfulness of the therapeutic space (i.e. their work and role in general) during the COVID-19 pandemic. This was evidenced in their previously mentioned feelings of helplessness, and further by their accounts of feeling both under-prepared, and ill-equipped to work as a psychologist during the COVID-19 pandemic (this will be discussed in more detail in the subthemes to follow).

Research has suggested that experiencing professional accomplishment, and deriving a sense of reward and fulfilment at work, both serve as mitigating factors for the development of various adverse mental health outcomes amongst healthcare professionals (Pimple, 2016; Vagni et al.. 2020; Billings et al., 2021). This can further be contextualised with the previously mentioned literature that postulates that because healthcare workers, like psychologists in training or those in the early stages of their careers, are in greater need of professional accomplishment, they are also at increased risk of experiencing the negative consequences of not having this at work. Generally, it seems that the psychologists in this study straddled and held both realities, that of feeling helplessness and also of feeling helpful.

4.3 Changes to Therapy during COVID-19:

The sudden emergence of the COVID-19 pandemic meant that public health care institutions, as well as the healthcare workers who were employed within them, had to make rapid changes to adapt and continue providing health care services to the population. Healthcare workers like psychologists were under considerable pressure to navigate these unprecedented changes, both efficiently and effectively (Finstad et al., 2021; Salari et al. 2020).

4.3.1 Masks as a barrier to rapport during therapy:

All of the psychologists in this current study expressed that they experienced masks as a barrier to the development of rapport during COVID-19. This was mostly related to the fact that non-verbal behaviour (which provides the psychologist with important information during therapy) could not be observed as easily with the use of face masks (Ribeiro et al., 2021) and further perhaps that psychologists could not use their faces to non-verbally communicate emotions like empathy to their patients. These findings were corroborated in some studies on psychologists experiences (Laurens & Uren, 2023; Ribeiro et al., 2021). This barrier could have implications for the quality of the therapeutic relationship between psychologist and patient. Research suggests that the therapeutic relationship is imperative for effective treatment outcomes in the field of psychology (Flückiger, et al., 2018). Some studies however have suggested that psychologists did not feel that the masks had

an impact on therapeutic effectiveness (Erschens et al., 2022). It is postulated that perhaps one differing factor could be related to the fact that the psychologists in this study were mostly in training and therefore had less years of clinical experience which could have impacted their perspectives.

4.3.2 Under-preparedness to work as a psychologist during COVID-19:

Many psychologists in this study expressed that they were not trained on how to conduct therapy during a pandemic. Participant two expressed: "*our training is done in a space where we are not taking covid into account"*. Most of the psychologists in this study felt a sense of under-preparedness to work effectively as a psychologist during the COVID-19 pandemic. This was evidenced by participant nine who shared: *"I don't believe we were prepared for it*". This notion of 'under-preparedness' may be further contextualised by the fact that the majority of the participants in this study were trainee psychologists. It is hypothesised that his might have contributed to the degree of under-preparedness they experienced. It is noteworthy however, that the fully qualified clinical psychologist in this study also concurrently felt under-prepared for how to treat patients during a pandemic like COVID-19. Only one psychologist in this study (who was in her community service year at the time) felt that the training adequately prepared her. She felt that the training she received had a 'centralized' aspect to it, such as trauma training as an example, that could then be applied to the COVID-19 context. Further, another psychologist expressed that whilst she did feel under-prepared, she did not think that any psychologist could realistically be fully prepared for the pandemic because it was such a novel experience. She mentioned that her supervisors were also uncertain about how to navigate therapeutic care during the pandemic.

It is hypothesized that Moral Injury could have resulted from these public-sector psychologists feeling as if they were at times providing a poorer or inadequate quality of psychological care to patients (based on their feelings of under-preparedness to work as a psychologist during the pandemic); thereby compromising their 'treatment integrity/fidelity'. Treatment integrity refers to whether the correct and appropriate therapeutic treatment was selected, and further, whether it was implemented in a competent manner that upholds standards of quality (Perepletchikova & Kazdin, 2005; McLeod et al., 2009). 'Moral injury' is a conceptual term originally used in the Military context, that encompasses the negative psychological consequences of certain actions or a lack thereof, that have an impact on an individual's conscience or moral code (Litz et al., 2009 as cited in Greenberg et al., 2020). Moral injury has been previously used to describe medical student's feelings of under-preparedness to navigate the trauma they were exposed to in emergency settings.

In essence, moral injury can be described as a desire to help, and simultaneously feeling ill-prepared or incompetent to help effectively, and suffering a 'moral injury' thereof. This can manifest as the individual experiencing of high levels of guilt, blame and shame. Moral injury has been identified as a risk factor for the development of various mental disorders such as PTSD and depression (Greenberg et al., 2020). Further, psychologists feeling a sense of incompetence and infectiveness can lead to burnout (Joshi & Sharma, 2020). The concept of 'Moral injury' has also been applied to frontline healthcare workers experiences of working during the COVID-19 pandemic (Billings et al., 2021).

Further, moral injury could have resulted from the resource and infrastructure constraints faced by healthcare workers working in hospitals during the pandemic. Further, the guilt that psychologists may have felt from their experiences of desensitization and depersonalisation (i.e. burnout consequences) that may have negatively impacted the patient and therapeutic relationship. Moral injury may be conceptually related to Imposter Phenomenon (IP), whereby health care workers may feel like they are 'frauds' or are 'incompetent' despite contrary evidence of competency, high achievement and success (Clance & Imes, 1978). Indeed, IP has been cited in the literature on healthcare workers during the COVID-19 pandemic (Sharma, & Bhaskar, 2020; Cawcutt et al., 2021; Peng et al., 2022; Hernandez et al., 2023). Further, the prevalence of IP in this study may have been exacerbated due to the amount of trainee psychologists that participated. Research has shown an increased prevalence of IP amongst healthcare workers (trainees and those with less experience) in general (Pimble, 2016) and especially during COVID-19 circumstances (Blake et al., 2023; Lourens & Uren, 2023).

4.3.3 Navigating Online therapy during COVID-19:

Some of the psychologists in this study used the words: 'uncomfortable', 'very difficult', 'big adjustment' and 'mixed-feelings' when asked to describe their experiences of providing online therapy during the pandemic. One psychologist (participant six) described the rapid transition to online therapy as uncomfortable for himself (as the therapist), for his patients and for his supervisors as well. The discomfort arose from the rapid changes to how mental health care treatment was usually provided, the novelty of online therapy (for both patient and therapist), and the need to become familiar with video-calling platforms at a fast pace. All psychologists in this study reported being untrained for online therapy and therefore considered it a considerable adjustment. Similarly, South African psychologists in the study by Lourens & Uren (2023) also expressed feelings of uncertainty conducting online therapy during the COVID-19 pandemic because they were reportedly untrained on it. Indeed online therapy training is not provided to psychologists in South

Africa (Colbow, 2013 as cited in Goldschmidt et al., 2021). Further, some of the psychologists in this study mentioned that they were not initially familiar with online video platforms and had to learn how to use them. This is confirmed by Taylor et al. (2020) who stated that psychologists in South Africa had to learn to use transfer and apply their therapeutic modalities to online platforms. Laurens & Uren (2023) also confirmed South African psychologists being ill-equipped with the technological skills needed to transition to online therapy. Participant six used the words 'at first' when talking of the unfamiliarity, suggesting that online therapy became less challenging over time. Research indicates that indeed many psychologists eventually adapted to conducting therapy online (*APA*, 2022). Contrastingly, only (20%) of psychologists in the study conducted in the USA by Sammons et al. (2020) felt under-prepared to conduct online therapy during the pandemic.

All of the participants in this study reported that their experiences of online therapy included challenges related to network technical difficulties which caused disruptions to the therapeutic process. These findings have been corroborated in the literature, even within HIC's (*APA*, 2022). Some of the participants in this current study also mentioned that data was an expense that many of their patients could not afford. Concerns regarding data expenses may have possibly been more common in LMIC's, like South Africa, especially amongst impoverished communities that have inadequate access to technology (Goldschmidt et al., 2021). Additionally, it has been further documented that the prices for mobile data is extraordinarily high in South Africa, compared to the rest of Africa and other countries such as those in Europe (Goldschmidt et al., 2021). Generally, the lack of financial resources for online therapy widened the pre-existing mental health treatment gap, by further increasing barriers to mental health care services for more impoverished communities.

Furthermore, the psychologists in this study also considered the inability to witness body language over a video calling platform, or through a screen to be a barrier to the development of rapport and trust in the therapeutic relationship, as was the case with psychologists in the study by Lourens & Uren (2023). One psychologist (participant 7) in this study mentioned that although online therapy was difficult to navigate, she enjoyed the perk of seeing her patients full face without the face mask. She mentioned that her patients too enjoyed the opportunity to see her face, because they could only see each other's eyes when wearing face masks in person. The transition to online therapy was further complicated by the different therapeutic modalities that psychologists were trained to use (Goldschmidt et al., 2021). Specifically, that there were difficulties conducting therapy using psychodynamic modalities (Smith, 2014) and that online therapy was more suited to solution focussed therapeutic approaches based on more short term interventions and containment strategies (Goldschmidt et al., 2021).

One of the psychologists (participant six) in this study shared that he felt it wasn't as easy for his patients to put their 'defences' when they were at home, compared to when they were attending therapy at a specific time and location in person. He suggested that the unpredictability of the pandemic and having therapy move over to the home environment, influenced the patients levels of vulnerability. He thus considered this to be a positive element of online therapy. Indeed some patients may feel more comfortable to express vulnerability through a screen compared to in person with the therapist. Ethical concerns regarding privacy and confidentially were also raised in relation to the transition to online therapy. First that the psychologists patients did not always have access to private spaces for online therapy, as they often lived in crowded conditions or just amongst family members who were confined to their homes during the pandemic. These ethical dilemmas an concerns were mentioned in other studies on psychologists experiences globally (Goldschmidt et al., 2021; Chenneville & Schwartz-Mette, 2022; Laurens & Uren, 2023). Generally, the psychologists in this study collectively felt under-prepared and ill-equipped to transition to online therapy during the COVID-19 pandemic.

4.3.4 Therapeutic space impacted by the therapist:

Many of the psychologists shared that they believed that the therapeutic space was impacted by their own mental health and heightened emotions due to the COVID-19 pandemic. One psychologist (participant 3) shared that he struggled to be a comforting and empathetic presence for his patients (when they were crying for example) because he was experiencing so many of his own anger and fearfulness that arose when a patient took their masks off and he felt exposed to the virus. He expressed that that experience must have been difficult for the client and seemed to feel guilt. Another psychologist (participant 7) shared that she was more irritable than usual and found herself being cynical and dismissive of her patient's issues. This has been described in the literature as a sense of depersonalisation, that has been identified as component of burnout (Maslach & Jackson, 2016**;** O'Connor, 2018). Another psychologist (participant 8) felt that she was emotionally desensitized and that this desensitization began without her being aware of it. She reflected that the desensitization does impact the therapeutic space and that that is coupled with a lot of guilt**.** This sense guilt experienced by these psychologists could be experienced as a form of moral injury, depending on how they internalise and make meaning of these experiences (Greenberg et al., 2020).

As previously indicated, the mental health of psychologists can have an impact on their effectiveness in the therapeutic space and could thus be harmful for the patient (Rupert & Morgan, 2005; Pimble,

2016). For example, experiences of burnout amongst psychologists may lead to a deterioration in the cognitive functioning related to attention, memory and overall executive functioning (Davies et al., 2021 as cited in Deligkaris et al., 2014, Grossi et al., 2015) which has implications for decision making (Shapiro et al., 2007). This is particularly concerning because as mentioned by the participants in this study, frontline psychologists had to make quick decisions during the COVID-19 pandemic.

Some psychologists further expressed that they were negatively impacted by the fear of contracting COVID-19 from a patient during face to face therapy, especially during peaks of COVID-19 infections. One psychologist (participant 10) shared: 'that's when you become scared of your own patient'. This psychologist (participant 10) reflected that the pandemic undoubtedly affected her work performance because she was also in a state of anxiety, She referred to being in 'survival mode' and reflected that it was challenging to conduct therapy whilst in that state. Research indicated that one of the main predictors of therapeutic effectiveness and success is the development of a safe and trusting therapeutic relationship between the psychologist and patient (Davies et al., 2021). It can be argued that the mental health (overall well-being) of psychologists is critical to the development of safe therapeutic relationships for patients. Sabin-Farrell & Turpin (2003) theorise that a lack of expressions of empathy by a psychologist could be experienced as further traumatising to the patient. Further, Swart (2013) argued that psychologists working in the public sector have an increased responsibility of ensuring quality care is being provided because they are working with mostly impoverished communities, so as to not worsen their pre-existing vulnerabilities **a**nd socio-economic challenges (Jack et al., 2014).

4.4 Experiences of COVID-19 exposure in public hospitals:

4.4.1 Anxieties and fears of COVID-19 exposure and Taking safety precautions

The subthemes: 'Anxieties and fears of COVID-19 exposure' and 'Taking safety precautions' will be discussed together. Psychologists in this study all experienced anxiety regarding exposure to COVID-19 in hospital settings. Participant one (1) shared that this was in part because she had previously been infected with COVID-19 'severely' and was therefore fearful of reinfection at work. Participant seven (7) expressed fears regarding exposing her own patients to COVID-19 whist she was simultaneously exposed daily. Another psychologist (participant 3) shared that was anxious and worried about the potential long- term effects of COVID-19 infection such as brain fog, for example. He however felt less anxious about COVID-19 exposure after he had been vaccinated. Frontline healthcare workers have consistently experienced poor psychological health from continuous

physical health risks (fears of infection) at work that threaten their mortality (Cabarkapa et al., 2020; Billings et al., 2021). Some psychologists further mentioned anxieties regarding potentially passing the virus onto their loved ones at home. Fears and anxieties of frontline healthcare workers infecting their family members and friends have also been frequently corroborated across studies (Msomi, 2020; Singaram et al., 2021; Schneider et al., 2021; Billings et al., 2021).

Psychologists in this study employed various ways of protecting themselves from COVID-19 infection in their high risk work environment (i.e. hospitals). These included the wearing of face masks, social distancing, and washing and sanitizing both their hands and work materials frequently. Some psychologists in this study experienced wearing face masks and visors to be an uncomfortable experience. One participant (2) mentioned that he felt hypervigilant at times and wore both a face mask and a visor to protect himself. A few psychologists shared that they sanitized quite often and cleaned surfaces. One psychologist in particular reflected that she found herself picking up her sanitiser 'randomly' during her consultations. She explained: "*so you develop a little bit of OCD to cope with anxiety…*" and further that she did not think these behaviours were to be considered pathological but rather as an indication of her anxiety due to being exposed to COVID-19 in the hospital setting. A study by Kannampallil et al. (2020) revealed that physicians in training reported higher levels of distress and burnout in the face of COVID-19 hospital exposure, as did a study be Cravero et al. (2021) on physicians in training based in the USA, China, Saudi Arabia and Taiwan. Overall, these experiences of prolonged exposure to COVID-19 in hospitals had indeed led to increased psychological distress and negative mental health outcomes such as heightened anxiety and burnout, amongst frontline healthcare workers generally (Kannampallil et al., 2020; Cai et al., 2020; Msomi, 2020; Singaram et al., 2021; Cravero et al., 2021). Although not directly reported as such by the psychologists in this current study, the seemingly 'excessive' safety precautions they took may be considered a protective coping mechanism for their mental health (i.e. heightened anxiety) at the time.

4.4.2 Challenges related to resources:

4.4.2.1 Space constraints

Some participants in this study faced space constraints in their various public institutions, that impacted their ability to work. One psychologist (participant 1) mentioned that she experienced disruptions during her therapy sessions, from other hospital staff who also needed to use the room. Another psychologist (participant 6) mentioned that he was sharing an office space with three other intern psychologists**.** This is similar to the experiences of public-sector psychologists in the study by

Soloman (2019) who reported that they were only given two office spaces to be shared amongst four staff members, at hospital in Botswana. Many psychologists in this aforementioned study reported that they improvised and employed creative strategies to navigate these space constraints. Further, Padfield (2013, 2015) shared her experiences of working as a community service psychologist, at a public hospital in the Western Cape. She reported that she too was not allocated any office in the beginning of her year, and that even when she had found a space to use for therapy, she was often disrupted by the nursing staff who used the same location as storage for their office stationary.

Space constraints are not uncommon in public health care institutions based in LMIC's (Manyisa & van Aswegen, 2017; Deng et al., 2020), and can be directly attributed to inadequate funding and implementation of resource allocation at a governmental policy-level (Rathod et al., 2017; Kar et al., 2020). Healthcare workers in these under-resourced settings may experience poor mental health outcomes (Rispel et al., 2016; Deng et al., 2020; Søvold et al., 2021) which can partially be attributed to the accumulative daily work-related stressors and frustrations that impact their ability to function effectively (Sovold et al., 2021), and can lead to instances of moral injuries (Greenberg et al., 2020). Ethical dilemmas faced by psychologists in this current study pertained to patient confidentiality with regards to disruptions to therapy by other staff members, as well as the navigation of a shared office space when conducting online therapy during COVID-19. It is noteworthy that the COVID-19 pandemic placed even more pressure on these public sector-healthcare professionals who were already constrained by fragile health care systems (Finstad et al., 2021; Deng et al., 2020).

4.4.2.2 Masks

Some psychologists in this study battled with a lack of the availability and provision of face masks for both themselves (hospital staff) as well as their patients. One psychologist specified that there would be a lack of masks available for patients attending group therapy.

Further, (participant 2) mentioned that even when masks were available in the hospital, there were additional challenges with the individuals responsible for the provision of these masks who demonstrated an unwillingness to assist. There seemed to be administrative hurdles and other barriers to obtaining masks. Some psychologists in this current study mentioned that they resorted to purchasing their own face masks. Research indicates that there was indeed a global shortage of PPE during COVID-19 particularly during the beginning stages of the pandemic (Burki, 2020). The shortage of PPE and other much needed resources in Africa specifically has been highlighted in the literature (Chersich et al., 2020). One psychologist (participant 3) got visibly angry during the

interview and expressed: "*I did resent the shit out of clinic management for not ensuring that we had masks and that the venues were COVID compliant".* The lack of access to personal protective equipment (PPE) such as face masks has been shown to negatively impact the psychological well-being of frontline healthcare workers as it increased their risk of COVID-19 infection and their feelings of being unsupported by their institutions (Gold, 2020; Soval et al., 2021). As previously mentioned, psychologists fearing the risk of COVID-19 infection due to inadequate PPE may compromise their mental state and thereby impact their therapeutic effectiveness.

4.4.2.3 A lack of psychologists

Most of the participants in this study mentioned that there was an insufficient number of psychologists based at the public institutions they worked in. They suggested that the number of psychologists at these public institutions were disproportionate to the demand (and need) for mental health care provision. Generally, shortages of psychologists (and other mental health professionals) are prominent in LMIC's (P Moodley et al., 2022; Pillay & Harvey, 2006; Rathod et al., 2017; Soloman, 2019; Swarts, 2013). In South Africa, there is currently an insufficient number of psychologists being trained at universities; with an average of only eight candidates selected per year (Padmanabhanunni et al., 2022). The shortages of professional healthcare workers compromise the quality of care provided to the public, and in turn have adverse consequences for the mental health of public-sector healthcare workers who are overburdened with work-related pressures and demands, such as high caseloads (Manyisa & van Aswegen, 2017; Rathod et al., 2017; Rispel et al., 201; Soloman, 2019; Swarts, 2013).

This is evidenced by a (participant 4) in this study who mentioned that she was the only psychologist based at the public hospital she was employed at during her community service year. Further, that if the hospital didn't offer her a permanent position at the end of her community service year, there would be no other psychologist placed at that hospital to replace her, leaving a mental health treatment gap at the hospital. Swarts (2013) shared a similar experience during her community service year where she was the only psychologist based at 11 public clinics in over three municipalities. In her study, Swarts (2013) shares how she worked without the presence of a psychiatric nurse and psychiatrist within the Overberg District Municipality in Cape Town. Swarts (2013) states that the systematic failures of South Africa's healthcare system are (i.e. evidenced by large staff shortages) have negative implications for the service delivery of psychologists, as well as for the both the availability and quality of mental health treatment for patients. It is not uncommon for trainee healthcare professionals in public institutions in LMIC's to function with insufficient

assistance and guidance from other healthcare specialists and or supervisors (Swarts, 2013). This could potentially lead to misdiagnosis and the selection of incorrect or inappropriate treatment for patients (Connel et al., 2007). Even more so, during COVID-19 related circumstances when healthcare workers often had to make quick decisions on the spot without access to guidance from supervisors. Psychologists in this current study did make reference to having to 'trust themselves' and make quick decisions at work, however they did not discuss the potential implications thereof. Arguably, (as previously discussed) this could also have also compromised the trainees access to opportunities for further professional development during the year of training.

4.4.3 The Sporadic nature of doing the work

The psychologists in this study all spoke of the *sporadic nature of their work* during the COVID-19 pandemic. Some psychologists expressed that the hospital wards would often shut down when COVID19 positive cases were identified. The psychologists in this study emphasised that their group therapy work with patients was disrupted by this. Additionally, changes to lockdown restrictions also negatively impacted the continuation of their work with patients. These factors were considered as barriers to treatment by psychologists. It could be argued that the 'sporadic nature of the work' also decreased trainee psychologists opportunities for work based learning (WBL) and professional development. Further, it may have decreased the opportunity for psychologists to experience therapeutic effectiveness and in turn, the opportunity for feelings of professional accomplishment and reword. These aforementioned barriers to therapy may have been demoralising to psychologists (Pimble, 2016). As previously mentioned, a lack of professional accomplishment may lead to adverse mental health outcomes, and in turn, experiences of professional accomplishment serve as a protective factor for poor psychological health, particularly in occupations characterised by high levels of stress (Pimble, 2016). Further, the lack of routine and experiences of uncertainty regarding work may have induced feelings of increased anxiety for these psychologists. These sporadic changes may have also contributed to psychologists experiencing a lack of control. The negative implications of a perceived lack of control in an individual's occupational environment has been previously discussed (i.e. in the 'A sense of helplessness subtheme).

4.5 Coping Mechanisms:

The psychologists in this study relied on various coping mechanisms to manage and protect their mental health, as was the case for other frontline healthcare professionals globally (Cai et al., 2020; Billings et al., 2021; Chutiyami et al., 2021). Coping mechanism may be regarded as those that are

'healthy' and beneficial to an individual's general well-being, namely: positive coping mechanisms. Those that are 'unhealthy' or harmful to general well-being are generally considered to be negative coping mechanisms. The psychologists in this study developed and relied upon both positive and negative coping mechanisms whilst working on the frontlines during the COVID-19 pandemic. Some psychologists seemed to normalize seemingly 'negative' coping mechanism and alluded to the importance of considering the pandemic-related context when evaluating coping mechanisms. Some psychologists in this study explained that they felt that some of the seemingly 'negative' coping strategies they employed were necessary and offered them positive benefits during the pandemic.

4.5.1 Positive Coping Mechanisms:

According to the Conservation of Resources Theory (COR) human beings are motivated to acquire, conserve and protect the necessary resources to effectively cope with distress and ultimately 'survive' in life (Hobfoll et al., 2018). These resources may come in the form of personal self-care strategies, skill development, acquiring and or strengthening personality traits (i.e. resiliency and optimism), relying on social support as well as the presence of material resources (i.e. basic living needs such as housing). Further, that without sufficient resources human beings are more vulnerable to the detrimental effects of distress (Hobfoll et al., 2018) and that acquiring a reservoir of these resources increases the opportunity for even more resources to be gained, that can then be relied upon during future trying circumstances (Hobfoll et al., 2018).

Keeping the COR theory in mind, the psychologists in this study emphasised the importance of self-care and made efforts to incorporate various forms of self-care into their daily lives as a coping mechanism during the highly stressful COVID-19 pandemic. Self-care was been widely documented as an effective coping strategy amongst frontline healthcare workers during the COVID19 pandemic (Heath et al., 2020; Lewis, et al., 2022); many psychological interventions tailored for healthcare workers have based on the premise of the promotion of self-care [Narasimhan et al., 2019]. It has been well established in the literature that self-care can buffer the adverse effects of burnout, compassion fatigue and PTSD, to name a few (Barrett et al., 2007; Sovold et al., 2021; Sultana et al., 2020) and therefore not only increase the overall well-being of psychologists but also contribute to the increased efficacy and quality of patient treatment provision (including increased capacity for empathy) (Zahniser et al., 2017).

All psychologists in this study attended their own individual therapy as a coping mechanism during the pandemic, they all viewed therapy as a positive and helpful coping mechanism that provided

psychological support for them. Therapy was also considered useful in the meta-review of systematic reviews conducted by Chutiyami et al. (2021) on frontline healthcare workers during COVID-19, as well as in the review by Shechter et al. (2020). In the profession of psychology, trainee psychologists and qualified psychologists (mental health professionals generally) are often encouraged to see their own individual therapists (Theriault et al., 2015). It is hypothesized that this could have made it 'easier' for the psychologists in this study to continue attending therapy during the pandemic because they had already been seeing a psychologist prior to pandemic-related circumstances; thus this positive coping mechanism had been established previously. This could have also made it easier for the psychologists in this study to mention attending therapy in their interviews because the practise is more 'normalized' within the mental health profession, and especially amongst trainee psychologists.

A further positive coping mechanism mentioned by many psychologists in this study was the presence and utilization of supervision, (Sovald et al., 2021) corroborates these findings. Supervision is critical for healthcare professions; especially during years of training, and is considered a protective factor for mental health (Martin et al., 2022). Supervision is a space where self-care can be encouraged and the supervisee can receive support to facilitate their professional development (Pack, 2015; Lourens & Uren, 2023). Further, collegial support was reported as a positive means of coping by the psychologists in this study. This was corroborated by Zahniser et al. (2015) whereby clinical psychology trainees experienced decreased stress and positive progression with their clinical work. Collegial support has been consistently found to serve a protective function for the mental health and well-being amongst frontline healthcare workers (Greenberg et al., 2020; De Brier et al. 2020). The psychologists in this study emphasized that it was particularly beneficial that their colleagues were also mental health professionals. Further, that they were also facing similar work-related challenges amidst the pandemic and could relate to each other. Psychologists in this study mentioned talking and communicating with their colleagues as a supportive and beneficial. Research suggests that the communicating about one's psychologically distressful experiences (i.e. traumatic experiences) may contribute to the processing of trauma in a safe space, that has been regarded as a significant contributor to the development of posttraumatic growth (PTG) (Feingold et al., 2022).

Psychologists in this study also mentioned the importance of emotional connection and support from their family and friends as a positive coping mechanism especially because COVID-19 was characterised by social isolation, as was corroborated in similar studies [De Brier et al. 2020; Ojo et al., 2021; Chutiyami et al., 2021; Muller et al., 2020). Generally, social support has been regarded as

beneficial amongst healthcare workers during COVID-19 (Kalaitzaki & Rovithis, 2021; Billings et al., 2021).This type of social support (both collegial and family and friends) can facilitate or enhance the development of resiliency in the face of traumatic experiences (Ojo et al., 2021; Bjørlykhaug et al., 2021) and can contribute to Posttraumatic growth (Ojo et al., 2021; Feingold et al., 2022).

A few psychologists used physical exercise as a strategy to cope with their high stress levels (running was mentioned specifically). One psychologist in this study explained that physical activity helped him get more connected to his body. Research indicates that regular exercise had positive mental and physical health benefits for healthcare works during the pandemic (Shechter et al., 2020), as further evidenced by Franck et al. (2021) who indicated that regular exercise was associated with lower symptoms of psychological distress and somatization amongst healthcare workers during the pandemic. Another exercise benefit mentioned by a psychologist in this study (participant 2) was related to improvements in quality of sleep. Exercise related improvements to quality of sleep has been widely documented as seen in the meta-review by Xie et al. (2021). This is important because psychologists often experience issues related to sleep (i.e. insomnia) (Posluns & Gall, **year**) which can impact their job performance. Participant three also mentioned using breath work techniques as a coping mechanism, similar findings have corroborated that breath work has been positively associated with increased psychological well-being (Park et al., 2021).

Some psychologists in this study seemed to experience a shift in their philosophical outlook on life (as was previously discussed in the subtheme 'changes to personality') it can be hypothesized that having more 'positive' or empowering attitudes philosophies or core perspectives may be regarded form of 'inner' self-care and can contribute to the conservation of valuable inner-resources (Babore et al., 2020). The psychologist (participant 2) who experienced an increase in his self-awareness and self -exploration, arguably, could be seen as the implementation of an aspect of 'inner' self-care. Self-awareness can lead to increased self-care if one is cognisant of their own needs they can more easily attend to them (Norcross & Guy 2007).

4.5.2 Negative Coping Mechanisms

The increased smoking of cigarettes for (participant 8) and emotional eating (for participant 10) were the only two 'negative' coping mechanism mentioned by the psychologists in this study. Gonzalez et al. (2021) indicated that individuals who were 'smokers' prior to the pandemic were most likely to increase their cigarette usage during and after lockdown periods. Increased cigarette smoking has been identified in some studies on healthcare workers during the pandemic

(Athanasiou et al., 2021) this could be attributed to their high levels of work-related distress and the negative impact on their mental health. Increased cigarette consumption was associated with the presence of mental health challenges, especially those related to anxiety, depression and insomnia amongst a sample of (n=6003) adults in Italy (Carreras et al., 2022). In other studies, cigarette smoking decreased amongst HCW's (Naik et al., 2021). This could be because tobacco was found to worsen the severity of COVID-19 symptoms (Chertok, 2020; Reddy et al., 2020). Many governments therefore placed bans on tobacco to alleviate the COVID-19 burden on healthcare systems (Egbe & Ngobese, 2020; Hopkinson et al., 2021). Further, HCW's frequently witnessed COVID-19 related deaths in hospital and this may have motivated them to either decrease or stop cigarette consumption entirely during COVID-19. It is possible that HCW's may have also experienced feelings of guilt and shame about identifying as a smoker when the virus impacted the functioning of lungs (i.e. respiratory health); thereby leading to an ethical dilemma.

Participant ten who used emotional eating as a coping strategy, regarded it as 'negative' and unhealthy. Changes in eating habits such as those connected to 'emotional eating' and 'binge eating' were found amongst both HCW's (Mota et al., 2021; Yaman & Hocaoğlu, 2023) and the general public (Herle et al., 2021; Buckland et al., 2021; Di Renzo et al., 2020) during the COVID-19 pandemic. The COVID-19 pandemic and related lockdown restrictions brought about various adverse mental health outcomes. Indeed increased psychological distress has been long associated with the onset of maladaptive coping mechanisms (such as those related to eating habits) in the literature (Yaman & Hocaoglu, 2023; Herle et al., 2021). The psychologist in this study (participant 10) further mentioned that eating healthy foods 'junk food' was a common phenomenon amongst healthcare workers in public hospitals. This assertion is probably connected to the public hospital environment which if often characterised by high caseload, long working hours, unstable life routines, increased pressures and demands, inadequate infrastructure and insufficient resources (Kunene & Taukobong, 2017; Al Hazmi et al., 2018). Emotional and or binge eating has been positively associated to weight gain, low self-esteem and depression (Camilleri et al., 2014; Rosenbaum & White, 2015) and in turn, depression has been linked to increased emotional eating amongst some individuals (Dingemans et al., 2017), creating a detrimental ecosystem. It is therefore important to build increased awareness and monitoring of the eating habits of HCW's both generally and specifically during pandemics or other disease outbreaks, which have been characterised by heightened distress (to protect their general wellbeing). Healthy lifestyle choices regarding eating habits is an important part of self-care.

4.5.3 Neither Positive or Negative: context dependent coping mechanisms

This subtheme encompassed the coping mechanisms that weren't regarded as either positive or negative by the psychologists in this study. Instead, they were normalized, and regarded as context dependent during pandemic-related circumstances. Participant (3) in this study explained that he frequently played video games. He then expressed that he didn't necessarily regard this as an unhelpful coping mechanism because it allowed him to connect with friends during a pandemic characterised by social isolation. Studies indicated that indeed online gaming allowed people the opportunity to socially connect during the COVID-19 pandemic and may be regarded as being a beneficial coping mechanism for some individuals (Bouza et al., 2023). However online gambling poses risks in that it can lead to gaming addiction, and can further inhibit individuals adjustment to in person human social life after the COVID-19 pandemic (Bouza et al., 2023).

Another participant (2) expressed that he often listened to music a as a coping strategy. He further explained that although it was helpful in that it distracted him (i.e. self-distraction), simultaneously it served a maladaptive function in that it led to him avoiding spending time with himself to acknowledge and experience his emotions. Literature indicates that indeed listing to music has been found to have positive benefits contributing to the lowering of stress levels (Franck et al. 2021). The adoption of avoidance strategies were also reportedly common amongst other healthcare workers during the pandemic (Tahara et al., 2020**;** Kackin et al., 2021). Maioirano et al. (2020) found that avoidance strategies were beneficial to workers in that it helped them feel more in control and lessened intensive feelings of helplessness during the COVID-19 pandemic. Whereas other studies indicated that avoidance strategies contributed to increased distress (Babore et al., 2020; Kalaitzaki & Rovithis, 2021).

Another psychologist (participant 9) in this study mentioned that she watched YouTube in excess and referred to it as somewhat of an obsession. This behaviour could be considered an adoption of an avoidance strategy to self-distract and self-soothe. She further explained that she enjoyed watching pimple popping videos in particular because it felt like an emotional release for her, as she stated: "*it was almost that release for me, a metaphor of getting rid of the festering".* Research indicates that some individuals find pimple popping to be pleasurable, satisfying and useful in the release of psychological tension. There were differences in brain activity amongst those who find this type of content rewarding verses those who find it disgusting and therefore avoided watching it (Wabnegger et al., 2021). However, most/all behaviours done in excess could potentially lead to addiction and produce negative outcomes in one's life. Overall, various coping mechanisms were adopted by the psychologists in this study with no clear cut binary between what was considered

'healthy/positive/beneficial' and what was "maladaptive/negative/harmful'. Oftentimes, the coping mechanisms mentioned in this subtheme could be considered both maladaptive and positively adaptive at the same time. The unprecedented nature of the COVID-19 pandemic must indeed but be considered in these evaluations.

4.6 Survivor guilt: Privilege highlighted during the pandemic

Many psychologists in this study seemed to experience a sense of guilt caused by the socio-economic disparities between themselves and the patients they were treating during the COVID-19 pandemic. One participant ten expressed: "*and you have your job, you're still able to sustain yourself, but the guilt that comes with that is really hard"* when talking about the job losses and financial devastation experienced by the public during the pandemic (Pedrosa et al., 2020). She further added that many of her patients had insufficient financial resources to travel to the hospital for therapy and additionally, to attend online therapy because of data expenses and lack of access to technology. This created even more barriers to mental health care service provision for her patients; she contrasted this to how accessible therapy was for her during times of distress. The psychologists in this study were acutely aware of their privilege during the pandemic, especially in contrast to the patients they were making efforts to treat.

'Survivor guilt' is a term often used to describe the guilt individuals feel after traumatic experiences where others have died and they survived (Murray & Medin, 2021). It is noteworthy that one of the participants (participant 3) in this study used this term to describe the type of guilt that he felt. This is perhaps telling of the severity of the guilt experienced. Survivor guilt has been associated with heightened psychological distress and negative thoughts about oneself. In some ways, it shares similarities with moral injuries (Greenberg et al., 2021).as discussed previously. This concept is important because feelings of extreme guilt (in this instance, 'survivor guilt') may compromise the psychologists mental health.

4.7 Limitations, Implications and Recommendations:

4.7.1 Limitations:

This study had several limitations. The first was related to the fact that it was being conducted during COVID-19 circumstances. Being that it has only been three years into the onset of the pandemic, the published research available on the lived mental health experiences of psychologists working in the South African public sector, were quite limited. This meant that there was a lack of

research from which to situate this current study. However, t also meant that there was an opportunity for this study to contribute to the current gap in the literature.

4.7.1.1 Methodological limitations:

A qualitative research method was selected for this particular study which aimed to explore the lived mental health experiences of psychologists working in the public sector during COVID-19, in South Africa. Qualitative research is commonly the method of choice when the purpose of the research is to explore and investigate lived human experiences from the participants standpoint, in-depth (Creswell, 2007; Hammarberg et al., 2018; Moser & Korstjens, 2017). The researcher used semi-structured interviews to explore the participants' views and experiences, this allowed the researcher to ask follow-up questions when needed or when they required further clarification (Adeoye-Olatunde et al., 2021; Creswell, 2007). Whilst the flexibility of semi-structured interviews is considered advantageous, it may also have implications for validity and standardisation, as responses to the same questions derived from the interview schedule (**Appendix A**) may differ depending on *how* and *when* the researcher probed the participant. Further, the type of follow up questions that the researcher may have asked could have influenced both the direction and substance of the participant's responses (Galletta, 2013; Whiting, 2008). However, I, the researcher made a list of probing questions and accompanying notes to guide my follow up questions. This was also done to lessen the chance of the researcher asking additional follow up questions informed by their own potential bias or vested interest, during the interviews.

A total of ten psychologists participated in this qualitative study. This sample size may be regarded as acceptable and appropriate for the purposes of qualitative research methods, where small samples are often used (Hammarberg et al., 2018). However, it is noteworthy that determining the appropriateness of sample size is a contentious topic amongst qualitative researchers; who have often been critiqued for provide very simplistic (i.e. reductionist) justifications for their sample size selection (Boddy, 2016). 'Data saturation' whereby no new findings emerge, has often been provided as an explanation for small sample sizes (Saunders et al., 2018). Indeed, this current study was reaching data saturation because participants were oftentimes sharing very similar experiences (Saunders et al., 2018). However, this does not mean that having more participants would have been unbeneficial; to the contrary, more participants could have contributed positively to this research by potentially offering more variability amongst shared lived experiences. Particularly, because this sample comprised of intern, community service and fully qualified psychologists experiences. It may be beneficial to shed light on their contrasting experiences from the angle of the different stages of

their careers. The findings of this current study could have been impacted by those very same factors (i.e. differences in career stages); but were not specifically investigated during the interviews. For example, whilst all the psychologists both worked in public institutions *and* experienced burnout; specific factors that may have been unique to being an intern psychologist could have contributed differently to the manifestation of burnout compared to a community service or fully qualified psychologist. Overall, it is proposed that this could have been investigated by the utilisation of a mixed-methods approach, whereby a larger proponent of the population could have been represented and therefore, investigated (Jamshed, 2014).

Semi-structured interviews could not be held in person due to the dangers of COVID-19. Therefore, all of the interviews were conducted online. I as the researcher, had no previous experience with conducting interviews on an online platform. This may have influenced my degree of nervousness and anxiety with the participants, which in turn, could have impacted the development of rapport between us, based on my non-verbal affect and communication style. Research indicates that rapport development may be important for improved data quality (Horsfall et al., 2021). Although, the development of rapport has also been associated with increased social desirability because respondents may want to avoid saying something that may negatively impact the rapport (i.e. may not want to appear offensive or say something that may lead to negative appraisal from the interviewer) (Horsfall et al., 2021). Additionally, it may have been considerably challenging to develop rapport because both the participants and myself could not witness each other's body language, and were limited to facial expressions behind a screen, during the online interview process. However, it was beneficial that at the least the participants were relatively comfortable and familiar with online engagements because they had been conducting therapy online with their patients during the COVID-19 pandemic.

The qualitative analytic method selected for this study is an Interpretive Phenomenological Analysis (IPA). Some critiques of IPA are that the method does not give an accurate reflection of the actual experience of the phenomenon, but rather the opinions of the experience of the phenomenon (Brocki et al., 2014). However, the various ways in which the participants experience and make meaning of the phenomenon is the very essence of IPA. Further, that IPA focuses on the individuals experience of the phenomenon but doesn't provide scope for sufficient inquiry into the more structural factors that contribute to the phenomenon in the first place (Brocki et al., 2014). I, the researcher, made an effort to include contextual factors at a societal level that may have influenced

the participant's experiences of the phenomenon. However, the main emphasis was on an in-depth account of their inner-worlds, which included their individual feelings, thoughts and experiences.

Ethical considerations regarding confidentiality were maintained in that participants were referred to using participant numbers and could not be identified by name. Anonymity, however, could not be maintained because interviews were conducted online with video cameras on (allowing for facial identification). Some psychologists appeared apprehensive to reveal too much about their experiences at the public institutions they were based at. This may have impacted the amount of information they provided during their interviews. The participants knowledge that they were being both audio and video recorded could have potentially made them feel less trusting of confidentiality and anonymity, compared to in person interviews where participants are usually only audio recorded.

Although the psychologists did speak about their mental health experiences, it is noteworthy that none of the psychologists used the word 'depression' verbatim or made reference to any depressive symptoms (i.e. even those related to low mood) when discussing the impact of the pandemic on their mental health and personalities. Yes, it is possible that none of the psychologists in this study experienced depressive symptoms, but they were evidently more comfortable disclosing their feelings of anxiety. This could possibly be attributed to mental health stigma (i.e. depression related) that does still exist in the mental health profession. Psychologists in training may be especially prone to concerns that their own psychological state may contribute to being viewed as incompetent by other mental health professionals (Devendorf & Victor, 2022). Further, many of the psychologists also appeared hesitant to talk freely about any potential pre-existing mental health conditions that may have been exacerbated during the COVID-19 pandemic. The fact that I, the researcher, was a research psychologist in training at the time, may have further impacted the degree to which the participants shared their true mental health experiences.

Research has suggested that many mental health professionals have been diagnosed with (or experience as undiagnosed) mental illnesses and related issues prior to entering the profession (Tay et al., 2018). Further, it has been documented that COVID-19 has impacted the mental health of mental health care professionals predominantly in relation to depressive symptoms, anxiety symptoms and PTSD (Aafjes-van-Doorn et al., 2022; Billings et al., 2021; Glowacz et al., 2022; Trombello et al., 2021). In spite of this, depressive symptoms remained unmentioned by the participants in this study. It is postulated that their experiences of intense guilt, helplessness, moral

injuries, and the employment of various self-distractive avoidance strategies during the COVID-19 pandemic, could be regarded as signs of depressive symptoms (Salari et al., 2020).

As previously mentioned in this study, my various social identifications (i.e. female, mixed-race, of a similar age group to the participants, and a Research Psychologist in training), opinions, values, and principles, may have influenced the lens through which I analysed the data; and situated the research findings (Berger, 2015). However, it was not the aim to completely exclude the researcher from the research outcomes. The researcher is an integral part of the production of qualitative research, which is by nature not an objective process (Berger, 2015; Creswell, 2007; Hammarberg et al., 2018; Holmes, 2020). Researcher's reflecting transparently about their role in the research, helps the reader to further contextualise the research findings (Holmes, 2020). I as the researcher, made a conscious effort to keep my own potential biases in mind throughout this research process. I documented my reflections so as to have a better understanding of the lens through which I approached this study.

4.7.2 Implications:

This study has implications for various stakeholders in the field of mental health, specifically for those in LMIC's like South Africa. These stakeholders include: public-sector psychologists, other mental health professionals, frontline healthcare professionals in general, the HPCSA, patients treated, public healthcare systems, universities, training sites (i.e. public hospitals), psychology supervisors, and lecturers in the profession. This study contributes not only to the limited body of knowledge on psychologists experiences of working during pandemics and other diseases outbreaks, but also to the mental health -related management of pandemics in LMIC's globally.

Psychologists based the public sector hold a pivotal responsibility of being the first point of call for public access to psychological care and treatment (Nguse & Wassenaar, 2021). Research findings have demonstrated the adverse mental health outcomes of the pandemic amongst mental healthcare professionals (Glowacz et al., 2022; Trombello et al., 2021).Therefore, public -sector psychologists should maintain an acute awareness of their mental health state during extreme contexts, such as natural disasters, pandemics and other disease outbreaks. As previously mentioned, their psychological well-being is of paramount importance to the continuation of quality mental health care service provision to the public. Heightened work-related distress in these contexts may negatively impact their work performance and attitudes towards their jobs and patients (Gilboa et al., 2008; Salari et al., 2020).

The findings of this study may help training institutions, universities, supervisors and lecturers gain a better understanding of trainee psychologists experiences of working during pandemics and other public health crises. This study has highlighted the need for increased monitoring of these trainee public sector psychologists by training sites, universities, supervisors and lecturers, so that those struggling may be identified for increased support (Greenberg et al., 2020). Trainee public sector psychologists should be encouraged to practise self-care. Interventions based on self-care practices and resiliency strategies should be implemented and continuously monitored for effectiveness. Self-care is widely documented as an imperative protective factor for healthcare workers psychological well-being (Barrett et al., 2007; Sovold et al., 2021; Sultana et al., 2020). The strengthening of resiliency has also been regarded as a protective factor to buffer the effects of burnout and PTSD (Ojo et al., 2021; Skovholt & Trotter-Mathison, 2014).

This study has further highlighted the increased need for psychologists, particularly those in training, to gain education and formal training on how to conduct psychotherapy during pandemics and other health disasters. There is additionally a need for formal training on the effective use of technology for online therapy provision. All of the psychologists in this study had never been trained on conducting online therapy prior to the onset of COVID-19 and were therefore ill-equipped for this transition. This also means that the supervisors must be trained on this online therapy provision so that they are competent to supervise and provide feedback to trainees. It has been postulated that the provision of online therapy in South Africa may increase access to mental health care services (Goldschmidt et al., 2021).

Working conditions in South African public institutions need to be improved to allow public- sector psychologists and other healthcare professionals the necessary resources and infrastructure to work effectively. Poor working conditions and a lack of institutional support directly influence their motivation, job satisfaction, rates of professional burnout, and impact the outcomes of patient care overall (Pillay & Harvey, 2006; Swarts, 2013).

Furthermore, this current study contributes to the body of knowledge on *distinctive* pandemic-related PTG accounts amongst psychologists working in the public sector during the COVID-19 pandemic, in South Africa. It explores some of the factors that contributed to PTG as well as those that may have hindered the development of PTG amongst the cohort.

These findings are significant in the field of psychology because the majority of studies on PTG amongst frontline healthcare workers were conducted prior to the COVID-19 pandemic. Therefore, pandemic related posttraumatic growth as a phenomenon of needs to be further investigated.

4.7.3 Recommendations for future research:

To build on the foundation of this current study, additional research may look at differences between the experiences of Intern clinical psychologists, Community service psychologists and fully qualified psychologists employed at public institutions in South Africa, during the COVID-19 pandemic. In this current study, these categorisations formed one cohort; and thus themes were developed based on patterns within their collective experiences. It would be beneficial to have further research focusing on each category separately.

Although the number of participants (ten) in this study may be considered sufficient for qualitative research, it would be beneficial to conduct future studies with a larger cohort, the implementation of this may require a mixed-methods approach to conducting the research.

Longitudinal research on this topic could be considered to track changes in mental health experiences over a period of time and also based on the different stages of the pandemic in South Africa. Longitudinal studies may also be beneficial when considering an investigation of the accuracy of the accounts of PTG amongst psychologists.

In general, it is recommended that further research be conducted the experiences of mental health professionals in South Africa and other LMIC's, as there is a significant dearth in the available literature on this topic.

4.8 Conclusion:

This study focused on a qualitative exploration of the lived mental health experiences of psychologists working in the public sector during the COVID-19 pandemic, in South Africa. Public-sector psychologists were at the forefront of providing mental health care treatment to the public in South Africa. Therefore, their psychological well-being is of paramount importance to ensuring the continuation of mental health care service provision. Overall, the experience of working as a psychologist in South Africa's public healthcare sector during COVID-19 pandemic, impacted the participants in a multitude of ways. Semi-structured interviews were conducted with each of the psychologists, and the data was analysed utilising an IPA. Findings indicated that psychologists in this study experienced *a sense of helplessness* due in part to the uncertainties of 'how to' work as a psychologist during an unprecedented pandemic. This sense of helplessness /powerlessness may have been compounded by the disadvantaged population they were working with; who often lived in harsh conditions and whose daily needs remained unmet. Indeed, one psychologist expressed that the helplessness experienced during COVID-19 was exacerbated by the already pre-existing systematic failures in South Africa's healthcare system. In addition, psychologists in this study also experienced 'Survivor guilt' from working with mostly impoverished patients whose lives were worsened during the pandemic. They felt guilt about their positions of privilege.

Psychologists also experienced a sense of a lack of control and blurred lines regarding their work roles amidst the uncertainties in their working environment, which further contributed to the aforementioned sense of helplessness. Psychologists in this study experienced inadequate exposure to training and WBL experiences which had implications for their professional development. Some psychologists felt anxious about feeling under-prepared and ill-equipped, as a result of the lost opportunities for adequate skill development during their training years. The COVID-19 related disruptions and changes to training programmes may have indeed impeded the participant's development of the necessary professional competencies. Psychologists in this study did not gain exposure to the same opportunities for professional development, that trainees were exposed to prior to the pandemic. Albeit, they did gain a different kind of exposure related to working during a pandemic that previous trainees' were not exposed to. Some psychologists in this study lacked experiencing a sense of professional accomplishment. It has been argued that the need for professional validation is increased during years of training and in the early years of healthcare professionals careers, generally.

All of the psychologists in this study experienced burnout. It is postulated that some of the contributing factors for their burnout may have been: heavy workloads, staff shortages, resource and infrastructure constraints in the public hospitals, prolonged feelings of helplessness and a lack of control in their occupational roles, prolonged heightened distress from risk of COVID-19 exposure in hospitals and well as from the nature of their work, a lack of sufficient professional accomplishment, and moral injuries, to name a few. Research indicates that trainee healthcare professionals like psychologists may be at increased risk for the development of burnout. Further, that working in public institutions with impoverished populations in LMIC's is an additional risk factor to burnout. The psychologists in this study all experienced feelings of anxiety from working in the public sector amidst the pandemic – main causal factors were anxieties about contracting the virus themselves and passing it onto loved ones. This often manifested as obsessive actions regarding hygiene (namely the washing of hands and sanitizing hands and other items that may be contaminated). Further public hospital challenges related to facing space constraints, inadequate provision of PPE, a lack of psychologists in the hospital and the sporadic nature of the work (frequent COVID-19 related interruptions). These experiences seemed to impact their mental health negatively.

The rapid changes to the delivery of mental health care services (in context of COVID-19 regulations as well) meant that these psychologists had to adjust and adapt at a fast pace to still provide therapeutic care to the public in spite of constraints like social distancing and isolation. These changes involved rapidly beginning online therapy. All of the psychologists mentioned that they were not trained to conduct therapy online (and within their specific therapeutic frameworks e.g. psychodynamic) and therefore they felt under-prepared. The experience of under- preparedness that existed from working during a pandemic, was further compounded by an under preparedness related to online therapy. It is suggested that may psychologists experienced Imposter syndrome and moral injuries during this period. Being a psychologist in training could potentially have amplified these feelings. Although, the fully qualified psychologist echoed the same sentiments and a few psychologists in training mentioned that their supervisors felt under-prepared too. Concerns with online therapy included: being untrained for online therapy, struggles with of witnessing body language (i.e. non-verbal communication), unfamiliarity with video calling platforms for both psychologists and patients, connection issues (network signal), the cost of data that was challenging for patients, and issues pertaining to ethical considerations such as privacy and confidentiality. This was confirmed in similar studies (both in LMIC's and in high income countries). However, some psychologists alluded to online therapy experiences improving in time as they had increased

exposure to it. One psychologist further mentioned that she enjoyed seeing her patients face during online therapy because face masks could be removed.

Most of the psychologists felt that some of the aforementioned challenges and experiences impacted the therapeutic space. Psychologists alluded to depersonalization – increased irritabilities and feeling desensitized (a component of burnout) and their own anxieties about exposure to COVID-19 as the main factors that may have affected the therapeutic relationship with their patients. Prior research has indeed suggested that the COVID-19 pandemic context as well as working in under-resourced public institutions and the frustrations thereof, could have contributed to this. An additional contextual factor is that many of the psychologists were in training and could perhaps be more susceptible to burnout symptoms manifesting because of a lack of experience and the increased need for supervision and support. Some psychologists grappled with feelings of grief and concerns about their therapeutic effectiveness which could be considered as moral injuries. However, some psychologists seem to express self-compassion and normalised their experiences based on the fact that they too were experiencing the pandemic. Generally, psychologists also struggled with mandatory mask wearing during face to face therapy which they considered a barrier to rapport during therapy.

The psychologists experienced various changes to their personalities, these came in the form of increased resiliency and adaptiveness, as well as a greater openness to rely on others for social support. One psychologist felt his ability for self-awareness and reflection increased. Psychologists also expressed changes in life philosophies and attitudes, such as an relinquishing of control and an acceptance of the unpredictable nature of life. These changes have been theorised as accounts of Posttraumatic growth in the literature. The psychologists collectively felt a sense of fulfilment and rewards from witnessing psychological change and improvement in their patients. It is theorised that this helped increase their confidence, and served as evidence of their professional competence and thereby served as a buffering factor to adverse mental health outcomes.

The psychologists employed various coping mechanisms whilst working during the pandemic. The positive coping mechanisms utilised were: their own individual therapy, supervision, social support (i.e. colleagues, family and friends), physical fitness and shifts in life philosophies, and other practices of self-care. Increased cigarette smoking and emotional eating were the only two negative coping mechanisms identified by two psychologists. Further coping mechanism utilised were increased time spent gaming, listening to music as an avoidance tactic and watching YouTube videos

in ‘excess’. These coping strategies were constructed as being context dependent and were normalized as being an understandable response to a high levels of distress during a pandemic.

This study has served as a significant contribution to the body of knowledge on the lived mental health experiences of psychologists working in the public sector during the COVID-19 pandemic in South Africa. It is recommended that further research be conducted to investigate the potential differences between the experiences of intern, community service and fully qualified psychologists that were based at public hospitals in South Africa during COVID-19. It is further recommended that longitudinal studies be conducted on this topic to investigate changes in mental health and accounts of PTG over a period of time, as many of the long-term effects on mental healthcare workers are yet to be discovered.

It is hoped that this study highlighted the importance of protecting the mental health of public sector psychologists; both in general and especially during pandemic and other disease outbreaks. There is need for changes in psychology training programmes, to better prepare and equip psychologists for managing public health crises. Further, there is an increased need for the monitoring of trainee psychologists by training sites and universities, so that those struggling may be identified for increased support. It is suggested that Interventions based on self-care and the development of resiliency be implemented.

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Appendix A. Qualitative Questions for interviews:

1. Could you talk about your experience of working during the COVID-19 pandemic in South Africa?
2. Could you talk about your experience of giving therapy to COVID-19 patients?
3. Was there anything in your work experience that prepared you for working during the COVID-19 outbreak?
4. Could you talk about how you have made sense of your experience of working as a healthcare worker during the COVID pandemic - both positive and negative?
5. Could you reflect on the psychological impact of witnessing patients with COVID-19?
6. Have you noticed that your health has been affected at all?
7. What were some of the challenges you experienced while working during this pandemic?
8. In terms of the resources or planning or infrastructure that you had available, do think there was anything that made life especially difficult or easier for you?
9. What coping mechanisms and support systems did you find helpful?
10. What was not helpful?
11. Did you feel that your co-workers were looking out for you/checking how you were coping? Did you do similarly for them?
12. Having reached the end of this pandemic, if you could tell the Minister of Health one thing, what would it be?
13. Could you talk about whether you feel this experience has changed you as a person (i.e. personality)?
14. What kind of long-term impact has your COVID experience had on your work and personal life?
15. How do you feel now about your work after the COVID -19 pandemic? Rewarding? Unrewarding? Upsetting? Rewarding?
16. Is there anything else you would like to share—positive or negative?

Appendix B. Participant Information Sheet for Qualitative Interviews

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4541 • Fax: 011 717 4559 • E-mail: psych.SHCD@wits.ac.za

Study title: An exploration of the Lived Mental Health Experiences of Psychologists working in the public sector during the COVID-19 pandemic in South Africa.

Dear Psychologist,

We would like to invite you to continue participating in this study by consenting to an interview based on your personal experience of being at the frontline during the COVID-19 pandemic.

Participation in this study is voluntary and you have the right to decline participation in this study.

The interview will be conducted at a time and place of your convenience and may be conducted via Teams/Zoom. The interview will be audio and video recorded and should take approximately 1 hour of your time. You will not receive any direct benefits from participating in this study, and there are no disadvantages or penalties for not participating. You may choose not to answer any question if you do not want to. All responses will remain confidential, and you will be referred to using a pseudonym (false name) in transcripts and publications.

The audio and video recordings and resulting interview transcripts will be stored in an encrypted password protected data cloud. A summary of the study and its results can be requested using the contact details below. The research may be presented at local/international conferences and published in a journal and/or book chapter.

If you experience any distress or discomfort following the interview, please contact the South African Depression and Anxiety Group (SADAG)-0800 567 567 (toll free) (SADAG provides 24-hour telephonic counselling). You will also be given a list of contact details of professionals practicing in the private sector who are available for online consultations.
If you have any questions afterwards about this research, feel free to contact me on the details listed below. If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on

telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Please detach and keep this sheet.

Yours sincerely,

Zena Harvey

Email address: 700332@students.wits.ac.za

Contact number: 076 2355287

Appendix C. Participant Consent form for interviews with health care workers and consent to record interviews

PSYCHOLOGY
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4541 • Fax: 011 717 4559 • E-mail: psych.SHCD@wits.ac.za

Study title: An exploration of the Lived Mental Health experiences of psychologists working in the public sector during the COVID-19 pandemic in South Africa.

I, _____ (participants name) consent to being interviewed by _____, for a research project on mental health of South African healthcare workers during the COVID-19 pandemic. I understand that;

- Participation in this study is voluntary
- I may withdraw from the study at any time before publication and that my withdrawal will not affect me negatively in any way.
- I may choose not to answer questions.
- There are no perceived benefits associated with this study.
- All information provided will remain confidential
- My name or any other personal information of mine will not be used in the interview, transcripts, notes as well as the research report.
- I am aware that some direct quotes from my interview may be used, but my name will not be used.
- When direct quotes from my interview are used my name will be substituted with the name Participant A or Participant B etc.
- The recordings and transcripts will be stored for the duration of the project and kept thereafter for potential future research.
- I am aware that the results of the study will be reported in the form of a research report, which may be published in a journal and or book.

Signed: _____ Date: _____

Appendix D: Ethical clearance form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG	HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

2021/04/08

Dr S Fraser, Professor S Laher, et al
School of Clinical Medicine
Department of Psychiatry
Medical School
University

Sent by e-mail to: Sumaya.Laher@wits.ac.za

Dear Professors Laher and Watermeyer

Re: **Protocol Ref No:** M200461
Protocol Title: *Mental health of South African healthcare workers during the COVID-19 pandemic*
Principal Investigator: Dr S Fraser, Professor S Laher, et al

I refer to our e-mail exchanges of 2021/03/18 *et seq.*

I confirm that we have noted and approve of the additional of two new co-investigators. For the record, they are:

1. Ms Z Harvey (student no. 700332)
2. Ms A Kazadi (student no. 2280936)

Thank you for keeping us informed.

Yours Sincerely

J. Burns

.....

Mr I Burns
For the Human Research Ethics Committee (Medical)

CB Penny

.....

Dr CB Penny, Chairperson, Human Research Ethics Committee (Medical)

c.c. Dr S Fraser