# NHS Staff Support Services:

# An Examination of a Therapeutic Intervention and an Exploration of Staff Experiences of Services

Hannah Carroll

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University of East Anglia

Faculty of Medicine and Health Sciences

Supervisor: Dr Imogen Rushworth

Secondary supervisors: Dr Sheryl Parke and Dr Lauren Grainger

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## Thesis Portfolio Abstract

Due to increased mental health risks among healthcare staff, worsened by the pandemic, NHS Trusts established in-house psychological support services and tailored treatments like the Emotional Freedom Technique (EFT). The aim of this research was to firstly examine EFT as a therapeutic intervention for healthcare staff and then to explore staff experiences of specialist in-house staff support services. A systematic review analysed eight peer-reviewed studies and found EFT, which combines cognitive and exposure therapy with acupressure, to be effective in improving psychological wellbeing in healthcare staff by reducing symptoms of anxiety, depression, and stress. However, further research is needed to confirm its effectiveness across different healthcare specialties.

An empirical study was then conducted to examine NHS staff experiences of in-house psychological support. Ten participants from two NHS staff support services were interviewed. Using Braun & Clarke's reflexive thematic analysis, the study identified four key areas: working in the NHS, accessing support, therapy experiences, and wider service reflections. The findings underscore the emotional impact of healthcare work and the importance of specific, accessible and in-house support, while also noting systemic barriers that hinder access to these services. The findings from both studies were critically discussed and evaluated.

## Access Condition and Agreement

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# Chapter One

## Introduction to the Thesis Portfolio

## Introduction

The mental health of employees and supporting those who have mental health difficulties is an important area for employers to focus on. An independent review (Stevenson & Farmer, 2017) explored how employers can better support the mental health of all people currently in employment, including how those struggling with their mental health can be supported to remain in work. This resulted in a ten-year vision that all organisations, regardless of their size, would be equipped with the tools to not only address but prevent mental ill-health caused or worsened by work (Stevenson & Farmer, 2017).

To those working in the United Kingdom's National Health Service (NHS) this would be especially important due to the challenges that working in a healthcare environment presents and the effect of these challenges on the mental health of those who work within it (Bria et al., 2012; Hall et al., 2016; Johnson et al., 2018; Laposa, J. M. et al., 2003; Ramirez et al., 1996). Working in healthcare settings can involve navigating highly stressful and emotionally charged situations, being confronted with human suffering and mortality, enduring lengthy and unpredictable work hours, and facing potential exposure to various forms of harm such as physical injury, infectious diseases, or hazardous substances (The National Institute for Occupational Safety and Health, 2023).

In light of these risks and challenges, healthcare staff are more likely to be particularly susceptible to work-related stress, due to, but not limited to, the demands of their clinical practice and the exposure to the suffering of their patients (Jovanovic et al., 2016; Ferrari et al., 2015). Chronic exposure to work-related stress can lead to burnout (Maslach & Leiter, 2006) which healthcare staff have been reported to be particularly vulnerable to (Shanafelt et al., 2003). This is due to the risk factors already mentioned, such as emotionally intense interactions and exhausting shift patterns, and the added challenge of having a lack of control over the demands placed upon them. Burnout is indicated by emotional exhaustion, depersonalisation, and a reduced sense of personal accomplishment (Maslach & Leiter, 2006).

According to the British Medical Association (BMA) a further risk that is distinctive to those who work in healthcare is suffering with 'moral distress' (BMA, 2021). Moral distress is the psychological discomfort felt when professionals recognise the ethically right course of action but are hindered from taking it (BMA, 2021). Sustained levels of moral

distress can lead to ‘moral injury’, where there is impaired function or longer-term psychological harm (BMA, 2021).

The coronavirus disease 2019 (COVID-19) pandemic placed further burdens on healthcare staff, with direct and indirect exposure to highly aversive events being one of the heaviest (Andhavarapu et al., 2022). Additional stressors the pandemic placed on healthcare staff were fear of infection, staff redeployment, sudden organisational changes, longer shifts and contact with patients who were also experiencing an adverse situation (Frenkel et al., 2022; Alimoradi, 2022). As a result, healthcare staff reported increased levels of work-related stress and symptoms of burnout throughout the pandemic (Aymerich et al., 2022). Up to 36 percent of healthcare staff reported experiencing depressive symptoms and up to 42 percent anxiety symptoms (Sun et al., 2021). Both suicidal risk and suicidal ideation also increased among healthcare staff from pre-pandemic rates (Ahrens, 2021). Unsurprisingly, over a third of those who worked through the pandemic were estimated to be suffering with post-traumatic stress symptoms (PTSS), which is a higher prevalence than that of the general population (Andhavarapu et al., 2022). A survey by the BMA in April 2020 found that more than 40% of doctors reported experiencing depression, anxiety, stress, or burnout that had been worsened by the pandemic and 60% reported more fatigue or exhaustion than prior to the pandemic (BMA, 2021). Even after the pandemic curve flattened, the prevalence of reported depression, anxiety and PTSS did not decline, but in fact began to climb (Ouyang et al., 2022; Spiller et al., 2022). With regards to the levels of burnout and moral injury, the pandemic exacerbated the pre-pandemic levels that already existed, causing acute moral injury (Best, 2021).

Post-pandemic, the Care Quality Commission (CQC) have reported that in 2022 and 2023, NHS staff were more than twice as likely to record mental ill health (anxiety, stress or depression) as their reason for sickness absence (CQC, 2023). This indicates that although the active pressures of the pandemic have passed, the prevalence of mental ill-health amongst the NHS workforce remains critically high.

The consequences of burnt out and psychologically unwell healthcare staff are both individual and systemic. These include poorer physical health of staff, risk of substance use, decreased job satisfaction, absenteeism, work-related delays, reduced efficiency, patient safety concerns, poor quality of care and high turnover of staff (De Hert, 2020; Goldberg et al., 1996; Parker et al., 1995). Post-pandemic, the rates of sickness absence amongst NHS

staff have remained high, despite falling rates in the number of COVD-19 cases (CQC, 2023).

In response to the pandemic, different bodies suggested ways to support the mental health of the NHS workforce. In 2019, NHS England set up The National Health and Wellbeing Programme to support the wellbeing of all NHS staff, setting out guidance for organisations on how to support their staff. Programmes covered various key areas including how to set up 'Health and Wellbeing Champions' and advice on how to instigate conversations around wellbeing (NHS England, 2019). During the initial phases of the pandemic, the British Psychological Society (BPS) issued guidance aimed at supporting the mental well-being of healthcare staff (BPS, 2020). This guidance recommended psychological interventions as a part of psychological care, on top of a foundation of communication safety and leadership. For staff who have or are at risk of poor mental health, the National Institute for Health and Care Excellence (NICE, 2022) advise that is the responsibility of employers to either offer or provide access to cognitive behavioural therapy sessions, mindfulness training or stress management training.

In response to UK national guidance many NHS Trusts developed a range of initiatives to support their staff both throughout the pandemic and beyond. Trusts set up in-house staff wellbeing services and telephone support lines, as well as dedicated services offering psychological therapies (Appelbom et al., 2021; Blake et al., 2020; Johnson et al., 2022; Miotto et al., 2020; Petrella et al., 2021). In early 2021, NHS England set up a total of 40 mental health hubs across England for frontline health and social care staff to access rapid mental health assessments and evidence-based support (BPS, 2023). Further, Improving Access to Psychological Support (IAPT) services, initially set up to offer primary care support, followed guidance from professional psychology bodies, and adapted their services to provide support to frontline NHS staff (Cole et al., 2020).

The current landscape of NHS staff support provision is marked by change and uncertainty. In April 2024, NHS England announced plans to withdraw mental health support provided by NHS Practitioner Health to secondary care staff (BPS, 2024). Following disagreement on this decision from unions and health bodies such as the BPS and the British Medical Association (BMA), NHS England reversed their decision some days later and pledged funding for a further year (BPS, 2024). This sudden reversal highlights the ongoing uncertainty and instability surrounding staff support provision within the NHS. Healthcare

workers, already under significant stress due to their demanding roles, are potentially left in a state of flux, unsure about the continuity and reliability of the mental health services they rely on.

In addition to specific services for healthcare staff, there was a need for tailored, quick, and effective interventions. Services developed during the pandemic primarily delivered CBT-based interventions (Cole et al., 2020), but also began piloting new approaches tailored specifically for frontline healthcare staff, including different psychological modalities. One example was the '20minCareSpace' pilot, which used compassion-based principles for healthcare staff (Jones et al. as cited in Cole et al., 2020). Additionally, a staff support service within a Trust in East Anglia incorporated the Emotional Freedom Technique (Craig & Fowlie, 1995) alongside other psychological interventions (Norfolk and Suffolk NHS Foundation Trust, 2024).

Emotional Freedom Technique (EFT) is an evidence-based therapeutic intervention that combines elements of cognitive therapy and exposure therapy with acupressure (Church & Brooks, 2013). It is commonly called “tapping” as it involves the stimulation of acupuncture points on the face and upper body by tapping of the fingers. Over 100 peer-reviewed publications have compared outcomes of EFT for various physical and mental health conditions, including pain, depression, anxiety, phobias, and addiction (Bougea et al., 2013; Church, 2014; Rowe, 2005; Wells et al., 2013). Church (2013) found EFT effective for treating various psychological health conditions in one to ten sessions. EFT also reduces physiological markers of stress, such as heart rate variability, blood pressure, and cortisol levels (Bach et al., 2019), making it potentially beneficial for healthcare staff working in high-demand environments.

Previous systematic reviews have shown EFT to be effective for various psychological conditions, including PTSD, depression, anxiety, and physiological problems like pain and autoimmune conditions, with moderate to large effect sizes (Church et al., 2022; Clond, 2016; Nelms & Castel, 2016) However, there is a lack of research specifically on the effectiveness of EFT for improving the psychological wellbeing of healthcare staff.

This thesis aims to explore NHS in-house staff support services, firstly, through a systematic review of the literature on the effectiveness of EFT for improving psychological wellbeing amongst healthcare staff, followed by an empirical study on the experience of those who have accessed these staff support services.

# Chapter Two

## Systematic Review

**Prepared for submission to the *British Journal of Clinical Psychology***

# Using the Emotional Freedom Technique to Improve Psychological Wellbeing in Healthcare Professionals: A Systematic Review

Hannah Carroll[a], Sophie Gennery[b]

Dr Sheryl Parke[a], Dr Lauren Grainger[c], and Dr Imogen Rushworth[a]

a Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, University of East Anglia

b Norfolk and Suffolk NHS Foundation Trust

c The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Corresponding author: Hannah Carroll (email: hannah.carroll@uea.ac.uk)

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## Abstract

**Background and Objectives:** Due to increased mental health risks among healthcare staff, worsened by the pandemic, NHS Trusts responded by establishing in-house psychological support services as well as creating tailored psychological treatments specifically for frontline healthcare staff (Ahrens, 2021; Blake et al., 2020). A National Health Service (NHS) Trust in East Anglia piloted the Emotional Freedom Technique (EFT) alongside other psychological interventions to support their staff (Norfolk and Suffolk NHS Foundation Trust, 2024). EFT, which combines cognitive and exposure therapy with acupressure, has been shown to help with various physical and mental health conditions, including pain, depression and anxiety (Bougea et al., 2013; Church, 2014). Previous systematic reviews have shown EFT to be effective for various psychological conditions in short time frames. None however have focused specifically on healthcare staff. This systematic review aims to fill that gap by synthesising existing research on the effectiveness of EFT for improving the psychological wellbeing of healthcare staff.

**Method:** This review utilised the PRISMA guidelines (Page et al., 2021) for systematic reviews. Narrative synthesis was used to analyse the quantitative outcome data that was extracted from the studies.

**Results:** A total of eight peer-reviewed studies were included in the review. Seven of the studies used quantitative methods and one used a mixed methods design. Four studies were cohort studies, two of which collected their post- test data immediately after one treatment session and two of which collected post- test data after participants had been practicing EFT for an extended period of time. Four studies were randomised control trial (RCT) studies; two of which compared EFT to different interventions (breathing therapy and music therapy). The psychological wellbeing outcomes collected included self-reported levels of anxiety,

depression, stress, burnout, public speaking anxiety, test anxiety and fear of COVID-19. EFT proved effective in improving psychological wellbeing, including lessening symptoms of low mood and anxiety as well as issues commonly encountered by healthcare staff such as high stress levels and fear of COVID-19.

**Conclusions:** EFT's self-guided nature, rapid effects, and group delivery make it advantageous for alleviating work-related stress and burnout in healthcare staff. However, further well-designed research is needed to provide more definitive conclusions on its effectiveness across various healthcare specialties.

**Keywords:** Emotional Freedom Technique, healthcare staff, psychological wellbeing

## Introduction

The World Health Organisation recognises work-related stress as one of the most powerful and stressful events for mental health (Leka et al., 2003). Healthcare professionals, particularly, face significant challenges and mental health risks due to the nature of their work environments. Working in healthcare involves navigating highly stressful situations, witnessing human suffering and mortality, enduring long and unpredictable work hours, and potential exposure to harm such as physical injury and infectious diseases (The National Institute for Occupational Safety and Health, 2023). This chronic exposure to stress can lead to burnout, characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Leiter, 2006). Moreover, healthcare staff experience unique challenges such as moral distress (British Medical Association [BMA], 2021) which occurs when staff recognise the ethically right course of action but are unable to pursue it, potentially leading to moral injury, where there is longer-term psychological harm.

The COVID-19 pandemic exacerbated these challenges, with healthcare staff facing additional stressors such as fear of infection, redeployment, organisational changes, longer shifts, and contact with severely affected patients (Alimoradi, 2022; Frenkel et al., 2022). Throughout the pandemic, healthcare staff reported increased levels of work-related stress, burnout, depression, anxiety and suicidal ideation (Ahrens, 2021; Aymerich et al., 2022; BMA, 2021; Sun et al., 2021). A significant proportion of healthcare staff reported experiencing symptoms of post-traumatic stress disorder (PTSD) surpassing rates observed in the general population (Andhavarapu et al., 2022). Surveys conducted during the pandemic revealed high rates of depression, anxiety, stress and burnout among healthcare professionals, with these issues persisting even after the pandemic's peak (Andhavarapu et al., 2022). Pre-pandemic, 40 percent of doctors working for the United Kingdom’s (UK) National Health Service (NHS) were experiencing depression, anxiety, stress, or burnout, which was worsened by the pandemic (BMA, 2021). The pandemic intensified pre-existing levels of burnout and moral injury, leading to acute moral distress among healthcare staff (Best, 2021).

It is recommended that healthcare employers support the psychological wellbeing of their staff by fostering a culture of effective communication, safety and good leadership, alongside access to specific psychological support, such as Cognitive Behavioural Therapy (CBT) or mindfulness training (British Psychological Society [BPS], 2020; NHS England, 2019; National Institute for Health and Care Excellence [NICE], 2022).

Throughout the pandemic, hospitals and healthcare organisations responded to the increased need for interventions to support the psychological wellbeing of staff. In the UK, many NHS trusts set up staff support initiatives, such as in-house psychological support services and helplines (Appelbom et al., 2021; Blake et al., 2020; Johnson et al., 2022; Miotto et al., 2020; Petrella et al., 2021). In early 2021, NHS England set up a total of 40 mental health hubs across England for frontline health and social care staff to access to rapid mental health assessments and evidence-based support (BPS, 2023).

With the psychological wellbeing of increasing numbers of healthcare staff being affected, there was a need for tailored interventions that were quick and effective. The services developed to support staff throughout the pandemic delivered mainly CBT-based interventions (Cole et al., 2020), but in addition began to pilot new interventions, based on different psychological modalities, tailored specifically to frontline healthcare staff. An example of this was the '20minCareSpace' pilot using compassion-based principles for healthcare staff (Jones et al. as cited in Cole et al., 2020). A staff support service within a Trust in East Anglia used the Emotional Freedom Technique (Craig & Fowlie, 1995) as a modality alongside psychological interventions (Norfolk and Suffolk NHS Foundation Trust, 2024).

Emotional Freedom Technique (EFT) is an evidence-based therapeutic intervention that combines elements of cognitive therapy and exposure therapy with acupressure (Church & Brooks, 2013). It is commonly called "tapping" as it involves the stimulation of acupuncture points on the face and upper body by tapping of the fingers. EFT starts with a straightforward acknowledgment of the issue at hand, referred to as the "set-up statement." The first half of the set-up statement is the exposure part and the latter half is self-acceptance. Whilst reciting and repeating this statement, tapping on specific acupressure points is done (Blacher, 2023). It is the tapping on the eight acupressure points that has a specific stress reduction effect on the body (Bach et al., 2019; Clond et al., 2016; Nelms & Castel, 2016).

There are over 100 peer-reviewed publications listed on an online bibliography (Research.EFTuniverse.com), comparing outcomes of EFT for various physical and mental health conditions including pain, depression, anxiety, phobias, and addiction (Bougea et al., 2013; Church, 2014; Rowe, 2005, Wells et al., 2013). Church et al. (2013) conducted a systematic review of 56 randomised controlled trials (RCTs) and found EFT to be effective at treating various psychological health conditions in very short treatment timeframes, from one

to 10 sessions. Research into the physiological effects of EFT found it to have a positive effect on physiological markers of stress, such as heart rate variability, blood pressure and cortisol levels (Bach et al., 2019).

EFT has been found to reduce physiological markers of stress, creating a calming effect on bodily systems meaning that other resources become available, even though external circumstances have not changed (Church et al., 2012; Church, 2013; Stapleton., 2020). This mechanism is pertinent to healthcare staff in particular, working in environments where there may be little opportunity for change to the demands placed upon staff. This evidence also suggests that EFT may be a useful tool to offer staff before they access further psychological therapies, so that they are better able to access and utilise other strategies.

Previous systematic reviews have synthesised research on the effectiveness of EFT for specific cohorts and conditions. Church et al. (2022) focused on transdiagnostic conditions and they found that EFT was effective for treating psychological conditions such as PTSD, phobias, depression, and anxiety and physiological problems such as pain and autoimmune conditions, as well as biological markers of stress. Their meta-analysis found the effect of EFT treatment to be moderate to large. Nelms and Castel (2016) completed a meta-analysis of studies evaluating the effect of EFT on depression, across different cohorts, including veterans, cancer patients and patients with major depressive disorder. They found large effect sizes for EFT delivered both in group and individual format, with treatment timeframes ranging from one to ten sessions, with a mean of –41 precent symptom reduction across all studies. They also found that participants maintained their gains over time. Clond (2016) completed a meta-analysis on studies exploring EFT for the treatment of anxiety and found a large effect size between pre-post scores, demonstrating a significant decrease in anxiety.

However, there have been no systematic reviews to date completed focusing on healthcare staff specifically. This review aims to synthesise the existing research on the effectiveness of EFT for improving psychological wellbeing of this cohort. The aim of this review is to ascertain the effectiveness of EFT for improving the psychological wellbeing of healthcare staff.

## Methods

This systematic review utilised the PRISMA guidelines (Page et al., 2021) for systematic reviews to conduct a review of the effectiveness of EFT for improving psychological wellbeing for healthcare staff. This review was prospectively registered on the PROSPERO register of systematic reviews (11th December 2023, CRD42023481093).

### Inclusion Criteria

The inclusion criteria are shown below in Table 1.

**Table 1**

*Inclusion Criteria*

| **Criteria** | **Specification** |
|---|---|
| Population | Healthcare staff (including doctors, nurses, allied healthcare professionals and healthcare students). |
| Intervention | Emotional Freedom Technique (delivered through any medium, in person or online, individually or in a group setting). |
| Comparator | If present, different therapeutic interventions, or psychological therapies. |
| Outcomes | The effect of EFT on pre- and post-intervention psychological wellbeing outcomes. |
| Setting | Any healthcare delivery setting i.e. inpatient or community settings. |
| Study design | Empirical studies that included quantitative data (randomised/quasi randomised controlled trial, controlled before-and-after, cohort, cross-sectional and mixed methods). |
| Language published | English |

Studies were excluded if they were not original research; were conducted as dissertations; were not written in English or were purely qualitative research.

### Search Strategy

Searches were completed on 29th December 2023 using the following databases: MEDLINE Ultimate, CINAHL Ultimate, APA PsycINFO and Scopus. Supplementary searches included hand-searching reference lists of identified articles, including systematic reviews. Search terms were (a) terms related to EFT AND (b) terms related to 'healthcare worker'. Table 2 below shows the full search terms used.

**Table 2**

*Search Terms*

| **Emotional Freedom Technique** | **Healthcare Worker** |
|---|---|
| "Emotional Freedom Technique" | "Healthcare staff" |
| | "Healthcare worker" |
| "EFT" | "Healthcare professional" |
| "tapping" | "Healthcare provider" |
| | "Healthcare personnel" |
| | "Doctor" |
| | "Nurs*" |

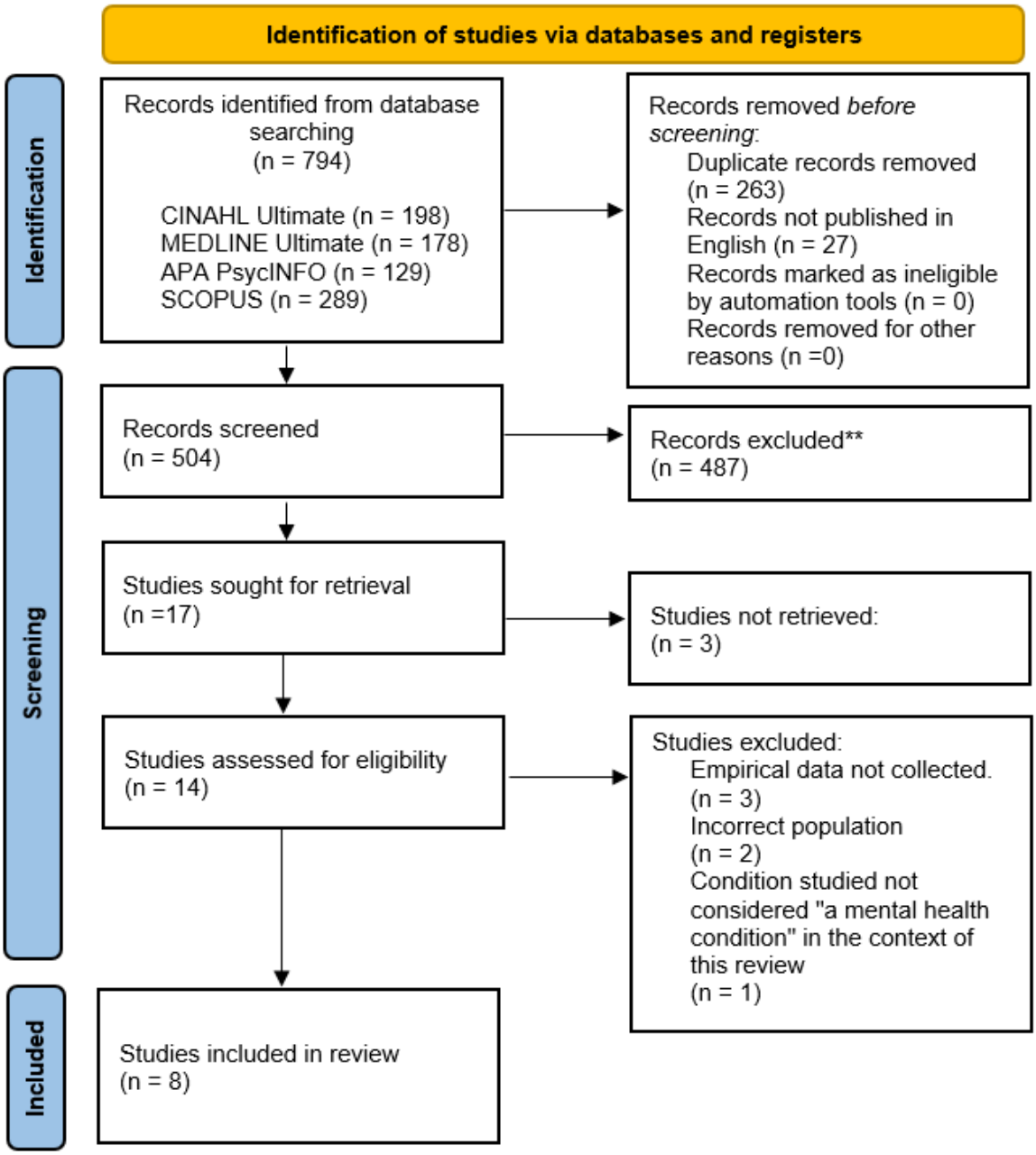
The initial search returned 794 results which were considered for inclusion in the review. The reference management software End Note was used to organise the studies. Search results from the databases were merged and duplicate records were removed. In an initial screen, all titles and abstracts of search results were reviewed to remove visibly irrelevant studies. For this initial screen, 20 percent of all search results were also reviewed by a second reviewer (SG) to ensure accuracy, reduce bias, and enhance the reliability and validity of the review. Any discrepancies were discussed and resolved. The reference management software Rayyan (Ouzzani et al., 2016) was used for the second review. The full texts of remaining studies were then retrieved, and studies were compared against inclusion/exclusion criteria. For the full text review, 50 percent of the studies were reviewed by the second reviewer (SG). Any differences in opinion were again discussed and resolved by consensus.

## Results

The PRISMA flowchart (Figure 1) illustrates the flow of publications through the systematic review, detailing the total number of studies screened, assessed for eligibility and excluded at each stage. From the initial 794 results, after duplicates were removed, a total of 504 publications were screened. After screening titles and abstracts, 14 full text publications were retrieved and reviewed; of these, eight studies met inclusion criteria.

**Figure 1**

*PRISMA Flowchart*



## Data Extraction and Synthesis

Data extraction was conducted by the primary author on Microsoft Excel using a predetermined data extraction template of key study characteristics including; author, year of publication, mean age and gender of participants, clinical population, research method, sample size, intervention delivery, presence of control group, comparator intervention, psychological wellbeing measures and key psychological wellbeing findings (see Table 4 and Table 5).

Quantitative data from the included studies were analysed using narrative synthesis due to the methodological and clinical heterogeneity between studies.

## Quality and Bias

Studies were critically appraised using the Effective Public Health Project Practice Quality Assessment Tool for Quantitative Studies (EPHPP; Effective Public Healthcare Panacea Project, 2022). The EPHPP is specifically designed for healthcare research. A weak rating in one area suggests moderate evidence and more than one weak rating suggests weak evidence. In order to increase confidence in the findings of the review, a second coder, SG, independently rated 20 percent of studies, selected at random. Any disagreements were discussed and resolved by consensus. Overall, two studies were rated ‘strong’, five were rated ‘moderate’ and two were rated ‘weak’. See Appendix D for full details of the quality appraisal ratings.

## Description of Studies

All eight of the peer-reviewed studies involved direct participant research and the total number of participants across the studies was 742. The smallest sample size was 37 (Patterson, 2016) and the largest sample size was 216 (Church & Brooks, 2010). Five studies recruited nursing students from undergraduate nursing degree courses at universities (Dincer et al., 2022; Inangil et al., 2020; Vural et al., 2019; Patterson, 2016; Wati et al., 2021) two studies recruited fully qualified nurses from acute hospitals (Dincer & Inangil, 2021; Okut et al., 2022) and one study recruited a mix of qualified healthcare professionals from a conference for healthcare professionals (Church & Brooks, 2010). Twenty-one percent of the participants were male, reflective of the fact that seven out of eight of the studies recruited nurses and nursing is a predominantly female profession (Bureau of Labor Statistics, 2022;

Nursing and Midwifery Council, 2022). The studies were undertaken in three different countries: the USA, Turkey and Indonesia.

Of the eight studies included, seven used quantitative methods and one used a mixed methods design (Patterson, 2016). Four studies were cohort studies, measuring differences in the same group before and after the intervention (Church & Brooks, 2010; Patterson, 2016; Vural et al., 2019; Wati et al., 2021.) All studies collected their pre-test data directly before the initial intervention. Two of the cohort studies collected their post- test data immediately after one treatment session. The other two cohort studies collected post- test data after participants had been practicing the intervention for an extended period of time. Four studies were randomised control trial (RCT) studies, where the researchers randomly allocated participants to an intervention or control group. Two of the RCTs had two groups; one intervention group and one control group. The remaining two RCTs had three groups; two groups that received different interventions and a control group. The interventions used as comparators were breathing therapy and music therapy.

The psychological wellbeing outcomes measured included self-reported levels of anxiety, depression, stress, burnout, public speaking anxiety, test anxiety and fear of COVID-19 (see Table 3). Anxiety measures varied across the studies with the most common measure being the State-Trait Anxiety Inventory (STAI; Spielberger et al., 1970), which was used in five studies. The Beck Anxiety Inventory (BAI; Beck et al., 1988) was also used. One study (Inangil et al., 2020) measured participants' vital signs (blood pressure, heart rate and capillary oxygen saturation levels) as indicators of anxiety. Psychological distress was measured across five studies and all five studies used the Subjective Units of Distress scale (SUDs; Wolpe, 1969). The Symptom Assessment-45 Questionnaire (SA-45; Davison et al., 1997), the Speech Anxiety Scale (SAS; Yaman & Sofu, 2013), the Burnout Measure-Short Version (BMS; Malach-Pines, 2005), the Perceived Stress Scale (PSS; Cohen at al., 1983) and the COVID-19 Phobia Scale (C19P-S; Arpaci et al., 2020) were also used. A full summary of study characteristics can be found in Table 4 and a summary of findings can be found in Table 5.

**Table 3**

*Psychological Outcomes Collected*

| Publication | Anxiety symptoms | Depression symptoms | Stress levels | Burnout levels | Fear of COVID-19 |
|---|---|---|---|---|---|
| Church & Brooks (2010) | X | X | | | |
| Dincer & Inangil (2021) | X | | X | X | |
| Dincer et al. (2022) | X | | | | |
| Inangil et al. (2020) | X | | | | |
| Vural et al. (2019) | X | | | | |
| Okut et al. (2022) | X | | | | X |
| Patterson (2016) | X | | X | | |
| Wati et al. (2021) | X | | | | |

**Table 4**

*Study Characteristics*

| Publication | Country | Study design | Clinical population | Sample size | Mean age (years) | % Male | Intervention mode of delivery | Length of time/ follow-up | Outcome measures | Comparator | Quality rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Church & Brooks (2010)** | USA | Cohort study (1 group, pre- and post-test) | Healthcare personnel, nonmedical personnel, chiropractors, physicians) | 216 | 48 | 24.1 | One 4-hour EFT workshop in person | Post- test measures were collected after 90 days. Participants indicated their frequency of EFT practice over 90 days (at least once per week, at least 3 times per week or not at all) | SA-45, Somatic and Emotional Indicators Rating form (SEI) | No | Weak |
| **Dincer & Inangil (2021)** | Turkey | RCT | Nurses (working in an acute hospital) | 72 | 33.45 | 11.1 | One guided 20-min group EFT session online | Post- test measures collected directly after the EFT intervention | SUDs, STAI, BMS | Control group (received no intervention) | Strong |
| **Dincer et al. (2022)** | Turkey | RCT | Nursing students | 76 | 20.42 | 10.5 | One guided 20-min group EFT session in person | Post- test measures collected directly after the EFT intervention | SUDs, STAI, SAS | Breathing therapy and control group (control received no intervention) | Moderate |
| **Inangil et al. (2020)** | Turkey | RCT (3 groups, pre- and post- test) | Nursing students | 90 | 19.27 | 17 | In-person group interventions (EFT & Music Therapy) delivered for 15 minutes. Control group had 15 minutes of free time. OSCE | Post- test measures collected directly after the interventions | Situational Anxiety Scale, Vital Signs Form (blood pressure, heart rate & oxygen saturation levels) | Music therapy and control group (control received no intervention) | Strong |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | examination took place directly after | | | | |
| **Vural et al. (2019)** | Turkey | Cohort study (1 group, pre- and post-test) | Nursing students | 80 | Not reported. (Age range: 19-20) | 17.5 | Following an in-person group EFT instruction, participants completed three 2-minute rounds of EFT (6 mins total). Nursing exam took place directly after | Post- test measures collected directly after each 2-min round of EFT | STAI, BAI, SUDs | No | Weak |
| **Okut et al. (2022)** | Turkey | RCT (2 groups, pre- and post- test) | Nurses | 84 | 29.1 | 44 | Initial in-person EFT session delivered individually, followed by daily online guided EFT sessions for 6 days (7 days total). 4 "rounds" of EFT completed in each session | Post- test measures collected after 7 consecutive days of daily EFT practice | STAI, C19P-S, SUDs | Control group (received no intervention) | Moderate |
| **Patterson (2016)** | USA | Mixed methods. Quantitative: quasi-experimental, time-series, one group, pre- and post-test. Qualitative: self-report short answer questionnaire | Nursing students | 37 | 34 | 10.8 | Initial EFT instruction in a group setting. Participants encouraged to practice self-guided EFT daily for 4 weeks. | Outcome measures collected weekly for 4 weeks. Qualitative questionnaire was administered at the end of the 4 weeks | STAI, PSS, Qualitative Questionnaire | No | Moderate |
| **Wati et al. (2021)** | Indonesia | Quasi-experimental cohort study | Nursing students | 87 | Not reported | Not reported | One guided group EFT session online | Post- test measures collected directly | SUDs | No | Moderate |

| | | |
|---|---|---|
| (1 group, pre- and post-test) | | after the EFT intervention |

**Table 5**

*Summary of Findings as Organised by Psychological Outcome*

| Publication | Anxiety symptoms | Depression symptoms | Stress levels | Burnout levels | Fear of COVID-19 |
|---|---|---|---|---|---|
| **Church & Brooks (2010)** | There was immediate significant improvement of anxiety levels at pre- post-test (straight away) (p=0.01). Gains maintained at 90-day follow-up.<br>Greater subsequent EFT use correlated with a greater decrease in symptom severity at follow-up. | Significant improvement immediately following intervention (p=0.001). Gains maintained at 90-day follow-up (p=0.014) | | | |
| **Dincer & Inangil (2021)** | Reductions in anxiety (p<.001) reached high levels of statistical significance for the intervention group. The control group showed no statistically significant changes on these measures. | | Reductions in stress (p<.001) reached high levels of statistical significance for the intervention group. The control group showed no statistically significant changes on these measures. | Reductions in burnout (p<.001) reached high levels of statistical significance for the intervention group. The control group showed no statistically significant changes on these measures. | |
| **Dincer et al. (2022)** | *Public speaking anxiety*<br>State anxiety: The median post-test STAI-TX1 scores of the Breathing Therapy and | | The SUDs was used as a measure of stress levels.<br>The median post-test SUDs | | |

| | | |
|---|---|---|
| | EFT groups were significantly lower in the intervention groups compared to the control group ($p<0.001$)<br>Constant anxiety: There was no difference to the constant anxiety scores pre- and post-test.<br><u>Speech anxiety:</u><br>The median post-test SAS scores of the breathing therapy and EFT groups were found to be significantly lower compared to the control group ($p<0.05$). ($p>.005$). | scores of the breathing therapy and EFT groups were significantly lower compared to the control group ($p<0.001$). |
| **Inangil et al. (2020)** | EFT led to a decrease in the mean pre-exam anxiety scores (p=0 001).<br>The difference between the mean vital signs of the groups was not statistically significant, except the pulse rate in the EFT and peripheral capillary oxygen saturation in the music group. | |
| **Vural et al. (2019)** | EFT significantly reduced pre-exam anxiety scores.<br>Both state and trait anxiety levels reduced significantly (P=0.003, p=0.000). BAI scores decreased but was not statistically significant (p=0.885). SUDs scores decreased significantly after | |

| | | | |
|---|---|---|---|
| | each of the 3 sessions of EFT (p=0.005, p=0.002, p=0.000). | | |
| **Okut et al. (2022)** | Both state and trait anxiety scores decreased significantly post EFT intervention (p<0.001, p=0.014), however when compared to the control group, only the decrease in state anxiety was statistically significant (p<0.001). SUDs scores also decreased significantly (p<0.001) when compared to the control group. | | After the EFT intervention, the fear of COVID-19 levels decreased significantly (p<0.001). The difference compared to the control group was also statistically significant (p<0.001). |
| **Patterson (2016)** | There was a significant decrease in both state and trait anxiety levels from baseline to week 2, and from week 2 to week 4 (p=0.05). Overall, there was a significant decrease in anxiety levels from baseline compared to week 4 (p=0.05). | There was a significant decrease in self-reported stress levels from baseline to week 2 and also from week 2 to week 4 (p=0.05). | |
| **Wati et al. (2021)** | Public speaking anxiety scores (SUDs) were significantly reduced following the EFT intervention (p<0.001). | | |

## Key Findings of Psychological Wellbeing Outcomes

Overall, EFT was found to be effective at reducing psychological wellbeing outcomes across all eight studies. Using a narrative synthesis approach, the results of the studies are organised by psychological wellbeing outcomes.

### *Anxiety Symptoms*

**Anxiety.** Four of the studies sought to investigate the effect of EFT on anxiety levels (Church & Brooks, 2010; Dincer & Inangil, 2021; Okut et al., 2022; Patterson, 2016). Two of these studies compared EFT to a control group that received no intervention (Dincer & Inangil, 2021; Okut et al., 2022) and two studies compared anxiety levels pre- and post-intervention (Church & Brooks, 2010; Patterson, 2016). Three of the studies used one measure to measure anxiety levels (ref) and one of the studies used two measures of anxiety (Okut et al., 2022). Three studies utilised the STAI as their measure of anxiety. The STAI consists of two scales; one that measures state anxiety (STAI-TX1) and one that measures trait anxiety (STAI-TX2). Two of the studies that used the STAI utilised both the state and trait scales (Okut et al., 2022; Patterson, 2016) and one study only used the state scale (Dincer & Inangil, 2021). One study utilised the SA-45 questionnaire (Church & Brooks, 2010) and one study used the SUDs as a measure of anxiety intensity (Okut et al., 2022). All the measures used are validated measures of anxiety (Maruish et al., 1998; Oei et al., 1990; Thyer et al., 1984). Three of studies required the participants to practice EFT over a period of time (Church & Brooks, 2010; Okut et al., 2022; Patterson, 2016) for 90 days, 7 days and 4 weeks respectively. Only one study collected post- measures immediately after one session of EFT (Dincer & Inangil, 2021).

All four studies that collected anxiety measures reported lower levels of anxiety after the EFT intervention. For the studies that used control groups, the anxiety levels in the control group did not decrease but the anxiety levels in the EFT group decreased significantly. In the three studies using the STAI to measure state anxiety levels, all three studies found a statistically significant decrease in state anxiety. The two studies that measured trait anxiety reported a decrease in trait anxiety levels, however only one of these was to a statistically significant degree (Patterson, 2016). There were similar levels of reduction in anxiety levels regardless of the duration of treatment (range of 1 to 90 days). With regards to intensity of anxiety, Okut et al. (2022) found that scores of the SUDs decreased significantly, and the difference compared to the control group was significant.

**Public Speaking Anxiety (PSA).** Two studies sought to investigate the effect of EFT on PSA (Dincer et al., 2022; Wati et al., 2021). Both studies conducted one session of EFT only and post-test measures were collected immediately afterwards. Dincer et al. (2022) conducted a RCT with three groups, comparing EFT to breathing therapy and a control group. Wati et al. (2021) conducted a cohort study with one group, comparing pre- and post-PSA levels. Both studies used the SUDs scale as a measure of psychological distress indicating anxiety levels. Dincer et al. (2022) also used the STAI and the SAS. All the measures used are validated measures of anxiety (Dincer et al., 2022; Oei et al., 1990; Thyer et al., 1984).

Both studies reported a statistically significant decrease in public speaking anxiety overall. Both studies reported a significant decrease in psychological distress as measured by the SUDs and studies reported a similar decrease in SUDs scores. In Dincer et al.'s (2022) study, when comparing SUDs across the three groups, the post-test scores were statistically significantly lower for the breathing therapy and EFT groups compared to the control group.

In Dincer et al.'s (2022) study, scores for the SAS decreased significantly for both the EFT group and the breathing therapy group. Out of the two interventions however, EFT was more effective at reducing speech anxiety scores than breathing therapy. State anxiety scores decreased significantly for both the breathing therapy and EFT groups compared to the control group. Trait anxiety scores did not decrease across any of the three groups, meaning no intervention had an effect on trait anxiety.

**Test Anxiety.** Two studies investigated the effect of EFT on test anxiety (Inangil et al., 2020; Vural et al., 2019). Both studies used non-clinical samples of nursing students who were sitting planned examinations as part of their nursing degree. Both studies followed similar procedures: pre- test measures were collected, one session of the intervention was delivered, post- test measures were collected and then the nursing students sat their examinations immediately after. Inangil et al. (2020) conducted an RCT, comparing EFT with music therapy and a control group. Vural et al. (2019) conducted a cohort study, comparing anxiety levels pre- and post- an EFT intervention. For measures, Inangil et al. (2020) used the SAS and a 'vital signs form' which included readings of blood pressure, heart rate and oxygen saturation levels. Vural et al. (2019) used the STAI, the BAI and the SUDs. All the measures used are validated measures of anxiety (Creamer et al., 1995; Inangil et al., 2020; Oei et al., 1990; Thyer et al., 1984).

Both studies reported statistically significant decreases in scores across all anxiety measures. Inangil et al. (2020) reported a statistically significant decrease in the SAS. Compared to the control group, there was significant difference in anxiety levels for the EFT group and the music group. With regards to the vital signs, there was a significant decrease in pulse rate in the EFT group and a significant increase in oxygen saturation in the music group. There was no significant difference in blood pressure. In Vural et al. (2019), participants completed three 'rounds' of EFT that lasted two minutes each. Pre- and post-measures were taken before and after each round. They found that SUDs scores dropped significantly after each session of EFT. The biggest difference was found pre- and post- the third session, but even one two-minute round showed a significant decrease in distress. Both state and trait anxiety levels reduced significantly ($p=0.003$, $p=0.000$) over the three rounds, with a bigger difference in trait anxiety levels before and after EFT. A decrease in BAI scores was recorded, however this was not significant.

***Stress***

Two studies looked at the effect of EFT on stress levels (Dincer & Inangil, 2021; Patterson, 2016). Dincer & Inangil (2021) conducted an RCT, comparing EFT to a control group, collecting post-test measures after one session of EFT. Patterson (2016) conducted a cohort study, comparing the effect of EFT on stress levels over a four-week period. Dincer & Inangil (2021) used the SUDs as a measure of stress and Patterson (2016) used the PSS. Both measures are validated measures of stress (Nielsen et al., 2016; Thyer et al., 1984). Both studies found a significant decrease in stress levels after receiving an EFT intervention. Dincer & Inangil (2021) found a highly significant decrease in SUDs scores for the group that received the EFT intervention ($p<0.001$). Patterson (2016), collected data across four weeks, found that stress levels decreased significantly from baseline to week two and from week two to week four. The results showed a continued decrease from week to week, with the lowest mean score collected at week four. There was a slightly larger decrease in mean scores from baseline to week two compared to week two to week four.

***Depression***

One study looked at the effect of EFT on depression (Church & Brooks, 2010). This was a cohort study that compared depression scores before and after a four-hour workshop on EFT. Depression was measured through the use of the depression subscale within the SA-45.

Mean depression scores decreased significantly pre- and post- the EFT intervention (P=0.001).

### *Burnout*

One study looked at the effect of EFT on burnout (Dincer & Inangil, 2021). This was an RCT, comparing the effect of EFT on burnout to a control group. A Turkish adaptation of the BMS was used, validated by Capri (2006). There was a significant reduction in burnout scores this change was also statistically significant compared to the control group, where there was no change in pre- post-test scores. Dincer and Inangil (2021) accepted their hypothesis that a single online session of EFT was effective in reducing the burnout levels of nurses.

### *Fear of Covid-19*

Okut et al. (2022) examined the effects of daily online sessions of EFT over 7 days compared to a control group that received no intervention. A Turkish adaptation of the COVID-19 Phobia Scale (C19P-S) was used, validated by Bakioğlu et al. (2021). After the EFT intervention, the fear of COVID-19 reduced significantly, and the difference compared to the control was also significant.

## Additional Findings

Across the studies included in this review there were differences in methodologies. There was variance in the delivery method of EFT (individual and group, online and in-person), a range in the duration of the initial guided session (6 – 20 minutes) and a range of timeframes that the participants were required to continue their EFT practice at home (7 – 90 days).

### *Method of EFT delivery*

Delivering the initial EFT instruction session individually and in groups, as well as administering EFT in both in-person and virtual settings, resulted in significant improvements in symptomology.

### *Length of Treatment*

Five of the eight studies refs required their participants to take part in a one-off EFT session, with post-test scores being collected directly after the intervention. Three studies required participants to participants to practice EFT at home after an initial instruction session. All studies, irrespective of how many times EFT was practiced concluded

improvements in symptomology. Reductions in psychological distress were maintained at follow ups, as long as 90 days.

### *Physiological Symptom Reduction*

One study in the current review collected data on physiological markers of psychological distress. Inangil et al. (2020) measured blood pressure and heart rate pre- and post- EFT intervention and reported a statistically significant decrease in both after the intervention, providing evidence supporting the proposed mechanism behind the psychological changes.

## Discussion

This review identified eight studies which met inclusion criteria and provided data that addressed the research question. The review synthesises the body of literature on the effectiveness of EFT for improving psychological well-being in healthcare staff.

EFT proved effective in improving psychological wellbeing, including lessening symptoms of low mood and anxiety as well as issues commonly encountered by healthcare staff such as high stress levels and fear of COVID-19. The reduction in depressive symptoms has been echoed by the meta-analysis completed by Nelms and Castel (2016) that found participant outcomes following EFT treatment were deemed "equal or superior" to both ‘treatment as usual’ and other active treatment controls. However, while these initial results are positive, they must be interpreted cautiously, as there is still limited research available, and the existing studies were designed and delivered in different ways. For example, the methods of intervention delivery differed significantly, with some studies using in-person sessions, while others implemented online or self-guided approaches. Additionally, the length of EFT sessions ranged from just a few minutes to over an hour, and the overall duration of the interventions varied widely, from a single session to multiple sessions spread over several weeks or months. Furthermore, the studies examined the effects of EFT over very different periods of time, from immediate post-intervention outcomes to follow-ups conducted several months later. They also assessed various mental health outcomes using different measures. This heterogeneity makes direct comparison of the results challenging and underscores that this initial review is merely a starting point, highlighting the need for more standardised and methodologically consistent research in the future.

Outcome studies, which assess patient results before and after treatment, can provide clinically robust results, however whilst demonstrating the effectiveness of a treatment deems it an "evidence-based" practice, clarifying the process behind its effectiveness enables us to understand the physiological changes that drive any clinical benefits. This type of research offers objective physiological evidence that strengthens subjective self-reports. One study in this review (Inangil et al., 2020) explored the effect of EFT on various biomarkers (heart rate and blood pressure), providing some insight into the physiological processes that may be driving the psychological outcomes. In this review, Inangil et al. (2020) found a lower average heart rate of the group receiving EFT compared to the group receiving a different intervention. Similar results were found by Bach et al. (2019) who reported significant improvements in heart rate as well as other physiological signs such as cortisol levels, immune factors and blood pressure for participants practicing EFT.

All studies in this review utilised a self-report methodology with non-clinical cohorts. This prevents the generalising of results to those with diagnosed clinical mental health conditions, however, it does provides information that is pertinent to healthcare staff. Although this cohort of participants is non-clinical, findings may be representative of the general state of psychological wellbeing of healthcare staff. This particular population would fail to meet thresholds on standardised tests of mental health diagnoses and if seeking support from traditional mental health services may be unlikely to receive treatment. EFT nevertheless was effective in reducing symptoms of psychological distress and in addition quick and easy to deliver could therefore be an appropriate intervention offered by healthcare employers to support the general psychological wellbeing of staff.

The length of time participants were required to practice EFT in one session in the current review was as short as six minutes. However, it is important to note that there was only a single study in the current review looking at each individual timeframe, so any claims regarding the effectiveness of such brief sessions are highly tentative. While the potential for EFT to be delivered and practiced in short timeframes may offer a promising tool for healthcare staff working in busy, time-pressured environments, these findings should be interpreted with caution. Further research is needed to explore whether EFT remains effective when practiced independently in such short durations.

In terms of how many sessions of EFT were practiced over the course of the interventions, some of the studies collected post-test scores after just one session of EFT,

while others required participants to practice EFT at home over varying periods of time, ranging from 7 to 90 days. While results showed a decrease in symptoms even after a single session, it is important to recognise that each study examined different timeframes and this variation provides only preliminary evidence regarding the number of sessions needed to see a meaningful difference. Moreover, since the longest time studied was just 90 days, further longitudinal research is needed to understand the longer-term effects of EFT beyond this period. Although these findings suggest a potentially faster impact compared to traditional therapies such as CBT, which often requires at least ten sessions (Aaronson et al., 2008), such conclusions should be approached cautiously. The lack of consistency in study designs and timeframes means these initial results are far from definitive.

Three studies in the current review measured self-reported anxiety levels following specific anxiety-provoking situations as opposed to clinical diagnostic classifications of anxiety. Wati et al. (2021) recorded anxiety levels caused by public speaking and Vural et al. (2019) and Inangil et al. (2020) recorded anxiety levels caused by an examination. Although these are situation specific and cause a short-term spike in anxiety as opposed to longer standing clinical anxiety disorders, we can deduce that EFT is effective in reducing short-term symptoms of anxiety caused by certain triggers and indicates potential utility for navigating acute anxiety. Further research may help to explore if this is true for other triggers that may cause short-term symptoms of anxiety in healthcare settings such as fear of making a clinical error or when under inspection.

It is important to emphasise that around seventy percent of the nurses included in this review were students. While students are a readily available group for recruitment, it is crucial to recognise the distinctions between students and fully qualified nurses. The significant improvements noted among students may not directly apply to fully qualified nurses due to variations in factors such as clinical pressures, time spent in clinical settings, and levels of responsibility (Robledo-Martín et al., 2023). Nevertheless, the results suggest that EFT may reduce psychological distress in nursing students related to exam anxiety. This indicates that EFT could potentially be a valuable tool to teach students during their training, possibly preparing them to utilise it in their professional careers.

The papers in this review evaluating EFT have not accounted for other factors that may significantly contribute to positive outcomes in therapy. Elements such as psychological validation, where a client feels heard and understood, and the strength of the therapeutic

alliance, which fosters trust and rapport between therapist and client, are well-documented as having therapeutic benefits independent of any specific technique (Flückiger et al., 2018; Horvath et al., 2011). These dynamics can influence the efficacy of EFT but have been overlooked in these particular studies. It is essential to remain mindful and sensitive to the possibility that these non-specific factors, rather than the technique itself, may be playing a crucial role in an increase psychological wellbeing.

**Research Implications**

This review has highlighted several gaps in the existing literature regarding EFT as an intervention for psychological wellbeing in healthcare staff. Firstly, the review has brought attention to the fact that most studies investigating EFT and healthcare staff primarily enlist participants from the nursing profession, including both students and registered nurses. While there were a few studies involving qualified nurses, a substantial portion of the research focused on recruiting nursing students. Conducting additional research that specifically recruits qualified nurses would enhance the robustness of the current findings. Additionally, research in this area involving healthcare professionals beyond nurses is notably scarce. Additional investigation is warranted to determine whether the findings observed among nurses would translate to other healthcare professions. Future studies could involve recruitment from medical practitioners, paramedics and allied health professionals. Considering the apparent immediate physiological advantages of EFT, it may also be worthwhile to explore its potential benefits for individuals working in high-stress healthcare settings, such as emergency departments.

Further exploration utilising a longitudinal design would be helpful in determining the durability of the intervention past 90 days. Exploring how often healthcare staff would practice EFT independently would provide further information on the usability of this intervention for this particular cohort of people.

Qualitative exploration of healthcare workers' experiences of using the intervention would be helpful in determining outcomes not assessable by quantitative methods. An example of this would be exploring whether or not finding time to practice EFT in busy and stressful work environments adds further pressure to healthcare staff or whether the benefits of EFT offset this pressure. To further extend the utility of EFT amongst healthcare staff it

may also be valuable to explore the effect of EFT on non-clinical outcomes, for example, in decision-making capabilities.

Further research could explore how effective EFT is at minimising the risk factors of common mental health symptoms amongst healthcare staff. For example, previous research has found that negative self-perceptions in healthcare staff with low self-esteem can lead to burnout (Shoptaw et al., 2000). It would therefore be valuable to know the effect of EFT on self-esteem as a way of avoiding burnout in the first place, as well as other risk factors.

The studies included in this review came from only three countries, with half of the studies coming from a single country. As the NHS becomes more multicultural (Workforce Team, NHS Digital, 2023) it would be important to understand if there are any potential confounding variables which may negatively influence the effectiveness of this intervention between cultures.

Subsequent research should also aim to rectify the limitations highlighted in the current studies. Employing a robust methodology, for example utilising an RCT design, with follow up, would enhance the quality of the evidence base. This approach successfully minimises potential confounding variables, mitigates participant allocation bias, and would facilitate a more accurate estimation of the genuine effects of EFT for healthcare staff.

### Clinical Implications

This review provides preliminary evidence that EFT is effective for treating symptoms of a range of symptoms of psychological distress that are commonly experienced by healthcare staff. The findings suggest that differences in symptomology can be observed after one session, and sessions can be as short as six minutes. The studies have indicated that EFT can be practiced independently after one demonstration session and that demonstration sessions can be delivered effectively both online and in groups. These attributes would make it attractive to healthcare providers as it is quick and straightforward to deliver, requiring one taught session, as opposed to multi-session therapies that are frequently offered as interventions for healthcare staff.

### Strengths and Limitations of Review

This review is the first of its kind known to the authors which explores the effects of EFT on psychological wellbeing for healthcare staff specifically. Using a comprehensive

search strategy, the review offers a valuable overview of the diverse psychological wellbeing outcomes that may benefit from the application of EFT.

A key limitation of this review is the heterogeneity of the included data, which restricted the depth of analysis that could be conducted. The absence of a meta-analysis prevented the determination of the overall magnitude of the reported effects. The limited range of healthcare roles represented in the studies also limits how generalisable the results are to professionals not included such as allied healthcare professionals or medics. This, however, is reflective of the limited research that has been undertaken. The review also did not incorporate studies from the grey literature or in languages other than English. Consequently, there is a potential for publication bias, and valuable information that could contribute to addressing the research question might be absent.

It is important to consider the quality of the studies included in the review with regards to limitations. Two out of eight of the studies in this review were rated ‘weak’ using the EPHPP quality assessment tool. Using studies of low-quality that are more prone to bias, methodological flaws, and confounding variables can introduce systematic errors that can lead to misleading conclusions in reviews.

**Conclusions**

The presence of a technique to alleviate psychological distress associated with work-related stress and burnout holds significant advantages for healthcare staff. The self-guided nature of EFT, coupled with its rapid effects and ability to be delivered in groups, makes it well-suited for on-the-job implementation in healthcare settings. Whilst this review summarises evidence suggesting the potential effectiveness of EFT for alleviating psychological distress among healthcare staff, further well-designed research, including studies involving fully qualified healthcare professionals from various specialties, is needed to provide more definitive conclusions.

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# Chapter Three

## Bridging Chapter

## Bridging Chapter

The systematic review aimed to explore the effectiveness of the Emotional Freedom Technique (EFT) for addressing psychological wellbeing in healthcare professionals. The findings indicate that differences in symptoms can be observed after just one session, with sessions lasting as briefly as six minutes. Studies suggest that individuals can practice EFT independently after a single demonstration session (Dincer & Inangil, 2021; Inangil et al. 2020) and such sessions can be effectively delivered both online and in group settings (Dincer & Inangil, 2021; Wati et al., 2021). These characteristics may make EFT appealing to healthcare providers due to its efficiency and simplicity, requiring as little as one instructional session.

A specific example of healthcare professionals seeking to improve their psychological well-being is National Health Service (NHS) staff utilising in-house staff support services. NHS staff support services were set up in response to the COVID-19 pandemic, with NHS Trusts aligning their actions with United Kingdom (UK) national guidance to implement various initiatives aimed at supporting staff during and beyond the crisis (Appelbom et al., 2021; Blake et al., 2020; Johnson et al., 2022; Miotto et al., 2020; Petrella et al., 2021). These initiatives involved the formation of in-house staff wellbeing services, support lines, and specialised services offering psychological therapies. NHS England launched 40 mental health hubs across England in early 2021, providing frontline health and social care staff with rapid mental health assessments and evidence-based support (British Psychological Society [BPS], 2023). Additionally, the Improving Access to Psychological Support (IAPT) services, initially designed for primary care, adapted their services to extend support to frontline NHS staff in accordance with guidance from professional psychology bodies (Cole et al., 2020).

Current literature has just begun to explore the experience of the NHS staff who are availing of these services with only one qualitative study published thus far. Olabi et al. (2021) conducted interviews with staff of an acute NHS hospital Trust who had accessed their in-house psychological support service during the pandemic. Employing an interpretative phenomenological approach, they explored staff experiences of the service. Additional qualitative research is required to supplement the sparse literature. The previous study focused on service utilisation during the pandemic, potentially influencing staff experiences, particularly regarding barriers to access. Post-pandemic it is now crucial to

ascertain the current experiences of those using these services especially in light of the current landscape of NHS staff support provision.

In April 2024, NHS England announced withdrawal of funding to NHS Practitioner Health who provide mental health support to secondary care staff (BPS, 2024). Following disagreement on this decision from unions and health bodies such as the BPS and the British Medical Association (BMA), NHS England reversed their decision some days later and pledged funding for a further year (BPS, 2024). However, the ambiguity stemming from recurrent short-term funding decisions means existing services are operating on the edge of potential closure, adversely affecting both service employees and users (Webber, 2024).

The literature extensively documents the challenges that healthcare staff face and the subsequent impact on mental health (Bria et al., 2012; Hall et al., 2016; Johnson et al., 2018; Laposa et al., 2003). In line with this, NHS England have outlined specific aims in caring for the mental health of staff in the current NHS People Plan 2020/2021' the workforce strategy for delivering the Long Term Plan for the NHS (NHS England, 2020). The plan acknowledges that the importance of providing psychological care for its' staff and states that NHS England "will continue to provide and evaluate the national health and wellbeing programme developed throughout the COVID-19 response" (NHS England, 2020, p. 18). The objectives of NHS England and the prevailing uncertainty surrounding funding appear contradictory, underscoring the importance of exploring the felt experiences of those utilising these crucial services.

The aim of the following empirical paper is to explore the experiences of the NHS staff who are utilising their in-house staff support services.

# Chapter Four

## Empirical Paper

**Prepared for submission to the *British Journal of Clinical Psychology***

# Exploring NHS Staff Experiences of Receiving Post-Pandemic Therapy Support from NHS Staff Support Services: A Thematic Analysis

Hannah Carroll[a], Dr Sheryl Parke[a], Dr Lauren Grainger[b], and Dr Imogen Rushworth[a]

a Norwich Medical School, University of East Anglia, Norwich, NR4 7TJ, UK
b The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Corresponding author: Hannah Carroll (email: hannah.carroll@uea.ac.uk)

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## Abstract

**Background and Objectives:** Healthcare staff face significant mental health risks due to the stressful nature of their work (Bria et al., 2012; Hall et al., 2016; Johnson et al., 2018). The COVID-19 pandemic worsened these challenges for staff, leading to increased stress, burnout, and mental health issues (Ahrens, 2021; Aymerich et al., 2022; BMA, 2021; Sun et al., 2021). In response to the worsening of challenges and an increase in mental health issues amongst staff in the United Kingdom, NHS Trusts implemented various support initiatives, including in-house wellbeing services and psychological therapies (Appelbom et al., 2021; Blake et al., 2020; Johnson et al., 2022). However, research on NHS staff support services remains limited and relatively new. Preliminary studies like Petrella et al. (2021) and Smith et al. (2022) have explored mental health symptoms, help-seeking behaviours, and the utilisation of various support services during the acute stages of the pandemic. Olabi et al. (2022) conducted interviews to understand staff experiences with in-house psychological support, highlighting the benefits and also the need for flexible and ongoing mental health investment. Further qualitative studies are therefore needed to explore the experiences of those accessing in-house psychological services, adding to the currently small body of research. Post-pandemic, it is crucial to understand current user experiences, especially considering the evolving landscape of NHS staff support provision.

**Method:** This study is a qualitative exploration of the experience of NHS staff who have accessed psychological support provided by their Trust's staff support service. Ten participants from two NHS staff support services were interviewed. Data from the interviews was transcribed and analysed using Braun & Clarke's reflexive thematic analysis (2006).

**Results:** The views of ten participants were summarised through four key areas; working in the NHS; accessing support; the experience of therapy and wider service reflections.

**Conclusions:** The stressors that healthcare staff face, such as under-resourced and overstretched services, have a significant emotional and psychological impact. This makes specific and accessible support essential. In-house staff support services are providing hugely valued support with unique advantages over external support services, such as the valued "colleague to colleague" relationship. However, wider systemic barriers and attitudinal shifts are needed to ensure all staff feel safe accessing these high-quality services.



**Keywords:** psychological support for healthcare staff, staff support services, NHS staff

## Introduction

Healthcare professionals face significant challenges and mental health risks due to the nature of their work environments (Bria et al., 2012; Hall et al., 2016; Johnson et al., 2018; Laposa, J. M. et al., 2003; Ramirez et al., 1996). Working in healthcare involves navigating highly stressful situations, witnessing human suffering and mortality, enduring long and unpredictable work hours, and potential exposure to harm such as physical injury and infectious diseases (The National Institute for Occupational Safety and Health, 2023). This chronic exposure to stress can lead to burnout, characterised by emotional exhaustion, depersonalisation, and reduced personal accomplishment (Maslach & Leiter, 2006). Moreover, healthcare staff experience unique challenges such as moral distress (British Medical Association [BMA], 2021) which occurs when staff recognise the ethically right course of action but are unable to pursue it, potentially leading to moral injury, where there is longer-term psychological harm (BMA, 2021).

Research also highlights a clear link between staff wellbeing and patient outcomes. When healthcare staff experience high levels of wellbeing, such as good mental health and job satisfaction, patient care tends to improve, leading to better safety, satisfaction, and recovery rates (Warr & Nielsen, 2018). For example, reduced staff burnout has been associated with fewer medical errors and better patient experiences. Conversely, poor staff wellbeing negatively affects care quality, increasing risks for mistakes and lowering patient satisfaction (Teoh et al., 2020). Supportive work environments that prioritise staff wellbeing are crucial to maintaining high standards of patient care. (Teoh et al., 2020).

The COVID-19 pandemic exacerbated these challenges, with healthcare staff facing additional stressors such as fear of infection, redeployment, organisational changes, longer shifts, and contact with severely affected patients (Frenkel et al., 2022; Alimoradi, 2022). Throughout the pandemic, healthcare staff reported increased levels of work-related stress, burnout, depression, anxiety and suicidal ideation (Ahrens, 2021; Aymerich et al., 2022; BMA, 2021; Sun et al., 2021). A significant proportion of healthcare staff experienced symptoms of post-traumatic stress disorder (PTSD) surpassing rates observed in the general population (Andhavarapu et al., 2022). Surveys conducted during the pandemic revealed high rates of depression, anxiety, stress, and burnout among healthcare professionals, with these issues persisting even after the pandemic's peak (Andhavarapu et al., 2022). The pandemic

intensified pre-existing levels of burnout and moral injury, leading to acute moral distress among healthcare staff (Best, 2021).

In 2019, NHS England initiated The National Health and Wellbeing Programme to aid the mental and physical health of NHS staff, offering guidance to organisations on supporting their workforce (NHS England, 2019). Key aspects include establishing 'health and wellbeing champions' and promoting discussions on wellbeing. Additionally, during the early stages of the pandemic, the British Psychological Society (BPS) provided guidance focusing on mental well-being support for healthcare staff, emphasising the importance of psychological interventions alongside effective communication, safety measures, and leadership (BPS, 2020). Furthermore, the National Institute for Health and Care Excellence (NICE) recommends that employers should provide access to cognitive behavioural therapy, mindfulness training, or stress management for staff experiencing or at risk of poor mental health (NICE, 2022).

With the pandemic as a driving force, NHS Trusts responded to UK national guidance by implementing various initiatives to support their staff during and beyond the pandemic (Appelbom et al., 2021; Blake et al., 2020; Johnson et al., 2022; Miotto et al., 2020; Petrella et al., 2021). These initiatives included establishing in-house staff wellbeing services, support lines, and specialised services offering psychological therapies. Additionally, in early 2021, NHS England established 40 mental health hubs across England to provide frontline health and social care staff with rapid mental health assessments and evidence-based support (BPS, 2023). Furthermore, Improving Access to Psychological Support (IAPT) services, originally designed for primary care, adapted their services to offer support to frontline NHS staff in accordance with guidance from professional psychology bodies (Cole et al., 2020).

As NHS Trusts began to develop new initiatives to support their staff, preliminary research emerged on how these services were being used. Petrella et al. (2021) conducted a rapid evaluation of healthcare staff at a London hospital in the acute stages of the pandemic, assessing prevalence of mental health symptoms as well as the utilisation of available support services. A profile emerged of who was most at risk (younger females and those already showing signs of burnout) and who was most likely to use the available support services (those from the high-risk group).

Smith et al. (2022) conducted interviews with the staff from a mental health Trust, exploring help-seeking behaviours and access to a range of support avenues, including a

counselling service, reflective Schwartz rounds, post-incident support sessions, ‘rest and recharge’ hubs, informal peer support and self-help materials. They found that peer-based support was valued and sought after but that access to support was hindered by work pressures and perceived cultural barriers.

Olabi et al. (2022) conducted interviews with staff from an acute hospital Trust who had accessed their in-house psychological support service. Using an interpretative phenomenological approach they explored staff experiences’ of the service. Staff described the benefits of the service as well as expressing a need for a flexible and responsive approach and the continued need to invest in the mental health of staff.

Further qualitative study is needed specifically on exploring the experiences of those who are accessing the in-house psychological services to add to this small body of research. Previous studies took place through the acute stages of the pandemic, colouring the way that staff were using the services, especially in relation to the barriers to accessing the services. Post-pandemic, it is now crucial to ascertain the current experiences of healthcare staff using these support services, especially given the evolving landscape of NHS staff support provision. Understanding these experiences will not only provide valuable insights into the effectiveness and accessibility of current services but also inform future improvements to better meet the psychological needs of healthcare workers. By focusing on this area, the research can contribute to developing more tailored and effective support mechanisms that ensure the wellbeing of healthcare staff, ultimately enhancing their ability to provide high-quality care to patients.

## Methods

### Design

This study is a qualitative exploration of the experience of NHS staff who have accessed psychological support provided by their Trust’s staff support service. Thematic analysis (Braun & Clarke, 2006) was utilised as the qualitative framework. This aligns with the critical realist perspective (Clarke et al., 2015) and supports the critical realism epistemological position of the research.

Ontology explores what exists and the nature of reality, while epistemology focuses on how we know what we know. A researcher's ontological position influences whether they see reality as a fixed fact (realism) or shaped by personal interpretation (relativism) (Braun &

Clarke, 2013). Epistemology ranges from positivism, which believes in objective, measurable truth, to constructionism, which sees knowledge as dependent on context and evolving with culture and experience (Killam, 2013; Madill et al., 2000). Critical realism can be considered as both ontological and epistemological in position (Fletcher, 2017) and critical realist research methods are primarily focused on understanding, rather than merely describing, social reality (Vincent & O'Mahoney, 2016). The data in this study were analysed from a position of critical realism, assuming that an ultimate reality exists, but it is experienced and understood through lenses such as culture and language. Thematic analysis in particular supports a critical realist position by acknowledging that while themes are drawn from real experiences, these interpretations are still shaped by the researcher's perspective. Both the critical realism perspective and thematic analysis allow researchers to identify and analyse patterns in data while recognising that their interpretations are influenced by underlying structures and their own viewpoints.

**Recruitment and Participants**

Participants recruited for the study were NHS staff who had accessed support from their Trust's staff support service. Participants were recruited from two staff support services settings within NHS Trusts in the East of England. Both services offer psychological support that is available to all Trust staff. Staff who had finished their therapeutic intervention were eligible to take part in the study. The full list of eligibility criteria are detailed below in Table 6. Participants were made aware of the study by the circulation of a study flyer that was included in discharge packs and distributed in Trust-wide communications, such as weekly newsletters. The flyer provided contact details of the lead researcher, informing staff to make contact if they were interested in taking part. Sixteen people contacted the lead researcher for further information, of which ten consented to take part in interviews.

**Table 6**

*Inclusion and Exclusion Criteria for Study Participants*

| Study participants had to meet the following criteria: |
| --- |
| 1) Participants needed to be employed by an NHS Trust. Patients who had accessed the service who were not employed by the NHS, such as those from health and social care organisations were not eligible.<br>2) Participants had to have finished their therapeutic intervention at the time of the interview.<br>3) Participants could not be enrolled as a Trainee Clinical Psychologist at the University of East Anglia (UEA). |

## Procedure

Those who were interested in taking part made contact with the lead researcher via email. The lead researcher responded with the Patient Information Sheet (PIS; Appendix H) and the offer of a telephone call to further explain the study and to provide the opportunity for questions. Ten people agreed to have a phone call and all ten consented to taking part in the study. During this phone call an appointment was arranged for the interview. Following the booking of the interview, the participants were emailed the Consent Form (Appendix I), a reminder of the important points of the study and details of their interview appointment. Nine of the interviews took place online, via Microsoft Teams, and one interview took place in person at an NHS site. The lead researcher conducted all interviews, which with consent were transcribed live using the transcription function on Microsoft Teams and audio recorded using a dictaphone. Participants were informed that the interviews would take around 1 hour, but to allow a 90-minute time slot to include the consent-taking and debriefing processes. Interviews ranged from 28 minutes to 1 hour 11 minutes in length and took place between October and December 2023. Following the interview, participants were sent a £10 Amazon voucher via email to thank them for taking part along with a Debrief Sheet (Appendix J), which included suggestions of supportive services if needed. The interview transcripts from

Microsoft Teams were checked for accuracy against the audio recordings by the lead researcher. Identifying information was removed to protect participant anonymity.

### *Ethics*

The study was reviewed and approved by The UK Health Research Authority Central Leicester Research Ethics Committee in August 2023 (23/EM/0158; HRA approval letter; Appendix B) and the participating NHS Trusts' Research & Development departments.

### *Interviews*

A semi-structured interview schedule was developed by the lead researcher in collaboration with Clinical Psychologists working within the staff support services (Appendix G).

## Data Analysis

The data were analysed using the Braun and Clarke's (2006) method of reflexive thematic analysis. Thematic analysis was chosen as it focuses mainly on patterning of meaning across participants, rather than the deep meaning within one participant, and would deduce the collective experience of the staff accessing the services. This involved identifying codes and building these into themes to build a coherent and accurate story of the data that represents all participants. Analysis was completed on Microsoft Excel by the lead researcher (HC) and Braun & Clarke's (2006) six phases of thematic analysis (Appendix K) were utilised to guide the analysis process.

## Reflexivity

The importance of reflexivity was considered throughout the study, prompting the researcher to consistently evaluate their own position and its potential influence on data interpretation (Green & Thorogood, 2018). To facilitate this process, the researcher utilised supervision and maintained a reflective journal.

Given the position of the researcher as a healthcare worker within the NHS and particularly as a clinician with experience in staff support initiatives, it was especially important for the researcher to remain mindful of their own experiences and how these might shape their perceptions. To capture these insights, the researcher recorded their thoughts in a

reflexive journal following interviews and during data analysis. Additionally, supervision sessions with the research supervisory team further supported reflexivity efforts. These practices were instrumental in ensuring the credibility and confirmability of the research findings.

### Quality Assurance

Three of the ten transcripts were analysed by a second member of the research team (SP) to increase inter-rater reliability. All of the codes derived from the analysis process were discussed and collaboratively explored with the research supervisory team. Any disputes amongst the coding framework were resolved through discussion to ensure inter-rater reliability.

## Results

Thematic analysis identified four main themes related to the exploratory research question regarding NHS staff experiences of their staff support service. The themes are presented below (Table 7) with selective verbatim quotations to illustrate each theme and subtheme.

**Table 7**

*Key Topic Domains*

| Theme | Sub-themes | Examples of codes |
|---|---|---|
| *Theme 1* | | |
| Working in the NHS | The emotional impact of working in the NHS | *The emotional toll of working in healthcare.*<br>*Prevalence of mental health symptoms.*<br>*Having to employ coping mechanisms (e.g. time off work, avoidance of symptoms).* |
| | Support needs | *Needing support to be able to stay at work.* |

| | | |
|---|---|---|
| | | *A need for support separate to immediate team.* |
| *Theme 2* | | |
| Accessing Support | Awareness of the service | *Advertising of the service.*<br>*Ambiguity around the scope of the service.*<br>*Ease of access to the service.* |
| | Barriers to accessing support | *Negative experiences of previous support.*<br>*Worries around confidentiality.*<br>*The knowledge that NHS services are stretched.*<br>*Not feeling deserving of support (feelings of guilt and shame).* |
| | Facilitators to accessing support | *Support from managers.*<br>*Flexibility from the service around practicalities (timing of sessions around shifts etc.)*<br>*The belief that you need to be well in order to help others.* |
| *Theme 3* | | |
| The Experience of Therapy | Vehicles for change | *Therapists' having knowledge of working in the NHS.*<br>*Individualised and flexible support.* |
| | Post-therapy outcomes | *Feeling supported in returning to work.*<br>*Increase in confidence.* |
| *Theme 4* | | |
| Wider Service Reflections | Benefits to the Trust | *Sick leave prevented.*<br>*Staff feel valued by the Trust.* |

| | | |
|---|---|---|
| | Fears around longevity of the service | *Uncertainty regarding future funding and the effect of this on therapy.* |
| | A valued service | *Feeling grateful that the service exists. Would use the service again.* |

**1. Working in the NHS**

Participants shared their experiences of working in the NHS, focusing on why they need support and the specific types of support they require. They described what it feels like when there is no support available and what the ramifications of this can be for themselves and the wider Trust. They described the emotional experience of caring for others as well as the long-term impact this can have on their own mental health.

***1.1. The Emotional Impact of Working in the NHS***

The staff described the emotional experience of caring for others, the feeling of giving part of yourself in order to hold the distress of your patients, and how experiencing this long-term can leave you depleted and vulnerable. Work-based contributing factors ranged from external pressures, such as working throughout the pandemic, to internal issues, such as working in under-funded services or experiencing interpersonal issues within their team. Staff discussed how their own psychological wellbeing was compromised and described symptoms of long-term stress, trauma and anxiety.

> *"But what we are dealing with day in day out is horrific things…. and the pressure is so much at the moment. We just deal with it and then you just move straight on to the next thing. Like you don't even stop to think about it, and we're all so desensitised to basically the absolute horrors that are happening on a daily basis."* – Participant 1

> *"I think, I think the work is very stressful, it's very draining. We deal with trauma and a lot of it's very, very distressing and you take it away with you in your head."* – Participant 9

Participants went on to describe the effects of psychological distress, particularly in the context of their work, such as doubting their ability to do their job. The staff described

coping mechanisms that they employed to deal with their struggling, such as having to take time off work or complete avoidance of symptoms and adopting the mentality of "just keep going".

> *"…knowing that I wasn't sort of at the top of my game professionally because of how unwell I was. You know, sort of thinking about the children that I work with and perhaps, you know, not being able to give them my full self…"* – Participant 3

> *"I was feeling really vulnerable and wasn't coping and kind of had a bit of a breakdown really. I'd been carrying on, carrying on, carrying on for absolutely, you know, I was just exhausted.."* – Participant 2

### *1.2. Support Needs*

Many of the staff discussed the need for support due to the psychological effects of working in healthcare under the current pressures of the NHS.

Staff felt that support was necessary to stay at work, as lack of support could lead to needing time off, and those who had time off work reported that they needed support to return to work.

> *"I was desperate [for support] and I was struggling to get through a day at work and it wasn't just at work anymore, I was getting home and I felt horrific. … I think I was off for maybe four months the first time, I didn't want to go back there and work was getting progressively worse. I did feel like I was stuck, I had to do something."* – Participant 6

Prior to the inception of the service, staff felt they weren't valued by the Trust and a lack of support conveyed a message of indifference towards staff's wellbeing. Many participants wanted support that was more formalised than the support offered colleague to colleague and it was important that this support was separate to their immediate team.

> *"You work so hard to keep your service-users safe, to keep your team going to, but who's holding you?"* – Participant 6

## 2. Accessing Support

All staff discussed their awareness of the staff support service, their referral experience and the factors that facilitated their access as well as obstacles that they had to overcome in order to access the support.

### *2.1. Awareness of the Staff Support Service*

There were varying experiences amongst the staff with regards to their knowledge of the staff support service. This was generally linked to the act of asking for support – those who were aware of the service seemed more able to consider the service as an avenue of support and to follow the self-referral process independently. Those who were unaware of the service needed more support or guidance from managers or other in-house services, such as Occupational Health, to access it. Most participants felt the service was easy to access, that the referral process was simple, and that they were responded to very quickly.

> *"I knew it would be quick. And I'd heard about it. … I'd just done a telephone call and the call was answered promptly. They spoke to me there and then."* – Participant 2

### *2.2. Barriers to Accessing Support*

Staff discussed factors that made it more difficult to access support or obstacles that needed to be overcome before they could engage in support. These fell mainly into the categories of organisational and practical barriers and emotions and beliefs that acted as barriers.

For some staff, part of the decision-making process to access the service included overcoming emotional barriers and changing their beliefs around accessing support. Staff experienced feelings of shame around needing support, especially for clinical staff who worked in mental health services, who expressed disappointment in themselves for not being able to use their own skills to overcome their difficulties.

> *"…because I'm in the professional, I should be immune to these things that I almost, like I should know better, these things shouldn't happen to me… it almost felt like I should not have allowed things in my life to have gotten to that point."*
> – Participant 4

*"...I felt like some of the service users I've worked with, I kept comparing myself and I thought no, I shouldn't be using this support. I shouldn't need this support. I think I felt a sense of guilt for struggling with my mental health generally, which sounds really strange because I know within healthcare, having that experience yourself is really useful like in a way... but for me it felt like, I think one of the expressions I used at the time was 'you wouldn't go to the bank and get advice on your mortgage from someone that was in debt'... and that's how I felt like how are my services going to want to take advice from me when I'm not doing OK myself?"* – Participant 6

Some of the staff expressed a sense of guilt for having to use services when they had first-hand experience of how stretched NHS services are and guilt for feeling that they were getting treatment ahead of their patients.

*"I did wonder if the provision for staff support was in any way taking away from provision for service-user support in that the time that, say, like the nurse that I was seeing was seeing me rather than someone on a waiting list..."* – Participant 5

Staff expressed feeling doubtful of their own clinical skills due to the fact they were struggling and some staff expressed worry about being perceived as weak by managers and colleagues. There was a strong sense of staff holding the belief that healthcare professionals should be strong and resilient. This fed into the feelings of shame for needing support.

*"I didn't wanna talk about the issue because I had this fear that it would make me seem weak within my role, and that was the perception that I had, that if I talk about it, then I'm gonna seem vulnerable which then means when I walk out of here, I'm still gonna have that vulnerability... if I'm vulnerable and I'm not at my best... how can I give the best care?" – Participant 7*

Many staff expressed how they had concerns around confidentiality and in order to proceed with therapy, needed discussion and reassurance from their therapist in their initial sessions. Due to the service being in-house, some staff described feeling anxious that the processes around confidentiality wouldn't be robust enough. Some feared that their colleagues or managers could read their notes on Trust systems and some felt anxious about coming across their therapist in a professional capacity. It is possible that these

confidentiality fears may, in part, stem from a fear of appearing weak or vulnerable, potentially leading to a perceived loss of professional credibility in a high-pressure work environment.

> *"The only reluctance I think was on a professional level of thinking. Would people sort of come across my name? So, that side of it made me a little bit apprehensive in that others would know how I was feeling and would they sort of see me as less professional because of that or less able? So that was always sort of in the background of my thoughts."* – Participant 3

Some of the staff explored how negative previous experiences with therapeutic services had left them feeling mistrustful and for some caused a delay in asking for support. In addition to this, some staff felt mistrustful of their Trust based on previous poor-quality Trust support or an absence of previous support.

> *"Oh, I was just really dubious. I think because of my prior, yeah, I was like, so you're just rebranding a service that doesn't exist?"… "I think it'd come up on one of our screensavers of all the support the Trust offers, and I was like, but do you? Is this real? Like, are you going to let people down again? I don't want people to feel how I felt. So, I was really dubious of it at first, yeah."* – Participant 6

### *2.3. Facilitators to Accessing Support*

Many of the staff discussed factors that allowed them to ask for support and aided them in attending and engaging in sessions. These ranged from emotional facilitators that allowed them to seek support, practical considerations that made the service attractive over external services and organisational factors that made it possible to attend sessions.

Some of the staff alluded to feeling deserving and worthy of support in the context of their work. This seemed to be tied to a belief that in order to be able to help others, you need to be well yourself. In contrast to those who had shame around struggling with their mental health, some staff did not feel negatively towards themselves for struggling and saw support as a necessary step in their recovery so that they give their best to their patients.

*"I kind of realised you have to kind of recognise when you're struggling yourself and it's OK to have support. No man is an island. That's kind of what I tell all my patients, you know, you don't have to do it on your own. So, I didn't see that as a barrier."* – Participant 3

Amongst some of the staff there was a sense of feeling safe and trusting of the service. For some, the fact that the service was run by the Trust allowed them to trust that the therapists were credible and regulated. The in-house nature of the service provides the option for a more systemic approach to support, between the staff support service, managers and Occupational Health, which some of the staff expressed as a positive and safe approach. Staff also felt a sense of safety because of the links with their work, with one describing how they believed that if their therapist felt it was unsafe for them to be working clinically then this would have been managed.

*"I think it was also like I knew then there was an element of safety around the work I was doing you know at work, that actually if someone who's delivering therapy, you know who works in the Trust is concerned about me that that would be raised in the right place and would be a protective factor for, you know, the job that I was doing and the people that I was working with, that information would be shared quite easily and appropriately."* – Participant 3

Staff highlighted the importance of having support from their managers. This support came in different forms, such as not feeling stigmatised to practical flexibilities, such as being allowed to fit sessions in around work schedules. Many of the staff felt the service responded flexibly when it came to practical considerations, such as being given appointment times that fitted in around work schedules and being offered a mode of delivery that suited (in person or online). For some, the knowledge of this flexibility was part of the decision to choose the service over external services, such as local Wellbeing Services, where they felt that choice and flexibility wasn't prioritised. Other factors that drew staff to the service over external services, were the fact that it was free, the referral process was simple and that they felt in control of their referral.

## 3. The Experience of Therapy

Staff spoke about their experience of the therapy itself in the context of factors that they felt facilitated change and benefits or changes that occurred as a result of attending therapy.

### *3.1. Vehicles for Change*

Staff reflected on their experiences of therapy, in particular the positive aspects that allowed them to engage in the process. Most of the staff felt that the "colleague to colleague" aspect of their therapy was hugely beneficial. The fact that the therapists are also Trust staff meant they had first-hand knowledge of how it feels to work in healthcare as well as an awareness of the pressures of the Trust. Staff felt that this had many benefits, such as feeling validated and feeling like they didn't have to over explain work related issues, allowing them to proceed with therapy more quickly.

> *"I felt like she understood it. Had she not have worked in the NHS previously or not been in the NHS currently, so if it had been somebody separate, I don't know if it would have taken me longer to feel understood."* – Participant 10

Staff reflected on a sense of kindness that they experienced from their therapist, most reporting that they felt held and cared for.

> *"She was an angel, an absolute like, incredible."* – Participant 1

> *"I realised that having that validation, having somebody say to me 'That sounds really s**t', and just kind of acknowledging the pressure I was under kind of helped me not to be so hard on myself. Because I was really kind of thinking 'Oh, I'm no good, I can't do this', but somebody said to me 'That sounds awful.' That in itself was quite powerful for me."* – Participant 2

Most of the staff commented on the therapeutic model that had been used and the processes or skills that had been helpful for them. Staff described the benefits of psychological formulation and how this resulted in them feeling like their support was completely individualised. Some described changing intervention or therapist during their

treatment, but this added to the sense that their intervention was suited to their individual needs.

> *"I had… say two, maybe three sessions of EMDR and found it horrific. It was not for me... But immediately I was transferred over to someone else to start trauma focused CBT."* – Participant 6

> *"… the physical technique or activity that we would do to kind of work through that thought or that event or whatever it was I was bringing that day. So, it always felt very acted, like we were taking action."* – Participant 3

### *3.2. Post-Therapy Outcomes*

All staff commented on the outcomes of their therapeutic interventions, both personally and professionally. Many felt an increase in confidence, which positively impacted on how they felt at work, as well as gaining new perspectives on situations and improved relationships with colleagues.

> *"I would say that it's significantly helped with [my confidence] because I was then able to attend events or meetings that I needed to. I was able to show up to the office and interact with my colleagues and then I was able to start interacting with service users face-to-face. So yeah, I could definitely see a significant change."* – Participant 4

## 4. Wider Service Reflections

Staff reflected more widely on various aspects of the service including benefits to the Trust, concerns about how long it would be available, and the general appreciation and worth they assigned to the service and the support they received.

### *4.1. Benefits to the Trust*

Staff reflected on positive outcomes of support, some of which were of benefit personally and some on a wider level, to the Trust. In-house support meant staff felt fully supported with returning to work if they were on sick leave. There was a sense that the

support had been instrumental in helping staff get back to work. Others felt that the support had allowed them to stay at work and continue in their roles and sick-leave was therefore prevented. The felt experience of this was largely of being seen as a person first and a staff member second and that although a benefit was getting back to work or staying at work, the consensus was that staff did not feel that getting back to work was pushed upon them, especially as the support was coming from the Trust.

> *"I probably would have ended up signed off sick or something. So, I'd say it was that valuable that it prevented me from needing to do that."* – Participant 5

> *"It really helped me to get back to work and get back to the tasks that I was doing before… I would say that it really helped me to get back to what was fully within my job description."* – Participant 4

Many staff felt that having a support service in-house was a sign that they were valued by the Trust.

> "*It's recognition of the fact that the work is hard and 'we see that and we value you and we will support you through that.'"* – Participant 9

### *4.2. Fears Around Longevity of the Service*

Some of the staff discussed their feelings around the uncertainty of the future of the service. This was in the context of wider NHS and political discussions about future funding for staff support services. The uncertainty around funding was shared with some staff during their intervention so that should sessions need to end abruptly they were prepared. Although participants acknowledged the value of knowing this, some expressed how this had felt destabilising. Others felt that the possible withdrawal of staff support was confirmation that staff wellbeing was not a priority of the Trust.

> *"…I guess that was the bit that that was just hard. So, knowing that this is a resource that might end is tricky."* – Participant 10

*"And yeah to think I had all of that input, it made me feel upset that they might potentially cut that."* – Participant 8

### *4.3. A Valued Service*

All staff indicated that they felt it was hugely important for Trusts to provide in-house support for their staff. Most had recommended the service to other colleagues and all of the staff said they would use the service again.

*"Yeh, I definitely would [use the service again] and I'd probably… go sooner and perhaps wouldn't be going at the point of real crisis."* – Participant 3

*"And I recommend it all the time to my colleagues…I was like 'go to staff support. Absolutely. Don't hesitate.'"* – Participant 5

*"I found it to be a really positive experience and I would really encourage other staff members to use the service."* – Participant 4

## Discussion

This qualitative study aimed to explore the experiences of NHS staff who had accessed their Trust's staff support service. The views of ten participants were analysed using Braun and Clarke's reflexive thematic analysis (Braun & Clarke, 2006) and summarised through four key areas; working in the NHS; accessing support; the experience of therapy and wider service reflections.

Staff shared a sense of the stressful environments in which they work, including the impact of long-term stress levels due to factors such as services being stretched, as well as the effects of critical periods of stress, such as throughout the Covid-19 pandemic. The impact on the individual when working in healthcare has been well documented in previous literature (Ferrari et al., 2015; Jovanovic et al., 2016; NIOSH, 2023) and specific psychological impacts such as burnout and moral injury have been noted (Riedel et al., 2022; Shanafelt et al., 2003). These were echoed in the experiences of staff in the current project through a

sense of struggling with symptoms of prolonged stress as well as symptoms of anxiety, depression and trauma.

When it came to accessing support, staff felt that the severity and persistence of their psychological distress symptoms sometimes hindered their ability to seek help. This meant that they lost the ability to plan and advocate for their own support and instead they had to employ coping strategies in order to "keep going", such as avoidance of symptoms or taking time off work.

In addition to not being well enough to seek support, staff recounted other barriers to accessing their support service. Literature suggests there is a complex myriad of forces that prevent or impede staff from accessing timely support, including uncertainty in identifying mental health problems, stigma regarding mental ill health, fears around perceived questioning of professional or clinical competence, social tensions, workload pressures, confidentiality expectations and lack of timely access to mental health support (Keyworth et al., 2022; Moll, 2014). Staff in the current study reflected on many of these barriers and noted the interaction between barriers, such as feelings of guilt around receiving support interacting with beliefs around accepting support.

As documented in previous research, stigma and shame impair ability to recognise mental illness and perceived need for help (Schomerus et al., 2019). Amongst the healthcare participants, the stigma and shame appeared to have an additional layer, in that it was linked to questioning their clinical competence which can impact their professional identity. Confidentiality fears may therefore be intertwined with these concerns, as seeking mental health support could be perceived as a sign of weakness, potentially threatening one's credibility or reputation in a high-stakes professional environment. Research into attitudes around mental health in the NHS revealed that sixty percent of NHS staff reported stigma as more damaging than the symptoms of their mental health condition, further emphasising how these fears, driven by concerns over both personal and professional image, can act as significant barriers to accessing even in-house support services (NHS Employers, 2024).

Peer support is recognised as important and valuable for healthcare staff (Gerada, 2019; Jackson, 2018). Peer support has emerged as a valuable resource for healthcare staff, offering emotional and professional benefits by fostering shared understanding and connection. Recent research highlights that peer support can reduce stress, burnout, and feelings of isolation, promoting resilience and psychological well-being in healthcare environments (Watson et al., 2020). Engaging with colleagues who share similar experiences enhances emotional validation and reduces stigma around mental health issues, contributing

to a supportive culture (Edmondson & Lei, 2022). Peer support is particularly favoured by staff who feel that sharing their difficulties with their family would be a burden (Billings et al., 2020).

Staff in this study described needing a protected space that was just for them and they highlighted the benefits of having empathic support from a fellow member of the Trust. The "colleague to colleague" relationship conveyed a sense of staff feeling validated and understood which was facilitated by the genuine empathy and authentic validation that a fellow staff member can provide. Research has confirmed links between validation in therapy and a more positive therapeutic process. Validation creates more trust between service-user and therapist, produces more positive therapy outcomes and increases the likelihood of future help-seeking behaviours (Blakeslee & Walker, 2018; Rickwood et al., 2007). The themes of the current study were consistent with the literature in that participants described feeling heard as a facilitator in seeking and maintaining treatment.

In relation to returning to work, staff reported that they did not feel pressured by their therapist to resume their duties prematurely, nor did they perceive this as the sole goal of therapy. Instead, they felt valued as individuals first, with their role as employees being secondary. This aligns with principles of person-centred care, which prioritize the individual's holistic needs, respecting their personhood beyond their professional identity (McCormack & McCance, 2017). The emphasis on seeing the individual as a whole person, rather than solely focusing on functional outcomes like returning to work, reflects key aspects of person-centred therapy, where the therapeutic relationship is built on empathy, respect, and the client's subjective experience (Rogers, 1951). This approach likely fostered a supportive environment where staff felt respected and understood, reinforcing the importance of prioritising personhood in healthcare settings.

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environment where staff felt respected and understood, reinforcing the importance of prioritizing personhood in healthcare settings.

Research suggests that when helping support people with post-pandemic psychological distress, a community-based approach is the most effective (Sibley et al., 2020). Previous guidance on community wide responses to crisis (Hobfoll et al., 2007) advises creating feelings of safety and calm, connecting with others and providing hope. Staff in the current study felt that the in-house support team were well-placed to empathise with the pressures of the Trust, whilst being separate enough that they felt comfortable sharing work-place and personal experiences.

In the current study, staff reflected on the immediate personal benefits of support but also longer-term benefits that have wider implications, such as being able to continue in their role. Protecting the wellbeing of healthcare staff will directly impact their ability to fulfil their roles (World Health Organisation, 2020) and existing literature indicates that psychological support should be integrated within a framework of support for NHS staff (NHS Employers, 2024).

A theme from this research that is particularly pertinent to the current landscape of NHS staff support was the fear among staff regarding the longevity of these services. On April 12th, 2024, NHS England announced plans to withdraw mental health support provided by NHS Practitioner Health to secondary care staff (BPS, 2024), only to reinstate the contract for another 12 months three days later. This inconsistency and instability are not new but have been enduring concerns among staff using support services for an extended period. Participants in the current study, some of whom who concluded their therapy in 2022, recounted experiences of confusion and instability regarding funding even then. A pervasive sense of uncertainty and inconsistency at the corporate level is keenly felt by staff, reflected in their confusion and sadness about the uncertain future of support services. Some staff were explicitly informed that funding could cease abruptly, fostering feelings of mistrust despite their appreciation for the high-quality support they received. This atmosphere of uncertainty cast a shadow over their therapy experiences, leading to disappointment and a sense of being undervalued in their relationship with the Trust. This situation poses additional challenges for Trusts, particularly if funding is restored in the future, as there is now a sense of mistrust among staff stemming from the current inconsistency. Future service providers will need to work diligently to maintain trust with their staff, demonstrating a more enduring commitment to providing support.

**Implications**

Previous literature highlights the importance of a long-term strategy to support the psychological and emotional wellbeing of NHS staff (Olabi et al., 2022). This research has highlighted that even when support is in place, there is a complex interaction of attitudinal, interpersonal and organisational barriers for staff to access the available support. A multi-layered response that considers the unique context of the healthcare working environment, including increasing mental health literacy and anti-stigma interventions is required to encourage staff to access the support that is available.

The research has also highlighted the valued aspects of support, notably that the in-house element creates a "colleague to colleague" relationship between staff and therapist which in turn creates so many benefits both within the therapeutic process and in terms of outcomes. It cannot be ignored how valuable it is that the support is coming from within the Trust.

### *Limitations and Strengths of the Study*

The current study should be viewed in light of a number of limitations. The use of volunteer sampling limits the conclusions that can be drawn. It is possible that staff who had less positive experiences were less likely to participate. Although those who participated reflected on barriers to accessing support, ultimately they were able to overcome these. The voices of those who felt the barriers were too high are missing from this study.

During Patient and Public Involvement (PPI) discussions in the planning stages of this research, the issue was raised of confidentiality as a huge concern to staff who use the support services. In order to stay sensitive to the ethical considerations with this cohort, it was decided to that demographic information would not be collected in order to rigorously protect the identity of the participants. It is therefore important to note that the conclusions drawn cannot be generalised to wider staff groups, as it is unknown where the included voices are coming from, for example gender, staff group, length of service. An additional limit is that it is not possible to know which groups of NHS staff are not being represented.

It is important to note that staff from only two staff support services were included in the study. Although some of the findings are not Trust specific, such as the impact of working in healthcare and are therefore more generalisable to wider NHS staff; some of the findings such as reflections around advertising of the service are only representative of that specific

service. The general understanding that staff want services to be visible however can be acknowledged by other services.

A strength of this research however is that due to many staff support services being in their infancy, there is limited literature on the experiences of the group who are accessing these services. By understanding their perspective, this research adds to the literature about not only how to best support these individuals but also what needs to be done in terms of removing barriers that prevent them from accessing the support in the first place.

With regards to areas for further exploration, future research should explore the experiences of healthcare staff from racialised communities. These individuals may face unique and intersecting vulnerabilities. For instance, healthcare staff from racialised communities were disproportionately affected by the pandemic (Intensive Care National Audit and Research Centre [ICNARC], 2021; Kursumovic et al., 2020). To capture a broader range of perspectives, future studies could utilise more purposive sampling, focusing on individuals from ethnically and culturally diverse backgrounds.

### *Conclusion*

Working in under-resourced and overstretched healthcare services with the added demands of acute periods of pressure, such as the Covid-19 pandemic, has created a unique set of challenges for healthcare staff. These stressors take an emotional and psychological toll on staff, and it is evident that specific and accessible support is essential in supporting them. In-house staff support services are providing hugely valued support with unique advantages over external support services, such as the valued “colleague to colleague” relationship. However, it is evident that there are wider systemic barriers that are impeding staff from accessing these services and there needs to be a shift in attitudinal factors so that all staff who require support feel safe enough to access the high-quality services that are available to them.

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# Chapter Five

## Additional Methodology and Design

## Additional Methodology and Design

This chapter offers additional information on the design and methodology sections of the empirical paper, providing further details on the qualitative research design and the Reflexive Thematic Analysis (TA) method used to analyse the data.

### Ontology and Epistemology

The ontological position of the researcher is important as it indicates whether or not the researcher holds that reality is a fact or an individual interpretation (Braun & Clarke, 2013), and therefore whether social phenomenon should be perceived as objective or subjective. These different positions of ontology are realism and relativism (Braun & Clarke, 2013).

Epistemological perspectives can be viewed along a spectrum, extending from positivism to constructionism (Braun & Clarke, 2013). Positivism suggests that truth is accessible and quantifiable, whereas constructionism views knowledge as contingent upon context and subject to evolution influenced by cultural and experiential factors (Killam, 2013; Madill et al., 2000).

The data in this study were analysed from a position of critical realism, assuming that an ultimate reality exists, but it is experienced and understood through lenses such as culture and language. Critical realism can be considered as both ontological and epistemological in position (Fletcher, 2017). Critical realist research methods are primarily focused on understanding, rather than merely describing, social reality (Vincent & O'Mahoney, 2016).

### Ethical Considerations

#### *Consent*

The recruitment process was designed so that participants were not contacted directly, but rather that promotional materials were distributed and should they wish to find out more, they contacted the lead researcher themselves. This process meant that the participants were in control of their decision to be contacted. Following initial conversations with the potential participant, if they agreed to take part in the study the Consent Form (Appendix I) was sent via email in advance of the interview, for the participants to have sight of prior to the interview appointment. Participants were informed that consent would be gained at the beginning of the interview after having gone through the Consent Form together with the lead

researcher. All participants were asked to provide written informed consent. For the interviews that took place on online, electronic consent was sufficient, and the signed Consent Forms were sent via email from participant to researcher before the interview questions began.

### *Confidentiality*

Confidentiality was respected at all times and was of great consideration following Patient and Public Involvement (PPI) conversations that confidentiality was an issue of concern to some staff who access the staff support services. Participants were aware that their choice to take part was not shared with the clinical teams of the staff support services. Only staff who had finished their therapy were eligible to take part and therefore the participants had either already been discharged or were in the process of being discharged from their service.

In planning for the interviews, participants were involved in conversations around the practical considerations, such as timings and locations in order to maintain confidentiality. These conversations were open, and the researcher was flexible so that participants could choose times and locations that felt completely comfortable to them. For those who chose to complete their interviews online and during work times, the researcher was sensitive to considerations such as which email address to send the Microsoft Teams links to, and where the participant was at the time of their interview. For the one interview that took place in person, consideration was given to the participant's level of comfort of completing the interview in a clinic room at the staff support service.

Participants were informed that all information given as part of the interview would remain confidential, unless significant risk to self or other was indicated. This was also outlined in the Consent Form. If risk to self was disclosed during the interview the lead researcher would share with them crisis team numbers and advise them to make contact with their GP.

The decision to offer online interviews was made in order to provide participants flexibility and ease when it came to attending their appointment. However, conducting interviews via Microsoft Teams required considerations specifically around recording and its ethical implications. Microsoft Teams records video and audio together and as such the research team decided not to use this recording function and instead a dictaphone was used to record audio only. The decision to not video record was made to further protect the identity

of the participants and to increase confidentiality. There was a sense that video recording would be unnecessary and potentially insensitive to this cohort, for whom confidentiality is a significant concern.

### *Potential for Distress*

Given the potentially emotive topic, the potential for distress and the management of it were considered throughout the interview. The use of a topic guide (Appendix G) meant that participants could expand upon parts of their experience if they felt comfortable to do so. The researcher reminded participants at different points prior to the interview that they would not be asked any questions directly related to their therapy or the psychological reasons that they sought support. This was also included in the Patient Information Sheet (PIS) (Appendix H).

Participants were given a choice of whether their interview took place in person or online via Microsoft Teams. During the initial telephone conversations, this was discussed in light of which mode would feel most comfortable to them to discuss potentially sensitive subjects, keeping in mind their location should they wish to discuss issues relating to their employment. Participants were informed during initial phone calls that they could decline to answer any questions and they could also choose to end the interview at any time should they wish to. This information was included in the PIS and they were also reminded at the beginning of the interview.

At the end of the interview, participants were given debrief information (Appendix J) verbally and this was also sent to them via email after the interview so that they could keep a reminder of the support available should they require it.

## Analysis

Reflexive Thematic Analysis (Braun & Clarke, 2006) was chosen as the analytic method as it focuses mainly on patterning of meaning across participants, rather than the deep meaning within one participant and therefore would enable the researcher to capture the collective experience of the staff accessing services.

### *Analytic Process*

Thematic Analysis (TA) is a six-step process whereby "the themes are identified within the data, rather than applying specific ideas and searching for supportive evidence" (Braun and Clarke, 2006). The application of this process to this research is outlined below.

*1. Becoming Familiar with the Data*

The lead researcher undertook all ten interviews, followed by checking the entire transcriptions from Microsoft Teams against the audio recordings. Transcription is identified as a helpful step in this early stage (Kisely & Kendall, 2011) and allowed the researcher to fully immerse themselves within the data. This was also a helpful process in beginning to develop themes.

*2. Generating Initial Codes*

After the researcher was familiar with the data, initial ideas and annotations were recorded on the transcripts using Microsoft Excel. 30 percent of the transcripts were also coded by a second member of the research team (SP) to increase inter-rate reliability. Second-level coding was completed by hand, on printed versions of the transcripts, as the lead researcher noticed trends in the data.

*3. Searching for Themes*

In order to begin building themes, the researcher used small pieces of paper annotated with individual codes. These were then moved around as the lead researcher began to see that codes were fitting into emerging themes. The researcher held the therapeutic journey of the staff in mind to help build the codes into themes that told the complete story of the data.

*4. Reviewing Themes*

Supervision was utilised to help in the reviewing of the themes. It was especially helpful to the lead researcher to have conversations with a member of the research team who works clinically within a staff support service. This allowed the researcher to think about telling the story of the data in a way that would be useful to those who may use the research to inform clinical practice within staff support services.

*5. Defining and Naming Themes*

This process meant that the names of themes and the sub-themes within them changed and evolved. Even at later stages sub-themes were merged and labels were changed. The

lead researcher constructed initial themes that were merged and relocated to tell a more succinct and cohesive story during supervision meetings. Supervision was also helpful in ensuring that the overarching themes were inclusive of the entire data set and the labels chosen for the themes were reflective of the codes within those themes.

*6. Summarising Themes and Writing Up*

The writing up of the results was an important and active part of the analysis as the researcher began to see that the themes fitted together well to reflect the data and tell the story. Supervision was utilised to choose which quotes would accompany the report to illustrate the themes. The researcher found this part challenging as after having been fully immersed in the data over they wanted to make sure all the participants' voices and experiences were heard.

## Reflexivity

Reflexivity involves the researcher's recognition and acknowledgment of their own role in the research process (Reinhart & Reuland, 1993). Reflexivity also supports the credibility of qualitative research by limiting researcher bias (Lincoln & Guba, 1985). The importance of reflexivity was considered throughout the study, prompting the researcher to consistently evaluate their own position and the potential influence on data interpretation (Green & Thorogood, 2018). To facilitate this process, the researcher utilised supervision and maintained a reflective journal, both of which were methods that supported reflexivity (Watt, 2007) thus ensuring the credibility and confirmability of the research findings.

The lead researcher was consistently aware of their position and experience and mindful of how these experiences might shape their perceptions, namely their experience as a healthcare worker within the NHS and particularly as a clinician with experience in staff support initiatives. To capture these insights, the researcher diligently recorded their thoughts in a reflexive journal following interviews and during data analysis. Two extracts from the lead researcher's reflective diary are provided below. The first outlines the researcher's early reflections on their experiences of working in staff support initiatives, the second, the researcher's post-interview reflections.

***Reflective journal extract regarding researcher's own experiences working both in the NHS and their previous experience of being involved in post-covid staff support initiatives.***

"Working in staff support initiatives in IAPT during the pandemic I remember the desperation of staff looking for support and the frustration they were expressing at the difficulty of finding it. From listening to staff's experiences of working throughout the pandemic, I felt saddened by the conditions they were describing and upset at the sacrifices they were making on behalf of their patients and their employing Trusts. Working in a primary care service that was commissioned in the height of the pandemic to provide support to staff, with little resources, and although the team was doing all it could, I felt uncomfortable that our efforts didn't seem to scratch the surface of the suffering of the staff who were coming forwards.

In listening to staff, I remember feeling struck by how difficulties seemed to be mounting for many staff prior to the pandemic and a lack of prior support meant that staff, although coping as best they could, had never had opportunities to explore coping strategies or ways to keep themselves well. It seemed that wellbeing initiatives for staff were needed even long before the pandemic."

# Chapter Six

## General Discussion and Critical Evaluation

## General Discussion and Critical Evaluation

This chapter will synthesise the findings from both the systematic review and empirical paper, interpreting their collaborative contributions to the domain of staff support. A critical assessment of each is provided, along with an examination of their broader implications within the context of National Health Service (NHS) staff support. Through this analysis, the chapter aims to provide an overview of the current landscape of staff support services, highlighting key insights and potential avenues for further research and practical application in this important area.

The aim of this thesis was to explore aspects of the provision of psychological support for healthcare staff working in the NHS. The research aimed to, firstly, explore a therapeutic intervention (Emotional Freedom Technique [EFT]), that has been documented to be effective in treating psychological conditions (Bougea et al., 2013; Church, 2014; Rowe, 2005, Wells et al., 2013) specifically the physiological impact of stress on the body and has been identified as being used in NHS staff support services (Norfolk and Suffolk NHS Foundation Trust, 2024). Secondly, the research also sought to understand the experiences of NHS staff who had accessed their NHS Trust's staff support service.

A systematic review synthesised relevant literature exploring the efficacy of the EFT for improving psychological wellbeing in healthcare staff. The review extracted and analysed the data from eight studies. The results provided preliminary evidence suggesting that EFT may be effective in alleviating various symptoms of psychological distress experienced by healthcare staff and improving psychological wellbeing. The findings indicate that differences in symptoms can be observed after just one session, with sessions lasting as briefly as six minutes. The studies suggest that individuals can practice EFT independently after a single demonstration session, and as such sessions can be effectively delivered both online and in group settings (Dincer & Inangil, 2021; Wati et al., 2021). These characteristics may make EFT appealing to healthcare providers due to its efficiency and simplicity, requiring only one instructional session compared to multi-session therapies often offered as interventions for healthcare staff.

These findings must, however, be considered in the context of the review's limitations, notably the heterogeneity of the included data, which constrained the depth of analysis, and the absence of a meta-analysis. This prevented determination of an overall effect size. Furthermore, the limited range of healthcare roles represented in the study,

namely that seven out of the eight studies recruited nurses or nursing students, limits the generalisability of the results to other professionals not included, such as allied healthcare professionals or medical professionals. Nevertheless, these limitations emphasise the scarcity of empirical data in this area and highlight the need for further research to provide a more comprehensive understanding of the effectiveness of EFT in improving psychological distress among healthcare staff.

The empirical paper sought to understand the experiences of NHS staff who had accessed their Trust's staff support service for psychological support. The views of ten participants were analysed using Braun and Clarke's Reflexive Thematic Analysis (TA; Braun & Clarke, 2006) and summarised through four key areas; working in the NHS; accessing support; the experience of therapy and wider service reflections.

**Summary of the Findings in the Context of the Literature**

The challenges that healthcare staff face and the subsequent effect on their mental health is well documented in the literature (Bria et al., 2012; Johnson et al., 2018; Ramirez et al., 1996). Healthcare staff experience high levels of job-related stress, burnout, and mental health issues such as post-traumatic stress disorder (PTSD) (Laposa et al., 2003; Hall et al., 2016). The challenges faced by staff were exacerbated by the COVID-19 pandemic and the prevalence of mental health conditions increased (Ahrens, 2021; Aymerich et al., 2022; British Medical Association [BMA], 2020; Shanafelt et al., 2003; Sun et al., 2021). These findings were echoed strongly in the current study, summarised though the subtheme of 'the emotional impact of working in the NHS,' where staff communicated the emotional toll of working in healthcare and the associated prevalence of mental health symptoms.
This study suggests that in-house staff support services are hugely valued by those using them, providing unique benefits that somewhat alleviate barriers that staff may encounter in seeking external support elsewhere. Peer support is acknowledged as vital for healthcare staff, particularly for those who find it challenging to discuss their difficulties with family members (Gerada, 2019). This study emphasises the importance of a protected space exclusively for staff, outside of their immediate teams, where empathetic support from fellow colleagues within the Trust fosters feelings of validation and understanding. The "colleague to colleague" dynamic contributes significantly to staff feeling validated and understood, aligning with research indicating the positive impact of validation on therapy outcomes and future help-seeking behaviours (Blakeslee & Walker, 2018; Rickwood et al., 2007).

Additionally, the themes identified in the study echo existing literature highlighting the significance of feeling heard in seeking and maintaining treatment refs. Participants in the study found that their in-house support team was well-positioned to empathise with Trust pressures while maintaining enough separation to facilitate comfortable sharing of workplace and personal experiences. These themes emphasise the immense and indispensable advantages of NHS Trusts providing in-house support for their staff, as the factors highlighted by staff align closely with those identified in previous literature as essential facilitators of effective therapy.

While in-house support is greatly valued by those who can access it, the present study highlighted obstacles that staff must overcome to access this support. This indicates that there may be staff members who are unable to overcome these challenges, thereby not accessing the support and as such, continue to experience psychological distress. Staff in the current study noted multiple barriers beyond simply not feeling well enough to seek support, including stigma surrounding mental health, workload pressures, and concerns around confidentiality. Wider literature has documented how stigma and shame surrounding mental illness can hinder both the recognition of mental health issues and the perceived need for help among healthcare professionals (Moll, 2014; Schomerus et al., 2019). The current study echoed these findings and also found that an additional layer for healthcare staff experiencing stigma in relation to their mental health was them questioning their professional competence, impacting their professional identity. These findings highlight the significance of addressing stigma as a barrier to accessing support services, even those provided in-house.

A theme from the empirical research that is particularly pertinent to the current landscape of NHS staff support was the staff having fears around the longevity of NHS staff support services. On the 12th of April 2024, NHS England announced plans to withdraw mental health support provided by NHS Practitioner Health to secondary care staff (BPS, 2024). On the 15th April, they announced that the contract for support would be reinstated for a further 12 months. The inconsistency and instability demonstrated in these recent decisions are not novel occurrences; rather, they have been enduring concerns among staff utilising support services for an extended period. Participants in the current study, some of whom concluded their therapy in 2022, recounted experiences of confusion and instability regarding funding even at that time. A pervasive sense of uncertainty and inconsistency perpetuated at corporate level is keenly felt by staff, reflected in their confusion and sadness when speaking about the uncertain future of staff support services. Some staff in the current study were explicitly informed that funding could cease abruptly, fostering feelings of mistrust despite

their appreciation for the high-quality support they received. This atmosphere of uncertainty cast a shadow over their therapy experiences. Additionally, there was a prevailing sentiment of disappointment and a sense of being undervalued in their relationship with the Trust. This situation poses additional challenges for Trusts, particularly if funding is restored in the future, as there is now a sense of mistrust among staff stemming from the current inconsistency. Staff members have felt disappointed, and this may create further barriers when accessing support should it become available again. Future service providers will need to work diligently to maintain trust with staff, demonstrating a more enduring commitment to providing support.

**Strengths and Limitations**

The systematic review in the current portfolio is the first of its kind to provide an exploration of the effectiveness of EFT for improving psychological wellbeing specifically in healthcare staff. The review was conducted in line with PRISMA guidelines (Shamseer et al., 2015), and the protocol was registered with PROSPERO to ensure research transparency. The review synthesised the literature relating to using EFT to improve psychological wellbeing in healthcare staff. To ensure inter-rater reliability, a second reviewer was involved in both the review and data extraction stages.

However, the review must be viewed in light of its limitations. A significant limitation is the heterogeneous nature of the included data, which constrained the depth of analysis possible. The absence of a meta-analysis prevented determining the overall scale of the reported effects. Additionally, while there were a few studies involving qualified nurses, a substantial portion of the research focused on recruiting nursing students. While students are often readily accessible for research recruitment, it is imperative to acknowledge the disparities between students and fully qualified nurses. The results observed among students may not necessarily translate directly to fully qualified nurses, given differences in factors such as clinical demands, duration of clinical exposure, and levels of professional responsibility (Robledo-Martín et al., 2023). Nevertheless, the findings demonstrate the effectiveness of EFT in reducing psychological distress among nursing students, implying its potential as a valuable training tool to equip students for its use in their future careers. The review also reflected that research in this area involving healthcare professionals beyond nursing professionals is notably scarce. This limited representation of healthcare roles in the review restricts the generalisability of the results to professionals not included, such as allied

healthcare professionals or doctors. Additionally, the studies that recruited fully qualified healthcare staff did not report professional characteristics such as how long the staff had been working in their respective fields and some of the studies did not report in which clinical areas the staff were working.

The empirical paper in this portfolio is only the second known study of its kind exploring the experiences of staff availing of NHS staff support services. The qualitative interviews conducted in the empirical paper have yielded valuable insights into the perspectives of NHS staff who are utilising their in-house support services. Rigorous measures were implemented to enhance the validity and credibility of the research, including maintaining a reflective diary and validity checks on the generation of codes and themes by academic supervisors.

However, the empirical paper should be viewed in light of a number of limitations. Firstly, the use of volunteer sampling may restrict the generalisability of the findings, as those with less positive experiences might have been less inclined to participate. Consequently, the voices of individuals who found barriers insurmountable may be absent from the study. Additionally, during the planning stages, concerns about confidentiality were raised during Patient and Public Involvement (PPI) discussions. To address this, demographic information was not collected to safeguard participant anonymity, thereby limiting the ability to generalise the findings to wider staff groups. Furthermore, the study only includes participants who accessed support from two NHS staff support services. While some findings, such as those related to the impact of working in healthcare, may be applicable to a broader range of NHS staff, others, such as reflections on service advertising, are specific to the individual services. Findings must also be viewed with consideration to the researcher's own biases potentially having an impact on the interpretation of the data although steps were taken to try and minimise this.

## Clinical Implications

The results from this thesis portfolio provide a number of implications for clinical practice. Firstly, the systematic review presents initial evidence supporting the effectiveness of EFT in alleviating an array of psychological distress symptoms commonly encountered by healthcare staff. Results indicate noticeable differences in symptomatology after just one session, which can be as brief as six minutes. Furthermore, EFT can be independently practiced after a single demonstration session, with effective delivery online or in group

settings. These characteristics may make it appealing to healthcare providers due to its efficiency and simplicity, requiring only one taught session compared to multi-session therapies often offered to healthcare staff.

The qualitative study aimed to understand the experiences of NHS staff using in-house staff support services. The study highlights the intricate challenges faced by staff in accessing available support, stemming from attitudinal, interpersonal, and organisational barriers. Addressing these barriers necessitates a multifaceted approach tailored to the unique context of the healthcare environment, including initiatives to enhance mental health literacy and combat stigma. Additionally, the research emphasises the significance of in-house support, fostering a "colleague to colleague" dynamic between staff and therapists, resulting in numerous therapeutic and outcome-related benefits. The inherent value of support originating from within a Trust cannot be overstated.

**Directions for Future Research**

This thesis portfolio has looked to explore the experience and the importance of staff support services. While EFT shows promise as a therapeutic intervention for healthcare staff, research in this area is sparse and narrow in scope, as emphasised by the systematic review. Specifically, the existing research tends to focus narrowly on specific professional groups, limiting the generalisability to other professional groups. It is important that future research focusses on recruiting qualified nurses to enhance the reliability of findings and expands to include other healthcare professionals such as medical practitioners, paramedics, and allied health professionals. Longitudinal studies are needed to assess the long-term effectiveness of EFT beyond 90 days, as well as qualitative exploration to understand the experiences of healthcare workers using EFT. Additionally, research should investigate how EFT impacts risk factors for common mental health symptoms among healthcare staff, such as self-esteem, and explore its effects on non-clinical outcomes such as decision-making capabilities. Given the diverse workforce in healthcare, studies should also examine potential cultural influences on the effectiveness of EFT interventions.

With regards to further understanding the experience of those who utilise staff support services, future research should explore the experiences of healthcare staff with various protected characteristics, as outlined in legislation (Legislation.gov.uk, 2010). These individuals may face unique and intersecting vulnerabilities. For instance, healthcare staff from Black, Asian, and minority ethnic (BAME) groups were disproportionately affected by

the pandemic (Intensive Care National Audit and Research Centre (ICNARC), 2020; Kursumovic et al., 2020). To capture a broader range of perspectives, future studies could utilise more purposive sampling, focusing on individuals from diverse demographic backgrounds.

## Conclusions

Working in stretched healthcare services presents unique challenges for healthcare staff, taking a toll on their emotional and psychological well-being (Bria et al., 2012; Johnson et al., 2018; Ramirez et al., 1996). Specific and accessible support is crucial in aiding them through these difficulties. In-house staff support services offer highly valued assistance, characterised by advantages including the valued "colleague to colleague" relationship. However, systemic barriers hinder staff from accessing these services fully, indicating a need for attitudinal shifts to ensure all staff feel safe accessing the available high-quality support. Additionally, the potential benefits of techniques like EFT in alleviating psychological distress among healthcare staff are promising, with its self-guided nature and potential suitability for group delivery (ref) aligning well with healthcare settings. Nevertheless, further well-planned research, involving fully qualified professionals from various specialties, is essential to provide more conclusive evidence of its effectiveness.

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**Appendix A**

**Author Guidelines for the *British Journal of Clinical Psychology***


# AUTHOR GUIDELINES

**Sections**



## 1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

New submissions should be made via the Research Exchange submission portal. You may check the status of your submission at any time by logging on to submission.wiley.com and clicking the "My Submissions" button. For technical help with the submission system, please review our FAQs or contact submissionhelp@wiley.com.

All papers published in the *British Journal of Clinical Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

**Data protection:**

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at https://authorservices.wiley.com/statements/data-protection-policy.html.

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This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

## 2. AIMS AND SCOPE

The *British Journal of Clinical Psychology* publishes original research, both empirical and theoretical, on all aspects of clinical psychology:

- clinical and abnormal psychology featuring descriptive or experimental studies
- aetiology, assessment and treatment of the whole range of psychological disorders irrespective of age group and setting
- biological influences on individual behaviour
- studies of psychological interventions and treatment on individuals, dyads, families and groups

For specific submission requirements, read the Author Guidelines.

The Journal is catholic with respect to the range of theories and methods used to answer substantive scientific problems. Studies of samples with no current psychological disorder will only be considered if they have a direct bearing on clinical theory or practice.

The following types of paper are invited:

- papers reporting original empirical investigations;
- theoretical papers, provided that these are sufficiently related to empirical data;
- review articles, which need not be exhaustive, but which should give an interpretation of the state of research in a given field and, where appropriate, identify its clinical implications;
- Brief Reports and Comments.

## 3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

Papers describing quantitative research should be no more than 5000 words (excluding the abstract, reference list, tables and figures). Papers describing qualitative research (including reviews with qualitative analyses) should be no more than 6000 words (including quotes, whether in the text or in tables, but excluding the abstract, tables, figures and references). Brief reports should not exceed 2000 words and should have no more than one table or figure. Any papers that are over this word limit will be returned to the authors. Appendices are included in the word limit; however online appendices are not included.

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Refer to the separate guidelines for Registered Reports.

All systematic reviews must be pre-registered and an anonymous link to the pre-registration must be provided in the main document, so that it is available to reviewers. Systematic reviews without pre-registration details will be returned to the authors at submission.

## 4. PREPARING THE SUBMISSION

**Free Format Submission**

*British Journal of Clinical Psychology* now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer (If you do submit separate files, we encourage you to also include your figures within the main document to make it easier for editors and reviewers to read your manuscript, but this is not compulsory). All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

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If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

**Revised Manuscript Submission**

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

## Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

## Title Page

You may like to use this template for your title page. The title page should contain**:**

i. A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
ii. A short running title of less than 40 characters;
iii. The full names of the authors;
iv. The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
v. Abstract;
vi. Keywords
vii. Data availability statement (see Data Sharing and Data Accessibility Policy);
viii. Acknowledgments.

**Author Contributions**

For all articles, the journal mandates the CRediT (Contribution Roles Taxonomy)—more information is available on our Author Services site.

### Abstract

Please provide a structured abstract under the headings: Objectives, Methods, Results, Conclusions. For Articles, the abstract should not exceed 250 words. For Brief Reports, abstracts should not exceed 120 words.

Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

### Keywords

Provide appropriate keywords.

### Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

## Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet points, following the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.

## Main Text File

As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors.
Manuscripts can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) format.

If submitting your manuscript file in LaTex format via Research Exchange, select the file designation “Main Document – LaTeX .tex File” on upload. When submitting a LaTex Main Document, you must also provide a PDF version of the manuscript for Peer Review. Please upload this file as “Main Document - LaTeX PDF.” All supporting files that are referred to in the LaTex Main Document should be uploaded as a “LaTeX Supplementary File.”

LaTex Guidelines for Post-Acceptance:

Please check that you have supplied the following files for typesetting post-acceptance:

- PDF of the finalized source manuscript files compiled without any errors.
- The LaTeX source code files (text, figure captions, and tables, preferably in a single file), BibTex files (if used), any associated packages/files along with all other files needed for compiling without any errors. This is particularly important if authors have used any LaTeX style or class files, bibliography files (.bbl, .bst. .blg) or packages apart from those used in the NJD LaTex Template class file.
- Electronic graphics files for the illustrations in Encapsulated PostScript (EPS), PDF or TIFF format. Authors are requested not to create figures using LaTeX codes.

Your main document file should include:

- A short informative title containing the major key words. The title should not contain abbreviations;
- Abstract structured (objectives/methods/results/conclusions);
- Up to seven keywords;
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- Main body: formatted as introduction, materials & methods, results, discussion, conclusion;
- References;
- Tables (each table complete with title and footnotes);
- Figure legends: Legends should be supplied as a complete list in the text. Figures should be uploaded as separate files (see below).

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-anonymous peer reviewed, the main text file should not include any information that might identify the authors. Do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

**References**

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

**Tables**

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

**Figures**

Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

**Supporting Information**

Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

## General Style Points

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association. The following points provide general advice on formatting and style.

- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
- **Numbers:** numbers under 10 are spelt out, except for: measurements with a unit (8mmol/l); age (6 weeks old), or lists with other numbers (11 dogs, 9 cats, 4 gerbils).

### Wiley Author Resources

***Manuscript Preparation Tips:*** Wiley has a range of resources for authors preparing manuscripts for submission available here. In particular, we encourage authors to consult Wiley's best practice tips on Writing for Search Engine Optimization.

***Article Preparation Support:*** Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence.

Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

## 5. EDITORIAL POLICIES AND ETHICAL CONSIDERATIONS

### Peer Review and Acceptance

Except where otherwise stated, the journal operates a policy of anonymous (double-anonymous) peer review. Please ensure that any information which may reveal author identity is anonymized in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, read the terms and conditions of submission and the declaration of competing interests.

We aim to provide authors with a first decision within 90 days of submission.

Further information about the process of peer review and production can be found in 'What happens to my paper?' Read Wiley's policy on the confidentiality of the review process.

### Appeals Procedure

Authors may appeal an editorial decision if they feel that the decision to reject was based on either a significant misunderstanding of a core aspect of the manuscript, a failure to understand how the manuscript advances the literature or concerns regarding the manuscript-handling process. Differences in opinion regarding the novelty or significance of the reported findings are not considered as grounds for appeal.

To raise an appeal against an editorial decision, please contact the Editor who made the decision in the first instance using the journal inbox, quoting your manuscript ID number and explaining your rationale for the appeal. Appeals are handled according to the procedure recommended by COPE. If you are not satisfied with the Editor(s) response, you can appeal further by writing to the BPS Knowledge & Insight Team by email at Academic.Publications@bps.org.uk. Appeals must be received within two calendar months of the date of the letter from the Editor communicating the decision. The BPS Knowledge and Insight Team's decision following an appeal consideration is final.

If you believe further support outside the journal's management is necessary, please refer to Wiley's Best Practice Guidelines on Research Integrity and Publishing Ethics or contact Academic.Publications@bps.org.uk.

## Clinical Trial Registration

The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

## Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

## Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

## Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: https://www.crossref.org/services/funder-registry/

## Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

> *"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)*

## Data Sharing and Data Accessibility Policy

The *British Journal of Clinical Psychology* recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

It is not necessary to make data publicly available at the point of submission, but an active link must be included in the final accepted manuscript. For authors who have pre-registered studies, please use the Registered Report link in the Author Guidelines.

In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

Finally, if submitting authors have any questions about the data sharing policy, access the FAQs for additional detail.

**Open Research initiatives.**

Recognizing the importance of research transparency and data sharing to cumulative research, *British Journal of Clinical Psychology* encourages the following Open Research practices.

*Sharing of data, materials, research instruments and their accessibility. British Journal of Clinical Psychology* encourages authors to share the data, materials, research instruments, and other artifacts supporting the results in their study by archiving them in an appropriate public repository. Qualifying public, open-access repositories are committed to preserving data, materials, and/or registered analysis plans and keeping them publicly accessible via the web into perpetuity. Examples include the Open Science Framework (OSF) and the various Dataverse networks. Hundreds of other qualifying data/materials repositories are listed at the Registry of Research Data Repositories (http://www.re3data.org). Personal websites and most departmental websites do not qualify as repositories.

## Publication Ethics

Authors are reminded that the *British Journal of Clinical Psychology* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). The Journal generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE). Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county.

Note this journal uses iThenticate's CrossCheck software to detect instances of overlapping and similar text in submitted manuscripts. Read Wiley's Top 10 Publishing Ethics Tips for Authors. Read Wiley's Publication Ethics Guidelines can be found.

## ORCID

As part of the journal's commitment to supporting authors at every step of the publishing process, the journal requires the submitting author (only) to provide an ORCID iD when

submitting a manuscript. This takes around 2 minutes to complete. Find more information here.

## 6. AUTHOR LICENSING

**WALS + standard CTA/ELA and/or Open Access for hybrid titles**

You may choose to publish under the terms of the journal's standard copyright agreement, or Open Access under the terms of a Creative Commons License.
Standard re-use and licensing rights vary by journal. Note that certain funders mandate a particular type of CC license be used. This journal uses the CC-BY/CC-BY-NC/CC-BY-NC-ND Creative Commons License.
Self-Archiving Definitions and Policies: Note that the journal's standard copyright agreement allows for self-archiving of different versions of the article under specific conditions.

***BPS members and open access:*** if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

## 7. PUBLICATION PROCESS AFTER ACCEPTANCE

### Accepted Article Received in Production

When an accepted article is received by Wiley's production team, the corresponding author will receive an email asking them to login or register with Wiley Author Services. The author will be asked to sign a publication license at this point.

### Proofs

Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

Please note that the author is responsible for all statements made in their work, including changes made during the editorial process – authors should check proofs carefully. Note that proofs should be returned within 48 hours from receipt of first proof.

### Early View

The journal offers rapid publication via Wiley's Early View service. Early View (Online Version of Record) articles are published on Wiley Online Library before inclusion in an issue. Before we can publish an article, we require a signed license (authors should login or register with Wiley Author Services). Once the article is published on Early View, no further changes to the article are possible. The Early View article is fully citable and carries an online publication date and DOI for citations.

## 8. POST PUBLICATION

### Access and Sharing

When the article is published online:

- The author receives an email alert (if requested).
- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receive a publication alert and free online access to the article.

**Promoting the Article**

To find out how to best promote an article, click here.

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

### Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with Kudos and Altmetric.

## 9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (bjc@wiley.com) or phone +44 (0) 116 252 9504.

# Appendix B

## HRA Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Hannah Carroll
Trainee Clinical Psychologist
Cambridge and Peterborough NHS Foundation Trust
Department of Clinical Psychology
University of East Anglia
Norwich Research Park, Norwich
NR4 7TJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

18 August 2023

Dear Miss Hannah Carroll

**HRA and Health and Care Research Wales (HCRW) Approval Letter**

| | |
|---|---|
| **Study title:** | **Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service: A Thematic Analysis** |
| **IRAS project ID:** | **323554** |
| **REC reference:** | **23/EM/0158** |
| **Sponsor** | **University of East Anglia** |

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

**How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?**
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

**How should I work with participating non-NHS organisations?**
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

**What are my notification responsibilities during the study?**

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

**Who should I contact for further information?**
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **323554**. Please quote this on all correspondence.

Yours sincerely,
Abitha Paimpillichalil
Approvals Specialist
Email: approvals@hra.nhs.uk
*Copy to:* *Ms Sarah Ruthven*

## Appendix C

## REC Approval Letter

NHS
Health Research Authority

**East Midlands - Leicester Central Research Ethics Committee**
2 Redman Place
Stratford
London
E20 1JQ

**Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval**

17 August 2023

Miss Hannah Carroll
Trainee Clinical Psychologist
Cambridge and Peterborough NHS Foundation Trust
Department of Clinical Psychology
University of East Anglia
Norwich Research Park, Norwich
NR4 7TJ

Dear Miss Carroll

| | |
|---|---|
| **Study title:** | **Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service: A Thematic Analysis** |
| **REC reference:** | **23/EM/0158** |
| **IRAS project ID:** | **323554** |

Thank you for your letter of 15 August 2023 , responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation

as revised, subject to the conditions specified below.

**Good practice principles and responsibilities**

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

**Conditions of the favourable opinion**

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device

- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit:
https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

**N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months**.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:
https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**After ethical review: Reporting requirements**

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study

- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

**Ethical review of research sites**

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

| *Document* | *Version* | *Date* |
|---|---|---|
| Copies of materials calling attention of potential participants to the research [Leaflet] | 1 | 15 August 2023 |
| Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Indemnity ] | 1 | 01 June 2023 |
| Interview schedules or topic guides for participants [Topic guide] | 001 | |
| IRAS Application Form [IRAS_Form_06062023] | | 06 June 2023 |
| Letter from sponsor [Cover Letter ] | 1 | 01 June 2023 |
| Letters of invitation to participant [Consent to Contact Form ] | 1 | |
| Other [Debrief Sheet Tracked Changes] | 2.00 | 21 July 2023 |
| Other [Debrief Sheet Clean] | 2.00 | 21 July 2023 |
| Participant consent form [Consent Form Tracked Changes] | 3.00 | 21 July 2023 |
| Participant consent form [Consent Form Clean] | 3.00 | 21 July 2023 |
| Participant information sheet (PIS) [Participant Information Sheet Tracked Changes] | 3.00 | 21 July 2023 |
| Participant information sheet (PIS) [Participant Information Sheet Clean] | 3.00 | 21 July 2023 |
| Research protocol or project proposal [Thesis Proposal Tracked changes] | 3 | 15 August 2023 |
| Research protocol or project proposal [Thesis Proposal Clean] | 3 | 15 August 2023 |
| Response to Request for Further Information [Response to PO] | | 15 August 2023 |
| Summary CV for Chief Investigator (CI) [Chief Investigator CV. Hannah Carroll.] | | 27 April 2023 |

| | | |
|---|---|---|
| Summary CV for student [Student CV. Hannah Carroll] | | 27 April 2023 |
| Summary CV for supervisor (student research) [Research Supervisor CV. Imogen Rushworth] | | 10 February 2022 |
| Summary CV for supervisor (student research) [Research Supervisor CV. Sheryl Parke] | | 24 October 2022 |
| Summary CV for supervisor (student research) [Research Supervisor CV. Lauren Grainger] | | 08 November 2022 |
| Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Sponsor Liability Letter] | 1 | 01 June 2023 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**User Feedback**

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

**HRA Learning**

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

**IRAS project ID: 323554 Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

PP
**Mr Richard Winning**
**Chair**

Email:leicestercentral.rec@hra.nhs.uk

*Enclosures:* "After ethical review – guidance for researchers" *[SL-AR2]*

## Appendix D

## Reference List of Included Publications


Church, D., & Brooks, A. J. (2010). The effect of a brief emotional freedom techniques self-intervention on anxiety, depression, pain, and cravings in health care workers. *Integrative Medicine: A Clinician's Journal, 9*(5), 40-43. https://eds.p.ebscohost.com/eds/pdfviewer/pdfviewer?vid=0&sid=96a2ae1c-4cff-4781-84c4-b690b5e37f14%40redis

Dincer, B., & Inangil, D. (2021). The effect of emotional freedom techniques on nurses' stress, anxiety, and burnout levels during the COVID-19 pandemic: A randomized controlled trial. *Explore, 17*(2), 109-114. https://doi.org/10.1016/j.explore.2020.11.012

Dincer, B., Özçelik, S. K., Özer, Z., & Bahçecik, N. (2022). Breathing therapy and emotional freedom techniques on public speaking anxiety in Turkish nursing students: A randomized controlled study. *Explore, 18*(2), 226-233. https://doi.org/10.1016/j.explore.2020.11.006

İnangil, D., Irmak Vural, P., Doğan, S., & Körpe, G. (2020). Effectiveness of Music Therapy and Emotional Freedom Technique on Test Anxiety in Turkish Nursing Students: A Randomised Controlled Trial. *European Journal of Integrative Medicine, 33.* https://doi.org/doi:10.1016/j.eujim.2019.101041

Okut, G., Alpar, Ş. E., & Dönmez, E. (2022). The effect of the emotional freedom technique on coronavirus disease 2019 (COVID-19) fear and anxiety levels of nurses working in the emergency department: A randomized controlled study. *Journal of Psychiatric Nursing, 13*(4), 269-278. https://doi.org/doi:10.14744/phd.2022.60948

Patterson, S. L. (2016). The effect of emotional freedom technique on stress and anxiety in nursing students: A pilot study. *Nurse Education Today, 40,* 104-110. https://doi.org/doi:10.1016/j.nedt.2016.02.003

Vural, P. I., Körpe, G., & Inangil, D. (2019). Emotional freedom techniques (EFT) to reduce exam anxiety in Turkish nursing students. *European Journal of Integrative Medicine, 32*, 101002. https://doi.org/doi:10.1016/j.eujim.2019.101002

Wati, N. L., Sansuwito, T. B., Sirait, H. S., Pusporini, L. S., Ruswadi, I., Rahayu, S. M., & Darmawati, I. (2021). The Effect of Emotional Freedom Technique to the Public Speaking Anxiety (PSA) among Nursing Students. *Malaysian Journal of Medicine and Health Sciences, 17,* 86-89. https://medic.upm.edu.my/upload/dokumen/2022010116590715)_2021_0688.pdf

## Appendix E

## Quality Ratings for Included Publications

### Effective Public Healthcare Panacea Project, 2022

| | Component Ratings (1 = strong, 2 = moderate, 3 = weak) | | | | | | |
|---|---|---|---|---|---|---|---|
| Study | A) Selection bias | B) Study design | C) Confounders | D) Blinding | E) Data collection methods | F) Withdrawals and dropouts | Global Rating |
| Church & Brooks (2010) | 2 | 2 | 3 | 3 | 2 | 3 | Weak |
| Dincer & Inangil (2021) | 2 | 1 | 1 | 2 | 1 | 1 | Strong |
| Dincer et al. (2022) | 2 | 1 | 1 | 3 | 1 | 1 | Moderate |
| Inangil et al. (2020) | 2 | 1 | 1 | 2 | 1 | 1 | Strong |
| Vural et al. (2019) | 2 | 2 | 3 | 3 | 1 | 1 | Weak |
| Okut et al. (2022) | 2 | 1 | 1 | 3 | 1 | 1 | Moderate |
| Patterson (2016) | 2 | 2 | 1 | 3 | 1 | 1 | Moderate |
| Wati et al. (2021) | 2 | 2 | 1 | 3 | 1 | 2 | Moderate |

# Appendix F

## PRISMA Checklist

| Section and Topic | Item # | Checklist item | Reported on page # |
|---|---|---|---|
| **TITLE** | | | |
| Title | 1 | Identify the report as a systematic review. | 15 |
| **ABSTRACT** | | | |
| Abstract | 2 | See the PRISMA 2020 for Abstracts checklist. | 16 |
| **INTRODUCTION** | | | |
| Rationale | 3 | Describe the rationale for the review in the context of existing knowledge. | 19 |
| Objectives | 4 | Provide an explicit statement of the objective(s) or question(s) the review addresses. | 20 |
| **METHODS** | | | |
| Eligibility criteria | 5 | Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses. | 21 |
| Information sources | 6 | Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted. | 21 |
| Search strategy | 7 | Present the full search strategies for all databases, registers and websites, including any filters and limits used. | 22 |
| Selection process | 8 | Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process. | 23 |
| Data collection process | 9 | Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process. | 24 |
| Data items | 10a | List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect. | 27 |
| | 10b | List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information. | 27 |
| Study risk of bias assessment | 11 | Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process. | 24 |
| Effect measures | 12 | Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results. | 27 |
| Synthesis methods | 13a | Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)). | 23 |

| Section and Topic | Item # | Checklist item | Reported on page # |
|---|---|---|---|
| | 13b | Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions. | |
| | 13c | Describe any methods used to tabulate or visually display results of individual studies and syntheses. | 27 |
| | 13d | Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used. | |
| | 13e | Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression). | |
| | 13f | Describe any sensitivity analyses conducted to assess robustness of the synthesized results. | |
| Reporting bias assessment | 14 | Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases). | |
| Certainty assessment | 15 | Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome. | |
| **RESULTS** | | | |
| Study selection | 16a | Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram. | 23 |
| | 16b | Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded. | 23 |
| Study characteristics | 17 | Cite each included study and present its characteristics. | 26 |
| Risk of bias in studies | 18 | Present assessments of risk of bias for each included study. | |
| Results of individual studies | 19 | For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots. | 26 |
| Results of syntheses | 20a | For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies. | 26 |
| | 20b | Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect. | |
| | 20c | Present results of all investigations of possible causes of heterogeneity among study results. | |
| | 20d | Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results. | |
| Reporting biases | 21 | Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed. | |
| Certainty of evidence | 22 | Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed. | |
| **DISCUSSION** | | | |
| Discussion | 23a | Provide a general interpretation of the results in the context of other evidence. | 36 |
| | 23b | Discuss any limitations of the evidence included in the review. | 39 |
| | 23c | Discuss any limitations of the review processes used. | 39 |
| | 23d | Discuss implications of the results for practice, policy, and future research. | 39 |

| Section and Topic | Item # | Checklist item | Reported on page # |
|---|---|---|---|
| **OTHER INFORMATION** | | | |
| Registration and protocol | 24a | Provide registration information for the review, including register name and registration number, or state that the review was not registered. | 21 |
| | 24b | Indicate where the review protocol can be accessed, or state that a protocol was not prepared. | 21 |
| | 24c | Describe and explain any amendments to information provided at registration or in the protocol. | |
| Support | 25 | Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review. | |
| Competing interests | 26 | Declare any competing interests of review authors. | |
| Availability of data, code and other materials | 27 | Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review. | |

*From:* Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

## Appendix G

## Qualitative Interview Topic Guide

# Topic Guide

**Study Title:** Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service: A Thematic Analysis

**Name of Researcher:** Hannah Carroll

**Questions and possible follow-up questions:**

1) As someone who works in healthcare, delivering support to others, what is it like to receive support?
    a. Did you feel deserving of support?
    b. Were you reluctant to access support? If so, why?
    c. What was it like to receive support from your Trust?
    d. Would it have felt different to receive help from another source, for example a private company, as opposed to your Trust's support service?
2) Did you experience any barriers to accessing this support? What would have stopped you from seeking support?
    a. Internal or external barriers?
    b. Worries about confidentiality, storing information?
    c. Worries about receiving support from other NHS professionals, NHS colleagues of yours?
3) What prompted you to seek help within the NHS specifically?
    a. What enabled you to take this step?
    b. Were there any particular things that made it easier?
    c. Are there any things that would have helped you more?
4) When you heard about the staff support service, what were your initial thoughts about the service?
5) What were your expectations for the therapy?

    a. What preconceptions did you have?
    b. Did you have any fears?
    c. Was it different from what you expected?
6) Do you think it is important for NHS services to provide mental health support for their staff?
    a. Why?
    b. What is it about being a healthcare worker specifically that calls for mental health support?
    c. Why do you think the government fund this over support for staff for their physical health?

7) Why did you choose to seek support from your staff support service rather than through other NHS channels, such as IAPT (Well Being services) or your GP?
    a. What was it that was helpful about your sessions? (a listening ear or specialist psychological work e.g., trauma work).
    b. What was less helpful?
8) Did the support received impact your work life?
    a. Did it help at all? Did it make any difference? In what way?
    b. Would you seek support from the SSS again?
    c. Would you recommend it to other colleagues?

**Appendix H**

**Patient Information Sheet**


## PARTICIPANT INFORMATION SHEET

# Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service:

# A Thematic Analysis

We are carrying out this study to find out more about the experiences of NHS staff who have received therapy support from NHS Staff Support Services.

You are contributing to this research as an employee of the NHS that has received support through the NHS Staff Support Service at your work place. We would like to undertake an interview with you about your experience of receiving this support.

Your participation is entirely voluntary.

### What is the purpose of this study?

The Covid-19 pandemic was a challenging time for many healthcare workers. In response to this, many NHS Trusts have set up services that provide support to their staff, such as talking therapy interventions. This study will look at the experiences of NHS staff who received support from NHS Staff Support Services.

### Who is taking part in these interviews?

We are inviting NHS staff members who have received support from NHS Staff Support Services. We are looking for staff who have *finished* their intervention with the

Staff Support Service. The research is looking for different staff groups and professionals to conduct these interviews with.

**What will the interview involve?**

We would like to interview you individually to discuss your experience as a health professional of receiving support through an NHS staff support service.

You will not be asked to disclose details of the content of your therapy sessions. The interview questions will be focused around your general experience of accessing support.

You have the option of doing this interview in person or virtually, via Microsoft Teams. Your interview will be audio recorded for analysis purposes. Both interviews that take place in person and virtually will be transcribed live during the interview using the transcription function on Microsoft Teams. The transcription will be checked for accuracy by the lead researcher following the interview. All recordings and transcriptions will be stored securely.

Should you choose to have your interview in person, this will take place on NHS premises.

The interview will last approximately 1 hour although it may be a little shorter or longer depending on how much we have to discuss. We will allow a time-frame of an hour and a half so that there is time to go through the Consent Form before the interview and time to debrief after the interview.

If you have expressed interest in taking part in this study by contacting the research team, the lead researcher will contact you by telephone to discuss any questions you might have and give you more details about the procedure of the study. If you decide to take part, we will arrange a time for your interview. Before the interview begins you will be asked to sign a Consent Form to say that you are happy to take part and that you have had the study explained fully to you. You will be given a copy of the Consent Form prior to the interview to look at but this will be completed with the interviewer at the beginning of the interview.

After the interview, the interviewer will check whether you are okay and will offer you a debrief. You will have the opportunity to ask questions, and you will be offered a £10 Amazon voucher to thank you for your time.

**Who are the researchers?**

The study is being conducted by Hannah Carroll, Postgraduate Researcher on the Doctorate in Clinical Psychology Programme at Norwich Medical School, University of East Anglia (UEA). The primary research supervisor is Dr Imogen Rushworth, and the secondary supervisors are Dr Sheryl Parke and Dr Lauren Grainger.
The study is sponsored by UEA.

**Who is conducting these interviews?**

The interviews will be conducted by Hannah Carroll, the lead researcher.

**What are the possible disadvantages of taking part?**

It can be challenging talking to someone new, and some of the interview questions may bring up feelings that may cause you to feel a mixture of emotions. If you feel upset or need a break, please let the researcher know who will offer you a break. The interview can be resumed after a break or can be stopped and re-arranged to be completed another day.

If you would like support, we advise you to get in touch with your Staff Support Service or your Occupational Health team within the Trust. Alternatively, you may prefer to talk to your GP or you can contact the following services:

- Samaritans – 24/7 confidential emotional support. Tel: 116 123
- First Response– 24/7 helpline offering immediate advice and support for people with mental health difficulties. Tel: 111 option 2
- Your local Wellbeing Service – you can find your local service via this link https://www.nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service

**What are the possible benefits of taking part?**

This study could highlight the importance of staff wellbeing and staff support services, which may have a positive impact on the funding of these services. This study may also enable further studies to explore how staff support services could be improved. You will also receive a £10 Amazon gift voucher for your participation. This will be sent to you via email following the interview.

**Do I have to take part?**

No, you do not have to participate. Participation is completely voluntary and it is up to you to decide. If you want to take part you will be asked to sign a Consent Form, a copy of which you will keep, along with this Participant Information Sheet.

You are free to withdraw from the study should you decide. You will have two weeks from the date of your interview to request that your data is removed from the study.

After this point it will not be possible to remove your data as it may already have been anonymised. This means it will not be possible to identify a specific transcript. You do not have to give us a reason if you choose to withdraw.

If you don't want to take part in the study or decide to withdraw from the study you will not be treated any differently by any NHS service.

**How do I request that my data is removed from the study?**

Within the timeframe of two weeks post-interview, you can contact the lead researcher via email to request that your interview is removed from the study.

Hannah Carroll Email: hannah.carroll@uea.ac.uk

**How will my data be kept confidential?**

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number or pseudonym instead. Any identifiable information will only be accessed by the research team and will be removed when the interview is being transcribed. The audio recording of your interview will be deleted once the transcription process has been completed. Only non-identifiable information will be recorded. Data will be stored securely according to relevant regulations and UEA policy. Specifically, it will be saved on password-protected documents within password protected systems. Only members of the research team will have access to these.

Information that is collected as part of the study will only be analysed by members of the research team. We will write our reports in a way that no-one can work out that you took part in the study. The results we obtain may be published in order to inform how other NHS staff support services are set up across the UK. The results may include quotes from your comments during the interview – however, you or your employer will not be named and you will not be identifiable in these publications, i.e. we will not publish your name, where you live, or any other information that might identify you.

If, during the research interview, you tell the researcher something which makes them concerned that you or someone else may be at risk of harm, it is possible that this information may have to be shared with your GP or other agencies. The researcher will endeavour to tell you before this happens and, whenever possible, the situation will be discussed openly with you so that you understand why it was necessary to break confidentiality. On rare occasions it is necessary to break confidentiality without letting a participant know, but this is only done if telling you first would jeopardise your safety or the safety of someone else.

**How will my information be used?**

We will need to use information from you for this research project. This information will include:

- Your name and contact details so that you can be contacted throughout the study. This information will be deleted following the completion of the study and will not be shared with any person who is not a member of the research team.
- Your transcribed interview.

The results of the study will be written up for a doctoral thesis and may be published in an academic journal. The researchers will make sure any publications about the study will be written in a way that no-one can work out that you took part in the study.

If you would like, it will be possible for you to be sent a copy of the results of the study once it has been completed. You can indicate whether or not you would like to receive a copy of the results on your Consent Form.

**What are my choices about how my information is used?**

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

**Where can I find out more about how my information is used?**

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- from the leaflet available from www.hra.nhs.uk/patientdataandresearch
- by sending an email to one of the research team (details provided on the last page of this document).
- by contacting the sponsor for this research, the University of East Anglia (UEA). The contact details for the Data Protection Officer from UEA are: David Bridge: dataprotection@uea.ac.uk

**Approvals**

The study has been checked at several stages during planning by UEA internal review panels and has full ethical approval from the Health Research Authority. This is a national organisation that ensures that all research done in health and social care is of good quality and protects the interests of the participants. This study has been reviewed and approved by this organisation. We have also been given permission by the NHS Trusts involved to conduct the research in their organisations.

**Who can I contact if I have a complaint?**

If you have any questions or concerns about the study, you can contact a member of the research team. If you would like to raise concerns or complaints to someone independent from the study, you can contact:

Professor Sian Coker
Postgraduate Director, UEA
Email: s.coker@uea.ac.uk

If you would like more information about the study, the main point of contact is:

Hannah Carroll
Lead Researcher
Email: hannah.carroll@uea.ac.uk

You can also contact the following members of the research team:

Imogen Rushworth
Research Supervisor
Email: I.Rushworth@uea.ac.uk

Sheryl Parke
Research Supervisor
Email: Sheryl.Parke@uea.ac.uk

Lauren Grainger
Research Supervisor
Email: Lauren.Grainger@qehkl.nhs.uk

***REMEMBER*:**

You do not have to take part in this study.

You can leave the study if you wish to within the stated timeframe.

**Thank you very much for reading this Information Sheet.**

**Appendix I**

**Consent Form**


# CONSENT FORM

## Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service: A Thematic Analysis

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet (version 5, dated 05/09/2023) for this study. I have had the opportunity to consider the information, ask questions and I have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw without giving any reason (within the 2-week timeframe post-interview), without my medical care or legal rights being affected. ☐

3. I consent to completing interviews relating to my involvement in this research study. ☐

4. I consent to my interview related to this research study being audio recorded. ☐

5. I understand that information discussed during the sessions will remain confidential unless there is concern regarding any risk to myself or others. The researcher will always aim to discuss this with the you first, but this may not always be possible. ☐

6. I understand that my data will be digitalised and saved on a secure server. This server will only be accessed by members of the research team. ☐

7. I understand that I have 2 weeks from the date of my interview to request that my data is removed from the study. I understand that after this point it will not be possible to withdraw from the study as the data will have been anonymised. ☐

8. I understand that the non-identifiable data collected for this research will be accessed by the research team, by collaborating researchers, and if required by regulatory authorities where it is relevant to my taking part in the research. I give permission for these individuals to have access to this data. ☐

9. I would like to be contacted once the study has been completed to be updated about the results. ☐

10. I understand that any personal information, including my contact details, will be saved securely and will only be accessible by the research team. ☐

11. I agree to take part in the above study. ☐

| Name of participant | Date | Signature |
|---|---|---|
| Name of researcher taking consent | Date | Signature |

When completed: 1 for participant; 1 for researcher site file.
V.3. 21/07/2023
IRAS ID: 323554

**Appendix J**

**Debrief Sheet**

**Debriefing Information Sheet**

# Title of Project:

## Exploring NHS staff experiences of receiving post-pandemic therapy support from an NHS Staff Support Service: A Thematic Analysis

Thank you for your participation in this research. As a token of our appreciation for your time and involvement we would like to offer you a £10 Amazon voucher. We will send this you after your interview via email.

**Purpose of this research**

The Covid-19 pandemic was a challenging time for many healthcare workers. In response to this, many NHS Trusts set up services that provide support to their staff, such as talking therapy interventions. This study will look at the experiences of NHS staff who received support from NHS Staff Support Services.

This study could highlight the importance of staff wellbeing and staff support services, which may have a positive impact on the funding of these services. This study may also enable further studies to explore how staff support services could be improved.

**Confidentiality**

As stated on your Participant Information Sheet, your information will always be treated confidentially. Your data will be stored securely on a University of East Anglia One Drive, and your Consent Form will be stored in a separate folder.

The Lead Researcher will review your transcript for accuracy and as they do this, they will remove any personal information which may identify you.

As discussed, confidentiality will only be broken if we deem you, or someone else to be at risk. Where there is a potential risk identified, contact may be made with other agencies to ensure the safety of you and/or others. The researcher will always aim to discuss this with you first, but this may not always be possible.

## Further support

Should you feel like you need further support, please see below for organisations that can contact:

- Your GP
- Your Trust's Staff Support Service
- Your Trust's Occupational Health team
- Samaritans – 24/7 confidential emotional support: Tel: 116 123
- First Response– 24/7 helpline offering immediate advice and support for people with mental health difficulties. Tel: 111 option 2
- Your local Wellbeing Service – you can find your local service via this link https://www.nhs.uk/service-search/mental-health/find-an-nhs-talking-therapies-service

## Your right to withdraw

If you no longer wish for your interview to be used for this research, then you may email the lead researcher to let them know. You may withdraw from the study at any point prior to data analysis which will take place two weeks after your interview has taken place. After this point it will not be possible to remove your data as it may already have been anonymised. This means it will not be possible to identify a specific transcript. You do not have to give us a reason if you choose to withdraw.

## Contact information

If you have any questions or concerns regarding this research, you may raise them with the interviewer during your debrief.

If you wish to raise anything following the debrief then please feel free to contact someone from the research team.

Hannah Carroll
Lead Researcher
Email: hannah.carroll@uea.ac.uk

Imogen Rushworth
Research Supervisor
Email: I.Rushworth@uea.ac.uk

Lauren Grainger
Research Supervisor
Email: Lauren.Grainger@gehkl.nhs.uk

Sheryl Parke
Research Supervisor
Email: Sheryl.Parke@uea.ac.uk

**Making a complaint**

If you would like to raise concerns or complaints to someone independent from the study, you can contact:

Professor Sian Coker
Postgraduate Director, UEA
Email: s.coker@uea.ac.uk

**What happens now?**

The results of this research will be written into a full research report, which will be submitted to the UEA as part of a doctoral thesis for the Clinical Psychology Doctoral programme. It is the researchers' intentions to submit this report to a peer reviewed journal for publication. You will have indicated on your Consent Form whether or not you would like to be contacted with the results of the study.

## Thank you again for participating in this research.

## Appendix K

## Braun & Clarke's (2006) Six Phases of Thematic Analysis

| Phase | Description of the process |
|---|---|
| 1. Familiarizing yourself with your data: | Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas. |
| 2. Generating initial codes: | Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. |
| 3. Searching for themes: | Collating codes into potential themes, gathering all data relevant to each potential theme. |
| 4. Reviewing themes: | Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis. |
| 5. Defining and naming themes: | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme. |
| 6. Producing the report: | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. |