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The perceived helpfulness and acceptability of a bespoke psychological therapy service for registered nurses experiencing psychological distress: A qualitative study

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Abstract

Aim: To understand the perceived helpfulness and acceptability of a bespoke psychological therapy service for registered nurses. The service provided a free and confidential specialist mental health service to all healthcare professionals, including nurses and nursing students.

Design: An exploratory study using a descriptive qualitative approach.

Methods: A purposive sample of 20 registered nurses accessing a bespoke psychological therapy service in Wales participated in audio-recorded semi-structured interviews in January 2022. Transcribed data were analysed using reflexive thematic analysis.

Results: Four interrelated themes were identified from the data analysis: COVID [SARS-CoV-2] changed things; You're a nurse, you're human; I've got 'me' back; and pretty close to miracle workers.

Conclusion: Participants attempted to live up to an idealized image of a nurse, generating self-stigmatizing beliefs that negatively affected their mental health. The psychological therapy service enabled participants to put their roles into perspective, that is, separate themselves from their role, be vulnerable, and develop confidence and adaptive coping strategies. Participants valued the minimal barriers and ease of access to support.

Implications for the Profession and/or Patient Care: The complex relationship between nurse identity and the challenges of the workplace needs to be central to nurse education. Nurses can benefit from rapid access to a timely, confidential, and independent self-referring psychological therapy service.

Impact: This qualitative study explored the helpfulness and accessibility of psychological support for nurses. The main themes were that COVID changed things; You're a nurse, you're human; I've got 'me' back; and pretty close to miracle workers. The findings will impact how nurses are supported in the United Kingdom and worldwide.

Reporting Method: This report adheres to the standards for reporting qualitative research (SRQR).

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
mental health, nurse well-being, psychological distress, psychological support, qualitative descriptive study, stigma

1 | INTRODUCTION

It is widely acknowledged that the well-being of staff working in healthcare services was affected by the challenges of delivering care during the acute phase of the SARS-CoV-2 pandemic, that is, the onset in December 2019 to the transition from the initial emergency response phase in March 2022 (Welsh Government, 2022). The impact on healthcare service delivery and the psychological burden placed on healthcare personnel, especially nurses, remains an enduring legacy of the pandemic. Equally, concerns about nurse well-being predate the pandemic (DoH., 2009; The King's Fund, 2022) and are a global phenomenon (Woo et al., 2020). This is important because nurses, the largest professional group within health services, are fundamental to the safe and effective delivery of care. Therefore, support for well-being among the high proportion of nurses reporting workplace stress is essential due to the impact time off from work or leaving the profession could have on staffing levels and patient safety.

This descriptive qualitative study explores the perceived helpfulness and acceptability of a bespoke psychological therapy service for nurses experiencing psychological distress.

2 | BACKGROUND

Appropriate and adequate staffing levels are fundamental to delivering safe, high-quality healthcare (Campbell et al., 2013; Leary & Punshon, 2019). Poor staffing leads to higher workloads and is associated with increased work stress (Liu et al., 2018). Health personnel are at greater risk of work stress compared to other industries (Health & Safety Executive). A UK NHS survey reported a 62% prevalence of work stress in nurses (Gray et al., 2020). The SARS-CoV-2 pandemic has increased concerns about staff well-being and burnout (Bell & Wade; Galanis et al., 2021). A survey of the NHS Wales nursing workforce reported high levels of workplace stress during the SARS-CoV-2 pandemic and raised concerns about the number of nurses who had considered leaving the profession (Gray et al., 2022). A recent longitudinal interview study of the UK nurses ($n=27$) reported moral distress, burnout, and ideas about leaving nursing among most participants (Maben et al., 2022). This finding is important because demand for nursingstaff is increasing faster than supply (Health and Social Care Committee, 2022) leading to a higher workload but increasingly limited staffing.

This crisis in healthcare provision is a global phenomenon. A cross-sectional study of nurses in the United States reported an association between higher levels of burnout and intention to leave nursing (Christianson et al., 2022). In Australia, a longitudinal cohort study reported that poor well-being was associated with increased intention to leave, with psychological well-being a crucial factor for overall resilience (Jarden et al., 2022). We suggest a bi-directional relationship between increased rates of burnout and psychological distress leading to higher levels of staff attrition and poorly resourced services, increasing the likelihood of exposure to potentially morally distressing events (Watts et al., 2023).

The medical profession has long recognized the value of accessible and confidential specialist mental health services for doctors (Garelick, 2012; Rawnsley, 1979). A specialist service was created in London and southeast England in 1997 which was underpinned by psychodynamic therapy principles, and the therapy was delivered by consultant psychiatrists. The service has been evaluated in a series of studies. In a cross-sectional study of doctors accessing the service from 2002 to 2004 ($n=121$), ~63% reported above the threshold for a mental disorder, 66% reported emotional exhaustion, and 33% were above the threshold for burnout (Garelick et al., 2007). A follow-up study with the same cohort indicated a statistically significant reduction in those meeting the threshold for mental disorder or burnout (Meerten et al., 2011). A 10-year study of the same specialist service reported that self-referrals had quadrupled, but the prevalence of mental disorder or burnout remained constant (Meerten et al., 2014). This suggests service acceptability and feasibility, because a greater proportion of doctors opted to use the service. Finally, a longitudinal cohort study of a sub-group from the same population reported a statistically significant reduction in both overall psychological distress and absenteeism (Davies et al., 2016). Clearly, some medical professionals were willing to access confidential specialist service and that doing so may promote resilience. Apart from physicians, we have not been able to identify research about a similar specialist service for other health personnel.

In the United Kingdom (Wales), during SARS-CoV-2 pandemic, a free and confidential specialist mental health service for doctors was extended to all healthcare professionals, including nurses and nursing students (https://canopi.nhs.wales/). The service is easy to access and provides cognitive behavioural therapy (CBT) to nurses reporting psychological distress. CBT is a family of psychological therapies that focus on the relationship between cognitions,

emotions, physical sensations and behaviours (BABCP, 2021). CBT is an effective intervention for a wide range of mental and physical health concerns that can lead to an improvement in quality of life (Fordham et al., 2021). In occupational settings, CBT can lead to a reduction in duration of sick leave but not necessarily the return to full employment (Axén et al., 2020). In the United Kingdom, there are national guidelines for evidenced-based interventions; CBT is a recommended intervention in those guidelines across a wide range of conditions (NICE, 2023).

The aim of this descriptive qualitative study was to understand the perceived helpfulness and acceptability of access to a bespoke psychological therapy service for those nurses who accessed it. This is important because of the high proportion of nurses reporting workplace stress and the impact this could have on staffing levels, staff retention and patient safety both in the United Kingdom and globally.

3 | THE STUDY

The aim of this descriptive qualitative study was to explore and better understand the perceived helpfulness and acceptability of a bespoke psychological therapy service for registered nurses.

4 | METHODS

4.1 | Design

An exploratory, qualitative descriptive approach was adopted. Descriptive qualitative research is a flexible and pragmatic approach to answering research questions that lend themselves to qualitative research designs (Doyle et al., 2020). The reporting of this study was guided by the standards for reporting qualitative research (SRQR) (O'Brien et al., 2014).

4.2 | Theoretical framework

This study focuses on support systems for nurses' experiencing work-related distress, including exposure to potentially morally distressing events. Cartwright and Cooper (2014) argue that work should provide the context for people to flourish and to achieve well-being. Thus, the theoretical framework that underpins this study is the Job Demands-Control Support model of work stress (Driscoll et al., 2009). Support is viewed as a moderator of strain, so lack of support increases work stress and provision of support reduces stress. The bespoke psychological therapy service in this study represents a support strategy, at the individual level, to reduce distress resulting from the high demand and low control experienced by nurses during the SARS-CoV-2 pandemic and beyond.

TABLE 1 Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
• Adults ≥18 years of age • Registered nurses (all fields of practice) or nursing students (all fields of practice) • Working in any clinical setting in NHS Wales during the COVID-19 pandemic • Self-referred to the service for COVID-19-related distress	• Registered nurses employed in the private sector during the COVID-19 pandemic • Registered nurses (all fields of practice) or nursing students (all fields of practice) who are accessing the service for reasons other than distress associated with COVID-19 pandemic • High risk of harm to self or others identified, as assessed by the Services' Doctor advisor

4.3 | Study setting and recruitment

A purposive sampling strategy was used to recruit registered nurses from across Wales, UK, who had accessed the service for psychological distress related to the SARS-CoV-2 pandemic and were willing to share their experiences of accessing support and the impact of the support received on their personal and professional lives. Access was granted by the Service's director, and potential participants' suitability for inclusion was assessed by the Service's doctor advisors. Eligible individuals' interest in participating was established by the service, which also provided these individuals with a study information pack comprised a letter of invitation, participant information sheet and an expression of interest researcher contact form. The research team was blinded to which individuals were provided with the study information pack. The expression of interest researcher contact form enabled potential participants to respond directly to the project researcher by either telephone or email. The project researcher responded to individuals directly by their preferred method of communication (i.e. either by email or by telephone) to answer any further questions.

4.4 | Inclusion and exclusion criteria

Inclusion and exclusion criteria are presented in Table 1.

4.5 | Data collection

With participants' consent, and in view of the SARS-CoV-2 pandemic physical distancing requirements, in-depth, individual, semi-structured interviews were conducted by a trained and experienced qualitative researcher (BJ) by telephone or secure video conferencing software (only the audio of video interviews were recorded in order to protect

participant anonymity), according to participant preference. Semi-structured interviews were selected as they allow core topics to be raised for discussion, while also allowing flexibility by leaving space and scope for the identification and exploration of unanticipated issues that may emerge (Burgess, 1982; Kvale and Brinkman, 2015; Mason, 2002). A loosely structured interview guide, based on core topics derived from literature review findings, professional experience and the overall study aim, was devised. This guide incorporated prompts to elicit further responses, enrich descriptions, illuminate experiences and enable clarifications to be sought where necessary (See Data S1). All interviews were conducted in January 2022 and on average lasted for approximately 1 h.

4.6 | Data management and analysis

The interviews were transcribed verbatim into Word© documents by a professional transcribing service. Identifying features were removed and transcripts anonymized. Transcript accuracy was checked against digital audio recordings prior to analysis. Data were analysed using inductive, reflexive thematic analysis (Braun & Clarke, 2006, 2019), guided by the research aim and led by BJ. This theoretically flexible, six-step analytic approach (Table 2) was chosen as it enhances transparency and detail of the analysis and ensures that key patterns and areas of participants' experiences are captured, relative to the study aim.

To familiarize themselves with the data and search for repeated patterns of meaning, one researcher (BJ) repeatedly read the interview transcripts in advance of the coding process. Initial codes were then systematically generated. DW coded a sample of the dataset and discussed potential themes with BJ. BJ scrutinized coded data across the dataset to search for and identify candidate themes in relation to the research question which united and evidenced shared meanings and had their own central organizing concepts. BJ then repeatedly reviewed the candidate themes in relation to both the coded data and the complete dataset and presented and discussed the findings with DW and TW. Finally, in advance of writing the final report, three overarching themes were defined and named.

TABLE 2 Thematic analysis – six-step approach.

Step	Process
1	Familiarization with the dataset
2	Generating initial codes
3	Searching for themes
4	Reviewing themes
5	Defining and naming themes
6	Producing the findings

Note: Adapted from Braun and Clarke (2006).

4.7 | Ethical considerations

The study was conducted in accordance with the UK Policy for Health and Social Care Research (HRA 2020b). Ethical approval was granted by the School of Healthcare Sciences Research Ethics Committee at Cardiff University (REC837). All participants provided written, informed consent prior to commencing the interview and were assured that they could withdraw from the study at any time. None ended their participation or withdrew from the study. Given that participating in the interviews could generate emotion, to verbally reaffirm consent each participant's willingness to continue with the interview was checked at regular intervals. This was done by using phrases such as 'Would it be okay if I asked about …'. When the interview ended, all participants were given the opportunity to talk to the researcher about the interview and were invited to disclose any sensitive issues that have arisen and to signpost participants to local support services if needed.

4.8 | Rigour and reflexivity

Techniques to achieve credibility, transferability, dependability and conformability enhance the study's trustworthiness (Lincoln & Guba, 1985). Meticulous interview transcription and checks, together with rigorous data analysis by two researchers, contribute to credibility and confirmability. Detailed descriptions of experiences aid transferability. An audit trail of methodological decisions enabled the research team to check their research procedures and therefore ensures the dependability of the research (Clark et al., 2021).

The researcher inevitably has an impact on, and is impacted by, the research. For this study, one researcher (BJ) carried out recruitment and data collection and two researchers (BJ DW) were involved in data analysis. In terms of positionality and its impact, both are white academics, one female and one male. Both have academic backgrounds in higher education: one in mental health nursing and one in health psychology. Both are experienced qualitative researchers.

5 | FINDINGS

5.1 | Characteristics of participants

Twenty-five individuals expressed an interest and 18 female, and 2 male nurses participated. Participants were either General Nurses ($n = 15$), namely nurses who are specifically prepared and registered with the United Kingdom's Nursing and Midwifery Council to care for adults, or Mental Health Nurses ($n = 5$). Participants had an average number of 14-year (range 2–30 years) experience. The majority were continuing to work in nursing, or on sick leave and intending to continue nursing in the future. However, two participants had left the profession since accessing the intervention.

5.2 | Themes

Four interrelated themes were identified from the data analysis: *COVID changed things; You're a nurse, you're human; I've got 'me' back; and pretty close to miracle workers*. The direct quotes use pseudonyms to protect participant confidentiality.

5.2.1 | "COVID changed things"

Participants articulated that the SARS-CoV-2 pandemic caused numerous uncertainties and generated additional pressures around providing patient care. Participants described the experience of nursing during the pandemic as being substantially different from pre-pandemic. Rapidly changing work environments produced harrowing working conditions and profoundly impacted their experience of work:

> Our whole… work pattern changed the way we tried to deliver care, changed out of… well, you could… in your worst nightmare, you could not make up the conditions we were working in.
>
> (Jules)

Participants indicated that clinical guidelines and policies were constantly updated. They described how rapidly changing methods of management created a loss of control over their working environments:

> You'd go in one day and this certain way of doing it is correct and the best way of doing it. And then you'd go in the next day, and it was, 'Forget everything we said yesterday, this is how you do it today.'
>
> (Alex)

Infection control and policy changes also meant that participants could not meet their personal, fundamental needs:

> We got some screens, screened off a small area of the four-bedder, put a kettle in there so that we could make ourselves a drink. Infection control came along and told us to get rid of it.
>
> (Jules)

Patient care changed fundamentally due to the pandemic. Higher numbers of patients were seriously unwell with SARS-CoV-2, but there was limited research about effective treatments. This influenced nursing care, and participants reported that they were unable to provide the holistic care they desired because of patient load and administrative burden:

> It's really difficult. It's the acuity of the patients. It's the amount of patients, and it's what you see, and wearing all this PPE equipment and there's no rest, there's no let-up.
>
> (Kerry)

> We can't give the same level of care as we did before, you know, where you could sit with a patient.
>
> (Alex)

Consequently, the psychological suffering and moral distress that participants experienced were evident to see:

> You see people [i.e. nurses], they don't even look the same anymore, they're just so worn down and beaten up by all of this.
>
> (Kerry)

> When I think about moral distress, I don't always think about some of the bigger decisions we've made about services; I think about the little things.
>
> (Zoe)

The psychological distress experienced was debilitating. Yet workplaces offered no relief. Additionally, support external to their workplace was considered inadequate:

> There's so many like basic things like rest rooms, places to relax. Like we don't have that. We don't have space away from where we're working…Not even therapies, just reflections, supervision, that kind of thing… people don't get that protected time… "I've got great support from my colleagues, but there's been a few things further up the chain where I don't think I've felt supported".
>
> (Hannah)

5.2.2 | "You're a nurse, you're human"

Participants described stereotypical images of the 'perfect' nurse, including how this nurse should feel and behave:

> No, nurses don't get PTSD. Shush.
>
> (Alex)

> You go into work, and you're expected to be a leader in work, and you're expected to show that everything's going to be alright in Covid.
>
> (Zoe)

Participants indicated that accessing CBT allowed them to express their vulnerability, rather than attempting to present themselves in an idealized, stereotypical image of a nurse:

> [therapist asks] "Why do you not think that you can feel like this?' And I said, 'Because I'm a nurse'. And then [therapist] just said to me so bluntly, he said, 'You're not Superwoman. You're a nurse, you're human.'"
>
> (Alex)

Participants tried to live up to this image out of guilt of letting others down:

> The only reason I went for [intervention] at the time was because I felt so guilty that I wasn't in work.
>
> (Kerry)

This self-imposed pressure caused anticipatory anxiety about making errors, and participants had to suppress how they were actually feeling:

> The first thing I would do every morning when I came into work, other than have a panic attack in the car park, was check that everybody I'd spoken to the day before was still alive.
>
> (Zoe)

> I don't go round talking about my problems to everybody, you know. Stiff upper lip and all that.
>
> (Jules)

The stigma of not coping and self-imposed pressure to be available to others were often barriers to seeking help. Thus, space to openly share their feelings in a confidential, non-judgemental environment that was separate from the workplace was particularly helpful:

> There is still a lot of stigma around mental health. And I think especially when you work in health, … there's an expectation to not have an issue with your mental health, because you're supposed to be an advocate for good mental health…. [Therapist] was that little voice for me in a time when I just felt… you know, when you've been the person who's reassuring everybody else.
>
> (Max)

Help from a therapist allowed participants to challenge their self-stigmatizing beliefs and process their feelings about not living up to unrealistic expectations of their work, as well as giving themselves permission to recognize their difficult experiences:

> And I remember thinking, 'Oh, yeah. He's got a point'. You know, 'I'm allowed to be ill, as well'. 'I'm allowed to be struggling, as well'.
>
> (Sarah)

5.2.3 | "I've got 'me' back"

CBT made a positive difference in participants' ability to cope by being able to recognize how distressed they were before accessing support, and how CBT had an impact on their acceptance and arousal:

> My way of thinking has changed.
>
> (Jules)

> I'm certainly a lot calmer this year than I was last year, I'm a lot more, kind of more content.
>
> (Sam)

Some described a feeling of having reclaimed something of themselves they had lost:

> I've got me back.
>
> (Alex)

> A lot of people are saying, "We're seeing the old [you] back." And they stop, and they're like, "I don't mean…" And I'm like, "No, that's always been the plan. I wanted that fun loving person back."
>
> (Nancy)

Guilt was a common contributor to the need to seek help, and post-intervention many participants reported feeling less guilt and self-doubt:

> I've stopped feeling guilty about certain things as well… So, yeah, it has really helped, and my partner says I'm a lot happier, I laugh a lot more, smile a lot more.
>
> (Jessie)

This increased confidence and assertiveness was reflected in their working lives:

> I'm a lot more confident, like I'm a lot more stubborn now, as well, I've noticed. There's certain skills that I want to learn, I'm like, "I want to do those study days" and they're like [?] and I'm like, "No, I want to do my study days!"
>
> (Jessie)

For others, the support had a more substantial personal impact:

> It sounds very dramatic to say it's given me my life back, but it has.
>
> (Nancy)

5.2.4 | "Pretty close to miracle workers"

Participants held the service provision in very high regard. They valued the lack of barriers to accessing help. The triaging system and

prompt access to support meant participants did not have a long wait between self-referral and accessing CBT:

> I think that the sort of rapid turnaround is a massive bonus because, you know, if you're feeling that rough you want support then.
>
> (Morgan)

> I then had my first CBT appointment on the Monday. So, that was like amazing. It was really, really good. Like really quick at a time when I really needed it as well.
>
> (Hannah)

The self-referral process and triaging reduced barriers to accessing help. This compared favourably with the longer waiting times for NHS support or costly private therapy:

> I didn't need anybody to refer me, I could self-refer, so it was really good.
>
> (Kerry)

> The difference between [other services] and [intervention] is like running 100 metres or running a marathon.
>
> (Zoe)

Participants' positive perceptions of the service extended to recommending the intervention to colleagues that they saw struggling. When they suggested the service to others, they typically focussed on the timeliness and ease of access to support:

> So, I would definitely recommend staff and colleagues because I just think, sometimes it takes time to be seen by psychiatrists; to be referred for counselling; to be referred for psychology; it's going to take months and months for you to get that through our GPs, but with [intervention] you get it pretty quickly, you get help pretty quickly.
>
> (Frankie)

Participants were clear that access to the intervention should continue in the longer term for all staff in both health and social care:

> Yeah, I think that it's going to be really important that [intervention] stick around; because I think they're going to have an influx of calls, if they haven't already.
>
> (Sarah)

6 | DISCUSSION

6.1 | Strengths and limitations of the work

The strengths of this qualitative descriptive study are, first, the timing of the research and access to a focused group of people who lived the SARS-CoV-2 pandemic and who have not been sampled before; second, the rigour of the research with a multi-professional group of academics who were able to provide different perspectives. Finally, the uncomplicated links with the therapy service. The main limitations are, first, that we used remote rather than face-to-face interviews. While this may have affected the participants' responses, it also had the advantage of ease of access, and we did not observe any significant communication difficulties. We considered the sample size to be small but in alignment with qualitative research methodologies. With regard to the sample, potential participants were identified by the service doctors, which could lead to selection bias. As participants were talking about past experiences, in common with other qualitative studies, there was the potential for recall bias. Finally, while our inclusion criteria included student nurses, none were recruited into the study.

6.2 | Recommendations for further research

Future research should include a longitudinal cohort study that builds on our findings by examining the impact of a confidential and separate psychological well-being service on longer term workforce attrition, exploring the predictors of outcome success, barriers and facilitators across workplace settings. This should include an economic analysis of the costs and benefits of funding such a service to the individual, NHS and wider society. In addition, we only interviewed those people who experienced psychological distress and sought help. Further qualitative or mixed methods research should seek out those people who felt unable to access help, as understanding the barriers may help to improve the service delivery model further and promote access to help for those nurses in need. Finally, we uncovered a concerning, idealized model of nursing that has proven to be unhelpful for the individual and society. Further research should explore how nurses construct their workplace identity, and this has implications for nurse education that should include knowledge about the harmful effects of inappropriate models of challenging professional healthcare roles.

6.3 | Implications for policy and practice

With regard to the Job Demands-Control Support theoretical framework, we argued that support is a moderator of strain, that is, strain

results from increased demand and insufficient support. We have identified two areas for support, the first relates to self-stigmatizing beliefs which are negatively associated with help-seeking behaviours among health personnel (Clement et al., 2015). More specifically, health personnel are concerned about confidentiality and being judged negatively by their peers. They may also internalize a negative belief that they should be resilient in the face of adversity (Conolly et al., 2022). This is supported by our findings in that participants described an idealized identity of a 'super nurse'. This may have perpetuated self-stigmatizing beliefs about not living up to that ideal when exposed to potentially moral distressing events and experiencing psychological distress. A recent mixed methods systematic review highlighted how important it is to focus on retention and identified timely access to supportive care as one strategy to promote well-being and protect the workforce (Watts et al., 2023). Consistent with this finding, we consider that a compassionate, people-focused health service needs to provide access to a timely, confidential and independent self-referring psychological support to those in need.

The second area where we consider nurses could be better supported is about preparing them for clinical practice. A sanitized, homogenous and one-dimensional nursing identity does not adequately represent the reality of the nursing role (Bell, 2021). Nurse identity can also be stereotyped as a task-focused, gendered work role underpinned by a simplified societal expectation that nurses should be kind and caring (van der Cingel & Brouwer, 2021). Arguably, it is unhelpful to foster a simplified identity of nursing as a calling. Nurses have internalized an idealized image and, when it clashed with the SARS-CoV-2 pandemic role demands, this created unmanageable stress in some individuals. Nurses have to adapt to ever-changing policies and guidelines and the worry of not doing 'the right thing'. This can lead to the loss of human touch to care, 'the small things', contributing to moral distress (Cristancho et al., 2021). Our participants described a conflict between their perceived ideal work identity and the reality of the workplace. Nursing is complex, and nurses are required to adopt a range of 'identities' and competencies including being compassionate, critical thinking and knowledgeable (van der Cingel & Brouwer, 2021). This complexity needs to be central to nurse education in order to foster resilience.

7 | CONCLUSION

This study highlights the excessive workplace stress experienced by nurses during the SARS-CoV-2 pandemic. Excessive workplace stress poses considerable risk for mental well-being, and the potential impact on nurse staffing levels, patient safety and health outcomes is a major cause for concern. This study explored the experiences of nurses accessing a bespoke psychological therapy service. Findings indicated that participants were exposed to potentially morally distressing events caused by an unprecedented public health stressor. Participants, trying to live up to an idealized image of a nurse, generated self-stigmatizing beliefs which negatively affected their mental health. Accessing CBT created a space to put the role of a nurse in perspective, to be human, to be vulnerable, and to develop more confidence and adaptive coping strategies. Finally, participants valued the minimal barriers to care and ease of access. While not a solution to poor working conditions, we consider that healthcare providers have a duty of care to their nursing personnel affected by the work environment. Employers should ensure that nurses have rapid access to a timely, confidential and independent self-referring psychological therapy service. Finally, it is vital for individual well-being and to sustain the workforce that professionals, both peers and leaders, normalize seeking help and support when needed and encourage access to help for those in need. After all, a bespoke psychological service can only help those who feel able to access it.

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CONFLICT OF INTEREST STATEMENT

The therapy service is administered by the School of Medicine at Cardiff University. One author (DW) delivered therapy for that service in 2020/2021 but not for the purposes of this study. In addition, DW was not involved in recruitment or data collection.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16160.

DATA AVAILABILITY STATEMENT

Author elects to not share data.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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