# “We are shattered. We are separated”. Experiences of clinically vulnerable, racially minoritized women during the COVID-19 pandemic.

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## Thesis declaration form

I confirm that the work submitted in this thesis is my own. Where information has been obtained from other sources, I confirm that this has been specified in the thesis.

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# Overview

This thesis explores the experiences of clinically vulnerable, racially minoritized women during the ongoing Coronavirus disease (COVID-19) pandemic.

Part one is a Conceptual Introduction; the aim is to provide an overview of the current and emerging literature on the lived experiences of individuals during the COVID-19 pandemic and relevant research on the intersection of race, gender and health inequities.

Part two is an interpretative phenomenological analysis (IPA) exploring the impact and significance of participants' experiences during the COVID-19 pandemic, from a sample of clinically vulnerable, racially minoritized women. Seven women participated in individual semi-structured interviews, focusing on their experiences during the pandemic. Four superordinate themes emerged from their narratives: '*multifaceted accounts of loss', 'devastations and consequences to health', 'systemic threat through intersectional inequalities' and 'excluded and unprotected'*. Part two concludes with a discussion of each theme and the current literature. The discussion includes strengths, limitations and implications of the research, as well as suggestions for further research.

Part three is a Critical Appraisal focusing on reflections on positionality, power, intersectionality and double hermeneutics while conducting insider research.

# Impact Statement

This qualitative research aims to shed light on the experiences of women who identify as racially minoritized and clinically vulnerable during the COVID-19 pandemic. Through carrying out in-depth individual interviews, themes were identified related to participant's experiences over the pandemic, including loss, consequences to health, threat and mistrust towards systems and feelings of exclusion.

The findings have important implications for mental health practitioners and policymakers working to improve the mental health outcomes for individuals from health, race and gender-related minority backgrounds. Specifically, the research suggests that practitioners need to be aware of the mistreatment that can occur for those with multiple minority statuses, through the layering of multiple systems of inequality (Harnois, 2015), and provide culturally sensitive care that is responsive to the distinctive needs and experiences of specific marginalised groups. This may entail improving greater diversity and inclusion in the psychology and mental health field, as well as including training on issues impacting marginalised groups in services and professional training courses.

Moreover, this research emphasises the importance of portraying diverse voices and experiences in order to facilitate understandings of those who have previously been underrepresented in psychology research. Additionally, this research highlights the importance of developing validating and safe spaces for individuals marginalised by social categories, such as race and gender, to receive mental health care.

In summary, this research provides important insights on how the pandemic has impacted racially minoritized, clinically vulnerable women, and emphasises the need for continued actions to improve mental health outcomes and enhance equity and inclusion of marginalised groups.

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# Acknowledgements

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# Dedication

I want to express my sincere gratitude and appreciation to the seven individuals who participated in this research, without whom this research would not have been possible. This work is dedicated to you. Your willingness to contribute your time and experiences has been invaluable. Thank you for your contributions, I hope my representation of your experiences does them justice.

# Part 1: Conceptual Introduction

## Abstract

The following conceptual introduction (CI) provides an explanation and rationale of the key terminology used throughout the thesis, such as the use of the term ‘racialised minority’. Following this, the CI provides an overview of the COVID-19 pandemic and recent relevant literature exploring the varying social inequalities and inequities exacerbated during the pandemic. This is followed by a summary on intersectionality and literature on conducting ‘insider’ research.

## Terminology

### *Racially minoritized*

The researcher has chosen to use the terms ‘racialised’, ‘racially minoritized’ and ‘racial minority’ in place of terminology such as ‘people of colour,’ ‘non-white,’ and ‘Black and Asian minority ethnic’ (BAME). These collective terms have been criticised for crudely combining people from different geographical, social, and cultural backgrounds, thereby reinforcing perceptions of homogeneity and disregarding diversity between groups and can perpetuate the idea that white-identified people are the ‘default’ (Khunti et al., 2020). Additionally, ‘people of the global majority’ (POGM) was not used as it does not necessarily reflect experiences of coming from a minoritized ethnic background, within a highly diverse society, whereby Whiteness is centred (Remedios, 2022). Whiteness refers to how systems, such as political, educational and healthcare systems provide White-identified people with power and privilege (Remedios, 2022).

A review of the current literature on constructive language use in research on race and COVID-19 found ‘racially minoritized’ to be the preferred term (Milner & Jumbe, 2020). However, there is no problem-free terminology, due to the socially constructed nature of race and ethnicity (Suyemoto et al., 2020) and the changeability of terms across time and culture.

Discussion with the research supervisor and consultation with two clinical psychologists and experts by experience helped to solidify these decisions in relation to terminology.  Guidance on racial categorisation and terminology from Black British Academics supports the use of ‘racialised minorities’ outlining that it highlights the racialisation of people and the ‘discursive power of whiteness’ (Gabriel, 2023). It could be argued that this term still combines individuals from a wide range of racialised backgrounds. However, it differs from previous terms in that it recognises people as minoritized because they are "racialised," a socially constructed form of categorisation (Lala et al., 2020; Suyemoto et al., 2020), and it identifies people who may have shared experiences of racism and discrimination (Milner & Jumbe, 2020).

### ***Clinically vulnerable***

Some people are at greater risk of infection serious consequences including mortality from COVID-19 (Smith et al., 2020). In early 2020, the National Health Service (NHS) identified individuals with certain health conditions, such as cardiovascular disease, respiratory disorders, diabetes, and those who are immunocompromised, as being at ‘high risk’ of becoming seriously ill if they were to contract COVID-19 (NHS, 2022a). This was referred to ‘clinically extremely vulnerable’ (CEV) or ‘clinically vulnerable’ (CV) to COVID-19 (Pergolizzi et al., 2020). This research will utilise the use of CV to include those who identify as CEV and CV based on certain health conditions. According to guidance from the Department of Health and Social Care (DHSC), individuals were identified as vulnerable based on a pre-existing medical condition or the clinical opinion of their GP or other medical professional involved in their healthcare (DHSC, 2021).

It is important to acknowledge issues with the word ‘vulnerable.’ For example, the use of ‘vulnerability’ in Disability studies suggests connotations with the idea of ‘weakness’

(Brown, 2012). However, ‘CV’ has been utilised throughout the current study, based on its use by health organisations and governments (e.g., DHSC, 2021; NHS, 2022a).

In March 2020, CV individuals were advised to “shield” as part of a UK government-run programme. People identified as CV were supported by the government with essential food packages and advised to take extra precautions to reduce the risk of contracting the coronavirus. The government paused the shielding programme in April 2021, following the rollout of the COVID-19 vaccine, and in September 2021 the programme formally ended (DHSC, 2021). In a survey by the Office for National Statistics (ONS), published in May 2022, 13% of CV respondents reported they were continuing to shield, and 69% reported that they were taking ‘extra precautions’ despite the shielding programme ending (ONS, 2022a).

In June 2020, Public Health England (PHE) acknowledged that physical health conditions and diseases were not the only CV identifiers (PHE, 2020). In a PHE report published on the GOV.UK website, ‘BAME groups’ were acknowledged to be at increased risk of exposure to and complications from COVID-19. The disparities outlined can be explained by varying factors, including socioeconomic inequalities, racism, discrimination, stigma, and occupational risk (PHE, 2020).

In the recruitment materials for the current research, it was made explicit that potential participants who identified as CV to COVID-19 did not require confirmation by a medical professional. It could include those who had been formally confirmed as being CV, as well as those who considered themselves to be CV. This decision was discussed with the research supervisor as well as two clinical psychologists and experts by experience. The rationale for this was due in part to difficulties experienced by people receiving late acknowledgement of CV status; a situation experienced first-hand by the researcher. Additionally, discussions in consultations were had around the importance of acknowledging that people can be at various stages of their medical journeys and that, for some, the acquisition of confirmed medical diagnoses can be difficult.

Initially, the research concentrated on the experiences of disabled and racially minoritized women during the COVID-19 pandemic. However, the construct of “disability” is very broad, and there is a danger of conflating the needs and lived experiences of, for example, people with mental and physical health issues. The question of ‘what is meant by disability and what is the shared experience?’ formed the basis of discussion in supervision and consultation. Language use was discussed in consultation with two clinical psychologists and experts by experience, specifically when considering adding a criteria of identifying as “chronically ill”. It can also be unhelpful to cluster disabilities together. For the purpose of homogeneity, sensitivity to diversity within groups, and considering that not everyone who is disabled may identify as CV, the criteria were adapted. The aim of the research was unanimously agreed upon through discussion with the research supervisor and consultants: to capture understandings of the shared experience of COVID-19, from the narratives of individuals who identified as women, racially minoritized and CV to COVID-19. In this research, the participants were specifically those who identified as CV due to a health condition in addition to being from a racial minority group.

### *Women*

Through supervision with the research supervisor, it was decided that using the term ‘women’ in recruitment materials and the research was most appropriate. From a review of the literature, it is suggested that using this term signifies inclusion of marginalised women, such as racially minoritized and transgender women, as it removes ‘men’ from the term and acknowledges that previously, feminist movements have excluded minoritized women by failing to consider the distinct challenges faced by women with intersecting identities (Zimman, 2017). Some consider the term ‘women’ as exclusionary and rooted in patriarchy which also excludes marginalised women (Kunz, 2019). However, others have suggested that, although the intention might be inclusive, the use of terms other than ‘women’ can be exclusionary (Lopez, 2021). For example, “Womxn” has been criticised as a distinction that, when used, could imply trans women are not women (López, 2021). Therefore, it has been argued that using “womxn” can be seen as divisive rather than inclusive of trans and racially minoritized women (Karpinski, 2020). The term “women” was therefore used in this research as it was understood through consultation to be inclusive of all women.

As noted in the section on racial identity, it is important to acknowledge that terminology related to identities is fluid and shifting. There are no ideal terms and none of these terms hold a static meaning. These terms frequently change and evolve according to time, culture and shifting socio-political narratives and contexts (Howard, 2000).

## The COVID-19 pandemic

In December 2019, the World Health Organisation (WHO) was notified of cases of pneumonia of an unidentified aetiology. Later, the cause was identified as a novel coronavirus labelled COVID-19 (WHO, 2020a). The first cases were acknowledged in Wuhan, Hubei Province, China (Phelan et al., 2020), and the precise origin of the virus was and remains unverified (Huang et al., 2020). COVID-19 can be fatal and affects the lower respiratory tract, manifesting as pneumonia, with typical symptoms being a cough and dyspnoea (Pan et al., 2020). COVID-19 is a highly transmissible disease (Wang et al., 2020), and in March 2020, the WHO acknowledged COVID-19 to be a global pandemic (WHO, 2020b), impacting global health and presenting a threat to societies and healthcare systems worldwide (Pan et al., 2020).

The WHO (2020b) instructed governments on a strategy to reduce the impact of the virus, including guidance on detection and protection. In response to the outbreak, governmental actions included advising physical distancing, self-isolation, and implementing country-wide ‘lockdowns’ to contain and reduce the spread of the virus (Paterlini, 2020; Pedrosa et al., 2020). The UK Government announced measures for citizens to ‘stay at home’, with provisions being essential food shopping and walking in outdoor spaces for exercise. In 2020, there were gaps in knowledge concerning the pathophysiology, clinical features, and complications of COVID-19 (Khot & Nadkar, 2020). Initially, it was acknowledged that this highly transmissible disease placed older adults and people with certain pre-existing conditions at increased risk of contracting the virus and experiencing severe symptoms (Di Gessa & Price, 2021; Zhou et al., 2020) and fatality (Gansevoort & Hilbrands, 2020).

### ***Risk and vulnerability***

Regarding the term ‘clinically vulnerable’, as described in the terminology section, those initially identified as CEV and CV to the virus were advised to ‘shield’. Shielding involved remaining indoors and isolated from non-household members and was introduced to protect those who were considered most at risk of serious illness and mortality from the virus (DHSC, 2021). Shielding support was initially provided, including food parcels and governmental letters to confirm shielding status. This ended in September 2021, however, there are CV people who continue to take extra precautions to reduce the risk of contracting the virus to date (ONS, 2022a).

In an opinion piece from author and columnist Frances Ryan, those CV to COVID-19 were subjected to media and public portrayals that implied “only” those with pre-existing physical health conditions are vulnerable, and that vulnerable people, including disabled people, can be “written off” (Ryan, 2020), meaning they could be removed from consideration, or to imply non-disabled people need not worry about the risks of COVID-19. Currently, there is a lack of formal research into the narratives of people who are CV to COVID-19, which highlights a gap in the literature.

Prior to the development of vaccines, there were suggestions from government bodies on implementing ‘herd immunity’, which would cause catastrophic outcomes for many, including the elderly, disabled people, and people with severe health conditions, people who are homeless, and refugees (Frey, 2020). These populations are also likely to have lower socio-economic status due to the relationship between poverty and ill health (Frey, 2020; Ridley et al., 2019). In January 2022, the USA’s Centers for Disease Control and Prevention (CDC), on a segment for ABC News, remarked that the majority of those dying from COVID-19 were people with pre-existing medical conditions, which was “really encouraging” (as cited in The

Washington Post, Farhi, 2022). This sparked a social media hashtag created by disability rights and inclusion activist, Imani Barbarin; #MyDisabledLifeIsWorthy (Barbarin, 2022). Many people who identified as CV and/or disabled wrote about feeling that the CDC had implied they were ‘disposable’ (e.g., Norko, 2022). Some also shared experiences of coercion to sign ‘do not resuscitate’ (DNR) orders (e.g., among people with learning disabilities and/or diagnoses of Autism, see Taggart et al., 2022). Imposed DNRs are further evidence of the social inequalities and injustices faced by marginalised and vulnerable people and are an important human rights concern (Chen & McNamara, 2020). Chen and McNamara (2020) suggest that disabled people experienced increased anxiety as a result of narratives of scarce medical resources and the allocation of resources worldwide. In an article by The Atlantic, those who were deemed to have the ‘greatest chance of survival’ in Italy were prioritised for receiving intensive care treatment (Mounk, 2020). Raine et al. (2020) deemed this an inequitable allocation of and access to resources, which would not assist individuals in achieving their optimal level of health. Additionally, in a scoping review of 36 papers related to lockdown-related disparities impacting disabled people, Jesus et al. (2021) outline that many disabled people conveyed worries and fears of being vulnerable to COVID-19 and not receiving equitable healthcare due to disability stigma and ableism, such as assumptions about their quality of life.

### *Long COVID*

The patient-made term ‘long COVID' refers to a multi-symptomatic and disabling post-viral condition (Crook et al., 2021; Hereth et al., 2022; Perego et al., 2020). As of March 2023, 1.9 million people living in the UK self-reported long COVID (ONS, 2023). The prevalence of long COVID is reportedly greater in certain people and groups, including women, those aged 35-69 years, individuals living in impoverished areas, and people with pre-existing health conditions or disabilities (ONS, 2022b).

Following COVID-19 infection, long COVID can present as a range of persistent symptoms. Symptoms include pain, extreme fatigue, shortness of breath, neurocognitive issues, such as memory and concentration problems, and the development of new mental health issues (NHS, 2022b; Ziauddeen et al., 2022). Long COVID can affect people for several months or years (NHS, 2022b), and recent studies suggest sufferers of long COVID experience discrimination in addition to the disabling symptoms. The Long COVID Stigma Scale (LCSS) was developed to measure the impact of long COVID related stigma in the UK (Pantelic et al., 2022). The reliability of the LCSS was assessed using Cronbach's alpha coefficient, although the specific value was not reported. Additionally, concurrent criterion validity was established by examining the correlations between the LCSS and its subscales with measures of symptoms of depression and disclosure concerns. The survey results revealed a high prevalence of stigma among those suffering from long COVID, particularly those who expected and anticipated bias and mistreatment from others and internalised negative connotations of the infection. Additionally, in a survey of recovered COVID-19 patients in Japan, 43.3% of patients reported experiences of COVID-19-related stigma and discrimination, which included verbal harassment and being treated as if they were contagious after they were no longer infected (Sugiyama et al., 2022). Logie (2020) suggests that healthcare services should apply HIV-related stigma interventions to reduce COVID-19-related stigma. For example, discussing stigma, addressing misconceptions about the virus, and emphasising the importance of reducing such misconceptions can improve patient care and treatment adherence (Nyblade et al., 2009).

Psychology has often situated disability and chronic illness within the field of rehabilitation, with little critical engagement with Disability studies literature (Goodley & Lawthom, 2005). More widely, discrimination and avoidance due to negative attitudes towards disability have been widespread (Temple et al., 2019). Specific research shows that disabled people are underrepresented in the media (Goodley & Lawthom, 2005), face prevalent ableism in academia (Nishida, 2016), and face employment discrimination (Bjelland et al., 2010). Morris (2004) maintains that it is important to study the experiences of disabling attitudes and environments that directly impact the psychological well-being of disabled people.

Altiery et al. (2021) suggest applying the social model of disability to responses to long COVID. This model situates disability within the context of negative attitudes and exclusionary structures in society, rather than viewing the "problem" as being situated within the disabled person (see Unison NW & Thomas, 2014). It is important for responses to healthcare inequities that exacerbate the effects of chronic illness and disease to be recognised and mitigated (Altiery et al., 2021), and specifically for the severity and debilitating symptoms of long COVID to be highlighted (Perego et al., 2020). There are calls for further research into the experiences of people suffering with long COVID, highlighting the differing experiences of those from socially disadvantaged and diverse backgrounds (Pantelic et al., 2022).

### ***COVID-19 vaccination***

In December 2020, the DHSC announced approval of a COVID-19 vaccination programme in the UK. Initially, the Pfizer/BioNTech COVID-19 vaccine was authorised for use in the UK (DHSC, 2020). The vaccination programme commenced on 8 December 2020, prioritising those most vulnerable to COVID-19 including older adults, CEV people, healthcare workers, social care workers and care home staff and residents (Cook & Roberts, 2021).

The NHS suggest that COVID-19 vaccines are the "best way" to protect anyone who gets the virus from becoming seriously ill or developing long COVID (NHS, 2022c). Reported 'common' side effects from the vaccine, include a sore arm from the injection, fatigue, nausea and a headache (Menni et al., 2021). Reports of more serious side effects, such as blood clotting were linked to the AstraZeneca vaccine (Pai et al., 2021). This later led to European countries discontinuing the use of the AstraZeneca vaccine (Wise, 2021). Blood clotting or allergic reactions are currently recorded as ‘very rare’ severe side effects of the vaccine (NHS, 2022c). Presently, there are six COVID-19 vaccines permitted for use in the UK (NHS, 2022c).

Since the start of the vaccination programme in the UK, studies of vaccine uptake and opinion have contributed unique insights to the literature. For example, uptake of the vaccine was lower among pregnant women, women from ethnic minority backgrounds, women from low-income households, and women under 25 years (Davies et al., 2022). Some reasons for rejecting the vaccine were attributed to mistrust in the healthcare system and the safety of vaccines (Davies et al., 2022).

‘Vaccine hesitancy’, describes either a delay in accepting an available vaccine or refusal of vaccination (MacDonald, 2015), and is a well-researched topic (see Dubé et al., 2013; Jacobson et al., 2015; MacDonald, 2015). Further studies have been conducted recently to explore current vaccine hesitancy and COVID-19. Troiano and Nardi (2021) reviewed fifteen studies exploring vaccine hesitancy in the context of COVID-19. Some of the most common reasons reported included concerns about safety and efficiency of the vaccine, lack of trust in healthcare systems, and beliefs that COVID-19 was harmless, therefore a vaccine was not needed.

Davies et al. (2022) found an association between age, ethnicity and gender with vaccine uptake in a sample of over 200 pregnant people. Their findings suggest that younger individuals may perceive that they are at lower risk of COVID-19, which could account for lower vaccine uptake in young adults. They also found that vaccine hesitancy was higher among women of Black and mixed ethnicities. Similarly, Robertson et al. (2021) report that vaccine hesitancy was greater in Black and Pakistani/Bangladeshi ethnic groups. There are likely to be a wide variety of possible explanations for these findings, underpinned by historical and contemporary experiences of systemic racism, discrimination, and the underrepresentation of diverse individuals in health research and health care (Davies et al., 2022). Previous research has established that prominent reasons behind vaccine hesitancy in racially minoritised groups are embedded in historic, political and sociocultural influences (Dubé et al., 2013).  In a BBC News article, Heather Nelson, chief executive officer of the Black Health Initiative (BHI) charity, reported that Black communities were facing blame for low vaccine uptake (Schraer, 2021). This resulted in racially abusive telephone calls and emails to the charity (Schraer, 2021). In a report from the BHI, it is indicated that lower vaccine uptake is based on historic non-consensual, unethical experimentation on racial and ethnic minority groups which influences medical mistrust (Charura et al., 2022). For example, beliefs that the USA government created HIV as a genocide against racialised minorities are embedded in historical and contemporary negative systemic experiences, such as poverty, violence by police and the racial residential segregation targeting Black people (Bogart et al., 2021; Charura et al., 2022; Jaiswal et al., 2019). The BHI report also outlines examples of recent incidences of structural racism e.g., the mistreatment and deportation of the ‘Windrush generation’ in 2017 (see Wardle & Obermuller, 2019). Such examples speak to ongoing structural racism and oppression, which impact mistrust in systems, including healthcare, among racially minoritised communities (Jaiswal et al., 2019). The BHI also explored feeling undervalued and marginalised and whether ‘feelings of mattering’ influenced COVID-19 vaccine hesitancy, however, found that this was not associated with the likelihood of getting the vaccine (Charura et al., 2022).

Reports of low uptake of the vaccine among racially minoritised groups fuelled racist telephone calls and emails to the BHI (Schraer, 2021). Additionally, in a US study, Graso et al. (2022) found that unvaccinated people were more likely to be blamed and ‘scapegoated’ for overwhelming the healthcare system, risking public health, prolonging the pandemic and government measures to reduce the impact of the virus, e.g., face mask mandates. However, a survey of over four thousand people in the US found that Black, Asian and Latina/o individuals were more likely to report wearing a face mask compared to White people, with White men reporting the highest reluctance to mask wearing (Hearne & Niño, 2021).

Burki (2020) discusses the ‘online anti-vaccine movement’ in the context of COVID-19. A survey by the Center for Countering Digital Hate (CCDH) of over 1,600 people found that one in six Britons were unlikely to agree to having the COVID-19 vaccine (CCDH, 2020). The CCDH reported that those who “relied on social media for information on the pandemic” were more cautious about the COVID-19 vaccine (CCDH, 2020). The anti-vaccine movement was around long before COVID-19 and is a nuanced and complex topic. Hussain et al. (2018) discuss the rise of parents in Western countries declining to vaccinate their children due to various perceived fears, including fear of developing autism. Despite this, an association between autism and the MMR vaccine have been disproven (e.g., Farrington et al., 2001). Disability studies have described ableism in the notion of an anti-vaccine movement. For example, the fear that a vaccine would result in autism, positions this disability identity as denigrated (Cohen-Rottenberg, 2013; MacMillan, 2021). Ableism can be defined as prejudice, discrimination and oppression toward disabled people (Bogart & Dunn, 2019), and the disparagement of disability identities can also account for this.

As some countries began mandating COVID-19 vaccination for healthcare workers (Iacobucci, 2022), controversy over the UK government’s plan, announced in November 2021, to mandate vaccinations for NHS staff caused a change in policy, with removal of mandatory vaccinations in January 2022 (Iacobucci, 2022). In a press release, the UK government outlined its decision to alter its position on mandatory vaccination was based on a public consultation, which uncovered 90% of responders were against mandatory vaccination (DHSC, 2022).

Current data shows as of 30 January 2023, in the UK over 45 million people have received a first dose of the vaccine, over 42 million have received a second dose and 33 million have received a booster or third dose as reported by the UK Health Security Agency (2023).

In summary, vaccine hesitancy and uptake literature are highly nuanced and complex topics. Understanding the reasons behind hesitancy is important to understanding the impact of historical and contemporary racism (Davies et al., 2022), mistrust in healthcare systems (Jaiswal et al., 2021), as well as possible influences of ableism as found in the anti-vaccine movement (MacMillan, 2021).

## Psychological Impact of COVID-19

Holmes et al. (2020) call for prioritising research to support reducing mental health issues in vulnerable groups including those with physical health needs and pre-existing mental ill-health in the context of the current pandemic. Early in the pandemic, studies found that individuals with pre-existing mental health problems suffered relapses in symptoms (Yao et al., 2020). Predictions about the psychological impact of COVID-19 noted that a lack of interpersonal communication resulting from measures such as isolation and physical distancing could worsen symptoms of anxiety and depression (Xiao, 2020).

Several health and social risks that existed pre-pandemic were heightened during the pandemic. For example, prior to the pandemic, CV older adults with pre-existing health conditions suffered difficulties including access to healthcare, social isolation, loneliness, and poorer quality of life when compared to non-CV people (Di Gessa & Price, 2021). While physical distancing was advised to minimise the spread of the virus, it was acknowledged that there would be implications to mental health related to loss of social connection and loneliness (Galea et al., 2020). The term “physical distancing” was advised over “social distancing” to acknowledge the potential harm and connotations of “social distancing,” such as rejection and feeling excluded (Wasserman et al., 2020).

Exclusion and isolation are issues notably explored in disability literature and rehabilitation studies (see; Barnes & Mercer, 2005; Cross, 2013; Hanson, 1970; Macdonald et al., 2018; Singleton & Darcy, 2013). The number of studies exploring the effects of isolation and social distancing in the context of the COVID-19 pandemic is growing. In a report published by the Academy of Medical Sciences, those with lived experience of mental ill-health reported fear and concern about the potential negative psychological and social effects of the pandemic (Cowan, 2020). Specifically, concerns about the impact of distancing and lockdown measures on mental health, including worsening symptoms of anxiety, depression and stress, were reported to be higher than concerns about contracting the virus (Cowan, 2020). Social isolation and loneliness are associated with negative mental health outcomes, such as depression, anxiety and stress (Wang et al., 2018) and negative physical health outcomes such as the risk of heart disease and stroke (Thurston & Kubzansky, 2009; Steptoe et al., 2013; Valtorta et al., 2016). During the pandemic, studies examining the effects of perceived social isolation and loneliness have shown an association between anxiety, loneliness and increased symptoms of depression (Keller et al., 2022). In a meta-analysis of thirty-three quantitative studies, social distancing measures were found to be associated with increases in experiences of loneliness (Knox et al., 2022). In a recent systematic review exploring the experiences of young people during the pandemic, Loades et al. (2020) found social isolation and loneliness were associated with high rates of depression and anxiety. In a qualitative study exploring the experiences of loneliness amongst majority adult women during the UK national lockdown, McKenna-Plumley et al. (2021) found that some participants perceived virtual social interaction as being inferior to face-to-face interactions, which contributed to feelings of loneliness. However, in a study exploring the views of 25 CV individuals who practised shielding during the pandemic, participants reported positive experiences of virtual healthcare, including through telephone and virtual meetings (Kemp et al., 2020). Additionally, this study revealed that most of the participants described the helpfulness of existing support networks, and the use of technology mitigated the challenges they faced, including coping with bereavement. Recommendations for combating loneliness and perceived social isolation promote the use of virtual environments that provide opportunities to contact and connect with others as remote interventions could enhance social support for people experiencing loneliness (Boulton et al., 2021). Additionally, while many face-to-face initiatives were paused, online programmes were created, such as remote befriending services for older adults in nursing homes (Fearn et al., 2021). In a study by Brouzos et al. (2021), a remote positive psychology group intervention was reported to be associated with significant improvements in psychological distress, including anxiety, depression and loneliness in a sample of 44 participants when compared to a control group of 38. The intervention sought to enhance participants' strengths and resilience as a strategy for coping with the negative psychological impact associated with COVID-19, such as loneliness, anxiety and fears. The researchers, therefore, advocate for the use of remote psychological interventions during the pandemic (Brouzos et al., 2021).

Studies proposed ways in which individuals may be and have historically been affected by measures to manage outbreaks, such as via reviews of the psychological effects of quarantine which can vary from increased fear, anxiety and depression to post-traumatic stress disorder (PTSD) and suicide (Brooks et al., 2020; Kemp et al., 2020). Though there are several emerging studies on the psychological impact of COVID-19, further longitudinal research is needed to inform psychological policy and intervention (Knox et al., 2022).

## Social inequalities and COVID-19

Social determination of health refers to how inequalities created by social dynamics and risk factors impact on determine a person’s health (Egede & Walker, 2020; Raine et al., 2020). COVID-19 has highlighted and exacerbated health and social inequalities nationally and globally, with significantly worse outcomes for poor, disadvantaged, and socially marginalised groups (Hankivsky, 2021). It is therefore important to not overlook the inequalities linked to the impact of COVID-19 on marginalised groups. Racially minoritized people disproportionately became critically ill with COVID-19 (ICNARC, 2020; Raine et al., 2020), with Runnymede Trust (2021) reporting that 34% of patients with COVID-19 who were critically ill were identified as being Black, Asian or from a minority ethnic background – almost double that which would be expected relative to the population. For context, in England, 9.6% of the population identified within “Asian, or Asian British,” 4.2% identified as “Black, Black British, Caribbean or African,” 3.0% identified as Mixed or Multiple ethnic groups,” 2.2% as “Other ethnic groups,” and 81% identified as “White” ethnic groups (Office for National Statistics, 2021). Racism and discrimination, including microaggressions and violence, were amplified within East Asian communities, in particular increased discrimination towards Chinese people (Coates, 2020; Devakumar et al., 2020; Sohrabi et al., 2020). Poorer populations were made more vulnerable through limited access to resources, employment and in suffering unreasonable benefit schemes (Ahmed et al., 2020).

Adams-Prassl et al. (2020) used surveys to research the impact of COVID-19 on employment, income and individuals' mental health. They found a disproportionately negative impact, such as poor mental health, financial distress and increased job loss on those from lower-income groups, women and young people. Nazroo and Bécares (2021) discuss the importance of equitable pay in relation to COVID-19. They highlight the risks of receiving low income, not being eligible for Statutory Sick Pay and the likelihood of those on lower incomes being forced to work while others were able to stay home to avoid the virus. In addition to financial benefits, work can also provide social interaction and facilitate connection with others. Embregts et al. (2022) explored the experiences of 23 people with mild intellectual disabilities during lockdown in the Netherlands. Participants expressed difficulties, including experiencing boredom and a sense of social isolation, partly resulting from their inability to attend their volunteer jobs. The researchers discuss a need for support for individuals with intellectual disabilities to be able to work from home during the pandemic, given the role work can play in facilitating social inclusion.

### ***The risk of racism***

Black, Asian, and minority ethnic groups are at increased risk to higher morbidity and mortality from COVID-19 than UK or USA white groups (Pan et al., 2020; Raine et al., 2020; Sze et al., 2020). In the USA, a cross-sectional analysis found Hispanic/Latinx, American Indian/Alaskan Native, Native Hawaiian/Pacific Islanders, and Black individuals were overrepresented in both incidence and mortality. It is therefore important to highlight the racial and ethnic inequalities present in relation to the pandemic (Raine et al., 2020). Additionally, Milner and Jumbe (2020) highlight the necessity of addressing racial health inequalities through change at individual and systemic levels. It is suggested that the higher mortality risk among racialised minority groups indicates a higher risk of becoming infected due to inequalities in living conditions, lower socioeconomic status, and exposure due to occupation, i.e., individuals from racially minorities backgrounds are more likely to be essential and frontline workers (Gansevoort & Hilbrands, 2020; Hawkins, 2020; Sze et al., 2020).

Additionally, those in lower-paid jobs are more likely to be racially minoritized women (Pearson, 2019). This is supported by a Runnymede Trust (2021) report which outlines that racialised minorities are at enhanced risk of exposure to infection, health risks and increased threat of loss of income. Sze et al. (2020) found evidence that individuals from Asian backgrounds were at increased risk of severe infection when reviewing intensive care unit admissions in hospitals in the UK. Turner-Musa et al. (2020) highlight social determinants of health that have impacted racially minoritized groups during the pandemic, such as poor access to healthcare, inadequate housing conditions and lack of resources that increase quality of life, e.g., economic security.

Fear during viral outbreaks is a driver and ‘key ingredient’ for racism and xenophobia (Devakumar et al., 2020). Historically, xenophobia and blame directed towards racial minority groups have occurred during and after outbreaks of pandemics (Cheng & Conca-Cheng, 2020; Gover et al., 2020). Scapegoating, racial discrimination and blame directed towards marginalised racialised groups are critical outcomes during crises. ‘Othering’ can be defined as processes by which, historically, racialised minorities are subject to stereotyping and racialisation (Thomas-Olalde & Velho, 2011), the purpose of which is to marginalise minority groups and maintain an idea of racial hierarchy, i.e., whiteness in Western society, born out of prejudice and fear (Gover et al., 2020). In a meta-analysis of 203 studies between 1983 and 2013, racism was reported to be significantly associated with worse outcomes in mental and physical health (Paradies et al., 2015). In the context of the COVID-19 pandemic, racism and systemic oppression contribute to an increased risk of morbidity and mortality within racial minority groups (Egede & Walker, 2020).

Racially motivated hate crimes increased towards Asian Americans since the beginning of the COVID-19 pandemic (Cheng, 2020; Gover et al., 2020; Lantz & Wenger, 2023). Han et al (2023) report a substantial increase in hate crimes targeting Asian Americans in 2020 as compared to 2019. Notably, there was a temporary surge in hate crimes against Asian Americans following March 16, 2020. Hate crime is a crime that is targeted at a specific group due to their association with that group (Gray & Hansen, 2021). Recent studies have explored the impact of the ‘pandemic of racism’, defined as the increased racism in the presence of the current pandemic (Cheng & Conca-Cheng, 2020). For example, in a thematic analysis of fourteen racially minoritized health care workers, Ncube and Parker (2021) found that participants were concerned about the increase in race-related hate crimes, systemic racism, prejudice and hostility towards racial minority communities.

People of Chinese and Southeast Asian communities felt open to attack, blame and prejudice following the racialisation of COVID-19 (Cheng & Conca-Cheng, 2020). In March 2020, the then President of the United States, Donald Trump, termed COVID-19 the “Chinese virus”. This racialized description of the virus served to perpetuate racist attitudes (Viala-Gaudefroy & Lindaman, 2020) and may have encouraged increased bias and anti-Asian discrimination (Gover et al., 2020). As Gover et al. (2020) argue this is partly a result of the reproduction of ongoing social inequalities and prejudice towards Southeast Asian individuals, exacerbated by the pandemic. In early March 2020, racist harassment towards Asian Americans surged, with the Federal Bureau of Investigations warning of increased hate crimes and the USA Department of Homeland Security warning of the possibility of white supremacist groups using the pandemic to justify and incite violence against Asian Americans (Viala-Gaudefroy & Lindaman, 2020). For example, in New York on March 10th, 2020, a Korean American woman was physically and verbally assaulted, whilst the attacker used racist language and accused the woman of having COVID while punching and pushing her (Sosa & Brown, 2020). The authorities in New York investigated the incident as a hate crime (Sosa & Brown, 2020).

In the UK, Gray and Hansen (2021) reviewed Metropolitan Police data on hate crimes during the first three months of the outbreak of COVID-19. They found that hate crimes against Chinese people increased from January to March 2020 when compared to pre-pandemic data from October to December 2019. Gray and Hansen (2021) suggest that the increase in hate crimes shows an increase in xenophobic and racist discrimination during times of fear and crisis. Cheng (2020) warns that xenophobia and racism contribute negatively to mental health, sense of self and identity. Therefore, mental healthcare systems need to understand the additional racial stress placed on Southeast Asian communities in the context of COVID-19.

On May 25th, 2020, George Floyd, a 46-year-old African American man, was murdered by a White police officer in Minnesota. George Floyd's murder highlighted anti-Black racism and prompted protests throughout the USA, illuminating racist discrimination and violence against Black Americans. During a national lockdown in the UK in May 2020, protests began in support of the Black Lives Matter (BLM) movement (Mohdin et al., 2020), a movement which has highlighted the racism embedded in systems (Lala et al., 2020). Founded in 2013, BLM is a global organisation which aims to "eradicate white supremacy and build local power to intervene in violence inflicted on Black communities by the state and vigilantes." The organisation spans the USA, Canada and the UK (BLM, n.d.). The death of George Floyd was identified as traumatising for the Black community, supported by survey results whereby Black Americans reported significantly increased psychological distress including symptoms of anxiety and depression (Eichstaedt et al., 2021). Findings presented by Eichstaedt et al. (2021) highlight that Black Americans are at increased risk of significant negative mental health outcomes following racial police killings, as compared to White Americans.

Burgess et al. (2022) explored the impact and emotional well-being of 40 racially minoritized young people in the UK, with a specific focus on mental health vulnerabilities amongst young Black people during the pandemic. Their findings highlighted that the constant information surrounding Black people's risk and mortality produced an additional burden to manage throughout the pandemic. The authors discussed the psychological pressures and dilemmas of conflicting decisions for participants, e.g., balancing the desire to attend protests with the challenge of following lockdown measures and avoiding the risk of contracting COVID-19. Burgess et al. (2022) outline the need for systemic changes and equitable economic resources to support the health of racially minoritized young people following the pandemic.

Whilst the empirical paper presents a thesis which focuses on racially minoritized individuals, it will be important for further research to focus on differential outcomes of the pandemic for different racial minority groups (Milner & Jumbe, 2020). Compounding racialised groups ignores impactful differences amongst racialised groups.

### *Gender and COVID-19*

Gender is also posited as an important social determinant of health (Connor et al., 2020), and the pandemic has specifically impacted women in gender-specific ways (Adisa et al., 2021). In the UK, some women's domestic workload increased during the COVID-19 pandemic. This produced a role conflict and a struggle for women to obtain a 'work life balance' due to social and cultural commitments as the main caretakers of children and elderly family members, and the need to attend to work duties (Adisa et al., 2021). Furthermore, in many countries, there was an increase in domestic violence (DV) against women during the pandemic (Pentaraki & Speake, 2020). In the UK, an increase in reported DV was partly attributed to perpetrators having more power over victims of DV during lockdowns (Pentaraki & Speake, 2020) and access to support being reduced (Pfitzner et al., 2022).

Hankivsky (2021) presents the gendered impacts of the recent pandemic and discusses the need to apply an intersectional lens to tackling multiple axes of vulnerability and addressing linked systems and structures of power and oppression. This is because risk factors and vulnerabilities relating to the virus are considered not to manifest in isolation. Rather, risk factors intersect and are embedded in connected systems and structures, such as patriarchy, racism and xenophobia (Hankivsky, 2021).

In a USA study, Riggle et al. (2021) explored the experiences of 18 African American, Latinx and White sexual minority women during the pandemic. Their findings highlighted the numerous challenges participants faced, including loss of connections to the LGBTQ community, anxiety about transmitting the virus to others and financial stress and uncertainty. The authors also represented the distinct impacts on participants from different racialised groups. For example, African American and Latinx sexual minority women reported experiencing heightened fears related to contracting the virus and threats of racist violence from others, including police and governmental officials. Riggle et al. (2021) outline the need for targeted interventions and policies that address the unique impacts experienced by racially minoritised, sexual minority women during the pandemic, including increased screening for psychological distress for specific minority groups.

A briefing from the UK Women’s Budget Group highlights how racially minoritised women are found to be overrepresented in the National Health Service (NHS) and are therefore at increased risk of exposure to COVID-19 (Abid, 2021). Racially minoritised, disabled women and single mothers on low incomes have suffered due to a ‘genderinsensitive' response to the pandemic (Abid, 2021). Researchers are calling for studies examining the gender specific nature of stigma and COVID-19 (Logie, 2020).

Researching participants who exist within the intersection of gender, health and race allows an understanding of the ways in which marginalised groups have been overlooked in dominant narratives of the pandemic. Moreover, additional research should explore how long-term effects of the COVID-19 pandemic, such as health and economic consequences, are impacting different communities, particularly, those who experience social inequalities (Raine et al., 2020).

## Intersectionality

The concept of intersectionality is widely used, although it can be misrepresented (Gillborn, 2015). This section will explain the origins of the concept and provide an explanation and outline of how intersectionality is used within psychology research.

The concept of intersectionality was pioneered by Black feminist women; Crenshaw (1989, 1990) coined the term 'intersectionality' to recognise and study the ways in which different oppressive systems marginalise Black women. Gillborn (2015) offers the following definition: "*The term addresses the question of how multiple forms of inequality and identity inter-relate in different contexts and over time, for example, the inter-connectedness of race, class, gender, disability, and so on.*" Hankivsky et al. (2014) describes intersectionality as a 'framework' that acknowledges how different 'social locations,' such as race, gender, sexuality and disability interact. These interactions are recognised as formed by systems of power, including government policy, the mainstream media and law which can produce oppression as well as privilege. Intersectional analyses also allow for insights into privileged groups (Cole, 2009; Riggs & das Nair, 2012). However, when examining discrimination, according to Crenshaw (2013), studying the perspectives of group members with the most advantages, create a distorted view of the “problems”. For example, when exploring discrimination focusing on privileged members within a group, such as White women, it can neglect the unique challenges women with intersecting identities face, such as those who identify as racially minoritized. Crenshaw (1989) argues for an intersectional, “bottom-up” approach to exploring discrimination for marginalised groups, as doing so highlights how forms of discrimination and oppression intersect and compound, as well as revealing more discrete forms of discrimination that would be missed when focusing on the most privileged group members. Therefore, without an intersectional approach the complexity of multiple power structures and socio-political processes that perpetuate discrimination cannot be understood or addressed adequately (Crenshaw, 2013; Kapilashrami & Hankivsky, 2018). Crenshaw (1991) discusses, for instance, the intersections of racism and sexism, and posits that movements against sexual harassment require representations of Black women and other ‘non-White’ women, to include and enable all women to identify with the movements.

Intersectionality studies have explored oppression and marginalisation experienced by people who exist “along the fault lines of social categories” (Cole, 2009), for example, Crenshaw (1991) researched how feminist and anti-racist narratives of sexual assault and domestic violence historically disregarded the nuanced experiences of Black women.

Power dynamics can be compounded for people who exist at the intersection of several marginalised identities and therefore experience multiple marginalisation (Lala et al., 2020). Communities are made up of diverse individuals who occupy different social positions and identities that are shaped by wider social norms and historical processes, such as racism, ableism and patriarchy (Hankivsky et al., 2014). Gillborn (2015) suggests that centring race and racism is ‘unpopular’. They suggest that it can be divisive to be critical of socially constructed identity categories, such as categories of race. Additionally, racism is complex and occurs differently in varying contexts, for example, insidiously through racist microaggressions. Previously, a lot of women's research has not integrated other identities, focusing only on gender (Gillborn, 2015). There is value in exploring the lived experience of people who exist at the intersection of multiple marginalised identities, social positions and locations (Abrams et al., 2020). Focusing on a single axis of oppression can further marginalise members of a group who suffer multiple forms of discrimination (Crenshaw, 2013). In the context of the current pandemic and for the purpose of public sector response, it is crucial to understand the risk and impact of intersecting inequalities (Nazroo & Bécares, 2021).

### ***Intersectionality in psychology***

Whilst intersectionality theory is regarded as a critical theoretical and methodical approach in health science, there are recent recommendations and considerations for the use of intersectionality theory in qualitative research (Abrams et al., 2020). Recent literature calls for medical institutions to adopt an intersectional approach to explore the nuanced way that social categories such as disability, race, class, gender, and sexuality intersect within wider systems and processes of power (Samra & Hankivsky, 2021). Rosenthal (2016) discusses integrating intersectionality in psychology as a way to examine and highlight structural issues related to interwoven systems of oppression and to encourage social justice.

Critical insights can be overlooked without considering intersecting inequalities (Rosenthal, 2016). For example, Settles (2006) explored the intersection of Black women's racialised and gender identities and found equal importance was placed on their race and gender by the women in their study and reported unique challenges due to combination of identities.  Applying an intersectional framework highlighted systemic and interpersonal oppression which create distinctive challenges for Black women, such as, racialised sexual harassment (Settles, 2006).

Intersectionality research must go beyond acknowledging intersecting identities and diversity within groups due to other intersecting identities and incorporate social justice (Kelly et al., 2021). Therefore, truly intersectional research acknowledges the inseparable nature of identities that are impacted by personal and structural factors, as well as outlines how power in produces and upholds social identities and categories (Bowleg, 2013; Rosenthal, 2016).

Rosenthal (2016) outlines how taking an intersectional framework increases interpretation of complex, dynamic, and unique psychological experiences. Intersectionality can encourage social justice and equity in psychology, through processes such as government and public sector policy change (Bauer, 2014; Bowleg, 2013; Cole, 2009).

Research that focuses on intersecting identities connects with experiences in wider communities and social structures. However, for this to be intersectional research there also needs to be action and explicit focus on social justice (Kelly et al., 2021). Though, some researchers suggest social justice is not an obligation for intersectionality research (Collins & Bilge, 2020, as cited in Kelly et al., 2021). Exploring intersectionality in psychology research can strengthen recognition of inequalities and the development of interventions and policy change (Bauer, 2014; Bowleg, 2013).

In clinical setting, Mosher et al. (2012) suggest practitioners practice cultural humility. This can be described as a framework to support therapists to engage with clients from diverse cultural backgrounds, e.g., through examining cultural biases and being attuned and open to the cultural experiences, including intersectional backgrounds of clients. For example, cultural humility and a strong working alliance is suggested to reduce the impact of racial microaggressions and microaggressions towards women in therapy (DeBlaere et al., 2022).

Riggs and das Nair (2012) propose the use of an intersectional and relational approach to exploring identities, positing that doing so allows therapists the scope to attend to the complexities of holding multiple marginalised identities and consider the context in which those identities interact within structures and norms of society. Collins (2000) outlines how examining our own biases, thoughts and actions that may interact with someone else's oppression is imperative, in order to safeguard against potentially participating in the oppression of others. Additionally, it is important to explore intersectional social categories and identities, as highlighted by Roberts et al. (2020), who call for psychological research that explores racial diversity and inequality. This is because experiences of discrimination, such as racism, can significantly negatively impact an individual's well-being and way of life (Roberts et al., 2020). However, it is essential to reference and utilise the already substantial body of work by Black feminist scholars that outline areas of work relevant to psychological practice (Riggs & das Nair, 2012; Spates, 2012).

### ***Multiple Jeopardy Theory***

The current thesis could also fit with a multiple jeopardy theory approach (King, 1988). Multiple jeopardy theory refers to the way in which being a member of multiple marginalised groups places an individual at increased risk of negative experiences and threats to well-being, such as the multiple discriminations experienced by Black women including racism, prejudice and sexism (King, 1988). In contrast, belonging to multiple advantaged groups increases a person's chances of positive experiences and enhanced well-being (Settles & Buchanan, 2014). Whilst this theory could apply to the approach taken to the following thesis; it was deemed that this project fits more with an intersectional approach as outlined below.

In summary, intersectionality is not about treating people's identities as separable, which misses the complexities and nuances of experiences (das Nair & Thomas, 2012). Additionally, perceiving diverse identities as ‘problems of addition’, ignores the interlocking nature of forms of oppression (Rosenthal, 2016). Psychology research must acknowledge the way in which different social contexts produce different effects. Intersectionality also helps to explore power relations in interactions (das Nair & Thomas, 2012) and to consider the social-relational context in psychology and reflection on whose best interests are serviced by policy and practice within healthcare (Cole, 2009).

## Insider Position

An “insider research position” refers to researchers who hold shared identities with the participants of their study. The purpose of this section is to situate myself, as the author, in this thesis and discuss the validity of insider research. Most of the conceptual introduction and empirical paper is written in the third person, however, this section and the critical appraisal will be written in the first person due to the personalised nature of these parts. Firstly, I identify as being part of the group interviewed in the empirical paper and could have answered the study advert to participate in the research. I recognise the privilege I hold, as I have been able to conduct research that has personal and emotional importance.

I have previously conducted ‘outsider status’ interviews as part of a qualitative study on neurodiversity at work. I recall feeling slightly insecure at times conducting interviews exploring experiences I felt I had little-to-no insight into, prior to embarking on the research. Conversely, when interviewing participants in this study, I noted that different emotions arose, such as feelings of security and responsiveness. Ross (2017) remarks upon similar findings and suggests that certain emotional experiences enable a richness to the interview process, specifically around rapport, which are not experienced when conducting outsider status interviews.

Interpretive paradigms perceive the insider research position as ‘valuable’ (Chavez, 2008). Ross (2017) discusses the benefits of researchers holding an insider position as being “integral to conducting ethical and effective research”. Sharing an emotional experience and showing empathy from a place of lived experience can offer validation, support and enable richness to the interview process (Ross, 2017). Others suggest that researchers cannot be completely isolated from what or whom they are studying, that they are in some way connected to, or part of, the focus of their study, regardless of whether they share identities with participants (Davies, 2008). Moreover, insider researchers may not possess all the same identities with participants in their study (Nelson, 2020). Some researchers argue that researchers often are neither the binary of insider or outsider and rather occupy a position ‘in the middle’ (Breen, 2017).

Feelings of comfort, reassurance and learning from reflections are suggested to be personal benefits associated with insider research (Ross, 2017). Whilst holding an insider position can provide a feeling of connection to the participant that enhances the ‘richness’ of the data and the experience of the researcher, there can also be disadvantages and pitfalls when conducting insider research. For example, assumptions may be made on part of the researcher and the researched (Rai, 2020). During an interview a participant shared, *‘you know why they don’t want you and me doing this’*. I recall nodding, thinking I had understood what was being communicated. I later recognised that I had assumed that I knew to what the participant was referring, and who *‘they’* were. To mitigate my earlier assumptions, I asked the participant to expand on their earlier comment. This experience was a helpful reminder to remain curious and careful about my objectivity and biases during the interview process.

LaSala (2003) suggests participants may trust researchers with whom they share identities and perceive them as invested in correcting social misconceptions of their cultural group. They discuss the strengths and weaknesses of an insider position when conducting research with gay men and lesbians. For instance, LaSala (2003) shares an example of understanding that intergenerational family gatherings may not include partners due to 'disapproval’ from parents of their daughter or son’s sexuality, and this awareness supported them to create interview questions that applied this insider knowledge. Additionally, during LaSala’s (2003) study, participants shared that they had wanted to participate due to perceiving that the researcher would be able to accurately depict their experiences. Limitations discussed include potential biases of the researcher, such as the researcher assuming they are understanding a perspective based on familiarity and knowledge of the situation (LaSala, 2003) – this mirrors my own experience above. Such assumptions can disregard idiosyncratic and illuminating insights (LaSala, 2003).

### *Power*

Power is an important consideration in insider research and should be mediated during the research process (Meriam et al., 2001). For example, it was important for me to consider the power I held as the researcher and, therefore, the producer of knowledge. I also needed to consider my association with a large academic institution because of the significant power and influence institutions of higher education can have (Amirbek & Ydyrys, 2014). Shared identity can be seen to partly mitigate the power differentials in research (Ross, 2017), and conducting research “with” participants instead of “on” them, is suggested to equalise the relationship and deconstruct power imbalance (Meriam et al., 2001). However, interpreting and, therefore, retelling participants' experiences involves an inevitable power imbalance. To attend to this, during the design of this research I consulted with two experts by experience. Additionally, I gathered feedback on themes from participants through a process of 'respondent validation'. Respondent validation involves participants cross checking research findings to establish credibility (Lincoln et al., 1985). It is also suggested as a tool for engaging participants further in the research process (Rowlands, 2021), and a way of acknowledging the contribution of participants (Valentine, 2007).

Johnston (2019) discusses advantages of self-disclosure whilst conducting mental health research, for instance, shaping knowledge production and 'intense' self-reflection. However, Abell et al. (2006) suggest that self-disclosure can contribute to the researcher-participant power imbalance through burdening participants. I attempted to balance this through disclosure of holding an insider position during the recruitment phase, without sharing details of, for example, what makes me CV to COVID-19. My insider position seemed unimportant to the participants, who were more interested in their experiences informing an understanding of the experiences of the COVID-19 pandemic for themselves and their communities. Many of the participants shared that they were drawn to the research as they valued social justice work. However, if the research were longitudinal, self-disclosure might have been more prominent during the research process, due to the extended time spent with participants. It may have been that participants would be more curious about my position, or I might have wanted to disclose and discuss the multiplicity of my position more.

While insider research can be seen as levelling of disparities between researcher and researched (Ross, 2017), researchers have a responsibility to practice self-awareness, for example, acknowledging that interpretation and knowledge production are socially and subjectively constructed (LaSala, 2003).

### *Reflexivity*

Reflexivity is a methodological tool in critical qualitative research. Self-reflexivity refers to the process of reflecting on one's own position, biases and assumptions, and how these may shape the research process and findings (Olmos-Vega et al., 2023). Pillow (2003) suggests there are ways to practice self-reflexivity effectively in qualitative research and argues for the use of 'uncomfortable reflexive practices' or 'reflexivities of discomfort.' For example, using reflexivity to explore the power imbalances that could limit the research process and outcomes (Hamdan, 2009).

Additionally, there are a variety of forms of reflexivity. For example, 'benign introspection', such as a fieldworker keeping a journal, which is private and individualistic (Woolgar, 1988). Meanwhile Davies (2008) describes complete reflexivity as requiring 'full and uncompromising self-reference', also termed 'radical constitutive reflexivity' (Woolgar, 1988). Literature on feminist ethnographic research outlines a need for reflexivity amongst researchers who are involved in the lives of people being studied, often using several qualitative techniques and observations (Davis, 2008). This research is usually multi-faceted and longitudinal.

In the current research I have pursued reflexive practices that explore how my beliefs, experiences and identity position me in relation to the participants in my research. For instance, my individuality appears throughout the research process, and I must recognise and explore this, not in pursuit of understanding myself 'better' or to 'neutralise' my influence but to acknowledge subjectivity and the messiness of self-representation and identity (Pillow, 2003). For instance, as I reflected on aspects of my identity and subjectivity with my research supervisor when designing the research question and aims, I found myself attempting to 'bracket' or ignore aspects of myself, such as how I am racialised. Reflexivity allowed me to go beyond acknowledgement and amend the research aims where appropriate, for example, by including racially minoritized individuals in sampling.  I was also supported by a peer who conducted a ninety-minute bracketing interview during the recruitment phase, the purpose of which was to enable me to acknowledge my expectations and assumptions prior to interviews (Ahern, 1999).

Different shared identities have different implications. Sharing an identity and experience, such as discrimination, is suggested to be emotionally salient and powerful for insider researchers (Song & Parker, 1995). Whilst I shared identities as outlined in the research inclusion criteria, there are also differences between myself and all of the participants in the current research, such as race and age. I found myself comfortable reflecting on differences in age, CV status and potentially disability. However, it was more difficult to explore my own race and racialisation. By way of engaging in “reflexivities of discomfort” (Pillow, 2003), I often found myself reflecting on my position as a mixed-race researcher, researching racially minoritized individuals and experiencing moments of discomfort and ethical questions such as whether my proximity to “whiteness” and white privilege placed further power differentials. I felt that ignoring this would be harmful. I considered disclosing and discussing how I am racialised with participants but concluded that this would be of benefit to me and potentially be oppressive and burdensome to them. The benefit to me might have been feeling a sense of belonging and acceptance, a need that has been found to be a reality for biracial women (Motoyoshi., 1990). Instead, this formed the basis for reflections via a reflective log kept during the research process and was explored in the bracketing interview conducted by a peer. I disclosed feelings of not being ‘brown enough’. Pillow (2003) asserts that engaging in uncomfortable reflexivity reveals ‘unfamiliar tellings.’ In my experience, longing for acceptance by a group, and feeling that I straddled both worlds of racialised and non-racialised were not unfamiliar, but they were ‘tellings’ that were uncomfortable and would have been easier to disengage with or exclude from my reflections and write up. There is no conclusion to these reflections, instead they are ongoing and evolving. These examples of uncomfortable and messy reflexivity can be understood as being a reality of qualitative research (Pillow, 2003).

Ross's (2017) reflections on the challenges of insider research formed a helpful basis for reflection throughout the process of data collection. For instance, choosing areas to focus on in interviews that may not have been for the benefit of the research but for my personal benefit. While there can be gains to this, Ross (2017) notes the potential for missed opportunities to pose questions about concepts or sense-making that are pertinent to the research aims. The interview schedule was designed to comprise open and exploratory questions, as is consistent with the chosen methodology (IPA, Smith et al., 2009), and to support the pursuit of the research aims over my personal interests, without ignoring my knowledge of context for appropriate questioning. Consultants and the research supervisor reviewed and supported edits to the interview schedule. Additionally, using an interview schedule of preconstructed questions with prompts limits the effects of the researcher on the social encounter (Davis, 2012).

Other insider researchers have described the ways in which they have personally benefited from research as well as wider implications (e.g., Johnston, 2019). Apart from trauma-related insider research, emotion-related benefits and challenges are not thoroughly explored in the literature (Ross, 2017). Further research could explore experiences of participants who have been involved in research where the researcher holds an insider position. This could shed light on further advantages and disadvantages involved in insider research from the perspective of the participant.

There are debates on the utility of insider research, including whether such a concept even exists (Davies, 2012; Merriam et al., 2001), and the idea that researchers cannot be completely ‘inside’ due to the barrier between researcher and researched (Corbin-Dwyer & Buckle, 2009, as cited in Hayfield & Huxley, 2015).

## Conclusion

This conceptual introduction has provided a rationale for the terminology used, an overview of the considerable impact of COVID-19 on marginalised groups, including those CV to the virus, an introduction to intersectionality and psychology research, and an in-depth exploration of insider research as it pertains to the thesis.

The empirical paper aims to address some of the gaps in the current literature, such as the dearth of research capturing the voices of people experiencing health discrimination in psychology (Malhotra & Rowe, 2013), and experiences of multiple discrimination during the ongoing pandemic (Devakumar et al., 2020). Neglecting to examine intersectionality is theoretically misguided (Davis, 2008). Therefore, this research aims to describe the experiences of the participants whilst acknowledging their position in society and the social inequalities that affect people differently (das Nair & Thomas, 2012). Failing to understand the significance of discrimination, such as racism, driving inequality during the ongoing COVID-19 pandemic risks furthering inequities in systemic response (Nazroo & Bécares, 2021). Therefore, this thesis aims to provide insights and understandings of the experiences of racially minoritised, CV women during the COVID-19 pandemic, while considering intersectionality through in-depth individual interviews. This research also aims to contribute to needed research on the lived experiences and the impact of the pandemic across diverse communities (Chen & McNamara, 2020).

## References

Abell, J., Locke, A., Condor, S., Gibson, S., & Stevenson, C. (2006). Trying similarity, doing difference: The role of interviewer self-disclosure in interview talk with young people. *Qualitative Research, 6*(2), 221-244.

Abid, H. (2021). *UK Women's Budget Group briefing. Women and employment in the recovery from Covid-19*. Retrieved from https://wbg.org.uk/wp-content/uploads/2021/10/Employment-Autumn-2021-PBB-1.pdf Accessed [01/12/2022]

Abrams, J. A., Tabaac, A., Jung, S., & Else-Quest, N. M. (2020). Considerations for employing intersectionality in qualitative health research. *Social Science & Medicine, 258*, 113138.

Adams-Prassl, A., Boneva, T., Golin, M., & Rauh, C. (2020). Inequality in the impact of the coronavirus shock: Evidence from real time surveys. *Journal of Public economics, 189*, 104245.

Adisa, T. A., Aiyenitaju, O., & Adekoya, O. D. (2021). The work–family balance of British working women during the COVID-19 pandemic. *Journal of Work-Applied Management*.

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative health research, 9*(3), 407-411.

Altiery De Jesus, V. V., Alwan, N., Callard, F., & Berger, Z. (2021). Listening to long COVID: Epistemic injustice and COVID-19 morbidity. *OSF Preprints*.

Amirbek, A., & Ydyrys, K. (2014). Education and soft power: Analysis as an instrument of foreign policy. *Procedia-Social and Behavioral Sciences*, *143*, 514-516.

Barbarin, I. (2022). *I Started #MyDisabledLifeIsWorthy, Here's Why The Response From Nondisabled People and Medical Professionals Should Alarm You*. Retrieved from: https://crutchesandspice.com/2022/01/26/%ef%bf%bci-started-mydisabledlifeisworthy-heres-why-the-response-from-nondisabled-people-and-medical-professionals-should-alarm-you/

Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity. *Social science & medicine, 110*, 10-17.

BLM. (n.d.). *BLACK LIVES MATTER, ABOUT*. Retrieved February 01, 2023, from https://blacklivesmatter.com/about/

Bogart, K. R., & Dunn, D. S. (2019). Ableism special issue introduction. *Journal of Social Issues*, *75*(3), 650-664.

Bogart, L. M., Ojikutu, B. O., Tyagi, K., Klein, D. J., Mutchler, M. G., Dong, L., ... & Kellman, S. (2021). COVID-19 related medical mistrust, health impacts, and potential vaccine hesitancy among Black Americans living with HIV. *Journal of acquired immune deficiency syndromes (1999)*, *86*(2), 200.

Boulton, E., Kneale, D., Stansfield, C., Heron, P. N., Sutcliffe, K., Hayanga, B., ... & Todd, C. (2021). Rapid systematic review of systematic reviews: what befriending, social support and low intensity psychosocial interventions, delivered remotely, may reduce social isolation and loneliness among older adults and how?[version 2; peer review: 2 approved with reservations]. *F1000Research*.

Bowleg, L. (2013). “Once you’ve blended the cake, you can’t take the parts back to the main ingredients”: Black gay and bisexual men’s descriptions and experiences of intersectionality. *Sex roles*, *68*(11-12), 754-767.

Breen, L. (2007). The researcher'in the middle': Negotiating the insider/outsider dichotomy. *The Australian community psychologist, 19*(1), 163-174.

Brouzos, A., Vassilopoulos, S. P., Baourda, V. C., Tassi, C., Stavrou, V., Moschou, K., & Brouzou, K. O. (2021). “Staying Home–Feeling Positive”: Effectiveness of an on-line positive psychology group intervention during the COVID-19 pandemic. *Current Psychology*, 1-13.

Brown, K. (2012). Re-moralising 'vulnerability.'. *People, Place & Policy Online, 6*(1).

Burgess, R. A., Kanu, N., Matthews, T., Mukotekwa, O., Smith-Gul, A., Yusuf, I., & Gul, M. (2022). Exploring experiences and impact of the COVID-19 pandemic on young racially minoritised people in the United Kingdom: *A qualitative study. Plos one, 17*(5), e0266504.

CCDH. (2020). *Failure to Act How Tech Giants Continue to Defy Calls to Rein in Vaccine Misinformation*. Retrieved from https://252f2edd-1c8b-49f5-9bb2-cb57bb47e4ba.filesusr.com/ugd/f4d9b9_8d23c70f0a014b3c9e2cfc334d44472dc.pdf [Accessed] 01/01/2023

Charura, D., Hill, A. P., & Etherson, M. E. (2022). COVID-19 vaccine hesitancy, medical mistrust, and mattering in ethnically diverse communities. *Journal of racial and ethnic health disparities*, 1-8.

Chavez, C. (2008). Conceptualizing from the inside: Advantages, complications, and demands on insider positionality. *The qualitative report, 13*(3), 474-494.

Cheng, H. L. (2020). Xenophobia and racism against Asian Americans during the COVID-19 pandemic: Mental health implications. *Journal of Interdisciplinary Perspectives and Scholarship, 3(*1), 3.

Cheng, T. L., & Conca-Cheng, A. M. (2020). The pandemics of racism and COVID-19: Danger and opportunity. *Pediatrics, 146*(5).

Cohen-Rottenberg, R. (2013). *Ableism in the Anti-Vaccination Movement: A Qualitative Content Analysis of the Great Mothers Facebook Page*. Retrieved from http://www.disabilityandrepresentation.com/ableism-in-the-anti-vaccination-movement-a-qualitative-content-analysis-of-the-great-mothers-facebook-page/

Cole, E. R. (2009). Intersectionality and research in psychology. *American psychologist, 64*(3), 170.

Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science, 568*(1), 41-53.

Connor, J., Madhavan, S., Mokashi, M., Amanuel, H., Johnson, N. R., Pace, L. E., & Bartz, D. (2020). Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. *Social science & medicine, 266*, 113364.

Cook, T. M., & Roberts, J. V. (2021). Impact of vaccination by priority group on UK deaths, hospital admissions and intensive care admissions from COVID-19. *Anaesthesia, 76(*5), 608-616.

Cowan, K. (2020) on behalf of MQ: Transforming Mental Health and the Academy of Medical Sciences. Survey results: Understanding people's concerns about the mental health impacts of the COVID-19 pandemic. *The Academy of Health Sciences*. Retrieved from: https://acmedsci.ac.uk/file-download/99436893

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. u. *Chi. Legal f.*, 139.

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev.*, *43*, 1241.

Crenshaw, K. (2013). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *In Feminist legal theories (pp. 23-51). Routledge*.

Crook, H., Raza, S., Nowell, J., Young, M., & Edison, P. (2021). Long covid—mechanisms, risk factors, and management. *bmj, 374*.

Davies, C. A. (2008). Reflexive ethnography: A guide to researching selves and others. *Routledge.*

Davies, D., McDougall, A., Prophete, A., Sivashanmugarajan, V., & Yoong, W. (2022). COVID-19 vaccination: patient uptake and attitudes in a multi-ethnic North London maternity unit. *Postgraduate Medical Journal, 98*(1164), 750-755.

DeBlaere, C., Zelaya, D. G., Dean, J. A. B., Chadwick, C. N., Davis, D. E., Hook, J. N., & Owen, J. (2022). Multiple microaggressions and therapy outcomes: The indirect effects of cultural humility and working alliance with Black, Indigenous, women of color clients. *Professional Psychology: Research and Practice*.

Devakumar, D., Shannon, G., Bhopal, S. S., & Abubakar, I. (2020). Racism and discrimination in COVID-19 responses. *The Lancet, 395*(10231), 1194.

DHSC (2021). *COVID-19: guidance for people whose immune system means they are at higher risk.* https://www.gov.uk/government/publications/covid-19-guidance-for-people-whose-immune-system-means-they-are-at-higher-risk

DHSC (2022). *Regulations making COVID-19 vaccination a condition of deployment to end* [Press release]. https://www.gov.uk/government/news/regulations-making-covid-19-vaccination-a-condition-of-deployment-to-end

Di Gessa, G., & Price, D. (2021). Changes in Health and Well-Being in COVID-19 Clinically Vulnerable Older English People During the Pandemic. *Innovation in Aging, 5*(Suppl 1), 95.

Dubé, E., Laberge, C., Guay, M., Bramadat, P., Roy, R., & Bettinger, J. A. (2013). Vaccine hesitancy: an overview. *Human vaccines & immunotherapeutics, 9*(8), 1763-1773.

Egede, L. E., & Walker, R. J. (2020). Structural racism, social risk factors, and Covid-19—a dangerous convergence for Black Americans. *New England Journal of Medicine, 383*(12), e77.

Embregts, P. J., van Den Bogaard, K. J., Frielink, N., Voermans, M. A., Thalen, M., & Jahoda, A. (2022). A thematic analysis into the experiences of people with a mild intellectual disability during the COVID-19 lockdown period. *International Journal of Developmental Disabilities, 68*(4), 578-582.

Farhi, P. (2022). *A Rochelle Walensky interview sparked outrage. But the CDC says ABC omitted crucial context*. Retrieved from https://www.washingtonpost.com/lifestyle/media/walensky-abc-interview/2022/01/12/b5744ad4-73be-11ec-bc13-18891499c514_story.html

Farrington, C. P., Miller, E., & Taylor, B. (2001). MMR and autism: further evidence against a causal association. *Vaccine, 19*(27), 3632-3635.

Fearn, M., Harper, R., Major, G., Bhar, S., Bryant, C., Dow, B., ... & Doyle, C. (2021). Befriending older adults in nursing homes: Volunteer perceptions of switching to remote befriending in the COVID-19 era. *Clinical Gerontologist, 44*(4), 430-438.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: the need for prevention and early intervention. *JAMA internal medicine, 180*(6), 817-818.

Gansevoort, R. T., & Hilbrands, L. B. (2020). CKD is a key risk factor for COVID-19 mortality. *Nature Reviews Nephrology, 16*(12), 705-706.

Gillborn, D. (2015). Intersectionality, critical race theory, and the primacy of racism: Race, class, gender, and disability in education. *Qualitative inquiry, 21*(3), 277-287.

Gover, A. R., Harper, S. B., & Langton, L. (2020). Anti-Asian hate crime during the COVID-19 pandemic: Exploring the reproduction of inequality. *American journal of criminal justice, 45*, 647-667.

Graso, M., Chen, F. X., & Aquino, K. (2022). Scapegoating of the Unvaccinated and the Role of Political Ideology. *Available at SSRN 4056613*.

Gray, C., & Hansen, K. (2021). Did COVID-19 lead to an increase in hate crimes toward Chinese people in London?. *Journal of Contemporary Criminal Justice*, *37*(4), 569-588.

Halbertal, T. H., & Koren, I. (2006). Between" Being" and" Doing": Conflict and Coherence in the Identity Formation of Gay and Lesbian Orthodox Jews. *American Psychological Association.*

Hamdan, A. K. (2009). Reflexivity of discomfort in insider-outsider educational research. *McGill Journal of Education, 44*(3), 377-404.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., ... & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for advancing equity. *International journal for equity in health, 13*(1), 1-16.

Han, S., Riddell, J. R., & Piquero, A. R. (2023). Anti-Asian American hate crimes spike during the early stages of the COVID-19 pandemic. *Journal of interpersonal violence, 38*(3-4), 3513-3533.

Hayfield, N., & Huxley, C. (2015). Insider and outsider perspectives: Reflections on researcher identities in research with lesbian and bisexual women. *Qualitative research in psychology, 12*(2), 91-106.

Hawkins, D. (2020). Differential occupational risk for COVID-19 and other infection exposure according to race and ethnicity. *American journal of industrial medicine, 63(*9), 817-820.

Hearne, B. N., & Niño, M. D. (2021). Understanding how race, ethnicity, and gender shape mask-wearing adherence during the COVID-19 pandemic: evidence from the COVID impact survey. *Journal of racial and ethnic health disparities*, 1-8.

Hereth, B., Tubig, P., Sorrels, A., Muldoon, A., Hills, K., & Evans, N. G. (2022). Long covid and disability: a brave new world. *bmj, 378.*

Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., ... & Bullmore, E. (2020). Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science. *The Lancet Psychiatry, 7*(6), 547-560.

Howard, J. A. (2000). Social psychology of identities. *Annual review of sociology, 26*(1), 367-393.

Iacobucci, G. (2022). Covid-19: Government abandons mandatory vaccination of NHS staff.

Jacobson, R. M., Sauver, J. L. S., & Rutten, L. J. F. (2015, November). Vaccine hesitancy. *In Mayo Clinic Proceedings* (Vol. 90, No. 11, pp. 1562-1568). Elsevier.

Jaiswal, J., Singer, S. N., Siegel, K., & Lekas, H. M. (2019). HIV-related 'conspiracy beliefs': lived experiences of racism and socio-economic exclusion among people living with HIV in New York City. *Culture, health & sexuality, 21*(4), 373-386.

Jesus, T. S., Bhattacharjya, S., Papadimitriou, C., Bogdanova, Y., Bentley, J., Arango-Lasprilla, J. C., ... & Refugee Empowerment Task Force, International Networking Group of the American Congress of Rehabilitation Medicine. (2021). Lockdown-related disparities experienced by people with disabilities during the first wave of the COVID-19 pandemic: Scoping review with thematic analysis. *International journal of environmental research and public health, 18*(12), 6178.

Johnston, M. S. (2019). When madness meets madness: Insider reflections on doing mental health research. *International Journal of Qualitative Methods, 18,* 1609406919835356.

Karpinski, M. (2020). *What You Need To Know About The Intersectional Term 'Womxn'. Vitals by Daye online blog.* Retrieved from: https://yourdaye.com/vitals/cultural-musings/what-is-the-meaning-of-womxn/

Keller, F. M., Derksen, C., Kötting, L., Dahmen, A., & Lippke, S. (2022). Distress, loneliness, and mental health during the COVID-19 pandemic: Test of the extension of the Evolutionary Theory of Loneliness. *Applied Psychology: Health and Well-Being.*

Kelly, C., Kasperavicius, D., Duncan, D., Etherington, C., Giangregorio, L., Presseau, J., ... & Straus, S. (2021). ‘Doing’ or ‘using’ intersectionality? Opportunities and challenges in incorporating intersectionality into knowledge translation theory and practice. *International Journal for Equity in Health, 20*(1), 187.

Kemp, O., Horne, G. A., & Soutar, R. (2020). The psychological impact of COVID19 on a shielding high-risk cohort. *Scottish Medical Journal, 65*(4), 120-122.

King, D. K. (1988). Multiple jeopardy, multiple consciousness: The context of a Black feminist ideology. *Signs: Journal of women in culture and society, 14*(1), 42-72.

Kunz, A. D. (2019). WOMXN: An evolution of identity. *Summit to Salish Sea: Inquiries and Essays, 4*(1), 2.

Lala, R., Baker, S. R., & Muirhead, V. E. (2020). A Critical Analysis of Underrepresentation of Racialised Minorities in the UK Dental Workforce. *Community dental health.*

Lantz, B., & Wenger, M. R. (2023). Anti-Asian xenophobia, hate crime victimization, and fear of victimization during the COVID-19 pandemic. *Journal of interpersonal violence, 38*(1-2), NP1088-NP1116.

LaSala, M. C. (2003). When interviewing “Family” maximizing the insider advantage in the qualitative study of lesbians and gay men. *Journal of Gay & Lesbian Social Services, 15*(1-2), 15-30.

Lincoln, Y. S., Guba, E. G., & Pilotta, J. J. (1985). Naturalistic inquiry. Beverly Hills. CA: Sage Publications. Lee, WS (2001). Parents divorce and their duty to support the expense of bringing up their child. *Asian Women, 13*(1), 85-105.

Loades, M. E., Chatburn, E., Higson-Sweeney, N., Reynolds, S., Shafran, R., Brigden, A., ... & Crawley, E. (2020). Rapid systematic review: the impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *Journal of the American Academy of Child & Adolescent Psychiatry, 59*(11), 1218-1239.

Logie, C. H. (2020). Lessons learned from HIV can inform our approach to COVID-19 stigma. *Journal of the International AIDS Society, 23*(5).

López , G. (2021, March 4). *Stop using the phrase 'womxn' to be trans-inclusive. It can be offensive to trans women and non-binary people.* Insider. https://www.insider.com/using-the-phrase-womxn-doesnt-mean-youre-trans-inclusive-2021-3

MacDonald, N. E. (2015). Vaccine hesitancy: Definition, scope and determinants. *Vaccine, 33*(34), 4161-4164.

MacMillan, A. (2021). Osteopathic ableism: A critical disability view of traditional osteopathic theory in modern practice. *International Journal of Osteopathic Medicine, 42*, 56-60.

McKenna-Plumley, P. E., Graham-Wisener, L., Berry, E., & Groarke, J. M. (2021). Connection, constraint, and coping: A qualitative study of experiences of loneliness during the COVID-19 lockdown in the UK. *PLoS One, 16*(10), e0258344.

Menni, C., Klaser, K., May, A., Polidori, L., Capdevila, J., Louca, P., ... & Spector, T. D. (2021). Vaccine side-effects and SARS-CoV-2 infection after vaccination in users of the COVID Symptom Study app in the UK: a prospective observational study. *The Lancet Infectious Diseases, 21*(7), 939-949.

Merriam, S. B., Johnson-Bailey, J., Lee, M. Y., Kee, Y., Ntseane, G., & Muhamad, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. *International journal of lifelong education, 20*(5), 405-416.

Mohdin, A., Swanna, G., & Bannock, C. (2020). *How George Floyd's death sparked a wave of UK anti-racism protests*. The Guardian. Retrieved from https://www.theguardian.com/uk-news/2020/jul/29/george-floyd-death-fuelled-anti-racism-protests-britain [Accessed] 01.02.2023

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations, 2*(4), 221.

Motoyoshi, M. M. (1990). The experience of mixed-race people: Some thoughts and theories. *The Journal of Ethnic Studies, 18*(2), 77.

Mounk, Y. (2020). The extraordinary decisions facing Italian doctors. *The Atlantic online.* Retrieved from: https://www.theatlantic.com/ideas/archive/2020/03/who-gets-hospital-bed/607807/.

Nazroo, J., & Bécares, L. (2021). Ethnic inequalities in COVID-19 mortality: A consequence of persistent racism. *Runnymede/CoDE briefing, January. www.runnymedetrust.org/uploads/Runnymede, 20.*

Ncube, M., & Parker, M. M. (2021). The disproportionate impact of COVID-19: A qualitative investigation into the experiences Black, Asian, Minority Ethnic (BAME) frontline workers within the NHS in West Yorkshire.

Nelson, R. (2020). Questioning identities/shifting identities: the impact of researching sex and gender on a researcher’s LGBT+ identity. *Qualitative Research, 20*(6), 910-926.

NHS (2022a). *Who is at high risk from coronavirus (COVID-19).* Retrieved from https://www.nhs.uk/conditions/coronavirus-covid-19/people-at-higher-risk/who-is-at-high-risk-from-coronavirus/

NHS (2022b). *Long-term effects of coronavirus (long COVID).* Retrieved from https://www.nhs.uk/conditions/coronavirus-COVID-19/long-term-effects-of-coronavirus-long-COVID/

NHS. (2022c). Coronavirus (COVID-19) vaccine. Retrieved from https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/coronavirus-vaccine/

Norko, Devin [@mxdevinn]. (2022, January 9). *folks have pushed the narrative of vulnerable people’s lives being disposable for this entire pandemic (& before), and to see @CDCDirector finding our deaths “encouraging” bc they are less valuable to y’all than economical stimulation is so so appalling. #MyDisabledLifeIsWorthy* [Tweet]. Twitter. https://twitter.com/mxdevinn/status/1480010681218969601

Nyblade, L., Stangl, A., Weiss, E., & Ashburn, K. (2009). Combating HIV stigma in health care settings: what works?. *Journal of the international AIDS Society, 12*, 1-7.

Office for National Statistics. (2021). *Ethnic group, England and Wales Ethnic group, England and Wales: Census 2021*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021#:~:text=the%20%22Asian%2C%20or%20Asian%20British,was%2081.0%25%20(45.8%20million)

Office for National Statistics. (2022a). *Coronavirus and clinically extremely vulnerable (CEV) people in England: 4 April to 23 April 2022.* Retrieved from: Coronavirus and clinically extremely vulnerable (CEV) people in England - Office for National Statistics (ons.gov.uk)

Office for National Statistics. (2022b). *Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 3 November 2022*. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/3november2022

Office for National Statistics. (2023). *Prevalence of ongoing symptoms following coronavirus (COVID-19) infection in the UK: 30 March 2023*. Retrieved from: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/30march2023#prevalence-of-ongoing-symptoms-following-coronavirus-infection-in-the-uk-data

Olmos-Vega, F. M., Stalmeijer, R. E., Varpio, L., & Kahlke, R. (2023). A practical guide to reflexivity in qualitative research: AMEE Guide No. 149. *Medical teacher, 45*(3), 241-251.

Pai, M., Grill, A., Ivers, N., Maltsev, A., Miller, K., Razak, F., ... & Morris, A. M. (2021). Vaccine-induced prothrombotic immune thrombocytopenia (VIPIT) following AstraZeneca COVID-19 vaccination. *Science briefs of the Ontario covid-19 science advisory table, 1(*17), 10-47326.

Palmer, G. L., Ferńandez, J. S., Lee, G., Masud, H., Hilson, S., Tang, C., ... & Bernai, I. (2019). Oppression and power. *Introduction to Community Psychology*.

Pan, D., Sze, S., Minhas, J. S., Bangash, M. N., Pareek, N., Divall, P., ... & Pareek, M. (2020). The impact of ethnicity on clinical outcomes in COVID-19: a systematic review. *EClinicalMedicine, 23*, 100404.

Pantelic, M., Ziauddeen, N., Boyes, M., O'Hara, M. E., Hastie, C., & Alwan, N. A. (2022). Long Covid stigma: estimating burden and validating scale in a UK-based sample. *Plos one, 17*(11), e0277317.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., ... & Gee, G. (2015). Racism as a determinant of health: a systematic review and meta-analysis. *PloS one, 10*(9), e0138511.

Pearson, R. (2019). A feminist analysis of neoliberalism and austerity policies in the UK. *Soundings, 71*(71), 28-39.

Pedrosa, Ana Luisa, Letícia Bitencourt, Ana Cláudia Fontoura Fróes, Maria Luíza Barreto Cazumbá, Ramon Gustavo Bernardino Campos, Stephanie Bruna Camilo Soares de Brito, and Ana Cristina Simões e Silva. "Emotional, behavioral, and psychological impact of the COVID-19 pandemic." *Frontiers in psychology 11* (2020): 566212.

Pentaraki, M., & Speake, J. (2020). Domestic violence in a COVID-19 context: Exploring emerging issues through a systematic analysis of the literature. *Open journal of social sciences*, *8*(10), 193.

Pfitzner, N., Fitz-Gibbon, K., & Meyer, S. (2022). Responding to women experiencing domestic and family violence during the COVID-19 pandemic: Exploring experiences and impacts of remote service delivery in Australia. *Child & Family Social Work*, *27*(1), 30-40.

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *International journal of qualitative studies in education*, *16*(2), 175-196.

Public Health England. (2020). *Beyond the data: Understanding the impact of COVID-19 on BAME groups.* (Publication No: GW-1307). Retrieved from: Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk) [Accessed] 24/06/2022

Rai, I. M. (2020). Emergent positioning in insider ethnographic field: Deconstructing the ideological frame of insider or outsider or both. *Dhaulagiri journal of sociology and anthropology*, *14*, 46-52.

Remedios, J. D. (2022). Psychology must grapple with Whiteness. *Nature Reviews Psychology*, *1*(3), 125-126.

Riggle, E. D., Drabble, L. A., Bochicchio, L. A., Wootton, A. R., Veldhuis, C. B., Munroe, C., & Hughes, T. L. (2021). Experiences of the COVID-19 pandemic among African American, Latinx, and White sexual minority women: A descriptive phenomenological study. *Psychology of sexual orientation and gender diversity, 8*(2), 145.

Riggs, D. W., & das Nair, R. (2012). Intersecting identities. Intersectionality, sexuality and psychological therapies: Working with lesbian, gay and bisexual diversity, 9-30.

Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: Trends of the past and recommendations for the future. *Perspectives on psychological science, 15*(6), 1295-1309.

Robertson, E., Reeve, K. S., Niedzwiedz, C. L., Moore, J., Blake, M., Green, M., ... & Benzeval, M. J. (2021). Predictors of COVID-19 vaccine hesitancy in the UK household longitudinal study. *Brain, behavior, and immunity, 94*, 41-50.

Rosenthal (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist, 71*(6), 474 10.1037/a0040323

Ross, L. E. (2017). An account from the inside: Examining the emotional impact of qualitative research through the lens of “insider” research. *Qualitative Psychology, 4*(3), 326.

Rowlands, J. (2021). Interviewee transcript review as a tool to improve data quality and participant confidence in sensitive research. *International Journal of Qualitative Methods, 20,* 16094069211066170.

Ryan, F. (2020). Coronavirus hits ill and disabled people hardest, so why is society writing us off? *The Guardian. Online.* Retrieved from:

https://www.theguardian.com/commentisfree/2020/mar/11/coronavirus-ill-disabled-people [Accessed] 20/04/2020

Settles, I. H. (2006). Use of an intersectional framework to understand Black women’s racial and gender identities. *Sex Roles, 54*(9-10), 589-601.

Settles, I. H., & Buchanan, N. T. (2014). Multiple groups, multiple identities, and intersectionality.

Schraer, R. (2021). *Covid: Black leaders fear racist past feeds mistrust in vaccine. BBC News Online.* Retrieved from https://www.bbc.co.uk/news/health-56813982 [Accessed] 01/02/2023

Smith, K. (2014). Challenging dominant narratives: Stories of women seeking asylum (*Doctoral dissertation, University of Huddersfield*).

Smith, A. A., Fridling, J., Ibrahim, D., & Porter Jr, P. S. (2020). Identifying patients at greatest risk of mortality due to COVID-19: a New England perspective. *Western Journal of Emergency Medicine, 21*(4), 785.

Smullin, M. (2023). The Effects of Target Facial Stimuli Race, Emotional Expression, and Time Delay on Facial Recognition Memory.

Song, M., & Parker, D. (1995). Commonality, difference and the dynamics of disclosure in in-depth interviewing. *Sociology, 29*(2), 241-256.

Sosa, A., & Brown, L. (2020). *Woman wearing face mask attacked in possible coronavirus hate crime. New York Post*. Retrieved from https://nypost.com/2020/02/05/woman-wearing-face-mask-attacked-in-possible-coronavirus-hate-crime/. [Accessed] 20/04/2020

Spates, K. (2012). “The Missing Link” The Exclusion of Black Women in Psychological Research and the Implications for Black Women’s Mental Health. *Sage Open, 2*(3), 2158244012455179.

Steptoe, A., Aparna, S., Demakakos, P., and Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences 110*, no. 15: 5797-5801.

Sugiyama, A., Miwata, K., Kitahara, Y., Okimoto, M., Abe, K., E, B., ... & Tanaka, J. (2022). Long COVID occurrence in COVID-19 survivors. *Scientific reports, 12*(1), 6039.

Sze, S., Pan, D., Nevill, C. R., Gray, L. J., Martin, C. A., Nazareth, J., ... & Pareek, M. (2020). Ethnicity and clinical outcomes in COVID-19: a systematic review and meta-analysis. *EClinicalMedicine, 29*, 100630.

Taggart, L., Mulhall, P., Kelly, R., Trip, H., Sullivan, B., & Wallén, E. F. (2022). Preventing, mitigating, and managing future pandemics for people with an intellectual and developmental disability-Learnings from COVID-19: A scoping review. *Journal of Policy and Practice in Intellectual Disabilities, 19*(1), 4-34.

Thurston, R. C., & Kubzansky, L. D. (2009). Women, loneliness, and incident coronary heart disease. *Psychosomatic medicine, 71*(8), 836.

Thomas-Olalde, O., & Velho, A. (2011). Othering and its effects–Exploring the concept. *Writing postcolonial histories of intercultural education, 2*, 27-51.

Troiano, G., & Nardi, A. (2021). Vaccine hesitancy in the era of COVID-19. *Public health,* 194, 245-251.

Turner-Musa, J., Ajayi, O., & Kemp, L. (2020, June). Examining social determinants of health, stigma, and COVID-19 disparities. *In Healthcare* (Vol. 8, No. 2, p. 168). MDPI.

UK Health Security Agency (2023, February). *Vaccinations in England. The official UK government website for data and insights on coronavirus* (COVID-19). Retrieved from https://coronavirus.data.gov.uk/details/vaccinations?areaType=nation&areaName=England

Unison NW &Thomas, P. (2014). *The social model of disability. Retrieved from Manchester Disabled People's Access Group*. Retrieved from: http://www.mdpag.org.uk/resources/the-social-model-of-disability/

Valentine, C. (2007). Methodological reflections: Attending and tending to the role of the researcher in the construction of bereavement narratives. *Qualitative Social Work, 6*(2), 159-176.

Valtorta, N. K., Kanaan, M., Gilbody, S., Ronzi, S., & Hanratty, B. (2016). Loneliness and social isolation as risk factors for coronary heart disease and stroke: systematic review and meta-analysis of longitudinal observational studies. *Heart, 102*(13), 1009-1016.

Viala-Gaudefroy, J., & Lindaman, D. (2020). Donald Trump's 'Chinese virus': the politics of naming. *The Conversation, 21*.

Wang, J., Mann, F., Lloyd-Evans, B., Ma, R., & Johnson, S. (2018). Associations between loneliness and perceived social support and outcomes of mental health problems: a systematic review. *BMC psychiatry, 18*(1), 1-16.

Wardle, H., & Obermuller, L. (2019). “Windrush generation” and “hostile environment”: symbols and lived experiences in Caribbean migration to the UK. Migration and *Society, 2*(1), 81-89.

Wasserman, D., van der Gaag, R., & Wise, J. (2020). The term “physical distancing” is recommended rather than “social distancing” during the COVID-19 pandemic for reducing feelings of rejection among people with mental health problems. *European Psychiatry, 63*(1), e52.

Wise, J. (2021). Covid-19: European countries suspend use of Oxford-AstraZeneca vaccine after reports of blood clots.

Ziauddeen, N., Gurdasani, D., O’Hara, M. E., Hastie, C., Roderick, P., Yao, G., & Alwan, N. A. (2022). Characteristics and impact of Long Covid: Findings from an online survey. *PloS one, 17*(3), e0264331.

Zimman, L. (2017). Transgender language reform: Some challenges and strategies for promoting trans-affirming, gender-inclusive language. *Journal of Language and Discrimination, 1*(1), 84-105.

# Part 2: Empirical Paper

# “We are shattered. We are separated”. Experiences of clinically vulnerable, racially minoritized women during the COVID-19 pandemic.

# Abstract

**Aims:** The Coronavirus disease (COVID-19) pandemic has highlighted and exacerbated social and political inequalities nationally and globally (Chen & McNamara, 2020; Hankivsky, 2021; Milner & Jumbe, 2020; Raine et al., 2020). The pandemic has had a vast and devastating effect on individuals' health, well-being and quality of life (White & Van Der Boor, 2020). Little is currently known about the experiences of and impact on those existing at the intersection of multiple marginalised identities, and psychological research in general has been criticised for relying on “Western, educated, industrialised, rich, and democratic” (WEIRD) samples (Henrich et al., 2010), with most samples being comprised of individuals from White ethnic groups (Smullin, 2023). Therefore, the current research aims to understand the experiences of clinically vulnerable (CV), racially minoritized women throughout the Coronavirus disease (COVID-19) pandemic, while considering intersectionality.

**Method:** The sample consisted of seven participants who identified as being women, racially minoritized and CV to COVID-19, resulting in a sample with homogeneity in relation to these characteristics. Seven individual semi-structured interviews were conducted over Microsoft Teams. Interview transcripts were analysed using interpretative phenomenological analysis (IPA).

**Results:** Four superordinate themes were identified from the data. Participants spoke of the *multifaceted accounts of loss* they experienced in various aspects of their life during the pandemic. They discussed *devastations and consequences to health*. Participants were aware of *systemic threat through intersectional inequalities* and discussed the ways in which threat manifested and how they coped. Participants expressed experiences whereby they felt e*xcluded and unprotected.*

**Conclusions:** The research supports the need for psychological research to explore the experiences of individuals with multiple marginalised identities (Buchanan & Wiklund, 2021), thus contributing to more inclusive research (Roberts et al., 2020). Furthermore, for research to recognise the social inequalities and inequities individuals experience (Roberts et al., 2020). It also adds to the growing body of research exploring diverse experiences of the COVID-19 pandemic. It was intended that the study would enrich psychology services' understanding of insight into the experiences of disadvantaged groups throughout the pandemic. It is hoped that the findings might help services ensure that interventions are equitable, accessible and acceptable.

# Introduction

Due to the severe global threat of COVID-19 to health, societies and economies, governments worldwide implemented measures to attempt to minimise the spread of the virus, including national lockdowns and physical distancing guidance (Hadjidemetriou et al., 2020). Swift changes, uncertainty and disruptions to daily life were experienced by people around the world (Riggle et al., 2021). Multiple systems, including healthcare systems, encountered strain which furthered inequalities experienced by vulnerable populations, such as those with pre-existing conditions (Quinlan, 2021). People grieved the loss of loved ones, exacerbated by the loss experienced due to the pandemic, such as support from interpersonal relations (Ratcliffe, 2022). Poor mental health outcomes, such as increased rates of depression, anxiety and psychological distress, were reported globally (Bueno-Notivol et al., 2021; Necho et al., 2021). This included poor mental health outcomes for healthcare workers (Awan et al., 2022; Smallwood et al., 2022) and social care staff (Gillen et al., 2022). In addition, the threat of serious health outcomes and death from COVID-19 was associated with increased feelings of death anxiety (Özgüç et al., 2021), stress and depression (Wang et al., 2020).

## *Impact on specific groups*

Riggle et al. (2021) suggest that differential experiences, such as to health and well-being, during the pandemic can be attributed to discrimination based on individuals' social identities and categories. As a result of systemic inequities, the impact and outcomes of COVID-19 have not been experienced equally (Meyer & Young, 2021). There is a growing body of qualitative research examining the experiences of the pandemic amongst marginalised groups, such as racially minoritized groups (Burgess et al., 2022; Nazroo &

Bécares, 2021), disabled people's experience of lockdown (Embregts et al., 2022; Jesus et al., 2021) and experiences of individuals on low incomes (Adams-Prassl et al., 2020). It is critical to investigate the effects of social oppression, marginalisation and discrimination since they play a significant part in general negative health and well-being outcomes (Gravlee, 2009). Furthermore, this research seeks to explore the experiences of individuals with multiple intersecting identities to provide a greater understanding of how intersectionality can shape an individual's experiences and effect health and well-being, as well as highlight systemic issues and inequality (Rosenthal, 2016).

The reduction in services provided for non-COVID-19 health problems as well as fear of exposure to the virus disrupted access to and delivery of care for all health conditions according to the World Health Organisation (WHO, 2020c). Individuals CV to COVID-19 and those with pre-existing health conditions faced difficulties in accessing healthcare that was redirected to test and treat individuals with the virus (Núñez et al., 2021). Additionally, fear of catching the virus, lack of information about healthcare and misinformation as well as financial barriers contributed to people forgoing healthcare when needed (Baggio et al., 2021).

Currently, little is known about the perspectives of CV people across other factors relevant to the pandemic, such as media reporting and the ending of the shielding programme in the UK as announced in September 2021 by the Department of Health and Social Care (DHSC, 2021). Researchers propose that healthcare professionals and policymakers should focus on the needs of vulnerable groups during outbreaks, for example, through measures such as financial support and targeted outreach to reduce marginalisation and increase access to healthcare (Baggio et al., 2021).

### *Racially minoritized groups*

Research so far indicates racially minoritized groups including Black, Asian and minority ethnic groups in the UK and USA were at a heightened risk of mortality from COVID-19 compared to White identified ethnic groups (Raine et al., 2020). Due to the racialisation of COVID-19, individuals of Southeast Asian descent suffered increased incidents of violent and racist hate crimes (Cheng, 2020; Cheng & Conca-Cheng, 2020). For example, in a review of Metropolitan Police data, Gray and Hansen (2021) reported an increase in hate crimes towards Chinese people during the start of the pandemic when compared to pre-pandemic data.

The summer months of 2020 saw a surge in protests calling for an end to police brutality and racist violence in America, spurred by instances of police killings of unarmed Black Americans (Crooks et al., 2021). In a qualitative study by Riggle et al. (2021) Black participants described further difficulties during the pandemic related to systemic racism and expressed feeling especially vulnerable due to heightened racism and sexism during the pandemic. In the UK, Black and South Asian people reported increased levels of discrimination during the pandemic when compared to White British individuals which was linked to increased levels of psychological distress and decreased life satisfaction (Jaspal & Lopes, 2021).

### *Gender specific impact*

Current research suggests cisgender men are at a disadvantage in terms of mortality from COVID-19, and this has been attributed to biological differences (Flor et al., 2022). Researchers have also explored some of the gender-specific social, economic and health-related impacts of COVID-19. For example, gender-specific inequalities, such as socially expected caregiving responsibilities placed on women and women being more likely to work in front-line healthcare roles, put women at a increased risk of being exposed to COVID-19 (Hall et al., 2020; Flor et al., 2022). Women also suffered increased gender-based violence (Flor et al., 2022) including domestic violence during the pandemic (Pentaraki & Speake, 2020). Wenham et al. (2020) advise including the perspectives and experiences of women and marginalised groups to enhance public health response to disease outbreaks and improve current practices.

Riggle et al. (2021) qualitatively researched the experiences of 21 African America, Latinx and White sexual minority women during the pandemic. In this study African American and Latinx participants conveyed experiencing feelings of social isolation from their communities, which were associated with increased levels of anxiety and depression, as well as additional stress linked to experiences of racism and discrimination. Additionally, these participants experienced further challenges such as systemic racism, violence and hostile political discourse in the context of COVID-19 (Riggle et al., 2021). The current research is similar to Riggle et al. (2021) in that it focuses on the experiences of women with intersecting identities. However, it differs by exploring the impact of clinical vulnerability during the pandemic on the group of participants. This is relevant as racially minoritized groups are more likely to suffer poor health outcomes (Etherington, 2015).

## Intersectionality

Crenshaw (1989, 1990) developed the term ‘intersectionality’ to recognise and study the ways in which different oppressive systems marginalise Black women. It is vital to expose intersecting injustices and structural oppression underpinning gender, health, racial and social inequalities (Hall et al., 2020). While there is emerging literature attempting to understand the impact of clinical vulnerability (Baggio et al., 2021), the impact of racism

(Jaspal & Lopes, 2021), and gender specific impacts (Flor et al., 2022) during the COVID-19 pandemic, the intersection of race, health and gender is important to explore because of the layering of several forms of oppression and discrimination that put individuals at a disadvantage (Crenshaw, 1989). Research exploring multiple forms of discrimination is valuable, as previous research has shown that discrimination encountered by women as medical patients is magnified when they are Black, Asian, Indigenous or Latinx (Ashing-Giwa et al., 2004). It is therefore essential to expose the gendered, racialised and health-related inequalities of the pandemic, along with the social and economic disparities to develop equitable and effective healthcare measures (Gibb et al., 2020).

This research seeks to capture and explore the experiences of a particular group and the layers of marginalisation that can occur, including health, social, and racial discrimination in the context of the shared experience of the ongoing pandemic. Taking an intersectional framework in research utilises the expertise of group members and explores systemic and interpersonal oppression and inequity (Rosenthal, 2016). However, das Nair and Thomas (2012) caution against treating individuals as being experts on or representative of their entire cultural group, instead regarding them as experts on their *view of* their cultural group(s) and personal experiences (Das Nair & Thomas, 2012). Therefore, this research will present the unique as well as the unifying aspects of participant accounts.

## Rationale

There are currently no studies exploring the diverse experiences and impacts of the pandemic on individuals who identify as women, racially minoritized and CV to COVID-19. This unique combination is important because psychological interventions need to consider intersectionality, specifically how multiple marginalised identities layer and interconnect, creating multiple forms of oppression. It is also necessary to consider the historic and contemporary discrimination experienced by individuals and groups (Abubakar et al., 2022; Crenshaw, 1989). This research enables consideration of the mistreatment that can occur for those with multiple minority statuses, through the layering of multiple systems of inequality (Harnois, 2015). This research is focused on a sample of individuals who identify as women, racially minoritized and clinically vulnerable to COVID-19, thus are homogenous in relation to these categories. However, the sample is heterogenous with regards to categories such as age range and representation of different racialised minority groups. According to Henrich et al. (2010), psychology has historically focused on the experiences of 'Western', educated, industrialised, rich, and democratic individuals (WEIRD). This has implications for how data is defined, researched and analysed (Clancy & Davis, 2019), and for what is known and understood about human psychology and behaviour (Muthukrishna et al., 2020). Relying on WEIRD samples creates a less general theory of human behaviour, and therefore limits the generalisability of psychological theory and empirical research (Muthukrishna et al., 2020). The lack of racial diversity in WEIRD samples, namely using primarily White ethnicity participants, fails to capture the effects of cultural and racial ostracism, such as systemic racism (Smullin, 2023). It is important for psychology research to portray diverse voices and experiences to facilitate an understanding of those who have previously been underrepresented. This can be achieved through the exploration of the lived experiences of marginalised groups, along with acknowledging historic and contextual inequalities (das Nair & Thomas, 2012).

Thus, this study proposes to interpret and present the experiences and insights of individuals who identify as women, racially minoritized and CV to COVID-19 through in-depth individual interviews. This is important because it can provide clinical insights that inform the work of mental health professionals, services and policy, as well as inform future research.

Utilising IPA for the research is useful as it supports the exploration of marginalised and underrepresented groups whose experiences are not ‘typical’ of the general population and are likely to be overlooked through quantitative means (Emery & Anderman, 2020). This research will help healthcare because presenting experiences and revealing inequities can support healthcare professionals and policymakers to provide more equitable access and reduce health disparities (Artiga et al., 2020). Additionally, using IPA can provide insight and understanding for healthcare professionals who may not have personal experience of the phenomenon being explored, and therefore enhance the quality of care for marginalised groups (Emery & Anderman, 2020).

## Aims

This study aims to understand, convey and interpret the experiences of racially minoritized, CV women during the COVID-19 pandemic. Further, this research aims to illuminate the social inequalities that are the root cause of the marginalisation and discrimination experienced by specific groups during the pandemic (Hankivsky, 2021). It is hoped that this research will contribute to the representation of individuals from marginalised groups within the current body of research exploring intersectionality and experiences of the COVID-19 pandemic.

# Method

This section discusses IPA; participants and recruitment; ethical and methodological considerations; and data collection and analysis.

## Interpretative Phenomenological Analysis

While quantitative research focuses on gathering and studying numerical data, examining cause and effect, and the generalisability of findings to wider populations, qualitative research is focused on how people make sense of their experiences, the interpretations of participants' and researchers' and the socially constructed nature of reality (Gelo et al., 2008; Pietkiewicz & Smith, 2014). Qualitative inquiry offers the opportunity to examine the integration of multiple factors that impact a person's experience and was therefore deemed the most appropriate approach considering the research aim (Emery & Anderman, 2020).

This study employed an idiographic and hermeneutic method to the research aim through the application of IPA. According to Smith et al. (2009), IPA is used in clinical, counselling, social and educational psychology, with much of the early IPA literature emerging within health psychology research. IPA is deemed best suited to research exploring participants' sense-making processes in detail (Pietkiewicz & Smith, 2012). It is understood as being a constructive approach for the exploration of lived experiences of a personal nature, such as social isolation and discrimination, due to the consideration of reflective, contextual, personal and cultural effects (Knight et al., 2003). Feminist researchers have promoted the use of reflexivity and subjectivity in research, presenting the importance of moving into a relational space to better 'listen and care' (Smith, 2014).

Developed by Smith (1996), IPA is experiential, concerned with lived experience and based on three philosophical principles: phenomenology, hermeneutics, and ideography (Pietkiewicz & Smith, 2014; Smith, 1996).

### ***Phenomenology***

The two approaches to phenomenological research are descriptive and hermeneutic phenomenology. Descriptive phenomenology aims to provide a detailed and unbiased exploration of the essential structure and meaning of lived experience, and hermeneutic phenomenology focuses on interpreting and understanding lived experiences within relevant cultural and historical contexts, exploring the meanings and interpretations individuals bring to their experiences (Wojnar & Swanson, 2007). Phenomenological epistemology aims to capture the richness of a person's experience through inquiry into perceptions and consciousness (Finlay, 2011; van Manen, 1997). According to the philosopher Edmund Husserl, accessing the 'essential structure' of a phenomenon as it occurs in an individual's consciousness is the way to truly grasp the phenomenon described (Husserl, as cited in, Dowling, 2007). Kirn et al. (2019) offer a portrayal of the role of the researcher in IPA as "walking along" with participants in a detailed examination of their personal lived experience.

### ***Hermeneutics***

Phenomenological psychology is concerned with both 'hermeneutics' – the development of descriptive accounts of a person's lived experience, which include cognitions, beliefs, emotions and physical feelings - and the process of interpretation/hermeneutic of these descriptions (Smith et al., 2009). The researcher making sense of participants' sense-making is a process of 'double hermeneutics' (Osborn & Smith, 2008). Interpretation in IPA is described as a dynamic process, that is continual and leads further to the interpretation upon further analysis (Smith et al., 2009).

### *Idiography*

IPA is concerned with nuanced and detailed data when examining a ‘phenomenon’ (Tuffour, 2017). This is achieved through small samples, e.g., six individuals, described as optimal for idiographic and in-depth analysis for student projects (Smith, 2004). Small, homogenous samples allow for in-depth analysis into the specific, providing ‘non-mainstream’ findings (Smith et al., 2009). Though ‘delving deeper’ into a specific experience can provide insight into the universal (Smith, 2004), IPA is concerned with the unique characteristics of participants, as well as interpreting meaning across participant accounts (Smith et al., 2009).

### *Alternative methods*

As the focus of this research was on exploring the experiences of participants and gathering in-depth information, it was deemed inappropriate to use a quantitative approach which investigates the objective (Smith & Rhodes, 2015). Alternative qualitative methods considered included narrative analysis (Crossley, 2000) and thematic analysis (Braun & Clarke, 2012). IPA was deemed most suited as it allows for a broader exploration of the research question, whereas critical narrative analysis examines texts through the perspective of social theory (Smith et al., 2009). Thematic analysis is often utilised in research concerned with finding patterns across the data and applied research that requires the development of, for example, frameworks or models (Braun & Clarke, 2021). However, the current research seeks to explore subjective experience, and the meanings participants give to their experiences, focusing on both individual experiences and patterns across accounts (Willig, 2019).

IPA was found to be the most preferable method considering the research aims and data type. For example, the aim of the research was to obtain comprehensive insights into the subjective experiences of participants (Tuffour, 2017). Previous qualitative research has successfully utilised IPA to explore the lived experience of intersectionality (e.g., Beese & Tasker, 2022; Semlyen & Flowers, 2018). Using IPA in psychology research can provide insight into the experiences of underrepresented groups and help researchers better understand issues of equity and inclusion by providing insight and understanding (Emery & Anderman, 2020). Smith et al. (2009) discuss criticisms of IPA including critiques that IPA does not explore context, however, they argue that IPA's use of hermeneutic, idiographic and contextual analysis aids the understanding of the cultural position and context of the experiences of participants, which is of particular importance in this research.

## Participants

To recruit a sample of participants who identified as women, racially minoritized, and CV to COVID-19, purposive sampling was utilised through public social media platforms.

### *Inclusion criteria*

Individuals were eligible for inclusion in the study if they (1) identified as racially minoritized (2) self-identified as women, (3) were aged 18 years and over, and (4) identified as CV to COVID-19. For homogenous sampling and due to the differences in country response to the management of COVID-19, participants were also those (5) who lived in the UK at the time of the pandemic. Table 1 provides a full list of inclusion criteria.

**Table 1**

*Inclusion criteria*

| Inclusion Criteria |
|---|
| Identify as belonging to a racialised minority group in the UK |
| Identify as a woman |
| Clinically vulnerable/clinically extremely vulnerable to COVID-19, whether medically diagnosed or self-diagnosed |
| Adult, aged 18 years and over |
| Living in the UK during the pandemic |
| Can provide informed consent |
| Fluent English speakers |

### *Participant characteristics*

Seven participants took part in online interviews over Microsoft Teams. Participant ages ranged from 30-60 years. The collection of participant health status, including factors that caused them to identify as CV to COVID-19, was not conducted. It is worth noting that all participants in the study were in employment. Pseudonyms have been used to ensure confidentiality, with participants having been given the option to choose a pseudonym or have one chosen for them by the researcher, guided by name dictionaries that were in line with the ethnicity of the participant. Table 2 presents participant characteristics.

**Table 2**

*Participant characteristics*

| Participant pseudonym | Age | Ethnicity |
|---|---|---|

| | | |
|---|---|---|
| Amal | 52 | North African Arab |
| Leila | 39 | Iraqi |
| Samantha | 53 | Black Caribbean and White British |
| Ria | 30 | South Asian and White Irish |
| Sangita | 60 | South Asian, Indian |
| Maya | 42 | Black Caribbean |
| Nina | 35 | South Asian and White British |

## Procedures

A study advert (see Appendix A) was shared openly on Twitter and on Facebook in a public group from August 2022 to December 2022. Following this, 51 emails containing expressions of interest were received. Of the emails received, 41 were identified as “phishing” emails - fraudulent attempts to steal confidential and personal information online (Khonji et al., 2013). This was identified due to many of the emails containing identical spelling errors, the use of repeated phrases or not being relevant to the research, e.g., emails asking to join a ‘group’. These emails were sent from Gmail addresses of similar names.

Over the course of recruitment, a total of 10 emails were initially evaluated as being "legitimate". Of these 10, three were later identified as being phishing emails and seven were authentic and led to an interview. Five of the final seven participants responded after having seen the study advert on Twitter. Two participants were recruited via Facebook. Figure 1 depicts the steps involved in the recruitment process.

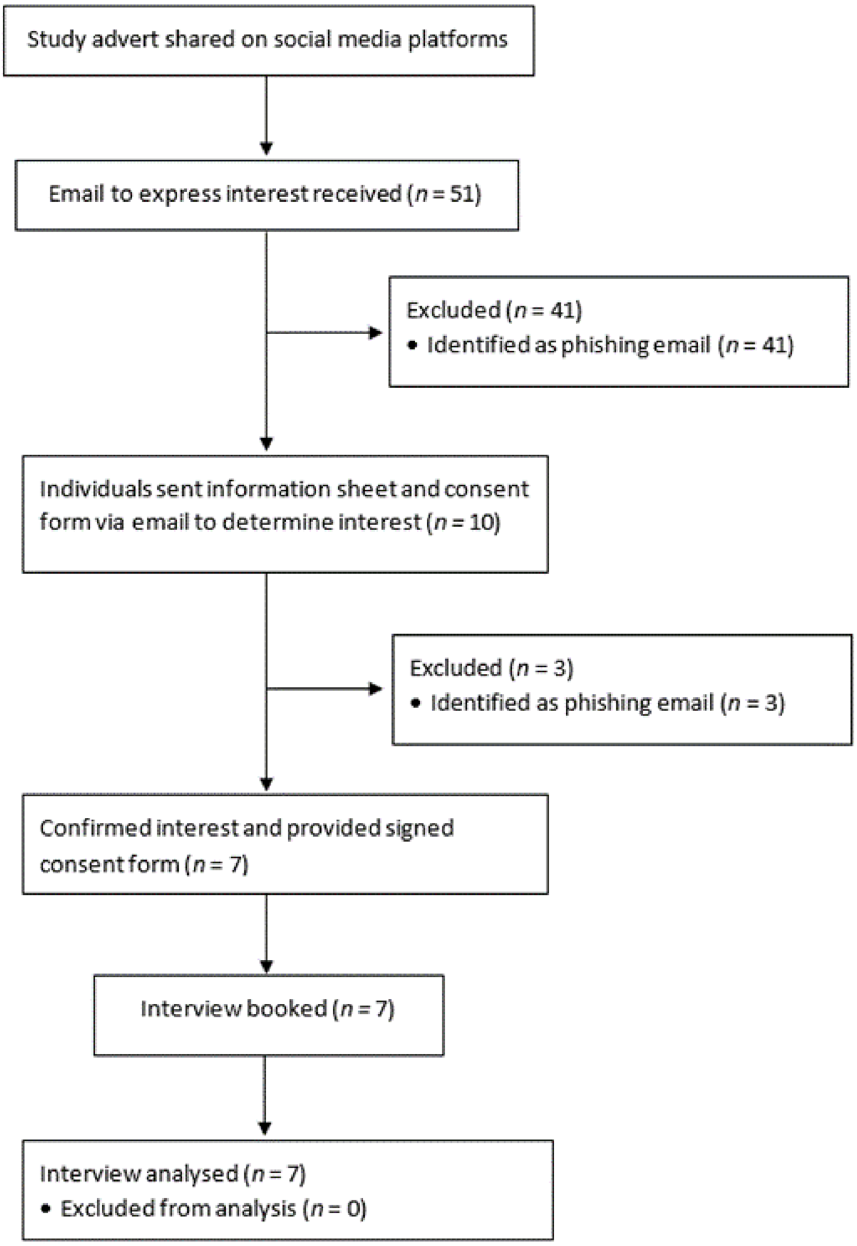


**Figure 1**

*Recruitment process flowchart*

Interviews were conducted from August 2022 to December 2022. Under supervision, the researcher decided to complete recruitment once seven participants had been interviewed. The decision was made based on guidance for professional doctorates from Smith et al. (2009) who advise between four and ten interviews for the purpose of ideographic detail and to allow for successful analysis that requires time, reflection and is a process of double hermeneutics (Osborn & Smith, 2008). Moreover, it was crucial to consider time constraints and ensure that ample time was available to conduct a comprehensive analysis of the data (Smith et al., 2009).

## Ethical Considerations

The UCL Research Ethics Committee provided ethical approval for the research (see Appendix B). Prior to participating in interviews, participants were emailed an information sheet (see Appendix C). They were asked to read the information sheet in full, and in case of any queries, they were advised to approach the researcher prior to signing the consent form (see Appendix D).

The information sheet provided an overview of the research purpose, the research procedure, potential risks and benefits of taking part, data storage and limits to confidentiality. The study advert also provided an explanation of key terms, which was expanded on in the information sheet (see Appendices A and C). Participants were encouraged to ask any questions over email and prior to the interview. No participant raised concern over the terminology used.

Having read the information sheet, all participants provided signed consent forms, which were kept in a password protected folder on a private computer. The folder was accessible only to the first researcher and was kept secure. Interview transcripts were also kept in the encrypted folder, but with any identifying information, such as names, changed or removed from the original transcripts before storage. This was done to ensure confidentiality.

Interviews were held over Microsoft Teams, a virtual video-calling software that is currently approved by the UCL Research Ethics Committee. Links to interviews were sent to participants, and were secure, e.g., participants had to be let into the interview at the time of joining. Following each interview, the participants were debriefed, during which the researcher checked on their emotional state and overall well-being. Participants did not report experiencing any form of distress or discomfort during or after the interview, and no requests for further support were made. However, had any participant requested further support, they would have been signposted to resources (see Appendix E).

### ***Confidentiality statement***

Participants were notified, via the information sheet, (see Appendix C), that all personal information, such as name and contact information, would be kept strictly confidential, and that identifiable information would be stored on UCL's Data Safe Haven, a GDPR-compliant, encrypted system for the duration of the research. Participants were informed that their interview data would be analysed by the researcher(s) and that they would not be identifiable in any subsequent reports or publications. Participants were assured that all information would be kept anonymously and would not be shared with any other parties aside from the first and principal researcher, as listed on the information sheet and consent form (see Appendix C and D). Limits to confidentiality, such as significant risk of harm to the participant, to others, or from others, were stipulated prior to interview and outlined on the information sheet. Should this arise, it was outlined that participants would be contacted to discuss limits to confidentiality and that UCL might need to contact relevant statutory bodies or agencies.

## Data Collection

In addition to the information sheet, prior to interview, participants were sent a consent form (see Appendix D). Interviews were conducted once informed consent had been obtained via email. Considering the COVID-19 pandemic, UCL provided guidance to support research moving to online methods. UCL outlined several sites via which to carry out online interviews, with Microsoft Teams being the preferred software. Interviews were audio recorded using a Dictaphone and transcripts were recorded using Microsoft Teams' in-built transcription service. Transcripts were cross-referenced with the corresponding audio recording to ensure verbatim transcription. Following this, the Dictaphone recording was permanently deleted. Interviews were conducted between August 2022 and December 2022, ranging from sixty to eighty minutes. Participants were remunerated with a fifteen-pound voucher of their choice.

### *Data storage*

Anonymised transcripts were stored on an encrypted, password-protected device accessible only to the first researcher. Original transcripts were deleted from the Microsoft Teams platform. Later, following analysis, transcripts were permanently deleted.

### *Interview schedule*

The flexible interview schedule, (see Appendix F), containing fourteen questions with prompts was developed following guidelines from Smith et al. (2009), and in consultation with the research supervisor, KA, and consultant RD and Sisters of Frida. The research questions included; "W*hat has COVID-19 meant for you?" "How have your experiences been different from/like those around you?" "How have your well-being and mental health been impacted?" "How do you see areas of your life going forward?"* Research questions in IPA should be exploratory and focus on lived experience with the use of questions such as 'what?' and 'how?' (Smith et al., 2009). In IPA, a flexible, open schedule is advised to enable unforeseen themes to develop (Callary et al., 2015). The schedule was created to allow the researcher to answer the research aims, with the caveat to allow for changes before and during the process of interviews as suggested by Smith et al. (2009). The questions were contextualised in order to focus on participants' experience during the COVID-19 pandemic.

The interview schedule includes a visual metaphor question, "*could you describe your experience of the pandemic so far as a metaphor?*". Elliot et al. (2017) describes a visual metaphor as a visual or symbolic image used as a tool to represent and explain a participant's concept or experience. Visual metaphors are said to complement phenomenological research, as generating a visual image involves reflection and critical thinking to illustrate the way a phenomenon is experienced with consideration of the context in which it is experienced (Elliot et al., 2017).

## Materials

The flexible interview schedule was developed following guidelines from Smith et al. (2009) and consultation with a clinical psychologist and expert by experience. The interview schedule was also informed by a bracketing interview led by a trainee clinical psychologist peer, using bracketing interview questions from Roulston (2010), such as, "*do you anticipate any difficulties experiencing power differentials during the interviews?*" and "*do you anticipate any blocks in the research process?*" This encouraged the researcher to examine preconceptions and biases (Tufford & Newman, 2012), which shaped some of the reflections throughout the research process.

The study advert (see Appendix A) was made available in PDF and google document format to allow for the use of screen readers. To ensure accessibility, the font and format were designed based on previous work by the researcher whereby a study advert and questionnaire were checked by a Digital Accessibility Specialist at UCL.

## Analysis

Verbatim, individual interview transcripts usually serve as the data for IPA, due to the ability to allow for idiographic detail, hermeneutic and phenomenological approach (Smith et al., 2009). Transcripts were analysed following the six-stage IPA guidance outlined in Smith et al. (2009). Firstly, transcripts were read and re-read to allow the researcher to immerse themselves into each account. Each transcript was analysed independently prior to looking for patterns across transcripts. Thoughts, feelings and biases of the researcher were bracketed using a reflective log before initial noting of descriptive, linguistic and conceptual comments were made. Subsequently, free-associating comments and deconstruction occurred.

### *Initial noting*

Initial noting comprises analytic observations of the transcript. Initial notes are concise, and the purpose is to familiarise the researcher further with the transcripts as well as initiate the analytic process (Smith et al., 2009). Table 3 is a typed example of initial noting that was conducted on transcripts by hand. Descriptive comments are displayed in red, linguistic in green and conceptual comments in blue and bracketed thoughts can be seen in parentheses.

**Table 3**

*Participant Maya, Original Transcript Page 12, Lines 1-22*

| Transcript extract | Initial noting |
|---|---|
| And I remember when I I remember when I realised and this is gonna sound morbid. And it's not.<br>It doesn't upset me now, but it was really interesting, thought that I had.<br>That Oh my God. So if I were to die of COVID.<br>They would report it, cause it felt like what they were doing when they were reporting numbers. What they were saying. Well, a thousand people died today, but 600 of them were, had had underlying health conditions, as if we were sort of throw away people because we had an underlying health condition and I was just like this is appalling like this is… and and people are doing it without blinking.<br>You are suddenly a throw away person. I get this was really. It was really clear to me. I don't become less of a person just because I have a condition, yeah. | Slight hesitation – could be due to emotion of topic or due to worry how it may be taken by me hearing this?<br>Morbid – (image of death, dying)<br>Suggests it did upset her at the time<br>Use of ‘interesting’, is it curiosity or something more emotive going on – (re-reading I thought this is heart-breaking) - omg – conveying shock, disbelief, upset<br>Having to consider mortality, life – becoming just a number in the reporting of COVID deaths – threat of death and dying<br>Needs and value dismissed due to underlying conditions?<br>Appalling – unacceptable<br>Meaning of reporting – thrown away, dismissed – sent away? Rejected? Dismissed as a person with health conditions – it's okay for them to die? |

***Developing emergent themes and superordinate themes***

Initial notes and transcripts assisted in the creation of emergent themes. Appendix G illustrates pictures and text of the stages of analysis. The aim was for emergent themes to capture the researcher’s interpretation whilst remaining faithful to the participant's sense-making and descriptions. Following initial noting, emergent themes were developed. Table 4 depicts an example of the process of developing emergent themes for the transcript extract used in Table 3.

**Table 4**

*Participant Maya, Original Transcript Page 12, Lines 1-22*

| Emergent themes | Transcript extract | Initial noting |
|---|---|---|
| Death anxiety<br>Threat/threat of death | And I remember when I I remember when I realised and this is gonna sound morbid. And it's not.<br>It doesn't upset me now, but it was really interesting, thought that I had. | Slight hesitation – could be due to emotion of topic or due to worry how it may be taken by me hearing this?<br>Morbid – (image of death, dying) |
| Shock | That Oh my God. So if I were to die of COVID.<br>They would report it, cause it felt like what they were doing when they were reporting numbers. | Suggests it did upset her at the time<br>Use of ‘interesting’ – (I thought heartbreaking) – omg – conveying shock, disbelief, upset |
|  | What they were saying. Well, a thousand people died today, but 600 of them were, had had underlying health conditions, | Having to consider mortality, life – becoming just a number in the reporting of COVID deaths – threat of death and dying |
| Sense of life not valued due to being clinically vulnerable/health conditions | as if we were sort of throw away people because we had an underlying health condition and I was just like this is appalling like this is… and and people are doing it without blinking. | Needs and value dismissed due to underlying conditions?<br>Appalling – unacceptable |
| Unsafe<br>Uncared for<br>Dismissed<br>Life devalued | You are suddenly a throw away person. I get this was really. It was really clear to me. | Meaning of reporting – thrown away, dismissed – sent away? Rejected? Dismissed as a person with health conditions – its okay for them to die? |

| | | |
|---|---|---|
| | I don't become less of a person just because I have a condition, yeah. | |

Once emergent themes were noted on the transcript, they were colour coded and written on individual pieces of paper for the purpose of cross-referencing across the data.

### *Identifying superordinate themes across the data*

Superordinate themes are refined from emergent themes. The emergent themes from each interview were compared across the data set and clustered together. Smith et al. (2009) recommend several processes when searching for patterns across the data. For example, numeration was used in the interest of trialling varying processes to identifying patterns. Emergent themes were tallied to see how often each occurred across the transcript. However, frequency was not found to meaningfully link with impact or significance of themes that were interpreted. Instead, subsumption, the grouping together of themes based on their core meanings; abstraction, whereby similarities in themes are noted; and function, the interpreted purpose or importance of an aspect of a participant's account (Smith et al., 2009) were used to create master themes from each transcript.

Master themes were hand written on individual pieces of paper and laid out across a large table. Themes were clustered together using the techniques as recommended by Smith et al. (2009). For example, themes that were assessed to illustrate similar underlying meanings were clustered together. Appendix G exhibits photographs of this process.

## Validity and Quality

Validity and quality were assessed using Yardley's (2000) four criteria: Sensitivity to Context, Commitment and Rigour, Transparency and Coherence, and Impact and Importance. Further areas of validity and quality were assessed including triangulation.

### *Sensitivity to context*

The interview schedule was discussed in research supervision and consultation, specifically in relation to the content of questions, language use and engagement. The interview schedule was amended following these discussions. Changes included rewording questions, in order to capture IPA's exploratory nature. To ensure sensitivity, participants were compensated for their contributions. Moreover, participants were given the option to review and offer feedback on the findings.

### *Commitment and rigour*

Participants were contacted following analysis for the purpose of respondent validation, also referred to as 'member checks.' Respondent validation requires participants to review the data analysis for accuracy and assess whether the interpretation is fair and reasonable in their view (Torrance, 2012). All seven participants were contacted via email to ask whether they would like to review a copy of a flowchart of the superordinate themes and subthemes, with an explanation of each theme attached. Five of the seven participants provided feedback on the findings, extracts of feedback from emails and quotes are included in Appendix H. Participants shared the feelings they had as they reviewed the analysis. The feedback impacted the process of analysis in terms of confidence in the research findings, and therefore interpretations were expanded on.

### *Transparency and coherence*

A bracketing interview was conducted prior to data collection to mitigate preconceptions or biases of the researcher. A reflective log was kept and updated from the inception of the research question throughout various stages of the research process. Additionally, the audit trail included reflections and bracketed comments throughout the process of analysis. The function of these processes was to allow the researcher to interpret participants' sense-making with negligible impact of their own preconceptions, including thoughts, feelings and own experiences. This was especially important considering the insider researcher position.

### *Impact and importance*

In the discussion section, impact and importance will be explored through discussion of the implications of the research.

### *Triangulation*

Triangulation refers to the use of several methods to obtain a deeper and more thorough understanding of phenomena (Patton, 1999). It is utilised to test validity and whether findings can be verified by different measures (Meijer et al., 2002). Investigator triangulation involved the research supervisor, KA, and consultant, RD, reviewing and providing feedback on all the master themes and related quotes. The percentage or proportion of this review was not measured. Rather, master themes were reviewed on multiple occasions and feedback provided. This iterative process shaped the development and refinement of the final themes. This process also supported confidence in the process of analysis and enabled the researcher to garner further insight into the interpretations and descriptions. Additionally, respondent validation is also a process of triangulation (Torrance, 2012).

### *Quality*

An extensive audit trail was evaluated and reviewed by the research supervisor, KA, and consultant, RD. This supported checks of dependability and confirmability. Dependability refers to the degree to which another researcher could follow, review and replicate the research procedure (Stenfors et al., 2020). Confirmability refers to the objectivity of the research data, that there is a comprehension between the dataset and research findings. Included in the audit trail were detailed and in-depth explanations of personal biases, reflections and emotions that occurred during the analysis. Pertinent quotes alongside descriptions and reflections showcase how themes were created. Photographs were provided of the analysis process that occurred offline and can be seen in Appendix G.

## Reflective passage

The recruitment process extended for approximately three months. Despite initial excitement over the response, I felt discouraged when I realised that most emails were phishing. However, I felt fortunate to have received expressions of interest from the seven women who ultimately participated in interviews. The recruitment experience taught me valuable lessons that I will take forward. For example, given additional time, alternative strategies other than social media for recruitment should have been explored, such as offline community spaces.

During the interview process, I observed a significant overlap in the questions in the interview schedule (see Appendix F). However, I was able to adjust and adapt the questions during interviews based on the participant's responses. Moving forward, to refine the interview schedule, I would engage in a pilot interview. Despite the interview schedule being edited during discussions in supervision and consultation sessions, a pilot interview likely would have facilitated the identification of overlap and resulted in a more efficient interview schedule.

I experienced a sense of enthusiasm and deep engagement during the analysis. Despite initial concerns about doing justice to the participant’s narratives, approaching the analysis with a rigorous approach helped mitigate these worries. Through prioritising rigour and using a range of strategies during analysis, including arranging themes on paper and experimenting with abstraction, subsumption, and frequency, the research was made more robust and instilled a sense of confidence in the findings. Moreover, the process of respondent validation enhanced the findings by further increasing my confidence in my interpretations.

## Findings

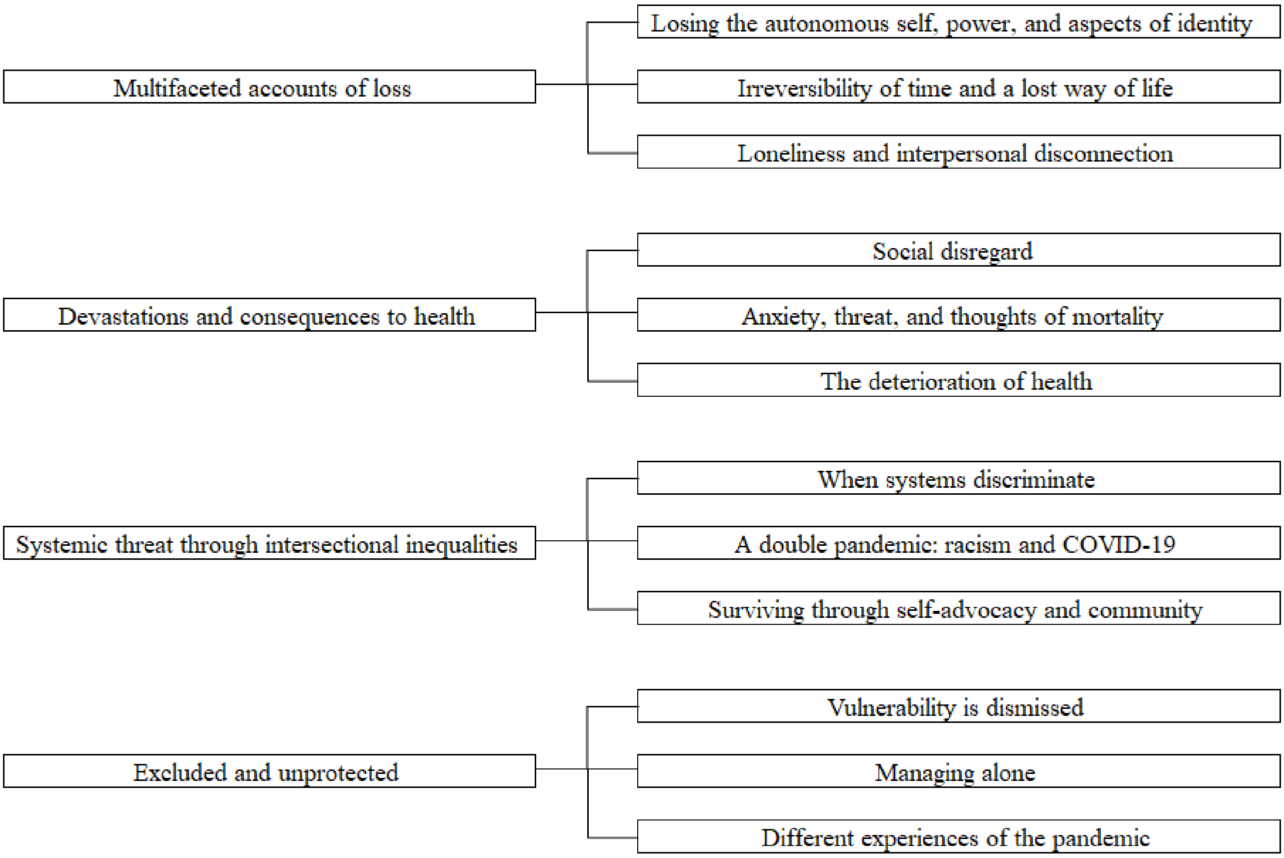
The analysis produced four superordinate themes:

1. Multifaceted accounts of loss
2. Devastations and consequences to health
3. Systemic threat through intersectional inequalities
4. Exclusion and isolation

Under each superordinate theme are three subthemes that were considered equally phenomenological and interpretative. Table 5 illustrates the four superordinate themes and twelve subthemes.

**Table 5**

*Superordinate themes and subthemes.*



## Multifaceted accounts of loss

A sense of loss permeated all participant accounts. When describing the impact of the COVID-19 pandemic, ‘losses’ were a central theme explicitly and implicitly spoken about throughout. Participants spoke of loss in the literal and felt sense. Three subthemes have been created that capture the losses described and interpreted throughout the data.

### *Losing the autonomous self, power, and aspects of identity*

As participants described what the pandemic meant for them, there was a sense of loss of choice, power, and control as well as aspects of identity. Originally, this subtheme was separated into *‘losing the autonomous self and aspects of identity’* and *‘a loss of choice, control and power*’, however, through interpretation and discussion in supervision, it was felt the two overlapped and worked better merged. It was felt that a loss of autonomy and power was closely linked with how participants viewed aspects of themselves. For example, Amal shared that she felt she had no choice but to 'pass through' the pandemic and shared:

> '*normally I'm a strong woman, but the first period of COVID I felt very weak and very vulnerable.'*

Leila shared the following metaphor that supports a sense of loss of power and autonomy:

> *'I suppose it's quite like being in a boat, in choppy waters, you know, out at sea. It's just this huge wave and we would just get carried along with it and there wasn't much I felt could do other than sit in the boat.'*

This metaphor described Leila being carried away by a vast external force (the wave), without perhaps the usual means of steering the boat and navigating the environment. Leila described instead being left to passively ride and survive the wave. For Leila and linked to loss of power, there was also a sense of loss of expertise relating to her work.

Ria shares loss related to identity and linked this closely to vocation:

> *'...some of how I thought of myself, was to do with work. And so, then I did lose a little bit of maybe how I saw myself. I couldn't do some of the things that I was doing before.'*

It is important to note that Ria went on to reflect that, in some ways, she felt that this 'loss' also had positive aspects - directing her towards strengthening other values, such as quality time with family and connecting with members of her community.

### ***Irreversibility of time and a lost way of life***

Participants were not asked directly to remark on their experience of time passing during the pandemic. However, themes relating to time and a way of life being lost were evident in the analysis. Time and, importantly, life as it had been for participants, was something that appeared to be a significant cost of the pandemic. Nina illustrates this when discussing experiencing the pandemic with young children:

> *'It feels like there was just this, couple of years that have just disappeared. I felt like it robbed me of that because they're only young once and now I can't get that time back… there's something significant about that time being lost and not being able to get it back.'*

Samantha shared a metaphor for describing the pandemic:

> *'Yeah, I think a big hole... an external big black hole of all those normal everyday experiences. Going to grab your cuppa, stroll into work. All that disappeared overnight... it's a bit like a black hole cause you can't see what was taken, you you've just got a frame of reference of how you used to exist in the world.'*

This metaphor conjured an image of aspects of Samantha's life being sucked into a void and becoming inaccessible and lost to her. Simple pleasures and occurrences in everyday life were engulfed. Samantha shared, '*COVID took everything away from all of us.'*

There was a sense of finality when she spoke of loss concerning things she used to do, as if she had had to accept that those activities, such as going to the supermarket like she used to, were gone forever. Additionally, similarly to Leila's description of being carried along by a wave, a vast, natural force seems to be at play. There is something uncontrollable and destructive in nature in her description.

### ***Loneliness and interpersonal disconnection***

Experiences of loneliness and interpersonal disconnection were not unique to periods of physical distancing and lockdowns. It's important to note and present the distinction that occurred for participants, that these experiences continued to persist after government measures had ended. Some participants discussed the difficulty of the country ‘opening up’ following lockdowns and the way in which this had highlighted the lack of interpersonal connection for them. The implication of this was loneliness that had a potency and significance, as it was no longer a shared, national experience. For example, Maya shared:

> *‘the connections are not the same as they were prior to covid, and I am certainly not social-able in any way as I was prior to COVID. Um, and part of that was because when everything opened up everyone's like this is fine and perfect, and we can just do everything we used to. And I was like, well I can't.’*

There was a sense that loneliness and interpersonal disconnection that occurred as a result of vulnerability were more difficult than when measures were enforced. This was interpreted as relating to a sense of ‘feeling left behind’ and a sense of aloneness in this experience. Additionally, Leila shared:

> *‘We lost all that. We lost all that sort of sense of community and cohesion and and even a lot of the interfaith work I was doing, you know, just a lot of the kind of impersonal stuff just shut down.’*

Loss of interpersonal connection and sense of community had implications for how participants existed during the pandemic. The idea, as Leila says that ‘stuff just shut down’ illustrates the abrupt transitions through the pandemic. For example, unexpected lockdowns. Nina shared:

> *‘you realise that oh, we do these things, and we spend time with other people. And our children spend time with their family and that, that keeps everything ticking along. So yeah, the value of that. I really, really, I really appreciated that all of those things contribute to feeling happy and being part of something and how important all of that is’*

Participants spoke of the importance of connecting to others, having a support system and a sense of belonging. As Nina illustrates, spending time with other people and family 'keeps everything ticking along.' There was a sense from participants that disruption resulted in feelings of loneliness and experiencing interpersonal disconnection.

## Devastations and consequences to health

Participants had experienced, fear, anxiety, and a decline in health over the course of the pandemic, and suffered ongoing thoughts of mortality, death, and dying. 'Devastations and consequences to health' aims to illustrate these experiences from their accounts.

Fear and anxiety emerged as occurring across participant accounts and, for two separate reasons, were interpreted as two different subthemes. Participants spoke of marginalising experiences of social disregard and worry and fear of disregard for others like them. Participants also experienced fear, anxiety, and worry related to getting seriously ill from COVID-19. It is important to note here that Leila did not share the sense of anxiety, threat, and thoughts of mortality that the other participants shared.

### *Social disregard*

Social disregard refers to the inequities that were experienced and feared by participants. For example, Samantha spoke of the reports of increased risk for racialised minorities and what this meant for her emotionally:

> *'I feel increased fear. I felt increased fear even though I was at home, but I was worried about all my peers that were out and about. I said we need to remember alongside the effect that racism has on people.'*

In addition, Leila discussed concerns for mothers, particularly those from racialised backgrounds:

> *'I think the other thing that wasn't really addressed as well was for mums. So just all this work started going coming home.... that's just a lot of pressure on, particularly on women. And I think it's multiplied when you're a BME woman. I think there's a cultural elements of of what is expected of, of women at home.'*

Amal expanded on this, outlining the different roles and expectations she feels are placed on her. She displayed compassion and worry for others like her. This sentiment occurred across accounts. For instance, Amal discussed 'weakness' in the system's response and support for racially minoritised mothers:

> *'With the vulnerable and with the normal people, and especially with single mums. Ethnic minorities mothers they don't know. So, what could be offered to them, to protect themselves in any crisis.'*

Participants discussed the lack of support, recognition of risk and need for protection of marginalised groups during the pandemic. Strikingly, participants spoke of the social disregard they had experienced and observed, but also actively discussed the ways in which they were supporting others and the concern and regard they held for members of their communities and beyond.

### ***Anxiety, threat, and thoughts of mortality***

Not including Leila, a strong theme throughout participant accounts was mental health difficulties, especially anxiety, having increased during the pandemic. Ria described ongoing anxiety related to thoughts of mortality:

> *'I'm really anxious, and I'm anxious still about you know getting covid, getting a bad strain or something and becoming really unwell or worse, yeah.' [looking away – long pause]*

During the interview, the researcher noted Ria noticeably looked away and paused. It was felt that perhaps she was holding back from showing emotional pain or perhaps taking a moment to reflect on the fear and threat she had been experiencing.

Sangita shared similar fears around contracting COVID-19:

> *'It might be really yeah might be deathly deathly consequences. I was so scared. Really really really scared of what would happen if I caught it.'*

Analysing and reviewing the above quotes was a reminder of the devastating and catastrophic impact of COVID-19. Nina shared concerns for her health and the impact of long-lasting and understandable anxiety around her health:

> *'I think that the pandemic really did not do my mental health much good at all. It really knocked it. I was extremely anxious. ... I was just surviving, and with all that anxiety in the background of this is this is going to last forever and am I gonna get really ill?'*

The description of mental health having been knocked by the pandemic was interpreted as a sense of damage and a profound negative impact. Participants emphasised the intense and devastating impacts of the pandemic on their mental health often linguistically, as seen in Nina's quote, 'extremely anxious' reinforces the destruction and despair experienced by the pandemic.

### *The deterioration of health*

Across all accounts, participants spoke of deterioration in their physical and mental health. They spoke of worsening symptoms, difficulty in accessing health care, and physical and emotional pain over the pandemic. Maya discussed her physical health conditions and worsening symptoms over the pandemic: *'my health was getting worse.'*

Leila discussed lockdowns and the impact staying at home had on her health:

> *'to never, ever leave my room and never, ever leave my computer, you know, from 9 until 5, just be on one webinar after another. I think it's quite concerning for long-term health outcomes. And it was also quite socially isolating. And I'm very much a social person...'*

Nina shared difficulties she had experienced with her mental health. She hypothesised that perhaps, without the pandemic, her mental health might have declined anyway but seemed to link the ongoing stressful nature of the pandemic to her worsening mental health:

> *'It feels like the my overall mental health is worse day-to-day generally. And who knows, maybe it wasn't linked... That's my understanding you, you know you put too much stress on, if someone's under too much stress for that long and it did feel like it just felt like surviving it didn't feel like. Yeah, it didn't feel like living, it was just surviving.'*

Some participants expressed difficulty in accessing appointments and care required for non-COVID-19-related health conditions and symptoms. The fallout and having to forgo treatments exacerbated pre-existing conditions and worsening of symptoms for participants. Sangita articulates this impact:

> *'I'm noticing medical help being really bad, appointments, GP appointments, hospital appointments. Um, I've really struggled with getting support when I needed it. Which maybe you know a bit of a side effect, but. It's really hard for you know, the things that I need help with.'*

Sangita emphasises the difficulty in accessing healthcare leading to the worsening of health. Similarly, Ria shared:

> *Physical health isn't good, isn't great. Um, again, there's like a lot of of things that I need to sort out. God was really difficult to do. Really difficult to get, like GP appointments, and I haven't been able to.'*

Across participant accounts were explanations of deteriorating health - further indications of the multifarious consequences of the pandemic.

## Systemic threat through intersectional inequalities

Participants shared a sense of threat and mistrust towards systems that are known to perpetuate harm towards those from marginalised groups, such as racism, sexism, and ableism. Examples were shared of experiences over the pandemic whereby intersections of disadvantage led to compounded marginalisation and discrimination. For example, Ria shared:

> *'I don't feel important to my work I don't feel I am important to wider kind of, ah, like organisations you know even the government again with their messaging around "it's only these people" that are really affected by covid.'*

Participants identified how they were under threat from or in fear of systems of power, such as the government, workplaces, academic institutions, and mainstream media. Participants highlighted instances where they perceived these systems as sources of potential harm or oppression, which had an impact on their emotions and overall well-being.

### *When systems discriminate*

Initially, this subtheme was labelled, *'broken trust in systems that are supposed to support'*. However, upon reflection the researcher felt that the assumption systems were trusted by participants in the first instance was implied. This idea of initial trust was not necessarily present in the data, descriptively or from interpretation. During the write-up of the results, the subtheme *'when systems discriminate'* emerged and felt congruous both with the descriptive accounts of participants and the interpretation of the researcher. For example, Leila describes contacting her workplace for support around protections for racialised minorities. She shares how she was met with abuse:

> *'the stuff around diversity, they didn't respond to, and I mean I got bullied essentially despite asking for something very reasonable. It got really intense, so yeah, very upsetting to be honest.'*

What stands out is a twofold response or lack of response. Firstly, those in the position of power did not act to protect Leila, as an employee at risk of harm. Secondly, Leila encountered further harm and discrimination through bullying, which she describes as 'intense' and 'very upsetting'. This illustrates an example of threat, harm, and discrimination being perpetuated by a system, and by individuals within a system of power.

Most participants felt that the government lacked leadership and provided a poor response to the pandemic. There was a sense that, further to this, there was direct discrimination and harm enacted by the government towards those from marginalised groups. Maya shared:

> *'the government didn't really think about people who were clinically vulnerable and disabled in that way when they were removing measures.'*

A common linguistic trend throughout the data was a tendency for participants to switch to speaking more generally about people who were vulnerable and at risk as opposed to talking about their own experience. This is illustrated in this quote from Amal:

> *'they don't care about us. Yes, the services try, they try to help people but there is a weakness for the minorities. There is a weakness, and they start to judge them straight away. They mentioned the Asian community – I thought, wow, this is judgemental when they bring it to the news.'*

In this example, Amal started speaking in the first-person plural with the use of *'us.'* Her words continue and she shifts to third-person plural with the use of, *'them', 'the minorities' and 'the Asian community.'* This was interpreted as Amal communicating what was meant by *'us.'* Additionally, Amal suggests services, in this instance, health care services, '*don't care about us*.' She says that services do try to help people but makes a distinction between the way in which marginalised and minoritised communities and individuals are treated as compared to other communities. In relation to the subtheme - *'when systems discriminate'*, there is a sense that it is known that systems work for some but not for all. Further to this, systems can perpetuate harm to those who are disadvantaged. This connects with the next subtheme.

### ***A double pandemic: racism and COVID-19***

The concept of the 'double pandemic' was mentioned by several participants. For them, this referred to the impact of racial discrimination amid the COVID-19 pandemic (Addo, 2020). Ableism was also spoken about by many of the participants, though this was linked directly to the management of the pandemic.

Speaking of the reports that people from 'BAME' backgrounds were at increased risk of contracting COVID-19, Sangita responded:

> *'I heard people from a BME background are more vulnerable, and that really scared me to cause it's almost like a double fear.'*

Sangita spoke of her fear, on learning of the risk to racialised people, describing it as a 'double fear' due to her already identified CV status. Several participants spoke about CV status related to health conditions as being acceptable, for example, sharing how they understood that there may be interactions that would place them at risk due to other pre-existing conditions. However, the risk and vulnerability related to 'race' was felt to reflect something insidious. Though some participants spoke of not being surprised of the risk of COVID-19 to racially minoritised groups, they experienced the reminder of the risk and harm of racism, discrimination and xenophobia as being ‘crushing’.

Samantha spoke of worry for her peers working in lower-paid, frontline jobs during the pandemic:

> *‘And nobody really cared because nobody really cares about minority communities those are kind of messages, I think we are getting at the moment. And then combined with that we had what many of us started to refer to as the double pandemic effects. And that was the murder of George Floyd combined with COVID. So, you’ve got this disproportionate impact on sections of the population.’*

Samantha spoke of the disproportionate impact of COVID-19 and the murder of George Floyd, a 46-year-old African American man who was murdered by a White police officer in Minnesota, United States on May 25th, 2020. Most participants referred to the impact of the resurgence of the Black Lives Matter (BLM) movement as a result and their experience of this amid experiencing the COVID-19 pandemic. Nina shared:

> *‘Actually, it's difficult to for me to to disentangle the pandemic and also everything that was going on with Black Lives Matter. I think made everyone sit and think about their own experiences of race, racism... we were kind of quite isolated. And then you know they're difficult topics. They're difficult things to think about on your own on on top of the fact of how COVID has been experienced differently by different racialised groups as well.'*

Many participants spoke of the devastating emotional impact of the US police brutality and killings that were highlighted in the summer of 2020. Participants feared for others, their friends and family and the multiple effects of racism being reported during the pandemic. In addition, there was a real difficulty reported of not being able to come together with others to process the vicarious trauma experienced.

Some participants seemed to describe a conflict between two needs. On the one hand, they felt the need to engage in activism, such as requesting action from senior managers at work to respond to reports of ‘BAME risk’ and racism and take a stance on the issue. On the other hand, they also felt the need to protect themselves from "intolerable" and potentially traumatic conversations about racism and the murder of George Floyd. This tension between activism and self-preservation created a challenging situation for the participants. Some shared feeling a sense of responsibility or pressure to speak on issues of racism raised in different spaces as the only racially minoritised person ‘in the room’. Additionally, some discussed the overwhelming observation of racism and discrimination, as illustrated in a quote from Maya:

> *‘I realised the callousness of people because what happened was it was horrific... It was horrendous I think, and and it really fed into a feeling of inequality and some quite racist attitudes in this country. And so we need support.’*

There is a sense of real threat and, as described, a real need for support. The seriousness of the threat feels illuminated by the words used by Maya, such as ‘callousness,’ ‘horrific,’ and ‘horrendous.’ The feeling following interpretation is that there is much more needed, and that support was insufficient and lacking for participants throughout the pandemic. This links with what some participants discussed as the lack of response to reports that racially minoritised groups were at increased risk of severe symptoms and mortality from COVID-19. Leila shared:

> *‘it was really good to see the data that for the first time put attention on race in healthcare cause we haven’t had that before. But then we didn’t do anything meaningful*

> *with that information…. Nothing was done practically to stop people from ethnic minorities dying.'*

There was a sense from participants of disappointment in the lack of response from systems investigating risk to racialised minorities. In addition, and in relation to the resurgence of BLM, some participants spoke of disappointment in the absence of action and the silence from systems of power in their lives.

### ***Surviving through self-advocacy and community***

The last subtheme, '*surviving through self-advocacy and community',* is related to explanations and descriptions from participants of ways in which they coped with the pandemic and systemic threat. It is important to note that, whilst this theme could be interpreted 'positively' and as a sign of strength and "resilience", self-advocacy and turning to community is not necessarily a choice. Instead, it was interpreted as being a necessary response to marginalisation and not having the privilege of support systems in place, such as, the government, NHS, and education systems.

The analysis outlined the importance of community for participants and, for some, a move towards this value. For example, Nina shared:

> *'I've been thinking a lot recently about collective care rather than self-care... and I think that's a beautiful way of supporting people looking after people. And rather than making people work in a really rigid way and then saying, but you now need to go and have some self-care into that. Actually, if everyone was looking after each other a little bit more in ways like that, then everyone's mental health would be a little bit better, I think.'*

Nina's description of the 'beauty' of collective care directed thoughts of where the onus of care is often placed in social systems. Nina later discussed the point that increased external and environmental stressors would lead to increased anxiety, though turning to a community could mitigate this. Ria also spoke of the helpfulness of connecting with communities she identified with:

> *'I've had to, I've been left to fend for myself in a way through this I've had to do that because of the different supports kind of falling away… tapping into different communities and people that I identified with online was also helpful.'*

What was also striking was the language used by Ria; *'left to fend for myself.'* This conjured an image of them being left behind in the cold, harmed and alone with no choice but to carry on and survive. This was interpreted with descriptions of self-advocacy in Ria's data and later, across the data. The interpretation was that self-advocacy was mandatory. It was interpreted as being a strength demonstrated by the participants, but it felt wrong to ignore the inequities that may have led to the need for self-advocacy.

Sangita spoke of connecting with family and with religious practices that she started at the beginning of the pandemic:

> *'I was in touch with family in India who were doing a lot of meditation to help with the stress and fear of COVID.'*

Her move towards community and important religious practices supported Sangita to cope with stress and fear related to COVID-19. There was a sense that Sangita moved towards these practices due to the time that lockdowns provided, as well as an increase in meditation meetings moving online. There was also a sense from participants across accounts that they needed to search out support or create support for themselves and others.

### Excluded and unprotected

This superordinate theme and the subthemes within represent experiences, thoughts, and feelings that permeated across the data. ‘Exclusion’ was felt to summarise several participant experiences. Being unprotected, the idea of this being purposeful, and feeling forgotten and left behind were strong feelings across many accounts.

***Vulnerability is dismissed***

Vulnerability, including CV status, was discussed across participant accounts, and the feeling that risk and vulnerability was of no importance to others. ‘Dismissed’ felt appropriate and was voiced by several participants as illustrated in a quote from Samantha:

> '*some of us have different needs and those need to be recognized as well rather than dismissed.’*

Participants spoke to the nuances of needs during the pandemic. What felt clear was that they felt their needs were dismissed by others. During the analysis, images of participants being pushed aside and excluded were interpreted from the data. It was interpreted that participants’ needs were not considered, for example, as plans to return to work in-person conversations started up following the government ending national lockdowns.

Several participants spoke about various systems, including their workplace, dismissing their level of risk and their need to justify and fight for their rights. For example, Maya shared:

> ‘*I just I was just very blunt and I said I'm not willing to risk my life.’*

There was a sense of not being protected or thought about when plans to change or even end, for example, remote working arrangements were being discussed. Additionally, many spoke of people not understanding their vulnerability and need to avoid COVID-19. A quote from Amal illustrates this idea further:

> *'So, some people they understand, some people they feel oh. Just we don't need to [follow lockdown rules]. You don't need to. So, this is, yeah, put you under kind of pressure.'*

Vulnerability being dismissed spanned people and systems as discussed by participants. There was a sense of dismissal due to not understanding or sharing the experiences of participants. There was also frustration over, for some, a positive aspect of the pandemic (remote access) potentially being taken away. However, this interpretation does not reflect all participants' thoughts and feelings. For example, Leila shared a different opinion:

> *'what if getting viruses is good for you? Like what if actually the immune system needs a kind of boost and by kind of walling yourself off and sitting, you know, sitting indoors and cutting yourself off from kind of, you know, sunlight, what if that actually weakens your immune system? So I just didn't feel that the approach was realistic.'*

Leila had a different opinion on the government measures and questioned the consequences in relation to lockdowns and physical distancing. It's important to contextualise that Leila identified as CV to COVID-19 for a period of the pandemic but not at the time of interview, whereas other participants still identified as CV at the time of interview. Though not related to vulnerability feeling dismissed, Leila's experiences were seemingly dismissed by others as she spoke of feeling like her views '*might end up being a bit unusual*' for the research. It was felt that Leila's reflection perhaps indicates experiences of her being dismissed and ostracised in her view of the measures and response to COVID-19.

### ***Managing alone***

There was a sense of managing feelings, experiences, and vulnerability alone. An idea of aloneness in the depths of an unusual and burdensome situation. For example, some participants discussed support from partners or family members, while having to grapple with vulnerability that was unique to them. For example, Sangita shared:

> *‘Um, you know, describe myself as disabled. I've had a lot gotta health lots of health problems over the years... Um and I'm the only one [in my family]. Although they [my family] are you know they give support. I think even they can't understand really what it's been like.*’

Participants shared the support they had, and the people they had connected with and disconnected from during the pandemic, although there was isolation in the uniqueness of the position they found themselves in, in relation to their family and social circles, and wider society.

Amal shared:

> *‘People, they start to loosen up after the vaccination. I remembered for a long time they didn’t give me permission to go out. So, this brought extra feelings, is it me or is it the people. Oh my god, people they start to reconnect and reunion. Me, I am still alone, and no one can see me. So, some people they understand, some people they feel oh we just don’t need to.’*

Amal discusses her plight, while other people were ‘allowed’ to go out, she was not. She could not join others as she had hoped. The image of her alone is powerful. There is a sense of her feeling ‘unseen.’ Amal discusses how some people understand her situation but that others do not understand why she is continuing to shield herself from COVID-19. Ria discussed similar thoughts:

> ‘*I am feeling that I need to do my own risk assessments. I don't want to take any risks, but if I'm going to take a risk, I want it to be for something that's important to me and not saying that works not important. But you know, if it it's not essential to be in, and*

> *it's not in my case, then I'm not gonna go in because I'm not gonna put myself at risk for something that doesn't need. There's no need.'*

Participants shared the feeling that they were managing the dilemmas of the pandemic alone. There were experiences that highlighted, for many participants, that conversations around risk and wanting to stay 'safe' were had many times. Most participants spoke of having to justify why they needed to remain working remotely, or why they couldn't attend a social event, and this was expressed with frustration and feeling misunderstood and alone. The idea of conducting your own risk assessment in relation to COVID-19 has implications for how safe and cared for participants may have felt.

### ***Different experiences of the pandemic***

Whilst there is a lot of cohesion across the accounts in this research, it is important to note the uniqueness of narratives. Leila shared she felt that she might not be as anxious as other participants about the effects of catching the virus. Though there is divergence in Leila's account from others in the research, there are some similarities in experiences and more so in feelings interpreted across the data. For example, Leila shared thoughts during the interview:

> *'I don't think I've had a forum to kind of express the range of things that I have inside of me before and to express them, then somebody argues with you about it.'*

There was an idea of her voice being excluded from the dominant narratives created around COVID-19. She expresses here the lack of space she has had to express a range of opinions, experiences, thoughts and feelings, and when she has experienced arguments rather than curiosity or engagement in a discussion. This has been included under this subtheme as an important account to reflect the uniqueness and feeling of experiencing the pandemic differently from others.

Maya described a visual metaphor to describe the pandemic:

> *'...sort of pushing a boulder up the hill and every time you think you're going up, you slide back down and then you're pushing it and you slide back down…. Everybody's pushing their boulders, but they're separate. Other people are getting it up at different stages. Some people it's almost hitting them, for others it's this lovely picnic and they're just kind of relaxing you know. So, it's very different.'*

This visual metaphor was vividly experienced by the researcher and explored in depth with Maya. An image of multiple people, all existing on the same hill and trying to get up. The hill represented the pandemic and terrain, obstacles and the activities of the people represented the differing inequities experienced. There was a sense that the pandemic was an impossible, strenuous and challenging task as illustrated by descriptions and metaphors from participants. What was presented by many, was the idea that this experience was not shared by all, that those disadvantaged, for example, CV to COVID-19, had experienced/were experiencing a difficult and different pandemic.

Sangita described her social life during the pandemic:

> *'Um social so socially. I think it's been WhatsApp video calls, phone calls that I've speak to people but otherwise I had very little social contact during the pandemic and still try to be careful now.'*

Participants highlighted the stark inequalities they experienced and witnessed through the pandemic. Many spoke of needing to stay safe and be careful, when compared to others. While 'different experiences of the pandemic' unified accounts, it also shows the idiosyncrasies in participant accounts. For example, the structural meaning of this subtheme converges accounts whereas the descriptions and interpretations are varied.

In summary, participants shared experiences, beliefs, emotions, bodily sensations and images while discussing their lived experiences of the pandemic. The superordinate themes and subthemes were arranged based on temporal markers. The losses were discussed by participants early on in interviews and weaved in and out throughout, for example, participants discussed what they had 'lost' which indicated losses that happened at the start the pandemic though many were still felt and had lasting consequences. Devastations and consequences to health along with systemic threat through intersectional inequalities were reflective of participants' discussions of experiences amid the pandemic, for example, during lockdowns and reporting of increased risk for racially minoritized individuals. Lastly, the theme *'excluded and unprotected'* was interpreted as a pervasive experience among participants throughout the pandemic. From the onset of the pandemic until the time of the interviews, participants expressed experiences of exclusion and a sense of being unprotected. Divergent aspects have been conveyed where appropriate throughout and have portrayed the uniqueness of accounts. Additionally, convergence and what has unified accounts and how, e.g., the underlying meaning or function of a theme has been illustrated.

## Discussion

This research qualitatively investigated experiences of the COVID-19 pandemic from a sample of seven individuals who identified as women, racially minoritized and CV to COVID-19. The researcher analysed seven semi-structured individual interviews using IPA. Four superordinate themes and twelve subthemes were interpreted from the data. The superordinate themes: *'Multifaceted accounts of loss', 'Devastations and consequences to health', 'Systemic threat through intersectional inequalities' and 'Excluded and unprotected'* will be discussed in turn, along with how each relates to previous research. The discussion section will also discuss strengths, limitations and implications of the research. Finally, this section will outline recommendations for future research and plans relating to dissemination of findings.

## Multifaceted accounts of loss

Across all participant narratives, accounts of loss were integral to the depiction of what the COVID-19 pandemic had meant for them. Participants expressed a sense of loss of choice, power and autonomy as well as loss of aspects of their identity. Loss of autonomy was expressed through descriptions of external forces, such as the government or workplaces reducing participants' abilities to make their own decisions. Some participants grappled with the loss of power and influence they had had in different areas of their lives, such as decisions related to childcare, feeling coerced to return to face-to-face working or feeling trapped at home. Depictions of being 'carried along' and having little choice encompassed these explanations. Aspects of this are similar to findings from research of different subgroups within the general population, such as Pandey et al. (2020) who suggest that measures instigated during outbreaks, such as quarantine and lockdowns, can result in a sense of loss of control and of feeling trapped, which can negatively impact upon psychological well-being. It is crucial to note that the time interviews were conducted, between August 2022 and December 2022, and the context of how COVID-19 was managed in the UK, including the fact that measures such as national lockdown had ended, play a crucial role in providing context for these findings and how they impact the participants in the current research.

This theme also encompasses the loss of normal/usual life activities, such as going to a supermarket, and the wider impact of this loss on the idea of self. The loss of a sense of normalcy can disrupt a person's worldview and threaten their well-being (Walsh, 2020). Participants also shared the ways in which they had lost a sense of themselves, instead feeling weak and vulnerable in the face of the threat of the virus. Irreversibility of time and a lost way of life was another subtheme within the multifaceted accounts of loss described by participants. This superordinate theme is in line with suggestions from other researchers, that the COVID-19 pandemic has produced an extensive sense of loss, including the deaths of loved ones, the loss of social contact and the loss of pre-pandemic ways of life (Walsh, 2020).

Descriptions and experiences underscored by loneliness and interpersonal disconnection permeated participant accounts. A lack of interpersonal communication and feelings of loneliness are related to new or worsening symptoms of anxiety and depression (Pandey et al., 2020). Experiencing feelings of loneliness and being socially isolated are key determinants of health (King, 2018). Loneliness is associated with experiencing multiple losses and is often explored in older adult samples due to the multiple losses experienced as a result of ageing, such as social losses, loss of loved ones and in some instances physical loss (Bhutani & Greenwald, 2021; Kirkevold et al., 2013). As a result of the consequences of the pandemic, the participants reported experiencing multiple types of losses, and thus the heightened likelihood of loneliness could also be attributed to the impact of these multiple losses. It's important to note that the loneliness and interpersonal disconnection described by participants was in the context of the pandemic. In a meta-analysis of studies examining the association between loneliness, social support and symptoms of mental health problems, loneliness was found to have a moderate association with symptoms of depression, anxiety and post-traumatic stress during the COVID-19 pandemic (Gabarrell-Pascuet et al., 2023). Additionally, recent research warns that social disconnection and other varying factors have implications for health and well-being, for instance, people not seeking help for serious conditions as they would usually be encouraged by others (Parretti et al., 2023).

## Devastations and consequences to health

Participant narratives highlighted multiple devastations and consequences of the pandemic on their physical health, mental health and well-being. Participants shared experiences that were interpreted as demonstrating social disregard, that is inequitable treatment and opportunities encountered during the pandemic. Some participants spoke of the various roles and expectations placed on them, for example, increased childcare responsibilities. All participants showed empathy and concern for others in similar situations and discussed the lack of systemic support for racial minority groups.

A sense of fear and threat was palpable across accounts, for a range of reasons. For some the fear related to contracting the virus, getting seriously ill or dying. For others, fear was related to the loss of positive physical or mental health strategies, or the experience of worsening physical health, such as a decline in stamina or an increase in chronic pain without treatment. Mental health difficulties, particularly anxiety, were a common theme throughout participant accounts, for a variety of reasons. This reflects recent research exploring the impact of the pandemic on mental health. For example, in a review and meta-analysis of 52 studies, anxiety, depression and distress were significantly increased during the pandemic, as compared with pre-pandemic prevalence (Necho et al., 2021). Additionally, with the exception of Leila, all participants discussed mortality, and anxious cognitions relating to becoming seriously ill or dying. In a systematic review of 13 studies exploring anxiety linked with COVID-19, Özgüç et al. (2021) found experiences of death anxiety or “fear of death” increased over the pandemic. The review also indicated that death anxiety was higher in healthcare workers, women and elderly people than younger people.

Most of the participants expressed apprehension about the reduction in or absence of follow-up appointments or treatments for their pre-existing health conditions and felt that their health had deteriorated as a direct result of this. This finding is supported by a recent report from the Runnymede Trust that found people CV to COVID-19 suffered difficulties in accessing healthcare during the pandemic (Núñez et al., 2021). Although the current research did not explore motivation to get help for non-COVID-19-related health issues, recent research suggests that media and public health messaging depicting a stretched and overburdened NHS, along with the fear of contracting and spreading the virus, could have reduced both opportunity and motivation to access the NHS (Parretti et al., 2023). Although there is no indication from the current findings that participants were discouraged from seeking healthcare, the findings do demonstrate that participants experienced disruptions to their healthcare, partly as a result of a strained public health system.

### Systemic threat through intersectional inequalities

Participants shared examples of compound marginalisation and discrimination that they had experienced due to intersecting inequalities, such as the "double pandemic" of racism and COVID-19. The findings suggest that participants felt a sense of threat from and mistrust towards systems that perpetuate harm towards marginalised groups, via racism, sexism and ableism. Participants identified the government, workplaces, academic institutions and the media as systems of power that neglected their needs and/or intimidated or oppressed them further when they asked for support. The results of the research reflect findings from Burgess et al.'s (2022) study on the experiences of young racially minoritized people during the pandemic. For example, participants in Burgess et al.'s (2022) study discussed varying impacts including experiencing incidences of racism and discrimination. Some participants reported experiencing increased anxiety and fear as a result of racist abuse experienced in person and online (Burgess et al., 2022).

Many participants highlighted the murder of George Floyd as having been a significant emotional and, for some, traumatic event during the pandemic. The subsequent uprising of the BLM movement was experienced as being entangled with the COVID-19 pandemic. Participants expressed a predicament between engaging in activism and following lockdown rules. A similar finding was discussed in Burgess et al.'s (2022) study, where young people discussed the dilemma of wanting to participate in protests but being apprehensive about their increased risk of contracting the virus. Additionally, Riggle et al. (2021) found that additional challenges were experienced by Black and Latinx sexual minority women due to intersecting systems of oppression that intensified their sense of vulnerability during the pandemic.

Finally, all participants spoke about the coping mechanisms they adopted to manage the consequences of the pandemic, including turning to communities and self-advocacy. The importance of valuing and turning to community was emphasised as being a means of support for participants, in contrast to the perceived threat of systems of power. The ideas of resilience and self-advocacy were explored during the analysis. It was felt that these ideas have positive connotations and that forming them into a separate superordinate theme would ignore the context within which these processes arise – out of necessity rather than desire. Sivashanker and Couillard (2022) propose a change in the way resilience is understood in healthcare, to consider the structural issues that need to be addressed. The authors discuss prioritising the narratives and voices of marginalised groups. Without critical understanding of the myriad difficult contexts in which resilience may arise, its development could be viewed as purely positive in nature, neglecting a crucial aspect of participants' experience. Therefore, the subtheme of survival through self-advocacy and community was developed, to acknowledge the process of resilience, self-advocacy and depending on communities, as a response to systemic threat. This is not to convey these processes are negative – they could indeed be described as beneficial. However, as Buchanan and Wiklund (2021) propose, it is crucial to be careful with language so as not to attribute issues to individuals, but rather to highlight that systemic inequities are often the primary cause of distress.

### Excluded and unprotected

All participant accounts described feeling unprotected, forgotten or left behind in some way. For most participants, vulnerability, whether related to CV or race, was dismissed and they expressed feeling alone in managing their emotions and experiences. This was not the case for Leila, rather she described experiences which were interpreted as her being alone in her thoughts, feelings and how she managed the pandemic in comparison to others, e.g., she conveyed apprehension about government measures, such as lockdowns but did not experience anxiety about the virus. So, although there were commonalities in the thoughts and emotions shared by participants, there were also unique narratives and experiences expressed.

Vulnerability, including CV status, was discussed by most participants, with many feeling that their needs were dismissed by others, for some this included family members, due to a lack of understanding of the unique challenges and risks they faced. Participants discussed having managed their emotions, experiences and vulnerability alone. Despite having support from loved ones, they described a sense of solitude in the distinctiveness of their situation, as compared to the wider population.

Currently, there is a lack of research exploring the experiences and perspectives of clinically vulnerable individuals during the COVID-19 pandemic. Experiencing feelings of dismissal and invalidation has been reported to be associated with negative health outcomes in a sample of people with chronic illness (McManimen et al., 2019). Additionally, as referenced in the findings section, it is imperative to note that belonging to a marginalised group or groups is not the root cause of discrimination and oppression, but rather it is the systems of power or individuals with power that perpetuate structural inequalities and inequities (Buchanan & Wiklund, 2021).

## Strengths and limitations

There were several strengths and limitations in the current research. Firstly, through IPA the research has attempted to understand the lived experiences of the participants and aimed to provide an in-depth presentation of the context and conditions that have influenced their experiences (Tuffour, 2017). The use of hermeneutic, idiographic and contextual analysis in IPA supported the researcher in understanding the cultural position of participants (see Smith et al., 2009). This was of particular importance in this research project, which explored the experiences of people from marginalised groups while considering intersectionality. The researcher sought to mitigate any potential limitations when using IPA. One potential limitation discussed in the literature is the lack of focus on language (Tuffour, 2017). However, Smith et al. (2009) have argued that IPA's use of linguistic noting and exploration may counter this criticism. Therefore, linguistic noting was used throughout the initial noting phase of analysis, along with conceptual and descriptive noting as recommended by Smith et al. (2009). Additionally, analysis included respondent validation, so that participants could provide feedback on interpretations, and to give structure to participants' experience (Slettebø, 2021).

This research provided insight into the experiences of individuals who exist at the intersection of multiple identities during the COVID-19 pandemic. The sampling could be seen as a strength of the current research, as psychology research has been criticised for mostly relying on WEIRD samples to represent human thoughts, development and behaviour (Henrich et al., 2010). However, the research sampling could also be criticised as inferring that all members of a group, e.g., racially minoritized individuals, have the same experiences. Although this was not the intention, and the research sought to acknowledge that individuals within certain groups have unique experiences and perspectives and that there is diversity within groups, sampling a group of racially minoritized individuals could lead to the interpretation of the findings being oversimplified or 'flattening’ the experiences of differences between groups (Selvarajah et al., 2020). Therefore, future research could explore the experiences of specific racialised groups so as not to conflate the experiences of all ethnic/racial minority people, instead attending to the nuanced and diverse experiences of individuals from varied racially minoritized backgrounds (Selvarajah et al., 2020). Moreover, the use of categories and terms, such as ‘CV’, ‘racialised minority’ and ‘woman,’ could not be useful if individuals do not relate to the chosen terms and may have affected the recruitment process as people may have refrained from expressing interest if they did not identify with these terms. However, Selvarajah et al. (2020) discuss categorisation as being helpful in some instances, in order to identify inequalities. It has been acknowledged that no terms are ideal and that terms/categories have been operationalised for the purpose of qualitative study and homogenous sampling where possible.

There is a call and need for psychology research to take an intersectional approach, although there is substantial debate as to what makes a truly intersectional research project (Buchanan & Wiklund, 2021; Reed et al., 2021). Buchanan and Wiklund (2021) suggest ways in which researchers can include intersectionality, such as being intentional about including diverse views and actively involving those with lived experiences of marginalisation. The researcher sought consultation with experts by experience who have personal lived experience with the subject matter, in order to try to ensure that the study would be meaningful and applicable to the individuals it affects (Veseth et al., 2017). Additionally, Buchanan and Wiklund (2021) recommend prioritising the voices of marginalised groups in research, and the current research specifically focused on the lived experiences of a sample of individuals who exist at the intersection of multiple marginalised identities.

Furthermore, when conducting intersectional research, Bowleg and Bauer (2016) recommend utilising a mixed methods approach to support insights into the complexity and nuance of participants' experiences. They suggest that using both qualitative and quantitative methods can allow researchers to obtain the meanings attributed to experiences as well as to collect information, such as patterns and frequency of experiences, to enable a more in-depth understanding (Bowleg & Bauer, 2016). The current study took a purely qualitative approach, with no quantitative methods employed. Although frequency was examined as part of the analysis, ultimately, it did not contribute meaningfully to developing themes.

Participants sent expressions of interest after seeing the study advert via social media platforms. Social media access is an ethical consideration when recruiting research participants online. Digital literacy is increasingly demanded in society, most recently due to the recent global pandemic and government measures, such as lockdowns and guidance to avoid ‘non-essential’ travel (Butarbutar et al., 2021). However, not everyone has internet access, or the skills required to navigate online platforms. Previous research has found those from underprivileged backgrounds, such as those with lower incomes, are less likely to have internet access and digital skills when compared to those from more privileged backgrounds (Hargittai et al., 2019). Therefore, a limitation of this research was that it did not employ more nuanced approaches when it came to advertising and sampling, thus neglecting digital inequalities (Hargittai et al., 2019). It could have been advantageous to use other advertising methods, such as community centres or public notice boards, to encourage a more accessible study and diverse sample. Additionally, the study advert was shared on social media platforms, Twitter and Facebook, which generated many phishing emails to the researcher and research supervisor, whose emails were listed on the advert. Checking each email for phishing was time-consuming. To prevent this, the researcher could have inquired into phishing protection prior to using social media for the purpose of advertising.

A further limitation could relate to the process of respondent validation. While this was acknowledged as a strength, it is also important to acknowledge a potential issue when respondent validation is conducted by the researcher, due to participants potentially feeling reluctant to criticise findings that may be perceived as criticism towards the researcher (Long & Johnson, 2000). To moderate this, Long and Johnson (2000) suggest that the researcher employ a third party to gather feedback from participants. Specifically, the researcher can present the findings to participants, and a third party could gather feedback directly from the participants to counteract concerns about voicing critical feedback.

## Implications

### *Psychology services and practitioners*

The current research contributes to the growing body of research exploring varying minority groups' experiences of the COVID-19 pandemic, for example, research into the lived experience of racially minoritized young people (Burgess et al., 2022) and experiences of racially minoritized, sexual minority women (Riggle et al., 2021). The findings suggest a need for services to consider the barriers faced by people who hold multiple marginalised identities. Psychology services may wish to consider the unique ways in which individuals experience disadvantages that are historically and contextually located. The COVID-19 pandemic has further intensified social inequalities and highlighted the need for policies and interventions that address these inequalities, including structural racism (Burgess et al., 2022). The findings of this research could facilitate understanding from practitioners working to support marginalised groups during the pandemic. For instance, although a lack of trust in systems may only be relevant to the participants in the current research, it highlights the importance for healthcare providers and professionals to acknowledge that this may hinder access to healthcare for certain groups.

The findings of the current research also highlight a demand for training on the social inequalities and potential challenges and needs of specific marginalised groups in order to provide improved mental health care. For example, participants in the current research expressed fear of social disregard, fearing of increased risk due to racism during the pandemic and feeling that their needs were dismissed during the pandemic. It is crucial for social inequalities to be recognised in mental health training programmes and interventions (Delgadillo, 2018). Additionally, as indicated by this research, participants expressed fear related to the disparities in COVID-19-related risks and outcomes impacting racially minoritized groups. As previously suggested, it is essential that culturally sensitive and carefully considered interventions are implemented to support marginalised groups (Chen & McNamara, 2020). Such interventions not only benefit the most marginalised, but taking a bottom-up, intersectional approach is suggested to create more equitable outcomes for all members of society (Crenshaw, 1989). Considering the impact of the global pandemic and increased demand for psychological services (Molodynski et al., 2021), it is important for psychologists to recognise intersections of advantage and disadvantage and understand the impact of marginalisation and discrimination on certain groups.

This research indicates that practitioners and services who are working with individuals during the pandemic need to be conscious that people may have experienced different types of loss due to the pandemic. These losses may include the bereavement, the loss of a sense of community, or the loss of the engagement in daily activities. For the participants in the current research, these losses were felt in combination with other losses. Therefore, those who work with individuals during the pandemic must be mindful of the various types of loss and the potential ways these losses can shape people's lives and experiences, such as a sense of loss of self, time and experiences of loneliness and disconnection.

Additionally, when discussing positive aspects of the pandemic participants expressed flexibility regarding access to remote working, access to cultural spaces that were once inaccessible due to physical demands, and flexibility related to receiving healthcare. When discussing NHS psychological services and hopes for the future, participants shared that they hoped for continued flexibility, such as the option of online therapy sessions. Some discussed accessibility gains related to having a physical disability and being able to attend appointments online. The current literature suggests that remote therapy during the COVID-19 pandemic has increased accessibility (Erlandsson et al., 2022) and a survey of psychotherapists and patients evaluating in-person and remote therapy found that patients reported a high level of satisfaction with remote sessions and no significant difference between in-person and remote therapy levels of satisfaction (Probst et al., 2021). However, there can be challenges that need to be considered when providing remote therapeutic support, such as issues relating to privacy and confidentiality (Whaibeh et al., 2020), and further research is required in order to explore the benefits and challenges in depth (Erlandsson et al., 2022).

### ***Social justice***

As was reflected in Burgess et al.’s (2022) study, participants in this research grappled with conflicting needs regarding their activism and protecting themselves and loved ones from the virus due to increased risk in the context of BLM protests. Furthermore, some participants reported feeling a sense of obligation to address racism in various spaces as the sole member of the group from a racialised background. This indicates a need for additional support and careful consideration of work towards racial equality, including mitigating the burden on racially minoritized people. In research on racial justice activist burnout in the US, findings suggest racially minoritized activists experienced additional burdens, such as racism, which compounded the effects of burnout (Gorski, 2019). The recommendations, such as combating systemic oppression and inequities, including creating communities to address burnout, could be applied to psychology by creating supportive communities (Gorski, 2019), and working with communities in decision-making processes to combat social and economic health inequalities (Marston et al., 2020).

The findings from the current research indicate a need for creating environments where individuals can gather to feel connected, empathised with and safe. Specifically, expressed feeling that they were isolated in their experiences, feeling that their experiences differed from others and sensing that their vulnerabilities were dismissed and disregarded. Mental health services may consider working towards developing distinct ‘safe spaces’ for marginalised groups to receive mental health care. Safe spaces are described as physical or virtual places where marginalised groups can come together with little risk of, for example, discrimination, that could be experienced in majority groups (Wallin-Ruschman & Patka, 2016). Deller (2019) suggest that safe spaces can encourage social justice and social change. Co-production with marginalised groups, where power differentials are addressed and relationships are built over time, can facilitate the creation of safe spaces (Burgess & Choudary, 2021). Though, challenges of creating safe spaces for marginalised groups within psychology need to be addressed, such as defining who the space is intended for and identifying what risks and challenges groups need to feel safe from (Wallin-Ruschman & Patka, 2016).

### ***Policy***

das Nair and Thomas (2012) provide guidance for therapists when considering intersectionality with clients, such as examining power differentials and taking care with disclosure. Additionally, Hankivsky (2021) calls for health policy and decision-making to be informed by an intersectional approach. Such an approach is essential to confront the unequal impact of the pandemic on marginalised groups. The current research findings contribute to knowledge of the unequal impact, for example, participants discussed the stark inequalities they experienced when compared to others. For instance, being CV to COVID-19 and at increased risk due disparities including socioeconomic inequalities, racism and discrimination (PHE, 2020).

The findings of this research highlight structural oppression and harm experienced by racially minoritized, CV women in the context of the pandemic. For example, experiences of lack of support from systems of power, bullying and discrimination. As indicated by this research, factors such as a sense of threat and mistrust in systems would indicate the need for carefully considered support and policy that addresses and names the ways in which pre-existing systemic inequities persist. For example, in the UK, racism is seldom recognised as a determinant of health in policy that local authorities use to evaluate the health needs of a local population (Salway et al., 2020). It is imperative for racism to be identified as a key determinant of health inequalities that amplify the exposure to and mortality from COVID-19 in government and public health policy (Nazroo & Bécares, 2020). Additionally, a majority of the participants in the current research discussed risk and vulnerabilities being ‘dismissed’ by others. Policymakers should name the ways in which certain groups are at risk of multiple forms of discrimination, such as racism, ableism and sexism, and identify the root cause of systemic inequalities rather than focusing only on the ‘symptoms’ (Nazroo & Bécares, 2021).

### ***Representation in psychology***

Loder (2022) suggests that difficulties in tackling health inequities are linked to a lack of medical doctors who represent the patients they serve in terms of characteristics. This is based on evidence that doctors who reflect the racial and cultural group of their patients are associated with improved health outcomes (Loder, 2022). Singh et al. (2022) proposes that biases and discrimination, such as racism, ableism, sexism, ageism and transphobia can impact diagnostic thinking, which can be reduced by recruiting and training medics from ‘diverse’ backgrounds. This has implications for clinical psychology as, over many years, efforts have been made to increase diversity within clinical psychology to ensure practitioners reflect the people they serve (Santiago & Miranda, 2014). This is important as research suggests that diversity among health practitioners improves the quality of care and addresses healthcare disparities through cultural competence and clients being more likely to trust professionals who share their racial or cultural background (Smedley & Mittman, 2011). Although not presented as a theme, a belief shared by most participants was the need for representative staff in psychological services. For example, two participants shared that they would want therapy in their first language. This is an important consideration as research indicates communicating in a client’s first language promotes positive healthcare outcomes, including increased rapport, client satisfaction and improved quality of care (Ranjan et al., 2020).

## Future research

Future research on the effects of the ‘double pandemic,’ defined as racial discrimination amid COVID-19 (Addo, 2020), is indicated by the findings of the current research. Future research should qualitatively investigate experiences of the pandemic with more homogenous participant groups to recognise the diversity that exists within groups. When exploring social identities which are linked to experiences of denigration, it is vital to recognise the complexity of marginalisation. While individuals may belong to a marginalised group, they may still possess certain characteristics or advantages (McCall, 2005). For example, the pandemic has exacerbated inequalities, such as the oppression of racially minoritized groups, however, there are differences, notably, the increased racial discrimination, violence and xenophobia that have been experienced by East Asian people during the current pandemic as a result of the racialisation of COVID-19 (Cheng & Conca-Cheng, 2020). Furthermore, the reporting of mortality and increased risk to Black people during the pandemic created an added layer of stress and burden to the challenges already faced during the COVID-19 pandemic (Burgess et al., 2022).

Garcia et al. (2020) assert that the negative impact on racial minority groups, such as increased mortality, can only be stopped by addressing systemic racism. Abubakar et al. (2022) propose several principles to address the harm to health caused by racism, xenophobia and discrimination which include addressing structural racism through transformative action such as equitable housing. In healthcare, the authors illustrate a decolonial approach to anti-racist interventions, such as taking ideas from outside western-dominant research. Other researchers also highlight the need for action, such as healthcare and policy to reflect cultural sensitivity, increasing diversity in senior leaders in the NHS to be representative of the population served (Salway et al., 2020) and support from those at ‘the top’ of systems to address systemic issues (Davies, 2022). These types of actions are posited as key drivers for health equity (Garcia et al., 2020). Future research may wish to take a decolonial approach as suggested by researchers when exploring racial trauma in Africana communities, such as storytelling in community settings to promote ‘community healing’, a sense of belonging and respecting diverse experiences and viewpoints (Chioneso et al., 2020).

## Dissemination

Considering debates over intersectional research, one area of critique is the lack of action discussed in research exploring the experience of people with multiple marginalised identities (Buchanan & Wiklund, 2021). Therefore, the researcher plans to disseminate the research findings and implications widely. Sharing research widely is considered as being transformative action, and vital to the research process, enabling wider audiences to access the research and potentially enhance the impact on policy and practice (Salway et al., 2020). Therefore, the intention is to publish the findings and implications of this research in journals that offer free access, such as the *Women & Therapy* open access journal. By doing this, it would facilitate transformative action towards disseminating research openly and to diverse audiences.

Aside from publishing in a journal, it is also important to consider other ways of communicating the findings of this research. For example, Salway et al. (2020) suggest going beyond western-dominant approaches to dissemination, such as journals and conferences, and instead working with communities to facilitate other ways of dissemination. Therefore, the researcher intends to contact appropriate charitable organisations to discuss sharing the findings.

## Conclusion

In conclusion, the findings of this research provide insight into the nuanced experiences of CV, racialised women during the COVID-19 pandemic. The findings and discussion recognise and contextualise participants' experience in the context of inequalities experienced during the pandemic, such as threat related to the increased risk towards racially minoritized groups. Participants discussed losses that they encountered, the devastating health consequences experienced, and the systemic inequalities and increased risk they faced due to marginalisation. Participants described experiences in which they felt excluded and unprotected. Convergence and divergence were discussed to share what unified accounts as well as to present unique challenges and differences between accounts. It is important to present convergence and divergence for the purpose of presenting variability in IPA and contextualising participant perspectives (Nizza et al., 2021). The findings and implications of the current research have contributed to understanding the lived experiences of racially minoritized, CV women during the COVID-19 pandemic, and the inequalities and processes that underpin these experiences. Future research may wish to qualitatively investigate experiences with more homogenous participant groups, paying attention to and recognising the diversity that exists within groups.

## References

Abubakar, I., Gram, L., Lasoye, S., Achiume, E. T., Becares, L., Bola, G. K., ... & Devakumar, D. (2022). Confronting the consequences of racism, xenophobia, and discrimination on health and health-care systems. *The Lancet, 400*(10368), 2137-2146.

Adams-Prassl, A., Boneva, T., Golin, M., & Rauh, C. (2020). *Inequality in the impact of the coronavirus shock: new survey evidence for the UK.*

Addo, I. Y. (2020). Double pandemic: racial discrimination amid coronavirus disease 2019. *Social Sciences & Humanities Open, 2*(1), 100074.

Artiga, S., Orgera, K., & Pham, O. (2020). Disparities in health and health care: Five key questions and answers. *Kaiser Family Foundation.*

Awan, S., Diwan, M. N., Aamir, A., Allahuddin, Z., Irfan, M., Carano, A., ... & De Berardis, D. (2022). Suicide in healthcare workers: determinants, challenges, and the impact of COVID-19. *Frontiers in psychiatry, 12*, 792925.

Baggio, S., Vernaz, N., Spechbach, H., Salamun, J., Jacquerioz, F., Stringhini, S., ... & Gétaz, L. (2021). Vulnerable patients forgo health care during the first wave of the Covid-19 pandemic. *Preventive medicine, 150*, 106696.

Barnes, C., & Mercer, G. (2005). Disability, work, and welfare: Challenging the social exclusion of disabled people. *Work, employment and society*, *19*(3), 527-545.

Beese, L. E., & Tasker, F. (2022). Toward an understanding of the experiences of Deaf gay men: an interpretative phenomenological analysis to an intersectional view. *Journal of Homosexuality, 69*(14), 2412-2438.

Bhutani, S., & Greenwald, B. (2021). Loneliness in the elderly during the COVID-19 pandemic: a literature review in preparation for a future study. *The American Journal of Geriatric Psychiatry, 29*(4), S87-S88.

Bjelland, M. J., Bruyere, S. M., Von Schrader, S., Houtenville, A. J., Ruiz-Quintanilla, A., & Webber, D. A. (2010). Age and disability employment discrimination: Occupational rehabilitation implications. *Journal of occupational rehabilitation*, *20*(4), 456-471.

Bowleg, L., & Bauer, G. (2016). Invited reflection: Quantifying intersectionality. *Psychology of Women Quarterly, 40*(3), 337-341.

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37-47.

Buchanan, N. T., & Wiklund, L. O. (2021). Intersectionality research in psychological science: Resisting the tendency to disconnect, dilute, and depoliticize. *Research on Child and Adolescent Psychopathology*, *49*(1), 25-31.

Bueno-Notivol, J., Gracia-García, P., Olaya, B., Lasheras, I., López-Antón, R., & Santabárbara, J. (2021). Prevalence of depression during the COVID-19 outbreak: A meta-analysis of community-based studies. *International journal of clinical and health psychology, 21(*1), 100196.

Burgess, R. A., & Choudary, N. (2021). Time is on our side: operationalising 'phase zero'in coproduction of mental health services for marginalised and underserved populations in London. *International Journal of Public Administration*, *44*(9), 753-766.

Burgess, R. A., Kanu, N., Matthews, T., Mukotekwa, O., Smith-Gul, A., Yusuf, I., ... & Gul, M. (2022). Exploring experiences and impact of the COVID-19 pandemic on young racially minoritised people in the United Kingdom: *A qualitative study. Plos one, 17*(5), e0266504.

Butarbutar, R., Sauhenda, A. F., Marnina, H. R., & Wahyuniar, S. M. R. L. (2021). Challenges and opportunities of accelerated digital literacy during the COVID-19 pandemic. *Hong Kong Journal of Social Sciences*.

Callary, B., Rathwell, S., & Young, B. W. (2015). Insights on the process of using interpretive phenomenological analysis in a sport coaching research project. *The Qualitative Report*, *20*(2), 63-75.

Chen, B., & McNamara, D. M. (2020). Disability discrimination, medical rationing and COVID-19. *Asian bioethics review*, *12*(4), 511-518.

Cheng, H. L. (2020). Xenophobia and racism against Asian Americans during the COVID-19 pandemic: Mental health implications. *Journal of Interdisciplinary Perspectives and Scholarship, 3(*1), 3.

Cheng, T. L., & Conca-Cheng, A. M. (2020). The pandemics of racism and COVID-19: Danger and opportunity. *Pediatrics*, *146*(5).

Chioneso, N. A., Hunter, C. D., Gobin, R. L., McNeil Smith, S., Mendenhall, R., & Neville, H. A. (2020). Community healing and resistance through storytelling: A framework to address racial trauma in Africana communities. *Journal of Black Psychology, 46*(2-3), 95-121.

Clancy, K. B., & Davis, J. L. (2019). Soylent is people, and WEIRD is white: Biological anthropology, whiteness, and the limits of the WEIRD. *Annual Review of Anthropology, 48,* 169-186.

Coates, M. (2020). Covid-19 and the rise of racism. *bmj*, *369.*

Connor, J., Madhavan, S., Mokashi, M., Amanuel, H., Johnson, N. R., Pace, L. E., & Bartz, D. (2020). Health risks and outcomes that disproportionately affect women during the Covid-19 pandemic: A review. *Social science & medicine, 266,* 113364.

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stan. L. Rev., 43,* 1241.

Crenshaw, K. (2013). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In *Feminist legal theories* (pp. 23-51). Routledge.

Crooks, N., Donenberg, G., & Matthews, A. (2021). Ethics of research at the intersection of COVID-19 and black lives matter: A call to action. *Journal of Medical Ethics*, *47*(4), 205-207.

Cross, M. (2013). Demonised, impoverished and now forced into isolation: the fate of disabled people under austerity. *Disability & Society*, *28*(5), 719-723.

Crossley, M. (2000). Introducing narrative psychology. McGraw-Hill Education (UK).

das Nair, R., & Thomas, S. (2012). Race and ethnicity. *Intersectionality, Sexuality, & Psychological Therapies: exploring lesbian, gay, and bisexual diversity. London: Wiley Blackwell/BPS-Blackwell imprint. Pp59-88*.

Davies, R. (2022). Delan Devakumar: redressing racism and discrimination in health. *The Lancet, 400*(10368), 2037.

Delgadillo, J. (2018). Worlds apart: Social inequalities and psychological care. *Counselling and Psychotherapy Research, 18*(2), 111-113.

Deller, R. A. (2019). Safer spaces.

Department of Health and Social Care. (2020). *UK authorises Pfizer/BioNTech COVID-19 vaccine.* [News story] https://www.gov.uk/government/news/uk-authorises-pfizer-biontech-covid-19-vaccine

Department of Health and Social Care. (2021). *Shielding programme ends for most vulnerable.* [Press release] Coronavirus and clinically extremely vulnerable (CEV) people in England - Office for National Statistics (ons.gov.uk)

Devakumar, D., Shannon, G., Bhopal, S. S., & Abubakar, I. (2020). Racism and discrimination in COVID-19 responses. *The Lancet*, *395*(10231), 1194.

Di Gessa, G., & Price, D. (2021). Changes in health and social well-being in the COVID-19 clinically vulnerable older English population during the pandemic. *Journal of Epidemiol Community Health*, *75*(11), 1070-1077.

Dowling, M. (2007). From Husserl to van Manen. A review of different phenomenological approaches. *International journal of nursing studies, 44*(1), 131-142.

Elliot, D. L., Reid, K., & Baumfield, V. (2017). Capturing visual metaphors and tales: innovative or elusive?. *International Journal of Research & Method in Education, 40*(5), 480-496.

Erlandsson, A., Forsström, D., Rozental, A., & Werbart, A. (2022). Accessibility at What Price? Therapists' Experiences of Remote Psychotherapy with Children and Adolescents During the COVID-19 Pandemic. *Journal of Infant, Child, and Adolescent Psychotherapy*, *21*(4), 293-308.

Etherington, C. (2015). Race, gender, and the resources that matter: An investigation of intersectionality and health. *Women & health, 55*(7), 754-777.

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods, 16*(1), 1609406917703539.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons.

Flor, L. S., Friedman, J., Spencer, C. N., Cagney, J., Arrieta, A., Herbert, M. E., ... & Gakidou, E. (2022). Quantifying the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators: a comprehensive review of data from March, 2020, to September, 2021. *The Lancet.*

Frey, I. (2020). *"Herd Immunity" is Epidemiological Neoliberalism', The Quarantimes. Online*. Retrieved from: https://thequarantimes.wordpress.com/2020/03/19/herd-immunity-is-epidemiological-neoliberalism/ [Accessed] 20/04/2020

Gabarrell-Pascuet, A., García-Mieres, H., Giné-Vázquez, I., Moneta, M. V., Koyanagi, A., Haro, J. M., & Domènech-Abella, J. (2023). The Association of Social Support and Loneliness with symptoms of depression, anxiety, and posttraumatic stress during the COVID-19 pandemic: a meta-analysis. *International Journal of Environmental Research and Public Health, 20*(4), 2765.

Gabriel, D. (2023). *Racial Categorisation and Terminology*. Retrieved from: Racial Categorisation and Terminology | Black British Academics

Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative psychological and behavioral science, 42*, 266-290.

Gillborn, D. (2015). Intersectionality, critical race theory, and the primacy of racism: Race, class, gender, and disability in education. Qualitative Inquiry, 21(3), 277-287.

Gillen, P., Neill, R. D., Manthorpe, J., Mallett, J., Schroder, H., Nicholl, P., ... & McFadden, P. (2022). Decreasing wellbeing and increasing use of negative coping strategies: the effect of the COVID-19 pandemic on the UK Health and Social Care workforce. *Epidemiologia, 3*(1), 26-39.

Goodley, D., & Lawthom, R. (Eds.). (2005). *Disability and psychology: Critical introductions and reflections*. Macmillan International Higher Education.

Gravlee, C. C. (2009). How race becomes biology: embodiment of social inequality. *American journal of physical anthropology, 139*(1), 47-57.

Güner, Ö., & Öztürk, R. (2022). Psychological and social impact and lifestyle changes among pregnant women of COVID-19 pandemic: A qualitative study. *Archives of Psychiatric Nursing*, *36*, 70-77.

Hadjidemetriou, G. M., Sasidharan, M., Kouyialis, G., & Parlikad, A. K. (2020). The impact of government measures and human mobility trend on COVID-19 related deaths in the UK. *Transportation research interdisciplinary perspectives, 6*, 100167.

Hall, K. S., Samari, G., Garbers, S., Casey, S. E., Diallo, D. D., Orcutt, M., ... & McGovern, T. (2020). Centring sexual and reproductive health and justice in the global COVID-19 response. *The lancet, 395*(10231), 1175-1177.

Hanson, H. H. (1970). Isolation, A Challenge of Disability-Guest Editorial. *Journal of rehabilitation, 36*(3), 2.

Hankivsky, O. (2021). Understanding Pandemics Through a Sex-and Gender-Based Analysis Plus (SGBA+) Lens. *Sex-and Gender-Based Analysis in Public Health*, 123-135.

Hargittai, E., Piper, A. M., & Morris, M. R. (2019). From internet access to internet skills: digital inequality among older adults. *Universal Access in the Information Society*, *18*, 881-890.

Hennink, M., & Kaiser, B. N. (2021). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, 114523.

Huang, C., Wang, Y., Li, X., Ren, L., Zhao, J., Hu, Y., & Cheng, Z. (2020). Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. *The Lancet*, *395*(10223), 497-506.

ICNARC. (2020*). Intensive Care National Audit and Research Centre report on COVID-19 in critical care: 10 April 2020. Online*. Retrieved from https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports, VID-19 report 2020-04-17[1].pdf Table Appendix 2020-04-17.xlsx [Accessed] 20/04/2020

Jaspal, R., & Lopes, B. (2021). Discrimination and mental health outcomes in British Black and South Asian people during the COVID-19 outbreak in the UK. *Mental health, religion & culture*, *24*(1), 80-96.

Kapilashrami, A., & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet*, *391*(10140), 2589-2591.

Khot, W. Y., & Nadkar, M. Y. (2020). The 2019 Novel Coronavirus Outbreak-A Global Threat. *J Assoc Physicians India*, *68*(3), 67-71.

Khunti, K., Routen, A., Pareek, M., Treweek, S., & Platt, L. (2020). The language of ethnicity. *BMJ, 371*.

King, M. (2018). Working to address the loneliness epidemic: perspective-taking, presence, and self-disclosure. *American Journal of Health Promotion*, *32*(5), 1315-1317.

Kirkevold, M., Moyle, W., Wilkinson, C., Meyer, J., & Hauge, S. (2013). Facing the challenge of adapting to a life ‘alone’in old age: the influence of losses. *Journal of Advanced Nursing*, *69*(2), 394-403.

Knight, M. T., Wykes, T., & Hayward, P. (2003). 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological Analysis (IPA). *Journal of Mental Health*, *12*(3), 209-222.

Loder, E. (2022). Progress against health inequities is slow and obstacles are numerous.

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical effectiveness in nursing*, *4*(1), 30-37.

Macdonald, S. J., Deacon, L., Nixon, J., Akintola, A., Gillingham, A., Kent, J., ... & Dore, S. (2018). ‘The invisible enemy’: disability, loneliness and isolation. *Disability & Society*, *33*(7), 1138-1159.

Malhotra, R., & Rowe, M. (2013). *Exploring disability identity and disability rights through narratives: Finding a voice of their own*. Routledge.

Manen, M. V. (1997). From meaning to method. *Qualitative health research*, *7*(3), 345-369., Chicago.

Marston, C., Renedo, A., & Miles, S. (2020). Community participation is crucial in a pandemic. *The Lancet*, *395*(10238), 1676-1678.

Martin, N., & Cannon, H. (2020). Studying during the COVID-19 (Coronavirus) pandemic: suggestions for autistic university students. *Journal of Inclusive Practice in Further and Higher Education*, *12*(1), 65-86.

McCall, L. (2005). The complexity of intersectionality. Signs: *Journal of women in culture and society, 30*(3), 1771-1800.

McManimen, S., McClellan, D., Stoothoff, J., Gleason, K., & Jason, L. A. (2019). Dismissing chronic illness: A qualitative analysis of negative health care experiences. *Health care for women international*, *40*(3), 241-258.

Meijer, P. C., Verloop, N., & Beijaard, D. (2002). Multi-method triangulation in a qualitative study on teachers' practical knowledge: An attempt to increase internal validity. *Quality and quantity, 36,* 145-167.

Meyer, M. L., & Young, E. (2021). Best practice recommendations for psychologists working with marginalized populations impacted by COVID-19. *Professional Psychology: Research and Practice, 52*(4), 309.

Mohdin, A., Swanna, G., & Bannock, C. (2020). *How George Floyd's death sparked a wave of UK anti-racism protests*. The Guardian. Retrieved from https://www.theguardian.com/uk-news/2020/jul/29/george-floyd-death-fuelled-anti-racism-protests-britain [Accessed] 01.02.2023

Molodynski, A., McLellan, A., Craig, T., & Bhugra, D. (2021). What does COVID mean for UK mental health care?. *International Journal of Social Psychiatry*, *67*(7), 823-825.

Muthukrishna, M., Bell, A. V., Henrich, J., Curtin, C. M., Gedranovich, A., McInerney, J., & Thue, B. (2020). Beyond Western, Educated, Industrial, Rich, and Democratic (WEIRD) psychology: Measuring and mapping scales of cultural and psychological distance. *Psychological science, 31*(6), 678-701.

Nazroo, J., & Bécares, L. (2021). Ethnic inequalities in COVID-19 mortality: A consequence of persistent racism. *Runnymede/CoDE briefing, January. www. runnymedetrust. org/uploads/Runnymede, 20*.

Necho, M., Tsehay, M., Birkie, M., Biset, G., & Tadesse, E. (2021). Prevalence of anxiety, depression, and psychological distress among the general population during the COVID-19 pandemic: A systematic review and meta-analysis. *International Journal of Social Psychiatry, 67*(7), 892-906.

Nishida, A. (2016). Neoliberal academia and a critique from disability studies. In *Occupying disability: Critical approaches to community, justice, and decolonizing disability* (pp. 145-157). Springer, Dordrecht.

Nizza, I. E., Farr, J., & Smith, J. A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*, 1-18.

Núñez, A., Sreeganga, S. D., & Ramaprasad, A. (2021). Access to Healthcare during COVID-19. *International journal of environmental research and public health, 18*(6), 2980.

Osborn, M., & Smith, J. A. (2008). The fearfulness of chronic pain and the centrality of the therapeutic relationship in containing it: An interpretative phenomenological analysis. *Qualitative Research in Psychology, 5*(4), 276-288.

Özgüç, S., Kaplan Serin, E., & Tanriverdi, D. (2021). Death anxiety associated with coronavirus (COVID-19) disease: A systematic review and meta-analysis. OMEGA-*Journal of Death and Dying*, 00302228211050503.

Palmer, G. L., Feŕnandez, J. S., Lee, G., Masud, H., Hilson, S., Tang, C., Thomas, D., Clark, L., Guzman, B., & Bernai, I. (2019). Oppression and power. *Introduction to Community Psychology.*

Pandey, D., Bansal, S., Goyal, S., Garg, A., Sethi, N., Pothiyill, D. I., ... & Sethi, R. (2020). Psychological impact of mass quarantine on population during pandemics—The COVID-19 Lock-Down (COLD) study. *Plos one, 15*(10), e0240501.

Pan, L., Mu, M., Yang, P., Sun, Y., Wang, R., Yan, J., & Jin, Y. (2020). Clinical characteristics of COVID-19 patients with digestive symptoms in Hubei, China: a descriptive, cross-sectional, multicenter study. *American Journal of Gastroenterology*.

Parretti, H. M., Belderson, P., Eborall, H., Naughton, F., Loke, Y., Steel, N., ... & Hardeman, W. (2023). "I have travelled along on my own"—Experiences of seeking help for serious non-COVID health problems during the COVID-19 pandemic: A qualitative study. *British Journal of Health Psychology, 28*(1), 116-135.

Patai, D., & Koertge, N. (1994). Professing feminism: Cautionary tales from the strange world of women's studies. *Basic Books.*

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health services research, 34*(5 Pt 2), 1189.

Pentaraki, M., & Speake, J. (2020). Domestic violence in a COVID-19 context: Exploring emerging issues through a systematic analysis of the literature. *Open journal of social sciences, 8*(10), 193.

Pergolizzi Jr, J. V., Magnusson, P., LeQuang, J. A., Breve, F., Paladini, A., Rekatsina, M., ... & Varrassi, G. (2020). The current clinically relevant findings on COVID-19 pandemic. *Anesthesiology and pain medicine, 10*(2).

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal, 20*(1), 7-14.

Phelan, A. L., Katz, R., & Gostin, L. O. (2020). The novel coronavirus originating in Wuhan, China: challenges for global health governance. *Jama, 323*(8), 709-710.

Probst, T., Haid, B., Schimböck, W., Reisinger, A., Gasser, M., Eichberger-Heckmann, H., ... & Pieh, C. (2021). Therapeutic interventions in in-person and remote psychotherapy: Survey with psychotherapists and patients experiencing in-person and remote psychotherapy during COVID-19. *Clinical Psychology & Psychotherapy, 28*(4), 988-1000.

Public Health England. (2020). *Beyond the data: Understanding the impact of COVID-19 on BAME groups.* (Publication No: GW-1307). Retrieved from: Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk) [Accessed] 24/06/2022

Quinlan, M. (2021). COVID-19, health and vulnerable societies. *Annals of Work Exposures and Health, 65*(3), 239-243.

Raine, S., Liu, A., Mintz, J., Wahood, W., Huntley, K., & Haffizulla, F. (2020). Racial and ethnic disparities in COVID-19 outcomes: social determination of health. *International journal of environmental research and public health, 17*(21), 8115.

Ranjan, P., Kumari, A., & Arora, C. (2020). The value of communicating with patients in their first language. *Expert Review of Pharmacoeconomics & Outcomes Research, 20*(6), 559-561.

Ratcliffe, M. (2022). Phenomenological reflections on grief during the COVID-19 pandemic. *Phenomenology and the Cognitive Sciences, 1-20.*

Reed, B. G., Jiwatram-Negrón, T., Gonzalez Benson, O., & Gant, L. M. (2021). Enacting critical intersectionality in research: A challenge for social work. *Social Work Research, 45*(3), 151-153.

Ridley, M., Rao, G., Vikram, P., & Schilbach, F. (2019). *Poverty and Mental Illness: Causal Evidence*. Mimeo.

Riggle, E. D., Drabble, L. A., Bochicchio, L. A., Wootton, A. R., Veldhuis, C. B., Munroe, C., & Hughes, T. L. (2021). Experiences of the COVID-19 pandemic among African American, Latinx, and White sexual minority women: A descriptive phenomenological study. *Psychology of sexual orientation and gender diversity, 8*(2), 145.

Riley, V., Ellis, N., Mackay, L., & Taylor, J. (2021). The impact of COVID-19 restrictions on women's pregnancy and postpartum experience in England: a qualitative exploration. *Midwifery, 101*, 103061.

Roberts, S. O., Bareket-Shavit, C., Dollins, F. A., Goldie, P. D., & Mortenson, E. (2020). Racial inequality in psychological research: Trends of the past and recommendations for the future. *Perspectives on psychological science, 15*(6), 1295-1309.

Rosenthal, L. (2016). Incorporating intersectionality into psychology: An opportunity to promote social justice and equity. *American Psychologist, 71*(6), 474.

Roulston, K. (2010). *Reflective interviewing: A guide to theory and practice*. Sage.

Salway, S., Holman, D., Lee, C., McGowan, V., Ben-Shlomo, Y., Saxena, S., & Nazroo, J. (2020). Transforming the health system for the UK's multiethnic population. *Bmj, 368.*

Samra, R., & Hankivsky, O. (2021). Adopting an intersectionality framework to address power and equity in medicine. *The Lancet*, *397*(10277), 857-859.

Santiago, C. D., & Miranda, J. (2014). Progress in improving mental health services for racial-ethnic minority groups: A ten-year perspective. *Psychiatric Services, 65*(2), 180-185.

Selvarajah, S., Abi Deivanayagam, T., Lasco, G., Scafe, S., White, A., Zembe-Mkabile, W., & Devakumar, D. (2020). Categorisation and minoritisation. *BMJ Global Health, 5*(12), e004508.

Semlyen, J., Ali, A., & Flowers, P. (2018). Intersectional identities and dilemmas in interactions with healthcare professionals: an interpretative phenomenological analysis of British Muslim gay men. *Culture, health & sexuality, 20*(9), 1023-1035.

Singleton, J., & Darcy, S. (2013). 'Cultural life', disability, inclusion and citizenship: Moving beyond leisure in isolation.

Sivashanker, K., & Couillard, C. (2022). Shifting narratives in health care from resilience to redress and resistance. *Nature Reviews Nephrology, 18*(5), 269-270.

Slettebø, T. (2021). Participant validation: Exploring a contested tool in qualitative research. *Qualitative Social Work, 20*(5), 1223-1238.

Smallwood, N., Harrex, W., Rees, M., Willis, K., & Bennett, C. M. (2022). COVID-19 infection and the broader impacts of the pandemic on healthcare workers. *Respirology, 27*(6), 411-426.

Smedley, B. D., & Mittman, I. S. (2011). The diversity benefit: How does diversity among health professionals address public needs*?. Healthcare disparities at the crossroads with healthcare reform, 167-193.*

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,*261–271.

Smith, K. (2015). Stories told by, for, and about women refugees: Engendering resistance. *ACME: An International Journal for Critical Geographies, 14*(2), 461-469.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Analysis: theory, method and research.

Smith, J. A., & Rhodes, J. E. (2015). Being depleted and being shaken: An interpretative phenomenological analysis of the experiential features of a first episode of depression. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(2), 197-209.

Sohrabi, C., Alsafi, Z., O'Neill, N., Khan, M., Kerwan, A., Al-Jabir, A., & Agha, R. (2020). World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19). *International Journal of Surgery*.

Stenfors, T., Kajamaa, A., & Bennett, D. (2020). How to… assess the quality of qualitative research. *The clinical teacher, 17*(6), 596-599.

Suyemoto, K. L., Curley, M., & Mukkamala, S. (2020). What do we mean by “ethnicity” and “race”? A consensual qualitative research investigation of colloquial understandings. *Genealogy*, *4*(3), 81.

Temple, J. B., Kelaher, M., & Williams, R. (2019). Disability discrimination and avoidance in later life: prevalence, disability differentials and association with mental health. *International psychogeriatrics*, *31*(9), 1319-1329.

Torrance, H. (2012). Triangulation, respondent validation, and democratic participation in mixed methods research. *Journal of mixed methods research*, *6*(2), 111-123.

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative social work*, *11*(1), 80-96.

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications*, *2*(4), 52.

Vagle, M. D. (2018). Crafting phenomenological research. *Routledge.*

Veseth, M., Binder, P. E., Borg, M., & Davidson, L. (2017). Collaborating to stay open and aware: service user involvement in mental health research as an aid in reflexivity. *Nordic Psychology*, *69*(4), 256-263.

Wallin-Ruschman, J., & Patka, M. (2016). Learning from critical collective spaces: Reflections on the community-diversity dialectic in safe spaces. *Journal of Social and Political Psychology, 4*(1), 318-331.

Walsh, F. (2020). Loss and resilience in the time of COVID-19: Meaning making, hope, and transcendence. *Family process, 59*(3), 898-911.

Wang, D., Hu, B., Hu, C., Zhu, F., Liu, X., Zhang, J., & Zhao, Y. (2020). Clinical characteristics of 138 hospitalized patients with 2019 novel coronavirus–infected pneumonia in Wuhan, China. *Jama, 323*(11), 1061-1069.

Wang, C., Pan, R., Wan, X., Tan, Y., Xu, L., Ho, C. S., & Ho, R. C. (2020). Immediate psychological responses and associated factors during the initial stage of the 2019 coronavirus disease (COVID-19) epidemic among the general population in China. *International journal of environmental research and public health, 17*(5), 1729.

Wenham, C., Smith, J., & Morgan, R. (2020). COVID-19: the gendered impacts of the outbreak. *The lancet, 395*(10227), 846-848.

Whaibeh, E., Mahmoud, H., & Naal, H. (2020). Telemental health in the context of a pandemic: the COVID-19 experience. *Current Treatment Options in Psychiatry, 7*, 198-202.

White, R. G., & Van Der Boor, C. (2020). Impact of the COVID-19 pandemic and initial period of lockdown on the mental health and well-being of adults in the UK. *BJPsych open, 6*(5), e90.

Willig, C. (2013). *EBOOK: introducing qualitative research in psychology*. McGraw-hill education (UK).

Willig, C. (2019). What can qualitative psychology contribute to psychological knowledge?. *Psychological Methods*, *24*(6), 796.

Wojnar, D. M., & Swanson, K. M. (2007). Phenomenology: an exploration. *Journal of holistic nursing*, *25*(3), 172-180.

World Health Organisation. (2020a). *Naming the coronavirus disease (COVID-19) and the virus that causes it*. Online. Retrieved from https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it [Accessed] 20/04/2020

World Health Organisation. (2020b). *WHO Director-General's opening remarks at the media briefing on COVID-19* - 11 March 2020. Online. Retrieved from https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020 [Accessed] 20/04/2020

World Health Organization. (2020c). *Maintaining Essential Health Services: Operational Guidance for the COVID-19 Context*. World Health Organ. Online. Retrieved from https://www.who.int/publications/i/item/WHO-2019-nCoV-essential-health-services-2020.1 [Accessed] 03/12/2021

Yao, H., Chen, J. H., & Xu, Y. F. (2020). Patients with mental health disorders in the COVID-19 epidemic. *The Lancet Psychiatry*, *7*(4), e21.

Zhou, F., Yu, T., Du, R., Fan, G., Liu, Y., Liu, Z., Cao, B. (2020). Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *Lancet*. doi:10.1016/S0140-6736(20)30566-3

# Part 3: Critical Appraisal

## Introduction

The following critical appraisal focuses on my experience of navigating complex reflections and experiences while conducting ‘insider research’. Under research supervision, this angle was chosen as, throughout the research process, I have frequently questioned why and what I am doing – a process which has been especially acute due to my insider researcher status. I have been concerned that I have been mistaken in my approach and, at worst, I have worried about doing harm to or misrepresenting the lived experiences of the seven women who participated in the research. Simultaneously, I have felt that my ‘insider researcher’ position enhanced the research due to experiential knowledge supporting me to make sense of the of participants' experiences and build trust and rapport (Couture et al., 2012).

In writing this critical appraisal, I feel a sense of relief, due to acknowledging thoughts and feelings that have been uncomfortable and intense. This feeling of relief sits alongside feelings of vulnerability about exposing these inner processes. These conflicting thoughts and feelings have been a distinctive feature of this research experience. In the following critical appraisal, I plan to reflect on some of these contradictions and complexities.

During the research process, I was supported by a trainee clinical psychologist who conducted a bracketing interview prior to commencing interviews, for the purpose of exploring my assumptions and personal biases about the research topics (Roulston & Shelton, 2015). I kept a reflective log throughout the research and bracketed my reflections, thoughts and feelings throughout analysis by way of reflexive writing alongside my interpretative phenomenological analysis (IPA). Additionally, I engaged in reflective discussions under research supervision. The sections below are illuminated with quotes from the bracketing interview, extracts from the reflective log and thoughts and reflections discussed under research supervision and consultation.

### *Positionality*

Patai (2014) questioned whether self-reflexivity creates better research - whether talking about our positions 'endlessly' actually reduces the consequences of our positions, or whether 'reflexivity talk' is merely narcissistic and self-indulgent. Although uncomfortable, I felt that this position applied when I became stuck in a cycle of worry or when I arrived at two different ideas and that felt I needed to decide which was 'truer' than the other. For example, I perceived that my insider position supported my ability to empathise with interviewees and that I was able to respect and understand experiences that differed from my own. During a bracketing interview, my peer probed me on how I might feel if I were to hear experiences that differed greatly from what I was expecting to hear. Taken from the interview transcript, I shared:

> *'I'd like to get to a position where I can say, look, I understand where, that these are my opinions. Well, that this is my influence and where I am coming from and this is not where other people are coming from. I would welcome it, I think, because I realised that you know I have my own echo chamber so I am expecting the*

> *unexpected. I think I am prepared for it to be a conversation, especially after differences in conversations I've had with the experts by experience.'*

During debriefing, one participant said that it had felt 'good' to have a forum in which to express themselves, which they hadn't had before. They also spoke about previous experiences, where they had voiced their views and others had argued with them. During analysis I noticed some worries creeping in directly about this, which I noted in my reflective log:

> *"What if she feels like an outsider due to my interpretations? It seems like she has been isolated further during an already intensely isolated experience [COVID-19]. What if my findings add another layer of isolation? It feels like she has positioned herself as an isolated voice in research and I might be reinforcing that before analysis, or my analysis may be biased based on this. I feel responsible and I feel slightly guilty I did not feel the same way as her and what if she picked up on this somehow and that's why she voiced that."*

There were some themes that did not reflect this participant's experience. I felt that, although this could not be resolved, it could be acknowledged in both the write-up and in the process of participant validation. For example, I named when themes did not apply for some participants, under relevant subthemes in the findings. I wondered whether my own expectations and biases may have influenced what came up during interviews and whether I had been as objective as possible. At the same time, I felt that my position as an insider researcher may have supported this participant to feel free to share their perspectives, as they may have felt able to trust that I would accurately represent their viewpoints as an 'insider' (LaSala, 2003). I felt connected to what the participant was saying even if I did not interpret a similar experience the same way. Ultimately, I felt my insider position and reflection on positionality supported me in considering multiple perspectives and respecting divergence across participant accounts.

Listening to other participants express similar thoughts and emotions to each other and to my own validated my own feelings and gave me the sense that my research was valuable, as it demonstrated that I was not alone in some of my experiences. However, I wondered if this might be an implicit burden on participants. For example, although this feeling was not made explicit to participants, knowing I was conducting the research as an insider researcher may have been enough to imply that I was seeking connection or validation. Debriefing following interviews and the process of respondent validation supported accuracy checks, although it may also have been a burden on participants, e.g., they may have felt obliged to agree or respond in support of findings. I consider that if the research had been longitudinal, it may have felt more natural to have self-disclosed beyond acknowledging during the recruitment phase that I was conducting the research as an 'insider' (but without expressively stating to which social categories I belonged). Some characteristics are visible, others are invisible. For example, I am visibly disabled in person but invisibly so over video. It is possible that, had the research been longitudinal, self-disclosure may have been more present or likely. However, this may not have changed my interpretations or findings.

### ***Minimising power***

I used several processes to try and reduce the power imbalance ingrained in the research process (Ross, 2017). For example, several aspects of the research were co-produced including the research design, interview schedule, analysis and write-up with paid experts-by-experience. Both consultants were experts by experience and clinical psychologists. Further involvement of individuals with lived experience of the research topic may have been possible if it were not for the timeframe of the thesis, for example, consultation with those who were not also in the field of psychology.

I recognised the power I had as the researcher, for example, interpreting the participants' stories, creating themes, deciding how they would be conveyed and in what order. I was given the stories by participants and felt trusted and responsible to do them justice. To minimise this power imbalance, I sought respondent validation. Participants were given the option to feedback on the research findings, specifically the final draft of superordinate themes and subthemes. The themes shared were done so following rigorous analysis and a process of triangulation by the research supervisor and a consultant. Five of the seven participants provided feedback and shared they felt their experiences had been represented and that they related to the themes interpreted (see Appendix X for anonymised feedback).

### ***Emotional impact of insider research***

During interviews I kept a notepad and pen next to me in order to capture thoughts or emotions that arose at the time. Following interviews, I recorded reflections, including emotions that came up during interviews in my research log. In a review of the log, most commonly I express feelings of sadness and frustration:

> *"Feeling a bit overwhelmed, I noticed I felt a bit of a sinking feeling when she was talking about responses from work. I related to it and wonder if that compounded my sadness. I also felt frustrated for her but also wonder if that is compounded by the fact I didn't think it was helpful to voice that frustration during the interview. I think it would have been more about me feeling better for voicing that to her than anything else."*

I recall several moments of wanting to respond to participants' expressions of feeling alone or excluded, for example, wanting to say that I understand or express how I wish I could provide support. Ross (2017) suggests that self-disclosure can support with building rapport but could also have emotional implications for participants and be 'self-indulgent'.

A worry that has occurred throughout the research process has been *"is this going to do more harm than good?"* This worry has been explored throughout the research process. During the bracketing interview, I discussed this worry and feelings of anxiety:

> *"I'm afraid of. I'm actually now afraid that I'm going to do more harm. Like, am I going to be? You know, is this gonna be? Yeah. Is it it? Is this gonna do? Yeah. Is this gonna do more harm? I think comes up. Comes to my mind a lot more sort of feeling worried."*

This concern was present throughout the research process and manifested in different ways throughout. For example, I initially worried that exploring the experiences of disabled, racially minoritized women may be unhelpful. Following review of the bracketing interview, I addressed this worry further in consultation with a clinical psychologist and expert by experience. They advised that "disability" is broad and that examining the experiences of disabled people could conflate the needs and lived experiences of people with differing disabilities. I then altered the sampling and approach of the research as a result.

### ***Intersectionality***

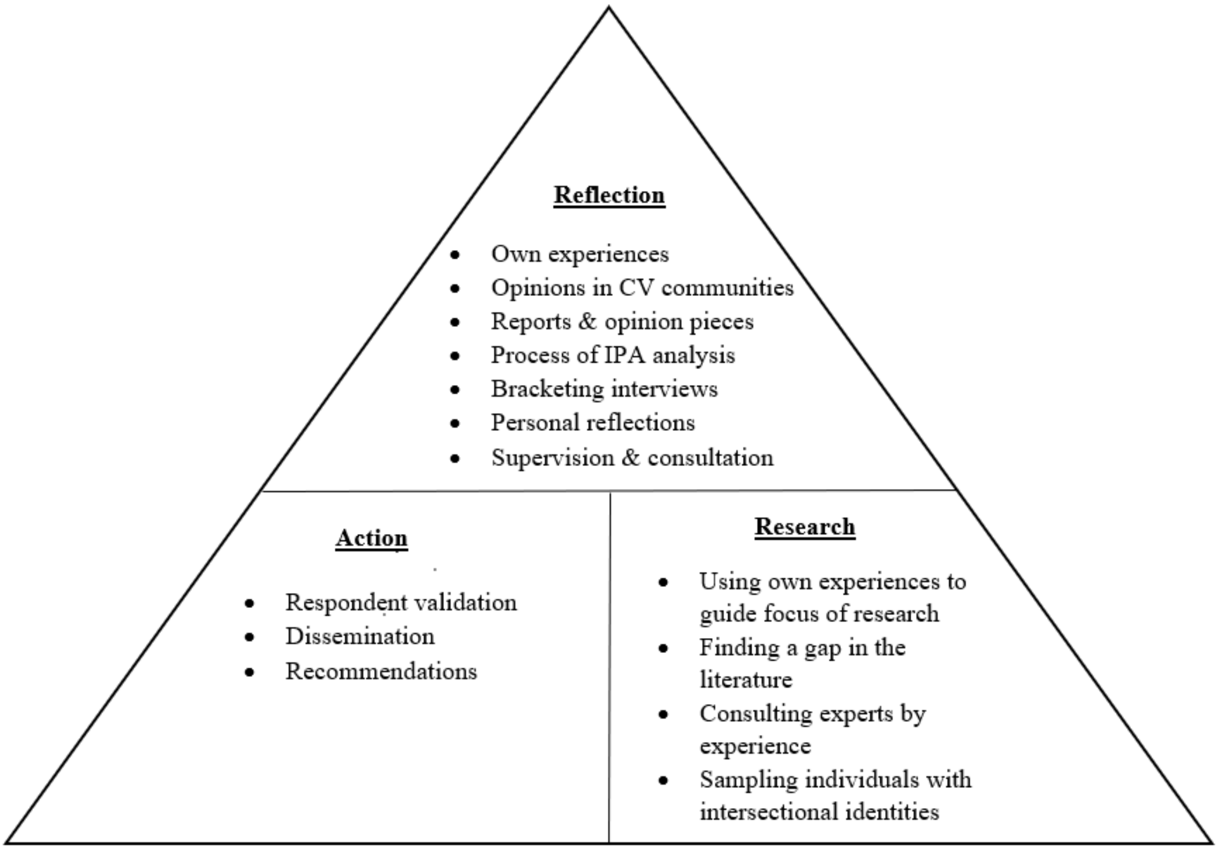
I felt thrown many times throughout the research process upon reading more peer-reviewed papers on intersectional research in psychology. Some researchers' positions outlined the ways in which previous intersectional research does not reflect intersectionality theory and praxis (e.g., Buchanan & Wiklund, 2021) because, for example, it does not involve a call to social action.

I recall a shrinking feeling on reading this. I felt that I had completely missed the mark and needed to change the angle of my research. Under research supervision, I voiced these concerns. I was advised to view my work and intersectionality in terms of praxis, e.g., reflection, research and action. Prilleltensky (2001) offers a definition of praxis as the unity of theory and action and discusses the aim of praxis which is translating reflection and social research into social action.

Under research supervision, discussion of social action supported me to think more about action related to my research process. My supervisor described praxis as a triangle, Figure 1 illustrates how I viewed this and understood and placed aspects of the research in terms of reflection, research and action.

**Figure 1**

Triangle of praxis



In relation to 'Reflection', in my research, I considered how my personal experiences of the pandemic contributed to the research aims and process. Initially, my own experiences prompted me to explore and seek out the unique and shared experiences of others like me, such as opinion pieces in clinically vulnerable communities and later, read reports and opinion pieces of people who share the characteristics of the research participants. Reflection also encompassed the process of IPA analysis, which is a reflexive and iterative process (Engward & Goldspink, 2020). Additionally, I engaged in bracketing interviews, personal reflections, supervision and discussions in consultations.

In relation to 'Research', I used my own experiences of the pandemic to guide the focus of my research, specifically, recognizing the interaction and impact of intersecting identities. I identified a gap in the literature regarding the experiences of marginalized groups during the pandemic, with little consideration of intersectionality. I consulted with experts by experience who contributed to all parts of the research process, which was important to ensure that the research was tailored to the needs of the participants (Rosenthal, 2016). Moreover, the research focused on and sampled individuals with multiple marginalized identities.

In addition, certain processes could be classified under ‘Action’. Firstly, respondent validation enabled participants to contribute to the analysis by way of checking the accuracy of interpretations and whether the findings reflected how they viewed their accounts (Torrance, 2012). As outlined by Ross, the dissemination plan could be considered a form of social action. Finally, the research included several concrete recommendations related to mental health services, trainings courses, mental health professionals and future research.

Buchanan and Wiklund (2021) suggest it is difficult for all the aspects of intersectionality theory to be delivered in one research study. Upon reflecting on their paper, I have identified some of what went well and what I could have improved in my research. For example, I believe the current research effectively presented the conceptualization of intersectionality theory, which goes beyond a description of layering systems of oppression and contains an explanation of the role of power and oppression. Additionally, the current research acknowledged and specified certain marginalized groups who should be prioritized in further research as a result of inequalities related to COVID-19 and the double pandemic. However, I recognize that my own research could have delved deeper into the presentation of participants’ social categories and identities. For example, I could have presented the privileged identities of some participants as well as their marginalized identities (Buchanan & Wiklund, 2021).

### ***Double hermeneutic***

In IPA research, the double hermeneutic is described as the process by which the analyst interprets an individual's account of their experience as well as interpreting their own interpretation of the individual’s account (Smith et al., 2009; Willig, 2013). The double hermeneutic process acknowledges that the analyst’s interpretations are formed by their own experiences, biases, beliefs and culture, which contributes to how they interpret a participant's interpretations. Therefore, reflexivity is crucial and projection from the analyst forms part of the sense-making in IPA (Smith et al., 2009).

During analysis, I bracketed my own thoughts for the purpose of being able to locate what was an initial note interpreted from the participants description and what was a unique thought of mine. I did not feel able to ‘bracket’ myself off completely from the research, which indeed is neither possible nor a requirement, but rather a key part of the development of themes and woven into my interpretations throughout the analysis.

What I understood from this process was that my interpretation would be divergent from another researcher’s, which is understandable given the double hermeneutic. I believe I may have initially felt the need to control or lessen my own thoughts, feelings and reflections during the process. This would be impossible and ultimately is not the point of IPA, and I realised through the process that all understanding involves interpretation as well as application (Bernstein, 1982).

## Conclusion

In this critical appraisal, I examined key reflections that occurred during the research process which included reflections on my positionality, power and emotions conducting insider research during the COVID-19 pandemic. Additionally, I discussed reflections related to intersectionality and praxis and the double hermeneutic. This research has provided me with a valuable experience of sitting with complexity - the “both-and” of lived experiences, rather than the more polarised “either-or” positions that humans often perhaps prefer to take, so as to simplify our understanding of the world.

## References

Buchanan, N. T., & Wiklund, L. O. (2021). Intersectionality research in psychological science: Resisting the tendency to disconnect, dilute, and depoliticize. *Research on Child and Adolescent Psychopathology, 49*(1), 25-31.

Couture, A. L., Zaidi, A. U., & Maticka-Tyndale, E. (2012). Reflexive accounts: An intersectional approach to exploring the fluidity of insider/outsider status and the researcher’s impact on culturally sensitive post-positivist qualitative research. *Qualitative Sociology Review, 8*(1).

Engward, H., & Goldspink, S. (2020). Lodgers in the house: Living with the data in interpretive phenomenological analysis research. *Reflective Practice, 21*(1), 41-53.

LaSala, M. C. (2003). When interviewing “Family” maximizing the insider advantage in the qualitative study of lesbians and gay men. *Journal of Gay & Lesbian Social Services, 15*(1-2), 15-30.

Patai, D. (2014). When method becomes power (Response). *In Power and method (pp. 61-73). Routledge.*

Prilleltensky, I. (2001). Value-based praxis in community psychology: Moving toward social justice and social action. *American journal of community psychology, 29*, 747-778.

Rosenthal, M. (2016). Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research. *Currents in pharmacy teaching and learning, 8*(4), 509-516.

Ross, L. E. (2017). An account from the inside: Examining the emotional impact of qualitative research through the lens of "insider" research. *Qualitative Psychology, 4*(3), 326.

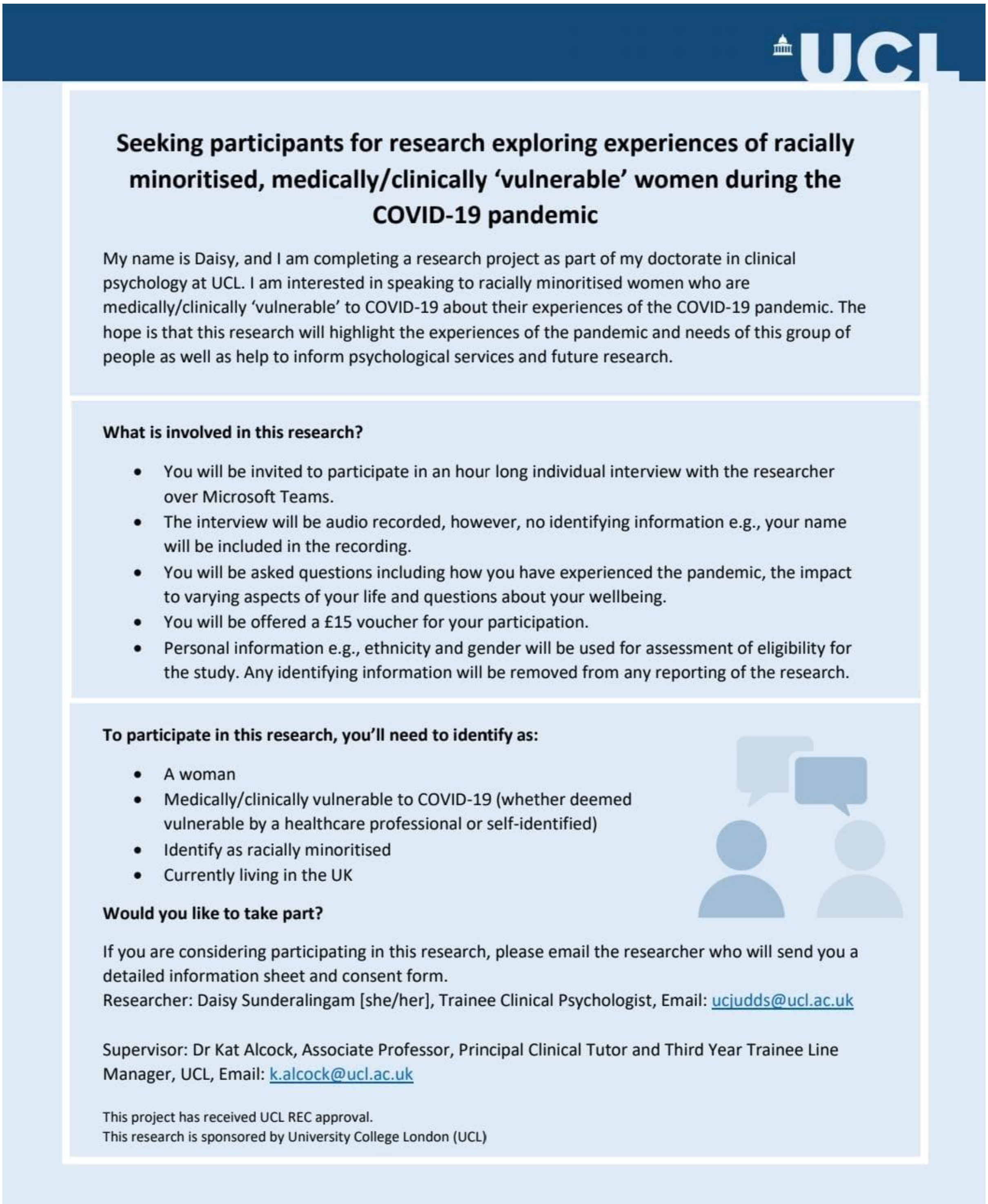
Roulston, K., & Shelton, S. A. (2015). Reconceptualizing bias in teaching qualitative research methods. *Qualitative Inquiry, 21*(4), 332-342.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Analysis: theory, method and research.

Torrance, H. (2012). Triangulation, respondent validation, and democratic participation in mixed methods research. *Journal of mixed methods research, 6*(2), 111-123.

# Appendices

## Appendix A: Study Advert



### Seeking participants for research exploring experiences of racially minoritised, medically/clinically 'vulnerable' women during the COVID-19 pandemic

My name is Daisy, and I am completing a research project as part of my doctorate in clinical psychology at UCL. I am interested in speaking to racially minoritised women who are medically/clinically 'vulnerable' to COVID-19 about their experiences of the COVID-19 pandemic. The hope is that this research will highlight the experiences of the pandemic and needs of this group of people as well as help to inform psychological services and future research.

**What is involved in this research?**

- You will be invited to participate in an hour long individual interview with the researcher over Microsoft Teams.
- The interview will be audio recorded, however, no identifying information e.g., your name will be included in the recording.
- You will be asked questions including how you have experienced the pandemic, the impact to varying aspects of your life and questions about your wellbeing.
- You will be offered a £15 voucher for your participation.
- Personal information e.g., ethnicity and gender will be used for assessment of eligibility for the study. Any identifying information will be removed from any reporting of the research.

**To participate in this research, you'll need to identify as:**

- A woman
- Medically/clinically vulnerable to COVID-19 (whether deemed vulnerable by a healthcare professional or self-identified)
- Identify as racially minoritised
- Currently living in the UK

**Would you like to take part?**

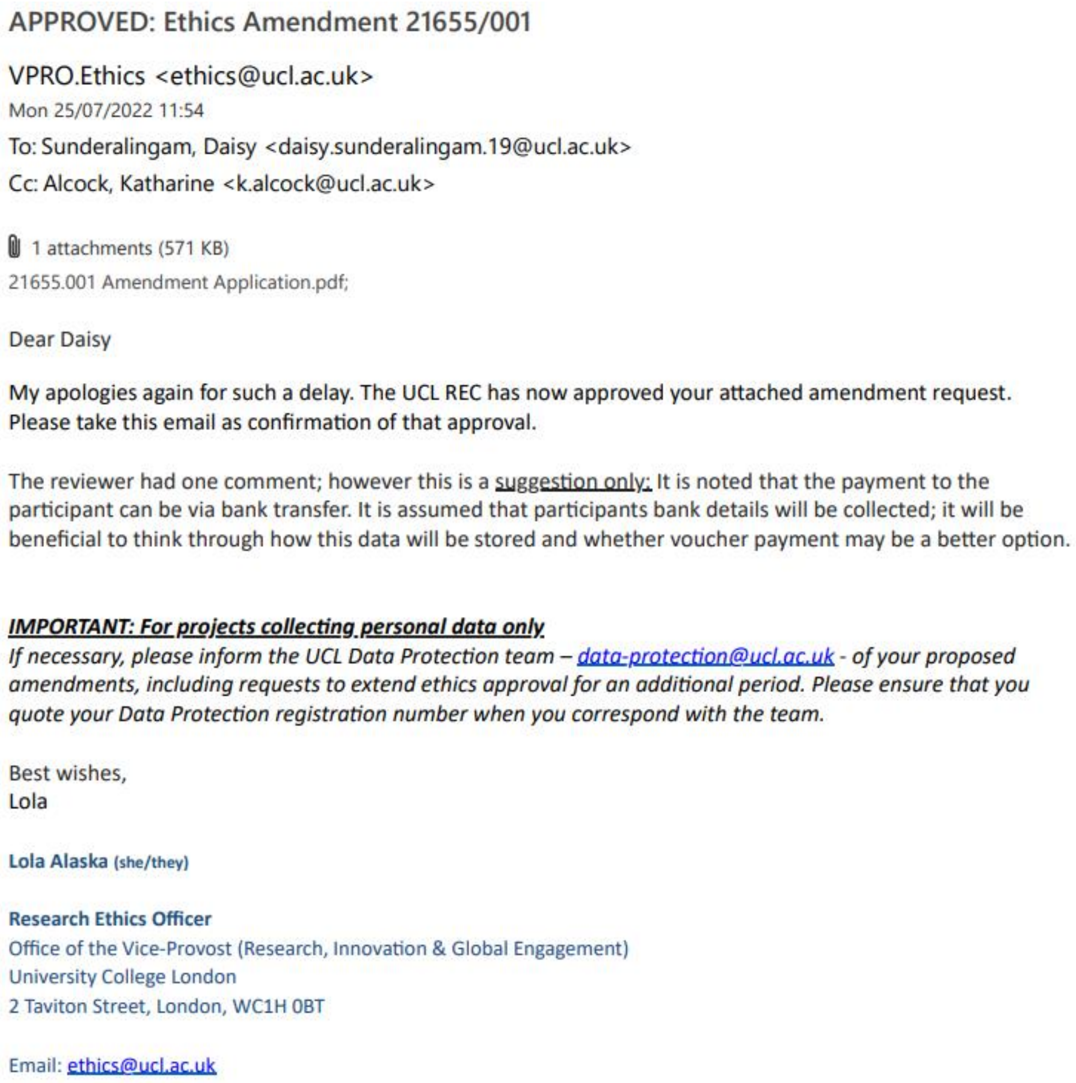
If you are considering participating in this research, please email the researcher who will send you a detailed information sheet and consent form.
Researcher: Daisy Sunderalingam [she/her], Trainee Clinical Psychologist, Email: ucjudds@ucl.ac.uk

Supervisor: Dr Kat Alcock, Associate Professor, Principal Clinical Tutor and Third Year Trainee Line Manager, UCL, Email: k.alcock@ucl.ac.uk

This project has received UCL REC approval.
This research is sponsored by University College London (UCL)

Google docs version: http://shorturl.at/bkly3

## Appendix B: Ethical Approval Letter



APPROVED: Ethics Amendment 21655/001

VPRO.Ethics <ethics@ucl.ac.uk>
Mon 25/07/2022 11:54
To: Sunderalingam, Daisy <daisy.sunderalingam.19@ucl.ac.uk>
Cc: Alcock, Katharine <k.alcock@ucl.ac.uk>

1 attachments (571 KB)
21655.001 Amendment Application.pdf;

Dear Daisy

My apologies again for such a delay. The UCL REC has now approved your attached amendment request. Please take this email as confirmation of that approval.

The reviewer had one comment; however this is a suggestion only: It is noted that the payment to the participant can be via bank transfer. It is assumed that participants bank details will be collected; it will be beneficial to think through how this data will be stored and whether voucher payment may be a better option.

***IMPORTANT: For projects collecting personal data only***
*If necessary, please inform the UCL Data Protection team – data-protection@ucl.ac.uk - of your proposed amendments, including requests to extend ethics approval for an additional period. Please ensure that you quote your Data Protection registration number when you correspond with the team.*

Best wishes,
Lola

**Lola Alaska** (she/they)

**Research Ethics Officer**
Office of the Vice-Provost (Research, Innovation & Global Engagement)
University College London
2 Taviton Street, London, WC1H 0BT

Email: ethics@ucl.ac.uk

## Appendix C: Information sheet

## Participant Information Sheet

UCL Research Ethics Committee Approval ID Number: 21655/001

**YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET**

**Title of Study:** Experiences of racially minoritised, medically/clinically 'vulnerable' women during the COVID-19 pandemic.

**Department:** Research Department of Clinical, Educational and Health Psychology, University College London (UCL)

**Name and Contact Details of the Researcher(s):** Daisy Sunderalingam [she/her]
Trainee Clinical Psychologist & Equality, Diversity and Inclusion (EDI) Representative
ucjudds@ucl.ac.uk

**Name and Contact Details of the Principal Researcher:** Dr Kat Alcock
Principal Clinical Tutor, Senior Admissions Tutor & Equality, Diversity and Inclusion (EDI) Lead
k.alcock@ucl.ac.uk

**Name and Contact Details of the UCL data protection officer:** Alex Potts
data-protection@ucl.ac.uk

### 1. Invitation to participate

You are being invited to take part in a research project exploring the experiences of racially minoritised, medically 'vulnerable' women during the COVID-19 pandemic.
Before you decide whether to participate or not, please read the following information sheet which explains the purpose of the study, what is involved and data protection information. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask the researcher if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

This research is sponsored by University College London (UCL) and will form part of a clinical psychology doctorate for Daisy Sunderalingam. The research is being conducted by researchers at University College London (UCL). Thank you for your consideration in taking part in this study.

### 2. What is the project's purpose?

The aim of the research is to understand the lived experiences of racially minoritised, medically 'vulnerable' women during the COVID-19 pandemic. Few studies exist on the psychological effects of disability prejudice, racial and sexist discrimination, which has been emphasised during the pandemic. In light of the impact and the responses to the virus on marginalised groups including women, racialised minorities and clinically 'vulnerable' people, the lack of research capturing this populations voice, the current study aims to put these narratives and lived experience of at the forefront.

3. **Why have I been chosen?**

   Inclusion criteria includes women who identify as*being clinically/medically 'vulnerable' to COVID-19, identify as **coming from a racially minoritised background, currently living in the UK and be willing to speak about your lived experience in relation to the COVID-19 pandemic.

   *Clinically/medically vulnerable does not need to be identified by a medical professional. People may also self-identify as clinically/medically vulnerable based on their own evaluations of their medical needs as it is acknowledge that people are at different stages of their medical journeys i.e. not under a consultant for treatment or diagnosis.

   **Racialised minority refers to anyone who belongs to a racialised and/or ethnic group that are in a minority in the population. In the UK, this includes minority ethnic groups not including those who identify as White British.

4. **Do I have to take part?**

   It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up until the point you decide to withdraw. You can decline to participate before, during or after the interview up until two weeks from the date of your interview. After which reporting of the research will be in its final stages and withdrawal will not be possible.

5. **What will happen to me if I take part?**

   If you would like to take part, please provide a signed consent form to the researcher. You will then be asked to arrange a one-time interview with the first researcher using teleconferencing software (Microsoft Teams). No identifying information will be sought from you during the interview. You will be asked about your experiences and responses to COVID-19, your well-being and the impact COVID-19 has had on varying aspects of your life including home, social, health and work. Interviews will last around 60-90 minutes. Arrangements can be made prior to interview to account for breaks or other needs participants may have.

6. **Will I be recorded and how will the recorded media be used?**

   MS teams will be used to conduct individual interviews and video and audio recording will be used for the purpose of the inbuilt transcription of audio that MS teams generates. A dictaphone will also be used to make audio recordings only, this is to ensure the MS teams transcription of the interview is accurate. Immediately following interview and transcription download from the recording, MS teams video recordings will be deleted. Audio recordings will be kept until analysis is completed and thereafter deleted. Transcripts of the interview will be used for analysis only, no other use will be made of them without your written permission, and no one outside the project will be allowed access to the transcripts.

7. **What are the possible disadvantages and risks of taking part?**

It is not anticipated that there will be any disadvantages and risks of taking part in an interview. However, you may feel emotionally distressed during the interview due to the topics being discussed. You may pause the interview at any time and skip questions at any point without having to give a reason. You will be signposted to support.

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

Participants will be offered £15 in voucher form of their choosing, e.g., Amazon voucher, for participating in the research. It is hoped that this research will highlight the impact and the responses to the recent pandemic and the importance of the narratives and lived experience of the participants. It is also hoped that this research can help to inform psychology research and services.

**9. What if something goes wrong?**

Should you experience any difficulties during the research process, in the first instance please contact the researcher, Daisy at ucjudds@ucl.ac.uk. If you feel that your concern is not adequately addressed by the first or second researcher, Dr Kat Alcock at k.alcock@ucl.ac.uk, and wish to raise a complaint, please contact the Chair of the UCL Research Ethics Committee at ethics@ucl.ac.uk

**10. Will my taking part in this project be kept confidential?**

All the information that we will have on you will be kept strictly confidential e.g. name, email address, any identifying information via interview. Any identifiable information will be stored on UCL's Data Safe Haven, a GDPR-compliant, encrypted system for the duration of the study. The data will be analysed by the researcher(s). You will not be able to be identified in any ensuing reports or publications. You will be asked not to provide any identifying information during interviews though if identifying information is included, this will be removed by the researcher at the time of transcription. Pseudonyms will be used.
All information will be kept anonymously and will not be shared with any other parties. The only limits to confidentiality is if there is a significant risk of harm identified to you or to others. In this instance, you will be contacted to discuss any limits to your confidentiality.

**11. Limits to confidentiality**

- Please note that assurances on confidentiality will be strictly adhered to unless evidence of wrongdoing or potential harm is uncovered. In such cases the University may be obliged to contact relevant statutory bodies/agencies.
- Please note that confidentiality will be maintained as far as it is possible, unless during our conversation I hear anything which makes me worried that someone might be in danger of harm, I might have to inform relevant agencies of this.
- Confidentiality will be respected subject to legal constraints and professional guidelines.
- Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this was the case we would inform you of any decisions that might limit your confidentiality.
- Confidentiality may be limited and conditional and the researcher has a duty of care to report to the relevant authorities possible harm/danger to the participant or others.

**12. What will happen to the results of the research project?**

The results of this research may feature in peer-reviewed publications, national or international conferences or media. You will not be able to be identified in any ensuing reports or publications.

**13. Local Data Protection Privacy Notice**

**Notice:**
The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice: https://www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the 'local' and 'general' privacy notices.

The categories of personal data used will be as follows: age, geographical location, employment status, psychological and physical health/disability, ethnicity and gender.

The lawful basis that would be used to process your *personal data* will be performance of a task in the public interest. The lawful basis used to process *special category personal data* will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

**14. Who is organising and funding the research?**

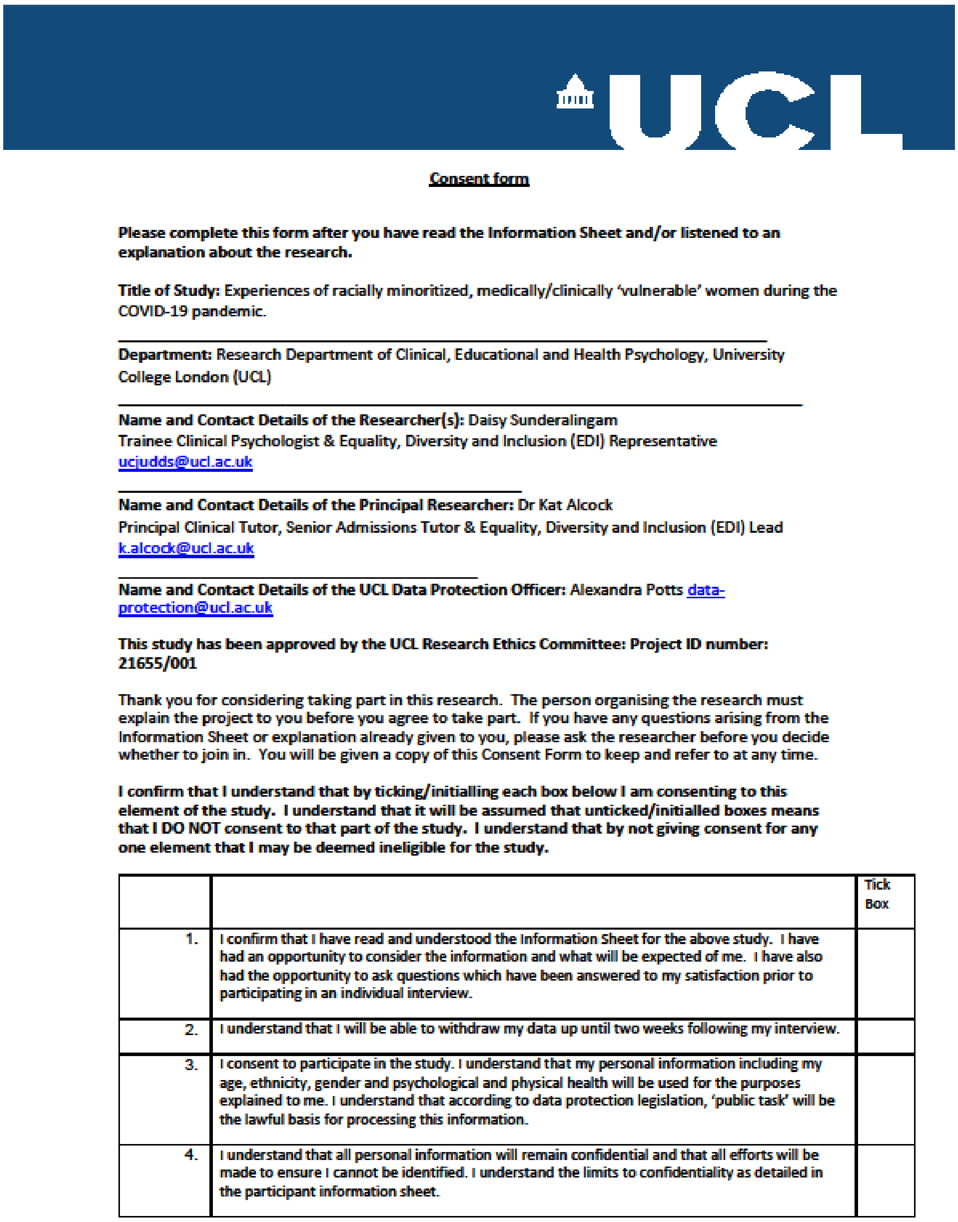
The research is led by researchers at University College London (UCL). UCL is sponsoring the research.

**15. Contact for further information**

If you would like to discuss this information sheet or require further information, please contact Daisy at ucjudds@ucl.ac.uk

**Thank you for reading this information sheet and for considering to take part in this research study.**

# Appendix D: Consent form



**Consent form**

**Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.**

**Title of Study:** Experiences of racially minoritized, medically/clinically 'vulnerable' women during the COVID-19 pandemic.

**Department:** Research Department of Clinical, Educational and Health Psychology, University College London (UCL)

**Name and Contact Details of the Researcher(s):** Daisy Sunderalingam
Trainee Clinical Psychologist & Equality, Diversity and Inclusion (EDI) Representative
ucjudds@ucl.ac.uk

**Name and Contact Details of the Principal Researcher:** Dr Kat Alcock
Principal Clinical Tutor, Senior Admissions Tutor & Equality, Diversity and Inclusion (EDI) Lead
k.alcock@ucl.ac.uk

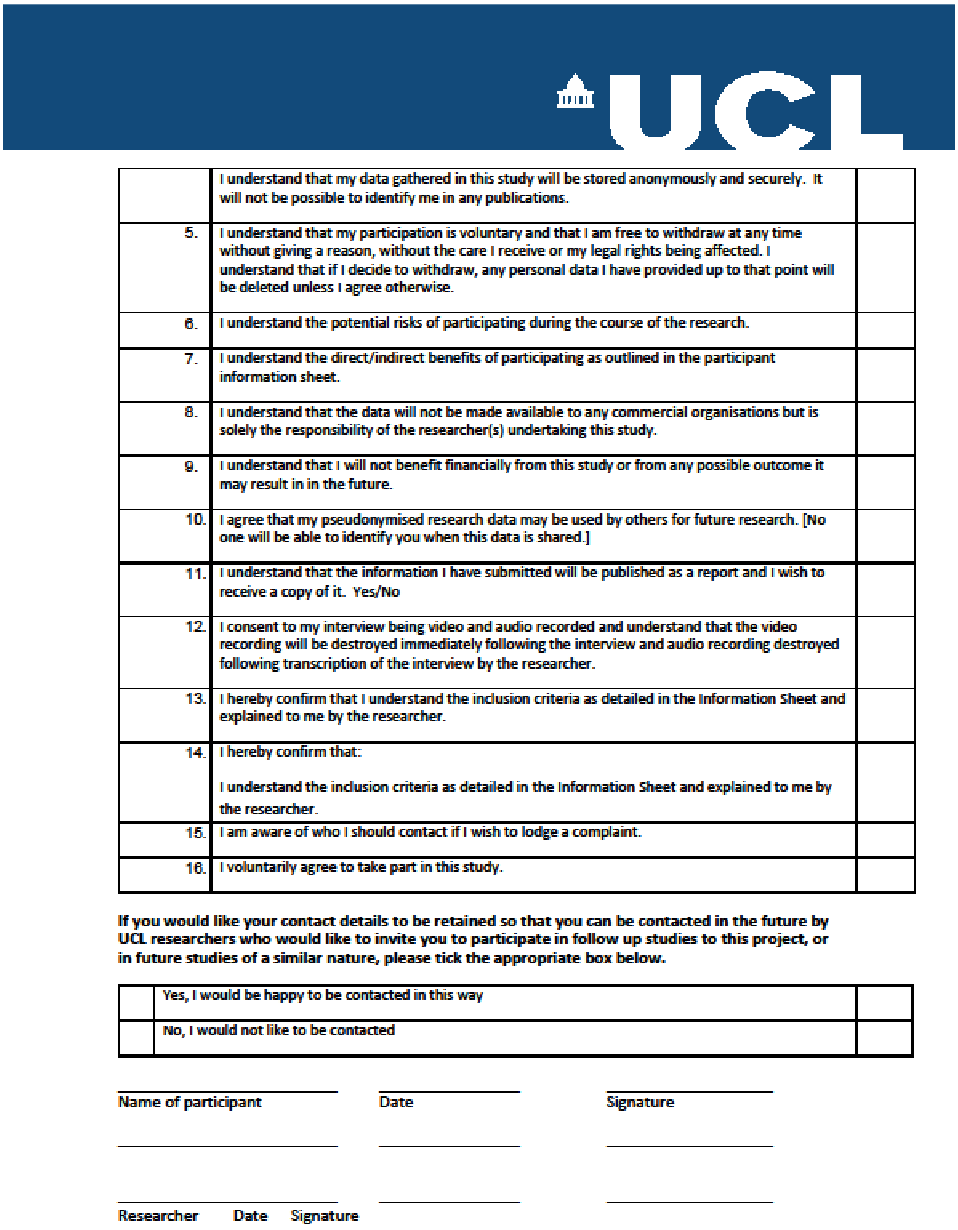
**Name and Contact Details of the UCL Data Protection Officer:** Alexandra Potts data-protection@ucl.ac.uk

**This study has been approved by the UCL Research Ethics Committee: Project ID number: 21655/001**

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

**I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.**

| | | Tick Box |
|---|---|---|
| 1. | I confirm that I have read and understood the Information Sheet for the above study. I have had an opportunity to consider the information and what will be expected of me. I have also had the opportunity to ask questions which have been answered to my satisfaction prior to participating in an individual interview. | |
| 2. | I understand that I will be able to withdraw my data up until two weeks following my interview. | |
| 3. | I consent to participate in the study. I understand that my personal information including my age, ethnicity, gender and psychological and physical health will be used for the purposes explained to me. I understand that according to data protection legislation, 'public task' will be the lawful basis for processing this information. | |
| 4. | I understand that all personal information will remain confidential and that all efforts will be made to ensure I cannot be identified. I understand the limits to confidentiality as detailed in the participant information sheet. | |



| | | |
|---|---|---|
| | I understand that my data gathered in this study will be stored anonymously and securely. It will not be possible to identify me in any publications. | |
| 5. | I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without the care I receive or my legal rights being affected. I understand that if I decide to withdraw, any personal data I have provided up to that point will be deleted unless I agree otherwise. | |
| 6. | I understand the potential risks of participating during the course of the research. | |
| 7. | I understand the direct/indirect benefits of participating as outlined in the participant information sheet. | |
| 8. | I understand that the data will not be made available to any commercial organisations but is solely the responsibility of the researcher(s) undertaking this study. | |
| 9. | I understand that I will not benefit financially from this study or from any possible outcome it may result in in the future. | |
| 10. | I agree that my pseudonymised research data may be used by others for future research. [No one will be able to identify you when this data is shared.] | |
| 11. | I understand that the information I have submitted will be published as a report and I wish to receive a copy of it. Yes/No | |
| 12. | I consent to my interview being video and audio recorded and understand that the video recording will be destroyed immediately following the interview and audio recording destroyed following transcription of the interview by the researcher. | |
| 13. | I hereby confirm that I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher. | |
| 14. | I hereby confirm that:<br>I understand the inclusion criteria as detailed in the Information Sheet and explained to me by the researcher. | |
| 15. | I am aware of who I should contact if I wish to lodge a complaint. | |
| 16. | I voluntarily agree to take part in this study. | |

**If you would like your contact details to be retained so that you can be contacted in the future by UCL researchers who would like to invite you to participate in follow up studies to this project, or in future studies of a similar nature, please tick the appropriate box below.**

| | | |
|---|---|---|
| | Yes, I would be happy to be contacted in this way | |
| | No, I would not like to be contacted | |

Name of participant Date Signature

Researcher Date Signature

# Appendix E: Signposting to resources

**Title of Study:** Experiences of racially minoritized, medically/clinically 'vulnerable' women during the COVID-19 pandemic.

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**Name and Contact Details of the Researcher(s):** Daisy Sunderalingam
Trainee Clinical Psychologist & Equality, Diversity and Inclusion (EDI) Representative
uciudds@ucl.ac.uk
**Name and Contact Details of the Principal Researcher:** Dr Kat Alcock
Principal Clinical Tutor, Senior Admissions Tutor & Equality, Diversity and Inclusion (EDI) Lead
k.alcock@ucl.ac.uk
**Name and Contact Details of the UCL Data Protection Officer:** Alexandra Potts data-protection@ucl.ac.uk

It is not anticipated that there will be any disadvantages and risks of taking part in an interview. However, you may feel emotionally distressed during the interview due to the topics being discussed. You may pause the interview at any time and skip questions at any point without having to give a reason. You will be signposted to support.

**Signposting to support if participants experience distress during or after interview, or, if participants request information:**

- **Mental health crisis support:**
  - If you feel unable to keep yourself self, or feel your life is at risk you should visit your local Accident & Emergency (A&E) or call 999
  - You can request an emergency or same-day appointment with your GP if you require urgent support for your mental health
  - **If you feel experiencing a mental health crisis, there are helplines available:**
    - **Samaritans.** To talk about anything that is upsetting you, you can contact Samaritans 24 hours a day, 365 days a year. You can call **116 123** (free from any phone), email jo@samaritans.org or visit some branches in person.
    - **SANEline.** If you're experiencing a mental health problem or supporting someone else, you can call SANEline on **0300 304 7000** (4.30pm–10.30pm every day).
    - **National Suicide Prevention Helpline UK.** Offers a supportive listening service to anyone with thoughts of suicide. You can call on **0800 689 5652** (6pm–3:30am every day).
    - **Campaign Against Living Miserably (CALM).** You can call the CALM on **0800 58 58 58** (5pm–midnight every day) if you are struggling and need to talk. Or if you prefer not to speak on the phone, you could try the CALM webchat service. Get Help & Support With... | Campaign Against Living Miserably (CALM) (thecalmzone.net)
    - **Shout.** If you would prefer not to talk but want some mental health support, you could **text SHOUT to 85258.** Shout offers a confidential 24/7 text service providing support if you are in crisis and need immediate help.
    - **The Mix. If you're under 25, you can call The Mix on 0808 808 4994** (3pm–midnight every day), request support by email using this form on The Mix website or use their crisis text messenger service.
    - **Papyrus HOPELINEUK. If you're under 35** and struggling with suicidal feelings, or concerned about a young person who might be struggling, you can call Papyrus HOPELINEUK on **0800 068 4141** (weekdays 10am-10pm,

        weekends 2pm-10pm and bank holidays 2pm–10pm), email pat@papyrus-uk.org or text 07786 209 697.
        - **Nightline. If you're a student,** you can look on the Nightline website to see if your university or college offers a night-time listening service. Nightline phone operators are all students too. Want to Talk? - Nightline Association
        - **Switchboard. If you identify as gay, lesbian, bisexual or transgender, you can call Switchboard on 0300 330 0630** (10am–10pm every day), email chris@switchboard.lgbt or use their webchat service. Phone operators all identify as LGBT+.

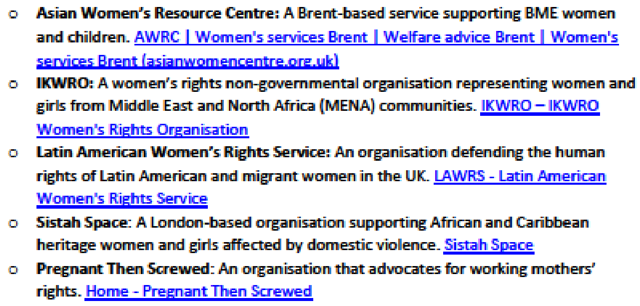
- **Therapeutic support:**
    - You can refer yourself, or your GP can refer you to psychological therapies services, such as your local Improving Access to Psychological Therapies (IAPT) service. This is usually for short-term Cognitive Behavioural Therapy (CBT). Find an NHS talking therapies services - NHS (www.nhs.uk)
    - Some GP practices have counsellors working within the practice
    - If you attend or work for a school/college/university – your institution should have an internal or external counselling service available for free

- **Low-cost therapy:** Other affordable options for people on low incomes – the free psychotherapy network

- **The Black, African and Asian Therapy Network directory:** Find a Psychological Therapist | The Black, African and Asian Therapy Network (baatn.org.uk)

- **Long COVID support:** Find help and support if you have long COVID - GOV.UK (www.gov.uk)

- **Charities that you may want to connect with:**
    - **COVID: Aid:** The charity supports anyone significantly affected by Covid-19 in the UK. Covid Aid – The UK's National Covid-19 Charity – Coronavirus Support | covid:aid (covidaidcharity.org)
    - **Black Lives Matter (BLM) UK help and support links:** •••▶ HELP & SUPPORT | BLACKLIVESMATTER.UK
    - **Sisters of Frida:** Sisters of Frida CIC is an experimental collective of disabled women. We want a new way of sharing experiences, mutual support and relationships with different networks. Sisters of Frida » Disabled Women CIC (sisofrida.org)
    - **Imkaan:** A Black feminist organisation dedicated to addressing violence against Black and minoritised women and girls. About Imkaan — Imkaan
    - **Angelou Centre:** A Newcastle-based service empowering women. Home - The Angelou Centre (angelou-centre.org.uk)
    - **Mama Health and Poverty Partnership:** A Manchester-based service providing support to (black and minority ethnic) BME African women and girls. (mhapp.org.uk)
    - **Safety4Sisters:** A feminist and anti-racist organisation in Manchester working for the safety of migrant women and to put an end to patriarchal and state violence. Safety4Sisters
    - **Southall Black Sisters:** A London-based organisation supporting Black, Asian and Caribbean women escape domestic abuse and poverty. Southall Black Sisters - Southall Black Sisters



- **Asian Women's Resource Centre:** A Brent-based service supporting BME women and children. AWRC | Women's services Brent | Welfare advice Brent | Women's services Brent (asianwomencentre.org.uk)
- **IKWRO:** A women's rights non-governmental organisation representing women and girls from Middle East and North Africa (MENA) communities. IKWRO – IKWRO Women's Rights Organisation
- **Latin American Women's Rights Service:** An organisation defending the human rights of Latin American and migrant women in the UK. LAWRS - Latin American Women's Rights Service
- **Sistah Space**: A London-based organisation supporting African and Caribbean heritage women and girls affected by domestic violence. Sistah Space
- **Pregnant Then Screwed**: An organisation that advocates for working mothers' rights. Home - Pregnant Then Screwed

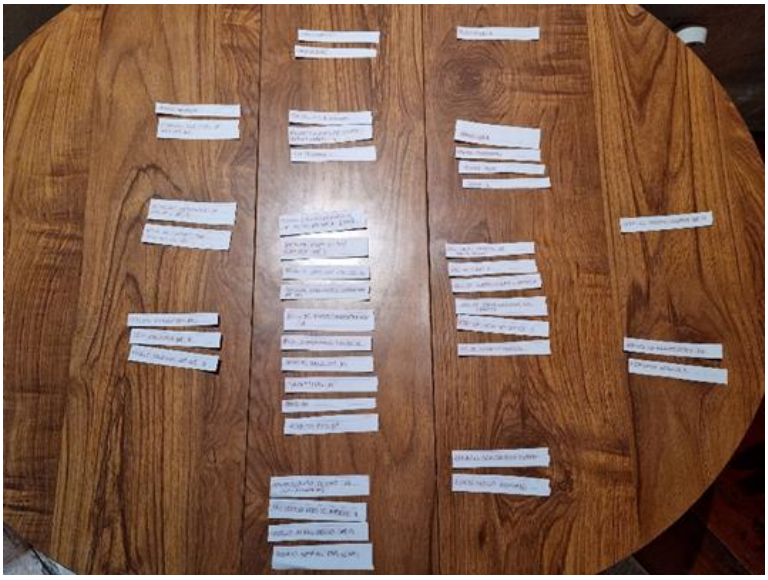
## Appendix F: Interview Schedule

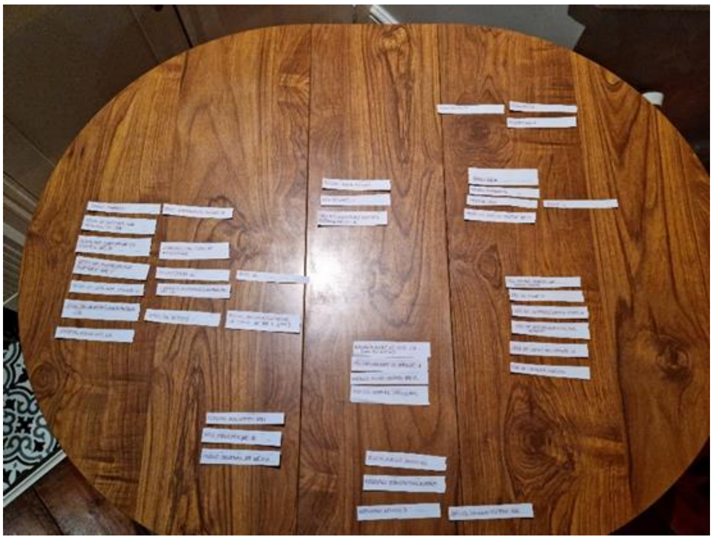
1. What made you want to participate in this interview/What drew you to this research?
2. What has COVID-19 meant for you? Prompts: social/relationships, work, physical/mental health. Follow up questions: can you tell me more about that? Tell me what you were thinking? How did you feel?

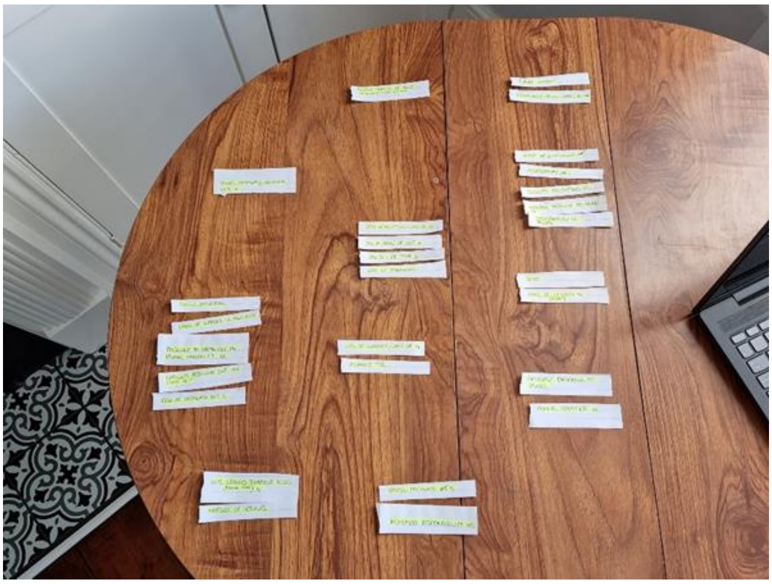
3. How has your experience of the pandemic been/your experience as someone who identifies as a clinically vulnerable racialised woman been during the pandemic? How have you made sense of your identity?
4. What changes in your life (work, social, healthcare, caring, responsibilities) have you experienced during the pandemic? Prompts: Positive, negative and neutral. How have you experienced those changes?
5. How are your experiences different/like those around you?
6. How have you made sense of the pandemic and the impact on you? E.g., shielding/being labelled vulnerable.
7. What has been your experience of being clinically vulnerable meant for you?
8. How have you gathered support?/How have you coped?
9. How have you experienced a sense of belonging in any spaces? Prompts: social, work, relationships. Follow up: what makes you feel this way?
10. How has your well-being and mental health been impacted during the pandemic?
11. How do you see areas of your life going forward considering COVID-19? Prompts: any changes in how you see the future? Impact on way you see the future?
12. Could you describe your experience of the pandemic so far as a metaphor?
13. What hopes do you have when thinking about psychological support/services? Prompts: What would you like to see happen in services going forward? How might psychological services best meet your needs?
14. Is there anything else you have wanted to share but have not done so?

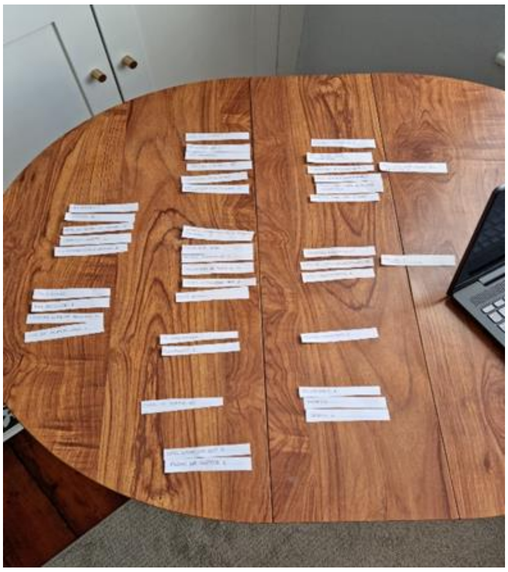
## Appendix G: Initial stages of analysis

Some pictures from this stage of analysis, emergent themes were written on left hand margin of printed transcripts following initial noting. Pictures depict emergent themes written on paper, colour coded, tallied and then set out on table to organise into clusters.

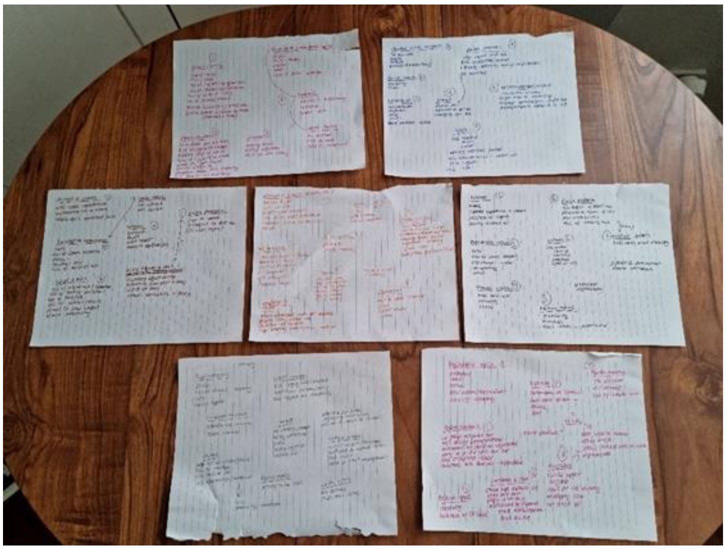


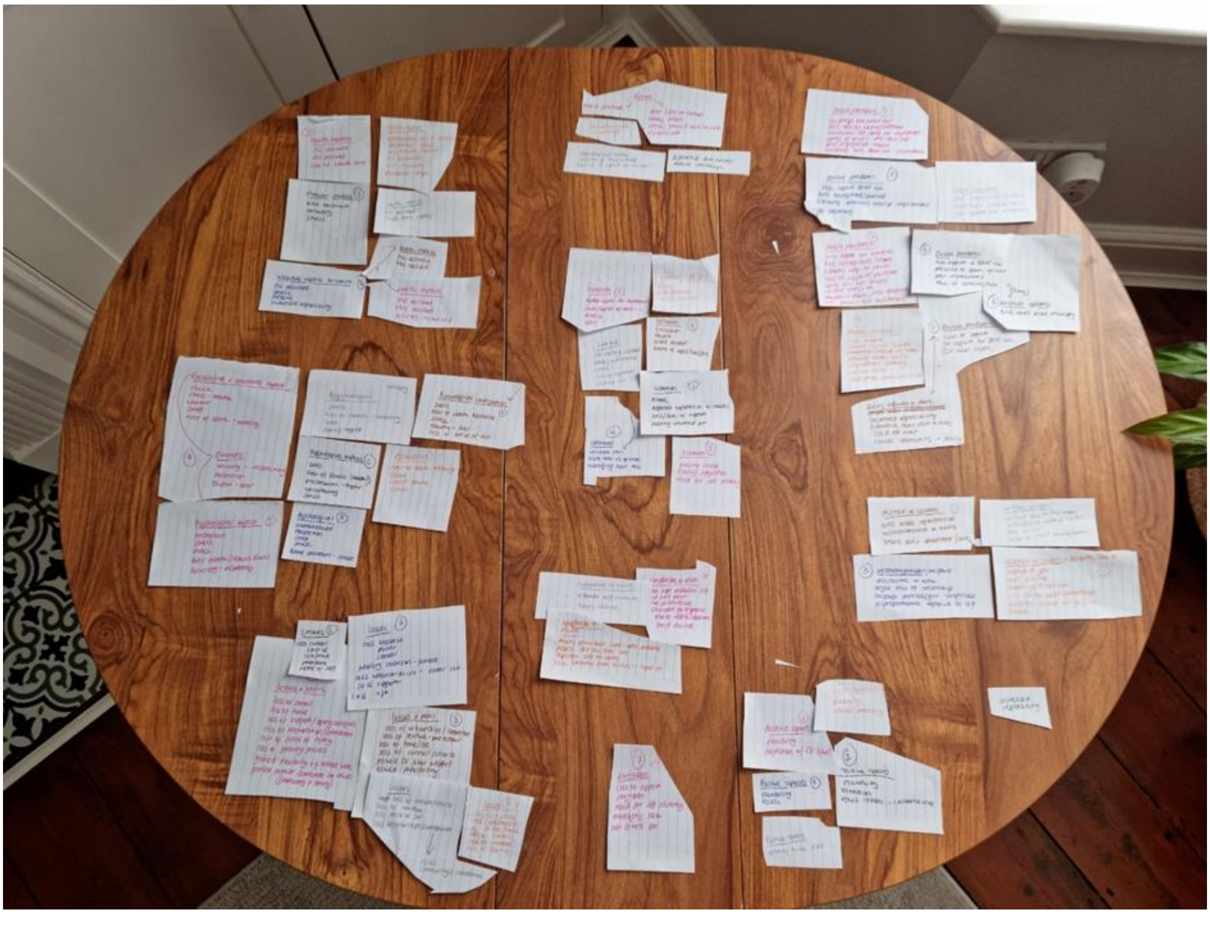


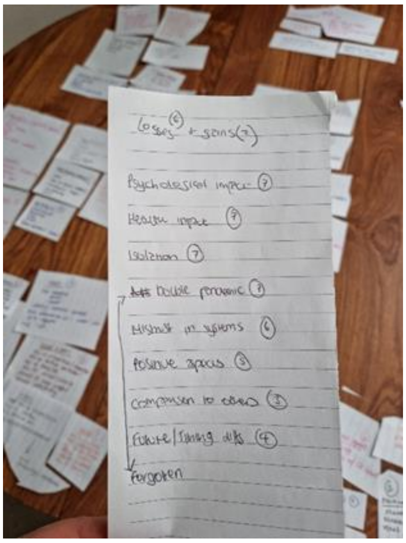




Wrote out each theme from each interview and cut and arranged on table. Colour coded for ease. Pictures depict arranged themes on table. Created a list of superordinate themes and how often they occur across the data.







Losses⑥ + gains(7)

Psychological impact ⑦

Health impact ⑦

Isolation ⑦

~~Add~~ Double pandemic ⑦

Mistrust in systems ⑥

Positive aspects ⑤

Comparison to others ③

Future/[illegible] diffs ④

Forgotten

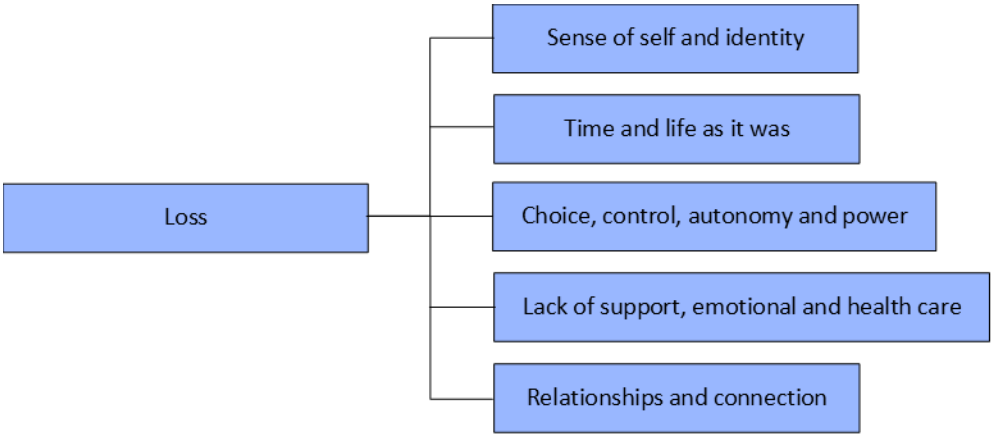
Table of superordinate themes and subthemes. Where subthemes have occurred in interviews marked in colour blocks. Reworded some things here and merged some subthemes/shifted from other superordinate themes.

| **Superordinate Themes** | **Subthemes** | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|---|---|---|---|---|---|---|---|---|
| **Losses** | Autonomy (control, choice, power, freedom) | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | Sense of self, identity | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | Relationships, connection | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | *Stamina* | | | 🟩 | | | | |
| | Time | | | | | | | 🟩 |
| | *Expertise* | | 🟩 | | | | | |
| **Gains/Positive aspects** | Flexibility – access | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | Connection to values – direction to values | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | Learning to be alone | 🟨 | | | | | | |
| **Psychological impact** | Fear of death – illness – mortality | ⬛ | | | ⬛ | ⬛ | ⬛ | ⬛ |
| | Shock – trauma | ⬛ | | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| | Grief | ⬛ | | | ⬛ | ⬛ | ⬛ | ⬛ |
| | Stress - frustration | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| | Anxiety - threat | ⬛ | | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| **Health impact** | Physical health declined | 🟧 | 🟧 | 🟧 | 🟧 | 🟧 | 🟧 | |
| | Mental health declined | 🟧 | | | 🟧 | 🟧 | 🟧 | 🟧 |

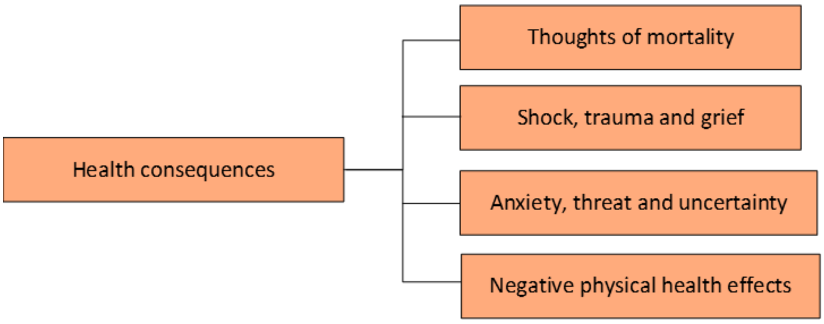
| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Isolation** | Feeling alone | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 |
| | Forgotten | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 |
| | Uncared for – unprotected | 🟦 | | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 |
| | Managing own risk | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 |
| | Need for self-advocacy | 🟦 | | 🟦 | 🟦 | 🟦 | 🟦 | 🟦 |
| **Idea of the double pandemic** | CV not cared for BME devalued | ⬛ | | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| | No support for BME risk | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| | BME scapegoated/blamed for risk | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| | Implications of speaking up | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ | ⬛ |
| **Mistrust in systems** | NHS lacks representation | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | Misinformation in media and systems | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | Forced to disclose at work/back to F2F | 🟨 | | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | COVID is divisive | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| | Mismanagement of COVID | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 | 🟨 |
| **Comparison to others** | Others have dismissed seriousness of COVID – it's not over – pressure to return to 'normal' | 🟩 | | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | Others don't understand | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | Different experience to others | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| | Others are selfish | 🟩 | | 🟩 | 🟩 | 🟩 | 🟩 | 🟩 |
| **Unknown future** | Unknown | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 |
| | Uncertain | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 |
| | Difference from start to now | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 | 🟥 |

I created a table in Microsoft word and revisited each transcript to gather and input quotes into each of the initial superordinate themes. Several quotes were included under each theme from each participant transcript. Below are edited down from the original analysis document and I have excluded quotes that were used in the empirical paper so as to avoid repetition.

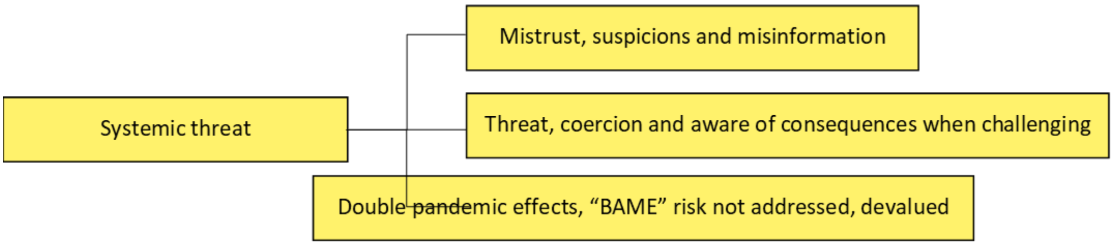
This supported restructuring of superordinate themes and subthemes which are presented then presented as a final analysis in the empirical paper.



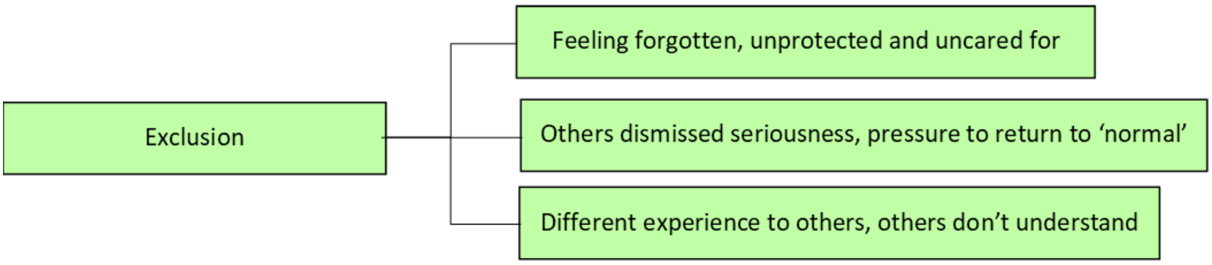
| | |
|---|---|
| 1 | “I felt I am in a prison, it’s quite hard. Quite difficult. Yeah. We felt disconnected. We are shattered. We are separated from each other, from services, from the community, from the government, from everything.” |
| 2 | “I usually go to kind of spiritual gatherings and we lost all of that. We lost all that sort of sense of community and cohesion” |
| 3 | “it signified a lot of loss.. so you lose everyday sense of self, you lose relationships, you lose people who are lost to you forever because you are bereaved of them” |
| 4 | “some of how I thought of myself, was to do with work. And so then I did lose a little bit of maybe how I saw myself. I couldn’t do some of the things that I was doing before” |
| 5 | “my world became very very small” |
| 6 | “during lockdown I was definitely on my own and we couldn’t get to each other. We would talk on the phone lots and do video calls, but it was really really lonely” |
| 7 | “I felt like I lost part of my life when COVID, when the pandemic happened. It feels like there was just this, couple of years that have just disappeared” |



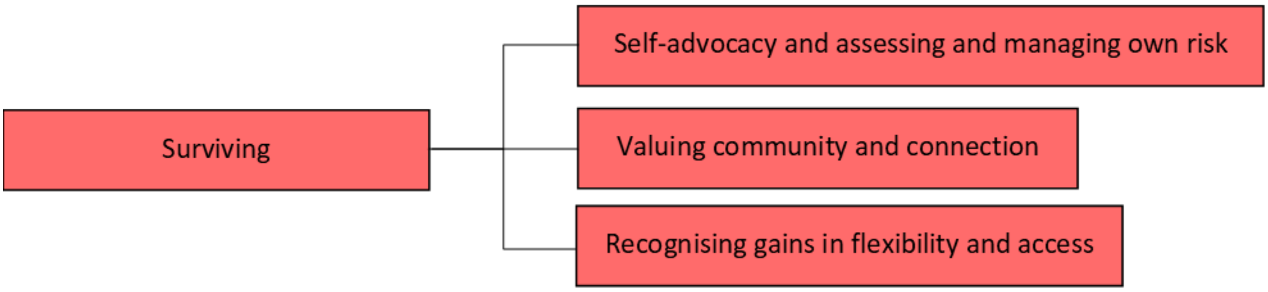
| | |
|---|---|
| 1 | “to be honest with you, till now, I still have the fear feeling inside me” |
| 2 | |
| 3 | “I think my physical health has definitely taken a knock. The stamina I’ve lost because I wasn’t even going out for a walk because at the start the advice was stay at home” |
| 4 | “it really changed things and made things worse in terms of how I got like treatments and stuff that I need to get on my health plan” |
| 5 | “it had an adverse reaction to my health because I wasn’t walking as much, its made it harder for me” |
| 6 | “I think in terms of mental health wise, I think it really challenged me” |
| 7 | “there was a lot of fear, I think at the beginning when I think back to that first bit, it was just really, really scary. We just didn’t know what was going to happen, we didn’t know what was safe” |



| | |
|---|---|
| 1 | they bring us from after covid to the normal life straight away, the transition is not smooth. So that’s really, really concerning, especially with the ethnic minorities because I mentioned they don’t know how to reach or approach the service and the service doesn’t come to them. And they’ve been judged by some services.” |
| 2 | “I had to lobby. I don’t know, that’s just a lot of pressure on, particularly women. And I think its multiplicated when you’re a BME woman. I there’s cultural elements of what is expected of women at home.” |
| 3 | “people from Black, Asian minority ethnic communities were told that we are hard to reach and its kind of like no, no you’re probably just not asking us to get involved in the right way.” |
| 4 | “the racialized aspect of the pandemic as well, kind of goes hand in hand for me from before pandemic and before being clinically vulnerable as well. When I think about health for me and like going to hospital, I also have to think about racism because of stuff I’ve experienced” |
| 5 | “I heard people from a BME background are more vulnerable, and that really scared me too cause it’s almost like a double fear” |
| 6 | “the government didn’t really think about people who were clinically vulnerable and disabled in that way when they were removing measures” |
| 7 | “its poor, its very poor… I’ve had lots of examples of situations I’ve thought, well, we can all just carry on being quiet but the people most affected by this are the ones consistently saying like we need to talk about this. Its coming from the groups that are most affected” |



| | |
|---|---|
| 1 | "What about us? Why didn't they think about us" |
| 2 | "I don't think I've had a forum to kind of express the range of things that I have inside of me before and to express them, then somebody argues with you about it" |
| 3 | "We've shifted from one extreme to the other… we really came together, the murder of George Floyd, so in the activism, in social media we saw it in terms of companies and corporations and people starting to speak out and to try to do good and try to do better and everybody trying to do the reading. It's like everybody's forgotten about all of that. I know it's a bit of a dog each dog world out there and you know we live in a society where it's very much individualistic. You're out to look after yourself" |
| 4 | "my experience was similar to people I knew, clinically vulnerable or living with someone clinically vulnerable but those that didn't it was super dissimilar. It was very very much dismissed. It was like oh it's a cold, and it was feeling like they were just not taking it as seriously" |
| 5 | "in a way the pandemic hasn't stopped for me. I still need to be careful" |
| 6 | "Some of the things are quite difficult for me to explain, if that makes sense, and often its sort of feeling of um, I guess not being thought about her not being kept in mind" |
| 7 | |



| | |
|---|---|
| 1 | "It's in front of my eyes now. It's a ghost. It's a ghost. And I feel myself I'm fighting. I go to protect myself, to protect my children, my community" |
| 2 | "I think there have been some positives as well, like I think there are certain spaces that I couldn't access before that are now open" |
| 3 | "I use my voice because if I don't speak up if I don't support (colleagues mentioned), who's going to do it for us? |
| 4 | "I've had to, I've been left to fend for myself in a way through this I've had to do that because of the different supports kind of falling away" |
| 5 | "I was in touch with family in India who were doing a lot of meditation to help with the stress and fear of COVID" |

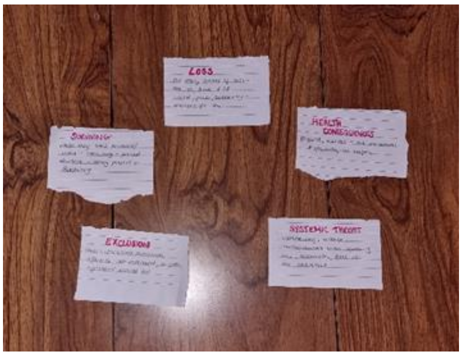
|  |  |
|---|---|
| 6 | “I am much more assertive when it comes to my health now and consultants hate me… I know my body best” |
| 7 | “Flexibility is positive for everyone like both ways I think it I think it will work both ways” |

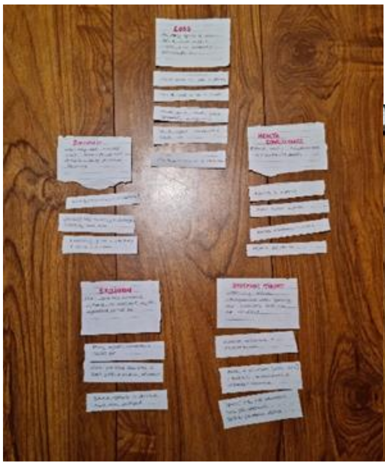
Following further analysis, supervision and triangulation – I created a flowchart of the above superordinate themes and subthemes. I started to write up the different themes, however, during the write up more insights and interpretations were identified which led me to change and collapse some themes further. The themes were reworked as I was writing which is part of the IPA process. Prompted by training on IPA, I translated my themes into a narrative account and was able to see further connections and spot contradictions.

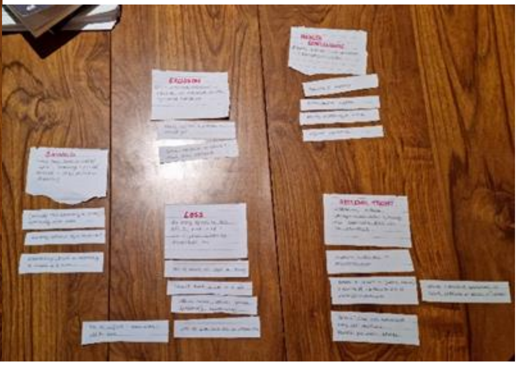
Following consultation and supervision:

- Rearranged sub themes and collapsed some into others, reworded a few
- Wrote and cut out sub themes – arranged on table to see if any sub themes fit under alternate superordinate themes than originally placed
- Moved themes around on table – felt loss – health consequences – systemic threat – exclusion – surviving – felt like a flow and also fit with temporal markers of the pandemic, e.g., loss felt first, then considering the risks and consequences, lastly the more lasting feeling and experience of exclusion and lack of protection.
- Felt a circle formed, almost like the most prominent ‘loss’ being first and the fall out and cyclical nature of talking, processing and experiencing pandemic is reflected in this
- Acted as if I was presenting the themes to someone – spoke out loud through each, the explanation and rationale. Checked in how this felt
    - Some worries crept in – e.g., Would she feel like an outsider? She named that she suspected her experiences would not relate to others in the study and there are some themes that do not reflect her experience. Way around this would be to acknowledge during respondent validation that in the write up, unique accounts and divergence will be articulated.

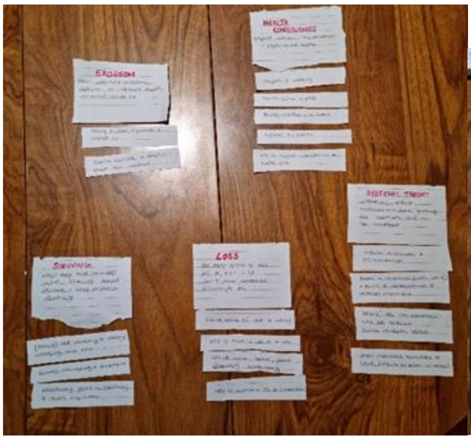
- I felt less that this looks ‘downplayed’ - feeling more confident that this does reflect the difficulties experienced by participants but wondered if wording is right

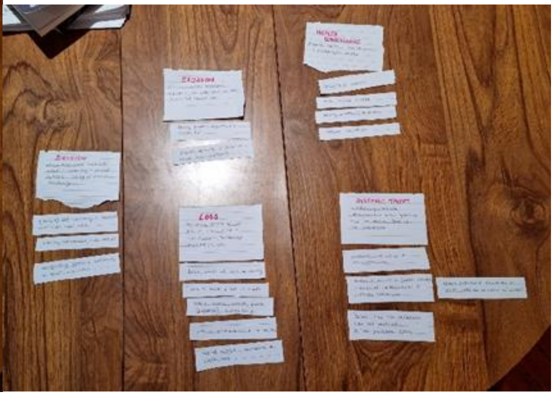






Pictures showing process of moving subthemes around and collapsing themes into others


HEALTH CONSEQUENCES
EXCLUSION
SYSTEMIC TRUST
LOSS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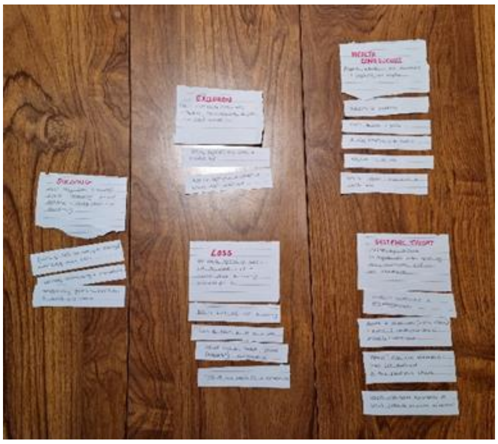
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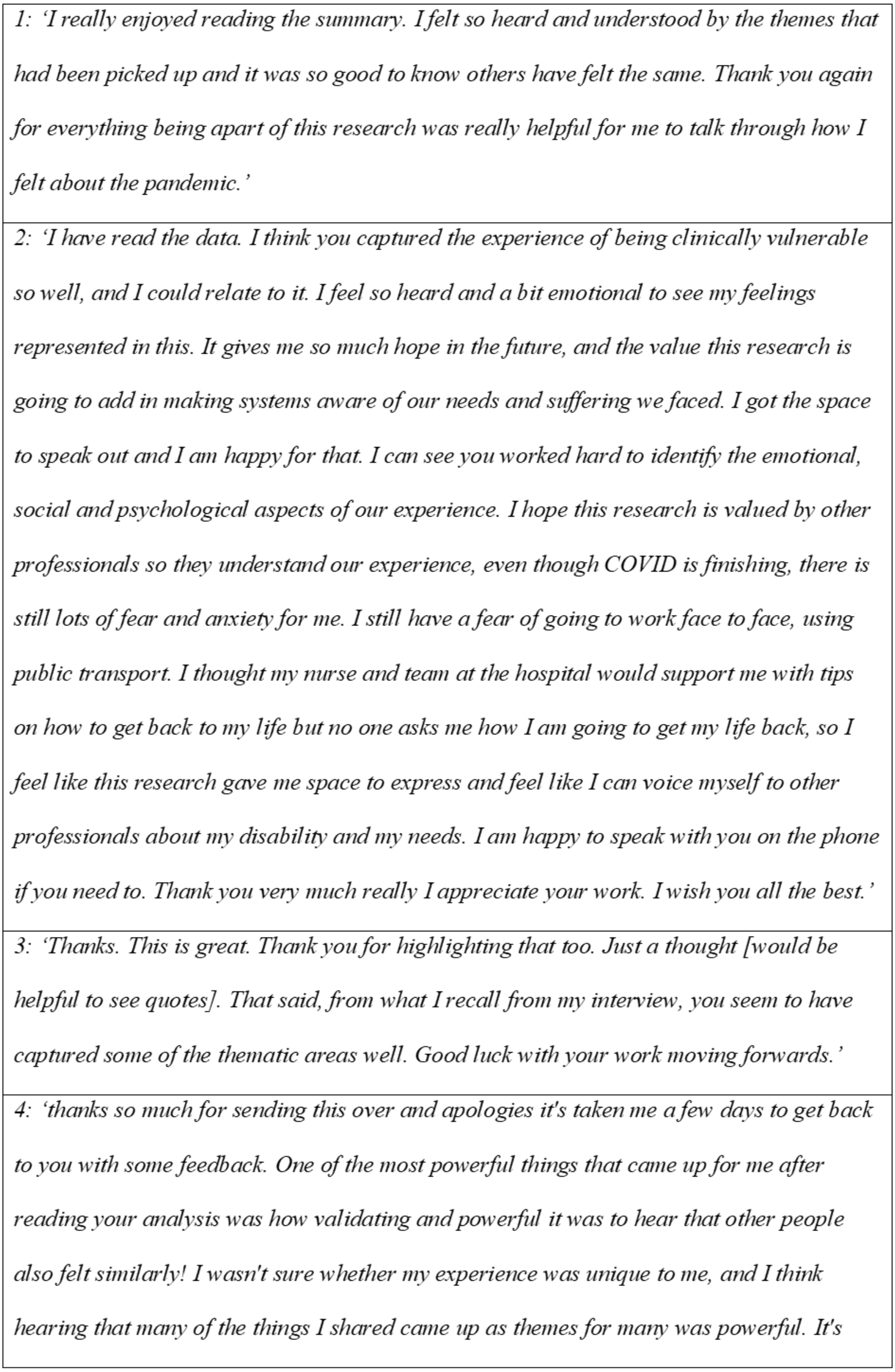
SYSTEMIC TRUST

## Appendix H: Respondent validation



*1: 'I really enjoyed reading the summary. I felt so heard and understood by the themes that had been picked up and it was so good to know others have felt the same. Thank you again for everything being apart of this research was really helpful for me to talk through how I felt about the pandemic.'*

*2: 'I have read the data. I think you captured the experience of being clinically vulnerable so well, and I could relate to it. I feel so heard and a bit emotional to see my feelings represented in this. It gives me so much hope in the future, and the value this research is going to add in making systems aware of our needs and suffering we faced. I got the space to speak out and I am happy for that. I can see you worked hard to identify the emotional, social and psychological aspects of our experience. I hope this research is valued by other professionals so they understand our experience, even though COVID is finishing, there is still lots of fear and anxiety for me. I still have a fear of going to work face to face, using public transport. I thought my nurse and team at the hospital would support me with tips on how to get back to my life but no one asks me how I am going to get my life back, so I feel like this research gave me space to express and feel like I can voice myself to other professionals about my disability and my needs. I am happy to speak with you on the phone if you need to. Thank you very much really I appreciate your work. I wish you all the best.'*

*3: 'Thanks. This is great. Thank you for highlighting that too. Just a thought [would be helpful to see quotes]. That said, from what I recall from my interview, you seem to have captured some of the thematic areas well. Good luck with your work moving forwards.'*

*4: 'thanks so much for sending this over and apologies it's taken me a few days to get back to you with some feedback. One of the most powerful things that came up for me after reading your analysis was how validating and powerful it was to hear that other people also felt similarly! I wasn't sure whether my experience was unique to me, and I think hearing that many of the things I shared came up as themes for many was powerful. It's*