



This is a peer-reviewed, post-print (final draft post-refereeing) version of the following published document and is licensed under Creative Commons: Attribution-Noncommercial-No Derivative Works 4.0 license:

**Kinsella, Elaine L., Hughes, Samantha ORCID logoORCID:
<https://orcid.org/0000-0002-7715-9808>, Lemon, Sarah,
Stonebridge, Natasha and Sumner, Rachel C ORCID
logoORCID: <https://orcid.org/0000-0002-2421-7146> (2022)
“We shouldn't waste a good crisis”: The lived experience of
working on the frontline through the first surge (and beyond)
of COVID-19 in the UK and Ireland. *Psychology and Health*, 37
(2). pp. 151-177. doi:10.1080/08870446.2021.1928668**

Official URL: <https://www.tandfonline.com/doi/full/10.1080/08870446.2021.1928668>
DOI: <http://dx.doi.org/10.1080/08870446.2021.1928668>
EPrint URI: <https://eprints.glos.ac.uk/id/eprint/9607>

Disclaimer

The University of Gloucestershire has obtained warranties from all depositors as to their title in the material deposited and as to their right to deposit such material.

The University of Gloucestershire makes no representation or warranties of commercial utility, title, or fitness for a particular purpose or any other warranty, express or implied in respect of any material deposited.

The University of Gloucestershire makes no representation that the use of the materials will not infringe any patent, copyright, trademark or other property or proprietary rights.

The University of Gloucestershire accepts no liability for any infringement of intellectual property rights in any material deposited but will remove such material from public view pending investigation in the event of an allegation of any such infringement.

PLEASE SCROLL DOWN FOR TEXT.

“We shouldn't waste a good crisis”:

**The lived experience of working on the frontline through the first surge (and beyond) of
COVID-19 in the UK and Ireland**

Elaine L Kinsella¹, Samantha Hughes², Sarah Lemon², Natasha Stonebridge², & Rachel C.
Sumner²

¹Department of Psychology, Centre for Social Issues Research, RISE (Research on Influence,
Social networks & Ethics) lab, and Health Research Institute, University of Limerick

²Department of Psychological Sciences, HERA Lab, University of Gloucestershire

Author Note

Elaine L. Kinsella

We have no known conflict of interest to disclose.

Correspondence concerning this article should be addressed to Dr. Elaine L. Kinsella,
Department of Psychology, University of Limerick, Castletroy, Limerick: Email:

elaine.kinsella@ul.ie

Word Count: 10,955

Abstract

Objective: Frontline workers have shown extraordinary resilience and sustained efforts since the outbreak of COVID-19. The present study used semi-structured interviews with 38 frontline workers in the UK and Ireland to explore the psychological impact of working through COVID-19.

Design: The qualitative data were analysed systematically using thematic analysis.

Results: Four themes were interpreted: 1) *"I've stopped turning the telly on. I've had to because the news was making me ill"*: An ecosystem of influence; 2) *"Dead, dead, dead"*: The emotional and psychological toll; 3) *"It's shone a light on what we're failing on as well"*: Injustices, hierarchies and heroes; and 4) *"I definitely think COVID happened for a reason to stop us in our tracks and to slow us down"*: Unexpected positives.

Conclusion: This research offers insights into how frontline workers make sense of their experiences during periods of enormous societal and occupational stress. The learnings generated have relevance for government and organisational policy-makers who have opportunities to shape future conditions for frontline workers.

Keywords: COVID-19, coronavirus, frontline workers, keyworkers, cv19heroes, resilience, wellbeing, health

“We shouldn't waste a good crisis”: The lived experience of working on the frontline through the first surge (and beyond) of COVID-19 in the UK and Ireland

Research conducted during previous health crises has consistently shown significant health and wellbeing fallout for those working on the frontline that lasts well beyond the crisis itself (Maunder et al., 2006; Stuijzand et al., 2020). Yet, the coronavirus pandemic differs to previous health crises in a number of ways, particularly in relation to significant stresses relating to social isolation and parenting (Gavin et al., 2020). Research conducted since the outbreak of COVID-19 illustrates the significant impact the pandemic is having on a variety of metrics associated with workers' welfare, from symptoms of depression and anxiety (Ali et al., 2020; De Boni et al., 2020; Foley et al., 2020; Khanal et al., 2020), to reduced wellbeing and increased burnout (Kannampallil et al., 2020; Sumner & Kinsella, 2021). These studies offer helpful insights into the negative impacts of working on the frontline, yet, we suspect that some of the nuances in the data are missing and prevent us from gaining greater understanding of the psychological experience of working on the frontline.

The complexities of working on the frontline likely include both struggle and reward. Struggle in many ways that are both obvious and previously well-accounted, such as self-isolation, the trauma of witnessing illness and death, the strain of longer working hours, and the responsibility of a duty to work (Maunder, 2004), as well as more subtle ways that may be more specific to the way the SARS-CoV-2 pandemic has played out particularly. The early experiences of panic buying and hoarding that over-stretched community supply chains, pandemic denial, failure to adhere to public health guidelines with regard to distancing and wearing of masks, as well as perceived delays in governmental strategy and response are all examples of very specific stressors to frontline workers in this pandemic (see: Vindrola-Padros et al., 2020). However, there are also likely to be positives to being involved in frontline working during such situations. The ability to act – the empowerment and self-efficacy derived from knowing that you have a role to play and that there is something that you can actually do to help – cannot be underestimated (Benight & Bandura, 2004). Equally, the experience of meaning in your life both personally and professionally (Kinsella et al., 2019) is of great benefit to those working on the frontline. The personal achievement and success that is derived through overcoming fears and challenges is a positive aspect of stress (eustress), rich in feelings of accomplishment and courage, that may also serve as a protective factor in handling these experiences (Simmons & Nelson, 2001). It is clear, therefore, that experiences such as those lived by our frontline workers during this pandemic are not

universal, unidirectional, nor unidimensional. Whilst surveys and questionnaires are able to capture large volumes of individuals to provide information into the outcomes we wish to understand, the pathways to these outcomes are less straightforward to explore with such modalities.

The present research aimed to explore how frontline workers make sense of their own personal experiences of COVID-19. Importantly, the project set out to collect data from all areas of frontline work, not restricted to frontline healthcare workers. This quite unique perspective for such work was purposive, providing the opportunity to explore experience that transcends boundaries of occupational role or organisational context, with the ability to learn more about what being on the frontline is like for those facing these complex challenges. Understanding that many different roles contribute to the continuation of civilisation in crisis, the present work draws together the voices of those in any area of frontline work to serve as a record and to provide a deeper exploration of the experiences of those who have sacrificed so much for the rest of us. The central research question was: *What are the experiences of working through the first surge (and beyond) of COVID-19 for frontline workers in the UK and Ireland?* A qualitative approach was chosen as a means of providing rich, detailed and nuanced data about frontline workers experiences in the early months of the COVID-19 pandemic, and is expected to complement ongoing efforts to understand the impact of working during COVID-19 through quantitative methods.

Method

Design

This study is a qualitative exploratory study investigating the lived experience of frontline workers in the UK and Ireland. A phenomenological approach was taken to both study and describe the frontline workers' experiences as fully and authentically as possible (Creswell, 2007). By describing the phenomenon under investigation through the participants own words (Colaizzi, 1978), the study aims to offer insights into the 'lived experience' (Creswell, 2007) of frontline workers during the first surge of the COVID-19 pandemic, and in turn, promotes a better understanding of the meaning of their life experiences.

Participants

We sought to understand the experiences of frontline workers from all sectors within the context of the UK and Ireland during COVID-19. Participants were originally recruited through social media and local and national news media. Via these means, people were invited to complete an online survey to track the wellbeing of frontline workers in the UK

and Ireland, and were asked if they would like to take part in follow-up interviews at a later date. An account of participant recruitment can be found in Figure 1a, and the consent procedure in Figure 1b. In the present sample, participants ranged from 20 to 66 years old, with the majority white (either White British or White Irish). The demographic information is summarised in *Table 1*.

Data Collection

The University of Limerick ethics committee provided ethical approval for this research study (2020_03_52_EHS ER). This study forms one part of a larger project pre-registered on the Open Science Framework (Sumner & Kinsella, 2020), the CV19 Heroes Project, tracking frontline worker wellbeing and burnout since the outbreak of COVID-19 (see www.cv19heroes.com).

Consenting participants were interviewed on the phone or using Voice over Internet Protocol (VoIP), depending on their own communication preferences. Interviews were recorded by the researcher conducting the interview and transcribed verbatim in anonymised format. All interviews occurred between June 8th and July 20th, 2020, and were carried out by one of three researchers (SH, NS, SL) who were blind to the quantitative research findings generated from the project to minimise influence in interview direction. At this point in the pandemic, both the UK and Ireland had moved out of the first respective lockdowns where coronavirus restrictions were being gradually lifted.

Interviews were semi-structured. An interview guide provided a loose structure, and participants were prompted to expand on relevant and interesting responses. The interview guide was developed to prompt insights into the lived experience of frontline workers during COVID-19. Broad and open-ended questions were used to facilitate a descriptive narrative that would include talking about any important changes in participants' lives since the outbreak. The interview schedule included 12 questions, conversational in tone, based on the following topics: 1) Life before COVID-19, 2) Experiences of COVID-19, 3) Views about how their country and organisation responded to COVID-19, 4) Sources of information, advice and support, 5) Impact of COVID-19 on self and others, and 6) Broader views about the impact of COVID-19 on society. Participants were also given the opportunity to share further information about their experiences of COVID-19 that they felt was not covered by the interview schedule. Interview length ranged from 22 minutes to one hour and 23 minutes.

Data Analysis

Thematic analysis was used to report themes within the data, without being theoretically bounded (Braun & Clarke, 2006). This flexible method of analysis was chosen

as a means of exploring the lived experiences of those working 'on the frontline' during COVID-19. The process itself involves six stages of coding and developing potential themes (as outlined by Braun & Clarke, 2006). Initially the transcripts were read and re-read in full by the first author (EK) who then identified initial first-level codes, which remained very close to the data. These initial codes were then presented to the other researchers. The second level of analysis involved four of the researchers (RS, SH, NS, SL) reviewing the first-level codes and considering how these could be interpreted within overarching elements that ensured the inclusion of the diversity of the many initial codes into higher level sub-themes. An iterative and inductive approach to interpreting themes within the data were used. The third stage involved agreeing overarching themes, at a semantic level, as well as providing lines of arguments for each theme and selecting quotes that illustrated them adequately. Our analysis resulted in four themes which are detailed fully below and aim to provide a rich description of the data overall.

Validity

The first step in increasing validity of this study was to choose well-trained and skilled interviewers who understood the importance of reflecting on their subjective position from the outset. With this reflective stance came an increasing awareness of their personal biases and assumptions as well as any influence this may have contributed to the findings (see reflexivity below). Second, the design of the semi-structured interview schedule was thoroughly discussed to ensure that it addressed the research question. Third, a diverse range of participant perspectives across different occupational sectors and demographic groups were carefully sought out by the research team. Seeking out these diverse perspectives and using multiple investigators with differing expertise are forms of triangulation that help to lend credibility and balance to the study (Denzin, 2017). Fourth, deep saturation into the research was sought. Fifth, the lead author who took primary responsibility for data analysis did not conduct any interviews and therefore, was not over familiar or attached to a particular interview or set of experiences, and for this reason was able to truly focus on identifying themes through participants' own voices. Sixth, participants were asked if they would like to see the results from the study and were invited to a mailing list for regular project updates. Also, regular communication to participants is published on the project website and social media as means of engaging with the sample, and establishing our dependability and confirmability as researchers.

Reflexivity

We are a group of female, white, educated researchers who are not working in frontline positions. Within the context of the current study, the members of the interview team considered the ways in which their interactions with the participants may have been influenced by their own professional qualifications, experiences, and prior assumptions. The three interviewers (SH, SL, NS) were all UK-based and completing postgraduate degree programmes at the time of the interviews. As a research team, we were all experiencing the challenges of lockdown in our personal lives and shared worries about loved ones who were vulnerable or working on the frontline themselves. We were all actively consuming media coverage of the pandemic globally and, in particular, for frontline workers. This awareness of both national and global contexts during the pandemic helped us to have a greater sense of empathy and respect for frontline workers, however, we acknowledge that this has also shaped the interview schedule, and subsequent data and analysis thereof.

As researchers we were acutely aware that engaging in these interviews could provoke a negative psychological response in participants. During each interview, the interviewees took time to check in with the participants to ensure they were not feeling distressed by their participation. While some participants did get emotional during the interviews, none of these participants wanted to stop the interview, and a number of participants expressed their gratitude for having space to discuss their own experiences. Many participants noted that it was helpful to talk about their experiences with someone outside of their own social and occupational network.

Results

Thirty-eight frontline workers (9 male, 29 female) from the United Kingdom ($n=17$) and Republic of Ireland ($n=21$) were interviewed as part of this research. Participants were all employed at the time of the interviews in roles that were considered “essential” and “frontline” roles in occupational sectors including healthcare, social care, retail, logistics, emergency services and defence forces.

Themes relating to the Psychological Impact on Frontline workers

The four themes interpreted were: 1) *“I’ve stopped turning the telly on. I’ve had to because the news was making me ill”*: An ecosystem of influence; 2) *“Dead, dead, dead”*: The emotional and psychological toll; 3) *“It’s shone a light on what we’re failing on as well”*: Injustices, hierarchies and heroes; and 4) *“I definitely think COVID happened for a reason to stop us in our tracks and to slow us down”*: Unexpected positives.

1. *"I've stopped turning the telly on. I've had to because the news was making me ill: An ecosystem of influence*

Many participants mentioned their own geographical location, and the extent that they felt close or far from the virus. One participant noted that they felt far "away from the epicentre" (M, 18-24 years, RoI, Process Technician). Another participant made their position very clear: "it's bad over the UK" (M, 45-54 years, RoI, Emergency Nurse), and another said about the Irish response: "it was well done and when I looked at the contrast, over the border in the north, it was such a different story and over in the UK." (F, 35-44 years, RoI, Child Mental Health Social Worker). A care home manager in the UK described her own frustrations with the UK government but felt relieved that things weren't as bad as in the USA; "it just felt like leadership might not have been there, although, of course, it could be worse, it could have been the USA." (F, 25-34 years, UK, Care Home Manager). An Irish paramedic said, "I think we're doing okay compared to the likes of America." (F, 25-34 years, RoI, Paramedic). An emergency nurse felt somewhat proud of the Irish response and seemingly embarrassed by the UK response with reference to pictures of crowded beaches: "I think Ireland has done very well and should be almost proud of what they've done over here and it's totally different that's all I'm going to say about the UK. It's almost embarrassing. It's embarrassing to be honest. I was talking about looking at Bournemouth yesterday, it's embarrassing. People are not doing that here, they're used to their summer there" (M, 45-54 years, RoI, Emergency Nurse).

For the most part, Irish frontline workers were reasonably happy with the (then) caretaker government response to move the country into the initial lockdown with many comments like "the response was good" (F, 18-24 years, RoI, Supermarket Cashier), "I'm, again, glad that I'm here" (F, 45-54 years, RoI, Healthcare contact tracing administrator) and most felt the government and public health response was clear and timely: "I thought the government were good. I thought they took action quite quick" (F, 35-44 years, RoI, Garda Sergeant). The Irish government were commended for "listening to health experts rather than economic experts." (F, 35-44 years, RoI, Manager of Community Centre). Some Irish participants worried that the country moved "out of lockdown too soon, people are moving around too much" (F, 35-44 years, RoI, Deli Assistant). A manager of a community centre expressed her anger with the Irish government's strategy to move out of lockdown with the planned phased approach and instead "chopping and changing based on what lobby group are most powerful this week" (F, 35-44 years, RoI, Manager of Community Centre). For her, this abdicated some responsibility to the incoming government, simultaneously safeguarding their

own reputation: "they'll be able to be in a position to say, well when we were in charge it was all good" (F, 35-44 years, RoI, Manager of Community Centre).

Many participants based in the UK questioned the speed of the UK government response with comments such as "I think lockdown was really late" and "I absolutely agree with people who are saying that the government haven't acted quickly enough (F, 18-24 years, UK, Mental Healthcare Worker) and "It's definitely been an afterthought" (F, 25-34 years, UK, Care Home Manager). Some participants debated the government agenda with statements like "even our Prime Minister's statements, sometimes you just feel like no matter how much of a health crisis we might be in, economic interest will still be the main thing for the world." (F, 25-34 years, UK, Care Home Manager). Other participants felt there was "a level of denial" that resulted in late decision-making (F, 45-54 years, UK, Deputy Head of Probation Delivery Unit).

Another key driver of negative perceptions of UK government response was inconsistency in messaging. One participant emphasised that "there was very mixed messages on the COVID briefings in the evenings on the telly" (F, 25-34 years, UK, Care Home Manager). In a similar vein, one participant said "Boris' speeches are very... you can easily misinterpret what he's saying. He doesn't just say it in black and white" (M, 25-34 years, UK, General Assistant in Supermarket). Another participant said "because of so much misinformation, contradicting information, the government really quite frankly, the chaos of the government advice - Boris Johnson, not my favourite human being – come the revolution, up against the wall" (F, 45-54 years, UK, Senior Radiographer) – expressing her immense frustration with the government and senior politicians, and a sentiment that a penalty would be required in the future for the decisions made. The same participant described Prime Minister Johnson's response as "indefensible":

I see people defending him, "well, you know, it was very hard, no one's had to deal with this before", and it's like, okay, so Boris Johnson hasn't had to deal with this before but neither had France, neither has Germany, neither has Australia and New Zealand, just like every other country, apart from America, has had to deal with it and have not, you know, and they've all done a better job, and you're defending him.

This is indefensible. It's a joke (F, 45-54 years, UK, Senior Radiographer)

In Ireland, a major identified problem with the Irish government response was their lack of protection of vulnerable elderly in nursing homes. One participant elaborates:

So I think they could've been more favourable to the nursing homes... So I don't think they dealt with it good in that way. (F, 35-44 years, RoI, Healthcare Assistant)

Another Ireland-based participant highlighted their frustration with lack of childcare for the workforce, including frontline workers during the first lockdown:

The whole childcare thing has been a total fuck up of epic proportion....that was very much like, really, at the end of the day, by and large, that was the women of Ireland's problem. (F, 35-44 years, RoI, Manager of Community Centre)

Other inequities were identified. For instance, a theatre nurse in the UK highlighted the inconsistent rules where "you've got people like Prince Charles and the Prime Minister getting tested" while others "like nursing homes couldn't get PPE or testing" (F, 55-64 years, UK, Theatre Nurse). It seemed in each country the response to the virus highlighted pre-existing biases and injustices facing vulnerable and underrepresented groups in society.

Almost all participants felt compelled to keep up with the news and government briefings via the news media, particularly during the initial weeks. However, many participants noted the negative impact of watching the news, health briefings and death tolls on their own mental health:

At the start, I was watching the daily updates, but I think that was just really, really depressing and it wound me up and I think my mental health just was put down because of it, I think. (F, 18-24 years, UK, Mental Healthcare Worker)

Similarly, a theatre nurse said "I've stopped turning the telly on. I've had to because the news was making me ill" (F, 55-64 years, UK, Theatre Nurse). Many participants described how they cut back on their interactions with the media, social media, and government briefing over time as a means of preserving their mental health. Some participants highlighted the media as problematic in terms of how it presented things "it's so sensationalised and they dumb everything down" (M, 45-54 years, RoI, Emergency Nurse), and particularly spreading incorrect and non-factual information.

2. "Dead, dead, dead": The emotional and psychological toll

Many participants described their experiences of seeing the grim reality up-close presented by a global pandemic. One healthcare worker said:

I saw people die from it, I'm not being funny, people were very, very, very sick. I saw people die from it. It's horrible. People were fairly well when I saw them, and then straight after you follow them up dead, dead, dead. (M, 45-54 years, RoI, Emergency Nurse)

Another healthcare worker described her own sense of having to resolve to the fact that many lives were going to be lost and it was outside of her control:

You know, like, you had to kind of harden your heart and stop caring that they were dying, because you couldn't do anything. (F, 35-44 years, RoI, Healthcare Consultant)

The same participant acknowledged the immense emotional toll of working in healthcare settings and watching people get very sick and die in large numbers, but also the need to hide ones emotions as medicine is "totally a 'stiff upper lip' culture". Many participants noted the emotional toll experienced, by themselves and also others. One healthcare worker described how both staff and clients were "emotionally feeling it, I think, more than the virus in itself" (F, 35-44 years, RoI, Healthcare Assistant). One participant summed this feeling up with this short and telling description: "I feel so heavy, deflated, tired and weary" (F, 35-44 years, RoI, Healthcare Assistant). Another described how the emotional toll of seeing others suffering was much more wearing than the long hours:

We're picking up shifts, doing long hours and it's tiring but the emotion like, you know, trying to deal with seeing people that we care for 'cause we're looking after them, how hard it is for them and being stuck in their rooms a lot of the time and not being able to do many activities and just seeing the difference in them and then I come home and I get upset about it. (F, 35-44 years, RoI, Healthcare Assistant)

One doctor shared an anecdote from a conversation she had with a nurse on the ward that really struck a chord with her:

She mentioned to me that she has to get new clothes for her children because she can't bear the sound of zips anymore after having to zip up body bags, and that really hit me.... She said she just can't bear the sound of a zip. So, it is totally like PTSD. (F, 35-44 years, RoI, Consultant Physician)

In this visceral story, we get a sense of the trauma some of the healthcare staff have experienced through repeated encounters with death and body bags. The same participant also noted how the virus impacted the ecosystem that is a hospital setting, particularly the interconnectedness of the different staff from nurses to kitchen staff to porters, and how the changing work context, along with the visiting restrictions led to having a devastating impact of the cultural traditions surrounding death in Ireland. She explained:

The deaths were very lonely. Culturally, in Ireland, people when they're dying, usually, their families would come in and sit with them and, also, Ireland is a very, very socially orientated, interpersonal interaction orientated culture. (F, 35-44 years, RoI, Consultant Physician)

A number of participants described the impact that living and coping with the virus had on their workforce:

The sick rate has gone massively up...[..]..there's been quite a number of NHS staff take their lives because they just can't cope unfortunately. (F, 35-44 years, UK, Occupational Therapist)

Many non-healthcare workers also expressed the emotional and psychological toll of working through the pandemic. One participant recounted her co-worker's response to the influx of customers at the supermarket:

When they came in and all the customers started coming in, they came in in large groups and my friend fainted, because she felt so overwhelmed. (F, 18-24 years, RoI, Supermarket Cashier)

Other participants expressed their frustration that they didn't feel that others "fully understood what was going on in terms of mental health" and that "people haven't thought about mental health as well as COVID" (F, 18-24 years, UK, Mental Healthcare worker).

A healthcare assistant described the heart-wrenching impact of separation on her dementia patient and subsequently herself from observing the patient's pain:

It gets emotional because it's been so hard for them and it's so hard then for a dementia patient to see her husband and then be completely confused, crying for him, shouting out his name for three days until he's gone from her mind. That's what impacts me more than the actual disease in itself, for the virus in itself. (F, 35-44 years, RoI, Healthcare Assistant)

Participants also expressed their fear of contracting the virus themselves and about spreading the disease to their loved ones, as well as their awareness of how their families worried for the health of those working on the frontline. Many were also conscious that the lives of their loved ones had been impacted by the fact that they were working on the frontline:

I feel sorry but feel worse for my wife to be honest, her life stopped because of me and where I work basically. (M, 45-54 years, RoI, Emergency Nurse)

Participants also expressed their own suffering in being separated from their loved ones, and in some cases their immediate family members:

Whereas the staff, a lot of the staff, have felt very much down and their moods definitely got worse because of not being able to see family, some not being able to see their partners. (F, 25-34 years, UK, Care Home Manager)

Participants articulated changes in their own behaviour and their mood. Here we see one example where a person described some withdrawal behaviours and low mood:

Yeah, definitely, I think I've regressed a little bit in my social-ness, I'm keeping to myself more, which probably isn't a good thing. [...] Yeah, less optimistic about things. (F, 25-34 years, RoI, Paramedic)

Another participant described how she felt she was “in a robotic mode” rather than processing the psychological impact of working during the first surge (F, 35-44 years, RoI, Healthcare Assistant) and another explained that once she stopped doing the overtime and slowed down a little bit she realised how “it’s starting to kind of impact me” (F, 18-24 years, UK, Mental Health Worker). We get a sense here that this participant, like many other frontline workers, were working such long hours, and in intense ways, that there was little time for reflection until some of the pressure eased.

A few participants felt that some positive changes to work practices (e.g., different shift patterns, greater flexibility) had come about since the start of the outbreak, and others noted that it had not affected them in a particularly negative way. However, others were concerned about the long-term impact of working on the frontline. Indeed, one participant expressed concern about the health of frontline workers and likened this issue to a “time bomb” (F, 35-44 years, UK, Occupational Therapist).

A number of those interviewed felt strong emotions, including frustration, with the community who were seen to blatantly flout the rules including physical distancing and social restrictions. One participant described how her neighbour “bought a hot tub and everything” and had “hot tub parties”, and expressed her own response to this behaviour: “when you’re like trying your best in your job to stop the spread and everything, it’s a bit frustrating.” (F, 35-44 years, UK, Occupational Therapist). An emergency nurse expressed that some community members did not seem to care about the threat of the virus: “They just don’t care. I’m pretty sure they just don’t care.” “They just can’t be bothered” and “Thinking about other people, it’s like a kick in the teeth if you’re a healthcare worker” (M, 45-54 years, RoI, Emergency Nurse).

Participants shared many examples of instances where they were going above and beyond to help others in their capacity as frontline worker, family member, neighbour, or community member. A theatre nurse described the behaviour of her colleagues:

I’ve known doctors hang around for a couple of weeks, hardly going home, hardly sleeping. (F, 55-64 years, UK, Theatre Nurse)

In leadership roles, some frontline workers expressed their own concern for the welfare of their staff, and their own guilt about asking others to work on the frontline, despite increased risks of contract the virus. One manager gives an example of a colleague who

“convinced” an employee to go to work and the same employee died a few weeks later from COVID-19:

It happened to someone I'm very close with and, you know, I'm wondering whether he's going to get some form of PTSD or some form of that, he forced...not forced, convinced someone to go to work who's then died a few weeks later. (M, 25-34 years, UK, Retail Supermarket Regional Facilities Manager)

The same participant emphasises his own personal difficulty with asking people to come to work given the risks of contracting the virus. Interestingly, he makes a point of distinguishing between telling his employees that it was a “safe place” and convincing employees that “we've done everything we can to make it safe” – this distinction appears to help this manager cope with these, in his words, “moralistic questions” by attempting to level with his employees.

One participant described how the “normal recharge things don't seem to....recharge it”, she reasoned that her own “battery was so low” that usual efforts to rejuvenate and restore wellbeing weren't working (F, 35-44 years, RoI, Consultant Physician) — which may be an indicator of burnout.

In terms of coping strategies, many frontline workers found diverse and creative ways to cope with what were undeniably challenging (and sometimes devastating circumstances) including engaging with formal and informal social support via counsellors and co-workers, family, and friends. Technology offered new ways to maintain social bonds despite physical distance, with many engaging in Zoom quizzes and conference calls to connect with family and friends. Others drew meaning from work and focused on striving to make a difference to people's lives as a way of keeping going. Many participants used walking, particularly in nature, gardening, DIY, and having hot baths as active forms of coping. One Garda Sergeant described her use of walking with family in nature to reflect and feel appreciative:

When COVID happened and we started going more as a family and seeing things and I suppose taking more nature into account and I think I'll have a better appreciation for that as well (F, 35-44, RoI, Garda Sergeant)

Many cited the feeling of “we're all in this together” helped them to cope with the challenge of lockdown and working in a care home. Many people used forms of escapism such as watching TV and movies, social media, playing videogames and drinking alcohol as tools of coping. Some felt so busy with work that they didn't have time to worry or ruminate. Other participants tried to find the humour in a given situation. Some participants developed

new routines to offer structure to their daily lives, and others tried to find the bright side to keep themselves going.

3. “It's shone a light on what we're failing on as well”: Injustices, hierarchies and heroes

Many participants claimed the pandemic highlighted social hierarchies and injustices. One participant eloquently described how the pandemic had brought the shadows of society into light and saw this as opportunity to do better in the future, both individually “I” and collectively “we”. She explained:

It's shone a light on what we're failing on as well, and I think it would be an awful shame, then to waste that. There was a good one that was like, "We shouldn't waste a good crisis." We do need to realise what we're doing wrong and what we could be doing better and I hope that gets realised soon. I'd engage with anything that was going on that would help promote change. I'd love to be involved in something.

What it is yet, I don't know. (F, 25-34 years, RoI, Paramedic)

Another participant contrasted the “old normal” and “new normal”, and her wish to cherry-pick the best of both:

There's been a lot highlighted recently about what's wrong with the old normal. Shed loads. We'll have some of the old normal and some of the new normal, and no virus please. (F, 55-64 years, UK, Palliative Care Pharmacist)

As a result of people engaging more with healthcare, emergency services, food banks and homeless shelters during the pandemic, those services have been put under the spotlight and it has become apparent that many of these crucial services are underfunded and under-resourced. One nurse describes the impact of more people engaging with healthcare, emergency services, food banks and homeless shelters during the pandemic saying:

We were struggling before and now, this has happened” (F, 55-64 years, UK, Theatre Nurse). As well as spotlighting issues with services, the pandemic has also highlighted the prevalence of drug and alcohol problems as well as homelessness. (F, 25-34 years, RoI, Paramedic)

The same participant also noted that nursing homes have been put under scrutiny as a result of the virus spreading rapidly in those environments: “nursing homes as well, they're getting a bit more light shone on them which is a good thing”.

Another important factor that was highlighted by participants was the high rates of mental health issues and loneliness in the community – all of which were further aggravated by restrictions put in place to contain the virus. Some participants reminded us that domestic

violence rates increased, recognising the fact that many of our citizens do not live in safe home environments.

Many social hierarches were described throughout participants' experiences of the pandemic. For instance, many referred to some frontline professions being held in higher regard than others. One participant implied that there was less effort to protect retail employees from the virus:

And where my sister works, they're very good with the screens and washing things down after people are there...whereas in the shop, I think we're more vulnerable than other workers would be.... other people would be there, and they'd be talking the head off you. (F, 35-44 years, RoI, Deli Assistant)

Another describes how she had received a letter saying she worked at the NHS and could therefore skip the supermarket queue that was "a mile long" while her brother was working at a large supermarket in Doncaster and did not get any such entitlements (F, 18-24 years, UK, Mental Healthcare Worker).

Where frontline healthcare workers were permitted to skip queues in some regions, other non-healthcare frontline workers struggled to keep working long hours and getting everyday activities completed. Indeed, some participants could not understand "why other keyworkers don't have this privilege when we do" (F, 35-44 years, UK, Pharmacist) referring to the receipt of free goods and avoidance of queues. One care assistant remembered her attempts to get into the supermarket in the short window of time that was available but was refused by the security as she was not a doctor or nurse, despite other shop-goers encouraging her to go ahead. She described the event and her feelings of finding the situation as "horrible" and "very, very stressful":

"Do you mind if I just go in?" And no, he wouldn't let me in and yet they were letting the doctors and nurses in, I had my uniform on, and people would go, "Oh, go before me", I said, "No, you know, I'll go somewhere else". But you know, it was horrible because I don't know, it was just very, very... everything was very, very stressful. (F, 55-64 years, UK, Community Support Assistant)

One participant was much more explicit of her sense of the hierarchy of frontline workers that exists "classically":

There are different categories of frontline workers, that you've got, you know, first of all you've got your COVID workers and you have the emergency people, and you have ambulance people and things like that, then you've probably got the next level

would be the supermarkets people, because, you know, when the rush is on and I think they would be second classically. (F, 45-54 years, UK, Bank Manager)

In one case, a participant felt that others were unhappy about frontline worker entitlements. One pharmacist felt that “most people are jealous that my daughter goes to school”. This was mainly due to the fact that her husband was not working outside the home. However, other participants felt embarrassed shopkeepers and delivery drivers were “ignored” despite “doing a lot of the hard work.” (M, 45-54 years, RoI, Emergency Nurse)

These perceived injustices were also expressed through the use of the labelling of some frontline worker as heroes: “You would hear a lot about nurses and a lot about doctors, but you wouldn't hear of shop people being heroes” (F, 35-44 years, RoI, Deli Assistant) and “there is a very strong tendency to really only consider the medical personnel and the nursing as the ‘heroes’” (F, 45-54 years, RoI Healthcare Contact Tracing Admin) – both participants expressed their sense that some frontline workers were not getting the credit they deserved. One participant noted the strategic use of the term “hero” where the “term is very much kept for the visible easily digested ‘heroes’” (F, 45-54 years, RoI, Healthcare Contact Tracing Administration). Many participants expressed their sorrow and rage that people in the supermarkets were abused and experienced negativity as they worked and not getting the appreciation they deserved. One participant worried that there are many “unsung heroes” such as train workers and cleaners that don't get the same acknowledgement as healthcare workers (F, 35-44 years, UK, Pharmacist).

In an interesting flip, some occupations which were previously seen as having a lower perceived value and status became more highly valued and better understood during the pandemic. One manager explained:

Cleaning has always been bottom of the list, the priority has been number one at the moment...the last couple of months has really... they get a lot more respect from people for being cleaners. (M, 25-34 years, UK Retail Supermarket Regional Facilities Manager)

Another participant noted that she felt her work was now better understood and appreciated:

They really appreciate us, and I don't think they realised how hard we work and what sort of work we do until this came, they felt we just made a cup of tea for little old nice ladies. (F, 55-64 years, UK, Community Support Assistant)

Another participant described how some frontline workers, like clerks and cleaners were delighted to receive free things because “they've never been appreciated that much before” (F, 35-44 years, UK, Pharmacist).

A minority of participants felt that they were uncomfortable with the label of frontline or essential worker. One participant who worked throughout the pandemic felt he was taken advantage of as his company stayed open despite “not playing any big role in the virus, it didn’t play any role in combating this or helping people, or anything” (M, 18-24 years, RoI, Process Technician). This participant articulated a sense of injustice that this apparently non-essential business remained open thereby putting his family members at greater risk of contracting the virus from him.

Almost all of the participants had strong opinions about the use of the label ‘hero’ and gestures of appreciating frontline workers, and for many this influenced their own perceptions of their role in society and the behaviour of others. Some participants described the commendation from the public as “lovely”, especially in the early days and weeks of the pandemic – particularly where people who do important jobs received greater recognition. However, the majority of participants felt they were not heroes and were “just doing their job”. A number of healthcare workers asked, “why now?”, why apply the label of hero now? These people had been working in these roles for many years. Others felt the labelling of them as heroes and Clap for the Heroes was “silly”, “embarrassing”, “cringe[-worthy]”, “nonsense”, and “patronising” – one participant reiterated “it’s just the everyday, isn’t it?” meaning that the work they do is important every day. Others wonder why the “perks” such as free parking and free meals were not available all the time, rather than only during the pandemic. One participant said she was glad the Thursday clapping has stopped as it had started to make her “feel a bit sick”, despite feeling immense pride in her own frontline contribution – “I’ve done my bit, that kind of superhero bit.. I have pride in that” (F, 45-54 years, UK, Senior Radiographer). Many participants were grateful when members of the community thanked them. Some participants questioned the motivation behind the appreciative gestures, for instance:

I don’t think the politicians who clapped actually felt that sense of community, but I feel like my neighbours definitely did. (F, 25-34 years, UK, Care Home Manager)

Some participants were angry that they save lives on a daily basis (“I don’t need a virus to recognise that”) and yet, many of the services remain underfunded. Some participants “hated the clapping”. They appreciated the sentiment that people “needed to give back” and were “well-meaning” but felt these actions and labelling fell short.

Throughout the interviews, participants felt they were not the heroes but that the other frontline workers were heroes. For instance, retail workers felt healthcare workers were the “real heroes”, while some healthcare workers felt supermarket workers were the “actual

heroes". The common trend was to push the hero label away from the self. The reason for the pushing off the label may be, in part, due to the pressure to achieve and perform associated with this label. For instance, one paramedic asserted that the label of hero "puts an awful lot of pressure on us to be something more" and "we are only trying to do our best" (F, 25-34 years, RoI, Paramedic). Another believed that labelling heroes detracts from more important issues being that these professions need to be respected and the healthcare sector needs to be funded adequately: "It needs to be shown that respect like that, not calling people heroes" (F, 35-44 years, RoI, Manager of Community Centre). One person noted how jaded she felt with the public commendation and hero labelling when she "realised, you know, actually most of us don't have a choice" (F, 35-44 years, RoI, Care Assistant). Another said, "you're in this position, like you get this label of essential worker, and then you feel like the choice has gone out of it" (M, 18- 24 years, RoI, Process Technician). Another noted how their view shifted to become very cynical of the hero label after the first few weeks: "it's ok to call us all heroes because then next year you won't have to give them all a pay rise will you, but you did give us a clap every Thursday" (F, 45-54 years, UK Deputy Head of Probation Delivery Unit). Another said: "I don't want everybody to be saying, "Oh, thank you very much", it's not that. I just think we needed more support" (F, 55-64 years, RoI, Senior Staff Nurse). This sentiment – the need for more support – was echoed by many frontline workers.

One participant felt that the hero labelling made things harder, where she (and "we", perhaps referring to healthcare workers) appears to have fallen short of expectations for saving lives:

And the hero thing, actually, in some way, kind of makes it harder, because we didn't save anybody. (F. 35-44 years, RoI, Healthcare Consultant)

Outside of the healthcare context, frontline workers also expressed their concerns about their own ability to fulfil role expectations by keeping up with demand (for example, in supermarkets):

They would make the job impossible, get more people in and then make it impossible again just so they [shoppers] could keep getting more...products. (M, 25-34, UK, General Assistant in Supermarket)

And also, in terms of trying to balance tensions between public health and business concerns:

I would question my own morals, was I doing what was right for the people, not just the business. (M, 25-34 years, UK, Retail Supermarket Regional Facilities Manager)

Many of the participants felt enormous pride in their role during the first surge of the pandemic, and their love for their jobs sustained them and provided them with a sense of

purpose and meaning during those challenging weeks. Many cited examples of heroic actions that they had taken pre-pandemic and others felt it was their duty to continue.

Other individuals who were experiencing less meaning and fulfilment from their work began to question their work role: “why am I doing this?” “why am I putting myself at risk?” and then realising that one’s choice was constrained due to financial pressures – “I’m the main bread winner so that was a tough one” (F, 45-54 years, RoI, Agriculture Production Manager). Only one participant took deliberate action to revoke the label of hero and to terminate her original role. She reminded us of the often-unrealistic expectations that are placed on frontline workers:

You know what, I am a frontline worker, but I am not going to do it anymore or at least not in the same capacity because of this. And I guess I just wanted to be able to tell that story you know, the person who said I’m not going to do this anymore or I’m not going to show up every day and put PPE on and work insane hours and, because I’m not a superhuman, I am only human. (F, 35-44 years, RoI, Care assistant)

Importantly, in the above excerpt we can see how difficult it was for an individual, labelled as a hero, to refuse to carry on. This participant reminded us of the limits of all individuals in terms of the resilience that they can develop over time. It is interesting that this individual felt it was important to join the study to give a voice to an alternative, typically unspoken path available to frontline workers, while most felt they “had to carry on” (F, 55-64 years, UK, Community Support Assistant).

4. “I definitely think COVID happened for a reason to stop us in our tracks and to slow us down”: Unexpected positives

Despite the great hardship that many participants described, almost all of them also described unexpected positives arising from the pandemic in their work and home lives, and in the wider community. A major positive was the sense of appreciation generated by others: “They really appreciate us”, and greater respect for certain roles that were perhaps undervalued previously: “I don’t think they realised how hard we work and what sort of work we do until this came” (F, 55-64 years, UK, Community Support Assistant). One participant viewed the pandemic as “a bit of a wake-up call for everyone to cop on and realise things are finite, resources are finite, and when they're gone, they are gone, and that was obvious with PPE”. The same participant also noted that staff burnout was being recognised in a way that was not present before: “I think staff burnout was a bit of a, ‘you'll be fine.’ It was dismissed a lot, and now we're realizing, no, this is actually a real thing, and this is a real problem that we really have” (F, 25-34 years, RoI, Paramedic).

Other benefits described by participants included closer working relationships with colleagues and finding new ways to connect and communicate with loved ones (often using technology). Others reported enhanced relationships with family and more time to spend with family members:

So, I mean, an unexpected sort of bonus for me, you know. So, everybody's perspective is different but we just... it was a really nice time for us actually from that point of view, outside workwise. (F, 58, RoI, Senior Staff Nurse)

Many frontline workers were heartened to see the "community kind of come together" (F, 25-34 years, UK, Care Home Manager). Other described how "people helped each other out in ways that we probably didn't see since the 70s or 80s, you know, dropping off shopping to people, checking in on elderly" (F, 35-44 years, RoI, Healthcare Care Assistant). Many participants reported acts of kindness, from donating board games to nursing homes to using craft skills to make face coverings for those in need.

Other participants reported a shift in personal values and priorities: "I'm more focused on dealing with various things and probably what I do with my time making good use of time" (M, 45-54 years, RoI, Child Protection Social Worker). Others noted how they rekindled their religiosity and on a person level, some realised they were more resilient than they previously thought. Many people developed a deep sense of gratitude and appreciation for their own lives, often because of comparing themselves to others who were less well off (i.e., had lost their job, or did not have a garden, or lived in small houses or apartments). Some participants felt gratitude for their loved ones, nature, and day-to-day activities like sharing a meal together. Others expressed abstract and profound sentiments about how the world would be better as a result of this great upheaval. One participant said:

I definitely think COVID happened for a reason to stop us in our tracks and to slow us down. I think the world was moving too fast. (F, 35-44 years, RoI, Garda Sergeant)

This sense of slowing down was echoed by many participants. One participant believed that we would learn from this pandemic and change "simple things like washing hands more frequently" which will have a positive impact of future outbreaks of disease (F, 35-44 years, RoI, Healthcare Assistant). The same participant commented on the robustness of supply chain and logistics in modern society and the fact that "despite the pandemic, everything's still convenient". Others appreciated a more simple style of life where consumerism was reduced and "people are getting to know their community" (F, 45-54 years, RoI, Nurse). Others reported unexpected positives such as spending less money and saving more. Some participants reported losing weight and exercising more while also discovering places in their

local communities. One participant reported career enhancement as a result of having the opportunity to show their capabilities in challenging circumstances.

One participant offered a contrasting perspective to many other participants, where he described the virus as a way of “clearing out dead wood”, indicating that the fittest and healthiest would prevail after the pandemic:

So now, when a disease comes through and, basically, it's a bit like a forest fire – this sounds terrible, but, like I say, I've thought about it a great deal and the language may be clumsy, but I hope you understand what I'm saying – it is kind of clearing out dead wood. Green shoots will come through. (M, 65-74, UK, General Practitioner)

Overall, participants were divided in terms of whether they felt that some of the positive aspects would remain beyond the pandemic. The prevailing sentiment was hope that at least some of the positive changes would remain.

Discussion

While previous research has evidenced the negative psychological effects of working on the frontline through various health crises (e.g. De Boni et al., 2020; Kröger, 2020; Maunder et al., 2006; Stuijzand et al., 2020), the present study details the nuances within participants' lived experiences of working through COVID-19, with particular focus on the collective factors that influence individual levels of functioning.

In their accounts, participants emphasised factors within their ecosystems and macrosystems (see: Bronfenbrenner, 1979) – ranging from geographical location, to government, organisational and leadership response, and the media – that had either direct or indirect influences on their own experience of working on the frontline during the first surge of the pandemic in Ireland and the UK. Participants talked in detail about wider factors that influenced their experience of working through the first surge of the pandemic, and their mental health – reiterating how interconnected the wider social and political systems are to one's individual experiences ‘on the ground’.

Managing their Distress

Participants talked extensively about the emotional and psychological toll of the virus on their loved ones, their patients/clients, and on them personally. This finding corroborates other research that shows the negative impact of working on the frontline in terms of mental health, wellbeing, burnout, lowered resilience and posttraumatic stress (Ali et al., 2020; Foley et al., 2020; Kannampallil et al., 2020; Ruiz & Gibson, 2020; Sumner & Kinsella, 2021). In the present research, some participants expressed a lowered sense of optimism which, as previous research has shown, is a key predictor of emotional distress and less effective

coping strategies (David et al., 2006). Feelings of inadequacy with regards to one's inability to save lives were echoed in parallel research carried out in China during the early phase of the pandemic (Liu et al., 2020). This perceived failure to live up to the expectations of the role, and its subsequent impact on feelings of futility and inadequacy, have been well-reported in the literature regarding burnout in healthcare workers (Özden et al., 2013; Vinje & Mittelmark, 2007). These descriptions of impactful stress are evocative of effort-reward imbalance on a more societal scale, with an incongruence between their personal efforts and the perceptions of the actions (if not words) of the public and legislature. Effort-reward imbalance has long been recognised as a potent organisational stressor that impacts health and wellbeing (e.g. Kuper et al., 2002; Siegrist, 2002), but here we see it bleed out beyond the context of their employment.

Participants engaged in a range of adaptive and maladaptive coping strategies. Frequently mentioned coping strategies from the present data included support from social relationships (Jetten et al., 2012) and exercising in nature (Gladwell et al., 2013). Many helped others as a means of coping (perhaps a form of altruism born of suffering: Staub & Vollhardt, 2008), which in turn appeared to offer a sense of meaning and purpose (Hooker et al., 2018), and sense of control (Steptoe & Appels, 1989) which have been linked to health and wellbeing. Others used more cognitive styles of coping (Carver et al., 1989) by gaining more knowledge about the virus and how to reduce the risk of spreading it. This resonates with parallel literature on these factors not just as a stress buffer, but also in a more active role as resilience builders (Haslam et al., 2018; van den Berg et al., 2010), particularly in this pandemic context (Hou et al., 2020; Samuelsson et al., 2020). What is particularly stark is the scale of the emotional toll that was described within this study and the fact that these experiences are lasting much longer than in previous health crises.

A few participants described switching to 'robotic mode' as a form of coping (perhaps the inverse of being mindful which has been linked to wellbeing: Grossman et al., 2007). There were also many instances where participants engaged in downward counterfactual thinking ("it could have been worse"), which may fulfil a mood-repair function and assist with coping with negative life events (e.g. Epstude & Roese, 2008; Sanna et al., 2001; Sanna et al., 1998; White & Lehman, 2005). Some participants described how they distanced themselves from any perceived sense of group failure — this may be akin to psychological distancing which has been described previously as a form of coping (Dundas, 2000; Snyder et al., 1986). On a wider scale, the participants in the present study expressed their awareness of proximity to the epicentre which has been indicated as being an important component of

burnout in frontline workers in the pandemic (Zhang et al., 2020). Also, participants often made cross-country comparisons to derive a sense of how well they felt their country was doing in terms of managing the virus (akin to form of country-level upward or downward social comparison: Festinger, 1954).

Many participants cited solidarity, that feeling that 'we are in this together', as positive and useful while they were working on the frontline. However, some participants noted their struggles as restrictions were lifted and there was an eroding in that sense of solidarity, at least at a wider societal level. More personal and localised actions of relatives, friends, and communities also served to function as modulators to this sense of solidarity and its impact on their wellbeing, as is seen in descriptions of those who have known of community members breaking lockdown rules, not appearing to care about the pandemic, and not adhering to public health guidelines.

The present research points to clear markers in the history of the pandemic in the UK and Ireland that actually served to both increase (e.g., decisive, early government action in Ireland) and decrease (e.g., the continuation of mass-gatherings and public contraventions of safety rules by Dominic Cummings and notable others in the UK) perceived sense of social solidarity and public trust. It was clear in terms of how participants talked about their governments that their trust in government was strongly influenced by the perceived timeliness of their actions, their clarity in messaging, the congruency they showed in terms of actions and behaviour, gestures of appreciation of frontline workers, and the extent that politicians were viewed as placing public interest ahead of political and economic gain. This expands our recent work that hinted towards the perception of government response as being particularly important in frontline workers welfare outcomes (Sumner & Kinsella, 2021), but provides much-needed context and depth to understand the mechanisms behind this association. As well as the emotional and psychological impact, participants talked about how the pandemic brought many injustices and social hierarchies to the forefront that required immediate attention, particularly where services were under-resourced.

The 'Heroing' of Frontline Workers

A novel and interesting discourse was the varied and contractionary depictions by participants in response to the label of hero and overt gestures of appreciation for frontline workers. While many participants appreciated genuine offers of thanks, others felt aggrieved where the labels put unrealistic pressure on frontline workers to show heroic qualities and not quit in the face of a global pandemic. A study carried out during the SARS pandemic of 2003 explored some of these experiences of the hero label in healthcare workers, and similarly

found that there were additional pressures felt as a result of the obligations, responsibilities, and pressure to continue (Tai, 2006), and more recent commentary has further eschewed the label from this context (Cox, 2020). The power of labelling to influence self-identity and behaviour has been shown in various psychological studies, particularly those that relate to stereotypes (Schmidt & Boland, 1986), mental health disorders (Link et al., 1989), and stigma (Goffman, 2009) – however, this is novel in relation to the power of the label ‘hero’ to influence the emotions of behaviours of the so-called heroes. This argues further reasons for the hero label becoming problematic in its bringing to the fore of injustices in credit to those whose work is undervalued, or to those whose work has been under-supported by central government. Others felt angered that some of the clapping and “heroing” were distractions from the bigger issues where services and individuals were under-resourced and underpaid.

The topic of heroism has been generally viewed in positive ways by the general public (Kinsella et al., 2015a), however, here we see an interesting twist where the label is applied strategically (or at least viewed as such) with some negative consequences. This has perhaps been most specifically apparent in the UK, where the rhetoric of heroism frequently used by the government in reference to its healthcare workers in particular has seemed to be at odds with political decision-making even after the first surge of the pandemic. This disparity between words and actions is illustrated well by the subsequent omission of healthcare workers in a public sector pay rise by the UK government in July 2020. We argue elsewhere that it is through these factors that the hero label itself may not be problematic, but perhaps the failure for the spoken label to be honoured through public deeds (Kinsella & Sumner, 2021).

It is particularly interesting that despite the fact that many of the frontline workers were not willing to accept the label of hero themselves or for their own profession, they were willing to label others and other professions as heroes. This is consistent with existing research that the majority of people derive psychological benefits from thinking about other people as heroes (Kinsella et al., 2017). This is an interesting observation in that we appear to seek out acts of heroism and derive benefits from thinking about heroes, but in some cases, the heroes themselves suffer psychologically as a result.

Early Signs of Growth

Despite the highly challenging circumstances, most of the frontline workers found positive aspects arising from the pandemic including increased gratitude, savouring, religiosity, changed priorities and enhanced relationships with others – these are consistent with the psychological constructs of benefit finding (Helgeson et al., 2006), strength through

adversity (Linley, 2005) and posttraumatic growth (Tedeschi & Calhoun, 2004). This would suggest that despite the hardships endured by our frontline workers, and those still yet to come, that the resilience of humanity is evident even in its darkest days.

Contribution, Limitations and Future Directions

The present study provides an account and exploration of the experiences of 38 frontline workers during the first surge of the COVID-19 pandemic in the UK and Ireland. The inclusion of all examples of frontline workers adds to the extant literature on the experiences of workers during disasters by also including those that are less commonly associated with frontline work, yet nonetheless endure hardships and risks as a result. The examination of these experiences in samples that span two nations with divergent pandemic strategies during this phase provides an account of frontline workers' experiences that is less bound to political context. The use of qualitative methods to explore these experiences adds much-needed context to parallel findings of the observations of high burnout, and impaired resilience and wellbeing in these individuals. Through this investigation, we have been able to provide context to our previous findings of the importance of government response in welfare outcomes for these workers, finding that decisive, clear, and strong action by central government resonates through the workforce, providing confidence in being supported to do their job. Moreover, government action should also support these workers, as it appears the incongruence has been particularly injurious for those on the frontline. The present work provides important lessons for all actors in the pandemic – from the individual to the community, to the organisations, and the legislature.

The heterogeneity of the present sample of frontline workers is a key strength of this research that offers credibility through triangulation. Indeed, this article offers a voice to a range of frontline workers across a spectrum of different occupational sectors and including those traditionally referred to as white-collar and blue-collar workers. By delving deep into the data across a range of sectors, the findings from this study may be more transferable to other sectors of frontline workers that were not sampled here, and across other political landscapes. However, a key limitation of the research is that there is little diversity in the ethnic profile of the sample herein. This is of critical importance when contextualised against the very specific experiences and vulnerabilities of ethnic minorities in the countries from where the samples were drawn, both in general, in terms of their work roles and – indeed – their heightened vulnerability to morbidity and mortality from COVID-19 (Kirby, 2020).

Another limitation of this work is the extent to which these findings offer dependability over time (see: Lincoln & Guba, 1985). It is likely that frontline workers'

experiences are changing dynamically during the course of the pandemic. The themes interpreted in this article are based on data collected after the first surge in the UK and Ireland, and may not represent their frontline worker experiences throughout the duration of pandemic. One way to overcome this limitation may be to invite the same participants, at a later stage of the pandemic, to evaluate the present findings, themes and recommendations in light of their more recent frontline experiences.

A key future direction from this work is to explore in greater detail the aspects of their experiences that have defined their resilience, as well as those experiences that have defined their times of doubt and insecurity. In terms of next steps, it will be essential to track frontline workers over time – particularly those at risk of negative mental health outcomes and assess what protective factors may reduce severity of outcomes, while also making real and sustainable changes to how we operate our businesses and organisations, and what are reasonable expectations for employees, during times of crisis.

Conclusion

The present study has highlighted some of the very context-specific factors that provide meaning for participants in understanding their roles in the pandemic in the UK and Ireland, as well as some factors that appear to be shared regardless of the geographic or situational context. Here, we find that frontline workers have experienced monumental hardships, but often offset their own tragedies and courage through downward social comparison (Gibbons & Gerrard, 1989). Unsurprisingly, they have all reported very much increased psychological stress, exhaustion, and emotional toll from their particular roles in the pandemic. The social responsibility that they report appears to be somewhat of a cross that they bear in terms of a duty to their work in the moment, but also a feature of pride and strength in reflection. Importantly, we see here that *all* frontline workers regardless of their role experience similar joys and sorrows; and whilst they are not comfortable with internalising the hero label, many point to other sectors of frontline workers as being the “real heroes”. There can be no doubt, however, that those who have sacrificed their health, their wellbeing, and their lives to keep society going and to help those in their hour of need are worthy of being hailed as heroes, but this must also come with respect, gratitude, and protection.

Acknowledgements

The authors wish to extend their sincere gratitude to the participants who donated their precious time to this project, and to this specific study. Thank you for entrusting us with your stories, and for granting us the privilege of being able to bring them to the world. Thank you to all frontline workers around the world for your courage and relentless effort to keep us safe, to keep food on our tables, and to care for those we love.

Disclosure of interest

The authors report no conflict of interest.

Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article.

Funding Details

This work was supported by two internal small grant awards from the University of Gloucestershire (Research Priority Area: Sport, Exercise, Health and Wellbeing): Awarded in May and September 2020.

References

- Ali, S., Maguire, S., Marks, E., Doyle, M., & Sheehy, C. (2020). Psychological impact of the COVID-19 pandemic on healthcare workers at acute hospital settings in the South-East of Ireland: an observational cohort multicentre study. *BMJ open*, *10*(12), e042930. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7750872/pdf/bmjopen-2020-042930.pdf>
- Benight, C. C., & Bandura, A. (2004, 2004/10/01/). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, *42*(10), 1129-1148. <https://doi.org/https://doi.org/10.1016/j.brat.2003.08.008>
- Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard university press.
- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. *Journal of personality and social psychology*, *56*(2), 267.
- Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), *Existential-Phenomenological Alternative for Psychology* (pp. 48-71).
- Cox, C. L. (2020). 'Healthcare Heroes': problems with media focus on heroism from healthcare workers during the COVID-19 pandemic. *Journal of Medical Ethics*, *46*(8), 510-513. <https://doi.org/10.1136/medethics-2020-106398>
- Creswell, J. W. (2007). *Qualitative Inquiry and Research Design* (2nd ed.). SAGE.
- David, D., Montgomery, G. H., & Bovbjerg, D. H. (2006). Relations between coping responses and optimism–pessimism in predicting anticipatory psychological distress in surgical breast cancer patients. *Personality and individual differences*, *40*(2), 203-213. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600560/pdf/nihms-67396.pdf>
- De Boni, R. B., Balanzá-Martínez, V., Mota, J. C., Cardoso, T. d. A., Ballester, P., Carbonell, B., Bastos, F. I., & Kapczinski, F. (2020). Depression, anxiety and lifestyle among essential workers: A websurvey from Brazil And Spain during the Covid-19 pandemic. *Journal of Medical Internet Research*, *22*. <https://doi.org/10.2196/22835>
- Denzin, N. K. (2017). *The research act: A theoretical introduction to sociological methods*. Transaction publishers.
- Dundas, I. (2000). Cognitive/affective distancing as a coping strategy of children of parents with a drinking problem. *Alcoholism Treatment Quarterly*, *18*(4), 85-98.
- Epstude, K., & Roese, N. J. (2008). The functional theory of counterfactual thinking. *Personality and Social Psychology Review*, *12*(2), 168-192. <https://doi.org/10.1177/1088868308316091>

- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7(2), 117-140. <https://doi.org/10.1177/001872675400700202>
- Foley, S. J., O'Loughlin, A., & Creedon, J. (2020). Early experiences of radiographers in Ireland during the COVID-19 crisis. *Insights into Imaging*, 11(1), 1-8.
- Franco, Z. E., Blau, K., & Zimbardo, P. G. (2011). Heroism: A conceptual analysis and differentiation between heroic action and altruism. *Review of general psychology*, 15(2), 99-113.
- Gavin, B., Hayden, J., Adamis, D., & McNicholas, F. (2020). Caring for the psychological well-being of healthcare professionals in the Covid-19 pandemic crisis. *Irish Medical Journal*, 113(4), 51-51.
- Gibbons, F. X., & Gerrard, M. (1989). Effects of upward and downward social comparison on mood states. *Journal of Social and Clinical Psychology*, 8(1), 14-31.
- Gladwell, V. F., Brown, D. K., Wood, C., Sandercock, G. R., & Barton, J. L. (2013). The great outdoors: how a green exercise environment can benefit all. *Extreme physiology & medicine*, 2(1), 1-7.
- Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and Schuster.
- Grossman, P., Tiefenthaler-Gilmer, U., Raysz, A., & Kesper, U. (2007). Mindfulness training as an intervention for fibromyalgia: evidence of postintervention and 3-year follow-up benefits in well-being. *Psychotherapy and psychosomatics*, 76(4), 226-233.
- Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, S. A. (2018). *The new psychology of health: Unlocking the social cure*. Routledge.
- Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology*, 74(5), 797.
- Hooker, S. A., Masters, K. S., & Park, C. L. (2018). A meaningful life is a healthy life: A conceptual model linking meaning and meaning salience to health. *Review of general psychology*, 22(1), 11-24.
- Hou, T., Zhang, T., Cai, W., Song, X., Chen, A., Deng, G., & Ni, C. (2020). Social support and mental health among health care workers during Coronavirus Disease 2019 outbreak: A moderated mediation model. *PLoS one*, 15(5), e0233831. <https://doi.org/10.1371/journal.pone.0233831>
- Jetten, J., Haslam, C., & Alexander, S. H. (2012). *The social cure: Identity, health and well-being*. Psychology press.

- Kannampallil, T. G., Goss, C. W., Evanoff, B. A., Strickland, J. R., McAlister, R. P., & Duncan, J. (2020). Exposure to COVID-19 patients increases physician trainee stress and burnout. *PloS one*, *15*(8), e0237301. <https://doi.org/10.1371/journal.pone.0237301>
- Khanal, P., Devkota, N., Dahal, M., Paudel, K., & Joshi, D. (2020, 2020/09/25). Mental health impacts among health workers during COVID-19 in a low resource setting: a cross-sectional survey from Nepal. *Globalization and Health*, *16*(1), 89. <https://doi.org/10.1186/s12992-020-00621-z>
- Kinsella, E. L., Igou, E. R., & Ritchie, T. D. (2019). Heroism and the pursuit of a meaningful life. *Journal of Humanistic Psychology*, *59*(4), 474-498. <https://doi.org/10.1177/0022167817701002>
- Kinsella, E. L., Ritchie, T. D., & Igou, E. R. (2015a). Lay perspectives on the social and psychological functions of heroes. *Frontiers in Psychology*, *6*, 130.
- Kinsella, E. L., Ritchie, T. D., & Igou, E. R. (2015b). Zeroing in on heroes: A prototype analysis of hero features. *Journal of personality and social psychology*, *108*(1), 114.
- Kinsella, E. L., Ritchie, T. D., & Igou, E. R. (2017). Attributes and Applications of Heroes: A brief history of lay and academic perspectives. In S. T. Allison, G. R. Goethals, & R. M. Kramer (Eds.), *Handbook of heroism and heroic leadership* (pp. 19-35). Routledge.
- Kinsella, E. L., & Sumner, R. C. (2021). High ideals: the misappropriation and reappropriation of the heroic label in the midst of a global pandemic. *Journal of Medical Ethics*. <https://doi.org/10.1136/medethics-2021-107236>
- Kirby, T. (2020). Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities. *The Lancet Respiratory Medicine*, *8*(6), 547-548. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7211498/pdf/main.pdf>
- Kröger, C. (2020). Shattered social identity and moral injuries: Work-related conditions in health care professionals during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*. <https://doi.org/10.1037/tra0000715>
- Kuper, H., Singh-Manoux, A., Siegrist, J., & Marmot, M. (2002). When reciprocity fails: effort–reward imbalance in relation to coronary heart disease and health functioning within the Whitehall II study. *Occupational and environmental medicine*, *59*(11), 777-784. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1740240/pdf/v059p00777.pdf>
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE.
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American sociological review*, 400-423.

- Linley, P. A. (2005). The human capacity for growth through adversity. *American Psychologist, 60*(3).
- Liu, Q., Luo, D., Haase, J. E., Guo, Q., Wang, X. Q., Liu, S., Xia, L., Liu, Z., Yang, J., & Yang, B. X. (2020). The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *The Lancet Global Health, 8*(6), e790-e798. [https://doi.org/10.1016/S2214-109X\(20\)30204-7](https://doi.org/10.1016/S2214-109X(20)30204-7)
- Maunder, R. (2004). The experience of the 2003 SARS outbreak as a traumatic stress among frontline healthcare workers in Toronto: Lessons learned. *Philosophical Transactions: Biological Sciences, 359*(1447), 1117. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1693388/pdf/15306398.pdf>
- Maunder, R. G., Lancee, W. J., Balderson, K. E., Bennett, J. P., Borgundvaag, B., Evans, S., Fernandes, C. M. B., Goldbloom, D. S., Gupta, M., Hunter, J. J., McGillis Hall, L., Nagle, L. M., Pain, C., Peczeniuk, S. S., Raymond, G., Read, N., Rourke, S. B., Steinberg, R. J., Stewart, T. E., VanDeVelde-Coke, S., Veldhorst, G. G., & Wasylenki, D. A. (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerging Infectious Diseases, 12*(12), 1924-1932. <https://doi.org/10.3201/eid1212.060584>
- Özden, D., Karagözoğlu, Ş., & Yıldırım, G. (2013). Intensive care nurses' perception of futility: Job satisfaction and burnout dimensions. *Nursing ethics, 20*(4), 436-447. https://journals.sagepub.com/doi/10.1177/0969733012466002?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed
- Ruiz, M. A., & Gibson, C.-A. M. (2020). Emotional impact of the COVID-19 pandemic on US health care workers: A gathering storm. *Psychological Trauma: Theory, Research, Practice, and Policy. https://doi.org/10.1037/tra0000851*
- Samuelsson, K., Barthel, S., Colding, J., Macassa, G., & Giusti, M. (2020). Urban nature as a source of resilience during social distancing amidst the coronavirus pandemic.
- Sanna, L. J., Chang, E. C., & Meier, S. (2001). Counterfactual thinking and self-motives. *Personality and Social Psychology Bulletin, 27*(8), 1023-1034.
- Sanna, L. J., Meier, S., & Turley-Ames, K. J. (1998). Mood, self-esteem, and counterfactuals: Externally attributed moods limit self-enhancement strategies. *Social cognition, 16*(2), 267-286.
- Schmidt, D. F., & Boland, S. M. (1986). Structure of perceptions of older adults: Evidence for multiple stereotypes. *Psychology and aging, 1*(3), 255.
- Siegrist, J. (2002). Effort-reward imbalance at work and health. In *Historical and current perspectives on stress and health*. Emerald Group Publishing Limited.

- Simmons, B. L., & Nelson, D. L. (2001). Eustress at work: The relationship between hope and health in hospital nurses. *Health Care Management Review, 26*(4), 7-18.
https://journals.lww.com/hcmrjournal/Fulltext/2001/10000/Eustress_at_Work_The_Relationship_between_Hope.2.aspx
- Snyder, C. R., Lassegard, M., & Ford, C. E. (1986). Distancing after group success and failure: Basking in reflected glory and cutting off reflected failure. *Journal of personality and social psychology, 51*(2), 382.
- Staub, E., & Vollhardt, J. (2008). Altruism born of suffering: The roots of caring and helping after victimization and other trauma. *American Journal of Orthopsychiatry, 78*(3), 267-280.
<https://onlinelibrary.wiley.com/doi/abs/10.1037/a0014223?sid=nlm%3Apubmed>
- Stephens, A., & Appels, A. (1989). *Stress, personal control and health*. John Wiley & Sons.
- Stuijzand, S., Deforges, C., Sandoz, V., Sajin, C.-T. C.-T., Jaques, C., Elmers, J., & Horsch, A. (2020). Psychological impact of an epidemic/pandemic on the mental health of healthcare professionals: A rapid review. *BMC Public Health, 20*:1230.
<https://doi.org/https://doi.org/10.1186/s12889-020-09322-z>
- Sumner, R. C., & Kinsella, E. L. (2020). *Grace under pressure: Elements of resilience in everyday heroes and heroes every day during the COVID-19 crisis*
<https://doi.org/10.17605/OSF.IO/HCR6X>
- Sumner, R. C., & Kinsella, E. L. (2021). Grace under pressure: Resilience, burnout, and wellbeing in frontline workers in the UK and Republic of Ireland during the SARS-Cov-2 pandemic. *Frontiers in Psychology, 11*. <https://doi.org/10.31234/osf.io/4tp35>
- Tai, D. Y. (2006). SARS plague: duty of care or medical heroism? *ANNALS-ACADEMY OF MEDICINE SINGAPORE, 35*(5), 374.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological inquiry, 15*(1), 1-18.
- van den Berg, A. E., Maas, J., Verheij, R. A., & Groenewegen, P. P. (2010, 2010/04/01/). Green space as a buffer between stressful life events and health. *Social Science & Medicine, 70*(8), 1203-1210. <https://doi.org/https://doi.org/10.1016/j.socscimed.2010.01.002>
- Vindrola-Padros, C., Andrews, L., Dowrick, A., Djellouli, N., Fillmore, H., Gonzalez, E. B., Javadi, D., Lewis-Jackson, S., Manby, L., & Mitchinson, L. (2020). Perceptions and experiences of healthcare workers during the COVID-19 pandemic in the UK. *BMJ open, 10*(11), e040503.
- Vinje, H. F., & Mittelmark, M. B. (2007). Job engagement's paradoxical role in nurse burnout. *Nursing & Health Sciences, 9*(2), 107-111. <https://doi.org/10.1111/j.1442-2018.2007.00310.x>

White, K., & Lehman, D. R. (2005). Looking on the bright side: Downward counterfactual thinking in response to negative life events. *Personality and Social Psychology Bulletin*, 31(10), 1413-1424. <https://doi.org/10.1177/0146167205276064>

Zhang, S. X., Huang, H., & Wei, F. (2020, 2020/06/01/). Geographical distance to the epicenter of Covid-19 predicts the burnout of the working population: Ripple effect or typhoon eye effect? *Psychiatry Research*, 288, 112998. <https://doi.org/https://doi.org/10.1016/j.psychres.2020.112998>

Table 1: Participant Demographics

Occupation	Sex	Age Range (years)	Race	Location	Timeline
Care Assistant	F	35-44	White Irish	ROI	June 2020
Police Constable	M	25-34	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Contract Tracing Admin	F	45-54	White Irish	ROI	June 2020
Agriculture Production Manager	F	45-54	White British/English/Scottish/Welsh/Northern Irish	ROI	June 2020
General Practitioner	M	65-74	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Consultant Physician	F	35-44	White Irish	ROI	June 2020
Community Matron	F	45-54	White Irish	UK	June 2020
Supermarket Regional Facilities Manager	M	25-34	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Bank Manager	F	45-54	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Process Technician	M	18-24	White Irish	ROI	June 2020
Deli Assistant	F	35-44	White Irish	ROI	June 2020
Theatre Nurse	F	55-64	Any other white background	UK	June 2020
Palliative Care Pharmacist	F	55-64	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Care home Manager	F	25-34	Any other White background	UK	June 2020
Paramedic	F	25-34	White Irish	ROI	June 2020
General Assistant	M	25-34	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Emergency Nurse	M	45-54	White British/English/Scottish/Welsh/Northern Irish	ROI	June 2020
Staff Nurse	F	45-54	White Irish	ROI	June 2020
Occupational Therapist	F	35-44	White British/English/Scottish/Welsh/Northern Irish	UK	July 2020
Mental Healthcare Worker	F	18-24	White British/English/Scottish/Welsh/Northern Irish	UK	July 2020
Community Support Assistant	F	55-64	White British/English/Scottish/Welsh/Northern Irish	UK	July 2020
Senior Staff Nurse	F	55-64	White British/English/Scottish/Welsh/Northern Irish	ROI	July 2020
Healthcare Assistant	F	35-44	White British/English/Scottish/Welsh/Northern Irish	ROI	July 2020
Nurse	F	45-54	White Irish	ROI	June 2020
Hospital Cleaner	F	55-64	White Irish	ROI	June 2020

Senior Medical Social Worker	F	35-44	White British/English/Scottish/Welsh/Northern Irish	ROI	June 2020
Senior Radiographer	F	45-54	White Irish	UK	June 2020
Pharmacist	F	35-44	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Garda Sergeant	F	35-44	Chinese	ROI	June 2020
Response Policing	M	35-44	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Police Dog Handler	M	35-44	White British/English/Scottish/Welsh/Northern Irish	UK	June 2020
Manager	F	35-44	White British/English/Scottish/Welsh/Northern Irish	ROI	June 2020
Supermarket Cashier	F	18-24	White British/English/Scottish/Welsh/Northern Irish	ROI	June 2020
Care Assistant	F	35-44	White Irish	ROI	July 2020
Deputy Head of Probation Delivery Unit	F	45-54	White Irish	UK	July 2020
Healthcare Assistant	F	35-44	White British/English/Scottish/Welsh/Northern Irish	ROI	July 2020
Child Mental Health Social Worker	F	35-44	Any other White background	ROI	July 2020
Child Protection Social Worker	M	45-54	White Irish	ROI	June 2020

Total Participants ($N = 38$)
