Trainee life under COVID-19: A systemic case report

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Abstract
The coronavirus disease 2019 (COVID-19) pandemic has had implications for all of us. For those of us studying on clinical psychology doctorates, and similar psychotherapeutic training courses, this pandemic has led to some particular challenges. This article explores the experiences of a group of clinical psychology trainees, who are also completing intermediate systemic qualification, during the COVID-19 pandemic using a systemic case study approach. We consider the challenges we faced in relation to systemic theory and the intervention we would have used if we were clients in a family therapy clinic. This enabled us to reflect on the importance of self-reflexivity and self-care during these challenging times.

KEYWORDS
clinical psychology, COVID-19, systems theory

INTRODUCTION
The COVID-19 pandemic is a ‘collective trauma event’ that has had a significant impact across the globe (Amorin-Woods et al., 2020). Yet whilst there is an element of ‘sameness’ to our experiences, the interaction of COVID-19 with wider social, cultural and political factors has resulted in a range of struggles for individuals and their systems. In her recent editorial for the Journal of Family Therapy, Lord (2020) considered the different responses we may have to global crises such as COVID-19. Referring to Lindemann’s (1944) crisis theory, Lord suggests that we all view
Practitioner points:

- Using systemic thinking and ideas can help organisations make sense of how the system has had to adapt to working during a pandemic and can bring to light some of the challenges.
- During the pandemic and at other times of crisis, opportunities for students and staff to reflect together are likely to be beneficial.
- When working independently, as necessitated by the pandemic, finding ways to remain connected to our colleagues will be especially important.
- Providing opportunities for individuals to give feedback regarding their experiences and to influence organisational change will help individuals gain a sense of agency during a time when they are likely otherwise to feel disempowered.

This pandemic from different lenses, and this will influence our responses that is, focusing on ourselves and our microsystem, or on addressing larger issues within the macrosystem.

As trainee psychologists completing our intermediate systemic qualification during COVID-19, we experienced personal and professional challenges both as individuals and as a cohort. During a number of discussions, we noticed some shared narratives and experiences in our thinking and decided it would be an interesting experience to reflect on our ‘cohort experience’ of COVID-19 using a systemic lens.

To allow us to step back and consider our experiences from a new, systemic perspective, we decided to reflect on our experiences as if we, as a cohort, were a team presenting for systemic therapy. Thus, we have written up our reflections in the form of a hypothetical systemic ‘case study’ and used this lens to make sense of some of the challenges we have faced as a group during this time. We have drawn on systemic theory to generate hypotheses about some of the challenges we faced and our reactions to them. We have then proposed systemic interventions we might use if working with a team with these presenting difficulties. Moreover, we have reflected on some of the steps we have taken as a cohort to try and maintain homeostasis and adjust to the ‘new normal’. While we recognise that some of our experiences may be unique to our own context, others learning or working in both university and National Health Service (NHS) settings may relate to the challenges we highlight around attempting to maintain previous ways of working and feeling disconnected from colleagues.

Central to the narrative we will present within this article is the concept of the cohort as a cohesive, supportive team. Previous research into family therapy training has highlighted the importance of peer support within cohorts (Nel, 2006), and research during COVID-19 has found that increased social support is associated with better mental health outcomes (Bauer et al., 2020). Clarke and Rowan (2009) describe teams as ‘socially constructed entities’, where alongside individuals’ own narratives, shared team narratives will develop. After situating our context, we will consider the difficulties we have experienced within our system. In this paper, we aim to reflect on both a process of adapting following the changes resulting from the pandemic and propose ways of addressing stuck situations using systemic ideas, which are likely relevant to those training or working in institutions during this current crisis.
‘Warming the context’

When we first started talking about experiences of training in the wake of COVID-19, we felt a huge sense of loss and sudden disconnection from important forms of support in our lives. There was already a pre-existing narrative for us about the need to keep multiple plates spinning. During one of our reflective sessions, we mapped out the various relationships that had been affected within our training (Figure 1). We started to talk about the pull to support the NHS, the tensions that exist between needing to be flexible, while still hoping to meet our training needs, all this in a context where we, and the rest of the world, were working through a sudden shock to our personal and professional systems. These initial reflective meetings raised multiple dilemmas about practical (e.g., should I move home or stay here?), professional (e.g., where am I best placed and what is my role?) and personal issues (e.g., do I feel safe? Do I want to keep practicing?) we were confronting.

In systemic practice, self-reflexivity has been referred to as an internal conversation between the self in relation to what is being created in the moment (Jude, 2018). Our experiences around the COVID-19 pandemic felt quite personal, though framing our experiences through a systemic lens encouraged us to remain curious around the ways COVID-19 interacted with systems on multiple levels.

This case study in some ways was a ‘dialogue with our selves’ (Anderson, 2014) as we learned to make sense of this experience. It has been suggested that being openly transparent about our experiences and thoughts within family therapy sessions can create new meaning (Shotter, 2014; Simon & Chard, 2014). By sharing our own experiences, we invite other practitioners to notice what comes up for them, and to reflect on how they relate to these experiences and how this might impact on their personal/professional practice.

![Ecomap of interactions between trainees and other systems](wileyonlinelibrary.com)
Another dilemma we faced was wanting to share our experiences and find commonality, whilst also doing justice to the different relationships to COVID-19 within our cohort. People from Black and ethnic minority and vulnerable groups have been disproportionately represented in COVID-19-related deaths (Public Health England, 2020), and people’s livelihoods have been impacted differently. For instance, 25% of workers have been on furlough, newly unemployed, off sick or in isolation because of COVID-19 since February 2020 (ONS, 2020). We reflected on our social GRRRAAACCEEESSS (Burnham, 2012) to help bring attention to some of the similarities and differences in the ways we related to the pandemic. Throughout this article, we felt it was important to recognise that most of us were economically stable, white, young adults who have not had to shield because of our physical health. Additionally, as trainee clinical psychologists, we were in a privileged position of having paid salaries which have not been affected by the COVID-19 pandemic, which was not the case for many others. We recognise these specific positions we occupy will have influenced the lens we have used to write this article.

PRESENTING PROBLEM

The changes that occurred because of the COVID-19 pandemic added to our already high stress levels as trainees on a clinical psychology doctorate. Although our teaching continued, albeit on a digital platform, our normal routines were turned upside down. There was uncertainty over placements and what they would look like. We were accessing our course in our own homes, with no commute to signal the day had started or finished. For some of us, the changes that occurred meant that entire research projects had to be redesigned as NHS trusts paused all non-COVID-19 research. These changes were difficult to manage, especially as we were all dealing with additional anxiety around COVID-19 and how it might affect us and our loved ones.

Our normal sources of support were not as easy to access. We no longer had our breaktime catch-ups, which made it difficult to maintain our connections with each other and debrief about the challenges of our week. After spending a working day on video during teaching, screen fatigue impacted our contact with family and friends, which was now also all digital (Wiederhold, 2020). Many of us felt isolated and lonely during this time. In addition to the specific stressors of training, like many others, we had to adapt to the challenge of home-working, and the particular difficulties of starting a new placement with a new team in the midst of a global crisis. Not having the opportunity to meet our new teams in person made it harder to feel part of a workplace community, with the challenge of suddenly delivering therapy from our homes blurring the boundaries between home and work.

INITIAL HYPOTHESES

We initially had the opportunity to share our experiences with one another as a cohort in a reflective practice session which highlighted some of the similarities in our experience. A small group of our cohort then met together to think about our experiences in more depth. Similar to a reflecting team, we reflected together in a small group about the wider group experience, discussed our own personal experiences and noticed themes that related to systemic ideas and theories.

A number of systemic hypotheses were devised to explain some of the difficulties being experienced by our cohort.
Hypothesis 1: An attempt to maintain homeostasis

The course attempted to maintain homeostasis by keeping everything going as they had been pre-lockdown.

Course saw that trainees were managing to continue as usual and this confirmed the effectiveness of the approach.

Trainees interpreted this as an expectation to continue working as they had been (maintain homeostasis).

It was hypothesised that some of the distress experienced by the cohort resulted from an attempt by different parts of the system to maintain homeostasis in the face of the considerable changes caused by COVID-19. Homeostasis in systemic theory is where individuals in the system try to maintain the same patterns in relationships despite a change (Jackson, 1957). The course staff can be understood to have felt pressured to take charge, lead and manage the situation for trainees, and may have responded to this by attempting to maintain the functioning of the course as it was prior to lockdown. This was likely to be in response, in part, to external pressure from the wider university and other professional bodies to continue operating. However, we hypothesised that this may have, inadvertently, conveyed the message to trainees that the expectation was to continue ‘as normal’, despite trainees struggling with a sense of disconnection and loss following these changes. As trainees responded to this by maintaining a high level of work output, this was likely to imply to the course team that trainees were coping well and confirm that they should continue to keep the course running ‘as normal’.

Hypothesis 2: A double bind

The course staff provide reassurance, acknowledging the challenge of the current global context. In an attempt to provide this reassurance and guidance, the levels of communication from the course are very high (advice, suggestions for reading, webinars etc.)

Trainees experience this high level of correspondence and resources as placing pressure on them to work consistently at a high level. Trainees placed in a double bind of wanting to demonstrate competence but also communicate distress and the need for change. As a result, communication to the course is mixed/unclear.

It was hypothesised that the course team and trainees may have put each other in a double bind, with both sides communicating mixed messages regarding their expectations and needs. A double bind is a theory which highlights communication as the problem; in such a double bind, contradictory messages are communicated on different levels, but it is difficult to comment or recognise the
inconsistency (Bateson, Jackson, Haley, & Weakland, 1956). Thus, both the course team and the trainees may have been left in a position where they felt unsure of what the other wanted, maintaining feelings of confusion, distress and disconnection.

**Hypothesis 3: Trainee life cycle**

As lockdown progressed, there were disruptions to the trainee role and the stages of training that had been hoped for and expected. It was hypothesised that, similar to the family life-cycle (Carter & McGoldrick, 1988), trainees hold in mind a ‘trainee life-cycle’, with a particular path of progression expected for their training course, for example, marking the end of each academic year with celebrations, starting and ending placements and the experience of elective placements. These experiences were significantly ruptured and interrupted by COVID-19, and we hypothesised this may have resulted in feelings of loss and grief. As training was a goal many of the cohort had worked towards for many years, we hypothesised the grief of it not occurring as envisioned may be particularly difficult.

**Hypothesis 4: Loss of the shared experience**

Finally, it was hypothesised that the loss of the shared cohort experience resulted in individuals feeling increasingly disconnected and unsupported, thus adding to our individual distress. We hypothesised that initially the cohort attempted to maintain a sense of cohesion by increasing our contact time with one another via online meetings, quiz nights and reflective sessions. However, as screen time increased in other forums, this overload of screen-based socialising became overwhelming, leading individuals to begin declining social activities and increasing feelings of disconnection.

These hypotheses are held lightly and understood in the wider context of multiple factors influencing the way that individuals responded within the various systems that they are part of and the various pressures on the different systems (e.g., the university). Central to all the hypotheses was the notion that systems reacted to the COVID-19 pandemic by attempting to maintain homeostasis, and to continue despite fundamental profound changes. The attempted solutions can therefore be understood as a consequence of taking a linear view of the problem: e.g., ‘I need
to do more/provide more/work more to make this better’ or ‘we need to keep things consistent and working as normal’. The proposed solutions, all striving for homeostasis, had thus become problems in themselves.

INTERVENTIONS

Hypothetical interventions

Reflecting on our experience within this unusual time raised questions of how we, as trainee systemic practitioners, would have worked with our own cohort if they had presented at a family therapy clinic as a client group. We identified a number of hypothetical ways of intervening with ourselves to promote second-order change (i.e., a change in the structure of the system; Davey et al., 2012), which in turn have produced some interesting realisations that were useful for us as a cohort to reflect on.

If we were working with such a client group, we believed that an integrated approach, incorporating elements of the post-Milan, solution-focused and structural approaches, would have been most useful. Key to some of the difficulties experienced by the cohort appeared to be the attempts to maintain homeostasis in the face of a total shift in circumstance, which reflected and was replicated by wider pressures from the system to continue ‘as was’. Promoting an increased circular awareness of this circular dynamic not only amongst the cohort themselves (i.e., self-reflexivity; Burnham, 2005), but also with key members of the wider system (in particular, the course team), may have helped promote recognition of this stuck state the cohort found themselves in and allowed room for second-order change. Such an intervention could have involved a joint meeting with the trainee cohort and the course team, at which circular questions (Tomm, 1988) could have been asked, such as: ‘when the course team sends more emails, how do the trainees respond?’; ‘if you were to tell the course you were stressed instead of looking to appear as if you were coping, how do you think the course would respond differently?’; and ‘who is most concerned about this within the course team/cohort?’

The intervention could provide a wider circular awareness by encouraging the cohort and the course team to focus on the different levels, such as those at a wider political level, at the level of professional bodies, at the level of individuals’ specific family systems and at the level of the wider university. Drawing in this consideration of the wider system may have facilitated greater consideration of multiple perspectives, and a recognition of the wider feedback loops that are at play in maintaining difficulties beyond the cohort and course team. The use of specific techniques such as circular questioning, reframing and exploring multiple perspectives could have facilitated this increased circular awareness and thus permitted shifts in the state of homeostasis (Tomm, 1988; Watzlawick, Weakland, & Fisch, 1974). Useful reframes may have included reframing the course staffs’ increased correspondence from signalling increased expectations of the trainees to showing that the course staff were also feeling anxious about the current changes, or reframing the trainees’ inconsistent communication as them being unsure regarding what the course is expecting of them. Moreover, questions exploring multi-versal thinking (e.g., ‘it sounds like the trainees have understood the increased correspondence as pressuring whilst you have understood it as supportive; why do you think they might have felt that way?’) and curiosity (Cecchin, 1987) (e.g., ‘I am interested in why this made you feel more pressurised; can you tell me a bit more about that?’) may have been useful techniques by which to explore multiple perspectives.
An intervention could also include a focus on building self-efficacy in the cohort to shift the sense of powerlessness shared by many experiencing the impact of COVID-19. Within our work with this cohort, we would look to build the self-efficacy of the group to allow for changes that may shift this state of homeostasis. Specific techniques such as scaling questions (e.g., ‘on a scale of 1–10, 10 being the best communication, how would you rate the communication between the trainees and course team at the moment?’ ‘What made you choose 6 and not 7?’ ‘What would need to change for it to become a 7?’), the miracle question (‘imagine if you woke up tomorrow, still within the pandemic but with these current problems we have been discussing solved, what would you notice that shows you this miracle has happened?’ ‘What would be different?’) and goal-setting could challenge the cohort and course team to reflect on new ways of being, as well as building a sense of hope that they could go on to actualise a ‘new normal’ that fitted better with the radically changed situation.

Finally, the intervention could include the use of an action technique such as sculpting (Duhl, Kantor, & Duhl, 1973) to explore how the cohort were now in their relationships with one another and the course team, and how they would like things to be. This would have the potential to reduce feelings of disconnection and loss and enable the cohort to find ways forward towards this ‘new normal’. A sculpt could be used to explore how the cohort are now in their relationships with one another and how they would like things to be. This could allow a change in energy which would enable the trainees to see what needs to change to reach the wanted outcome version within this ‘new normal’.

DISCUSSION

The writing of this article proved a helpful way of processing and naming our experiences, and was also helpful in developing our self-reflexivity. This skill feels particularly needed within therapeutic work with clients during this time, but also is arguably harder to make time for as we find ourselves at a point of crisis (Amorin-Woods et al., 2020). We have found reflecting together to be a normalising and validating experience. Seeing how the solutions we attempted at times fed into the problems we were experiencing highlighted that we, similarly to the families and systems we work with, are generally doing the best we can in a difficult set of circumstances. Having the space and time to reflect helped us recognise these unhelpful patterns. In many ways, writing this article drove home to us that, as systemic practitioners in training, a key contribution we can make to the families and systems we work with is to provide them with a safe space to make sense of what they are doing. This in itself can often be a catalyst for change, as we noticed ourselves within this experience of COVID-19.

Some changes did occur naturally as we adapted to the shifting context we live in. For example, more reflective practice sessions were facilitated by the course, due to a recognition of trainees’ need for a space to reflect on the changes that had occurred as a group. Moreover, informal feedback sessions with course staff members provided an open space to consider how the course needed to adjust in light of COVID-19 (e.g., changes that could be made to teaching, extensions to deadlines, etc.) as some trainees had shared their concerns with the course team. The course team acknowledged that we must be finding it difficult, which provided the space to have a different kind of conversation. This highlighted how the systems we work with already have the knowledge and capacity to bring about change to their situation. Our role is to provide a space which helps them realise this and put those changes into action. We felt that some of our reflections as a subgroup had an influence on our communication with each other and the wider
staff team, and this may have also contributed to the changes we noticed. Through developing an awareness of how our actions may have been contributing to the problem, we realised the importance of being open and honest with the course team in order to think about what could change. In our reflective practice sessions, we recognised the need to have more informal spaces to connect with one another as a cohort, without feeling overburdened by excessive screen time, and a reduction in screen time during teaching implemented by the course helped facilitate this. Our solution-focused approach in the reflective practice sessions helped us to recognise when we are missing experiences from not seeing one another in person, and encouraged us to creatively find ways to meet this need. Moving forward, like the way a reflecting team can be used, it may be helpful for us to reflect on these system changes in front of the wider system (i.e., whole cohort and staff team) to continue to promote further change. These sorts of spaces have been provided in the informal feedback sessions where we, as trainees, have the opportunity to talk together about how we are finding things, while the course team listen and then comment after.

Given parallels between our experience and systemic practitioners and students adapting to working in a pandemic, we have outlined some of the learning points from our experience and reflections. One of the key learning points is that reflective conversations can help cohorts and teams make sense of the challenges they are experiencing as a result of the pandemic. We would recommend that organisations provide an opportunity for cohorts and teams to reflect on their experiences together. These conversations may increase circular awareness of any problems or challenges resulting from how groups are trying to adjust, such as trying to continue helpfully ‘as was’. Having open conversations within organisations can help further increase circular awareness and allow the system to develop alternative ways of coping. We recognise that, in a time of crisis, it can be difficult to prioritise time for reflection when there is a focus on doing, but it is likely that such opportunities will help to identify unhelpful circular processes and improve well-being. For both student cohorts and staff teams, it is likely that sharing their experiences during such periods of crisis and having the opportunity to contribute to discussions about consequent organisational changes will help reduce any sense of powerlessness. For example, in our course, we were asked to give suggestions on how teaching staff deliver online training, allowing us to suggest ideas which reduced the burden of screen time.

Our experiences over the recent months have made us more aware of our need for each other as support, particularly as trainee psychologists. In times of stress, such as during this pandemic, the need to support one another is much greater, but this has been challenging when it has been much harder to be with each other. As Amorin-Woods et al., (2020) put it: ‘It seems ironic that an enforced need to “stay apart” from one another (in order to stay alive), has birthed an invitation to be more human (in order to stay emotionally and relationally alive), and be closer to each other than ever before.’ During times when direct contact has been possible, mutual support has been easier. When restrictions have meant this has not been possible, our cohort has needed to find a balance between offering one another sufficient virtual support whilst avoiding the burden of excessive time on screen. Furthermore, this experience has highlighted the importance of self-care during training, a factor which research has previously illustrated is important to develop in the culture of clinical psychology training (Zahniser, Rupert, & Dorociak, 2017).

We are aware that in this article we are mainly discussing the dominant narratives within our cohort, and it is likely that other subjugated narratives have been missed (Clarke & Rowan, 2009). There are multiple ways of constructing a narrative around an experience, and we recognise that this narrative does not speak to all clinical psychology trainees, or even all trainees in our cohort. Certainly, we were interested to notice how this experience of COVID-19 intersected with our other existing identities to form a unique experience for each of us. Again, this highlighted to us
the importance of holding in mind multiple perspectives when working with a family or system, as one individual within that unit might have a very different experience of what is happening to another.

In later meetings as a subgroup, in the process of writing this article, we reflected back on our experiences, broadened our contexts and integrated them into a wider narrative which has helped to reframe our perspective. The COVID-19 pandemic has highlighted some of the pre-existing differences and inequalities in societies. For example, the disproportionate impact of COVID-19 on Black, Asian and other ethnic minority groups in the UK and the United States (Boserup, McKenney, & Elkbuli, 2020; Phiri, Delanerolle, Al-Sudani, & Rathod, 2021) has highlighted and made visible social inequalities in both countries. Acknowledging the multi-faceted difficulties experienced by some people during the pandemic has contributed to the changing relationship to our own struggles as we recognise that the impact and risk to ourselves is comparatively lower. For example, if we had been from more diverse cultural backgrounds, we may have faced different, additional challenges and arrived at different conclusions to the ones we have made in this paper. Exploring these intersections further is beyond the scope of this current paper; however, we feel they are worth acknowledging, particularly when considering how our experiences may or may not generalise to other teams and cohorts.

In conclusion, this paper has highlighted how systems have had to adjust to working in a pandemic. This change in context can present challenges for both individuals and their systems, particularly when trying to maintain a level of homeostasis that is no longer possible. However, by using systemic approaches and providing space for groups to reflect on their experiences together, groups can communicate their experiences, consider the wider systems and contextual factors, identify circular feedback loops that may be playing out, and find more effective ways forward. As we experienced ourselves through writing this paper, this process in itself may help systems creatively adapt to this ‘new normal’ we find ourselves in.

AUTHOR NOTE

All authors are affiliated with the University of Bath Professional Doctorate of Clinical Psychology Programme and are enrolled on the AFT intermediate systemic qualification.

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