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Experiences of Outpatient Mental Health Counselors Building Relationships with Clients During COVID-19 in Michigan

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2024

Abstract

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MS, University of Phoenix, 2009

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Dissertation Submitted in Partial Fulfillment

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Abstract

The COVID-19 pandemic has had a significant impact on the mental health of many individuals and communities and their access to mental health counseling. This study explored the experiences of mental health counselors attempting to build online relationships with clients during the COVID-19 pandemic and how these workers experienced and interpreted relationships with their clients during that period. The transactional theory of stress and coping model provided theoretical foundation to this study. One limited licensed and eight fully licensed professional counselors participated in this study. A generic qualitative design was used, and data were collected by audio recording interviews via Zoom, transcribed, and analyzed using content analysis. The analysis identified themes of (a) mental health counselors' interpretation of the meaning of client engagement, (b) mental health counselors' interpretation and experience with COVID-19 protocols, and (c) mental health counselors' interpretation and experience of building client relationships during the COVID-19 pandemic. This study may impact social change by providing information that can encourage new policies and procedures for not just mental health counselors but also other professionals working online with individuals with mental challenges.

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Dedication

This research is dedicated to clinical professional counselors who continued to work with clients during the pandemic. I thank you for being able to remain dedicated to client care during the time of uncertainty and for taking care of individuals within the community with mental health challenges.

I also dedicate this study to my niece Amara, who entered this world three years after COVID-19 stricken the United States. I hope you will follow in your aunt's footsteps by making an imprint to create a positive social change for your generation and generations to come.

Acknowledgments

I would like to acknowledge how God guided and helped me throughout the entire doctoral process. I took breaks, had challenges, and kept my faith.

"I can do all things through Christ which strengtheneth me"

Philippians 4:13(*KJV*).

I would like to thank my support system, my cheer team, my family, and friends for your words of encouragement. I especially would like to thank my parents Paul Sr. and Candy, without you both there is no me! Thank you for reminding me "If a Ph.D. was easy, everyone would have one." Thank you, my little/big brother Paul Jr., and his wife Hilniqua for telling me "You got this," and to my client, who has been with me and encouraged me throughout my doctoral journey, I truly thank you S.D. for always thinking of me! I appreciate my village so much, without you all, I would not be where I am today!

I would also like to acknowledge my Chair Dr. Barbara Benoliel and Second Committee Mentor Dr. Dorothy Seabrook for their encouragement and engagement during my dissertation journey. A special thank you to Dr. Dorothy Scotten, thank you for our creative talks and your encouraging words at the start of my dissertation.

Lastly, I cannot allow this page to be complete without mentioning Dr. Derrick Barbee (Doc) who got me through many nights of doubting myself, you were there at the beginning telling me, "Let's get it done Doc." I thank you for your support, mentorship, and understanding.

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Chapter 1: Introduction to the Study

For centuries, epidemics and pandemics have affected populations all over the world (Huremović, 2019). During a pandemic, poor and vulnerable populations can be hit the hardest, including those persons with severe mental illnesses (Druss, 2020). The vulnerability triggers a higher risk of post-trauma stress (PTSD), depression, anxiety, and substance use disorders among individuals (Zang & Ma, 2020). Previous research indicates that the COVID-19 pandemic changed the way outpatient community mental health centers (CMHC) in Michigan provide services to clients; however, research has failed in understanding how staff built relationships with clients during this time. The Covid-19 Pandemic presented significant challenges for healthcare professionals, particularly with caring for populations and building relationships with clients experiencing challenging behaviors and individuals diagnosed with mental illnesses (Blanchard et al., 2022). The purpose of this study was to analyze the lived experiences and interpretations of outpatient community MHCs in building relationships with mental clients at CMHCs during the COVID-19 pandemic in the state of Michigan.

This chapter provides a comprehensive overview of the research study and outlines the need to further explore experiences of how community mental health outpatient professional counselors built relationships with their clients during the Coronavirus Pandemic in Michigan from March 2020 to March 2023. This chapter will provide background information on the issue and highlight the problem and the existing gaps in research that need to be addressed. The nature of the problem and the research question will also be discussed.

Background

The evolving variants and transmission of coronaviruses (CoV) still affect individuals globally. Despite vaccines and other precautions to help slow the spread, several mutations and variants of concern continue to increase case numbers and deaths in the United States. At the end of 2021, the United States had 53,795, 407 positive cases, and 820,355 Americans who have lost their lives since the start of the pandemic in 2020 (CDC, 2021). Further, the demand for new regulations, training of staff to properly use personal protective equipment (PPE), isolation and quarantine protocols, and telepsychiatry sessions have left behavior health systems challenged and overwhelmed (Pinals et al., 2020). Research has noted the unpreparedness in the United States even with the advancement of medical sciences and resources (Raven et al., 2018; Shah et al., 2020).

Scholars have not examined the experiences of counselors who continued working and managing the mentally ill population during COVID-19. There have been numerous studies detailing HCWs lived experiences during COVID-19 (Alizadeh et al., 2020; Lai et al., 2020), but the research did not include MHCs in these studies. A critical aspect of burnout is emotional exhaustion or the development of a negative attitude towards clients, also impacting their relationships (Rudaz et al., 2017). But few studies have examined MHCs during COVID-19 and their overall experience building relationships with clients at the initial start of the first wave and throughout the time of this study with various variants and variants of concern circulating. The virus impacted the way in which mental health services were implemented for clients throughout

Michigan. Therefore, additional qualitative studies are needed to learn about MHCs' experiences and the impact of the pandemic on patient relationships. MHCs can play a valuable role at outpatient CMHCs, encompassing specialties in risk assessments, crisis, case management, individualized and community treatment, and the provision of helpful resources for the population with mental illnesses (Blanchard, et al., 2022). MHCs, defined in this study as limited license professional counselors (LLPC) and licensed professional counselors (LPC) face many of the same challenges as healthcare workers (HCW) defined as registered nurses (RN), licensed practical nurses (LPN), and direct care workers (DCW). Like HCWs working in nursing homes, assisted living facilities, and urgent care locations, MHCs also continued to support clients by maintaining their wellbeing during COVID-19 (Dress, 2020).

Problem Statement

In early 2020, Michigan experienced the first initial wave of COVID-19. For many, those working in the field of human service continued to deliver services to vulnerable populations despite the raising number of positive cases and deaths from COVID-19. Individuals with preexisting mental diagnoses tend to have an increase in stress due to a reduction or lack of treatment services (Unützer et al., 2020). However, while patients are experiencing increased stress, health care workers (HCWs) are prone to undergo more psychological challenges than those working outside of the healthcare field, impacting the quality of care and connections between service providers and service recipients (Humer et al., 2022). Changes in HCWs' mental health stemmed from the fear of possible infection and spreading the virus to family and friends (Dobson et al.,

2020). HCWs have a high risk of adverse mental outcomes, indicating a need for psychological support as it relates to building relationships with patients (Lai et al., 2020).

Despite this research on the experiences of HCWs during the COVID-19 pandemic, I found no research about the experiences of MHCs building relationships with their clients during the COVID pandemic, specifically those at outpatient CMHCs in Michigan. Given this gap in the literature, further research is needed to explore the interpretation of the experiences faced by community outpatient MHCs in providing adequate care to their clients with mental illnesses. This research will help to address the documented problem and address the gap in understanding MHCs' overall experiences and interpretation in building a relationship with clients during the COVID-19 pandemic to present.

Purpose of the Study

Pandemics have affected the economy, health systems, mental health, and well-being of many, including those working in the healthcare field (Lai et al., 2020). The way counselors performed their day-to-day activities was impacted by the COVID-19 pandemic (Blanchard, et al., 2022). Counselors continued to deliver mental health counseling in different centers despite the significant challenges faced during the pandemic. The pressure of finding resources for patients while balancing their own physical and mental healthcare needs can cause moral injury and mental health problems (Greenberg et al., 2020). The purpose of this study was to explore the experiences of outpatient community MHCs and how they interpret the process of building a

relationship with clients during COVID-19. The focus was on experiences encountered during the initial wave of the pandemic leading into the present time of this study with the contagious variants still circulating. The global pandemic has altered how mental health counselors provide patient care, including factoring in an increase in anxiety and despair linked to COVID-19 and using novel techniques remote technology. Thus, the roles and responsibilities of counselors have evolved since the COVID-19 outbreak. Further, the same worries that COVID-19 related illnesses cause in patients may also affect counselors while building relationships with clients.

Research Question

How did outpatient community mental health professional counselors experience and interpret building relationships with their clients during the COVID-19 pandemic in the state of Michigan?

Theoretical Foundation

This section of the research provides the theory that was used to address this study from the perspective of different arguments made by theorists. The transactional theory of stress and coping model (TTSC) focuses on the way people cope with the adverse effects of stress. Richard Lazarus partnered with one of his colleagues, Susan Folkman, to create a framework that assesses experiences, working conditions, and environmental factors. They attempted to model the social and psychological variables of counselors to the work processes. The tenets of the theory reveal that the assessment evaluates the challenges, threats, and damages that a pandemic had on mental health counselors' lived experiences in building relationships with clients (Lazarus, 1966).

The general public is facing numerous stressors related to the ongoing pandemic (Folkman, 1984), but personnel in the human services and health care sectors are facing additional challenges. Healthcare professionals globally were confronted with an unparalleled scenario where they must make difficult choices and work with a significant number of stressors (Greenberg et al., 2020). Challenges regarding the psychological health, mental well-being, and rehabilitation of healthcare professionals who treat and provide care to patients detected with COVID-19 are increasingly emerging (Lai et al., 2020). Leaders must evaluate issues about the safety of physicians and healthcare professionals to help them preserve their well-being and resiliency all through the epidemic (Dewey et al., 2020).

The TTSC is a contemporary framework of social science that contributes to the scope of work-related stress and conflict about roles. Despite the rising number of COVID-19 positive cases and fatalities, many people in the human services sector continued to provide services to affected citizens. These include a higher risk of contracting the virus due to exposure and a shortage of personal protective equipment (PPE) needed to protect themselves. The TTSC provided a model that addresses the components of interaction between the workers, the threats, challenges, and damages of their social and physical environment (Sharma & Gupta, 2022) and their impact on efficiency and emotional well-being (Gholami, et al., 2021). Therefore, the tenets of the theory helped in establishing which components played a vital role in the way the participants coped with the pandemic.

Nature of the Study

The study used interpretive phenomenological analysis (IPA) methodology, which is a qualitative research approach used to understand the essence of a particular experience, as it is lived and perceived by the individual (Husserl, 1911). It is used to describe and interpret the subjective meaning and purpose behind an experience, rather than just objectively documenting its occurrences. The study utilized the principles of a qualitative, phenomenological methodology to capture the lived experiences of MHCs building relationships with their clients during the COVID-19 pandemic. IPA was effective in obtaining the needed data for this study and contributed to the suitability, which helped in mapping the research question that ensured an overall understanding of those experiences. This approach allowed me to uncover the unique and individualized experiences of the counselors, including their thoughts, feelings, emotions, and subjective meaning attributed to the pandemic (see Blanchard, et al., 2022). Increased knowledge of stress management contributes to the success of coping strategies. Perceived stress, efficacy of coping mechanism, social support, and impacts of the pandemic helps in entrenching resilience among social workers (Yuksel & Yildrim, 2015).

The sources of data came from limited and fully licensed professional counselors with 3 or more years of experience postmaster's degree, working in the field of mental health with the State of Michigan and employed full-time during the first wave of COVID-19 to present at an outpatient community mental health center in the Metropolitan Detroit area. Zoom, a video platform used with online Internet provided access to conduct virtual meetings. This platform allowed me to record and collect data

from interviewees. By using interviews as a primary source of data I was able to understand and listen to the participants' interpretations of the phenomenon.

Definitions

The following definitions provided context to the study which ensured that terminology was explained for this study.

Community mental health center (CMHC): An organization under contract with the county of the mental health authority complying with state standards offering an array of community-based mental health services such as outpatient treatment, consultation, education, pre-screening, interventions, and aftercare (Bergwerk, et al., 2021).

Coping: Constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised by exceeding the resources of the person (Lazarus & Folkman, 1984, p. 141).

Essential workers: Those who conduct a range of operations and services in industries that are essential to ensure the continuity of critical functions in the United States (CDC, 2021).

Professional counselors (MHC): Master-degreed mental health service providers, trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders (Bergwerk, et al., 2021). In the state of Michigan, professional counselors can be identified as limited licensed professional counselors (LLPC) and licensed professional counselors (LPC).

Fully vaccinated: For the primary vaccine series, people who have compromised immune systems were recommended to receive three doses of an mRNA vaccine (either

Pfizer or Moderna) or one dose of the Johnson & Johnson vaccine followed by a dose of an mRNA vaccine (either Pfizer or Moderna). It is preferred that mRNA vaccines be used, but the Johnson & Johnson vaccine is still an option for those who are unable or unwilling to receive the Pfizer or Moderna vaccines for their primary doses or booster doses.

Intervention: What is done by the counselor (Norcoss & Lambert, 2018).

Relationship: How therapist and clients behave toward each other (Norcoss & Lambert, 2018).

Severe mental illnesses (SMI): Individuals with severe mental symptoms such as chronically elevated risk of severe functional impairments, psychiatric hospitalizations, and exhibit harmful behaviors (Kopelovich et al., 2020).

Technique: What is done by the counselor (Norcoss & Lambert, 2018).

Therapeutic relationship: The feelings and attitudes that the therapist and the client have toward one another and the way these are expressed (Norcoss & Lambert, 2018).

Assumptions

I assumed that the COVID-19 pandemic affected how mental health counselors were able to build relationships with clients at outpatient community mental health centers in Michigan. There was also an assumption that the counselors participating in this study would be forthcoming and truthful about their experiences during the pandemic. The aspects of previous lockdowns and social distancing requirements made counselors and centers adjust how services were provided to clients. Because of this, one

can assume counselors have returned to seeing some patients face-to-face. Additionally, I assumed that while positive cases of the COVID virus are still circulating, the period of lockdown has ended for now.

Scope and Delimitations

The study focused on the lived experiences of mental health counselors in Michigan during the COVID-19 pandemic. Literature indicates that COVID-19 had significant and different impacts on people across the world (Bergwerk et al., 2021). Therefore, the study only included mental health counselors living in Michigan in keeping with the scope of the study. Data were collected related only to the experiences of outpatient mental health counselors building relationships with clients during COVID-19. Although counselors from other states may have had similar experiences, they were not included. Delimiting the scope of the study in this way helped to make the research more manageable and focused, allowing the researcher to address the research question and objective more effectively.

Limitations

The limitation of the study was the use of the qualitative phenomenological approach. Given that this research approach derives from the lived experiences of mental health counselors, it may be difficult to replicate this study with other mental health workers with similar job duties. This study was limited to mental health counselors working at outpatient CMHCs in Michigan. Interviews for this study were conducted using an online video platform to conduct a virtual interview with participants; therefore, another limitation is potential participants not having access to Zoom.

Significance

The significance of this study lies in its ability to provide insight into the experiences and challenges faced by mental health counselors in Michigan building relationships with clients during the COVID-19 pandemic. By understanding the interruptions, stressors, and other experiences of these workers, the research helped to identify areas where support and resources was needed to ensure the effectiveness of these professionals as they continue to provide care to clients during and after the pandemic. A global outbreak can cause fear, concern, and influence how individuals cognitively process a pandemic (Shah et al., 2020). Long-term risk during a pandemic may affect physical, mental, spiritual, and emotional well-being (Dewey et al., 2020). Clinical staff must protect themselves and other colleagues to avoid poor patient care and adverse outcomes (Dewey et al., 2020). Emphasizing wellness is necessary and enables staff to provide quality care (Dewey et al., 2020). Despite recent research on coping skills and adverse actions during an epidemic or pandemic for HCWs, data was lacking as it relates solely to MHCs working during the first wave of COVID-19 and their experiences building relationships with clients.

Summary

The chapter presented the background of the study, research question, and the problem. The chapter also outlined the significance of the study, its scope, delimitation, assumptions, and nature of the study. The next chapter will be a literature review on the mental health and well-being of healthcare professionals during pandemics, with a particular focus on the experiences of mental health counselors during the COVID-19

pandemic. This review helped to provide a foundation for the current study and helped to contextualize the research question and problem being addressed.

Chapter 2: Literature Review

The chapter is a review of literature and also addresses the theoretical foundation to answer the research question. The review of literature provides a background of lived experiences among HCWs providing patient care during a pandemic. This allowed for thematic focus to address key issues of mental and psychological stressors. The literature review focuses on related studies, barriers, patient care, coping skills, stress, and the overall mental health of HCWs. This literature review also summarizes previous investigations from other researchers and addresses a gap in the literature to support the need for more qualitative research. The research gap existed because of a lack of focus on the experiences and interpretations of outpatient community mental health professional counselors in their efforts to build relationships with their clients during the COVID-19 pandemic. Previous results address dimensions of healthcare workers and social workers but do not assess the challenges that mental health professional counselors face and the association it has on their efficacy.

Literature Search Strategy

Walden University library had several search engines that provided numerous relevant research articles. I used ProQuest, Academic Search, Google Academic, Google Scholar, PubMed, PsychInfo, PMC, CDC, and the WHO website. To identify pertinent research, I searched these databases for articles published between 2016–2022 using the keywords and phrases: *coronavirus, COVID, COVID-19, SARs, MERS, United States COVID numbers, current COVID-19 numbers, Michigan COVID-19, COVID-19 symptoms, smallpox, epidemic(s), history of epidemics, global influenza(s), global*

viruses, global pandemic(s), global outbreak, history of pandemics, Ebola, Wuhan China virus, behavioral health during pandemics, behavioral health care during global outbreaks, behavioral health facilities and COVID, mental health during pandemics, mental illnesses during pandemics, mental health counselors during COVID-19, mental health practitioners and COVID, and *licensed professional counselors during COVID-19.* The identified search strategy provided the basis for my research.

Theoretical Foundation

Transactional Theory of Stress and Coping

The TTSC, proposed by Richard Lazarus and Susan Folkman, suggests that individuals encounter stressors in their environment and that their perceptions of and responses to these stressors can have a significant impact on their mental health and well-being. According to this theory, individuals go through a process of appraisal when encountering a stressor, evaluating whether the stressor is challenging or threatening, and whether they have the resources to cope with it (Biggs et al., 2017). This appraisal process can influence the individual's emotional, physiological, and behavioral responses to the stressor.

In the context of this study, the TTSC informed the research by providing a framework for understanding how mental health counselors in Michigan appraised and coped with the stressors and challenges they faced with client care during the COVID-19 pandemic. This theory helped shed light on the factors that have influenced these counselors as well as the strategies they used to cope with the stressors they encountered while attempting to build relationships with clients during the COVID-19 pandemic.

Literature Review Related to Key Concepts

Classification of Coronaviruses

Different strains of Coronaviruses (CoVs) have surfaced around the globe causing various infections in both animals and humans. CoVs are composed of different variants and belong to a classification as with most viruses. CoV belongs to the Nidovirales order (Fehr et al., 2015) composed of a large family of viruses called Coronoviridae (Rabadan, 2020) and a subfamily called Coronavirinae (Jahangir et al., 2020). The subfamily is further divided into four groups called Alphacoronavirus, Betacoronavirus, Gammacoronavirus, and Deltacoronavirus based on phylogenic clustering (Lu et al.,2016). CoVs can infect different species of animals and even humans, causing various diseases in both (Weiss et al., 2011). Dating back to the 1930s, the first known case of CoVs surfaced in domesticated chickens who exhibited acute respiratory infections (Aijaz, n.d.). The first human case was discovered in the 1960s when a patient complained of having symptoms of the common cold (Jahangir et al., 2020). During this time, a virologist studying the different strains of human and animal viruses stumble upon this virus calling it Corona (Jahangir et al., 2020). The name Corona came from the resemblance of spikes on a crown under an electron microscope (Rabadan, 2020). Research has documented this virus as several different mutations over time.

Historical Mutated Strains of Coronaviruses

Previous history of CoVs documented primarily mild respiratory infections. Studies suggest that CoVs are responsible for 15-30% of respiratory tract infections yearly in humans (Jahangir et al., 2020). In 2002, a strain of CoVs, known as severe acute

respiratory syndrome (SARS-CoV) was discovered in China causing an epidemic that resulted in high mortality rates in older adults (Weiss et al., 2002) and left those with underlying illnesses prone to get the virus (Jahangir et al., 2020). SARS-CoV was transmitted by direct contact with infected individuals during the onset of the illness, making it easier to confine the virus to infected households and hospitals (Jahangir et al., 2020). China was able to control the outbreak by 2003, and it has not returned (Jahangir, et al., 2020). Although China was able to contain SARS-CoV, the possibility of mutations is an outgoing concern.

CoVs can cause a variety of diseases and a new strain can surface at any time. In 2012, another strain of CoVs emerged in the Middle East called Middle East Respiratory Syndrome-CoV (MERS)-CoV (Jahangir et al., 2020). The virus caused respiratory tract infections throughout Saudi Arabia and other close countries (Fehr et al., 2015). This strain caused an even higher mortality rate than that of SARS early in the outbreak (Jahangir et al. 2020). The MERS outbreak was controlled in 2013, however, a spike in sporadic cases reoccurred in 2014 causing fears of another mutation (Jahangir et al., 2020). The strain of MERS has not returned; however, the lasting effects on the country and neighboring countries as with SARS cause fear long after containment.

The evolution of CoVs continues to leave uncertainty about whether the virus originated from animals or humans. CoVs have been found in a variety of hosts, such as birds, bats, and humans (Rabadan, 2020). By comparing genes and their specific order of genomes, scientists can determine how similar or different the strain of viruses is in a host (Rabadan, 2020). For example, by comparing genes and genomes, scientists

determined the SARS-CoV outbreak in 2002-2003 came from bats (Fehr & Perlman, 2015). Like previous CoVs, the ongoing mutation of COVID-19 produces different strains of the virus that force countries to try and figure out the next course of action to lessen the spread.

COVID-19 Pandemic

In 2019, the newest strain of the CoVs was discovered in Wuhan, China (WHO, 2020). The country reported cases of pneumonia from an unknown etiology with signs and symptoms of fever and difficulty breathing. Initial reports linked the discovery to a seafood market and an animal to human transmission (Jiang et al., 2020). Surrounding countries continued to monitor the increasing number of cases in China. Because the potential modes of transmission were still unclear, the WHO (2020) recommended all travelers take precautions when traveling to reduce the chance of an acute respiratory infection. During this time domestic flights and international flight traffic were affected due to the lockdown 3 weeks after the outbreak in China (Lau et al., 2020). Health organizations made suggestions to travelers to avoid close contact, practice frequent hand washing, utilize proper cough etiquette, and avoid contact with live or dead animals (WHO, 2020). These recommendations continued to stay in place even though later reports confirmed it was human-to-human transmission (Jiang et al., 2020). While the virus continued circulating in China, WHO and the Centers for Disease Control (CDC) continued to provide recommendations to reduce the rate of transmission. However, these recommendations did not prevent the spread of the virus to the United States and other countries.

Since COVID-19 surfaced there have been notable mutated variants to date. However, a more predominant variant called Delta has surfaced causing concern as this variant spreads twice as quickly as COVID-19 (Lauring & Malani, 2021). In December 2020, India was the first to identify the Delta variant. Despite vaccinations, this variant quickly spread rapidly to other countries including the United States in March 2021 (Rio et al., 2021). The Delta variant has become the predominant variant in the United States mostly due to the ratio of unvaccinated to vaccinated Americans (Rio et al., 2021). Despite a push by the government for all Americans to get vaccinated, there has only been about 62% of Americans fully vaccinated. To help slow the spread the goal is for at least 85% of the population to get fully vaccinated. In November 2021, another highly transmissible variant surfaced in South Africa and Botswana called Omicron (Rio et al., 2021). Since emerging Omicron has been detected in over 90 countries and 46 states in the United States making the transmission rate three times as high as the Delta variant (Rio et al., 2021).

Symptoms and Diagnosis of COVID-19 and Variants

COVID-19 can cause a high rate of hospitalizations and may even lead to death if not effectively treated. In humans, COVID-19 causes respiratory infections and has a wide range of symptoms such as fever, cough, difficulty breathing, headache, nasal congestion, muscle pain, sore throat, loss of smell/taste, and diarrhea (CDC, 2020a). There is a median of 5 days for the estimated incubation period which can persist for 2 to 14 days (WHO, 2020). For some, the virus can be undetected producing asymptomatic symptoms.

Transmission. Respiratory viruses such as COVID-19 can be transmitted to a healthy individual by encountering an infected person or surface. Through various modes of contact, transmission can occur by droplets and airborne transmission (CDC, 2020b). Droplet transmission can spread by an exhaled infectious person and airborne exposure occurs when infectious particles remain suspended in the air for a period (CDC, 2020b). Another method of transmission is when a hard surface is infected with the virus and later touched by a healthy person. Touching of the eyes, nose, or mouth can cause an individual to become infected with COVID-19 (CDC, 2020b). Airborne transmitted pathogens by close contact can also occur in enclosed spaces causing exposure to multiple people simultaneously due to prolonged exposure to respiratory particles (CDC, 2020b). Although there are various modes of transmission practicing social distancing and good hand-washing hygiene can assist with lessening the spread of transmission.

Overview of COVID Cases in Michigan

In March 2020, Michigan reported confirmed COVID-19 cases ranking 8th place in the United States. According to Bean (2020b) from February 2020 to May 2020 Michigan had 54,881 positive COVID-19 cases. The city of Detroit ranked in 7th place in the United States having a high death toll totaling 1,510 during this short period (Ben, 2020a). Data provided by the State of Michigan (2023) reported from the start of the pandemic until May 29, 2023, Michigan had 3,110,737 cases and 42,974 deaths. Across the United States, there were 99,429,000 cases and 1,101,771 deaths during this time frame (CDC, 2023).

Michigan's Interventions for COVID-19

To contain COVID-19, Michigan's governor issued a state of emergency in March and issued state orders and directives to contain the virus. Michiganders were required to wear a mask, practice social distancing, and avoid large indoor gatherings (State of Michigan, 2020). Indoor dining was prohibited and reduced to carry out. It was also recommended for establishments to keep a list of patrons for contact tracing (State of Michigan, 2020). Michigan had a devasting loss during this time with the loss of life, overcrowded funeral homes, full hospitals, protestors not wanting to wear a mask, and a hard hit to the economy. However, as the year 2020 was ending, slowly the governor increased the capacity for restaurants and indoor establishments.

U.S. Containment Recommendations and Interventions

Across the United States, the recommendation was consistent, wear a mask and social distance. To stop the spread of COVID-19, the CDC (2020a) recommended wearing a mask, staying at least six feet from others who do not reside in the same home, avoid crowds and poorly ventilated indoor spaces. Each state provided residents access to COVID testing to determine the presence of the virus (CDC, 2020a). If a positive test is confirmed the infected individual should separate from others, rest, and hydrate (CDC, 2020a). Each state provided guidelines to prevent the spread and methods to remain healthy.

Other methods of intervention were considered to help prevent the spread of COVID-19. According to the CDC (2020a) continuance of social distancing, wearing masks, hand hygiene, surface cleaning, ventilation, and avoiding crowds can help lower

the rapid positive cases. Several organizations and businesses also utilized interventions to continue to see their clients. Telemedicine and remote work were introduced to reduce the need for physical attendance in an outpatient clinic, reducing the need for direct contact (Spinelli & Pellino, 2020). Although these interventions have not been used by some, immediate solutions and/or methods need to be put in place to keep staff and clients safe.

Prevention and Treatment

Due to the massive death toll and positive cases across the world, vaccine trials began rather quickly for a vaccine to combat COVID-19. WHO (2021) states vaccines save millions of lives by helping to train the body's immune system to fight off viruses and bacteria. According to the CDC (2021c), authorized and recommended vaccines made by Pfizer and Moderna are available to combat COVID-19. Once an initial vaccine is provided another vaccine from the same manufacturer is needed three to four weeks later (CDC, 2021c). Both Pfizer and Moderna continued to conduct trials for approval for pregnant women and younger children to receive the vaccine.

Michigan's goal for the vaccines was to start with the most vulnerable and later expand to others. Officials developed a two-phase plan to provide vaccines (State of Michigan, 2020). Staff working on the front line and nursing home residents were permitted to receive the first dose of the Pfizer vaccine (State of Michigan, 2021). On December 14th, the first doses were administered to hospital staff across the state.

History of Pandemics and Healthcare Workers

Throughout history, humans have been exposed to pathogens that caused plagues,

diseases, and viruses. Populations have endured the Justinian Plague (541-542 AD), the Black Death (introduced in Europe in 1347), Yellow Fever (16th century), Influenza (1918), HIV/AIDS, SARS, and H1N1 (The Lancet, 2012). In 2006, The National Biodefense Science Board (NBSB) was created to provide expert advice and guidance under the Pandemic and All-Hazards Preparedness Act to the Secretary of the U.S. Department of Health and Human Services (HHS) (Pfefferbaum et al., 2012). Oshitani et al. (2008) suggested when an influenza pandemic emerges, it is inevitable for the effects to be felt globally. The Spanish flu was classified as a pandemic in 1918 and had extreme circumstances on healthcare workers, emergency services, and military personnel (Nguyen-Van-Tam et al., 2003). Similar research revealed the shortage of resources during the flu jeopardized the standard of care for patients (Spinelli et al., 2020). During a pandemic public health and clinical infrastructures are at risk and disasters adversely affect the well-being of affected populations influencing emotional problems and dysfunctional behaviors (Pfefferbaum et al., 2012).

Healthcare Workers' Perspectives of Historical Outbreaks

During the H1N1 influenza pandemic, first detected in the United States in 2009, the virus was a combination of influenza genes never identified in animals or humans (CDC, 2010). Challenges associated with H1N1 cause healthcare workers to have concerns about conflicting information related to protective measures, threats to the continuity of care, and noncompliance with health directives (Pfefferbaum et al., 2020). Studies conducted in Toronto during the 2003 SARS outbreak, revealed healthcare workers wanted to comply with quarantine orders to prevent the spread to the general

population and loved ones (DiGiovanni et al., 2004). Pfefferbaum & North (2020) also stated communities affected by SARS revealed that although healthcare workers were willing to quarantine to reduce the risk of influencing others, however, they were tempted to violate the quarantine orders because of emotional distress. Healthcare workers discussed their stressful experiences during the 2003 SARS outbreak reporting concern for family, fear of contagion, interpersonal isolation, perceived stigma, and attachment insecurity (Maunder et al., 2006).

Numerous research has demonstrated the importance of healthcare workers. The Lancet (2020) revealed that healthcare workers are the most valuable resource and cannot operate as ventilators at 100% capacity. During the crisis with HIV and Ebola counselors and healthcare workers played an invaluable role by promoting social distancing, providing interventions, dispelling myths, performing screenings, and tracing contacts (Chersich et al., 2020). Watkins (2020) reported during SARS and H1N1 workers assist with containment by buying some time before viruses get out of control. Staff also assist in limiting the spread by isolating and quarantining the most at risk (Barranco & Ventura, 2020). Effective staff support, moral support, careful planning, and psychological support may benefit staff during a pandemic (Maunder et al., 2006).

Healthcare Workers' During COVID-19

In general, people experience many emotions during a pandemic. A considerable amount of literature has been published on the psychological toll on healthcare workers working with patients during a pandemic. One central emotional response during a pandemic is fear (Van Bravel et al., 2020). Providers providing treatment are vulnerable

to emotional distress due to their possible risk of exposure (Pfefferbaum & North, 2020). In addition to fear as an emotional response, workers can also experience anxiety and other psychological distress, especially those caring for vulnerable populations such as children and the elderly (The Lancet, 2020). In 2019, Wuhan, China was the first area of the COVID-19 outbreak and presented with the highest confirmed cases and mortality rate. Despite emotions and other distress, frontline workers were still saving lives despite lockdowns and public fear (Zhu et al., 2020).

Healthcare workers worldwide suffered some mental problems during the pandemic (Liang et al., 2020). Several studies revealed COVID-19 had a psychological impact on healthcare workers working with patients. Healthcare workers reported acute stress and anxiety symptoms (Zhu et al., 2020). Naser et al. (2020) conducted a study in Jordan and found that healthcare workers experienced anxiety and depression. In the country of Poland out of the 441 healthcare workers surveyed 70.7% had depression (Liang et al., 2020). Qi, Xu et al. (2020) found that frontline workers had a higher rate of sleep disturbances and worse quality of sleep than non-front-line workers. A study in Nepal also concluded that healthcare workers experienced anxiety, depression, and insomnia (Khanal et al., 2020).

Healthcare Workers and Work-Related Stressors

Healthcare workers undergo work-related stressors related to various components of their jobs. Many hospitals report mental and physical stress on workers due to managing sick patients and the increased deaths among patients and colleagues (Barranco et al., 2020). WHO (2020) suggested healthcare and social workers face additional

challenges in the wake of COVID-19. These challenges included staff shortages, repurposing of staff, shortage of personal protective equipment (PPE), risk of infection, death, stress, burnout, self-isolation requirements, and the need to care for an infected loved one (WHO, 2020). Work-related stressors during a pandemic can lead to an increased workload, excessive absences from work, and other identified stressors. Despite the duty to continue to work, fear spreads into the homes of these professionals leading to experiences of isolation for the worker and their families (Werner et al., 2020).

Several studies revealed how healthcare workers undergo emotional strain and traumatic experiences working with sick patients daily. Secondary traumatic stressors can be attributed to caring for others when the caregiving professional has a desire to ease the pain and suffering of those they treat (Ruiz-Fernandez et al., 2020). Recently burnout among healthcare workers has become a serious concern and affects 40%-75% of professionals (Powell, 2020). Those who experience burnout tend to have emotional exhaustion and lack of fulfillment at work due to occupational stressors (Rodrigues et al., 2018). Fernandez et al. (2020) evaluated compassion fatigue, burnout, compassion satisfaction, and perceived stress during COVID-19. The researchers found healthcare workers exhibited stress, compassion fatigue, and burnout especially those working with patients affected with COVID-19. Findings have shown the toll pandemics can take on healthcare workers. The increasing number of staff complaining of burnout can be overwhelming for healthcare workers and patients.

In other countries' research have identified healthcare workers face many of the same challenges as those in the United States during the COVID-19 outbreak. In Africa,

there were significant shortages in staff, critical care beds, and possible water supply in some parts of Africa (Chersich et al., 2020). Neto et al., (2020) found that work-related stress is a potential cause of concern for healthcare workers in Italy and China due to long shifts and unknown treatment demands for COVID-19 patients. The study continues by stating depression and anxiety lead to psychic exhaustion. In Chengdu city, China Wu et al. (2020) identified five stressors: the first was the risk of higher exposure, the second, the lack of contingency planning, the third was a conflict with professional values, the fourth was the conflict between family and their work, and lastly, the delay of personal life and career planning (Wu et al., 2020). Bargello et al. (2020) identified high levels of work-related psychological pressure and frequent somatic symptoms for Italian healthcare workers.

Overcrowding in hospitals has been a common theme throughout several studies. Due to poor planning outpatient mental health facilities had to close which led to mental clients seeking treatment in emergency rooms. Another theme was being prepared for an outbreak. The lack of communication and protocols also left workers uncertain of the next steps. Gathered research has described secondary trauma, vicarious trauma, PTSD, emotional strain, and compassion fatigue. Individuals working during COVID-19 have experienced anxiety, depression, and trouble sleeping. Studies were examined from many other countries outside the United States as exhibited and the results remain consistent with the same symptoms.

Healthcare Workers and Coping

Data from several studies suggested methods to help healthcare professionals

engage in self-care practices and to reduce psychological distress as a component of coping (Werner et al., 2020). Self-care for healthcare workers during a pandemic involves knowing about illnesses, the associated risks, appropriate information on seeking professional assistance, and monitoring reactions to stress (Pfefferbaum et al., 2020). Prevention efforts and psychosocial support should be the focus for staff who are at risk for adverse outcomes (Pfefferbaum et al., 2020). Chersich et al. (2020) reported psychological support and structural interventions are vital. A task force can assist by meeting clinicians' basic daily needs, increasing communication, and developing psychological and mental health support options (Ripp et al., 2020). Joint efforts such as the government and other entities are needed to help how to manage public health organizations and their patients.

Recommendations for Healthcare Workers

Other recommendations identified working remotely during COVID-19 for healthcare professionals who can. The American Psychiatric Association (APA) (2020) recommends keeping a regular schedule to help maintain a routine. When isolated from family and friends stay connected by using technology and other supportive outlets (APA, 2020). Staying active, supporting a healthy immune system, prioritizing personal hygiene by handwashing, and using proper etiquette when sneezing or coughing may assist with lessening the spread of COVID-19 (WHO, 2021). Staying informed with open communication, setting work boundaries, and recognizing warning signs and triggers related to mental health also may lessen stressors during a pandemic.

Standards for Building Relationships

According to research, a good relationship helps clients to stay in therapy (DeAngelis, 2019). The counseling relationship involves establishing trust by safeguarding the integrity of the relationship and avoiding actions that cause harm to the client (Ybañez-Liorente, 2018). Counselors should also provide a supportive network as it relates to resources within the community and the involvement of positive individuals in the client's lives (ACA, 2014).

Counselors have a professional responsibility to practice in a nondiscriminatory manner and uphold the American Counseling Association (ACA) Code of Ethics (ACA, 2014). In this section, the code of ethics will be provided as it relates to relationships, trust, and building rapport with counselor. Counselors are expected to promote change to improve the quality of life by removing potential barriers that affect individuals and groups in which they counsel (ACA, 2014). In Section A of the ACA Code of Ethics, I will highlight some key components in building a relationship with clients. In the client welfare section A.1. the primary responsibility of counselors is to respect the dignity and promote the welfare of clients, A.1.b. standards for records and documentation is for counselors to create, safeguard, and maintain documentation, A.1.c states that counselors and clients should work jointly together to review and revise counseling plans as needed to insure effectiveness and with respect of the clients' freedom of choice.

In Section A.4.-b. counselors should avoid harm to clients and avoid imposing their values, attitudes, and beliefs onto clients, A.5.e. counselors are prohibited from engaging in a personal virtual relationship with current clients through social media,

A.6.b. states that counselors should maintain boundaries by considering the risk of extending counseling relationships beyond certain parameters such as attending a ceremony or visiting an ill family member in the hospital.

In support of both disciplines, whether healthcare workers or mental health counselors attempting to build a relationship with clients during a pandemic, support is needed for both occupations. Providing support for workers may prevent mental health concerns within the workplace (Nyashanu, et al., 2020). Involvement during a pandemic creates traumatic and stressful experiences which create mental health risks for staff and impact mental health services during a pandemic (Choi et al., 2020). These gathered risks for staff also lead to risks for clients which can affect the quality of care during a pandemic. Providing strategies to assist staff with their clients and having protocols during a pandemic may produce a more efficient outcome for staff. Interventions such as incorporating telehealth to limit worry and fear for those needing assistance, being flexible regarding funding revenues for organizations, and redesigning existing models of care (Smith et al., 2020).

Summary

The latest variant of the CoVs was found in Wuhan, China, in 2019. The city, which has a populace of 19 million people, serves as the provincial capital of Hubei, which has a total of 58,000,000 people (WHO, 2020). Unfamiliar etiology pneumonia cases having fever and respiratory difficulties were recorded across the nation. Initial reports connected the finding to a seafood market and migration from an animal to humans (Jiang, et al., 2020). The frequency of instances documented increased even

though China remained unsure about the transmission method. The review provided an overview of Corona virus, examined the COVID-19 pandemic in Michigan, and assessed the stressful experiences among mental health counselors. The review provided an overview of coronaviruses, COVID-19, past and present pandemics, and healthcare workers' lived experiences working during a pandemic. In further exploration of research, there was a gap in finding relevant information to solely reflect mental health clinicians' lived experiences during a pandemic. Information collected on healthcare workers' perceptions during past and present pandemics supported this research. The next chapter will discuss the methodology used for this research. The chapter covers the research design, my role as the researcher, the collection of data, and issues of trustworthiness. The chapter will conclude with a summary.

Chapter 3: Research Method

This interpretive phenomenological study was conducted to explore the lived experiences and interpretations of outpatient community mental health professional counselors building a relationship with clients during the COVID-19 pandemic in Michigan. Even though the outbreak was unexpected and led to many businesses closing their doors, work did not stop for those working in the mental health and healthcare industries. The psychological toll of the disease affected both the public and mentally ill populations (Moreno et al., 2020). Previous responses to pandemics and epidemics addressed the strain on healthcare workers but has not included those who work with mentally ill clients (Moreno et al., 2020). To date, there has been no known research recognizing outpatient MHCs working in the capacity of licensed professional counselors (LPC) and limited license professional counselors (LLPC) in the state of Michigan building relationships with their clients during the COVID-19 pandemic. This chapter focuses on the research design, its rationale, and the methodology used for this study.

Research Design and Rationale

Research design is a critical approach that helps researchers achieve the desired goals of the project (Creswell, 2018). Qualitative research is derived from a methodological way to understand how people view, approach, and experience the world and make meaning of it (Ravitch & Carl, 2016). A quality research study must be able to withstand rigor (Conway, 2003). This method allows the researcher to be immersed in the participants' experiences (Errasti-Ibarrondo et al., 2018).

The purpose of a qualitative phenomenological study is to understand the human

involved in an experience and how a phenomenon is perceived so it can be put into context (Dawidowicz, 2016). Specifically, interpretative phenomenological analysis (IPA) was used, which was first developed in the 90s for health and clinical counseling psychology (Eatough & Smith, 2017). IPA incorporates the concept of phenomenology developed by Edmund Husserl, helping researchers gather detailed descriptions from studying people ideographically to obtain an in-depth exploration of participants' lived experiences and how they make sense of them (Pietkiewicz & Smith 2014). IPA probes participants in detail, allowing researchers to understand how participants make sense of their own experiences (Smith & Osborn, 2007). The multi facets of information move the research from description to interpretation to help the researcher better understand the phenomenon (Conroy, 2003). Furthermore, phenomenology captures the experience of unexamined everyday lives (Merriam & Grenier, 2016). The research design helped to answer the research question and achieve the desired objectives of the study. The research question for this study was, "How did outpatient community mental health professional counselors experience and interpret building relationships with their clients during the COVID pandemic in the state of Michigan?"

Rationale

Given that IPA is an extended qualitative inquiry, it helped to explore the phenomenon of the experiences of mental health clinicians' during COVID-19. IPA aims for flexibly, details, and explores a phenomenon of concern in small sample sizes (Smith &Osborn, 2007). The phenomenological approach incorporates the hermeneutical spiral of interpretation to achieve a relationship between the researcher and participant to help

reflect and interpret the nature of the results (Conway, 2003). Therefore, the findings of this study will mirror the multiple realities within the learning trends and social frameworks. When using IPA, the researcher should be analytic, organized, self-aware, and have good recording keeping skills (Engward & Goldspink, 2020). In this study, the participants provided their perceptions that contributed to understanding their experiences, challenges, and trends of their work activities during the pandemic. Utilizing this design laid the groundwork for exploring the lived experiences of mental health clinicians. The research design helped to document the counselors' experiences whose impact will help close the gap in research related to mental health clinicians and their perceptions while building relationships with clients during the COVID-19 pandemic.

Role of the Researcher

According to Dawidowicz (2016) when using qualitative phenomenology research, the researcher explores, gathers, organizes, and analyzes experiences of a phenomenon from participants. Merriam & Grenier (2019) were not interested in participants' surface opinions but what is the actual meaning of their experience. It is also the responsibility of the researcher to analyze the interpreted data from participants. Additionally, according to Bengtsson (2016), researchers should identify external and internal sources that may influence the shaping of the research.

To conduct a phenomenological study, the researcher must possess several desirable characteristics, including the ability to ask good questions and fairly interpret answers, receive information in a variety of formats, remain adaptable, and have a firm grasp of the problem at hand (Neubauer et al., 2019; Yee, 2019; Yin, 2017). To avoid any

conflict of interest I was not in direct contact beforehand with the participants used for this study. I possessed the necessary skills and training to perform the designed study where the skills included listening and interviewing abilities.

I used an instrument to collect data through semi-structured open-ended questions. In this role, collecting, processing, and analyzing gathered information from participants was my primary focus. My role also included actively listening to the participant's experience during COVID-19. Gaining an in-depth understanding also was equally important while collecting data during interviews.

My goal with each participant was to build a rapport and make each participant feel comfortable enough to share their experiences with an assurance of keeping all shared data confidential. Included as my role as a researcher was transparency with participants by being forthcoming as it related to recording the interview and how their data will be utilized. I also explain to participants their voluntary participation and the option of withdrawal at any time during the interview without intimidation or retaliation to complete the interview.

Methodology

The methodology of a study refers to where ideology and epistemology meet the research approach and specifically shape the research methods to collect and analyze data (Ravitch & Carl, 2016). Data collection and understanding of the phenomena studied happens simultaneously to the specific experience (Qutoshi, 2018). In this section, I will provide detailed information on participant selection, including strategies and sampling size, as well as the instrument used, procedures for recruitment, and the data collection

and analysis procedures.

Sample Size

According to (Tisdell, 2015) researchers need to determine sample size before selecting participants. When considering a sample size for qualitative studies, the main concept is saturation, which is generally tied to a methodology (Malterud et al., 2016). I aimed to interview ten participants and a stopping criterion for a saturation of three, the stopping criterion is the number of additional interviews with no new themes (Francis et al., 2010). Providing a sample size of ten should provide an appropriate amount of data to reach saturation in understanding the phenomenon (Alase, 2017).

The study utilized a purposive sampling method (Sharma, 2017) to determine which participants met the predefined criteria for the study. The participants were comprised of limited (those who have not completed the requirement for the State of Michigan licensure) and fully licensed professional counselors who have met the requirements by the State of Michigan in completing the number of supervision hours and passed the National Counselor Examination (NCE).

Participant Selection

I recruited participants from social media through fliers and local outpatient community mental health centers (CMHC). Social media recruitment occurred through two Facebook groups called Michigan LPCs Advocacy and Michigan Counseling Association. I obtained permission from group supervisors to make a general post detailing the purpose of the study and identifying the criteria to participate. In addition to online recruitment, I contacted several outpatient CMHCs requesting contact information

from a phone call to the office via the contact information on their website and social media pages. I was able to identify a point person to send an email for distributing a mass email to staff as well as some posted flyers detailing information for the study.

The population identified in this study are those licensed through the State of Michigan as professional counselors. The sampled population for the study met the following redefined requirements: there is no gender preference, three or more years of experience postmaster degree, working in the field of mental health as a limited or fully licensed professional counselor with the State of Michigan and employed full time during the first wave of COVID-19 to present at an outpatient community mental health center in the Metropolitan Detroit area.

Instrumentation

Researchers utilize instruments to collect relevant information from participants. The main principle of phenomenological research is to gain insight from the perception of participants (Matua, 2015). Research conducted by Bevan (2014) suggested collecting data starts with phenomenological methods such as intuiting which remains flexible and practical and that the researcher is immersed in this method from start to finish.

In this study, I served as the instrument to collect data using semi-structured interviews. This method offered a flexible interviewing style (Dejonckheere & Vaughn, 2019). Through this style, I employed the use of open-ended questions to collect data and explored the thoughts and feelings of participants (Dejonckheere & Vaughn, 2019). Utilization of this style provided a strong foundation for probing follow-up questions and exploring deeper feelings related to working during COVID-19.

Face-to-face interviews were not utilized to collect data because technology was used to both recruit participants and collect data. The sampled population received an email invitation to use Zoom as the method of virtual communication for interviews. Zoom provides videotelephony and online chat software as a platform used for teleconferencing (Spathis & Dey, 2020). The recording of the live session was in the form of data. The interviews were audio recorded by Zoom, to my computer which is equipped with password and authentication verification process for safety measures. All of the recorded sessions were transcribed and turned into a portable document format (PDF) and saved on my computer.

Data Analysis Plan

I built my data one participant at a time before going to the next interviewee. Utilizing this method helped me decide if different questions needed to be asked. After completing each interview, I analyzed the data using the recording from Zoom. Once handwritten notes were gathered, and audio was saved to an encrypted file, Microsoft Word 365 recognition software transferred the audio voice file to a texted document.

The collected data from the respondents was analyzed manually to identify themes and categories. The data was transcribed into a written format to start the interpretation process to identify themes and categories. The themes and categories were grouped for identification of word frequencies to interpret results. Once redundancy was reached from not having any new themes, the data reached saturation (Braun, 2019).

My next step, I utilized backup planning by using a password secure cloud service called Dropbox. This plan enabled me to guarantee the security of the data collected from

the respondents which will be stored for five years after the completion of the study. In securing the data collected on my computer, I secured the gathered data by enabling a password and fingerprint login for my computer. Once logged into the computer, data is stored in a password enabled encrypted file on my computer where the computer is kept at home within my personal room because I am the only person authorized to enter the room and it is always locked.

Issues of Trustworthiness

Trustworthiness is a critical component of the qualitative process. In qualitative research, the researcher must adhere to a perspective and achieve rigor for results to be trustworthy (Bengtsson, 2016). Establishing trustworthy data also includes creditability, transferability, dependability, and confirmability (Lemon & Hayes, 2020; Lincoln & Guba, 1985). To determine credibility, the researcher must develop a level of confidence with the findings, and transferability relates to the findings being applied in other contexts and settings (Lemon & Hayes, 2020). Dependability provides consistency across data and confirmability accounts for the findings being true of lived experiences and not presented as the researchers' own biases (Lemon & Hayes, 2020).

The research focused on the four general criteria in ensuring that issues of trustworthiness are addressed. For this reason, I ensured that credibility, dependability, confirmability, and transferability were utilized across the data collection. The ideal theory of phenomenological design is to describe concepts and principles utilizing the opinions of the research participants. Thus, the study applied the interaction framework to demonstrate the narrative and descriptive capacity of the study. This facilitated creativity,

honesty, and discovery.

The study used protocols and procedures that readers consider to be worthy. According to Lemon & Hayes (2020), the criteria will include credibility and dependability to enhance the confidence of the audience in the results. The transparency in conducting the research and the value of the methodology promoted the validity and reliability of the results. These are critical issues to the usefulness and integrity of the findings. The purpose of focusing on trustworthiness is to ensure that the qualitative inquiry supports the findings of the study. Given that data analysis takes the inductive content analysis, it is imperative to ensure that the raw data triangulation.

During the interview process, I employed the use of reciprocity to improve trust and engagement. Being free from reflexivity enhanced the interview process by avoiding premature interpretations and world views. I needed to conceptualize information to maintain quality and trustworthiness. Additionally, providing transparency of the process and how data was used would be an equal factor.

Ethical Procedures

I obtained permission from Walden University review board to conduct my qualitative study. An informed consent form was provided to participants by email disclosing the nature of the study. The form provided detailed information regarding the protection of their name, phone number, email address, and workplaces reported in the study. Participants were informed of their rights to withdraw from the study and will be assured of continued privacy of their personal information. I provided participants with at least five days to review the consent form before returning in the event of any questions

or concerns before the study. I am also held to strict ethical guidelines to prevent any unethical behaviors. For this reason, I adhered to seeking the consent of the participants before the interview commences. I also protected the privacy and anonymity of the participants. Additionally, the participant's personal information was not disclosed and remains confidential. All recordings and transcriptions are kept in a file on a password protected desktop computer and safely kept within my room for no authorized access.

Summary

This chapter began with an introduction and overview of the problem. A qualitative phenomenological approach guided this study. This study captured the data obtained from semi-structured interviews documenting the live experiences of clinical mental health professional counselors. In concluding the chapter, a discussion related to trustworthiness and ethical procedures was addressed. The next chapter will outline the results, discussion of the findings, and how they will be presented using a table.

Chapter 4: Results

The purpose of this qualitative IPA study was to explore the experiences of outpatient community MHCs that are limited and fully license professional counselors (LLPCs & LPCs) in the State of Michigan. I wanted to understand how MHCs interpreted building relationships with their clients during the COVID-19 pandemic. This chapter contains results answering the research question: How did outpatient community mental health professional counselors experience and interpret building relationships with their clients during the COVID-19 pandemic in Michigan? In addition to the results, this chapter will provide the setting and participants' demographics. Further explanation will also be provided on the process used to analyze transcripts from the nine individual interviews as it relates to coding, key themes, categories, and analyzing the data. The chapter will conclude with a summary of findings concerning the research question.

Setting

For scheduling convenience and protection from the still circulating variants of COVID, participant interviews were conducted virtually via Zoom in my home office. Each participant entered the virtual room as a guest with no video feed to protect their identities. Participants agreed to have their audio recorded to capture their responses and stated they were in an area where they can speak confidentially and free from distractions. The setting for each participant was quiet with little to no background noise.

Demographics

IPA studies generally focus on a small sample size (Alase, 2017). The sample size for this study consisted of nine participants: two males and seven females. There was one

limited license professional counselor (LLPC) and eight fully license professional counselors (LPC) all employed full-time from January 2020 to February 2024 at a community mental health center (CMHC) in the metropolitan Detroit area of Michigan. Participants chosen to take part in the study have a postmaster degree for at least 3 years and provide counseling for individuals seeking mental health services.

Data Collection

I received IRB approval January 2024 to start the process of recruitment. There were 13 willing participants who responded to the participant wanted flyer by email. I sent a reply email to each respondent thanking them for their response, introduced myself, and provided more details about the study to ensure participants met the criteria. The reply email included several dates, times, or an option to send their availability as I wanted to be flexible. I also attached the consent form to the email.

After assessing the participants' responses nine participants met the criteria and were willing to participate in the study and were asked to read the consent form. These nine participants provided their consent by email indicating the words "I consent," along with a confirmation of an interview date and time. Once consent was received back, a Zoom invitation was sent immediately with the agreed upon date and time to each participant. I provided each participant with a confirmation email a day prior to their interview as a reminder.

Data collection was conducted from semi-structured open-ended questions for each participant. Participants consented to an hour interview, but on average the interviews lasted about 40 minutes. To protect the identities of the participants, each

participant was assigned a participant number beginning with the letter P and the number assignment 1 through 9. During the interviews, I utilize the participant identifiers to take notes in a journal to notate words that stood out during the interview. Because of using IPA, I immersed myself in the data by taking notes and using Microsoft Word to transcribe the audio data.

After each interview, audio was stored on a personal desk top computer with password and fingerprint encrypted access, there was also a password protected file for each participant, which included their audio and transcription. Participants for the study received a summary by email as well as a $5.00 e-gift card to the Five and Below store for participating in the study. All nine participants responded back by email with the words “thank you.”

Data saturation was met at participant six, and I continued with the interviews of the remaining three participants. There were no variations in data collection from the plan presented in Chapter 3 nor any unusual circumstances were encountered in data collection.

Data Analysis

Experiences can be subjective in meaning; therefore, to analyze the data, I was consistent with the research methodology of IPA. According to Eatough and Smith (2017), “attending to things that matter to people means distinguishing between different parts of experience and making decisions about which parts to focus on” (p. 8). In keeping with recommendations of Nowell et al. (2017) to start the analysis process, I uploaded each participant audio file to Microsoft Word 365 for the software to transcribe

the audio file. After the first participant file was transcribed, I compared the transcription to the audio file. This process took some time because I focused on words that were incorrectly transcribed, and I wanted to improve the accuracy of the transcript. During the transcription process, I immersed myself in the data, listened to the audio several times and made any necessary edits before moving on to the next step. Once edits were complete, the audio file was saved as a portable document format (PDF) with the code of P1 in an encrypted folder. Each transcription was filed in the same subsequent manner with the letter "P" following the participant number.

When analyzing each individual participant's data, I printed out each transcript. This process allowed me to take efficient notes and to focus on one participant at a time. I listened to the audio file several times, pulling out key words, and phrases that were significant either because the key words were from the literature or had been repeated in other interviews. All key words and phrases were written on the left side of the printed transcript. During the analysis process, I began to identify codes based on repetition or affinity to other similar meaning words. Then I placed similar meaning into categories. These steps were in place for each participant.

Emerging patterns arose by the sixth participant answering the research question and these patterns were identified as themes. I continued with three more participants to ensure saturation of the analysis for trustworthiness. After the analysis of the transcriptions was completed three major themes emerged. These themes are discussed further down in the chapter in the Results section. I cross-referenced all my data along with my notes to ensure that I interpreted each participant's experiences.

Evidence of Trustworthiness

Trustworthiness is a vital aspect of research. In qualitative research there are several components to show evidence of trustworthiness such as credibility, transferability, dependability, and confirmability (Wood et al., 2020). Trustworthiness also upholds the way in which I collected the data, transcribed, and stored it.

Credibility

To ensure credibility, I made sure each participant met the criteria of the study. I responded to each participant's inquiries as it related to the study before the interview process began. During the interview process audio was recorded and transcribed for an accurate account of participant experience and interpretation. The IPA method and credibility parallels as both employ the assurance of telling the true stories of participants. Each participant received an email summary of their responses. The summary captured their interpretation and experiences related to building relationships with clients at the time of learning of the pandemic, during the stay-at-home order, and after the order was lifted.

Transferability

Transferability provides the means for others to duplicate this study. I provided the process, some raw data from participants, and research methods for others to achieve comparable results. I used true descriptions of participants' experience and interpretation by using exact words in this study to enhance transferability. Providing true descriptions from participants will allow results to be transferred to another context (Smith et al., 2012).

Dependability

Dependability means having consistent reliable information. My study provides dependability by having a clear outlined collection of data that accurately captured the information from each participant. My intent for this study is for readers to immerse themselves in the data. I would like for readers to reflect on what they read in the study and capture the same experiences of the participants. The results were reviewed with committee members to ensure the data is traceable and clearly documented.

Confirmability

According to Ravitch and Carl (2016) when the researcher does not include their own personal opinions with the experiences of their participants then confirmability has been met. Confirmability was reached because my interpretations were obtained from the collection of data allowing me to demonstrate how the conclusion of the study has been reached. Bias was absent from this study to ensure accurate data collection and analysis. I used a guide to assist with interview questions to aid in a semi-structured interview format. I also obtained participants from a circulated flyer and social media; I did not coerce participants in volunteering for this study.

Results

The purpose of this study was to capture and understand the live experiences of outpatient community mental health counselors while building relationships with their clients during the COVID-19 pandemic. The research question addressed was "How did outpatient community mental health counselors experience and interpret building relationships with their clients during the COVID-19 pandemic in the state of Michigan?"

There were 26 interview questions that provided a rich collection of data as it related to how nine participants engaged with clients prior to the pandemic, during the pandemic, and after the stay-at-home orders were lifted by Michigan's Governor. The themes that emerged from the analysis of the data collected in the interviews were (a) mental health counselors' interpretation of the meaning of client engagement, (b) mental health counselors' interpretation and experience with COVID-19 protocols, and (c) mental health counselors' interpretation and experience of building client relationships during the COVID-19 pandemic.

Theme 1: Mental Health Counselors' Interpretation of the Meaning of Client Engagement

Participants were asked, "What does client engagement mean for you?" P1 responded by stating, "engagement depends on the client, those that are willing to participate in counseling voluntarily, engagement is easier than those that may be court ordered and/or petitioned." At the community level, there is an array of clients that come through the door for treatment. Most clients seeking treatment have a severe mental illness (SMI), are noninsured or have Medicaid or Medicare. Some clients may be seeking outpatient services because of a recent inpatient psychiatric hospitalization, court order, exhibiting harmful behaviors, parole or probation requirements, and homelessness.

According to P3, "the process of engagement starts at the beginning when intake takes place." When clients are seen by MHCs, they build on a therapeutic relationship which includes making a connection, having rapport, building trust, and reaching out to clients to check-in. MHCs reach out to clients when they miss appointments or have been

hospitalized for inpatient psychiatric treatment.

MHCs want to ensure compliance for their clients to keep a connection and to show support. Clients typically receive phone calls or a no-show letter if an appointment is missed. If a client does not show up for an appointment, the counselor will click "no show" in the client electronic chart, which generates a letter for the counselor to mail out. If there is no response back from clients, counselors continue to connect by sending additional correspondence, more phone call attempts, and in some cases contacting emergency contacts. After a grace period of noncompliance, the counselor will close the client's case.

During the therapeutic relationship with clients, counselors pay close attention to the clients' body language as well as exhibit certain body language themselves. P4 reported, "the use of leaning in to show interest or using a simple empathic gesture like providing a tissue" is a form of engagement". MHCs make engaging eye contact or provide a nod to let the client know that they are actively listening which provides a nonverbal line of communication. This communication shows the client that they are being attentive to their needs and provides an understanding of what is being told.

In addition to nonverbal cues, counselors engage clients by saying words to let clients know they are listening by saying such phrases as, "how did that make you feel" or "tell me more." In providing face to face sessions, counselors provided gestures and were able to effectively notice cues from clients as it relates to how engagement was going. According to P9, "gestures build a connection between counselor and client that employs rapport and trust".

Providing mental health services in an intimate setting can also assist with client engagement. P7 states that, “intimacy provides an alliance that shows the counselor as a supportive person that the client can confide in, it is a nonjudgment zone”. Counselors utilize their offices as intimate settings to conduct engaging activities such as games, puzzles, the use of sand, drawing, painting, and writing exercises.

The engagement with clients never stops, it starts with the intake and does not end until the client’s case closes with the CMHC. According to P6, “the engagement process is ongoing, we are always engaging”. Counselors continue to build rapport, trust, provide support, show transparency, and maintain a connection with clients. Being able to build upon these things, have a mutual understanding between the counselor and the client, provides effective treatment planning for mental stability and can keep the therapeutic relationship intact with clients.

Theme 2: Mental Health Counselors’ Interpretation and Experience with COVID-19 Protocols

Participants shared an overall experience of a lack of communication about how to support their clients during COVID-19. CMHCs have routine protocols in place to promote the health and safety of their staff and clients. Participants in this study discussed the protocols at their CMHCs. The standard protocols in place for staff and clients include inclement weather and fire drills. However, in more recent years CMHCs added active shooter training for staff. These drills offer staff an identified protocol, direction, and survival techniques in the event of inclement weather, fire, or when encountering an active shooter. CMHCs across the Metropolitan Detroit area have never

had any protocols for staff related to a global event, viral, or bacterial infection prior to January 2020.

Subtheme 1: Prior to the COVID-19 Pandemic

Participants were asked, "What protocols were in place at your center in the event of a catastrophic event prior to the COVID-19 pandemic?" P1-9 responded by stating, "the protocols in place were for inclement weather, fire, and more recent active shooter". The CMHCs had no protocols in place as it related to viral or bacterial infections, hence in the event of an epidemic or pandemic such as COVID-19.

In Michigan, inclement weather consists of floods, tornados, and snow. Most outpatient centers list procedures for emergencies in a handbook for new hires and digital access on the company's website. The protocols that are provided to staff entail what to do if you encounter an active shooter, evacuation routes for fire, safety areas within the building event of a tornado, and if there is a snowstorm. In the event of a snowstorm the CMHCs are aware ahead of time, an announcement is made the day before to staff or sent to local news to report a closure. If snow conditions worsen throughout the day, then an early closure is announced for the safety of staff and clients. For any event, the protocol is for staff to contact the clients on their caseloads.

Subtheme 2: Learning of COVID-19

Participants were asked, "What protocols were put in place once your organization learned of COVID-19?" P5 responded, "This was the first of its kind" and "no one knew what to do". The first identified case in Michigan took place March 10, 2020. MHCs were fearful, frustrated, overwhelmed, and dealt with a lack of

communication at their CMHCs. At the time of learning of the pandemic, counselors considered themselves as frontline workers because of the responsibility they had to their clients' wellbeing.

According to P5, "clients were dealing with the same upset of uncertainty as counselors". MHCs remained fearful, frustrated, and overwhelmed during this time because of the associated risk of being on the front-line to provide psychotherapy to clients. There were client questions and cancellations during the time of learning of COVID-19. The centers provided and implemented the use of personal protection equipment (PPE) before the mandatory shut down by the Governor.

At the time of learning of the pandemic, utilizing PPE was supposed to make staff feel protected however it was not enough to stop the spread of the virus and the fear exhibited from counselors and clients. P1 reported, "I feared for my life and was scared for clients because people were dying." P3 stated, "no one wanted to die, and it seems as if everybody was dying, my clients would tell me, I don't want to die".

Once protocols were figured out by the CMHCs, it was required to practice social distancing, wear face mask, disinfect hard services, and use sanitizer before and after clients. The CMHCs also implemented hybrid schedules created for staff that shared offices to reduce transmission and overcrowding of staff and clients. If counselors had to communicate with other staff, it was by phone or email. This practice continued until new recommendations related to COVID-19 changed how existing protocols were managed. Learning of the pandemic was an uncertain time for clients and counselors.

Subtheme 3: During the Stay-At-Home Order

Participants were asked, "What protocols were in place during the stay-at-home order from the Governor?" According to P7, "media coverage and reports from the Center of Disease Control (CDC) was disheartening, there was no control over the virus and the spread". At the beginning of the stay-at-home order, counselors were working as frontline workers. To prevent close contact all information related to scheduling, supervision, resources, and other questions were sent through email to prevent gatherings in the office.

MHCs were still seeing clients although some canceled appointments due to the virus while others continued services. Communication mostly took place virtually by using video conferencing for large staff meetings and to keep staff up to date on protocols. P4 reported, "this was such a frustrating time considering no one knew what to do or an effective way to get things accomplished". There were new protocols on a regular basis based on information from the CDC, media outlets, and Michigan's' Governor. The Governor of Michigan was responsible for the details and requirements of the stay-at-home order.

During the time of Michigan's' stay-at-home order implemented on March 24, 2020, and lasted for 70 days, residents were required to stay-at-home to suppress the spread and to prevent hospitals from being overwhelmed with cases of COVID-19. Depending on the mental health setting some counselors remained as frontline workers. For example, those who worked in an inpatient setting or nursing home continued to work for facilities that remained open despite the stay-at-home order. P6 reported, "there

was so much confusion, were we considered as frontline or not, would we remain open or not, we did not know".

In the executive stay-at-home order from Michigan' Governor certain places were able to remain open for in person services if it was necessary to sustain or protect life. The CMHCs had to follow up the County and State (funding sources) to see if they fell under the criteria to sustain and protect life. The protocols for CMHCs changed once again as outpatient services did not meet this criterion.

Counselors were informed by management that the center would be closing, and all active clients should be notified immediately. Once closed, counseling services would at this time be provided telephonic and virtually. P6 states, "we were provided with different modes of communication to continue engagement with our clients". P8, responded by stating, "we had to meet clients where they were at, we had to be flexible as it related to services." Counselors were informed to update consent forms for each active client. The new consent form included how services would be delivered and the additional risk associated with service delivery such as confidentiality. This information was provided by email and postal mail for client signatures.

MHCs were required by their CMHC to continue to engage with their clients. P4 reported, "we were required to checking in on clients regularly by phone, especially for those clients that did not have technical equipment". For those that did not have working phone numbers counselors and support staff mailed letters to engage with services. In some cases, counselors were asked to drop off consent forms while practicing social distancing guidelines to ensure safety. Due to the changing coverage of the pandemic, the

extended executive stay-at-home orders, and ever-changing protocols from their CMHCs counselors experienced uncertainty, frustrations, and faced the unknown during this time. CMHCs provided flexibility for counselors encouraged to continue to engage in therapeutic relationship with their clients.

Subtheme 4: After the Stay-At-Home Was Lifted

Participants were asked, "What protocols were in place once the stay-at-home order was lifted?" The executive stay-at-home order was lifted for Michigan on June 1, 2020. P4 shared, "it was hard not seeing others, not being able to hug someone, there were no longer empathic gestures". Counselors remained telephonic and virtual for some time. The CMHC remained flexible regarding client services. A few weeks after the order was lifted other local businesses slowly reopened with limited hours. The CMHC continued to remain remote with the same protocols in placed.

Over time, the protocol changed once again for counselors. They were slowly able to come back to the center on a hybrid schedule. There was still a limited about of clients back at the CMHC for face-to-face sessions. Counselors were virtually speaking to clients at the CMHC for those who did not want to meet face-to-face. According to P2, "clients continued to engage with me and were more compliant than ever before with outpatient services because of the flexibility offered for treatment services".

On September 9, 2021, the Biden Harris Administration mandated that healthcare settings that receive Medicaid and Medicare reimbursements, staff had to obtain the COVID vaccine. CMHC protocols continued for counselors and clients that were coming into the office, counselors were instructed to continue to wear masks, practice social

distance, and disinfect. However, there was yet again another protocol for counselors, an additional one but this time it was mandated. According to P3, “vaccinations were mandatory to remain employed with the CMHC, no one wanted it because the vaccine was developed too quickly, it was a lot of conspiracy surrounding the vaccine”. Counselors experienced dissatisfaction with the mandatory COVID vaccinations. Some were excluded due to religious beliefs, while others felt a responsibility to their family and clients to get the vaccination.

As time passed, and positive COVID numbers were decreasing the protocols for wearing a mask became optional. P6 mentioned, “office schedules continued as a hybrid schedule and clients had a choice to continue virtually or come in the office for sessions”. Counselors continued meeting clients where they were at by being flexible. Counselors started seeing clients for home visits for those clients that previously had in home services. Counselors have new protocols in place in the event of another deadly circulating virus. Counselors in this study discussed how being flexible with these new protocols improved compliance with clients and kept clients engaged in treatment services.

Theme 3: Mental Health Counselors’ Interpretation and Experience of Building Client Relationships During the COVID-19 Pandemic

During the stay-at-home order, CMHCs had to figure out how to keep staff and clients safe. P2 reported, “they feared the unknown for themselves, family, and clients in which they service”. The CMHCs in the Metro Detroit area was the hardest hit area with increasing COVID-19 positive cases and deaths, especially in the county of Wayne.

During the pandemic there was a lack of resources available, and it was difficult to support clients' needs during this time." P9 reported, "everything was at a standstill, there were not any new referrals coming into the CMHCs to start new services, some staff were out sick, and it was an uncertain time, every circumstance was new".

MHCs experienced heighten emotions because of the increasing COVID-19 numbers, death toll in the surrounding CMHC area, and overall numbers across the United States. Counselors communicated with each other and with upper management to figure out how to continue client care. P8 stated, "I was overwhelmed with the needs of my clients and home life, because I was working in a public setting my family was fearful". During the time of learning of the pandemic, it was a great concern of spreading the virus to vulnerable populations. There were reports from the media and CDC regarding individuals with medical concerns, poor immunity, and the elderly being at grave risk.

MHCs at the CMHC level were used to outsourcing for client needs and providing referrals for food, utilities, housing, and employment assistance to name a few. P6 stated, "because everything was shut down, it was chaos, no one knew how to cope". Counselors had to get accustomed to not helping clients face to face but remotely, which was overwhelming for some.

For MHCs, there was a lack of communication and direction from the CMHC at the start of the stay-at-home order with established clients. Eventually it became more apparent to remain transparent with clients to keep the relationship intact. Counselors wanted to "meet the client where they are at" meaning being flexible in providing the

necessary mental health services to their clients. Allowing flexibility provided a platform for clients to still have the necessary support in uncertain times. P2 states, “those clients that were at one point noncompliant with treatment services now were compliant because of the flexibly”. Compliance with treatment numbers were higher than before the pandemic because barriers such as transportation, work, or childcare were no longer a factor.

During the shutdown, counselors did not lack a connection with their clients but there was a lack in intimacy. P1 responded by stating, “I missed the intimate setting where I was able to observe a client’s status face to face”. The closeness of seeing a client face to face meant they were able to assess their appearance, notice body language, or personally hand a client tissue to show an empathic gesture.

Despite the lack of intimacy, client connection remained by providing client check-ins. This process did not change as this was the same process prior to the pandemic except for it being remote. Counselors provided the same sentiments as it related to if clients missed an appointment or have not been compliant with services. They continued to provide follow up calls and send out letters to keep the therapeutic relationship intact.

During the shutdown MHCs had to be creative. P9 stated, “to keep clients engaged screens were virtually shared for virtual appointments at times or therapeutic assignments were personally delivered”. For virtual sessions clients were able to select the camera off option for privacy while in their homes or go outside the house to ensure confidentiality while in sessions.

The experience of building relationships with clients during the pandemic was

tough at the beginning. However, as time went on it got easier, and it became the norm. According to P2, “clients needed to keep the therapeutic relationships going as well as the counselor needed to know that their clients were okay”. Counselors refocus their abilities from in person services to remote. MHCs’ listening skills became sharper and were now known as primary for noticing cues from clients. Counselors were able to determine a clients’ current state by their voice, long pauses, breathing, or avoidant behaviors that was outside of the norm.

Summary

The data provided in this study was obtained by using IPA as a method to explore the experiences of outpatient MHCs. I was able to interview nine participants using semi-structured interview questions. Each participant committed to an hour Zoom virtual session. Each session had its own individual invitation link to ensure confidentiality.

I asked participants permission to record responses anonymously to collect data. I uploaded audio files to Microsoft 365 to transcribe the audio. During the process of reviewing transcripts and recordings from participants, I discovered three themes that answered my research question, how did outpatient community mental health counselors experience and interpret building relationships with their clients during the COVID-19 pandemic in Michigan.

Participants reported client engagement is when you build a connection, rapport, trust, show transparency, and create a bond to uphold the therapeutic relationship. Prior to the pandemic there were no protocols for a deadly circulating virus. Most of the protocols were for inclement weather, fire, and active shooter. No one knew what to do during the

time of the pandemic as it related to client care, counselors had uncertainty, fear, and frustrations.

Recommendations were followed based on the CDC and Michigan's Governor. Prior to the shutdown PPE was provided to keep clients and staff safe. Counselors were also instructed to go on a hybrid schedule. The shutdown created new protocols in which counselors had to see clients virtually or provide sessions by phone.

After the stay-at-home order was lifted, protocols remained in place to keep staff and clients safe. A hybrid schedule remains as well as the flexibility to see clients, face to face, virtually, or provide teleconferencing. MHCs believe that the pandemic opened doors to keep client's compliance with treatment services. Clients experience less barriers than before the pandemic due to the flexibility provided by CMHCs.

In this chapter, I described the setting, participant demographics, data collection process, reported how I analyzed the data, trustworthiness, and the results. The results included overviews of participants interpretations and rich responses from participants. Chapter 5 will conclude the study by providing interpretation of the findings, limitations of the study, recommendations, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Involvement during a pandemic creates traumatic and stressful experiences, which create mental health risks for staff and impacts mental health services during a pandemic (Choi et al., 2020). The purpose of this study was to capture the thoughts, feelings, emotions, and subjective meaning attributed to the way MHCs were able to build relationships with clients during the COVID-19 pandemic. This study took place in the metropolitan Detroit area, which had high COVID numbers. This study was significant because I sought out to explore the experiences of MHCs specifically employed January 2020–February 2024 because of when the United States identified its first positive case and the year of this publication as post COVID experiences. My research uncovered the unique and individualized experiences of participants who worked in an outpatient CMHC setting in Michigan. CMHCs provides an array of services for all types of clients; however, their main focus is mostly geared towards individuals with SMII utilized a qualitative, interpretative phenomenological approach to understand how counselors interpreted building relationships with clients at a time when most exhibited fear and uncertainty. Participants viewed client engagement, protocols, and how they built relationships with clients during a time when there was a drastic change to service delivery. In this chapter, I will discuss the interpretation of my findings. There will also be a discussion on the limitations of the study and recommendations. I will also provide my implications for the study and conclude with my final thoughts.

Interpretation of the Findings

My review of literature revealed a gap as it relates to other professionals such as the ones presented in this study. Although there was a gap for this discipline, HCWs experienced some of the same emotions and challenges as MHCs in the presented findings. There were no studies found that explored the experiences and interpretations specifically of professional counselors working at a CMHC attempting to build relationships with clients during the COVID-19 pandemic, hence the reasoning for this phenomenological study. There were several identified themes presented in this study that applied to each participant's experience and their interpretation during the pandemic. While each counselor had their own unique experiences, they shared the same sentiments on protocols and client engagement on how they built a relationship with their clients during the pandemic.

Meaning of Client Engagement

Participants mentioned that engagement in a CMHC setting is based on each client individually. If the client is court ordered or petitioned for mental health treatment, then engagement is slightly harder than those who are willing to obtain mental health services voluntary. Most reported engagement with clients never ends; it starts at the beginning during the intake process until the case is closed. Participants in this study expressed that it was important to have rapport, trust, transparency, and respect while building a relationship with clients. Data showed that participants believed having these qualities in a therapeutic relationship keeps it intact. Several participants stated, "A good relationship helps clients stay in therapy." The literature also noted that the counseling

relationship involves establishing trust and avoiding actions that may harm the client (Ybanez-Liorente, 2018).

Experience with COVID-19 Protocols

The changing protocols produced a stressful environment as participants attempted to obtain a process for their clients. Providers providing treatment are vulnerable to emotional distress due to their possible risk of exposure (Pfefferbaum & North, 2020). Participants reported there was a lack of communication and direction from management. Effective staff support, moral support, careful planning, and psychological support may benefit staff during a pandemic (Maunder et al., 2006). Several participants stated, "there were no protocols in place for a deadly viral infection until the pandemic occurred in Michigan." Because the CMHC has never experienced staff working during a pandemic, there were no protocols in place to support staff and plan out efficient protocols when learning of COVID-19. Participants concurred in stating that prior to the pandemic the only protocols in place were for inclement weather, fire, and for an active shooter.

Experience of Building Client Relationships During the COVID-19 Pandemic

When participants learned of the pandemic, they experienced fear, a lack of communication, and feelings of being overwhelmed because of the uncertainty of the unknown. Despite emotions and other distress, frontline workers were still saving lives despite lockdowns and public fear (Zhu et al., 2020). During the time of the pandemic participants experienced a breakdown in communication due to not knowing if they would continue to see their clients face-to-face as frontline workers. One participant

stated, “the lack of communication and protocols left us uncertain of the next steps.” Participants could not efficiently inform clients on what to expect regarding their treatment services.

Participants also mentioned that when the Governor of Michigan issued an order for a shutdown, they assumed the CHMC would remain open despite concerns of exposure. Several participants reported being relieved that they were not considered as frontline workers due to associated risk. The CMHCs implemented a remote method of communication to keep clients engaged with services. Participants contacted active clients by telephone, videoconferencing, text, email, and postal mail. This mode of communication was effective for some clients but not for all. Clients who receive services through community mental health are more vulnerable during a public health crisis (Druss, 2020). CMHC clients are mostly SMI clients, making it harder to track down these individuals for services. Participants reported that, “I had to be creative and think like my client,” “My clients never keep the same phone number,” and “I had to do a lot of outreaching.” Participants pointed out some challenges but made efforts to protect the well-being of their client for engagement in treatment.

The ACA (2014) suggests that counselors are expected to promote change to improve the quality of life by removing potential barriers that affect individuals and groups in which they counsel. Participants were able to provide flexibility as it related to the method of treatment services. This method helped with compliance for most clients that had potential barriers such as transportation, childcare, and work. Interventions such as incorporating telehealth to limit worry and fear for those needing assistance, being

flexible, and redesigning existing models of care assisted with the relationship with the client (see Smith et al., 2020). Despite the stress, frustration, and uncertainty during the pandemic the process of engagement remained intact. Participants kept a connection, remained consistent with reaching out, kept the line of communication open, provided the necessary transparency, was flexible with session options, and continued to build upon the therapeutic relationship.

Participants interpreted building relationships with their clients as being easier during the pandemic because the relationship that was built prior to the shutdown. Clients during this time were more forthcoming and less shy to engage. Several participants mentioned, "clients were in their comfort zone and did not have as many barriers as showing up for face-to-face appointments." Another participant stated, "clients were more compliant with treatment and willing to be themselves because of their familiarity with their own surrounding environment." During the time of the stay-at-home order there were little to no new clients attempting to establish new services. Referrals stopped and everything was at a standstill as it relates to new willing clients seeking mental health counseling.

It was also found that participants were able to build relationships with clients as before the pandemic; however, the biggest difference was they remotely provided services and thought of creative ways to engage clients. Listening skills were sharpened as they were able to notice cues on the client's mood by attentively listening. Prior to the pandemic when services were face-to-face, participants were able to physically see the client's appearance, body language, and fascial expressions.

Limitations of the Study

Findings in this study revealed rich data describing the interpretation and experiences of counselors who built relationships with clients during the COVID-19 pandemic. It was slightly difficult to recruit participants due to the criteria involved. There were several social workers, psychologists, and private practice practitioners who were interested in the study. However, the goal of the study was to capture experiences of a discipline that can be overlooked as well as the setting of a community mental health center. Because this study captured experiences of MHCs to think back to 2020, the next limitation may be some distortion of what occurred during a global pandemic. Lastly, another limitation is the use of the transactional theory of stress and coping (TTSC), which was the framework for this study. The appraisal process of this theory can influence the individual's emotional, physiological, and behavioral responses to the stressors.

Recommendations

Although researchers have conducted studies on how the pandemic affected staff and patients, I recommend further research to explore how other human service facilities implemented how to engage clients post pandemic. I recommend looking further into client compliance prior to the pandemic and post pandemic to determine what may lead to compliant clients seeking treatment. Providing strategies to assist staff with their clients and having protocols during a pandemic will produce a more efficient outcome for staff.

Implications

This study promotes social change through a better understanding of mental health professional counselors' experience building relationships throughout a global pandemic. This study provides awareness of the various accommodations used to continue to engage clients despite living through a tough time for most. There were several implications that resonated from the study findings regarding social change. This study could encourage outpatient CMHCs to create new protocols as it relates to process and procedures for counselors. In the event of a catastrophic occurrence, counselors would be better equipped to service their clients. This study also brings insight into how CMHC can be flexible, transparent, and have a streamline process for a better outcome on client engagement with their counselors. Providing essential planning for staff and clients will contribute to a better relationship.

Conclusion

The purpose of this qualitative IPA study was to understand the experiences of outpatient MHCs working during the Covid-19 pandemic. I chose this setting because engagement can be quite different between outpatient community mental health and private practice. In a community health setting MHCs mostly see clients that are low income, noninsured, or are Medicaid and Medicare recipients. These clients may also encounter several barriers throughout the treatment process while being serviced. In a private practice setting MHCs tend to work with clients who are privately insured and willing to seek services. However, whether in a community or private setting, when

working in the human services field MHCs tend to bridge a gap for the well-being of the population in which they serve.

Counselors lost clients, clients lost family members, and counselors lost their own family members during the Covid-19 pandemic. Despite the uncertainty, counselors continued to engage their clients regardless of the circulating virus. Counselors utilized tools such as video conferencing platforms like Zoom, Microsoft Teams, Face Time, and Google Meet to continue mental health treatment sessions. If clients did not have access or were unable to utilize conferencing tools, clients were able to have sessions by email, telephone, messaging systems for texting and/or chat, and in some cases dropped by the client's residence. As centers became accustomed to the different types of communication, Health Insurance Portability and Accountability (HIPPA) compliant technology was used to aid in confidentiality measures such as the use of Doxy me and by updating consent forms. Throughout the engagement process, MHCs experienced many obstacles. At the time of learning of the pandemic, counselors and clients did not know what to expect. As time continued clients and counselors gained momentum by providing treatment alternatives to better serve their clients. This led to a more efficient outcome for client engagement and help with compliant issues from clients with SMI.

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Appendix: Interview Questions

Hello, my name is Paulette Gaines and I want to thank you for taking the time out of your schedule to be interviewed for research related to your experience and interpretation of building relationships with clients as an outpatient community mental health professional counselor during the COVID-19 pandemic in Michigan. I would like to ask you a series of questions to capture your perspective during this time. At any time during the interview, if you feel uncomfortable or need to stop, please let me know.

Job Role and Experience

1. What is your current job title?
2. How many clients are typically on your caseload?
3. When we talk about client engagement, what does that mean to you?
4. Before the pandemic, tell me a bit about what methods did you use to keep clients engaged with mental services?

Learning of COVID-19 before the Shutdown

5. Do you remember and can you share with me some of your clients' concerns related to COVID-19 before the shutdown of face-to-face sessions?
6. In the event of a catastrophic event what type of protocols were in place for clients before the emergency stay at home ordered by the Governor?
7. Tell me how your organization communicated with staff about managing client relationships during COVID?
8. Were there other communications from the organization about COVID?

During COVID Shutdown

9. Tell me how did your organization respond to the mandatory shutdown?
10. Starting at the beginning of the mandatory shut down in April 2020, tell me what method or methods of communication were in place for clients?
11. Tell me how concerned you were about clients on your caseload? How did you manage your concerns?
12. Tell me about some of your clients' concerns? How did you support your clients' concerns?
13. What type of protocols were in place by your organization for clients during the emergency stay at home order by the Governor?
14. Tell me how you felt about the protocols your organization put into place for clients?
15. Tell me how effective were the protocols for clients?
16. Tell me how you felt about services and resources for your clients?
17. How did you manage when you were unable to communicate with clients face to face?
18. Tell me how did your clients manage not having in-person services during the shutdown?
19. Tell me how not being face to face affected how you related to your clients?
20. Tell me what you would have done differently, if anything, then your organization during the stay-at-home order as it related to client care?

After Mandatory Shutdown

21. In comparison to prior to the COVID shutdown how have things changed, if at all, with building relationships with clients?
22. Tell me how you feel present day about the relationships with your clients?
23. Present day, tell me what protocols are in place, if any, or what do you do for client engagement and building relationships?
24. Tell me how you think your organization is prepared to keep clients engaged if another stay-at-home order happens in the future?
25. Tell me how prepared do you feel with your clients if another pandemic occurs?
26. If you could change one process in building relationships with clients during a pandemic what would happen?

This concludes my interview, and I would like to thank you again for your time, I will send a brief 2-page summary of my findings to your email.