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The Lived Experiences of Clinically Licensed Counselors During COVID-19

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This is to certify that the doctoral dissertation by

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2025

Abstract

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Dissertation Submitted in Partial Fulfillment

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Abstract

The COVID-19 pandemic has proven to be an equal opportunity crisis. There is substantial research to better understand how individuals have reacted to crisis experiences like the COVID-19 pandemic. However, little is known about the lived experiences of clinically licensed counselors during COVID-19. This gap in the literature is important because the increase in the number of individuals seeking counseling to deal with their fears and concerns related to the COVID-19 pandemic may have put a strain on counselors that were also experiencing the effects of the COVID-19 pandemic. The purpose of this interpretative phenomenological analysis was to bridge the gap in the literature and to explore the lived experiences of seven clinically licensed counselors, in solo private practice, during the COVID-19 pandemic. Constructivist self-development theory provided the theoretical foundation for the study. A purposive sample of seven participants were recruited and participated in 60-minute semi-structured interviews about their lived experiences during COVID-19. Findings revealed the clinical counselors' professional and personal challenges as well as their areas of growth during the COVID-19 pandemic. The interpretative phenomenological analysis revealed the following emergent themes: private practice, COVID-19 quarantine experiences, counselor adaptations to COVID-19, and future research recommendations. The results of this study indicate the need for future research on clinical counselor wellness after a crisis situation. These findings implicate social change by increasing awareness of the possible long-term side effects of working with counseling clients during crisis situations.

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Dedication

This dissertation is dedicated to my amazing son, Chanz. I started my first master's program while you were still in my womb and you have been with me every step of the way as I have continued my education. Time and energy were sacrificed to complete my degrees and I often struggled with not feeling as present as I should have been with you. Despite all of our obstacles, you have always been my biggest cheerleader and I cannot thank you enough for that. You have blossomed into an outstanding young man, Kappa, and now…father! You, by far, are my greatest achievement and I stand in awe of the fact that I am your mom. Thank you for your continued support throughout my educational journey. This terminal degree is for the both of us. To God be the Glory! It is done! We did it, son!

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Chapter 1: Introduction to the Study

Introduction

Carl Jung (1963) stated, “The doctor is effective only when he himself is affected. Only the wounded physician heals.” More specifically, when the helping professional is affected by adverse circumstances, they are enabled with the ability to heal in the form of increased levels of empathy and insight (Scrutton, 2015). The wounded healer concept provides an overview of how the healer’s wounds and subsequent healing can be of benefit to the people they serve (Roots & Roses, 2020; Scrutton, 2015). In other words, as counselors help others they also help themselves (Roots & Roses, 2020; Scrutton, 2015).

From this standpoint, clinical authority is effectively achieved when the counselor has been afflicted in some way and has overcome that particular affliction (Kirkmayer, 2003). The counselor’s battle with the affliction serves as their call to action and their ability to overcome the affliction empowers them and solidifies their clinical authority (Kirkmayer, 2003). Once clinical authority is achieved and the counselor is perceived to be the wounded healer, then the nature of their job is aimed at stimulating the inner healing of the client and fostering their potentially transformative growth (Kirkmayer, 2003; Scrutton, 2015). The interactions between the counselor-healer and client occur on the professional or conscious level, the personality or spontaneous level, and the ethos or ethical level (Kirkmayer, 2003). With that said, it can be surmised that the validity and effectiveness of the counselor is based on the counselor’s lived experiences with similar afflictions as experienced by their client, their ability to survive and overcome their

affliction, which then empowers them to better understand their client needs and endows them with the ability to help the client overcome their affliction (Kirkmayer, 2003).

In contrast to this positive perspective towards the concept of the wounded healer, it is important not to romanticize the idea of suffering (Scrutton, 2015). The cost of caring is often described as the negative side effects that occur when helping professionals work closely with traumatized populations (Ludick & Figley, 2017). Trauma occurs when a person experiences physical, mental, or emotional harm due to a direct or indirect traumatic event (Salvilla & Bedoria, 2021). Vicarious trauma (secondary traumatization), compassion fatigue, burnout, and traumatic countertransference are a few of the negative side effects that can occur because of prolonged and repeated exposure to people who have experienced trauma (Kanno & Giddings, 2017; Ludick & Figley, 2017).

Despite the adverse side effects helping professionals may experience when working with individuals who have experienced trauma, many helping professionals are unaware that they are exhibiting the signs of vicarious trauma or they perceive the symptoms of vicarious trauma to be a form of weakness (Makkai, 2018; Quitangon & Eves, 2015). This unawareness and/or rejection of vicarious trauma symptoms can reduce the counselor's ability to effectively work with their clients, which suggests the importance of recognizing vicarious trauma symptoms in their early stages (Salvilla & Bedoria, 2021). Helping professionals may also reject the idea of needing help due to the stigma that exists about the need for emotional or psychological help when serving in the capacity of a helping professional (Straussner et al., 2018; Zerubavel & Wright, 2012).

Unfortunately, the idea of helping professionals serving others while wounded or suffering is not a novel concept. Clinically licensed counselors as well as other helping professionals often work in high-stress environments that put their emotional and professional well-being at risk (Makkai, 2018). *Clinically licensed counselor* is the term that will be used in this paper to indicate any licensed professional counselor. Clinically licensed counselors are master-level practitioners who are highly trained to observe, identify, and treat the mental and emotional needs of their clients (Alterkruse et al., 2001; American Counseling Association [ACA], 2023). However, they can often be unaware of their own mental and emotional needs (Makkai, 2018; Quitangon & Eves, 2015).

Researchers have conducted many studies to better understand how individuals have reacted to traumatic or crisis experiences and the benefits of mental health counseling (Glennon et al., 2019). Most of the research that explores how helping professionals have been affected by working with people during crisis situations, such as COVID-19, have focused on school counselors, counselors-in-training, helping professionals, counseling psychologists, licensed social workers, volunteers, medical personnel, and counselor educators (Kruczek et al., 2022; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). In contrast, there is little research on how a clinically licensed counselor's emotional or psychological wounds may affect their ability to work with their clients during crisis situations or how the clinically licensed counselor can decipher if healing has indeed occurred in relation to their own wound prior to working with traumatized individuals (Zerubavel & Wright, 2012). There is no research that specifically explores how a clinically licensed counselor working in a solo private

practice is affected by working with clients during a long-term crisis situation, such as the COVID-19 pandemic (Salvilla & Bedoria, 2021). The need for this area of research is evidenced in researchers' recommendations that future research be conducted on counselor stress and resilience after a crisis situation (Aafjes-van Doorn et al., 2020; Glennon et al., 2019; Kanno & Giddings, 2017; Lanier & Carney, 2019; Litem et. al., 2021). Researchers have also recommended that the focus of these future studies investigate whether or not workplace setting, counselor demographics, client demographics, self-care practices, and hours worked per week contribute to burnout, compassion fatigue, vicarious traumatization, or vicarious resilience (Aafjes-van Doorn et al., 2020; Glennon et al., 2019; Kanno & Giddings, 2017; Lanier & Carney, 2019; Litem et. al., 2021). These recommendations and apparent gap in the literature justified the purpose of this study which was to better understand the lived experiences of clinically licensed counselors during COVID-19.

Background

When viruses are transmitted from person to person on a global level, it is called a pandemic (Centers for Disease Control and Prevention [CDC], 2016; "Pandemic," 2023). Pandemics are not a new phenomenon in the United States or internationally. Prior pandemics include the 1346 Bubonic Plague or Black Death, the 1918 H1N1 influenza pandemic, and the 1968 H3N2 virus (Avian Flu) pandemic (Algine, 2016; CDC, 2018, 2019; "Pandemic," 2023).

Coronavirus is an all-inclusive name for a group of viruses that can cause mild cold-like symptoms as well as severe respiratory diseases ("Pandemic," 2023). One

specific coronavirus, COVID-19, has taken the lives of 6,908,554 people globally and the lives of 1,128,404 U.S. citizens (CDC, 2023; World Health Organization [WHO], 2023). COVID-19 has proven to be an equal opportunity crisis because despite race, culture, religious background, socioeconomic level, or gender, it has directly or indirectly affected everyone in the United States ("COVID-19," 2023). Despite new advances in medicinal remedies, people continue to be infected with the virus.

The literature indicated that during prior pandemics and other crisis events mental health issues typically increase during crisis situations (Bindas, 2022; "Great Depression," 2023, Singh et al., 2020). For example, during the Great Depression (1928-1932) the fear complex increased which caused increases of domestic violence, child abuse, homelessness, mental hospitalization, and suicide rates (Bindas, 2022; "Great Depression," 2023). The increase in these maladaptive behaviors during this crisis situation were often due to a person's inability to meet their basic needs including shelter, food, clothing, medical care, employment, and education (Bindas, 2022; "Great Depression," 2023). Similarly, after the September 11, 2001, terrorist attacks on the World Trade Center, reports of posttraumatic stress disorder (PTSD) symptoms, depressive symptoms, and cognitive decline among those who served in helping professions also increased (Singh et al., 2020). The COVID-19 pandemic appears to be following the same trajectory. Since the start of the COVID-19 pandemic, there has been an increase in the number of reports of people seeking counseling due to experiencing mental health issues such as anxiety, depression, and stress (Cohen et al., 2023; Li et al., 2023). The National Domestic Violence Hotline is reported to have received over 2000

COVID-19 calls in a one-month span (mid-March to early April 2020) mostly from healthcare workers and essential workers that were not able to report to work due to their partner fearing unnecessary contamination or in an effort to make them lose their job (Barker & Barker, 2022). The increase in the number of individuals seeking counseling to deal with their fears and concerns about job loss, social distancing, fear of infection and transmission, isolation due to mandatory quarantines, and the lack of goods due to product instability continues to put a strain on counselors that are also experiencing the effects of the COVID-19 pandemic (Whitt-Woosley et al., 2022).

When a crisis occurs, clinically licensed counselors and other helping professionals are often on the frontlines (Kruczek et al., 2022; Litam et al., 2021; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). Prior studies have shown that when treating clients who have post-traumatic stress and other trauma stories, counselors have often presented with symptoms of compassion fatigue and burnout for months or even years after working with a traumatized client (Lee, 2017; Silveira & Boyer, 2015). More specifically, clinically licensed counselors that work in a solo private practice are simultaneously directly and indirectly experiencing the effects of the COVID-19 pandemic while working with clients who are also experiencing the effects of the pandemic (Aafjes-van Doorn et al., 2020). This is novel territory. Under normal circumstances, clinically licensed counselors are generally the emotionally detached expert in the room which allows them to objectively provide counseling services for their clients (Glennon et al., 2019; Litam et al., 2021). However, experiencing the same crisis

situation at the same time as their client may have left the clinically licensed counselor vulnerable (Glennon et al., 2019; Litam et al., 2021).

Problem Statement

Researchers have indicated that individuals and the helping professionals that serve them have oftentimes experienced negative emotional and/or psychological issues as a result of experiencing a crisis situation (Bindas, 2022; "Great Depression," 2023; Singh et al., 2020). Persistent contact with client trauma stories has often resulted in the counselor experiencing symptoms of vicarious trauma, compassion fatigue, burnout, or countertransference (Kanno & Giddings, 2017; Ludick & Figley, 2017). The effects of vicarious trauma, compassion fatigue, burnout, or countertransference can be detrimental to the helping professional's personal and professional well-being (Martin-Cuellar et al., 2019).

Despite much research on the topic of how counselors can best meet the needs of their clients during crisis situations such as COVID-19, the research that has been conducted on the effects of COVID-19 on counselors has focused on school counselors, counselors-in-training, counselor supervisors, counselor educators, as well as other non-licensed counselors (Kruczek et al., 2022; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). These studies have predominantly occurred internationally and they often generalize the type of counselor included in that research (Salvilla & Bedoria, 2021). This is an important area of differentiation because clinically licensed counselors differ from credentialed counselors in a number of ways (Salvilla & Bedoria, 2021). Clinically licensed counselors are a specific subset within the counselor category due to

specific attributes such as expertise, experience, education, licensing requirements, and specialized training that differentiate a clinically licensed counselor from a credentialed counselor (Alterkruse et al., 2001; ACA, 2023; Leahy et al., 2015).

With that said, the problem is that researchers do not know how counselors are faring as a result of counseling their clients during COVID-19. Researchers also do not know, as a result of counseling during COVID-19, whether or not variables such as workplace setting, counselor demographics, client demographics, self-care practices, and hours worked per week have led to counselor burnout, compassion fatigue, vicarious traumatization, or vicarious resilience (Aafjes-van Doorn et al., 2020; Glennon et al., 2019; Kanno & Giddings, 2017; Lanier & Carney, 2019; Litem et. al., 2021). Vicarious resilience is the personal growth that a helping professional may experience in their own life after witnessing the growth of their clients.

There is an apparent gap in the literature in regards to how the clinically licensed counselor, who works in a solo private practice, is faring 3 years after the COVID-19 pandemic began, while continuing to counsel individuals that may have directly or indirectly experienced trauma during this crisis situation. This framework will help us better understand what happens to clinically licensed counselors during crisis situations and to discover what, if any, is the emotional and psychological aftermath that the counselors face after working through a crisis situation. To gain needed insight, this study seeks to learn more about the lived experiences of clinically licensed counselors during COVID-19.

Purpose of the Study

The purpose of this qualitative, interpretative phenomenological analysis (IPA) was to gain needed insight into the lived experiences of clinically licensed counselors during COVID-19. Phenomenology and the constructivist self- development theory provided the framework for the study. I selected these tools to help discover the themes that may have emerged as a result of the selected clinically licensed counselors' solo work with clients during a worldwide crisis.

These findings offer other clinically licensed counselors, counselor supervisors, and higher education faculty members insight into the often-overlooked lived experiences of clinically licensed counselors that are solo private practice owners. In addition, the findings from this study contribute to social change by increasing researchers and clinically licensed counselors' awareness of the possible long-term, residual side effects of working with clients during crisis situations. Lastly, this study encourages future researchers to conduct research that increases awareness about the importance of clinically licensed counselor well-being in solo private practice as well as encourages them to create diagnostic assessments that could be used to identify the early warning signs of burnout, compassion fatigue, and vicarious traumatization in this population of counselors.

Research Question

What are the lived experiences of clinically licensed counselors during COVID-19? This research question was selected to direct the focus of this study to a specific phenomenon. To obtain answers to this question, semi-structured interviews were

utilized. The findings from this research provided insight into the often-overlooked lived experiences of clinically licensed counselors in solo private practice during COVID-19.

Theoretical and Conceptual Framework

The descriptive phenomenological approach seeks to fully understand the essential meaning derived from a specific phenomenon (Willis et al., 2016). More specifically, it is a methodological research method that explores people's perceptions of their unique experiences (Ungvarsky, 2020). These perceptions about a person's unique experiences provides information about how the individual makes sense of their world and is often rooted in their own subjective and personal truths rather than in reality (Dean, 2018). The meaning of the person's unique experience, or essence, is the studied phenomena (Abalos et al., 2016; Gao, 2020). Husserlian phenomenology is often called descriptive phenomenology because the essence, or the meaning the person gives to their unique experience, lies at the core of their reality (Abalos et al., 2016; Willis et al., 2016).

The constructivist self-development theory (CSDT) served as the theoretical lens for this study. This theory was created by Dr. Lisa McCann and Dr. Laurie Anne Pearlman of the Traumatic Stress Institute (McCann & Pearlman, 1990). The CSDT is a personality development theory that is often regarded as a clinical trauma theory (Vides et al., 2022). This theory is integrative in nature and is the result of the integration of traumatic stress literature, constructivist theory, developmental theory, self psychology, social learning theory, and other cognitive theories (McCann & Pearlman, 1990). It provides a framework for understanding and treating adult trauma survivors (McCann & Pearlman, 1990). The premise of CSDT is that individuals possess the ability to construct

their own personal realities as they interact with their environment (McCann & Pearlman, 1990).

Historically, trauma theorists were psychodynamic theorists that focused on the individual's pre-existing pathology (McCann & Pearlman, 1990). They believed that people who experience trauma due to WWII were most likely more psychologically vulnerable to new trauma due to their past trauma (McCann & Pearlman, 1990). Other theorists of that time believed that under certain conditions, and if the situation was severe enough, all individuals were vulnerable to breakdown (McCann & Pearlman, 1990). Since the mid-1970s, the focus has been on the actual stressor due to new empirical research that showed that specific severe events such as the Vietnam war, rape, and incest, also produced severe stress reactions and mental health issues in most of the individuals exposed to those crisis situations (McCann & Pearlman, 1990). This solidified Freud's previous claims that a severe traumatic incident will most likely affect almost everyone exposed to it (McCann & Pearlman, 1990).

According to McCann and Pearlman (1990), "the person-situation interaction or the Interactive Approach is now a prominent approach in trauma theory because it takes into account both the individual's unique psychological development and the role of the traumatic experience itself in post trauma adaptation." This integration provides a more holistic view of the unique ways that individuals adapt to trauma (McCann & Pearlman, 1990). CSDT is integrative in that it combines both the idea that pre-existing pathology and the severity of the situation could cause trauma/mental health issues and incorporates constructivist theory (McCann & Pearlman, 1990). Constructivist theory suggests that an

individual actively constructs their life experiences or their own reality as they interact with the world (McCann & Pearlman, 1990). Constructivist theory also identifies schema as the mental framework that helps individuals organize, process, and store information about their inner and outer world (McCann & Pearlman, 1990). Finally, CSDT stresses the idea that an individual's reaction to trauma is individual and unique (McCann & Pearlman, 1990).

The CSDT approach is based on three major psychological systems: the self or an individual's sense of himself or herself; psychological needs, which motivate a person's behaviors; and cognitive schema, which are conceptual frameworks individuals use to help organize and interpret their life experiences (Lee, 2017; Roberts et al., 2022; McCann & Pearlman, 1990; Wallace, 2021). As people grow, they assimilate more of their surrounding environment into their existing schemas (McCann & Pearlman, 1990). In other words, as people interact with their environment, they develop their sense of self and their perceptions of the world (Lee, 2017; McCann & Pearlman, 1990; Roberts et al., 2022).

In CSDT, the self is an individual's inner world or the way that the individual views themself in relation to their psychological foundation (McCann & Pearlman, 1990). The hypothetical self-construct includes self-capacities, or the ability to regulate positive self-esteem, and ego capacities, or the individual's ability to regulate interactions with the world (McCann & Pearlman, 1990). Psychological needs motivate behavior to get needs met and cognitive schema is the conceptual framework utilized to organize life experiences with the hypothetical self and the outside world (McCann & Pearlman,

1990). The self-development component of CSDT suggests that the psychological systems of the self progressively mature and develop as the person grows and has life experiences (McCann & Pearlman, 1990). In other words, as people interact with their environment, they develop their sense of self and their perceptions of the world (Lee, 2017; Roberts et al., 2022). Therefore, if a person directly or vicariously experiences trauma, then their sense of self and the world can be negatively or positively altered (Branson et al., 2014; Darroch & Dempsey, 2016). Trauma changes people. It can disrupt an individual's cognitive schema and frame of reference (McCann & Pearlman, 1990). When a trauma occurs the individual must accommodate the new experience or modify old schema (McCann & Pearlman, 1990). Conceptually, CSDT studies trauma and how a person adapts to their experienced trauma (McCann & Pearlman, 1990).

CSDT served as a lens to better understand the possible negative experiences and changes related to COVID-19 as well as positive experiences and changes that are the result of making accommodations and adapting to the crisis situation. The literature supported the use of CSDT because it has been shown to be an effective theory to use in order to explain the progression of trauma and vicarious traumatization (Trippany et al, 2004). Therefore, to better understand how this theoretical framework was connected to the lived experiences of clinically licensed counselors during COVID-19, it was taken into consideration that CSDT is often utilized to gain insight into the effects of trauma on an individual and how they view themselves and the world as a result of the traumatic experience (Pearlman, 1998).

Nature of the Study

This study utilized a qualitative descriptive phenomenological approach. This approach was selected because the descriptive phenomenological approach focuses on making meaning of the studied phenomenon (Merriam & Tisdell, 2016). In this study, the studied phenomena was the lived experience of clinically licensed counselors during COVID-19. The research question is qualitative in nature and focused on understanding how the participants constructed meaning from their unique experiences (Patton, 2015). Information-rich data was collected via semi-structured interviews (see Creswell & Creswell, 2018). Despite validity or trustworthiness being a strength of qualitative research, the descriptive nature of the descriptive phenomenological approach can inadvertently include the researcher's biases unless validity procedures are utilized (Creswell & Creswell, 2018; Ravitch & Carl, 2016). Documenting procedures so that they can be followed by future researchers can help to increase the reliability of the study (Creswell & Creswell, 2018). Qualitative reliability procedures, such as cross-checking codes and writing memos about the codes, were also utilized to counter researcher errors (see Creswell & Creswell, 2018).

The quantitative research method was not used in this study because most quantitative research methods involve manipulating different variables to test and answer a predetermined hypothesis (Creswell & Creswell, 2018; Smith et al., 2022). The quantitative research design method seeks to randomly collect numerical data which would not have been appropriate in this study because this study sought to utilize a more purposively selected and homogenous sample of participants to better understand how

clinically licensed counselors make meaning, or utilize sensemaking, of their unique experiences (see Dean, 2018; Smith et al., 2022). Finally, the quantitative research method utilizes closed-ended questions to obtain data, which would not have been conducive to obtaining the rich, meaningful stories of the clinically licensed counselor's lived experiences (Creswell & Creswell, 2018).

IPA is the selected research design. The IPA approach is a phenomenological approach that interprets the experienced phenomena of the study's participants (Patton, 2015; Southby et al., 2021; Thackeray & Eatough, 2018). This research design was appropriate for this study because it was utilized to gain insight into how the participants interpreted or made sense of their experience and it allowed the researcher to gain a more in-depth perspective concerning the constructs within the participant's inner world (Lucey & van Nieuwerburgh, 2021). The overall goal of the IPA approach was to obtain rich, detailed descriptions of the participant's experiences and to decipher if there was any ambiguity concerning the participant's perception of their lived experience (Smith & Nizza, 2022).

Quantitative research designs such as experimental designs and longitudinal research designs would not have been appropriate for this study for various reasons. Experimental designs often require adding or removing a particular variable in order to assess the outcome (Creswell & Creswell, 2018). No variables were added or removed in this study. Longitudinal research designs seek to research events over a prolonged period of time, which would not have been appropriate for this current study due to time constraints.

Definitions

In this section, I provide the definitions of important words and/or phrases used in the study.

Burnout: Burnout is a group of symptoms that can include emotional exhaustion, cynicism, and can cause high absenteeism, conflicts, and reduced productivity at work (Renaud & Lacroix, 2023). Burnout is described as mental, physical and/or emotional exhaustion that occurs as a result of working in a high stress environment (Taylor et al., 2018).

Clinically licensed counselors: Clinically licensed counselors are master's level mental health professionals that are licensed by their state and have the ability to diagnose mental disorders for insurance purposes (Alterkruse et al., 2001; ACA, 2023). Clinically licensed counselors often work in various settings such as private practice, group practices, school districts and counseling organizations (Leahy et al., 2015).

Compassion fatigue: Compassion fatigue is a group of symptoms such as overwhelm, helplessness, isolation, and the inability to make good decisions that occur as a result of consistent strain and preoccupation while working with clients (CDC, 2016, 2018, 2019). Compassion fatigue occurs when a person is unable to fully experience emotions while hearing a client's trauma story (Taylor et al., 2018).

Counselors: According to the American Psychological Association (2023), "a counselor is an individual professionally trained in counseling, psychology, social work, or nursing who specializes in one or more counseling areas, such as vocational, rehabilitation, educational, substance abuse, marriage, relationship, or family counseling.

A counselor provides professional evaluations, information, and suggestions designed to enhance the client's ability to solve problems, make decisions, and effect desired changes in attitude and behavior."

Countertransference: Countertransference is thought to be helpful at times because the counselor's deep, personal understanding of the client's issues suggests that they can be more deeply attuned and beneficial to the client's self-healing (Zerubavel & Wright, 2012). However, traumatic countertransference is a cluster of symptoms that describe the counselor's reaction to their client's trauma stories that result in negative behaviors such as avoidance, defensiveness, numbing, denial, or overidentification with the client (Kanno & Giddings, 2017). Common traumatic countertransference symptoms can be crying, shame, re-activation of the counselor's trauma, and guilt (Kanno & Giddings, 2017).

COVID-19: Coronavirus is an all-inclusive name for a group of viruses that can cause mild cold-like symptoms as well as severe respiratory diseases ("Pandemic," 2023). The coronavirus that caused the COVID-19 pandemic is a new strain (SARS-CoV-2 or Severe Acute Respiratory Syndrome Coronavirus 2), is zoonotic, which means it can be transmitted from animals to humans and is often erroneously considered to be an influenza-related virus ("COVID-19," 2023; "Pandemic," 2023).

COVID-related stress syndrome: COVID stress syndrome is a collection of distress and anxiety symptoms that often focus on the fear of COVID-19 contamination, socioeconomic worries, traumatic stress due to concerns about COVID-19, and self-protective compulsive behaviors (Taylor et al., 2020).

Helping professionals: Helping professionals are a group of health and education providers such as doctors, nurses, counselors, social workers, teachers, volunteers, and so forth (Szilagyi, 2021).

Pandemic: A pandemic occurs when a new virus is easily transmitted from person to person in a consistent pattern and affects people globally (CDC, 2016; "Pandemic," 2023).

Shaman: A shaman is considered to be a spiritual healer that is the go-between the spiritual and material world and who has also been called a witch doctor, medicine man, or medium (Dean, 2018). The shaman embarks on the archetypal, hero's journey, which includes becoming afflicted, overcoming that affliction, and then becoming a person of power that is endowed with the ability to help others obtain their own inner healing (Dean, 2018; Kirkmayer, 2003).

Shamanism: Dean (2018) states, "shamanism is believed to be the oldest and longest lasting, healing, psychotherapeutic, and religious tradition."

Vicarious trauma: Vicarious trauma or secondary traumatization is a work-related traumatic stress and a form of PTSD that occurs when individuals have directly or indirectly experienced trauma while working with traumatized individuals (Kanno & Giddings, 2017; Kounenou et al., 2023; Savilla & Bedoria, 2021). Vicarious trauma occurs when an individual begins to negatively process their experiences after working with a traumatized person (Taylor et al., 2018).

Wounded healer: The wounded healer concept varies across cultures and is based on the idea that the healer's wounds and subsequent healing can benefit the people they

serve (Roots & Roses, 2020; Straussner et al., 2018). It is believed that wounded healers have a heightened ability to identify and treat afflictions and wounds in others (Roots & Roses, 2020). Carl Jung is credited with introducing the idea of the wounded healer to the area of psychotherapy (Scrutton, 2015).

Assumptions

It was assumed that the requirement of a 2-year minimum time frame in private practice may positively or negatively affect the clinically licensed counselor's ability to navigate and cope with the effects of working with clients during COVID-19. It was assumed that the participant's age, race, and gender may also be factors that could affect the outcome of this study. It was assumed that the location of the participants does not represent the whole of this particular group of clinically licensed counselors. These assumptions were considered as the desired homogenous group of participants were purposively selected which included any clinically licensed counselors that worked in a solo private practice for at least 2 years and who counseled clients during COVID-19. Future studies that focus on gender-specific counselors, age-specific counselors, counselors who work in group practices or other organizations, or counselors who live in rural or urban geographic areas should be considered.

Scope and Delimitations

The impact of this study will not only help to close the knowledge gap concerning the well-being of clinically licensed counselors during COVID-19, but it will contribute to social change by increasing awareness of the possible long-term, residual side effects of working with counseling clients during crisis situations. It will also stimulate future

researchers to examine the lived experiences of clinically licensed counselors that work in solo private practices.

Clinically licensed counselors were the selected participants in this study. This participant group was selected because they would be able to provide information about the particular phenomenon of interest which is their lived experiences as clinically licensed counselors during COVID-19 (Smith et al., 2022). The participant recruitment procedures consisted of utilizing referrals, opportunities, and snowballing (Smith et al., 2022). The scope of this study was limited to a 10-person group of participants. The small participant group is in keeping with the IPA approach (Smith et al., 2022). IPA studies often require a minimum of five participants but smaller studies have been conducted (Smith & Nizza, 2022).

Further delimitations of the study included the use of participants who had ownership of their solo private practice. Another delimitation was that the participants were all clinically licensed counselors who have continued to work in their private practice since the pandemic began in March 2020. Finally, these participants were purposively selected and met the requirement of being a clinically licensed counselor that lived within the United States. The research timeline consisted of semi-structured interviews beginning February 2024 and ending April 2024. The participants were allowed to preview interview transcripts at least 30 days prior to final submission from April 2024 to February 2025.

Limitations

There are many strengths within phenomenological research design. However, there are also several limitations. One limitation is that the IPA approach generally utilizes a small sample size (Smith et al., 2022). Small sample sizes do not accurately represent the whole of a particular group (Smith et al., 2022). A sample size of up to 10 participants was preferred, however, the eventual sample was comprised of only 7 participants. An additional limitation of this study was that due to the small sample, I anticipated that obtaining a homogenous group of participants would be more difficult. Another limitation could have been the inability to obtain willing participants. Participant reactivity could have occurred because I am also a clinically licensed counselor and solo private practice owner, and there was the possibility that other clinically licensed counselors might not be willing to admit that they were mentally and emotionally struggling. These participants could have opted out of the study (see Makkai, 2018).

Despite the strengths of utilizing semi-structured, one-on-one interviews as a research methodology, a limitation of that research method is that the self-reported historical data provided by the participants was based on their sole perspective and may not be valid or reliable (see Creswell & Creswell, 2018). Another limitation was potential technological discomfort due to the participants potentially not being in their natural setting due to health concerns as a result of COVID-19, potentially not appreciating the artificiality of audio tools, and potentially not being comfortable with being recorded during the interview (Creswell & Creswell, 2018).

Significance

The COVID-19 pandemic has had some type of effect on everyone in the United States (Cohen et al., 2023; "COVID-19," 2023; Li et al., 2023). Clinically licensed counselors were not immune to the mental, emotional, financial, and possibly physical strain that this pandemic placed on their loved ones as well as themselves (Aafjes-van Doorn et al., 2020). In most normal circumstances, clinically licensed counselors in solo private practices are the emotionally detached expert in the room which allows them to objectively provide counseling services for their clients (Glennon et al., 2019; Litam et al., 2021). However, experiencing the same crisis situation at the same time as their client may have left the clinically licensed counselor vulnerable (Glennon et al., 2019; Litam et al., 2021). This is why research to investigate the experiences of clinically licensed counselors during COVID-19 is important. This often-overlooked subset of counselors is missing in the literature especially in relation to how they fared during COVID-19 (Salvilla & Bedoria, 2021). They are included in the all-encompassing group of counselors but they possess specific skillsets and licenses that differentiate them from that group (Salvilla & Bedoria, 2021). This research study contributed new knowledge concerning the effects of providing counseling services in solo private practice during COVID-19.

This research project helped decrease the knowledge gap related to nonexistent literature concerning the lived experiences of clinically licensed counselors in solo private practices during COVID-19. Insights may be gained by learning more about the well-being of clinically licensed counselors that have counseled clients throughout

COVID-19. This study also contributes to new knowledge concerning the effects of COVID-19 on clinically licensed counselors. This new information will benefit future counselors, counselors-in-training, counselor educators, counselor supervisors, and other solo private practice owners.

Summary

In this chapter, I provided cumulative background information that describes why a study on the lived experiences of clinically licensed counselors during COVID-19 is necessary and beneficial. I also included the problem statement which describes the problem I explored and investigated. I provided the purpose of this study, the research question and the theoretical framework that formed the research design of the study. The nature of the study, definitions, assumptions, scope, and delimitations as well as the limitations were also outlined. Finally, I discussed the significance of the study and provided this summation of why studying the lived experience of clinically licensed counselors during COVID-19 is a research-worthy topic.

In Chapter 2, I provided the results from my literature review and explored the topics of clinically licensed counselors, pandemics, and wounded healers among several other important topics.

Chapter 2: Literature Review

Introduction

Clinically licensed counselors and other helping professionals can be found on the frontlines and at the center of crisis situations (Kruczek et al., 2022; Litam et al., 2021; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). Despite this fact, little to no research on the well-being of helping professionals experiencing traumatic stress or vicarious trauma was conducted until after 1980 (Kanno & Giddings, 2017). In the 1990s, social workers and other helping professionals were called the "hidden victims" of vicarious trauma (Kanno & Giddings, 2017).

COVID-19 is believed to have begun in Wuhan, China, in December 2019 and the COVID-19 pandemic quarantine officially began in the United States in March 2020 ("COVID-19," 2023). Since then, research has indicated that at least 25% of the population have reported a significant increase in stress and anxiety-related symptoms (Taylor et al., 2020). Much research has been conducted on the emotional and psychological needs of individuals when presented with a traumatic or crisis situation (Kruczek et al., 2022; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). This is most likely a direct result of counseling referrals being suggested when a person experiences a traumatic or crisis event. However, crisis situations usually result in increased caseloads for clinically licensed counselors, but the emotional and psychological well-being of the licensed professional counselor is generally not the focus (Lee, 2017; Silveira & Boyer, 2015).

Some research does exist on the psychological and emotional well-being of helping professionals, including counselors, after a traumatic or crisis situation (Liang et al., 2022). However, a preponderance of the research on the COVID-19 crisis has occurred internationally and largely focused on the effects of the pandemic on helping professionals such as medical healthcare providers, social workers, counselors-in-training and their doctoral supervisors, school counselors, unlicensed counselors, and the provision for telehealth services (Kruczek et al., 2022; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). Little to no research has been conducted on the effects of COVID-19 on clinically licensed counselors who have also served on the frontline during the COVID-19 pandemic in private practices, group practices, and other organizations (Litam et al., 2021).

Despite the lack of focus in the literature on the clinically licensed counselor subgroup, other studies have shown that counselors who treat clients who have experienced trauma have often presented with cumulative and persistent symptoms of vicarious trauma, compassion fatigue and burnout (Lee, 2017; Silveira & Boyer, 2015). The normal response to direct or narrated incidents that involve extreme terror, grief, or threats of bodily harm is to trigger a trauma response of fight, flight, or freeze but clinically licensed counselors are expected to calmly listen to and empathize with the individual telling the terrorizing life story (Kanno & Giddings, 2017). Clinically licensed counselors are simultaneously directly and indirectly experiencing the devastating effects of COVID-19 while counseling clients who are also experiencing the devastating effects of the pandemic (Aafjes-van Doorn et al., 2020). This is unprecedented territory. Since

the future of COVID-19 is still unknown, the implications of this pandemic are potentially long-lasting and clearly demonstrate the relevance of and need for research in this overlooked area.

In this chapter, the literature search strategy and relevant literature are discussed. The theoretical framework that grounds my study is also provided. Finally, the key concepts discovered in the literature review are reviewed.

Literature Search Strategy

Walden's database and Google Scholar were the two main resources I used to conduct my literature review. Seminal books and textbook chapters that specifically targeted a specific aspect of my study were also used. I defined my search by selecting scholarly journals and peer-reviewed, full articles produced within a 10-year period. My preliminary review of the literature involved selecting articles that focused on the effects of COVID-19 on helping professionals, such as doctors, nurses, school counselors, clinically licensed counselors, and licensed social workers. As I reviewed the articles, I extracted key terms that the researcher used in the article for more in-depth research. The selected keywords that were subsequently utilized as future search terms were *COVID-19, pandemic, COVID-related stress syndrome*, *COVID-related burnout*, *clinically licensed counselors, professional counselors, counselors, helping professionals, school counselors, licensed counselors, licensed therapists, vicarious trauma, secondary traumatization, secondary traumatic stress, burnout, trauma therapists, trauma counselors, trauma professionals, mental health professionals, behavioral health professionals, mental health therapists, trauma, resilience, wounded healer, wounded*

healer theory, Shamanism, global crisis, trauma-focused counseling, countertransference, impairments, self-care, positive outcomes, self-efficacy, empathic acceptance, subthreshold PTSD, coping, motivation, compassion fatigue, prior trauma, work-life balance, and coping skills. The databases used were ERIC, SAGE journals, Dissertations and Theses Online, PsychINFO, Google Scholar, and ProQuest Central.

Theoretical Foundation

Constructivist Self-Development Theory

CSDT, which serves as the lens from which this study is conducted, is an integrative personality development theory often used interchangeably with clinical trauma theory (Vides et al., 2022). The foundational principal of this theory is that individuals construct and give meaning to their perception of reality based on cognitive schemas that were constructed as a result of their individual lived experiences (McCann & Pearlman, 1990; Trippany et al., 2004). CSDT is based on four domains including self-capacities, ego resources, psychological needs, and cognitive schemas (McCann & Pearlman, 1990; Trippany et al., 2004; Wallace, 2021). The self-capacities domain refers to a person's identity and self-esteem (Lee, 2017; McCann & Pearlman, 1990). Self-capacities refers to the person's sense of self and focuses on a person's connection to others, management of their affect, and the maintenance of a positive self-image and self-worth (Pearlman, 1998). The ego resources domain focuses on how the person relates to the world (Lee, 2017; McCann & Pearlman, 1990). The psychological needs domain includes the personal needs that cause a person to behave in a particular way to get those needs met (Lee, 2017; McCann & Pearlman, 1990). Some examples of psychological

needs are safety, trust, power, esteem, intimacy, and independence (Lee, 2017; McCann & Pearlman, 1990). The cognitive schemas domain refers to the beliefs the person holds about themselves and the world they inhabit (Lee, 2017; McCann & Pearlman, 1990).

CSDT rests on the premise that as people interact with their environment or the people in their environment, they develop their sense of self and how they view the world (Lee, 2017; McCann & Pearlman, 1990; Roberts et al., 2022). This theory examines the relationship between the person's self-development and the impact of trauma or vicarious trauma (Lee, 2017). This theoretical framework effectively correlates traumatic experiences with the need for attachment and emotional regulation in order to achieve positive outcomes (Vides et al., 2022). Furthermore, constructivists believe that when a person directly or vicariously experiences trauma, their sense of safety, self-esteem, trust, intimacy, and control can be drastically altered as an adaptive response (Branson et al., 2014; Darroch & Dempsey, 2016). Thus, when the counseling environment consists of people who have experienced trauma, the clinically licensed counselor may experience a change in their sense of self and their perception of the world (Lee, 2017).

To better understand how this theoretical framework connects to the lived experiences of clinically licensed counselors during COVID-19, we must consider that the CSDT is often utilized to gain insight into the effects of trauma on an individual and how they view themselves and the world as a result of the traumatic experience (Pearlman, 1998). When a clinically licensed counselor encounters trauma stories repeatedly in session, several of the domains of the CSDT may become distorted (Miller, 2010). These trauma stories can have an effect on the counselor's well-being, self-

perceptions, and view of the world (Miller, 2010). The extent of this impact often depends on the what the counselor views as meaningful about the traumatic event as well as the counselor's prior life experiences, psychological resources, and their view about the sociocultural context of the traumatic event (Pearlman, 1998; Saakvitne et al., 1998).

Psychological needs typically represent a person's need for safety, esteem, intimacy, trust, and control which all work together to help form the person's identity (Miller, 2010). Identity consists of the reflexive beliefs we have about ourselves and further foster with social interactions (Dean, 2018). It is how we answer the question, "Who am I?" based on our occupations, friendship circles, and professional organizations (Dean, 2018). When clinically licensed counselors directly or vicariously come into contact with trauma, their personal lens about their own personal safety and well-being may become distorted (Lee, 2017; McCann & Pearlman, 1990). Everyone responds to traumatic stress and traumatic events differently due to their own life experiences and cognitive schemas prior to the traumatic event (Lee, 2017; McCann & Pearlman, 1990). With that said, once the counselor's cognitive schema has been affected by the client's traumatic stories, their beliefs can change negatively or positively regarding their sense of identity and their view of how safe they are in the world (Miller, 2010; Saakvitne et al., 1998; Salvilla & Bedoria, 2021). These cognitive schemas, or beliefs, are linked to the counselor's emotions (Miller, 2010). Memory can also be affected by repeated exposure to traumatic stories and this can cause the counselor to experience vicarious traumatization (Miller, 2010). Vicarious trauma occurs when the counselor is traumatized

by the trauma stories of the client as if they themselves experienced the trauma (Miller, 2010).

Literature Review Related to Key Concepts

The Historical Impact of Crisis

Pandemics have occurred throughout the United States and internationally. A pandemic occurs when a new virus is easily transmitted from person to person in a consistent pattern and affects people globally (CDC, 2016; "Pandemic," 2023). Many of the diseases that were at the core of prior pandemics, such as smallpox, cholera, typhus, measles, tuberculosis, leprosy, malaria, yellow fever, influenza, and HIV/AIDS, still exist and continue to affect individuals currently ("Pandemic," 2023).

The Bubonic Plague or Black Death, which occurred in 1346 in Western Eurasia and North Africa, is considered to be the first recorded and deadliest flu pandemic because it resulted in 75 to 200 million deaths ("Pandemic," 2023). The H1N1 influenza pandemic of 1918 was the first major pandemic on U.S. soil and was estimated to have caused the death of 50 million people worldwide including 675,000 people in the United States (Aligne, 2016; CDC, 2019). Since then, the United States has detected and experienced several pandemics prior to the COVID-19 pandemic including the 1957 H2N2 virus (Asian Flu) pandemic, the 1968 H3N2 virus (Avian Flu) pandemic, and the 2009 H1N1 virus pandemic (CDC, 2018).

The all-inclusive name for a group of viruses that can range from mild cold-like symptoms to severe respiratory diseases is *coronavirus* ("Pandemic," 2023). The coronavirus that caused the COVID-19 pandemic is a new strain (SARS-CoV-2 or Severe

Acute Respiratory Syndrome Coronavirus 2) and is zoonotic, which means it can be transmitted from animals to humans and is often erroneously considered to be an influenza-related virus ("COVID-19," 2023; "Pandemic," 2023).

Since the COVID-19 virus was initially detected in Wuhan, China, in December 2019, people across the globe have been directly or indirectly affected despite their race, socioeconomic status, or gender ("COVID-19," 2023). It has proven to be a modern-day equal-opportunity crisis. According to the CDC (2023), as of April 12, 2023, "there were 104,348,746 reported cases of COVID-19 and 1,128,404 deaths in the United States." Globally, 763,740,140 cases of COVID-19 and 6,908,554 deaths have been reported (WHO, 2023). Despite the enormous number of cases reported and subsequent deaths since December 2019, these numbers are pale in comparison to the previous pandemic infection rates and death tolls.

Researchers suggest that the psychological toll of COVID-19 will be much greater than the infection rates and death tolls (Taylor et al., 2020). Many people have resorted to overbuying alcohol and drug consumption to cope with fears and stress about contracting COVID-19 rather than seeking mental health care (Taylor et al., 2020). This grouping of negative symptoms that occur as a result of a person's fears about COVID-19 have been aptly named, COVID-related stress syndrome (Taylor et al., 2020).

The Impact on Helping Professionals

The wounded healer concept varies across cultures and is based on the idea that the healer's wounds and subsequent healing can benefit the people they serve (Roots & Roses, 2020; Straussner et al., 2018). The wounded healer concept is grounded in

Shamanism and is based on the belief that shamans should endure a deliberate physical or psychological crisis, including suffering and isolation, as part of their training process to obtain true wisdom (Singh, 2018). Shamanism and Greek mythology amalgamate around the concept of the wounded healer with the story of Chiron, the healing centaur, who suffered unbearable pain due to Hercules's arrow (Piredda et al., 2022). Asklepios, who was wounded by a stray arrow, also suffered an irreparable wound, and subsequently became a great healer under the guidance of Chiron (Kirkmayer, 2003).

Carl Jung

Carl Jung is credited with applying Greek mythology and the concept of the wounded healer to therapeutic practice (Scrutton, 2015). According to Kirkmayer (2003), "A healer can be a technical expert, educator, helping professional, spiritual teacher, master, or guru." The process of the symbolic healing of the wounded healer, or the archetypal hero's journey, includes the concepts of the person as a sufferer and healer, a healing place where rituals and rejuvenation can occur, the symbolic actions that cause the healing to occur, and the hope and expectation that healing will indeed be a result of specific, intentional actions (Dean, 2018; Kirkmayer, 2003). In comparison, during the therapeutic process, the counselor embodies the hero's journey as they take on the role of the former sufferer and empowered healer who utilizes the counseling environment and interventions to help the client overcome and heal from their afflictions.

Jung believed that only wounded physicians can heal and was credited with applying the concept of the wounded healer to therapeutic practice (Scrutton, 2015). Jung suggested that the wounded physician was more equipped to heal while simultaneously

experiencing limitations due to their wound (Straussner et al., 2018). Licensed counselors often work in high-stress environments that put their emotional and professional well-being at risk (Makkai, 2018). The cost of caring is described as the often-negative side effects that occur when helping professionals work closely with traumatized populations (Ludick & Figley, 2017).

Vicarious trauma (secondary traumatization), compassion fatigue, burnout, and traumatic countertransference are a few of the negative side effects that can occur because of prolonged and repeated exposure to people who have experienced trauma (Ludick & Figley, 2017).

Vicarious Traumatization

McCann and Pearlman are credited with coining the term and originally assessing vicarious trauma (Kanno & Giddings, 2017). Vicarious trauma occurs when a person is working with someone who has experienced trauma and feels traumatized as a result of this work (Glennon et al., 2019). Vicarious trauma is the counselor's reaction to the client's trauma stories and only occurs in counselors who work with trauma (Trippany et al., 2004). Vicarious trauma is considered to be work-related traumatic stress and a form of PTSD that can create a "mirrored reaction" in individuals that have indirectly experienced trauma while working with traumatized individuals (Kanno & Giddings, 2017; Kounenou et al., 2023; Savilla & Bedoria, 2021; Zaccari, 2017). Individuals experiencing vicarious trauma may exhibit PTSD symptoms and psychological issues as well as experience issues at work and within their interpersonal circle (Hunt, 2018; Lanier & Carney, 2019). Many counselors who experience vicarious trauma opt to leave

the profession due to the effects of traumatic stress and diminished self-efficacy (Isawi & Post, 2020; Lanier & Carney, 2019). Self-efficacy refers to a person's belief in their ability to complete a task or perform a job (Ender et al., 2018; Isawi & Post, 2020). McCann and Pearlman (1990) stated,

> Vicarious trauma is a disruption of important beliefs that an individual has about themselves, other people, and the world, and the process through which the trauma therapists' cognition and inner experience is negatively transformed as a result of empathic engagement with client's trauma.

Vicarious trauma can cause the individual to experience anxiety, terror, stress, intrusive thoughts, grief, rage, distrust, withdrawal from important relationships, and distort the perception of threat or harm (Lanier & Carney, 2019; Kanno & Giddings, 2017; Salvilla & Bedoria, 2021). The effects of vicarious trauma can also impact the individual's cognitive schemas in the areas of safety, trust, esteem, intimacy, and control (Kanno & Giddings, 2017).

Compassion Fatigue

Compassion fatigue is a cluster of symptoms that can include feelings of overwhelm, helplessness, confusion, and isolation which can hinder an individual's ability to make sound decisions and is a side effect of consistent psychological and emotional strain while working with clients (CDC, 2016, 2018, 2019; Martin-Cuellar et al., 2019). Despite prior research on the effects of compassion fatigue on nurses, Figley is credited with defining the disorder as subsequent behaviors and emotions that occur when an individual desires to help a person who has experienced trauma (Kanno & Giddings,

2017; Ludick & Figley, 2017). The term, compassion fatigue, describes a high-level stress and fatigue that helping professionals may feel while working with traumatized individuals (Kanno & Giddings, 2017). The effects of compassion fatigue can vary from intrusive thoughts, hypervigilance, avoidance/numbing behaviors, and physical symptoms such as headaches, sleep issues, and digestive problems (Kanno & Giddings, 2017). Some researchers consider compassion fatigue to be the combined result of burnout and vicarious trauma (Glennon et al., 2019).

Burnout

Herbert Freudenberger coined the term burnout in the 1970s (Makkai, 2018). Burnout typically affects three domains: emotional exhaustion, depersonalization, and professional achievement and can occur in any profession (Makkai, 2018; Trippany et al., 2004). Burnout is a classification of symptoms that can include overwhelming emotional exhaustion, fatigue, disengagement, depersonalization, and cynicism which can result in high work absenteeism, conflicts at work, impaired personal and professional accomplishment, and reduced productivity (Kanno & Giddings, 2017; Renaud & Lacroix, 2023). Individuals experiencing burnout may experience decreased motivation, anxiety, depression, sleep disturbances, loss of memory, and no longer enjoy their present life as a result of working in their stressful work environment (Makkai, 2018). Burnout syndrome also makes the person more susceptible to infections like the flu, cardiovascular diseases, and diabetes (Makkai, 2018). A person's very survival may be compromised by burnout (Makkai, 2018). In essence, when helping professionals feel that they are emotionally,

physically, and mentally exhausted, they are unable to give more on the job and tend to make more costly mistakes (Makkai, 2018).

Traumatic Countertransference

Countertransference is thought to be helpful at times because the counselor's deep, personal understanding of the client's issues suggests that they can be more deeply attuned and beneficial to the client's self-healing (Zerubavel & Wright, 2012). However, traumatic countertransference is a cluster of symptoms that describe the counselor's reaction to their client's trauma stories that result in negative behaviors such as avoidance, defensiveness, numbing, denial, or overidentification with the client (Kanno & Giddings, 2017). Common traumatic countertransference symptoms can be crying, shame, re-activation of the counselor's trauma, and guilt (Kanno & Giddings, 2017).

Helping Professionals

Despite the adverse side effects, many helping professionals are unaware that they have experienced secondary traumatization or they perceive the symptoms of secondary traumatization to be a form of weakness or an undesired impairment (Coaston & Lawrence, 2022; Makkai, 2018; Quitangon & Eves, 2015). Helping professionals who are unaware of their woundedness may negatively impact their clients by projecting onto their clients, over-identifying with their clients, or violating boundaries (Coaston & Lawrence, 2022). The idea of helping professionals serving others while wounded or suffering is not a novel concept, so releasing the blind spot viewpoint that suggests that the client is wounded and the counselor is healed will help the counselor remain empathic and aware of both the client's and their own vulnerabilities (Coaston & Lawrence, 2022).

Helping professionals are defined as people who typically work in professions that provide care and/or assistance to others such as doctors, nurses, counselors, social workers, teachers, volunteers, and so forth (Blikhar et al., 2023; Szilagyi, 2021). It is believed by many that helping professionals choose their careers due to their own traumatic past and desire to be a support for others experiencing trauma (Straussner et al., 2018). However, these emotional and psychological wounds can make them more vulnerable to being vicariously traumatized by their client's trauma stories (Straussner et al., 2018).

Healthcare Providers

During the COVID-19 pandemic, healthcare providers were faced with a dramatic increase in patients, a lack of necessary resources, and a plethora of misinformation (Piredda et al., 2022). Doctors and nurses reported having mental health fears and concerns about infecting others, guilt as a result of infecting others, stigma of working with infected individuals, loneliness due to quarantine isolation, and concerns about what recovery could look like for them as well as their patients (Samyuktha et al., 2022; Wang et al., 2023). Some reported having nightmares and the fear of death or being on life support (Samyuktha et al., 2022). The literature also indicated that nurses experienced feelings of meaninglessness, powerlessness, vulnerability, sadness, tiredness, anxiety, and guilt in relation to their inability to avoid the infection and when they passed it on to their family members and/or patients (Piredda et al., 2022). Some healthcare professionals indicated that they felt abandoned by their place of employment and society in general because they were left to deal with their own illnesses and their patients' illness with little

to no support despite risking their lives on a daily basis (Piredda et al., 2022; Wang et al., 2023). They also shared that they encountered social prejudice after returning from quarantine (Piredda et al., 2022; Wang et al., 2023).

Social Workers and Counseling Psychologists

A review of the literature indicated that licensed social workers were also prone to vicarious trauma and as a result struggled with psychological issues, drug and alcohol-related issues, smoking issues, as well as gambling issues (Straussner et al., 2018). Studies have also been conducted to learn more about the effectiveness of counseling psychologists that were wounded by some affliction (Zerubavel & Wright, 2012). Researchers found that identifying, understanding, and processing the affliction or emotional wound is the cornerstone of resolving the wound (Zerubavel & Wright, 2012). Counseling psychologists that positively worked on their emotional wounds were better able to help their clients due to their heightened levels of empathy, tolerance, and patience (Zerubavel & Wright, 2012). The impaired counseling psychologists that experienced emotional wounds but did not effectively work through them often experienced negative reactions with their clients that included poor boundary-keeping, countertransference, projection and overidentification (Zerubavel & Wright, 2012). It should also be noted that many helping professionals have reported feeling stigmatized when admitting that they have an emotional or psychological issue which causes them to continue to silently help others while experiencing their own wounds (Straussner et al., 2018; Zerubavel & Wright, 2012).

Credentialed Counselors

Counselors interact with the pain, grief, trauma, dysfunction, and stressors of the clients they serve on a daily basis (Coaston & Lawrence, 2022). Counselors use the whole of who they are, or the self, to help clients through their various struggles (Merriman, 2015). It is believed that many counselors seek to work with clients that are experiencing trauma due to their own experiences with trauma which is in alignment with the wounded healer concept (Coaston & Lawrence, 2022). These experiences with their personal traumas can cause issues with their own well-being and professional competence (Martin-Cuellar et al., 2019). Counselors often work to make sure their clients take care of themselves but fail to provide adequate self-care for themselves (Lanier & Carney, 2019). Counselors-in-training are rigorously trained to work with clients in various capacities but few are prepared for the emotional, mental, and physical strain that working with traumatic client stories and debilitating disorders can place on the counselor (Merriman, 2015). Researchers have suggested that prevention-based training be conducted in universities to better prepare these future counselors for their exposure to trauma (Lanier & Carney, 2019; Merriman, 2015). Research has shown that the possibility of becoming vicariously traumatized is higher in younger and newly trained counselors (Aafjes-van Doorn et al., 2020).

Vicarious Resilience

In contrast, vicarious resilience is a positive side effect of vicarious traumatization (Salvilla & Bedoria, 2021). Vicarious resilience can be described as a person's actions in the face of trauma that promote wellness and health (Litam et al., 2021). It is argued that

once a wound or affliction is acknowledged, understood, and no longer denied, then the experience of the affliction can become potentially transformative for the individual (Scrutton, 2015). Research has been conducted on health care providers has revealed that some found that working throughout the COVID-19 pandemic made them feel even more dedicated to their profession (Wang et al., 2023). The literature indicated that after becoming infected with the virus and/or working throughout the pandemic, many healthcare providers shared that it not only deepened their commitment to their field but it made them more compassionate towards their patients due to their own experience with having contracted the virus (Piredda et al., 2022). In an effort to further the counselor's sense of vicarious resilience, protective factors such as self-care, supportive work environments, vitality, relaxation, and self-efficacy should be utilized (Martin-Cuellar et al., 2019; Merriman, 2015).

The Impact on Clinically Licensed Counselors

Historically, counseling was conducted in unregulated ways and in various settings in ancient Greece and Rome, prior to the official use of the word "counseling" in 1931, when it was used to describe the techniques and philosophies used by individuals who provide counseling services (Leahy et al., 2015). Vocational guidance began in the United States in 1909 by Frank Parsons, whereas school-based vocation guidance was introduced by Jesse Davis and Stratton Brooks (Leahy et al., 2015). Teachers were considered to be vocational counselors from 1940-1950 and taught vocational guidance as a part of their classroom curriculum (Leahy et al., 2015). Carl Rogers's client-centered

counseling revolutionized and changed the trajectory of the counseling profession (Leahy et al., 2015).

The ACA was founded in 1952 and was originally called the American Personnel and Guidance Association (APGA; Leahy et al., 2015). After the name change to the American Association for Counseling and Development (AACD) in 1983, it subsequently became the ACA and since then has served as the main professional association for counselors (Leahy et al., 2015). The Commission on Rehabilitation Counselor Certification (CRCC) was the first to credential school counselors in 1973 while the National Board for Certified Counselors was established in 1982 to take counselor credentialing to the national level (Leahy et al., 2015).

Clinically licensed counselors initially were licensed only in Virginia in 1975, but now all 50 states have counseling licensure laws (Leahy et al., 2015). Clinically licensed counselors vary in name and licensure requirements from state to state (ACA, 2023). Clinically licensed counselors are also called licensed professional counselors (LPC), licensed mental health counselors (LMHC), licensed clinical professional counselors (LCPC), licensed professional clinical counselors of mental health (LPCC), licensed clinical mental health counselor (LCMHC) and licensed mental health practitioners (LMHP), depending on the state of the licensed individual (ACA, 2023). Despite the variability, for the purposes of this research, I will refer to the designated counselor group as clinically licensed counselors. Clinically licensed counselors are master's level mental health professionals who are licensed, have passed a national exam such as the National Counselors Exam (NCE) or the National Clinical Mental Health Counseling Exam

(NCMHCE), and have completed direct and indirect clinical hours (ACA, 2023). After completion, they have the ability to diagnose mental disorders for insurance purposes and counsel individuals experiencing various mental health issues such as anxiety, depression, feeding disorders, and PTSD (Alterkruse et al., 2001; ACA, 2023). Clinically licensed counselors often work in various settings such as private practice, group practices, school districts and counseling organizations (Leahy et al., 2015).

Clinically licensed counselors work to uplift their clients but the process of delving into the client's issues and traumas can cause the counselor to experience emotional exhaustion and affect their work ethics and sense of self (Martin-Cuellar et al., 2019). During counseling sessions, clinically licensed counselors are expected to be fully engaged in the client's experiences in order to fully assess the client's emotional safety without becoming emotionally dysregulated (Glennon et al., 2019; Litam et al., 2021). This immersion into the client's trauma stories often puts the counselor at risk (Glennon et al., 2019). The counselor is then working to safeguard the client, the integrity of the therapeutic relationship or dynamic, and themselves during the counseling session (Glennon et al., 2019).

Summary and Conclusions

Chapter 2 provided a detailed analysis of the current literature regarding the effects of COVID-19 on helping professionals as well as the research strategies utilized to obtain this information. This in-depth analysis indicated an exciting gap in the literature. The gap in the literature indicates that minimal research has been conducted on

the effects of COVID-19 on the clinically licensed counselor population which provides the foundation for future research.

Chapter 3: Research Method

Phenomenology

Phenomenology originated as a countermovement philosophy to logical empiricism in the 1900s by Edmund Husserl (Abalos et al., 2016; Giorgi, 2005). The preparatory phase of phenomenology was led by Frantz Brentano and was psychological in nature due to its description of the mind and its phenomena, and concentrated on intentionality (Abalos et al., 2016; Bakhtiarian & Benvidi, 2021; Gao, 2020). The second phase, or the German phase, which heavily involved Husserl and Heidegger, emerged and changed the focus to the concepts of essences, intuiting, and phenomenological reduction (Abalos et al., 2016; McGaha & D'Urso, 2019). The third phase was the French phase and the key figures are Gabriel Marcel, Jean-Paul Sartre, and Maurice Merleau-Ponty, who focused on the concept of embodiment (Abalos et al., 2016; Giorgi, 2005; Tayko, 2023; Ungvarsky, 2020). Although Husserl and Heidegger are considered dominant figures in the world of phenomenology, several researchers were also recognized for their contributions to phenomenology during its three phases, including Colaizzi, Giorgi, Paterson, Zderad, Spiegelberg, Streubert, Van Kaam, and Van Manen (Abalos et al., 2016).

Phenomenology is a methodological research method that investigates people's views or perceptions of their experiences (Ungvarsky, 2020). A key aspect of phenomenology is that humans learn from their experiences (McGaha & D'Urso, 2019). The goal of phenomenology is to gain clear perceptions about what has occurred, or the

phenomena (Giorgi, 2005). In other words, the meaning of the experience, or essence, is the studied phenomena (Abalos et al., 2016; Gao, 2020).

Husserlian Phenomenology

Edmond Husserl's approach to phenomenology is often called descriptive phenomenology because it suggests that essence, or the meaning one gives to a particular experience, resides at the core of their reality (Abalos et al., 2016; Willis et al., 2016). In an effort to obtain transcendental subjectivity, the techniques utilized in Husserlian phenomenology include phenomenological reduction and bracketing (Abalos et al., 2016; Zhang, 2021). Phenomenological reduction is the initial process of setting aside assumptions and biases regarding a particular phenomenon so that the essence, or essential meaning of the phenomenon, can be derived as the researcher reasons and thinks about the phenomenon in different ways (Abalos et al., 2016; Himanka, 2019; Smith et al., 2022). Bracketing, or parenthesizing, is a central component of the reductive process because it requires the researcher to reserve, or put aside, their prior knowledge when interacting with study participants, while reflecting on the participant's perception of the world within the data (Abalos et al., 2016; Gutland, 2018; Smith et al., 2022).

Hermeneutic Phenomenology

Hermeneutics differs from Husserlian phenomenology because it is mostly interpretative and has philosophical roots (Smith et al., 2022). A main proponent of hermeneutics was Heidegger, who concluded that the appearance of things has a conspicuous and hidden meaning based on the individual (Smith et al., 2022). To Heidegger, phenomenology explores that which is hidden and that which comes to light

(Smith et al., 2022). Phenomenon is then the perception of things that appear and logos is the analyzation of or judgments about what appears creating the meaning for and aim of the word “phenomenology” (Smith et al., 2022).

Interpretative Phenomenological Analysis

The IPA approach is grounded in the essence of phenomenology because all experienced phenomena are interpreted (Patton, 2015; Southby et al., 2021;Thackeray & Eatough, 2018). The participants’ interpretation of their experience, or how they make sense of their experience, provides the researcher with a more in-depth perspective concerning the participant’s inner world (Lucey & van Nieuwerburgh, 2021). The goal of the IPA approach is to elicit rich descriptions of the participant’s experiences and to decipher if there is any ambiguity concerning the participant’s perception of their lived experience (Smith & Nizza, 2022). More specifically, the IPA approach consists of utilizing techniques such as conducting interviews, analyzing, and interpreting the meaning of the data, and validating the data by allowing a small group of participants to assess and validate their interpretations (McGaha & D’Urso, 2019; Pritchard & van Nieuwerburgh, 2016).

Research Design and Rationale

The qualitative research method was the most appropriate method to utilize to gain knowledge about the lived experiences of clinically licensed counselors. Qualitative research methods help researchers gain deep, in-depth, and complex understanding of a participant’s specific issue which for the purposes of this study are their lived experiences (Salvilla & Bedoria, 2021; Smith & Nizza, 2022). This was in alignment with Edmund

Husserl's request that phenomenological researchers "go back to the things themselves" instead of studying how the manipulation of different variables change a person's perspective seen in quantitative studies (Smith et al., 2022). Therefore, the goal was to help the participants go inward to explore their perceptions about the events versus simply witnessing the actual events (Smith et al., 2022).

IPA is a qualitative research method that enabled me to obtain rich, detailed data from clinically licensed counselors about how they make sense of their lived experiences during COVID-19. Like most phenomenological research methods, IPA seeks to discover the personal meaning behind the person's unique experiences (Alsawy & Mansell, 2013; Smith & Nizza, 2022). IPA has roots in phenomenology, hermeneutics, and idiography (Smith et al., 2022). IPA is phenomenological in nature because it focuses on learning more about how people consciously and intentionally make meaning of their experiences (Smith et al., 2022). IPA lends itself to hermeneutics because of its interpretative nature as the researcher seeks to notice what appears or comes to the surface during the participants' account of their experiences while also analyzing or making sense of the participants' perceptions of their lived experience (Smith et al., 2022). IPA has an idiographic focus which means the researcher pays close and systematic attention to revealed details as they seek to gain insight into how the participant makes sense of a given situation (Smith et al., 2022). The focus then is not on the actual participant but on the particular lived experience of that participant (Smith et al., 2022).

Role of the Researcher

Positionality

The researcher's role is to elicit the participant's personal and unique accounts about their lived experience, to reflect upon and interpret the information provided, and then to write in detail about the participant's described perceptions in order to better understand their experience (Smith et al., 2022). In essence, the researcher takes on the dual role of striving to make sense of the participant's efforts to make sense of their unique experience which is considered to be a double hermeneutic technique (Smith et al., 2022). The researcher does this by acknowledging one the founding principles of phenomenology which is to explore experiences without any manipulation on the part of the researcher (Smith et al., 2022).

Methodology

Participant Selection Logic

Participants were purposively selected to participate in this study based on their ability to provide information about the particular phenomenon of interest which is their lived experiences as a clinically licensed counselor during COVID-19 (Smith et al., 2022). Other inclusion criteria includes having ownership of a solo private practice for a minimum of 2 years, having met the criteria of having earned a minimum of a Master's degree in counseling, and having met their state's criteria to obtain licensure. The literature indicates that the field of psychology is mostly inhabited by women (Beasley et al., 2021). However, for ease of recruitment, all individuals were invited to participate in the study.

Instrumentation

Semi-structured interviews were conducted to explore how the clinically licensed counselors fared during COVID-19. Ravitch and Carl (2016) stated,

> The primary goals of qualitative interviews are to gain focused insight into individuals' lived experiences, understand how participants make sense of and construct reality in relation to the phenomenon, events, engagement, or experience in focus; and explore how individuals' experiences and perspectives relate to other study participants and perhaps prior research on similar topics.

A semi-structured, one-to-one interview schedule was created to investigate the lived experiences of the clinically licensed counselors. The interview questions were constructed to help the participants recall parts of their experience (Smith et al., 2022). The questions explored the experiences of the clinically licensed counselors during COVID-19 and gained information about what, if any, emotional or mental effects did counseling during COVID-19 have on them, how did that experienced change them for the better or worse on a professional and personal level, and what did they do to cope with any negative effects of counseling during COVID-19. Interview questions were used flexibly by removing or adding questions depending on previously addressed topics or the presentation of novel topics (see Smith et al., 2022).

Procedures for Recruitment, Participation, and Data Collection

Recruitment

In keeping with the IPA method of participant recruitment procedures, participants were recruited by utilizing referrals, opportunities, and snowballing (Smith et

al., 2022). Referrals from gatekeepers of online counseling communities on Facebook were utilized. When approval was received, flyers and posters were posted in these groups (Negrin et. al., 2022). Opportunities from my own contacts as well as from the directory, Psychology Today, were also utilized. Utilizing contacts from a population from which the researcher is known is considered to be advantageous to recruitment and helps with building rapport due to the inherent trust, credibility, and respect that others in the population may have for the researcher (Negrin et. al, 2022). Other attempts to recruit participants resulted from snowballing or receiving possible candidates for the study from other referrals.

Participation

The IPA approach suggests the use of small sample sizes due to the time-consuming nature of detailed analyzation of participant transcripts (Smith et al., 2022). Ideally, six participants is recommended to keep the participant sample small (Smith et al., 2022). However, a maximum of 10 participants were to be selected for this study and were to be interviewed one time. Participation was based on specific inclusion criteria. The clinically licensed counselor needed to be an individual who has owned and worked in their solo private practice for a minimum of 2 years. The solo private practice criterion and 2-year threshold were selected because it narrowed the gap of experience and helps to create a more highly recommended homogenous participant group (Smith et al., 2022).

Data Collection

Data collection began with asking the participants a few questions contained in a brief questionnaire designed for use in this study. Requested questionnaire information

included their demographic information, counseling specializations, and open-ended questions about their lived experiences during COVID-19. According to Ravitch and Carl (2016), " Thus, interview transcripts are of central concern as a hallmark of qualitative data; they are most often viewed as necessary to rigorous data collection and analysis." Then a semi-structured interview was conducted to ensure that participants have the opportunity to fully share their thoughts, ideas, concerns, and feelings within the interview. The semi-structured interview format was also selected because it offers the flexibility to change the structure or organization of the interview schedule based on the participant's personal account. The aim of the remote, semi-structured interview was to present the overall topic for the interview and then allow the participant to discuss in great detail their unedited account of their lived experience. Questions were utilized to keep the participant talking, thinking and reflecting on their lived experience (Smith et al., 2022). Any epiphanies that occurred while listening to the participant's account were noted in a separate notebook for future review.

Each remote, semi-structured interview was audio-recorded and then later transcribed verbatim. If a participant opted to answer the interview questions in a written or diary form, then the contents of the written form (diary) would be transcribed to a line-numbered format (Smith et al., 2022). During transcription of the semi-structured interview, all utterances (i.e., laughter, pauses, hesitation, etc.) were noted with bracketed italics as suggested by the IPA approach (Smith et al., 2022).

Data Analysis Plan

The systematic, qualitative analysis process of IPA provided a detailed examination of the participant's personal lived experience (Smith et al., 2022). I analyzed the semi-structured, one-to-one interview transcripts using a systematic approach that involved recalling the parts of the participants' lives that they mentioned, analyzing how they are connected, and gaining knowledge about the common meaning or themes that emerged (see Smith et al., 2022). The IPA methodology began with reading/re-reading the interview transcription. After listening to the recorded audio of the interview, I transcribed the interview verbatim. Once that was completed, I listened to the audio of the interview again while reading the completed transcript. I also reviewed any notes, if any, that I took while conducting the interview. I re-read the interview transcript as needed to obtain the fullest interpretation of their lived experience. I then completed exploratory notes concerning any pattern or saying that is of interest or was not previously noticed. I also constructed experiential statements based on the participant's transcript and my exploratory notes. These experiential statements consisted of a summation of what I deemed to be crucial aspects within the various sections of the transcript. These experiential statements combined not only the participants' thoughts and perceptions but also my own thoughts about their personal account (Smith et al., 2022). Next, I connected and organized the experiential statements by utilizing a selected charting or mapping method (i.e., Atlas Ti) to obtain patterns within the participant's personal account. Identifying emerging themes, more specifically, identifying personal experiential themes (PETs) for each participant was conducted by organizing the

experiential statements onto a summary table that includes the page number and key words/themes in the transcript. This step highlights the interpretative part of the IPA approach (Smith et al., 2022). The culmination of systematically analyzing each participant's transcript as listed above is the attainment of group experiential themes (GETs) which indicate patterns of convergence and divergence within the personal accounts of the participants (Smith et al., 2022).

Issues of Trustworthiness

The term, validity, refers to the degree of authenticity, appropriateness, and rigor of a qualitative research design and methodology (Ravitch & Carl, 2016; Singh et al., 2021b; Smith et al., 2022). In other words, if the research design and methodology are appropriate, rigorous, and contribute to the literature, then it is deemed valid. Acceptable IPA research must have a phenomenological orientation, focus on the participants' experiences, be interpretative and create new insight into a phenomenon, and should be idiographic in nature, be transparent in data collection and analysis methods, and show examples of findings (i.e., PETs, GETs, experiential statements, etc.) in included tables (Smith et al., 2022).

Despite the proven strengths of validity, or trustworthiness, in qualitative research, the act of describing things within the descriptive phenomenological approach can inadvertently cause research bias to occur unless validity procedures are outlined, stipulated, and utilized throughout the study (Creswell & Creswell, 2018; Ravitch & Carl, 2016). As a result, the rigor of this type of research has been questioned (McGaha & D'Urso, 2019). Criticism of this approach intensifies the importance of accurately

documenting procedures that can be systematically reproduced and adhered to by future researchers (Creswell & Creswell, 2018).

Credibility

Credibility refers to the internal validity of the research design (Ravitch & Carl, 2016). In other words, qualitative research is deemed credible if the researcher's chosen research design and instruments measures what it is supposed to measure while appropriately considering unforeseen occurrences or patterns (Ravitch & Carl, 2016). Establishing credibility can be strengthened with the use of several tactics such as utilizing triangulation, member checking, and using thick descriptions (Ravitch & Carl, 2016). Triangulation was utilized by cross-checking and analyzing the data gathered from the interviews, to what I actually observed, as well as by reviewing collected documents (Merriam, 2009). To establish credibility, I clearly outlined and defined the appropriateness of my selected research design and conducted reflexive journaling to better understand my personal perspectives, values, search for truth and how they influence my research decision-making (Banks et al., 2023; Singh et al., 2021b).

Transferability

Transferability, or generalizability, measures how well qualitative research stands up to external validity or comparison to other settings and context (Ravitch & Carl, 2016). I explored and detailed the context of my research in relation to prior research.

Dependability

Dependability, or reliability, in qualitative research suggests that the research will stand the test of time because the data collection process and result data are consistent

and stable (Ravitch & Carl, 2016). I provided detailed accounts of my research processes and findings within the context of my research design, notes, and summary tables.

Confirmability

Confirmability, or objectivity, is important in qualitative research because qualitative research is often not objective but it can demonstrate confirmability by acknowledging research bias in our interpretations of the data (Ravitch & Carl). To ensure confirmability, I conducted reflexive journaling in an effort to stay abreast of any biases and prejudices I may have throughout the research process.

Ethical Procedures

Ethical procedures were in place and strictly adhered to throughout the study. The overall ethical standard that I adhered to is to do no harm to the study's participants. It is understood that talking about the sensitive subject of mental and emotional well-being could unintentionally cause harm to the participants, so an informed consent form detailing the contents of the prospective interview guide, their rights, as well as how their verbatim accounts may be used was distributed and required for participation (Smith et al., 2022). If a participant consented to the remote interview and was negatively affected in some way by their disclosures, I would assist them with obtaining mental health care by providing a number to a national counseling helpline.

In an effort to ensure confidentiality, suggested methods to ensure privacy while personal data is collected were discussed prior to the semi-structured interview. The participant was allowed to opt for remote interviewing via phone and had the option of disconnecting from the interview at any time. Participants may be offered to provide a

written account of the interview schedule if they are uncomfortable with or unable to technically accommodate remote interviewing. The participant was notified that no unedited transcripts would be shared with anyone, that any edited and shared transcripts would not contain any identifiable information, participant identifiers would be provided initially (i.e., P1, P2, etc.) and then changed to a non-descript pseudonym within the study, and if transcription services were used the information sent to them would be anonymous. The participant was also notified that they can review the complete transcript and suggest possible edits prior to final submission. The participant was also given the opportunity to withdraw from the study for up to one month after the interview or until final submission of the transcribed interview was submitted, whichever occurred first.

Summary

In this chapter, I outlined my chosen methodology and detailed my research design and rationale. I shared aspects of my role as the researcher and described my data collection and analysis plan. I also reviewed several issues of trustworthiness, offered strategies I utilized to avoid those issues, and delved into the ethical practices used to ensure participant's safety and care. In Chapter 4, I discuss the results of this study.

Chapter 4: Results

Introduction

The purpose of this qualitative, interpretative phenomenological analysis was to gain needed insight into the lived experiences of clinically licensed counselors during COVID-19. The results of my research findings are presented in Chapter 4. In this chapter, the setting, demographics of the participants, data collection methods, and data analysis methods are discussed. Trustworthiness, credibility, transferability, dependability and confirmability are also described. The themes or group experiential themes that emerged as a result of this study are also explored in this chapter.

The foundation of this study was centered on the research question: What are the lived experiences of clinically licensed counselors during COVID-19? Semi-structured interviews were conducted via telephone using the Free Conference App. Interviews were scheduled for at least 60 minutes. Once the participants logged into the secure and private conference waiting room, they were greeted with a brief, pre-recorded introductory message about the study before the interview began. Once the participant was allowed to enter the conference room, they were warmly welcomed. Next, the informed consent was reviewed and some demographic information was collected including gender, race, marital status, counselor specialty and geographic location. Each participant was asked a series of questions and subquestions during the interview to obtain descriptive narratives about their pre- and post-COVID-19 experiences.

The following 24 questions were included in the interview guide:

1. Could you please tell me why you became a clinically licensed counselor?

2. What made you decide to go into private practice?
3. Can you tell me what your job entails or consists of day to day?
4. What is the difference between a good day at work and a bad/rough day at work?
5. What is the difference, if any, between a good day at work and a bad day at work since the COVID-19 pandemic?
6. Are you currently in-office, telehealth only, or a hybrid? Is it easier or harder working with clients via telehealth? More or less fatigued with telehealth? Why do you think telehealth may be more tiring?
7. How do you feel after a bad/rough day at work?
8. Can you tell me about what your experience was like working in a solo private practice during COVID-19?
9. What, if any, trends did you notice with your clients? How did they cope? Did you notice any symptoms lessened or worsened? How did COVID-19 affect them?
10. What, if any, conflicts did you have with telling your clients to reach specific treatment goals and knowing that they could not accomplish the goals at that time due to COVID-19?
11. What was the transition to being home, using telehealth, etc. due to COVID-19 (i.e., quarantine) like for you personally?
12. Can you tell me if there was more or less of a connection to your clients due to experiencing the same thing at the same time?

13. Did you transition back to your practice and what was it like? What made you decide to stay with telehealth?
14. How did you prepare to transition back to in-person? (Opt.)
15. What was it like to remove your mask in session with your client after the mandate was lifted? (Opt.)
16. What, if any, was your experience with contracting COVID-19?
17. How did you cope with negative experiences while working in your solo private practice during COVID-19?
18. Can you tell me about any positive experiences that occurred while working in your solo private practice during COVID-19?
19. How do you think your life has changed as a result of counseling clients during COVID-19? What do you do differently since COVID-19?
20. What, if any, office setup changes or office procedure changes did you make during COVID-19? (Opt.)
21. What, if any, self-care practices do you utilize as a result of counseling during COVID-19?
22. What do you think future researchers need to investigate in regard to the post-COVID-19 state of the clinically licensed counselor profession?
23. If you could sum up your COVID-19 experience in a word or sentence, what would it be?

24. Would you like a follow-up email that includes my takeaways from the interview so that you can confirm whether or not my interpretations accurately convey your views/sentiments? (Member Checking)

In this study, the participants' personal experiential themes (PETs) were analyzed and re-analyzed to obtain the participants' group experiential themes (GETs). The group experiential themes provided rich insight into the lived experiences of these clinically licensed counselors during COVID-19. Each audio interview was transcribed using Rev.com after the interview. Member checking was utilized to ensure validity. The consenting participants received a copy of their transcript as well as a thematic summation of their sentiments to review and to redact, if needed (Ravitch & Carl, 2016).

The evaluation of the transcripts involved several steps. The audio of each participant's interview was reviewed once to digest the information that they provided without making notes to re-immerse myself into their personal narrative. Then, the audio of the participant was reviewed again while interacting with their interview transcript. Exploratory notes were made on the printed transcript. The first cycle of coding involved reading the interview transcript again and making descriptive notes that identified the participant's personal experiential themes/statements (PETs) in Atlas-ti. When using IPA methodology, experiential themes or statements are the same as emerging themes (Smith et al., 2022). The second cycle of coding involved creating patterned, thematic codes from the personal experiential themes of each participant to create group experiential themes (GETs). Finally, the audio was reviewed again alongside the transcript, notes, and codes to ensure accuracy and decrease the potential for researcher bias.

The two cycles of coding clearly illuminated where participants' experiences converged and diverged during their experiences of the same phenomenon, COVID-19. Thoughts and analytic processes were written in a field notes journal throughout the evaluative, data collection process.

Setting

The semi-structured interviews were conducted via the Free Conference App. Participants received an encrypted email that provided the login information to access the interview conference line. There were no technological glitches while utilizing this platform. Once the participant logged in, they listened to a brief, pre-recorded introductory welcome message. Once the recording ended, the participants were instructed to record their name so that they could be moved from the waiting room into the actual call conference room. At the start of the interview, participants were personally welcomed, reminded of the purpose of the interview, provided with a statement concerning confidentiality and the data collection process, given their personal identifier (i.e., P1, P2, etc.), and the informed consent was reviewed. The participants were afforded the opportunity to ask any questions they had about informed consent and they were reassured that if they needed to stop the interview for any reason they could choose to utilize that option. At the start of the interview, participants were asked a few questions to gain demographic information including insight into their gender, race, marital status, geographic location, counseling population, and area of specialization (if any). During the interview, participants were asked questions according to the interview guide. Additional subquestions were asked if clarity was needed. Questions were rephrased if additional

clarity concerning the asked question was needed. After each interview, the participants were asked if they had any questions that needed to be answered before ending the call and gratitude was expressed for their participation. If the participant opted to participate in member checking, they were reminded that they would receive a copy of the transcript as well as a thematic summation of my interpretations of their sentiments for their perusal (Ravitch & Carl, 2016).

Demographics

Upon approval from Walden University Institutional Review Board (02-01-24-0100268), invitations to participate in the study were posted in online counselor groups, Walden's participant pool, and sent via email to counselors on the Psychology Today platform. All participants in the study resulted from online counselor groups. A total of seven participants met the inclusion criteria and elected to participate in the study. The social media invitation letter included a brief description of the study, eligibility requirements, and contact information. Once the participant responded to the invitation via email with "I'm interested," they were emailed the informed consent letter to review. If they opted to participate in the study, they responded to the encrypted informed consent letter with "I consent" and included three preferred interview dates and times. Once their response was received, the participant was sent an encrypted respondent email that stipulated their selected date and time for the telephone interview as well as login information for the Free Conference audio room.

Despite the study being open to any individuals, the seven participants that met inclusion criteria and elected to participate in this study were self-identified cis-gendered

women. Table 1 provides demographic information on each of the seven participants to allow the reader to gain additional insight into each of the participants. To further protect the privacy of the participants their initial interview participant identifiers (i.e., P1, P2, etc.) have been changed to pseudonyms for the purposes of this study.

Table 1

Participant Demographic Information

Name [a]	Race	Gender	Marital status	Location	Virtual, office, or hybrid	Counseling population/ specialization
Finley	White	Female	Married	Connecticut	Hybrid	Adults only (trauma)
Quinn	African-American	Female	Married	South Carolina	Virtual	General
Jordan	White	Female	Married	Colorado	Virtual	Addiction counseling
Blake	African-American	Female	Married	South Carolina	Hybrid	General
Harper	African-American	Female	Single	Ohio	Virtual	Couples (sex therapy)
Jamie	White	Female	Married	Maryland	Virtual	Children (some adults)
Emerson	Hispanic	Female	Single	Colorado	Hybrid	General

[a] Pseudonyms were assigned to protect the identity and privacy of the participants.

Data Collection

Seven women participated in the telephone interview utilizing the platform, Free Conference. Each interview was allotted 60 minutes, but some interviews concluded after 45 minutes. All interviews were audio-recorded and completed in one session and there were no connectivity issues. There was an issue in which the participant was not moved from the waiting room into the telephone conference room because the Free Conference App did not announce the arrival of the participant. After emailing each other and then

logging back onto the platform, the issue was resolved and the interview continued as planned. The interview guide was utilized during the telephone interview. Several intentional efforts were made to ensure the confidentiality of the participant such as storing the audio recordings and code book separately and securely from the interview transcripts and utilizing identifiers (i.e., P1, P2, etc.) throughout the process. The initial participant identifiers were changed to pseudonyms after the interview was completed. The original plan submitted to Walden's IRB was adhered to with no changes.

Data Analysis

The data analysis process was rigorous and consisted of immersing myself in the data using various techniques to fully understand the lived experiences of the clinically licensed counselors during COVID-19. The data analysis process included listening and re-listening to the audio transcripts, writing exploratory notes, two cycles of coding, journaling, writing field notes, and deeply reflecting to derive meaning from the participant's experiences. Initially, during the first cycle of coding, descriptive coding was utilized to create codes that represented the participant's personal experiential themes/statements (PETs). The elemental coding method, or descriptive coding, utilizes the technique of designating descriptive codes to participant's experiential statements for the purposes of creating an inventory of emergent themes (Saldana, 2016). During this inductive, first cycle coding process, codes began to emerge from the data as each participant's experiential statements were analyzed. Once the descriptive coding was completed, the second cycle of coding commenced which consisted of pattern coding. Pattern coding helped me to encapsulate the participants' group experiential themes

(GETs) and to ascertain where the experiences of the clinically licensed counselors converged and diverged. Pattern coding was used to discover the personal experiential themes which were then categorized into an inventory of emergent themes (Saldana, 2016). The emergent themes are discussed in the Results section.

Journaling was utilized to help separate my own experiences of being a clinically licensed counselor in private practice during COVID-19 from my participants' experiences. Overall themes emerged as the data was evaluated. The 4 emergent themes were: private practice, COVID-19 quarantine experiences, counselor adaptations to COVID-19 and future research recommendations.

Evidence of Trustworthiness

Acceptable IPA research must have a phenomenological orientation, focus on the participants' experiences, be interpretative and create new insight into a phenomenon, and should be idiographic in nature (Smith et al., 2022). It should also be transparent in data collection and analysis methods and show examples of findings or emergent themes in included tables (Smith et al., 2022).

Credibility

Credibility refers to the internal validity of the research design (Ravitch & Carl, 2016). In other words, qualitative research is deemed credible if the researcher's chosen research design and instruments measures what it is supposed to measure while appropriately considering unforeseen occurrences or patterns (Ravitch & Carl, 2016). Establishing credibility can be strengthened with the use of several tactics such as utilizing triangulation, member checking, and using thick descriptions (Ravitch & Carl,

2016). Triangulation was utilized by cross-checking and analyzing the data gathered from the interviews, to what was actually observed, as well as by reviewing collected documents (Merriam, 2009). To establish credibility, the appropriateness of my selected research design was clearly outlined and defined. Reflexive journaling was conducted to better understand my own personal perspectives, values, search for truth and how these values influenced my research decision-making (Banks et al., 2023; Singh et al., 2021b).

Transferability

Transferability, or generalizability, measures how well qualitative research stands up to external validity or comparison to other settings and context (Ravitch & Carl, 2016). The context of my research in relation to prior research was explored and detailed.

Dependability

Dependability, or reliability, in qualitative research suggests that the research will stand the test of time because the data collection process and result data are consistent and stable (Ravitch & Carl, 2016). Detailed accounts of my research processes and findings were provided within the context of my research design, notes, and summary tables.

Confirmability

Confirmability, or objectivity, is important in qualitative research because qualitative research is often not objective but it can demonstrate confirmability by acknowledging research bias in the interpretations of the data (Ravitch & Carl). To ensure confirmability, reflexive journaling was conducted to stay abreast of any biases and prejudices that may have occurred throughout the research process.

Results

Participant responses were analyzed and personal experiential themes (PETs) were created for each participant. The IPA approach suggests that the term, emergent themes, be replaced with personal experiential themes (Smith and Nizza, 2022). However, for the purposes of this study, they will be used interchangeably. The personal experiential themes were analyzed multiple times to discover where the participants' experiences converged and diverged. This data was used to create group experiential themes (GETs) or overall emergent themes. Figure 1 shows the main group experiential themes that emerged from the data. Table 2 illuminates the subthemes and subtopics that also emerged from the data.

Figure 1

Emergent Themes

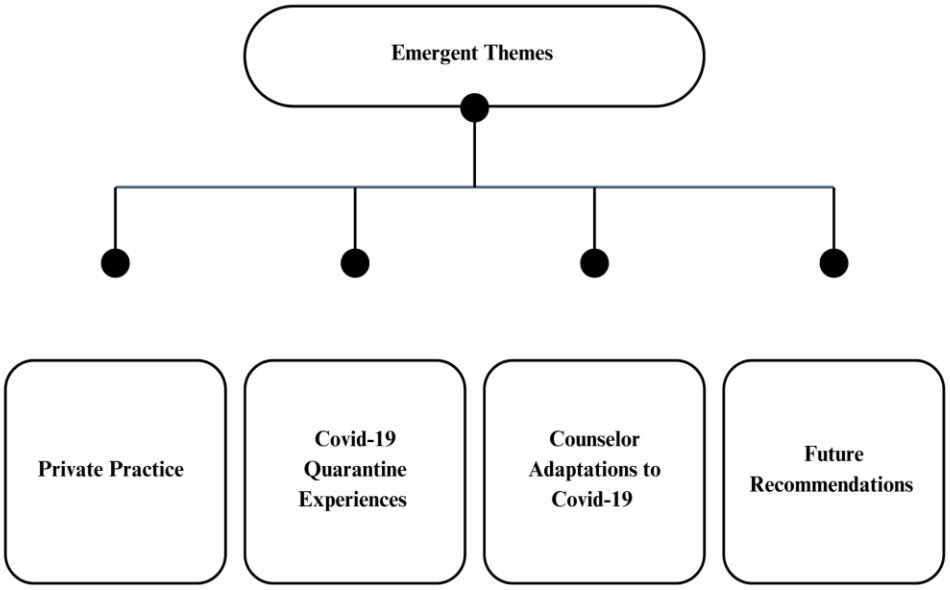

Table 2

Emergent Themes, Subthemes, and Subtopics

Emergent themes	Subthemes and subtopics
Private practice	Factors for clinical licensing
	Factors for starting private practice
	Navigating work experience in private practice Positive work experiences Negative work experiences
COVID-19 quarantine experiences	Counselor experiences Quarantine Telehealth Isolation Connection Treatment goals
	Client experiences
Counselor adaptations to COVID-19	Professional adaptations
	Personal adaptations Coping mechanisms Self-care
Future research recommendations	Summation of COVID-19 experience
	Research recommendations post-COVID-19

Emergent Theme 1: Private Practice

Emergent Theme 1 is the result of probing interview questions that sought to gain insight into the participants' professional and personal lived experiences before and after the COVID-19 pandemic. The participants shared their rationale for becoming a clinically licensed counselor and for starting a private practice. The initial interview questions were used to obtain an in-depth look into how positive and negative work experiences psychologically and emotionally impacted each participant and to discover if

there were any changes in the participants' perception of positive and negative work experiences as a result of the COVID-19 pandemic.

Factors for Clinical Licensing

The seven participants shared several intrinsic, extrinsic, and happenstance professional and personal reasons for becoming a clinically licensed counselor. Finley and Blake both credited family mental health issues with their quest for knowledge to better understand what makes a person process information and behave differently. Finley stated,

> Initially, when I was younger, my mother had depression. She had a lot of self-help books on the bookcase and I was a reader. I loved to read and I just started reading some of her books. I thought they were really, really interesting and I got really excited about it. Then I took psychology classes and I just developed a passion for it … like just the topic of helping people. Just the way that the brain works and how to talk to people and just learning about how our thoughts impact our emotions and just all of that. Neuroscience is really interesting to me as well.

Blake expanded these sentiments with her initial interest in serial killers and family members that have experienced mental health issues:

> Two components. I guess I've always had an interest in behavioral health … kind of weird … but I've always been very interested in serial killers. Like what makes their mind do this and everybody else's mind do that. So, I've always had an interest in behavioral health and I guess when the opportunity presented itself, I just kind of jumped into it because it was natural. It was a natural interest of mine.

> In addition to that, over the years I've seen—unbeknownst to myself because I was not necessarily trained—I've seen many of my family members endure mental health issues from mood disorders, substance abuse issues, and things of that nature. So, it's always been something that has been kind of in the background of my life. So, it just seemed like a natural thing to do when I decided to get my master's degree.

Quinn credited engaging in marital counseling with her desire to become clinically licensed:

> I actually had a completely different profession so I kind of started late in this profession. I worked for the government. I was a human resources specialist and a military wife. So, we traveled quite a bit. So, what kind of led me down this road … I wasn't happy in my job and there was a lot of struggles that my husband and I experienced while he was in the military with me just following around. I was a soldier as well and we met in the military. I decided to get out and just focus on our family. We experienced a lot of, you know, a lot of issues in our marriage and we went to counseling. I experienced the working on yourself part of it. Just seeing when you really make a decision to work on the things you don't like about yourself how impactful that can be and that's what kind of made me want to do this work. To help people get to that place where they wanted to do the work.

Jordan and Jaime both started out on a different career path and wanted more connection with the population they served. Jordan stated,

> I was a nurse for about ten years before I kind of made the transition into counseling. I worked with the elderly at first and then I moved into more psychiatric care and just the longer-term mental health stuff. I worked detox and I worked inpatient. When I was there and finishing my undergrad in psychology, I just wanted to do more than just pass pills, you know, so I was like I wanna talk to these people. I wanna have the time to talk to them. So, when I finished my undergrad in psychology, I went ahead and looked at counseling and the different avenues that entail like social workers and professional counselors and I settled on professional counseling. I liked the focus of a professional counselor.

Jamie worked in public education but wanted a closer relationship with her students:

> I was a high school teacher after a lot of other careers. I taught high school for 10 years. I explored several other things within the school system because what I was finding was that I didn't love the curriculum or the standardized testing, but I did love working with the students. I loved helping the students. So, I looked at school counseling and I looked at becoming a pupil personnel worker and I took some classes in each of those. While in my own therapy, as I was getting divorced, my therapist said, "You really need to go back to school and be a therapist." So, two weeks later, I signed up for the online course with a university. Then I quit my teaching job to do the practicum and internship.

Harper's unexpected pregnancy after obtaining her undergraduate degree led her to seek an online counseling program:

So, my journey started after undergrad school. Two months after graduating, I found out that I was pregnant with my son at that time. Something in me was like, you need to focus and you have an interest in working with families. So, I went through the program and enjoyed every ounce of it. I was really learning about myself as an individual and learning about the field in systems and thinking about systems—from a systems perspective and approach—therapeutic approach. At the core of us is two people. I wanted to only focus on couples from the beginning. Educating and providing therapy to them has been my driving force in itself.

Emerson shared that she entered the counseling profession by experiencing a series of unexpected events:

So, I was never the person that was like … oh my gosh, I wanna be a therapist for like a long time. I actually played volleyball in college, so I didn't really think much about career stuff during that time. I was a communication major at that point. And then my senior year, my spring semester—so right before graduation––I took a career planning class that was actually a human services course. I took it for like an easy "A" and we did a lot of like self-assessments. In that class, I kind of realized that wanting to be a social media manager would kill my soul a little bit. Sitting behind the computer all day— because I'm like so extroverted that I was like—I didn't realize this is really gonna take a toll on me. So, at that point I became very interested in career counseling specifically to athletes because I felt like we don't get a lot of support around career development when you're an athlete. So, I was doing career work and my internship was at an agency that

> worked with substance use. So, then that's kind of when I started to branch out past just career work. It kind of fell into my lap and that's how I became a counselor and why I became a counselor.

Factors for Starting Private Practice

The seven participants shared their rationale for starting their own private practice versus working for an agency or group practice. The participants credited the need for freedom, independence, control of their schedule and client load among the reasons why they chose private practice. Jordan, Blake, Quinn, Emerson, and Jaime started their counseling career with an agency. Jordan stated,

> So, I did my internship, practicum, and then part of my fellowship at an agency and it was not my speed. It was just very…like as many people as we can see, as fast as we can see 'em. I felt like there was just a limit to the quality of care that you give and also just the capacity of the counselors. Like you get worn out and you get burned out very quickly with 40 hours of scheduled time with people. I mean, I'm not even sure how I remembered half of their stories at that point. Kind of cookie cutter. So, private practice offered like a flexibility that I wanted and more quality care that I wanted to give.

Blake shared,

> I did do some work in agency. I worked with the Department of Mental Health, which is our state mental health system, and I also worked in our inpatient program treating eating disorders. I did part of my internship process in private practice and it just seemed as if you had a little bit more freedom, so to speak, in

> private practice. In agency work, it became you have to meet these quotas—it became very stressful. You're already stressed because you are working in a very highly emotional population that can have a number of twists and turns—emotional twists and turns. So, transitioning to a private setting was a natural progression for me because I'm naturally an entrepreneur. I had already run several businesses before I became a therapist and also I just felt as if it would give me a little bit more freedom to practice without all of the added agency stress.

Quinn stated,

> So I think for me, I realized in school that I wanted to have my imprint on it. I wanted my experiences being implemented in the counseling process. So, I saw early on that working for an agency, I didn't really feel that was my lane. I wasn't necessarily opposed to working with other practices, but when I realized I could do it on my own, it was an even more rewarding situation.

Emerson stated,

> So, I did my internship at an agency, and then I actually went straight into my PhD program in counselor education and supervision. So, I was really passionate about substance use and working with the court system. I did that for a few years and then figured out—like I am getting really burnt out. So, then I decided that I wanted just to go into private practice because at that point I was licensed and I just wasn't getting paid very well. I also wasn't like treated super great. I mean, I was still very torn like, it was hard because I was passionate about the

> demographic, but just the agency itself was very tough. For the most part, it really was about just getting out of the agency, not getting treated well, and realizing like I'm licensed so like I can handle things on my own. So, that's when I finally kind of just took the jump to go into private practice.

Jaime shared,

> When I got fully licensed, I decided that I had enough experience in other things and also my business background, that I decided to start a private practice. So, as soon as—I mean like literally the day I got my full license—I had already had the website created. I already had everything ready. But I mean, if I'm going to get down to the real reason, they were paying me $20 an hour and insurance rates are slightly higher. So, I was fifty and I am looking at retirement, and it just didn't make any sense to continue to make $20 an hour when I have student loans to pay off and all of that.

Finley discussed how working in a hospital setting caused her to change careers and seek private practice:

> I was working at a hospital initially. I think the independence of working for yourself and not having a boss and being caught up with bureaucracy. The flexibility in the schedule, of course, and the opportunity to make more money was definitely there.

Harper's marriage and family-focused internship supervisor was murdered by her husband which almost caused her to not pursue marriage and family counseling as a

profession. However, after an extensive career in intensive counseling environments, she shared how she found her way back to marriage and family counseling:

> So, when I first started out, I was in a private practice doing my internship, and unfortunately during that time my supervisor was murdered by her husband. So, that of course changes your perspective for a moment when you're like—I wanna work with couples—and then that happens during internship and it's like, "Oh wait, do I really want to work with couples?" Well, unbeknownst to me, I started working with youth who were transitioning from a correctional facility, juvenile justice system from a state level, or a residential treatment facility. I also worked in another site that was community based but it really focused on adoption. Then, I worked with the Department of Mental Health and Addiction Services. I had seven prison facilities that I would go into and work with individuals who were preparing to return home. Those individuals had severe mental illness. From there I was promoted to a state psychiatric hospital. It was six years after, you know, the death of my supervisor before I got back to like saying, "Okay, I wanna work with couples." A full circle moment, when I worked in the prison, I ran into her husband.

Navigating Work Experiences in Private Practice

The seven participants shared what they consider to be positive and negative work experiences in private practice. The seven participants did not note any changes in their perceptions of what constitutes positive and negative work experiences in the aftermath of the COVID-19 pandemic.

Positive Work Experiences. Two of the seven participants attributed client symptom reduction to positive work experiences. Jaime shared,

> Oh, my gosh a good day is when my eight-year-old client, who I talked to about parts work the week before comes in and says, "I talked to my parts every night this week and I've been going to sleep so much better." I love when kids, well, when anybody has that light bulb moment, you know?

Finley expounded the idea of positive work experiences occurring as a result of client symptom reduction:

> I think a good day is when—I mean a really good day is when I hear from somebody that reports back to me that they're feeling better or that they can report back that their symptoms have decreased in some way. And they're happy about it—or not necessarily happy— but they're reporting they're feeling less suffering in some way.

Finley and Emerson also shared that having a daily schedule that is manageable and doesn't leave them feeling overwhelmed constitutes a positive work experience. Finley stated, "That my schedule is also manageable where maybe I'm not, you know, kind of overloaded that day and when you have people that come in that are thankful and appreciate you and express that." Emerson discussed feeling more accomplished when she has a schedule that is manageable:

> So, I would say a good day is…just because of my personality type…I would say a good day is when I have like, maybe like four or five clients back to back, which I know is not everyone's cup of tea. I don't love spreading things out a lot.

> I just feel like I'm kind of on a roll and in like a certain head space. I think also if there's like stuff that's spaced out, it's easy for me to like, get distracted. So, I would say like a good day is like when I'm feeling accomplished—when I'm feeling like I've done good work.

Quinn and Jordan shared that their client's willingness to work during the counseling session creates a positive work experience. Quinn stated,

> So, to me, a good day would be if I have several clients and they're ready to conquer whatever challenges are in front of them. That, to me, feels like we're both on the same page about—yes, this is a difficult situation, but what are we gonna do? Like, we're both on the same page about working through whatever it is that they're faced with.

Jordan furthered this thought by stating,

> A good day is feeling that you had good discussions—that there were good conversations. That we're working towards what the client is wanting from the treatment. I do a lot of trauma work and it combines a lot with like a dual diagnosis situation. So, I'd say about half my caseload is dual diagnosis. So, they're both addiction issues and trauma or some other kind of mental health issues. So, any day that they can process through their feelings, where they feel open enough to share, that feels good because then they're making progress.

Blake and Harper provided different perspectives. Blake explained, "A good day…I guess everybody showed up. Everybody showed up and practiced all of your

coping skills is a good day. No extra paperwork requests." Harper stated, "A good day is my normalcy of meeting with clients and talking to them. That's really energizing."

Negative Work Experiences. Three of the seven participants shared their viewpoints of how feeling unhelpful causes them to have negative work experiences. For example, Finley stated,

> A bad day would be those days where if I struggled with a client or if I felt like I wasn't … how do I wanna say this? If I didn't think I did a good job, maybe if I didn't … I kind of doubted myself about my skills that day or maybe something I said or did that I wasn't quite sure if it was helpful. Or, you know, one of those days where I see too many people and I get overwhelmed. Like, if I see like over seven people, like eight people or something, I haven't done that in a long time, but you know your brain's getting tired … it's hard to focus. Maybe my emotional boundaries are not really solid enough—where you start to kind of take in people's feelings more so than you really should—you know that kind of thing. Like, the boundaries are getting a little blurred by the end of the day. Yeah, I definitely … like in the past I've had that happen, you know, where I would get really kind of upset with myself and I could probably like withdraw, get sad, and have like some self doubt and my confidence will go down.

Jaime reported feeling unhelpful and stressed when her clients are in situations that are toxic and she can't do anything about it:

> When a client is in a situation that I don't have the ability to control or effect change and so they're kind of stuck. Especially in my group of eighteen to

> twenty-somethings that are still living at home. They're working, but they're being charged rent, and they can't afford to move out even though it's a toxic environment. That's probably the most stressful for me because it doesn't matter how much they do, you know, they're making $20 an hour and you can't live alone on $20 an hour in this world.

Blake shared that she feels more stressed and unhelpful when she has to turn potential clients away that have come to her for help:

> We have more people—we have to turn more people away and refer them to other agencies because maybe we can't treat them. So, I think COVID has significantly impacted behavioral health. If you're looking at it from a financial perspective, a lot of people have increased their businesses, but if you're looking at it from a personal stress level, it has made us even more stressed out.

Quinn and Jordan cited that working with clients that are ambivilant or resistant to treatment create negative work experiences. Quinn stated,

> In my opinion, a bad day is when you're with a client and they do not want to work through whatever it is they're faced with. That happens sometimes. Not because people don't want to work out life. Sometimes, it can be overwhelming and people tend to get stuck in that. I feel those are days where it gets a little difficult.

Jordan expanded the concept of client stuckness as a negative work experience due to feelings of self-doubt:

> Bad days looks more like people are stuck. They're kind of spinning in a circle and just trying to help sometimes thats a struggle for them. If it repeats, you know like over and over, that feels bad on my part because it's like…sometimes you self-doubt yourself. Like, am I saying the right things? Am I asking the right questions? I know as counselors we're trained, you know, like it's not you, there's this whole mentality. Like, don't take that personally, but if they don't feel comfortable sometimes, or it's a struggle with the therapeutic relationship, I think those are bad days. I definitely feel more anxious myself. I feel like something is undone. Like something needs to be completed or things aren't done. Almost like an irritability or like a restlessness kind of feeling.

Emerson's concept of a negative work experience differed from the other counselors because she cited having long blocks of downtime in between clients as her idea of a bad day:

> So, I would say it's like someone canceled and then I have like a weird hour or two hour break. Like I have ADHD, so like I just kind of like … bounce around. So like, I think the days that I just have weird spaces and stuff to be hard. I'm not as focused. Super discombobulated. I don't feel as like I achieved. I have a daughter so I have to work that much harder to be present with her because my mood just isn't as good.

Harper's view of negative work experiences also differed from the group with a more positive viewpoint. Harper stated that because she has worked in some of the most difficult counseling enviornments (i.e., penitentiaries, psych hospitals, etc.), she does not

view any day as a bad day. Harper did mention that a non-client related negative work experience is having to market her business in order to gain more private pay clients:

> I'd say…because it's my own private practice…I can venture to say that I have not had a bad day. And I only say that because it's my practice. Things go the way that I want it to go and see it going. When I have to do marketing, that would be my idea of a bad day. When I have to focus on marketing and I don't have that skillset nor drive to sell or anything like that.

Emergent Theme 2: COVID-19 Quarantine Experiences

Emergent theme 2 was derived from interview questions that were designed to explore the lived experiences of the participants during quarantine. Each participant shared their professional and personal point-of-view of what it was like to enter into quarantine, provide virtual telehealth services, cope with isolation, virtually connect with their clients, and maintain treatment goals during the COVID-19 pandemic. This section includes the counselors' direct experiences and the counselor's perception of their clients' experiences.

Counselor Experiences

The seven participants shared their personal and professional lived experiences during the COVID-19 quarantine.

Quarantine. The seven participants shared their initial reactions to the quarantine mandate. Five of the participants shared their experiences with fear and disbelief upon learning that they were required to stay home at the start of the COVID-19 pandemic.

These five participants discussed their immediate concern for their children, partners, and older family members as well as for their own safety. Finley stated,

> Oh, God. I think it was a scary time. I mean…I do remember feeling anxious. You know, I have kids. So, as a mother, I think you just naturally get anxious about them getting sick or whatnot. The way the news was putting it out—like people were dying and all. It was scary. It was stressful. My husband's a firefighter, so even though they might have put these mandates out, it didn't really apply to my husband. So, there was more stress with that too. Kinda like people couldn't go in—but my husband had to go in because he was like a first responder.

Blake and Harper shared that they also felt anxiety due to their worries about infecting older family members and their own wellbeing. Blake shared,

> Well, it was hard. It was anxiety-inducing. I guess from a perspective of…any of us can get COVID. Because even though we were quarantined, we still had to go out and do certain things. So, I became very apprehensive of…okay, I have to go out and go shopping. And also I have older family members who I couldn't see and I know they had to go out and do things. So, the anxiety of what if they get COVID and what happens. Or even when our restrictions were a little bit more lax and we started to get…okay, you can wear a mask and you can go and get vaccines and stuff. And when they started to kind of relax—it still was a little bit of anxiety of—well, what if I give it to a loved one? So, I can say that from a

> perspective of mental health…it increased my anxiety and awareness of…oh my gosh, anybody could get this.

Harper stated,

> I can tell you personally, my mom and dad…they're in their sixties. My mom has lupus and fibromyalgia. And not understanding the impact of COVID and hearing all of the cases of people dying—it was traumatic. You're watching the news because you have nothing else to do. Nothing. There's no new programming because everything is shut down. And so, not really understanding at the beginning and midway through—still not really understanding what is this…like what is this…what's happening.

Jordan shared that she experienced shock and disbelief at the quarantine mandate. Jordan stated, "I feel like it was…I was almost in disbelief. I was like…how in the world can they mandate us to stay home? Like this doesn't sound right. Like…I was shocked. I was like…this sounds crazy." Quinn shared a similar moment of disbelief and used the analogy of the movie, "Independence Day", to describe how she felt. Quinn described her experience by stating,

> What it felt like…and I don't know if you'll get analogy…but I don't know if you've seen the movie, "Independence Day", with Will Smith. There's a scene in the movie where he walks outside to get like the paper or the mail or something like that…and he looks up and he sees this big spaceship up in the sky and everybody's like freaking out or whatever. But life is still like…the sun's out, you know? It was a normal day except for that huge spaceship. I kind of likened

> COVID to that. So, what I found was people were, of course, going through life. It did not stop, you know, bills were still coming, marriages were still in trouble, people were still going through life changes and the ebbs and the flows but the difference between now and COVID—was that spaceship. I felt like that fear—that thing that was hovering over everybody's head—just maybe exacerbated life's ebbs and flows.

One participant did not state that she felt anxiety due to the COVID-19 pandemic and subsequent quarantine. However, she noted that her struggles were in direct relation to her extroversion. Emerson discussed her need to leave the house and work from her office even if clients were not initially being seen in-office:

> We weren't allowed to go into the office to see clients in-person. I think in the beginning—I know at some point, I started going back to the office even to do telehealth because I needed out of my house. Like I needed to be in a different environment. The transition going into COVID was really freaking hard, I think, because I enjoyed doing work in-person. I will say even—actually before COVID—I actually was a hybrid at that point too. So, to go from hybrid to completely online was really tough.

One participant's perspective was in sharp contrast with the other participants. Jaime did not immediately go into quarantine when everyone else was mandated to enter into quarantine. Jamie stated, "We were asked to stay in the office. We were considered essential for the longest time."

Telehealth. The seven participants considered the benefits and challenges of offering telehealth services during the COVID-19 pandemic. Two of the participants reported that their biggest challenge was moving to an online platform because they did not conduct virtual sessions prior to the COVID-19 pandemic. Notably, four participants did not report issues with moving to the full-time use of virtual technology but did report personal challenges as a result of counseling virtually during the pandemic. All seven participants were able to cite benefits of the utilization of telehealth services during the quarantine. As a result, four participants have opted to convert to an online-only telehealth private practice. Three participants decided to permanently utilize the hybrid model, which consists of in-office and telehealth services.

Finley and Blake shared their initial struggles with moving to an online-only counseling model due to the required quarantine because they were both inexperienced with working with clients virtually. Finley also shared her concerns with generating income due to the sudden loss of clients that did not want to move into an online-only model of counseling:

> I know that the first week was tough in terms of…the clients weren't sure of what to do and I had to figure out a telehealth program. I had to figure out how to do that because I never did that before. So, that was a little stressful, a little uncomfortable, some anxiety, you know…with that. Then, having to talk to my clients about it—of course they were uncomfortable. Not everybody agreed to do it. So, I think it was stressful because like the first week or two or three, you know, not everybody continued with therapy. So, I was then worried about getting

> a paycheck. Like how am I gonna make money now? There was definitely an adjustment period.

Blake stated,

> Well, a part of it was, okay, how do we do it? Because telehealth was not a market that we were told we can freely operate in as therapists. So, the first part of it was trying to figure out the requirements of what I had to do in order for my insurance billing to still process properly. The first part of that was really documentation. So, there were a lot of administrative things that had to be taken care of in the beginning and afterwards.

Four participants expressed their personal struggles with providing telehealth services during the COVID-19 pandemic. These participants were already utilizing a hybrid model of counseling prior to the pandemic. Quinn reported having some struggles with feeling connected to clients when counseling them virtually. Quinn stated, "I feel that it [telehealth] can also be a detriment when it comes to being able to connect with whatever it is they're experiencing emotionally. Sometimes not having that face-to-face presence can be a barrier." Jordan reported struggling with privacy during the pandemic:

> I think naturally I am more introverted. So, I didn't mind staying home. I didn't mind like the less interaction. This is why I like private practice too because I don't have to work eight to ten hours a day and actually don't see that many clients because that's overstimulating for me. So, when we all had to go home and figure that part out…I think a lot of it was like, now we don't get away from all the people in our home anymore. And that was a huge adjustment… trying to find

> a private space to work. I wouldn't say there were like more conflict or anything, but just the adjustment in general was just different. While I don't love to change––it does cause like an anxiousness for a little bit—to change.

Emerson and Jaime reported more internal and physical struggles when transitioning to telehealth services full-time. Emerson stated, "It was very hard to transfer to like fully online—not seeing people was very isolating." Jaime shared a similar perspective:

> I think for me it was more the stress everybody else was undergoing and I was trying to help them. I was trying to see clients and I was trying to keep myself safe. So, it wasn't COVID itself, but it was COVID-related stuff that was going on that had me really stressed out. In fact, I ended up physically sick because of the stress. Like the, the technology of telehealth wasn't hard but the reality of telehealth was difficult.

All seven participants were able to note the benefits of offering telehealth services during the COVID-19 quarantine. Four participants reported benefits related to their client behaviors and well-being. Three participants reported personal feelings of being more "balanced" while utilizing telehealth services.

Quinn shared that she believes that the clients were more comfortable during telehealth sessions because they were in the privacy of their own homes. Quinn stated, "So, I think there's a bright side and a not so bright side on both…from both aspects. I think for me, what I love about the virtual client or the virtual session, is the comfortability that the client has, you know, just being in their own space." Harper,

Emerson, and Jordan noted that there were less client no-shows and higher rates of attendance to telehealth counseling sessions during the COVID-19 pandemic. Harper stated,

> After COVID, it's more controlled because you're joining via video. So, their very first appointment in person before COVID, they would schedule it and then not show. After COVID, they schedule it, they actually show. And if they don't show, then I'm at home.

Emerson considered her increased flexibility and the comfort of her clients during telehealth counseling sessions:

> I have more flexibility. Honestly, I think it's easier because I think having the online option is more flexibility both for me and the client. In terms of no-shows, I have less no-shows or cancellations via telehealth. With telehealth, people are in the comfort of their own home.

Jordan lives in a rural area and shared her thoughts about the increased access that clients have to counseling sessions due to telehealth services, reduced no-show rates, and flexibility:

> I think the convenience that telehealth brought to our nation is more care to people who could not get it before. Like they didn't have transportation or they live in a rural town and it's an hour to an office, you know? I had a better show rate for therapy appointments. I got so used to like multitasking, not having a commute, and not having to be trapped in my office all day. I felt like I was getting more done because there wasn't so much other interaction, right? Like, I

> could talk to my clients, can do my work, and then I can step out of my office and go back to my life.

Finley, Blake, and Jaime reported experiencing more balance while working with their clients via telehealth services. Finley stated, “It is a little bit of a break because you’re kind of…you don’t have people coming in-person all day, so you get a little bit of a balance between in-person and then being on the computer and vice versa.” Blake shared that the ability to mix up virtual and in-person sessions also provided a sense of balance for her:

> I think telehealth is a good balance. I mean, during 2020, it was not a good balance on the computer all day, every day. But I do think virtual is a good balance. Do I think it’s a good health balance? I don’t and I say that just because I consider how long we’re sitting in front of a screen and our eyes are on a computer. So, from a health perspective, I don’t think it’s the greatest thing, but I think it balances out when you can kind of mix it up.

Jamie described how she felt less energetically drained as a result of using telehealth services in her private practice:

> I identify as a highly sensitive person and I noticed immediately with telehealth that I was not nearly as exhausted at the end of sessions. And I know a lot of people report the other way—that they find telehealth exhausting. The level of empathy is still there, but the draw on my energy is not, if that makes sense. I can still empathize. I can still be with a client. I can still be very present, but it’s not draining my battery in the way that it was in- person.

Isolation. The theme of isolation was prevalent in three of the seven participants' interviews. In contrast, four participants credited introversion, family members in the home, and being categorized as an essential worker as their rationale for not experiencing feelings of isolation during the COVID-19 quarantine.

Finley stated, "I think generally in private practice you're more isolated. I spend a lot of time alone. I don't really have coworkers to talk to during the day. You know, it's really just me and my clients." Quinn used the word "loneliness" to describe her sense of isolation. Quinn stated, "I think before…I knew being a counselor was tough and it's not gonna be easy and all those things, but I think COVID like magnified the loneliness of this profession." Emerson added to the idea of isolation:

> Like when I would have, you know, four clients in a row on telehealth. Like, I felt really good. Like I felt happy. I felt like, okay, cool. Like I've done some good work. And that helped, like just my extrovertedness. So, even though like at times I felt isolated, it still helped me feel connected.

In contrast, Jordan credits her introversion for not feeling isolated. Jordan stated, "I think naturally I am more introverted. So, I don't mind…I didn't mind staying home. I didn't mind like the less interaction…" Blake and Harper stated that they did not experience isolation due to family members being in the home during COVID-19. Blake stated, "I wasn't isolated because it was me, my husband, and my daughter, and we just had our own personal activities that we did during COVID that kind of helped us through." Harper added to this point:

> And so I think from that standpoint, my son and my parents were staying with us at that time. So, it didn't impact to that extreme directly, but just seeing clients, hearing that family members and coworkers experienced it and what their experience was like—it was just a very fortunate space for us to not have to experience it—but be able to be a support to others.

Jaime was the only participant who was considered to be an essential worker and did not go immediately into quarantine. Jamie stated, " We didn't have that. We were asked to stay in the office. We were considered essential for the longest time."

Connection. The seven participants described whether or not they were able to feel connected to their clients despite counseling them virtually during the COVID-19 pandemic. Six of the seven participants reported feeling more connected with their clients. A unified feeling of being in this together was mentioned often. In contrast, Finley shared her mixed feelings about feeling more distant towards her clients due to not being in-person.

Quinn, Jordan, Blake, Harper, Jaime, and Emerson reported feeling more of a connection with their clients during the COVID-19 quarantine. Quinn stated,

> I think it was more. I think I felt more of a connection because there was, you know, along with COVID, there were some racial tensions happening in our country. So, it was a lot of stuff swirling around all at one time. I think as a humanity, we were being tested, you know, just humanity itself. So, I felt the connection with my clients because of that. I think I felt, you know, we all need each other right now. Like, yes, you're my client and I'm your counselor, but this

> affects me just as it affects you. So, I think that brought a connectedness that otherwise wouldn't have been there." Jordan stated, "I think they shared a lot more because now, at least that's my perception, they feel safer to be more—they felt more safe to be more vulnerable about things."

Blake discussed the closeness and connection clients seemed to feel with therapy and their counselor during the COVID-19 pandemic:

> I think people really checked into, okay, I'm going to take care of myself and therapy is the thing that I'm doing. And so, people became very connected to therapy and their therapists during that time because that was going to be your minute that you got to really communicate your feelings and things like that. So, I don't think it really created distance. I think it created more connectivity and actually had a lot more people engage in therapy from my perspective.

Harper explained how she believes that her clients connect with her more due to her honesty and how she didn't falsely reassure them that everything would be ok:

> I would say more of a connection. Yeah. More of a connection with them. My clients being African American, anytime I can connect with them on what they're experiencing and feeling and normalize that, creates more of that connection where they start to trust more. They're trusting that you're going to be honest with them and you're gonna let them know. Like, you're not going to sugarcoat and say it's okay. We're all gonna be safe. And that's not true. Like it builds more trust when you're honest, and validating, and listening, and normalizing versus

> saying it is going to resolve and we'll figure it out. Like I've got the answer type of approach. I never used that approach.

Jamie credited her increased connection with her clients due to the rapport that was established as a result of working together during the COVID-19 pandemic:

> I've got probably fifty or sixty people on my caseload right now. I don't see them all weekly, obviously. But probably a third of them are folks that have been with me since before COVID. And yeah, if I had to tell them I didn't have insurance and if they couldn't figure out, out of network or whatever, I would feel horrible. And, you know, as much as I recognize that they could find another therapist and that I am not the end all be all, it would still be…it would still be hard. And then I think a lot of that relationship rapport is because of having helped them get through COVID.

Emerson shared that she felt an increased connection with her clients while working to maintain balance in their relationship despite experiencing the same things that they were experiencing during the COVID-19 pandemic:

> I would say for the most part, like, it was pretty rough on clients. And then it was just such an interesting situation because I was going through it also. So, to hear them talk about the things they were struggling with, knowing I was struggling with the same thing, you know? I had to like use my brain power. I think it was more exhausting because I had to like continually check myself. Just work harder, be present, and not turn it into…oh my gosh, me too. While I do think self

> disclosure is super powerful and at some point I did do stuff like that, I had be just more hyper-aware of like…that it's not just gonna turn into a chit chat session.

In contrast, Finley expressed mixed feelings about whether or not she felt more connected to her clients. In some ways, she expressed that she did feel a connection with them when she self-disclosed her own concerns about the quarantine and pandemic, but she explained that she also struggled with not feeling as close to her clients due to not seeing them in-office:

> You know, that's a great question because I think there is a level of working virtually that is very tiring because I think you have to work harder to connect with your clients. And that can be tiring, whereas the physical being in-person can also be exhausting when you feel the energy of your client—when you're sitting in the room with them. I do remember sort of a little bit more self-disclosure. I think I did, you know, I'm very careful with self-disclosure, but I did say a little bit about—kind of normalized with them—the anxiety and the changes. And I think I said that I was going through some of that as well.

Treatment Goals. The seven participants described their experiences with working toward treatment goals during the COVID-19 pandemic. All seven of the participants reported having to shift or adjust client goals due to the pandemic. Four of the participants specifically adjusted their client's social goals in particular due to the COVID-19 pandemic.

Jordan stated, "I think a lot of the established treatment goals and the things that we were trying to achieve took a little bit of a backseat to the immediacy that we are all at

home and alone. So, I think, like once we adjusted after a couple of months, and got more used to doing things differently, it seemed we were able to go back to working on the things that we established." Harper stated, "And then when COVID came, their goals shifted. So, goals don't always stay the same. Like we'll work towards them but if something else is pressing and I'm hearing something else, we about to shift it because you're either not ready or you've surpassed that goal." Finley stated,

> I guess the best that we could do though is just talk about it or talk through it. You know, during those times where we really couldn't do much about it. I would kind of turn to just talking about concepts like goal setting, you know. Things like that. Kind of just working on coping skills.

Quinn, Emerson, Blake, and Jaime discussed their issues with having to change their client's social treatment goal due to their client's resistance or mental health disorder. Quinn discussed her older client's resistance to change, online counseling, and revised treatment goals:

> I think actually there was one that I can remember, an older gentleman when COVID first started, and he was like an elder at his church. And at that time, they were shutting down the services. They were just closing everything up and he struggled with depression during that time. Like I said, he was an older gentleman, he was referred by his doctor to see me and wasn't really buying into therapeutic techniques, and treatment plans, and goals, and all that stuff. So, I found it hard to try to get him to do other things.

Emerson, Blake and Jaime shared their struggles with providing realistic interventions to meet their treatment goals for their depressed clients. Emerson stated,

> Oh, absolutely. I can think of one client that I still see to this day. Like, her depression was very, very, very high. Not necessarily in a way that like it was like suicidal, but it was like just so down. And I think it was also tough because it was like, you know, when you think about working with someone with depression right now, like you can suggest things like that. Like, oh, you're feeling disconnected. Like what are some communities that you could try? Like what are some things, you know, things that you could try to join and all the things. But like, she couldn't do that. And she already had it. So, that was the other piece is like, she had it and then it was taken away.

Blake stated,

> Well, I think a lot of people, they became very anxious with the social goal. We got to figure out how to engage people. And so we had to shift the way people engaged with each other because social engagement could be having lunch with a girlfriend, going to a gym and exercising. So, we had to make adjustments in how the goals were actually accomplished—especially for people who were depressed and isolated. It was, "Okay, can you set up a Zoom meeting with your family members who are far away or maybe have a girlfriend night where y'all get online and play bingo or something like that?" So we had to make adjustments to how people socialize and manage their anxiety and isolation during that period of time.

Jamie stated,

> Oh, yeah, there was a lot of improvising. We had a pretty strict treatment plan—goals. I've always used smart goals just because that, again, teacher brain. But it was a lot of like what would I say—incremental progress for the kids. Like the, the socially anxious kids, when they were able to go home and they didn't have to deal with bullies or they didn't have to deal with being popular or any of that kind of stuff…it was funny because their academic stuff went way up. But then their ability to work on the social goals was just—it was non-existent. Right? I mean, they didn't have that. So, yeah it was a lot of like switching, you know, what are we gonna work on?

Client Experiences

In this section, the seven participants shared their perceptions about how their clients fared during the COVID-19 quarantine. Two of the seven participants reported that their clients were experiencing fear and anxiety-related symptoms during the COVID-19 quarantine. Three of the participants shared that their clients had issues with feelings of loneliness and isolation. One participant shared that her clients were experiencing relationship issues that jeopardized their union and often resulted in breakups once the quarantine ended. Another participant discussed the effects of the forced quarantine on student attendance especially when their home life was not ideal.

Finley and Jordan reported increased fear, anxiety, and depression-related symptoms with their clientele. Finley stated,

> Yeah, there definitely was a trend of people during COVID. Yeah, I think that there definitely was an increase in anxiety and depression because people were

> more isolated and home. You know, people were anxious about the whole thing. So, people that were depressed, it did seem like they were kind of making it worse. I noticed some people were getting worse. Clients that were anxious about going out. Let's say that was their initial problem to begin with…and now COVID hit. So, they were kind of happy. Now I don't have to push myself to go out. So, they're kind of happy but it was not helpful for them because they were not pushing themselves to do so.

Jordan shared how her clients feared being out of control because there was nothing they could do to change the situation they were in:

> I think there was more fear and like I can't change the situation. Like lack of control in the world basically interfered a lot during like the shutdown specifically. Once we started to like branch back into going to the store again and people were able to see people again, I can say that some of them did better.

Quinn, Blake, and Emerson reported increased feelings of isolation among their clientele. Quinn stated,

> I felt like they were beginning to see that this might be the way things are going now and I need to get on board. It wasn't easy to get people who aren't used to connecting online. Older people are used to going to church socials and all kinds of ways to connect with people and now you're saying you can't do that. Now, I have to find a way to connect with someone. That part was a bit challenging but I also felt encouraged simply because the people, the clients I was seeing, saw that this was the way things were beginning to go.

Blake discussed how her clients were struggling with feelings of isolation and also mentioned increased alcohol usage by those clients:

> The isolation was a very big thing for people who didn't have support because they no longer could go to work and see and engage with people. So, isolation was a big challenge for many people. And also what else? Oh, increased alcohol use. So, that was one of the things that I saw a lot of during COVID—is people who kind of just drank socially—their go-to was I'm seeing that I'm drinking a whole bottle of wine. And I saw increased alcohol use in people and they even had some concerns about themselves and they said that I've kind of fed this routine and now it's just my routine.

Emerson shared how her clients struggled with the lack of human connection and how clients that traveled for work struggled with longer quarantine times away from their families:

> Yeah. It was awful because I think a lot of my clients were similar to me, where like, they just really crave that human connection. So, to not be able to like go to the gym like they used to and see their friends. I know a lot of people struggled with like…oh, I had to travel for work or something. And so, now I have to quarantine even longer because someone I know is at a higher risk and I don't wanna risk getting them sick. So, there was a lot of like internal turmoil in that regard too.

Harper and Jaime shared more interpersonal issues among their clientele. Harper discussed a trend among her couples that involved not faring well with the increased time

together during quarantine. While Jaime shared that some of the students she served online did not attend sessions due to issues in their home life for fear that it could be seen or heard via video. Harper stated,

> I noticed a trend of like, for once they had to focus on them versus like…well, I can leave and go to work. I don't have to deal with this. Or I can leave and go outside. But when COVID happened, they had to focus on each other. They had to…there was no way around it. They had to sit in the house. There was nowhere to leave. There was mandates you couldn't leave. There was nowhere to go. Everything was shut down. But they had to really focus on each other and I think a lot of couples had that moment of realization of like, do we work or do we not work? And some of them got to a point where they're like, well, now that we're stuck with each other, we really realized this ain't gonna work. And so as soon as the pandemic is over, we're getting a divorce.

Jaime shared how some of her clients improved as a result of being quarantined while others struggled due to their home life:

> At that time I had mostly school aged clients. I'd say probably 75% of my clientele was school age. And it was really interesting, the teacher in me recognized immediately the kids that struggled with social anxiety or learning issues. I saw remarkable improvement when they were sent home. On the flip side, the kids who had bad situations at home. The kids who used school as a respite. Those kids struggled tremendously being forced to stay. Not only are they stuck at home, but their home is now being open to the public because they're

> now on a screen trying to do their schoolwork. And so, these kids weren't showing up. These kids had perfect attendance before and they weren't showing up online. It was big, big, big dichotomy between the two populations.

Emergent Theme 3: Counselor Adaptations to COVID-19

Emergent Theme 3 is derived from interview questions that sought to discover professional and personal adaptations the participants have made as a result of experiencing the COVID-19 pandemic.

Professional Adaptations

The seven participants provided insight into the workplace adaptations that they have made as a result of experiencing the COVID-19 pandemic. Three of the participants have opted to utilize a hybrid method of counseling which includes virtual telehealth services and in-office sessions. Four of the seven participants have opted to completely and/or permanently move their private practice to an online-only private practice model which solely provides virtual telehealth services.

Finley, Blake and Emerson have opted to utilize the hybrid private practice model. Finley decided to go back to the office once the quarantine was lifted. However, the participant has since decided to operate as a hybrid private practice. Finley stated,

> I did. Yes, I went back. I don't remember how long it was before I went back. I think it was, you know, whenever they kind of allowed it or whatever. It must have been months. I didn't have any anxiety about it and I say that because I didn't get COVID the whole time.

Finley provided more details about the change to a hybrid private practice model. Finley stated, “I really think it’s about preference for me. I’ve gotten very used to being virtual, so it’s not as difficult as it may be back, you know, back then.”

Blake discussed her decision to utilize the hybrid model of private practice due to the need for some clients to be in-person while being open to clients that prefer to utilize virtual telehealth services:

> It’s a hybrid right now. Of course, during COVID and through a good part of 2021, it was just virtual. And then once we got the vaccines and everything squared away, it was like, okay, so we can start reintegrating into the office. Because I had clients where they enjoy virtual because they can do it on their own time. They can do it before they start work. They can do it on their lunch break. They can do it after work and they don’t have to leave their home. So, I had those individuals that wanted to stay virtual. But then, I have some people who prefer in-person therapy because they enjoy the connectivity of being in the space with the therapist.

Emerson shared her rationale for utilizing the hybrid model of private practice to ensure that those clients that need in-person counseling sessions are accommodated:

> I have less no-shows or cancellations via telehealth. With telehealth, people are in the comfort of their own home. And then there are clients who do need the in-person. So, I think being hybrid has been super helpful even for my mental health.

Four participants decided to permanently shift their private practice to an online-only model and to no longer see clients in-office. Jordan stated,

> At least two…I would say two years at home. I got so used to like multitasking. Not having a commute and not having to be trapped in my office all day. I felt like I was getting more done. Like, I could talk to my clients, can do my work, and then I can step out of my office and go back to my life.

Quinn stated, "My practice pretty much started on the onset of COVID. So, I've experienced nothing but telehealth clients." Harper opted to close her brick and mortar office and to practice solely online due to the fact that COVID-19 still exists and people are still becoming infected with the virus. Harper stated,

> Oh yes. One because COVID is still happening. That's the number one. So, even though they're like the pandemic's over like, no thank you, people are still catching it. Y'all are normalizing it a little bit too much from my liking because people are still experiencing COVID symptoms after they have had it. So, that's definitely when I decided to close my physical practice location. I did that during COVID because of the overhead. I have been telehealth since then.

Jaime shared that she has chosen the online-only counseling model because of its convenience and due to the inability to pay the office rent:

> Yeah. Oh, I don't have to drive anywhere. I'm a half an hour from either of the major cities that are close by. There's, well, there's rent. We haven't gotten a raise since I started this work seven years ago. I can't afford to pay rent. I just…I flat can't afford to pay it. If they suddenly said to me, you can't do telehealth anymore, I honestly don't know what I would do.

Personal Adaptations

The seven participants shared the coping mechanisms and self-care practices that they utilized during the COVID-19 pandemic and beyond. Quinn shared her perception about what she believes to be the stigma that clinically licensed counselors face when it comes to asking for help, which in turn keeps them from reaching out for help:

> I think there's definitely stigma. I think there's stigma, but I also think that there is a lack of safety. And not because people don't want safety or people don't wanna be safe, but I think it's just a scary thing. Like full transparency…I struggle with the idea of your counselor should have a counselor and most counselors want that. They want that safe space but I think it's just hard to find it. To really believe it exists because you have to be so guarded with not just your information but with the information of your clients. So, turning that off can be challenging.

Coping Mechanisms. The seven participants shared the coping and meaning-making techniques they utilized to help them persevere through difficult times during the COVID-19 pandemic. Two participants shared that they used humor as coping mechanisms. Harper shared how she purposely seeks to bring humor to any situation. Harper stated, "Like we're going to relate to something and talk about something, so that we can lighten the mood because it's exhausting." Emerson shared that she also uses humor as a coping mechanism:

> So, I think between that and then just having to deal with my own mental health, you know, I was a therapist seeing a therapist for all of this. And I would even

> joke with clients sometimes, like…Hey, you know, grandma therapist had some good insight. They liked hearing that kind of stuff. Like they thought it was funny or enjoyed it.

Finley shared that she took a more logical coping approach by utilizing counselor trainings to keep her mind busy and to hone her skillset. Finley stated, "I always found that training and keeping myself just learning new skills—like kind of keeping up on the EMDR skills and stuff like that definitely is helpful."

Jaime, Jordan, and Blake shared that they practiced mindfulness techniques and focused on maintaining a positive mindset. Jaime shared, "A lot of really intentional, mindful self care. I joke with my therapist all the time that the reason that I'm so good at any of this stuff or any good at any of this self-care mindfulness stuff is because I tell my clients eight times a day. And I'm like, oh, maybe I should listen to that myself." Jordan shared that she used optimism and focusing on positive solutions to cope. Jordan stated,

> In general, I've tried to just keep up an optimistic view of it. We're gonna figure this out. We're gonna readjust this. Like with my clients, with myself, I was like, this is not forever. Just kind of remember keep telling myself that this is so we can get it under control or they can figure out how to better treat this. Or maybe we'll go back to work in a month. I've just tried to embrace making it work, I guess.

Blake shared that she utilized silence to stay mindful and to decompress and cope with stressful days:

> After I have a rough, long day, it is just really silence because so much of what we do with listening, talking, reframing, redirecting and giving room and space to

> hear some very difficult things sometimes. So, when it's been a hard day, I just like a lot of silence. Sometimes I will go home and since COVID, I actually moved further away from my office. So, I just take my commute time. And even when I do get in front of my door, I might just sit in my car for 10 or 15 minutes before I go in my house, and just sit in silence. That's my decompressing time.

Quinn reflected on how she dealt with not sharing things that occurred during her day and her experiences with burnout and compassion fatigue. Quinn shared a more passive approach to coping:

> I don't think there was any…I can't recall that there was something that I did to help with that experience. I think time. Time is definitely one of the things that I do feel that in this profession, it does help with getting through maybe seasons where you feel overwhelmed. But I would say that was the first experience—I mean I've heard, you know, people talk about burnout and compassion fatigue and all of that—I just never thought it would happen to me…and it did.

Self-Care. The seven participants shared some of the self-care activities utilized during the COVID-19 pandemic to improve their mental, physical, and emotional wellbeing. Two participants reported that the use of baths or water-based activities like a float tank were self-care methods that they utilized to combat stress. Quinn stated,

> I think a part of this job is you still hold on to things that you don't verbally share with everybody else. Maybe the way it makes you feel to hear certain things, you know? And so, I think for me, what I took away from that experience was, okay, I'm probably not gonna share what I see, what I felt about all of this with people.

> I gotta find a way to wash that off. Like, I gotta find a way to get rid of it. Because if I don't, it's going to sit there and it could eventually affect the way that I perform this job, you know? So, I think for me now, I've learned…I'm learning to find a way to wash away the stuff that I'm not able to say to people about what I'm doing.

Harper shared several self-care techniques she utilizes such as listening to music, traveling, visiting a float tank, and other hobbies but bathing was at the top of the list. Harper stated, "I am not lying at the end of every day that I have a session, I am running a bubble bath. My secret is a bath." Finley and Jordan shared self-care activities that require more physical exertion. Finley stated, "You know, definitely like exercise and like the kind of self-care—like yoga and stuff like that." Jordan shared her love for and rationale for using hiking and walking to combat stress:

> I try to spend a lot more time outside. Because I naturally like nature and I took up like heavy hiking. I really like to walk. Just going outside, getting some sunshine, hearing animals again. Like getting out of my house is still super important to just maintaining. That was a huge thing because it almost, you know, like we all felt trapped. I guess I can't speak for everyone, but even the most extreme introvert still needs people. And that was also another space, I could see other people without having that anxiousness of, like, catching it.

Blake and Emerson shared that they utilized time away from work tasks to self-care. Blake chose to use days off to recalibrate while Emerson shared that she distracted herself with television shows. Blake stated, "I do take days off. I try to take maybe a

week or two off just to make sure I'm maintaining a balance." Emerson discussed her bouts with depression due to being quarantined and how she utilized tv shows to self-care and cope with the isolation:

> So, I'm not gonna lie, I went into a very dark and twisty place. Like my depression was pretty high during COVID. So, because of that, self-care was really hard. Self-care was sitting at home watching Netflix and I will say that Netflix is still self-care, but more intentional. So, like now things like Netflix or reading is intentional. Like getting myself out of a place that I can immerse myself—in the show or in the movie—and like just not think about maybe some of the heavy sessions or, you know, just relax. Where my self-care at that point was like, I would be in bed for hours because I had nothing else to do and not a lot of motivation.

Jaime shared that she used therapy as a part of her support system as a form of self-care:

> My therapist and I have been on-again and off-again. So, when things got really stressful with COVID, I went back to seeing him once a week. And that was extremely helpful. So, it was just a lot of really good support in that way.

Emergent Theme 4: Future Research Recommendations

Emergent theme 4 is derived from interview questions that delved into the macro-processing of the participants' experience of the COVID-19 pandemic. The seven participants were asked to summarize their COVID-19 pandemic experience into a word

or phrase. The participants were asked to provide future research recommendations that will be of benefit to all clinically licensed counselors and promote social change.

Summation of COVID-19 Experience

The seven participants were asked to summarize their COVID-19 pandemic experience in one word or phrase. Six of the seven participants shared words that their experience was "mixed" or an opportunity for growth. One participant shared that she felt a sense of loss as a result of experiencing the COVID-19 pandemic.

As Quinn processed her experiences with COVID-19, she came up with a word for her experience. Quinn stated,

> Life changing. I would say in general; I don't think it was negative completely. I don't think it was positive completely. I think it was a life-changing experience that I needed in a good way and in a bad way.

Jordan shared how she felt blessed to not have suffered any devastating loss during the COVID-19 pandemic. Jordan stated,

> My experience, I think I got away pretty unscathed in comparison. I think I was set up pretty well to go into it. Like stability wise. I didn't really have a lot of people so negatively affected. I didn't lose anyone to it. That was a blessing.

Blake noted areas of professional and personal growth. Blake shared, "A lot of business growth, a lot of increased anxiety, and for me, an examination of personal wellness." Harper shared that the COVID-19 pandemic brought her life purpose into focus. Harper stated, "Clarity and balance. Being able to understand and have more clarity towards purpose in your life and balancing what that now means with you being a clinician."

Jaime shared that she was thankful for various aspects of her professional and personal life that were unaffected:

> Fortunate. I feel very fortunate that I only got sick once and that I was able to work from home. That I had a support system, especially my husband. That I didn't lose any clients. I know so many folks who lost clients either, you know, by suicide or COVID during that time and I am…I just feel very blessed in that way that I did not have that.

Emerson summarized her COVID-19 experiences by comparing it to the creation of a diamond:

> Well I am going to give you a motto that is now my motto for many areas of my life that I think you'll be able to understand. Diamonds are made under pressure. So, I think in terms of like the COVID transition, you know, all these things that we've had to adapt to. Looking at it in the lens that like, even if it's stressful, even if you're under a lot of pressure, even if it's whatever…like diamonds are made under pressure and so something beautiful can come out from it.

In contrast, Finley shared that she regarded COVID-19 as a time of loss. Finley stated,

> I think it was a scary time. And I think that it was a time of loss. Loss of connection because my kids weren't able to go into school and be with people. So, I think overall that was the biggest problem … losing connection with people.

Research Recommendations Post COVID-19

The seven participants shared their recommendations for future research topics that would provide insight into the lived experiences of clinically licensed counselors and promote social change for this population. Four of the seven participants recommended various counselors-helping-counselors' types of research. Quinn stated,

> Like these, these conversations…this…what you're doing is definitely a step in the right direction. Open dialogue for people who are doing solo practice work. I think giving those experiences life and validity and then maybe us finding ways to provide resources. I would even say like virtual meetups where practices where clinicians who are in private practice can connect with other clinicians. Maybe not in the same state. Maybe in different states and just talk through these experiences because it can be lonely. And if there was one thing I could say about the plight of a counselor is the loneliness. I think that there just isn't space for that.

Jordan shared that counselors endure the same life stressors that their clients endure and suggested that they would benefit from support from other counselors. Jordan also shared that crisis education training would better equip all clinically licensed counselors to handle future crisis situations:

> Like we are people—like how we process and do all the same things that we help clients do. And maybe more into like how therapists can be there for other therapists. How can we better help each other in the therapy setting, in general? I think too, like just watching that caregiver role that we play. Like the compassion fatigue stuff. I am sure it's being studied or people are think…thought of it but

what comes to mind too is crisis education. I think I've totally lacked on getting enough of that.

Jaime shared that she feels that counselors' national licensing system needs to be evaluated and access to counseling for counselors and clients need to be researched and evaluated:

> The first is licensure. We take a national freaking exam. We should have national licensure. This site compact is bs and it's not working. I had so many kids in the midst of COVID who were high school seniors and then went away to college in a different state and excuse my mouth, but they got screwed over royally because I couldn't continue to see them. I had three that I can think of off the top of my head that failed out of their freshman year because they didn't have supports in place in the middle of this COVID bs. And that's not fair. That's not okay. Continuity of care should be of the utmost importance.

Jaime further elaborated:

> And therapy for therapists needs to be covered. The amount of money that I've had to spend out of pocket on just copays to get my own therapy so that I could be a good therapist to my clients is absolute utter bs. Oh, we need to do some research on the efficacy of telehealth. I am afraid that at some point they're gonna say, yeah, we're done paying for it and force us to go back to the office and then a lot of people are gonna be without it. So, I think we need to do some research on, you know, how many people are, are getting better and how many hospitalizations

were avoided because people could get care. Because you know, if you can't access care, you're the one that's likely to have a breakdown. Right?

Emerson shared her thoughts about the need for more community and consultation among counselors:

I would say something that could be really important is like how to find community as a practice owner. Because I have a community now and I can feel such a difference in like how I show up. It's not as draining. Like I just feel a difference in like being able to consult.

Blake recommended research on the pay disparity of counselors versus other medical professionals:

A very important thing is the financial perspective of behavioral health occupation. I think, not to minimize what doctors do, not to minimize what nurse practitioners do, but they spend a significantly minimized amount of time with patient care. However, their pay is exorbitantly higher than ours. When you look at the difference in that dynamic, there has to be a consideration that you're not going to draw a lot of people to this occupational field. With all the dynamics of the world, and we can see trauma after trauma after trauma, anxiety after anxiety inducing instances. We just had a bridge collapse earlier this week, right? We've had more mass shootings than we can count at elementary schools at churches. When you see the number of incidences that can induce a mental health challenge…death and grief. Post-COVID brought to light the need for our occupational field. And I think when you look at what we are compensated from

> an insurance perspective within this industry, we are being failed. The pay disparity for us as master's level providers, even sometimes doctoral level providers, needs to be examined. We need to be paid more because we are not going to draw people to this occupation paying what we pay. And we're not going to sustain people in this occupation paying what we pay. And there's a greater and greater need every day…every incident, Every day. So, that is something that I think needs to be exposed post-COVID.

Another participant recommended research on counselor depression in private practice. Finley stated,

> Maybe depression. I think, generally in private practice, you are more isolated. I spend a lot of time…I don't really have coworkers to talk to during the day. It's really just me and my clients. So, I think in general that definitely would be good to look into.

Harper took a more scientific approach and recommended research into the effects of COVID-19 on the brain and how that may affect a client's brain functioning:

> When we're working with clients, we are trying to get a better understanding from a mental health perspective. If they have had COVID, there are lasting, impacting symptoms of COVID. It's called long-term COVID or long COVID. I can't remember. These symptoms that just consistently happen…whether it's brain fog…whether it's, you know, them being able to function on a day-to-day basis. Like all of that makes a difference in how they're functioning in your sessions.

Summary

In this section, the results of my findings were summarized to answer the research question: What were the lived experiences of clinically licensed counselors during COVID-19? The participants shared professional and personal accounts to help us better understand their experiences and their clients' experiences during the COVID-19 pandemic.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative, IPA was to gain needed insight into the lived experiences of clinically licensed counselors during COVID-19. The research question was: What are the lived experiences of clinically licensed counselors during COVID-19?

The research topic was selected because before this study, limited research had been conducted specifically concerning clinically licensed counselors and their experiences of working in private practice during the COVID-19 pandemic. My research was conducted to help elucidate this phenomenon. Understanding the clinically licensed counselor's lived experience during the COVID-19 pandemic will bring awareness to what professionally and personally happens to clinically licensed counselors during crisis situations. It will also provide valuable insights into the emotional and psychological aftermath that the counselors experienced after working through a crisis situation.

The IPA was used to obtain data about the lived experiences of clinically licensed counselors during the COVID-19 pandemic. After an in-depth analysis, four themes emerged from the seven semi-structured interviews. The four emergent themes are private practice, COVID-19 quarantine experiences, counselor adaptations to COVID-19, and future research recommendations. Within these emergent themes, several subthemes and subtopics became evident. The subthemes and subtopics are factors for clinical licensing, factors for starting private practice, navigating work experiences in private practice (i.e., subtopics: positive work experiences and negative work experiences), counselor experiences (i.e., subtopics: quarantine, telehealth, isolation, connection, and

treatment goals), client experiences, professional adaptations, personal adaptations (i.e., subtopics: coping mechanisms and self-care), summation of COVID-19 experience, and research recommendations post-COVID-19. An in-depth exploration of each of these emergent themes, subthemes and subtopics were detailed in Chapter 4. In this chapter, the findings regarding the lived experiences of clinically licensed counselors during COVID-19 are discussed. The limitations of the study, recommendations for future research, and implications for social change are also explored.

Interpretation of the Findings

Historically, it has been well-documented that during crisis situations clinically licensed counselors and other helping professionals are often heavily utilized to provide mental health care for mentally and emotionally disordered individuals (Kruczek et al., 2022; Litam et al., 2021; Prasath et al., 2021; Richmond et al., 2021; Samyuktha, et al., 2022). However in Chapter 2, the literature review revealed that there is currently little to no research on the wellbeing of clinically licensed counselors who may be experiencing traumatic stress or vicarious trauma as a result of working with individuals during a crisis situation (Kanno & Giddings, 2017). This research filled this important gap of understanding the lived experiences of clinically licensed counselors during the COVID-19 pandemic.

As a result of an in-depth analyzation of the data, four main themes emerged. The four emergent themes are related to the clinically licensed counselors' experiences of being in private practice, COVID-19 quarantine experiences, counselor adaptations to COVID-19, and the counselor's future research recommendations.

Emergent Theme 1: Private Practice

Emergent theme 1 was the result of the participants' evaluation of their professional and personal lived experiences before, during, and after the COVID-19 pandemic. Each participant shared their individual rationale for becoming clinically licensed and for starting their private practice. The participants also provided insight into how they navigate positive and negative work experiences in private practice.

Factors for Clinical Licensing

Several participants shared that experiencing critical life issues steered them into the counseling profession and eventually clinical licensing so that they could provide mental health care to individuals experiencing mental health disorders. Participants that witnessed their family members endure mental health issues shared that this was a direct factor in becoming a clinically licensed counselor. This is in alignment with the literature that suggests that some helping professional's childhood experiences may steer that individual's future career choice (Bryce et al., 2023). Other participants indicated that marital issues or an unexpected pregnancy caused them to become clinically licensed. As stated in the literature review, it is also an indicator that helping professionals often choose their career due to their own traumatic life experiences and the desire to help others that are also experiencing trauma and/or traumatic stress (Straussner et al., 2018). The remaining participants sought a career change for various reasons such as to work more directly with the population they served, to move from the medical side of client care, and to have a career that is in direct alignment with their personality type. The

literature did not account for these perspectives despite being indicative of their decision to become clinically licensed.

Factors for Starting Private Practice

Clinically licensed counselors can work in many capacities and in various organizations. They can be found in agencies, group private practices, hospital systems, and in private practices. Each participant considered why they chose to move into a private practice of their own. Several participants that worked in an agency prior to moving to private practice shared that the need for freedom, independence, control of their schedule and client load were some of the main reasons they made the switch. Several of the participants noted that they were entrepreneurs or had business experience prior to opening their private practice and described how the private practice model was a natural fit. Money was also mentioned by the participants as a deciding factor to move to private practice. Several of the participants shared that agency work was not substantial enough to pay for their lifestyle and/or student loan payments. One participant shared a traumatic event that involved her licensing supervisor's murder that almost derailed her desire to become a counselor and to move into private practice. However, her preference for family systems and desire to counsel couples led her back to the private sector of counseling and opening her own private practice.

Navigating Work Experiences in Private Practice

The participants were asked to describe what they considered to be positive and negative work experiences in private practice before and after the COVID-19 pandemic. The participants did not note any changes in how they perceive positive and negative

work experiences in relation to the COVID-19 pandemic. In other words, what the participants perceived to be negative or positive work experiences remained the same irrespective of the COVID-19 pandemic.

Several of the participants indicated aspects of client improvement as positive work experiences. The participants attributed client symptom reduction, client's willingness to work on their issue, and effective conversations with their client that help the client process their feelings as positive work experiences. The other participants shared that having a manageable work schedule that does not cause them to feel overwhelmed or stressed and having clients attend sessions as scheduled contribute to positive work experiences.

Negative work experiences were identified by several participants as feeling unhelpful or unable to help their client process their issues. Other negative work experiences reported by the participants were issues with client resistance to treatment or stuckness. One participant credited having long breaks between sessions as a negative work experience due to her issues with attention deficit hyperactivity disorder. An outlier participant shared that she has worked in several intensive mental health treatment centers including prisons, so she does not have negative work experiences now that she works for herself in private practice.

The findings revealed that the participants' negative or positive perception of self was based on how well their clients' symptoms were improving or regressing. Work demands and increased workload also affected the participants' sense of efficacy and efficiency. The literature suggests that when an individual is experiencing compassion

fatigue they may experience feelings of overwhelm and helplessness in response to consistent psychological and emotional strain while working with clients (Centers for Disease Control and Prevention [CDC], 2016, 2018, 2019; Martin-Cuellar et al., 2019).

Emergent Theme 2: COVID-19 Quarantine Experiences

Each participant was asked to describe their COVID-19 quarantine experience. The participants shared their individual perspectives about quarantine, telehealth, isolation, connection, and treatment goals. They also discussed their perceptions about how their clients fared during the COVID-19 pandemic.

Counselor Experiences

Quarantine. The participants discussed their unique and individual experience of the COVID-19 quarantine. Several of the participants described their initial reaction to the required quarantine as experiencing fear, anxiety, shock and disbelief. These participants shared that their concern was for themselves but also for their children, partners, and older family members. One member shared that she did not feel fear, shock or disbelief but endured mental health struggles as a result of the being forced into isolation and needing human connection. One participant sharply contrasted the other participant's initial reactions because she did not have to quarantine. The participant was considered to be an essential worker and therefore continued to work for a period of time despite the mandate.

Telehealth. The move to virtual telehealth services adversely affected two participants that were not utilizing telehealth services prior to the COVID-19 pandemic. The two participants shared that they felt stress due to having to figure out what

technology was acceptable, acclimating their clients to the new online platform, losing clients that did not want to move to the online platform, as well as figuring out the documentation needed to provide to clients and to enable insurance companies to be billed for telehealth services. The remaining five participants shared that it was not difficult for them to move their in-person office to an online format. However, these participants did share that they experienced personal challenges while using telehealth services. The participants shared that they had some issues with feeling connected to their clients because they were not in-person, feelings of anxiousness due to the immediate changes they had to make to online-only counseling, and feelings of isolation due to having to work from home.

The participants did share positive aspects of utilizing telehealth services during quarantine. Several participants shared that they noticed improvements among clients that did not want to go outside of their home and were more comfortable being at home. They also noticed that they had less clients to cancel appointments or not show up to their appointment because they did not have to travel or do anything besides turning on their computer. Some of the participants that returned to their private practice before and after the mandate was lifted shared that they noticed that they felt more balanced utilizing telehealth services. Notably, four participants have decided to permanently adapt the hybrid counseling model which includes conducting in-person and telehealth counseling sessions. The other three participants have opted to provide online telehealth services only and no longer have a brick and mortal office.

Isolation. Three of the participants described their quarantine experience as a period of isolation. The participants noted that working from home with no one to talk to about their clients and the things they were experiencing attributed to feelings of isolation and loneliness. One participant noted that having telehealth sessions with her clients helped her to not feel so isolated despite preferring to work in-office. Four of the participants did not note any issues with isolation because they were quarantined with family members. One of the four participants shared that she did not feel isolated because being an introvert, she enjoyed the isolation. One participant contrasted with the other participants because she did not quarantine. She was considered to be an essential worker in her state, so she continued to work on a daily basis.

Connection. The participants described how connected they felt to their clients while working with them virtually. Six of the seven participants shared that they felt more connected with their clients. The participants noted that there was a feeling of we are in this together and reported more instances of self-disclosure in an effort to relate with the client during the COVID-19 pandemic. One participant shared that she did not feel a closer connection to her clients because she was accustomed to working with them in-person and felt that virtual sessions were a barrier to feeling connected.

Treatment Goals. The participants described their experiences with maintaining pre-set treatment goals with their clients while experiencing the COVID-19 quarantine. All of the participants shared that a shift or adjustment to their preset goals happened naturally due to the inability to leave the house. This was especially true for the clients

who had social goals set and could no longer work on the set intervention that may have included attending functions, dating, and so forth.

Client Experiences

The participants shared their perceptions about how their clients fared during the COVID-19 pandemic and quarantine. The participants reported increased levels of fear, anxiety, and depression-related symptoms as well as an increase in alcohol usage. This is in-keeping with the literature which suggests that maladaptive behaviors may increase in times of stress and in crisis situations (Bindas, 2022; Cohen et al., 2023; "Great Depression," 2023; Li et al., 2023). Several of the participants shared that their clients also struggled with feelings of isolation especially in the older populations and in clients that travel for work which caused them to have longer times of quarantine before they could be reunited with their families. One participant shared insight into how the quarantine was negatively affecting couples and cited an increase in couples declaring that they would be breaking up and moving out as a result of the quarantine. Another participant noted that her student clients struggled with taking classes online and showing up for counseling sessions due to embarrassment or fears concerning their negative home environment.

Emergent Theme 3: Counselor Adaptations to COVID-19

The participants described how they have professionally and personally adapted to the COVID-19 pandemic.

Professional Adaptations

The main professional adaptation that the participants shared is the implementation of telehealth services permanently in their private practice. Two participants had never utilized telehealth services prior to the COVID-19 pandemic. These participants noted that they were unaware of the accessibility of this feature by insurance companies. Despite all the participants' decision to incorporate telehealth services in their private practice, four participants decided to only use this modality due to its convenience. The convenience of working from home and the inability to pay office rent was noted as reasons why the participants will continue to implement telehealth services either as a hybrid or exclusively in their private practice.

Personal Adaptations

The participants described the personal coping mechanisms and the self-care strategies that they used during the COVID-19 pandemic. To differentiate, coping mechanisms are mental and emotional strategies used to make-meaning of difficult situations while self-care strategies are activities used to improve a person's mental, emotional, and physical wellbeing.

Coping Mechanisms. Several of the participants shared that they use humor as a coping mechanism within their own life as well as with their clients. Three of the participants shared that they use mindfulness techniques to stay focused on positive outcomes, to increase optimism, and to relieve stress and anxiety. One participant shared that she just allowed the passage of time to help her through difficult moments she experienced with clients or in her personal life during the COVID-19 pandemic. Silence

was also noted by some of the participants as a way to cope with stress brought on by their work with their clients. The participants shared that they often felt that they could not "safely" speak with anyone about how they truly felt as well as about how they may have struggled with client content. One participant shared insight about how counselors may feel the stigma of asking for help which is in alignment with the literature. Quinn shared,

> I think there's definitely stigma. I think there's stigma, but I also think that there is a lack of safety. And not because people don't want safety or people don't wanna be safe, but I think it's just a scary thing. Like full transparency…I struggle with the idea of your counselor should have a counselor and most counselors want that. They want that safe space but I think it's just hard to find it. To really believe it exists because you have to be so guarded with not just your information but with the information of your clients. So, turning that off can be challenging.

The literature suggests that helping professionals may disregard the need to ask for help due to perceived stigmas that exist about needing emotional or psychological help when you provide those services to others (Straussner et al., 2018; Zerubavel & Wright, 2012).

Self-Care. All seven of the participants described techniques they were utilizing to help promote emotional, mental, and physical wellbeing during the COVID-19 pandemic. Two participants noted the importance of water and cleansing in their self-care repertoire to "wash away" daily stressors. Physical exercise such as walking, hiking, and

yoga were other self-care strategies used by several participants not only to stay in shape but to provide an outlet for stress and to see people even when they were not able to be physically close to individuals. Some of the participants used time away from work, hobbies, therapy, traveling, music, and television show/movies to distract themselves from their work life.

Emergent Theme 4: Future Recommendations

The participants summarized their COVID-19 pandemic experience and provided some ideas for future research in this section.

Summation of COVID-19 Experiences

The participants described their COVID-19 pandemic experience in one word or phrase. The responses from the participants were mostly positive but one participant viewed the COVID-19 pandemic experience as a negative one associated with a time of loss. The participants positively associated the pandemic with words such as life-changing, unscathed, professional and personal growth, clarity, balance, fortunate, and being a diamond under pressure. These six participants associated the pandemic as a time of personal and professional growth despite the hardships they may have faced. This indicates the possibility of resilience that often occurs when a person overcomes obstacles. One participant associated the pandemic with a loss of connection. The participant felt that her children were not able to attend school and people were unable to be around each other due to the quarantine.

Research Recommendations Post-COVID-19

The participants shared their recommendations for future research that could provide insight into the lived experiences of clinically licensed counselors as a result of having endured the COVID-19 pandemic and promote social change for this population of counselors. Several of the participants suggested more research on ways that counselors can help other counselors (counselor support) through tough times. Several of the counselors mentioned the feelings of loneliness and isolation that they feel on a daily basis and shared that peer consultation or a structured setting to safely give voice to their thoughts and emotions would be helpful to most counselors. Other recommendations were to find ways to allow for national licensure so that clients are not lost when they have to go to another school such as college or move away. One participant stressed the importance of this because several of her clients flunked out of school because they had no support and she was not able to assist them because their school was in another state. Free therapy for counselors and research on the efficacy of telehealth services was shared. The participant shared that paying for mental health therapy is expensive and based on the content that clinically licensed counselors' intake when interacting with their clients, the participant felt that it should be free and accessible to all. The participant also recommended that the efficacy of telehealth services be researched to see if there are less hospitalizations due to the increased access to counseling services via telehealth services. One participant suggested that the pay disparity between other helping and medical professionals be researched because of her concerns that counselors are leaving the field due to low insurance reimbursements. Another suggestion for future research

was on the topic of counselor depression. The participant noted that counselors in private practice are often isolated and only have their clients to talk to on a daily basis. Another recommendation was for research to be conducted on the effects of COVID-19 on the brain and how that may affect the future of counseling clients who have contracted COVID-19.

Theoretical Implications

Husserlian Phenomenology

Husserlian phenomenological research, or pure phenomenology, seeks to elucidate and comprehend the essential meaning or "essence" derived from a specific phenomenon (Willis et al., 2016). More specifically, it is an approach that explores people's perceptions and meaning-making of their unique experiences and how they assimilate their experiences into their consciousness (Patton, 2015; Ungvarsky, 2020). According to Patton (2015), "Consciousness is the only access human beings have to the world." Therefore, these conscious perceptions about a person's unique experiences provides information about how the individual makes sense of their world and is often rooted in their own subjective and personal truths rather than in reality (Dean, 2018). The meaning of the person's unique experience, or essence, is the studied phenomena (Abalos et al., 2016; Gao, 2020). Husserlian phenomenology is often called descriptive phenomenology because the essence, or the meaning the person gives to their unique, sensory experience, must be described and interpreted to obtain a full understanding of their sensory data (Patton, 2015). This essence lies at the core of the individual's reality (Abalos et al., 2016; Willis et al., 2016). Utilizing this process, I consciously worked to

suspend judgment, or epoche, while conducting the seven semi-structured interviews and while analyzing the subsequent data. The phenomenological reduction approach, or bracketing, was also utilized to obtain the purest form of my participants' interpretations. By utilizing the descriptions and explanations of their unique experiences, I was able to interpret the meanings they attributed to their COVID-19 pandemic experiences.

Constructivist Self-Development Theory

The CSDT served as the theoretical underpinning of this study. CSDT was created by Dr. Lisa McCann and Dr. Laurie Anne Pearlman of the Traumatic stress institute (McCann & Pearlman, 1990). The CSDT essentially is a personality development theory that is often regarded as a clinical trauma theory (Vides et al., 2022). It provides a framework for understanding and treating adult trauma survivors (McCann & Pearlman, 1990). CSDT is integrative in that it combines both the idea that pre-existing pathology and the severity of the situation could cause trauma/mental health issues and incorporates constructivist theory (McCann & Pearlman, 1990). Like phenomenology, at the core of the CSDT is the premise that in reaction to trauma, individuals possess the ability to construct their own unique and personal realities as they interact with their environment (McCann & Pearlman, 1990). Therefore, if a person directly or vicariously experiences trauma, then their sense of self and the world can be negatively or positively altered (Branson et al., 2014; Darroch & Dempsey, 2016). The CSDT examines an individual's experience of trauma and how that person adapts to their experienced trauma (McCann & Pearlman, 1990). Findings from this study provided critical insight into the positive and negative experiences of the clinically licensed counselors during the

COVID-19 pandemic. Findings from this study also included changes the participants made professionally and personally as a result of making accommodations and adapting to the crisis situation.

Limitations of the Study

A gap in the literature existed in the area of research that focused on the wellbeing of clinically licensed counselors in the aftermath of the COVID-19 pandemic. Despite the insight that this study provided into the lived experiences of clinically licensed counselors during the COVID-19 pandemic, this study has several limitations. The IPA approach suggests a small sample size due to the time-consuming nature of detailed analyzation of the participants' transcripts (Smith et al., 2022). Ideally, a sample size of six participants is recommended (Smith et al., 2022). Fifty emails were sent to various counselors via the Psychology Today website and no one responded. Social media groups yielded 12 interested participants but only seven followed up and consented to participate in the study. These outreach attempts resulted in seven participants and is not indicative of the full breadth of clinically licensed counselors. Another limitation is that the study consisted of only cis-gender women.

Despite opening the opportunity to participate to all individuals, only cis-gender women responded to my call for participants. This created a rather homogenous participant sample. Another limitation of the study is that it required only clinically licensed counselors in private practice to participate. Clinically licensed counselors work in various settings such as agencies, hospital systems, group practices, and a plethora of other locations. Limiting the participants to solo private practice is not indicative of the

counseling profession as a whole. Potential issues with the participants' self-reported data was another limitation. The historical data provided was based on the participants' sole perspectives and recollections which may not be valid or reliable. The participants had to recall their COVID-19 experiences despite the height of the pandemic occurring in 2020. This study occurred in 2024 and some participants struggled with remembering how they felt or what occurred in 2020. The potential for researcher bias is also a limitation. The researcher was also a clinically licensed counselor in solo private practice so to mitigate researcher bias, validity procedures were utilized such as reflexive journaling, member checking, and conducting multiple reviews of the audio transcript along with the physical transcript, notes, and codes to ensure accuracy and increase reliability. Potential participant reactivity posed another potential limitation. The participants may not have been fully forthcoming about their mental and emotional struggles due to the fact that the researcher was also a clinically licensed counselor that works in private practice (i.e., power dynamics bias). The participants may have given acceptable answers due to fear of judgment (i.e., social desirability bias). Lastly, the semi-structured interviews were conducted via a recorded telephone line. The participants may have experienced technological discomfort due to having to participate in a recorded telephone (i.e., audio) interview.

These limitations can affect transferability, or generalizability. It is recommended that future researchers conduct studies utilizing a larger and more diverse participant sample based on location, gender, race, as well as workplace setting. It is also recommended that future researchers take into account the potential for researcher and

participant bias as well as the participants' comfort with utilizing recorded audio/video devices during participant interviews.

Recommendations

Future research recommendations are a culmination of my own recommendations and recommendations from the participants of this study. Based on the findings of this study, I would recommend that future studies consist of population samples that are more indicative of the diverse counselor population. The researcher should consider utilizing participant samples based on age, race, gender, and location-diverse clinical counselor populations. Utilizing the foundation of this study, additional studies investigating clinical counselor diversified workplace settings such as agencies, hospital systems, and group practices and their contribution to burnout, compassion fatigue, vicarious traumatization, and vicarious resilience should be considered. Future studies that focus on clinical counselor diversified workplace settings and their contribution to burnout and compassion fatigue based on personality type should also be considered. Another recommendation is to explore the lived experiences of clinically licensed counselors in relation to their overall personal or professional well-being. Lastly, conducting a study to explore clinical counselor well-being after a crisis situation is recommended. These approaches would widen the scope of understanding the professional and personal well-being of clinically licensed counselors.

Implications

The findings of this study implicate social change by increasing researchers and clinically licensed counselors' awareness of the possible long-term, residual side effects of working with clients during crisis situations. These findings indicate a necessity for research to be conducted on the wellbeing of the often-isolated population of clinically licensed counselors. The necessity for more crisis-related training in counselor education programs is also indicated. Lastly, this study seeks to encourage future researchers to conduct research that will increase awareness about the importance of clinically licensed counselor well-being in solo private practice as well as to encourage them to create diagnostic assessments to help identify the early warning signs of burnout, compassion fatigue, and vicarious traumatization in this population of counselors.

Conclusion

This study sought to explore the lived experiences of seven clinically licensed counselors during the COVID-19 pandemic. IPA was used to obtain rich data from the semi-structured interviews. As a result, four themes emerged from the data: private practice, COVID-19 quarantine experiences, counselor adaptations to COVID-19, and future research recommendations. These emergent themes address the gap in the literature by providing insight into the professional and personal lived experiences of clinically licensed counselors during COVID-19. It also highlights the need for future research on the underrepresented clinically licensed counselor's wellbeing.

In conclusion, the wounded healer concept is grounded in Shamanism and is based on the belief that shamans should endure a deliberate physical or psychological

crisis, including suffering and isolation, as part of their training process to obtain true wisdom (Singh, 2018). The clinically licensed counselors navigated their own professional and personal challenges during the Covid-19 pandemic to emerge as wounded healers. They were able to persevere through their own fears, sadness, anxiety, and potential burnout while continuing to hold space for their clients. Like the wounded healer, the Covid-19 pandemic seemed to deepened their empathy and compassion while strengthening their connection to their clients. In navigating their professional and personal challenges, the counselors demonstrated shared humanity and what it means to care through crisis.

References

Aafjes-van Doorn, K., Békés, V., Prout, T. A., & Hoffman, L. (2020). Psychotherapists' vicarious traumatization during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S148–S150. https://doi.org/10.1037/tra0000868

Abalos, E., Rivera, R., Locsin, R., & Schoenhofer, S.(2016). Husserlian phenomenology and Colaizzi's method of data analysis: Exemplar in qualitative nursing inquiry using nursing as caring theory. *International Journal for Human Caring, 20*(1), 19-23. https://doi.org/10.20467/1091-5710-20.1.19

Alterkruse, M. K., Harris, H. L., & Brandt, M. A. (2001). The role of the professional counselor in the 21st century. *Counseling and Human Development, 34*(4), 1.

Aligne, C. A. (2016). Overcrowding and mortality during the influenza pandemic of 1918. *American Journal of Public Health*, *106*(4), 642–644. https://doi.org/10.2105/AJPH.2015.303018

Alsawy, S., & Mansell, W. (2013). How do people achieve and remain at a comfortable weight?: an interpretative phenomenological analysis. *Cognitive Behaviour Therapist*, *6*, Article e13. https://doi.org/10.1017/S1754470X13000184

American Counseling Association. (2023, August 12). *Credential titles and levels.* https://www.counseling.org/knowledge-center/licensure-requirements

Bakhtiarian, M., & Benvidi, F. (2021). The relationship between psychology and phenomenology: An analysis based on Husserl's views. *Philosophical Investigations, 15*(36), 245–258. https://doi.org/10.22034/jpiut.2021.48054.2982

Banks, J., González, T., Mueller, C., Pacheco, M., Scott, L. A., & Trainor, A. A. (2023). Reflexive quality criteria: Questions and indicators for purpose-driven special education qualitative research. *Exceptional Children*, *89*(4), 449–466. https://doi.org/10.1177/00144029231168106

Barker, G. G., & Barker, E. E. (2022). Online therapy: lessons learned from the COVID-19 health crisis. *British Journal of Guidance & Counselling*, *50*(1), 66–81. https://doi.org/10.1080/03069885.2021.1889462

Beasley, S. T., Sánchez, B., Butler, M., & Chapman-Hilliard, C. (2021). "Other fields are more lucrative and sexy": A qualitative examination of the low number of men in psychology. *Journal of Career Development*, *48*(2), 182–196. https://doi.org/10.1177/0894845319838054

Bindas, K. J. (2022). The crossroads of identity: Psychology's (re)action to the Great Depression. *Social Science Journal*, *59*(4), 646–656. https://doi.org/10.1080/03623319.2020.1727243

Blikhar, V., Kovalchuck, Z., Vavryniv, O., Yaremko, R., Bodnarchuk, V., & Tsiupryk, A. (2023). Results of the implementation of a comprehensive socio-psychological program to foster professional empathy among professionals in the helping professions. *Brain: Broad research in artificial intelligence & neuroscience*, *14*(2), 1–13. https://doi.org/10.18662/brain/14.2/440

Branson, D. C., Weigand, D. A., & Keller, J. E. (2014). Vicarious trauma and decreased sexual desire: A hidden hazard of helping others. *Psychological Trauma-Theory Research Practice and Policy, 6*(4), 398–403. https://doi.org/10.1037/a0033113

Bryce, I., Pye, D., Beccaria, G., McIlveen, P., & Du Preez, J. (2023). A systematic literature review of the career choice of helping professionals who have experienced cumulative harm as a result of adverse childhood experiences. *Trauma, Violence & Abuse, 24*(1), 72–85. https://doi.org/10.1177/15248380211016016

Centers for Disease Control and Prevention. (2016, November 3). *Pandemic basics*. U.S. Department of Health and Human Services. https://www.cdc.gov/flu/pandemic-resources/basics/index.html

Centers for Disease Control and Prevention. (2018, August 10). *Past pandemics*. U.S. Department of Health and Human Services. https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html

Centers for Disease Control and Prevention. (2019, March 20). *1918 pandemic (H1N1 virus)*. U.S. Department of Health and Human Services. https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

Centers for Disease Control and Prevention. (2023, April 14). *COVID data tracker weekly review.* U.S. Department of Health and Human Services. https://www.cdc.gov/coronavirus/2019-ncov/COVID-data/COVIDview/

Coaston, S. C., & Lawrence, C. (2022). Self-compassion and support for the wounded healer in counselor education. *Journal of Creativity in Mental Health*, *19*(1), 85–96. https://doi.org/10.1080/15401383.2022.2146027

Cohen, M., Cruz, L. N., Cardoso, R. B., Albuquerque, M. de F. P. M. de, Montarroyos, U. R., de Souza, W. V., Ludermir, A. B., de Carvalho, M. R., da Silva Vicente, J.

D., Viegas Filho, M. P., Cortes, F. J. M., de Siqueira Silva, M. T., Almeida, C. M. C., Lima, L. N. G. C., Veras, M. A. de S. M., Kendall, C., Kerr, L. R. F. S., Martelli, C. M. T., & Camey, S. A. (2023). Impact of the COVID-19 pandemic on the mental health of frontline healthcare workers in a highly affected region in Brazil. *BMC Psychiatry*, *23*(1), Article 255. https://doi.org/10.1186/s12888-023-04702-2

Conchar, C., & Repper, J. (2014). "Walking wounded or wounded healer?" Does personal experience of mental health problems help or hinder mental health practice? A review of the literature. *Mental Health and Social Inclusion, 18*(1), 35–44. https://doi.org/10.1108/MHSI-02-2014-0003

COVID-19. (2023, April 17). In *Wikipedia*. https://en.wikipedia.org/wiki/COVID-19

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods* (5th ed.). Sage Publications.

Darroch, E., & Dempsey, R. (2016). Interpreters' experiences of transferential dynamics, vicarious traumatization, and their need for support and supervision: A systematic literature review. *European Journal of Counselling Psychology, 4*(2), 166–190. https://doi.org/10.5964/ejcop.v4i2.76

Dean, A. (2018). The supernatural salesman: Unpacking shaman "witch doctor" identity work. *Journal of Marketing Management, 34*(17/18), 1608-1631. https://doi.org/10.1080/0267257X.2018.1549091

Ender, Z., Saricali, M., Satici, S. A., & Eraslan-Capan, B. (2019). Is mindful awareness effective on hope, burnout and self-efficacy among school counsellors in Turkey?

British Journal of Guidance & Counselling, *47*(6), 712–726. https://doi.org/10.1080/03069885.2018.1458072

Gao, M. (2020). The "things themselves": Challenging heuristics and inciting empathy via Husserlian phenomenology. *Advances in Health Sciences Education, 25*(3), 769–775. https://doi.org/10.1007/s10459-019-09926-0

Giorgi, A. (2005). The phenomenological movement and research in the human sciences. *Nursing Science Quarterly, 18*(1), 75–82.

Glennon, A., Pruitt, D. K., & Rouland Polmanteer, R. S. (2019). Integrating self-care into clinical practice with trauma clients. *Journal of Human Behavior in the Social Environment*, *29*(1), 48–56. https://doi.org/10.1080/10911359.2018.1473189

Great Depression. (2023, April 15). In *Wikipedia.* https://en.wikipedia.org/wiki/Great_Depression

Gutland, C. (2018). Husserlian phenomenology as a kind of introspection. *Frontiers in Psychology, 9*, Article 896. https://doi.org/10.3389/fpsyg.2018.00896

Himanka, J. (2019). Reduction in practice: Tracing Husserl's real-life accomplishment of reduction as evidenced by his idea of phenomenology lectures. *Phenomenology & Practice, 13*(1), 7–19. https://doi.org/10.29173/pandpr29371

Hunt, T. (2018). *Professionals' perceptions of vicarious trauma from working with victims of sexual trauma* [Doctoral dissertation, Walden University]. Walden Dissertations and Doctoral Studies.

Isawi, D. T., & Post, P. B. (2020). Self-efficacy of counselors working with refugees. *Adultspan Journal*, *19*(2), 107–117. https://doi.org/10.1002/adsp.12099

Jung, C. (1963). *Memories, dreams, reflections*. Crown Publishing Group/Random House.

Kanno, H., & Giddings, M. M. (2017). Hidden trauma victims: Understanding and preventing traumatic stress in mental health professionals. *Social Work in Mental Health*, *15*(3), 331–353. https://doi.org/10.1080/15332985.2016.1220442

Kirkmayer, L. (2003). Asklepian dreams: The ethos of the wounded-healer in the clinical encounter. *Transcultural Psychiatry*, *40*(2), 248–277. https://doi.org/10.1177/1363461503402007

Kruczek, T., Geesa, R. L., Mayes, R. D., & Odell, K. M. (2022). School counselor and administrator perceptions of response to the COVID-19 pandemic. *Professional School Counseling, 26*(1C), 1–12. https://doi.org/10.1177/2156759X221134661

Lanier, B. A., & Carney, J. S. (2019). Practicing counselors, vicarious trauma, and subthreshold PTSD: Implications for counselor educators. *Professional Counselor*, *9*(4), 334–346. https://doi.org/10.15241/bal.9.4.334

Leahy, M., Rak, E., & Zanskas, S. (2015). A brief history of counseling and specialty areas of practice. In M. Stebnicki & I. Marini (Eds.), *The professional counselor's desk reference* (pp. 3-8). Springer Publishing Company.

Lee, R. (2017). The impact of engaging with clients' trauma stories. *Probation Journal, 64*(4), 372–387. https://doi.org/10.1177/0264550517728783

Li, T. H., Kamin, L., George, J., Saiz, F. S., & Meyer, P. (2023). Impact of the COVID-19 pandemic on treatment for mental health needs: A perspective on service use patterns and expenditures from commercial medical claims data. *BMC Health*

Services Research, *23*, Article 163. https://doi.org/10.1186/s12913-023-09080-9

Liang, Y., Sun, L., & Tan, X. (2022). Mental health research during the COVID-19 pandemic: Focuses and trends. *Frontiers in Public Health*, *10*, Article 895121. https://doi.org/10.3389/fpubh.2022.895121

Litam, S. D. A., Ausloos, C. D., & Harrichand, J. J. S. (2021). Stress and resilience among professional counselors during the COVID-19 pandemic. *Journal of Counseling & Development*, *99*(4), 384–395. https://doi.org/10.1002/jcad.12391

Lucey, C., & van Nieuwerburgh, C. (2021). 'More willing to carry on in the face of adversity': How beginner teachers facing challenging circumstances experience positive psychology coaching: An interpretative phenomenological analysis. *Coaching: An International Journal of Theory, Research and Practice, 14*(1), 62–77. https://doi.org/10.1080/17521882.2020.1753791

Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and reduction: Reimagining a theory of secondary traumatic stress. *Traumatology*, *23*(1), 112–123. https://doi-org/10.1037/trm0000096

Makkai, K. (2018). Evaluating the level of burnout among healthcare professionals. *Acta Universitatis Sapientiae - Social Analysis*, *8*(1), 23–39. https://doi.org/10.2478/aussoc2018-0002

Martin-Cuellar, A., Lardier, D. T., Atencio, D. J., Kelly, R. J., & Montañez, M. (2019). Vitality as a moderator of clinician history of trauma and compassion fatigue. *Contemporary Family Therapy: An International Journal*, *41*(4), 408–419. https://doi.org/10.1007/s10591-019-09508-7

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.

Merriam, S., & Tisdel, E. (2016). *Qualitative research: A guide to design and implementation* (4th ed.) Sage Publications.

Merriman, J. (2015). Prevention-based training for licensed professional counselor interns. *Journal of Professional Counseling: Practice, Theory & Research*, *42*(1), 40–53. https://doi.org/10.1080/15566382.2015.12033943

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformatio*n. Brunner/Mazel.

McGaha, K. K., & D'Urso, P. A. (2019). A non-traditional validation tool: using cultural domain analysis for interpretive phenomenology. *International Journal of Social Research Methodology, 22*(6), 585–598. https://doi.org/10.1080/13645579.2019.1621474

Negrin, K. A., Slaughter, S. E., Dahlke, S., & Olson, J. (2022). Successful recruitment to qualitative research: A critical reflection. *International Journal of Qualitative Methods*, *21*, 1–12. https://doi.org/10.1177/16094069221119576

Pandemic. (2023, April 20). In *Wikipedia*. https://en.wikipedia.org/wiki/Pandemic

Patton, M. (2015). *Qualitative research and evaluation methods* (4th ed.). Sage Publications.

Piredda, M., Fiorini, J., Marchetti, A., Mastroianni, C., Albanesi, B., Livigni, L., Carrabs, G., Zaghini, F., Grazia De Marinis, M., & Sili, A. (2022). The wounded healer: A phenomenological study on hospital nurses who contracted COVID-19. *Frontiers*

in Public Health, *10*, Article 867826. https://doi.org/10.3389/fpubh.2022.867826

Prasath, P. R., Mather, P. C., Bhat, C. S., & James, J. K. (2021). University student well-being during COVID-19: The role of psychological capital and coping strategies. *Professional Counselor, 11*(1), 46–60. https://doi.org/10.15241/prp.11.1.46

Pritchard, M., & van Nieuwerburgh, C. (2016). The perceptual changes in life experience of at-risk adolescent girls following an integrated coaching and positive psychology intervention group programme: An interpretative phenomenological analysis. *International Coaching Psychology Review, 11*(1), 57–74. https://doi.org/10.53841/bpsicpr.2016.11.1.57

Quitangon, G., & Evces, M. (2015). *Vicarious trauma and disaster mental health: Understanding risks and promoting resilience*. Routlege.

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage Publications.

Renaud, C., & Lacroix, A. (2023). Systematic review of occupational burnout in relation to cognitive functions: Current issues and treatments. *International Journal of Stress Management, 30*(2), 109–127. https://doi.org/10.1037/str0000279

Richmond, S. G., Samuels, A. M., & Crunk, A. E. (2021). Vicarious grief in supervision: Considerations for doctoral students supervising counselors-in-training. *Professional Counselor, 11*(2), 161–172. https://doi.org/10.15241/sgr.11.2.161

Roberts, C., Darroch, F., Giles, A., & van Bruggen, R. (2022). You're carrying so many people's stories: Vicarious trauma among fly-in fly-out mental health service providers in Canada. *International Journal of Qualitative Studies on Health &*

Well-Being, 17(1), 1–11. https://doi.org/10.1080/17482631.2022.2040089

Roots, & Roses. (2020). Wounded healer experiences in art therapy. *Art Therapy: Journal of the American Art Therapy Association*, *37*(2), 76–82. https://doi.org/10.1080/07421656.2020.1764794

Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues*, *54*(2), 279–299. https://doi.org/10.1111/j.1540-4560.1998.tb01219.x

Saldana, J. (2016). *The coding manual for qualitative researchers*. Sage Publications.

Salvilla, G. B. & Bedoria, C. S. (2021). Wounded healers: Coping with vicarious trauma among mental health professionals. *Philippine Social Science Journal, 4*(4). https://doi.org/10.52006/main.v4i4.433

Samyuktha, V. N., Venkatesh, V., Kattula, D., Wilson, B. P., & Ravan, J. R. (2022). Wounded healers of the pandemic: A qualitative study on mental health and protective factors of physicians who recovered from COVID-19. *Indian Journal of Occupational & Environmental Medicine*, *26*(2), 105–109. https://doi.org/10.4103/ijoem.ijoem_28_21

Scrutton, A. (2015). Suffering as potentially transformative: A philosophical and pastoral consideration drawing on Henri Nouwen's experience of depression. *Pastoral Psychology*, *64*(1), 99–109. https://doi-org/10.1007/s11089-013-0589-6

Singh, A., Zeig-Owens, R., Rabin, L., Schwartz, T., Webber, M. P., Appel, D., Prezant, D. J., & Hall, C. B. (2020). PTSD and depressive symptoms as potential mediators of the association between world trade center exposure and subjective

cognitive concerns in rescue/recovery workers. *International Journal of Environmental Research and Public Health*, *17*(16). https://doi.org/10.3390/ijerph17165683

Singh, M. (2018). Why is there shamanism? Developing the cultural evolutionary theory and addressing alternative accounts. *Behavioral and Brain Sciences, 41*. https://doi.org/10.1017/S0140525X17002230

Singh, N., Benmamoun, M., Meyr, E., & Arikan, R. H. (2021). Verifying rigor: analyzing qualitative research in international marketing. *International Marketing Review*, *38*(6), 1289–1307. https://doi.org/10.1108/IMR-03-2020-0040

Silveira, F. S., & Boyer, W. (2015). Vicarious resilience in counselors of child and youth victims of interpersonal trauma. *Qualitative Health Research*, *25*(4), 513–526. https://doi.org/10.1177/1049732314552284

Smith, J., Flowers, P., & Lankin, M. (2022). *Interpretative phenomenological analysis: Theory, method, and research* (2nd ed). Sage Publications.

Smith, J. & Nizza, I. (2022). *Essentials of interpretative phenomenological analysis*. American Psychological Association.

Southby, K., Keating, F., & Joseph, S. (2021). The meanings of mental health recovery for African and Caribbean men in the UK. *International Journal of Men's Social and Community Health, 4*(1). https://doi.org/10.22374/ijmsch.v4i1.53

Straussner, S. L. A., Senreich, E., & Steen, J. T. (2018). Wounded healers: A multistate study of licensed social workers' behavioral health problems. *Social Work, 63*(2), 125–133. https://doi.org/10.1093/sw/swy012

Szilagyi, A. (2021). Stress and burnout for helping professionals. Counselors navigating the COVID pandemic. *Journal of Educational Sciences & Psychology, 11*(2), 128–134. https://doi.org/10.51865/JESP.2021.2.14

Taylor, A. K., Gregory, A., Feder, G., & Williamson, E. (2019). "We're all wounded healers": A qualitative study to explore the well-being and needs of helpline workers supporting survivors of domestic violence and abuse. *Health & Social Care in the Community*, *27*(4), 856–862. https://doi.org/10.1111/hsc.12699

Taylor, S., Landry, C., Paluszek, M., Fergus, T., McKay, D., & Asmundson, G. (2020). COVID stress syndrome: Concept, structure, and correlates. *Journal of Depression and Anxiety*, *37*(8), 706-714. https://doi.org/10.1002/da.23071

Tayko, L. J. (2023). Gabriel Marcel's existential phenomenological method as basis for ecumenical dialogue. *Scientia, 12*(1). https://doi.org/10.57106/scientia.v12i1.140

Thackeray, L. A., & Eatough, V. (2018). 'Shutting the world out': An interpretative phenomenological analysis exploring the paternal experience of parenting a young adult with a developmental disability. *Journal of Applied Research in Intellectual Disabilities, 31,* 179–190. https://doi.org/10.1111/jar.12313

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development*, *82*(1), 31–37.

Ungvarsky, J. (2020). Phenomenology. *Salem Press Encyclopedia*.

Vides, B., Middleton, J., Edwards, E. E., McCorkle, D., Crosby, S., Loftis, B. A., & Goggin, R. (2022). The trauma resilient communities (TRC) model: A theoretical

framework for disrupting structural violence and healing communities. *Journal of Aggression, Maltreatment & Trauma, 31*(8), 1052–1070. https://doi.org/10.1080/10926771.2022.2112344

Wallace, K. M. (2021). Male counselors' experiences of their child-clients' trauma. *International Journal on Social and Education Sciences, 3*(4), 618–635.

Wang, Q., He, P., Tian, Y., Zhu, Y., Qin, Y., Qiu, X., Liu, Y., Xu, X., Hu, W., & Shi, Z. (2023). Experiences of healthcare workers following occupational exposure to COVID-19 at the early stages of the pandemic: A phenomenological qualitative study. *Nursing Open*, *10*(6), 3696–3706. https://doi.org/10.1002/nop2.1623

Whitt-Woosley, A., Sprang, G., & Eslinger, J. (2022). The impact of COVID-19 and experiences of secondary traumatic stress and burnout. *Psychological Trauma: Theory, Research, Practice & Policy*, *14*(3), 507–515. https://doi.org/10.1037/tra0001183

Willis, D. G., Sullivan-Bolyai, S., Knafl, K., & Cohen, M. Z. (2016). Distinguishing features and similarities between descriptive phenomenological and qualitative description research. *Western Journal of Nursing Research*, *38*(9), 1185–1204. https://doi-org /10.1177/0193945916645499

World Health Organization. (2023, April). *WHO Coronavirus (COVID-19) Dashboard.* https://COVID19.who.int/

Zaccari, A. (2017). *Vicarious trauma coping and self-care practices among trauma therapists* [Doctoral dissertation, Walden University]. Walden Dissertations and Doctoral Studies.

Zhang, J. (2021). Transcendental co-originariness of subjectivity, intersubjectivity, and the world: Another way of reading Husserl's transcendental phenomenology. *Human Studies, 44*(1), 121–138. https://doi.org/10.1007/s10746-021-09573-8

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*(4), 482–491. https://doi.org/10.1037/a0027824

Appendix: Interview Questions

1. Could you please tell me why you became a clinically licensed counselor?
2. What made you decide to go into private practice?
3. Can you tell me what your job entails or consists of day to day?
4. What is the difference between a good day at work and a bad/rough day at work?
5. What is the difference, if any, between a good day at work and a bad day at work since the COVID-19 pandemic?
6. Are you currently in-office, telehealth only, or a hybrid? Is it easier or harder working with clients via telehealth? More or less fatigued with telehealth? Why do you think telehealth may be more tiring?
7. How do you feel after a bad/rough day at work?
8. Can you tell me about what your experience was like working in a solo private practice during COVID-19?
9. What, if any, trends did you notice with your clients? How did they cope? Did you notice any symptoms lessened or worsened? How did COVID-19 affect them?
10. What, if any, conflicts did you have with telling your clients to reach specific treatment goals and knowing that they could not accomplish the goals at that time due to COVID-19?
11. What was the transition to being home, using telehealth, etc. due to COVID-19 (i.e., quarantine) like for you personally?

12. Can you tell me if there was more or less of a connection to your clients due to experiencing the same thing at the same time?
13. Did you transition back to your practice and what was it like? What made you decide to stay with telehealth?
14. How did you prepare to transition back to in-person? (Opt.)
15. What was it like to remove your mask in session with your client after the mandate was lifted? (Opt.)
16. What, if any, was your experience with contracting COVID-19?
17. How did you cope with negative experiences while working in your solo private practice during COVID-19?
18. Can you tell me about any positive experiences that occurred while working in your solo private practice during COVID-19?
19. How do you think your life has changed as a result of counseling clients during COVID-19? What do you do differently since COVID-19?
20. What, if any, office setup changes or office procedure changes did you make during COVID-19? (Opt.)
21. What, if any, self-care practices do you utilize as a result of counseling during COVID-19?
22. What do you think future researchers need to investigate in regard to the post-COVID-19 state of the clinically licensed counselor profession?
23. If you could sum up your COVID-19 experience in a word or sentence, what would it be?

24. Would you like a follow-up email that includes my takeaways from the interview so that you can confirm whether or not my interpretations accurately convey your views/sentiments? (Member Checking)