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A Qualitative Study on the Experiences of Burnout Among Mental Health Practitioners Rendering Clinical Care During COVID-19

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Walden University, 2021

BA, University of California, Berkeley, 2014

Dissertation Submitted in Fulfillment

of the Requirements for the Degree of

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Abstract

Prior to the COVID-19 pandemic, between 21% and 67% of mental health practitioners in the United States experienced signs of burnout. The pandemic exacerbated these challenges, with an increased demand for mental health services. By 2022, 45% of practitioners reported burnout, and the APA's 2023 Practitioner Pulse Survey noted that psychologists were working at the limits of their capacity, with high levels of burnout. While research on COVID-19 and burnout has expanded for physicians and nurses, less focus has been placed on mental health practitioners' experiences. The purpose of this generic qualitative study aimed to understand how mental health practitioners experienced burnout during the COVID-19 pandemic. Using Maslach's multidimensional theory of burnout, the concepts contributing to burnout were explored. Interviews with eight practitioners were conducted using 10 semi-structured open-ended questions via videoconferencing (Zoom), and transcription was analyzed thematically. The study's findings identified burnout factors such as isolation, increased client volume, and lack of peer consultation, with emotional exhaustion stemming from work overload. Despite these challenges, many practitioners reported improved personal accomplishment and competence. Recommendations included prioritizing self-care, offering flexible scheduling, and providing additional support for practitioners in community health and hospital settings. This study's potential for positive social change lies in raising awareness among practitioners and organizations about recognizing and managing burnout, especially during future waves of the COVID-19 pandemic or other State of Emergency Crises.

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Dedication

I would like to dedicate this dissertation to my family, whose love and unwavering support have carried me through this journey. To my mother, Narvell, for her constant encouragement and strength; to my brother, Hakeemm, for his belief in me and his steady reassurance; and to my fiancé, Joshua, for his patience, understanding, and steadfast support at every step of the way. Thank you all for standing beside me through the challenges and triumphs of this process.

I extend my deepest gratitude to Dr. Perry and Dr. Robbins, whose invaluable guidance, thoughtful feedback, and commitment to my growth shaped this dissertation at every stage. Your mentorship has been instrumental in both my academic development and personal resilience.

Finally, I dedicate this work to my grandmother Marvella, whose influence and love continue to resonate within our family. It is with profound honor that I carry her name forward with this degree, as a testament to the lasting impact she has made on my life and the lives of those around her.

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Chapter 1: Introduction to the Study

In this study, I sought to understand better burnout experiences among mental health practitioners who rendered clinical care during COVID-19. The aim of the study was to gain a deeper understanding of how practitioners experienced burnout throughout the pandemic and the self-care strategies they used to alleviate some of the perceived challenges. The positive social change this study aimed to achieve was by bringing awareness to practitioners and organizations on how to recognize and manage burnout amongst this population in future waves of the pandemic. In Chapter 1, the background addressed the scope of the study, the literature gap, and why this study was needed. The problem statement addressed the problem, its significance, and any relevant findings on the topic. In the purpose of the study, the intent of the study and its justification were elaborated. Next, the research question and conceptual framework explained how they related to the study. After that, the nature of the study focused on the rationale for the design and concept being investigated. The scope of the study and delimitations were explained, and the definitions for key concepts were discussed. Afterward, any assumptions regarding the research design and why it was necessary in the context of the study were addressed. Following this, any limitations of the study were presented, including any potential for bias. Lastly, the significance of the study and the potential implications for positive social change were addressed, along with a summary of the chapter's main points.

Background

Burnout was first described by Freudenberger in 1974. As a psychologist and psychotherapist, he made the term famous in several publications. Due to this, he was widely considered the founding father of the concept (Heinemann & Heinemann, 2017). However, it is essential to note that Freudenberger did not invent the term. Instead, he was credited for systematically describing and analyzing a mental condition he observed in some of his colleagues and that he also experienced himself, which his colleagues described as being burned out. Freudenberger's initial work was followed by many psychological and medical studies, starting with research by Christina Maslach and her colleagues in the late 1970s and early 1980s (Heinemann & Heinemann, 2017).

Maslach was one of the prominent pioneers in burnout research. In contrast to Freudenberger's qualitative, almost autoethnographic account, the social psychologist Maslach focused on measuring burnout. Maslach characterized burnout in three dimensions: sustained feelings of emotional exhaustion, depersonalization, and reduced personal accomplishment. Maslach also developed the Maslach Burnout Inventory (MBI), which remained the most widely used questionnaire for measuring burnout (Maslach & Jackson, 1981). Burnout among mental health practitioners became a global problem, with 21% to 67% of mental health service providers reporting high levels (Morse et al., 2012).

In 2020, burnout became an even more prominent topic of conversation after the onset of the COVID-19 pandemic. Considering the essential role that mental health practitioners played during the pandemic, analyzing burnout prevalence and predictors

among this group was essential. According to Lin et al. (2023), practitioners' workloads increased substantially throughout the pandemic. In response to a survey in September 2022, 38% of U.S. licensed mental health practitioners reported working more than before the pandemic. The APA (2023) Practitioner Pulse Survey reported that many patients needed more care and were presenting with more severe symptoms than in the past. Psychologists were often working at the limits of their capacity, and levels of burnout were high. Faced with the increased workload, the percentage of practitioners who reported being unable to meet the demand rose from 30% in 2020 and 41% in 2021 to 46% in 2022. Almost half reported feeling burned out in 2022, with similar levels of 41% reported in 2020 and 48% reported in 2021.

However, research during the COVID-19 pandemic regarding the burnout experiences of mental health practitioners has been sparse, and burnout analyses have typically focused on medical physicians (Jeppson, 2021; Liberati, 2021). During the pandemic, mental health practitioners took on additional clinical and educative duties that may have enhanced burnout, such as educating staff and the public on coping with anxiety and depression, staffing after-hour resource hotlines and support groups, and more frequently engaging in trauma-focused psychotherapy work (Trombello, 2022). The combination of these unique and specific risk factors placed practitioners that provided clinical care at an even greater risk of burnout during the COVID-19 pandemic. Unfortunately, the research into the burnout experiences of mental health practitioners that rendered clinical care during the COVID-19 pandemic has yet to be explored. This

study was needed to help inform practitioners and organizations on how to identify and manage burnout in future pandemic waves or state of emergency crisis.

Problem Statement

Extensive research literature has described how burnout has detrimentally impacted mental health practitioners, and lead to outcomes like overwhelming exhaustion, depersonalization, and a sense of ineffectiveness (Clay, 2018). As indicated by the APA (2018), emotional exhaustion includes feeling overextended, being unable to feel compassion for clients, and feeling unable to meet workplace demands. Depersonalization is the process by which providers have distanced themselves from clients to prevent emotional fatigue. Finally, feelings of ineffectiveness and lack of personal accomplishment could occur when practitioners felt a negative sense of personal or career worth.

The Substance Abuse and Mental Health Services Administration (2022) reported an estimated 50% of mental health practitioners felt burnt out due to high levels of stress, low salaries, perceived lack of career advancement opportunities, and increased caseloads. Scott (2022) discussed how burnout could result in adverse outcomes for both practitioners and their clients. Symptoms could manifest psychologically; practitioners may have experienced depressed moods, feelings of worthlessness, suicidal ideation, and fatigue. Moreover, burnout was also linked to physical ailments such as headaches, high blood pressure, poor immune function, and sleep issues (Scott, 2022). Based on the Simionato and Simpson (2018) study, over half of the sampled mental health practitioners practicing psychotherapy reported moderate-high levels of burnout, which,

highlighted how common the experience of burnout was among practitioners before the onset of the COVID-19 pandemic.

However, COVID-19 exacerbated many of the difficulties mental health practitioners faced. For example, the levels of burnout among practitioners rose exponentially due to the increased demand for mental health services throughout the pandemic (Gold, 2021). Slone et al. (2021) study assessed the impact of COVID-19 on mental health practitioners in the southeastern region of the US. Findings related to the effects of the pandemic on the logistics of delivering care showed that 87% of practitioners reported seeing a combination of established and new clients. Practitioners also reported a 44% increase in new clients seeking services. Nearly half of the providers reported an increased frequency of appointments for their average clients. A relatively even distribution of practitioners reported that their no-show rates had decreased by 30%. Lastly, despite half of the practitioners feeling comfortable seeing patients in person, most reported providing care via telemedicine (Slone et al., 2021). Increased weekly work hours and higher caseload were predictors for the emotional exhaustion dimension of burnout (Kim et al., 2018).

Since the levels of burnout affecting mental health practitioners after the onset of the COVID-19 pandemic were significant, practitioners utilized helpful coping strategies to alleviate and even prevent symptoms of burnout. In a study conducted by Sutton (2023), some of the strategies and approaches practitioners implemented to avoid feeling emotionally exhausted from work and disengaged from clients included managing and reducing one's workload, focusing on self-care and mindfulness, and building

supervisory relationships and safe spaces. Reducing clients and the number of sessions formed an essential part of preventing feelings of being overwhelmed, and allowed practitioners to focus more on the needs of their clients while maintaining their well-being. Such strategies also helped ensure that mental health practitioners offered appropriate empathy, therapeutic listening, and unconditional positive regard to their clients.

Regular mindfulness practices helped practitioners view themselves with greater self-compassion, which had been shown to reduce burnout (Sutton, 2023). Although practitioners could not remove all the factors contributing to burnout, mindfulness and self-care practices helped manage them more effectively (Sutton, 2023). Lastly, the quality of supervisory relationships and the availability of safe spaces to talk were linked to reduced burnout. Seeking an experienced supervisor and having regular meetings and a safe space to discuss demanding aspects of one's role as a practitioner reduced disengagement and the likelihood of burnout (Sutton, 2023).

Substantial evidence regarding mental health practitioners' experience of burnout during the pandemic was limited. While physician burnout was well-documented, limited research occurred among mental health practitioners providing clinical care (Trombello, 2022). Most researchers who discussed the qualitative experiences of burnout among mental health practitioners rendering clinical care during COVID-19 were mainly conducted outside the United States, primarily in Europe (Singh et al., 2023). Studies that aligned with practitioners' burnout experiences from a qualitative perspective in the United States had yet to be determined. The research problem under investigation was the

experiences of burnout among mental health practitioners who rendered clinical care during the COVID-19 pandemic.

Purpose of the Study

The purpose of this generic qualitative approach was to understand better how mental health practitioners experienced burnout while rendering clinical care during the COVID-19 pandemic (Captari, 2020; Joshi & Sharma, 2020). This research problem focused on individual experiences, and the qualitative approach provided a deeper understanding of the experiences and context to discern how practitioners saw this problem (Cleland, 2017). Exploring practitioners' experiences of burnout led to opportunities to support them in future waves of the pandemic.

Research Question

What were the experiences of burnout in mental health practitioners rendering clinical care during the COVID-19 pandemic?

Conceptual Framework

The framework for this study was based on Maslach's multidimensional theory of burnout. Maslach (1998) conceptualized job burnout as a prolonged response to chronic interpersonal stressors on the job. The three key dimensions of this response were overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and failure (Maslach, 1998). Previous researchers showed that with the ongoing pandemic and its associated anxiety, mental health practitioners might have experienced emotional contagion from the negative feelings and emotions regarding COVID-19 from patients, leading to emotional exhaustion and depersonalization from

therapy (Joshi & Sharma, 2020). Through tele-counseling and the absence of face-to-face interactions, many mental health practitioners felt they might not have been able to deliver sessions as planned, leading to helplessness and perceived therapeutic inefficiency (Joshi & Sharma, 2020). This qualitative lens sought to understand how mental health practitioners experienced burnout throughout the COVID-19 pandemic, using the three dimensions of Maslach's Multidimensional Theory of Burnout. Semi-structured interview questions were formed to explore participants' experiences to generate themes and patterns for qualitative data.

Nature of the Study

I used a generic qualitative approach to seek detailed reflections on the experiences of burnout in mental health practitioners rendering clinical care during the COVID-19 pandemic. The generic qualitative approach was a methodology that sought to understand human experience by taking a qualitative stance and using qualitative procedures (Kostere & Kostere, 2021). In this method, understanding participants' experiences related to how they constructed meaning interrelated to themselves, others, social situations, and world occurrences was a part of the thematic analysis process (Clark, 2006; Kostere & Kostere, 2021).

This topic focused on mental health practitioners (licensed psychologists, licensed professional counselors, licensed marital and family therapists, licensed clinical social workers, and licensed clinical alcohol and drug abuse counselors) from the U.S. who rendered clinical care during the COVID-19 pandemic. The recent literature that discussed burnout among mental health practitioners prior to and after the pandemic had

been primarily approached through a quantitative lens, including systematic reviews (Serrano-Ripoll et al., 2020), cross-sectional studies (Giusti et al., 2020), and meta-analyses (O'Connor et al., 2018). Research had been undefined regarding any interview-based qualitative perspective of mental health practitioners' experiences of burnout during the COVID-19 pandemic in the United States. Therefore, a generic qualitative approach regarding their experience potentially helped inform practitioners and organizations on how to identify and manage burnout among this population in potential pandemic waves.

The study's data were collected via interviews with 10 semi-structured open-ended questions and recorded via videoconferencing (Zoom), and transcription was performed for thematic analysis (Braun & Clarke, 2006). Thematic analysis included six steps (familiarizing oneself with the data, surveying patterns for codes, organizing codes into themes, reviewing themes for validity, creating definitions for themes, and analyzing data collection for report) to identify codes, themes, and subthemes that helped create conclusive data regarding participant experiences.

Definitions

COVID-19: A highly contagious respiratory disease caused by the SARS-CoV-2 virus. SARS-CoV-2 was thought to spread from person to person through droplets released when an infected person coughs, sneezes, or talks (NCIRD, 2023).

Pandemic: A pandemic was defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affected a large number of people (Last, 2001).

Burnout: Was defined as a psychological syndrome characterized by emotional exhaustion, depersonalization and a reduced sense of professional efficacy that could appear in caregiving professions (Maslach & Jackson, 1981).

Depersonalization: Depersonalization was characterized by impaired and distorted discernment of oneself, of others and one's environment and it manifested itself as an affective-symptomatic lack of empathy (Maslach & Jackson, 1981).

*Reduced Personal Accomplishment**:*** Reduced personal accomplishment was the tendency to negatively evaluate the worth of one's work, feeling insufficient in regard to the ability to perform one's job, and a generalized poor professional self-esteem (Mealer et al., 2016).

Emotional Exhaustion: Emotional exhaustion was characterized by the feeling of being emotionally fatigued and unable to face the demands of one's job or engage with people or clients (Maslach & Jackson, 1981).

Assumptions

Assumptions were aspects of the study that were believed but could not be demonstrated to be true. The assumptions for this study were as follows. Each participant was expected to understand how to answer all questions regarding their experiences during the pandemic. The participant was expected to understand burnout and apply past and present awareness accurately. Participants were expected to be able to identify any coping skills used to manage burnout symptoms. The study participants were expected to be emotionally articulate regarding burnout and their experiences rendering clinical care

during the pandemic. Participants were expected to be mental health practitioners with experience in clinical care during the pandemic.

Scope and Delimitations

The study's participants included mental health practitioners who provided clinical care in the U.S. during the pandemic. In this study, I focused on their experiences of burnout while rendering clinical care during the pandemic. What I excluded in this study were any medical professionals who were not mental health practitioners. I ensured that all practitioners had no conflict of interest and no preconceived biases. The research context was explained in the consent form to each participant as a method to address potential transferability.

Limitations

Limitations that might have impeded the study included the challenge of finding participants who were willing to discuss topics related to COVID-19, as COVID-19 had caused many individuals trauma (Foli et al., 2021). While I attempted to gather a diverse practitioner sample size to increase the relevance of the study's findings for practitioners that worked in different treatment settings and across the nation, the findings could not be interpreted as representative of all mental health practitioners nationally. There may have been several unexamined practitioner demographics that influenced their experiences and attitudes toward rendering clinical care. These factors could include the nature of the practitioners' professional networks, as well as other relevant professional and personal experiences both during and before COVID-19. Such factors might have skewed the

reflections of experiences across specific groups of mental health practitioners (Békés et al., 2021).

Ensuring that interview questions were not misinterpreted and were answered truthfully was a concern (Braun & Clarke, 2021). Braun and Clarke (2006) described how interview questions could have limited the phenomena due to how the experience was recorded. Further, whenever a researcher explored human experiences, there was no set way to control the validity of the individual's experience due to the possibility that participants might not have been truthful or forthcoming about their actual experiences, and issues of anonymity and confidentiality could have presented problems when presenting findings (Anderson, 2010). Lastly, thematic analysis might have become limited if there was redundancy within the interview process (Braun & Clarke, 2021).

Significance of the Study

As Americans headed into another year of pandemic living, practitioners around the country found themselves on the front lines of a mental health crisis. Mental health practitioners—including psychologists, professional counselors, marital and family therapists, clinical social workers, and clinical alcohol and drug abuse counselors—from every state reported that they could not keep up with an unrelenting demand for their services, and many had to turn away patients, including children who were desperate for support (Center for Integrated Training & Education, 2023). When The New York Times asked 1,320 mental health practitioners how their patients were coping as pandemic restrictions eased, they identified general anxiety and depression as the most common

reasons for seeking support, with family and relationship issues also dominating therapy conversations.

According to the 2022 KFF/CNN Mental Health in America survey, concerns about mental health and substance use remained elevated years after the onset of the COVID-19 pandemic, with 90% of U.S. adults believing that the country was facing a mental health crisis. The pandemic had affected the public's mental health and well-being through isolation and loneliness, job loss and financial instability, and illness and grief. Although COVID-19 restrictions had eased, mental health practitioners continued to serve on the front lines of a crisis that demanded continual therapeutic services (Parker-Pope et al., 2021). I aimed to fill a gap in understanding practitioners' experiences of burnout while providing clinical care during the pandemic.

The pandemic had been life altering, and many practitioners had suspected that the high demand for services would remain elevated for some time; 40% of those surveyed had predicted that conditions would worsen in the coming months before improving (Parker-Pope et al., 2021). Although COVID-19 cases and restrictions had begun to taper, the United States continued to experience the effects of collective trauma from living through the pandemic, particularly among children and adolescents (Parker-Pope et al., 2021). The findings presented in this study aimed to support positive social change by illuminating the burnout experiences of mental health practitioners who had rendered clinical care during COVID-19, thereby informing strategies to prevent practitioner burnout in future waves of the pandemic or state of emergency crisis.

Summary

In this study, I explored mental health practitioners' experiences of burnout while rendering clinical care in the U.S. during the pandemic through interviews conducted via Zoom. All data collection methods related to thematic analysis were utilized to ensure that interviews were consistently recorded and collected. It was necessary to gather data on participants' opinions, attitudes, and emotions to bring awareness to the burnout they experienced throughout the pandemic. Researchers had not yet substantially addressed mental health practitioners' experiences of providing clinical care during the COVID-19 pandemic, having focused more on the challenges faced by emergency room physicians and nurses (Jeppson, 2021; Liberati, 2021).

In 2021, Sampaio et al. surveyed mental health practitioners' ratings of burnout before versus during COVID-19 and found a statistically significant 37% increase in self-ratings of burnout during the pandemic. A qualitative study on the experiences of National Health Service mental health practitioners during the COVID-19 pandemic highlighted the feelings of grief, distress, and burnout many practitioners experienced in response to the nature of their work (Liberati et al., 2021). Mental health practitioners faced multiple adversities during the pandemic that had significant consequences for their well-being. This study aimed to offer an educated exploration of their experiences.

In Chapter 1, a background of the study, problem statement, purpose of the study, research question, conceptual framework, nature of the study, definition of terms, assumptions, scope and delimitations, limitations, significance of the study, and a summary were provided. Chapter 2 presented information on the history of burnout

among mental health practitioners, the prevalence and causes of burnout prior to COVID-19, assessments of burnout—including emotional exhaustion, depersonalization, and reduced personal accomplishment—before the pandemic, the impact of burnout on mental health practitioners during COVID-19 while rendering clinical care and remote therapy, qualitative research relevant to practitioners' experiences of burnout both abroad and within the United States, and finally, the self-care practices for burnout among mental health practitioners during COVID-19 self-care practices for burnout among mental health practitioners during COVID-19.

Chapter 2: Literature Review

Before COVID-19, Clay (2018) demonstrated a well-established link between burnout and outcomes of emotional exhaustion, detachment, and feelings of ineffectiveness among mental health practitioners. In 2021, Sampaio et al. surveyed mental health practitioners' ratings of burnout before versus during COVID-19 and found a statistically significant 37% increase in self-ratings of burnout during the pandemic. The purpose of this generic qualitative study was to gain a better understanding of the burnout experiences of mental health practitioners who rendered clinical care during the COVID-19 pandemic. Substantial growing evidence had suggested that burnout was prevalent among mental health practitioners during the pandemic due to issues such as practitioner shortages and increased demands for mental health services.

However, previous quantitative and qualitative research had almost entirely focused on the rise in nurse and physician burnout levels when providing emergency care during COVID-19 (Jeppson, 2021; Liberati, 2021). Most qualitative studies discussing the burnout experiences of mental health practitioners during COVID-19 had been conducted outside the United States, primarily in Europe (Singh et al., 2023). The qualitative research conducted within the United States had focused on general health workers' experiences and well-being during the pandemic, encompassing physicians, nurses, physical therapists, social workers, and psychologists. The pandemic had exacerbated many difficulties that mental health practitioners were already facing. They struggled with the ethical responsibility to continue providing services to meet dramatically increasing demands while simultaneously trying to incorporate coping

strategies to alleviate stressors during this global crisis. Although numerous quantitative studies had measured the prevalence of burnout among mental health practitioners during COVID-19, research focusing on an interview-based qualitative perspective of their burnout experiences in the United States was lacking.

In Chapter 2, the literature search strategy was outlined, detailing the library databases and search engines used to identify relevant scholarship. The conceptual framework then identified and defined the key concepts and described how these had been applied and articulated in previous research. The literature review relating to key concepts described studies related to the central themes and the chosen methodology and methods consistent with the scope of the study. The summary described the major themes presented in the literature, demonstrating how the present study aimed to fill a gap in the literature and extend knowledge in the discipline.

Literature Search Strategy

A comprehensive literature search was conducted across multiple databases, including ScienceDirect, PubMed, MedlinePlus, APA PsycInfo, ProQuest, Social Sciences Citation Index, Education Source, Google Scholar, and CINAHL Plus with Full Text. Searches spanned publications from 1974 through 2023. When full-text articles were not directly available, the Walden University online library was used to retrieve them. Search terms combined descriptors for profession (e.g., *psychologists, counselors, therapists, mental health practitioner*) with key burnout constructs (*burnout, stress, depersonalization, reduced personal accomplishment, emotional exhaustion, compassion fatigue*) and pandemic-related terminology (*COVID-19, coronavirus, SARS-CoV-2*).

Additional filters included author names (e.g., Maslach) and theoretical constructs (e.g., *multidimensional theory of burnout*). Dissertations and peer-reviewed articles were reviewed to ensure inclusion of qualitative perspectives. While quantitative studies on practitioner burnout before and during COVID-19 were plentiful, qualitative research specifically exploring U.S. mental health practitioners' lived experiences of burnout during the pandemic was scarce.

Conceptual Framework

The multidimensional model of burnout was used as the conceptual foundation to understand better the burnout experiences of mental health practitioners rendering clinical care during COVID-19. The MBI was the most widely used measure in burnout research. It is composed of a three-component model developed by Jackson and Maslach (Maslach & Jackson, 1981). Burnout is considered a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment, which could occur among individuals who work with others in some capacity. Extensive research has been conducted to describe how burnout has detrimentally impacted mental health practitioners leading to overwhelming exhaustion, detachment, and a sense of ineffectiveness (Clay, 2018).

Morse et al. (2012) examined the extent to which burnout was a problem among mental health services staff and found that between 21% and 67% of mental health practitioners may experience high levels of burnout. Maslach discussed the high burnout rates that practitioners were prone to even before the COVID-19 pandemic and how it has been even harder to keep up with the demands during the COVID-19 pandemic in

caretaking professions (Abramson, 2022). The levels of burnout affecting mental health practitioners after the onset of the COVID-19 pandemic were significant, and further exploration of mental health practitioner experiences of burnout rendering clinical care during the pandemic was needed.

The Maslach multidimensional model of burnout contained three components: emotional exhaustion, depersonalization, and reduced personal accomplishment. The first component of burnout was emotional exhaustion; this referred to feelings of being emotionally overextended and depleted of one's emotional resources (Schaufeli et al., 1993). The primary sources of emotional exhaustion were identified as work overload and personal conflict at the workplace. For example, work overload could occur when job demands exceeded human limits. Individuals had too much to do with too little time and resources. Increased workload had a consistent relationship with burnout, especially with the exhaustion component (Maslach, 2015). An example of personal conflict occurred when the individual's values conflict with their job. As demonstrated by Maslach and Leiter (2016), values were the ideals and motivations that initially attracted the individual to their job. They were the motivating connection between the individual and the workplace, which went beyond the utilitarian exchange of time for money or advancement. Personal conflict arose when there was a gap between individual and organizational values, individuals found themselves making a trade-off between the work they wanted to do and the work they had to do, which could lead to more significant burnout. Emotional exhaustion represented burnout's basic individual stress concept (Maslach, 1998).

The second component of burnout was depersonalization; this referred to a negative or excessively detached response to other people, who were usually the recipients of the individual's service or care (Schaufeli et al., 1993). The depersonalization component represented the interpersonal concept of burnout, as it related to relationships between the individual and the client (Maslach, 1998). Early qualitative research conducted by Maslach et al. (1993) described how human services employees would try to cope with the emotional stress of their work by moderating their compassion for clients by emotionally distancing themselves.

This detached concern was viewed as a way to protect the employees from intense emotional arousal that could interfere with effectively functioning on their job. However, an imbalance of excessive detachment and little concern seemed to lead employees to respond to clients in negative and dehumanized ways, which resulted in a lower quality of care (Maslach, 1998). A study by Joshi and Sharma (2020) explained how mental health practitioners might experience emotional contagion from patients' negative feelings and emotions around COVID-19, leading to both components of burnout: emotional exhaustion and depersonalization from therapy.

The third component of burnout was reduced personal accomplishment; this referred to a decline in one's feelings of competence and achievement in one's work (Schaufeli et al., 1993). For example, reduced personal accomplishment occurred when an individual experienced emotional turmoil and interpreted it as a failure to be professional, which led them to question their ability to work in their profession (Schaufeli et al., 1993). This lowered sense of self-efficacy was linked to depression and

an inability to cope with job demands. It was exacerbated by a lack of social support and professional development opportunities (Maslach, 1998). Individuals experienced a growing sense of inadequacy in their ability to help clients, which resulted in a self-imposed verdict of failure. Research by Joshi and Sharma (2020) expanded on this third component of burnout observed among mental health practitioners who worked through tele-counseling during the COVID-19 pandemic. Due to the absence of face-to-face interactions, many mental health practitioners felt unable to deliver therapy sessions as planned, leading to feelings of helplessness and perceived therapeutic inefficiency. The reduced personal accomplishment component represented the self-evaluation concept of burnout (Maslach, 1998).

Maslach's multidimensional model improved on Freudenberger and Richelson's (1980) Unidimensional model of burnout, which had focused solely on exhaustion, by adding depersonalization and reduced personal accomplishment as additional dimensions. The current study benefited from Maslach's framework because it examined burnout through three conceptual lenses—emotional exhaustion, depersonalization, and reduced personal accomplishment—each of which provided valuable insights into the burnout experiences of mental health practitioners who rendered clinical care during COVID-19.

Literature Review Relating to Key Variables/ Concepts

Extensive research literature described how burnout had detrimentally impacted mental health practitioners, leading to outcomes such as overwhelming exhaustion, detachment, and a sense of ineffectiveness (Clay, 2018). In 2018, the American Psychological Association analyzed several studies on burnout among mental health

practitioners and found that between 21% and 61% of practitioners experienced signs of burnout. However, after the impact of COVID-19, levels of burnout among mental health practitioners steadily rose due to the exponentially increasing demand for mental health services throughout the pandemic (Gold, 2021). The levels of burnout affecting mental health practitioners after the onset of COVID-19 were significant, and further exploration of their experiences rendering clinical care during the pandemic was needed.

History of Burnout Among Mental Health Practitioners

Reith (2018) discussed burnout's historical and conceptual development and its introduction in the mid-1970s. Burnout was first described in 1974 by clinical psychologist Freudenberger, who borrowed the term from the illicit drug scene, where it colloquially referred to the devastating effects of chronic drug abuse (Freudenberger, 1974). He used burnout to describe the gradual emotional depletion, loss of motivation, and reduced commitment among volunteers at the St. Mark's Free Clinic in New York's East Village, whom he observed as a consulting psychologist (Schaufeli, 2017). Freudenberger himself experienced burnout twice, which increased his credibility when advocating for awareness of the condition. His writings on the subject were intensely autobiographical. Rather than approaching the topic as a scholar, he was a psychoanalytically trained mental health practitioner primarily interested in preventing and combatting burnout rather than investigating its theoretical underpinnings (Schaufeli, 2017). He noted that burnout often occurred in contexts requiring significant personal involvement and empathy, particularly in the relationship between the practitioner and the client (Reith, 2018).

Independently and simultaneously, Maslach and her colleagues encountered the term burnout in California while interviewing various human services workers. As a social psychology researcher at the University of California, Berkeley, Maslach investigated how these workers coped with emotional arousal while performing their demanding jobs. Through these interviews, she found that the workers often felt emotionally exhausted, developed negative views and feelings about their clients, and experienced crises in professional competence due to emotional turmoil (Maslach, 1979). Based on the workers' self-descriptions of their symptoms, Maslach referred to this psychological condition as burnout. Maslach and her colleagues subsequently developed an accessible and easy-to-use self-reporting questionnaire for assessing burnout, which became known as the MBI (Maslach & Jackson, 1981). The MBI became the most widely used assessment tool for burnout.

Initially, the scientific community dismissed burnout as a pseudoscientific concept and denounced it as pop psychology. However, this perception changed after the introduction of the MBI, which triggered a wave of empirical burnout research (Maslach & Schaufeli, 1993). McGeary and McGeary (2012) documented an exponential increase in burnout publications following the introduction of the MBI. From the 1980s to the 1990s, publications increased by 64%, and from the 1990s to the 2000s, they increased by 150%. Maslach's model of burnout consisted of three empirically proven dimensions: emotional exhaustion, depersonalization, and a diminished sense of personal accomplishment (Maslach & Jackson, 1981). The original version of the MBI applied only to the human service sector due to the content and wording of its questions. Until the

mid-1990s, when a general version was published, burnout remained a phenomenon primarily associated with the so-called caring professions (Schaufeli, 1996).

Researchers increasingly recognized burnout as a significant challenge for many mental health practitioners. A meta-analysis of 33 studies indicated that between 20% and 40% of practitioners had experienced burnout, including high levels of emotional exhaustion and moderate levels of depersonalization (O'Connor et al., 2018). Workplace variables were found to be more stressful for mental health practitioners than other factors and, as a result, were more likely to perpetuate burnout (Bressi et al., 2009). Among the most significant factors was the working relationship between practitioners and clients experiencing psychological trauma. The challenging demands posed by these and other difficult clients often led to increased stress and frustration, fueling the exhaustion, cynicism, and inefficacy associated with burnout.

The experience of burnout became overwhelming when mental health practitioners became targets of anger, hatred, and even violence due to negative transference (APA Dictionary of Psychology, n.d.). Violent patient incidents were emotionally draining and difficult to manage, leading practitioners to psychologically distance themselves from their work. Such occurrences also contributed to feelings of a lack of control over their job, further challenging their professional efficacy (Maslach & Leiter, 2016).

Higher levels of burnout among mental health practitioners were correlated with negative practitioner experiences and poorer quality of patient care (Holmqvist & Jeanneau, 2006; Scott, 2022). Research on how burnout manifested in practitioners'

demeanor supported the link between burnout and adverse client care. For example, changes in the practitioner's appearance, such as looking fatigued, exhibiting avoidant behavior, becoming more irritable, and demonstrating poor communication, were evident among those who reported burnout (Maslach & Leiter, 2016). Symptoms of burnout also manifested psychologically; practitioners reported experiencing depressed moods, feelings of worthlessness, suicidal ideation, and fatigue (Scott, 2022).

Working with demanding patients and their families was closely associated with mental health practitioners' levels of exhaustion and depersonalization (Bressi et al., 2009). These interactions often intensified practitioners' frustrations with the limits of their profession. Contact with patients' families exacerbated these feelings, particularly when family members held unrealistic expectations for treatment. Practitioners became emotionally drained by their inability to meet both the strenuous demands they placed on themselves and the expectations inherent in their interactions with patients and their families (Maslach & Leiter, 2016). In contrast, diminished personal accomplishment was more closely associated with problematic relationships with superiors and colleagues rather than patient demands. Colleagues provided the most relevant source of information regarding one's sense of professional efficacy. When those relationships were strained, finding meaningful confirmation of one's job performance became difficult (Maslach & Leiter, 2016).

Prevalence and Causes of Burnout Prior to COVID-19 Pandemic

Prevalence

Burnout commonly affected individuals involved in the direct care of others, such as mental health practitioners. Prior to the COVID-19 pandemic, researchers estimated that the prevalence of burnout ranged between 21% and 61% among mental health practitioners. Some signs included high rates of depersonalization, high rates of emotional exhaustion, and feelings of low personal accomplishment (SAMHSA, 2022). Simionato and Simpson's (2018) study highlighted that over half of the sampled mental health practitioners practicing psychotherapy reported moderate to high levels of burnout, demonstrating how commonly experienced burnout was among practitioners before the onset of the COVID-19 pandemic.

Prevalence, Experienced Effects, and Determinants of Burnout

When examining the prevalence and experienced effects of burnout among mental health practitioners over the seven years preceding the COVID-19 pandemic in the United States, Dreison et al. (2016) conducted a quantitative study of mental health practitioners working in mental health agencies in Indiana, New Jersey, and New York. Their findings indicated that practitioners reported significantly high levels of emotional exhaustion. Similarly, Garcia et al. (2016) conducted a cross-sectional study examining burnout among mental health practitioners in Veterans Affairs hospitals, reporting high levels of exhaustion and cynicism among respondents. A significant 50% of practitioners reported high exhaustion, 47% reported high levels of cynicism, and 12% endorsed low

professional efficacy. Additionally, many practitioners felt that emotional exhaustion impacted the quality of care they provided to their patients (Garcia et al., 2016).

O'Connor et al. (2018) conducted a meta-analysis study to estimate the level of burnout in mental health practitioners and identify specific determinants of burnout. Through a systematic search of original research published between 1997 and 2017, data on the prevalence of burnout dimensions were extracted. The overall estimated pooled prevalence for emotional exhaustion was 40%, depersonalization was 22%, and low levels of personal accomplishment were 19%. The random effects estimate of the mean scores on the Maslach Burnout Inventory indicated that the average mental health practitioner had high levels of emotional exhaustion and moderate levels of depersonalization, though most retained reasonable levels of personal accomplishment. Work-related factors, such as workload and workplace relationships, were identified as critical determinants of burnout. Meanwhile, role clarity, professional autonomy, a sense of being fairly treated, and access to regular clinical supervision appeared to be protective factors that reduced burnout (O'Connor et al., 2018).

Prevalence and Community, Inpatient, Outpatient and Private Practice Settings

When examining the prevalence of burnout among mental health practitioners across different practice settings, a quantitative study published by Dupree and Day (1995) investigated burnout among 60 private practitioners and 26 mental health practitioners working in managed mental health care (MMHC) and other public sector positions. Using the Maslach Burnout Inventory, results indicated that mental health practitioners in private practice reported higher levels of job satisfaction and lower levels

of burnout than those working in public sector settings, such as community and state hospitals, public safety departments, and veterans' affairs (Acker, 2011).

Lent and Schwartz (2012) investigated the prevalence of burnout among a national sample of mental health practitioners in various clinical work settings. Their findings indicated significant differences in burnout levels among practitioners working in community mental health outpatient centers, private practice, and inpatient hospital settings. To differentiate between these work settings, a community mental health outpatient center was defined as a community-based facility that provided mental health services, typically as an alternative to the care offered by mental hospitals (APA Dictionary of Psychology, n.d.). Private practice referred to a method of delivering mental health, medical, and other services in the practitioner's office space, allowing them to be selective with their schedule and clientele (Good Therapy, 2016). Inpatient hospital practitioners were responsible for conducting assessments and evaluations of new patients and often worked as part of a multidisciplinary team to provide comprehensive patient assessments (Miller, 2016).

Lent and Schwartz (2012) discussed how practitioners working in community mental health outpatient centers reported significantly greater burnout than those in private practice or inpatient hospital settings. Mental health practitioners in outpatient community settings scored significantly lower on personal accomplishment and higher on depersonalization compared to practitioners in private practice (Lent & Schwartz, 2012). Additionally, practitioners in outpatient community settings scored significantly higher on emotional exhaustion than those working in inpatient hospital settings (Lent &

Schwartz, 2012). Specific organizational or environmental characteristics, either unique to or more pronounced in community settings, may have contributed to these findings. For example, Sullivan (1989) identified work overload, lack of influence on the job, and lack of supervisory support as crucial factors related to burnout among mental health practitioners. These factors appeared to be more extreme in fast-paced, overburdened public mental health centers that had to comply with accreditation and compliance guidelines while simultaneously competing for funding and balancing annual budgets.

Prevalence and Rural/Urban Practice Settings

When examining the prevalence of burnout among rural and urban mental health practitioners, Oser et al. (2013) conducted a study on 28 mental health practitioners working in Kentucky state-funded substance abuse treatment programs. Two focus groups consisted of practitioners in urban counties, while the other two included practitioners in rural counties. Compared to urban substance use treatment practitioners, those in rural settings reported more contributors to burnout, including high caseloads and office politics (Oser et al., 2013). Managing office politics and frustration with colleagues was a stressful experience that practitioners identified as a significant contributor to burnout. Office politics was a more prominent concern for rural practitioners than for their urban counterparts because rural facilities often had fewer staff members available to deliver treatment services, requiring increased workplace collaboration (Bouffard & Smith, 2005). The disparities in the staffing ratio of mental health practitioners between rural and urban settings were substantial. According to the *American Journal of Preventative Medicine*, shortages of mental health practitioners

were more pronounced in rural areas; about 19% of metropolitan counties lacked a mental health practitioner, compared to nearly 47% of rural counties (Andrilla et al., 2018).

Prevalence and Practitioner Demographic

When examining the prevalence of burnout among mental health practitioners based on demographic characteristics such as gender, age, or length of time working in the field, Dupree and Day (1995) and Van Morkhoven (1998) reported that male practitioners experienced higher levels of burnout than their female counterparts. Additionally, Vredenburg et al. (1999) found that the number of years spent in the same position was positively correlated with burnout among mental health practitioners. However, other studies suggested that total years of professional experience were inversely related to burnout. For example, Craig and Sprang (2010) found that younger professionals reported higher levels of burnout compared to more experienced professionals who had provided trauma treatment for a longer period. Although analyzing the relationship between demographic characteristics and burnout among mental health practitioners remained complex, understanding these factors was crucial in identifying why burnout was so prevalent in the field.

Causes

Although burnout was prevalent among mental health practitioners, the literature also demonstrated the causes of burnout among mental health practitioners prior to the COVID-19 pandemic. Wigert and Agrawal (2018) indicated that organizational factors were increasingly recognized as the primary contributors to burnout among mental health

practitioners. The top five causes included unfair treatment at work, unmanageable workload, lack of role clarity, lack of communication and support from managers, and unreasonable time pressure. First, unfair treatment at work occurred when practitioners believed they were being mistreated, making them 2.3 times more likely to experience high levels of burnout. Unfair treatment encompassed bias, favoritism, inadequate compensation, or corporate policies. Second, an unmanageable workload arose when practitioners felt overwhelmed by their responsibilities. When workload demands became excessive, performance declined, damaging confidence and perpetuating further stress (Wigert & Agrawal, 2018).

A lack of role clarity emerged when accountability and expectations were inconsistent or unclear. Practitioners could become exhausted simply trying to determine what their supervisors or peers expected from them. Inadequate communication and support from managers contributed to burnout. Managerial support and frequent communication served as a psychological buffer, providing reassurance and security. When practitioners felt unsupported by their managers, the cumulative lack of support over time contributed to burnout. Unreasonable time pressure was another significant factor. Wigert and Agrawal's (2018) research found that mental health practitioners who felt they had sufficient time to complete their work were 70% less likely to experience high burnout. However, when unreasonable deadlines and pressure were imposed, a snowball effect often led practitioners to fall behind on subsequent tasks, exacerbating their stress and increasing the likelihood of burnout.

Burnout Assessing the Condition: Emotional Exhaustion, Depersonalization, Reduced Personal Accomplishment Prior to COVID-19

Job burnout was conceptualized as a prolonged response to chronic interpersonal stressors in the workplace. Three key dimensions of this response included overwhelming exhaustion, feelings of depersonalization and detachment from the job, and a sense of reduced personal accomplishment and failure (Maslach, 2000). The experience impaired both personal and social functioning. While some mental health practitioners quit their jobs due to burnout, others remained but only performed the bare minimum rather than their best. This decline in work quality proved costly for both practitioners and their clientele.

Emotional Exhaustion

The first dimension of burnout, emotional exhaustion, referred to feelings of being emotionally overextended and depleted of one's emotional resources (Maslach, 2000). McCormack et al. (2018) found that emotional exhaustion was the most frequently reported dimension of burnout. Job demands, practitioner demographics, and client outcomes played essential roles in developing emotional exhaustion among mental health practitioners and in determining how it impacted those working in the profession.

Job Demands

Several studies reported a significant relationship between job demands, both physical (e.g., workload, hours worked) and psychological (e.g., empathizing with clients) and feelings of emotional exhaustion (Gibson et al., 2009; Steel et al., 2015). One commonly studied aspect of the physical demands of being a mental health practitioner

was workload, which referred to the number of hours worked per week. Studies indicated that increased workload was positively correlated with emotional exhaustion among practitioners. For example, Warren et al. (2013) found that individuals who worked fewer than 35 hours per week experienced less emotional exhaustion than those who worked more than 35 hours per week. Increased weekly work ho

urs and higher caseloads were key predictors of emotional exhaustion among practitioners (Kim et al., 2018).

One frequently observed aspect of the psychological demands of being a mental health practitioner was countertransference. Hammond et al. (2018) interviewed practitioners working in independent practice, and four of them reported that countertransference-based emotions and attitudes were a precursor to burnout, particularly in long-term therapy. Hammond and colleagues found that frequent and intense emotional reactions, particularly when working with complex clients, contributed to emotional exhaustion. Over

time, practitioners risked depleting their internal resources needed to manage stress, leaving them more vulnerable to emotional exhaustion when they struggled to maintain a sense of equanimity with their clients.

Practitioner Demographics

Practitioner demographic factors played a role in the emotional exhaustion component of burnout within the mental health profession. Some studies suggested that practitioners with fewer years of experience experienced more significant burnout than those with more experience. Warren et al. (2013) reported that practitioners with fewer

than five years of experience exhibited higher levels of emotional exhaustion compared to those with more than 5 years of experience. Additionally, Warren and colleagues found that practitioners younger than 35 reported higher emotional exhaustion than their older counterparts. Although age as a predictor was not particularly informative in explaining the process of experiencing or preventing burnout, it seemed plausible that older practitioners developed strategies to mitigate burnout through accumulated experience.

Client Outcomes

Practitioner burnout likely affected client treatment outcomes. Salyers et al. (2015) examined mental health practitioners' experiences with emotional exhaustion and its potential impact on client care. They found that practitioners experiencing higher levels of emotional exhaustion were less likely to acknowledge that burnout influenced their clients' outcomes. It was possible that emotionally exhausted practitioners exhibited decreased energy or engaged in self-protective denial, making them less able to recognize the effects of burnout on their clinical work (Salyers et al., 2015).

Impact of Emotional Exhaustion on the Profession

More recently, Sexton et al. (2022) investigated emotional exhaustion among U.S. healthcare workers before and during the COVID-19 pandemic. The study was conducted in three waves, with an electronic survey administered in September 2019, September 2020, and between September 2021 and January 2022. Participants included hospital-based healthcare workers in clinical and non-clinical roles within two large U.S. healthcare systems. Findings from mental health practitioner participants indicated that

their reported emotional exhaustion increased from 34% in 2019 to 39% between 2021 and 2022. Several factors contributed to this rise in emotional exhaustion, including the unique demands of remote work, uncertainty regarding available resources, accessibility of vaccines, and the overt politicization of public health during historically tumultuous times (Sexton et al., 2022). The findings of this survey study provided substantial evidence that emotional exhaustion among mental health practitioners was a significant concern prior to the COVID-19 pandemic and was further exacerbated after its onset.

Depersonalization

The second dimension of burnout, depersonalization, referred to a negative, cyclical, or excessively detached response to others, typically developing as a reaction to emotional exhaustion (Maslach, 2000). The effects of depersonalization impacted mental health practitioners' performance in various ways. For example, depersonalization altered practitioners' feelings toward clients, exacerbated by large caseloads, which could reduce the effectiveness of their therapeutic techniques. Additionally, depersonalization increased the levels of stress practitioners experienced.

Depersonalization and Altered Feelings Towards Clients

Holmqvist and Jeanneau (2006) conducted a quantitative study examining how burnout affected mental health practitioners' feelings toward their patients. The study analyzed the relationship between practitioners' emotional responses and burnout, using a feeling checklist to measure practitioners' emotions toward patients and the Burnout Measure (BM) and MBI to assess burnout levels. Psychiatric mental health practitioners from 28 treatment units rated their feelings toward their patients as a collective group.

The study results indicated a strong correlation between burnout, high scores on the BM and MBI, and practitioners' altered feelings toward clients. The overarching pattern suggested that depersonalization strongly correlated with high burnout among psychiatric mental health practitioners, who were more likely to exhibit unhelpful and rejecting attitudes toward their clients. These findings demonstrated the significant impact of depersonalization on mental health practitioners' experiences prior to the pandemic, highlighting the need for further exploration of how these experiences evolved after the pandemic.

Caseload Size and Feelings of Depersonalization

Acker (2010) examined the correlation between practitioner caseload size and feelings of depersonalization through self-perceived competence in the context of managed care and a burnout questionnaire. The results from 591 practitioners revealed a significant positive correlation between increased caseload size and depersonalization. Similarly, Fukui et al. (2015) found that overwhelming caseloads contributed to higher job turnover rates, with depersonalization positively correlating with mental health practitioners’ intentions to leave their jobs. More recently, Pimble (2016) researched the impact of burnout on therapeutic effectiveness among mental health practitioners. The findings suggested that the greater the number of hours spent conducting therapy per week, the higher the level of depersonalization experienced by practitioners. McCormack et al. (2018) reported similar results, highlighting that as work hours increased, so did feelings of depersonalization among mental health practitioners.

Depersonalization and Effectiveness

Several studies supported the notion that burned-out practitioners were less effective than those who had not experienced burnout. Delgadillo et al. (2018) conducted a study involving 49 practitioners providing evidence-based interventions for clients with depression and anxiety. The findings demonstrated that depersonalization was inversely related to client outcomes. Specifically, depersonalization impaired practitioners' ability to express empathy and build rapport with clients, which could impede their effectiveness and lead to poor treatment outcomes (Delgadillo et al., 2018; Wampold, 2015). Additionally, Pimble (2016) suggested that the less effective practitioners felt, the more depersonalized they became toward clients. These findings reinforced the importance of addressing burnout to preserve both practitioner well-being and therapeutic effectiveness.

Depersonalization and Levels of Stress

High-stress levels also contributed to depersonalization among mental health practitioners. Pimble (2016) utilized the Perceived Stress Scale, indicated that higher perceived stress levels correlated with increased depersonalization. The results suggested that practitioners who engaged in self-care experienced lower levels of depersonalization and a greater sense of personal accomplishment. While these studies explored mental health practitioners' experiences of depersonalization prior to the COVID-19 pandemic, further research is needed to examine how these experiences evolved after the pandemic.

Reduced Personal Accomplishment

The third dimension of burnout, reduced personal accomplishment, referred to a decline in feelings of competence and productivity at work. Mental health practitioners

experiencing this form of burnout often developed a growing sense of inadequacy regarding their ability to help clients, sometimes leading to a self-imposed verdict of failure (Maslach, 2000). When practitioners experienced reduced personal accomplishment, they often exhibited non-specific symptoms such as frustration, fear, or anxiety. Additionally, some reported an inability to experience happiness, joy, or contentment. When left unaddressed, physical symptoms such as insomnia, muscle tension, headaches, and gastrointestinal issues could manifest (Mealer et al., 2016). Leiter and Harvie's (1996) review examined the syndrome of reduced personal accomplishment among mental health practitioners across multiple factors, including practitioner demographics, practice settings, individual characteristics, client and work characteristics, workload, and perceived stress.

Practitioner Demographics

When examining practitioner demographics, gender differences correlated differently with experiences of reduced personal accomplishment. In a study by Hoeksma et al. (1994), male mental health practitioners from Divisions 29 and 42 of the American Psychological Association (who practiced psychotherapy) scored higher on the MBI for personal accomplishment than their female counterparts. However, more recently, Pimble's (2016) quantitative analysis of mental health practitioners' therapeutic effectiveness and its correlation with reduced personal accomplishment found no significant relationship between gender and lower scores on the personal accomplishment subscale of the MBI. When assessing the relationship between age and personal accomplishment, O'Connor et al. (2018) found that increasing age was associated with a

heightened sense of personal accomplishment. This finding suggested that as mental health practitioners aged, they might still feel competent in their skills, reinforcing the idea that experience played a protective role against reduced personal accomplishment.

Practice Setting

Regarding practice settings, practitioners working in the private sector reported lower levels of reduced personal accomplishment than those in non-private sector roles (Rosenberg & Pace, 2006). One explanation for this trend was that private-sector practitioners were more likely to perceive their work as directly impacting their financial stability, which could reinforce a sense of accomplishment (Vredenburgh et al., 1999). Rosenberg and Pace (2006) found that practitioners in the private sector reported greater feelings of personal accomplishment compared to those working in the medical sector or academia. One of the primary contributors to this phenomenon was thought to be autonomy, practitioners in private settings often had greater control over their workload, scheduling, and client selection, which may have contributed to an enhanced sense of professional fulfillment.

Individual Characteristics

When examining the individual characteristics of mental health practitioners in relation to feelings of reduced personal accomplishment, Skorupa and Agresti (1993) conducted a quantitative study using a random sample of 226 practitioners from a clinical section of a state psychological association. The findings indicated that practitioners who were knowledgeable about strategies to prevent burnout showed a significant positive correlation with personal accomplishment. This suggested that awareness and

implementation of burnout prevention strategies helped practitioners maintain a stronger sense of professional fulfillment.

Pimble (2016) further examined the relationship between therapeutic effectiveness and reduced personal accomplishment among mental health practitioners. The correlational analysis revealed that practitioners who reported lower scores on the Therapeutic Effectiveness Measure—indicating a perception of being less effective—also scored lower on the Personal Accomplishment subscale of the MBI. Additionally, Pimble (2016) found that the number of years practitioners spent in the field was positively associated with higher scores on the Personal Accomplishment subscale of the MBI, further reinforcing the idea that experience played a protective role against feelings of reduced personal accomplishment.

Client and Work Characteristics

When examining client characteristics, Raquepaw and Miller (1989) conducted a survey of a random sample of 68 practicing mental health practitioners in Texas, utilizing the MBI. Their findings indicated a significant positive correlation between caseload size and personal accomplishment among psychotherapists. However, while having a larger caseload initially correlated with greater personal accomplishment, an overabundance of clients was significantly associated with higher burnout levels, suggesting that excessive workload could diminish the protective effect of professional engagement.

Regarding work characteristics, Farber (1985) conducted a quantitative study investigating the experiences of 952 members from a clinical psychology division of a large state psychological association. Of the 33% of participants who responded,

practitioners working in private practice reported higher levels of personal accomplishment compared to those working in institutional settings such as hospitals or community clinics. This finding aligned with other research suggesting that autonomy and greater control over workload contributed to a stronger sense of professional fulfillment among private practitioners.

Practitioner Workload and Perceived Stress

When examining practitioner workload and perceived stress, Ballenger-Browning et al. (2011) conducted a study on mental health practitioners, reporting that those who had more patients per week experienced decreased feelings of personal accomplishment. Similarly, Rupert and Kent (2007) found that practitioners who spent a significant amount of time on administrative tasks or paperwork also reported lower levels of personal accomplishment. This suggested that excessive non-clinical duties could detract from the sense of fulfillment derived from direct client care.

Pimble's (2016) correlational analysis revealed that mental health practitioners with higher scores on the Perceived Stress Scale were more likely to have lower scores on the Personal Accomplishment subscale of the Maslach Burnout Inventory (MBI). This indicated that increased stress levels were directly associated with diminished feelings of professional effectiveness and fulfillment.

The analysis found that practitioners who reported more weekly hours spent on self-care activities had higher scores on the Personal Accomplishment subscale of the MBI. This finding reinforced the importance of self-care practices in mitigating burnout and enhancing a sense of professional accomplishment. While these studies provided

insight into mental health practitioners' experiences of personal accomplishment prior to the COVID-19 pandemic, further research is needed to explore how their experiences have evolved since the pandemic.

Impact of Burnout on Mental Health Practitioners During COVID-19 Rendering Clinical Care and Remote Therapy

Before COVID-19, research by Clay (2018) established a strong link between burnout and emotional exhaustion, detachment, and feelings of ineffectiveness among mental health practitioners. However, with the onset of the pandemic in 2020, the prevalence of mental health illnesses increased significantly across populations. Data from Mental Health America indicated that between January and September 2020, over half a million people reported symptoms of depression or anxiety, with screenings for anxiety increasing by 634% and screenings for depression increasing by 873% compared to pre-pandemic levels (Mental Health America, 2021). As demand for mental health services surged, practitioners experienced changes in client volume. More than 37% of practitioners reported an increase in client referrals, while 44% noted a reduction in no-shows or cancellations (American Psychological Association, 2020; Slone et al., 2021).

While most practitioners reported no changes in the racial/ethnic composition of their clientele, some reported increases within specific groups: 9% percent of practitioners reported seeing more Asian clients, 11% reported seeing more African American clients, 8% reported seeing more Hispanic clients, and 19% reported seeing more Caucasian clients (American Psychological Association, 2020). By age group, practitioners also observed shifts in their caseloads: 29% reported seeing more adult

clients (ages 18-64), 21% reported seeing more adolescent clients (ages 13-17), 17% reported seeing more older adult clients (ages 65-79), and 30% of practitioners reported seeing fewer children under 13 (American Psychological Association, 2020).

Mental health practitioners faced a wave of suffering clients head-on with little protection from the inevitable physical and mental consequences that followed. In 2021, Sampaio et al. surveyed mental health practitioners' ratings of burnout before and during COVID-19 and found a statistically significant 37% increase in self-reported burnout during the pandemic. A qualitative study on the experiences of National Health Service (NHS) mental health practitioners during the pandemic highlighted feelings of grief, distress, and burnout that many practitioners experienced in response to the demands of their work (Liberati et al., 2021).

Mental health practitioners encountered multiple adversities during the pandemic, which had significant consequences for their well-being. The primary factors that contributed to the rise in burnout rates among mental health practitioners included a shortage of mental health practitioners, diminished professional boundaries, and the transition to remote therapy**.**

Mental Health Practitioner Shortage

Concerns over the shortage of mental health providers predated the COVID-19 pandemic. In 2016, the Health Resources and Services Administration projected a demand for 250,000 additional mental health practitioners by 2025. However, when the COVID-19 pandemic began in 2020, the demand for mental health practitioners surged

exponentially as reported rates of anxiety, depression, isolation, and fear increased across the U.S. population.

In 2019, one in five individuals in the United States, approximately 51.5 million people were reported to have a mental illness (Substance Abuse and Mental Health Services Administration, 2020). Then, COVID-19 struck, exacerbating mental health struggles as fears surrounding the deadly virus and the painful social isolation caused by the pandemic further eroded the well-being of communities across the country.

Increased Anxiety and Depression Across the United States

At the height of the COVID-19 pandemic, 40% of adults reported experiencing symptoms of anxiety or depression, a stark increase from 11% pre-pandemic (KFF, 2022). However, the United States lacked the necessary mental health professionals to meet the growing demand for treatment. The Health Resources and Services Administration (HRSA) projected that by 2030, the country would face a national shortage of between 11,530 and 12,530 mental health practitioners (Health Resources and Services Administration, n.d.). Additionally, in a 2018 report on the behavioral health workforce shortage, Coffman et al. raised concerns that 45% of psychiatrists and 37% of psychologists would likely retire within a decade. The COVID-19 pandemic accelerated this trend, leaving many job openings unfilled and increasing the burden on remaining practitioners, who were forced to carry heavier caseloads.

Mental Health Professional Shortage Areas

In 2021, the U.S. Department of Health and Human Services designated 5,930 geographic areas as having shortages in mental health practitioners, affecting

approximately 39% of the U.S. population, or 150 million people (Health Resources and Services Administration, 2022). To address these shortages, the nation needed an additional 6,398 mental health practitioners (USAFacts, 2021).

The severity of mental health professional shortages varied across the country, with two-thirds of shortage areas located in rural or partially rural regions. States with the highest percentage of residents living in mental health shortage areas included Wyoming (96.4%) and Utah (83.3%), where access to mental health care remained significantly limited. In contrast, northeastern states had the lowest proportion of residents in shortage areas, with New Jersey (0.4%) and Massachusetts (4.0%) experiencing far fewer gaps in mental health service coverage (USAFacts, 2021). The number of mental health providers needed to address these shortages also varied by state. Delaware required 15 additional practitioners to meet demand, whereas Texas faced the largest gap, needing 638 more practitioners to fill shortages (USAFacts, 2021). These disparities highlighted the uneven distribution of mental health resources across the United States, with rural and underserved areas continuing to experience the greatest challenges in accessing care.

Despite these shortages, the demand for anxiety and depression treatment remained high. The American Psychological Association's 2022 COVID-19 Practitioner Impact Survey reported that the need for treatment for trauma, stress-related disorders, and substance use disorders continued to be substantial. Additionally, there was a growing demand for mental health services among populations of color, younger individuals, and healthcare workers. The steady increase in demand throughout 2020, 2021, and 2022 exceeded pre-pandemic levels, placing an immense strain on mental

health practitioners (APA, 2022). These combined factors significantly increased the risk of burnout among behavioral health professionals, as they struggled to meet the rising need for care in an already overburdened system.

Consequences of Practitioner Shortage

The shortage of mental health practitioners during the COVID-19 pandemic pushed practitioners to their limits as they struggled to meet the increasing demand for care. Parker-Pope et al. (2021) reported that about 10% of practitioners raised concerns about burnout, while nearly one in five surveyed practitioners had to cut back their hours due to personal and family demands during the pandemic. Many practitioners described feeling overwhelmed and emotionally drained as the demand for therapy services across the U.S. surged.

Despite their best efforts, the limited number of mental health professionals forced many practitioners to turn away new clients or extend waitlists, leading to feelings of guilt over their inability to accommodate all those in need (Parker-Pope et al., 2021). The article further highlighted the unique challenge mental health practitioners faced, unlike typical circumstances where they support clients through difficulties without experiencing the same struggles, the pandemic forced practitioners to grapple with the same emotional stressors as their clients. Many reported feeling caught between supporting others' emotional burdens while struggling with their own pandemic-related stressors, making it even more difficult to maintain their own mental well-being (Parker-Pope et al., 2021).

Diminished Professional Boundaries

Mental health practitioners recognized the importance of boundaries in the workplace; however, during the COVID-19 pandemic, their innate drive to help others often took precedence over their own well-being. As the pandemic progressed, practitioners experienced a surge in patients seeking treatment for anxiety and depression. In 2020, a survey conducted by the APA reported that nearly 29% of mental health practitioners saw more clients overall since the start of the pandemic. Among those providing treatment for anxiety disorders, 74% reported an increase in demand, while 60% of those treating depressive disorders saw a rise in client volume (American Psychological Association, 2020).

Increased Demands for Treatment

By 2022, the COVID-19 Practitioner Impact Survey, conducted by the APA, confirmed that the demand for anxiety and depression treatment remained high. The percentage of practitioners reporting increased client demand for anxiety disorders rose to 79%, while 66% reported increases in depressive disorders. Additionally, two-thirds of practitioners observed an increase in symptom severity among their clients (APA, 2022).

As a result, mental health practitioners' workloads and caseloads continued to rise. The percentage of practitioners working more than they did before the pandemic increased from 31% in 2020 to 38% in 2022 (APA, 2022). Additionally, 60% of practitioners reported having no openings for new patients, while 38% maintained waitlists. Among those with waitlists, 72% indicated that their waitlists had grown longer since the start of the pandemic (APA, 2022). The 2024 Practitioner Pulse Survey

highlighted capacity challenges within the mental health field, exacerbated by low participation rates in insurance networks among psychologists. Overall, 18% of psychologists had never accepted insurance throughout their careers. Psychologists who had never accepted, stopped accepting, or recently left an insurance panel cited three primary barriers to participation: insufficient reimbursement rates (82%), administrative burdens such as preauthorization requirements and audits (62%), and payment reliability concerns, including delayed payments and refund demands (52%). (APA, 2024) These findings underscored the significant strain mental health professionals faced with increased caseloads, ongoing financial and administrative challenges, and limited access to mental health services during the pandemic.

Inability to Meet Demand

To accommodate growing caseloads, longer waitlists, and increased requests for more frequent consults, many mental health practitioners felt pressured to loosen essential professional boundaries by extending their working hours. Full caseloads and overbooked schedules left practitioners with little time for self-care, leading to higher rates of burnout during the pandemic. As workloads increased, more practitioners reported being unable to meet the demand for treatment, rising from 30% in 2020 to 46% in 2022 (APA, 2022). The percentage of practitioners who agreed or strongly agreed that they felt burned out remained high, with 45% reporting burnout in 2022, closely mirroring the 48% reported in 2021. However, both figures were significantly higher than the 41% of practitioners who reported burnout in 2020 (APA, 2023).

Consequences of Diminished Professional Boundaries

Mental health practitioners were expected to maintain healthy boundaries and engage in regular self-care to remain effective in their roles (Stebnicki, 2017). However, the increasing complexity of client concerns, the challenges of navigating telehealth, ethical obligations, and personal stressors related to COVID-19 created significant barriers to maintaining wellness. These challenges compromised practitioners' ability to sustain their well-being during the pandemic (Cullen et al., 2020) and negatively impacted their professional quality of life. Findings by Litam et al. (2021) aligned with previous research that indicated work-related stressors were significant predictors of burnout (Maslach et al., 2001; Moore et al., 2020; Mullen et al., 2017) and practitioner impairment (Maslach, 2003; Stebnicki, 2008). Additionally, Litam et al. (2021) contributed new insights into how perceived stress during the pandemic affected mental health practitioners. To reduce burnout, mental health practitioners needed to extend themselves the same empathy and care they provided to their clients. By role-modeling healthy boundaries, self-care, and wellness, practitioners not only protected their own mental health and professional effectiveness but also reinforced ethical and sustainable practices within the field.

Switch to Remote Therapy

Before COVID-19, most mental health practitioners expressed concerns about treating patients remotely via telehealth and primarily conducted in-person therapy. However, during the COVID-19 lockdown, patients still required therapy, yet in-person sessions became unsafe. Sampaio et al. (2021) conducted a study to measure the use of

online therapy before and during COVID-19, the level of training practitioners received, and their knowledge of legal restrictions on telehealth. A sample of 768 U.S. mental health practitioners completed a 29-item online survey, with participants from both private practice settings (independent, small group, and large group practices) and public practice settings (health or behavioral health clinics, hospitals, military and university healthcare facilities, and the U.S. Department of Veterans Affairs).

Increase in Telehealth Therapies

The results showed that before COVID-19, most practitioners only saw patients in person, with only 39% of respondents utilizing telepsychology. However, during the COVID-19 pandemic, 98% of practitioners reported using various telecommunication technologies to connect with quarantined patients. Sampaio et al. (2021) found a significant increase in the use of telehealth technologies, including Zoom Free, Zoom Pro, Doxy.me, FaceTime, and personal phones. When using telehealth tools, mental health practitioners in the study reported ethical and regulatory concerns, particularly regarding security, confidentiality, HIPAA compliance, and the ability to handle emergencies. These concerns highlighted the challenges associated with the rapid shift to remote therapy during the pandemic.

Challenges With Remote Therapy

The APA (2020) elaborated on several challenges associated with providing mental health services remotely. Most practitioners reported that treating patients remotely was more difficult than conducting in-person therapy. Approximately 26% of practitioners indicated that patients faced significant barriers in accessing treatment via

telehealth, while 16% reported no barriers. When asked about specific barriers to telehealth, practitioners identified internet access and connectivity issues, general technical difficulties, and privacy concerns, such as clients lacking private spaces to engage in therapy (American Psychological Association, 2020).

According to Chenneville and Schwartz-Mette (2020), mental health practitioners were permitted to extend their practice beyond their identified competence in emergencies, if necessary. Consistent with the APA Ethics Code, despite concerns about being underprepared for telehealth, nearly all practitioners in the study continued providing online therapy to treat socially isolated clients. Additionally, 85% of Sampaio et al. (2021) respondents expressed that increasing access to telehealth training would be valuable, particularly in areas such as laws and regulations regarding telehealth, using secure online communication platforms, and managing emergencies, such as suicidal clients (Sampaio et al., 2021).

Stresses of Remote Therapy

Although telehealth allowed mental health practitioners to continue providing care, the COVID-19 pandemic also introduced significant stressors for practitioners. Sampaio et al. (2021) found a statistically significant 37% increase in practitioners' self-ratings of burnout during the pandemic compared to pre-pandemic levels. Many practitioners reported that their patients experienced greater-than-usual difficulties, which likely contributed to the rise in burnout rates.

In addition to managing a high percentage of clients in crisis, practitioners also grappled with their own stressors, including isolation-related difficulties, fears, and

anxieties brought on by the pandemic (Sampaio et al., 2021). The combination of heightened client distress and personal struggles placed an immense burden on mental health practitioners, further exacerbating their risk for burnout.

Qualitative Research Relevant to Mental Health Practitioners Experiences of Burnout Throughout COVID-19 Abroad and Within the United States

There was a prevalence of literature that discussed mental health practitioners' experiences of burnout throughout the COVID-19 pandemic from a quantitative perspective (Dreison et al., 2016; Sampaio et al., 2021). However, most studies that explored the qualitative experiences of burnout among mental health practitioners providing clinical care during COVID-19 were conducted outside the United States, primarily in European countries (Singh et al., 2023). The qualitative studies conducted within the United States primarily focused on general healthcare workers' experiences and well-being during the pandemic, including a mixture of physicians, nurses, physical therapists, and social workers. There was limited qualitative literature that exclusively examined the experiences of burnout among mental health practitioners providing clinical care during COVID-19.

United Kingdom

In the United Kingdom, Singh et al. (2023) explored the lived occupational experiences of clinical psychologists, counselors, and psychotherapists working in the NHS and private practice during the COVID-19 pandemic. The data analysis utilized interpretative phenomenological analysis, which identified three prominent themes: the transition from face-to-face to online therapy, novel changes and well-being, and

uncertain professional support in uncertain times. The first theme highlighted a pattern also observed in Sampaio et al. (2020), which described the difficulties many mental health practitioners faced while transitioning from in-person therapy to online or telephonic therapy (Singh et al., 2023). Many practitioners found that telehealth therapy had certain limitations; for example, it inhibited observation of the client's full body language which threatened the loss of essential clinical information.

The second theme discussed novel changes and wellbeing. Singh et al. (2023) reported that after the end of the first national lockdown, many NHS mental health practitioners' caseloads escalated to unmanageable proportions. One participant stated, "the waiting for counseling at their service in the past year increased from 5-6 weeks to 3 months" (Singh et al., 2023, p. 9). The APA (2022) reported similar findings, as mental health practitioners' caseloads continued to rise in response to increased demand, growing from 31% in 2020 to 38% in 2022. Practitioner well-being was also a major concern, as many practitioners found it difficult to psychologically separate themselves from clients' experiences, given that they were also experiencing the same struggles during the pandemic. Such challenges had a negative impact on practitioners' psychological well-being, leading some to emotionally detach from their clients, which is a characteristic outcome of burnout (Singh et al., 2023).

The third theme examined professional support in uncertain times. Many mental health practitioners reported receiving some level of support from professional bodies, clinical supervisors, managers, co-workers, or organizations. Such professional support helped practitioners adjust to the new reality of remote work, encouraged self-care, and

promoted seeking counseling when necessary (Singh et al., 2023). In contrast, some practitioners described negative experiences with senior management, reporting a lack of support from higher levels of leadership. This lack of support created feelings of discontent and contributed to reduced personal accomplishment; another key factor associated with burnout.

United States

In the United States, Goff et al. (2022) examined health workers' experiences during the early surges of the COVID-19 pandemic and explored the implications for ongoing occupational health challenges. The study aimed to gain a deeper understanding of health workers' experiences, thoughts, concerns, and recommendations during one of the first major COVID-19 surges in the U.S. Additionally, the study sought to determine how these experiences could inform future efforts to mitigate the psychological and occupational health impacts of the pandemic on healthcare workers. The participants in the study included a diverse group of health workers, such as physicians, nurses, physical therapists, social workers, and other healthcare professionals. Researchers conducted semi-structured interviews via video conference and used the Social-Ecological Model as a framework for data interpretation. The study identified four major themes: Institutions, Infrastructure, and the Pandemic; Working Under Fire; The Political Becomes Personal; and Hope. These themes highlighted the structural, emotional, and personal challenges faced by health workers during the pandemic, emphasizing the complex interplay between institutional preparedness, frontline work conditions, political influences, and resilience among healthcare professionals.

Among the four themes identified in the study, "working under fire" emerged as a prominent experience among mental health practitioner participants. This theme highlighted the increased workload practitioners faced, as many reported having larger caseloads than before the pandemic. Practitioners felt pressured to complete all of their work while simultaneously taking on additional clients, balancing multiple responsibilities, and managing the increasing demands of their profession (Goff, 2022). Another key challenge discussed within this theme was the loss of personal connection with clients. Mental health practitioners emphasized the importance of face-to-face therapy, noting that while Zoom and other telehealth platforms served their purpose, they could not fully replicate the in-person therapeutic experience. Practitioners described how sitting just a few feet away from clients in person allowed them to actively listen, engage, and better understand their clients' emotions and experiences, an element they felt was lacking in virtual therapy sessions (Goff, 2022). These limitations of telehealth therapy were also highlighted in Singh et al. (2023), further reinforcing the challenges practitioners faced in adapting to remote therapy while striving to maintain meaningful therapeutic relationships with their clients.

The third theme, *the political becomes personal,* was also a prominent experience among all health worker participants, highlighting the negative impacts of the pandemic on their personal lives, particularly the emotional toll. Many participants described how their experiences as healthcare workers during the pandemic negatively affected their physical and emotional well-being. Some health workers struggled to maintain sobriety, while others experienced heightened anxiety as they continued working through the

crisis. Many expressed a wide range of work-related concerns, including the overwhelming stress of providing care under extreme conditions and the uncertainty surrounding the pandemic's long-term effects. These challenges contributed significantly to provider burnout, further exacerbating the mental and emotional strain experienced by frontline health workers (Goff, 2022).

In the United States, Mittal et al. (2023) examined the impact of COVID-19 on mental health providers' well-being and clinical work. The study aimed to analyze open-text responses to explore how COVID-19 shaped the well-being of second-line workers, specifically mental health providers treating individuals impacted by COVID-19; as well as their clinical work during the early months of the pandemic. The data was analyzed using thematic analysis, and the results indicated that mental health practitioners experienced significant COVID-19-related burnout, along with poor physical and mental health outcomes. The first theme revealed that burnout and trauma associated with COVID-19 negatively impacted the quality of clinical care. Many practitioners described how being a mental health provider during the early months of the pandemic had a severe toll on their mental and physical health. They reported feeling stressed, overwhelmed, and emotionally burned out, struggling to maintain their well-being while managing the increasing demands of their profession (Mittal et al., 2023).

A second theme identified in Mittal et al., (2023) study focused on resilience and the sense of meaning that many practitioners experienced while working during COVID-19. Some participants expressed that being a mental health practitioner during the pandemic was both challenging and rewarding (Mittal et al., 2023). Several practitioners

found their work gratifying, as it gave them a sense of pride and meaning, knowing they were able to help people during an incredibly stressful time. This sense of purpose contributed to feelings of personal accomplishment; despite the difficulties they faced. Another key finding within this theme was that some participants reported a reduction in stress levels. They attributed this relief to working from home, which allowed them to spend more time with their families and benefit from more flexible schedules. Interestingly, across both well-being and clinical work domains, many participants described a "two sides of the same coin" effect, recognizing both the positive and negative aspects of being a second-line worker during the COVID-19 pandemic (Mittal et al., 2023).

Self-Care Practices for Burnout Among Mental Health Practitioners During COVID-19

Despite staggering burnout rates, burnout was not inevitable for all practitioners. The pandemic forced many mental health professionals to re-evaluate their priorities, slow down when possible, and reconsider their state of being, working, and living. In response to the American Psychological Association's (APA) COVID-19 Telehealth Practitioner Survey at the start of the pandemic in 2020, 68% of mental health practitioners reported stress levels between 5 and 8 on a 10-point scale. However, 66% of practitioners also indicated they were able to practice self-care, and 55% reported maintaining a positive work-life balance. By 2022, these percentages increased, with 77% of practitioners reporting the ability to engage in self-care and 63% maintaining a positive work-life balance (APA 2021).

Several wellness strategies were identified as effective in minimizing burnout, including mindfulness practices, expressing emotions, maintaining nonjudgmental awareness, and engaging in self-care and healthy physiological habits (Sutton, 2023). Additionally, self-reflection was recognized as an essential strategy for cultivating self-awareness and preventing burnout among mental health practitioners (Merriman, 2015; Young, 2013). During national crises, professional practitioners were encouraged to prioritize their interpersonal relationships, including those with partners, friends, and family, as a means of emotional support. Seeking personal counseling, consultation, or supervision was also recommended to help practitioners process challenges associated with providing mental health services during the pandemic.

Peer support played a crucial role in helping practitioners validate their experiences and cope with work-related stress. When faced with clinically challenging situations, acknowledging client difficulties as a natural part of the therapeutic process was suggested as an effective strategy to mitigate stress (Macdonald & Mellor-Clark, 2015; Nissen-Lie et al., 2017). These self-care practices and support systems were instrumental in helping practitioners navigate burnout and maintain their well-being throughout the COVID-19 pandemic.

Mindfulness

Mindfulness is defined as the deliberate and nonjudgmental focus on thoughts and bodily sensations in the present moment. Research has linked mindfulness to numerous benefits, including increased resilience, enhanced well-being, burnout prevention, and improved self-care for mental health practitioners (Norcross & VandenBos, 2018). As

highlighted by Chenneville and Schwartz-Mette (2020), it was crucial for mental healthcare providers to acknowledge their sources of stress during the pandemic and take proactive steps to minimize their negative impact. The American Psychological Association (2013) emphasized the ethical responsibility of mental health practitioners, stating that "Psychologists should remember their ethical duty to care for themselves and their colleagues so that they can care for those in need" (Chenneville & Schwartz-Mette, 2020, p. 3).

Practitioners could benefit from learning psychological techniques, such as mindfulness, to reduce stress and prevent burnout, particularly during global crises (Luken & Sammons, 2016). Sampaio et al. (2020) indicated that more than half of the surveyed practitioners reported practicing mindfulness as a coping strategy for managing stress. There was a significant increase in the number of hours per week that practitioners dedicated to mindfulness practices during the pandemic, underscoring its role as an effective tool for mental health professionals in stress management and burnout reduction.

Mindfulness Techniques

Given its significant positive impact, various mindfulness models have been developed specifically for mental health practitioners to enhance self-care. Wise et al. (2012) introduced the Mindfulness-Based Positive Principles and Practices Model, which emphasized four key components: flourishing, intentionality, reciprocity, and daily self-care practices. The first component, flourishing, aimed to counteract the natural tendency to ruminate about stress by emphasizing the positive aspects of the practitioner's

occupation. This included recognizing personal and professional growth that practitioners experienced through their work in therapy. The second component, intentionality, encouraged practitioners to accept their potential weaknesses and stressors and commit to making intentional changes in their attitudes and behaviors to address these issues. The third component, reciprocity, focused on the dynamic exchange of healthy lifestyle attitudes and practices between practitioners and clients, reinforcing the mutual benefits of well-being and self-care. The final component, daily self-care practices, highlighted the importance of consistency in establishing and maintaining self-care routines to promote long-term wellness (Wise et al., 2012).

Self-care for practitioners included maintaining healthy physiological habits, such as caring for their physical health. One crucial aspect of this was engaging in regular physical activity. The National Institutes of Health (2020) emphasized that exercise can reduce stress and depression while enhancing mood and overall well-being.

Another essential self-care practice was ensuring adequate sleep. Sleep quality directly impacted a practitioner's emotional regulation, as insufficient sleep could lead to increased irritability and anger. Over time, chronic sleep deprivation could increase the risk of developing depression (National Institutes of Health, 2020). It was crucial for practitioners to maintain a regular sleep schedule and prioritize quality rest each night to support their mental and emotional resilience.

Another essential aspect of self-care for mental health practitioners was maintaining a healthy diet. Good nutrition not only supported physical well-being but also played a crucial role in mood regulation, stress reduction, and anxiety management

(National Institutes of Health, 2020). Eating a well-balanced diet ensured that practitioners obtained the necessary nutrients to function optimally, both physically and mentally. While burnout among mental health practitioners was a significant concern, its impact could be mitigated through proactive self-care strategies. By recognizing their personal limits, practitioners could identify when boundaries were being overstepped and implement appropriate self-care measures to prioritize their mental well-being. Through a combination of mindfulness, physical activity, adequate sleep, and healthy eating, mental health practitioners could enhance their resilience, improve their overall quality of life, and sustain their effectiveness in providing care to others.

Self-Awareness

Self-awareness played a crucial role in reducing burnout symptoms among mental health practitioners during the pandemic. Rokach and Boulazreg (2020) emphasized that self-awareness was the foundation for any attempt to reduce stress and was considered an essential component of a practitioner's well-being. According to the APA (2010), self-awareness positively impacted the therapeutic relationship, helped reduce burnout symptoms, and facilitated self-care. While practitioners often encouraged self-awareness among clients, it was equally important for them to apply these principles to their own lives, both during and outside of client sessions, to fully experience the associated benefits.

Self-Awareness Techniques

Self-awareness involved having objective knowledge of one's strengths and areas for growth, particularly within one's personality and professional practice (Hutchison,

2022). In a therapeutic setting, self-awareness allowed practitioners to reflect on their thoughts, feelings, and biases, ensuring that they were not unconsciously reacting to their own or their clients' subconscious programming. Increasing self-awareness helped practitioners better relate to their clients' personalities, ultimately advancing their professional and personal development (Hutchison, 2022).

Ackerman and Sauber-Millacci (2020) discussed multiple techniques to cultivate self-awareness, emphasizing its importance for mental health practitioners' well-being and effectiveness. The first technique, creating space and time for self-reflection, encouraged practitioners to connect with themselves daily by reviewing their thoughts, feelings, and behaviors. This practice helped them assess whether they met their professional standards, identify areas for improvement, and address personal and occupational challenges. The second technique, journaling for awareness, involved processing thoughts and emotions through writing. Journaling allowed practitioners to identify, clarify, and accept their thoughts and feelings, helping them determine what they valued, what worked for them, and what was unimportant (Ackerman & Sauber-Millacci, 2020). The third technique, practicing active listening skills, emphasized paying close attention to clients' verbal and nonverbal cues, including emotions and body language. Practitioners were encouraged to actively listen without judgment or premature evaluation, enabling them to gain deeper insight into their clients' perspectives and therapeutic needs (Ackerman & Sauber-Millacci, 2020).

Self-awareness techniques were shown to lessen the effects of burnout. For instance, Rupert and Kent (2007) surveyed 595 mental health practitioners to examine

burnout-related factors and found that maintaining self-awareness ranked as the second most important career-sustaining behavior. Self-awareness had multiple benefits; when practitioners employed self-awareness during therapy sessions, it enhanced the quality of therapy in various ways. Self-awareness was found to be essential in managing countertransference during therapy sessions (Hayes et al., 2011).

In-session, self-awareness was associated with increased interpersonal engagement with clients. This technique also served as a marker of clients' perceived support; practitioner self-awareness accounted for over 50% of the variance in interpersonal involvement and the perceived therapeutic alliance (Fauth & Williams, 2005). In contrast, a lack of self-awareness regarding therapeutic process issues, such as countertransference, was linked to higher rates of burnout (Chang, 2014). Countertransference often originated from unresolved personal issues, including those related to the practitioner's family background or cultural upbringing. However, when mental health practitioners became more aware of their internal reactions and gained insight into them, they were better equipped to manage their responses and became more effective in their therapeutic work (Hutchison, 2022).

Without proper understanding, countertransference could interfere with the therapy process. When practitioners actively engaged in increasing their awareness of their thoughts, feelings, and biases, it enhanced the therapeutic relationship and helped prevent harm to the client. Recognizing one's personality traits and biases allowed practitioners to better manage their internal reactions and remain fully present with their clients (Hutchison, 2022). Self-awareness enabled practitioners to develop an objective

understanding of their strengths and areas needing growth within their personality. This technique also helped practitioners recognize early signs of burnout, allowing them to take proactive steps to seek help and implement self-care strategies before long-term issues developed.

Social Support

Social support has been defined as "the resources and interactions provided by others or the connection to others that help one cope with stressful circumstances… that can come from various sources, including family, friends, co-workers, and supervisors" (Clark et al., 2009, p. 582). Since isolation is a known risk factor for burnout among mental health practitioners (Stebnicki, 2007), research has examined the role of personal and professional social support in practitioners' self-care. Mental health practitioners relied on multiple sources of support, including peer support, individual or group supervision, involvement in professional associations, colleague assistance programs, and personal therapy (Barnett et al., 2007). While some studies suggested that social support was of little importance to mental health professionals (Stevanovic & Rupert, 2004), other research highlighted its significance. For example, Killian (2008) found that social support was the most significant predictor of compassion satisfaction among trauma practitioners. Additionally, strong social support was linked to lower levels of perceived stress (Myers et al., 2012), whereas lower levels of personal (e.g., family) and professional (e.g., collegial) support were associated with greater psychological distress (Nelson et al., 2001).

Personal Support

Personal support, which includes friends, family, and personal therapy, has been recognized as a crucial element of self-care and a means of promoting work-life balance for mental health practitioners (Barnett et al., 2007). Satisfaction with personal support is associated with higher self-esteem, better psychological adaptation, improved professional functioning, lower anxiety and depression, and reduced reliance on avoidance coping strategies (Kuyken et al., 2003). However, Rupert and Kent (2007) found that practitioners who discussed work frustrations with spouses and colleagues reported higher levels of emotional exhaustion. While this finding might suggest a negative spillover of work stress into personal life, it could also indicate that practitioners tend to seek external support when feeling overwhelmed by job demands. Personal therapy has also been recommended as an essential self-care strategy (Thériault et al., 2015). Despite its benefits, many mental health practitioners face barriers to seeking therapy, including concerns about confidentiality, financial costs, and time constraints (Dearing et al., 2005). Bearse et al. (2013) found that 59% of professional practitioners did not seek therapy, even though they acknowledged it would be beneficial for their well-being.

Professional Support

Mental health practitioners benefited from professional support through clinical supervisors, mentors, advisors, professional colleagues, and professors. Experienced practitioners ranked professional and peer supervision among the top three most essential and valuable coping strategies for managing self-care and feelings of incompetence

(Thériault et al., 2015). Zahniser et al. (2017) found that professional support provided multiple benefits for clinical psychology students, including enhancing professional development, improving work-life balance, increasing cognitive awareness and positive affect, supporting progress in clinical and academic work, and reducing perceived stress and negative affect. Beyond being a highly recommended self-care practice, professional support methods such as supervision became a mandatory requirement in many mental health professions.

Clinical supervision served as an important resource for raising awareness about the risks and symptoms of adverse outcomes experienced by mental health practitioners. At the same time, supervision provided a safe space for recognizing and addressing these challenges (Merriman, 2015). Merriman (2015) further argued that supervision should ideally involve the development and monitoring of self-care plans for supervisees. In addition to supporting supervisee competence (Bradshaw et al., 2007), supervision helped identify gaps in training, monitor caseload and work-life balance, direct career development, encourage self-care, and support supervisees facing professional challenges (Pack, 2015). Clinical psychology graduate students reported being most satisfied with their supervisors when they received guidance on self-care and work-life balance (Peluso et al., 2011). Additionally, work-based social support, such as supervision, enabled trainees to adopt adaptive coping strategies, ultimately reducing the risk of burnout (Kuyken et al., 2003).

Peer Support

Peer support and collaboration existed at the intersection of professional and personal social support, as it was less hierarchical and could foster self-care both inside and outside the workplace (Barlow & Phelan, 2007). Peer consultation played a critical role in helping practitioners address biases about their competence, maintain adherence to therapeutic models, and reduce burnout and anxiety (Waltman et al., 2016). Socioemotional support from faculty members was found to be positively associated with graduate students' satisfaction with their academic programs and overall life satisfaction (Tompkins et al., 2016). Involvement in professional associations provided a valuable avenue for identifying issues of professional impairment and addressing concerns related to practitioners' mental, physical, and spiritual well-being (Stebnicki, 2007). By engaging in peer support networks, seeking collaboration, and participating in professional associations, mental health practitioners could strengthen their resilience, enhance job satisfaction, and reduce the impact of burnout-related stressors.

Summary and Conclusions

The pandemic was a life-changing experience for mental health practitioners across America. Through the pandemic that has claimed the past three years, the nation saw a dramatically increased prevalence of mental health illnesses such as depression and anxiety across all populations compared with before the pandemic (Mental Health America, 2021). Due to this, mental health practitioners took the wave of suffering clients head-on, while simultaneously struggling with a national mental health practitioner shortage, diminished professional boundaries due to the pandemic, and challenges with

the switch to remote therapy services. Many practitioners felt they had little protection from the inevitable physical and mental consequences to come.

Sampaio et al. (2021) survey of mental health practitioner ratings of burnout before versus during COVID-19 found a statistically significant 37% increase in self-ratings of burnout during the pandemic. Despite glaring statistics of significant increases in practitioner burnout, the majority of research has been almost entirely focused on the rise in levels of physician and nurse burnout in providing emergency care during the multiple waves of the pandemic (Trombello et al., 2021; Liberati, 2021, Shah et al.,2022). Furthermore, qualitative literature that explored mental health practitioners' experiences of burnout prior to and during COVID-19 was difficult to find. Out of the few qualitative studies in the literature that discussed the experiences of burnout among mental health practitioners during the COVID-19 pandemic, most were conducted outside of the United States, with majority being conducted in the United Kingdom (Billings et al., 2021; Singh et al., 2023) The recent literature that discussed burnout among mental health practitioners prior to pandemic and after has been primarily through a quantitative lens, including systematic reviews (Serrano-Ripoll et al. 2020) cross sectional studies (Giusti et al., 2020), and meta-analysis (O'Connor et al., 2018). Literature has yet to define an interview-based qualitative study that seeks to understand better mental health practitioners' burnout experiences during the COVID-19 pandemic in the U.S.

The levels of burnout affecting mental health practitioners after the onset of the COVID-19 pandemic is prominent, as the demand for mental health services among the general population of the U.S. have steadily risen (Gold, 2021). This study will focus on

the gap in literature to better understand the burnout experiences of mental health practitioners that rendered clinical care during the COVID-19 pandemic through a qualitative lens. Chapter 3 will explain the overview of the generic qualitative inquiry research design and approach.

Chapter 3: Research Method

The purpose of this research study was to understand better how mental health practitioners experienced burnout while rendering clinical care during the COVID-19 pandemic (Captari, 2020; Joshi & Sharma, 2020). The study offered insight into various dimensions of burnout, including overwhelming exhaustion, emotional detachment from work, and reduced personal accomplishment among mental health practitioner working throughout the pandemic. The research question focused on the burnout experiences of mental health practitioners who rendered clinical care during the pandemic. This chapter will outline the study's research design and rationale, discuss the role of the researcher, detail the methodology, address issues of trustworthiness, and conclude with a summary.

Research Design and Rationale

The following research question was to understand better the experiences of burnout among mental health practitioners that rendered clinical care during the COVID-19 pandemic.

What are the experiences of burnout in mental health practitioners rendering clinical care during the COVID-19 pandemic?

In this study, the concept was to understand better how mental health practitioners experienced burnout while rendering clinical care during the COVID-19 pandemic. To address the research question in this study, the generic qualitative approach was used (Kostere & Kostere, 2022). Qualitative research was best suited for this study because it focused on meaning-making and how individuals make sense of their lived experiences. The generic qualitative approach is a research tradition that seeks to understand

participants' experiences by using qualitative procedures to gather and analyze data (Kostere & Kostere, 2022). The research tradition was the generic qualitative approach, as it embraced the first-person narrative and asked questions that encouraged descriptive data, strived for discovery, understanding, and meaning. Generic qualitative research uses procedures that generate descriptive data. The most used procedure for collecting qualitative data was the qualitative interviews. Semi-structured interviews were recommended, while open-ended conversational interviews were suggested for studies requiring deeper exploration of a topic (Kostere & Kostere, 2022).

Other acceptable forms of data collection in generic qualitative research included journals, diaries, documents, observations, photographs, memos, and field notes (Kostere & Kostere, 2022). As the goal of this study was to better understand individual experiences, utilizing the generic qualitative approach allowed mental health practitioners to reflect on their experiences of burnout while rendering clinical care during the COVID-19 pandemic.

Role of the Researcher

According to Ravitch and Carl (2021), the researcher serves as the primary instrument in qualitative research. My role as a qualitative researcher was to gather in-depth experiences from study participants regarding their experiences rendering clinical care during the COVID-19 pandemic. In this process, I took on the role of an observer-participant, where I listened, probed, and clarified responses to encourage descriptive data collection, leading to a broader and more complex understanding of participants' experiences (Kostere & Kostere, 2022). In this study, I did not have any professional or

personal relationships with potential participants, nor did I hold any supervisory or instructional roles that could have created a power dynamic within the study.

Ravitch and Carl (2021) emphasized the importance of researcher positionality and social identity, particularly in how researchers engage with and interpret study settings, participants, and contextual phenomena. Given this, I remained mindful of potential biases throughout the research process. To ensure the trustworthiness of collected data and minimize bias, I employed member checking, a widely used validation technique in qualitative research (Birt et al., 2016). Member checking, also known as participant or respondent validation, involved returning data or findings to participants to confirm accuracy and alignment with their lived experiences. This technique helped enhance credibility and trustworthiness in the study (Birt et al., 2016).

Because qualitative research requires researchers to set aside pre-understandings and pre-suppositions to remain open to individual differences, I implemented ongoing reflexivity as part of my research process (Kostere & Kostere, 2022). Reflexivity involved self-reflection and critical awareness of potential biases regarding data collection, interpretation, and analysis. By utilizing continuous reflexivity, I ensured that my perspectives did not unduly influence the findings, thereby maintaining the integrity and rigor of the research (Olmos-Vega et al., 2023).

As the researcher, I maintained transparency throughout the study by documenting my biases, thoughts, and self-reflections in a journal or diary. Journaling served as a tool for bringing intentionality to the research process, allowing me to acknowledge and manage potential biases while refining my understanding and

assumptions (Olmos-Vega et al., 2023). There were no ethical concerns associated with using a generic qualitative approach in this study. To express appreciation for participants' time and contributions, each participant received an Amazon gift card valued at $30.00 as a thank-you gift for their participation in the research. Offering this incentive did not pose any ethical risks or negative impacts on the study, as compensation was reasonable and aligned with common research practices.

Methodology

Participant Selection Logic

The target population for this generic qualitative research study consisted of mental health practitioners within the United States who provided clinical care during the COVID-19 pandemic. To be eligible for the study, participants had to have rendered clinical care at any point between the official declaration of the coronavirus outbreak as a public health emergency on January 31, 2020 (U.S. Department of Health & Human Services, 2023) and the official end of the public health emergency declarations on May 11, 2023 (Cox et al., 2023).

Creswell (2018) described purposeful sampling as the primary sampling strategy in qualitative research, making it the most appropriate method for a generic qualitative approach. Purposeful sampling involved selecting participants who had direct experience with the phenomenon under study and were willing to describe their experiences (Kostere & Kostere, 2022). Snowball sampling, a derivative of purposeful sampling, was employed as a secondary recruitment strategy. Snowball sampling was particularly useful in qualitative research, as participants with relevant experiences could refer other

potential participants who met the eligibility criteria (Etikan & Bala, 2017). For this study, I used networking and criteria-based selection to identify and recruit mental health practitioners who met the study's eligibility requirements. The recruitment process focused on practitioners with firsthand experience providing clinical care during the pandemic, ensuring that interview participants could provide meaningful insights into their burnout experiences.

This study focused on a specific population of licensed mental health practitioners who provided clinical care during the COVID-19 pandemic. Eligible participants included licensed psychologists, licensed professional counselors (LPCs), licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), and licensed clinical alcohol and drug abuse counselors (LCADCs). To ensure that participants had completed their formal education and licensure requirements before the onset of the pandemic, the study was limited to practitioners who obtained their licenses before 2020. This requirement ensured that all participants had established professional experience prior to the pandemic and could offer valuable insights into how their work was impacted by COVID-19-related stressors.

Mental health practitioners who were not licensed, did not provide clinical care during the pandemic, or were not practicing in the United States were excluded from the study. Recruitment efforts involved contacting potential participants via email or social media using a recruitment flyer. The flyer inquired whether participants had experienced pandemic-related stressors that contributed to burnout and whether they were familiar with the definition of burnout. Once a sufficient number of eligible participants were

identified, Zoom was used as the primary platform for scheduling and conducting interviews. This platform provided a convenient scheduling system, allowing participants to select available time slots, which were then automatically added to their calendars for their videoconference interview.

The population for this study consisted of mental health practitioners who rendered clinical care during the COVID-19 pandemic within the United States. In a generic qualitative dissertation, when individual interviews are used as the data collection procedure, the recommended sample size ranges from eight to 15 participants (Kostere & Kostere, 2022). For this study, I aimed to interview eight to 11 participants to ensure a comprehensive exploration of burnout experiences among mental health practitioners. Kostere and Kostere (2022) emphasized the importance of collecting enough data to answer the research question while ensuring that the data is substantial, meaningful, and rich in depth.

Data saturation occurs when the researcher perceives that no new information is being added during data collection, and responses become repetitive and redundant (Kostere & Kostere, 2022). To ensure that saturation was reached, I developed a recruitment flyer and shared it across various professional psychology listservs such as the Bay Area Psychological Association (BAPA), Los Angeles County Psychological Association (LACPA). Additionally, I distributed the flyer to my Walden dissertation Cohort via GroupMe, and WelbeHealth's listservs to recruit participants who met the criteria-based characteristics for this study. These recruitment efforts ensured that I

achieved the appropriate sample size of 8 participants, aligning with the standards for qualitative research (Kostere & Kostere, 2022).

Instrumentation

Researcher Developed Instrument

I used an interview protocol to ensure consistency across participants. The interview protocol was designed following the guidelines provided by Jacob and Furgerson (2012) on structuring qualitative interviews. The protocol outlined how the interview began, including introducing myself and the study topic, collecting participant consent, asking interview questions, and concluding the interview with debriefing procedures. The primary goal of the interview guide was to understand, explore, and describe the burnout experiences of mental health practitioners who provided clinical care during COVID-19.

The use of semi-structured, open-ended questions was a valid and widely accepted data collection method in generic qualitative research (Kennedy, 2016). For this study, a semi-structured interview format was implemented, consisting of 10 open-ended questions (Appendix A). These questions were developed based on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) and peer-reviewed literature. The MBI was the first scientifically developed measure of burnout and has been widely applied for individual diagnosis as well as organizational assessments. Since the onset of COVID-19, research has highlighted how the pandemic exacerbated burnout and workplace distress. As the pandemic extended from 2020 through 2023, discussions surrounding burnout prevalence in the workplace became more prominent (Maslach & Leiter, 2021).

The first nine semi-structured interview questions were developed based on the three subscales of the MBI: Emotional exhaustion, depersonalization, and personal accomplishment **(**Maslach & Jackson, 1981**).** The 10th interview question was inspired by Maresca et al. (2022)**,** whose research focused on coping strategies among healthcare professionals experiencing burnout syndrome. They identified efficient coping mechanisms**,** including social and emotional support, physical activity, physical self-care, and emotional and physical distancing from work as strategies for mitigating burnout symptoms.

Interview Questions 1 through 3 were designed based on the emotional exhaustion subscale to determine whether participants had experienced energy depletion or exhaustion while rendering clinical care during COVID-19. Questions 4 through 6 were based on the depersonalization subscale to explore whether participants had developed increased mental distance from their job or feelings of negativism or cynicism related to their professional role during the pandemic. Questions 7 through 9 were aligned with the personal accomplishment subscale to assess whether participants had experienced reduced professional efficacy while delivering clinical care during COVID-19 Lastly, Interview Question 10 was based on Maresca et al. (2022) to examine whether participants had developed coping mechanisms to manage or alleviate burnout symptoms during the pandemic. By structuring the interview questions around validated burnout subscales and established research on coping strategies, this study ensured that participants' experiences of burnout and resilience were thoroughly explored.

Sahoo (2022) discussed how the open-ended nature of semi-structured interviews allows for in-depth discussions, enabling the researcher and participants to explore topics thoroughly. This interview format also provided flexibility, allowing me to probe participants further for clarification of responses or to pursue additional lines of inquiry to ensure accuracy in data reporting. For this study, individual interviews served as the primary method of data collection. Each interview was scheduled to last up to 60 minutes. Interviews were conducted via Zoom using its recording feature, or alternatively, an audio recorder was used to ensure all participant responses were accurately captured. All audio recordings were transcribed, and participants were given the opportunity to review their interview transcripts to clarify any information provided.

To maintain confidentiality, I assigned each participant an alphanumeric code instead of using their names. This coding system allowed for effective organization of participant data while protecting their identities. After all interviews were conducted and transcribed, participants received a copy of their interview transcript to confirm that their responses accurately reflected their experiences. All interview questions, hand-coded notes, and typed transcripts were retained for a minimum of three years after the research was completed and the study was closed with the Institutional Review Board (IRB) (Elsevier, 2022). For confidentiality purposes, all collected data were stored in a locked file cabinet and on a password-protected flash drive, accessible only from a password-protected computer. In accordance with research data storage and retention policies, all collected data would be securely destroyed after five years (Elsevier, 2022).

Procedures for Pilot Study

A pilot study serves to determine whether a research study can be successfully conducted, whether researchers should proceed with it, and if so, how to refine and improve the process. Pilot studies are conducted on a smaller scale than the main research study and play a crucial role in enhancing the quality and efficiency of the full-scale study (In, 2017). The goal of the pilot study was to obtain feedback from two participants on the interview protocol, allowing for any necessary modifications to improve the research study.

This pilot study was designed as a small-scale version of the research procedures to increase the validity of the study. The same procedures that were planned for the main research study were implemented in the pilot study. Two participants were recruited to participate in pilot interviews, where they answered the same semi-structured interview questions that would be used in the main research study. The pilot study served as a practice for refining the cadence, timing, and clarity of interview questions, ensuring that the researcher was well-prepared before conducting the full-scale research study. Feedback from pilot participants helped identify any issues with question clarity, flow, or participant comprehension, allowing for necessary adjustments to optimize the interview process before proceeding with the main study.

Procedures for Recruitment, Participation, and Data Collection Procedures for Recruitment

Mental health practitioners who experienced burnout while providing clinical care during the COVID-19 pandemic were recruited using a recruitment flyer (Appendix B). The flyer was distributed via email to mental health practitioner networking group listservs, including the Los Angeles County Psychological Association and the Bay Area Psychological Association. The flyer contained relevant study information, allowing potential participants to make an informed decision about their participation. When a participant expressed interest, I communicated with them through their primary contact method, primarily via email. Additionally, I encouraged participants to share the recruitment flyer with colleagues to support snowball sampling, expanding the participant pool to increase study validity and diversity of experiences. If participants agreed to take part in the study, they scheduled an interview at their convenience. A consent form (see Appendix C) was sent via email, and participants confirmed their participation by responding with the words "I consent."

After the completion of the interview and member checking process, participants in the study received a $30.00 Amazon gift card as a thank-you gift for their participation in the research. Muscente (2021) explained that small gifts or compensation serve as a predetermined form of payment provided to research participants as appreciation for their engagement in a study. Compensation could include monetary items, such as electronic gift cards. A small compensation as an incentive for study completion was permissible, provided it was not coercive. The monetary value of the gift card was considered

reasonable and was intended solely as a token of appreciation for participants' time and willingness to share their experiences. No negative impacts were foreseen as a result of offering a $30.00 gift card to study participants.

A compensation plan was implemented to outline the method of compensation, the amount and form of compensation, and the process for distributing compensation. The plan also ensured that any identifiable information collected during the compensation process was handled ethically and confidentially. The plan specified circumstances under which participants may or may not receive compensation (Muscente, 2021). This structured approach ensured transparency, fairness, and compliance with ethical research guidelines.

A consent form (Appendix C) was used to ensure confidentiality and align with IRB guidelines at Walden University. The consent form outlined participants' rights, including the protection of their identity and their ability to withdraw from the study at any time. Each participant was asked to read the consent form and reply via email with the words “I consent” to confirm their participation in the study. To protect participant privacy, each participant was assigned an alphanumeric identification code instead of using their real names. This coding system ensured confidentiality throughout the research process. The interview protocol ensured that all participants received the same set of questions and had time to reflect before responding. Open-ended questions were used to encourage detailed and meaningful responses.

A 60-minute videoconferencing platform (Zoom) was used for interviewing participants, with the videoconferencing software recording responses and closed

captioning enabled. The recorded interviews were transcribed for documentation. If the initial recruitment process resulted in too few participants, a follow-up plan was implemented to contact previously interested participants to inquire whether they were still willing to participate.

Participation in the study was voluntary, and participants could withdraw at any time, with or without providing a reason. For debriefing, participants were thanked and provided with a debriefing sheet that included resources for emotional support if they experienced distress from sharing their experiences. To enhance validity, participants were emailed their interview transcripts and given the opportunity to review them for accuracy. They were allowed to add, remove, or edit any information to ensure their responses accurately reflected their experiences.

All collected data were stored securely on a password-protected computer and in a locked file cabinet at my residence. The data, including consent forms with participant names and assigned alphanumeric codes, was stored for a minimum of 5 years. Additionally, hand-coded notes and all documents used for data analysis were kept securely locked. After 5 years, all participant data will be shredded to maintain confidentiality and compliance with research data retention policies.

Data Analysis Plan

Each interview was transcribed using the videoconferencing software (Zoom), which converted the video recordings into audio files. To protect participant confidentiality, alphanumeric identifiers such as ‘DLT1’ were assigned to each participant. I carefully reviewed the transcripts multiple times to ensure accuracy in the

transcription process. The organization of data was conducted using a Microsoft Word data analysis table, which helped structure the data for thematic analysis. To analyze the data, I applied Braun and Clarke's (2006) six-phase thematic analysis framework to identify themes related to common experiences among participants. In phase one, I familiarized myself with the data by actively reading and searching for meanings and patterns. This was achieved by reading the transcripts multiple times and identifying emerging patterns. During this phase, I noted ideas and highlighted potential areas of interest, focusing on gathering information rather than making deductions.

In Phase 2, I generated initial codes by listing ideas that emerged from the data (Braun & Clarke, 2006). This step involved surveying patterns and identifying recognizable data points that were meaningful to the research question. I ensured that the coding process captured essential features of the data and created labels or tags in a separate document to systematically track relevant findings. The research question remained central to the coding process, ensuring alignment with the study's objectives.

In Phase 3, I sorted the different codes into candidate themes and sub-themes (Braun & Clarke, 2006). This process involved exploring themes by organizing related codes and identifying similarities among data points. The primary goal was to generate themes by clustering related codes. To assist in this process, I implemented thematic maps and tables to visualize potential relationships between themes. This phase was interpretive, requiring a focus on shared meaning when grouping data into distinct themes.

In Phase 4, I reviewed and refined the identified themes to ensure their validity in relation to the entire data set (Braun & Clarke, 2006). To accomplish this, I ensured that each theme was well-supported by the data, thoroughly testing the themes and examining their frequency throughout the transcripts. I determined whether each theme had sufficient quality and focus, ensuring that the coded data accurately represented the participants' experiences. This phase was iterative, requiring continuous reflection until each theme had clear boundaries and consistency across participants' data.

In Phase 5, I defined and named the themes that were presented for analysis. To achieve this, I generated definitions and descriptions for each theme, ensuring they were grounded in the data. I developed central concepts for each theme and wrote concise descriptions detailing how each theme was presented within the data. To maintain cohesion and avoid fragmentation, I limited the structure to three to four levels of themes, including overarching themes, themes, and sub-themes (Braun & Clarke, 2006).

In Phase 6, I produced the final report with fully developed themes and a final analysis. To achieve this, I analyzed the thematic findings and structured the report in a logical order to ensure a coherent presentation of the themes. Each theme was constructed in relation to the others, creating a comprehensive narrative that reflected the research question and aligned with the existing literature. Finally, I provided analytic conclusions across the themes, ensuring that the data was illustrated appropriately and clearly conveyed the burnout experiences of mental health practitioners during the COVID-19 pandemic.

Issues of Trustworthiness

According to Norman and King (2020), trustworthiness in qualitative research is assessed using four general criteria: credibility, transferability, dependability, and confirmability. These criteria ensure that qualitative findings are accurate, meaningful, and applicable beyond the study's immediate context. Unlike quantitative research, which emphasizes internal validity, qualitative research aims for trustworthiness, which allows readers to confidently interpret the findings as credible and well-supported.

Credibility

Credibility refers to how well the findings align with reality, similar to internal validity in quantitative research (Norman & King, 2020). A key method to establish credibility is member checking, where participants verify the accuracy of their interview transcripts to ensure there are no errors or misinterpretations. In this study, member checking was implemented by providing each participant with a copy of their transcript for review and validation. Participants were able to request adjustments or corrections via phone or email, ensuring that the data accurately reflected their experiences.

Another method for credibility is reflexive self-analysis, often facilitated through research journals (Norman & King, 2020). To maintain awareness of potential biases, I documented my thoughts, reflections, and interpretations throughout the data collection and analysis process. This self-reflective practice helped to identify and mitigate any unconscious biases that could influence data interpretation. Institutional oversight through Walden University’s IRB ensured that all ethical guidelines and research procedures were followed correctly, further strengthening the credibility of this study.

Transferability

Transferability refers to the extent to which the findings can be applied to other contexts (Norman & King, 2020). Unlike generalizability in quantitative research, qualitative transferability relies on rich, thick descriptions that allow readers to determine whether the findings are applicable to similar populations. This study sought to provide a detailed portrayal of the burnout experiences among mental health practitioners who rendered clinical care during the COVID-19 pandemic. Using snowball sampling, data were collected from diverse practitioners, allowing for identification of common patterns that may be relevant to other mental health professionals experiencing burnout in high-stress environments.

Dependability

Dependability ensures that the research process is consistent and replicable (Norman & King, 2020). To achieve dependability, this study employed structured data collection methods, including semi-structured interviews with open-ended questions to elicit spontaneous and unbiased responses. Digital recordings via videoconferencing (Zoom) and manual and automatic transcripts were used to document the interviews accurately (Quantilope, 2023). Further measures included the use of hand-coded notes during data interpretation, as well as strict confidentiality protocols to protect participant identities. These procedures ensured that the research remained trustworthy, transparent, and well-documented, making it possible for other researchers to replicate the study under similar conditions.

Confirmability

Confirmability aims to eliminate researcher bias and ensure that findings reflect participants' views rather than the researcher's interpretations (Quantilope, 2023). To achieve confirmability, I maintained detailed research materials, including all transcripts, coding records, and theme development notes, to provide transparency throughout the study. Additionally, data verification was conducted throughout thematic coding and analysis, ensuring that the themes were grounded in participants' responses rather than subjective biases. The pilot study, interviews, and coding processes were also carefully checked and reviewed to ensure that the results were consistent and could be replicated by future researchers analyzing burnout experiences among mental health practitioners.

Ethical Procedures

This study adhered to Walden University's IRB regulations and Health Insurance Portability and Accountability Act (HIPAA)-compliant guidelines in the United States to ensure participant confidentiality. All recruitment efforts and outreach to potential participants took place only after receiving IRB approval, and the interview questions were aligned with Walden University's IRB guidelines. Given the professional environment of the participants and the sensitive nature of working through the COVID-19 pandemic, confidentiality was a critical ethical consideration for this study.

To protect participant confidentiality, all identifiable demographic information (e.g., names, addresses, phone numbers, and other personal details) was removed from the dataset. Instead, participants were assigned alphanumeric codes (e.g., DTL1, DMM2, DBM3, etc.) to maintain anonymity. Only the dissertation chair, committee members, and

the researcher had access to participant information. A consent form was created, in accordance with Walden University's IRB policies, to document participants' agreement to confidentiality and ensure accountability.

Before the interviews began, each participant was fully informed about the voluntary nature of the study. Participants were made aware that they could withdraw from the study at any time without consequences. Additionally, participants were informed that the interviews would be audio recorded, but only with their explicit permission.

To secure research data, hand-coded notes, interview transcripts, and digital recordings were stored on a flash drive and locked in a secure cabinet. The collected data would be retained for five years in accordance with research data storage and retention policies (Elsevier, 2022) before being permanently destroyed. The dissertation chair and committee members reviewed the interview instrument and provided feedback for any necessary revisions before the study was conducted. Participants had full autonomy throughout the study and could terminate the interview if they felt uncomfortable or no longer wished to participate. As a thank-you for their time, each participant received a $30.00 Amazon gift card. Participants who experienced emotional distress as a result of discussing burnout during the pandemic were provided with mental health resources. If needed, participants were referred to local therapeutic providers. They were also given the 988 Suicide & Crisis Lifeline contact information, which provides 24-hour, confidential support for anyone in suicidal crisis or emotional distress.

Summary

Chapter 3 outlined the generic qualitative research process and design approach used in this study. The generic qualitative approach was selected to gain a deeper understanding of the burnout experiences among mental health practitioners who rendered clinical care during COVID-19. This chapter detailed the research design and rationale, the role of the researcher, the pilot study, the population and sampling procedures, as well as the inclusion and exclusion criteria for participant selection.

Once recruitment began, purposeful snowball sampling was used to identify and recruit eligible participants. Participants engaged in semi-structured interviews, which were designed to address the research question. As a gesture of appreciation, each participant received a $30.00 Amazon gift card for their time and contribution to the study. Ethical considerations were strictly followed, ensuring compliance with Walden University's IRB guidelines. Issues related to trustworthiness, credibility, transferability, dependability, and confirmability were carefully addressed to uphold the integrity of the research process.

All semi-structured interviews were manually transcribed, followed by hand-coding and thematic analysis to identify patterns and draw conclusions from the data. Confidentiality was rigorously maintained to protect participants' identities throughout the study. No harm occurred to participants, and they were protected at every stage of the research process. Chapter 4 presents a summary of the study's results, including data collection and data analysis findings.

Chapter 4: Results

The COVID-19 pandemic brought unprecedented challenges to mental health practitioners, many of whom experienced significant professional and emotional strain while providing essential clinical care. The purpose of this generic qualitative study was to better understand how mental health practitioners experienced burnout during that time. The central research question guiding this inquiry asked: What are the experiences of burnout among mental health practitioners rendering clinical care during the COVID-19 pandemic? Through interviews and detailed analysis, this study sought to capture the nuanced realities of these practitioners' experiences and the implications for their well-being and professional practices.

Chapter 4 presented the findings from the study and was organized as follows. First, an overview of the pilot study was provided to establish the preliminary groundwork. Next, the data collection process was described, detailing participant recruitment and interview protocols. The subsequent section focused on data analysis, outlining the steps used to interpret the data. Evidence of trustworthiness was then discussed to demonstrate the study's rigor and validity. The results section highlighted key themes and insights derived from the data, followed by a summary that synthesized the chapter's findings and connected them to the broader purpose of the study.

Pilot Study

The purpose of the pilot study was to assess the interview process and ensure the questions aligned with the study's objectives. I asked a friend, who was not a mental health practitioner, to treat the pilot as an interview and provide feedback on the clarity of

the questions. I conducted the interview over Zoom to observe how the 10 open-ended questions were perceived. This process reinforced my confidence in the effectiveness of the questions and provided valuable insights for enhancing note-taking accuracy and refining probing techniques for further clarification. No modifications were made to the instrumentation or data analysis strategies between the pilot study and the main study. The pilot study was not finalized until I received approval from the Walden IRB.

Setting

For this research, providing a confidential setting was straightforward due to the consent form, which outlined the requirements for ensuring a secure and private environment. The use of videoconferencing software (Zoom) allowed for the verification that each participant was in a safe and confidential space before the interview began. A total of eight participants were interviewed, and each was instructed to remain in a confidential setting for the duration of the session. This structured setup ensured that privacy was maintained throughout the interview. Additionally, organizational conditions were not a factor and did not influence the participants or the results of the study.

Demographics

The study included eight research participants, six of whom were licensed psychologists and two who were licensed marital and family therapists. All participants actively practiced throughout the COVID-19 pandemic and were licensed prior to the year 2020. The sample consisted of seven female participants and one male participant. In terms of racial demographics, three participants identified as African American, and five identified as Caucasian. All participants owned private practices and had different

ages with varying years of experience providing therapy. Despite differences in professional backgrounds and levels of experience, all participants reported experiencing burnout while rendering clinical care during the pandemic.

Data Collection

Data collection involved eight mental health practitioners who shared their experiences of burnout during the COVID-19 pandemic. Among these participants, six were licensed psychologists, five of whom resided in Southern California, while one was based in Northern California. Additionally, two licensed marital and family therapists participated in the study, with one located in New York State and the other in Georgia. The diversity in geographic representation allowed for a more comprehensive exploration of burnout experiences across various professional and regional contexts.

Each interview was conducted only once via the Zoom platform, interviews were recorded, transcribed and saved via Zoom. Each interview lasted approximately one hour, and the data was stored securely on a password encrypted MacBook. Only the researcher and committee chair had access to the documents. After completing the interviews, participants received their transcripts via email. They were given the opportunity to engage in member checking, ensuring the accuracy and credibility of the data by reviewing and validating their transcriptions.

The research study instrument used a ten open-ended semi-structured interview guide, to gather the experiences of burnout among mental health practitioners that rendered clinical care during the Pandemic. The data collection process was initiated after receiving my approval number (02-26-24-0983052) from Walden's IRB on February 26,

2024. Recruitment flyers were distributed through two professional listservs: the LACPA and the SFPA. I shared the recruitment flyer with members of my dissertation cohort to identify potential participants.

There were no major changes or situations encountered in the data collection process outlined in Chapter 3. There were no unusual circumstances encountered in data collection. The procedures adhered to the established protocols, particularly those ensuring trustworthiness and reliability in qualitative research. This systematic approach to data collection provided rich, detailed insights into the experiences of mental health practitioners during a time of unprecedented global challenges, laying the groundwork for subsequent analysis and interpretation.

Data Analysis

My data analysis for this study followed Braun and Clarke's (2006) six-phase framework for thematic analysis, to refine individual codes to subthemes and larger themes. The participants were identified alphanumerically as DHP1-DAP8 for confidentiality. After transcribing the interviews and having them member checked for accuracy, the first step taken was to familiarize myself with the data by reading the interview transcripts several times to become acquainted with the interview responses. The second step was to create preliminary codes by identifying connections within the transcriptions. The coding was prepared by hand and using the NVivo software to store and organize the data. Patterns and phrases were gathered to discover subthemes, and ultimately emergent themes once the subthemes kept repeating.

For the initial endeavor in cycle coding, 67 codes were analyzed. After significant processing, the second cycling coding offered 40 analyzed codes. The codes were condensed according to the relevancy of produced subthemes. Some codes were no longer relevant once subthemes were created. Some sub-themes were aligned with others and were combined. The grouping was helpful in categorizing the codes and placing them in the appropriate subthemes. The 40 codes were grouped into 23 categories, the data were cycled where pattern occurrences became prominent, and emergent themes became clear. Braun and Clark's (2006) fifth step of six-step the thematic analysis was to label and describe the themes and subthemes that presented. The concluding step showcased the final four themes, and five sub-themes to a codebook (Table 1) prepared by using Microsoft Word. No conflicting cases were discovered in the analysis of this study.

Table 1

Codes and Themes

Theme	Subtheme	Category	Codes
1. The Overwhelming Emotional Strain of Providing Care During COVID-19	**A. Enduring the Weight of Stress and Fatigue** **B. Adapting Therapy Modalities and Increased Caseloads**	**1. Ongoing Pandemic Stress** **2. Emotional Strain from Client Dynamics** **3. Burnout and Physical Fatigue** **4. Compounded Stressors** **5. Remote Therapy Struggles** **6. Strain of In-Person Therapy** **7. Positive Shifts Over Time**	Code 1: Stayed open during entire pandemic. Code 2: Clients anxiety about pandemic was draining. Code 3: Not knowing what COVID-19 was and would turn into. Code 4: Emotionally Drained from work during beginning of the pandemic. Code 5: Emotionally Drained from work before pandemic. Code 6: Relief with Vaccines. Code 7: Stressed from working with clients in person during the pandemic. Code 8: Stressed from working remotely with clients during the pandemic. Code 9: Juggling work and family life stress. Code 10: Feeling Burnout. Code 11: Burned out by client's response to the fear of the pandemic. Code 12: Isolating experience. Code 13: Physically tired of being on the screen all day. Code 14: Novelty of dealing with the exact same problem as the client. Code 15: Dealing with everyone's emotions (family, clt's, self). Code 16: Inconvenience of remote therapy. Code 17: Harder to use therapeutic tools. Code 18: Easier to use therapeutic tools. Code 19: Having COVID-19. Code 20: Increased Caseloads. Code 21: Heavy content discussed in session. Code 22: Less Client Cancellations. Code 23: Starting medication to manage stress. Code 24: Physically drained from daily disinfecting of office. Code 25: Lack of boundary adherence by remote clients. Code 26: Political climate of anti-maskers and anti-vaccines.

2. Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures	A. Navigating Professional-Client Dynamics	**1. Emotional Hardening** **2. Variability in Emotional Presence** **3. Friction from Service Modality Changes** **4. Challenges in Empathy and Understanding** **5. Grief and Loss** **6. Jaded Outlook**	• Code 1: More callous towards clients during pandemic. • Code 2: Less callous towards clients during pandemic. • Code 3: Hardened emotionally working during pandemic. • Code 4: Hardened emotionally working before pandemic. • Code 5: Push back from clients for going virtual. • Code 6: Push back from clients for staying in person. • Code 7: Clients were understanding about virtual, not blaming. • Code 8: Jaded about the excessive fear of exposure to COVID. • Code 9: Hard to be as present. • Code 10: More emotionally present. • Code 11: Loss of a loved one during pandemic. • Code 12: Feeling underpaid and taken for granted. • Code 13: Clients assuming I couldn't relate to their experiences. • Code 14: Dealt with emotional problems calmly during the pandemic. • Code 15: Clients were happy being in person during pandemic.
3. Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care	A. Driven by Gratitude and Commitment to Client Well-being	**1. Resilience and Growth** **2. Positive Client Impact** **3. Emotional Gratification** **4. Commitment to Client Care**	• Code 1: Dealt with emotional problems Calmly during pandemic. • Code 2**:** Effectively handled clients fears and problem during pandemic. • Code 3: Positively Influenced other people's lives during pandemic. • Code 4: Convenience of remote therapy. • Code 5: Happy to be Working/grateful to do this work/ energized. • Code 6: Remorse when unable to see clients. • Code 7: Working with having COVID-19. • Code 8. Gained more clinical experience.
4. Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis	A. Fostering Relationships, Achieving Balance, and Envisioning Future Growth	**1. Individual Practices** **2. Environmental Supports** **3. Social Connections** **4. Work Life Balance** **5. Commitment to Growth and Client Care** **6. Early Intervention Advocacy**	• Code 1: Cope with own feelings about COVID-19. • Code 2: Supporting clients during the pandemic. • Code 3: Mindfulness practices. • Code 4: Support from friends/family. • Code 5**:** Social interactions with friends and family. • Code 6: Healthy physical and eating habits. • Code 7: Keeping up with personal medical appointments and care. • Code 8: Breaks in b/w clients. • Code 9: Modified work schedule. • Code 10: Break from motherhood duties. • Code 11: Reading.

• Code 12: Pandemic compounded client's problems.
• Code 13: Importance of not abandoning clients.
• Code 14: Wasn't 100%
• Code 15: Pandemic compounded client's problems.
• Code 16: Calm Personal life
• Code 17: Pets for social support.
• Code 18: The need for more early interventions in mental health.

Evidence of Trustworthiness

Credibility

Credibility in this study was ensured through the implementation of strategies outlined in Chapter 3, with adjustments made as necessary to align with the research process. One primary strategy was member checking, which involved providing participants with their interview transcripts to review for accuracy and completeness. This step allowed participants to verify that their experiences and perspectives were correctly captured, ensuring the findings reflected their voices authentically. Participants were given the option to communicate any corrections or clarifications through phone or email, which helped to maintain open and transparent communication throughout the process. No major adjustments to this strategy were needed, as the method proved effective in confirming the accuracy of the data.

Another strategy to enhance credibility was reflexive self-analysis, facilitated through the use of a research journal. I maintained a daily log to document personal thoughts, biases, and reflections on the data collection and analysis processes. This practice helped me remain aware of potential biases and avoid letting preconceived notions influence the interpretation of findings. Adjustments to this strategy included

increasing the frequency of journal entries during periods of intensive data analysis, ensuring continuous awareness of personal influence on the research. These credibility strategies, member checking and reflexive self-analysis were implemented as planned. Together, they ensured that the findings of this study were authentic, trustworthy, and grounded in the genuine experiences of the participants.

Transferability

Transferability in this study was addressed through the implementation of strategies outlined in Chapter 3, ensuring the findings could be applicable to other similar contexts. A primary strategy was the use of thick description, which involved capturing detailed and nuanced accounts of participants' experiences of burnout during the COVID-19 pandemic. These detailed narratives included not only the practitioners' direct experiences but also the contextual factors, such as the impact of remote therapy, increased client anxiety, and challenges in balancing professional and personal responsibilities. By providing this level of depth, the study created a foundation for readers to determine the applicability of its findings to other populations or settings facing comparable challenges.

I employed snowball sampling to recruit participants, which allowed for the inclusion of diverse perspectives from licensed psychologists and licensed marriage and family therapists across different geographic regions. This approach enriched the dataset by ensuring that the findings captured patterns and variations in burnout experiences across various professional and environmental contexts.

No significant adjustments to transferability strategies were required, as the planned approaches effectively gathered the depth and diversity of data needed. However, an additional emphasis was placed on contextualizing participants' quotes within their professional and personal circumstances during the analysis phase, further enhancing the ability of future researchers and practitioners to apply the findings to similar settings. By adhering to these strategies, the study successfully expanded understanding and created opportunities for its findings to inform other contexts involving mental health practitioners' experiences of burnout.

Dependability

Dependability in this study was ensured through the consistent application of strategies outlined in Chapter 3, with minor adjustments (i.e., follow up questions) to enhance reliability throughout the research process. One key strategy was the use of open-ended questions during interviews. These questions encouraged participants to provide spontaneous, detailed, and unbiased responses, allowing for authentic insights into their experiences of burnout. The flexibility of these questions ensured that the data collected reflected the participants' unique perspectives while maintaining consistency in the topics covered across interviews.

Another strategy to enhance dependability was the use of digital tools for data collection and analysis, including videoconferencing software for interviews, audio recordings, and automated transcription tools. These tools provided an accurate record of the participants' responses, which were further reviewed through manual transcription checks to ensure consistency. Hand-coded notes were used during the analysis phase to

systematically organize and interpret the data, ensuring a structured approach to identifying themes and patterns.

Confidentiality measures were implemented to create a secure and trustworthy environment for participants, encouraging openness in their responses. This included securely storing digital recordings and transcripts and anonymizing participant information throughout the research process. These measures were critical in building trust with participants and ensuring consistent data collection practices. No major adjustments to dependability strategies were required, as the planned methods effectively supported the study's goals. However, the researcher incorporated additional reviews of coded data to verify consistency across themes, further enhancing the study's reliability. By adhering to these strategies and making minor adjustments where necessary, the study ensured that its methods were dependable, and its findings could be trusted as a reliable representation of participants' experiences.

Confirmability

Confirmability in this study was achieved through the implementation of strategies outlined in Chapter 3, with adjustments made to strengthen objectivity and ensure the findings accurately represented the participants' perspectives. A primary strategy involved maintaining detailed and transparent documentation of all research activities, including interview recordings, transcripts, coding notes, and analysis processes. This comprehensive audit trail allowed for independent verification of the findings, demonstrating that the results were grounded in the participants' data rather than the researcher's biases or assumptions.

To further ensure confirmability, I employed reflexive journaling throughout the study. This process involved regularly documenting personal reflections, biases, and decisions related to data interpretation. Reflexive journaling helped the researcher remain aware of and mitigate potential biases, ensuring that the analysis remained centered on participants' authentic experiences. Adjustments included increasing the frequency of journaling during the data coding phase to track emerging insights and ensure transparency in how themes were developed.

Another strategy was participant member checking, where participants reviewed their interview transcripts to confirm accuracy. This step not only enhanced credibility but also reinforced confirmability by validating that the data used for analysis truly reflected participants' narratives. Participants had the opportunity to correct any misinterpretations or inaccuracies, providing an additional layer of assurance that the findings were derived from their input.

Finally, the findings were cross verified by comparing the coded data and emerging themes with raw data to ensure consistency. By maintaining an audit trail, engaging in reflexive practices, and validating data through participant feedback, the study ensured that its findings were objective, transparent, and firmly rooted in the participants' lived experiences. These strategies underscored the study's commitment to producing results that could be independently corroborated and confidently applied in similar research contexts.

Results

The data analysis of this study identified four themes and five sub-themes that emerged from the main research question (Figure 1 and Figure 2). The eight participants were given 10 semi-structured interview questions that explored their experiences of burnout while rendered clinical care during the COVID-19 pandemic. The following themes and subthemes emerged regarding Maslach's (2000) three dimensions of burnout and effective coping strategies utilized by participants.

Table 2

Themes

EMOTIONAL EXHAUSTION	EMOTIONAL DETACHMENT	PROFESSIONAL ACCOMPLISHMENT
Theme 1: The Overwhelming Emotional Strain of Providing Care During the COVID-19 Pandemic.	**Theme 2:** Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures.	**Theme 3:** Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care
Subtheme 1A: Enduring the weight of stress, uncertainty, and relentless physical and emotional fatigue	**Subtheme 2A:** Navigating professional-client dynamics and coping with personal and collective loss	**Subtheme 3A:** Driven by gratitude and fueled by a commitment to client well-being.
Subtheme 1B: Adapting Therapy modalities and increasing caseloads with limited relief in evolving circumstances		

Figure 1

Maslach's Three Dimensions of Burnout

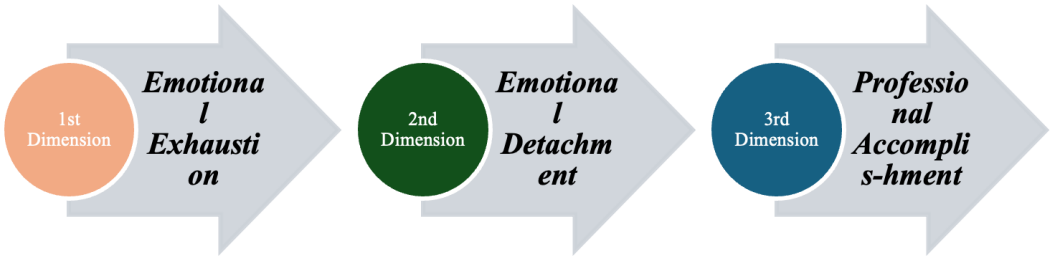

Figure 2

Strategies

Strategies for Addressing Burnout
Theme 4: Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis **Subtheme 4A:** Fostering relationships, achieving balance, and envisioning future growth in mental health care.

Theme 1: The Overwhelming Emotional Exhaustion of Providing Care During the COVID-19 Pandemic

Each participant was currently working in private practice and some had experience working in mental health organizations throughout their career. During the COVID-19 pandemic, many faced unexpected changes that posed significant challenges in adapting to the uncertainty it brought for both their clients and them. Despite varying specialties within clinical practice, all participants reported experiencing overwhelming

emotional exhaustion, which impacted their well-being while providing care to clients. P2 shared the following insight.

> The beginning was the hardest part, like the first, 4 to 6 months was when I felt most drained. I think this is because I like everyone else, had no idea what this was, and what this was going to turn into. I think also kind of being on a screen that was relatively novel, certainly doing it all day. So, I think there was just physical strain as well, you know, just staring at the screen all day, and all of that. I also had to cope with my own feelings about COVID. I have kids, so dealing with, what am I doing with them and them being off for school kind of juggling who's with them at various points. I see a lot of people with a lot of different issues. And for the first time everyone was talking about the same thing.

P7 also shared their experience in reference to feeling emotionally drained working during the pandemic,

> I absolutely did, probably mid to late 2020 going into 2021. It definitely started to weigh heavy just hearing everyone's panic and anxiety intensify during that time. As well as dealing with it in, you know, in your own life. The things that we hear as clinicians are not mirrored in our own lives, but that was definitely a very unique time where everyone, including the clinician was going through the same thing.

P6 shared their experience of feeling emotionally drained from working in the field even prior to the pandemic,

> I also had times when I felt emotionally drained during my work before the pandemic. I really want to make the point this was not unique to the pandemic. This was unique to doing psychotherapy…At KP, you know the demands kept increasing so that I I had to go to work earlier. I had to stay longer to do the kind of therapy that I wanted to do and was taking more and more out of my time and more out of my energy. I was feeling less and less supported, and it's from what I hear, it's just gotten worse, which is really sad.

Other participants noted experiencing burnout due to the challenges of balancing their personal lives while continuously working with patients and navigating the uncertainties of the pandemic. P2 shared,

> I have 3 kids. So, when they were out of school, and I was working, and my husband was working, there was a lot of juggling that I had to do. A lot of dealing with my own emotions, a lot of dealing with my kid's emotions, my husband's emotions, and then my clients, emotions. Then again, all the uncertainty that people were experiencing, and I have expertise right in my field. But I did not in any way have expertise on the pandemic. Even the experts didn't have expertise on the pandemic. So, it was. I felt sort of this alignment with my clients, right? This really shared experience that was special and bonding in a lot of ways, but also, I think it was sort of harder to use my therapeutic tools. I couldn't do any sort of reassurance; you know I was just in it with them.

Subtheme 1A: Enduring the Weight of Stress, Uncertainty, and Relentless Physical and Emotional Exhaustion

Many participants-such as P2, P3 P4, P7, and P8 discussed the constant pressure navigating the unknowns of COVID-19 and highlighted the emotional strain of clients' anxiety, which added to the burnout. Specifically, the ongoing emotional toll from clients' fear and the heavy, often repetitive content of sessions was draining. At the same time, all participants P1 P2, P3, P4, P5, P6, P7 and P8 noted the physical and emotional exhaustion working during the pandemic, the added stress of family life, and/or managing health challenges, such as COVID-19, which intensified their burnout.

P4 shared in reference to feeling burnout from the emotional strains of their client's anxiety,

> Yeah. I mean, I think again, the isolation was an impact on that. I think as I said, I was seeing more clients, and I think you know everyone, not even just the newer ones, but the ones I've been seeing previously, there was just a heightened sense of anxiety. Even it wasn't even if it wasn't you know, pandemic specific, that sort of everything else was sort of charged by that and so I think that there's still a lot more emotional energy going around which I think I felt.

P1 also discussed,

> I think it's very important not to abandon people, you know, especially during a crisis. In part, I think what was really hard for me was that I wasn't that frightened of working, but a lot of clients and patients were scared. So, they had that kind of dynamic where they wanted to come, but like they'd wear the mask, or they'd want

> a social distance, or they'd want hand sanitizer or whatever. And so, their stress, was stressful for me, and then when I was, for instance, doing supervised visitation. The visiting parents were usually cool. The custodial parents were very like, oh, you know, my child can only take off their mask to eat something, and you know we have to get them a booster shot, and it's just like their anxiety was really draining for me. So, I feel like people projected their anxiety onto me and that made me burnt out.

P4 shared their experience of feeling emotionally drained from work during the pandemic,

> Yeah, I mean, it was, I think, you know, adjusting to like the COVID isolation and stuff. Also, I was much busier, busier than I never been at that time, you know, client wise. And so, I think that was a lot and so I would get very tired very easily. And just feel very, you know, exhausted a lot. 2020, and 2021 felt like one day to me all rolled into one. So, it was a very, a very draining process.

P6 also shared,

> Absolutely. I also had times when I felt emotionally drained during my work before the pandemic. I would say, this is not any different from the experience that I had pre and post pandemic. You know that I had before, when I was seeing people in person, depending on how my clients were doing and what the topics we were discussing and depending on how many, how many clients I saw in the day. And that's a big factor you know, I would leave at the end of the day, being really tired.

P8 shared their experience of juggling the multiple stressors of work and family responsibilities noting,

> During the pandemic, of course, the kids were now home schooled, and I work from home. I do virtual therapy and so balancing between, they were teenagers at the time, while they still are but at the time middle school and 1st year of high school. And so middle school, which is already in and of itself, that developmental stages is lot. So, managing him and ensuring that he was on top of his academics and then my daughter, 1st experiencing high school, and not being able to be with her friends and everything. She was fine with her academics, because that's just who she's always been, but the emotional part having to manage that like her losing social net was a lot for her, so managing that. But then, being downstairs and having my own clients I'm managing as well. Then, just you know, family, I'm in Georgia, but most of my family is in New York, and New York was hit pretty significantly. And so, even having to deal with just that personal aspect of it, you know, is everyone okay? And, mom, do you have your mask on? And you're going to the store like, just kind of that hyper vigilance because of what it looked like for them in New York. So yes, emotionally. It was a very taxing time.

Subtheme 1B: Adapting Therapy Modalities and Increasing Caseloads With Limited Relief in Evolving Circumstances

Participants described the shift in therapy modalities during the pandemic as introducing significant challenges. The transition to remote therapy required them to adapt quickly to new technologies, manage an expanded clientele, and overcome barriers to effective communication and therapeutic engagement.

P2 shared their challenges of adjusting to working remotely during the pandemic noting,

> Yeah, so it was the adjustment that was the hardest part for me. Just, I was so used to the in person, kind of the visual cues. You know all of that and so in the beginning it was hard for me to adjust. I saw I found myself looking at the clock, you know, in the corner of the screen, the time. You know, it was like time passed differently, like I noticed time passing in a way that I didn't when I had in person session. So, I think just that adjustment. My eyes hurt in the beginning. I got those like blue ray glasses, right? And then again, I would say, after 4 to 6 months I felt adjusted.

Despite these obstacles, moments of relief emerged for participants as vaccines were introduced, and stricter mandates were lifted that shifted the dynamics of therapy. P4 discussed their decision for choosing to return to in person sessions from being virtual during the pandemic, sharing,

> I was pretty much a hundred percent virtual for the first year and a half, almost 2 years. I would say. After the sort of the mandates cooled off you know, I had a

> couple of clients who really struggled with doing virtual and even a couple who, you know, stopped after a while just because it didn't work for them. And so, I wanted to accommodate some of those folks, and also wanting to get out of the house.

However, for some participants that returned to in person therapy, the heightened disinfecting protocols and extended hours due to the use of PPE continued to contribute to stress and fatigue.

P5 described the physical and emotional toll of managing in-person sessions, including the constant need for disinfecting, which further drained their energy, sharing,

> I would say it was always an underlying worry. In 2020 I turned 59 and I had just had this major surgery (double mastectomy). But with all that I wanted work. I went into this business because I care about children and family. My PCIT clients were struggling. I'll be honest. What was more stressful than meeting in person, although it was that my days were very long. I left an hour in between sessions [to disinfect] and then, at the end of the night there was another whole layer of cleanup, because I [disinfected] in between appointments, I had time to clean up play cars and the doorknobs and some of the toys. So, the days were very, very long, but the phone never stopped ringing. Nobody could find anybody in person. Parents and little kids were just needing help and that was more stressful than anything. Because I just worked as many hours as I physically could.

Meanwhile, P3 reflected on the difficulties of managing increased caseloads during this time.

> I am a private practitioner, in solo practice. So, I do everything. And what I have now come to realize is the fact that, unlike an M.D. I do everything, billing, the administrative part that plays a role in how quickly I'm now starting to feel burnt out. What the pandemic did, once telehealth became way more prevalent. I had never done telehealth before, so the volume went up literally, and I share this with my colleagues. Literally, my practice exploded 5-fold, maybe more than that. So just dealing with the volume dealing with the administrative end of it. It got to be a bit much.

Theme 2: Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures

Participants P1, P2, P3, P4, P5, P6, P7, and P8 discussed how the pandemic posed unprecedented challenges, reshaping their professional identity and emotional engagement. Many experienced shifts in their ability to connect emotionally, oscillating between emotional hardening and moments of heightened presence during sessions. This theme explored how therapists navigated emotional detachment while maintaining their professional responsibilities amidst the pressure of the pandemic. Some participants mentioned balancing personal well-being with the need to support clients often created a tension between emotional callousness and striving for empathetic understanding. P7 shared,

> You know, I probably have become more callous. Now I don't know if my clients would have recognized it, right? But I just knew internally that I'm not connecting on any type of deeper level. Like, I said it was that point where everything started

> to sound the same, right? And not only am I hearing the same thing while I'm on the clock. I'm hearing the same thing when I'm off the clock right? And so, it was just a lot to process, take in, and then at the same time, try to have some type of emotional connection to this right? So, I definitely, I'm sure, was a little bit more callous than usual. Yet towards both clients and myself.

P4 shared their feelings of being more callous to their clients during the pandemic, sharing,

> I mean, I guess if I'm a hundred percent honest, like probably a little. I think it was just the drain sort of like we're talking about. And I think maybe like this is probably like the you know, the unfair part, if you want to call it that that, like all the stuff that's going on, and people are still sort of stuck in a lot of the same issues that they had before [the pandemic] without sort of any sort of appreciation for, you know, the larger picture of what's going on.

Some participants described having a heightened presence during sessions, allowing them to empathize and connect more deeply with clients. For the first time, they were experiencing the same challenges as their clients, creating a sense of a "shared experience." P2 highlighted,

> If anything, I would almost think it's the opposite. Again, like sort of having that shared experience, right? There are times that clients might have shared in the past things with me that you know, I had to work to sort of emphasize, or you know, maybe I thought they were magnifying things. But again, because I thought I was in it with them, you know. Certainly, my clients who are more obsessive or

> more anxious, it was going to be hard on them. Although with some it was kind of the opposite, where it's like they were hyper, vigilant always, so it's sort of like they were more prepared. But I think because I thought of it as a universal experience, like, we're all in this together, so I don't think it made me more callous. I think it made me more understanding and empathetic.

P5 shared having increased empathy and less callousness towards their clientele during the pandemic,

> That's not my typical response to life. There were times where you know, I had to reframe things for myself, so I could continue to be compassionate. I did have increased [empathy], and once in a while the surface level of what clients were saying, I'd say, Are you frigging kidding me? But then for myself, too, you know, I'm checking my counter transference. There were moments where I had to check my counter transference, but for the most part I didn't feel callous.

P8 also shared their experience of maintaining a heightened presence during sessions, striving not to add to their clients' stress,

> I know there was an added pressure to make sure I was always present. I don't know if that means anything. But during COVID I was hyper vigilant on being on time. Maybe it's because how I felt on the other end like if they missed, and I know what that brought up for me, and so wanting to ensure that, like, I was always on time, or I was showing up. Not that I typically didn't. But if there would have been a time where I would kind of send out a message and say, you know, today's not a good day. We're gonna have to reschedule. I was present more

> during COVID, just kind of wanting to ensure that I was there. I think it's just the pressure I was putting on myself to make sure that I'm not adding a stressor to them, on top of what is already going on for them. And a lot of times, not necessarily they're going through COVID related issues, but just know that this may be an added stressor and not wanting to be a part of that story for them.

The variability in participants emotional presence highlighted the complexity of maintaining authenticity and compassion during a pandemic marked by overwhelming stress and uncertainty.

Subtheme 2A: Navigating Professional-Client Dynamics and Coping With Personal and Collective Loss

All participants noted the evolving dynamics between themselves and their clients during the pandemic brought about unique professional challenges. Some participants discussed the service modality changes, such as transitioning to virtual therapy or continuing in-person sessions, were met with pushback from clients on both sides. One participant described experiencing pushback from clients for continuing in-person sessions during the pandemic.

P1 shared,

> I don't think that anyone blamed me for their problems in general. I do feel that some people, umm parents resented my being open and available in person to the other parents because of their fears of COVID. You know people wanting to make sure that the little children kept their masks on for like a 3-hour visit, which I think is sort of umm, what's the word…difficult for lack of a better word. It's

> difficult. Yeah, I mean, they want to eat. They want to drink. They want to hug and kiss their visiting parent. So, it was hard to manage their rules and requests. And I did have people switch to other monitors who were more stringent than I was. And didn't you know allow as much freedom as I did. And enforced the rules more harshly, or didn't do in person visitation during the pandemic? Because they were, they were scared so.

Some participants shared that they received pushback from clients when transitioning to virtual therapy during the pandemic. P2 stated,

> I think maybe some of them were unhappy about having to do virtual. And I did get some pushback on that, especially as sort of things changed right? Because COVID and our understanding of it kind of evolved right over time. And so there were certain people who kind of we're ready to go back as soon as you know, mandates were lifted, and all of that, umm so I did feel like some clients were frustrated that I was no longer seeing people in office, and that continued, because even when people were, even in my group practice, some people were seeing people in office, and I didn't. So, I think there was some frustration and maybe anger on those people's parts. I think maybe some of them were unhappy about having to do virtual. And I did get some pushback on that, especially as sort of things changed right? Because COVID and our understanding of it kind of evolved right over time. And so there were certain people who kind of we're ready to go back as soon as you know, mandates were lifted, and all of that, umm so I did feel like some clients were frustrated that I was no longer seeing people in

> office, and that continued, because even when people were, even in my group practice, some people were seeing people in office, and I didn't. So, I think there was some frustration and maybe anger on those people's parts.

Some participants emphasized that these changes, combined with feelings of being underpaid and underappreciated, further complicated their ability to maintain professional boundaries and emotional balance. P3 shared,

> It’s exhausting, and I think for me a factor is feeling underpaid. Taken for granted and when it comes to getting paid, abused. I used to say, I love my job, and I would do until I dropped dead. I had this vision of just killing over one day, being an old lady in session, you know, and the client having to go process that. That's how much I loved what I did. It’s completely, flipped. and it’s not necessarily the work with the clients, is the whole package…Before COVID, I felt underpaid and abused by the insurance companies, but now it's reached just an unbearable pitch.

P5 shared,

> There is so many people who work so hard during COVID that were overlooked. I'm glad that the medical profession got all the kudos that they got, I remember they went outside at 7 o'clock and bang their pots. But you know the people who worked in the fast-food industry, people who worked in the groceries and therapist, nobody banged their pots for us. Personally, I didn't lose any sleep over it, but yeah, I noticed, that's all.

At the same time, participants reported facing significant personal and collective losses. Grieving the death of loved ones during the pandemic was a reality for some

participants, while others reported becoming jaded by the pervasive fear of exposure to COVID-19. These losses, whether deeply personal or broadly collective, further tested many participants resilience as they worked to support others while managing their own emotional and psychological burden.

P7 shared,

> You just didn't feel the same levels of …you may have like for me, displayed empathy. I use the language of empathy, but I necessarily didn't feel the empathy, because once you've had four patients a day telling you about a loved one that passed away, or a loved one that's in the hospital, you know, and then you get off the phone, and then you have a loved one that's in the hospital. So, the feeling, the feeling of empathy wasn't necessarily there, because unfortunately, it became more of a normal.

P3 shared,

> I think of myself as an HSP (Highly Sensitive Person), and one of the things COVID did, because I'm working out of my personal space and I'm an early riser. I would wake up, put on NPR (National Public Radio) and you're listening to bad news all day long. I read the New York Times online in between clients, that's more bad news all day long. Then I had the Wall Street Journal, they were gifting me with the subscription…So I look at the Wall Street Journal all day long, and I've noticed a deadening between my work and the constant barrage of bad news. So yeah, just a bit hardened.

Theme 3: Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care

Amidst the challenges of the pandemic, every participant found moments of professional fulfillment that reinforced the significance of their work. Many participants attributed these experiences to their ability to adapt to adversity, remain committed to their clients, and find meaning in the positive impact they had on others. P6 stated, “Let me count the ways, I was able to teach webinars to therapists. I had a Zoom consultation group I did individual consultation, and then I saw my clients 3 days a week. And if you're doing a whole lot of successful objective therapy, it sure helps prevent burnout.” This theme highlighted how resilience, gratitude, and dedication to client care enabled participants to navigate the unprecedented pressures of the pandemic while discovering personal and professional satisfaction in their roles. P5 emphasized the importance of not abandoning their clients during a time of widespread uncertainty, finding fulfillment in their ability to positively influence others’ lives.

P5 shared,

> My families that I work with were so happy when we went back to the office. They were just so happy not to have all of that other responsibility. I went into this business because I care about children and family. They were struggling, families were really struggling. And I, being not a technology fan had so much empathy for the kids who were not able to learn off the screen. So, everybody was so sick of the screen. Plus, I'm a feeler and I can't feel through the screen.

Participants reflected on their resilience and growth as they navigated the pandemic's emotional and practical demands. P6 described their ability to effectively handle their clients' fears and problems.

P6 shared,

> For example, in that 1st year the pandemic, when there was no [vaccine], right after there was a vaccine and the vaccine was required for things like going to school. I volunteered to do some pro bono work to help people with needle phobia. And again. All of this was through virtual reality, exposure that was done through remote tele therapy. I want to tell you every single one of those people got their vaccine.

Another participant shared how they approached their own emotional challenges with calm and resilience during the pandemic.

P2 shared,

> Sometimes I felt like fed up and sort of, I would say the thought running through my mind probably was, I can't do this, or how is this like, this isn't possible? That was mostly when my kids were not in school cause it seemed really hard to balance all of that. And then there were times that I, you know, was able to keep my s*** together and to like kind of proceed calmly. So, I probably vacillated between the 2. [Therapy] felt like my turn to be a human and to forget my worries for a bit and go and help my client.

All participants mentioned gaining valuable clinical experience that enhanced their professional skills. Finding a sense of purpose and accomplishment that reinforced

their commitment to their work and strengthened their sense of professional identity. P7 shared,

> Before the pandemic I was only licensed in Georgia. During the height of the pandemic, they lifted a lot of the restrictions for cross state. So, I started working in New York and New Jersey and a couple of other places taking on clients there and which led to me then becoming licensed in New York. So, the amount of couples increasing but I also think it's the content, right? Because that forced you as a clinician, to take on way more than what you usually take on. So, I went from being a couple's therapist to a grief counselor and grief is not one of my chosen. It's not fun for me, but in a situation like the pandemic, when everybody was dealing with grief you couldn't pass those along, because it was the next client was coming right along for. So, it forced you to kind of step outside of your box as a clinician and take on these things that you would normally turn away from.

Subtheme 3A: Driven by Gratitude and Fueled by a Commitment to Client Well-Being

Gratitude and motivation emerged as powerful motivators for participants during the pandemic. Despite the overwhelming challenges, many participants expressed a deep appreciation for their ability to work in such a meaningful capacity.

P6 acknowledged, "I could leave at the end of the day, being tired. I also had the exact opposite experience of feeling exhilarated. I mean, more than satisfied just thrilled, and you know, happy and grateful be to be doing this work." P6 further shared how

having successful therapeutic moments with their clients reinforced their commitment to client care stating. P6 shared,

> Well, if my sell-by date is sooner than I thought it would be, what do I want to leave behind. So that's when I wrote the Therapist Manual on using virtual reality to treat anxiety disorders and gave a lot of webinars. And really, you know, sort of thought about what's important. And treating clients, having people get over their phobias preying on their lives, was just, it's just so meaningful.

Some participants reported feeling motivated and obliged to continue supporting their clients, even while managing personal difficulties such as illness or limitations in client access. P1 shared,

> I felt really bad when I couldn't show up for my clients when I was sick. I think that weighed heavily on me. When I was on quarantine, I was not allowed to leave my house and so during that period I did not. Later they loosened the restrictions on quarantine and the amount of time and duration, and so forth. And I did go to work sick, and we all wore masks and stuff, but I wanted to return as soon as possible and not leave patients hanging. I think it’s very important not to abandon people, you know, especially during a crisis.

Participants also shared a profound sense of commitment to client care, often working through personal hardships to ensure their clients felt supported. P2 shared,

> So, it was this hardship, this hard time, this time of uncertainty. And again, was I 100% as a therapist? Maybe not, because maybe it was hard for anyone to be 100% a therapist, right. And so that's why, especially at the beginning. I say, it

> was hard to feel like I was at 100%. So, you know, because I think it was just hard to be, at anyone's best. I would venture to guess right? But you know it's like at some point I think I realized, like just showing up and being there and being constant in people's lives and doing the best I can do what I have always done. That's all I can do, and I think it serves the client, and it serves me so it's kind of like everybody wins in this really trying time.

P5 candidly shared that during the pandemic, there were times when they were not at their 100% but still gave their best in sessions, "But if I had to rate what I felt I gave the [clients], you know, it would be like a B-minus or a C. I don't know what else to tell you."

Theme 4: Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis

The participants reported the COVID-19 pandemic posed unprecedented challenges, many were not only managing the emotional weight of their clients but also grappling with their own personal and professional stressors. To navigate this complex landscape, all participants developed and relied on adaptive strategies to manage burnout. This theme explored the various ways therapists prioritized their well-being through personal resilience and environmental supports. By adopting these strategies, participants P1, P2, P3, P4, P6, and P8 were able to care for others while preserving their own mental health and stability during a global crisis. They achieved this by incorporating individual practices such as mindfulness, maintaining healthy physical and eating habits, and engaging in restorative activities like reading.

P3 shared,

So, the self-care consisted of the 2-hour [lunch] break when possible. Definitely exercise every day, but that's been, you know, how I've been since I was an adult. So that wasn't an add-on that's always been my practice. I have been a yoga practitioner since 1993. So, it was a transition doing that at home it's not the same but doing that every day. I've always been a sleeper; I'm blessed I've never really struggled with insomnia so definitely trying to get 8 hours every night and eating well.

P2 shared, "Let's see what else? Meditation, I did a meditation sometimes. What else helped me cope was reading. I'm a big reader. I like reading, so that helped me cope." P6 also shared their enjoyment of reading as a self-care strategy for coping during the pandemic stating, "I would, I would read relaxing novels in the evening where everything worked out in the end. I read happy ending books."

P4 also shared,

> It took me a while before I was doing it, probably in the best manner. But you know, after a while I really made it a point to go, for you know at least a 20 min walk every day. Stop eating out as much as I was. So yeah, I developed some healthier habits.

These practices helped many participants foster a sense of balance and emotional grounding during an otherwise overwhelming period. Additionally, some participants described how their ability to maintain personal routines contributed to their resilience, enabling them to cope with the challenges of both their professional and personal lives.

P8, shared,

> I think myself curious. Just always been, you know, COVID or not, there's just certain practices that I have just being in the helping profession. You have to take care of yourself. Right? And so, I don't think COVID made it any different. The same meditation practices I have in the morning prayer. My spirituality, you know just those things that give me strength. I didn't change it. I maintained them during COVID, I definitely did not neglect them, because it wouldn't be the right time to do that at all.

P3 also shared,

> Yes, I felt we were overtaxed. I felt like I would finish the day, and I had to make all those calls, but because of my personal life being very I say it as a joke, but it's not a joke, it's boring, and I love it. I have a child, and I have an ex-spouse, and I know what it was like during those years. I would think to myself, could I do what I do if I were still actively involved in the marriage and parenting? H-E-L-L no, but we rise to the occasion. What helped me was, after I finished the full day and returned the calls and took my notes and responded to emails and did the billing and contemplated my next fight to get paid. After all of that I could then sit down with a cup of tea or something stronger and have silence. I'm an introvert, so that's what I need. So, then I could go to bed when I wanted to, in peace.

Environmental supports also played a crucial role in sustaining some participants well-being during the pandemic. Pets emerged as a significant source of social support, offering comfort and companionship amid isolation. P3 shared, “I have a cat who I enjoyed a lot. So, my cat provided company.”

P1 also shared,

> Something that was very hard and did cause me a lot of distress was I lost 2 pets during the pandemic a year and a half apart. I lost my 16-year-old dog in 2021 to Lymphoma, and then in 2022, I lost my dog, who was my therapy dog. I did animal assisted therapy with her, I lost her when she was 14, to inflammatory bowel disease, and that, was very hard for me. And I do think the fact that it happened during the pandemic, when there was so much isolation, and I couldn't find like a pet lost support group, or a therapist, or anything for myself, was very painful.

Subtheme 4A: Fostering Relationships, Achieving Balance, and Envisioning Future Growth in Mental Health Care

During the pandemic, participants P1, P2, P4, P5, P6, P7 and P8 relied on a combination of interpersonal support, intentional work-life balance, and forward-looking advocacy to manage the demands of their roles and foster resilience. These strategies not only helped many participants navigate the immediate challenges of the global crisis but also inspired reflections on future mental health practices. Interpersonal support played a vital role in sustaining many participants through the pandemic's emotional strain. Some participants shared how connections with friends served as a vital source of support during illness in a time of widespread isolation.

P1 shared,

> When I was really sick, I did stay home and take care of myself and sleep and at the time I had a number of roommates who helped me by going grocery shopping for

> me and cooking for me and bringing me food and umm taking care of my pets because I was really out of it. And so, I had assistance from, you know, trusted friends and roommates and umm I took the time off when I knew I was too sick to work.

Other participants discussed support and social interactions with loved ones offered them opportunities to recharge emotionally, reinforcing the importance of maintaining meaningful relationships while navigating professional responsibilities.

P5 shared,

> My husband is a saint. I have to tell you that was really helpful for me to have him at home for a lot of reasons. One was he worked a little bit less and as long as he was available on the phone he could do all the shopping and everything. So, we sort of worked out that since I was in person all day long. I was using up all my risk quotient if there was such a thing. So, at that point he took up a lot of the shopping and errand running so I didn't have to do all that which was awesome because I didn't like any of that before all of this. I mean I did it, but I don't want to be in the store with all these people knocking each other over to get toilet paper like that is not my scene. So, I was very fortunate in that respect.

P8 shared,

> My support system, just, I think as far as village is concerned, like family, we became even closer. Obviously, during that time and so even using them as outlets where I need to vent or where things are not making sense, or I need to stop

thinking about clients or work, just having like that time, that social time to get away, and it not be serious or worrying.

Participants highlighted balancing work and personal life as an essential strategy for managing stress and maintaining energy. Some implemented measures such as limiting the expansion of their client load, adjusting their workspaces, and intentionally making time for clients while navigating the demands of motherhood.

P6 shared,

Well, I had set limits, and in solo private practice I had the authority to set limits. Now I had to wrestle with myself that just because someone called me didn't mean that I had to put them in my caseload. So, I had to practice you know, saying no, and saying, you know I don't have openings right now. But that was one of my copings [strategies], you know.

P4 shared,

I developed some healthier habits. One of them, which I think I was talking about in terms of like the whole adapting to doing virtual was, you know instead of just doing everything on my couch like doing therapy there, watching TV there, you know. I moved my workspace to the kitchen table and that was specifically for my workspace. So that made a difference when I would then go back to hang out at the end of the day, it felt like there was more of a transition.

P2 shared,

Okay. So again, strange as it seems seeing my clients was one of my methods for coping. Cause I needed to not just be a mom all the time, and not just sort of help

> with homework, and, you know, get them on their zoom and arrange lunch. And I, you know, feel very productive when I work, and so that helps me to you know, kind of helps me to be my own independent person. So that was one coping [method].

All these adjustments created space for the participants to focus on self-care while still maintaining their commitment to client care. Despite not always feeling at their best, participants emphasized their dedication to providing support, even as the pandemic compounded their own issues.

P7 shared,

> Yeah, I came down with COVID myself, and I found myself still trying to see clients in the midst. I didn't have an asymptom case of COVID. I had bad COVID like, almost put in hospital COVID. So, I was forced again, to kind of step away because I could barely get through a session. So, it just really put a spotlight on how much I needed it and so what I began doing is two things. One I got back into my routine of some morning daily self-care. So, I wouldn't see clients prior to a certain time in the morning because that would be my time where I could focus on pouring into myself.

Some participants looked forward and reflected on the importance of advocating for early interventions in mental health care. The pandemic underscored the urgency of addressing mental health challenges proactively, inspiring participants to envision practices that prioritize prevention and timely payment from insurance companies.

P5 shared,

> I don't know whose job it is, but our attitudes about mental health as a society need to change. We need to have more early intervention. Insurance companies, I don't know if it was intentional or not, but my experience is chronically being bullied. Even when they're nice because they don't know the answer, and then they send you to someone else who doesn't answer, and they send you to someone else who doesn't know the answer. And then, when you say you know your rate of payment is kind of low to begin with, now it's spending 3 hours on the phone trying to get an answer. So, you're paying me a $125 an hour of therapy but I spent 4 hours, and I haven't even written a note. I got a PhD and I'm making what $15 an hour, people are not getting paid. I mean when you do the math right? It's all a friggin mess. No one's gonna be taking insurance for mental health less and less and less because it is such torture.

Summary

Regarding the experiences of burnout among mental health practitioners, the findings revealed participants cycled through three dimensions of burnout and implemented necessary coping strategies to mitigate the effects of burnout while rendering clinical care during the COVID-19 pandemic. The first dimension was overwhelming emotional exhaustion with all participants describing feelings of emotional strain due to the uncertainty surrounding COVID-19, the increased anxiety in their clients, and the challenges of balancing work and family responsibilities. P2, P3, P4, P5, P6, P7, P8 discussed experiencing physical and mental manifestation of burnout, particularly as they adapted to remote therapy modalities and dealt with higher caseloads.

The second dimension of emotional detachment and professional identity emerged as participants described adopting emotional detachment or callousness to cope with overwhelming stress, while others reported minimal difficulty in maintaining emotional engagement with clients. P2, P7, and P8 shared experiences of burnout, feeling as though they were on autopilot, and occasionally struggling to remain fully present during sessions. While P5, P6, and P8 described their ability to remain emotionally present and connected while managing to avoid becoming overwhelmed by the emotional demands of their work. The third dimension was professional accomplishment through resilience and commitment to care highlighted moments of resilience and a renewed sense of purpose in their work. P1, P2, P3, P5, P6, and P8 expressed fulfillment from helping clients navigate crises and from observing their clients' progress during a difficult time. This sense of professional growth was essential in balancing the emotional toll of burnout.

The final theme, while unrelated to the three dimensions of burnout, focused on coping strategies that helped participants stay grounded and prevent burnout. All participants highlighted diverse approaches to manage burnout, including mindfulness practices, maintaining physical health routines, and seeking support from family and friends. Additionally, many participants adjusted their work schedules and established boundaries to safeguard their work-life balance and overall mental well-being.

Findings indicated all eight participants believed they experienced the multi-dimensional nature of burnout during the pandemic, and employed coping strategies that helped them manage these difficulties. All participants indicated that while burnout was a

widespread experience, moments of accomplishment and effective coping strategies allowed them to continue their work and find meaning in their professional roles. Four participants P3, P4, P5, P7 emphasized the importance of comprehensive support systems to help mental health professionals manage burnout during future crises. They highlighted strategies such as early intervention measures, simplifying processes for timely insurance reimbursements, and leveraging the flexibility of private practice that allows for breaks between client sessions compared to community mental health clinics.

Chapter 4 comprised of an overview of the demographics, research setting, data analysis, data collection, evidence of trustworthiness, results, and summary. Chapter 5 discussed findings in relation to the existing literature on burnout among mental health practitioners. Then explored how the results aligned with and expanded upon previous research, identified areas where the study offered new insights or confirmed existing theories. The implications of these findings for clinical practice were be explored, the limitations were be acknowledged, and suggestions for future research was provided to better address burnout and improve overall well-being during times of crisis.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative research study was to explore how mental health practitioners experienced burnout while providing clinical care during the COVID-19 pandemic. Due to the recency of the pandemic, limited research had been conducted on the burnout experiences of mental health practitioners during this time. This study focused on the burnout experiences of eight mental health practitioners who rendered clinical care throughout the pandemic. Data was collected through in-depth, semi-structured interviews conducted via the Zoom videoconferencing platform. A generic qualitative approach was employed to document, analyze, and better understand the burnout experiences of these practitioners.

The results from the eight semi-structured interviews revealed that burnout was characterized by overlapping key dimensions and highlighted the importance of coping strategies to mitigate its detrimental effects. The findings brought attention to significant challenges faced by solo-operated private practices. The remainder of Chapter 5 discussed the study's findings in relation to the literature reviewed in Chapter 2, as well as the study's limitations, recommendations for future research, implications for social change, and conclusion. The themes that emerged from a deeper understanding of the experiences of burnout during the pandemic included the following:

Theme 1: The Overwhelming Emotional Strain of Providing Care During the COVID-19 Pandemic

Subtheme 1A: Enduring the weight of stress, uncertainty, and relentless physical and emotional fatigue.

Subtheme 1B: Adapting Therapy modalities and increasing caseloads with limited relief in evolving circumstances.

Theme 2: Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures

Subtheme 2A: Navigating Professional-Client Dynamics and Coping with Personal and Collective Loss

Theme 3: Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care

Subtheme 3A: Driven by gratitude and fueled by a commitment to client well-being.

Theme 4: Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis

Subtheme 4A: Fostering relationships, achieving balance, and envisioning future growth in mental health care.

Interpretation of the Findings

Chapter 2 outlined that, prior to COVID-19, research had already established a strong link between burnout and outcomes such as emotional exhaustion, detachment, and a sense of ineffectiveness among mental health practitioners (Clay, 2018). However, studies comparing burnout levels before and during COVID-19 revealed a statistically significant 37% increase in self-reported burnout during the pandemic (Sampaio et al., 2021). The findings of this study confirmed that practitioners' experiences of burnout were exacerbated by the pandemic, which impacted both their ability to provide care for

their clients and their own well-being. The study's results were organized into four themes and five subthemes, which emerged from the analysis of the semi-structured interviews.

Theme 1: The Overwhelming Emotional Strain of Providing Care During the COVID-19 Pandemic

The first finding highlighted the profound emotional exhaustion experienced by participants as they navigated the uncertainties of the pandemic while balancing personal and professional responsibilities. Participants, all of whom worked in private practice reported experiencing significant emotional exhaustion that negatively impacted their well-being. A shared challenge was adapting to the sudden and unpredictable changes brought by the pandemic, including transitioning to virtual care, increased caseloads, managing personal anxieties about COVID-19, and addressing the collective trauma faced by their clients. P2 vividly described the strain of the initial months, which were marked by heightened uncertainty, screen fatigue from prolonged virtual sessions, and the added stress of juggling professional duties with personal responsibilities, such as caring for children during school closures. Participants P2, P4, P5, and P7 also noted a sense of alignment with their clients, as both practitioners and clients grappled with the shared experience of navigating a global crisis. While this created a unique bond, it also diminished the effectiveness of traditional therapeutic tools, such as offering reassurance, due to the universal uncertainty surrounding the pandemic. This dual burden of managing their own emotions while supporting others compounded their experience of burnout.

This research aligned with and built upon previous studies that examined burnout among mental health practitioners. Particularly, the impact of job demands and client outcomes on emotional exhaustion the first dimension of burnout (Maslach, 2000). Gibson et al. (2009) confirmed the critical role of these factors in burnout development, reinforcing this study's findings on the significant burden practitioners face. Similarly, Steel et al. (2015) provided further validation by demonstrating the strong relationship between both the physical (e.g., workload, hours worked) and psychological (e.g., empathizing with clients) demands of practitioner work and emotional exhaustion. Singh et al. (2023) expanded upon this research by highlighting how the COVID-19 pandemic intensified these challenges, with practitioners experiencing a dramatic increase in caseloads after the first national lockdown. Likewise, APA (2022) reported a continued rise in practitioners' caseloads from 31% in 2020 to 38% in 2022, confirming this study's conclusion that growing workload demands directly contribute to heightened burnout levels. These findings collectively support and extend this research by demonstrating how increasing job demands exacerbate emotional exhaustion, particularly in the context of rising mental health service needs.

Hammond et al. (2018) confirmed and expanded upon the findings of this research by identifying countertransference as a significant psychological demand contributing to burnout among practitioners in independent practice. Their study reinforced the role of countertransference-based emotions and attitudes as precursors to burnout, aligning with this research's focus on emotional exhaustion. Their findings supported this study's conclusion that frequent and intense emotional reactions,

particularly when working with complex clients, deplete practitioners' internal resources over time, increasing their vulnerability to burnout. This research further builds upon prior studies by demonstrating how the pandemic exacerbated these effects, intensifying emotional strain and job demands beyond pre-pandemic conditions. The increased caseloads and emotional burdens faced by practitioners during the pandemic compounded the challenges already identified in previous studies, further validating the connection between heightened job demands and burnout.

Subtheme 1A: Enduring the Weight of Stress, Uncertainty, and Relentless Physical and Emotional Exhaustion

The first subtheme, enduring the weight of stress, uncertainty, and relentless physical and emotional fatigue, illustrated how participants' emotional exhaustion stemmed from the sustained stress and uncertainty of the COVID-19 pandemic, compounded by physical and emotional fatigue. Participants frequently described the pressure of navigating the unknowns of the pandemic alongside the emotional strain of managing clients' heightened anxiety. P1 stated that clients often projected their anxiety onto them, which intensified their emotional strain. Managing clients' heightened concerns about social distancing, mask-wearing, and other pandemic precautions further added to their stress.

Physical fatigue also played a significant role, as participants recounted long working hours, family demands, and health challenges such as dealing with COVID-19, all of which exacerbated their exhaustion. P5 reported the overwhelming demand for in-person therapy during a time when resources were limited, which led to working as many

hours as physically possible. Ultimately, the relentless stress and overlapping demands of professional and personal life during the pandemic significantly contributed to participants' experiences of burnout.

This study confirmed and built upon past findings, such as Sexton et al. (2022), which reported an increase in emotional exhaustion among mental health practitioners from 34% in 2019 to 39% during 2021–2022. By examining the unique challenges practitioners faced during the pandemic, this research advanced the understanding of burnout beyond prior studies. Consistent with Maslach's (2000) conceptualization of burnout, this study reinforced Sexton et al.'s (2022) findings by highlighting practitioners' struggles with remote work demands, uncertainty around resources, and vaccine availability. Additionally, this research expanded on previous work by identifying the compounding effects of emotionally heavy and repetitive session content, as well as the challenges of balancing work, family responsibilities, and personal health. These findings further validated and extended existing literature by demonstrating how these intersecting stressors left practitioners profoundly depleted, exacerbating burnout beyond previously documented levels.

Subtheme 1B: Adapting Therapy Modalities and Increasing Caseloads with Limited Relief in Evolving Circumstances

The second subtheme, adapting therapy modalities and increasing caseloads with limited relief in evolving circumstances highlighted the significant challenges participants faced as they adapted to new therapy modalities during the pandemic. The transition to remote therapy required participants to quickly adjust to new technologies,

manage larger client volumes, and navigate barriers to effective communication and therapeutic engagement. P2 specifically mentioned the difficulty of adjusting to virtual therapy, as they were accustomed to in-person sessions and relied on visual cues for engagement.

While some participants initially struggled with the transition to virtual therapy, many embraced it and chose not to return to in-person sessions, viewing it as the new norm. They highlighted the convenience and ability to build rapport once they adapted to the format, including focusing more on visual cues through the screen. P7 noted that although they initially valued the connection of in-person sessions, transitioning to 100% virtual during the pandemic demonstrated that the quality of connections remained intact and provided greater flexibility for clients.

Participants discussed the obstacles and moments of relief experienced as vaccines were introduced. The easing of restrictions allowed some participants to return to in-person sessions, offering a sense of normalcy. However, additional challenges emerged for participants working in person during the pandemic, such as heightened disinfecting protocols and extended hours due to PPE use, which contributed to their burnout. P5 described the physical and emotional toll of managing in-person sessions, particularly the constant need for disinfecting, which further drained their energy.

P3 expanded on the overwhelming increase in caseloads during the pandemic. As a solo practitioner, P3 felt the burden of managing all aspects of their practice, including billing and administrative tasks. They noted that the shift to telehealth significantly expanded their client volume, which grew five-fold.

This study confirmed and expanded upon past research, such as Sampaio et al. (2021), which examined the dramatic shift in mental health practitioners' use of telepsychology before and during COVID-19. While only 39% of practitioners had used telepsychology before the pandemic, 98% reported utilizing various telecommunication technologies during the pandemic to reach quarantined patients. These findings aligned with and reinforced this study's conclusions regarding the widespread transition to remote therapy. This research advanced the understanding of the challenges associated with providing telehealth services, corroborating APA's (2020) findings on barriers such as internet connectivity issues, technical difficulties, and privacy concerns.

Beyond confirming these logistical challenges, this study further contributed to the literature by demonstrating the increased burden practitioners faced in managing their practice, as the shift to telehealth significantly expanded their client volume. Goff (2022) similarly found that practitioners felt an expectation to not only maintain their existing workload but also accommodate additional clients while balancing other professional responsibilities. This study built upon these findings by exploring the emotional and professional strain caused by this increased demand, particularly its role in exacerbating burnout.

The subtheme expanded upon prior studies by examining practitioners' perspectives on the advantages and disadvantages of remote therapy. While some mental health professionals found telehealth more challenging than in-person sessions, this study introduced new insights by confirming that many participants—six out of eight—found virtual therapy more convenient. Participants cited benefits such as eliminating constant

disinfecting protocols and reducing potential exposure to COVID-19. Additionally, many reported that the same level of therapeutic connection could often be achieved virtually as in person. However, despite these advantages, the substantial increase in caseloads, combined with administrative demands and the adaptation of therapy modalities, placed immense strain on practitioners. This study built upon existing research by illustrating how these intersecting stressors intensified emotional exhaustion and significantly contributed to practitioner burnout, further emphasizing the long-term impact of the pandemic on mental health professionals.

Theme 2: Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures

The second finding highlighted how the pandemic reshaped many participants' professional identity and emotional engagement with clients. Many described navigating shifts in their ability to connect emotionally, oscillating between emotional detachment and moments of heightened empathy. P7, acknowledged experiencing emotional hardening, as the repetitive and overwhelming nature of their clients' concerns mirrored their own struggles. This detachment often extended to both their clients and themselves, creating an internal tension between emotional callousness and maintaining empathetic understanding. Two (P3 and P7) out of eight participants mentioned they had become emotionally hardened at a point in time while working throughout the pandemic.

Conversely, other participants, found a heightened emotional presence during sessions. They described a sense of shared experience with clients, which deepened their ability to empathize. For P2, recognizing the uniqueness of the shared experience of

going through the same emotional reaction to the pandemic as their clientele. The notion of being in it together, made them less callous and more understanding and empathetic. P5 mentioned there were moments where they had to check their counter transference, but for the most part they didn't feel callous, instead they had increased empathy for clients.

This study confirmed and expanded upon prior research by examining how participants navigated Maslach's (2000) second dimension of burnout-emotional detachment and redefined their professional identity amidst the pressures of the pandemic. These findings supported Singh et al.'s (2023) research, which highlighted the adverse psychological impact of pandemic-related challenges on mental health practitioners, often resulting in emotional detachment from clients as a symptom of burnout. Similarly, Sampaio et al. (2021) confirmed that a high percentage of practitioners and their clients were in crisis during the pandemic, struggling with isolation-related difficulties, fears, and anxieties brought on by COVID-19. The present study aligned with these findings by revealing how participants' experiences of depersonalization were exacerbated by the pandemic. Many practitioners found it difficult to maintain psychological boundaries from their clients' experiences, as they were often grappling with the same fears and uncertainties themselves.

Beyond confirming these patterns, this study also contributed new insights into the emotional complexities practitioners faced. Participants described how the shared experience of confronting similar challenges as their clients deepened their empathy and strengthened interpersonal connections. While Goff (2022) argued that the shift from in-

person therapy to virtual modalities led to a loss of personal connection between practitioners and clients—citing difficulties in active listening and understanding clients' perspectives—this study offered a contrasting perspective. Findings indicated that despite the shift in modality, participants were able to maintain and, in some cases, even enhance their personal connections with clients. This was largely attributed to the shared experience of navigating the pandemic's uncertainties, which fostered a deeper sense of connection and empathy.

This study expanded on previous research by illustrating the varied emotional responses among practitioners, emphasizing the complexities of maintaining authenticity, compassion, and professional responsibility during an unprecedented period of stress. While most participants reported an increased emotional presence in sessions, a few acknowledged becoming more callous toward clients during the pandemic. These findings underscored the delicate balance practitioners sought between prioritizing their own well-being and providing support to their clients, with the pressures of the pandemic significantly contributing to both emotional detachment and burnout. By capturing these nuanced emotional responses, this study built upon existing literature, offering a more comprehensive understanding of how practitioners adapted to the evolving demands of their profession during a global crisis.

Subtheme 2A: Navigating Professional-Client Dynamics and Coping with Personal and Collective Loss

The second subtheme went into further detail of how participants navigated client dynamics and coped with personal loss. All participants highlighted the professional

challenges brought on by the pandemic, including adapting therapy modalities and managing heightened client demand. Five (P2, P3, P4, P7, P8,) out of 8 participants reported receiving pushback from their clints for transitioning to virtual therapy and not resuming in person therapy. Many participants cited COVID-19 safety concerns for not resuming in-person sessions. Participants that resumed in person session after some of the restrictions eased were also met with pushback from clients that wanted to be seen virtually. P1 noted client dissatisfaction with their in-person flexibility during visitation sessions, citing difficulties managing strict COVID-19 protocols while maintaining therapeutic rapport.

This theme also went into detail of how participants navigated professional dynamics, as some participants shared feelings of being underappreciated and underpaid, which exacerbated the emotional and professional strain. P5 expressed appreciation for the recognition given to the medical profession during COVID-19 but felt that mental health practitioners, despite their hard work, were overlooked and taken for granted. This lack of recognition, combined with systemic challenges such as inadequate compensation and frustrations with insurance processes, contributed to participants' disillusionment and emotional exhaustion.

All participants experienced personal and collective losses, including grieving loved ones or navigating the constant fear of COVID-19 exposure. These challenges profoundly tested their resilience, with some describing an emotional hardening caused by repeated exposure to client trauma, compounded by their own grief and pandemic fatigue. P4 shared the personal loss of their mother during the pandemic, while P7

reflected on the relentless cycle of hearing clients discuss the loss or hospitalization of loved ones, only to face similar situations with their own family members. This ongoing exposure to distressing news further exacerbated feelings of emotional detachment and burnout among participants.

The subtheme confirmed previous research by highlighting the compounded challenges practitioners faced due to increasingly complex client concerns, the navigation of telehealth practices, ethical obligations, and personal experiences related to COVID-19 (Cullen et al., 2020). Consistent with Litam et al. (2021), my study found that work-related stressors were significant predictors of burnout, reinforcing findings from Maslach et al. (2001) that identified job demands as central contributors to emotional exhaustion.

This subtheme aligned with the work of Jeppson (2021) and Liberati (2021), whose research focused on the experiences and well-being of healthcare workers during the COVID-19 pandemic, including physicians, nurses, and physical therapists. Both studies noted that research on burnout among mental health practitioners during the pandemic was relatively sparse. My findings built upon this gap in the literature by specifically addressing the experiences of mental health practitioners, providing a more detailed examination of their unique challenges.

Liberati et al. (2021) found that many healthcare practitioners, including mental health professionals, experienced significant feelings of grief, distress, and burnout due to the demands of their work during the pandemic, which mirrored the findings in my study. My research confirmed these findings, showing how mental health practitioners struggled

with multiple adversities such as navigating increased client caseloads and managing the emotional toll of remote therapy that significantly impacted their well-being.

Despite these challenges, participants in my study, similar to those in Liberati et al. (2021), demonstrated resilience by continuing to navigate the complexities of their roles. They worked to balance their personal well-being with the demands of supporting their clients, illustrating the ongoing efforts of mental health practitioners to maintain professional responsibility in the face of unprecedented stress. This study builds upon the existing literature by specifically highlighting the burnout experiences of mental health practitioners during the pandemic and contributing a more nuanced understanding of the challenges they faced.

Theme 3: Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care

The study's third finding related to how participants found moments of fulfillment amidst the pandemic's challenges. Many participants attributed these moments to their resilience, ability to adapt, and commitment to their clients. One participant highlighted their ability to find fulfillment through varied professional activities. P6 shared that their ability to teach webinars, lead a Zoom consultation group, provide individual consultations, and see clients 3 days a week contributed to their professional fulfillment. Another participant described the internal struggle of managing personal challenges while maintaining professional responsibilities. P2 remarked, fluctuating between feeling overwhelmed and staying calm, especially when balancing work and parenting during

school closures. They found therapy sessions to be a reprieve, allowing them to focus on helping clients and momentarily set aside their own challenges.

Some participants explained how the pandemic pushed them to expand their skills, taking on new challenges and working beyond their usual clinical boundaries. P7 said how pandemic-driven changes allowed them to expand their practice across multiple states and a significant increase in couples' therapy clients. The pandemic also compelled them to address grief counseling, an area outside their usual focus, due to the overwhelming need as clients faced widespread loss, pushing them to step out of their comfort zone as a clinician, adapting to challenges they would typically avoid.

Past research by Mittal et al. (2023) was confirmed by this study, as many practitioners reported experiencing resilience and a sense of meaning while working during COVID-19. They described being mental health practitioners during the pandemic as both a difficult and rewarding experience. My research expanded on Mittal et al.'s (2023) findings by providing a deeper exploration of how practitioners found their roles gratifying, instilling a sense of pride and personal accomplishment as they helped clients navigate such a stressful time. This study built upon Mittal et al.'s work by emphasizing how practitioners not only maintained their commitment to their clients but also derived a sense of meaning from their ability to offer support during a global crisis.

Rosenberg and Pace (2006) found that practitioners in the private sector reported greater feelings of personal accomplishment compared to those in the medical and academic sectors, attributing this to the higher level of autonomy in private practice. My study confirmed these findings, as participants consistently highlighted the role of

autonomy in fostering a sense of professional fulfillment. The ability to set their own schedules, choose their clientele, and implement personalized therapeutic approaches contributed to their resilience and overall job satisfaction. Additionally, my research expanded upon Rosenberg and Pace's (2006) work by illustrating how autonomy served as both a protective factor against burnout and a source of motivation during the pandemic. Despite the increased caseloads and emotional exhaustion, participants expressed that their ability to maintain control over their practice helped them sustain a sense of purpose and accomplishment amidst the heightened challenges.

Mittal et al. (2023) noted a "two sides of the same coin" effect, where practitioners recognized both the positive and negative aspects of being second-line workers during the pandemic. This theme was mirrored in the current study, as participants acknowledged the overwhelming challenges they faced such as burnout but also expressed deep appreciation for the opportunity to work in such a meaningful capacity. The findings in my research provided further insight into how practitioners navigated the duality of these experiences, highlighting the complexities of maintaining resilience and a sense of purpose in the face of adversity.

Subtheme 3A: Driven by Gratitude and Fueled by a Commitment to Client Well-Being

The third subtheme's findings revealed that gratitude and motivation emerged as key drivers for participants during the pandemic. Despite the overwhelming challenges, many participants expressed a deep appreciation for their ability to work in such a meaningful capacity. Some participants shared the emotional weight they carried when

personal health issues prevented them from supporting their clients. P1 mentioned feelings of guilt during periods of quarantine when they were unable to fulfill their professional responsibilities, emphasizing their deep commitment to their clients by recounting their decision to return to work as soon as possible, even while still managing their own illness. While other participants reflected on the difficulty of maintaining their usual professional standards amidst the uncertainty and stress of the pandemic, P2 acknowledged the difficulty of performing at their best, recognizing that perfection was unrealistic in such challenging times. Instead, they focused on the importance of consistency and presence, believing that simply showing up and being a constant support for their clients was enough to serve both the clients and themselves.

Past research has discussed how mental health practitioners felt overwhelmed as the demand for therapy surged across the U.S. during the pandemic. Parker-Pope et al. (2021) highlighted that many practitioners reported feelings of guilt about being unable to accommodate all their patients. This study extended Parker-Pope et al.'s (2021) research on the pandemic's impact on mental health practitioners by emphasizing that, unlike typical circumstances where practitioners maintain professional boundaries, many found themselves simultaneously managing their clients' emotions while struggling with their own. My research confirmed and expanded upon these findings, illustrating how the emotional weight of supporting clients during a global crisis compounded practitioners' own stress, increasing their vulnerability to burnout.

The subtheme expanded on Maslach's (2000) third dimension of burnout, reduced personal accomplishment, which refers to a decline in feelings of competence and

productivity at work. Maslach (2000) noted that practitioners in caring professions often experience a growing sense of inadequacy in their ability to help clients, leading to a self-imposed sense of failure. My study disconfirmed these findings by offering new insights, highlighting how gratitude, motivation, and a deep commitment to client care enabled practitioners to persevere through personal and professional challenges, ultimately enhancing their sense of personal accomplishment.

Farber's (1985) quantitative study further supported this sub-theme, demonstrating that among the 33% of participants who responded, those in private practice reported greater personal accomplishment compared to those working in institutional settings such as hospitals or community clinics. Similarly, Skorupa and Agresti (1993) found a significant positive correlation between practitioners' knowledge of burnout prevention strategies and their sense of personal accomplishment. My research built upon these findings by illustrating how practitioners' awareness of self-care strategies, combined with their ability to exercise autonomy in private practice, contributed to their resilience and sustained sense of professional fulfillment. This resilience reinforced their personal accomplishment and underscored the meaningful nature of their work, even amidst the heightened stressors of the pandemic.

Theme 4: Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis

The study's final finding demonstrated how participants navigated the unprecedented challenges of the COVID-19 pandemic, balancing the emotional weight of their clients with their own personal and professional stressors. To cope with these

challenges, all participants developed adaptive strategies to manage burnout, emphasizing personal resilience and environmental supports. These strategies were essential for maintaining all participants mental health and stability while continuing to care for others during the global crisis. Many participants relied on self-care practices, such as mindfulness, physical exercise, maintaining healthy eating habits, and engaging in restorative activities like reading. P3 discussed their routine, which included daily exercise and yoga practice, as well as prioritizing sleep and a healthy diet. P2 also mentioned meditation and reading as essential tools for coping with the pressures of the pandemic.

Creating or maintaining personal routines was another important strategy for resilience. Some participants found that their ability to establish predictable routines helped them manage the complexities of their professional and personal lives. P3 highlighted the role of a consistent daily schedule, noting that despite the demands of work, they were able to find solace in personal routines, such as enjoying quiet moments at home and engaging in introspective practices.

Environmental supports, such as pets, also played a significant role in sustaining participants' well-being. For some, pets provided companionship and emotional support during the isolation of the pandemic. P3 mentioned the comfort provided by their cat, while P1 shared the distress of losing two pets during the pandemic, which compounded feelings of isolation and grief. P1's experience of losing a therapy dog and coping with the absence of support systems for pet loss reflected the emotional toll of the pandemic and the challenges of finding adequate support during such a difficult period.

The APA (2021) confirmed this theme through its COVID-19 Telehealth Practitioner Survey, which found that 68% of mental health practitioners reported increased stress levels at the start of the pandemic. Despite these challenges, 66% indicated they were able to practice self-care, and 55% reported maintaining a positive work-life balance. By 2022, these percentages had increased, with 77% of practitioners engaging in self-care and 63% successfully maintaining work-life balance, suggesting an adaptive response over time.

Sutton (2023) built upon these findings by elaborating on specific wellness strategies practitioners used to minimize burnout. These strategies included mindfulness practices such as expressing emotions, cultivating nonjudgmental awareness, and prioritizing self-care and healthy physiological habits. My study further expanded on these insights by highlighting how practitioners not only implemented these strategies but also tailored them to their unique circumstances. For example, some participants reported creating structured self-care routines, while others relied on peer support or adapted their work schedules to prevent burnout. These findings reinforce and build upon existing research by emphasizing the individualized and evolving nature of self-care practices among mental health practitioners during the pandemic.

To build upon existing research, Macdonald and Mellor-Clark (2015) highlighted the importance of professional practitioners nurturing their interpersonal relationships during national crises, emphasizing the role of partners, friends, and family in providing emotional support. My study confirmed and expanded upon these findings by demonstrating that participants who maintained strong personal connections reported

greater resilience and a stronger ability to manage the stress of the pandemic. Nissen-Lie et al. (2017) further contributed to this discussion by exploring strategies practitioners implemented to enhance self-awareness and emotional well-being. These strategies included seeking personal counseling, joining support groups, and relying on colleagues and peers for validation and guidance. My research aligned with these insights, revealing that many participants actively sought out professional networks and peer support as a way to process the challenges of providing services during the pandemic. Further reinforcing the significance of interpersonal connections in mitigating burnout and maintaining professional well-being.

This theme expanded upon existing research by confirming that a combination of personal resilience, self-care practices, and environmental supports played a crucial role in helping practitioners manage the strain of the pandemic. These findings align with Sutton (2023), who highlighted the importance of mindfulness, emotional expression, and self-care in minimizing burnout. Similarly, the APA (2021) found that practitioners who actively engaged in self-care and maintained a positive work-life balance reported lower stress levels over time.

My study built upon these insights by contributing new perspectives on resilience strategies that were not extensively discussed in previous research. Specifically, many participants emphasized the significance of maintaining personal routines as a grounding mechanism during times of uncertainty. Additionally, my study uniquely highlighted the role of pet companionship in mitigating feelings of isolation and stress among practitioners living alone. While past research primarily focused on human support

systems Barnett et al., (2007), my findings underscored how non-human companionship also provided emotional stability, further broadening the understanding of resilience-building strategies during crises. Moreover, participants noted that establishing predictable daily routines helped them manage both professional and personal demands, reinforcing the idea that structured self-care practices serve as an effective buffer against burnout.

Subtheme 4A: Fostering Relationships, Achieving Balance, and Envisioning Future Growth in Mental Health Care

The subtheme detailed the diverse strategies participants employed to navigate the challenges of the COVID-19 pandemic, emphasizing the importance of interpersonal support, intentional work-life balance, and forward-looking advocacy. These approaches helped many participants manage the demands of their roles while fostering resilience, offering both immediate relief during the global crisis and insights for future mental health practices. Interpersonal support emerged as a crucial resource for participants managing the emotional and physical toll of the pandemic. P1 recalled how friends and roommates supported them during illness by shopping for groceries, cooking meals, and caring for their pets which allowed them to focus on recovery without additional stress.

Connections with friends, family, and partners provided much-needed assistance and emotional reinforcement during a time of widespread isolation. P5 described their husband as a “saint,” detailing how he managed household errands and shopping to minimize their exposure to risk which enabled P5 to focus on their professional responsibilities while maintaining emotional balance. Many participants reported

maintaining close relationships during the pandemic provided a sense of stability and opportunities to recharge emotionally, helping them stay grounded in their professional roles. Some participants highlighted the lack of peer and professional support as a significant challenge in their private practice after transitioning to remote work. P3 mentioned their practice grew exponentially, creating overwhelming administrative demands, compounded by the isolation of working from home. Unlike the limited but meaningful collegial interactions they had in their office suite, the pandemic eliminated even those small connections, leaving them without social or professional support.

Many participants discussed balancing their work and personal life was another key strategy for managing stress and maintain energy levels. P6 highlighted the importance of limiting their client load, describing the challenge of saying no to new clients but recognizing it as a vital coping strategy to avoid burnout. By setting boundaries, adjusting workspaces, and prioritizing self-care, participants created a sense of control over their demanding routines. P4 shared how transitioning their workspace from the couch to the kitchen table allowed them to create a clear division between work and relaxation, fostering a sense of routine and structure. Some participants reflected on the broader implications of the pandemic, advocating for systemic changes in mental health care. P5 expressed frustration with insurance companies, citing the excessive administrative burden and inadequate compensation for mental health practitioners. They advocated for systemic changes to reduce barriers and ensure timely payments, emphasizing the need for a societal shift toward prioritizing mental health. Participants reflections underscored the participants' forward-thinking approach, as they sought to

address systemic challenges and envision a more sustainable future for mental health care.

Stebnicki (2007) identified isolation as a significant risk factor for burnout among mental health practitioners and emphasized the essential role of both personal and professional social support in self-care. My study confirmed these findings, as participants highlighted the importance of peer support in managing stress and maintaining emotional well-being during the pandemic. Similarly, Barnett et al. (2007) found that personal support from friends and family played a crucial role in fostering life balance and reducing burnout among practitioners. My research built upon these insights by demonstrating that participants who actively sought and maintained strong personal support networks reported greater resilience and emotional stability.

Kuyken et al. (2003) linked personal support to increased self-esteem, psychological adaptation, and professional functioning. I further extended these findings by revealing how practitioners not only benefited from emotional and social support but also experienced a reinforced sense of professional purpose through these relationships. Participants noted that meaningful personal connections provided a sense of validation, allowing them to process their challenges more effectively and remain engaged in their work. By highlighting the interplay between personal support and professional well-being, my research contributed new insights into how mental health practitioners navigated unprecedented stressors while maintaining their commitment to client care.

Thériault et al. (2015) highlighted the importance of mental health practitioners seeking professional support from colleagues and peers as an essential and effective

coping strategy for managing self-care. My study confirmed these findings, as participants frequently emphasized the significance of peer collaboration and professional camaraderie in mitigating burnout and sustaining their emotional well-being. Similarly, Waltman et al. (2016) found that such support networks positively impacted practitioner burnout and anxiety, reinforcing the notion that shared experiences and mutual validation serve as protective factors against occupational stress.

The APA (2024) confirmed the challenges practitioners faced with insurance networks, highlighting the administrative burdens as significant barriers to participation. My study reinforced these findings, as participants described frustration with excessive paperwork, delayed payments, and inadequate reimbursement rates, all of which contributed to their reluctance to accept insurance. Both the literature and my study underscored the impact of these challenges on access to mental health services, emphasizing the need for systemic reforms to reduce administrative barriers and ensure fair compensation for practitioners.

I built upon these insights by demonstrating that practitioners not only relied on peer support to navigate the immediate challenges of the pandemic but also incorporated these strategies into long-term self-care routines. Participants noted that engaging in regular peer consultations and informal discussions with colleagues provided both emotional relief and professional reassurance. These strategies not only helped participants cope with the demands of their roles but also contributed to a sense of professional growth and fulfillment. I confirmed the challenges practitioners faced with insurance networks, highlighting the administrative burdens as significant barriers to

participation. Practitioners' ability to adapt and persevere in a burnout-inducing environment highlighted their resilience and underscored the meaningfulness of their work, even amidst the unprecedented adversity of COVID-19

Conceptual Framework

Maslach's (2000) multidimensional model of burnout provided the conceptual framework for this study. Maslach defined burnout as a psychological syndrome characterized by overwhelming exhaustion; feelings of depersonalization and detachment from the job; and a sense of reduced personal accomplishment and failure, commonly experienced by individuals working closely with others. Over time, the concept of burnout expanded to encompass other human service professions, with its definition evolving to reflect the unique challenges faced by mental health practitioners in their demanding roles (Schaufeli, 1996).

The study's participants supported the definition of burnout. Towards the end of each interview, the definition of burnout became clearer due to how it pertained to participants emotional responses related to the pandemic. P4 mentioned the factors contributed to their burnout while working during the pandemic being the isolation had a significant impact, along with the increased number of clients. P4 further elaborated that even longstanding clients displayed heightened anxiety, not always pandemic-specific, but amplified by the overall charged atmosphere, which required more emotional energy from them. P3 shared that isolation, increased client volume, and lack of peer consultation contributed to burnout during the pandemic. P3 further explained that, unlike pre-pandemic times, clients rarely canceled appointments due to fewer outside

commitments, resulting in a consistently full caseload. This, coupled with the need to follow up daily with prospective clients, led to an overwhelming workload.

The concept of burnout evolved in alignment with Maslach's (2000) original framework, particularly regarding the first dimension: overwhelming exhaustion. The findings of this study revealed both parallels and deviations from Maslach's second dimension, depersonalization. Notably, participants' responses to the third dimension reduced personal accomplishment, offered a distinct perspective, shaped by their lived experiences during the pandemic. Through the examination of individual hardships and reflective accounts of burnout, this study illuminated the multifaceted nature of the syndrome and its profound impact on mental health practitioners.

The practitioners in this study dealt with levels of emotional exhaustion that led to burnout for most. Emotional exhaustion referred to feelings of being emotionally overextended and depleted of one's emotional resources (Schaufeli et al., 1993). The primary source of emotional exhaustion was identified as work overload. Participants cited work overload as a job demand that exceeded many of their limits, as caseloads exponentially increased due to pandemic-induced demands. Some participants reported having too much to do in terms of therapy, billing, case notes, client callbacks, and disinfecting protocols, with too little time and resources as solo private practitioners. Increased workload has a consistent relationship with burnout, especially with the exhaustion component (Maslach, 2015).

Practitioners in this study also dealt with varying degrees of depersonalization, which refers to a negative or excessively detached response to others, typically the

recipients of the individual's service or care (Schaufeli et al., 1993). Maslach et al. (1993) described how human services employees would attempt to cope with the emotional stresses of their work by moderating their compassion for clients through emotional distancing. Participants in this study fluctuated between emotional distancing, emotional hardening, feeling underappreciated, difficulty being present, and at times becoming more callous toward clients during the pandemic. However, the study's participants also provided a renewed perspective on depersonalization, as some described feeling more emotionally present in sessions, less callous toward clients, and while acknowledging they weren't at 100%, they still gave their best given the challenging circumstances of the pandemic affecting both their clientele and themselves.

The study's findings provided new insights and perspectives on the third dimension of reduced personal accomplishment. While this dimension traditionally refers to a decline in one's feelings of competence and achievement in work (Schaufeli et al., 1993), my study found that personal accomplishment was, in fact, improved. Despite the overwhelming challenges, many participants expressed a deep appreciation for their ability to work in such a meaningful capacity. Additionally, many reported an increase in their competence with therapeutic tools, as some expanded their practice across multiple states or added counseling skills to address new scopes beyond their typical clientele.

Participants employed various self-care practices to mitigate the effects of burnout. The pandemic prompted many mental health professionals to reassess what was important, slow down when possible, and reevaluate their overall state of being, working, and living. Some participants incorporated wellness strategies, including mindfulness

practices, maintaining healthy physical and eating habits, and keeping up with personal medical appointments and care (Sutton, 2023). Many participants focused on nurturing their interpersonal relationships, sustaining social interactions and support from partners, friends, family, and pets. An additional strategy, not mentioned in the literature review, was the ability of private practice practitioners to modify their schedules. This included taking breaks between clients, adjusting work hours for longer lunches or designated administrative days, and limiting intakes or delegating clients to other practitioners within their practice. This flexibility in scheduling was a unique advantage of private practice, which may not be available to practitioners in community health or hospital settings.

This study built upon the concept of burnout through experiential learning in the unprecedented and challenging environment of COVID-19. Maslach's (2000) definition of burnout evolved, offering a new perspective on the depersonalization and personal accomplishment dimensions, which provided fresh insights into these burnout factors. The study also uncovered new coping strategies that practitioners struggling with burnout developed during the COVID-19 pandemic, as well as approaches they could use to mitigate burnout in response to future waves of the pandemic.

Limitations of the Study

This study provided in-depth knowledge about mental health practitioners experiences of burnout while rendering clinical care during the pandemic, and limitations of trustworthiness could be present because the truthfulness of their statements cannot be tested. As the researcher, I executed the interview assuming that all participants were truthful and accurate in delivering answers. Secondly, I obtained practitioners from

southern and northern California, New York, and Georgia, seven out of eight participants were female and one participant was male. Three participants were African America, and five participants were Caucasian. All participants worked in private practice. This limited sample may not fully capture the experiences of practitioners from other regions, genders, or racial/ethnic backgrounds, potentially restricting the generalizability of the findings. Furthermore, the exclusive focus on private practice practitioners may overlook the unique challenges and strategies employed by those working in community health or hospital settings, where flexibility and autonomy in scheduling may be more limited. Additionally, limitations in transferability may arise due to the study being conducted specifically during the pandemic, with data collected 3-4 years after the onset of the crisis.

Recommendations for Future Research

The study was conducted to better understand the experiences of burnout among mental health practitioners that rendered clinical care during the pandemic. Current research on this study has not been made, and a generic qualitative study has not been done on the scope of burnout in this manner. Further qualitative studies could benefit from exploring a more diverse participant pool that represents a broader range of geographic locations, genders, and racial/ethnic groups to better understand how burnout is experienced across different demographics. Additionally, including practitioners from varied work environments, such as community health clinics, hospitals, or academic institutions, could provide a more comprehensive understanding of the challenges and coping strategies unique to these settings. Comparative studies between private practice

and other work environments may also offer valuable insights into how organizational structures influence burnout and self-care practices.

Future research should also consider using mixed-methods studies to explore how developing effective coping strategies mitigated the effects of burnout and enabled practitioners to remain committed to client care. Combining qualitative interviews with quantitative surveys could provide a more nuanced understanding of the relationship between specific coping strategies and burnout prevention. For example, examining the effectiveness of mindfulness practices, family support systems, flexible scheduling, or other interventions could help identify the most impactful strategies for sustaining practitioner well-being and professional commitment during crises. This approach could also capture the dynamic nature of coping mechanisms and how they evolve over time.

Future research could further explore how Maslach's three dimensions of burnout emotional exhaustion, depersonalization, and personal accomplishment manifest during prolonged crises, with a particular focus on the personal accomplishment dimension. Findings from this study suggested that practitioners experienced an improved sense of personal accomplishment while supporting clients during the pandemic, which contrasted with the traditional definition of reduced personal accomplishment in burnout. Investigating whether this pattern holds across different contexts or crises could provide valuable insights into how practitioners' sense of achievement and purpose can be influenced by external challenges and how this dimension could act as a protective factor against burnout.

Implications for Social Change

Mental health practitioners experienced significantly heightened levels of burnout during the COVID-19 pandemic. Exploring their experiences during this unprecedented time revealed how they navigated the challenges of staying committed to their clients, themselves, and, in many cases, their families. Addressing these challenges required creating environments that acknowledged their struggles through intentional language and increased awareness. The misconception that mental health practitioners experienced burnout to a lesser extent than physicians was proven inaccurate, as practitioners bore a significant share of the emotional and psychological toll caused by the pandemic while supporting individuals through its far-reaching effects. This study provided critical insights into the daily realities practitioners faced and had profound implications for social change. By bringing their challenges and resilience to light, the findings underscored the importance of implementing targeted strategies to prevent and address burnout during prolonged crises, fostering a more resilient, sustainable, and supported mental health workforce.

By uncovering the resilience and adaptability of practitioners who maintained their commitment to client care despite overwhelming challenges, this study emphasized the importance of prioritizing practitioner well-being to sustain the mental health workforce. Organizations, policymakers, and training programs could use these findings to develop initiatives that promoted effective coping strategies, such as flexible work arrangements, peer support systems, and mindfulness training, to mitigate burnout. Furthermore, the study's insights into the evolving experience of Maslach's burnout dimensions,

particularly the improved sense of personal accomplishment, challenged traditional views and opened pathways for reexamining how practitioners derived meaning and purpose from their work. These findings could inspire systemic changes that fostered healthier, more sustainable practices in the mental health field, ultimately improving the quality of care provided to clients and contributing to a more resilient and supported society.

Conclusion

Using a generic qualitative approach, I gained an understanding of eight practitioners' experiences of burnout during the COVID-19 pandemic. The participants shared their experiences within their respective modes of private practice, either in-person or through telehealth. The study's findings revealed that their experiences led to burnout, manifesting in the dimensions of emotional exhaustion, depersonalization, and personal accomplishment. These dimensions required practitioners to employ various coping strategies to improve resilience and mitigate the effects of burnout, allowing them to remain committed to client care. No current qualitative research had explored mental health practitioners' experiences of burnout during the pandemic in the United States, making this study a valuable contribution to understanding burnout and the necessary coping mechanisms for practitioners providing clinical care during such a crisis.

As a scholar-practitioner for positive change, it was essential to explore practitioners’ experiences of burnout during the pandemic to implement meaningful changes within the mental health profession. The participants offered insight into the challenging and rewarding experiences of bearing the emotional burden of supporting Americans through the pandemic while maintaining their dedication to client care. The

study found that practitioners' well-being was significantly impacted by their ability to manage caseloads, adapt their work environment, and integrate self-care practices and support systems, which allowed them to remain present for their clients despite experiencing burnout. Additionally, this study confirmed the onset of burnout among practitioners while rendering clinical care during the pandemic, highlighting the need for systemic support and strategies to prevent burnout in future crises.

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Appendix A: Interview Questions

A Qualitative Study on the Experiences of Burnout among Mental Health Practitioners Rendering Clinical Care during COVID-19

Emotional Exhaustion

Q1. Can you tell me if you ever felt emotionally drained from your work during the COVID-19 pandemic?

Q2. Can you tell me if you ever felt working with people directly put too much stress on you during the COVID-19 pandemic?

Q3. Can you tell me if you ever felt burnout while working during the COVID-19 pandemic?

Depersonalization

Q4. Can you tell me if you ever felt you have become more callous towards your clients during the COVID-19 pandemic?

Q5. Can you tell me if you ever worry that this job has hardened you emotionally during the COVID-19 pandemic?

Q6. Can you tell me if you ever felt your clients blame you for some of their problems during the COVID-19 pandemic?

Personal accomplishment

Q7. Can you tell me if you ever felt in your work, you've dealt with emotional problems very calmly during the COVID-19 pandemic?

Q8. Can you tell me if you ever felt you have dealt very effectively with the problems of your clients during the COVID-19 pandemic?

Q9. Can you tell me if you ever felt that you've positively influenced other people's lives through your work during the COVID-19 pandemic?

Coping Strategies

Q10. How did you manage or cope with symptoms of burnout during the COVID-19 pandemic?

Appendix B: Coding Table

Theme	Sub-Theme	Category	Codes
1. The Overwhelming Emotional Strain of Providing Care During COVID-19	**A. Enduring the Weight of Stress and Fatigue** **B. Adapting Therapy Modalities and Increased Caseloads**	**1. Ongoing Pandemic Stress** **2. Emotional Strain from Client Dynamics** **3. Burnout and Physical Fatigue** **4. Compounded Stressors** **5. Remote Therapy Struggles** **6. Strain of In-Person Therapy** **7. Positive Shifts Over Time**	Code 1: Stayed open during entire pandemic. Code 2: Clients anxiety about pandemic was draining. Code 3: Not knowing what COVID-19 was and would turn into. Code 4: Emotionally Drained from work during beginning of the pandemic. Code 5: Emotionally Drained from work before pandemic. Code 6: Relief with Vaccines. Code 7: Stressed from working with clients in person during the pandemic. Code 8: Stressed from working remotely with clients during the pandemic. Code 9: Juggling work and family life stress. Code 10: Feeling Burnout. Code 11: Burned out by client's response to the fear of the pandemic. Code 12: Isolating experience. Code 13: Physically tired of being on the screen all day. Code 14: Novelty of dealing with the exact same problem as the client. Code 15: Dealing with everyone's emotions (family, clt's, self). Code 16: Inconvenience of remote therapy. Code 17: Harder to use therapeutic tools.

			Code 18: Easier to use therapeutic tools. Code 19: Having COVID-19. Code 20: Increased Caseloads. Code 21: Heavy content discussed in session. Code 22: Less Client Cancellations. Code 23: Starting medication to manage stress. Code 24: Physically drained from daily disinfecting of office. Code 25: Lack of boundary adherence by remote clients. Code 26: Political climate of anti-maskers and anti-vaccines.
2. Navigating Emotional Detachment and Professional Identity Amidst Pandemic Pressures	**A. Navigating Professional-Client Dynamics**	**1. Emotional Hardening** **2. Variability in Emotional Presence** **3. Friction from Service Modality Changes** **4. Challenges in Empathy and Understanding** **5. Grief and Loss** **6. Jaded Outlook**	• Code 1: More callous towards clients during pandemic. • Code 2: Less callous towards clients during pandemic. • Code 3: Hardened emotionally working during pandemic. • Code 4: Hardened emotionally working before pandemic. • Code 5: Push back from clients for going virtual. • Code 6: Push back from clients for staying in person. • Code 7: Clients were understanding about virtual, not blaming. • Code 8: Jaded about the excessive fear of exposure to COVID. • Code 9: Hard to be as present. • Code 10: More emotionally present. • Code 11: Loss of a loved one during pandemic. • Code 12: Feeling underpaid and taken for granted. • Code 13: Clients assuming I couldn't relate to their experiences.

			• Code 14: Dealt with emotional problems calmly during the pandemic. • Code 15: Clients were happy being in person during pandemic.
3. Experiencing Professional Accomplishment Through Resilience, Gratitude, and Commitment to Client Care	**A. Driven by Gratitude and Commitment to Client Well-being**	**1. Resilience and Growth** **2. Positive Client Impact** **3. Emotional Gratification** **4. Commitment to Client Care**	• Code 1: Dealt with emotional problems Calmly during pandemic. • Code 2**:** Effectively handled clients fears and problem during pandemic. • Code 3: Positively Influenced other people's lives during pandemic. • Code 4: Convenience of remote therapy. • Code 5: Happy to be Working/grateful to do this work/ energized. • Code 6: Remorse when unable to see clients. • Code 7: Working with having COVID-19. • Code 8. Gained more clinical experience.
4. Adaptive Strategies for Managing Personal and Professional Burnout During a Global Crisis	**A. Fostering Relationships, Achieving Balance, and Envisioning Future Growth**	**1. Individual Practices** **2. Environmental Supports** **3. Social Connections** **4. Work Life Balance** **5. Commitment to Growth and Client Care** **6. Early Intervention Advocacy**	• Code 1: Cope with own feelings about COVID-19. • Code 2: Supporting clients during the pandemic. • Code 3: Mindfulness practices. • Code 4: Support from friends/family. • Code 5**:** Social interactions with friends and family. • Code 6: Healthy physical and eating habits. • Code 7: Keeping up with personal medical appointments and care. • Code 8: Breaks in b/w clients. • Code 9: Modified work schedule.

			• Code 10: Break from motherhood duties. • Code 11: Reading. • Code 12: Pandemic compounded client's problems. • Code 13: Importance of not abandoning clients. • Code 14: Wasn't 100% • Code 15: Pandemic compounded client's problems. • Code 16: Calm Personal life • Code 17: Pets for social support. • Code 18: The need for more early interventions in mental health.

Appendix C: Consent Form

You are invited to take part in a research study about the experiences of burnout among mental health practitioners that rendered clinical care during COVID-19. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study seeks 8-15 volunteers who are:

- Licensed mental health practitioners (licensed psychologist, licensed professional counselor, licensed marital and family therapist, licensed clinical social worker, licensed clinical alcohol, and drug abuse counselor) that rendered clinical care during the COVID-19 pandemic.
- Licensed mental health practitioners that have had their license in their profession before the year 2020.
- Licensed mental health practitioners that practiced within the United States

This study is being conducted by a researcher named Mykiyaa Walker-Sanchez, who is a Ph.D. student at Walden University.

Study Purpose:
The purpose of this study is to understand better how mental health practitioners experience burnout while rendering clinical care during the COVID-19 pandemic.

Procedures:
This study will involve you completing the following steps:

- Take part in a recorded confidential videoconference (1 hour)
- Speak with the researcher for feedback and interpretations for member checking after transcription. Participants will be emailed interview transcripts to check for accuracy and allowed the opportunity to add, remove, or edit any information. (may take 20-30 mins, phone or email option is available)

Here is a sample question:
Can you tell me if you ever felt emotionally drained from your work during the COVID-19 pandemic?

Voluntary Nature of the Study:
Research should only be done with those who freely volunteer. So, everyone involved will respect your decision to join or not. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing. If you become distressed during the study and need further assistance, please use the following national hotline resources for further assistance:

- Suicide & Crisis Lifeline at 988 (call or text) the lifeline provides 24-hour, confidential support to anyone in suicidal crisis or emotional distress.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by bringing awareness to practitioners and organizations on how to recognize and manage burnout amongst this population in future waves of the COVID-19 pandemic. Once the analysis is complete, the researcher will share the overall results by emailing you a summary of the findings and a link to the full report if the participant wants more information or wants to share it with other colleagues.

Payment:
The researcher will email a $30 Amazon gift card to the first 15 volunteers as thank you gift for their participation in the research.

Privacy:
The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. The researcher is only allowed to share your identity or contact info as needed with Walden University supervisors (who are also required to protect your privacy) or with authorities if court-ordered (very rare). Overall, your identity will be kept confidential. You will be given an alias. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by password protection and data encryption. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:
You can ask questions of the researcher by email at mykiyaa.walker-sanchez@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is **IRB will enter approval number here**. It expires on **IRB will enter expiration date.**

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by replying to this email with the words, “I consent.”

Researcher’s Signature _____