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Counselors' Experience of Vicarious Trauma Symptoms During the COVID-19 Pandemic

Aleah B. Curley
Walden University

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Aleah B. Curley

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the review committee have been made.

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Walden University
2025

Abstract

Counselors' Experience of Vicarious Trauma Symptoms During the COVID-19

Pandemic

by

Aleah B. Curley

MA, Webster University, 2019

BS, Philander Smith College, 2017

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2025

Abstract

As caseloads increased during the COVID-19 pandemic, counselors experienced a shift to telehealth counseling and double exposure to trauma and pandemic elements. Some counselors experienced symptoms of vicarious trauma (VT). A gap in the literature existed regarding the interaction of the pandemic among clients and counselors' experiences of VT symptoms. The purpose of this narrative inquiry was to explore the lessons learned by capturing the stories of counselors who experienced VT symptoms during the COVID-19 pandemic. The research question concerned the retrospective experiences of counselors who self-reported experiencing VT symptoms during the COVID-19 pandemic. Seven licensed professional counselors who experienced symptoms of VT while providing counseling for a minimum of 2 months during the COVID-19 pandemic completed semistructured interviews. John Dewey's theory of learning, which served as the study's conceptual framework, informed the creation of full narratives for each participant. Interview transcripts were analyzed using Labovian structural analysis to identify the beginning, middle, and end of the narratives. Additionally, the six parts of Labovian story structure—(a) the abstract, (b) orientation, (c) complicating action, (d) evaluation, (e) result, and (f) the coda of a story—were identified. Two recommendations are (a) to promote reflective storytelling as a form of self-care for counselors after working through a shared crisis and (b) to not pathologize survival responses. The implications for positive social change include the promotion of practices and policies that acknowledge the ethical obligation for counselors to be well and act in a beneficent manner for clients, in a state of wellness.

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Dedication

This dissertation is dedicated to my father, Rodney Darnell Randolph. I lost you as I completed my master's degree in 2019. Overwhelmed with grief, I opted out of the winter graduation, and COVID stole my opportunity for an in-person commencement in May 2020. If I were honest, I was not sure if I planned to participate in that graduation either. You were a father who was present and did all that you could to make sure that your children had what they needed as well as a few things that they wanted. You pushed me to be the best version of myself and throughout this process, I have greatly missed your words of encouragement and hugs during difficult times. I often think about how you will miss another big moment, but I know that you will be here in spirit. I will push through this monumental moment knowing that you are proud of me and that I have become a woman of service. You were a man of service at heart, and I hope to carry on your work in a way that showcases your spirit of giving and the love of God through service.

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A multitude of thanks are due to those in my circle who took the time to text, call, email, or pop up at my home to check on me during this doctoral journey. A simple, genuine act of kindness has been truly restorative during this over 500-day process. The genuine check-ins from colleagues and old friends have been a blessing and push to continue the journey.

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I started this process with my Dissertation Crew, and they have been a continued source of support even after they finished before me. I am not sure who else I could have received such validation from, and they have become lifelong friends and colleagues.

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Chapter 1: Introduction to the Study

American life was drastically changed as the onset of COVID-19 pandemic became a public health emergency in the United States and worldwide in March 2020. Many states immediately implemented social distancing shutdowns in an effort to help prevent the spread of the coronavirus (COVID-19). This shift required most workers to immediately pivot and make adjustments to working from home offices rather than continuing to work in public office spaces (Coate, 2021). Despite the declared end of the pandemic in May 2023, the fully realized global impact caused by the COVID-19 pandemic will likely not be known for an extended time.

Litam et al. (2021) studied the impact of perceived stress on counselors during the COVID-19 pandemic and found that counselors working face-to-face or via distance platforms during the COVID-19 pandemic experienced burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization. Pre-COVID-19 pandemic research focused on the vicarious trauma symptoms found among counselors and Aafjes-Van Doorn et al. (2021;2022) found that counselors experienced psychological impact from working throughout the pandemic. However, a lack of personal accounts of the impact of the COVID-19 pandemic on counselors who also experienced vicarious trauma symptoms during that period was noted within the literature.

Dewey (2005) theorized that people learn through the experiences that they have, and they conceptualize those experiences in a way that is meaningful to them. Based upon Dewey's (2005) theory, I anticipated that personal recounts of experiences, specifically the experience of vicarious trauma symptoms during the COVID-19

pandemic by counselors, would be valuable to the counseling field. The anticipated value of these personal recounts was that they would provide deep insights into the collective experience of the pandemic for counselors and clients, as well as the impact that vicarious trauma symptoms had on counselors during the COVID-19 pandemic. I used the conceptualization of experience (Dewey, 2005; Kim, 2016), interacting factors, and subsequent learning to explore the shared narratives of participants.

Counselors are often active participants in crisis response during crisis events such as terrorist attacks (Miller, 2020), mass shootings (Alexander, 2021), tornadoes, floods, hurricanes (Dass-Brailsford, 2008), and wildfires (American Red Cross, 2025). They have administered psychological first aid and long-term clinical intervention for those who have survived the crisis events (American Red Cross, 2025; Wang et al., 2024). The COVID-19 pandemic was a crisis that was shared among and across the response teams, including counselors, and the public (Hutto et al., 2024). Unlike a localized crisis event, the global impact of the COVID-19 pandemic was inescapable for counselors. This study explored unique lessons learned by counselors who worked with clients who experienced a crisis during the COVID-19 pandemic and concurrently experienced vicarious trauma symptoms.

I used narrative inquiry within this study to collect the stories and understand the lessons learned by counselors who were working during the COVID-19 pandemic and simultaneously experienced vicarious trauma symptoms during that time. The experiences of counselors during the pandemic are important to the profession because a recount can inform current and future counselors about the presentation of vicarious

trauma symptoms in those who work during highly stressful times or crises, including pandemics. This study provides counselors with an enhanced understanding of how colleagues who were providing counseling services during the COVID-19 pandemic experienced concurrent symptoms of vicarious trauma. My intention was to capture the way that these co-occurring experiences shape counselors and other service providers; to gain insight on the lessons they have learned and use those lessons to prepare for similar experiences in the future.

In this chapter, I include the study background, the purpose of the study, the research question, and the conceptual framework. Additionally, I introduce the nature of the study, provide definitions associated with the study, and outline assumptions. Finally, I review the scope and delimitations, limitations, and significance of the study.

Background

The COVID-19 global pandemic began to significantly impact Americans starting in March 2020 (Centers for Disease Control and Prevention [CDC], 2023). The onset of the pandemic brought a new reality for many as the public was advised by the World Health Organization (WHO) to social distance, ensure handwashing, and to wear face coverings in efforts to decrease the spread of the virus (Bruine de Bruin et al., 2020). Social distancing measures included maintaining a distance of six feet from others in public places, wearing a medical face mask in public or around persons who were suspected or confirmed to have infection from COVID-19, increased hand hygiene, isolation after infection, and reduced travel (CDC, 2023; Honein et al., 2020).

For some Americans, the COVID-19 pandemic included elements of anti-Asian sentiments (Dougan et al., 2024), violence against Asian Americans (Yuan et al., 2024), political polarization (due in part to the 2020 election year being during the onset of the pandemic; Camobreco & He, 2022), and the syndemic created by the epidemic of racism simultaneously occurring with and influencing the effects of the COVID-19 pandemic (Gravlee, 2020; Jones, 2021).

The pandemic brought an immediate pivot from providing face-to-face services to implement telehealth or other social distancing measures for counselors (Assistant Secretary for Public Affairs, 2023; Barna, 2022; Coate, 2021; Mittal et al., 2022). Furthermore, there were changes to caseloads along with physical and emotional impacts on clients and counselors. Mittal et al. (2022) found that general health outcomes for mental health professionals ($n = 136$) working during the pandemic included back pain, headaches, insomnia, and eye strain along with continued reports of burnout, compassion fatigue, and secondary traumatic stress. Findings from Mittal et al. (2022) bolstered the preceding study findings from Aafjes Van Doorn et al. (2021) which found that counselors experienced emotional distress during the COVID-19 pandemic. Additionally, Whit-Woosley et al. (2022) found that there was an increase in secondary traumatic stress in participants, early and middle pandemic ($n = 64$), and that the primary impact from COVID-19 on counselors in their study ($n = 550$) was psychological, with only 1% ($n = 5.5$) reporting a diagnosis of a serious physical illness.

The COVID-19 pandemic has been considered a collective trauma in some of the literature. The shared experience of the COVID-19 pandemic with clients is a collective

experience with loss and impact from additional elements. Additional elements during the COVID-19 pandemic included political polarization due to 2020 being an election year (Camobreco & He, 2022; Gadarian et al., 2024), anti-Asian American sentiments (Dougan et al., 2024), and structural racism (Brimah et al., 2022). Some counselors experienced vicarious trauma symptoms throughout the COVID-19 pandemic (Aafjes Van Doorn et al., 2021; 2022). The confirmed experience of vicarious trauma symptoms led to the use of defense mechanisms by counselors to help address or ward off continued vicarious traumatization (Aafjes Van Doorn et al., 2021; 2022). However, the literature did not provide detailed accounts of how vicarious trauma symptoms were experienced by counselors working during the collective trauma of the COVID-19 pandemic and the impact the pandemic's additional elements had on the experience of vicarious trauma symptoms.

This study was needed to gather the lessons learned through experiencing vicarious trauma symptoms while working during the COVID-19 pandemic and provide the counseling profession, educators, and supervisors with implications for future vicarious trauma presentation during an inescapable, collective crisis experience, like a pandemic or national crisis.

Problem Statement

The American Psychological Association (APA, 2021) reported that an increased public demand for counseling services existed during the COVID-19 pandemic occurring March 2020 through May 2023 (Assistant Secretary for Public Affairs, 2023). Many counselors experienced unexpected changes to caseloads and an unexpected immediate

shift from face-to-face service to telehealth provisions using Zoom and other HIPAA-compliant platforms. An increase in COVID-19 related racism and violence resulted had negative mental health impacts on Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPI; Dougan et al., 2024; Yuan et al., 2024). Additionally, there were disturbing news headlines or trending social media topics. Trends included the social justice movement for the end of police brutality toward African Americans which may have contributed to increased incidence of vicarious trauma among the public and health care providers (Eichstaedt et al., 2021; Yuan et al., 2024).

The current literature had not captured the impact of working during COVID-19 on counselors personally and professionally in a way that tells the stories of counselors who experienced vicarious trauma symptoms throughout the COVID-19 pandemic and beyond the conclusion of the pandemic. There was a gap in literature about the interaction of pandemic elements and the experience of vicarious trauma symptoms by counselors, and the impact on counselors personally and professionally. The specific research problem that was addressed through this study was the lack of knowledge around the personal and professional experiences of counselors who had a simultaneous experience of self-identified symptoms of vicarious trauma and the COVID-19 pandemic.

Purpose of the Study

The purpose of this qualitative study was to explore the lessons learned by capturing the stories of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic and the impact that has had on them, both personally and professionally. The COVID-19 pandemic had a global impact and was a shared

experience for counselors and clients. I also explored the interactive impact of the COVID-19 pandemic, the experience of vicarious trauma symptoms, and living through the pandemic that counselors experienced and helped others through. I anticipated that the narrative derived from this study would inform how counselor supervisors may support supervisees in future situations that require counselors to help others while living through the same pandemic or crisis.

Research Question

What are the retrospective experiences of counselors who self-report experiencing vicarious trauma symptoms during the COVID-19 pandemic?

Conceptual Framework for the Study

John Dewey's theory of learning provided the foundation for this study, with a specific focus on the impact of aesthetic experiences. In his theory of learning, Dewey (2005) posited that learning occurs through experience (see also Kim, 2016). Internal interaction within the experience of an individual and the environment in which the person is within changes perspective, breeds transformation, and creates meaning (Dewey, 2005; Rintoul, 2020). The expressed experiences of participants are part of the problem to be studied because the experience actively and passively impacts everyone who lives through it (Kim, 2016). That continuity and interaction form the aesthetic viewpoint that can be demonstrated in narrative inquiry. Dewey's theory of experience can be explored through a lens of reflection (Anderson et al., 2023). My study participants used reflection to narrate their vicarious trauma experiences specific to providing clinical services during the COVID-19 pandemic.

In Chapter 2, I provide a detailed analysis of how John Dewey's theory of learning was applied to the gathering of the retrospective accounts of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic. In addition, I reflect on John Dewey's theory as I created the interview protocol. My goal was to create a protocol that engendered reflection to capture the experiences of the counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic. Additionally, data analysis employed a Labovian structural analysis lens to examine the experience and learning events. This type of analysis orders the beginning, middle, and end of participant narratives. Additionally, Labovian structural analysis labels story parts to further understand the flow of events within the individual's shared narrative. In Chapter 3, I provide further details of the analysis process.

Nature of the Study

I used a narrative inquiry research design to gather an in-depth understanding of the personal and professional experiences of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic. Counselors who worked clinically, offering direct counseling during the COVID-19 pandemic and experienced vicarious trauma symptoms, were ideal candidates for this study. Participants were asked to share their experiences through a narrative, semi-structured interview. Transcripts from those interviews were analyzed using a structural, Labovian model analysis. Labovian analysis employs the use of six categories to identify the beginning, middle, and end of a narrative. The six categories include: (a) the abstract, (b) orientation, (c) complicating action, (d) evaluation, (e) result, and (f) the coda of a story (Delve & Limpaecher, 2020).

I used Labovian structural analysis to provide a reflection of the aesthetic experience theorized by John Dewey (2005) and the latent impact of COVID-19 on counselors who experienced symptoms of vicarious trauma during this period. I captured the retrospective experiences of counselors who self-reported experiencing vicarious trauma symptoms during the COVID-19 pandemic in a narrative format.

Definitions

The following terms are defined within the context of this study:

Aesthetic experience: a perceptual experience of an object or aspect of nature, focused on the beauty or lesson perceived (Kim, 2016; Peacocke, 2023)

Burnout: the exhaustion, anxiety, depression, and progressive loss of energy or motivation toward goals due to personal or work-related stress (Figley, 2012).

Collective trauma: the double exposure to trauma through assisting others in the community handle the emotional and psychological distress caused by a shared event that health care professionals (i.e. counselors) are also experiencing for themselves. In this study the COVID-19 pandemic is the collective or shared trauma (Hutto et al., 2024; Kaubisch et al., 2022; Mittal et al., 2022).

Compassion fatigue: a desensitization to the stories of clients and a decrease in the care for clients that gradually builds as emotional and physical exhaustion increases (Figley, 2012).

Double exposure: the experience of the COVID-19 pandemic as a citizen or personally, and the subsequent reexposure, professionally, through the stress,

experiences, and traumas of clients while offering mental health services (Mittal et al., 2022; Werner et al., 2020).

Media: platforms that shared information about current events and COVID-19; whether that was traditional formats like television, radio, and newspaper, or modern formats like social media applications or podcasts (Riehm et al., 2020).

Racism: the belief that race determines an inherent superiority of a particular race which fuels the systemic, structural oppression of a racial group on an emotional, social, political, and economic level (Jones, 2021; Zhou et al., 2022).

Secondary traumatic stress: A condition that mimics the symptoms of posttraumatic stress disorder (PTSD) following exposure to traumatic information or hearing about a traumatic event. Symptoms include avoidance of reminders, hypervigilance, functional impairment, distressing emotions, and intrusive imagery like flashbacks (Figley, 2012).

Second-line health care workers: mental health professionals who were a part of the response to the COVID-19 pandemic through their work with those impacted by the COVID-19 pandemic (Mittal et al., 2023; Rossi et al., 2020). This includes social workers, professional counselors, psychiatrists, psychologists, and other behavioral health professionals (Morse & Del, 2021).

Survival responses: natural reactions to abnormal or unnatural experiences. This includes fight, flight, freeze, and fawn responses used when safety is threatened (Levine et al., 2018; LeWine, 2011).

Syndemic: the relationship between two or more epidemics and the interaction between them promoted by socioenvironmental context (Singer, 2009). The pandemic and racism are the interacting epidemics in the syndemic described in this study (Hudson et al., 2022).

Vicarious Trauma: a change within a trauma professional's worldview or a decrease in hope that occurs over an extended period of exposure to traumatic information and presents with symptoms associated with PTSD (Figley, 2012; Quitangon & Evces, 2015).

Assumptions

It was assumed that participants would be truthful and accurate in recounting their experiences. The impact of long-COVID effects can impede the guarantee that experiences have been remembered with precision (Delgado-Alonso et al., 2024; Mayo Clinic, 2024). An additional assumption of this study was that the impact of anti-Asian sentiments (Yuan et al., 2024), racism (Burch & Jacobs, 2022; Read et al., 2023), polarized politics (Carey et al., 2023), and a change to the in-person work environment would be reported as additionally stressful to counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic (Barna, 2022; Kotera et al., 2021). Another assumption was that experiencing vicarious trauma symptoms while working during the COVID-19 pandemic was impactful to the personal and professional lives of counselors, postpandemic or beyond May 11, 2023 (Assistant Secretary for Public Affairs, 2023). This study assumed that participants would recount common experiences

stemming from their shared experiences of the COVID-19 pandemic and that consistent themes would emerge in their narratives.

It was assumed that the misunderstanding of the definition and presentation of vicarious trauma symptoms could have yielded results from participants that do not fully capture the experience being studied, specifically, symptoms of vicarious trauma in counselors during the COVID-19 pandemic. There is a common interchangeable misuse of terms like burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma (Figley, 2012). A single individual can experience compassion fatigue, secondary traumatic stress, burnout, and vicarious trauma; however, they are not the same experience (Figley, 2012). It was assumed that participants may provide symptoms attributed to experiences other than vicarious trauma symptoms, and that it would be my responsibility to identify the correct application within the stories captured using the established definitions for this study throughout the analysis process described in Chapter 3.

Scope and Delimitations

The narrative inquiry nature of the study and the application of John Dewey's learning and experience theory as a conceptual framework for this study were directed at collecting the stories of counselors who experienced symptoms of vicarious trauma while working during the COVID-19 pandemic. Furthermore, the study was directed at exploring the reflective experiences of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic and how they were impacted professionally and personally beyond the COVID-19 pandemic that ended in Spring 2023. The study

required participants who were independently licensed, worked during the COVID-19 pandemic, and experienced symptoms of vicarious trauma during that time. Counselors who did not work during the COVID-19 pandemic, were not independently licensed between March 2020 and May 2023, and who did not experience vicarious trauma symptoms during that period were excluded from the study.

It is important to mention that a few prior studies have focused on the presence of burnout, compassion fatigue, secondary traumatic stress and vicarious trauma in mental health professionals during the COVID-19 pandemic (Aafjes-Van Doorn et al., 2021; Arpacioğlu et al., 2021; Holmes et al., 2021; Powell et al., 2022; Whitt-Woosley et al., 2022). However, this study only focused on the experience of vicarious trauma symptoms through the framework of John Dewey's theory of learning and experience. This allowed me to focus directly on the lessons learned by counselors from the experience of vicarious trauma symptoms while working during the pandemic. The use of John Dewey's theory as a framework is best combined with narrative inquiry because the in-depth interviews offer a full storyline of the experiences collected during data collection (Kim, 2016).

Phenomenological research designs were not chosen for this study due to the focus on the essence of experience or phenomenon rather than the rich, personal stories of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic (Kim, 2016; Parcell & Baker, 2018; Peoples, 2020). I anticipated the chronological sequence provided in narrative inquiry research to present results as the participants construct their narrative (Kim, 2016). Collecting these stories and

understanding lessons learned in the narrative provided an extensive view to be transferred to similar situations. I further discuss transferability in Chapter 3.

Limitations

A potential barrier when recruiting participants was thought to include having a difficult time finding counselors who are willing to discuss their experience of vicarious trauma symptoms during the COVID-19 pandemic, March 2020 through May 2023. There was also the potential that it would be difficult to find participants willing to be interviewed for an extended amount of time. The projected time for interviews was 60–80 min, which could have been beyond the availability of some potential participants. Additionally, there was the potential for it to be difficult for counselors to separate professional and personal impacts of experiencing vicarious trauma symptoms during the COVID-19 pandemic. An additional limitation to this study was that participants may not attribute their experiences to direct impacts of the COVID-19 pandemic and vicarious trauma symptoms. Furthermore, vicarious trauma has improperly been interchanged with terms like secondary traumatic stress or compassion fatigue (Figley, 2012). In Chapter 2, I provide an explanation of the differences between the experiences of burnout, compassion fatigue, secondary traumatic stress, and vicarious traumatization.

A limitation to narrative research is the issue of trustworthiness (Kim, 2016; Loh, 2013). Narrative trustworthiness works within the dimensions of verisimilitude or believability and utility or usefulness (Loh, 2013). I remained transparent about the methods used and the data analysis process to show credibility and the truth of what was collected from participants to achieve verisimilitude. Utility is tested through protocol

utility or ensuring that the semistructured interview protocol is comprehensible and anticipatory and provides a guide to deepening the experience of what is being narrated (Loh, 2013). An additional limitation to be addressed was researcher bias. In qualitative research reflexivity is the act of acknowledging the power held by myself as the researcher and taking intentional steps to remain authentic to the accounts of participants (Ravitch & Carl, 2016). Reflexivity was the answer to mitigating bias as I took video journals of my own thoughts and reactions throughout the data collection. This helped me understand my voice and separate my bias from the collected stories of participants. I provide a thorough explanation of the steps taken to ensure verisimilitude and utility in Chapter 3.

Significance

The COVID-19 pandemic was a nuanced, shared event that held multiple stress or impact points to be explored within the personal and professional experiences of counselors. The significance of my study lies in its focus on the impact on counselors, both, personally and professionally, as they provided clinical support in a high-pressure, crisis-like environment. Specifically, it focused on the interaction of the COVID-19 pandemic and the counselors' experience of vicarious trauma symptoms. I anticipated that my study would provide a detailed iteration of how vicarious trauma symptoms can present for counselors as they worked through a collective and impactful event like a global pandemic. I also explored the impact that experiencing vicarious trauma symptoms during the shared experience of COVID-19 had on counselors personally and professionally. The outcomes were anticipated to inform the way counselors

conceptualize the impact of working with clients in a shared crisis phenomenon and to equip counselors with the knowledge and skills to address concerns of vicarious traumatization within themselves as they support clients during collective experiences. This study informs counselors on how to prepare for and manage a similar phenomenon, like working with clients who share the experience of a crisis, as the counselor experiences the same crisis. Additionally, the result of this study provides insight to counselor educators and supervisors about the way vicarious trauma symptoms present during a shared crisis-like event. Results offer guidance for how to best support students and supervisees during similar situations in the future. This study was different from other research on vicarious trauma in counselors because it focused directly on the experience of vicarious trauma symptoms during the COVID-19 pandemic, which was a collective experience. Additionally, the impact that the experience had on the counselors personally and professionally was an anticipated outcome of the study.

Summary

The COVID-19 pandemic was a shared experience for counselors and the public they served, and it was found that counselors experienced vicarious trauma while working through many elements related to the pandemic (Aafjes-Van Doorn et al., 2021). The experiences of vicarious trauma symptoms during the COVID-19 pandemic and the personal and professional impacts of those experience were the unknown factors that I explored. I examined those experiences through narrative inquiry utilizing a framework of John Dewey's theory of learning and experience (Dewey, 2005). In Chapter 2, I provide a review of the current literature relevant to my study.

Chapter 2: Literature Review

Introduction

The unknown impacts of the COVID-19 pandemic are a social problem that will be studied for a significant time beyond its end in Spring 2023 (U.S. Department of Health and Human Services, 2023). The current literature shows that the impact of the COVID-19 pandemic and the lessons learned from the experience are a point of interest for researchers. Counselors who provided services during the pandemic had an experience different from the way they have previously responded to crises because those responding to the crisis may not have had to share the collective experience while helping others through the crisis. This overview of literature introduces research about the COVID-19 pandemic and prepare for the possibility of a similar experience in the future. Specific to this study, the experience of counselors who have experienced symptoms of vicarious trauma during the COVID-19 pandemic have a nuanced narrative in the interaction of the pandemic and vicarious trauma (Aafjes van Doorn et al., 2020; 2022). The purpose of this qualitative study was to capture the stories of and understand the lessons learned by counselors who have experienced vicarious trauma symptoms and the impact of COVID-19 on counselors personally and professionally.

Researchers have explored multiple impacts from the COVID-19 pandemic including the elements that were further impacting individuals during that time. Those elements included the change in the work environment, workload, racism (Brimah et al., 2022; Desmarais et al., 2023; Gravlee, 2020; Hudson et al., 2020), hate-driven assault (Dougan et al., 2024; Litam et al., 2021 Yuan et al., 2024), disparities in health care and

supplies in communities of color and low socioeconomic status, and political influences in the media (Camobreco & He, 2022; Gadarian et al., 2024). Additionally, researchers have explored the experiences of counselors during the COVID-19 pandemic, with few focusing on vicarious trauma symptoms experienced by counselors during the that time. Major themes included the experience of changes to caseloads (Fish & Mittal, 2021), the shift to telehealth (Maier et al., 2021), the collective trauma of the COVID-19 pandemic, counselor well-being (Mittal et al., 2022; Powell et al., 2022; Rossi et al., 2020), and vicarious trauma (Aafjes van Doorn et al., 2020; 2022; Holmes et al., 2021; Whitt-Woosley et al., 2022).

In Chapter 2 I examine the current themes in the existing literature, specifically focusing on the impact of the COVID-19 pandemic on individuals and counselors. The literature review addresses the experiences of vicarious trauma in counselors during the COVID-19 pandemic. The examination provides a view of what is currently understood about counselors' experience of vicarious trauma during the COVID-19 pandemic and provides potential gaps in knowledge about those experiences and how to mitigate them in the future.

Literature Search Strategy

There is a limited, but growing, amount of literature surrounding the COVID-19 pandemic. The current review of the literature began with the purpose of discovering the experience of mental health professionals and counselors during the COVID-19 pandemic. Specifically, the literature review focused on the relevant factors involved in

the COVID-19 pandemic, the experiences of counselors who worked during the pandemic, and the experience of vicarious traumatization for counselors during that time.

The Walden University Library and Google Scholar were used to explore electronic databases to assess and understand the current literature on the relevant topics. The current research on the COVID-19 timeline, factors, counselors who worked during the pandemic, and vicarious traumatization experienced by counselors during the COVID-19 pandemic took place in the spring, summer, and fall of 2024. In addition to brief uses of Google Scholar, commonly used databases within the Walden University Library included: Sage Journals, APA PsycInfo, ProQuest Central, EBSCOhost, and Walden University's Thoreau search function. The use of search terms was repeated on multiple databases to explore the extent of the literature. The following search terms were explored: *COVID-19, timeline, pandemic onset, dual pandemic, syndemic, Navajo nation, panic buying, supplies, low-income households, state requirements, shortages, nonprofits, caseloads, counseling, mental health professionals, counselors, therapist, psychologist, social workers, vicarious trauma, politics, shared trauma, United States of America, media, racism, anti-Asian, violence, police brutality, double exposure, distance counseling, telehealth, and mental health.*

The literature provided relevant information from the years 1995 to 2024 and included peer-reviewed empirical research, state regulations, seminal works, and public information provided by government entities. Peer-reviewed empirical research reviewed in the literature was mainly from 2020 to 2024 and included qualitative, quantitative, mixed methods, meta-analyses, pilot studies, case studies, and focus groups. A variety of

populations, such as Asians, AANHPI, African Americans, individuals from low socioeconomic living situations and health care providers are represented in the literature reviewed.

The timeline of the COVID-19 pandemic from March 2020-Spring 2023 along with related latent effects being studied provided a limited number of studies that directly focused on the experience of vicarious trauma symptoms in counselors during the pandemic. There were several studies where researchers examined the experiences of counselors during the COVID-19 pandemic and even more about the experiences of frontline health care workers. The studies that examined vicarious trauma in counselors during the pandemic were quantitative using the Vicarious Trauma Survey and Professional Self-Doubt scale (Aafjes van Doorn et al., 2020; 2022) The lack of available personal recounts of vicarious traumatization in counselors during the pandemic furthered my interest in the topic. It also furthered the necessity of the current study to understand the learned lessons and capture the stories of the counselors who experienced symptoms of vicarious trauma during the COVID-19 pandemic.

Conceptual Framework

John Dewey's theory of learning postulates that experiences are where learning occurs (Kim, 2016). Experiences actively and passively impact each individual and the interaction of cognitive and emotional processes flow together to form the perception or aesthetic experience. Greenberger et al. (2022) stated that aesthetic experiences can be found in reflective narratives. I anticipated being able to collect the aesthetic experiences found in the stories of counselors who worked during the COVID-19 pandemic and

experienced symptoms of vicarious trauma as the conceptual foundation of this study.

John Dewey's theory values the transformative nature of lived experiences (Pugh et al., 2020). The theory encompasses perceptions, thoughts, and emotions, integrated into recounts or perspectives.

Experiences are seen as transformative and impact the perspective of those who have lived them (Dewey, 2005; Pugh et al., 2020). The transformative nature of vicarious trauma and the shift in core beliefs about hope align with John Dewey's theory of experience. An individual's internal interaction with the experience and the environment they are within creates meaning, breeds transformation, and provides a change in perspective (Dewey, 2005; Rintoul, 2020). John Dewey's ideals on aesthetic experience and the transformative element of experience are the applied components of this study's framework as I sought to find them within the reflective narratives of counselors.

Literature Review Related to Key Variables and/or Concepts

Timeline and Impacts of the COVID-19 Pandemic

The global impact of the COVID-19 pandemic was no respecter of persons, and anyone was susceptible to infection and impact. The COVID-19 pandemic touched the lives of everyone in one or more forms. The global impact was emotional, financial, physical, and psychological (Bullock et al., 2022; CDC, 2023). The status quo of American life was drastically changed as a global health emergency became prevalent in the United States (CDC, 2023; Shklarski et al., 2021). After sending other countries into states of shutdown, the spread of coronavirus (COVID-19) made a rapid, impactful entrance into the United States.

Onset of the COVID-19 Pandemic

The WHO declared the COVID-19 global health emergency a pandemic on March 11, 2020. Four days later, multiple states within the United States began issuing varying forms of shutdowns (CDC, 2023). The shutdowns impacted schools and businesses alike as multitudes of employees were required to switch to remote working and remote learning without knowing how long the alternate format might be necessary (Coate, 2021). Others, such as those who worked in the hospitality and food industries, retail workers, and manufacturers were left without employment and uncertain how long that would last (Head et al., 2020).

The onset of the pandemic and resulting global emergency status included a forced quarantine for cruise ships, international travel bans, and domestic travel advisories (CDC, 2023). Expansion of telehealth benefits to decrease the number of individuals traveling to in-person health care appointments were implemented. There was a request for healthy individuals to donate blood to mitigate the rising shortage (CDC, 2023). Additionally, the implementation of social distancing guidelines in government buildings during the first 20 days of the officially declared pandemic foreshadowed the many changes and impacts to come (CDC, 2023). The shutdowns brought on a new reality.

New Reality

The CDC (2023) reported that within the 1st month of the declared COVID-19 pandemic, the United States became the leading country in confirmed COVID-19 cases and had the highest number of individuals lost to COVID-19. Within the 2nd month, it

became clear to clinicians that children and elderly individuals were at a higher risk for complications due to infections. Beyond April 2020, the COVID-19 pandemic continued, and the economic impact began to be of highest priority concern and influenced decision-makers in the United States (CDC, 2023). The new reality continued as the first 2 months of pandemic progressed beyond May. In May 2020, the American unemployment rate reached 20,500,000 individuals and was the highest it had been since the Great Depression.

The Navajo Nation was heavily impacted by the spread of COVID-19. The Navajo Nation had an infection rate of over 2300 per 100,000 capita resulting in over 140 deaths in the Navajo community by mid-May 2020. Due to the high infection rate in the US, the Navajo Nation leaders implemented a strict lockdown on their community which was the most unified pandemic response in the country (CDC, 2023; Hozien, 2024; Silverman et al., 2020). In addition to individuals of Indigenous descent, Black Americans (39.17 per capita of 100,000) and Hispanic (17.61 per capita of 100,00) individuals had a higher mortality rate than other racial groups in the United States. May 2020 ended with more than 100,000 US citizens lost to COVID-19 (CDC, 2023). This number would continue to increase resulting in 1,132,653 US citizens lost to COVID-19 by the end of the declared public health emergency in May 2023 (CDC, 2025; U.S. Department of Health and Human Services, 2023).

The COVID-19 pandemic brought on a new reality that people were unprepared to accept. There were conflicting views and instructions from United States leaders and government officials (Camobreco & He, 2022; CDC, 2023). Bullock et al. (2022)

reported issues of adjustment to full-time virtual work and the development of zoom fatigue, or the exhaustion from extended use of virtual communication platforms. The COVID-19 pandemic was a time when individuals had to choose between efforts towards staying safe from infection or continuing to hold previously planned family functions such as birthday celebrations, weddings, and funerals. All were encouraged to wear a face mask in public spaces, implement physical distancing from others, avoiding non-essential gatherings indoors, increase hand hygiene, testing and isolating when positive cases of infection occurred, and postponing travel if possible (Honein et al., 2020). The increased guidelines for travel and quarantine following travel or exposure to COVID-19 infection became the standard (CDC, 2023). When traveling, all were mandated to wear a mask, encouraged to increase hand hygiene, and quarantining post travel for up to 2 weeks or wear a mask in spaces with those who have not traveled (Honein et al., 2020).

The mortality and morbidity numbers continued to rise following major holidays where crowds gathered and by July 7, 2020, there had been more than 3,000,000 Americans who had tested positive for COVID-19 (CDC,2023). By August 2020, it was discovered that the third leading cause of death in the United States was COVID-19 infection. Sheils (2022) reported that COVID-19 remained the third leading cause of death in the United States until October 2021. In the first 20 months of the pandemic 1 in 8 deaths ($n = 697,000$) were due to COVID-19 infection (Sheils, 2022). Heart disease was the first leading cause of death and cancer was the second leading cause of death, with 21,500,000 deaths combined between the two causes (Sheils, 2022).

Disparate Impacts for Different Populations

The COVID-19 pandemic was a nuanced phenomenon and the elements that added to its effect are worth mentioning. Individuals of Indigenous descent and people of color had a higher mortality rate than their white counterparts (CDC,2023; Gawthrop, 2023). Previously existing medical conditions and the age of individuals were factors in the risk of death from COVID-19 infection (CDC,2023; Gawthrop, 2023). In addition to disparities in health care (CDC, 2023), there were polarized politics (Camobreco & He, 2022), and an increased community focus on police violence against African Americans (Eichstaedt et al., 2021). Asians, AANHPI were subjected to an increase in race-directed violence in the United States and there was consistent saturation within media coverage regarding COVID-19 related fatalities (Thompson et al., 2022). These additional elements are influential and memorable aspects of experiencing the COVID-19 pandemic in the United States.

Food Scarcity and Housing Insecurity. Disparities in housing and food scarcity increased during the COVID-19 pandemic. For some communities, the COVID-19 pandemic exacerbated the issues they were already facing. Black mothers with low income reported the need to make difficult decisions about food during the COVID-19 pandemic. This included the need to skip meals to ensure their children were fed or purchasing groceries rather than taking care of other financial commitments (Versey & Russell, 2023). In addition to food insecurity, these mothers reported a fear of housing outcomes due to increased prices or inflated screenings of credit and income; as well as harassment from landlords, despite the protections afforded to them through the eviction

and foreclosure moratorium enacted in March 2020 (Calabro, 2022; Versey & Russell, 2023).

Those with less access to livable wages were greatly impacted. The issue of food scarcity had a greater impact on communities of color. Individuals of the global majority were more likely to experience an impact from food scarcity than White and Asian adults during the pandemic (Morita & Hirotaka, 2023). College students represented another specifically impacted community. College students have historically experienced food and housing insecurity, due to the diminished access to a livable wage (Glantsman et al., 2022). During the pandemic, housing insecurity remained relatively stable while food insecurity increased for college students. The COVID-19 pandemic left many with concerns about how they would be able to survive and provide for their basic needs (Glantsman et al., 2022; Versey & Russell, 2023).

Impact of Anti-Asian Sentiment. Due to the spread of misinformation and the COVID-19 pandemic country of origin being China, hateful and racist remarks and behaviors began to ensue toward Asian, Asian American, and Pacific Island presenting individuals in the United States (Litam et al., 2021; Yuan et al., 2024). The impact on AANHPI individuals was significant due to the discrimination and anti-Asian sentiment that grew during the pandemic (Dougan et al., 2024; Yuan et al., 2024). The AANHPI community endured an increase in verbal and physical attacks following the public voices and influential media association of COVID-19 to individuals of Chinese descent. Anti-Asian sentiment grew, and subsequent assaults increased from 2019 (8.5% of assaults; $n = 84,825$) to 2020 (9.2% of assaults; $n = 96,314$; Yuan et al., 2024). Yuan et al. (2024)

found that individuals from AANHPI communities experienced an increase in assaults, which is different than the experiences of other ethnic groups during the COVID-19 pandemic. The mental well-being of those in the AANHPI community who reported experiencing discrimination or racially charged assaults were negatively affected and a significant number of individuals reported thoughts of suicide (Dougan et al., 2024; Litam et al., 2021).

Political Polarization

The COVID-19 pandemic's impact was greatly affected by partisanship (Camobreco & He, 2022; Gadarian et al., 2024). The divisiveness in politics impacted the health behaviors of U.S. citizens. Early in the pandemic the impact of the support or opposition to the sitting president, Donald J. Trump, was a predictor for the choices U.S. citizens made regarding the pandemic. It was found that this contrast in support or opposition carried more weight than ideology or partisan identity (Gadarian et al., 2024). U.S. citizens who supported Donald J. Trump were less likely to wear a mask and participate in the social distancing guidelines suggested by the CDC (Bruine de Bruin et al., 2020; Carey et al., 2023; Gadarian et al., 2024). The CDC (2023) reported that there were concerns that Donald J. Trump was politicizing the public health emergency by halting funding to the WHO in April 2020 and mandating that hospitals report personal protective equipment and infection rate information to the U.S. Department of Health and Human Services rather than the CDC in July 2020 (CDC, 2023). Carey et al. (2023) reported warnings about how those and similar decisions made by Donald J. Trump resulted in potentially avoidable casualties of U.S. citizens (CDC, 2023).

The year 2020 was an election year and the major political parties had different campaign priorities regarding the impact of the COVID-19 pandemic. Republican party members prioritized the state of the economy, while COVID-19 response was the priority of the Democratic party members. Those partisanship priorities shaped the core political values and decision making by elected officials (Camobreco & He, 2022). An example of this is the limited shutdown periods and premature lifting of social distancing recommendations in Republican-led states such as Florida, Texas, Arkansas, South Carolina, North Carolina, South Dakota, Nebraska, and Oklahoma due to the core political value of limited government. Camobreco and He (2022), concluded that the core political values shaped by partisanship can impact apolitical issues like response to a global pandemic.

The Syndemic

The impact of racial injustice was an additional element to the experience of the COVID-19 pandemic. Within their timeline of events the CDC (2023) reported that 2 days after WHO declared that COVID-19 was an epidemic, on March 13, 2020, Breonna Taylor was shot in her home by police officers. On May 25, 2020, the murder of George Floyd by police officers was captured on camera and shared on social media. The world watched George Floyd beg for his mother as an officer kneeled on his neck until he died. Eichstaedt et al. (2021) reported that this increased exposure to traumatic material and subsequent depression led to more mentally unhealthy days for Black Americans during the COVID-19 pandemic. The death of George Floyd shed a global light on the “syndemic” facing people of color. A syndemic is the relationship between two or more

epidemics and the interaction between them promoted by socioenvironmental context (Singer, 2009). The relationship between racism, COVID-19, and racial injustices formed the syndemic experiences during the COVID-19 pandemic (Gravlee, 2020; Hudson et al., 2020; Zhou et al., 2022).

Racism is the belief that race determines an inherent superiority of a particular race which fuels the systemic oppression of a racial group on a social, political, and economic level (Jones, 2021; Zhou et al., 2022). Jones (2021) described racism as the oldest pandemic. Structural racism was evident in the health disparities and the impact of COVID-19 on Black, Indigenous, and other people of color (BIPOC) communities (Braithair et al., 2022; CDC, 2023; Jones, 2021). It was not just the loss of BIPOC lives by the hands police officers that were impacted by racism. The evidence of racism was shown in the impact of COVID-19 on BIPOC families. Low income earning, BIPOC families were more likely than white American families with middle-to-high income earnings to lack access to childcare, or supplemental sources of education during the pandemic. This forced parents to take their children with them to work or leave the care of smaller children to older children who were also supposed to be in virtual classrooms (Braithair et al., 2022; Jones, 2021). Additionally, BIPOC individuals were found to be significantly more likely to be infected with and to die from COVID-19 (CDC, 2023). Despite this truth, Black American households were found to have increased anxiety focused on police violence while White Americans were found to be more anxious about the impact of COVID-19 on their health and the economy (Burch & Jacobs, 2022; Read et al., 2023). In summary, the phenomena of the syndemic, the interactions of systemic

racism, racial injustices, and COVID-19, created an additional impact on Americans in general and specifically for BIPOC communities.

Impact of Media

The media outlets had a significant role in shaping the view of the COVID-19 pandemic in the United States. Traditional media like television, radio, and print, along with social media influenced the perceptions of the COVID-19 pandemic and impacted the psychological well-being of consumers (Head et al., 2020; Maloney et al., 2022). In the first 100 days of the pandemic, there were distinct changes in the narrative of media sources. The first messages centered around the distant virus plaguing China. Head et al. (2020) reported that those messages evolved to the arrival of the virus in the US, and then to how there had been a grand impact on businesses, health care, sports, entertainment, and politics. The misperceptions about COVID-19 were more prevalent among those under 60 years old and within the Black community, but also more commonplace among those who consumed 24-hr news networks like FOX and MSNBC (Maloney et al., 2022). Desmarais et al. (2023) found that the misperceptions of COVID-19 in traditional and social media outlets led to discourse on the perception of sanitation in other countries, religious affiliations, and genders. The discourse exposed those of differing religions, nationalities, and races to derogatory, racist beliefs posted on social media forums. It also furthered the impact of racism toward BIPOC, AANHPI, and Islamic communities during the COVID-19 pandemic (Desmarais et al., 2023).

Exposure to COVID-19-related media led to higher levels of stress, anxiety, COVID-19-related worry, and suicidal ideation. News and information consumed

through traditional media outlets was less impactful on psychological well-being (Jalan et al., 2022). Social media was more impactful on psychological well-being and distinctly connected to a higher prevalence of suicidal thoughts for those who consumed their news through this format (Dyar et al., 2024; Mancini et al., 2024; Reihm et al., 2024). Stress around the susceptibility to COVID-19 infection was fueled by exposure to media. The increase in COVID-19-related media exposure, the impact of political affiliations, demographics, and neuroticism were predictive of high anxiety about COVID-19-related impacts (Lueck et al., 2024; Mancini et al., 2024).

Impacts of the COVID-19 Pandemic on Counselors

WHO advised individuals to implement social distancing protocols that included mask wearing, increased hand hygiene, testing for infection before and after travel, quarantining after travel, keeping six feet of space between yourself and others in public places, and isolation during infection periods to help decrease the spread of COVID-19 (CDC, 2023; Honein et al., 2020). This change directly impacted the way mental health professionals were able to show up for clients while mitigating their exposure to the virus. Counselors used distance-communication platforms such as Zoom, Skype, WebEx (Bullock et al., 2022) and SimplePractice (Ellingson, 2020), which they had never used before or had used minimally to offer services via telehealth counseling. They also were adjusting to using spaces not previously set up for offering confidential or private services (Barna, 2022; Mittal et al., 2022). The change brought about concerns for ethics and opened the door for continued changes in the field's licensing protocols regarding

distance counseling and the privilege to practice in states outside of a counselor's primary home state of licensure (Hardy et al., 2021, McKee et al., 2022).

The Shift to Telehealth

Counselors became creative in their quest to continue providing services during the pandemic. The need for social distancing and the shutdown orders in some states led to the need for counselors to provide services via telecommunications (Kotera et al., 2021; Lin et al., 2022; McCoyd et al., 2022). Lin et al. (2022) found that for a majority, about 76% ($n = 381$), of mental health professionals the transition to telehealth went without interrupting their existing clients' services. The challenges that came up for mental health professionals were in the change in therapeutic space. The need to working in a place dually used as a living space was a point of strain on the adjustment during the COVID-19 pandemic (McBeath et al., 2020). In addition to making a living space a dual-purpose environment, there were other challenges in the face of switching to full-time telehealth counseling (Shklarski et al., 2021). Technological issues, therapeutic intervention concerns, and ethical dilemmas plagued mental health professionals making the shift to telehealth difficult at the start of the COVID-19 pandemic (Kotera et al., 2021; Lin et al., 2022; McBeath et al., 2020).

Technology Issues. The technology issues included poor internet connection strength and material barriers to providing seamless services. Mental health professionals, in some areas, experienced issues with sustainable connection due to limited internet bandwidth and could not solve the problem if it was the strength of the client's internet connection (Maier et al., 2021). Still, the impact on the therapeutic process was minimal,

but significant for those individuals (McBeath et al., 2020; Mischler et al., 2021). The distraction contributed to the concerns about effective therapeutic interventions in virtual spaces.

Interventions

The therapeutic interventions in question were possible and effective despite the change in the platform (Maier et al., 2021; McBeath et al., 2020; McCoyd et al., 2022). Counselors were able to make use of interventions previously used in an in-person setting to support clients during the COVID-19 pandemic. This included the use of eye movement desensitization and reprocessing (EMDR) and family systems interventions via telehealth (McKee et al., 2022; Mischler et al., 2021).

Ethical Concerns

In addition to technology issues, mental health professionals were concerned about the ethical implications of the change to working in virtual spaces. Mental health professionals faced the need to comply with their respective professional ethical codes concerning confidentiality and security of confidential information. For those who needed to turn their living space into a dual-purpose space, the adjustment was an additional stressor considering the desire for protection from the COVID-19 virus (Mittal et al., 2022).

Boundaries

The issue of boundaries and work-life balance was an additional early issue in the COVID-19 pandemic as counselors made a workplace of their homes (Kotera et al., 2021; Lin et al., 2022; Maier et al., 2021). There was a nuance to making their home

office a virtual, safe, and therapeutic space for clients and creating separation from their family members in other areas of the home (Maier et al., 2021; Mittal et al., 2022). As the United States moved further into the COVID-19 pandemic, mental health professionals adjusted and became comfortable with telehealth provisions. Counselors generally agreed that the services rendered were welcomed and effective for clients despite the move to a virtual setting (Kotera et al., 2021; Maier et al., 2021; McBeath et al., 2020).

Caseload Changes

Shutdowns, social distancing, and the overall impact on medical professionals had varying effects on mental health professionals' caseloads. Nonprofit organizations, significant staples in their communities, underwent waves of adjustment throughout the COVID-19 pandemic. Fuller et al. (2023) reported that at the onset of the COVID-19 pandemic and into the first 6 months, non-profit organizations with a history of handling crises, effectively communicating, and adapting were better equipped to persevere through COVID-19, over organizations that did not have a history of handling crises. Some mental health professionals saw an initial decrease in caseloads at the start of the COVID-19 pandemic. This led to stress related to economic strains accompanied by the additional impact of polarized views, news reports, and the racial justice movement (Mittal et al., 2022).

Increased Need for Counseling

As the pandemic progressed the need for mental health professionals' services increased and the presentation of depression and anxiety symptoms grew among Americans (Barna, 2022; Mittal et al., 2023; J. Singh et al., 2024). Over 125,000,000

Americans experienced mental health issues during the COVID-19 pandemic, which was a reported 28% increase in depression and anxiety symptoms from 2019 to 2020 (Barna, 2022). Barna (2022) reported that 42,900,000 people with symptoms of anxiety and depression were unable to be treated due to shortages of available mental health professionals. With more Americans recognizing a need for mental health services, mental health professionals saw an increase in caseloads as the pandemic continued. Counselors who met their capacity reported waitlists growing to about 10- 20 people resulting in an average of 12.8 weeks of waiting to begin counseling services, which was a rise from the prepandemic wait time of 9.4 weeks (APA, 2022; Peipert et al., 2022). The Substance Abuse and Mental Health Services Administration (SAMHSA) reported that 6,948,994 Americans sought mental health services to address their need in 2020. This was an increase from the previous 2 years by approximately 3,000,000 (SAMHSA, 2023).

Continuing Impacts on Counselor Practice

Telehealth continues to be a common practice beyond the COVID-19 pandemic, with emergency COVID-19 protocols ending as the Public Health Emergency expired on May 11, 2023, in the United States (Assistant Secretary for Public Affairs, 2023). Approximately 74% ($n = 299$) of mental health professionals ($n = 404$) surveyed in Summer 2020 using the Telehealth Usage and Education Survey reported that they sought telehealth education before its use and 61% ($n = 246$) reported that they sought additional education after using telehealth (Perle, 2022). There is value in education on the ethical, legal, and clinical implications of telehealth counseling services, as it was

found that about 80% ($n = 268$) of 335 surveyed counselors found that remote work was challenging and about 83% ($n = 278$) of the counselors agreed that there was value in teaching remote counseling skills. (McBeath et al., 2020; Perle, 2022). Hardy et al. (2021) surveyed couples' counselors ($n = 58$) about their intentions to continue offering telehealth services and 74% ($n = 43$) reported an intention to continue offering telehealth counseling. McKee et al. (2022) found that approximately 37% ($n = 232$) of the 626 family systems counselors will continue to offer telehealth counseling services postpandemic. According to Mulvaney-Day et al. (2022) the use of telehealth in behavioral health spaces seems to be more accepted by practitioners than it previously had been prior to the onset of the COVID-19 pandemic and increased need to use virtual platforms. Mulvaney-Day et al. (2022), found that about 40% ($n = 340$) of 849,000,000 claims for mental health providers included codes that identified the use of telehealth in November 2021 and postulated that continued use of telehealth services is probable.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) followed the lead of U.S. Department of Education in requiring institutions to meet the licensure application needs of students in the state in which the institution is located (CACREP, 2024). Arkansas, California, and Louisiana have amended their licensure requirements to include that the applicants have completed coursework in technology-assisted counseling, postgraduate continued education for distance counseling, or a course in distance counseling (ABEC, 2024; California BBS, 2024; Teletherapy Guidelines for Licensees, 2023). Connecticut, Delaware, South Carolina, and Washington, require those who plan to offer telehealth services to be registered with the

state's respective licensing board to do so and maintain competency (Connecticut State Department of Health, 2024; Distance Professional Services, 2016; Registration of Behavioral Telehealth Counselors, 2022; Washington State Department of Health, 2024). For Delaware and South Carolina, these rules apply to in-state counselors, and for another, Connecticut, it is only required of out-of-state counselors while they wait for approval for licensure within the state (Connecticut State Department Public Health, 2024; Registration of Behavioral Telehealth Counselors, 2022; Telehealth services, 2016). While the Counseling Compact was in the works before the onset of COVID-19, the increase in telehealth services during the pandemic brought increased attention to the progress of the compact (American Counseling Association, 2021; DeDiego et al., 2023). At the time of this review (February 9, 2025), the compact has since been signed into law by 37 states along with the District of Columbia, and there is pending legislation for Oregon, New Mexico, and Texas to increase the portability of counseling licenses and access to counseling services.

Emotional Impact

The impact on mental health professionals during the COVID-19 pandemic was not just logistical, but also emotional. Mittal et al. (2023) surveyed 136 counselors about the impact of COVID-19 on their well-being and found that common themes included an increase in trouble sleeping, headaches, back pain, eye strain, poor appetite, and exacerbation of preexisting physical conditions. Additionally, emotional distress was a common theme found in responses from the counselor participants (n = 136) who provided services during the pandemic (Mittal et al., 2023). The political climate,

decrease in caseloads, financial concerns, personal loss of loved ones, and racism-related stress took a toll on some mental health professionals and impacted clinical practice (Mittal et al., 2023; T. Singh et al., 2022). For some, satisfaction in their work decreased as the limitations on their clinical practice increased due to COVID-19, which made it difficult to be present for clients. For those who experienced the positive impacts on their clinical work professional boundaries were implemented. Decreased caseloads were required for increased empathy, therapeutic deepening, and work satisfaction (Mittal et al., 2023). Mental health professionals reported increased rates of grief, burnout, and trauma during the COVID-19 pandemic. All of which led to the presentation of compassion fatigue and symptoms of secondary traumatic stress (Mittal et al., 2023; Ricks & Brannon, 2023). The COVID-19 pandemic had a notable impact on counselors as they addressed the emotional distress in their communities.

Counselors' Experience of Vicarious Trauma During the COVID-19 Pandemic

Counselors have experienced the burdens of caring for others and being helpers in the past (Michalchuk & Martin, 2019). Vicarious trauma has been named among the potential costs of caring for others in a multitude of studies that have explored the experiences of counselors who work with trauma survivors (Dayal et al., 2021; Michalchuk & Martin, 2019). During the COVID-19 pandemic, mental health professionals had the potential for multiple layers of impact on their psychological well-being. Vicarious traumatization is the shift in worldview and disruption of meaning or hope that results from continuous exposure to traumatic information while working with traumatized individuals (Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995).

Mental health professionals are exposed to traumatic information when directly helping clients or patients process the traumatic experiences in their lives. Often used interchangeably with compassion fatigue, burnout, and secondary traumatic stress, vicarious traumatization is difficult to pinpoint in the literature. It is important to clarify that these four terms have different meanings and that this review highlights the experience of vicarious traumatization as defined above.

Vicarious traumatization is a phenomenon specific to those who directly work with individuals who have experienced traumatic events. Different from burnout, compassion fatigue, and secondary traumatic stress, vicarious trauma is deep-rooted and is a change to the core of individuals who experience the shift in worldview. Where vicarious trauma presents as a loss of hope or meaning, burnout presents similarly to depression. Burnout is the exhaustion, anxiety, depression, and progressive loss of energy or motivation toward goals due to personal or work-related stress (Figley, 2012). Compassion fatigue is a desensitization to the stories of clients and a decrease in the care for clients that gradually builds as emotional and physical exhaustion increases (Figley, 2012). Compassion fatigue can present as a loss of empathy for others or the population that a counselor serves. Secondary traumatic stress occurs due to exposure to traumatic information or hearing about a traumatic event. Secondary traumatic stress mimics the symptoms of PTSD via avoidance of reminders, hypervigilance, functional impairment, distressing emotions, and intrusive imagery similar to flashbacks (Figley, 2012). While overlap has been seen in the literature, this study will directly focus on the deep-rooted

change that happens during the phenomenon of vicarious traumatization not the presentation of burnout, compassion fatigue, and secondary traumatic stress.

Vicarious traumatization occurs over time. It is a change within the person that happens over an extended period of exposure to traumatic information. Exposure to traumatic information can happen in many ways, like working in victim services, being a first responder, or being a mental health professional working with traumatized clientele (Figley, 2012; Quitangon & Evces, 2015). The change impacts core beliefs about meaning and hope while mimicking the hypervigilance and avoidant behaviors commonly associated with PTSD or secondary traumatic stress. Someone experiencing vicarious traumatization may experience diminished hope in the work that they do or have a lost sense of meaning behind the work that they do. This is what makes vicarious trauma an exclusive phenomenon to professionals who work with traumatized populations rather than individuals who personally hear of a friend's traumatic experience (Figley, 2012; McCann & Pearlman, 1990; Quitangon & Evces, 2015). Vicarious traumatization is not an overnight or one-time exposure consequence. It builds silently within a professional as they work to help those who have experienced a traumatic event or events (Figley, 2012; Rauvola et al., 2019).

Collective Trauma

The COVID-19 pandemic has been considered a shared or collective trauma in the literature and a point of double exposure (Werner et al., 2020) to those who were working to assist their communities in handling the emotional and psychological distress during the pandemic (Hutto et al., 2024; Kaubisch et al., 2022; Mittal et al., 2022).

Mental health professionals were confronted with their concerns and fears of contracting COVID-19 and the grief from losing people in their personal lives. In addition to their personal experiences, mental health professionals were exposed to the traumatic information from clients experiencing grief, anxiety, depression, and other psychological distress during the COVID-19 pandemic (Michalchuk & Martin, 2019; Mittal et al., 2023). This personal and professional or double exposure to the circumstances related to the COVID-19 pandemic is linked to the psychological distress of counselors or second-line health care workers.

Previous literature on working amid crisis shared a theme of needing adaptability and coping strategies for mental health professionals during the COVID-19 pandemic (Kranke et al., 2020; Suarez et al., 2022). In addition to adaptability and coping strategies, this shared experience with clients required some mental health professionals to rely on personal and professional support systems (Aafjes van Doorn et al., 2020). For some mental health professionals, adaptability, resilience, coping strategies, and strong support systems helped them find meaning in the work they did despite the double exposure during the collective trauma of the COVID-19 pandemic. For others, the initial impact proved difficult in working with clients experiencing the physical and psychological distress related to the onset of the COVID-19 pandemic that they were also personally mitigating (Mittal et al. 2023).

Vicarious Trauma Among Second-Line Health Care Workers

Vicarious trauma during the COVID-19 pandemic was comparable to the findings of prepandemic studies (Aafjes van Doorn et al., 2020). The initial research during the

pandemic focused on the experiences and well-being of frontline health care workers. This research then extended to those who cared for and supported the psychological needs of the frontline workers. Mental health professionals and others who supported those who directly treated individuals impacted by COVID-19, like frontline workers, have been referred to as second-line workers (Fish & Mittal, 2021; Rossi et al., 2020). Both groups were essential in caring for their communities during the COVID-19 pandemic and the impacts of their service were felt around the globe (Arpacioglu et al., 2021; Dela Cruz et al., 2023; Powell et al., 2022). Frontline and second-line health care workers experienced emotional and psychological impacts during the pandemic. In addition to burnout, compassion fatigue, and secondary traumatic stress, both groups experienced vicarious trauma while working during the COVID-19 pandemic.

Though the literature discussing the psychological impact on mental health professionals during the COVID-19 pandemic exists, there is little that specifically addresses vicarious trauma. There has been some research completed by Aafjes van Doorn et al. (2022) to compare the findings of their study completed at the onset of the pandemic to data collected at the 12-month, 18-month, and 24-month mark. What we do know is that mental health professionals experienced vicarious traumatization toward the beginning of the pandemic that carried on into the 24th month of the pandemic (Aafjes van Doorn et al., 2020; 2022). We also know that the moderate to high level (77.65, $n = 266$) of vicarious trauma experienced by counselor participants in Aafjes van Doorn et al. (2020) study was found to be similar to studies previously completed about vicarious trauma in helping professionals prior to the COVID-19 pandemic (Aafjes van Doorn et

al., 2020). In a third COVID-19 study completed by Aafjes van Doorn et al. (2022) mental health professionals who had personal and professional support and high levels of vicarious traumatization were able to experience posttraumatic growth.

Summary and Conclusions

The global impact of the COVID-19 pandemic was historical and impactful in many ways. For the United States, the onset of the COVID-19 pandemic brought uncertainty and changes to status quo of life. From March 2020 to May 2023 the country was deemed to be in a public health emergency. This caused mask wearing, increased hand hygiene, social distancing, isolation during suspected or confirmed infection, decreased air and boat travel, and consistent testing to become the new normal. During the COVID-19 pandemic some began to work from home, often spending more time on video calls than they previously had. In addition to the day-to-day changes caused by the COVID-19 pandemic, elements like anti-Asian sentiments, the supply deficit, media influence, political polarization, and racial injustices interacted to create the syndemic experienced by United States citizens.

The interaction of the discussed additional elements, including systemic racism, created an impactfully nuanced syndemic for United States residents and citizens during the COVID-19 pandemic. The misinformation about the COVID-19 pandemic sparked anti-Asian sentiments that were at the root to verbal, emotional, and physical assaults against Asians, AANHPI. Food and housing insecurities were an additional point of concern for low-income and BIPOC citizens during the COVID-19 pandemic.

Additionally, the same groups were facing injustice within systems and had less access to

childcare, medical attention, and educational resources compared to White Americans and those in higher levels of socioeconomic status. With 2020, being an election year, the COVID-19 pandemic played a role in polarizing politics. The interaction of the COVID-19 pandemic, American politics, and the movement against police violence against African Americans was an additional stressor to BIPOC groups; the fear of police violence being greater than the fear of COVID-19 infection. The media reported all the aforementioned elements of the COVID-19 pandemic and was a point of stress for some who consistently consumed the media outlets of their choice.

Counselors were active responders to the COVID-19 pandemic efforts as second-line health care workers. As second line health care workers counselors had a double exposure to the collective trauma of the COVID-19 pandemic. This double exposure to the crisis-like event was linked to the emotional and psychological distress of counselor during the COVID-19 pandemic. Vicarious trauma symptoms were found to be experienced as a psychological stressor for counselors during the COVID-19 pandemic. The few studies about vicarious trauma symptoms in counselors during this period found that the symptoms did occur for counselors because of their work as a second-line health care worker. Few detailed experiences of vicarious trauma and the COVID-19 pandemic for counselors were found in the literature.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to explore the lessons learned by capturing the stories of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic and the impact that it has had on them, both personally and professionally. In this chapter, I introduce the method used in the study. This includes an explanation of the qualitative, narrative design and rationale. Additionally, I review my role as the researcher, the logic behind participant selection, and the semistructured interview protocol to be used in the study. I also discuss the procedures for recruitment, participation, and data collection along with the data analysis plan. I address the element of trustworthiness of the study. Finally, I outline the ethical procedures to ensure participant safety and ethical research practices throughout the study.

Research Design and Rationale

I sought to answer the following research question: What are the retrospective experiences of counselors who self-report experiencing vicarious trauma during the COVID-19 pandemic? To address this question, I used a narrative inquiry research design. A narrative inquiry allows researchers to gather an in-depth understanding through interviews (Kim, 2016). Narrative inquiry requires researchers to examine the stories and patterns within those stories to develop an understanding. Thus, bringing together an extensive view of experience in a way that provides a rich and deep look into the participants' experiences, more so than that of other research designs (Clandinin, 2007). Narrative inquiry provided me the ability to explore the impact on counselors who

experienced vicarious trauma symptoms during the COVID-19 pandemic, as well as postpandemic impacts personally and professionally.

The narrative inquiry design enables the co-constructors, including the participants and researcher, to develop a comprehensive understanding of what is being studied (Kim, 2016; Murray, 2003). The use of narrative inquiry in this study was rationalized by the fact that experiencing vicarious trauma is nuanced (Figley, 2012), and the overlay of the COVID-19 pandemic added a lot of additional factors to the experiences that counselors may have had alongside vicarious trauma symptoms. Figley's (2012) work demonstrated that the nuanced nature of vicarious trauma will better align with collecting the stories of counselors to provide deeper insight and understanding. I explored the progression of impact on counselors, personally and professionally, after they experienced vicarious trauma symptoms during the COVID-19 pandemic. Additionally, the narrative approach allowed the participants to provide a story-like, aesthetic understanding of events as they shared their experience of vicarious trauma symptoms during the COVID-19 pandemic and its impact on them personally and professionally (Clandinin, 2007; Kim, 2016).

Phenomenological research designs were not chosen for this study because the focus on the essence of experience or phenomenon rather than the rich, personal stories of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic (Kim, 2016; Parcell & Baker, 2018; Peoples, 2020). I anticipated that the chronological sequence provided in narrative inquiry research would present results as the participants construct their narrative (Kim, 2016). Collecting these stories and

understanding lessons learned from the narrative would provide an extensive view to be transferred to similar situations.

Role of the Researcher

Hollingsworth and Dybdahl (2007) postulated that the constructivist, narrative researcher co-constructs the research focus of the research by managing the intentions of the participants through conversational, semistructured interviews. The power relationship between the researcher and the participants is shared as the researcher creates a conversational environment to collect the narrative in question (Hollingsworth & Dybdahl, 2007). My role as a researcher and approach to this study was that of an engaged co-participant. The narrative researcher interprets and analyzes the stories of participants and creates a collective narrative through the understanding of their experiences (Kim, 2016). Additionally, my identity as a licensed professional counselor who worked during the COVID-19 pandemic and who has experienced symptoms of vicarious trauma while working in a remote capacity impacted my lens as a researcher. I worked remotely for over 2 years throughout the duration of the COVID-19 pandemic. I used Simple Practice, Zoom video conferencing, and Google Meet video conferencing platforms to provide telehealth counseling to clients. I also experienced vicarious trauma symptoms through my work with survivors of domestic violence, sexual assault, and parents working toward reunification with their children. My experience of vicarious trauma symptoms did not leave me impaired, but I did seek counseling services to address personal traumas. I did not anticipate that participants would experience vicarious trauma symptoms to the point of impairment. I was aware it might lead to assumptions

about the experiences of participants. To mitigate this issue of assumptions, I used video journaling in my effort toward reflexivity and self-awareness about how my own experiences and biases could impact my interpretation of data. I was intentional about focusing on the aspects of the participants' experiences and gathering rich details from their stories throughout data collection rather than allowing my personal assumptions to be the focal point of their stories (Kim, 2016; Patton, 2015).

I did not anticipate any unethical power dynamics because participants were not under my instruction or supervision. I used Zoom to video journal my feelings and thoughts throughout the interview process to mitigate the issue of bias in data collection. The journal served as a vehicle for reflexivity and pivotal to the interview process. Reflexivity is the process where the researcher takes time to examine their personal experiences, potential biases, and assumptions that may influence the research process and data interpretation (Patton, 2015). I journaled instantaneously following each interview. I recorded the journal via video on the Zoom video conferencing software and had it transcribed using the transcription service provided by Rev online transcription.

Methodology

Narrative inquiry was the methodological framework for this study. Additionally, I incorporated John Dewey's theory of learning (2005) as the conceptual framework. The following section provides insight into participant selection, instrumentation, data collection, and data analysis using Labovian structural analysis.

Participant Selection Logic

I recruited counselors who worked using a distance platform (such as Zoom, etc.) during the COVID-19 pandemic. The inclusion criteria for the counselors were that participants had to have worked remotely for a minimum of 2 months during the pandemic, self-report experiencing vicarious trauma symptoms, and be licensed in their home state during the pandemic. The rationale for participants to have had a minimum of 2 months of work during the pandemic was influenced by the diagnostic criteria for PTSD and the tenets of vicarious trauma. Vicarious trauma presents with symptoms of PTSD, and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* notes that symptoms lasting longer than 30 days posttraumatic event progress the diagnosis from acute stress disorder to PTSD (APA, 2022; Figley, 2012). These symptoms can include intrusion of memories, flashbacks, and nightmares related to the traumatic experience. Additional symptoms include avoiding reminders that may be associated with the traumatic experience, negative changes in beliefs, thoughts, and mood. In addition, there may be detachment from others or positive feelings (consequently experiencing isolation or negative emotions), hypervigilance, reactivity, and sleep disturbances associated with the traumatic experience (APA, 2022).

I used purposive sampling to ensure that I had participants who could provide the needed information to answer my research question. Purposive sampling is a commonly used option for narrative inquiry (Kim, 2016). Narrative inquiry involves collecting rich stories from life experiences. The depth and quality of data collected is more relevant to narrative inquiries than the quantity of participants (Kim, 2016). Purposive sampling the

purposive sample size during data collection. I used saturation to guide me when determining the size of the purposive sample. I used saturation to guide me when determining the sample size during data collection, and I also used saturation to inform my selection of participants (Kim, 2016). For this study, I included counselors who worked a minimum of 2 months during the COVID-19 pandemic, held an independent license, and self-reported the experience of vicarious trauma symptoms during that time.

Qualitative, narrative inquiry research designs often do not have a set number of participants, and data collection continues until saturation is met. Participant maximums in previous studies have varying from 6 to (Vasileiou et al., 2018). For this study, six to 10 participants were expected to be sufficient for reaching saturation, given the in-depth nature of the narrative research. Saturation was met at a total of seven participants. The interview process pursued deeper and more descriptive narratives from participants, justifying the considerability of small sample sizes (Clandinin, 2007; Young & Casey, 2018).

Recruiting took place using social media groups for counselors, professional counseling associations' member lists, and Walden University's Participant Pool list for soliciting research participants. An electronic flyer was distributed. The flyer included a brief overview of the research and the survey (see Appendix A). Interested individuals were sent a letter of invitation via email to confirm their eligibility and provide consent to participate in the study (see Appendix B). Once eligible participants were identified and consent was provided, video calls were scheduled to complete the semistructured interview.

Instrumentation

A semistructured interview was the most appropriate method for gathering the stories of counselors who experienced vicarious trauma during the COVID-19 pandemic and how vicarious trauma has impacted them personally and professionally (Kim, 2016). This retrospective approach required participants to reflect on their experiences and provide insight into the impact on their lives then and now.

Jovchelovitch (2000) described the narrative inquiry interview as semistructured. Rubin and Rubin (2012) defined a semistructured interview as an interview with a specific topic to inquire about and with minimally prepared questions. A semistructured interview uses probing and follow-up questions (Rubin & Rubin, 2012). To align the interview with the approach, I formed the interview based on the four phases of narrative interviewing. The four phases include the initiation phase, the main narration phase, the questioning phase, and the concluding talk phase (Jovchelovitch, 2000). In addition to using those phases to structure the interview, I ensured that outside of the probing questions suggested by Jovchelovitch (2000), my questions were open-ended, unassuming, and deepening to increase the details collected in the narrative (Patton, 2015).

Narrative interviews are detail-oriented and have a beginning, middle, and end. Narrative interviews begin with a broad question to capture the story, then probe and ask additional questions. I used the original four-phases design, asking about participants' experience of vicarious trauma symptoms during the COVID-19 pandemic during the main narration phase. I then used the questioning phase to further collect the professional

experiences and the personal, vicarious trauma experiences of the participants. The concluding phase thanked participants for their time and for sharing their experiences, and also reminded them of their opportunity to bolster trustworthiness, an effort I describe later in this chapter. The interview protocol and concluding statement can be found in Appendix C.

Procedures for Recruitment, Participation, and Data Collection

I collected data by conducting semistructured interviews until I achieved saturation. I anticipated that six to 10 participants would be enough to meet saturation. Interviews continued until saturation was reached, and a total of seven participants completed the data set. I developed the interview protocol using a narrative interview framework as best practice by Jovchelovitch (2000) and aligned my questions to the current literature reviewed in Chapter 2. The semistructured narrative interview provided me with a full story or picture of the participants' shared experiences. I used Zoom to facilitate and record the interviews. Interviews were estimated to last between 60 and 80 min. If the initial round of recruitment had not produced enough participants, then the recruitment practices would have been repeated.

Only one interview was conducted within a day and that left ample time for me to journal and secure the collected data. All data was transcribed with the tools available via Zoom workspace. Once transcriptions were reviewed for accuracy, they were analyzed, and I created narrative summaries that were sent to the participants for approval. There were no suggested changes from the participants. Through this communication, the participants were thanked for their participation.

Data Analysis Plan

The data analysis plan was based on the Labovian model of structural analysis suggested for narrative inquiry. The Labovian model of analysis uses six categories for coding that include the abstract, orientation, complicating action, evaluation, result, or the coda of the story provided by participants (Kim, 2016; Parcell & Baker, 2018; Patterson, 2013). The Labovian model of structural analysis identifies the beginning, middle, end, setting, and characters included in the narrative. Characters are the term used in Labovian analysis to describe the important parties or people within the narrative. For example, I anticipated that participants' family, friends, coworkers, and clientele would be characters in their narratives. This type of analysis aligns with the semistructured narrative interview and identified and formed the combined narrative of the participants. Additionally, the Labovian model aligned well with Dewey's theory of learning. Both Labov and Dewey emphasized the importance of context, reflection, and problem-solving to make sense or create understanding of a situation (Kim, 2016; Patterson, 2013). I used a function within Delve, an online analysis software, to identify and categorize themes within the narratives that aligned with the literature. Then I used Microsoft Excel to organize the data and complete the Labovian analysis. Delve allowed me to categorize snippets to identify the beginning, middle, end, setting, characters, and then export the codes to Microsoft Excel to further code the six categories of the Labovian Model (Delve & Limpaecher, 2020). These categorized concepts and story elements were pieced together to form the final narratives.

Issues of Trustworthiness

Trustworthiness is the standard for assessing the quality of qualitative research (Patton, 2015). In qualitative research, trustworthiness is composed of four elements of measure. Lincoln and Guba (1985) defined these elements as credibility, dependability, transferability, and confirmability. Credibility is the alignment of participants' perceptions and the researcher's representation of the participants' experiences. Dependability is measured by the consistency of the researcher's process and the ability for it to be repeated (Lincoln & Guba, 1985; Patton, 2015). Transferability refers to the ability to apply research findings to other contexts. Confirmability is the extent to which the findings are not fully influenced by the researcher's bias or motivation but influenced by the participants. The following sections provide insight into the steps that were taken to mitigate potential issues of trustworthiness.

Credibility

In qualitative research, the data is found naturally through many means of observation or information gathering. In narrative inquiry, this data is collected through semistructured interviews that prompts participants to recount their experiences. Lincoln and Guba (1985) stated that member checking is a crucial technique in establishing credibility. Member checking is the act of ensuring the data collected is accurate and properly interpreted by the researcher (Lincoln & Guba, 1985). I completed member checking by sending analysis results to participants to ensure accuracy. Once approved by participants, I provided the results in Chapter 4. The affirmed data was used to create the full narrative summary for all participants. Additionally, I used reflexive journaling to

ensure credibility. Reflexive journaling is a method for keeping a record of one's feelings, values, interests, and reasons for methodological decisions (Lincoln & Guba, 1985). This was done to enable the researcher to examine the potential influence and avoid implications for the findings. Reflexive journaling was done in the form of videos rather than written format. I recorded my journal immediately after each interview. The videos were transcribed using the Zoom Workplace transcription tool and kept alongside the data from each interview.

Dependability

To achieve dependability in this study, the same protocol was used for each participant. Ensuring that the process remains consistent for each participant will enhance the dependability of the findings (Lincoln & Guba, 1985; Patton, 2015). Each participant was asked the same initially structured questions, and the nature of the narrative interview allowed for relevant follow-up questions to be asked of participants (Jovchelovitch, 2000). The semistructured interview protocol was reviewed and approved by my committee members. This approval increased the dependability and confirmability of the study's findings (Lincoln & Guba, 1985).

Transferability

To measure the transferability of qualitative research, there must be a sufficient account of the data collection and the social environment in which the data was collected. Lincoln and Guba (1985) and Holloway (1997) referred to this kind of validation technique as a thick description. Providing a sufficient explanation of the population that I studied allows consumers of the research to properly assess and apply the information

as it is relevant. This study explored the experiences of counselors who worked during the COVID-19 pandemic and experienced vicarious traumatization. This means that consumers of the research findings can be relevantly transferred to clinicians who work in similar situations with similar symptomology. The thick description also enables the replication of the study for those wishing to repeat or apply it to a similar population (Lincoln & Guba, 1985).

Confirmability

Confirmability is the assurance that the findings are accurate and unbiased by the researcher (Lincoln & Guba, 1985). As stated previously, the semistructured interview protocol will be approved by my committee members to ensure confirmability. I used triangulation to ensure confirmability. Triangulation was achieved by comparing the information gathered from sources. The participant demographics, interview transcriptions, and observed materials of data were compared to ensure consistency. The observed materials included any notes taken during each interview and the journal transcriptions. I also compared the data to ensure the consistency of the data gathered (Denzin, 1978; Patton 2015). This consisted of a review of each participant's data source, interview transcription, demographics, and observed materials, to confirm the accuracy of the information.

Ethical Procedures

To complete an ethically sound study, I completed several procedures to protect the interests of participants and the findings. Ethical procedures began with approval from Walden University's Institutional Review Board (IRB). Upon IRB approval (no. 06-

13-25-1061677), participants were recruited through a recruitment flyer shared via social media, a call for participants on the Walden University Participant Pool webpage, and recommendations from members of my professional network. I did not anticipate any unethical or problematic power dynamics with participants because no participants were under my supervision or instruction. The participants agreed to engage in the study by reviewing the informed consent and provided their consent via email with “I consent” in response to the informed consent. Participants were offered the opportunity to ask any clarifying questions through the recruitment process and confirmed their consent at the time of data collection. Data collection took place using a private Zoom video conference. I conducted the semistructured narrative interviews in a private room to ensure the interview were not overheard at the researcher’s end of the conference. The video conferences were audio recorded via Zoom functions. The video conferences were then transcribed using the tool Rev. Transcriptions were then uploaded to Delve for analysis. The data on Zoom, Rev, and the storage of the recorded data on Delve are under password-protected accounts. Participants chose pseudonyms to protect their personal identities throughout the study. All data and informed consents will be kept on file for 5 years. Data and informed consents will be stored separately to maintain confidentiality, but all information will be password-protected. Data will be deleted from its online database on Delve online analysis software and Google Drive online database at the conclusion of the 5 years.

Summary

I integrated John Dewey's theory of learning and the Labovian model of analysis to analyze the collected narrative data. These practices addressed the research question and met the purpose of the study. The narrative inquiry gathered the stories of counselors who experienced vicarious trauma while working through the COVID-19 pandemic. Participants were recruited until the point of saturation and were active participants in mitigating issues of trustworthiness through member checking. Participants were recruited through social media, my professional network, and the Walden University Participant Pool webpage. I used Zoom, Rev, and Delve software to collect, transcribe, file, and analyze data. In Chapter 4, I provide detailed results found from the data collection and analysis process.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore the lessons learned by capturing the stories of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic and the impact that has had on them, both personally and professionally. The research question for this study was, What are the retrospective experiences of counselors who self-report experiencing vicarious trauma during the COVID-19 pandemic? In Chapter 4 I will review the results found in the data collection stage. This will include the setting or description of influence on participants at the time of the study, participant demographics, a description of how data was collected and analyzed narratively, and a review of trustworthiness strategies used throughout the data collection and analysis process. I will also provide the results of the study within the format described from the Labovian structural analysis method.

Setting

The nature of this study required participants to retroactively reflect on their experiences of vicarious trauma symptoms during the COVID-19 pandemic. Semistructured interviews were completed using Zoom Workplace video call. This setting made it convenient for me to reach interviewees in any physical location and widened the range of potential participants. The use of Zoom Workspace video calls could have influenced participants to remember forgotten experiences during the COVID-19 pandemic when they were required to use telehealth platforms. However, no participants verbally noted this as a conscious influence. The study included seven

participants with varying workplace settings throughout the COVID-19 pandemic that had impact on how they told their narratives. The settings include adolescent inpatient, private practice with a range of age groups, substance use outpatient services, inpatient eating disorder treatment facility, outpatient non-profit addressing domestic violence survivors, and college students who were forced to return home during the COVID-19 pandemic. The range in level of care within the workplaces of the participants provided a wide view of how counselors may be able to better conceptualize the impact of working with clients in a future shared crisis phenomenon like the COVID-19 pandemic.

The response of workplace settings had a reported impact on the experiences of the participants. There were some participants who reported very poor response to the COVID-19 pandemic within their agency and there were others who experienced thoughtful and responsible responses to the COVID-19 pandemic. Participants shared that they were instructed to begin working from home at the onset of the COVID-19 pandemic and social distancing protocols. Others were pressured to meet their billable hours goals, with one participant reporting that she was instructed to continue to see clients after reporting potential exposure to COVID-19 infection the previous week. The data has yielded many similarities within the participants' experiences. However, the setting in which they worked, the population they served, and additional personal traumas impacted their experiences of vicarious trauma symptoms during the COVID-19 pandemic. For example, one participant described being pregnant during the pandemic and having to attend doctors' appointments alone. Another shared that her brother was diagnosed with brain cancer during the pandemic. A third participant shared the impact of

physical and medical issues that also impacted her experiences of vicarious trauma symptoms during the COVID-19 pandemic. Another participant shared that they experienced a house fire during the pandemic and were displaced for a period. She shared that she spent 3 weeks in a hotel and then an undisclosed length of time within a residential home that did not belong to her. She did not share if the delay was due to her Veterans Affairs benefits or if there were other circumstances that made it difficult to get into her own home quickly. She did share that she eventually bought an older home and enjoys remodeling and “creating a place of peace.” This experience of a personal trauma was an additional life event during the COVID-19 pandemic and an experience of vicarious trauma symptoms.

Demographics

All participants reported living and working within the United States, during the COVID-19 pandemic. The regions in which they work will be identified but the states will not be reported to align with the ethical protection of their identities. The first participant chose the study alias of Diamond. Diamond is a 57-year-old African American woman. She is a licensed professional counselor and approved clinical supervisor within two states in the Midwest and Southern regions. She has been in clinical practice for approximately 20 years. At the start of the pandemic, Diamond was toward the end of her coursework for a PhD in Counselor Education and Supervision. She was attending an online program and the Residencies that she would have traveled for at the start of the COVID-19 pandemic were shifted to full days on Zoom workspace

with her peers and professor. Additionally, she owned a private practice and was a supervisor to interns and residents or prelicensed professional counselors.

The second participant chose the study alias of Michelle. Michelle is a 35-year-old African American woman. She is a licensed professional counselor supervisor and licensed chemical dependency counselor in a Southern state. She has been in clinical practice for approximately 9 years. Throughout the pandemic she worked a state-wide non-profit organization that provides multiple services to survivors of domestic violence, including counseling. Michelle shared that she became a supervisor and was promoted to a leadership role within her agency during the COVID-19 pandemic.

The third participant chose the study alias of Dawn. Dawn is a 44-year-old African American woman. Dawn is a licensed professional counselor supervisor in a Southern state. She has been in clinical practice for approximately 17 years. Throughout the pandemic Dawn maintained her role as a counselor for college students enrolled in a university. She also started her own private practice during the pandemic.

The fourth participant chose the study alias of Matilda. Matilda is a 44-year-old European American woman. She is a licensed professional counselor in a Midwestern state and was granted a temporary license to practice in a neighboring state during the COVID-19 pandemic. She has been in clinical practice for approximately 15 years. Matilda maintained her role in a group practice during the pandemic. Matilda noted that unlike her private practice counterparts, her major clientele base were children and adolescents.

The fifth participant chose the study alias of Jennifer. Jennifer is a 50-year-old European American woman. She is a licensed professional counselor in a Midwestern state. She has been in the mental health field for approximately 20 years. At the start of the COVID-19 pandemic, Jennifer worked for a local agency that provided counseling services to adolescents experiencing substance use disorder who were either brought by their parents for counseling services or court mandated. In November 2020, Jennifer left her role at the local agency and started her own private practice.

The sixth participant chose the study alias of Alice. Alice is a 28-year-old Hispanic woman. Alice is a licensed professional counselor in a Midwestern state. She has been in the mental health field for approximately 6 years. Throughout the COVID-19 pandemic, Alice maintained her role as a counselor within the clinical team of a local pediatric residential behavioral health facility. She shared that during a significant portion of the pandemic, where she was required to participate in the local shutdown, she was pregnant with her second child.

The seventh participant chose the study alias of Jordan. Jordan is a 36-year-old European American woman. She is a licensed professional counselor in a Midwestern state. She has been in clinical practice for approximately 5 years. Jordan shared that she was a counseling student at the start of the pandemic. She was attending an institution that switched from in-person courses to online courses for the remainder of her final semester of her time in the program. She shared that this changed how they would practice skills with one another for faculty review and how she had to complete her internship hours. Everything became virtual, her class meetings as well as her sessions

with clients. She then graduated, virtually, in May 2020 and continued her role as a counselor at a local agency that provided counseling services to adolescents who were brought in by their parents or court mandated experiencing substance use disorder. In 2021, Jordan transitioned to private practice while keeping the job at the local agency. Jordan then gained employment at a local residential eating disorder treatment facility in 2022. She was no longer working at the other agency with substance use disorder treatment. Jordan completed her supervised clinical hours and became an independently licensed counselor toward the end of the COVID-19 pandemic.

Data Collection

Participant recruitment began on June 13, 2025, upon approval from the Walden University IRB and ended on July 31, 2025. All seven participants completed semistructured, narrative interviews on Zoom workspace. The interviews varied in length with the average of approximately 50 min. The length of interviews was estimated to be a minimum of 60 min; however, most participants were succinct in their responses. All interviews were held on separate dates, as outlined in Chapter 3. Each interview was audio recorded using Zoom workspace. Each audio was then uploaded to Rev, an online transcription tool that is HIPAA compliant, for transcription. I reviewed each transcript for accuracy and edited to match the audio recording. The use of Rev for transcription was a variation made through the IRB approval process. All transcripts were then uploaded to Delve for data analysis. There were no unusual circumstances.

Data Analysis

Once all transcripts were uploaded to Delve, they went through two rounds of coding. I completed deductive coding using Delve to organize data and create a structure for analysis. The first round of data analysis was the deductive assignment of themes that were consistent with the literature. The second round of deductive coding included assigning story parts to the existing snippets of coded information. The story parts assigned were “beginning,” “middle,” and “end.” The data was then organized within an Excel spreadsheet, showing the data alongside the codes previously assigned, from the first two rounds of data analysis. The data then went through two additional rounds of coding within the Labovian structural analysis model. This included parsing out the saved snippets and then assigning them a label within the six story parts of the Labovian structural analysis: abstract, orientation, complicating action, evaluation, result/resolution, and coda. The data within the Labovian structural analysis round of coding is a pivotal part of data analysis and interpretation of participants’ narratives.

Round 1

The first round of deductive coding was completed with the use of Delve software to organize the identified themes that were consistent with the literature on the experiences of counselors during the COVID-19 pandemic and the experiences of counselors who have reported a history of vicarious trauma symptoms. This first round of analysis also was an opportunity to code themes of lessons learned throughout the data to align with the conceptual framework of John Dewey’s theory of learning. The thematic codes found in this first round included: life events, COVID-19 concerns, syndemic,

vicarious trauma symptoms, learning through experience, and postpandemic experiences and changes.

Life Events

Life events was a theme that arose from the many large life transitions or events for participants. One participant noted the loss of the graduation celebration earned leading up to the onset of the COVID-19 pandemic in March 2020. Jordan shared, “I graduated with my degree virtually because I graduated in May 2020, so I didn’t get any of the graduation stuff.” This same participant noted multiple job transitions during the pandemic and ultimately ended with working in private practice and at a residential facility to accomplish the required hours and training for independent licensure. She met requirements for independent licensure prior to the end of the COVID-19 pandemic. Jordan shared, “in 2022, I decided to go back to agency work and found a job in an eating disorder residential facility” In addition to her graduation and pursuit of full licensure Jordan noted, “I had my own medical issues going on, and I was having really intense panic attacks,” during the pandemic that were additional impacts on her during that time. During a significant portion of the county-imposed quarantine, interaction with medical professionals was also a large part of Alice’s experience. She shared that she was pregnant and had a child during the COVID-19 pandemic.

Jennifer shared that she encountered multiple life events during the COVID-19 pandemic. She shared that following a difficult situation at place of employment. “I immediately put my 2 weeks in,” noted Jennifer in the aftermath. She also shared that, “... my older brother, who I was very close with, was diagnosed with brain cancer.” She

shared that these two events were major life events during the pandemic. Diamond shared that “during 2020 I had a (house) fire,” which was an additional stressor and life event during the COVID-19 pandemic. “I was actually working on my doctorate at the time...” noted Diamond.

The COVID-19 pandemic itself was a life event for each participant. “I do think that was a collective trauma that we all went through,” noted Matilda. Multiple participants noted that the pandemic was a shared experience with clients. Some have shared that the COVID-19 pandemic is something that they often address with clients post pandemic. Michelle shared an initial impact that she and some of her clientele experienced. “I had a friend pass away really soon into the pandemic, and I could not properly grieve it,” Michelle noted as a parallel to the experiences of her clients.

COVID-19 Concerns

The COVID-19 pandemic brought many similar challenges to the participants. Participants shared how their places of employment handled the onset of the pandemic and how that pivot impacted their experience of the COVID-19 pandemic. Jennifer shared that, “they (her place of employment) completely did not follow any of the recommendations...I was working for an agency that handled the pandemic horrendously.” In contrast, Michelle had a different but surprising response from her agency. She shared how crises had not usually been handled as seriously as COVID-19 within her place of employment. “A bunch of trainings happened quickly. Then I just started doing telehealth,” Michelle noted. Additionally, Matilda noted that her place of employment brought about different concerns during the COVID-19 pandemic. “I was in

a private practice, so if I don't work, I don't get paid," Matilda shared. Matilda shared that she was concerned about how her adolescent clientele would transition to telehealth counseling and if their parents would even continue their counseling services. Furthermore, she was concerned about how to implement her play therapy modality, that does not usually include the use of electronic devices, on a telehealth platform.

Telehealth. The onset of the pandemic brought about points of issue with how services were rendered and how that impacted the experiences of participants during that time. Alice shared that the use of telehealth in her residential environment, "was more of a barrier than it was a bridge." Dawn noted that she was impacted by the environment of her college student clients. "I think that was the biggest struggle again, if they weren't in a safe home, where are we even having these sessions at?" Matilda, who mostly works with children, noted a significant struggle at the start of the pandemic and use of telehealth. "I felt like all of a sudden I had to learn to do my job completely differently and learn to do a job that I had never trained for," noted Matilda about the need to use play therapy in a way that it was not originally designed. She also shared that she did seek consultation with other clinicians using play therapy, but that they were all trying to figure it out together.

Parallels With Clients. Participants shared how the onset of the COVID-19 pandemic created a condition where mental health professionals were experiencing parallel struggles with their clients. Dawn shared her frustration with limited coping skills for herself and her clients, "...how do you continue coping with something that no one has ever experienced." Jordan shared that she noticed how both she and clients were

lacking the structure they desired. Jordan noted that “there was no control over anything, nothing.” Participants reported that parallel experiences with their clients made it difficult to maintain the usual boundaries. Michelle shared her reflection of the earlier part of the pandemic, “they (clients) were telling me about what they were going through, and it was just no separation at all.” Michelle shared this as personal point of struggle with symptoms of vicarious trauma and described herself as being “over empathetic” due to the parallels between her experiences and her clients’ experiences. Michelle did not see this as her being within an ethical dilemma or as if she was an impaired clinician. However, she did note that she took on less work for a week during the COVID-19 pandemic to address her symptoms of vicarious trauma.

Syndemic

While the world was facing the COVID-19 pandemic, the already existing systemic issues for the African American community were exacerbated. Racism is the belief that race determines an inherent superiority of a particular race which fuels the systemic, structural oppression of a racial group on an emotional, social, political, and economic level (Jones, 2021; Zhou et al., 2022). Jones (2021) shared that racism is the oldest existing pandemic that has been shaped systems in which we live within. That includes education, health care, housing, income, and unemployment systems (Jones, 2021). When these systems collide, they create a systemically oppressive dynamic for BIPOC (Carter et al., 2023; Jones, 2021). Diamond shared how her practice was impacted heavily by the syndemic. “When America bleeds, African American culture goes into a whole different ballgame,” noted Diamond as she reflected on how her

practice offered those working with the Black Lives Matter movement free counseling. The proximity of the end-of-life services for George Floyd had an impact on Michelle as well. “I think that (death of George Floyd and Breonna Taylor) also played a part because then that social activism, political awareness really, really came to the forefront,” noted Michelle. This theme was mostly evident for participants who identified as African Americans and had clientele that were also African American. This seemed to be rooted in the way the participants understood themselves and their role within their community. “I’m a black woman and I am the matriarch of my family,” noted by Diamond, who emphasized the importance of her holding things together for her family and her community despite the system threats to their wellbeing.

Vicarious Trauma Symptoms

The experience of vicarious trauma symptoms was evident in each participants’ story. The symptoms reported were physical, emotional, and psychological. Each participant had varying awareness of vicarious trauma symptoms as they occurred, but all reported that being asked about their experience is what brought a deeper realization of how things unfolded during the COVID-19 pandemic. The initial need to quarantine or participate in social distancing had an impact on how participants felt following session. “Home was isolating. Work was isolating. Everything was isolating,” Jordan reflected. Participants discussed an issue with sleep dysregulation and finding that they were experiencing trauma responses. Alice noted that the formation of vicarious trauma symptoms was not immediate, “It wasn’t one singular moment; it was a thousand of them that just compounded the weight of that vicarious trauma over time.” She also shared that

she now has a full understanding of what it feels like to be triggered by the work she is trained to do. Alice's experience shows how supervisors and counselor educators can caution and model for future counselors in training about the ways that small moments can compound to present as physical, emotional, or psychological symptoms of vicarious trauma.

The physical and emotional symptoms experienced by participants continued to show as a theme within the vicarious trauma symptoms. "I was still having migraines, the blood pressure (increased), my cynicism was through the roof, just feeling like hopeless," Jennifer shared. She reported that these physical and emotional symptoms continued after she resumed her self-care activities. She was exhausted by the requirements of her agency, the lack of response to the global pandemic her agency had, and her grief for her clients' loss of milestones and normalcy. She was instructed to not count her overtime work and was made responsible for the firing of another coworker. Jennifer eventually decided that she needed to leave the agency that she worked at and that led to a decrease in her emotional symptoms of vicarious trauma.

Matilda described how she would be consistently "vibrating" and unable to sleep. She shared that the vibrating would make it impossible for her to get sleep when she usually did not have issues with sleeping. Matilda conceptualized the vibrating as a physical representation of the anxiety that she was experiencing during the COVID-19 pandemic. Her struggles to sleep and vibrating were somatic signs that she was experiencing vicarious trauma symptoms. She also shared how "hearing other people's worlds be upside down and be able to do absolutely nothing about it was terrifying and

awful.” This sentiment flowed through other interviews as well. Multiple participants reported a sense of hopelessness, lack of direction, pessimistic dispositions, decreased compassion, and a lack of belief in helpfulness to clients. Jennifer expressed the lack of belief in helpfulness by sharing that she got the “sense of rearranging chairs on the Titanic.”

Learning Through Experience

Learning through experience became a theme as participants shared about what has changed for them or what they gained from having experienced symptoms of vicarious trauma during the COVID-19 pandemic. Most of what was learned related to how the participants better care for themselves and how they grew as clinicians from their experiences. Diamond shared that she realized that she “can’t be everything to everyone.” She also improved her practice by strengthening her modalities. “I became a brainspotter,” noted Diamond. Brainspotting is a counseling modality developed by David Grand, PhD, LCSW in 2003. Brainspotting is the use of connection between eye position and where thinking processes lie within the client’s sub-cortical portion of the brain (Grand, 2013). This process includes a clinician finding an eye position that allows the client to bypass their neo-cortex or decision-making brain and access deeper body based and emotional processes in the sub-cortex of the brain (Grand, 2013). The modality is often used by clinicians that treat clients for trauma related distress.

Matilda reported that she “learned a lot of stuff about setting boundaries during COVID.” Additionally, she learned that the support systems that clinicians expect clients to have do not always exist. Participants discussed the need for separation in their work

life and home life to be successful. Dawn even shared that she needed to create boundaries with the news and media she consumed, by opting out of watching the news all together. A profound moment with Alice occurred as she reflected on the changes to the way she approaches trauma treatment. “I don’t pathologize those survival responses anymore,” noted Alice. Her experience of being in survival mode for a period during the COVID-19 pandemic led her to acknowledge a different way to conceptualize trauma responses.

Postpandemic Experiences and Changes

Post pandemic, participants noted the change in their experiences. There was a similarity in the gratitude participants had for the growth of telehealth. “I actually am thankful that telehealth is more normalized now because it is preferable to some people,” noted Jennifer. She does not prefer telehealth but respects it as a helpful tool to have. Multiple participants shared the use of COVID-19 within intakes or in other moments where they are assessing problem solving skills or providing psychoeducation on trauma. Michelle reported that she prompts clients to share about their COVID-19 experiences during intakes with new clients. “We’ll start with the pandemic. That was a shared trauma, and then I educate them on what trauma could look like,” noted Michelle.

Additionally, participants consistently reported a change in their values and priorities following the COVID-19 pandemic. Six of seven participants noted a change in self-care and overall wellbeing. “I would say that I am more protective of my time and energy than I used to be,” shared Alice. Diamond shared that she is less stressed within her professional life. She also shared how she prevents being without needed community

resources for clients when they need them or strategies for using telehealth to counsel children. Diamond further noted that “Every intern that comes in has to add to our resource drive as to what can be helpful”. Diamond also reported that for her personal wellbeing she takes the chance to travel, often.

Jennifer expressed a viewpoint that was an interesting discrepancy. She shared that she has been seeing familiarity between COVID-19 situations and the current political landscape within her clientele’s reaction. This report speaks to the political polarization that grew from the 2020 U.S. Presidential Election and the impact that partisanship had on how people viewed the COVID-19 virus. Gadarian et al. (2024) reported that support for Donald J Trump was a predictor of health behaviors. Donald J. Trump’s presidency and expressed opinions during the early portion of the COVID-19 pandemic led to a difference in how his supporters responded to COVID-19 pandemic than those who did not support him. Jennifer reports that she works in an area where support for Donald J. Trump was great and that she had clientele who believed that mask wearing was “stupid” or that the COVID-19 pandemic itself was “ridiculous.” She shared how it was a “challenge” for her to meet her clients where they were when they fell on the different end of the polarization that occurred during that time. Jennifer shared that she relied on basic counseling skills to support clients in their distress from the political climate. With the reelection of Donald J. Trump in the 2024 U.S. Presidential Election, Jennifer has noticed that she is facing similar challenges in her sessions as she did during the COVID-19 pandemic. “I parallel with clients as far as what I was doing then and really what I’m doing now,” noted Jennifer. She compares her experience of frustration

and feelings of helplessness during this second presidential term for Donald J. Trump to be like the response of clients impacted by the political landscape during the COVID-19 pandemic.

Round 2

I continued deductive coding using Delve software to categorize the existing snippets of information from the first round of coding into the beginning, middle, and end of the participants' narratives. I was able to see the formation of a story format through the second round of analysis. This round of coding also prepared the snippets for the subsequent rounds of coding. The second round of analysis brought insight to the implications for social change discussed in Chapter 5. The noted similarities of experiences during the beginning, middle, and end of the participants' narratives lends to the confirmability, evidence of trustworthiness, discussed later in this chapter.

Beginning

The WHO declared the spread of the COVID-19 virus a pandemic and global health emergency on March 11, 2020 (CDC, 2023). Within a week of this declaration, multiple U.S. states began shutdowns with varying rules per state (CDC, 2023). These shutdowns and implementation of CDC suggested social distancing guidelines led to layoffs and remote work for some (Coate, 2021; Head et al., 2020). Participants aligned with the literature by marking the onset of the of the COVID-19 pandemic and social distancing mandates as a milestone for themselves and their clientele. The pivot for five of the participants was as immediate as within the 1st week after the COVID-19 pandemic was declared. For one there was not an ability to pivot to telehealth due to the

residential level of care status of their clientele. The final participant followed the instructions of their agency and did not pivot to remote work until 2 months after the pandemic and only remained remote within that agency until June 2020. During the beginning of the pandemic two of the single participants moved in with their parents for support during isolation. This made it so that all participants were in family units with two to three generations within their homes. Each participant noted that the beginning of the pandemic was marked by uncertainty, swift changes to professional expectations and environment, and increased time with their families due to being compliant with shutdown guidelines that limited public outings to essential needs (i.e. groceries, essential jobs, medical appointments).

Middle

The middle part of the participants' story was marked by uncertainty. Participants were unsure of when the pandemic would come to an end and how to continue handling the struggles presented during the beginning of the COVID-19 pandemic. Participants expressed their need to shift to more sustainable practices. This included seeking different work environments, limiting the number of clients that participants worked with, and implementing different coping skills. Six of the participants noted that they had to change a room in their home around to accommodate ethical telehealth practices and ensure privacy for their clientele. Two participants reported having to take on the role of homeschooling their own children as they adjusted to working from home. All participants did not share the platforms used for telehealth services but the three who did used video platforms like Zoom Workspace, Simple Practice, and Doxy. Two shared that

they used audio only telephone calls at the instruction of their agency of employment. It was during this period that most participants began to seek their own mental health services via counseling or psychotropic medication management. Multiple participants reported increased time outdoors or exercising. They began walking outdoors multiple times a day, increasing the mileage they walked, and starting fitness challenges with others in their network. It was during this period that participants noticed their symptoms of vicarious trauma and began to address them by decreasing daily caseloads, increasing exercise, consulting with their local peers, and seeking counseling for themselves.

End

The ending portion of the participants' story is marked by the end of the declared public health emergency. The end of the U.S. declaration of the public health emergency was May 11, 2023 (Assistant Secretary for Public Affairs, 2023), however all participants reported returning to hybrid work by the beginning of 2022. During this time participants were either returning or continuing the in-person work with clients and report a sense of "normalcy" that had returned to their work. At the end of their stories, it had been approximately 3 years since the onset of the COVID-19 pandemic and at the time of data collection, June and July 2025, participants have had time to reflect on how their experiences of vicarious trauma symptoms have impacted them professionally and personally.

Participants noted the evolution of themselves from their experiences of vicarious trauma symptoms during the COVID-19 pandemic and how that has impacted them in the 2 years beyond the end of the declared public health emergency. All of the

participants noted a change in how they use telehealth platforms. Alice, Jennifer, Jordan, and Matilda note that they have returned to mainly seeing clients in person but are quick to use telehealth as an option during times where they or their clientele may be sick or it is more convenient for the client. However, the use of telehealth for Matilda and Jennifer is used as needed due to their work being primarily with children. Diamond reported that she has her clinicians and interns choose a day to work from home to offer telehealth to accommodate the demands of their clientele. Additionally, all participants have noted a change in how they conceptualize trauma and provide psychoeducation to their clientele. These changes will be discussed in detail in the results section of this chapter.

Six of the participants recognized that they simply moved on from the events of that time without processing it as an experience of vicarious trauma symptoms. When asked about what brought about the awareness to experiencing symptoms of vicarious trauma, Jordan boldly said, “You asking me about it (vicarious trauma symptoms) ... I compartmentalized really well.” Five participants noted that their awareness and reflection came from their participation in this study. Alice shared that she “dismissed things like the exhaustion as it is just pandemic fatigue,” rather than the “emotional numbing” that she reported experiencing. All participants have reported that they have experienced a decrease in vicarious trauma symptom presentation within themselves and an increased effort to take care of their own mental and physical wellbeing following the end of the COVID-19 pandemic. Diamond and Alice shared that they prioritize travel and time with their families for their wellbeing. While Jennifer and Matilda keep separate spaces for home and work to take care of their mental wellbeing. Additional examples of

these changes can be found in the narratives of each participant within the results section of this chapter.

Round 3

The third round of analysis involved parsing or separating the large snippets. Separating the snippets into smaller or simple sentences allowed me to prepare the previously saved codes for the final round of analysis. I realized that many of the originally saved snippets of data were not small enough to code with clarity in Labovian structural analysis. There were snippets that appeared to fit more than one code and made it difficult to understand the structural importance of the sentences. For example, the snippet from Diamond originally stated, “I am not just vicariously getting it through my clients, but I'm getting it from my residents and interns who are getting it from their clients.” I then broke that down to be three separate lines on the Excel spreadsheet. The first stated, “I am not just vicariously getting it through my clients.” The second said, “but I'm getting it from my residents and interns.” The third stated, “who are getting it from their clients.” This was done for each participant's snippets from the previous rounds of data analysis.

Round 4

I used Labovian structural analysis in Round 4. In this round of analysis each snippet was coded in one of six categories that belong to the Labovian structural analysis model. The six codes are abstract, orientation, complicating action, evaluation, results, and coda. These six categories represent a part of the story presented within the participants' narratives. Snippets placed within the abstract code provided insight as to

what the story was about. Those placed in the orientation code exhibited the setting, involved people, and time of the story. The snippets that presented the problem or main issue within the story were assigned the code complicating action. Snippets that provided insight into how the participant made sense of what was happening and how the complicating action impacted them or others within the story were coded for evaluation. The snippets that gave insight into how participants solved their problems or the outcomes from their evaluation were coded as a result. Finally, snippets that shared about the outcomes and postpandemic happenings were coded as coda.

Evidence of Trustworthiness

The quality of this qualitative study is assessed through trustworthiness. I used multiple strategies to include the four elements of credibility, dependability, transferability, and confirmability that are used to measure trustworthiness (Lincoln & Guba, 1985). These efforts ensure that I have taken intentional steps to be as truthful with my findings and as methodical as I can be in this data collection and analysis process. I provide a thorough explanation of how each element was approached within the following sections.

Credibility

Credibility is determined by how the perceptions of the participants align with the researcher's representation of the participants' experiences through data analysis. I created summaries of each participant's interview once I went through each round of coding. Participants were then sent their summaries and given the opportunity to confirm their representation within the study, as well as my understanding of the major points of

their narrative. Five of the seven participants gave feedback about their summaries, and all have confirmed the accuracy of the interpretations, with no suggested changes.

Additionally, I completed reflexive journaling following each interview. I did this by recording my immediate after thoughts via video. These recorded thoughts helped to acknowledge and verbally process the personal connections, research connections, and participant to participant connections that I noticed throughout the data collection process. This helped me to recognize when my personal experiences aligned with those of participants and acknowledge the need to be cognizant of how that can show up throughout the data analysis.

Dependability

I completed data collection with the same protocol for each participant to ensure dependability. Each participant answered the initial narrative question within the semistructured interview protocol and was asked the same follow-up questions listed in the protocol. Additional follow-up questions were asked in an effort to gather details about a point of interest within each participant's interview. This process aligns with Jovchelovitch (2000) semistructured narrative interview. The interview protocol was reviewed and approved by the Walden University IRB and my dissertation committee members prior to data collection.

Transferability

I have provided detailed descriptions of my process in data collection and data collection environment to ensure transferability. The thick description is a validation technique used to help future researchers replicate the study. Additionally, the consumers

of my study will be able to recognize the similarities within the narratives that may apply to those who work within similar situations with similar symptomology. This includes other licensed professional counselors and other professionally licensed clinicians who work with similar populations or experience similar circumstances and experience symptoms of vicarious trauma.

Confirmability

To ensure confirmability, I sent a summary of the data analysis to each participant for feedback. Additionally, the semistructured interview protocol was approved by my committee members as well as Walden University's IRB. This means that the interview protocol was drawn from the literature review, formed with intentionality, oversight, and ethical consideration. Participants' demographics, interview transcriptions, and my observations of participants were compared to ensure consistency. I was able to track consistencies throughout each participant's shared experiences throughout the data collection stage. There were many consistencies in vicarious symptom presentation throughout the narratives of each participant, and all met the same qualifications for study participation.

Results

The research question for this study was answered via the retrospective accounts of the participants who self-reported experiencing symptoms of vicarious trauma during the COVID-19 pandemic. I have constructed the results for each participant, using the Labovian structural analysis. There are many similarities across the participants' recounts. However, the differences in the recounts add context to the experiences that co-

occurred alongside the experience of vicarious trauma symptoms. These differences allow for counselors and counselor supervisors to assess the impact of shared crisis-like experiences on themselves or supervisees in future situations and adjust to current best practices for trauma-informed care. The results of the analysis will be provided in the format of a narrative summary and is accompanied by charts depicting the structural codes used to create the narratives.

Diamond's Narrative

Diamond's experience of vicarious trauma symptoms during the COVID-19 pandemic were a result of the work she did with clients, residents, and interns. These symptoms were also exacerbated by the personal challenges she faces during the COVID-19 pandemic. These challenges included surviving a house fire and completing a PhD program during that time. Diamond was a small private practice owner, resident supervision, and PhD student at that onset of the pandemic. Her additional identities of being a mother, grandmother, and the matriarch of her African American family were influential to her experiences throughout the COVID-19 pandemic.

Diamond shared how the onset of the COVID-19 pandemic brought growth to her private practice with an influx of African American clientele. She expressed that this was due to the social climate and impact of the Black Lives Matter movement during that time. She partnered with the organization to offer free counseling for those on the "frontlines" of the movement. Her practice had gone virtual, and she followed the lead of her doctoral program by using Zoom to continue her practice's provision of counseling services. Diamond shared that her experience with telehealth was made easy due to the

platforms available to her and her practice. The only struggles came with compiling necessary resources, tutorials, and virtual materials to provide competent telehealth counseling to children and adults.

Diamond's recount of vicarious trauma symptoms included intense paranoia and a heavy feeling within herself that came from the pressure to "hold it all together" for her family and residents. Her poor experiences with the three social workers provided by Veteran Affairs increased her paranoia due to the lack of cultural competence and rigidity of the treatment modality. Her increased exposure to traumatic information from her clients and residents' clients had become overwhelming and added to her paranoia. Additionally, experiencing a house fire and being displaced from her home was also impactful to her experience of vicarious trauma symptoms. She shared how she was followed by an unknown white male in the neighborhood of her temporary home and was paranoid about the potential outcomes of the situation. Table 1 shows the Labovian codes identified in Diamond's responses.

Table 1

Diamond's Labovian Analysis

Interview excerpt	Labovian code
"My vicarious trauma either came from my residents who were going through and my [stuff]."	Abstract
"I am a practice owner and supervisor."	Orientation
"I started telling everybody, this is how we're going to do it. All appointments are now moving virtual."	Complicated action

“I have residents. I got to hold them together so they can be what they need to be to their clients.”	Evaluation
“Painting, the coloring, the exercise, eventually the medication, ... working in my garden.”	Result
“I am not as stressed.”	Coda

Michelle’s Narrative

Michelle’s experience with vicarious trauma symptoms during the COVID-19 pandemic was marked by the need to be “on” constantly for clients as she navigated her own challenges experienced during the COVID-19 pandemic. Michelle noted that at the onset of the COVID-19 pandemic brought a lack of separation between her experiences and the experiences of her clients. She referred to the COVID-19 pandemic as a shared trauma that led to a blurring of boundaries between her own feelings and fears and those her clients were experiences. These fears included the concerns for elderly family members that were at a greater risk for health impacts from COVID-19 infection.

As the COVID-19 pandemic continued, Michelle learned of her vicarious trauma symptoms through trainings and consultation. Michelle found that she was over-empathizing with clients and blurring the boundaries that are expected within the profession. She noted that her increased empathy transformed to “numbness” as time went along. She began to address her presentation of vicarious trauma symptoms by increasing her exercise and connecting with others through that exercise. Michelle reported that the implication of her coping strategies played a large role in her being able

to continue showing up for clients. She reports that eventually she began to enjoy the virtual group work that she facilitated.

Michelle shared that her experienced was additionally impacted by the socio-political issues that were prevalent during the COVID-19 pandemic. She reported that the Black Lives Matter Movement deeply resonated with her due to her shared ethnic background with many of her clientele. Michelle shared that the funeral of George Floyd was held in her local area and that it was difficult to separate herself from the grief and loss found in the socio-political climate's impact on her clients. Michelle's account of her vicarious trauma symptoms illustrates how the impact of personal and professional experiences during a crisis intertwines with one another as she continued to provide counseling for her clients during the COVID-19 pandemic. Table 2 shows the Labovian codes identified in Michelle's responses.

Table 2

Michelle's Labovian Analysis

Interview excerpt	Labovian code
"Because I was always on"	Abstract
"Because I was virtual...me as a clinician, I was at home just like they [clients] were."	Orientation
"And their [clients'] experiences were bleeding into mine."	Complicated action
"It went from overcompassion to under."	Evaluation

“I would cook different recipes...I was connecting with my support.” Result

“And then I educate them [clients] on what trauma could look like.” Coda

Dawn’s Narrative

Dawn’s experience of vicarious trauma symptoms during the COVID-19 pandemic were a result of burnout, emotional exhaustion, and an increase in clients seeking counseling services. Dawn shared that her experience of the COVID-19 pandemic began with the change to her clients’ daily lives. Dawn’s work with college students put her in the position to be concerned about students who were required to return to abusive environments and feeling isolated in those spaces. Her concerns about their safety and the lack of privacy on the clients’ end exacerbated her own concerns about the COVID-19 pandemic.

Dawn shared that she noticed a decrease in her self-care activities during this time. She reported feeling aversive to the idea of socializing through a virtual platform that she had to spend the day working with. She noted that she was not interested in sitting in front of another screen at the end of her workdays. Dawn also noted an emotional deterioration during the COVID-19 pandemic and feeling sadder “all the time.” Dawn found that she was withdrawn from her social interactions and feeling exhausted of energy. She shared that she “did not have the energy to give,” to social

interactions even though her isolation increased her sadness and feelings of heaviness during the COVID-19 pandemic.

As Dawn continued to work throughout the COVID-19 pandemic she began to realize that her isolation and avoidance of news outlets were not enough to warding off symptoms of vicarious traumatization. She realized the impact of negative experiences shared by clients on her own way of thinking and feeling. Dawn described herself as pessimistic and reported that the struggles that her clients were facing felt outside of her reach of effectiveness. She reported that seeking counseling for herself, setting a limit to her daily session number, and increasing her socialization helped her to decrease the symptoms of vicarious trauma that she experienced. Postpandemic, Dawn shared that noticed that she has begun to slowly shift to having full workdays and that she realizes the importance of maintaining the boundaries set during the COVID-19 pandemic. Table 3 shows the Labovian codes identified in Dawn’s responses.

Table 3

Dawn’s Labovian Analysis

Interview excerpt	Labovian code
“But I didn’t have any more energy to give.”	Abstract
“And I was with my parents...so I moved in with them during the pandemic.”	Orientation
“But there was an uptick in people trying to get in for counseling.”	Complicated action

“I think I started finding it harder to just do things that took care of myself.”	Evaluation
“I was seeking out my own therapy because I was like, I don’t know what’s even going on at this point.”	Result
“I think somewhere in there I found a good balance.”	Coda

Matilda’s Narrative

Matilda’s experiences of vicarious trauma symptoms during the COVID-19 pandemic were of a result of the stress she experienced as a counselor working with children and adolescents. Her work with children and adolescents left her to observe the grief, loss, and confusion within the population. She recognized the loss of milestones for her clients and the impact that had on their mental wellbeing. Her inability to make alleviate the hurt of those losses left her feeling helpless.

Matilda noted profound changes to her behaviors in handling the emotional needs of her clients while learning a new way to do her job that proved difficult. Matilda’s traditional use of play therapy proved to be difficult to adapt to telehealth platforms. Play therapy thrives through interaction in shared physical space. She initially found it challenging to meet the intentions of play therapy when having to directly go against the suggested protocols by needing to use telehealth platforms to provide counseling. Matilda’s experience of switching to telehealth created feelings of inadequacy and frustration. The emotional weight of her client’s experiences added to her feelings of

inadequacy and increased anxiety symptoms within herself. Matilda reported that she increased her tobacco use, insomnia, and feeling stuck in a “freeze response.”

With the switch to use of telehealth, Matilda was working from home and found that she was unable to maintain the boundaries between work and home. She shared that constant exposure to clients’ distress during the collective trauma experience of the COVID-19 pandemic resulted in her struggle to separate the feelings of anxiety from the feelings of her clientele. Matilda noted increased prioritization of the COVID-19 pandemic within her sessions and how the shared experience of the pandemic became apparent to her as the pandemic continued. To cope with her anxiety and struggle with boundaries, Matilda was intentional about keeping her dog with her in sessions and for sleep. She also would watch television shows from her teenage years to escape from the reality of the pandemic and find a sense of control. Matilda reported that she has acknowledged that she needs separation from home life and work life. Additionally, she has found that her experiences during the COVID-19 pandemic have made it important for her to acknowledge vicarious trauma symptoms within her practice and see trauma in a contrasting context. Table 4 shows the Labovian codes identified in Matilda’s responses.

Table 4

Matilda’s Labovian Analysis

Interview excerpt	Labovian code
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“I think a lot of the vicarious trauma came from just watching the grief and not being able to do anything about it.”	Abstract
“So, I work with kids and adolescents...I do play therapy.”	Orientation
“Hearing other people’s worlds be upside down and be able to do absolutely nothing about it was terrifying and awful.”	Complicated action
“I was just in a freeze response...that was the most useless I’ve ever felt in my life.”	Evaluation
“I tried to sleep a lot of the time with my dog, spent a lot of time with my dog.”	Result
“I think I’m quicker to acknowledge vicarious trauma and educate my clients on it.”	Coda

Jennifer’s Narrative

Jennifer’s experience of vicarious trauma symptoms during the COVID-19 pandemic were a result of initial poor decisions by her place of employment at the onset of the pandemic. Jennifer expressed that her status as a seasoned professional left her surprised by the presence of vicarious trauma symptoms as she reflected on her experiences during that time. She was working for a community mental health agency that provided counseling to adolescents and families dealing with substance use related

issues. She shared that much of her population were at a socioeconomic disadvantage prior to the onset of the pandemic and that the change caused by the pandemic exacerbated their personal struggles. Jennifer understood the importance of her role for her clientele, but the pressure and questionable directives from her place of employment threatened her personal wellbeing.

Jennifer's agency had a brief switch to telehealth services without any training that would have been helpful to her. She shared that she struggled to engage her clientele through telehealth in an effective way. Additionally, she shared that her agency applied pressure to herself and others to meet billable hours, implied that her lack of meeting those hours were the reason for firing another counselor and would not allow her to note any overtime work on her timesheet. Another point of concern for Jennifer was that she was exposed to COVID-19 through one of her clients and her supervisor dismissed the potential health impacts and encouraged her to continue working like usual. Jennifer shared that she eventually had to make the difficult decision to leave the agency without another job secured for herself. She was unable to continue experiencing the pressure from the agency, support clients who were losing milestones and stability, and address her familial needs as well.

During the COVID-19 pandemic, Jennifer had a brother who was being treated for brain cancer and elderly parents to protect from COVID-19 exposure. The stress from her agency, clientele's reported traumas, starting a new private practice, adapting to telehealth, and being the teacher to her children were influential to her experience of vicarious trauma symptoms. Jennifer reported feelings of hopelessness and cynicism, in

addition to physical symptoms such as increased blood pressure and migraines. She noted that her feelings seem to mirror the helplessness and uncertainty of her clients. As the pandemic continued she was able to recognize the importance of setting professional boundaries and self-care to increase professional stamina and empathy needed to validate the experiences of her clientele. In her reflection, Jennifer noted that leaving the agency was a large aide to lowering her personal anxieties and maintain the ethical standards that she believed would best benefit clients. She also shared that she has noticed the need for similar empathy used during the COVID-19 pandemic, in the post pandemic political parallels. Table 5 shows the Labovian codes identified in Jennifer's responses.

Table 5

Jennifer's Labovian Analysis

Interview excerpt	Labovian code
"I didn't even think about it as vicarious trauma that I was also taking on."	Abstract
"During the pandemic, I was working at, I guess a community mental health agency...providing counseling to adolescents and families who were either currently using substances...mandated for charges related to use of substances."	Orientation
"We're all going through it together...the hopelessness of it and the uncertainty...just the sense of rearranging chairs on the Titanic."	Complicated action

“I was still having migraines, the blood pressure, my cynicism was through the roof, just feeling like hopeless...my focus and memory was not good...I was not sleeping.”	Evaluation
“I gave my 2 weeks [notice] in October 2020 and started private practice in November 2020.”	Result
“We always can’t fix this...helping and supporting is sometimes enough.”	Coda

Alice’s Narrative

Alice’s experience of vicarious trauma symptoms during the COVID-19 pandemic are a result of the acuity of her clientele, personal struggles, and increased time spent working in a residential care setting for youth. Alice shared that the onset of the COVID-19 pandemic was different from those who worked in outpatient settings. She did not have a quick switch to providing telehealth services for her clients but was required to spend additional time at work providing care beyond that of a counselor due to staff shortages. Alice reported that holding the trauma of dozens of youth was especially difficult do to their being pregnant and uncertainty of the when the pandemic would end became a large emotional load for her during the COVID-19 pandemic.

Alice shared that the relentlessness of the pandemic attributed to her exhaustion and emotional numbing. She initially recognized this as “pandemic fatigue” but has since reflected on her experience as vicarious trauma symptoms. In addition to her exhaustion

and emotional numbing, Alice reported difficulty sleeping, enduring intrusive thoughts about clients, hypervigilance, blurred professional boundaries, and hopelessness as the pandemic continued and her clientele continued to struggle. She reported that telehealth was more of a barrier to success than helpful in engaging clients with family therapeutically. The limitations of telehealth and lack of in-person interactions seemed to increase feelings of isolation and disconnect for her clients, impacted her own grief and hopelessness as a professional.

As the COVID-19 pandemic progressed, Alice was able to find helpful tools to address her symptoms and the needs of her clients. She shared that co-regulation was found to be very important to the success of therapeutic alliance in clients with trauma histories. Alice shared that consultative groups with other counseling professionals, taking physical breaks throughout her workday, seeking counseling for herself, and prioritizing time with her family were helpful to addressing her vicarious trauma symptoms. Alice's experience during the COVID-19 pandemic has changed how she educates clients and supervisees about trauma, co-regulation, and prioritizing time away from work. Most importantly, her experiences have created a mindset where she refuses to cancel any vacation time or interrupt any plans that she must be surrounded by her family. Table 6 shows the Labovian codes identified in Alice's responses.

Table 6

Alice's Labovian Analysis

Interview excerpt	Labovian code
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“It was more likely stepping away years later kind of coming out of that I’m like, oh, that was definitely some vicarious trauma happening.”	Abstract
“I worked in pediatric residential care throughout the COVID-19 pandemic.”	Orientation
“So, I remained physically present in a facility filled with kids that were already dealing with layers of trauma now made even more complex by the global fear, the isolation, the disruption.”	Complicated action
“The emotional load was pretty relentless...difficulty sleeping, the intrusive thoughts about specific kids...crying on drives home.”	Evaluation
“I was taking more intentional breaks when I could...I definitely sought kind of my own therapy.”	Result
“I don’t skip vacations anymore...I don’t skip the opportunity to do things with my children.”	Coda

Jordan’s Narrative

Jordan’s experience of vicarious trauma symptoms during the COVID-19 pandemic were a result of disappointments in transitions, paralleled experiences with clients, and personal struggles. Jordan shared that she was a new counseling graduate 2 months into the COVID-19 pandemic. The abrupt switch in her reality was a personal

and professional challenge. She reported her disappointed in the systems that were meant to be supportive to her clients' therapeutic processes and participation as they were not engaged in helping her adolescent clientele at the start of the pandemic. Jordan worked for a community mental health agency providing counseling to adolescents within a substance use program. She shared how she felt an overwhelming sense of helplessness and frustration as she attempted to work within a system that seemed to lose its structure during the COVID-19 pandemic.

Jordan shared that her need to use telehealth is how she eventually became comfortable with the platform. She noted that her lack of confidence in herself as a new clinician had an impact on her professional anxieties during the COVID-19 pandemic, in addition to her preexisting panic disorder diagnosis. Jordan reported that she likes to know what the structure of a situation is and with multiple changes to her reality during the COVID-19 pandemic she struggled to manage her own panic and the struggles that clients shared. In addition to panic attacks, Jordan reported feelings of helplessness, increased fear, isolation, inconsistent sleep routines, and the sense of overwhelm that came from being under-resourced during the COVID-19 pandemic. Jordan's vicarious trauma symptoms seemed to be consistent despite the multiple changes in work environment.

Throughout the COVID-19 pandemic, Jordan worked in three different settings to get the required hours for independent licensure and the structure she felt she needed. Toward the middle of the pandemic, Jordan settled into working at a private practice and a local residential facility for those experiencing eating disorders. Jordan shared that

while the stability and structure helped her professionally, she was learning a new population and felt the overwhelm and hopelessness of being unable to meet the needs of clients. Additionally, Jordan noted that her supervisory relationship played a role in her increased empathy, which had noted positives and negatives for Jordan. In the end, Jordan was able to meet the required hours for full licensure prior to the end of the COVID-19 pandemic and learned the importance of boundaries for herself in professional spaces. Jordan shared that her experience of vicarious trauma symptoms during the COVID-19 pandemic has led her to seek additional treatment modalities for traumatic stress and to continue the work of maintaining boundaries to create space from work. Table 7 shows the Labovian codes identified in Jordan's responses.

Table 7

Jordan's Labovian Analysis

Interview excerpt	Labovian code
"So, I guess my theme is that just utter sense of helplessness."	Abstract
"I was also working in an outpatient substance use program for adolescents."	Orientation
"That helplessness of there's just the systems that existed and the drive and the goals that originally existed all of a sudden just no longer exist."	Complicated action
"I was either not really sleeping at all or always sleeping...it wasn't a lot of hours [of direct services]."	Evaluation

“And then I did the private practice thing...2022, I Result
decided to go back to agency work.”

“We all have trauma, and I genuinely don’t think that Coda
would’ve been anything I would’ve said before.”

Summary

Counselors having experienced symptoms of vicarious trauma during the COVID-19 pandemic, have had similar experiences and lessons learned. The results found through the data analysis show the shared experiences of counselors during the COVID-19 pandemic and the emotional toll that it took to manage their personal lives and the struggles of their clientele. Each participant noted the helplessness or hopelessness of the situation at some point within their story. Additionally, each participant shared both physical and emotional impact within their presentation of vicarious trauma symptoms. Participants all reported attempts to manage their vicarious trauma symptoms. Most reported increased physical exercise and several shared that they sought some form consultation or counseling for themselves. The need for boundaries, continued self-care, and personal therapeutic intervention were lessons learned by counselors that experienced symptoms of vicarious trauma during the COVID-19 pandemic. Further, each participant shared the way that their experience of vicarious trauma symptoms impacted their practice of counseling. All have a greater acknowledgement of vicarious, shared, or collective traumas, and use this knowledge to educate clients and build rapport during intakes. Several have begun to use a hybrid work

style to accommodate those who request telehealth and collect resources for themselves and their practice colleagues to feel better prepared in the event of a similar situation. In Chapter 5, I will discuss the implications for social change and impact of these results for counselors, counselor educators, and counselor supervisors.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this retrospective qualitative study was to explore the lessons learned by capturing the stories of counselors who have experienced vicarious trauma symptoms during the COVID-19 pandemic and the impact that has had on them, both personally and professionally. I used a narrative inquiry design and conceptual framework of John Dewey's theory of learning to address the purpose of the study. I found that lessons learned by counselors who had experienced symptoms of vicarious trauma during the COVID-19 pandemic included recognizing the value of boundaries, prioritizing time with loved ones, the importance of continued self-care, and personal therapeutic intervention. Additionally, they learned more about trauma through the experience of working through symptoms of vicarious trauma. In this chapter, I will provide an interpretation of findings, limitations of the study, recommendations, and implications for future research.

Interpretation of the Findings

Alignment With the Literature

The insights shared by participants of this study aligned with the literature available on the experiences of counselors during the COVID-19 pandemic. The lived experiences during the COVID-19 pandemic were a nuanced phenomenon that was further refined among the counselors who continued to show up for clientele during the shared experience. They viewed the COVID-19 pandemic as a shared, collective traumatic experience (Hutto et al., 2024; Kaubisch et al., 2022; Mittal et al., 2022). Their

continued work with clientele during this time was an additional layer or double exposure (Mittal et al., 2022; Werner et al., 2020) to the collective trauma that warrants future research. All participants discussed the parallels between the experiences of their clientele and themselves during the COVID-19 pandemic. Their personal exposure to the same traumatic events as their clientele reported who were coming to counseling to discuss included the double exposure to the COVID-19 pandemic impacts which led to shared feelings of uncertainty and hopelessness.

Some of the counselors that I interviewed noted the lack of social supports and community resources that clientele had access to and how unexpected that was for them as the clinician. For example, they reported that many of their clients did not live within a community that had a homeschooling co-op to support the number of children completing their studies remotely. These missing community resource supports additionally included access to food sources during the COVID-19 pandemic, which also aligns with the literature. I also found that participants experienced working with clients who held differing beliefs about the COVID-19 pandemic itself or had a significant shift in their clientele demographics due to the political climate or syndemic impact during that time. Participants confirmed the experience of living near or providing counseling services to those who expressed disbelief in the COVID-19 pandemic or frustrations with the social distancing requirement such as to wear a mask in certain spaces. They also shared how the political beliefs of the clientele or their parents influenced their beliefs about the COVID-19 pandemic and compliance with suggested social distancing guidelines (Bruine de Bruin et al., 2020; Carey et al., 2023; Gadarian et al., 2024). Additionally, by

offering free or discounted services to those working the “frontlines” of the Black Lives Matter movement, a participant noticed that her private practice’s clientele shifted to mostly African Americans. This was following the death of Breonna Taylor and George Floyd early in the COVID-19 pandemic (CDC, 2023; Eichstaedt et al., 2021).

The tensions from political polarization, systemic oppression interacting with the impact of the pandemic (Hudson et al., 2022), frustrations with failing systems, and the double exposure within the collective trauma of the COVID-19 pandemic were confirmed in the narratives of my study participants and warrant further study particularly in the wake of a disruptive political cycle being experienced in 2025 (Hutto et al., 2024; Kaubisch et al., 2022; Mittal et al., 2022; Werner et al., 2020). Participants shared that the polarized beliefs of how to address the COVID-19 pandemic, driven by polarized politics, was a point of countertransference and a moment where they had to refocus on what was important to the clients’ values. One participant noted that the 2024 reelection of Donald Trump as the U.S. President has brought familiar counseling experiences with her clients to the experiences from the COVID-19 pandemic. She reported needing to revert back to the basics of helping skills and validating through reflection with clients struggling during this current presidential administration. Two other participants reported needing to do the same with their clientele from the Black Lives Matter movement or within the African American community as they faced the systemic barriers to physical health during the COVID-19 pandemic and the uproar about the impact of police brutality on African Americans. The impact of political implications with the narratives of study participants, highlight the importance of counselors needing to be attuned to

what is going on politically and how that can impact personal and professional spaces for themselves and their clientele. Additionally, this demonstrates that importance of the lesson learned because history can repeat itself. While political implications may not be exactly the same, they may be similar enough to clientele to need similar empathy and cultural awareness from counselors.

My study findings align with the experiences of counselors in the current literature. The literature described the onset of the COVID-19 pandemic in March 2020 as a time of uncertainty for counselors, with a swift change to the way counseling looked for the majority of those in the field. There was the near-immediate switch to telehealth platforms such as Zoom or Simple Practice for most participants and there were a few difficulties in switching to this type of counseling (Kotera et al., 2021; Lin et al., 2022; McCoyd et al., 2022). Participants noted initial issues with venue-switching due to disdain for telehealth counseling or needing to create space of privacy in their home that they previously did not need. However, all participants reported adjusting to the shift from face-to-face counseling to distance-based platforms without continued issue and use telehealth as needed at this time. As noted within the literature, a majority of my study participants were able to switch to using telehealth with little to no interruption. However, there were some who struggled due to the residential environment of their work setting or the need to relearn their counseling modality in a virtual space (Lin et al., 2022). My findings note that caseloads were initially challenging for some participants to maintain within the beginning of the COVID-19 pandemic which aligns with the literature in that caseloads had decreased for the first 6 months of the pandemic (Mittal et

al., 2022). They reported fear of financial strains and fear of losing their job due to not meeting billable hour requirements.

The emotional and psychological impact of providing counseling services during the COVID-19 pandemic described in the literature aligns with the experiences of my study participants. The experience of burnout symptoms, compassion fatigue, secondary traumatic stress symptoms, and symptoms of vicarious trauma in counselors during the COVID-19 pandemic are referenced consistently in the literature (Mittal et al., 2023; Ricks & Brannon, 2023; Singh et al., 2022). Participants within my study reported feeling burned out and disconnected from the empathy and compassion needed for their role as a counselor, aligning with the previous findings of Mittal et al. (2023) and Ricks and Brannon (2023). Additionally, my study participants shared similar frustrations with feeling helpless to addressing the comprehensive needs of their clients and feeling stuck with the intrusive imagery or thoughts about the reported experiences of their clients.

Additionally, my findings align with the studies that tracked the finding on counselors having symptoms of vicarious traumatization during the COVID-19 pandemic. Vicarious traumatization is the shift in worldview and disruption of meaning or hope that results from continuous exposure to traumatic information while working with traumatized individuals (Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995). My findings confirmed that there was a consistent expression of helplessness and hopelessness for some counselors during the COVID-19 pandemic aligned with the findings of Aafjes van Doorn et al. (2020). The participants expressed a collective

concern about whether they were truly helpful to their clients at some point during the COVID-19 pandemic and their experience of vicarious trauma symptoms.

Conversely, the literature included some elements that did not present during my study. For example, my study did not yield information about the increased race-based violence against those in the Asian American, Native American, and Pacific Islander communities caused by anti-Asian sentiments and the connection between the onset of the COVID-19 virus and China (Yuan et al., 2024). Additionally, my study findings did not include impact of the media's report of the 2020 election. Participants often shared that they avoided traditional media sources like newspaper, television reporting, and radio reporting. The impact of the COVID-19 pandemic on the U.S. 2020 presidential election was not something that participants mentioned within their narratives (Camobreco & He, 2022). Finally, the impact of food insecurity and housing insecurity was not something that directly impacted study participants and my findings. There was one participant who noted the lack of food resources for their low socioeconomic status clientele. Another participant noted housing insecurity due to a house fire they survived during the COVID-19 pandemic; not due to the lack of housing resources or threat of eviction reported within the literature (Calabro, 2022; Versey & Russell, 2023).

Continued Impacts for Counselor Well-Being and Professional Practice

The literature provided robust description of the events that could have and did impact counselors during the COVID-19 pandemic. The findings from my study aligned with the literature's stance that symptoms of vicarious traumatization occurred for counselors who worked during the COVID-19 pandemic. Beyond alignment, my study's

findings include the details of how counselors got to the point of experiencing symptoms of vicarious trauma during the COVID-19 pandemic. Participants expressed that they believed the change to their status quo and the relentlessness of the COVID-19 pandemic led to feelings of hopelessness and uncertainty about the productivity of their therapeutic intervention with clients. Additionally, the inability to separate from the work they did during that time and sharing experiences related to the collective trauma of the COVID-19 pandemic with their clients was an additional emotional distress. Experiencing the pandemic alongside their clients led to an increase in empathy and compassion. As the COVID-19 pandemic persisted beyond the initial onset, the empathy and compassion for clients became a numbness felt toward the content shared in their counseling sessions. That numbness and realization of physical distress alongside the emotional distress were what led to participants changing their behaviors to cope. These changed behaviors were also detailed in the data and created their aesthetic experience; further shaping the lessons they learned.

Alignment With the Conceptual Framework

My findings were gleaned within the framework of John Dewey's theory of learning and his ideals on aesthetic experience. The participants' narratives showed that their experience of vicarious trauma symptoms during the COVID-19 pandemic reframed the way they conceptualize trauma and how they care for themselves. When forming the narratives of participants it became clear how the environment in which they worked, the level of support they had in their lives, and the impacts of the COVID-19 pandemic actively and passively interacted to create their unique experience. Those external

interactions along with their cognitive and emotional processes during that time creates the aesthetic experience unique to these counselors (Greenberger et al., 2022). My findings show that counselors who experienced symptoms of vicarious trauma during the COVID-19 pandemic led to learning new ways to approach new clients with trauma, advanced trauma treatment modalities, and the importance of being intentional about self-care practices and boundary setting (Kim, 2016).

Limitations of the Study

Expected barriers for finding participants who were willing to discuss their experience of vicarious trauma symptoms during the COVID-19 pandemic and the predicted length of time for the interviews were not impactful to this study. I was able to obtain enough participants to meet saturation of data. Additionally, I was able to use my knowledge of vicarious trauma from the literature to analyze and separate misunderstood terms being used interchangeably by participants. The history of improper interchangeable use of vicarious trauma, secondary traumatic stress, or compassion fatigue (Figley, 2012) was an initial point of concern noted within Chapter 1. The use of definitions from Chapter 1 during data analysis helped to clarify terminology and prevent potential misuse.

In Chapter 1, I mentioned a concern for participants to be unable to separate professional and personal impact of experiencing vicarious trauma symptoms during the COVID-19 pandemic. Participants in this study were able to identify and separate the different impacts, as well as express the overlap in their awareness of the impact on both their professional and personal lives. Participants were able to recognize that their

experience of vicarious trauma symptoms impacted them in the ability to sleep, regulate their blood pressure, or generate the motivation to do things they enjoy or socialize. The inability to sleep or focus impacted them professionally and their reported experiences of increased health symptoms like blood pressure and fatigue impacted them personally. However, fatigue and inability to concentrate would translate to both personal and professional impacts and lead to boundary setting, increased physical activity, and seeking counseling for themselves. The initial concern was that participants would not be able to separate the categorical impacts, however, they were able to do that and conceptualize the way their symptoms of vicarious trauma impacted both personal and professional areas of their lives.

Recommendations

My study was a way to understand what counselors learned from their experiences of vicarious trauma symptoms during the COVID-19 pandemic, both personally and professionally. Both the personal and professional learned lessons have value toward the future of how counselors take care of themselves in extended crisis-like events while simultaneously caring for clientele and how to best approach the traumatic, survival symptoms within their clientele. Counselors are tasked with being beneficent individuals toward the wellbeing of clientele and practice from a place of relative health (American Counseling Association, 2014). My findings confirm the threats to counselor wellbeing from the experiences of counselors during the COVID-19 pandemic found within the preceding studies (Aafjes Van Doorn et al, 2021; Mittal et al., 2022; Whit-Woosley et al., 2022). Symptoms of vicarious trauma left unaddressed have the potential

to predispose a lack of relative health. Each participant reported doing something productive toward addressing their symptoms of vicarious trauma to ensure that they were able to be beneficial to support their clients. My study yielded a convincing notion that the well-being of counselors is a critical point of social change in addition to being an ethical obligation.

The focus on counselor wellbeing has increased since the 1990's when the terms related to vicarious trauma, secondary trauma, compassion fatigue, and burnout began to show up in literature (Figley, 2012; Pearlman & Saakvitne, 1995; Stamm, 1999). My study findings review the fact that counselors experienced symptoms of vicarious trauma, but also it tells the story of how those symptoms present and impact the personal well-being of counselors during a collective traumatic event. It is socially important to be aware of how counselors can be impacted by shared crisis-like events and vicarious trauma symptoms, because they are responsible for providing essential clinical support to the general population. The study was completed in the Summer 2025, and the reflection of the experience was reported as meaningful experiences for participants. The reflection of their experience of vicarious trauma symptoms during the COVID-19 pandemic brought about an awareness as to how they have made changes to their trauma treatment as well as a realization that participants had not considered the postpandemic impact of their experiences on themselves.

Two striking themes that came from my findings that could guide further research are the lack of reflection participants reported and the shift in how counselors conceptualize survival responses. All of the participants expressed gratitude for an

opportunity to reflect on their experience of vicarious trauma symptoms during the COVID-19 pandemic. Those who were not participating in counseling themselves noted that they plan to seek support following the realization of never processing their vicarious trauma symptoms.

Future researchers could explore what motivated some counselors to move on without reflection on or acknowledgement of their vicarious trauma symptoms. I recommend continuing research on how counselors' experience of vicarious trauma symptoms during the COVID-19 pandemic have impacted trauma treatment and focus on counselor wellbeing. Additionally, further research is recommended to compare the experiences of counselors who did stop to reflect on their experiences of vicarious trauma and those who did not.

Future researchers could also further explore the way that experiencing symptoms of vicarious trauma impacts the conceptualization of survival responses and the inclination to no longer pathologize survival responses. Survival responses are natural reactions to abnormal or unnatural experiences, and pathologizing these responses can lead to minimizing the root cause of trauma or misdiagnoses and treatment planning (Levine et al., 2018; LeWine, 2011). Levine (2010) defined trauma as a psychological "stuckness" that occurs when a person does not complete a fight, flight, or freeze response, which are natural survival responses to threatening experiences. Additionally, future research can include a look at how harmful pathologizing natural responses can be to clients and explore the methods used by counselors to refrain from pathologizing natural survival responses.

Implications

The narratives of counselors who experienced vicarious trauma symptoms during the COVID-19 pandemic created three potential impacts of positive social change. The shared experiences have the potential to influence the way counselors acknowledge their symptoms of vicarious trauma, reflect on tough experiences during collective traumas, and become intentional about restoring themselves throughout the workday. Restorative practices include making time for restroom breaks, taking a walk outside of the building in which they work, or spending time away from their workspace and connecting with colleagues in a supportive way. Additionally, the shared experiences generate positive social change in the organizational structures of the agencies in which counselors work and the way they treat counselor wellbeing as being mitigated through organizational policy. Further, counselor education programs can be influenced by the narratives to prepare counseling students for the potential impacts of counseling during a collective trauma or crisis-like event. These positive social changes can enhance the wellbeing of counselors and future counselors as they care for the general population.

Individual Level

The narratives from my study champion intentional, restorative actions that allow counselors to acknowledge and reflect upon their experience of vicarious trauma symptoms. Study participants shared that they learned that taking time to exercise, garden, connect through socialization, and seeking their own therapy were pivotal to acknowledging their symptoms of vicarious trauma. Additionally, their participation in this study brought about an awareness of the importance of reflection.

Reflecting on the experience through storytelling can be an important step within the learning process and seemed to materialize unrealized truths about the participants' experiences of vicarious trauma symptoms during the COVID-19 pandemic. The reflection via storytelling can be a restorative action and an integral part of personal and professional growth.

Organizational Level

The experiences of vicarious trauma symptoms were reported by counselors working in multiple settings, however, the organizational responses to the COVID-19 pandemic and wellness of their staff were influential in the narratives of the participants. Participants noted that guidance from the WHO and the CDC being implemented in their places of employment as a positive experience during the COVID-19 pandemic. They shared that their organizations had applied the precautionary measures for social distancing, quarantine periods, and remote work as often as possible. Participants who noted that a lack of implementing the suggested guidelines for businesses impacted their experience of vicarious trauma symptoms. Their experiences of vicarious trauma symptoms were exacerbated by a lack of concern for employee well-being and a greater focus placed on billable hours and the shaming of employees for not reaching billable hours, making them feel responsible for their peers being fired. Places of employment can learn from this feedback and begin to examine how their policies and mandates impact employee well-being. Once examining their policies, organizations will need to be intentional about changing those that potentially harm employees or add new ones to increase employee well-being.

Another organizational level point of positive social change is within the curriculum of counselor education programs. Participants noted that their reflection was what brought awareness to the fact that they experienced symptoms of vicarious trauma. Reflection through storytelling can be included within the curriculum of counselors. Currently, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) tasks counselor education programs with including self-care, self-awareness, and self-evaluation within the course objectives for the Professional Counseling Orientation and Ethical Practice course (CACREP, 2024). This course is a wonderful place to apply the idea of using reflection through storytelling to provide another tool for students to use to become self-aware about their experiences of vicarious trauma or other threats to counselor well-being such as burnout and compassion fatigue. This practice aligns with the American Counseling Association's ethical mandate for counselors to be active in self-care tasks and ensure they are seeing clientele from an unimpaired status. The participants in my study were able to notice the need to address symptoms of vicarious trauma during the COVID-19 pandemic, but they also noted that it was helpful to give those symptoms a name during the reflective actions of data collection.

Societal Level

My study further supports the need for intentional efforts toward counselor wellbeing. Every participant's narrative showed the need to take a break from their work and a focus on themselves to continue being of service to their clientele. Potential positive social change is an acknowledgement of the fact that counselors are people who

share experiences in the world alongside their clientele. There was an increased need for mental health professionals during the COVID-19 pandemic and counselors reported having waitlists up to approximately 20 people with an average wait time of 12.8 weeks (APA, 2022; Peipert et al., 2022). In March 2023 it was found that 160,000,000 Americans lived in areas without adequate access to mental health care provider shortages (Counts, 2023). Counts shared that it would take approximately 8000 more mental health professionals to meet the needs of those Americans. The findings of my study provide insights into what could lead to additional shortages.

The U.S. Bureau of Labor Statistics (2024) projects that there will be 42,000 employment openings, for mental health counselors, annually until 2032. With this many potential new members to the field counselor longevity and retention should be of importance to those in a position to make positive social changes. The narratives of counselors who experience symptoms of vicarious trauma are among those advocates that policymakers should be looking to when determining the best course of action for future mental health professionals. Efforts have been made for other fields such as nursing, insurance case management, piloting, and air traffic controllers to have acuity limits for the safety of those they serve; however, the pressure of billable hours has exacerbated symptoms of vicarious trauma for counselors (Air Traffic Controller Qualifications, 2025; Bogue & Bogue, 2020; Craig & Flaherty-Quemere, 2009). Retention efforts for counselors can be an effort to protect the general population who need the clinical support of mental health professionals through policies on acuity limits and adequate payment for services rendered. This can be a positive social change to better prepare the

field of counseling and support them during the next collective trauma or shared crises with clientele.

Conclusion

My study presented the existing literature that found that counselors experienced symptoms of vicarious trauma during the COVID-19 pandemic and expounded on the understanding of what that experience included. Counselors who experienced symptoms of vicarious trauma during the COVID-19 pandemic have unique perspectives on the interaction between the two. The impacts on how they make decisions in their personal lives and the ways they make decisions in clinical practice are meaningful to engendering positive social change within the field of counseling but also for individuals who want better for themselves and their clientele. Their narratives provide insight into the importance of counselors taking time for themselves to restore themselves throughout the day and reflecting on their experiences during collective traumas beyond the experience.

Counselors who have experienced symptoms of vicarious trauma during the COVID-19 pandemic change the way they conceptualize survival responses and use the experience of COVID-19 to understand how clients have previously handled trauma. They also value their time away from clients and prioritize the boundaries they need between work and home in order to be present and productive clinicians for the general population. Most importantly, this study has provided insight into how counselor education programs can implement reflective storytelling into the ethics involved in self-care practices. On a societal level, the study highlighted the need for intentional efforts to promote counselor longevity and retention. Creating workspaces that have policies that

foster counselor wellbeing and ethical mandates against billable hours to protect the wellbeing of counselors can be a stride toward ensuring that there are enough counselors to fill the growing field.

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Appendix A: Recruitment Flyer

RESEARCH STUDY SEEKS

Independently Licensed Counselors Who Worked During the COVID-19 Pandemic



About the Study

This study will examine the experiences of counselors who experienced symptoms of vicarious trauma while working during the COVID-19 pandemic.

Vicarious Trauma Definition: *a change within the person that happens over an extended period of exposure to traumatic information. The change impacts core beliefs about meaning and hope while mimicking the hypervigilance and avoidant behaviors common with post-traumatic stress disorder or secondary traumatic stress. Someone experiencing vicarious traumatization may experience diminished hope in the work that they do or have a lost sense of meaning behind the work that they do.*

Volunteers Must Meet These Requirements

- Independently Licensed Counselor during the COVID-19 pandemic (March 2020 -May 2023)
- Self-reported experience of vicarious trauma symptoms during the COVID-19 pandemic (March 2020-May 2023)
- Provided counseling services for a minimum of two months during the COVID-19 pandemic (March 2020- May 2023)

Time Commitment

1. Interview

Study volunteers can expect to spend **60-80 minutes** completing the interview.

2. Results Review*

Study participants will be offered the opportunity to review analysis results for accuracy. **15 minutes** is the projected time the task may take.

If you are interested in participating in the study please email Aleah Curley by clicking the icon below.



Aleah Curley

LPC, NCC, PhD Candidate

Walden University
aleah.curley@waldenu.edu

Appendix B: Participant Invitation Email

Dear Participant,

I hope this email finds you well. I am Aleah Curley, a doctoral student at Walden University. I am conducting research to answer the following research question: “What are the retrospective experiences of counselors who self-report experiencing vicarious trauma during the COVID-19 pandemic? I invite you to participate in my research. Insights gained from this study could evoke social change in the way that counselors prepare for and experience collective traumas. The results may directly impact the future implications for research of counselors during the COVID-19 pandemic.

The research will be conducted through virtual, Zoom semi-structured interviews. The interview should be between 60– and 80 – minutes. During the narrative interview, I will ask open-ended, semi-structured questions. While your experience vital to my research, there will not be any compensation for your voluntary participation. Your experience during the COVID-19 pandemic is valuable to the field of counseling, specifically those at risk for experiencing vicarious trauma. Your story is vital to this research, and you can withdraw your consent to participate anytime.

If you have questions regarding this study, please do not hesitate to contact me via email at aleah.curley@waldenu.edu. Your voluntary participation in this research is greatly appreciated. Thank you!

Warmest Regards,

Aleah Curley, LPC, NCC

Appendix C: Interview Protocol and Concluding Statement

Demographic information gathering:

1. Study alias
2. Pronouns
3. Age
4. Gender
5. Ethnicity
6. Race
7. State(s) of licensure
8. Provided counseling services for a minimum of 2 months during the pandemic?
9. Did you self-identify symptoms of vicarious trauma during the COVID-19 pandemic?

Initiation Phase:

Thank you very much for being open to sharing your story for this study. Your participation in this interview is greatly appreciated. Sharing your experience may lead to informing counselor educators and supervisors in how they support supervisees in events similar to the COVID-19, in the future. In our email communications you shared that you have experienced symptoms of vicarious trauma during the COVID-19 pandemic.

Main Narrative- One major questions:

- A. **Tell me about your experience of vicarious trauma symptoms during the pandemic.**

Questioning phase (Only ask questions about topics that have gone mentioned) -

Mentioned (x)	Topic	Notes
	What were the parallels between your experiences and the experiences of clients during the COVID-19 pandemic?	
	What brought awareness to your experienced vicarious trauma symptoms during the pandemic? - Tell me more about your symptoms?	
	How did you address symptoms of vicarious trauma during the COVID-19 pandemic?	

	How has your experience of vicarious trauma symptoms during the COVID-19 pandemic impacted the way that you treat trauma?	
	How would you describe your work-life balance post COVID-19 pandemic (after May 2023)?	
	What were the changes to your day-to-day professional reality caused by the onset of COVID-19?	
	If you have worked during previous crises, what differences did you notice in your experience working during the COVID-19 pandemic from previous crisis response work?	
	What was your experience of providing telehealth services during the COVID-19 pandemic? - What about now?	
	Were there any other experiences during the COVID-19 pandemic that impacted your vicarious trauma symptoms?	
	Ask any follow-up for topics presented by the participant.	

Concluding Statement (Stop recording prior to this phase):

Thank you for your willingness to participate in this interview. I am profoundly grateful for your time and your candidness in sharing your experiences during the COVID-19 pandemic. I may need to confirm or verify that I have understood the information you shared with me today. I will do this via email like we have previously communicated. Lastly, I will keep you updated as the study moves through the approval process and is completed.