A Phenomenological Study on the Contributors of Compassion Fatigue With Substance Use Disorder Counselors During the COVID-19 Pandemic

Jennifer Ann Galvano

Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2024

A Phenomenological Study on the Contributors of Compassion Fatigue With Substance Use Disorder Counselors During The COVID-19 Pandemic

Jennifer Ann Galvano

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University, Lynchburg, VA

2024

Approved by:

Dr. John King, Ph.D., Committee Chair

Dr. Timothy Stauffer, Ph.D., Committee Member

Abstract

This phenomenological study aimed to understand the experience of compassion fatigue in substance use counselors in Western New York during the COVID-19 pandemic. Many studies have reviewed burnout, compassion fatigue, and secondary trauma and have discussed the outcomes of their unmanaged effects on healthcare professionals. Few have focused directly on the impact that key contributors of compassion fatigue have on substance abuse disorder (SUD) counselors. This qualitative study is designed to support substance abuse counselors' mental health and well-being. Counselors are exposed to clashing situations such as turnover, larger caseloads, client trauma, regulations, lack of training, lack of understanding of self-care–or a combination of all–which can lead to compassion fatigue. Compassion fatigue can negatively affect the therapeutic relationship, the overall treatment outcome, and the counselor's personal and professional life. Evaluating the various key contributors of compassion fatigue during a global pandemic promotes change in recognizing the importance of self-care and provides guidance on the multidimensional facets of compassion fatigue for substance-use counselors. Several studies attempt to understand burnout, compassion fatigue, and secondary trauma while they support other healthcare and mental health careers during the COVID-19 pandemic. However, few studies attempt to understand the challenges and struggles SUD counselors go through in silence.

Keywords: COVID-19, substance use disorder, compassion fatigue, burnout, secondary trauma, self-care, SUD counselors.

Dedication

The study is dedicated to God, who has brought me on this journey with the purpose of healing my brokenness and using it for His glory. When times were dark, and it seemed like it would take forever to finish, God held me close and carried me through it. I dedicate this work to God's glory.

I also dedicate this work to my fantastic husband, Robert, who has stood with me during this graduate school journey and was the caregiver to my parents and to myself in the grief of their passing. When I doubted myself, Robert would encourage and remind me that God brought me to this journey and will bring me through it. To my parents, even in their illness, their example of faith and trust in God was an inspiration. To my Aunt Barb, for your love and support, for stepping in to help with Mom and Dad during this journey, and for words of encouragement. I am also grateful for my children: Erin, Brendon, and Madison and their sacrifices during this journey of mom returning to school to change careers. I am so proud of you as you have all grown into amazing adults with your amazing personalities, talents, and abilities.

Lastly, I am dedicating this work to the SUD counselors who work day in and day out to help support those who are struggling with the disease of addiction. May this work shed light on the emotional, mental, and physical strain SUD counselors can endure and how to manage that strain. For those SUD counselors who have suffered in silence with their struggles and thought their only way to stop the emotional, mental, and physical strain was to take their own lives, may this work give them the voice they could not find.

Acknowledgments

I would like to acknowledge my Lord for giving me the strength and perseverance to complete this research. I want to acknowledge my chair, Dr. John King, for always encouraging me, praying for me, and believing that I could finish. I am truly blessed by his words of wisdom and the abundance of his encouragement through this process. I want to also thank my reader, Dr. Tim Stauffer, for the encouragement and support during this process. Thank you to my five participants for having the courage to share their stories to help shed light on the contributing factors to compassion fatigue and burnout.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Alcoholics Anonymous (AA)

American Counseling Association (ACA)

Center for Disease Control and Prevention (CDC)

Credentialed Alcoholism and Substance Abuse Counselor (CASAC, CASAC-T)

Conceptual Mapping Task (CMT)

Compassion Fatigue (CF)

Computer Assisted Qualitative Data Analysis (CAQDA)

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Dialectical Behavior Therapy (DBT)

Drug Enforcement Agency (DEA)

Institutional Review Board (IRB)

Medication for Opioid Use Disorders (MOUD)

Mindful-Based Stress Reduction (MBSR)

Mindful Self-Compassion (MSC)

Narcotics Anonymous (NA)

Office of Addiction Services and Supports (OASAS)

Personal Protective Equipment (PPE)

Post-Traumatic Stress Disorder (PTSD)

Professional Quality of Life (proQOL)

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

Severe Mental Health Illnesses (SMI)

Substance Abuse and Mental Health Service Administration (SAMHSA)

Substance Use Disorder (SUD)

U.S. Food and Drug Administration (FDA)

World Health Organization (WHO)

Chapter One: Introduction

Overview

The Centers for Disease Control and Prevention (CDC) reported that there were approximately 81,000 deaths due to drug overdose from May 2019–May 2020. In 2019 there were 47,511 suicides reported, the tenth leading cause of death in the United States (CDC, 2021). The trauma around the death of a client can leave substance use disorder counselors with varying levels of emotions, yet data regarding the frequency of SUD counselors seeking support during this time of grief is limited. Carl Jung explained that those who want to help others typically have wounds that are both a burden and a driving force to helping others (Farber, 2017). Understanding this struggle with the soul can be the best form of training that can help others.

In 2019, the Substance Abuse and Mental Health Service Administration (SAMHSA) reported that out of the 11.4 million adults diagnosed with severe mental health illnesses (SMI) in the United States, 3.2 million had a co-occurring substance use disorder (SUD) (Kelly et al., 2021). However, only 13.7% of adults with SMI received specialty SUD treatment with mental health services (SAMHSA, 2019). Many counselors self-report that their challenges with mental health and substance use disorders within their families or themselves have been factors for why they decided to work with others who are struggling. The adverse effects of emotions and compassion fatigue or distress can impact the therapeutic relationship, overall treatment outcome, and also the personal life of the therapist. The experiences of depression in counselors were cited as work stress and their emotional wounds were not sufficiently addressed, resulting in negative results for their clients' treatment (Straussner et al., 2018).

The Office of Addiction Services and Supports (OASAS) in the State of New York oversees one of the nation's largest substance use disorder systems of care (OASAS, 2023). One

of the tasks of OASAS is to manage the credentialing of all professional substance use counselors and prevention practitioners with approximately 1,700 substance use programs in New York (OASAS, 2023). One of the programs' outpatient services provides clinical services and support to individuals and their families struggling with substance use disorders. Outpatient SUD counselors' days are high-stress environments because of client treatment, large caseloads, productivity requirements, state regulations, and ethical obligations to ensure adequate care for individuals struggling with substance use disorders (Cook et al., 2021). The COVID-19 pandemic changed treatment and procedures for SUD treatment, causing additional stress in an already high-stress environment (Oesterle et al., 2020).

It is fair to say that research has focused on compassion fatigue and burnout as it relates to individuals working as social workers, care providers, and other healthcare professionals who work with individuals struggling with mental health illnesses and other traumas. However, little focus has been on those individuals specifically working with substance use counselors (Chizimuzo et al., 2020; Hatch-Maillette et al., 2019; Straussner et al., 2018). The purpose of this study was threefold. First, this research increased the awareness of compassion fatigue and burnout that has gone unnoticed in the SUD professional healthcare sector, especially during the COVID-19 pandemic. Secondly, this study pointed out the importance of training and supervision for those in the substance use disorder field. Lastly, as compassion fatigue and burnout are further investigated within the substance use disorder clinical population, this study's focus on these concepts increased awareness of them and of self-care.

Background

On March 11, 2020, the World Health Organization (WHO) announced that the COVID-19 pandemic was changing life as individuals knew it (Oberfeld et al., 2020; Rothan &

Byrareddy, 2020; Williamson et al., 2020). The national emergency and stay-at-home orders due to the COVID-19 pandemic went into place. The COVID-19 pandemic was caused by the airborne spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) with no known cure and, at times, ineffective treatment (Cossarizza et al., 2020; Heath, 2022; Oberfeld et al., 2020; Rothan & Byrareddy, 2020). Best practices for defense against COVID-19 were adhering to protocols that include social distancing, wearing a face mask, avoiding crowded spaces, avoiding touching the face, frequent hand washing and using hand sanitizer, and sanitizing surfaces (Cossarizza et al., 2020; Heath, 2022; Oberfeld et al., 2020; Rothan & Byrareddy, 2020).

Nevertheless, healthcare workers, including SUD counselors, were essential despite these changes. The demands only increased personal and professional stressors, including financial hardships, social isolation, and increased mental health needs (CDC, 2020; Cook et al., 2021). Compassion fatigue, burnout, and secondary trauma are recognized as potential occupational hazards for substance use disorder counselors (Cosden et al., 2016; Davis et al., 2012; & Finan et al., 2021). This fatigue can negatively affect the therapeutic relationship and cause countertransference. Although several studies have focused on other healthcare professions, limited studies have focused specifically on counselors who work with individuals struggling with the disease of addiction (Chizimuzo et al., 2020; Hatch-Maillette et al., 2019; Straussner et al., 2018). However, SUD counselors incorporated several functions of these various healthcare professions in their daily practice. Working with individuals who struggle with the disease of addiction requires a SUD counselor to be a case manager, nurse, social worker, and therapist–to list a few. They must also manage the expectations of the code of ethics for the profession, requirements for the location at which they work, state regulations, and personal expectations.

Clients come into SUD treatment with multiple levels of need such as food, clothing, housing, medical, mental, etc. During treatment, counselors continue to assess the clients' needs and meet them where they are while managing the requirements of multiple organizations as well as state and federal regulations. Throughout the literature, mental health care is recognized as a stressful occupation with a high risk of burnout (Finan et al., 2020; Straussner et al., 2018).

Historical Perspective

The New York State Office of Addiction Services and Supports (OASAS) reported that in 2012 almost two million New York residents experienced substance use disorders (Wani et al., 2019). Approximately 100,000 individuals were enrolled in one of more than 900 certified programs in NY State at OASAS (OASAS, n.d.). It is essential to understand the various elements of a SUD counselor's day–counselor mental health, client impact, and workplace impact–and how changes to care caused by the COVID-19 pandemic have influenced the overall well-being of the counselor. Historically, SUD counselor turnover can be linked to organizational commitment and compassion fatigue perceptions. Counselors are responsible for applying case management skills, staying up to date on person-centered therapy skills, educating clients and their families, planning, delivering group and individual counseling, and providing updates to other professional groups such as healthcare, courts, and other legal groups (Rothrauff et al., 2011). Coordination of care is essential to the support and success of treatment.

Healthcare professionals like physicians, nurses, school counselors, and others have studied compassion fatigue, burnout, and secondary trauma in their fields. Compassion fatigue, burnout, and secondary trauma are all indicators that also affect the stability of the performance of a SUD counselor. These indicators can be prevented and reduced through supervision, training, and overall clinical commitment (Knudsen et al., 2012).

Social Context

The importance of studying the contributors of compassion fatigue for substance use disorder counselors is significant because identifying these contributors can lead to proactive support for wellness. Comorbidity is elevated during a pandemic, and counselors are expected to manage both their well-being and others'.

Most SUD counselors enter this profession as individuals in recovery or are impacted by loved ones struggling with substance use (Martin-Cuellar et al., 2019; Rothrauff et al., 2011). This sense of connection brings a commitment based on a psychological relationship to the field. Counselors are vested organizationally and occupationally but need inner strength and resilience (Martin-Cueller et al., 2019; Rothrauff et al., 2011).

Some changes in how services have been provided during the COVID-19 pandemic, like going from in-person counseling to telehealth, supported individuals struggling with addictions. Telehealth connected SUD counselors and medication-assisted treatment physicians, improving the quality of care and access to services for patients with SUDs (Oesterle et al., 2020). However, due to social distancing demands from the government, self-help groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were less accessible (Oesterle et al., 2020). This limited the support network SUD individuals had as a resource for support. After clinics were able to have clients come back into the facility, mask mandates became a way of protecting immune-compromised individuals from potentially contracting the virus and any of its possible complications (Heath, 2022). These restrictions lead to an increase strain on physical, emotional, and mental well-being. The increased stress, anxiety, and anger influenced SUD counselors' burnout and secondary trauma (Cook et al., 2021; Horesh & Brown, 2020).

Situation to Self

This qualitative study was proposed, designed, and completed by a sole researcher with a research partner who coached the researcher. Since this research was completed with only this perspective, it is essential to understand the potential biases and motivations that this researcher had by examining the philosophies and paradigms (Creswell & Poth, 2018).

Everyone has a story of how the COVID-19 pandemic impacted their lives, work, and families. Lives were changed both professionally and personally. This researcher's family was no different. By the end of March 2020, all-day care programs closed and this researcher's father, who struggled with Alzheimer's disease, had his routine change. This meant that his mental state suffered yet again. With the researcher's father being home all day, he required additional support, but the support that could come into the house was limited due to COVID-19 restrictions. While caring for their father, this researcher continued her studies at Liberty University and worked in an inpatient SUD facility for youth. Her father would be placed in a facility at the end of July 2020, where family could only see him through a window due to the COVID-19 virus. He passed away on April 10th, 2021, due to a fall that created a brain bleed.

While journey toward this doctorate had begun in 2019, the dissertation process started in May of 2022. The COVID-19 pandemic profoundly affected this researcher both professionally and personally. Stories of SUD counselors taking their own lives due to compassion fatigue impacted this researcher significantly. She experienced the death of a colleague due to suicide, which was related to increased stress. This prompted research and the realization that it was essential to study the impact of compassion fatigue on SUD counselors during the COVID-19 pandemic.

Philosophies and Paradigms

The philosophical assumption that underlied this research was epistemological. This researcher's interest was to obtain subjective evidence based on the views and experiences of participating counselors. During the research, she provided a view of the critical components of compassion fatigue for substance use disorder counselors during the COVID-19 pandemic (Creswell & Poth, 2018). It is through the perspective of the SUD counselor that essential information surrounding this phenomenon is added to the information gathered in the search for a better understanding of compassion fatigue in SUD counselors.

As a post-positivist, the researcher thought that the attempt to seek an understanding of the SUD counselor's world drove the paradigm. SUD counselors have developed varied meanings for why they struggle with compassion fatigue, leading this researcher to have a complex view rather than one single approach. This researcher had a bias that there was a series of logically related steps like the mental state of the counselors and clients as well as the workplace requirements that influenced the counselor's compassion fatigue, burnout, and secondary trauma (Creswell & Poth, 2018). As a post-positivist, the researcher believed that there is always a concern the research may be flawed, but she believed this research provided various insights into the contributing factors to compassion fatigue and furthered the understanding of a substance use disorder counselor (Creswell & Poth, 2018; Heppner et al., 2016).

Researcher Motivation and Background

I am a substance use disorder counselor in an outpatient facility in the Western New York area and a doctoral candidate at Liberty University in the online community care and counseling program. As a part of my caseload, I provide professional substance use and mental health

services to adults with SUD and their families. During my clinical work, it had come to my attention that SUD counselors struggle to balance their clinical work and self-care. These struggles have led to compassion fatigue, burnout, and secondary trauma.

Unfortunately, the COVID-19 pandemic significantly increased the challenges for counselors, from their mental health to struggles that trickled down from the business end (Shoptaw et al., 2000; Singh et al., 2020; Skinner & Roche, 2021). In the State of New York, providers of substance use disorder services experienced significant challenges and changes in their ability to provide supportive services to individuals struggling with substance use disorders during the pandemic (Mandavia et al., 2022; Nesoff et al., 2011). Some of these changes involved telehealth sessions, changes in medication distribution, and then–after re-opening–cleaning and mask requirements. The push for counselors to learn new software for telehealth sessions and the lack of internet capabilities for clients also impacted the continuity of care.

As a result, I listened to counselors and clients express a significant increase in their anxiety, depression, and ability to manage the stress caused by the pandemic. Some counselors struggled with the difficulties of managing their own challenges with unhealthy coping through substance use while attempting to deal with the many adjustments clients experienced. As a substance use disorder counselor with a person-centered focus, I became interested in understanding more about the phenomenon of what I was witnessing. This research attempts to give those counselors a voice and a means to gather their thoughts and experiences surrounding this phenomenon while providing a detailed, heartfelt, and expansive description of its impact and how to help them overcome and sustain themselves moving forward.

Problem Statement

During the COVID-19 pandemic in New York State, every professional service supporting individuals struggling with substance use changed how they were delivering substance use treatment. These changes included moving to telehealth services, social distancing, wearing masks, changing or closing facilities, and changing the expectation of treatment. SUD counselors changed their services from face-to-face individual and group sessions to telehealth sessions. Individuals with substance use struggles wondered if they could have medications to support their recovery. Some struggled with connecting with telehealth services due to the inability to afford a smartphone or internet services (Oesterle et al., 2020).

The problem was the lack of research attempting to understand the impact that the changes in professional services and requirements for clients to enter and maintain treatment had on the SUD counselor. The expectation to treat and change the mindset of those struggling with addiction was very difficult for SUD counselors, especially when the change in treatment to harm reduction offered an opportunity for reuse and overdose. In New York, the Erie County Medical Examiner's Office reported an increase in fentanyl overdose from 78% in 2017 to 88% in 2021 (Erie County Department of Health, 2020). However, the true impact of what the COVID-19 pandemic will have on drug use is unknown (Lopez-Pelayo et al., 2020).

Purpose Statement

This transcendental phenomenological study aimed to describe the experiences of SUD counselors caring for individuals who struggle with addictions while the counselors were dealing with compassion fatigue, burnout, and secondary trauma during the COVID-19 pandemic in the Western New York area. This study defined the critical components of compassion fatigue, burnout, and secondary trauma for SUD counselors in Western New York. The theories guiding

this study were trauma theory and mindfulness-to-meaning theory. The first theory was trauma theory (Van der Kolk & Van de Hart, 1989) as it relates to the secondary trauma that SUD counselors may experience by taking on the trauma experienced by their clients. The second was the mindfulness-to-meaning theory (Garland et al., 2015) as it relates to how SUD counselors cope with compassion fatigue and promoted self-care. These theories provide a framework for understanding the complexity of SUD counseling and the experiences that influenced counselors' overall well-being. Understanding how counselors attempted to process the challenges and changes to facilitating SUD treatment during the COVID-19 pandemic is an integral part of understanding the impact compassion fatigue, burnout, and secondary trauma may have had on a counselor.

Significance of the Study

In treating individuals with SUD, there are many steps and multiple requirements a SUD counselor must follow. This study aimed to provide an understanding of the impact of the daily activities of SUD treatment on counselors and how they managed the impact of COVID-19. Utilizing the method of conceptual task mapping (CMT) (Impellizzeri et al., 2017), participants provided, in their own words, their stories of treating SUD clients with an emphasis on the feelings they experienced. A SUD counselor's voice and perspective are rarely found in the research on compassion fatigue, burnout, and secondary trauma. Counselors can feel alone in their work and silenced in their suffering with no outlet to share their concerns. The risks of compassion fatigue, burnout, and secondary trauma are more significant for SUD counselors than other healthcare workers trained to work with individuals who are chronically ill or dying (Shoptaw et al., 2000). OASAS Learning Thursday training reports a 15% increase in deaths of individuals struggling with addiction compared to 2020, with two-thirds of those deaths

involving synthetic opioids (2022). Changes in care due to the COVID-19 pandemic have left this vulnerable population struggling with negative mental and physical health consequences (Barry, 2023). High levels of compassion fatigue, burnout, and secondary trauma were found in counselors struggling with high levels of anxiety and stress without tangible support (Shoptaw et al., 2000). This struggle can be so significant and silent that SUD counselors may take their own lives because they had not learned or found the support to manage their compassion fatigue, burnout, and secondary trauma.

This study can make a difference by highlighting SUD counselors' experiences providing services for those struggling with substance use disorders during the COVID-19 pandemic. It provided critical information for professionals to help meet the SUD counselor's needs in current and future pandemic situations.

This study also provided a glimpse into how Western New York approaches supporting SUD counselors navigating treatment for those struggling with addictions. Additionally, this study provided information to policymakers to better understand the impact process changes can have on individuals struggling with addictions and those who support them–particularly SUD counselors.

Currently, researchers are attempting to understand the impact the COVID-19 pandemic had on individuals struggling with the disease of addiction. However, few studies have attempted to understand SUD counselors' experiences navigating treatment protocol changes. Moreover, no studies have investigated how changing treatment processes and limiting consequences for continued use have affected the mental health treatment counselors provide.

SUD counselors can also benefit from this study through its positive reflections on the use of mindfulness in combating compassion fatigue, burnout, or secondary trauma. This study also provided a voice for those who could not communicate their struggle. Any positive effects of SUD treatment can benefit the system through a positive feedback loop (Barry, 2023). This study allowed SUD counselors to narrate their lived experiences of the SUD treatment process: clinical impact, client impact, treatment impact, and workplace impact during and after the COVID-19 pandemic. By doing so, this study has given an in-depth understanding of the phenomenon to other critical stakeholders like professional care providers and government policy officials.

Research Questions

RQ1: *How do SUD counselors describe their experience of providing treatment to individuals struggling with addiction during the COVID-19 pandemic in the Western New York area?*

This question was an essential foundation for the research. It addressed the phenomenon surrounding the experience of providing treatment to individuals struggling with addiction during the COVID-19 pandemic using an open-ended model that allowed the counselor to provide a meaningful understanding of working with individuals struggling with addictions (Creswell & Poth, 2018). This question focused on the lived experiences of the counselor; their response represented their subjective experience and provided insights into the challenges and successes they experienced with the clients, treatment changes, and support from supervisors over a two-year period (Kelly et al., 2021; Nesoff et al., 2021).

RQ2: *How do SUD counselors describe their experiences of self-care, training, peer-to-peer support and supervision?*

This question sharpened the focus on both the individual care support counselors provide and the interactions with their supervisors and trainers as parts of counselors' experience with the phenomenon. For this study, this was the central question in this specific area of inquiry (Creswell & Poth, 2018). Understanding the relational aspects of this phenomenon can shed light on either positive or negative exchanges between counselors and themselves, as well as exchange between counselors with their supervisors and trainers (Kelly et al., 2021; Singh et al., 2020).

RQ3: *How do SUD counselors describe the difference between providing treatment to individuals struggling with addiction before, during, and after the COVID-19 pandemic?*

This sub-question attempted to understand the temporal aspects of phenomenological research (Heppner et al., 2016). In this selection process, counselors discussed only clients who had received their diagnosis before March 2020 to ensure they were exposed to treatment before and during the COVID-19 pandemic.

RQ4: *How do SUD counselors describe the personal impact of providing treatment, receiving supervision, and following policy influencers during the COVID-19 pandemic?*

This primary research question attempted to understand the impact providing treatment, receiving support from supervisors, and following changes made in treatment during the COVID-19 pandemic. This descriptive question left room for the participants to describe their experience (Creswell & Poth, 2018). This study focused on the contributors of compassion fatigue, burnout, and secondary trauma.

Definitions

ATLAS.ti - A software program for qualitative research data collection and analysis (Creswell & Poth, 2018).

Burnout - An overwhelming emotional exhaustion that can adversely affect compassionate care and productivity at work (Okoli et al., 2020).

Computer-Assisted Qualitative Data Analysis Software (CAQDA) - Software created to assist qualitative researchers in analyzing, collecting, storing, and organizing text and image data (Creswell & Poth, 2018).

Conceptual Mapping Task (CMT) - a qualitative interviewing tool and protocol that contains four distinct, internal member-checking mechanisms within a single-interview format (Impellizzeri et al., 2017).

Compassion fatigue - An empathetic reaction resulting from repeated listening or witnessing of others' emotional or physical suffering influencing the quality of client care and the counselor's emotional and physical health (Zhang et al., 2021).

COVID-19 - A respiratory disease caused by SARS-CoV-2, a coronavirus discovered in 2019. The virus spreads mainly from person to person through respiratory droplets produced when an infected person coughs, sneezes, or talks (Centers for Disease Control and Prevention, 2022).

Credentialed Alcoholism and Substance Abuse Counselor (CASAC, CASAC-T) - Credential provided through OASAS, intended for individuals who provide direct clinical care services and substance use disorder counseling (OASAS, 2017).

Mandated Reporter - A person working in a profession that is required by state law to report the suspected abuse of a minor or older adult to the proper authorities (Wilcoxon et al., 2013).

Medication-Assisted Treatment - Medication approved by the U.S. Food and Drug Administration (FDA) to treat substance use by alleviating withdrawal symptoms, reducing cravings, or decreasing the response to future drug use while reducing the risk for fatal overdose (Leshner & Mancher, 2019).

Office of Addiction Services and Supports (OASAS) - The New York State Office of Addiction Services and Supports oversees one of the nation's largest substance use disorder systems of care providing prevention services, treatment, and recovery services for over 680,000 individuals per year (OASAS, n.d.).

Otter.ai - Speech and text transcription and translation application using artificial intelligence and machine learning (Creswell & Poth, 2018).

Phenomenology Study - Focuses on describing an ordinary meaning for several individuals and their lived experiences (Creswell & Poth, 2018, p. 75).

Qualitative research - A set of interpretive and material practices that provides a window into the world (Creswell & Poth, 2018).

Secondary Trauma - Indirect exposure to traumatic events, graphic content, people’s cruelty to one another, and observation of traumatic reenactments (Benight, 2016).

Substance Use Disorder (SUD) - Dependence on a chemical substance that affects the thinking and reasoning cerebral cortex and the part of the brain responsible for feelings (Milhorn, 2018).

Standard Deviation (SD) - A statistical term used to explain deviations from the mean in either direction from the center of the distribution, typically there are only three deviations from the mean, and they are represented by this number (Warner, 2021).

Storying - A term used during phase 2 of conceptual mapping tasks that describes the participants' narration of their experience of the phenomenon being studied (Impellizzeri et al., 2017).

Summary

The situation at hand was the limited research attempting to understand the impact that the changes to outpatient treatment during the COVID-19 pandemic in the Western New York area have had on SUD counselors caring for individuals who struggle with addictions while the counselors were dealing with compassion fatigue, burnout, and secondary trauma. SUD counselors are vital in supporting individuals struggling with addiction, so understanding how compassion fatigue, burnout, and secondary trauma impacted the SUD counselor is critical to understand how to support individuals with substance use disorder. Recent data showed more than 93,000 deaths due to overdoses in 2020, most attributed to illicit fentanyl (Todd, 2022). This phenomenological study aimed to describe the experiences of SUD counselors caring for individuals who struggle with addictions while the counselors were dealing with compassion fatigue, burnout, and secondary trauma during the COVID-19 pandemic in the Western New York area.

Additionally, this study provided the view of the SUD counselor as an essential member of the support system for the individual struggling with addictions and the influence of burnout, compassion fatigue, and secondary trauma on the counselors' overall well-being. The study

recognized a tension between the professional and personal support services addressing the client's needs and the counselors' need to take care of themselves. SUD counselors can sometimes be compromised due to the complexities and emotional challenges associated with the profession (Kapoulitsas & Corcoran, 2015). Therefore, as the SUD counselor is impacted by their own experiences, client impact, treatment, and workplace impact, it was essential to understand how they influenced them to identify ways to help manage a compromise.

This chapter and the following chapters provided a window into the potential benefits of this study, with the ultimate focus on providing an informative understanding of the influences of burnout, compassion fatigue, and secondary trauma on the SUD counselor. Counselors supporting individuals with substance use disorder can benefit from this study through insight into the influencers that have potential insight into preventing burnout, compassion fatigue, and secondary trauma. In addition, SUD counselors can benefit from this study by following any positive changes this study suggested for supporting their emotional and mental well-being. Furthermore, even a small positive effect on the SUD clinical process through the real stories of the participants and the understanding of the protective processes and resilience can impact the system (Kapoulitsas & Corcoran, 2015).

Chapter Two: Literature Review

Overview

This chapter aimed to conduct a literature review to explore the gap in the literature researching how the COVID-19 pandemic affected SUD counselors and their struggles with compassion fatigue. This chapter begins with a description of the underlying theoretical orientation of the study, the Eight Dimensions of Wellness (SAMHSA, 2016). It explains the various contributors to stress for SUD counselors.

To understand what compassion fatigue encompasses for SUD counselors, it was essential to understand the reality of the stressors they regularly encounter in their work. Additionally, it was essential to understand that SUD counselors in 2020–2021 struggled with the regular duties of their work and the compound effects of the COVID-19 pandemic had on their profession, clients, and themselves.

The remaining parts of this chapter has a more detailed description of the COVID-19 pandemic. This chapter also has a discussion on the pandemic's impact on clients, their workplace, treatment, and options. Afterwards, this chapter has an examination of how the pandemic has impacted SUD counselors professionally and personally.

This study investigated the critical contributors of compassion fatigue in substance use disorder counselors during the COVID-19 pandemic. While there has been a focus on understanding compassion fatigue in various healthcare professions during the global COVID-19 pandemic, few studies have focused on the impact of compassion fatigue on substance use disorder counselors (Huggard et al., 2017). The COVID-19 pandemic is not the only phenomenon that needs to be studied to understand its long-term effects; the impact of compassion fatigue on SUD counselors also needs to be understood. Their vulnerability–often

the driving force for SUD counselors to enter a specialized profession like the substance abuse field–the client's vulnerability, and the lack of support provided to them during the COVID-19 pandemic can all result in adverse health and behavioral outcomes for the SUD counselors (Bride & Kintzle, 2011; Cosden et al., 2016; Reyre et al., 2017). This impact can put SUD counselors at a higher risk of secondary traumatic stress, compassion fatigue, and burnout (Beitel et al., 2018; Bride & Kintzle, 2011; Callender et al., 2019; Skinner & Roche, 2021).

To understand how SUD counselors experienced COVID-19, it was essential to first develop an understanding of COVID-19 and its causes and effects. SUD counselors provide support to individuals and their families struggling with substance use disorders by providing support for their eight dimensions of wellness: the social, emotional, occupational, financial, environmental, physical, intellectual, and the spiritual (SAMHSA, 2016; Figure 1). Therefore, one must understand how COVID-19 affected the clients' wellness, workplace, and treatment. The reviewed literature highlighted how SUD counselors were affected during the COVID-19 pandemic. In addition, the reviewed literature pointed out the need for SUD counselors to focus on their own eight dimensions of wellness and incorporate self-compassion (Germer & Neff, 2019; SAMHSA, 2016).

A counseling career can be rewarding, but if symptoms of burnout are not kept in order, the client's care becomes compromised, and their life satisfaction can be questioned (Cook et al., 2021). Based on self-reported numbers, more than 50% of drug counselors experience burnout or symptoms of burnout (Beitel et al., 2018). Secondary traumatic stress and compassion fatigue are interchangeable as both explain the distressing emotions, functional impairment, physiological arousal, avoidant responses, and intrusive thoughts that adversely affect the retention of clinical professionals (Bride & Kintzle, 2011). As substance use disorder counselors

enter the field of helping others, they must develop an understanding of their role and function in their life and work.

By developing this understanding, the SUD counselor reduces their risk of compassion fatigue, feels fulfilled in their work, and provides client-centered care. The key contributors to compassion fatigue investigated in this study are counselors' mental health, client impact, treatment impact, and workplace impact. This qualitative study aims to evaluate the various contributors of compassion fatigue to help reduce risks, promote the importance of self-care, and provide guidance into the multidimensional facets of compassion fatigue for substance use disorder counselors. Understanding the levels of burnout is critical to identifying ways of supporting counselors and reducing the risk of strong emotions that can hinder the growth of an SUD counselor. This study is essential to provide SUD counselors with research that directly addresses the impact of experiences in treatment that lead to compassion fatigue and burnout and how it affects them personally, professionally, and with clients (Warlick et al., 2021). While simultaneously providing an understanding of the importance of self-care and self-compassion, training, and supervision, reducing the risks of compassion fatigue.

Theoretical Framework

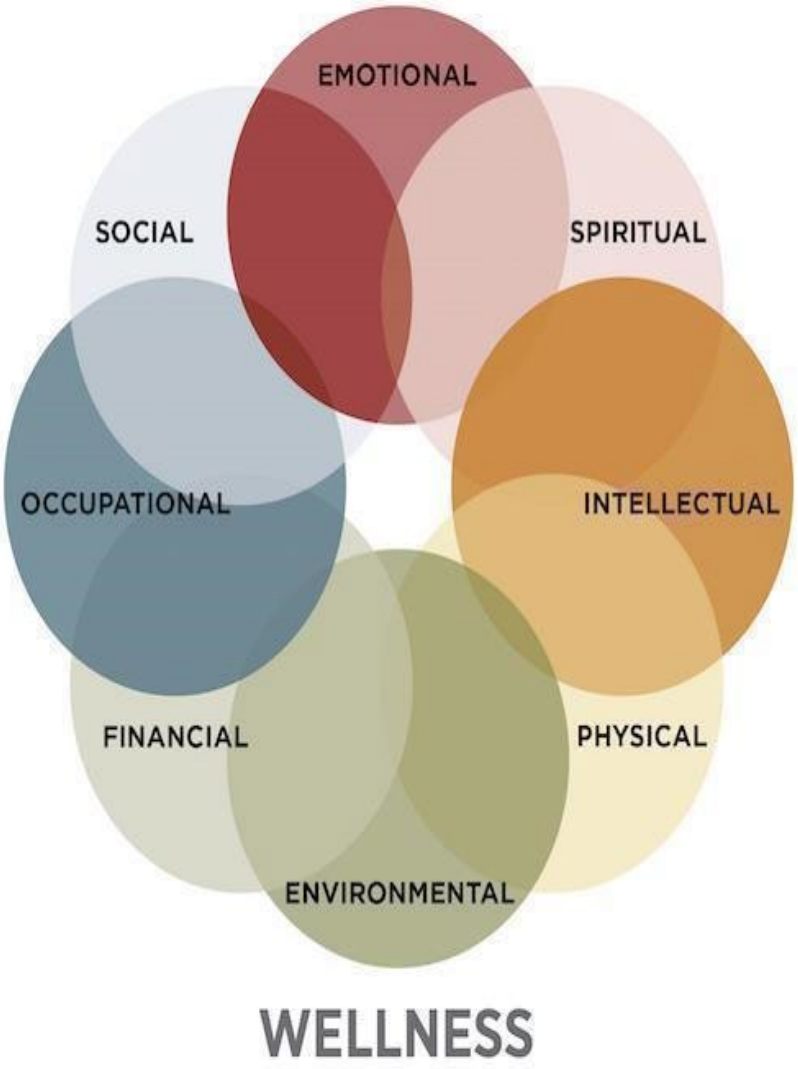
The concept of wellness can be traced back thousands of years and is referenced in the Bible several times. Jeremiah 33:6 reminds us that God will bring health, healing, abundant peace, and security (New International Version, 2011). Recognized as the father of the modern wellness movement, Alfred Adler believed that one's well-being was more than just physical wellness (Adler, 1959; Myers, 2009). Adler's theory implied that an individual's physical, emotional, intellectual, and spiritual wellness are interconnected (Britzman & Henkin, 1992; Reyes, 2022; Witmer & Sweeney, 1992). This interconnectedness occurred in an unusual goal-

oriented approach that incorporated an interest in the well-being of others (Reyes, 2022; Sweeney, 2019). Adler's theory of wellness encourages SUD counselors to be responsible, cooperative, and active members of society who enjoy and like themselves and others (Reyes, 2022; Sweeney, 2019).

As one of the earliest advocates for wellness in psychotherapy, Adler saw the self as indivisible, a view established in the idea of holism as the foundation of wellness (Ansbacher, 1969; Myers & Sweeney, 2004; Reyes, 2022). Adler looked at an individual's psychology by considering the person and their environment, including work, friendship, love, spirituality, and self (Reyes, 2022). Promoting wellness and encouragement, Adler's therapy sought to understand how a person's lifestyle influences both their healthy and unhealthy choices that impact wellness (Britzman & Henkin, 1992). This focus on wellness can help make a more satisfying lifestyle (Swarbrick, 2006). Although wellness is a broad concept, it is a holistic and multi-dimensional balance that relates to the quality of a person's life (Swarbrick, 2006). The dimensions of wellness include social, emotional, occupational, financial, environmental, physical, intellectual, and spiritual (SAMHSA, 2016; Figure 1).

Figure 1

Eight Dimensions of Wellness

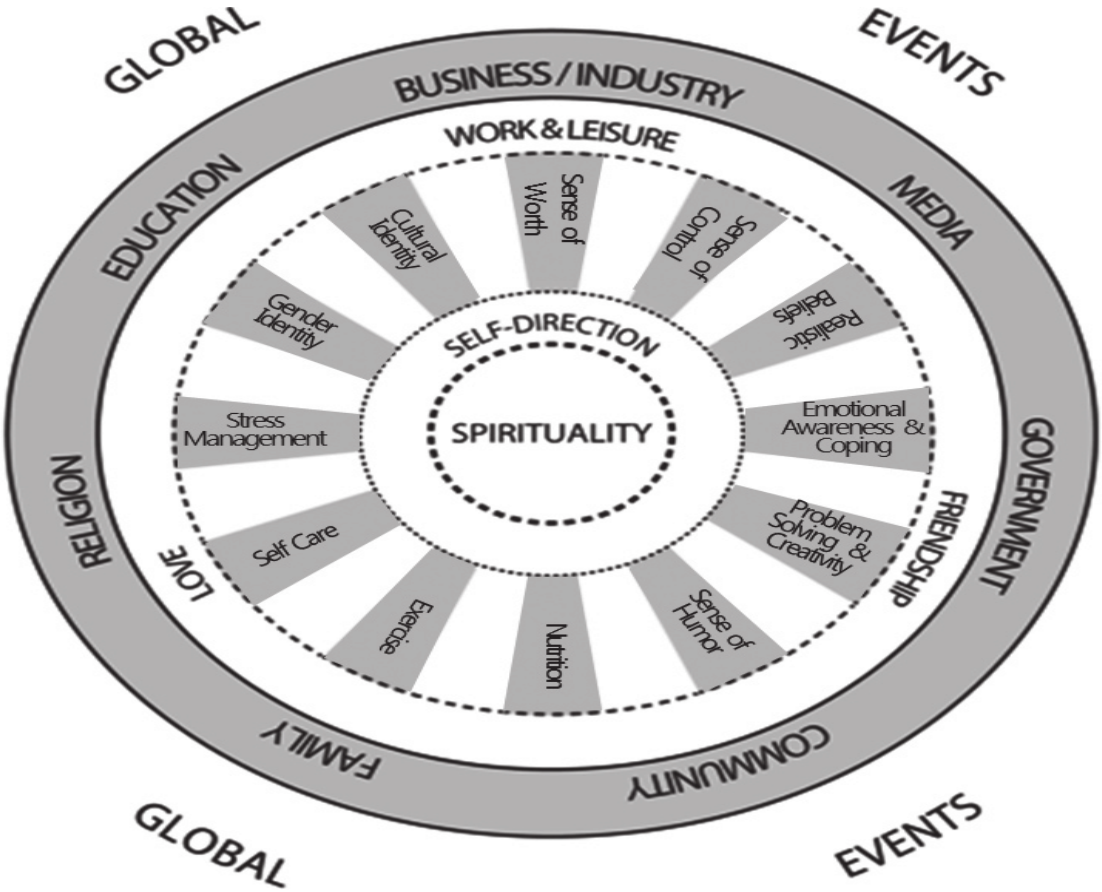


(SAMHSA, 2016).

Wellness is not the absence of disease, illness, and stress. However, wellness is a positive and purposeful life, satisfying work and plays, and enriching relationships with a healthy body and living environment (SAMHSA, 2016). Aligned with Adler's five major life tasks–work, friendship, love, spirituality, and self–wellness focuses on the whole self (SAMHSA, 2019; Witmer & Sweeney, 1992). Wellness is a state of being that is conscious, self-directed, and focused on promoting better quality of life, healthy habits, and self-control (Montoya & Summers, 2021; SAMHSA, 2019; Witmer & Sweeney, 1992).

Figure 2

Wheel of Wellness Model

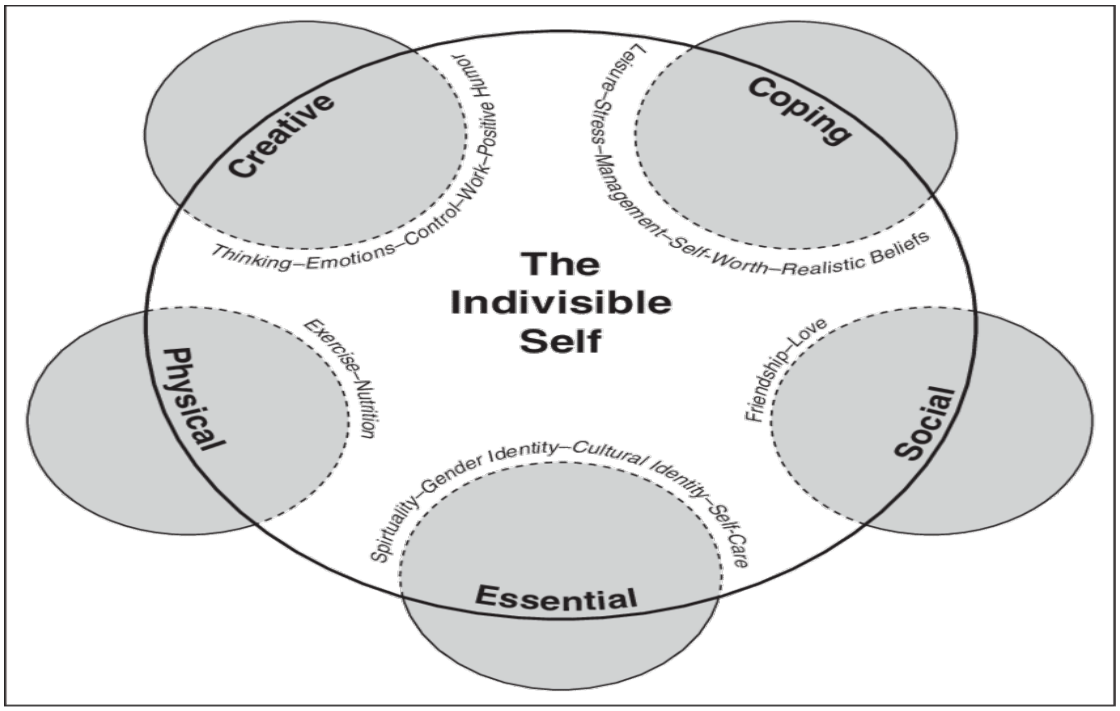


(Witmer & Sweeney, 1992).

Based on Adler's theories, the Wheel of Wellness Model focused on spirituality as the core element of wellness (Dreikurs & Mosak, 1967; Reyes, 2022; Witmer & Sweeney, 1992; Figure 2). Additionally, the Indivisible Self Model of Wellness incorporated psychosocial-emotional, physiological, and spiritual dimensions (Blount et al., 2016; Myers & Sweeney, 2004; Reyes, 2022; Figure 3). This model highlighted five factors of the self: creative, coping, social, essential, and physical which are like Adler's five major life tasks (Myers, 2009; Reyes, 2022). These theories of wellness point to the necessity of maintaining self-responsibility and self-care to make healthy daily choices for better physical, emotional, spiritual, environmental, occupational, intellectual, financial, and social well-being (Reyes, 2022; SAMHSA, 2019; Sweeney, 2019).

Figure 3

The Indivisible Self Model



(Myers & Sweeney, 2004, 2008).

After recognizing the influence that the eight dimensions of wellness have on living a healthy life with joy and fulfillment, it is essential to look at how. For example, worrying about finances can lead to emotional anxiety for SUD counselors, which can influence counselors' medical problems and their ability to maintain their caseload. SUD counselors can be short-staffed at work or have larger caseloads, leading to working long hours and being physically exhausted causing sleep problems. SUD clinicians work with clients to address addiction, assess dysfunctional diagnoses, meet the client where they are at with their eight dimensions of wellness, and restore life satisfaction (Friedman, 2017; Hattie et al., 2004; Reyes, 2022). Creating a balance of work, social life, and family is essential for SUD counselors. Developing a healthier routine can increase positive feelings, relationship satisfaction, energy, inspiration, and a sense that one's talents are being used to the fullest (SAMHSA, 2019).

Physical Wellness

Good physical health habits like proper nutrition, exercise, and appropriate healthcare make up the physical dimension of wellness (SAMHSA, 2019). SUD counselors often feel so extended by professional and personal demands that they do not make time for physical wellness (Montoya & Summers, 2021). When counselors deplete their sense of physical wellness, they are more susceptible to physical and mental illness (Montoya & Summers, 2021; SAMHSA, 2019).

Intellectual Wellness

More than keeping the brain active, intellectual wellness involves broadening one's perspective and understanding diverse points of view (SAMHSA, 2019). Incorporating personal interests, education, brain exercises, and conversation expands counselors' knowledge of person-centered practices, particularly when providing harm-reduction treatment to clients (Montoya &

Summers, 2021). Continuing education helps nurture SUD counselors' intellectual well-being (Montoya & Summers, 2021; SAMHSA, 2019).

Financial Wellness

Financial wellness involves income, debt, savings, and the person's satisfaction (SAMHSA, 2019). Beyond that, financial wellness directly affects SUD counselors' ability to support their life, health, and mental well-being (Montoya & Summers, 2021). If obligations cannot be met, this can increase stress which challenges how the counselor responds to treatment. SUD counselors are passionate about their work. However, they can be preoccupied or overwhelmed by financial stress. This can lead to the limits of SUD counselors' mental capacity preventing them from being fully mindful and critically conscious in their practices and relationships (Montoya & Summers, 2021).

Environmental Wellness

Safety, both being safe and feeling safe, is a component of environmental wellness (SAMHSA, 2019). Environmental wellness establishes a foundation that helps minimize stress for SUD counselors and their clients while also supporting their overall wellness (Montoya & Summers, 2021). Clinics provide cool temperatures, cleanliness, and even painted walls to positively influence the moods of those who enter the clinic (Montoya & Summers, 2021; SAMHSA, 2019).

Spiritual Wellness

Spiritual wellness involves the personal beliefs and values that give the SUD counselor meaning, purpose, as well as a sense of balance and peace (SAMHSA, 2019). The establishment of an appreciation for life and a purpose in existence is unique to each counselor. SUD counselors can deepen their spiritual wellness by examining aspirations and reflecting with

journaling, meditation, and self-help books (Montoya & Summers, 2021). Examination of scripture, like observing John 14:27 which explains that God gives peace that the world cannot and that one's heart should not be troubled or afraid, can also deepen spiritual wellness (New International Version, 2011).

Social Wellness

Social wellness involves having healthy relationships with friends, family, and the community while having a concern for the needs of others (SAMHSA, 2019). For SUD counselors, this is the foundation for their work with clients and their participation in the community, and it is rooted in respect (Montoya & Summers, 2021). When counselors ensure there are opportunities to interact with others outside the workplace they create a healthier work-life balance (Montoya & Summers, 2021).

Occupational Wellness

SUD counselors' occupational wellness can be harmed by extended work hours, large caseloads, limited growth opportunities, lacking supervision, and even low work morale (Montoya & Summers, 2021; Saliba & Barden, 2017). Balancing leisure time and work when considering time spent can influence occupational wellness (SAMHSA, 2016). SUD counselors must ask themselves if work provides personal satisfaction and stimulation (SAMHSA, 2016).

Emotional Wellness

Emotional wellness involves expressing feelings, adjusting to challenges, and coping with life stressors while enjoying life (SAMHSA, 2016). Self-care and self-compassion are both critical pieces to this dimension of wellness. Emotional wellness is a significant component of a SUD counselor's daily life as it affects their interactions with various people (Montoya & Summers, 2021). SUD counselors often need to manage their personal and professional feelings

while working with someone struggling with addiction and caring for their emotional needs. Part of a person-centered treatment requires SUD counselors provide their active listening skills. Developing mindfulness techniques helps SUD counselors examine their emotional state, increasing their understanding of the present and decreasing the likelihood of them dwelling on the past or having unrealistic expectations for the future (Smarinsky et al., 2021).

The American Counseling Association promotes wellness through the growth and development of all counselors and encourages ethical practices (ACA, 2019). Professional counselors should be mindful of their wellness. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires education programs to teach strategies that help assess, maintain, and improve personal wellness (CACREP, 2016; Meany-Walen et al., 2016). It is explained in the literature that the most effective counselors are those who continually work on their wellness (Reyes, 2022; Yager & Tovar-Blank, 2007). Additionally, counselors practicing wellness are more helpful in their services than those struggling with compassion fatigue or burnout (Reye, 2022; Lawson & Myers, 2011).

Related Literature

It is essential to understand the nature of compassion fatigue (CF). Like many helping professionals, SUD counselors enter the field with a desire to help others–bringing hope, energy, and empathy to those they engage with (Martin-Cuellar et al., 2019; Silver, 2018). Over time, SUD counselors can experience exhaustion and emotional depletion due to harmful components like stress, financial concerns, or re-experiencing clients' trauma (Blount et al., 2016; Martin-Cuellar et al., 2019; Robino, 2019).

The cost of caring and compassion fatigue is psycho-emotional distress due to endless self-sacrifice and prolonged exposure to clients' fears, pain, and suffering (Can & Watson, 2019;

Figley, 2002; Zhang et al., 2021). Compassion fatigue has also been found to change the therapeutic response by causing depersonalization, diminished performance, loss of empathy, and poor judgment in the SUD counselor (Zhang et al., 2021). This phenomenon is more likely to occur with SUD counselors whose lack experience, knowledge, and support creates self-doubt (Can & Watson, 2019; Skovholt & Trotter-Mathison, 2016).

Despite the exposure to emotional distress, SUD counselors are expected to put their personal feelings aside while providing person-centered care in response to the client's presenting needs (Can & Watson, 2019; Figley, 2002). This detachment comes with a cost. SUD counselors can find themselves experiencing physical, emotional, and mental exhaustion and a sense of helplessness (Can & Watson, 2019). These factors produce compassion fatigue, which leads to a lack of empathy for clients, decreased motivation, and diminished effectiveness that result in the risk of counselors harming clients (Can & Watson, 2019).

Compassion fatigue symptoms are like those of someone struggling with post-traumatic stress syndrome sand can include anxiety, depression, withdrawal, avoidance, exhaustion, preoccupation with trauma, self-harm, and suicidal ideations (Figley, 2002; Martin-Cuellar et al., 2019). Other factors that can impact the professional and personal lives of SUD counselors include a personal history of trauma, the impact of the workplace, support from peers, supervisor support, length of time as a SUD counselor, and self-care practices (Martin-Cuellar et al., 2019; Thompson et al., 2014; Knudsen et al., 2017; Williamson et al., 2020).

Compassion fatigue combines burnout and secondary traumatic stress (Figley, 2002; Martin-Cueller et al., 2019). Burnout is the result of ongoing demands and stressful work environments, whereas secondary traumatic stress is the byproduct of hearing clients' stressful and traumatic experiences on an ongoing basis (Cook et al., 2021; Foreman, 2018). It is the state

in which the compassionate energy of SUD counselors has been expended and surpassed their therapeutic processes (Zhang et al., 2021).

SUD counselors are more likely to experience compassion fatigue, burnout, and secondary trauma when there is past personal trauma, high emotional involvement with clients, reduced healthy coping skills, and low self-awareness (Robino, 2019). Many SUD counselors bring afflictions that can be difficult to differentiate between experiencing empathy for a client and countertransference (Martin-Cueller et al., 2019). The ACA Code of Ethics provides guidelines for SUD counselors to monitor for signs of physical, emotional, or mental symptoms of impairment (American Counseling Association, 2014; Foreman, 2018; Robino, 2019).

Larger caseloads, non-counseling duties, lack of on-the-job support, office morale, and other professional issues can leave a SUD counselor experiencing burnout (Brown et al., 2022; Cook et al., 2021; Thompson et al., 2014). Additional indicators, such as negative emotional experiences, fatigue, physical illness, and self-perceived ineffectiveness, can contribute to experiences with burnout (Brown et al., 2022; Cook et al., 2021; Giordano et al., 2021; Zhang, et al. 2021). Burnout can also increase the risk of SUD counselors leaving the field (Cook et al., 2021; Mullen et al., 2018).

Secondary traumatic stress is conceptually linked with compassion fatigue due to the direct service to clients who have experienced trauma (Cook et al., 2021; Johansen et al., 2019). Individuals with substance use disorders have higher exposure rates to traumatic events due to working with SUD clients; one in five SUD counselors experience secondary traumatic stress (Johansen et al., 2019). Presenting similar symptoms to post-traumatic stress disorder (PTSD), secondary traumatic stress can impact the mental health of a SUD counselor with intrusive thoughts, hypervigilance, and avoidance (Brown et al., 2022; Molnar et al., 2017). This indirect

exposure to trauma while working with SUD clients can produce decreased job satisfaction and high turnover risks if not appropriately addressed (Johansen et al., 2019).

Compassion fatigue, burnout, and secondary trauma by themselves can cause personal and professional issues for SUD counselors. Furthermore, the COVID-19 pandemic impacted mental health care, including how individuals received substance use treatment (Alharbi et al., 2020; Cook et al., 2021). This also impacted the SUD counselors' personal and professional lives (Litam et al., 2021). The anxiety from the pandemic, with significant variables such as organizational factors and increased personal and professional stressors, heightened the risk of burnout, compassion fatigue, and secondary trauma (Cook et al., 2021).

Considered frontline workers, SUD counselors are tasked with listening to the impact of the pandemic on clients without absorbing the emotional pain from the stories (Litam et al., 2021). SUD counselors are expected to recognize stressful clinical experiences and learn how to respond to emotional stress (Cook et al., 2021; Litam et al., 2021). During the COVID-19 pandemic, SUD counselors were not immune to developing compassion fatigue, burnout, and secondary trauma and needed to maintain healthy boundaries and utilize regular self-care (Zabukovic et al., 2021).

Mindful Self-Compassion

People generally understand what compassion is, as most world religions have some reference to the concept of doing to others how one would have done to them found in Matthew 7:12 (Germer & Neff, 2019; New International Version, 2011). However, providing care for oneself can be difficult for some. Germer and Neff (2019) identified the importance of self-compassion to bringing confidence and inspiration into personal practice through the Mindful Self-Compassion (MSC) program. MSC was built on personal experiences and supported by

scientific research (Germer & Neff, 2019, p. 2). Research showed that when MSC is implemented, individuals provide support to themselves, allowing them to manage life more easily and to enhance their self-compassion through confidence. Mindful self-compassion has been modeled on mindful-based stress reduction (MBSR) and mindfulness-based cognitive therapy programs focusing on being aware of and providing kindness for oneself (Germer & Neff, 2019). For SUD counselors in New York State, Office of Addiction Services and Supports (OASAS) guidelines focus on person-centered treatment (OASAS, n.d.). Neff and Germer (2019) provided a curriculum that evokes mindfulness and self-compassion in one's daily life and provides a person-centered approach to treatment. MSC counselors learn to provide compassion to themselves while leading by example for their clients. Neff and Germer (2019) explain that maintaining the personal practice of mindfulness and self-compassion keeps the challenge of self-care and self-compassion fresh in the counselor's mind (p. 7). When practicing MSC, counselors learn a particular way of interacting with their clients, which mirrors their self-compassion and self-understanding. MSC is designed to cultivate mindfulness and self-compassion by allowing SUD counselors to support their personal and professional development (Neff & Germer, 2019).

COVID-19 Pandemic Background

The World Health Organization (WHO) declared COVID-19 a pandemic in March 2020. Soon after, President Donald Trump declared a national emergency (AJMC Staff, 2021; Blithikioti et al., 2021; Oberfeld et al., 2020; Rothan & Byrareddy, 2020). This change for society, including lockdowns and stay-at-home orders, impacted every community, leaving the nation grappling with increased numbers of individuals struggling with mental health care concerns, including substance use disorder (Blithikioti et al., 2021; Trivedi, 2022). The COVID-

19 pandemic introduced challenges for substance use disorder treatment initiation and continuation (Nesoff et al., 2021; Zhen-Duan et al., 2022). When looking at what the critical components of compassion fatigue, burnout, and secondary trauma are to SUD counselors, it is just as essential to look at the impact of the COVID-19 pandemic and its influence it on those working and dealing with substance use disorders. Under this influence, support provided to individuals struggling with substance use abruptly changed lives and burdened healthcare.

The substance use population has an increased risk of COVID-19 and can suffer more severe outcomes due to compromised immune systems and complications that have multiple physiological and social causes (Vallecillo et al., 2020; Zhen-Duan et al., 2022). Before COVID-19, the nation was dealing with high rates of suicide and overdose that were alarming because statistically they were the leading causes of premature illness and death in the United States (Trivedi, 2022; Wani et al., 2019). State responses failed to look at the prevalence of substance abuse apart from the opioid pandemic (Nesoff et al., 2021).

The COVID-19 pandemic created challenges for individuals receiving outpatient therapy for substance use disorder (Zhen-Duan et al., 2022). Social distancing disrupted care delivery and added to the stress of how individuals on medication for opioid use disorder (MOUD) would get their medications (Melamed et al., 2022; Nesoff et al., 2021). Substance use treatment was also interrupted in the hospital settings when mental health and substance use disorder wards were re-purposed for the COVID-19 pandemic wards (Dannatt et al., 2021). Individuals struggled with managing the illness and hardship of COVID-19, resulting in them experiencing new trauma or retraumatizing from memories resurfacing (Browne et al., 2020).

New York State Impact

In 2020, New York State reported more than 84,000 admissions for individuals struggling with opioid use to an OASAS-certified chemical dependence treatment program (New York State Department of Health, 2021). With the increase in the need for substance use disorder counselors, it is essential to have well-qualified support. Those closest to individuals who are struggling with addiction or are in recovery often want to give back and help support them (Martin-Cuellar et al., 2019; Rothrauff et al., 2011). However, this can increase the likelihood of a counselor experiencing compassion fatigue (Beitel et al., 2018; Browne et al., 2020; Cook et al., 2021). With at home overdose deaths making up over 60% of all overdose deaths, grief and anger can be a driving force to enter the SUD field of care (New York State Department of Health, 2021).

Erie County Impact

The Erie County Opiate Epidemic Task Force confirmed 44 opioid-related overdose deaths in July 2020, with another suspected 127 cases pending confirmation (Erie County, 2020). The county reported that the Erie County Medical Examiner's Office found an increasing percentage of deaths were associated with fentanyl and cocaine, from just over 15% in 2016 to 45% of the closed cases for 2020 (Erie County, 2020). The death of an individual to overdose leaves family members and friends' grief-ridden and searching for an understanding of why. Counselors are also left grief-ridden and searching for answers. The emotional demands of counseling can result in excessive amounts of emotional strain for counselors and can also cause burnout, compassion fatigue, and secondary traumatic stress disorder which is a result of counselors setting aside their own self-care needs and ability to process their grief (Friedman, 2017).

Workplace Impact

The everyday impact of a counselor's workload can hurt their overall well-being. This neglect leads to a hypercritical approach to their work and not "practicing what they preach" to their clients (Dattilio, 2015). Unreasonable workloads make it difficult for counselors to focus on self-care and increase the risk of burnout (Xu et al., 2019). Depending on the staffing and work environment, taking a leave of absence might not be an option for the counselors. Organizations need to consider incorporating a prevention and intervention approach to reducing the negative impact stressors at home and in the workplace have on counselors (Padmanabhanunni, 2020; Xu et al., 2019). Continuing education courses can also help to support SUD counselors with their occupational stress by providing internal and external resources to help self-care; education courses should be encouraged as they increase the awareness and emphasis on self-care competencies as a core part of helping others (Hallam et al., 2021; Xu et al., 2019). Neglecting one's self-care while working with compromised individuals struggling with trauma, substance use, grief, and pain increases the risks of compassion fatigue (Jarrad et al., 2018).

The results of the combined escalating burdens of a SUD counselor's work and home life can add to increased levels of compassion fatigue, which can increase a counselor's use of unhealthy coping outlets: smoking, sleeping pills, anti-depressants, alcohol, and more (Jarrad et al., 2018). Supervision and group support have also been found to help support counselors' fears of incompetency by providing them with the space to process the daily stressors and receive verbal and written feedback on distressing caseloads (Draper et al., 2014; Padmanabhanunni, 2020; Redman et al., 2017). For counselors, integrating excellent communication skills, completing accurate and timely documentation, and successfully transitioning clients helps create a less stressful atmosphere (Redman et al., 2017). Senior counselors can help to support

newer counselors in developing a healthy work environment and a treatment for the clients where the counselors are more actively involved. Proactive support can reduce reluctance to accept help when traumatic events, treatment concerns, or questions arise.

Occupational stress affects over 65% of Americans (Saliba & Barden, 2017). Occupational stress or compassion fatigue can increase the clinical risk of mental health-related issues, including job dissatisfaction, decreased overall work performance, and reduced self-care measures (Bride & Kintzle, 2011; Hallam et al., 2021). SUD treatment facilities struggle with this occupational stress that leads to turnover, poor staff morale, the ineffectiveness of staff, reduced productivity, financial strain on an organization, and lawsuits (Bride & Kintzle, 2011; Hatch-Maillette et al., 2019; Peters, 2018). Organizations can prevent this by adding supportive measures to encourage strategies for self-care, such as mentors, literature on compassion fatigue and resources available, therapeutic incentives, and other cost-effective methods to incorporate prevention strategies (Hatch-Maillette et al., 2019; Peters, 2018). When employers help professionals build their resilience to compassion fatigue, it reduces burnout and improves overall wellness (Hallam et al., 2021). Professional development focuses on self-care and compassion, which can help combat compassion fatigue's effects (Hallam et al., 2021).

One role of clinical supervisors is to guide and assist substance use disorder counselors through the risks of burnout, the management of a client’s co-occurring trauma symptoms, and secondary trauma stress related to caseloads (Jones & Branco, 2020; Wagner et al., 2020). Trauma-informed supervision provides professional development and education on subjects such as interventions used in trauma-informed care, burnout, and secondary traumatic stress (Jones & Branco, 2020). SUD supervisors can play a critical role in helping SUD counselors develop the skills needed to identify and address signs of compassion fatigue, burnout, and secondary trauma

(Cook et al., 2021). Supervisors need to be trained and prepared to approach staff in a trauma-informed manner that includes suicide prevention. Training related to suicide prevention can help counselors identify and respond to suicidal ideations, gain knowledge and skills for working with suicidal clients, and develop self-efficacy (Wagner et al., 2020). Interactions with supervision can influence how a counselor deals with the uncertainty of a client's death and various other traumas. Ineffective supervision can lead to burnout; when counselors work under impaired supervisors, there is a risk of misuse of power (Muratori, 2001).

When counselors are educated instructors must incorporate trauma-informed supervision and other supervision practices into their lectures (Jones & Branco, 2020). In addition to training, counselors found that if there was an organizational suicide response policy, counselors' responses were more organized and empathetic, which is helped with clients' recovery process (Wagner et al., 2020).

Comorbidity can also lead to complications with other life areas such as finance, housing, and social contacts (Petersen et al., 2021). Counselors are usually the first point of contact for individuals to get linked with support in life areas also affected by SUD. Lack of support, training, and collaboration with different clinics can impact the outcome of the therapeutic engagement (Petersen et al., 2021).

Treatment Impact

Burnout, compassion fatigue, and secondary trauma can impact a counselor's ability to provide quality client care (Singh et al., 2020). It is essential to identify ways to protect and reduce the risks of burnout. Work burnout and personal burnout refer to fatigue and exhaustion inside and outside the workplace, respectively. Exposure to either can adversely impact cognitive, emotional, and physical development resulting in compassion fatigue (Eyal et al.,

2019; Oser et al., 2013; Sinclair et al., 2017). SUD counselors carry heavy workloads and multiple responsibilities that require resources to manage trauma-related symptoms (Eyal et al., 2019). Trauma-informed care and mind-body work provide self-care tools that help address both client trauma and clinical stress (Eyal et al., 2019). Learning self-care techniques like progressive muscle relaxation, meditation, guided imagery, mindfulness, and yoga can directly influence SUD counselors' healing from traumatic events (Eyal et al., 2019). Installing mind-body skills as a means of self-care and coping can improve understanding of trauma-related stress and reduce stress for professionals (Eyal et al., 2019).

For counselors, the benefits of group support, trauma training, and out-of-office interactions can give them insight into how to better understand and counsel clients as well as how to reduce burnout by providing additional knowledge on critical tools for clinical practice (Beitel et al., 2018; Butler et al., 2017; Reyre et al., 2017). Work-life balance is critical for managing burnout. Engaging in pleasurable activities and exercise were commonly reported as off-site strategies, while supervision and paid time off were considered on-site strategies (Beitel et al., 2018).

Finding ways to provide oneself with compassionate care is essential for substance abuse counselors who experience larger caseloads, resistance from clients, and the risk of client reuse. One way of providing compassionate care is to utilize mindfulness-based intervention through a mobile application (Callender et al., 2021). The use of a mobile application gives counselors the flexibility to have access to mindfulness and self-compassion at their fingertips. Mobile applications for mindfulness intervention promote change in a counselor's well-being (Callender et al., 2021).

Counselors participate in different types of psychotherapy, which can lead to overwhelming exhaustion, cynicism, detachment from the job, depersonalization-dehumanization of clients, and the loss of professional accomplishment (Tratakovsky & Kovardinsky, 2013). Finding a style of psychotherapy that fits the SUD counselor can reduce these negative feelings. Cognitive behavioral therapy and dialectical behavior therapy can be used to help treat those struggling with addictions. Use of cognitive behavioral therapy when working with substance use clients has been shown to leave therapists feeling more accomplished and with lower levels of compassion fatigue (Tratakovsky & Kovardinsky, 2013). Dialectical behavior therapy (DBT) is used to educate clients on how to reduce and manage the stressors in life by using healthier coping skills and mindfulness practices. Counselors who utilize mindfulness training and other DBT skills within their practice and personal lives can reduce the risks of burnout (Warlick et al., 2021). Burnout can impact counselors at various points in their careers. Counselors must learn ways to support themselves. Research shared that DBT counselors do not differ in the level of burnout they experience, but DBT does provide a level of protection against personal and work burnout (Warlick et al., 2021).

Over the last few years, changes in the legal status of cannabis have impacted individual treatment plans. SUD counselors must be prepared to assess, treat, and discuss the effects of cannabis (Kelly et al., 2021). This can present a challenge to counselors when there is a dual diagnosis and individuals are using cannabis for medical support. Although the evidence does suggest cannabis benefits some medical and mental health issues, additional evidence suggests cannabis can be ineffective and have harmful risks (Borodovsky & Budney, 2018).

COVID-19 and Workplace Impact

During the COVID-19 pandemic, the change to the process of substance use disorder treatment impacted not only the clients but the counselors as well. Substance use disorder treatment methods were significantly impacted by the suspension of gatherings and the government lockdowns. Regulations around medication disbursements were loosened to help those on medication for opioid use disorder (MOUD). Telehealth visits were implemented with little training or technical support (Browne et al., 2020). The flexibility from the Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administrations (SAMSHA) meant agencies could provide patient-centered care and accommodate medication-assisted treatment for patients (Mandavia et al., 2022).

To support counselors, employers found it necessary to promote short-term and long-term mental health services for burnout and generalized trauma (Jun et al., 2020; Trivedi, 2020). The overall infrastructure provided to counselors gave them the psychological and social support tools necessary to provide person-centered care during and after the pandemic (Schwartz et al., 2020).

Before COVID-19, state-funded psychiatric beds per capita declined by 97% and reduction continued as beds were used to care for COVID-19 patients (Trivedi, 2020). Inpatient facilities were changed or closed as mental health units because of the economic effects of COVID-19, with the possibility that they could fail to reopen (Dannatt et al., 2021).

Client's Impact on SUD Counselors

When trying to understand the experiences of helping those who are hurting, it is essential to analyze the nature of the difficulties of helping others, their effects, and how individuals overcome them (Reyre et al., 2017). Client trauma can impact SUD counselors as the

memories of client's trauma can mimic the symptoms of post-traumatic stress disorder and lead to secondary traumatic stress disorder in SUD counselors (Coetzee & Klopper, 2010; Perkins & Sprang, 2013). Counselors have a higher risk of compassion fatigue when there is a similarity between their client's life story and their own or a family member's (Beckerman & Wozniak, 2018; Perkins & Sprang, 2013). Clients seeking counseling for substance use can also have a co-occurring disorder that requires navigating treatment with a multifaceted approach (Cosden et al., 2016). Understanding the client's stage of change can assist in identifying what style of treatment can support the best outcome. Clients struggling to navigate through negative feelings can struggle to learn skills. Client-related burnout impacts the client's quality of care (Warlick et al., 2021). With higher levels of burnout among substance abuse counselors, it is critical to identify different interventions that can decrease levels of burnout and increase mindfulness and self-compassion (Callender et al., 2021). Motivational interviewing can be a means of helping clients increase their levels of motivation for change (Berman et al., 2019). It is the counselor's responsibility to know the various resources that are available for the client. A combination of prevention strategies, additional prescriber practices, naloxone training and distribution, and increased awareness of community resources can help to promote change in a client and facilitate a more complex approach to treatment (Powell et al., 2019).

The Centers for Disease Control and Prevention (CDC) reported a dramatic 500% increase in drug overdose from 1999 to 2020 (CDC, 2022). Overdose impacts more than just the person whose life was lost; counselors risk experiencing complicated and unaddressed grief after the loss of a patient (Al-Mareen et al., 2018; Urmanche, 2020). Healthcare professionals with less than five years of professional experience are impacted by suicide deaths significantly more than sudden deaths (Draper et al., 2014). The death of a client during counseling can leave a

counselor with feelings of grief and self-doubt (Ellis & Patel, 2012; Jorgensen et al., 2021; Yaseen et al., 2017). Counselors can question their role in a client's death, reflecting on the type or style of treatment provided and questioning their assessment of risk and ability to know when to reassess. Some professionals feel they are not prepared or appropriately trained to deal with clients who struggle with suicidal ideations or behaviors that lead them to death (Jorgensen et al., 2021). Counter transferential hate and remorse against the self can come into play when the counselor tries to process the clients' distressed and self-directed negative emotions (Yaseen et al., 2017). A counselor's judgment cannot predict how a client will behave regarding suicide. No matter the process of a client's suicide, the repercussions can include a lack of accountability for mistakes, blaming, the need for additional resources, and the potential involvement of state or federal agencies (Darden & Rutter, 2011). No matter how long a counselor has been practicing, all counselors need to seek support as death impacts both the professional practice and one's personal life (Draper et al., 2014). Providing information that can give a deeper understanding of self-harm can add to the clinical resources for counselors. Limited knowledge of what constitutes self-harming behaviors can prevent staff from observing red flags. Prevention and intervention structures and support systems can aid in de-escalating instances of harm (Evans & Hurrell, 2016).

With the increase in overdoses and struggles with addiction, treatment programs have had to add resources quickly that are not always practical. This rapid expansion brings stressors to a counseling organization that can impact the staff and the client base with larger caseloads, patient shifting, and even the moving of clinics (Hatch-Maillette et al., 2019). For some SUD counselors, the increased demand for integrating mental health with substance use disorders and the changing focus from abstinence to harm reduction can add to counselors' stress and can

create overwhelming challenges for them. Substance use disorder clients who present with a co-occurring disorder might struggle with a harm reduction philosophy due to the variety of psychosocial problems accompanying co-occurring disorders like schizophrenia, borderline personality disorder, other impulsive disorders, or multiple co-occurring psychiatric conditions; harm reduction may not be the best solution based on the medications required to support their psychiatric needs (Davis et al., 2012). Regulatory departments have focused on harm reduction in order to respect the client's autonomy and retain sessions. Counselors need to remember that whatever personal, professional, and theoretical reasons one might have, the attempt to not support a client's desire to reduce harm can lower the success of improving the client's functioning (Davis et al., 2012). While accommodating the client's desire to focus on harm reduction, the challenge comes when there is also a co-occurring mental health concern. SAMHSA (2019) reports that out of 11.4 million adults diagnosed with severe mental health illnesses (SMI) in the United States, over 3 million also struggle with a co-occurring SUD, with only 13.7% receiving SUD and mental health counseling (Kelly et al., 2021).

COVID-19 and Client Impact

Previous studies showed that mental health concerns increased during epidemics and pandemics (Blithikioti et al., 2021; Vallecillo et al., 2020). The COVID-19 pandemic disproportionately affected individuals with substance use disorders due to the absence of support from both community support, such as AA or NA, and counseling support, both inpatient and outpatient, which led to increased re-use as a means of coping with the pandemic (Boschuetz et al., 2020; Melamed et al., 2022).

Despite the changes in how clients received their treatment and medication support, there were still some challenges with certain medications that require high regulation (Zhen-Duan et

al., 2022). Methadone treatment, compared to buprenorphine, has a higher risk of misuse. In New York, the reported increase in the use of alcohol, tobacco, and marijuana during COVID-19 was explained to be because of the difficulties in obtaining services (Mandavia et al., 2022).

Counselors' Mental Health

Previous studies have indicated that counselors who provide trauma-related services can experience emotional and psychological stress, increasing a counselor's risk of compassion fatigue (Shepherd & Newell, 2020; Straussner et al., 2018). Physical manifestations of compassion fatigue include exhaustion, muscle tension, irritable bowel complications, and emotional and attitudinal components. When working with individuals who struggle with their own mental, emotional, physical, and spiritual challenges, counselors should prepare for the effect of past traumatic events, physical and emotional rigors, and strains (Cosden et al., 2016; Davis et al., 2012; Straussner et al., 2018). A counselor's emotional and mental state can be influenced by their struggle with adverse childhood experiences, substance abuse, problems with physical wellness, sleep problems, and other mental health challenges (Bowen & Moore, 2014; Straussner et al., 2018; Yaseen et al., 2017). If a counselor has unfinished past traumas or mental health issues that have gone untreated, the ability to provide sound counsel is compromised (Bowen & Moore, 2014; Chaverri et al., 2018; Cosden et al., 2016). Traditional conflict areas are compounded when counselors struggle with burnout, countertransference, and vicarious traumatization (Dattilio, 2015).

Secondary traumatic stress, compassion fatigue, and vicarious trauma have been described as having similar and sometimes overlapping symptoms as post-traumatic stress disorder (Brown et al., 2022). Since they are in a state of chronic stress, SUD counselors are at a higher risk of making poor professional judgments such as misdiagnoses, depersonalization, and

poor treatment planning and using a decreased amount of self-care activities (Cosden et al., 2016; Huggard et al., 2017; Oser et al., 2013; Simionato & Simpson, 2018). Research has found that risks of burnout and secondary trauma can be linked to both individual and organization factors; individual factors include age, race/ethnicity, and gender while organization factors include work setting, number of direct client hours, caseload, and productivity requirements (Brown et al., 2022; Cook et al., 2021).

Previous research indicated that counselors experiencing burnout risk losing their sense of identity, experiencing physical manifestations, feeling emotional overload that leads to emotional exhaustion, and having experiences that were not in a linear or phased (Finan et al., 2020; Tzu et al., 2016). Questioning one's inner self drives one to find a safe place (Tzu et al., 2016). Researchers have just begun to explore the impact of trauma on the personal and professional experiences of counselors (Conteh et al., 2017; Cook et al., 2021). The loss of sense of self can leave counselors questioning their desire to continue practicing counseling. This can also lead to reduced job performance and ability to connect with clients (Finan et al., 2020). Burnout can also be linked to experiences with low job satisfaction and may increase the risk of SUD counselors leaving the field, (Cook et al., 2021).

Having personal traumatic experiences increases the risk of compassion fatigue with SUD counselors. In contrast, protective factors like compassion satisfaction result in positive experiences and a supportive workplace can reduce the risk of compassion fatigue (Thieleman & Cacciatore, 2014). Positive experiences can help shape SUD counselors so that they are able to live a meaningful and fulfilled life. This meaning added to life includes the ability to process that one can create meaning in their work that increases their well-being (Russo-Netzer et al., 2019). Finding balance in life can be challenging for SUD counselors who provide mental health

services and promote self-care to clients and families while risking their own emotional and physical health. SUD counselors enter the field with a deep passion for helping those struggling with addictions. Studies have suggested that while building rapport with clients and consequently developing an emotional involvement in the care of an individual, one can struggle with distress and grief (Wells-English et al., 2019).

When SUD counselors are impaired by occupational issues, cynicism, emotional and psychological distress, and addictions it leads to compassion fatigue or illness (Miller et al., 2011; Reyes, 2022). The change in cortisol levels due to stress is linked to mood changes, reduced energy levels, sleep disruptions, and even behavioral and cognitive difficulties (Miller et al., 2011). SUD counselors can experience these changes in cortisol levels; they can increase doubts about the effectiveness of treatment, cause them to be unable to be person-centered for the clients which can cause distance, and increase the risk of leaving the profession (Miller et al., 2011).

COVID-19 and Counselors' Mental Health

Research on previous pandemics reported an increased impact on mental health concerns for healthcare workers in the areas of individual, organizational, and societal needs (Schwartz et al., 2020). Substance use disorder counselors were considered essential workers in some facilities and were still required to work during the pandemic, whereas others could work remotely or go on furlough (Melamed et al., 2022). Compassion fatigue, burnout, and secondary trauma were exacerbated by the demands placed on counselors, as seen during previous pandemics (Schwartz et al., 2020).

While counselors balanced their own care as the demands for services increased, counselors considered specializing in telehealth and interdisciplinary support. The expansion of

trauma-informed care drove the expansion of substance abuse counselors to collaborate more closely with families, legal entities, and primary physicians (Browne et al., 2020; Jun et al., 2020). However, even with this collaboration healthcare workers struggled with psychological symptoms, including anxiety, depression, obsessive-compulsive tendencies, and paranoid ideation (Jun et al., 2020; Schwartz et al., 2020). The lack of personal protective equipment (PPE) also left counselors struggling to understand their health and well-being during COVID-19 (Schwartz et al., 2020).

Summary

Existing research highlights the need for more comprehensive research on how the COVID-19 pandemic and its restrictions affected the mental health of those who persevered through it (Heath, 2022). Research has focused on how the COVID-19 pandemic contributed to compassion fatigue in essential workers like nurses and physicians. Further consideration must be given to SUD counselors and how the COVID-19 pandemic affected their personal and professional well-being. Most substance use disorder counselors derive satisfaction from their work with a strong sense of personal and professional wellness (Cook et al., 2021; Lawson & Myers, 2011). However, there is always a high risk of compassion fatigue, burnout, and secondary trauma. Seen in the literature, healthcare professions struggled with increased burnout, compassion fatigue, and secondary trauma during the COVID-19 pandemic. This study brings the components that contribute to these high risks to the forefront of the counseling profession and provides insight into ways to reduce the risk of burnout, compassion fatigue, and secondary trauma. This study also gives a glimpse of how SUD counselors in Western New York approached their clinical environments to ensure they provided person-centered care to individuals struggling with addiction during the COVID-19 pandemic.

Previous research provided several facets to healthcare professionals' risks for burnout, compassion fatigue, and secondary trauma (Alharbi et al., 2020; Barry, 2023; Brown et al., 2022; & Heath, 2022). It was found that various components influence the risk to counselors' emotional and psychological well-being. SUD counselors can have previous unresolved emotional and psychological stress from client crises, including potential suicide (Hallam et al., 2021; Jones & Branco, 2020; Okoli et al., 2020; Romance, 2020; Sheperd & Newell, 2020). The research focused on one component or another but neglected to look at their combined impact. While examining the components of compassion fatigue for SUD counselors, it is essential to sample various suggestions for reducing the risks of compassion fatigue. Incorporating various self-care and self-compassion exercises, supervision, and training can support SUD counselors caring for a high-risk population (Urmanche, 2020). Over the last few decades, more research focused on the importance of counselors' mindfulness for their clients and themselves. Mindfulness can be a tool to help SUD counselors reduce their stress and decrease their suffering while improving their lives (Thieleman & Cacciatore, 2014).

This chapter detailed key contributing factors to a counselor's day that are foundational to understanding the systemic nature of burnout, compassion fatigue, and secondary trauma of SUD counselors. These contributing factors help understand the clinical day surrounding the counselor and how they interact with clients. The reviewed literature provided data sharing the impact of compassion fatigue, secondary trauma, and burnout for healthcare professionals working with compromised individuals struggling with mental health illness and substance use disorders. However, little focus has been placed precisely on substance use disorder counselors. Although there is no accurate accounting for this limited focus, one thought may be that it is due to the amount of training and support required within the substance use sector. This study is

critical because it gives the SUD counselor a voice and helps give the lived experiences, challenges, and in some areas, the benefits the SUD counselors felt during the COVID-19 pandemic.

Chapter Three: Methods

Overview

The methods section provides details on the design of this study, which explores the compassion fatigue, burnout, and secondary trauma SUD counselors experienced during the COVID-19 pandemic in Western New York. This phenomenological qualitative study aims to understand the impact of critical contributors to compassion fatigue, the knowledge and use of prevention and intervention, the effect of regulations, support from supervisors or lack thereof, and the training used for substance use disorder counselors. This chapter describes the guiding research quest used, the setting, a brief description of the process for selecting participants, and the procedures used in this study. In addition, the researcher's role, categorizing, and analysis methods are also discussed.

The data was collected using a transtheoretical interviewing process, conceptual mapping task (CMT), which is a four-phase procedure that gives SUD counselors a voice and provides built-in validity through verification checkpoints (Impellizzeri et al., 2017). This strategy provides a second data collection strategy that allows the SUD counselors to deepen their description of the phenomenon through visual representation. The third data collection method used memos that the researcher wrote documenting what she experienced while collecting and analyzing the data. Two computer programs were used to aid in the analysis of the data: Otter.ai transcription software to record all the interviews and ATLAS.ti qualitative analysis software that supported the determination of themes while it provided the necessary audit trail. Lastly, this section gives the readers a description of the efforts used to reduce bias and ensure the trustworthiness of the data collected and the analysis of the data completed by the researcher.

Design

This phenomenological study used a qualitative approach to conduct the research. This approach was deemed appropriate because the study will identify variables that cannot be easily measured yet still need to be studied (Creswell & Poth, 2018). Qualitative research provides an approach that emphasizes the understanding of the context and the discovery of orientation; it is particularly suited for counseling research (Heppner et al., 2016, p. 361). Conducting interviews and listening to the participants' stories empowers them and de-emphasizes the researcher and participant relationship (Creswell & Poth, 2018, p. 45).

The design of the research questions is to engage the participants in an interactive process to gather information on the personal history and worldviews of the critical contributors of compassion fatigue as it relates to substance use disorder counselors. The research questions guide the counselor to tell their story in the time allotted, are reflective of the study, and are uncompromising for the parties involved. The researcher developed questions around lived experiences regarding the specific phenomenon that explores and generates a reliable and valid hypothesis (Heppner et al., 2016).

The conceptual mapping task (CMT) further honors SUD counselors' perspective of their experiences through an inventive and thought-provoking member-checking process (Barry, 2023; Martin, 1987; Martin et al., 1989; Novak, 1990; Leitch-Alford, 2006; Impellizzeri et al., 2017). Methodological rigor in the data collection and the phenomenological data analysis are increased in the Conceptual Mapping Task by helping SUD counselor participants enrich their narrative in their pictorial map (Impellizzeri et al., 2017). This additional data source provides valuable information from written text and numerical calculations to a link in theoretical and methodological foundations for qualitative research (Barry, 2023).

Research Questions

1. How do SUD counselors describe their experiences of burnout, compassion fatigue, and secondary trauma during COVID-19 restrictions in Western New York?
2. How do SUD counselors describe their interactions with clients, supervisors, and state regulations during the pandemic?
3. How do SUD counselors describe their self-care, training, and supervision before the COVID-19 pandemic and during the pandemic?

Setting

The general setting for the research is in Western New York State. Five SUD counselors were selected from this area, and every effort was made to ensure the interviews were conducted in a comfortable, convenient, and confidential setting. The researcher facilitated using one of the group rooms at the SUD counselors' clinical site. The participants selected the space in their site for the interview and the researcher traveled to the participant, ensuring the study had a mobile and flexible recording and interview strategy. Each setting where the interviews took place was similar in that the participant selected them, was private, and provided enough space for the participant to feel comfortable and ensure clear recordings of the interviews. Due to the nature of using the CMT protocol for interviews, virtual interviews were not offered to participants as an option.

Participants

This qualitative phenomenological study includes five participants from outpatient addiction recovery facilities in Western New York. The sample size aligns with the recommended size of three to 15 for a qualitative research study to ensure data saturation is met (Creswell & Poth, 2018). The research saturation was met when counselors presented similar

themes and experiences. Participation in the study was voluntary. Each participant was encouraged to contact their site supervisors to contact the researcher if they were interested in participating in the study. The research ensured the heterogeneity of participants by choosing participants with the same severity of symptoms, socioeconomic status, education level, degree of caseload activity, and also ensured participants were all conducting at least two groups a week and working at least 35 hours a week. The inclusion criteria specified a counselor who started practicing before 2020 and who has been providing face-to-face and telehealth professional services during the pandemic.

Additionally, each participant was asked to complete the proQOL self-assessment. Professional Quality of Life (proQOL) is intended for any helper to understand better the influence of experienced trauma and suffering (proqol.org, 2021). Participants scoring 23 or higher will be considered for the study. This data only identifies candidates at risk of compassion fatigue, burnout, and secondary trauma. It will not be used as data in the qualitative study but for descriptive purposes when each participant is considered.

The sampling strategy used to determine the criteria that differentiated the participants was maximum variation sampling (Creswell & Poth, 2018). Utilizing this strategy ensures the maximum heterogeneity of the participants to provide a deeper understanding of the phenomena from multiple clinical situations and symptom severity. The criteria used to differentiate participants were based on the age of the counselor, sex, if they were a recovering addict or family member of a person with an addiction, socioeconomic status, ethnicity, education level, and licensure status (See Appendix D).

Participants were recruited from various outpatient and inpatient substance use facilities in the WNY area through emails, recruitment letters, and professional referrals (See Appendix A,

B, & E). Targeted agencies included Northern Erie Clinical Services, ECMC Downtown Clinic, ECMC Depew Clinic, Clearview, Horizon Health Services, and Best Self. Information on the research to aid in recruiting participants has been communicated with clinical supervisors through researcher in-person visits and discussions with local inpatient and outpatient facilities. Once the participants contacted the researcher, an initial screening phone call was conducted. Participants provided basic demographic information without personal identifying information to ensure selection criteria were met before they were accepted as a participant and to ensure diversity in the sample (See Appendix D).

Procedures

Before initiating the study, the researcher completed and applied to the Institutional Review Board (IRB) at Liberty University to ensure that the study met the ethical standards criteria. After receiving approval (See Appendix I), the researcher began the recruitment process as described above and scheduled interview times with the selected participants. The researcher began phase one by contacting each participant to gather information in the rapport-building phase of the conceptual mapping task (CMT). The interview process was the linchpin of the CMT interview process. This method of interviewing incorporates a semi-structured interview technique using questions that provide an intended safety barrier on the free association requested of the participant. Semi-structured interviews provide essential consistency to the questions asked about the phenomenon to each participant while giving room for follow-up clarification questions so participants can offer a richer, deeper, and more personalized response (Heppner et al., 2016; Impellizzeri et al., 2017).

Each interview was audio recorded using a dual recording method of an iPhone and a digital voice recorder, ensuring excellent capture of the participants' responses. The digital voice

recording tool used was the Otter.ai application, which could provide both an audio recording and a transcription. Using the CMT protocol during the interviews, the researcher incorporated sticky notepads to record ideas during phase two of the interview protocol and requested the participant to organize them on large sheets of paper. Memoing techniques describing the researcher's interactions with the participants, the data collection, and the data analysis were completed (Creswell & Poth, 2018). The qualitative software analysis, ATLAS.ti, was used to enter transcripts, memos, and participant drawings collectively to provide an audit trail of the research, supporting the researcher in organizing the data and identifying themes in the research (Creswell & Poth, 2018).

The Researcher's Role

The researcher in a phenomenological study is to suspend judgment, focus on the analysis of the experience, and specifically state their position on the research they are conducting (Creswell & Poth, 2018; Heppner et al., 2016; Moustakas, 1994). These standards provided the researcher with an awareness of any potential bias during the data collection and analysis. The mitigation of the COVID-19 pandemic efforts impacted the researcher and the participants of this study. As an SUD counselor living through the COVID-19 pandemic, the researcher was on the front line of engaging with individuals struggling with addictions and surviving the pandemic. The researcher in this study is a substance use disorder counselor in an outpatient facility in the Western New York area and a doctoral candidate in the online Community Care and Counseling program at Liberty University. As an SUD counselor, the researcher provides professional substance use and mental health services to adults with SUD and their families. During the researcher's clinical work, it came to their attention that SUD counselors had difficulties finding a balance between their clinical work and self-care. Unfortunately, the

COVID-19 pandemic significantly increased the challenges and key components of burnout, compassion fatigue, and secondary trauma in these SUD disorder counselors. Providers of substance use disorder services in the Western New York area experienced many disruptions to their ability to support their clients and the methods counselors use as the Department of Health, OASAS, and other governing agencies issued varying guidance during the pandemic. These disruptions resulted in some agencies closing their practice for a short while and some never reopening. Upon reopening, new face masks and cleaning requirements were mandated, followed by telehealth appointments and a return to face masking, temperature testing, and cleaning requirements.

Providers of substance use disorder services expressed a significant increase in stressors and chaos caused by the pandemic and the difficulties they had while attempting to adjust to the many changes in person-centered care not only in their homes but also in their work environment. This researcher attempted to provide those SUD counselors with a place to gather their thoughts and experiences surrounding this phenomenon and give a detailed, robust, and expansive description of their experience. In a transcendental phenomenological qualitative study, the researcher makes every effort to set aside their experiences and take a different, unbiased approach to this phenomenon, which starts with bracketing, ensuring those who read the study will understand the position of the researcher (Creswell & Poth, 2018; Moustakas, 1994). This is not accomplished solely through one's willpower; techniques and protocols like the CMT interviewing method and a code of ethics allow the researcher to focus on the participant's voice instead of influencing it. The American Counseling Association *Code of Ethics* provides a framework related to research responsibilities (American Counseling Association, 2014). The investigator should be an objective, unbiased seeker of truth and able to

remain an impartial observer throughout the study (Heppner et al., 2016). It is not always possible because of human behaviors, and a system of checks and balances needs to be implemented. Considering the possibility of any potential system errors, it is essential to have a solid plan for the research study (King, 2013). The CMT is a well-aligned research tool that increases methodological rigor and provides a single-interview method of data verification that limits exposure to painful lived experiences (Impellizzeri et al., 2017). Positions the researchers to practice competently and ethically (American Counseling Association, 2014, p. 3)

Data Collection

This study used multiple data collection methods to understand the phenomenon as SUD counselors described their experiences. Elaborate data was gathered through in-depth, semi-structured interviews using the CMT interviewing technique; Interviews produced textual data and visual, conceptual maps designed by the participants. As referred to by Moustakas (1994), this phenomenological technique allows the SUD counselor to look at the experience, describe it, look at it again, and describe it again, which explains the essential nature of the phenomenon (p. 91).

Recording devices captured the interviews. The visual representation allowed the SUD clinical participants to create a pictorial representation of their experiences and then reflect on and analyze the picture during the interview (Impellizzeri et al., 2017). Additionally, this study utilized the data collection method of memoing–which recorded the researcher's thoughts and experiences during the interviews–for data analysis and discussion confirming participants. The memos were an essential element of data collection, and adding the memos to ATLAS.ti, a qualitative software, aided in auditing transparency and helped to develop themes. Multiple data collection methods, such as interviews, pictorial documents, memoing, and participant

confirmation, significantly increase validity and trustworthiness (Creswell & Poth, 2018; Heppner et al., 2016; Moustakas, 1994).

Conceptual Mapping Task (CMT) Interviewing Techniques

The conceptual mapping task (CMT) derives from Novak's (1990) conceptual mapping (CM) research that studied elementary students' conceptual understanding of science and math in the early 1970s. Martin (1987, 1989) built on this idea by introducing the conceptual mapping task (CMT), which Leitch-Alford further developed (2006) into a four-phase structure which used in this study (Martin, 1987; Martin et al., 1989; Leitch-Alford, 2006; Impellizzeri et al., 2017). This projective, free-association interviewing method provides a participant with a visual depiction of the phenomenon while recording their vocalized thoughts and ideas surrounding their experiences (King, 2013). In this study, five participants were interviewed for 90-120 minutes using the following CMT four-phase methodology and procedures.

Phase 1: Rapport Building and Information Gathering

In an effective practice, the therapeutic alliance between the client and therapist increases the outcomes and is an underlying factor for change to occur in therapy (Sprenkle et al., 2009). Like the CMT, building rapport provides an essential foundation for a strong alliance between the researcher and each participant, beginning with this first phase and sustained throughout the remaining three phases (Impellizzeri et al., 2017). Participants look for validation that their personal stories and their emotional well-being are treated with respect and heard without changing their stories.

Building rapport begins with the participants receiving a recruitment letter requesting their involvement (See Appendix B), followed by a phone call reviewing the screening criteria

(See Appendix C). This first step is essential as it allows the researcher to gather demographic information to determine the participation and heterogeneity of the sample (See Appendix D). As a result, the participants' importance in the study was validated. For this study, the recruitment letter was given to clinical supervisors to hand out to potential SUD clinical participants. The researcher's contact information was listed on the letter, allowing each participant to contact the researcher via phone call, text, or email. The researcher returned the call/email/text using the script detailed in Appendix C. This information-gathering process-built rapport as the researcher utilized the same person-centered skill set to establish the therapeutic alliance. Specifically, the researcher ensured she used a person-centered skill set by utilizing active listening skills: giving reflective responses, confirming what the participants said, validating their feelings, reflecting on the meaning of their words, and summarizing their perspective (Bolton, 1979).

In continuation of rapport building, the researcher sent an email confirming the interview time and location (See Appendix E). At the beginning of the interview, establishing rapport was emphasized by acknowledging the participants' safety, reviewing the informed consent forms, and discussing confidentiality while providing time for participants to ask questions and sign the consent form (See Appendix F). After signing the consent form, the researcher encouraged questions and provided answers about the process of the interview, the purpose, and procedures of the study, and described the process of capturing the participants' stories through a conceptual mapping task interview before beginning the next phase in CMT (Barry, 2023; Impellizzeri et al., 2017).

Phase 2: Participant Storying

During the participant storytelling phase, participants created a verbal and pictorial description of their lived experiences treating individuals with SUD during the COVID-19

pandemic, addressing the research questions developed for this study to understand the phenomenon. In this phase, participants were asked two open-ended questions and then provided 20-30 minutes to free associate their answers while the researcher recorded the main ideas from the participant's storytelling on sticky notes (Impellizzeri et al., 2017; Leitch-Alford, 2006). See Appendix G for the entire script. The researcher wrote down vital phrases and ideas that each participant shared while using person-centered active listening skills, validating, and encouraging them to continue sharing their stories. Once they were finished telling their experiences, participants reviewed the sticky notes depicting their concepts to ensure they accurately represented what the participants said and felt (Impellizzeri et al., 2017). While reviewing the notes, participants were encouraged to make corrections or add to any of the concepts listed and provide greater detail where necessary.

The open-ended questions provided each participant the ability to describe their experience of the phenomenon:

"Please describe your experience of Substance Use counseling, regulations, SUD counselors, SUD supervisors, mental health experts, and medical support during the COVID-19 pandemic?" (See Appendix G)

After providing their answer to this question, the researcher will ask the participant a follow-up question as a means of deepening the discussion of the phenomenon and ensuring all the research questions were addressed:

"*Can you please describe how the change in care during the pandemic impacted your well-being, clients, and office?"* (See Appendix G).

Participants were eager to share their stories and provide honest descriptions of each question, taking between 20 and 30 minutes to answer each. Once participants shared their

stories, the researcher followed the protocol listed above and asked each participant to review the written concepts, make corrections, and approve (Impellizzeri et al., 2017).

> *"I would now like you to look at each of the details I wrote on these Post-it notes and ensure that these details are accurate and a proper reflection of your experience. Are there any other details you would like to add?"* (See Appendix G)

The free association, participant validation, and correction during this phase provided a venue for an accurate description of the phenomenon. Participants completed two more tasks to provide a robust expansion of the description and visual depiction of the participants' experience.

Phase 3: Creating the Conceptual Map

During the data collection process in phenomenological research, the participant and researcher can describe the experience in a textural language beyond seeing external objects but also in "the rhythm and relationship between the phenomenon and the self" (Moustakas, 1994; p. 90). The qualities of the experiences became the focus, and in this third phase, the participants were invited to provide a deeper understanding of their experiences by creating a conceptual map that includes a grouping of their sticky note concepts, labeling groups, and additional symbols that indicate the relationship between each concept (Impellizzeri et al., 2017; Leitch-Alford, 2006).

Each participant was instructed to arrange their notes on a large white tag board, grouping significant concepts for a visual of their experience. The instructions provided to each participant before beginning their task were:

"*Now that we have all the details checked and reviewed, I will give you the easel pad, which can be placed in your lap or on the table for ease of use. I would like you to take each of these Post-it notes® and arrange them on the pad in a way that represents your lived experience*

of accessing the overall well-being of and the professional care for your client with SUD during the COVID-19 pandemic and how the concepts of these notes relate to each other." (See Appendix G) (Impellizzeri et al., 2017; Heath, 2022).

Once this task was completed, participants were asked to draw geometric or conceptual figures around each of the clusters of sticky notes they arranged into groups (Impellizzeri et al., 2017). Conceptual figures facilitate each participant's ability to explore their inner experiences and gave them a tactile element to physically symbolize what the cluster represents, providing meaning for the participants (Fleet et al., 2021). The prompt given for this task was:

"Wonderful! Thanks for doing that. I am now going to give you some colored markers. I would like you to draw a shape around each of the clusters of concepts; it can be a circle, triangle, square, star, heart, tree, or any other shape that comes to mind. These shapes should represent the meaning of your cluster of concepts in a way that is important to you. Please feel free to make any comments you like about the process or the concepts as you are working" (See Appendix G).

After completing this task, participants were asked to label each cluster with a word or phrase that best represents the cluster and draw lines, arrows, or symbols that provide a directional flow between each concept. Instructions provided to participants were:

"Now, I would like you to draw lines or arrows indicating how these concepts interact or are related. If there is directional flow in the concepts, please feel free to use arrows or other symbols to depict that flow." (See Appendix G) (Impellizzeri et al., 2017; Heath, 2022).

The researcher clearly understood that at any time the participants could change or modify their map until they felt comfortable that their map provided an accurate picture of their life experience (Impellizzeri et al., 2017; Leitch-Alford, 2006; Moustakas, 1994). Participants

were encouraged to vocalize their thoughts while creating their maps. The researcher validated the participants' thoughts, reflected on critical ideas, or clarified critical concepts as each participant assigned language to each of the experiences that represented their core meaning (Impellizzeri et al., 2017; Leitch-Alford, 2006; Moustakas, 1994).

Phase 4: Reflecting on the Conceptual Map

In this final phase of CMT, each participant provided a synthesized meaning and essence of their responses by integrating the textual and structural descriptions of the phenomena while reflecting on their developed conceptual map (Barry, 2023; Impellizzeri et al., 2017; Moustakas, 1994). To ensure a robust meaning and assist each participant in this task, the researcher constructed questions based on the created conceptual map and the storytelling of each participant's lived experiences (Impellizzeri et al., 2017). The researcher asked the following questions and provided instructions to each participant during this phase to enable the reflection of the conceptual map:

"Now that you have created this conceptual map about your experience of working in a substance use outpatient clinic and caring for individuals struggling with addiction during the global COVID-19 pandemic take a few minutes to reflect on it.

(Pause until participant indicates they have completed reflecting.)

"What thoughts enter your mind as you look at your conceptual map?"

"How have things changed for you during the pandemic providing counsel to individuals struggling with addiction?"

"What advice would you give yourself back in February of 2020 to make things better in working in a substance use outpatient clinic and caring for individuals struggling with addiction?"

"Where are you now in your story?"

"Is there anything else you feel compelled to say from this experience?"

The response from each participant provided a deep textural and structural understanding of the meaning the participants associated with their experiences, often allowing them to develop themes and concepts that had not been considered previously (Barry, 2023; Impellizzeri et al., 2017; Leitch-Alford, 2006; King, 2013). During this final phase, each participant was provided the last opportunity to revise their map and reflect on their experience while evaluating the effectiveness of their conceptual map that provides meaning to their experiences (Impellizzeri et al., 2017). It can be challenging to provide an understanding of lived experiences. However, adding visual representation linked the participants and their "cognitive understanding with emotional engagement through arts-based approaches" which allowed each participant to describe the phenomenon in an opulent and methodical manner (Barry, 2023; Impellizzeri et al., 2017; p. 40).

Each interview session was scheduled for up to two hours based on the participant's responses, with 90 minutes of the interview reserved for creating the CMT conceptual map and the extra time allocated for heightened emotional responses. The researcher completed test runs before the interviews to ensure her familiarity with the questions and recording equipment (Creswell & Poth, 2018).

Once the interviews were completed, the researcher secured all Post-it notes® on the conceptual map board with clear tape to keep them from moving during transit. The researcher also took photos of each conceptual map board to avoid redundancy in the data collection and storage and to provide a visual representation of the study for the reader and the participants. Before ending the interview, participants were asked how they felt and if they had any concerns

that they felt were not communicated. Participants were asked about their self-care and if they needed recommendations to speak to someone to help them with self-compassion and self-care. The book *Teaching the Mindful Self-Compassion Program: A Guide for Professionals* by Christopher Germer and Kristin Neff (2019) recommended that participants encourage self-compassion through the interview. A follow-up to the participants via email was sent to thank them for their time at the conclusion. (Barry, 2023; Impellizzeri et al., 2017; Heath, 2022; see Appendices G & H).

Memoing

During the interview process, an additional source of data collection, memoing, was used. Memoing is a journaling process that the researcher used to record their experience during the interviews and data analysis (Creswell & Poth, 2018). As the process unfolds, the interviewer writes down concepts from the first phone screening to the end of the interview and then incorporates the data into the analysis process. The memos document what the researcher sees and provide a view of the flow along with details not addressed by the participant (Creswell & Poth, 2018).

Data Analysis

The general process used in analyzing the data for this research was to first prepare and organize the test into transcripts and the visual data into a conceptual form for analysis. Then, the researcher reduced the data into themes using qualitative software as well as a thorough reading and re-reading of transcripts. The final step was a methodical process where the data was formatted into figures, tables, and themes for discussion (Creswell & Poth, 2018; Heppner et al., 2016; Moustakas, 1994). This Imaginative Variation, described by Moustakas (1994), allowed the researcher to explore the systematic variation between the potential structural meanings and

an underlying textural meaning. After recognizing the foundational themes that account for the exposure of the phenomenon, the researcher considered the omnipresent structures that precipitated the thoughts and feelings of the participants. The researcher identified key imagery, both visual and exemplary text, that provided a vivid picture of the participant's description of the phenomenon (Moustakas, 1994). In the final steps of the analysis, the fundamental textural and structural descriptions were unified to capture the essence of the experience for all (Moustakas, 1994).

By the general processes of data analysis in a phenomenological qualitative research study, the data was captured and recorded using two devices: a voice recorder and a computer transcription application called Otter.ai. The researcher compared and corrected the transcription from the software when necessary to ensure a verbatim transcription of each participant's interview. For the participants' privacy, the counselor was provided a pseudonym, and the data was protected using encrypted thumb drives for data storage and a password-protected computer by the researcher.

Both textural and conceptual representation of what each participant communicated, transcripts were read several times, and each concept map was analyzed to ensure accuracy and complete understanding. Key phrases and sentences were extracted and explored with a direct focus on the participants' experience working in a substance use outpatient clinic and caring for individuals struggling with addiction during the global COVID-19 pandemic. The researcher formulated meanings from the participants' responses, clustering them into common themes using qualitative software. Using CMT not only focuses on the data collection but also provides a three-tier analysis protocol for the researcher to provide a fully integrated description of the phenomenon. (Impellizzeri et al., 2017). The first-tier analysis occurred when participants

reflected on their conceptual map and arranged their concepts into clustered ideas, representing potential themes in their experiences. In the second-tier analysis, the researcher interpreted the data gathered data from the participants as depicted. The final tier analysis was completed using probing and follow-up questions and participant clarifications of the data (Barry, 2023; Impellizzeri et al., 2017; Leitch-Alford, 2006).

The qualitative processing software program used to manage and cluster the data into themes was ATLAS.ti. The researcher uploaded the interview transcripts and memoing to ATLAS.ti, which allowed the researcher to rapidly retrieve, search, document, organize, and browse all data segments (Barry, 2023; Creswell & Poth, 2018). Although this qualitative software was instrumental in capturing and identifying potential themes in the participants' interview transcripts and conceptual maps, the researcher stayed focused on the data analysis for phenomenological qualitative research reflected in the study (Heppner et al., 2016). After ATLAS.ti generated codes based on descriptions and classifications, the researcher identified the most appropriate themes to amalgamate text and conceptual data experiences. In addition, to provide robust themes, the researcher compiled memos throughout the analysis process and input them into ATLAS.ti.

Trustworthiness

In qualitative research, it is essential to meet the standards of trustworthiness in terms of credibility, dependability, transferability, and confirmability (Barry, 2023; Creswell & Poth, 2018; Heppner et al., 2016). The CMT procedure has a verification method built into its process. The interview protocol of a CMT increases trustworthiness using four strategic member-checking points throughout the development of the participants' conceptual map (Impellizzeri et al., 2017).

For accuracy in the first phase, each participant can review the written concepts the researcher documented while listening to the story. In this first member-check phase, the participants can correct, add, expand on, or delete the captured concepts. After each participant has created their concept map, the second member check allows them to make modifications until they are satisfied with the accuracy of the reflection on their experiences (Impellizzeri et al., 2017). The third member-check participants create labels and themes for their concept clusters, providing a visual relationship between them. The CMT protocol's final member check allows each participant to reflect on their conceptual map, make changes if needed, and provide clarification to ensure the lived experience is represented accurately (Impellizzeri et al., 2017).

Credibility

Using the CMT model leaves the researcher powerless over the story, allowing each participant to create their own story (Impellizzeri et al., 2017). This processes the risk of researcher bias and engagement in misleading or fraudulent research, which aligns with the *ACA Code of Ethics* (2014, Standard G.4.a.) The credibility of this study was ensured by having each participant review the analysis after it was completed and provide feedback to the researcher to guarantee the accuracy of the information surrounding the phenomenon. There is increased transparency in the interpretive trail through the researcher’s use of Post-it notes® as a means of capturing and understanding the essence of the participant’s lived experience and the conceptual maps incorporated in the research documentation (Impellizzeri et al., 2017).

The use of three types of memoing–segment memos, document memos, and project memos–throughout the study adds to the support of the credibility of the research (Creswell & Poth, 2018). Memoing was organized and collected during the data collection and in each

analytic session in ATLAS.it. Tracking developed ideas throughout the process lends credibility to the analysis process and outcome (Barry, 2023; Creswell & Poth, 2018).

Dependability and Confirmability

ATLAS.ti is a computer-assisted qualitative data analysis software (CAQDA) that provides dependability and confirmability in the research by providing an audit trail. It is essential as it assists in understanding the cognitive process and clarity for those interested in expanding on this phenomenon (Creswell & Poth, 2018). The use of ATLAS.ti. ensures excellent documentation of the procedures used during the analysis, providing the need for replication of this study in the future (Barry, 2023; Creswell & Poth, 2018).

Transferability

Transferability refers to the importance, worth, and meaningfulness of the elements of the research results and their future use in similar phenomenological studies seeking for similar outcomes (Sundler et al., 2019). The participants' feedback ensured transferability by supporting the researcher's unbiased approach. The researcher sets aside any prejudices and predispositions, depicting the participant's experience as authentic as possible (Impellizzeri et al., 2017; Moustakas, 1994).

Ethical Considerations

Finally, ethical considerations were attended to by ensuring the participant's protection was paramount throughout the study (Creswell & Poth, 2018). Password-protected data achieved this, and the names of the participants were changed to pseudonyms. Embedded member checking during the CMT protocol ensured that participants' information and experiences were not distributed to other participants (Creswell & Poth, 2018).

Following IRB approval, data was transferred to a Lexar 256 GB USB 3.0 fingerprint password-protected flash drive. The research was completed on a password-protected computer, and all data was stored only on the Lexar encrypted flash drive and in a fireproof security lock box to ensure multiple levels of security. The participants' conceptual maps were stored in a locked file cabinet at the researcher's home office. All participants signed a consent form that provided details of this security and privacy protection, assuring them of the confidentiality of their information (See Appendix F).

Following the research process for the American Counseling Association (2014, section G.2.a), each participant will have the right to decline or withdraw their participation at any time in the research process. In addition, as an SUD counselor, the researcher made every effort to avoid any relationships with the participants that could impair professional judgment or increase any risks of exploitation (Barry, 2023; Wilcoxon, 2013).

In agreement with informed consent, if the participant reveals information that leads to the suspect of abuse or neglect of a minor or disabled individual, as a mandated reporter for the State of New York, the researcher will report the event to the proper authorities. The interview was extended to two hours to allow appropriate time for processing emotional content. If the participants needed additional support for their emotions surrounding their experiences, they were referred to a licensed mental health counselor and encouraged to speak to their supervisor.

Summary

This chapter describes the research methods used to conduct this transcendental phenomenological research. This study aims to describe the experience of compassion fatigue, burnout, and secondary trauma for SUD counselors during the COVID-19 pandemic in Western New York. The methods, research design, questions, setting, participants, procedures, data

collection, data analysis, and measures taken for validity and security were explained. Everything from the research design to the selection of participants and their representation of compassion fatigue, burnout, and secondary trauma experienced during the COVID-19 pandemic in Western New York was considered carefully to provide a voice for SUD counselors working with a vulnerable population ethically struggling with addiction.

Chapter Four: Findings

Overview

The purpose of this transcendental phenomenological study is to provide a voice to the experience of components of compassion fatigue in substance use disorder counselors during a global COVID-19 pandemic in Western New York. This chapter will provide a depiction of the participants, their demographics, and their descriptions of their experiences during the pandemic. Moreover, this chapter will provide the research results regarding the themes that emerged from the answers to the research questions that initiated this study.

Research findings were the result of five in-depth, semi-structured interviews of participants of diverse demographics with either a CASAC or CASAC-T license and had a caseload of patients with substance use disorder before, during, and after the COVID-19 pandemic. Additionally, participants completed a conceptual mapping task, which allowed them to deepen their descriptions of their experiences and provide a pictorial representation of their organized concepts and linked them to one another (Barry, 2023; Impellizzeri et al., 2017). The conceptual mapping task was completed in conjunction with the researcher memoing during the interviews and using both the transcripts of the interviews and the conceptual maps. During this process, the researcher made every effort to allow the participants' voices to come forward and describe their experiences. Several participant quotes allowed the reader to see the participants' experiences through the stories they told.

Participants' Portrait

The five participants were SUD counselors carrying the certification of a CASAC working in the Western New York area who experienced either symptoms of compassion fatigue, burnout, or secondary trauma while working during the COVID-19 pandemic. The

period researched was from prior experiences to March of 2020 to August 2023, when the interviews took place. Participants were of various races and 33 to 63 years old: three married, one divorced, and one never married. There was one male and four female participants. All participants work in suburban settings, with 6 to 30 years of clinical experience in outpatient or inpatient substance use disorder clinics. The participants reported no previous experience with the procedures used to create their conceptual map. Digital photos of each participant's conceptual mapping task are provided in Appendix K; as a reference to the conceptual maps, there are figures at the end of each participant's portrait. Each participant was asked for a pseudonym they would like to use to protect their identity. Word documents were created to provide a visual of the conceptual maps created by each participant, and photos of the original maps are documented in Appendix K. Additionally, some of the direct quotes were altered to protect confidentiality.

Table 1

Participant Demographics

Participant Demographics					
	Claire	**Charles**	**Harper**	**Ivy**	**Marie**
Counselor Age	**34**	**33**	**34**	**63**	**63**
Relationship Status	**Married**	**Engaged**	**Married**	**Married**	**Divorced**
Race	**Caucasian**	**Asian**	**Caucasian**	**Caucasian**	**Caucasian**
Identity - Female/Male	**Female**	**Male**	**Female**	**Female**	**Female**
Work Setting - Outpatient, Inpatient	**Outpatient**	**Outpatient/Inpatient**	**Outpatient**	**Outpatient**	**Outpatient**
Work Location - Inner City, Rural, Suburban	**Suburban**	**Suburban**	**Suburban**	**Suburban**	**Suburban**
Number of Years CASAC or CASAC-T	**8 years**	**6 years**	**8 years**	**34 years**	**32 years**
Current caseload	**62**	**81**	**30**	**50**	**40**

Claire

Claire (pseudonym) is a 34-year-old Caucasian married woman with a caseload of 62 patients. She has been working in an outpatient setting for eight years. Claire works eight-hour shifts Monday through Friday. Before the pandemic, Claire provided face-to-face individual and group sessions. Claire had just given birth to her second child in December 2019. She recalled that at the start of the COVID-19 pandemic no one knew what it was. Claire was home with her new baby and a toddler until she returned to work in March 2020. Claire reported that she did not watch television or listen to the radio much, so she did not realize what was happening globally. She explained that she felt so uncertain about things and described how, on Monday, she dropped her children off at daycare, and everything was shut down by Friday. Her husband also worked in the field and endured the same uncertainty. She described how worried she was not knowing what each day would be for her family but also the patients because they did not know what was happening. Claire described it as scary for her family, clients, and their families.

Claire interview lasted 96 minutes and was conducted in the kitchen of her home. Claire was engaging and articulated her story with passion. She needed help comprehending the concepts and steps required to complete the conceptual mapping exercise. Throughout the process of the interview, Claire expressed her frustrations, struggles, stress, and challenges as she told of her story of being a SUD counselor during the COVID-19 pandemic.

During her story, Claire was emotional, explaining how challenging it was for her patients. She expressed how concerned she was about the population having coexisting morbidities like COPD and other health issues that put the patients at a higher risk of getting COVID-19. Claire shared that she was not scared as much but more questioned how they would

handle it. After the interview, Claire conveyed that with the changes in regulations, patients may not abstain from substance use, but as a counselor, she is doing good work.

Textural Description

Before the pandemic, Claire and her husband worked in two different clinical locations for the same hospital. Claire would drop off her children at daycare before going to work, and her husband would pick them up when Claire worked late. Claire felt as a family they had a good routine down. The family would routinely go to the nursing home to see her grandmother.

As part of her day, Claire would see as many as 5-9 clients daily and run three groups a week. Claire reported that she enjoyed her women's group the most. Supervision, treatment team case conferences, and weekly staff meetings were also done. Claire recalled that although her days were extended as a new mother and a counselor, she felt rewarded. She explained that at the time there were fewer attendance issues and that even those legally mandated to receive treatment participated.

At the onset of the COVID-19 pandemic, Claire and her husband changed their work schedules, so they worked opposite each other as no daycare settings were open. Claire explained that because they worked for the hospital their positions were considered mandatory and they both were required to report to work. Claire was thankful that she and her husband did not have any comorbidities or significant issues because they eventually they got COVID, even after being vaccinated.

Claire remembered that other outpatient facilities closed their doors, but her facility never really did. She reflected that telehealth was how most facilities continued to support individuals with substance use disorders. However, her facility used more of a hybrid model. This hybrid

model also provided the facility with more opportunities for referrals from the court systems. Claire expressed how, even three years later, other facilities only do telehealth.

With facilities closing, Claire questioned why her facility stayed open for face-to-face sessions when others were doing telehealth. Claire explained that the best practice mode is in-person, but at what cost? Eventually, most of the staff and patients at the clinics got COVID-19, even after all protocols were done, masks were worn daily, the office was wiped down before each client, and hand sanitizer was used before and after each client. Claire communicated her frustration about being the only facility doing face-to-face sessions and not feeling valued as a clinician by her employer.

Claire verbalized that groups were all done with a virtual option to accommodate individuals and that the women's group was the last to stop doing virtual options because children were still home from school. She spelled out how the groups became a lifeline for people, that despite everything happening in their lives the clients felt connected even through Zoom. Claire explained that there was a different bond with people during the COVID-19 pandemic. She provided two examples where she felt joy during the chaos:

> One of the clients could not get the formula for her child, and another bought it for her and dropped it off at her house. Another example shared was how one client could not pay their phone bill, so another person in the group paid for it.

Claire shared that events like these helped push her through and were an excellent experience. For that, she shared that she is grateful. What Claire found interesting to navigate because of the COVID-19 pandemic is:

> It brought up a lot of people's political sides, ideations, and affiliations that would not have been touched on. So, it's been interesting to try and navigate because, as a counselor, we must remain neutral, but we have our thoughts.

Claire conveyed that her supervisor wanted to retire and OASAS was changing the regulations. These events added to the frustrations and struggles of her workday. Those who were supposed to be the ones leading were resentful about changes, which showed in their language and decisions for the clinic. Claire shared that she needed someone to guide them through the changes.

On top of the fear of the COVID-19 pandemic, needing a tech-savvy supervisor, and being a satellite clinic for a major hospital, patients needed more support almost daily with setting up virtual groups or navigating the regulations changing. Claire explained that she had to set up telehealth for the clinic and felt she needed to be more tech-savvy. Since her clinic was only a substance use clinic, Claire explained that referring clients to mental health counselors was also a challenge because many were not open or were doing limited service or only telehealth, leaving clients disappointed.

In addition to the various changes in how to treat clients, Claire explains that some would wear a mask 100% of the time, and others would not. Claire expressed that this was difficult for her to navigate because she got pregnant during the COVID-19 pandemic and did not want to get sick. She shared that most of her clients were respectful and would call if sick, but some did not.

The clinic where Claire worked required mask-wearing as it followed the hospital guidelines. Groups were still limited in numbers and usable space. Midway through 2022, clients and staff were able to remove the masks. The restriction of a 14-day quarantine required if you

tested positive for COVID-19 was reduced to five days if you tested positive for COVID-19. Once clinics were open with staff again, many clinics in the area stayed virtual only, whereas Claire indicated that her clinic continued face-to-face and limited the virtual sessions to when clients could not get into the office due to health reasons.

Additionally, Claire vocalized that there seem to be fewer people entering the counselor profession as there are open counselor spots not only in her clinic but also in others around the area. Clients are experiencing longer wait times to see a psychiatrist and they are struggling to get other services they need. Many mental health counselors left outpatient sites to open virtual private practices, frustrating the clients. Claire shared that in her clinic there was a complete turnover of all the clinicians she started working with four and a half years ago, they all left for private practice.

Most of these clinicians who went into private practice did not take Medicaid. Claire reported that many of the clients served in the clinic were on Medicaid, so there was a huge struggle for them to find a mental health counselor or counselors who specialized in trauma therapy and took Medicaid. Claire reflected on how she was trying to help her client find a therapist who specialized in trauma therapy and there was not a single private practitioner who took Medicaid. Clients struggled to link with the appropriate mental health support. Claire said that this affected her emotionally and mentally.

Conceptual Mapping Task

Claire's conceptual map (Figure 4) is grouped on the top of the page into five columns and one below representing the main contributing factors that impacted her and her family: client impact, work impact, OASAS impact, other mental health providers impact, self-impact, and technology impact. In each poster cluster, Claire's stress and frustration experience lead to

compassion fatigue and burnout. Claire created columns on client impact, work impact, OASAS impact, other mental health providers' impact, self-impact, and technology impact during the COVID-19 pandemic. In each cluster, she highlighted her sadness and frustration at the various contributing factors that added to her stress and risks of burnout.

The top three middle impacts cluster represented Claire's experience with how the workplace, the governing body of OASAS, and other MH providers influenced her during the COVID-19 pandemic. She emphasized how these three areas were all on different pages when it came to the care of the clients. Claire explained that it was a struggle to know what and how to care for clients when the directions from work and the state were constantly changing. In the top left cluster, client impact provides a visual on how COVID-19 impacted the clients, which would impact Claire as she would have to change how she provided care to her clients. In the top right cluster, self-impact, Claire expressed her disappointment at not receiving the level of care needed for herself and the impact that not being able to use her self-care while also caring for her family would have on Claire's emotional and mental well-being. In the last bottom cluster, she highlighted the difficulties with technology that had impacted not just herself but her clients, employer, and the state.

The researcher prompted Claire to visually depict how all these concepts related to one another, which proved difficult for her. Claire had the notes on the floor, trying to identify what cluster she wanted them in. Looking at her poster, she thought they all interacted as crucial contributing factors of compassion fatigue and burnout, even though they were not mainly ordered that way. She stated interaction this way: she "puts the various impacts in a side-by-side line up showing they are all influencers of burnout," which meant that each category she arranged from side-to-side concepts provided a visual of her thoughts sequentially.

Figure 4

Claire's Conceptual Map Representation

Charles

Charles (pseudonym) is a 33-year-old Asian single man with a caseload of 81 patients. He has worked in an outpatient setting for six years and an inpatient setting for two years. Charles works eight-hour shifts Monday through Friday in an outpatient setting and picks up addiction hours at an inpatient facility over the weekend. Before the pandemic, Charles provided face-to-face individual sessions and group sessions. Charles also cared for and lived with his two elderly parents and reflected on the challenges of ensuring his family stayed healthy. He explained that in his culture, it was his responsibility to follow his older brother's direction, which included caring for his parents and helping to remodel his brother's home. Charles indicated that English was a secondary language for his parents, and he would have to explain to them what was going on and how severe the pandemic was.

Charles reflected on how the COVID-19 pandemic also changed how his family practiced their religion as they could not gather. Instead of going to their church to practice prayer and ceremonies, Charles' family would use their prayer room at home. For Charles' family, it was essential to continue practicing of their religion. Charles explained that it was even challenging to get certain foods from their culture during the pandemic as local grocery stores did not have shipments of specialty foods in before the pandemic disrupted shipment.

Charles participated in the interview which lasted 104 minutes and was conducted in the conference room at his office. Charles was engaging and articulated his story with passion. He was thought-provoking in his comprehension of the concepts and steps required to complete the conceptual mapping exercise. Throughout the process of the interview, Charles expressed his frustrations, struggles, stress, and challenges as he told of his story of being a SUD counselor during the COVID-19 pandemic.

Textural Description

Before the pandemic, Charles would stop at the grocery store to pick up anything his mother needed for her meal preparation. He expressed that he also enjoyed shopping for himself and how that changed from in-store shopping to more online shopping. Charles shared that he would also leave on a Friday and drive to his brother's home in a different state for the weekend until travel was limited during the COVID-19 pandemic.

For Charles, it was a crazy time as not only was there an ongoing conversation about substance use challenges like the crack and opiate epidemic but there was no one prepared for the COVID-19 pandemic. There was no rhyme or reason to the regulations. Charles explained that one minute client visits were still in person, and then the next minute, due to this part of the country being in a red district, his clinic was seeing clients virtually. This process would change Charles' daily routine.

As part of his day, Charles would see as many as 6-10 clients daily and run five groups a week. Charles reports he ran a stabilization group daily and could see how it was helping those in early recovery. Supervision, treatment team case conferences, and staff meetings were held weekly during the work week. Charles recalled that although his days were long, he felt he was giving back and helping others. He explained that people wanted help and that there were fewer attendance issues at the time.

Charles reflected on the direction from management and how it was challenging for them to guide the clinical staff with all the state changes. He articulated how the regulations changed daily. Charles shared this example:

> One week, we received emails stating we must see people because the numbers were so bad, and then everything was done by phone until the following week when everything was on Zoom. Nobody had answers to explain which way was better.

Charles conveyed that no one was trained in using Zoom correctly and clients were unfamiliar with it. Charles verbalized that he had to learn how to use Zoom and become the expert teaching everyone else how to use Zoom. He shared that it was challenging as some clients would not come to virtual groups or individual sessions. Clients explained that they did not have internet capability or the capability to access the Zoom links on their smartphones. Charles explained that the clients had phones that could not connect to the internet or had unlimited minutes on their phones. Additionally, some needed help understanding how to use Zoom. Charles reflected on how things felt in the facility during the COVID-19 pandemic:

> Everything was just chaotic. There was no longer a relationship with the clients, and the clinic was coming up with care requirements on the fly.

Charles explained that before the pandemic, clients came in for treatment because they also wanted to get their medications for medication-assisted treatment. However, he explained that during the COVID-19 pandemic the clinics would have to continue providing medication prescriptions for clients even without them participating in groups or individual sessions. Charles explained that this was frustrating for him and would continue after life went back to normal:

> They (the clients) did not have to come to the site or do anything to get their life-saving medications or come in for individual or group sessions to get medications.

Even if clients did not return to the clinic, Charles shared the facility's expectations were to continue to try to engage the client in treatment. Before the COVID-19 pandemic, Charles

explained that clients knew they had to come to treatment to get their medication. However, there would be a change to the counseling dynamics once clients realized they did not need to attend the clinic for individual and group sessions to get medication. Clients could no longer be disciplined for lack of engagement and positive or fake toxicology reports. Charles indicated that it felt like counselors lost the ability to provide therapeutic sessions to support healthy recovery for clients.

Charles shares that some positives came out of the COVID-19 pandemic. He explains that the supervisor training he wanted to take was more doable because everything was online and free instead of having to travel to a training site and pay for it. Charles was thankful for the various training opportunities during the pandemic. However, he expressed that there needed to be training on engaging with clients using therapeutic telehealth techniques because it did not exist. Charles described that he felt this was because the state and OASAS needed to learn it for themselves as they are not in the daily events of a facility or have not been in the field for several years attempting to create regulations.

For Charles, those regulation makers do not see how these changes have negatively impacted the field. He divulged a story of one of his clients:

> A client overdosed on Benzodiazepines and continued to use them even while on Suboxone for his opiate use, influencing his mental health. The client did not want to go to detox or inpatient but wanted to continue receiving Suboxone for his opiate use. He died from an overdose.

Charles explained that he had to continue working with the client even though the treatment recommendation was a higher level of care. The COVID-19 pandemic would influence

regulation changes on treatment. Charles shared that if the client does not want to take the treatment recommendations, the counselor must continue to work with them at the level of care that they want. Frustrated, Charles expressed that the counseling team provided this client with group, individual, and peer sessions, but he did not want to go to the higher level of care and meeting him at the level of care he was at did not help him from overdosing and dying.

Clients continued to push the envelope with their attendance and treatment. Charles explained that when the facility started bringing back face-to-face sessions, clients would call and say they could not come in due to having COVID. The protocol was that they would have to wait two weeks before returning and asked for their medications to be sent to the pharmacy. Charles articulated that clients who had been sober with the support of Suboxone started testing positive for other drugs, and based on his caseload, he had at least 50% of his clients had relapsed.

When asked if Charles experienced burnout, he recounted that engaging with clients on a half-hour or hour phone session was the hardest because some struggled to talk over the phone and through Zoom. Charles explained that assessing how the client was doing too much work because of this. Sometimes, technology would be glitchy or not work, frustrating to Charles and his clients. The most considerable fatigue Charles shared was the phone sessions and how the client always wanted to have them. The facility continued using them for some time. However, Charles explained that he was also told to convince the client to come into the facility for face-to-face sessions.

Charles expressed that burnout affected him when his facility moved to a new location. He divulged that it has always been a numbers game with management, and they did not consider it when they moved. There needed to be an advertisement or education about the facility

and its new location. The pressure from management to achieve numbers left Charles feeling like he had to cover additional shifts due to a lack of staff. Charles felt that when he said something to his supervisors, they did not listen. He felt they just kept believing he could continue to take on additional shifts and clients without listening to him when he needed time for a break. Charles reported that he almost quit because of it. He explained:

> There were many changes, and people needed to learn how to deal with the changes regarding new regulations or managing shifts, asking everyone to do more, but then with less clinical staff, demanded producing numbers of units of services and taking on more clients. That is when the burnout happened.

When asked how Charles managed this burnout, he discovered that he had to step away from the clinic and started saying no to extra work hours. Charles conveyed that when he was seeing people on top of people and keeping up with things, people asked for more. Charles articulated that he felt guilty when he said he could not do more and told himself he could do it even without good pay or more help. Charles started to ask himself "if no one else was taking on more and even his supervisor was not willing to help, why should he."

Steps for self-care: Charles started stepping away from work and planning trips, playing video games, and playing with his dog. Charles continues to spend more time with his family and now knows his worth. He communicated that he values himself more, makes sure he leaves work on time and does not stay at the clinic late.

Conceptual Mapping Task

Charles' conceptual map (Figure 5) is grouped according to the various areas that were made different during the COVID-19 pandemic. The main contributing factors that impacted

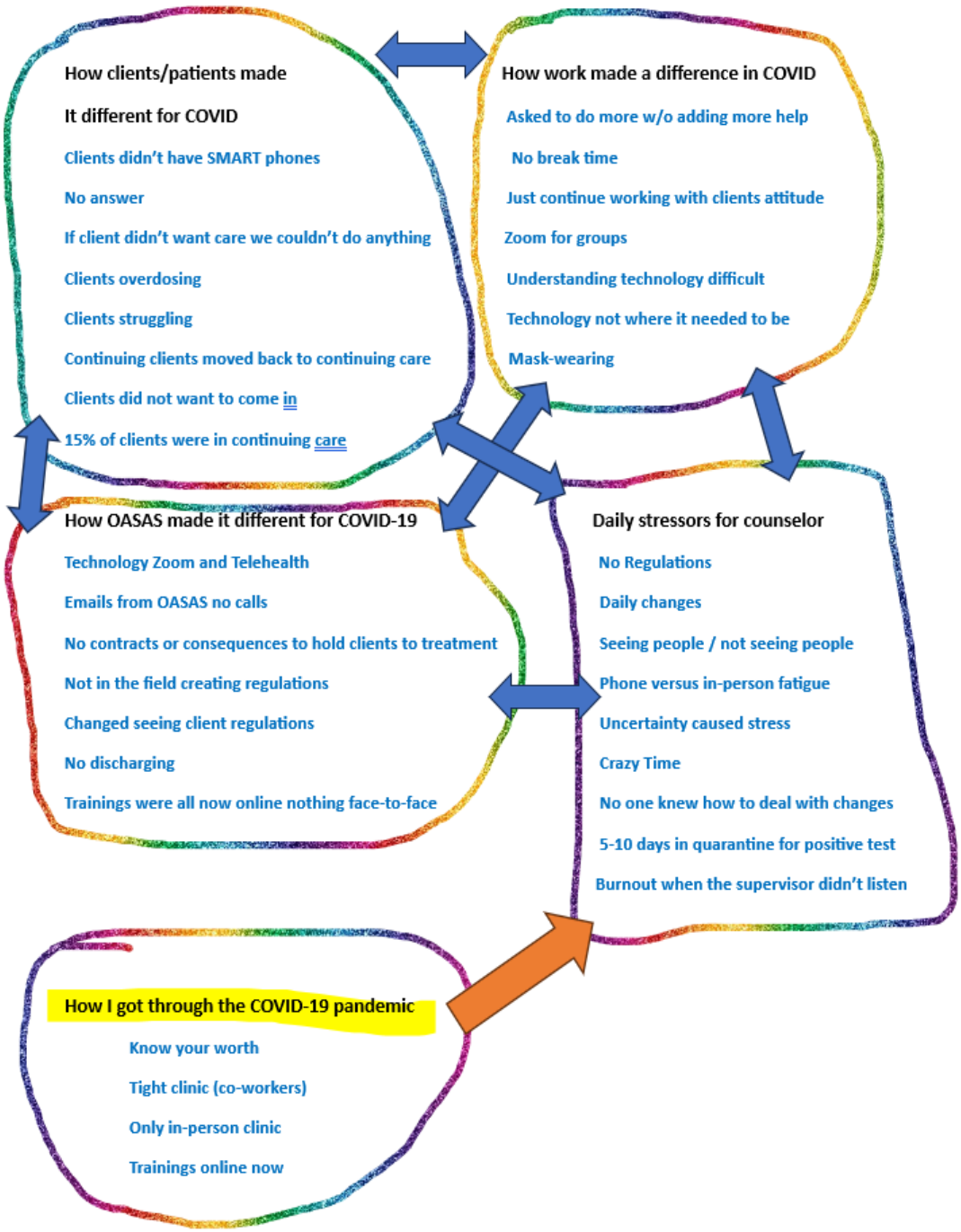
Charles' life were how clients, how OASAS, how work, and daily stressors for counselors. In each of the poster clusters, Charles' experience of stress and frustration leads to compassion fatigue and burnout. Charles also used a cluster of how he overcame the COVID-19 pandemic. In each cluster, he highlighted his challenges with interacting with each of the areas focused on and his frustration at the various contributing factors that added to his stress and risks of burnout.

Each impact cluster represented Charles' experience with how the workplace, the governing body of OASAS, the clients, and self-stressors had on him during the COVID-19 pandemic. He emphasized how these four areas were not all communicating when it came to the care of the clients. Charles explained that it was a struggle to know what and how to care for clients when the direction of the workplace, the state, the clients, and even himself were constantly changing. In the top left cluster, client impact provides a visual of how COVID-19 impacted the clients and how that impacted Charles as he would have to change how he provided care to his clients. The top right cluster focused on work and the lower left focused on OASAS. Charles expressed his disappointment at not receiving the level of support he needed for himself and the impact it had on his compassion fatigue and burnout. Charles highlighted how he overcame the COVID-19 pandemic in the last bottom cluster.

The researcher prompted Charles to depict how all these concepts related to one another visually, which took some time for Charles. He had the notes on the table, trying to identify what cluster he wanted them in. Looking at his poster, he thought they all influenced the key contributing factors of compassion fatigue and burnout, even though they were not mainly ordered that way. Charles uncovered that the most crucial cluster was identifying what would help in times of frustration. He said, "you got to learn your worth and take a step away." It was important for Charles to show a cluster of what helps him decompress.

Figure 5

Charles' Conceptual Map representation



Harper

Harper (pseudonym) is a 34-year-old Caucasian married woman with a caseload of 30 patients. She has been working in an outpatient setting for eight years. Harper works eight-hour shifts Monday through Friday in an outpatient setting. Before the pandemic, Harper was newly married and had begun her life with her husband. Harper expressed that her husband is a firefighter, and she worries for his safety when every call comes in. She provided face-to-face individual and group sessions at the clinic where she worked. Harper is an only child and reflected on the challenges of ensuring her parents stayed healthy. She explained that she would check on them regularly to ensure they did not need anything.

Harper participated in the interview, which lasted 92 minutes and was conducted in the dining room of her home. Harper was engaging and explained her story with passion. She needed help comprehending the concepts and steps required to complete the conceptual mapping exercise. Throughout the process of the interview, Harper expressed her frustrations, struggles, stress, and challenges as she told her story of being a SUD counselor during the COVID-19 pandemic.

During her story, Harper was emotional, explaining how challenging it was for her to deliver care to patients who lacked the desire to engage in treatment. She expressed how frustrating it was because there was no real connection, as treatment was all telehealth. Harper explained that a population having coexisting morbidities like malnutrition and other health issues not only put the patients at a higher risk for getting COVID-19 but only doing telehealth made it challenging to assess the clients as well. Harper disclosed that she was not as scared for herself as for those who could not get the essentials needed to maintain their health. After the

interview, Harper had discovered that she knew that despite the limitations, she was still doing good work.

Textural Description

Before the COVID-19 pandemic, Harper and her husband would do family dinners with their parents, were actively involved in the firehouse, and explored life as a newly married couple. Harper reflected that they had bought a house and were working on decorating it how they wanted it to look. She shared that she and her husband enjoyed going to the movies and enjoying time with their friends.

Harper explained that supervision never happened in an outpatient facility during the COVID-19 pandemic. She disclosed that her supervisor left and took another position elsewhere, and the person who took over that position worked remotely. Harper reported that they used an instant messenger system if the office struggled to figure things out. However, when she was offline, the office would try to call her when they needed direct support. Harper would work on figuring it out independently and only reach out in emergencies. For Harper, this was something she had never experienced before the pandemic.

The concept of working from home was new for Harper as well. She revealed that some staff were allowed to work from home full-time, others came in part-time, and she and another coworker were the ones who came in every day. Harper discovered that the two relied on each other when questions or concerns arose. However, her coworker was new in the field, so Harper felt the coworker came to her and she could not go to the coworker. Although this was stressful for Harper, she was thankful for the developed relationship.

Harper conveyed that she felt highly stressed when her supervisor went out on maternity, and she was the interim supervisor. The previous supervisor took additional time off for her maternity leave and train Harper over Zoom on the various reporting that had to be completed. This situation required Harper to take on more responsibilities and supervision of other counselors. Harper expressed her frustration because she was taking on a role she never signed up for and felt she was being taken advantage of. She divulged how she was told to take on these new responsibilities:

> I took on many responsibilities, feeling like I was forced because it was just like, you are the only one who is qualified. So, you must do this because if you don't it is going to take a lot of work.

Harper explained that she initially asked to take several training courses to help her supervise her fellow counselors. She recounted that one of the counselors was fresh out of college and had to be taught about ethical responsibilities and the requirements for notes every step of the way. Harper disclosed that because the clinic was short-staffed, not only was she doing supervision, but she also had a caseload of her own.

When asked about the regulations during the COVID-19 pandemic, Harper voiced that there were many unknowns. She explained further that it felt like they were making up their own rules. The way they cared for clients would change almost daily. Harper mentioned:

> I remember being told we were allowed to do the telehealth sessions, and then it turned into not being allowed to, and we needed them in the office. However, it was like as long as it was these specific groups of people and only certain people were allowed to do telehealth. We never knew what it was going to be like from day to day, and there was never any consistency. It was constantly changing.

When asked to share how the changes impacted on her clients, Harper explained that this ever-changing way of providing care was also challenging. She disclosed that some of them did well and understood that each day was constantly changing. However, some would use the changes to their advantage to try and get out of attending counseling, but these were usually the ones that were mandated to treatment by the court for their legal issues. Harper explained that these clients would use the COVID-19 pandemic as an excuse for not coming into the office but only do telehealth. Not seeing the client in person caused additional stress and frustration as these clients would continue to use substances and avoid providing toxicology reports that the courts would require. These clients were in the pre-contemplation stage of treatment and were only doing treatment for their legal mandates. Harper expressed that she felt that the clients who were trying to work on their addiction showed initiative, and the clients still attended treatment, even though there was a worry they wouldn't.

When asked how the COVID-19 pandemic impacted her, Harper described that giving clients the needed care was very challenging. For a period when everything was telehealth, consents would have to be verbal over the phone, and hard copies would be sent in the mail to be returned with the client's signature on them. For Harper, she felt that building rapport with her clients was difficult over telehealth. Doing telehealth sessions, Harper recounted that it was difficult to judge how the client was doing as some of them did not have the technology to do video conferencing and could only be over the phone, and for those that could do Zoom, it was difficult to read body language or tell if the client was struggling with their addiction.

Harper explained that the COVID-19 pandemic impacted her work environment because of social distancing and the lack of privacy when talking to people on the phone. She provided details on how the office felt disorganized. At her clinic, she explained that the facility had

counselors in a central area sharing the space and social distancing. Harper disclosed that this was very different for her as they would be on the phone with clients. She just wondered how, with HIPAA and everything, it did not make sense to have multiple people doing their jobs in the same room. Harper shared that she did what her managers told her daily and figured they knew the regulations.

When asked about a time when Harper experienced compassion fatigue or burnout, she explained that she did experienced burnout:

> She would feel burned out occasionally because it can get overwhelming when trying to do all the job requirements. Then, there is an expectation to do the extra things not necessarily accounted for in the daily schedule, like reports for the courts, training, letters to reengage, phone calls to collaterals, and other things that may come up.

Harper explained that she dealt with some things that were traumatizing and that she just had to work through them. She could relate to some things, but how would she be there for her client if she could not handle herself? Harper conveyed that this was no different before, during, or after the COVID-19 pandemic. However, Harper explained that she felt things were forced on her and would have been different without COVID-19. Harper explained that if it were not for COVID, she would not have been asked if she was interested in becoming a supervisor and had an opportunity to take the training to prepare better for the position. She articulated that she felt taken advantage of because of her schooling. Additionally, Harper felt she did not have support from her supervisor, divulging:

> My supervisor never made known that there was an opportunity for me. Instead, I explained that I was going to start taking on extra tasks. Not knowing my schedule, my

> supervisor expected me to set aside time to conduct my supervision or review notes and case conference tasks.

Harper explained that when she would ask about her time, her supervisor told her it was about time management and that she could do half sessions. Providing a half session would give Harper the time so she could still complete her notes and get everything else done. However, Harper had discovered that this was only sometimes possible as some of her clients were familiar with their sessions or would only come in with a problem or a crisis, which does not give her the option of saying 'your time is up.' When days like this happened, Harper discovered that it put her behind, leaving management to ask why things did not get done.

When asked what techniques and tools Harper used for self-care to help prevent burnout and compassion fatigue, she shared several things she tried to do. Especially with burnout, Harper explained:

> I found myself making a to-do list that she completed daily by taking her schedule each morning and reviewing what she needs to complete by prioritizing. When I have a list, and I check it off, it helps me to feel more accomplished as I like checking them off and making progress.

Harper also expressed that she neglected some things she wanted to do for herself because she wanted to get to work early to get ahead of her daily tasks. Harper explained that by doing this if someone came into a crisis, she could give them the extra attention they would need. Not only would tasks be neglected, but Harper also shared that implementing self-care took work as she has always been anxious. Harper explained that usually, she would go for walks, do

breathing techniques, stop for a few minutes before taking her next client, and continue to work on developing time for herself.

Conceptual Mapping Task

Harper's conceptual map (Figure 6) was grouped according to the various areas that were made different during the COVID-19 pandemic. Personal, clients and the office were the main contributing factors that impacted Harper. In each of the poster clusters, Harper's experience of stress and frustration lead to compassion fatigue and burnout. Harper also created a cluster for personal care during the COVID-19 pandemic. In each cluster, she highlighted her challenges in interacting with each of the focused areas and her frustration at the various contributing factors that added to her stress and risks of burnout.

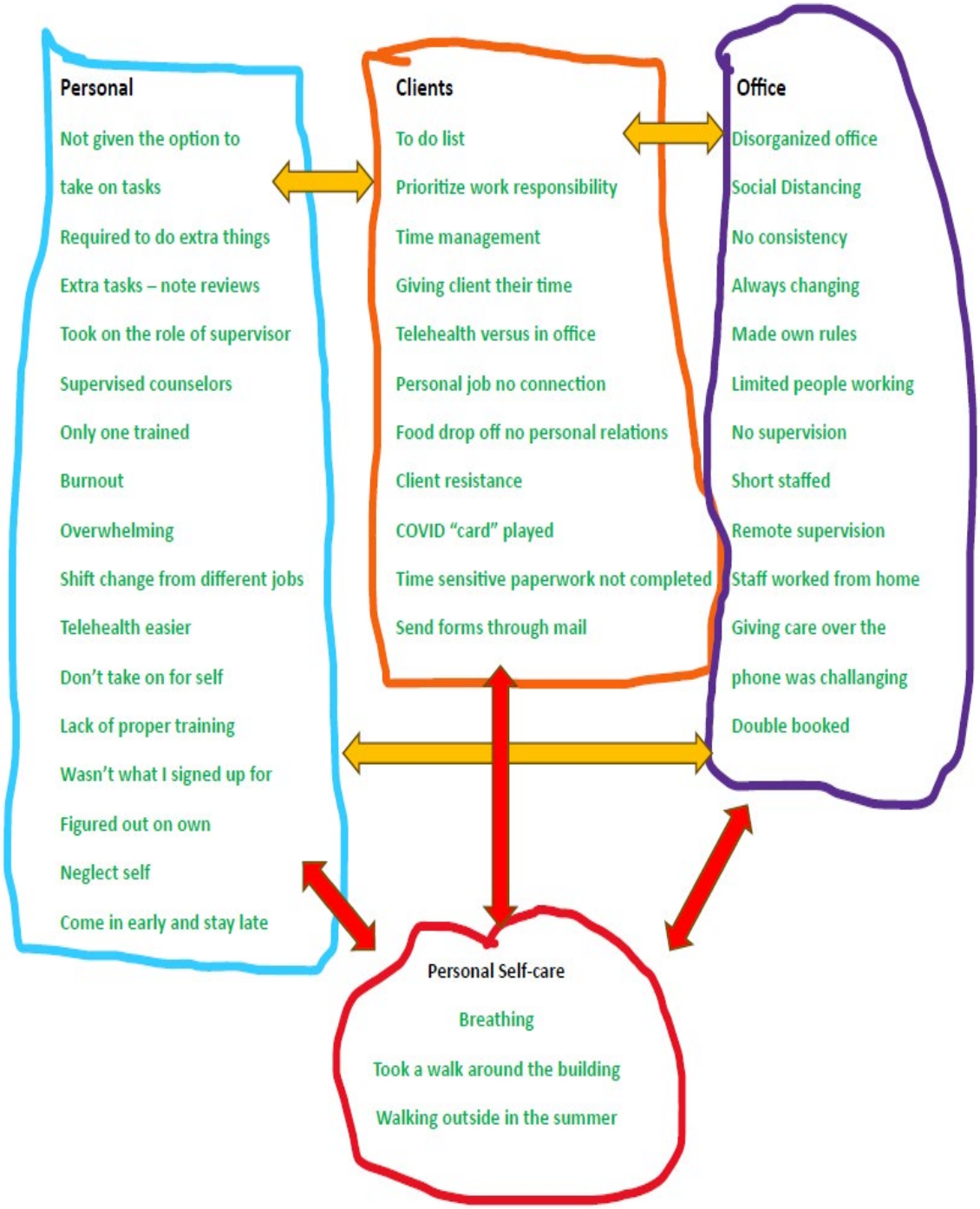
Each impact cluster represented Harper's experience with how her personal life, clients, and work affected her during the COVID-19 pandemic. She emphasized how the three areas impacted how she would provide care to the clients. Harper explained that it was difficult to know how to care for clients when the directions for the workplace, the clients, and even herself were constantly changing. The top left cluster, entitled *personal*, provides a visual of how COVID-19 impacted Harper, how that would change her role as a counselor, and how he provided care to his clients. The top middle cluster focused on clients, and the top left focused on work. Harper expressed that work would give her much frustration in not receiving the support she needed for herself and the impact it would have on her compassion fatigue and burnout. In the last bottom cluster, Harper highlighted how she overcame the COVID-19 pandemic.

The researcher prompted Harper to illustrate how all these concepts related to one another visually, and this took some time for Harper to make sure she showed an accurate picture of the contributing factors of burnout. She had the notes on the table, trying to identify what

cluster she wanted them in. Looking at her poster, she thought they all made up the key contributing factors of compassion fatigue and burnout, even though they were not mainly ordered that way. Harper recounted that the most crucial cluster was identifying what helped her in times of frustration. She disclosed that she is a very stressful and anxious person, to begin with, and it was important to learn what would help lower those feelings in times of crisis. It was important for Harper to show a cluster of what helps her decompress.

Figure 6

Harper's Conceptual Map Representation



Ivy

Ivy (pseudonym) is a 63-year-old Caucasian married female with a caseload of 30 patients. She has been working in an outpatient setting for thirty-four years. Ivy works eight-hour shifts Monday through Friday in an outpatient setting and is the site supervisor for her clinic. Before the pandemic, Ivy provided face-to-face individual sessions and weekly supervision for five counselors. Ivy also lives with her husband and two dogs that she cares for. She also helps her grandson and her elderly in-laws. Ivy reflected on the challenges of making sure her family stayed healthy. She explained that her daughter and son-in-law also worked various hours that required them to work on the weekends. Ivy explained that she enjoyed helping with her family.

Ivy reflected on how her husband worked as the grounds manager for a youth inpatient facility. She explained the concern of ensuring they stayed healthy and safe during the COVID-19 pandemic. With their role in their family as caregivers, it was important that both Ivy and her husband took precautions to stay healthy. Ivy disclosed that when she and her husband came home from work, they would go to the basement, wash his clothes, and shower immediately.

Ivy participated in the interview, which lasted 110 minutes and was conducted in the conference room at her office. Ivy was engaging and articulated her story with passion. She was thought-provoking in comprehending the concepts and steps required to complete the conceptual mapping exercise. Throughout the interview, Ivy expressed her frustrations, struggles, stress, and challenges as she told her story of being a SUD supervising counselor during the COVID-19 pandemic.

During her story, Ivy was emotional, explaining how challenging it was as a supervisor and delivering care to patients who lacked the desire to engage in treatment. She expressed how frustrating it was because the hospital or the state had no organization or planning. Ivy reflected

that it felt like everyone was going by the seat of their pants as if no one had any answers on how to provide care to their patients. As places began to shut down and organizations were lacking, clients fell between the cracks.

Textural Description

Before the COVID-19 pandemic, Ivy and her husband would make family dinners with their children, go to their favorite restaurants with friends, enjoy watching their favorite sports teams play, and take their family on vacation. Ivy discovered that it was a significant change for them and their social life. She shared that she and her husband learned to do things around the house to keep themselves busy. Ivy revealed that she learned to make candles and soap to keep herself busy.

For Ivy, work was very different during the COVID-19 pandemic. Ivy recounted that her clinic needed to have the telehealth system set up, and no one was supposed to come into the building. Not only were directions from the hospital and the state changing almost daily, but the licensing body, OASAS, could have been more helpful, too. Ivy explained that clients could come into the building at one point, and the next, they could not.

When asked about the support Ivy received as a supervisor and for the clinic, she expressed frustration. As an employee, Ivy felt she was just being told this was how it was. In return, she would have to tell her staff the same thing. Ivy conveyed that the hospital could not even be blamed for the lack of direction as they were in crisis. Ivy expressed that:

> The hospital was in the middle of the crisis, with many people dying, being short staffed, nursing, more equipment, and more support are needed. However, I
> I also did not feel they were evident to my supervisor, who could not be apparent to me,

leaving me unclear to my counselors. I do not think anybody understood how afraid people were, and there was not much support.

When asked how regulations changed during the COVID-19 pandemic, Ivy articulated that OASAS would have on-site audits before COVID-19. However, during the pandemic, OASAS did virtual audits instead. Ivy divulged that OASAS changed treatment from an abstinence-based treatment to a harm reduction. She further explained that treatment changed from an abstinence-based clinic to using motivational interviewing and meeting people where they were to not hold anybody accountable, in addition to learning how to do telehealth and being thrown back to the clinic to try and figure it out.

Ivy explained that the changes during the COVID-19 pandemic impacted her well-being. She shared that she was unfortunate and bored because everything suddenly stopped. Ivy would come in and work her eight-hour shift but felt no purpose. She felt sad for her clients as they were not getting the needed care. Ivy explained that the clients were dropping off left and right. Ivy clarified that some clients had been lost to death, and some were just a loss of contact or dropping out of care.

As a supervisor, Ivy revealed that her staff was frustrated, stressed, and confused. She disclosed that some of her staff worried about their families and the impact that the COVID-19 pandemic had on their own families. Ivy voiced that this would add stress for her as she would work for and with them. The clinic was a family, and Ivy recalled that they all cared about each other. She shared that they worked on lifting each other, but the clinic was quiet, and she felt unfortunate.

Before the COVID-19 pandemic, Ivy reflected that you would hear laughter from the counselors' offices as clients would feel comfortable in their sessions and the staff would enjoy

time with each other. It felt like there was no laughter or joy in the office like there was before the pandemic.

Ivy explained that she feels burnout is a buildup of time and something personal. When asked to share a time she felt she had burnout, Ivy recounted:

> I started feeling burned when they wanted to close our clinic, and our clients would call and ask me to fight to keep it open. She was able to and then, it felt like I could not trust anyone. The final straw was during the last.
>
> OASAS audit and with all the craziness going on with the COVID-19 pandemic,
>
> it just felt like it was way more than it should have been."

Ivy was asked to explain how the audit during the COVID-19 pandemic influenced her sense of burnout. After processing for a moment, Ivy explained that the audit from OASAS came one month before they would change the regulations from abstinence-based to harm reduction. This process would mean they needed an honest audit because they knew the clinic could not go back and correct anything. Ivy reported that she felt this could have been more helpful for the clinic to provide person-centered care, and it was her impression that one of the functions of OASAS was to help enhance person-centered care in the clinics. There was nothing for the clinic to grow from amid all the changes happening during COVID.

When asked what tools and techniques Ivy uses to help with this burnout and other stressful feelings, Ivy gave details of how she enjoys reading and going home to discuss things with her husband. She discovered that this helps to put herself in a different space. Ivy shared that she did feel that her burnout influenced her decision to retire. She clearly explained that her

burnout and reasons for retiring were not from helping clients but rather from the politics of the hospital and OASAS.

Ivy's final comments about the COVID-19 pandemic were more about being more prepared. She expressed that if the hospital learned anything from the pandemic, it would have some plan even though no one anticipated the COVID-19 pandemic. There needs to be a clear plan or plan b to make things wishy-washy. Ivy presented that having a committee to plan the what ifs is necessary. Ivy divulged that she knows it would not be perfect, but it would be beneficial if it helped reduce stress and helped people feel like they matter.

Conceptual Mapping Task

Ivy's conceptual map (Figure 7) is grouped on the top of the page into four clusters, and one below represents the coping of burnout: clinic, clients, self, and OASAS. Ivy's experience of chaos, stress, and frustrations in each poster cluster leads to compassion fatigue and burnout. Ivy created clusters that impacted her during the COVID-19 pandemic. In each cluster, she highlighted her feelings of uncertainty and frustration at the various contributing factors that added to her stress and risks of burnout.

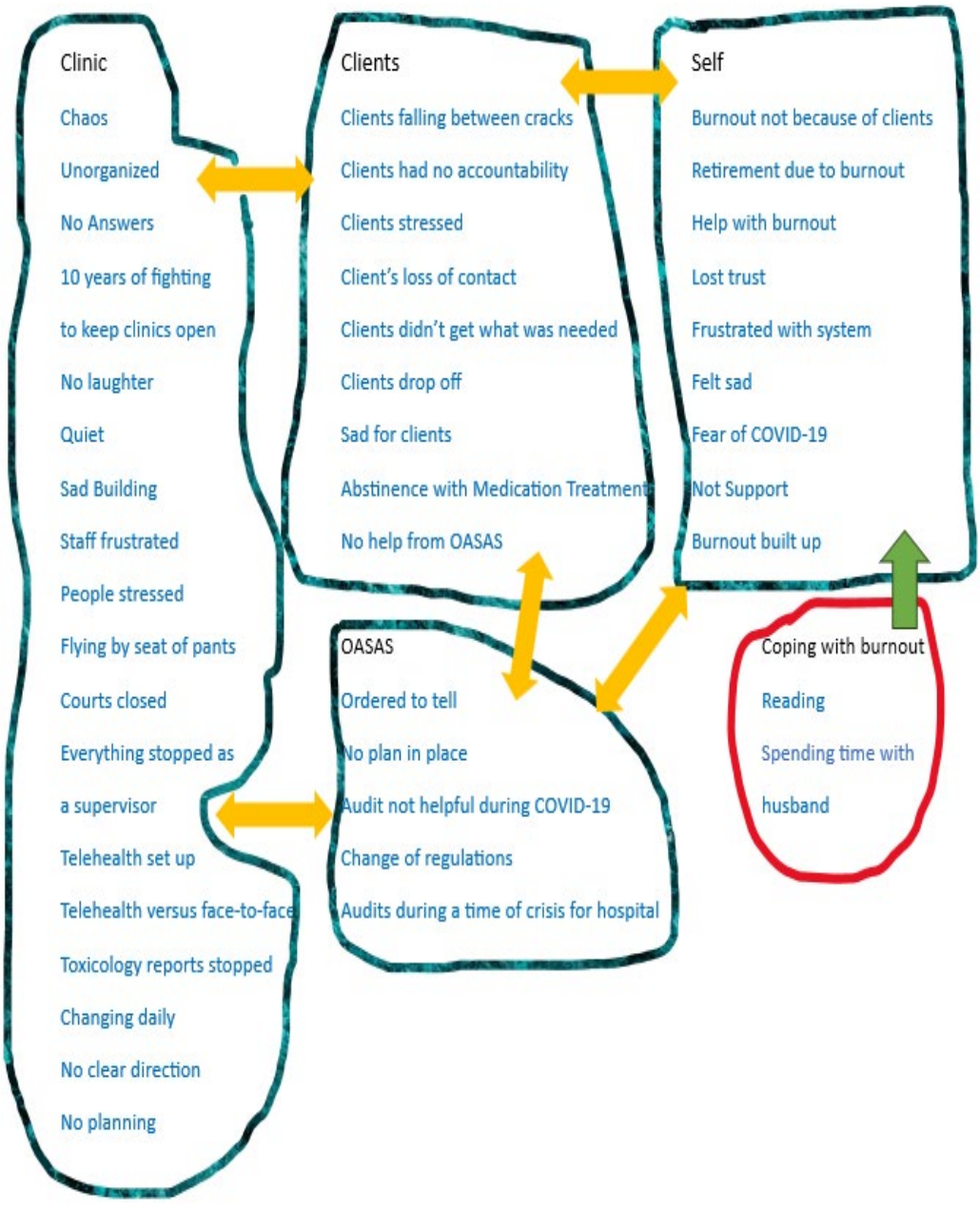
The four clusters represented Ivy's experience with how the clinic, clients, herself, and the governing body of OASAS influenced her during the COVID-19 pandemic. She emphasized how these four areas needed help with their ideas of how to care for the clients. Ivy explained that it was a struggle to care for clients when the direction of the clinic and the state were constantly changing. In the top middle cluster, client impact provides a visual on how COVID-19 impacted the clients, which would impact Ivy as she had to change how she provided care to her clients. In the top right cluster, self-impact, Ivy expressed the struggle with burnout because of her clients, the clinic, and OASAS–which were factors in her retirement. The clusters also

provide a visual of the lack of care that she needed for herself and the impact of not being able to use her self-care while also caring for her family, which influenced Ivy's emotional and mental well-being. In the last bottom cluster, she highlighted what she did to help cope with the burnout.

The researcher prompted Ivy to visually depict how all these concepts related to one another, which proved difficult for her. Ivy had the notes spread on the table, trying to identify what cluster she wanted them in. Looking at her poster, she thought they all interacted as crucial contributing factors of compassion fatigue and burnout, even though they were not mainly ordered that way. She stated, "my burnout was not because of the clients; it was because of the politics of the clinic and OASAS." Ivy arranged the concepts from side to side to visualize her thoughts sequentially.

Figure 7

Ivy's Conceptual Map Representation



Marie

Marie (pseudonym) is a 63-year-old Caucasian married female with a caseload of 40 patients. She has been working in an outpatient setting for thirty-two years. Marie works eight-hour shifts Monday through Friday. Before the pandemic, Marie provided face-to-face individual sessions and weekly group sessions. Marie has adult children and grandchildren with whom she had weekly meals until the COVID-19 pandemic.

Marie participated in the interview, which lasted 96 minutes and was conducted in the conference room at her office. Marie was engaging and articulated her story with passion. She was thought-provoking in comprehending the concepts and steps required to complete the conceptual mapping exercise. Throughout the interview, Marie expressed her frustrations, struggles, stress, and challenges as she told her story of being a SUD supervising counselor during the COVID-19 pandemic.

During her story, Marie was emotional, explaining how everything had stopped and that her facility had not been set up for telehealth. She felt like they had to make things up as they went along. Marie disclosed that she struggled with the fear of the facility shutting down and the potential to lose her job or get laid off. She explained that it was a terrifying period with a weird feeling of safety because of all the healthcare protocols like washing your hands and wearing masks.

Marie reflected that she shared with her children about how places first started shutting down in San Franciso because of the COVID-19 pandemic. Things would quickly shut down in Western New York. She reflected on how the only places that were still open were the grocery stores and the liquor stores. Although many cautionary things were implemented–such as gloves, hand sanitizer, and face masks–there was much fear of the unknown. Marie expressed her

sadness over the elderly and vulnerable individuals and how terrifying it was for her and her older family members.

Textural Description

Marie communicated that she has adult children, and they would gather for family meals before the COVID-19 pandemic. She articulated that family is important to her, and it was difficult for her not to see her children as often as before COVID. Marie reflected, remembering that doing Zoom with her children as well as they lived out of the area. She reflected that although this was challenging, she drew comfort in seeing and talking to her children and knowing they were healthy.

Marie reflected that work was strangely different during the COVID-19 pandemic. Sharing how things changed, Marie explained that the transition to telehealth was unfamiliar, and she had to learn how to set up sessions quickly. Not long after learning telehealth, patients were not allowed in the building, and connecting with them was either over the phone or video calls. Marie explained that:

> This brought on a lot of confusion and stumbling by people who didn't know how to use the internet and some older clients did not want to be on camera. There were also times when the video would not work, and clients would get frustrated and just not connect with their scheduled calls.

Marie also relayed that she felt her listening skills had to be sharper since she had to try to interpret her patients' faces over a fuzzy camera, creating a struggle because nonverbals are 70-80% of understanding how the patient is doing. Not having the opportunity to see a patient in person left questions on whether they were still drinking or using substances. Because patients

could not come in, there would be no toxicology reports to provide those answers. Marie divulged that it felt like her tools were taken away:

> One of the most significant tools is face-to-face interaction. Having clients provide a toxicology sample, giving patients handouts, seeing them, and seeing how they were physically managing were all gone.

Marie voiced that it felt like she was stumbling through it and hoping it would change to an acceptable feeling, but it never did. She reflected on how her coworkers would joke that this is the new norm and that we must get used to it. Marie expressed frustration and thought her clients were not getting the best care they deserved. Reflecting on how it was almost a year into the pandemic, and there was no end in sight, and you felt like this was going to be the new forward, Marie discovered that she still pushed through. Marie shared that there were still pressures from work to get units of service and get clients to attend groups.

Groups were difficult to run during the COVID-19 pandemic as people would have to log onto a Zoom meeting from their homes. Marie divulged that you did not know if the person was doing inappropriate activities, and you also could not have confidentiality as you did not know who else was in the house at the same time when they were logged onto the group session or even their sessions. Marie shared that she also struggled with non-verbal and misinterpretation. While on a telehealth session, Marie thought someone was crying, but they were not.

Marie revealed that she did find some advantages of telehealth. She explained that with telehealth, one would get the opportunity to see the world of her clients. Marie explained that her clients would carry the phone around the house and share their dogs, hobbies, aquariums, and gardens. This also provided a window into their families as well. She remembered one client

whose children were fighting, and she could see how the client handled the stress. Marie articulated that there is a place for telehealth, and it should be integrated more into the treatment plan for the clients.

When asked how the changes in regulations from abstinence to harm reduction from OASAS impacted Marie, she recounted that she has been pushing abstinence for years. It took a while for Marie to realize that it was too strict for some, almost too black and white. Marie detailed that abstinence was too rigid for some. For the population that Marie works with, some might feel that having a drink but not getting drunk all weekend is a positive step for them.

Marie communicated that in the facility she was in during the COVID-19 pandemic, her colleagues supported one another and were like family. It was like both their professional worlds and their personal worlds were in chaos, and yet they felt like they could push through together. Marie reflected that because of the pandemic, there was no traveling on airplanes, and all you had was work. Marie revealed that after the pandemic, her facility would close, and she would have to find another facility.

With that frustration, some clients not returning to treatment, people's life that was now lost, and too many people struggling with too many traumas being thrown at her, Marie would describe her life as a high-stress environment. When asked how she dealt with these stressful events and gave herself self-compassion and self-care, she divulged that she has weights in her office and would turn off the lights and lift her weights. She let on about how she would play some relaxing music and do much deep breathing. Most importantly, Marie discovered that when she has a full schedule, she takes about five minutes to decompress to be there for the next client.

Conceptual Mapping Task

Marie's conceptual map (Figure 8) is grouped into negative and positive impacts. The five negative clusters, personal, personal job-related, personal home and family, workplace, and patients, represent the contributing factors of compassion fatigue and burnout. Marie discovered her fears, confusion, and stress in each negative cluster. The three positive clusters, workplace, personal, and coping skills, influenced Marie's wellness support. In each of these clusters, Marie disclosed the various ways of support she received and the self-care she would use to help her overall wellness. Regardless of the negative or positive cluster, Marie created clusters that impacted her during the COVID-19 pandemic. In each cluster, she highlighted her feelings of uncertainty and frustration at the various contributing factors that added to her stress and risks of burnout.

The seven clusters represented Marie's experience with how the clinic, patients, herself, and her family influenced her during the COVID-19 pandemic. She emphasized how these five areas struggled with the care of the patients. Marie explained that it was a struggle to care for clients and herself when the clinic's and the state's direction were constantly changing. In the negative cluster, patient impact provides a visual of how COVID-19 impacted the patients, which then impacted Marie as she had to change how she provided care. Marie expressed the positive clusters: workplace, patients, and coping skills, which were all a support for her during the COVID-19 pandemic and helped her with her fears of burnout. The positive clusters also influenced her to practice self-care while also caring for her family. In the last bottom cluster, she highlighted what she did to help cope with the burnout.

The researcher prompted Marie to visually depict how all these concepts related to one another. Although challenging, Marie spread the notes on the table, trying to identify the cluster

she wanted them in. Looking at her poster, she thought all the negative clusters interacted as crucial contributing factors of compassion fatigue and burnout, even though they were not mainly ordered that way. Marie also thought the positive clusters interacted with her emotional and mental well-being to support her. She stated, "Moving from one patient to the next, it is important to make time for yourself so you can give proper care to your patients while caring for yourself." Marie visualizes her thoughts sequentially and arranged them into clusters of concepts.

Figure 8

Marie's Conceptual Map Representation

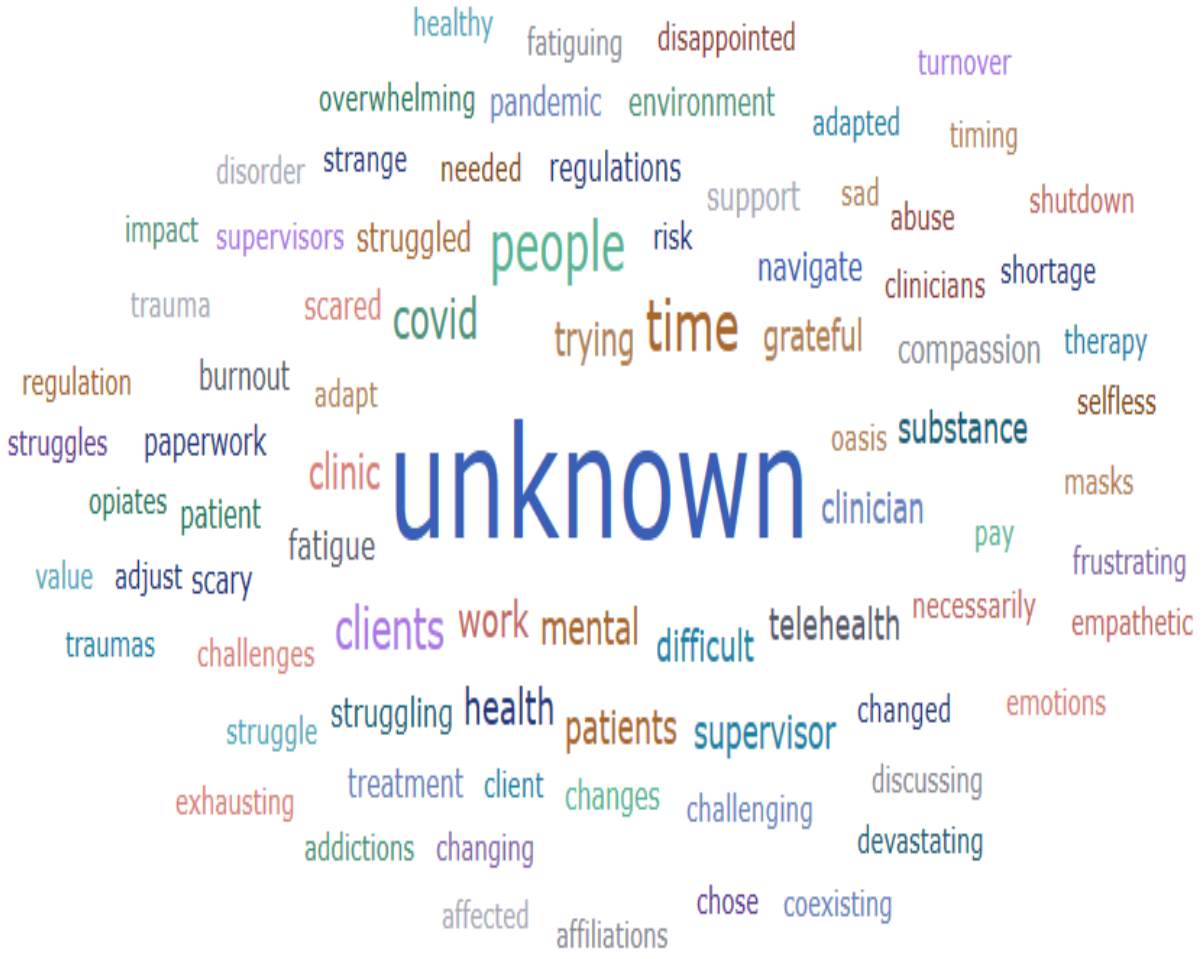
Results

In auditing the results from the participant interviews, the text was captured using Otter.ai, an advanced transcription software, and then examined and re-written by the researcher, where conflicts occurred. The pictorial representations from each participant's conceptual map are found in Appendix K, and pictorial abstract of each participant's conceptual map were added to their description above and used to develop themes (Figures 4-8). The researcher's memoing of thoughts and experiences during the interviews, data analysis, and participant confirmed discussions were added to Atlas.ti, the qualitative data analysis software (Creswell & Poth, 2018; Heppner et al., 2016; Moustakas, 1994).

This technique provided a natural flow for the research process as described by Moustakas (1994) in the phenomenological reduction step that utilizes the participant to look at their experiences, describe them, look at them again, and describe them again (Moustakas, 1994). During this process, the researcher explored a systematic varying of the potential structural meanings that supported textural meanings using the researcher's meticulous analysis and the Atlas.ti qualitative software to ascertain themes. The researcher read and re-read each transcript multiple times, and during this process, inceptive themes emerged. After foundational themes were identified and represented the phenomenon, the researcher used the qualitative analysis of concepts and orchestrated them into critical concepts that related directly to the research questions. These concept words are directly related to each participant's statements and are portrayed in a "concept cloud" produced by Atlas.ti, shown in Figure 9.

Figure 9

ATLAS.ti Concept Cloud



Note: The "cloud" is a pictorial portrayal of the various statements associated with each concept. The larger the word pictured, the more often used by the participants. The portrayed representation of this "cloud" is presented in Figure 10.

Figure 10

Numerical of Code Representation

As outlined in Chapter Three, research methods were employed using Otter.ai to record all the interviews and the Conceptual Mapping Task. In addition, each participant completed a Professional Quality of Life Scale (proQOL), providing a numeric indicator of the level of compassion satisfaction, burnout, and secondary traumatic stress experienced (Table 2). Participants were asked to complete the proQOL self-assessment. Professional Quality of Life (proQOL) is intended to be used to better understand the positive and negative aspects of helping those who experience trauma and suffering (proqol.org, 2021). Participants scoring 23 or higher was the threshold for the study. This data only identified candidates at risk of compassion fatigue, burnout, and secondary trauma. It was not used for the data in the qualitative study but for descriptive purposes, as each participant was considered. The transcripts and participants' maps were analyzed, organized in a data spreadsheet, and reviewed by each participant for accuracy (Table 3). During the analysis, the researcher identified participant pivotal imagery, either visual or laudable text that perceivably illustrated the participant's description of the phenomenon (Moustakas, 1994). Through the process of generating the codes by ATLAS.ti, the researcher determined the most appropriate themes to incorporate text and conceptual data collected from each interview into experiences central to the phenomenon. The participants expressed their experience with the various components influencing compassion fatigue and burnout during the COVID-19 pandemic. However, it is essential to note participants are still working on the impacts COVID-19 has had on compassion fatigue, burnout, and the changes to how they provide counseling to patients with substance use disorder.

Table 2

Professional Quality of Life Scale Results

Participant	Professional Quality of Life Scale (proQOL)	Score	Level
Claire #1	Compassion Satisfaction Scale	39	Moderate
Age: 34	Burnout Scale	27	Moderate
	Secondary Traumatic Stress Scale	23	Moderate
Charles #2	Compassion Satisfaction Scale	41	Moderate
Age: 33	Burnout Scale	17	Low
	Secondary Traumatic Stress Scale	24	Moderate
Harper #3	Compassion Satisfaction Scale	39	Moderate
Age: 34	Burnout Scale	29	Moderate
	Secondary Traumatic Stress Scale	17	Low
Ivy #4	Compassion Satisfaction Scale	44	High
Age: 63	Burnout Scale	24	Moderate
	Secondary Traumatic Stress Scale	22	Low
Marie #5	Compassion Satisfaction Scale	37	Moderate
Age: 63	Burnout Scale	24	Moderate
	Secondary Traumatic Stress Scale	20	Low

Definitions of levels	**The sum of the questions**	**The level**	
Compassion Satisfaction Scale	22 or less	Low	
	Between 23 and 41	Moderate	
	42 or more	High	
Burnout Scale	22 or less	Low	
	Between 23 and 41	Moderate	
	42 or more	High	
Secondary Traumatic Stress Scale	22 or less	Low	
	Between 23 and 41	Moderate	
	42 or more	High	

Table 3

Themes of The Contributing Effects of Compassion Fatigue

Participant	Map Labels	Immediate Effects	Short Term Effects	Long Term Effects	Barriers	Support
Claire #1	Client Impact	Disappointed	Feelings of loss	Not sure of the future	comorbidities	In-person & Telehealth
Age: 34	Work Impact	State of confusion	Lack of communication	Not valued as an employee	Regulations	work-life balance
	OASAS Impact	No Answers	Change in medication requirements	Changes in Care - Harm Reduction	More paperwork Regulations	Emails with no response
	Other MH Providers Impact	Challenges	Virtual only	Closing of clinics	Longer times between appointments	
	Self-Impact	Negative emotions frustration/fear	Struggle	Self-doubt	Could not do self-care	Well-being adaptation
	Technology Impact	Challenges	Virtual courts	HIPPA concerns	Connections to WIFI	
Charles #2	How clients/patients made it different for COVID	No answer	Clients didn't want to come in	Overdose	Client didn't have technology for virtual sessions	
Age: 33	How work made a difference in COVID	Continue working with clients	Technology difficulties	Burnout when supervisor didn't listen	Technology not where it needed to be	Work-life balance
	How OASAS made it different for COVID-19	Confusion	No discharging	Changing of regulations	Emails no calls to OASAS	Trainings online with no fees
	Daily Stressors for counselor	Uncertainty	Stress - frustration	Worry for health of self and parents	Phone vs. in-person fatigue	
	How I got through the COVID-19 pandemic	Took trainings online	Only in-person clinic	Relationship with coworkers	Burnout	Know your worth
Harper #3	Personal	Overwhelmed	Shift change/role change	Didn't take care of self	Burnout	
Age: 34	Clients	Uncertainty	Client resistance	Telehealth vs. in-person	Sending forms through the mail	Building relationships
	Office	Social Distancing	Disorganized office	No consistency	No supervision	Flexible work arrangements
	Personal Self-care	Breathing	Took walks around the building	Walking outside in the summer	Time management	Work-life balance

Ivy #4	Clinic	Chaos	Unorganized	Lack of communication	Work-related stress	
Age: 63	Clients	Anxiety - fear	No accountability	Loss of clients (contact and death)	Change of regulations	Telehealth
	Self	Negative emotions - frustration	Lack of energy	Not supported	Burnout build up	Positive experiences with clients
	OASAS	Lack of communication - no plan in place	Disorganization	Change of regulations	Audits done virtually	
	Coping with burnout	Reading	Spending time with husband	Retired	Boredom	Supportive staff
Marie #5	Personal	Scary	Confusion	Terrifying	Fear of shutdown	Just work
Age: 63	Personal - Negative Job-Related	Frustration	Drop in productivity	Career turned upside down	What impact am I making	Work-life balance
	Personal - Negative Home/Family	Safety precautions	No family meals	Fear of finances	Stress of getting food	Adaptability
	Workplace	Job appreciation	Abstinence vs. harm reduction	More creativity	Abstinence too harsh	Work-life balance
	Workplace - Negative	Technology difficulties	Pressure for units of service	No confidentiality	Made it up as we went along	Education
	Positive for patients	Virtual meetings	Seeing into their world	Multiple forms of treatment	Adjustment to stress	Seeing interactions of family
	Negative for patients	Technology difficulties	Transition to telehealth	Isolation	Loss of contact	
	Coping skills	Give 5 minutes between clients	Talk to coworkers	Deep breathing	Ordering out	Family

Theme Development

The researcher for the above concepts and meanings and clustered them into common themes aided by the qualitative software. The themes and subthemes represent the data from participants' experience in the contributing factors of compassion fatigue and burnout with SUD counselors during the COVID-19 pandemic in Western New York. Each participant used their own wording in their themes and provided these similar themes: personal impact, client impact, and workplace impact.

The first theme to emerge was around how one's individual personal life, outside of the walls of work, impacted them during the COVID-19 pandemic. The second theme revolved around the influence of the client and the challenges they faced that impacted on the participant. The third theme provided a window into how participants struggled with the workplace dynamics, which includes the site at which the participant worked and the governing entities such as hospital regulations, state regulations, and OASAS. These themes were further broken down into subthemes to understand the impact on the SUD counselors further. While examining the themes, a fourth theme also impacted the participants, where all three themes influence each other.

Theme 1: Personal Impact

The theme of personal impact was prominent in each participant's experiences. This theme indicated how each participant felt their own lives impacted their overall well-being regarding compassion fatigue and burnout during the COVID-19 pandemic. In recalling their experiences, the descriptions from participants were of feeling overwhelmed, sad, frustrated, and scared.

Subtheme: Immediate Effects

Participants felt negative emotions of fear and frustration. Each reflected on the uncertainty and feeling overwhelmed. These feelings would impact not only the participants' personal lives but also their professional lives. Claire reflected on the personal impact of her experience:

> We are scared for ourselves, and like I said, I have two small children, and my husband is also in the field. So, we are both going to work every day.

For Charles, there was a fear of caring for his parents and ensuring their needs were met. Charles reflected on the uncertainty:

> No one was prepared for the COVID epidemic.

Harper shared how overwhelmed and anxious she was:

> I am already a very stressful and anxious person. So, everyone is always telling me to relax in general, but with COVID, I always feel more anxious. I guess that was more from fear of the uncertainty.

Ivy explained her negative emotion as frustration:

> I was very bored. It was boring, and I will tell you why it was boring because suddenly everything stopped. I had young grandchildren, and I was so worried about their health and well-being. Getting together with my daughter and seeing the grandchildren was not an option. My daughter brought the kids to wave at me from outside when I got sick with COVID.

Marie describes her the personal impact of her experience:

> … because we were suffering in our professional world, and we were suffering in our personal lives. I was not able to do things that I wanted, like take a vacation, not able to get on an airplane, or go anywhere, you know, so all you had was work. If you are lucky enough to have work. It was very scary.

In the above descriptions, the participants describe the immediate effects on their personal and professional well-being. The COVID-19 pandemic led to a fear of the unknown. Ivy recounted this fear by explaining how the unknown of COVID-19 and the reactions people were hearing on social media were impacting her:

> I do not think anybody understood how afraid people were about COVID-19. There needed to be more support.

Subtheme: Short-Term Effects

Participants felt a struggle, a loss of trust, and additional frustration with stress. The continuation of immediate effects would cross over into short-term effects for the participants. One of the participants explains this as a shift change or role change for some. While others explained how the COVID-19 pandemic affected their personal lives as well. Claire expressed the struggle she had with childcare:

> So, I dropped my child off at daycare and went to work that week, but they had shut down by that Friday. It was bizarre. This thing was creeping in, and I did not know much because I was not watching the news regularly with a toddler and newborn.

Charles explained the short-term effect as stress due to frustration:

> …and it was just like no one understood. I was trying to explain to my family what was happening. We have family in India and Canada, and we could not cross the border to see how they were doing.

Harper shared her short-term struggles based on worrying:

> As an only child to my parents, I was apprehensive about their well-being and making sure they were cared for. My husband would go out on a call, and I would worry about his well-being.

While each participant explained how their short-term effects impacted their well-being, Ivy explained how she lacked energy:

> Everything felt like there was no laughter or a reclaimed start; it was just quiet. Trying to recover from COVID-19 took a while. My energy level was shallow, and all I wanted to do was sleep.

Marie expressed that with all the struggles at work; for her, it was more about family. She shared that although it had a short-term effect, it still bothers her:

> So now, before COVID, my family had family meals once a month. We tried a couple of zooms, but it was not different. It was awful.

Subtheme: Long-Term Effects

Participants felt self-doubt, felt not supported, and had financial fears. The continuation of the first two effects would cross over into long-term effects for the participants. Claire expressed her struggle with self-doubt:

> So, I do not think I am of greatness or not replaceable as a counselor. I think the
> The biggest thing was that I do not; I cannot necessarily have that scary feeling.
> However, I do remember having a coworker who took a leave of absence to stay home with her child and I remember thinking that I have little kids and what am I doing to my family by continuing to see clients. However, I could not stop doing my job as we needed the income.

Charles exclaimed that he continues to struggle with the long-term effects of his health and his parents' health. He reflected that:

> …like they were not listening. My parents struggled to understand what was happening, and it felt like they would not listen to what I told them. Also, when I would tell them what was happening, I was only causing worry for my mom.

Harper divulged that for her the long-term effect was neglecting to care for herself. She explains:

> I tried to implement self-care, but it did not work during the pandemic. I am
> A naturally stressful and anxious person. Going for walks has always helped me, but I could not do that during the pandemic. There were several times when clients were more work and more draining, and deep breathing wasn't helping.

Ivy discovered that she struggled with feeling supported by all:

> I do not think anybody understood how afraid people were with the knowledge of COVID. I do not think there was much support personally and for others. It was like I had to find answers for myself and the clients and the counselors I supervised.

Marie explained that the long-term effects are still influencing her actions today and that there is still a struggle for her:

> Financial instability was a struggle for me. It felt like I should work at a grocery store. There was much fear that we would shut down here and lose our jobs and get laid off. So, it was, you know, a terrifying period.

Each participant acknowledged that there were both barriers and support that influenced their impact to clients. Reviewing the barriers, participants shared that the inability to do self-care, fatigue from phone sessions instead of in-person, no supervision, the questioning of one's impact, and the buildup of stress were all influences of compassion fatigue and burnout. Participants reflected on that for the theme of self-impact. This support helped with understanding wellbeing adaptation, knowing your self-worth, having a work-life balance, and having supportive staff and coworkers.

Theme 2: Client Impact

The theme of client impact was projected in each participant's experiences. This theme indicated how each participant felt the clients impacted their overall well-being regarding

compassion fatigue and burnout during the COVID-19 pandemic. In recalling their experiences, participants described when clients felt scared, overwhelmed, with no response from clients, and chaos.

Subtheme: Immediate Effects

Participants provided insight into the immediate effects of client impact on their compassion fatigue and burnout. Clients struggled with being scared and uncertain of the unknown. Participants reflected that clients would not answer and felt the world's chaos as impactful. Claire reflected on being scared for her clients:

> I mean, we have boundaries and ethics, but when I would go home to my family and come back to work the next day to see clients, I would worry about whether I am bringing COVID to them, or the opposite, are they bringing it to me? We took all the precautions like wearing a mask, sanitizing everything, and distancing ourselves, but there was still that question.

Charles reflected that the struggle was more about how clients responded to their treatment. He explained that he would continue calling people if they did not answer him:

> … engaging some clients in a half an hour phone session is probably the hardest thing because some do not like to talk over the phone. These sessions had me question if my support was helpful to their needs.

Harper reflected that the uncertainty did not come from just herself but also from her clients:

> So, I remember no one knew what was okay and what was not. My supervisor would say, 'Okay, so you can do the telehealth sessions.' And then it turned into, like, 'You cannot do them.' They need to be in the office if it is like these specific groups of people. Then, it was like only certain people were allowed to do telehealth. So, I just felt like it was

> always changing, and this was a struggle for our clients to understand what group they would be labeled.

The struggle that clients faced during the COVID-19 pandemic added to their anxiety and fear. Ivy shared how she struggled because of how her clients did:

> I felt sad for the clients. Clients were not getting the care that they needed. I felt like clients were dropping off, left and right.

Marie explained that the client's impact was both positive and negative for her. She shared that for her clients:

> … telehealth is needed. Telehealth is wonderful because I have used it several times and recognized its limitations. However, the ability to say hey, you broke your leg. We can still do telehealth for a few weeks. It was positive for both the client and me as I felt like I was meeting the client where they are at.

Subtheme: Short-Term Effects

The struggle of immediate effects on the participants due to the client impact would roll over into the short-term effects. Participants shared that they struggled with feelings of loss, frustration with the lack of attendance, both in-person and virtual, and no accountability. The short-term effects for the participants were very similar in that they worried about their client's well-being. Claire explained that:

> I know that some of our clients are not ready for change, and COVID gave them an excuse not to attend treatment or engage in the support that they need. Excuses bothered me as I know they needed support and help with their addiction.

Charles described how frustrated he got due to the lack of accountability with clients:

> It was just like nobody answered or knew how to Zoom. They would just not

> pick up their phones or tell me they did not get the link to log onto Zoom. Clients had not been seen for toxicology reports either. When we opened for
>
> In face-to-face sessions, clients would say they had COVID, so they did not have to come in. I was just like, I wanted to help, but they did not care about themselves.

Harper shared that she enjoyed her clients. However, Harper got frustrated:

> Some would use COVID to their advantage to try and get out of
>
> things, like coming to their appointments. They always would say that telehealth was easier because they could talk for a few minutes and think they were all
>
> set. It was hard to assess how the clients were doing using telehealth sessions.

Ivy reflected on how her frustration with clients due to the lack of accountability being sharing:

> Clients that were in court had no accountability during COVID. Courts were
>
> closed, so any cases or charges that someone had were just put on hold. This was a struggle because if the person were not ready for treatment, the courts would
>
> mandate them, and now that was not happening. This process made me feel like any support I provided fell on deaf ears.

Marie reported that she had both positive and negative experiences looking at the effects of her client's impact. Reflecting, Marie shared that:

> Although the transition to telehealth was difficult for her to connect with her
>
> clients, it gave her a window into a part of the client's life that we do not normally see. Many patients would carry the phone around the house and show their dogs, hobbies, aquariums, and gardens. Moreover, seeing them in their real world, you know, put it put the reality to know like, oh, this person is destitute. That would be the part I struggled with, and I wish there was more that I could do.

Subtheme: Long-Term Effects

The long-term effects of the client's impact on the participants had some of the participants struggling to find words. They reported not knowing the future after the COVID-19 pandemic, isolation, the therapeutic difference between telehealth and in-person sessions, overdoses, and especially the loss of clients. Claire explained that she struggled with the future of her clients:

> It is an interesting time in their lives. We know that as SUD counselors, there is a connection between mental health and physical health issues and addiction. Some clients are so deeply rooted in their traumas that they become part of them. Not being able to find the support that the clients need was sad. It was difficult when clients would call or need various support services, and as their counselor, the referral options were not always available. Some of our clients found themselves disappointed a lot of the time because they wanted services, like mental health or housing support, that they could not find during COVID.

Harper commented that the client's impact of the use of telehealth was difficult for her as she reflected on some of the phone calls:

> I understand why the office did telehealth calls and the COVID requirements for distance. However, I feel like with HIPPA and confidentiality, it was not easy to know how truthful the client was being. There was resistance to even getting anything from the client at times. I felt as if I was not being very therapeutic at times.

Marie reported similar feelings of questioning the ethics around telehealth and confidentiality:

> I felt very uncomfortable while on a telehealth session with a young man, and explained things he was struggling with. Out of nowhere, his mom comes

> and grabs his phone, and they start wrestling over his cell phone. All the
>
> while we are still in a telehealth session. I had to call child and family services.

Charles explained that for him, the lasting impact is more on what he felt he could have done to support his clients more. He was emotional, explaining:

> I remember this case very clearly. The client continued to use benzodiazepines as well, and he was on Suboxone for his opioid use disorder. He did not want to detox or go inpatient. Telehealth and face-to-face sessions were completed, and the provider still ordered his Suboxone for him. However, the client continued to use and overdosed.

Ivy, like Charles, provided details on how the loss of a client left a lasting impact on her. She struggled at times to find the words to express her sadness:

> During COVID, when we lost contact with someone, we all thought, was it a loss of contact or are they okay? I did not know if we lost people to just stopped engaging, overdose or health issues, and death. I do know we had many people we lost contact with. As a supervisor, it was difficult for me to be supportive of my staff and help them and deal with my feelings of loss as well.

It is important to note that for this entire central theme of client impact, the participants all struggled with the significant uptick in the number of overdoses and deaths of their clients. This struggle resulted in a very significant emotional toll on their own compassion fatigue and burnout. In each interview, participants often shared emotionally about how the loss of clients impacted them significantly.

Theme 3: Work Impact

The theme of work impact considered the actual work site, hospital regulations, New York State regulations, and the Office of Addiction Services and Supports (OASAS). This theme

indicated how these entities impacted the participants overall well-being regarding compassion fatigue and burnout during the COVID-19 pandemic. It is important to note that the struggles of client overdoses and deaths of their clients added to the struggles of the work impact. In each interview, participants often shared emotions about how the loss of clients impacted them significantly. However, they felt that there was little support or time for the counselors to process the grief of the loss of a client. Readers of this research need to understand the profound emotional impact of the lack of support generated for participants in recalling their experiences with confusion, communication, support, and disorganization.

Subtheme: Immediate Effects

Participants provided insight into what they felt was the immediate effects of work impact on their compassion fatigue and burnout. The participants felt they had to adhere to multiple sources of data. Participants reflected on how they would struggle with confusion and uncertainty as a counselor. Claire reflected on the state of confusion she felt she was in:

> When COVID-19 started, I remember no one knowing what it was and what was happening globally. I remember how challenging it must be for the patients if we do not know what is happening. I remember feeling like just how are we going to do this? We did not have answers, and it felt like no one did.

Charles explained that he struggled with the confusion from OASAS and continued to work with clients face-to-face. He shared his frustration, stating:

> One moment, we were told we had to see patients, and the next day, we would be told we had to do telehealth because we were in the red state or red county or red district. With OASAS, it was like one minute you could talk to a person and the next time you called in, told to email them, and it would take days to get any answers.

Harper conveyed that for her agency, it was difficult due to social distancing and confusion:

> Well, it was different because of the social distancing. Only a few would come into the office to work, while others worked from home. Those who report to the office would be in one big room but socially distanced. I always thought that confidentiality with clients and doing telehealth was odd, but I guess it worked.

Ivy felt the office was chaotic, and the lack of communication was making it difficult to support the counselors she supervised. Reflecting, Ivy divulged:

> There were just a lot of words being thrown around, and responses to this are the way it is, which I would have to tell my counselors then the same response. Things changed daily. We completed an audit over the phone over the phone instead of in person. This process was odd because the audit was on old regulations, and OASAS was changing them. So how could we correct anything if they were not the same?

Marie disclosed that as an older counselor, it was challenging to understand and implement telehealth sessions with her clients. Explaining her frustrations Marie articulated that:

> So, when the clients were not allowed into the facility, we began the process of reaching out to connect with them over the phone and with video calls. I got set up with a video camera, but there was much confusion and stumbling learning how to use it.

Subtheme: Short-Term Effects

The immediate effects would carry over into short-term effects, leaving the participants struggling with confusion, communication, support, and disorganization. In addition, participants also pointed out that the changes in the regulations from OASAS changed the approach they

were taking with patients from an abstinence-based treatment to a harm-reduction treatment. Claire divulged how this impacted her:

> The regulations had changed and adapted to the harm reduction model as opposed to an abstinence model, we struggled, and when you have a supervisor who is also struggling with the change, you do not need someone to guide you. These changes also mean that clients are no longer held accountable for their treatment. Under the new regulations, our doctors must give a client their Suboxone or other medications, even if they do not attend their appointments. This process is very frustrating as a counselor.

Charles expressed his frustrations with regulations and the lack of technological support when implementing telehealth. Putting his frustrations into words, Charles shared that:

> One minute, we were seeing clients face-to-face, and the next minute, there was a change. Every day, there was a new regulation for seeing a client. At first, we could not use Zoom, and all our sessions were completed telephonically. When the facility could get a telehealth platform up and running, I was delegated to teach everyone how to use it. This service change was not easy for the facility as the telehealth software was for the entire hospital, so if you were not careful, you were scheduling someone for the dental clinic instead of the SUD clinic.

Harper admitted that the disorganization of her site was impacting her overall well-being. She shared that the disorganization and chaos affected her anxiety. Harper explained that:

> While I was qualified to do certain tasks, I was not asked if I wanted them but rather, I was told that because the supervisor was leaving for maternity leave, that I would be taking over her supervisees. I think because of COVID, they were so

> short-staffed that they just began to delegate. On top of that, it felt like the facility was making up their own rules. One minute, we were told to do telehealth sessions, and the next, we were told the client had to come into the office for a face-to-face session. It was so confusing and stressful.

As a site supervisor, Ivy shared her frustration with the disorganization of all the different entities that pushed into her site. Ivy shared that:

> They did not have the telehealth system set up, and no one was supposed to come into the building; then it was okay for them to come into the building, only to be told clients could not come into the building. This regulation was so frustrating as a supervisor. It felt like I was getting the brunt of both ends. I felt like I was letting my staff down because I did not have the answers. I cannot even blame the hospital as there were a lot of dying people, and they needed to be more staffed (not enough nurses, equipment, and doctors). I believe the hospital was in a crisis. However, they were still unclear to my boss, making things challenging daily.

Marie conveyed that the confusion of regulations and the pressure to maintain units of service had an impact on her. OASAS had changed its protocol of care from an abstinence treatment plan to a harm reduction one. The therapeutic approach of abstinence focuses on restraining the use of all mood-altering substances. At the same time, harm reduction is an evidence-based approach where the counselor works with the client to equip the client with life-saving tools and information to promote quality of life with or without the use of substances. She acknowledged that she struggled with the changes and confusion:

> When we went from abstinence to harm reduction treatment, I thought this was

> a positive step for treatment and meeting the clients where they are at with their recovery. The regulation changes and confusion around what we can and cannot bill for services provided. What equaled a unit of service also changed, and phone sessions were now included as a unit. Not making enough units of service would put fear in me that we would shut down and that we would lose our jobs or get laid off.

Subtheme: Long-Term Effects

Each participant explained that long-term effects would also be a carryover from both the immediate and short-term effects of the work impact, leaving the participants still struggling with not feeling valued, not heard, not consistent, and not supported. In addition, participants also pointed out that the changes in the regulations from OASAS would continue to affect the approach they were taking with patients from an abstinence-based treatment to a harm-reduction treatment. Claire explained that for her she struggled with feeling supported:

> I do not want to say we struggled, but when your supervisor struggled to adapt to current regulations, you also struggled because you did not have anybody to guide you. In addition, with the changes from abstinence to harm reduction, some mental health providers would not take a client if they were still using substances. It was also difficult to find mental health facilities that were doing face-to-face sessions instead of telehealth. I would also share that since the COVID-19 pandemic, there are fewer numbers of substance use disorder providers than prior.

Charles disclosed that he struggled with feeling heard. This struggle led him to bitterness about his job and to feelings of burnout. Charles attested that:

> For me at work, it was like they just kept, they just believed that you could continue to do this over and over and over and over and over. Moreover, it was not going to happen.

> Everyone is asked to do more, but the clinician's well-being needs to be addressed. We have fewer staff, but you still must produce your numbers on top of taking on more people. However, now that it is a harm reduction-based treatment, some clients have learned that they do not need to come and see their counselor and can still see the doctor and get their medication-assisted treatment. However, I am still asked to produce service units with no support from the facility to promote the building or advertise the location. That contributed to burnout happened.

Harper explained that for her, the non-consistency of things between management and other counselors put a strain on her. Pointing out the strain, Harper established that:

> The facility I was at for part of the COVID-19 pandemic would lack supervision. When she started working for this facility, she shared that she had supervision until her supervisor left for another job. The interim supervisor was at another location and would have me use Messenger if I needed anything or had questions. I only had direct supervision with her once or twice and felt like I was left alone to figure it out. When I changed the facilities that I worked for; my supervision would become more regular. However, the inconsistency of being able to see clients or do telehealth was constantly changing.

Ivy elaborated on the inconsistencies she experienced were one of the reasons she considered retirement. Divulging how she felt, Ivy communicated that:

> OASAS was not very helpful with the changing of their regulations during the COVID-19 pandemic and their lack of clarification on things were not supportive for her as a supervisor and providing clinical care to clients. So, it went from an abstinence-based clinic, using motivational interviewing and meeting people where they were to

> not hold anyone accountable for their actions. In the beginning of the COVID-19 pandemic, the regulations were that we could not do telehealth with clients and support them with their medication-assisted treatment. Then we were allowed, but it would take a while to set up as there were all sorts of new regulations with the hospital and OASAS to ensure we could invoice correctly for the services provided. My burnout started when the hospital was going to close the clinic, and I had to fight very hard to keep the clinic open. This event is when I lost trust. When OASAS changed its regulations and then came to do an audit based on old regulations, we cited the clinic for mistakes that we could not correct. This process was not supportive, which was part of the audit to help the clinic do better in helping those with substance use disorders. I was agitated by this, and at this point, I knew I was burned out.

Marie acknowledged that she continues to struggle with ethics around confidentiality. She sometimes worked from home and thought that was a good thing. Marie also reflected on the pressure for units of service:

> I think we were several months into the COVID-19 pandemic and there was no end in sight. I remember thinking, could I see myself doing this forever? The pressures from management were to get the units of service by individual and group sessions. Groups were complex because you never knew what the clients were doing or who was in the home with them while they were with others from the clinic, and nonverbals were often misinterpreted.

To summarize this section, it became very apparent to the researcher that the regulations from the state and the agencies themselves were changing consistently, and as a result, all participants felt as if they were not appreciated and expected to function, produce, and continue

with no consideration of their own mental health needs. Participants shared with passion and emotion that they felt they did not have a voice to give feedback.

Theme 4: Blending Impact

While reviewing each participant's stories, there was a common theme among all three themes. Each theme influenced and built on the other themes. Which in return led to the fourth theme, blending impact. One impact was not more influential than the others.

Each participant shared how they were concerned about the well-being of their own families, clients, and their families. There was a concern and fear of getting the COVID-19 virus and spreading it to family because of one's interactions at work or bringing it to work. Participants shared how they took precautions to reduce the risk.

Barriers the participants shared included their clients' comorbidities, the lack of technology to attend virtual sessions, the change of regulations, additional paperwork, the worry of exposing family and clients to the COVID-19 virus, and the inability to do self-care. Participants acknowledged fatigue and burnout. Additionally, participants shared that they have had to learn new ways to practice a good work-life balance.

Participants in this study articulated how they would experience two or more themes simultaneously, adding to their confusion and frustrations. Based on what was divulged by the participants, a blended impact that led to the unknown, chaos, and frustration was identified.

Summary

The research made the findings represent the voice of the participant's experience of the contributing factors of compassion fatigue and burnout as a substance use disorder counselor during the COVID-19 pandemic. The presented themes included participant quotes so the reader could hear the lived experiences directly from the participants. Personal impact left participants

feeling afraid for themselves and their families with increased feelings of frustration and sadness. The second impact had participants concerned for the struggles that their clients had with the uncertainty of the unknown. Participants reflected on how the clients were dealing with the COVID-19 pandemic. Leaving the participants feeling scared and worried about the overall wellbeing of clients. Participants identified the loss of a client impacted them significantly. The work impact reflected on how participants felt supported by their employers, struggles with change and the unknown, and the state of disorganization. The combination of all three would influence the blending impact. Participants identified that it was the influence of each impact that increased their feelings of confusion, chaos, and the unknown. Which led to feelings of being overwhelmed and struggling with compassion fatigue and burnout.

Each participant completed an in-depth interview and created a conceptual map which provided a deeper description of their experiences and added a pictorial representation. These lived experiences of SUD counselors during the COVID-19 pandemic impacted the participants personally, causing concern for their own physical and emotional health. COVID-19 impacted the clients that SUD counselors served, which lead to increasing burnout and compassion fatigue for the counselors that supported them. Finally, the lived experiences of SUD counselors during the COVID-19 pandemic were significantly impacted by the regulations of the work site, hospital regulations, New York State regulations, and the Office of Addiction Services and Supports (OASAS). The next chapter will discuss the impact of these findings and make some recommendations for the organizations and counselors that care for those suffering from SUD.

Chapter Five: Conclusion

Overview

This phenomenological study provided an opportunity for five substance use disorder counselors to describe the critical contributors of compassion fatigue and burnout in substance use disorder counselors during a global COVID-19 pandemic in Western New York. The sections in this chapter will provide a summary of findings, a discussion of findings, implications, delimitations, limitations, and recommendations for future research. In addition, the researcher will provide specific recommendations to substance use disorder counselors and implement self-compassion techniques.

Summary of Findings

The research participants provided a copious description of their lived experiences in the components of compassion fatigue and burnout during the COVID-19 pandemic. In summary, SUD counselors' lived experiences during COVID-19 were a substantive struggle for them. The impact of personal life outside of work, client struggles, counselors' concerns for them, and the work environment impacted and influenced the overall well-being of each SUD counselor. This struggle increased the SUD counselors' questions of self-worth and their inability to use self-care. Due to the increased burden of learning technology for virtual care, SUD counselors were frustrated and misguided. This frustration would spill over into frustration for the clients who could not log on for the virtual session or did not know how to use the technology. Participants felt they needed support from the hospital, the state, and OASAS. Due to the delivery of care changing from virtual to face-to-face, participants felt increased concern for clients and providing them with the correct level of care. They also described feeling overwhelmed by the

multiple daily changes in regulations, therapeutic processes, and documentation from the various governing bodies.

This study provided clear answers to each research question, as SUD counselors shared their feelings regarding the contributing factors of compassion fatigue and burnout during the COVID-19 pandemic. The first research question was, *"How do SUD counselors describe their experience of burnout, compassion fatigue, and secondary trauma during COVID-19 restrictions in Western New York."* The study found that the high expectations of care delivery meant participants placed extra pressure on themselves. They described their experience with virtual sessions as confusion, inconsistency, technology challenges for them and their clients, lack of interaction and support with other healthcare agencies, and inconsistent support from the hospital, state, and OASAS. This study found that participants were eager to share the increased emotional upheaval they experienced due to the COVID-19 pandemic. All participants shared a range of emotions, uncertainty being the most prominent, followed by feeling overwhelmed, confused, and chaotic.

The second research question was, *"How do SUD counselors describe their interactions with clients, supervisors, and state regulations during the pandemic?"* This study identified the change of how to conduct an individual session was challenging. Participants identified that there was much chaos, and they didn't know from each day how they would engage with the clients. Interacting with clients, supervisors, and the always changing regulations during the COVID-19 pandemic left participants feeling frustrated and fearful of what was going on at that moment. Participants disclosed how changes in treatment from harm reduction to an abstinence-based treatment left them feeling uncertain to how they would be facilitating treatment and be remote. Which stands to reason that prior to the COVID-19 pandemic, SUD counselors could have

managed the regulation changes based on what they reported in their interviews. The SUD counselors expressed that they felt frustrated, confused, fearful, anxious, lonely, scared, lacking energy, feeling loss, and self-doubt. SUD counselor participants also reported that they had concerns for their families and risks of infection for them and their clients.

The third research question was, *"How do SUD counselors describe their self-care, training, and supervision before the COVID-19 pandemic and during the pandemic?"* This study showed significant contributing factors that the counselors had to cope with during the COVID-19 pandemic that would make them feel overwhelmed, unsupported, frustrated, and that they lost trust. SUD counselors shared how the lack of support and trust from supervisors, management, state representation, and OASAS led to feelings of frustration. Participants reported feeling overwhelmed with the daily changes in how to support clients, concerns with the home and health of their own families, and concerns about clients' well-being.

The answers led to an additional interview question: *"What techniques or tools do you use to help assist through difficult times?"* Participants shared support from their direct supervisor and facility administration, and OASAS did help with affirmation that they were doing a good job. Participants also reported that a work-life balance was essential, positive experiences with clients, and flexible working arrangements support their well-being. Participants shared that going for walks, seeing and interacting with family, education on self-compassion, and remaining adaptable were all ways to support them through difficult times.

Based upon the responses from all the participants, a comprehensive study statement was created to encapsulate all that was shared with the researcher in the interviews: *During the COVID-19 pandemic, substance use disorder counselors amalgamated their personal lives with the clients and work impact, leaving them to struggle with compassion fatigue and to question*

their self-worth. Feelings of being overwhelmed, uncertain, and doubting themselves are powerful feelings that SUD counselors encountered as they provided therapeutic care to their clients while experiencing daily changes in the facility, state, and OASAS. They also felt scared and fearful at the thought of what might happen to their families and the financial challenges some experienced. During the height of the pandemic shutdowns when there was a move to virtual therapy sessions and many changes in therapeutic practices, it was apparent in the SUD counselor participants' comments that the risk of compassion fatigue was heightened.

Discussion

The findings in this study confirmed much of the factual evidence and theoretical literature from previous research explored in Chapter Two. The research findings also provided unprecedented contributions that point to a deleterious impact with theoretical implications through mindfulness-to-meaning theory as it is applied to the SUD counselor participants' lived experiences.

Confirmation of Previous Research

This study confirms much of the collective research on compassion fatigue and burnout. Specifically, more than 50% of drug counselors experience burnout or symptoms of burnout (Beitel et al., 2018). Previous research explained potential occupational hazards for substance use disorder counselors such as compassion fatigue (Cosden et al., 2016; Davis et al., 2012; Finan et al., 2021). For the participants in this study, three out of the five interviewed either experienced a client overdose or lost a client to substance use. One of the participants lost a co-worker due to suicide. Three of the five participants interviewed had significant life changes which included the birth of a new child and the death of a loved one during the COVID-19

pandemic. During the length of this study, this researcher also experienced the death of three clients, as well as two colleagues' deaths in the region due to suicide.

This study accentuates the impact that the COVID-19 pandemic has had on SUD counselors. At the same time, they attempted to provide person-centered care to individuals struggling with addiction while adjusting to the challenges of regulations and COVID-19 protocols from the facility, New York State, and OASAS. Previous studies on substance use disorder counselors showed that many enter this profession as individuals in recovery or impacted by loved ones struggling with substance use (Martin-Cuellar et al., 2019; Rothrauff et al., 2011). Previous studies found that SUD counselors are vested organizationally and occupationally but need inner strength and resilience (Martin-Cueller et al., 2019; Rothrauff et al., 2011). This study confirms those findings, as all participants had to use that inner strength and resilience to meet the personal and professional challenges during the COVID-19 pandemic.

Moreover, the uncertainty and state of confusion caused by the pandemic made it challenging to assess the client and their situation while providing the proper support and resources for the client's recovery. In previous studies promoting wellness and encouragement, SUD counselors use Adler's therapy to help clients understand how a person's lifestyle influences healthy and unhealthy choices around wellness (Britzman & Henkin, 1992). This study confirms how all the participants had to rearrange the person-centered care for their clients to meet the needs of recovery and the regulations from the government.

The most enthralling confirmation of previous research is the impact on SUD counselors' well-being. Alfred Adler believed that one's well-being was more than just physical wellness, implying that an individual's physical, emotional, intellectual, and spiritual wellness are interconnected (Britzman & Henkin, 1992; Myers, 2009; Reyes, 2022; Witmer & Sweeney,

1992). All five participants indicated a decrease in their overall well-being, providing accuracy to Adler's theory. Participants expressed their experience cause acute stress reactions with PTSD-like symptoms. Moreover, the fear, anxiety, and financial difficulty from the pandemic negatively impacted the SUD counselor by impeding the ability to utilize self-care techniques, leading to a lower quality of life for the SUD counselor.

Divergence From or Extension of Previous Research

Although this study confirmed previous research that reported an adverse effect on the retention of SUD counselors, it did diverge from past research in astounding and fortuitous ways. One previous finding is that SUD counselors are expected to put their personal feelings aside while providing person-centered care in response to the client's presenting needs (Can & Watson, 2019; Figley, 2002). This finding was different in this research. This study demonstrated a direct refutation of the previous research, as one of the themes was how there was a blending of influencing components to compassion fatigue and burnout.

An extension of previous research revealed in this study was that at the beginning of the pandemic, various healthcare professions reported compassion fatigue and burnout (Okoli et al., 2020). Healthcare workers, including SUD counselors, were essential despite changes due to the COVID-19 pandemic. In this study, the demands only increased personal and professional stressors, including financial hardships, social isolation, and increased mental health needs (Centers for Disease Control, 2020; Cook et al., 2021). As mentioned, all five participants expressed personal and professional stressors. Two out of the five participants expressed social isolation and missing direction. Previous studies found that telehealth can provide similar results to in-person treatment, reducing the burden of travel and the risk of health concerns due to the pandemic (Oesterle et al., 2020). This study directly contradicted that finding as participants

reported chaos and lack of technology abilities for both the facility and its clients. Finally, it should also be noted that substance use disorder treatment was available to all who met DSM-5 criteria, primarily online, from March 2020 to the late summer–early fall of 2021.

Another extension of previous findings on the ineffectiveness of online therapies was regulatory barriers, including insurance reimbursement and state licensure requirements (Oesterle et al., 2020). Participants reported confusion about how to record and obtain client consent regarding confidentiality. Additionally, the complications with overdose and deaths caused additional stress and anxiety in participants. The OASAS changes in treatment to harm reduction offer an opportunity for reuse and overdose. In New York, the Erie County Medical Examiner's Office reported an increase in fentanyl overdose to 88% in 2021 (Erie County Department of Health, 2020). Following is a more detailed analysis of these findings included because the SUD counselors deserve a voice, and the details deserve to be made known.

First, SUD counselor participants reported uncertainty in their personal and professional lives, which is consistent with previous research. The participants reported that the uncertainty of their jobs, the support from their facility, New York State, and OASAS impacted their dimensions of wellness. Participants expressed additional stress from the pressures to meet goals for retention. Moreover, they also reported that the stress was affecting them physically and mentally. Participants reported an increase in overdoses and deaths of individuals struggling with addiction.

Second, participants experienced some benefits of telehealth such as insight into the client's world as they used their phones and walked around their homes. Participants expressed concern with identifying how impactful group therapy was and how engaging the clients were. Additionally, participants reported that intrapersonal, face-to-face interactions were disrupted,

and clients struggled with reliable phone and internet access. Furthermore, the participants expressed concern about work efficiency due to the implementation of new telehealth software and the reimbursement from insurance for services. This additional worry likely hurt the participants' well-being and ability to provide client-centered care. The existing processes for reimbursement were based on in-person, face-to-face sessions and were discontinued during the pandemic.

New Contributions from this Research

In addition to the disparities from previous research, this study is the first to examine the contributing factors of compassion fatigue among substance use disorder counselors during the COVID-19 pandemic. This approach views the SUD counselors' personal and professional lives and how they influence their well-being and risk for compassion fatigue and burnout. Unmet personal and professional needs influence the person's emotional, physical, social, spiritual, environmental, occupational, financial, and intellectual dimension of wellness. Changes in care regulations, learning new technology, concerns for clinic closing causing financial concerns, concern for family's well-being, isolation, and concern for client well-being are just a few examples of challenges expressed by participants.

The increased uncertainty and confusion noted in the participant results also impacted their eight dimensions of wellness, increased their stress, and, in some cases, made them more creative. Reciprocally, SUD counselor anxiety levels correlated with the regulation changes from the facility, the state, and OASAS as well as the recovery of their clients.

Participants described the lack of communication and feeling unheard with their concerns, which left feelings of low job satisfaction. One previous study acknowledged this phenomenon for mental health professionals but did not consider substance use disorder

counselors (Singh et al., 2020). As noted in the results section, by the end of the pandemic, participants experienced an increased concern for their physical and emotional health.

Theoretical Mindful Self-Compassion

The design of this study has its theoretical roots in mindful self-compassion. It focuses on how the impact of personal and professional wellness during the pandemic impacted substance use disorder counselors' compassion fatigue and burnout. As an SUD counselor interacts with their home life, clients, and work, it can lead to an increase in the risk of compassion fatigue and burnout. SUD counselors are tasked with identifying new sources of support. Mindful self-compassion is a model for stress reduction and mindfulness-based cognitive therapy that can help SUD counselors provide care and kindness to themselves (Germer & Neff, 2019).

Research suggests that the changes in social and professional support increased the risk of compassion fatigue and burnout (Zabukocic et al., 2021). This study exhibited the same interaction and supported that research. Moreover, it supported the premise of system theory as participants detailed their experiences of contributing factors of compassion fatigue and how that had influenced their personal and professional lives.

In agreement with Adler's theory (Britzman & Henkin, 1992; Reyes, 2022; Witmer & Sweeney, 1992), this study found an association between an SUD counselor's professional support and their personal lives with compassion fatigue and burnout. In this study, participants discussed their confusion, uncertainty, and feelings of being overwhelmed and scared. Adler's theory encourages the interconnectedness of mind, body, and spiritual wellness (Britzman & Henkin, 1992; Reyes, 2022; Witmer & Sweeney, 1992). Participants shared how increased negative emotions impacted their overall functioning as SUD counselors and how those negative emotions have impacted their burnout. As noted by some participants, they felt they had no

support from supervisors, the facility, the state, or OASAS. Viewing participant experiences through the lens of mindfulness, self-compassion, and person-centered care revealed how all the components–self, client, and work–that an SUD counselor endures were interrelated.

Implications

This section provided an explanation of the theoretical empirical and practical implications. Additionally, this section explained how this study has been guided by SAMSHA's eight dimensions of wellness, fundamental Christian principles, and the Christian perspective focusing on stewardship. There are also recommendations for various stakeholders, specifically the SUD counselors and the agencies supporting them.

Theoretical Implications

This study confirmed previous qualitative and quantitative studies on compassion fatigue and burnout that have been conducted previously. While the results' theoretical implications constitute the SUD counselor's experience, it also widened the gap to mindfulness-to-meaning theory. These results helped to shed light on trauma theory and how sudden intrusion and unexpected situations can leave one feeling emotionally and intellectually divided. The participants in this study shared how the unexpected events during the pandemic affected their personal lives and the client experience and how it influenced their overall well-being. When examining the SUD counselor and the contributing factors of compassion fatigue, burnout, and secondary trauma, research should consider the blended causality experienced in the SUD counselor's personal and professional well-being.

There is little doubt that personal distress, client distress, and work distress impacted the SUD counselor and their well-being. Research in the development of SUD counselors should examine this fundamental premise, as these factors lead to compassion fatigue and burnout.

Empirical Implications

A key observation from this research is the need for better access to implement self-compassion and self-care, a factor noted in multiple studies. There are many reasons to implement these practices, including self-doubt, uncertainty, grief, loss, and difficult working conditions. Regardless of the reasons, SUD counselors in this study have experienced compassion fatigue and burnout both personally and professionally. However, they managed to develop self-efficacy and were able to sustain themselves.

All the participants in this study felt uncertain, confused, frustrated, and scared during the pandemic. However, it was also important that they provided person-centered care to their clients and followed safety measures like frequently sanitizing, screening themselves and clients before sessions, wearing masks, social distancing, turning away clients for pandemic-related reasons, and using telehealth sessions. As one participant noted, even during lockdown, they still cared for their own families, had to report to the office as essential workers, saw clients face-to-face until they moved to virtual sessions, went to the grocery store, and did other things. At the same time, health and contact status would change daily based on the status of the counselors' area and the New York State Health Department. Participants shared that facility precautions and screenings provided a safer place, providing some relief.

Participants gave voices about the added stress and pressure that the changes in regulations and the lack of communication brought them. In addition, SUD counselors reported an increased prevalence of anxiety and fear. Every participant described an increase in their frustration and stress that can be related to an increase in their baseline of stress before the COVID-19 pandemic, as noted in other studies and corroborated in this study. When treating someone in New York State with substance use disorder, participants used an abstinence-based

therapy approach where the therapy process encourages clients to stop all mood-altering substances while in treatment. During the pandemic, the New York Office of Addiction Services and Support changed their treatment requirements to person-centered therapy, meeting the clients where they are at with their recovery. This change added additional stress for the participants because they felt strongly about the accountability factors for clients in an abstinence-only model. Participants shared questions about how a blended person-centered model with accountability could be more effective.

Besides the participants who retired this year, all the other participants were in households concerned about their financial well-being. One participant shared that both her husband and she worked, and daycare was essential for the functioning of their household. Therefore, when the daycare unsurprisingly closed, their family system would have to adapt to a new way of living with separate shifts so one could be home with the children while the other worked. When the daycare opened back up, the children struggled with going back, causing additional stress on this participant.

Previous research has established that SUD counselors often reported isolating themselves from social situations and even from family with Zoom calls. Participants reported that even when they had to go to work, they would stay in their offices and not spend time with other SUD counselors. This isolation also brought a need for more communication and support. Participants reported that telehealth sessions were helpful in that they provided insight into the client's world but were also more challenging due to connections with the WIFI, loss of contact, and HIPPA concerns. Consequently, changes in what insurance will allow for billing and internet costs would reduce some of the stress telehealth creates.

Practical Implications

Based on the participants' experiences recorded in this study, a practical implication would be that researchers evaluating the contributing factors of compassion fatigue and burnout are not seeing SUD counselors' development improve but instead are seeing lack of avidness. Participants shared their lack of positive feelings to want to push forward. Additional validity can be added by including more research as well as input on self-care and self-compassion. Understanding how self-care and self-compassion can change alongside the opposing desire to push forward. Participants indicated in their interviews that the inability to do self-care influenced how they felt and managed the stressors during the COVID-19 pandemic.

Recommendations for Stakeholders

New York State OASAS and SUD facilities can add, partner with, or fund development programs for SUD counselors to learn and implement mindfulness self-compassion. Partnering would help eliminate the gap of confusion and uncertainty between the SUD counselors, the SUD facilities, and OASAS. Additionally, OASAS could use a clear view of client impact, work impact, and personal impact that led to compassion fatigue and burnout of SUD counselors and the difficulty for them to stay in their positions. Moreover, suppose OASAS and SUD facilities are providing person-centered support to the SUD counselors, that is what is expected of the SUD counselors to the clients. If that were the case, that can be communicated to current and future SUD counselors through studies and analysis of their effectiveness. Additional research by NY OASAS evaluating the efficacy of person-centered care for SUD clients during the pandemic should also be considered. OASAS can support the SUD counselors by working with the state health department on a plan that can be communicated to lessen the chaos.

State health departments could also consider that with the increase in substance use, individuals struggling with addiction need access to outpatient facilities. Outpatient therapy and other medical offices provided screening, sanitizing, and masks for in-person visits. These outpatient clinics provided person-centered therapies, both in-person and if potentially contagious, virtual sessions. SUD counselors were expected to assess clients to make sure they met health requirements for face-to-face sessions. The uncertainty and concern of SUD counselors for their well-being, the clients, and their families was elevated. Therefore, communication on regulations and a specific plan for potential future pandemics would help reduce the stress SUD counselors feel.

SUD facilities and supervisors need to note the regulation changes and procedure updates while supporting the SUD counselor through the changes. Supervisors must maintain scheduled meetings with newer counselors to provide insight and support, reducing confusion and self-doubt. Supervisors will be able to assess the capabilities and emotional strength, along with a SUD counselor's willingness to learn mindfulness and self-compassion. This assessment could reduce compassion fatigue and burnout with an active supervisor supporting the SUD counselor.

Moreover, the participants were in unison when they expressed how disorganized communication was and the personal and professional uncertainty. Participants who could use telehealth sessions had a reduced fear of getting the COVID-19 virus. However, there was increased frustration due to patients' difficulties in using and accessing online platforms. Those participants who continued seeing patients face-to-face expressed fear for themselves and their clients. Participants shared that the chaos of the daily changes and uncertainty from authority increased their anxiety and stress. To reduce exposure or compromise themselves, participants should consider moving to more online therapies during the higher risk times of the year for

infection. However, moving to online therapies only is not supported by the implications of this study.

Christian Worldview Considerations

This study was not specifically a study of how Christianity cooperates with an SUD counselor's experience with contributors to compassion fatigue and burnout. However, the Christian view acknowledges the importance of ministering to the hurting and needy. A Christian worldview postulates doing unto others as one would want to be done to them (Germer & Neff, 2019). Moreover, having the foundation of self-compassion can bring confidence and inspiration to others. By practicing and learning mindful self-compassion, SUD counselors lead by example while keeping the challenge of self-care and self-compassion fresh (Germer & Neff, 2019).

Professional guidance, direct training, and support allowed SUD counselors to be engaged and be enriched in mindfulness-based stress reduction (MBSR) to cultivate mindfulness and self-compassion (Germer & Neff, 2019). Encouraging the interconnectedness of mindfulness and a goal-oriented approach for SUD counselors increased their interest in the well-being of themselves and others (Reyes, 2022; Sweeney, 2019). People live in relationships with one another (Balswick & Balswick, 2014). Philippians 2:1-5 encourages one to be mindful and live with the awareness of the present, keep a calm mind, and focus on one's wellness and connection with others and God (New International Version, 2011).

Wellness is the foundation of promoting the quality of life, encouraging healthy habits and self-control. Wellness is a state of being that is conscious, self-directed, and focused on promoting increased quality of life, encouraging healthy habits and self-control (Montoya & Summers, 2021; SAMHSA, 2019; Witmer & Sweeney, 1992). To cultivate this wellness,

nurturing both body and spirit together is essential. In the Christian sense, the well-being of an individual comes from within. Emmanuel Abimbola (2023) states:

> "Wellness from within encompasses the holistic well-being of an individual, encompassing their physical, emotional, and spiritual health. It is a state of thriving that goes beyond the mere absence of illness, embracing a vibrant and balanced life in alignment with God's design. As Christians, understanding and pursuing wellness from within is essential, as it enables us to fulfill our God-given purposes and live lives that bring glory to Him" (Abimbola, 2023, paras. 1-2).

Consequently, this study focuses on the contributing factors of compassion fatigue, burnout, and secondary trauma of counselors who are providing therapy to individuals struggling with the disease of addiction and following the various regulations from each facility, the state, and OASAS while also providing and caring for themselves and their families.

Delimitations and Limitations

When researching the contributing factors of compassion fatigue with substance use disorder counselors, the research focused only on hearing the SUD counselor's voice. SUD counselors are an excellent source of information because they have multiple sources of stress on a near-constant basis. Another delimitation was using the conceptual mapping task, and the built-in validity checks during only one interview with the participant (Impellizzeri et al., 2017).

The choice of only looking at SUD counselors was conscious and brought bias into the research as they are only sometimes privy to the day-to-day demands from management, the state, and OASAS and what is expected of these stakeholders from a legal standpoint. Understandably, SUD counselors often can be impatient and frustrated, given the multiple

protocol changes and the chaos of learning new ways of providing care. They are not experts on insurance guidelines, legal requirements from various agencies, or health department requirements. Therefore, only hearing from one stakeholder regarding the work impact on compassion fatigue potentially could reduce the study's validity. However, including the voices of clients or facilities is not what this research was for.

Development is only a part of their experiences, and the breadth of this research had to be limited due to the investment and time available to the researcher. Therefore, a decision was made to honor the SUD counselor's voice only when researching the contributing factors of compassion fatigue and burnout during the COVID-19 pandemic because the primary research question is about an SUD counselor's experience. Therefore, prioritizing their voice was prudent.

Potentially, there may have been an element of volunteer bias because the participants had their own motivations for completing such an involved and lengthy interview process with no monetary compensation. Paying for participant time would have added a potential bias as well. Additionally, SUD counselors had to be inclined to meet in person and may have had some reluctance for some potential participants or they did not complete the requirements to participate in the study.

As all research has limitations, this study is no different. One limitation of the study was having only one male participant, and potentially a higher male-to-female ratio could have an increase on the variance between the interviews. This study also needed to be more extensive in answering the third question about self-care, training, and supervision before and during the COVID-19 pandemic because only three of the five participants had a few months of counseling before the outbreak and changes due to pregnancies for one and the changing of facilities for

another. However, this was mitigated by hearing about the confusion and frustration they had following the restrictions of services during the pandemic.

This study was also geographically limited to two counties in New York State: Niagara, and Erie. This limitation was incumbent to accomplish the in person semi-structured interview with the conceptual mapping task.

Further limitations involved the living areas and race of participants. The counties were in suburban areas. Therefore, the participants were from somewhere other than a metropolitan area. In this study, only Caucasian and Asian Indian races were represented. The experiences from other races cannot be generalized and may have impacted the research as well.

Recommendations for Future Research

The research sample was small, with only five SUD counselors considered to reduce validity the research sample could be increased. Additionally, it considered the contributing factors of compassion fatigue from only the SUD counselor's view. Future research with a qualitative exploration of a SUD counselor's experience with self-compassion would be vital for further understanding of coping with compassion fatigue and burnout. Based on the answers from a few of the participants the research could have studied more on self-care. Additionally, a quantitative evaluation of the use of mindful-based stress reduction (MBSR) therapy before the pandemic and again at the time of this research might yield more validity to the scope of compassion fatigue and burnout of the SUD counselors. This concept could be compared to SUD counselors in similar pre-pandemic conditions could utilize MBSR therapy and be cross tabbed to compare the extent of compassion fatigue and burnout.

Future studies could also focus on support for early wellness care from facilities, state, and OASAS entities. These organizations are influencers in the field and having involvement from them as resources and professional support for SUD counselors. The consistency of each study would likely yield very different results from the participants.

Lastly, a study that casts a wider net on SUD counselors' experiences in different states and counties would illuminate and provide essential information sources for each geographic area. Throughout the research, it was apparent that the struggles that SUD counselors experienced with the contributing factors of compassion fatigue were both pandemic restriction-based, which was applied differently throughout the state, and based on the local area. Support varied significantly based on the facility and supervisor support received, state and OASAS regulations, clients' overall well-being, and the counselor's overall wellness.

Summary

This phenomenological research study focused on the lived experiences of substance use disorder counselors as they attempted to navigate the changing regulations, the demands of the facilities, state, and OASAS, the person-centered care of the clients, and their overall well-being and family's well-being during the COVID-19 pandemic. The research findings represented the participants' voice as a substance use disorder counselor on the experience of the contributing factors of compassion fatigue and burnout during the COVID-19 pandemic. The lived experiences of SUD counselors during the COVID-19 pandemic impacted the participants personally, causing concern for their own physical and emotional health. COVID-19 impacted the clients that SUD counselors served, significantly increasing burnout and compassion fatigue among these counselors. The study demonstrated the circular nature in which SUD counselor distress impacts the facility, the clients, and the SUD counselors' families, impacting their well-

being. A contributing feature in all the participant experiences was the need for self-care and self-compassion. Access to training and supervisor support with self-care and self-compassion was limited, and it did impact the SUD counselors.

Another important takeaway from this study was that SUD counselors preferred communication and support from the governing agencies. Additionally, participants appreciated training and technical support when there were regulation changes or the treatment process, in-person or telehealth. Participants added that additional stressors of clients impacted by death, overdose, anxiety, and other mental health concerns had a tremendous impact on counselors. Participants provided a window into the contributing factors of compassion fatigue and burnout. This research has shown that the trauma of caring for others, the changes in regulations, and personal stressors during the COVID-19 pandemic affect the short-term and long-term well-being of SUD counselors.

The experience of SUD counselors during the COVID-19 pandemic was marked by increased stress and uncertainty in both their personal and professional lives. The personal, client, and work impact of COVID-19 alleviation efforts by the facilities, the state, and OASAS were significant to SUD counselors. It is important to note again that participants all struggled with the significant uptick in the number of overdoses and deaths of their clients. These events resulted in a very significant emotional toll on the counselors' own compassion fatigue and burnout. If stakeholders apply these findings to substance use disorder counseling, then influencers can assess and address some of the factors that cause compassion fatigue and burnout with SUD counselors and improve their quality of life while also improving their counseling skills. Finally, it is crucial to restate that the lived experiences of SUD counselors during the COVID-19 pandemic were significantly impacted by both personal and professional challenges which left a lasting impression.

References

Abimbola, E. (2023, June 21). *Nurturing your body and spirit together establishes wellness from within.* iBelieve. https://www.ibelieve.com/health-beauty/nurturing-your-body-and-spirit-together-establishes-wellness-from-within.html

Adler, A. (1956). *The individual psychology of Alfred Adler* (H. L. Ansbacher & R. R. Ansbacher, Eds.). New York, NY: Basic Books.

AJMC Staff. *A timeline of COVID-19 developments in 2020*. AJMC. Retrieved [January 1, 2021] from https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020

Alharbi, J., Jackson, D., & Usher, K. (2020). The potential for COVID-19 to contribute to compassion fatigue in critical care nurses. *Journal of Clinical Nursing, 29*(15-16), 2762-2764. https://doi.org/10.1111/jocn.15314

Al-Mareen, C. S., Jones, K., Linker, J., O'Keefe, D., & Cimolai, V. (2018). Counselor response to a child who commits suicide. *Child and Adolescent Psychiatric Clinics of North America. 27*(4), 621–635. https://doi.org/10.1016/j.chc.2018.05.006

American Counseling Association. (2014). 2014 ACA code of ethics. https://www.counseling.org/docs/default-source/default-document-library/2014-code-of-ethics-finaladdress.pdf

Balswick, J. O. & Balswick, J. K. (2014). *The family: A Christian perspective on the contemporary home* (4th ed.). Baker Academic.

Barry, P. (2023). A phenomenological study of parents accessing and receiving professional care for their child with autism spectrum disorder (ASD) during the COVID-19 outbreak in Washington State. Dissertation in progress.

Beckerman, N. L., & Wozniak, D. F. (2018). Domestic violence counselors and secondary traumatic stress (STS): A brief qualitative report and strategies for support. *Social Work in Mental Health, 16*(4), 470-490. https://doi.org/10.1080/15332985.2018.1425795

Beitel, M., Oberleitner, L., Muthulingam, D., Oberleitner, D., Madden, L. M., Marcus, R., Eller, A., Bono, M. H., & Barry, D. T. (2018). Experiences of burnout among drug counselors in a large opioid treatment program: A qualitative investigation. *Substance Abuse, 39*(2), 211–217. https://doi.org/10.1080/08897077.2018.1449051

Benight, C. C. (2016). Secondary trauma and burnout in military behavioral health providers: Beyond the battlefield. Palgrave Macmillan US. https://doi.org/10.1057/978-1-349-95103-1

Berman, A. H., Lindqvist, H., Källmén, H., Durbeej, N., Hermansson, U., & Forsberg, L. (2019). Counselor and drug detox inpatient verbal behaviors in a single session of motivational interviewing and subsequent substance use-related patient outcomes. *International Journal of Mental Health and Addiction, 17*(1), 73-88. https://doi.org/10.1007/s11469-017-9866-4

Blithikioti, C., Nuño, L., Paniello, B., Gual, A., & Miquel, L. (2021). Impact of COVID-19 lockdown on individuals under treatment for substance use disorders: Risk factors for adverse mental health outcomes. Journal of Psychiatric Research, 139, 47-53. https://doi.org/10.1016/j.jpsychires.2021.05.006

Boschuetz, N., Cheng, S., Mei, L., & Loy, V. M. (2020). Changes in alcohol use patterns in the United States during COVID-19 pandemic. *Wisconsin Medical Journal, 119*(3), 171-176.

Blount, A. J., Taylor, D. D., Lambie, G. W., & Anwell, A. N. (2016). Clinical supervisors' perceptions of wellness: A phenomenological view on supervisee wellness. *The Professional Counselor*, *6*(4), 360–374. doi:10.15241/ab.6.4.360

Bolton, R. (1979). *People skills: How to assert yourself, listen to others, and resolve conflicts.* Simon & Schuster, Inc.

Borodovsky, J. T., & Budney, A. J. (2018). Cannabis regulatory science: Risk-benefit considerations for mental disorders. *International Review of Psychiatry* (Abingdon, England), 30(3), 183-202. https://doi.org/10.1080/09540261.2018.1454406

Bowen, N., & Moore III, J. L. (2014). Common characteristics of compassionate counselors: A qualitative study. *International Journal for the Advancement of Counselling, 36*(1), 17-29. https://doi.org/10.1007/s10447-013-9187-7

Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology* (Tallahassee, Fla.), *17*(1), 22-28. https://doi.org/10.1177/1534765610395617

Britzman, M. J., & Henkin, A. L. (1992). Wellness and personality priorities: The utilization of Adlerian encouragement strategies. *Journal of Individual Psychology, 48*, 194–202.

Brown, E. M., Carlisle, K. L., Burgess, M., Clark, J., & Hutcheon, A. (2022). Adverse and positive childhood experiences of clinical mental health counselors as predictors of compassion satisfaction, burnout, and secondary traumatic stress. *The Professional Counselor (Greensboro, N.C.), 12*(1), 49–64. https://doi.org/10.15241/emb.12.1.49

Browne, D., Roy, S., Phillips, M., Shamon, S., & Stephenson, M. (2020). Supporting patient and counselor mental health during COVID-19: Via trauma-informed interdisciplinary systems. Canadian Family Physician, 66(7), e190-e192.

Butler, L. D., Carello, J., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma, 9*(4), 416-424. https://doi.org/10.1037/tra0000187

Can, N., & Watson, J. C. (2019). Individual and relational predictors of compassion fatigue among counselors-in-training. *The Professional Counselor, 9*(4), 285-297. https://doi.org/10.15241/nc.9.4.285

Callender, K. A., Trustey, C. E., Alton, L., & Hao, Y. (2021). Single case evaluation of a mindfulness-based mobile application with a substance abuse counselor. *Counseling Outcome Research and Evaluation, 12*(1), 16–29. https://doi.org/10.1080/21501378.2019.1686353

Center for Disease Control and Prevention. *Drug overdoses: An evolving public health crisis.* Retrieved [March 1, 2022] from https://www.cdc.gov/drugoverdose/prevention/index.html

Center for Disease Control and Prevention. *How to protect yourself & others.* Retrieved [April 22, 2020] from https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

Center for Disease Control and Prevention. *Mortality in the United States, 2019.* Retrieved [April 22nd, 2021] from https://www.cdc.gov/nchs/products/databriefs/db395.htm

Chaverri, J., Praetorius, R. T., & Ruiz, E. (2018). Counselor happiness: Effects of therapy work with similar trauma. *Social Work in Mental Health, 16*(4), 419-435. https://doi.org/10.1080/15332985.2017.1419535

Coetzee, S. K., & Klopper, H. C. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing & Health Sciences, 12*(2), 235-243. https://doi.org/10.1111/j.1442-2018.2010.00526.x

Cook, R. M., Fye, H. J., Jones, J. L., & Baltrinic, E. R. (2021). Self-reported symptoms of burnout in novice professional counselors: A content analysis. *The Professional Counselor* (Greensboro, N.C.), *11*(1), 31-45. https://doi.org/10.15241/rmc.11.1.31

Conteh, J. A., Huber, M. J., & Bashir, H. A. (2017). Examining the Relationship between Traumatic Experiences and Posttraumatic Growth among Counselors-in-Training. *The Practitioner Scholar: Journal of Counseling & Professional Psychology, 6* (1), 32-46. Retrieved [March 20th, 2023] from https://corescholar.libraries.wright.edu/human_services/35

Cosden, M., Sanford, A., Koch, L. M., & Lepore, C. E. (2016). Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. *Substance Abuse, 37*(4), 619-624. https://doi.org/10.1080/08897077.2016.1181695

Cossarizza, A., De Biasi, S., Guaraldi, G., Girardis, M., Mussini, C., Modena Covid-19 Working Group (MoCo19), & for the Modena Covid-19 Working Group (MoCo19). (2020). SARS-CoV-2, the virus that causes COVID-19: Cytometry and the new challenge for global health. *Cytometry. Part A, 97*(4), 340-343. https://doi.org/10.1002/cyto.a.24002

Council for Accreditation of Counseling and Related Educational Programs. (2016). *CACREP 2016 standards.* Retrieved [March 20th, 2023] from http://www.cacrep.org/wp-content/uploads/2012/10/2016-CACREP-Standards.pdf

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE publications, Inc.

Dannatt, L., Ransing, R., Calvey, T., Scheibein, F., Saad, N. A., Shirasaka, T., Ramalho, R., Pant, S., Vadivel, R., Siste, K., Stowe, M. J., Kalita, K. N., Boujraf, S., Testa, R., Arya, S., Morgan, N., & Grandinetti, P. (2021). The impact of stigma on treatment services for people with substance use disorders during the COVID-19 pandemic-perspectives of NECPAM members. *Frontiers in Psychiatry, 12*, 634515-634515. https://doi.org/10.3389/fpsyt.2021.634515

Darden, A. J., & Rutter, P. A. (2011). Psychologists' experiences of grief after client suicide: A qualitative study. *Omega: Journal of Death and Dying. 63*(4), 317-342. https://doi.org/10.2190/OM.63.4.b

Dattilio, F. M. (2015). The self-care of psychologists and mental health professionals: A review and practitioner guide. *Australian Psychologist, 50*(6), 393-399. https://doi.org/10.1111/ap.12157

Davis, A., Saladin, S., Hansmann, S., & Velgersdyk, N. (2012). Professional Bereavement: A Qualitative Examination of Rehabilitation Counselors in Grief. *Journal of Applied Rehabilitation Counseling, 43*(4), 3-11. http://ezproxy.liberty.edu/login?qurl=https%3A%2F%2Fwww.proquest.com%2Fscholarly-journals%2Fprofessional-bereavement-qualitative-examination%2Fdocview%2F1269470665%2Fse-2%3Faccountid%3D12085

Draper, B., Kõlves, K., Diego De Leo, D., & Snowdon, John. (2014). The impact of patient suicide and sudden death on health care professionals. *General Hospital Psychiatry. 36*(6), 721-725. https://doi.org/10.1016/j.genhosppsych.2014.09.011

Dreikurs, R., & Mosak, H. H. (1967). The tasks of life: II. The fourth life task. *Individual Psychologist, 4*(2), 51–56.

Ellis, T. E., & Patel, A. B. (2012). Client suicide: What now? *Cognitive and Behavioral Practice*. *19*(2), 277-287. https://doi.org/10.1037/tep0000127

Erie County, NY Department of Health. (2020). *Erie County alerts the community to cocaine deaths due to suspected cocaine plus opioid overdose.* Retrieved [March 20th, 2023] from *https://www2.erie.gov/health/index.php?q=press/erie-county-alerts-community-deaths-due-suspected-cocaine-plus-opioid-overdoses*

Evans, R., & Hurrell, C. (2016). The role of schools in children and young people's self-harm and suicide: Systematic review and meta-ethnography of qualitative research. *BMC Public Health. 16*(1), 401-401. https://doi.org/10.1186/s12889-016-3065-2

Eyal, M., Bauer, T., Playfair, E., & McCarthy, C. J. (2019). Mind-body group for teacher stress: A trauma-informed intervention program. *The Journal for Specialists in Group Work, 44*(3), 204–221. https://doi.org/10.1080/01933922.2019.1634779

Farber, S.K. (2017). The concept of the wounded healer. In S. Farber (Ed.), *Celebrating the wounded healer psychotherapist* (pp. 40-69). Routledge. https://doi.org/10.4324/9781315683058-12

Finan, S., McMahon, A., & Russell, S. (2021). "At what cost am I doing this?" an interpretative phenomenological analysis of the experience of burnout among private practitioner psychotherapists. *Counseling and Psychotherapy Research, 22*(1), 43-54. https://doi.org/10.1002/capr.12483

Fleet, D., Reeves, A., Burton, A., & DasGupta, M. P. (2021). Transformation hidden in the sand; a pluralistic theoretical framework using sand-tray with adult clients. *Journal of Creativity in Mental Health*, ahead-of-print(ahead-of-print), pp. 1–19. https://doi.org/10.1080/15401383.2021.1936738

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling, 40*(2), 142–155. https://doi.org/10.17744/mehc.40.2.04

Friedman, K. (2017). Counselor self-care and mindfulness. *Contemporary Buddhism, 18*(2), 321-330. https://doi.org/10.1080/14639947.2017.1373437

Garland, E. L., Farb, N. A., Goldin, P. R., & Fredrickson, B. L. (2015). The mindfulness-to-meaning theory: Extensions, applications, and challenges at the attention-appraisal-emotion interface. *Psychological Inquiry, 26*(4), 377-387. https://doi.org/10.1080/1047840X.2015.1092493

Germer, C. & Neff, K. (2019). *Teaching the mindful self-compassion program.* The Guilford Press.

Giordano, A. L., Gorritz, F. B., Kilpatrick, E. P., Scoffone, C. M., & Lundeen, L. A. (2021). Examining secondary trauma as a result of clients' reports of discrimination. *International Journal for the Advancement of Counseling, 43*(1), 19–30. https://doi.org/10.1007/s10447-020-09411-z

Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. Journal of Counseling and Development, 82(3), 354-364. https://doi.org/10.1002/j.1556-6678.2004.tb00321.x

Hallam, K. T., Leigh, D., Davis, C., Castle, N., Sharples, J., & Collett, J. D. (2021). Self-care agency and self-care practice in youth workers reduces burnout risk and improves compassion satisfaction. *Drug and Alcohol Review, 40*(5), 847–855. https://doi.org/10.1111/dar.13209

Hatch-Maillette, M. A., Harwick, R., Baer, J. S., Masters, T., Cloud, K., Peavy, M., Wiest, K., Wright, L., Beadnell, B., & Wells, E. A. (2019). Counselor turnover in substance use disorder treatment research: Observations from one multisite trial. *Substance Abuse, 40*(2), 214–220. https://doi.org/10.1080/08897077.2019.1572051

Heath, B. B. (2022). *The effects of the global COVID-19 pandemic on pastors in the Church of the Nazarene.* Doctoral Dissertations, Ed.D. Liberty University.

Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4th ed.). Cengage Learning, Inc.

Horesh, D., & Brown, A. D. (2020). Traumatic stress in the age of COVID-19: A call to close critical gaps and adapt to new realities. *Psychological Trauma: Theory, Research, Practice and Policy, 12(4*), 331–335. https://doi.org/10.1037/tra0000592

Huggard, P., Law, J., & Newcombe, D. (2017). A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug counselors. *Australasian Journal of Disaster and Trauma Studies, 21*(2), 65–72.

Impellizzeri, J., Savinsky, D. M., King, J. A., & Leitch-Alford, L. (2017). Conceptual mapping task: An effective verification tool for qualitative counseling research. *Counseling Outcome Research and Evaluation, 8*(1), 31–47. https://doi.org/10.1080/21501378.2017.1327745

Jarrad, R., Hammad, S., Shawashi, T., & Mahmoud, N. (2018). Compassion fatigue and substance use among nurses. *Annals of General Psychiatry, 17*(1), 1-13. https://doi.org/10.1186/s12991-018-0183-5

Johansen, A. B., Kristiansen, E., Bjelland, I., & Tavakoli, S. (2019). Secondary traumatic stress in Norwegian SUD-therapists: Symptoms and related factors. *Nordisk Alkohol- & Narkotikatidskrift : NAT, 36*(6), 522-531. https://doi.org/10.1177/1455072519847014

Jones, C. T., & Branco, S. F. (2020). Trauma-Informed Supervision: Clinical supervision of substance use disorder counselors. *Journal of Addictions & Offender Counseling, 41*(1), 2-17. https://doi.org/10.1002/jaoc.12072

Jorgensen, M. F., Bender, S., & McCutchen, A. (2021). "I'm haunted by it:" Experiences of licensed counselors who had a client die by suicide. *Journal of Counselor Leadership and Advocacy, 8*(2), 100-115. https://doi.org/10.1080/2326716X.2021.1916790

Jun, J., Tucker, S., & Melnyk, B. M. (2020). Counselor mental health and well-being during global healthcare crises: Evidence learned from prior epidemics for COVID-19 pandemic. Worldviews on Evidence-Based Nursing, 17(3), 182-184. https://doi.org/10.1111/wvn.12439

Kapoulitsas, M., & Corcoran, T. (2015). Compassion fatigue and resilience: A qualitative analysis of social work practice. Qualitative Social Work: QSW: *Research and Practice, 14*(1), 86-101. https://doi.org/10.1177/1473325014528526

Kelly, E., Pasquarella, F. J., Davis, L., Hunt, A., Lee, S., Fairhurst, S., Giambone, L., Murch, L., Thorning, H., & Brekke, J. S. (2021). Managing substance use for clients with serious mental illnesses: Knowledge, attitude, and training challenges among outpatient behavioral health providers in California, Ohio, and New York. *Journal of Substance Abuse Treatment*, 131, 108547-108547. https://doi.org/10.1016/j.jsat.2021.108547

King, J. A. (2013). The essence of becoming men: Maturation of boys into adulthood.

Knudsen, H. K., Roman, P. M., & Abraham, A. J. (2013). Quality of clinical supervision and counselor emotional exhaustion: The potential mediating roles of organizational and occupational commitment. Journal of Substance Abuse Treatment, 44(5), 528-533. https://doi.org/10.1016/j.jsat.2012.12.003

Lawson, G., & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? Journal of Counseling and Development, 89(2), 163-171. https://doi.org/10.1002/j.1556-6678.2011.tb00074.x

Leitch-Alford, L. (2006). *I think I might be in over my head: A study of counselor ethical decision-making patterns in boundaries of competence situations*. Doctoral dissertation. Available from ProQuestDissertations and Theses database. (UMI No. 3272158)

Leshner, A. I., Mancher, M., National Academies of Sciences, Engineering, and Medicine (U.S.). Committee on Medication-Assisted Treatment for Opioid Use Disorder, Board on Health Sciences Policy, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine, & Committee on Medication-Assisted Treatment for Opioid Use Disorder. (2019). In Alan I. Leshner, Michelle Mancher (Eds.), Medications for opioid use disorder save lives. *National Academies Press*. https://doi.org/10.17226/25310

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

López-Pelayo, H., Aubin, H., Drummond, C., Dom, G., Pascual, F., Rehm, J., Saitz, R., Scafato, E., & Gual, A. (2020). "The post-COVID era": Challenges in the treatment of substance use disorder (SUD) after the pandemic. BMC Medicine, 18(1), 241-249. https://doi.org/10.1186/s12916-020-01693-9

Mandavia, A. D., Campbell, A., Henry, B. F., Chaple, M., Hunt, T., Arout, C., Wu, E., Pincus, H. A., Nunes, E. V., Lincourt, P., Levin, F. R., & El-Bassel, N. (2022). Support for COVID-19-related substance use services policy changes: A New York State-wide survey. *The Journal of Behavioral Health Services & Research* https://doi.org/10.1007/s11414-021-09784-y

Manjaly, Z., & Iglesias, S. (2020). A computational theory of mindfulness-based cognitive therapy from the "Bayesian brain" perspective. *Frontiers in Psychiatry*, *11*(404). https://doi.org/10.3389/fpsyt.2020.00404

Martin, J. (1987). Cognitive change in clients: Cognitive-mediational models. *Counselor Education and Supervision, 26*(3), 192-203. https://doi.org/10.1002/j.1556-6978.1987.tb00718.x

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

Martin, J., Slemon, A. G., Hiebert, B., Hallberg, E. T., & Cummings, A. L. (1989). Conceptualizations of novice and experienced counselors. *Journal of Counseling Psychology, 36*(4), 395–400. https://doi.org/10.1037/0022-0167.36.4.395

Meany-Walen, K. K., Davis-Gage, D., & Lindo, N. A. (2016). The impact of wellness-focused supervision on mental health counseling practicum students. *Journal of Counseling and Development, 94*(4), 464-472. https://doi.org/10.1002/jcad.12105

Melamed, O. C., deRuiter, W. K., Buckley, L., & Selby, P. (2021). COVID-19 and the impact on substance use disorder treatments. The Psychiatric Clinics of North America, https://doi.org/10.1016/j.psc.2021.11.006

Maslow, A. (1970). *Motivation and personality* (2nd ed.). New York, NY: Harper & Row.

Milhorn, H. T. (2018). *Substance use disorders: A guide for the primary care provider*. Springer.

Miller, G. E., Chen, E., & Parker, K. J. (2011). Psychological stress in childhood and susceptibility to the chronic diseases of aging: Moving toward a model of behavioral and biological mechanisms. *Psychological Bulletin, 137*(6), 959–997. https://doi.org/10.1037/a0024768

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. *Traumatology, 23*(2), 129–142. https://doi.org/10.1037/trm0000122

Montoya, A. L., & Summers, L. L. (2021). Eight dimensions of wellness for educators. *The Journal of Staff Development, 42*(1), 49-62.

Moustakas, C. (1994). *Phenomenology and the social sciences.* Northwestern University Press.

Mullen, P. R., Blount, A. J., Lambie, G. W., & Chae, N. (2017). School counselors' perceived stress, burnout, and job satisfaction. *Professional School Counseling, 21*(1), 2156759. https://doi.org/10.1177/2156759X18782468

Muratori, M. C. (2001). Examining supervisor impairment from the counselor trainee's perspective. *Counselor Education and Supervision, 41*(1), 41-56. https://doi.org/10.1002/j.1556-6978.2001.tb01267.x

Myers, J. E. (2009). Wellness through social interest: The goal of helping. In T. J. Sweeney (Ed.), *Adlerian counseling and psychotherapy: A practitioner's approach* (pp. 33–44). New York, NY: Routledge.

Myers & Sweeney, 2004 - Myers, J. E., & Sweeney, T. J. (2004). Advocacy for the counseling profession: Results of a national survey. Journal of Counseling and Development, 82(4), 466-471. https://doi.org/10.1002/j.1556-6678.2004.tb00335.x

Myers & Sweeney, 2008 - Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. Journal of Counseling and Development, 86(4), 482-493. https://doi.org/10.1002/j.1556-6678.2008.tb00536.x

Nesoff, E. D., Marziali, M. E., & Martins, S. S. (2021). The estimated impact of state-level support for expanded delivery of substance use disorder treatment during the COVID-19 pandemic. Addiction (Abingdon, England), https://doi.org/10.1111/add.15778

New International Version Bible. (2011). Zondervan. (Original work published 1978).

New York State Department of Health. (2021). *New York State Opioid Annual Data Report.* Retrieved [March 20th, 2023] from https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2021.pdf

Novak, J. D. (1990). Concept mapping: A useful tool for science education. *Journal of Research in Science Teaching, 27*(10), 937-949. https://doi.org/10.1002/tea.3660271003

Oberfeld, B., Achanta, A., Carpenter, K., Chen, P., Gilette, N. M., Langat, P., Said, J. T., Schiff, A. E., Zhou, A. S., Barczak, A. K., & Pillai, S. (2020). Snapshot: COVID-19. *Cell*, *181*(4), 954-954.e1. https://doi.org/10.1016/j.cell.2020.04.013

Oesterle, T. S., Kolla, B., Risma, C. J., Breitinger, S. A., Rakocevic, D. B., Loukianova, L. L., Hall-Flavin, D. K., Gentry, M. T., Rummans, T. A., Chauhan, M., & Gold, M. S. (2020). Substance use disorders and telehealth in the COVID-19 pandemic era: A new outlook. *Mayo Clinic Proceedings*, 95(12), 2709–2718. https://doi.org/10.1016/j.mayocp.2020.10.011

Office of Addiction Services and Support. *About us.* Retrieved from https://oasas.ny.gov/about

Office of Addiction Services and Support. (2017). *Credentialed Alcoholism and Substance Abuse Counselor: CASAC, CASAC 2, CASAC* – Advanced. New York State https://oasas.ny.gov/system/files/documents/2021/04/casac-initial-application.pdf

Okoli, C. T. C., Seng, S., Otachi, J. K., Higgins, J. T., Lawrence, J., Lykins, A., & Bryant, E. (2020). A cross-sectional examination of factors associated with compassion satisfaction and compassion fatigue across healthcare workers in an academic medical centre. International Journal of Mental Health Nursing, 29(3), 476-487. https://doi.org/10.1111/inm.12682

Oser, C. B., Biebel, E. P., Pullen, E., & Harp, K. L. H. (2013). Causes, consequences, and prevention of burnout among substance abuse treatment counselors: A rural versus urban comparison. *Journal of Psychoactive Drugs, 45*(1), 17-27. https://doi.org/10.1080/02791072.2013.763558

Padmanabhanunni, A. (2020). The cost of caring: Secondary traumatic stress and burnout among lay trauma counsellors in the Western Cape province. *South African Journal of Psychology, 50*(3), 385-394. https://doi.org/10.1177/0081246319892898

Perkins, E. B., & Sprang, G. (2013). Results from the pro-QOL-IV for substance abuse counselors working with offenders. *International Journal of Mental Health and Addiction, 11*(2), 199-213. https://doi.org/10.1007/s11469-012-9412-3

Peters E. (2018). Compassion fatigue in nursing: A concept analysis. *Nursing forum, 53*(4), 466–480. https://doi.org/10.1111/nuf.12274

Petersen, E. J., Thurmond, S. M., & Jensen, G. M. (2021). Severity, Irritability, Nature, Stage, and Stability (SINSS): A clinical perspective. *The Journal of manual & manipulative therapy, 29*(5), 297–309. https://doi.org/10.1080/10669817.2021.1919284

Powell, K. G., Treitler, P., Peterson, N. A., Borys, S., & Hallcom, D. (2019). Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse. *The International Journal of Drug Policy, 64*, 21-29. https://doi.org/10.1016/j.drugpo.2018.12.004

ProQOL. (2021). *ProQOL measure*. Retrieved [March 20th, 2023] from: https://proqol.org/proqol-measure

Redman, M., Pearce, J., Gajebasia, S., Johnson, M., & Finn, G. (2017). Care of the dying: A qualitative exploration of foundation year doctors' experiences. *Medical Education. 51*(10), 1025-1036. https://doi.org/10.1111/medu.13358

Reyes, D. E. (2022). *Walking the talk: A phenomenological study on wellness of graduate Counseling students at a Christian university.* Doctoral Dissertations, Ed.D. Liberty University.

Reyre, A., Jeannin, R., Largueche, M., Moro, M. R., Baubet, T., & Taieb, O. (2017). Overcoming professionals' challenging experiences to promote a trustful therapeutic alliance in addiction treatment: A qualitative study. *Drug and Alcohol Dependence, 174*, 30-38. https://doi.org/10.1016/j.drugalcdep.2017.01.015

Robino, A. E. (2019). Global compassion fatigue: A new perspective in counselor wellness. *The Professional Counselor (Greensboro, N.C.), 9*(4), 272-284. https://doi.org/10.15241/aer.9.4.272

Romance, A. A. (2020). Bearing witness to the epidemic: Supporting counselors after a client overdose death. *Practice Innovations.*, *5*(4), 275–289. https://doi.org/10.1037/pri0000115

Rothan, H. A., & Byrareddy, S. N. (2020). The epidemiology and pathogenesis of coronavirus disease (COVID-19) outbreak. *Journal of Autoimmunity, 109*(102433), 102433. https://doi.org/10.1016/j.jaut.2020.102433

Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. *Journal of Substance Abuse Treatment, 40(*1), 67–76. https://doi.org/10.1016/j.jsat.2010.08.008

Russo-Netzer, P., Sinai, M., & Zeevi, M. (2020). Meaning in life and work among counsellors: A qualitative exploration. British Journal of Guidance & Counselling, 48(2), 209-226. https://doi.org/10.1080/03069885.2019.1625026

Saliba, Y., & Barden, S. (2017). Counselors and workplace wellness programs: A conceptual model. *The Professional Counselor, 7*(2), 104-113. https://doi.org/10.15241/ys.7.2.104

Schwartz, R., Sinskey, J. L., Anand, U., & Margolis, R. D. (2020). Addressing post-pandemic counselor mental health: A narrative review and conceptual framework. Annals of Internal Medicine, 173(12), 981–988. https://doi.org/10.7326/M20-4199

Shepherd, M. A., & Newell, J. M. (2020). Stress and health in social workers: Implications for self-care practice. *Best Practices in Mental Health, 16*(1), 46–65.

Shoptaw, S., Stein, J. A., & Rawson, R. A. (2000). Burnout in substance abuse counselors: Impact of environment, attitudes, and clients with HIV. *Elsevier Inc.* https://doi.org/10.1016/S0740-5472(99)00106-3

Silver, J., Caleshu, C., Casson-Parkin, S., & Ormond, K. (2018). Mindfulness among genetic counselors is associated with increased empathy and work engagement and decreased burnout and compassion fatigue. *Journal of Genetic Counseling, 27*(5), 1175–1186. https://doi.org/10.1007/s10897-018-0236-6

Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of Clinical Psychology, 74*(9), 1431–1456. https://doi.org/10.1002/jclp.22615

Sinclair, S., Raffin-Bouchal, S., Venturato, L., Mijovic-Kondejewski, J., & Smith-MacDonald, L. (2017). Compassion fatigue: A meta-narrative review of the healthcare literature. *International Journal of Nursing Studies, 69*, 9-24. https://doi.org/10.1016/j.ijnurstu.2017.01.003

Singh, J., Karanika-Murray, M., Baguley, T., & Hudson, J. (2020). A systematic review of job demands and resources associated with compassion fatigue in mental health professionals. *International Journal of Environmental Research and Public Health, 17*(19), 6987. https://doi.org/10.3390/ijerph17196987

Skinner, N., & Roche, A. M. (2021). 'Very demanding. extremely rewarding': Exploring the co-occurrence of burnout and engagement in alcohol and other drug workers. *Drug and Alcohol Review, 40*(6), 989–997. https://doi.org/10.1111/dar.13250

Skovholt, T. M., & Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout and compassion fatigue prevention and self-care strategies for the helping professions.* Routledge.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice.* The Guilford Press. Retrieved [March 20th, 2023] from https://www.guilford.com

Smarinsky, E. C., Brown, C. L., & Christian, D. D. (2023). Examining the effects of a mindfulness-based intervention using a neurofeedback device on adolescent introspection: A quasi-experimental time-series design. *Counseling Outcome Research and Evaluation, 14*(1), 43-57. https://doi.org/10.1080/21501378.2021.2017770

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

Substance Abuse and Mental Health Services Administration (2016). Creating a healthier life: A A step-by-step guide to wellness. Retrieved [March 20th, 2023] from https://store.samhsa.gov/product/Creating-a-Healthier-Life/SMA16-4958

Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS publication no. PEP19-5068, NSDUH Series H- 54). Rockville, MD Retrieved [March 20th, 2023] from https://www.samhsa.gov/data/.

Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, 6(3), 733-739. https://doi.org/10.1002/nop2.275

Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal, 29*(4), 311-314. https://doi.org/10.2975/29.2006.311.314

Sweeney, T. J. (2019). *Adlerian counseling and psychotherapy: A practitioner's wellness approach* (6th ed.). New York, NY: Routledge.

Tartakovsky, E., Ph.D., & Kovardinsky, S., M.S.W. (2013). Therapeutic orientations, professional efficacy, and burnout among substance abuse social workers in Israel. *Journal of Substance Abuse Treatment, 45(*1), 91-98. https://doi.org/10.1016/j.jsat.2013.01.002

Thieleman, K., & Cacciatore, J. (2014). Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. *Deutsches Zentralinstitut für soziale Fragen/DZI*. https://doi.org/10.1093/sw/swt044

Todd, C. (2022) *Erie County opioid task force updates the community on overdoses.* [Comment on the webpage Spectrum Local News]. Retreived [November 8th, 2022] from https://spectrumlocalnews.com/nys/buffalo/news/2021/11/08/erie-county-opioid-task-force-updates-the-community-on-overdoses-?cid=share_clip

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling, 36*(1), 58–77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Trivedi, H. K. (2022). Sheppard Pratt: Lessons learned during COVID across a system of care. The Psychiatric Clinics of North America, 45(1), 211-225. https://doi.org/10.1016/j.psc.2021.11.015

Tzu, G., Bannerman, B., & Hill, N. (2017). From grey nothingness to holistic healing: A non-dual approach to the treatment of burnout. *International Journal of Mental Health and Addiction, 15*(3), 652-669. https://doi.org/10.1007/s11469-016-9701-3

Urmanche, A. A. (2020). Bearing witness to the epidemic: Supporting clinicians after a client overdose death. *American Psychological Association, 5*(4), 275-289. http://dx.doi.org/10.1037/pri0000115

Vallecillo, G., Perelló, R., Güerri, R., Fonseca, F., & Torrens, M. (2021). Clinical impact of COVID-19 on people with substance use disorders. *Journal of Public Health*, 43(1), 9-12. https://doi.org/10.1093/pubmed/fdaa181

Van Der Kolk, B. A, & Van Der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. The American Journal of Psychiatry, 146(12), 1530-1540. https://doi.org/10.1176/ajp.146.12.1530

Wagner, N. J., Grunhaus, C. M. L., & Tuazon, V. E. (2020). Agency responses to counselor survivors of client suicide. *The Professional Counselor* (Greensboro, N.C.)*, 10*(2), 251-265. https://doi.org/10.15241/njw.10.2.251

Wani, R. J., Wisdom, J. P., & Wilson, F. A. (2019). Emergency department utilization for substance use-related disorders and assessment of treatment facilities in New York State, 2011-2013. *Substance use & Misuse, 54*(3), 482-494.

https://doi.org/10.1080/10826084.2018.1517801

Warlick, C. A., Farmer, N. M., Frey, B. B., Vigil, K., Armstrong, A., Krieshok, T. S., & Nelson, J. (2021). Cost borne by the counselor: Comparing burnout between dialectical behavior therapy (DBT) counselors and Non-DBT counselors. *Journal of Counseling and Development, 99*(3), 302–314. https://doi.org/10.1002/jcad.12376

Warner, R. M. (2021). *Applied statistics II: Basic bivariate techniques* (3rd ed). Sage Publications

Wells-English, D., Giese, J., & Price, J. (2019). Compassion fatigue and satisfaction. *Clinical Journal of Oncology Nursing, 23*(5), 487–493. https://doi.org/10.1188/19.CJON.487-493

Wilcoxon, S. A., Remley, T. P., & Gladding, S. T. (2013). *Ethical, legal, and professional issues in the practice of marriage and family therapy* (5th ed.). Pearson Education Inc.

Williamson, E. J., Walker, A. J., Bhaskaran, K., Bacon, S., Bates, C., Morton, C. E., Curtis, H. J., Mehrkar, A., Evans, D., Inglesby, P., Cockburn, J., McDonald, H. I., MacKenna, B., Tomlinson, L., Douglas, I. J., Rentsch, C. T., Mathur, R., Wong, A. Y. S., Grieve, R., Harrison, D., … Goldacre, B. (2020). Factors associated with COVID-19-related death using OpenSAFELY. *Nature, 584*(7821), 430–436. https://doi.org/10.1038/s41586-020-2521-4

Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development, 71*(2), 140–148. doi:10.1002/j.1556-6978.2013.00041.x

Xu, Y., Harmon-Darrow, C., & Frey, J. J. (2019). Rethinking professional quality of life for social workers: Inclusion of ecological self-care barriers. *Journal of Human Behavior in the Social Environment, 29*(1), 11–25. https://doi.org/10.1080/10911359.2018.1452814

Yager, G.G. & Tovar-Blank, Z.G. (2007) Wellness and counselor education. *The Journal of Humanistic Counseling, Education and Development, 46*(2), 142-153. https://doi.org/10.1002/j.2161-1939.2007.tb00032.x

Yaseen, Z. S., Galynker, I. I., Cohen, L. J., & Briggs, J. (2017). Counselors' conflicting emotional responses to high suicide-risk patients—association with short-term suicide behaviors: A prospective pilot study. *Comprehensive Psychiatry, pp. 76*, 69–78. https://doi.org/10.1016/j.comppsych.2017.03.013

Zabukovic, B. W., Wisniewski, N. G., & Vachon, D. O. (2021). A compassionate communication refresher for clinicians experiencing COVID fatigue: If the stress of the pandemic has challenged your patient communication skills, here's how you can reestablish rapport. *Family Practice Management, 28*(4), 30.

Zhang, L., Ren, Z., Jiang, G., Hazer-Rau, D., Zhao, C., Shi, C., Lai, L., & Yan, Y. (2021). Self-Oriented Empathy and Compassion Fatigue: The Serial Mediation of Dispositional Mindfulness and Counselor's Self-Efficacy. *Frontiers in Psychology*, *11*, 613908. https://doi.org/10.3389/fpsyg.2020.613908

Zhen-Duan, J., Gade, N., Falgas-Bagué, I., Sue, K. L., DeJonckheere, M., & Alegría, M. (2022). Using a structural vulnerability framework to understand the impact of COVID-19 on the lives of Medicaid beneficiaries receiving substance use treatment in New York City. Health Services Research, https://doi.org/10.1111/1475-6773.13975

Appendices

Appendix A

Letter to Professional Substance Use Counselors

Dear Substance Use Counselor,

I am conducting research to *understand the impact of compassion fatigue, burnout, and secondary trauma on substance use counselors during the COVID-19 pandemic*. Your voice should provide valuable information to us as professional providers as we navigate our COVID-19 protocols. As a doctoral student in the School of Behavioral Sciences/Department of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for an Ed.D. Degree in Community Care and Counseling to better understand the impact of burnout, compassion fatigue, and secondary trauma on the counselor and the quality of care we as professionals provide to individuals with substance use disorders and their families.

As a professional SUD counselor, you interact with SUD clients daily and, therefore, would be an excellent source for recommending qualified parents who could participate in this study. In honor of client privacy and HIPAA requirements constraints, I am only requesting that you allow the posting of recruitment flyers or that you provide recruitment letters to qualified counselors. Information about the study and researcher is listed on the recruitment letter, where counselors will be directed to contact the researcher through text, email, or phone if they are interested.

For the participants, the researcher will conduct only one in-depth, semi-structured interview lasting around 90 -120 minutes in a private setting selected by the participant or in a therapy office. SUD counselors will be screened to maximize diversity but must be substance use counselors before 2020.

Contacts and Questions: The researcher conducting this study is Jennifer Galvano, phone: 716-930-0493 or by email at jagalvano@liberty.edu. You may also contact the researcher's faculty chair, Dr. John King, at jking105@liberty.edu.

Suppose you have any questions or concerns regarding this study and want to talk to someone other than the researcher. In that case, contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Thank you in advance for your assistance in finding qualified participants for this study. Your professionalism and care for individuals struggling with addiction are greatly appreciated.

Jennifer Galvano, MA, CASAC-T, doctoral candidate

Appendix B

Recruitment Letter

Dear Potential Participant:

This study aims to understand the impact of compassion fatigue, burnout, and secondary trauma on substance use counselors during the COVID-19 pandemic. The SUD counselor's voice is one of the most critical factors in attempting to understand how changes to care may have impacted both the counselor and the people treated with SUD. I sincerely hope you will consider participating in this study. As a graduate student in the School of Behavioral Sciences/Department of Community Care and Counseling at Liberty University, I am conducting research as part of the requirements for an Ed.D. in Community Care and Counseling to further our professional understanding of treatment during COVID-19 and beyond.

Suppose you are a SUD counselor working with individuals struggling with addiction before 2020 and are willing to participate. In that case, you will be asked to complete a short demographic questionnaire and potentially be selected to be interviewed. The interview should take approximately 1.5 to 2 hours for you to complete. Your name and other identifying information will be requested as part of your participation, but the information will remain confidential in strict adherence to ethical guidelines.

To participate, contact me via voice or text to schedule an interview at 716-930-0493 or email at jagalvano@liberty.edu.

Sincerely,

Jennifer Galvano, MA, CASAC-T
Doctoral Candidate
School of Behavioral Sciences
Department of Community Care and Counseling

Appendix C

Part I: Participant Screening Instrument (Phone)

Hello, and thank you for your time and willingness to participate in this study. My name is Jennifer Galvano, Doctoral Candidate at Liberty University, and I am in the research phase of my dissertation entitled A PHENOMENOLOGICAL STUDY ON THE CONTRIBUTORS OF COMPASSION FATIGUE WITH SUBSTANCE USE DISORDER COUNSELORS DURING THE COVID-19 OUTBREAK IN WESTERN NEW YORK. You were selected by professionals in the field of SUD care and given this phone number to begin the participant process. I have a few follow-up questions to ensure your participation would fit this study well. We could talk about 10 to 15 minutes now, or if we can schedule another time for me to contact you, that would be more convenient.

If the nominee says, they can talk now, then proceed with protocol. If the nominee cannot talk now, say: "Then let us schedule a convenient time." At the conclusion, the nominee will be thanked for their time.

As we begin, I have a few questions I would like to ask you:

1. Are you a substance use disorder counselor?
    - ***If the nominee answers no to this question, say, "Thank you for your willingness to talk with me. Being a substance use disorder counselor is a qualifying factor for participation in this study. Thank you for your time."***
    - ***If the nominee answers yes to this question, then go on to question #2.***
2. Have you been a SUD counselor both before 2020 and during the COVID-19 pandemic to the present?

- ***If the nominee answers no, say, "Thank you for your willingness to talk with me. Being a SUD counselor before 2020 and during the COVID-19 pandemic is a qualifying factor for participation in this study. Thank you for your time.***

If the nominee answers yes to Question #2, then say, "To ensure that the study includes participants from different social locations, I have a few demographic questions I would like to ask you; would that be okay? What is your current working situation in terms of inpatient or outpatient? What are the years in this profession, your age, approximate annual income, whether you live in a rural, suburban, or urban area, and how do you describe your race, ethnicity, and sex?

If the nominee is a potential participant, say, *"Thank you for your information. I will get back to you and let you know if you have been selected to participate in the study. Various factors are going into who will ultimately be chosen as participants for my study based on demographic factors. My goal is to choose people that fit the best for my research, so if you are not chosen, it in no way reflects on your ability or capabilities. I want to ensure I have your contact information (double check on e-mail and phone number from the nomination form). If you are chosen to be one of the participants, I will contact you when Liberty University approves this study. If you have not heard from me, you can assume you have not been chosen. Do you have any questions for me? (Answer questions, and thank the nominee for their time).*

Continue Conversation (if the nominee is chosen for the participant pool): I would like to talk with you further about this study. May I continue? (Obtain verbal consent). The process of my research will occur through one lengthy interview that will likely last between 90 minutes and 2 hours. You do not need to prepare for this interview. However, I would like to meet with you at a comfortable and confidential location in a therapy clinic in Western New

York or an equally suitable location that is convenient to you and relatively free from distractions. I will also need for research purposes to audio record our interview. Your identity will be strictly guarded; I will use a pseudonym for you, and any identifying information will only be reported in aggregate or group form. At the beginning of our time together, I will go over an informed consent form that will provide details about your interview, the study, and your identity being confidential.

If you are willing to participate in my research, I would like to schedule a time for our interview, which will last between 90 minutes and two 2 hours. Do you have any questions before I go on with more information? (Answer questions).

Thank you for your time and willingness to talk with me and to be a participant in my research. Let us schedule a time and place to meet, ensuring that we have 2 hours of uninterrupted time should we need it. I will also need an e-mail address (preferably) to follow up on our phone conversation.

- Obtain contact information, meeting time, and location.

Then say, "Thank you for your time. I look forward to our conversation soon."

Part II: Initial Phone Screening Report

First Name:

Phone Number:

Date:

Inpatient or Outpatient_____. Number of years in the SUD profession _____. Counselor's age _____. Approximate household annual income _____.

Geography _____. Race _____. Ethnicity _____. Sex _____.

General Impressions of Nominee:

Is this Nominee a study participant?

YES NO Maybe (will consider in the future)

E-mail (or regular mail) address of Participant:

(Barry, 2023)

Appendix D

Participant Demographic Information Form

Date:

Participant Pseudonym and Number:

1. What is your current position?

2. When did you get your CASAC or CASAC-T?

3. What is the highest level of education you have completed?

4. How many clinical hours do you perform in an average week

5. How many groups do you currently run?

6. What is your current age?

7. What is your approximate average annual income for your household?

8. Do you live in a rural, suburban, or urban area?

9. How do you describe your race, ethnicity, and sex?

Appendix E

Sample E-Mail or Letter Text to Participant Before First Interview

Date

Name

Address

E-Mail

Dear _____,

Thank you very much for your willingness to participate in my study entitled A PHENOMENOLOGICAL STUDY ON THE CONTRIBUTORS OF COMPASSION FATIGUE WITH SUBSTANCE USE DISORDER COUNSELORS DURING THE COVID-19 OUTBREAK IN WESTERN NEW YORK. Based on our recent conversation, we are scheduled to meet at the following place and time:

I will do my best to ensure that our time together is no longer than two hours for this meeting. A consent document is attached to this letter for your convenience. The consent document contains additional information about my research. You will be asked to sign the consent document during the interview.

Thank you for your time. I look forward to our meeting.

Sincerely,

Jennifer Galvano

Jennifer Galvano, MA, CASAC-T
Doctoral Candidate, Department of Community Care and Counseling
Liberty University, School of Behavioral Sciences, Community Care and Counseling

Appendix F

CONSENT FORM

A Phenomenological Study on the Contributors of Compassion Fatigue with Substance Use Disorder Counselors during the COVID-19 Outbreak in Western New York.

Jennifer A. Galvano

Liberty University
School of Behavioral Sciences/ Department of Community Care and Counseling

You are invited to be in a research study of substance use disorder counselors' experience of burnout, compassion fatigue, and secondary trauma during COVID-19. This study will provide an opportunity for SUD counselors to share their experiences and feelings concerning the changes implemented in New York State by the Department of Health and OASAS, passed down to SUD counselors, and how that impacted you and your clinical practice by providing a platform for your voice to be heard. You were selected as a possible participant because you are a substance use disorder counselor. Please read this form and ask any questions you may have before agreeing to be in the study.

Jennifer Galvano, a doctoral candidate in the School of Behavioral Sciences/Department of Community Care and Counseling at Liberty University, is conducting this study.

Background Information: This study aims to understand how the changes in substance use professional care, required or influenced by the COVID-19 pandemic, impacted SUD counselors and practice to prepare care providers for future events better.

Procedures: If you agree to be in this study, I will ask you to do the following things:

1. Complete a Demographic Questionnaire. This should take approximately 10-15 minutes.
2. Participate in an interview which will be conducted with specific questions allowing the participant to tell their story and experience. This should take approximately 30 minutes.
3. Create a Conceptual Map (CM) representing this experience. This step should take approximately 15 minutes.
4. Reflect and discuss the symbols and ideas on the map to deepen your experience description. Time will be allowed for you to reflect on the map and make corrections or adjustments as needed. This should take approximately 15 minutes.

Risks: The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. Sharing feelings and memories may be traumatic or have a psychological effect. If this occurs, participants will be provided with a list of resources for

counseling if they need assistance. As a mandated reporter, I must report any disclosure of child abuse, neglect, elder abuse, or intent to harm myself or others.

Benefits: Participants should not expect a direct benefit from participating in this study. However, this study may affect SUD care providers' local and state communities by bringing SUD counselors' stories/experiences to them and providing them with concentrated feedback on the impact of their policies/changes during the pandemic. This study could have significant applications for New York, one of the most stringent states regarding lockdown and COVID-19 mitigation efforts, either supporting their decisions or encouraging them to consider new approaches. Listening to the stories of SUD counselors and understanding the implications of professional care changes in support of individuals with substance use disorder during the pandemic could significantly impact their policy and how they coordinate care for the future.

Compensation: Participants will not be compensated for participating in this study

Confidentiality: The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records. The researcher may share the data collected from you for use in future research studies or with other researchers; if your data is shared with other research, any information that could identify you, if applicable, will be removed. To further ensure anonymity and safety of personal information:

- Participants will be assigned a pseudonym. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked and encrypted thumb drive and may be used in future presentations. After three years, all electronic records will be deleted. Data will be locked in a 3-lock system: 1. Locked in a file cabinet; 2. Locked in the office; 3. Locked in the building. Data in spreadsheet form and audio recordings on the thumb drive will be encrypted, password-locked, and password-timed out.
- Interviews will be recorded and transcribed. Recordings will be stored on an encrypted thumb drive that is password-locked for three years and then erased. Only the researcher, chair, and reader can access these recordings.
- There are no limits to confidentiality, as participants will be interviewed separately.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision on whether or not to participate will not affect your current or future relations with Liberty University or the organization that referred you. If you decide to participate, you are free not to answer any question or withdraw at any time without affecting those relationships.

How to Withdraw from the Study: If you choose to withdraw, please contact the researcher at the email address/phone number in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Contacts and Questions: The researcher conducting this study is Jennifer Galvano. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 716-930-0493 or by email at jaglavano@liberty.edu. You may also contact the researcher's faculty chair, Dr. John King, at jking105@liberty.edu.

Suppose you have any questions or concerns regarding this study and want to talk to someone other than the researcher. In that case, contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515, or email at irb@liberty.edu.

Please notify the researcher if you would like a copy of this information for your records.

Statement of Consent: I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Signature of Participant Date

_____

Signature of Researcher Date

Appendix G

Full Interview Protocol

(Content extracted from Barry, 2023)

Thank you for your willingness to meet with me. As we begin, I would like to share an ***INFORMED CONSENT DOCUMENT*** *with you, and for the next few minutes, we will walk through this document and answer any questions you may have.* (Read through Appendix D and answer questions. Sign the consent form and make a copy for the participant and the researcher.)

I will now start our audio recording. (Turn on the audio recording. Test the equipment to make sure that it is working correctly.) *We will now spend roughly the next 60 to 90 minutes in an interview where I will ask you questions and probe for more information from these initial questions. We will walk through a conceptual mapping exercise, a straightforward visual exercise to help you organize your story. There are no wrong answers to questions, and you are encouraged to take your time and think deeply about your responses. As a researcher, I am very interested in the story of your experience. I will ask questions, solicit answers, and then probe deeper for more information. Are you ready?* (Make sure the participant is ready and there are no further questions.)

During this phase of our interview, I will record key ideas, concepts, and events on Post-it notes® while you share your story. I will first give you a statement that I would like you to reflect on for a few moments, and then when you are ready, please let me know, and you can proceed while I record some of your thoughts.

Let us take 15-20 minutes. In that time, please describe your experience of Substance Use counseling, regulations, SUD counselors, supervisors, mental health experts, and medical support during the COVID-19 pandemic.

Once the participant completes answering this question, ask the following question:

Can you please describe how the change in care during the pandemic impacted your well-being, clients, and office?

Please describe when you experienced burnout, compassion fatigue, or secondary trauma.

If you have experienced either of these situations, what techniques or tools can you use to help you through these times?

If you have not experienced either of these situations, what are some techniques and tools used to support you?

(For each question, pause after the asking to allow the participant to gather their thoughts and to ensure you are encouraging them to tell their story. Moreover, while the participant speaks, be prepared to ask further clarifying questions. When they indicate they are complete, then say:)

"I would now like you to look at each of the details I wrote on these Post-it notes® and ensure that these details are accurate and a proper reflection of your experience. Are there any other details you would like to add?"

Conceptual Mapping Task

Now that we have all the details checked and reviewed, I will give you the easel pad, which can be placed on your lap or the table for ease of use. I would like you to take each of these Post-it notes® and arrange them on the pad in a way that represents your lived experience of accessing the overall well-being of and the professional care for your client with SUD during the COVID-19 pandemic and how the concepts of these notes relate to each other.

"Wonderful! Thanks for doing that. I am now going to give you some colored markers. I would like you to draw a shape around each of the clusters of concepts; it can be a circle, triangle, square, star, heart, tree, etc. These shapes should represent the meaning of your cluster of concepts in a way that is important to you. Please feel free to make any comments you like about the process or the concepts as you are working."

After the CMT has been created, ask the following questions:

- *"Now that you have created this conceptual map about your lived experience of accessing the overall well-being of you and the professional care for your client with SUD during the COVID-19 pandemic, take a few minutes to reflect on it.* (Pause until participant indicates they are done reflecting.)
- *What strikes you as you look at your conceptual map?*
- *How have things changed for you during the pandemic because of your experience in accessing and providing clinical care for individuals struggling with addiction?*
- *What advice would you give yourself back in February of 2020 to improve your access and overall well-being and the professional care for your client with SUD now that you have lived through it?*
- *"Where are you now in your story?"*
- *"Is there anything else you feel compelled to say from this experience?"*

(Once the participant has had the opportunity to answer the questions, conclude the interview by saying:)

- *"Thank you very much for sharing your experience with me. Your time commitment to this project is significant, and I am very grateful. As mentioned previously, this interview has been audio recorded. I want to remind you that this audio recording and your*

conceptual map will be described in a way that will protect your confidentiality. If there ever comes a time when you have concerns about confidentiality regarding the conceptual map and your audio recording, please feel free to contact me. We can discuss your concerns and take further steps to ensure your confidentiality. Thank you again for participating and sharing your experiences."

Appendix H

Sample Letter to Participant After Face-to-Face Interview

Date

Name

Address

E-Mail

Dear _____,

Thank you very much for your willingness and time as a participant in my study entitled *A Phenomenological Study on the Contributors of Compassion Fatigue with Substance Use Disorder Counselors during the COVID-19 Outbreak in Western New York*. Your information is precious to this research, and I look forward to reviewing your responses, along with those of other participants in this study. I want to recognize that our conversation may have conjured up complicated feelings for some participants in my study. For that reason, I want to remind you that if you need further care around these issues, I am willing to provide referrals for mental health professionals who can work with you in dealing with these feelings.

As mentioned previously, your interview was audio-recorded. I want to remind you that the audio recording and your conceptual map will be described in my dissertation in a way that will protect your confidentiality. If there ever comes a time when you have concerns about confidentiality regarding the conceptual map and your audio recording, please feel free to contact me, and we can discuss your concerns and take further steps to ensure your confidentiality.

Thank you again for your time.

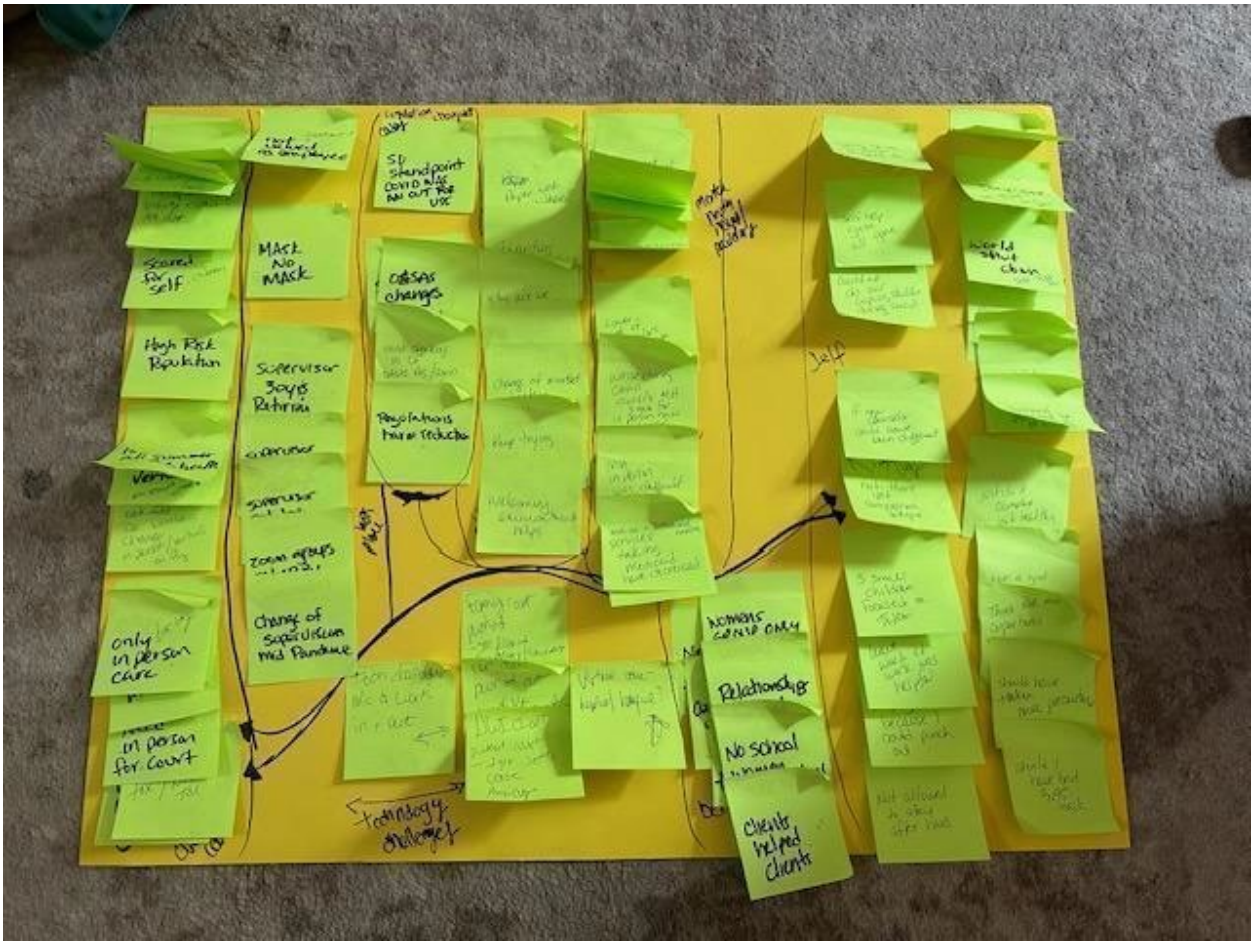
Sincerely,

Jennifer Galvano

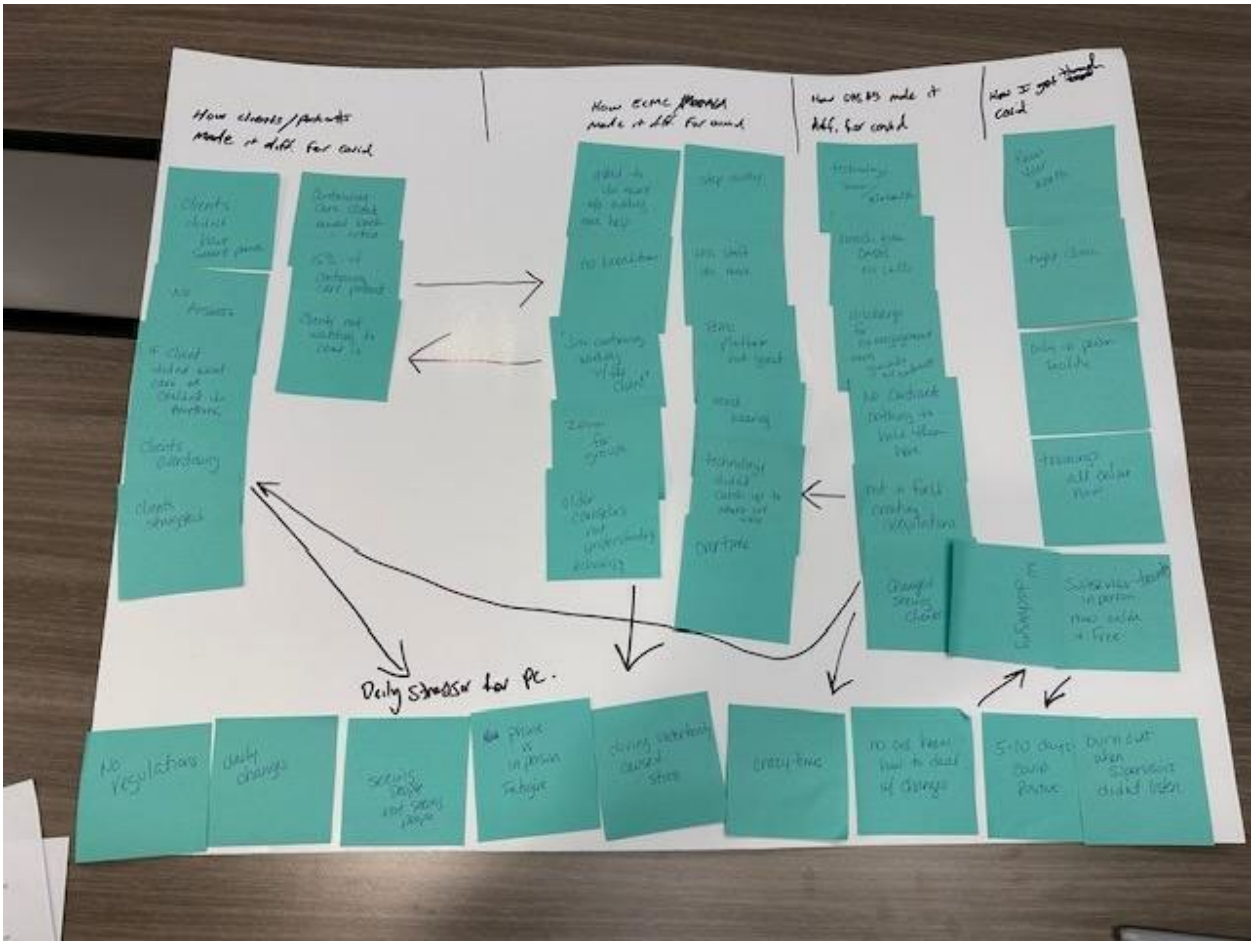
Jennifer Galvano, MA, CASAC-T
Doctoral Candidate, Department of Community Care and Counseling
Liberty University, School of Behavioral Sciences, Community Care and Counseling

Appendix K

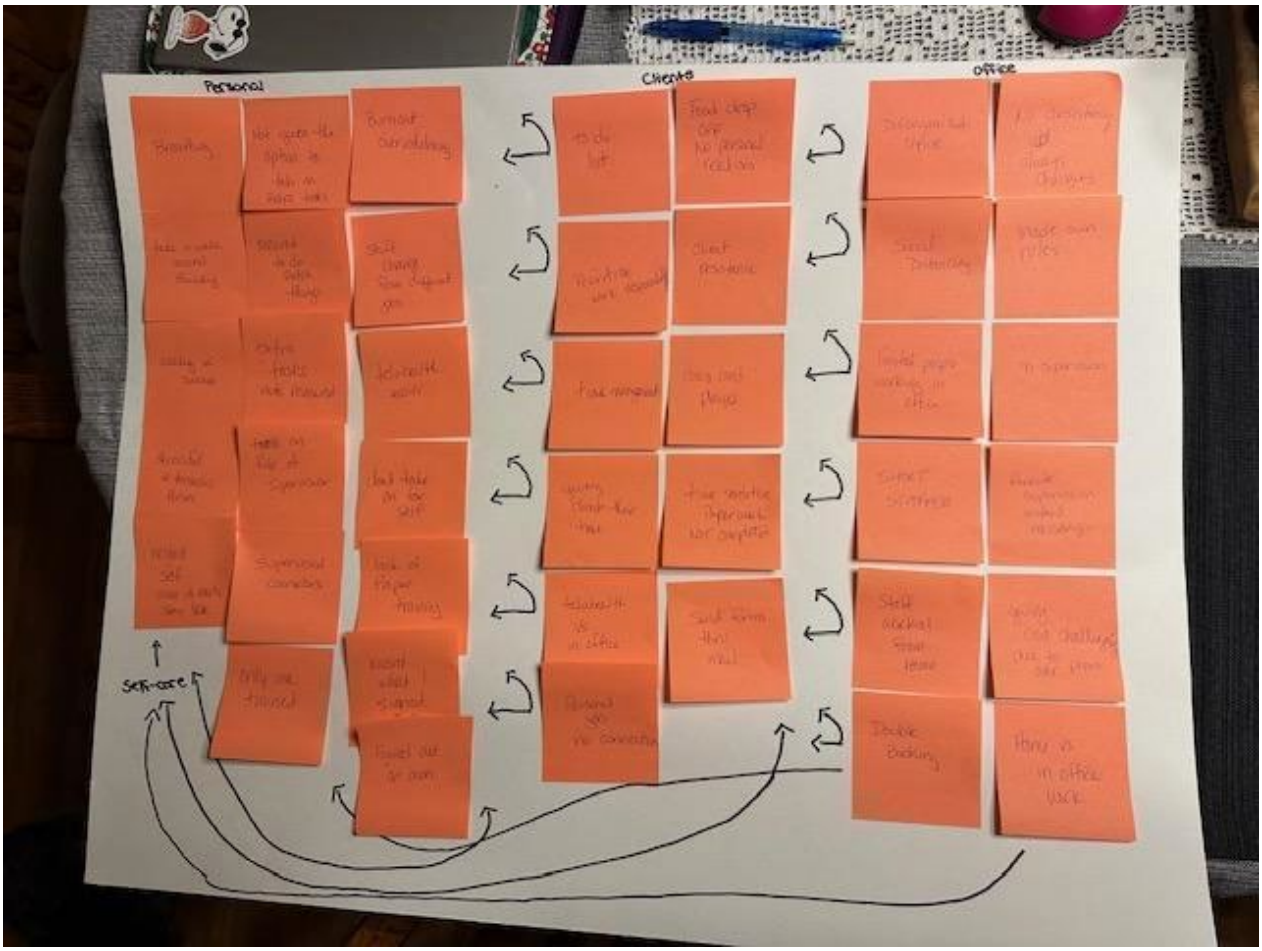
Pictures of the Participant Conceptual Mapping Task



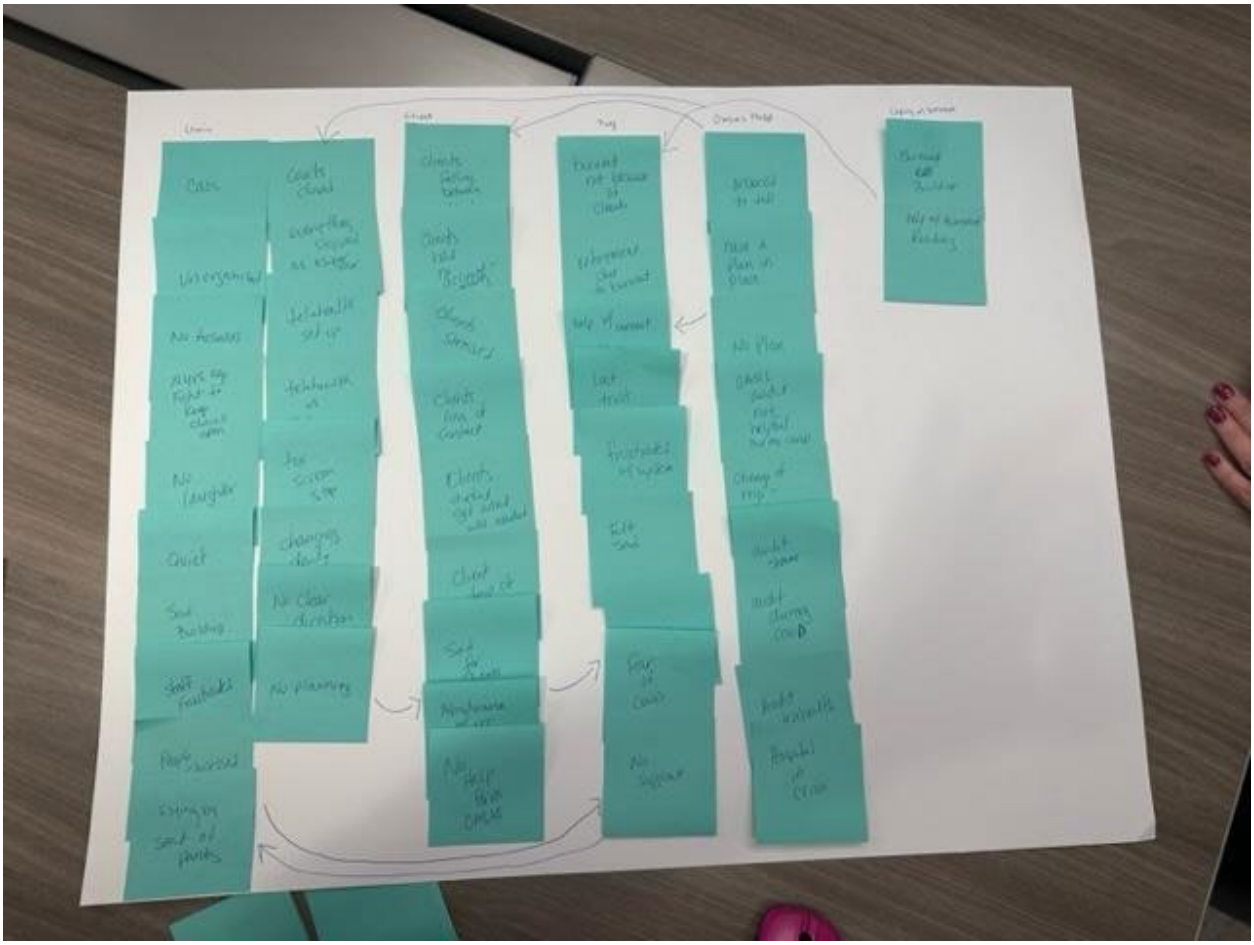
Claire's Conceptual Mapping Task



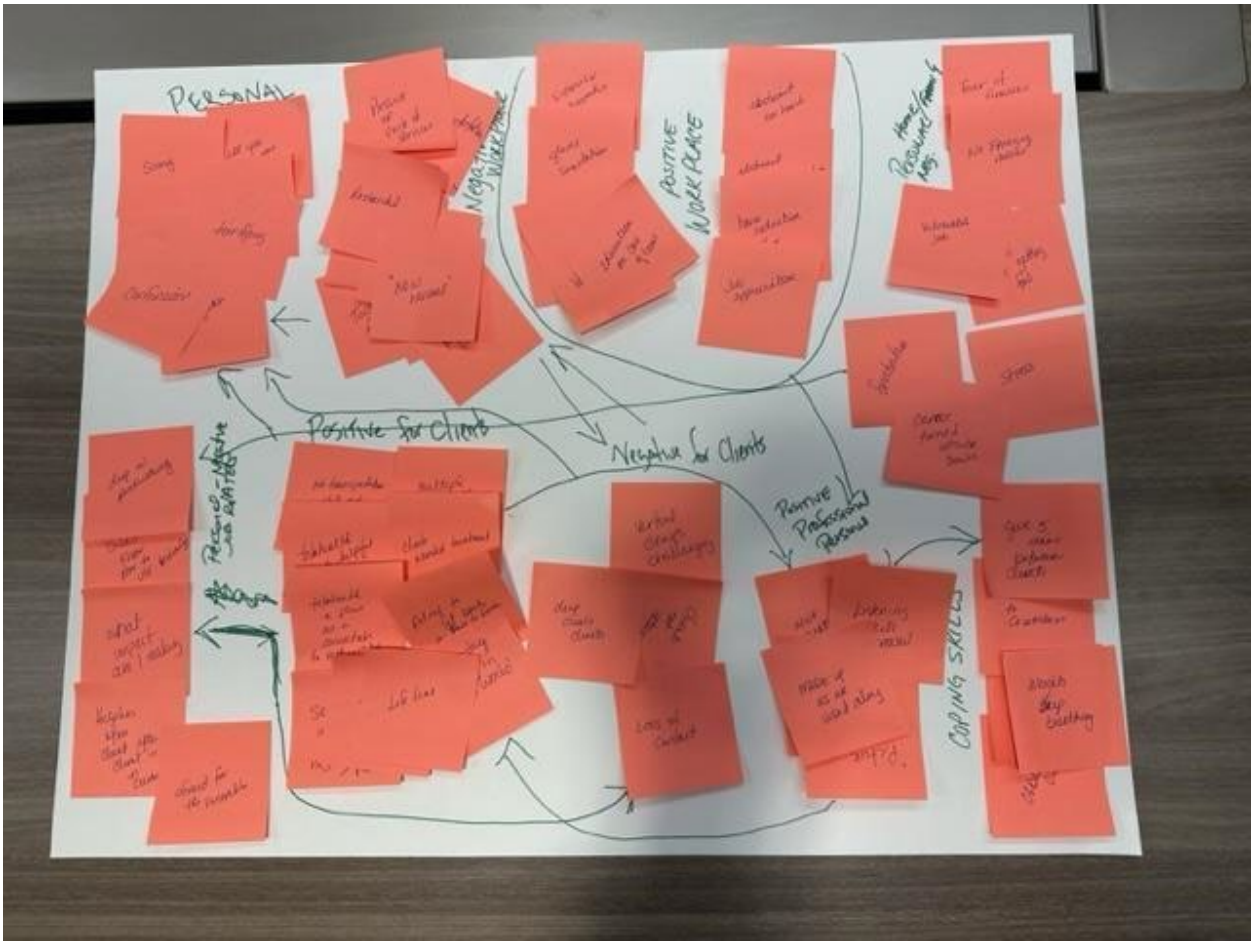
Charles' Conceptual Mapping Task



Harper's Conceptual Mapping Task



Ivy's Conceptual Mapping Task



Marie's Conceptual Mapping Task